SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

2002 ANNUAL MEETING

Philadelphia, PA ■ May 18-23, 2002

PROCEEDINGS SUMMARY

FOR YOUR RECORDS

The Certificate of Attendance below is for your personal records.

This is to certify that

_____

was a registered
participant at the
155th Annual Meeting of the APA
Philadelphia, PA, May 18-23, 2002
President's Theme: The 21st Century Psychiatrist

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

Richard Harding, M.D.
APA President

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Medical Director

James W. Thompson, M.D.
Director, Division of Education, Minority and National Affairs

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 up to 66 hours in Category 1 credit towards the Physician's Recognition Award of the American Medical Association and for the CME requirement of the APA. Each physician should claim only those hours of credit 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 18-23, 2002, Philadelphia, PA

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

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

American Psychiatric Association
Continuing Medical Education Requirement

APA Continuing Medical Education Requirement

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

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

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

Obtaining an APA CME Certificate

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, 1400 K Street NW, Washington DC 20005, 202-682-6179, or on the APA website 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 a 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 Category 1 credits for each hour of lecture to a maximum of 10 credits per year. 2 AMA PRA Category 1 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. These include the certifying examinations 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 within 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-FIFTH
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

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May 18-23, 2002

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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 Sheena Majette, Kendra Grant, Robbie Morsette, and Frank Berry in the APA Annual Meetings Department.

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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.

2002 ANNUAL MEETING
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1. AIDS and HIV-Related Disorders
2. Alcohol and Drug-Related Disorders
3. Anxiety Disorders
4. Cognitive Disorders (Delirium, Dementia, Amnestic, etc)
5. Dissociative Disorders
6. Eating Disorders
7. Mental Retardation (Child/Adolescent/Adult)
8. Mood Disorders
9. Personality Disorders
10. Premenstrual Dysphoric Disorder
11. Schizophrenia and Other Psychotic Disorders
12. Sexual and Gender Identity Disorders
13. Sleep Disorders
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15. Other Disorders Not Listed Above

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22. Consultation-Liaison and Emergency Psychiatry
23. Cross-Cultural and Minority Psychiatry
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26. Ethics and Human Rights
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GUIDE TO USING THE TOPIC INDEX

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

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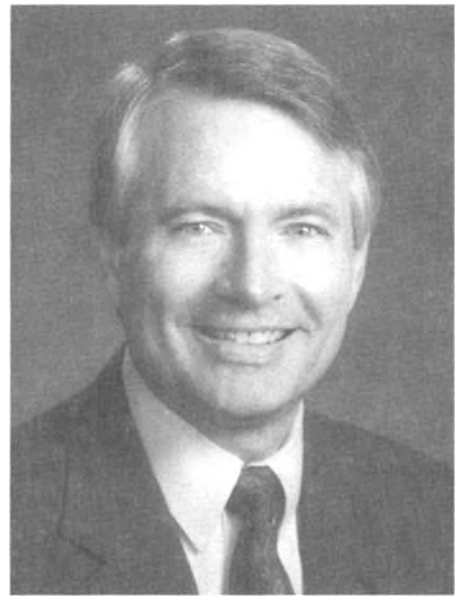

Richard Harding, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

THE 21st CENTURY PSYCHIATRIST

On behalf of the Board of Trustees of the American Psychiatric Association, I welcome you to our 155th Annual Meeting of the APA.

Our focus this year is the 21st Century Psychiatrist. This theme was chosen to show the dramatic changes that our profession has dealt with and, will respond to, in this new century as we continue to deliver the best care possible to those patients we serve. It is trite to say that things have changed since 2001, but they have. At last year's wonderful annual meeting in New Orleans, only a few were thinking about terrorists, trauma, and posttraumatic stress disorder. Only a few members were familiar with bioterrorism and contagion. Things have changed.

Our noble profession is being summoned by history to rise to the challenge of this new century's problems. We will do that. We will incorporate the science of the brain, the efficiency of new information systems and the psychodynamic principles and potential genetic therapies that will allow a quantum leap in advancing our treatments and research. While the doctor-patient relationship will always be our essential domain, we as psychiatrists will become increasingly important to the health of our communities. In fact, in the 21st Century the overall health of our communities will rise and fall on the treatments we develop and deliver to all those in need of our care.

Welcome to Philadelphia, the cradle of American Psychiatry. Enjoy this meeting prepared by our dedicated Scientific Program Committee. Let us all take the time to rededicate ourselves to our professionalism and to quality care our patients deserve.

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MONDAY, MAY 20, 2002

SCIENTIFIC AND CLINICAL REPORT SESSION 1—ANXIETY DISORDERS

No. 2
SWITCHING FROM IMIPRAMINE TO SERTRALINE IN PANIC DISORDER WITH AGORAPHOBIA

Matig R. Mavissakalian, M.D., *Department of Psychiatry, Case Western Reserve/University, 11100 Euclid Avenue, Cleveland, OH, 44106*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to gauge the significant improvement that the advent of SSRIs had in the outcome of panic disorder patients treated with antidepressants.

SUMMARY:

Objective: To gauge the usefulness of switching from imipramine to sertraline in 18 panic disorder patients with agoraphobia patients.

Method: Fifteen patients with unsatisfactory response to a protocolized, 24-week, open imipramine treatment at the weight-adjusted fixed dose of approximately 2.25 mg/kg/day and three patients who responded, but subsequently relapsed following imipramine discontinuation, were systematically switched to sertraline treatment of a 24-week duration at 50 mg to 100 mg per day. Efficacy and side effects were measured uniformally throughout the study and a net benefit accrued from the switch was assessed by using an operationalized outcome grade (0 = no adequate trial or nonresponse, 1 = partial response or full response with side effects necessitating a change in treatment; 2 = full response, no adverse effects).

Results: Paired t-tests found a significant improvement following the switch from imipramine to sertraline on phobic and panic symptomatologies, side effects, and overall outcome grade (0.67 $\pm$ 0.77 to 1.17 $\pm$ 0.92, $p \leq .05$). Nine (50%) of the patients clearly gained from the switch, six (33.3%) patients had a similar outcome, and three (16.7%) patients had a worse outcome following the switch to sertraline. Looked at differently, five (55.5%) of nine imipramine failures responded to sertraline, whereas two (22.2%) of nine patients who had responded well to imipramine failed with sertraline.

Conclusion: Switching to sertraline from imipramine was very useful in panic disorder patients who were intolerant or unresponsive to imipramine.

Supported in part by NIMH (MH42730) and unrestricted grant from Pfizer.

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1. Mavissakalian MR, Ryan MT: Rational treatment of panic disorder with antidepressants. Ann Clin Psychiatry 1998:318–323.
2. Scott EL, Pollack MH, Otto MW, Simon NM: Clinician response to treatment-refractory panic disorder: a survey of psychiatrists. Journal of Nervous & Mental Disease 1999;187:755–757.

No. 3
ATYPICAL DEPRESSION IN PRIMARY ANXIETY DISORDERS

Michael A. Van Ameringen, M.D., *Department of Psychiatry, McMaster Medical Center, 1200 Main Street, West, Hamilton, ON L8N 3Z5, Canada;* Catherine L. Mancini, M.D., Jonathan Oakman, Ph.D., Mira Campbell, B.A., Chris Watson

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the relationship between anxiety and mood disorders with a focus on the relationship between the atypical depression subtype and primary anxiety disorders.

SUMMARY:

Objective: Studies have linked social phobia (SP) to the atypical subtype of major depressive disorder (MDD). In one study, two of three of patients with MDD and SP also met criteria for atypical depression (ATYPMDD). In another investigation, the atypical subtype was more prevalent only when SP was comorbid with avoidant personality disorder. Monoamine oxidase inhibitors are effective in both ATYPMDD and SP, adding additional support for this relationship. However, this relationship has only been studied in select populations of SP or ATYPMDD.

Method: We evaluated rates of depression in 723 anxiety disorders clinic admissions and compared the rates of ATYPMDD in three groups of primary anxiety disorders with a group of primary MDD patients.

Results: Twenty five percent (180/723) met criteria for a current MDD, with 18.9% (34/180) qualifying for ATYPMDD. Significantly fewer patients with primary MDD (10.6%) versus a primary anxiety disorder (panic disorder 31.0%, obsessive compulsive disorder 15.4%, SP 22.9%) qualified for ATYPMDD ($X^2 = 8.087$, df = 3, $p \leq .05$). Rates of ATYPMDD were not significantly different between primary anxiety disorder groups.

Conclusion: This study does not support a specific relationship between ATYPMDD and SP but suggests a general link between ATYPMDD and anxiety disorders. We will discuss potential treatment implications of these findings.

REFERENCES:

1. Alpert JE, Uebelacker LA, McLean NE, Nierenberg AA, et al: Social phobia, avoidant personality disorder, and atypical depression: co-occurrence and clinical implications. Psychological Medicine 1997; 27:627–633.
2. Mannuzza S, Schneier FR, Chapman TM, Liebowitz MR, et al: Generalized social phobia. Arch Gen Psychiatry 1995; 52:230–237.

No. 4
RISK FACTORS FOR PTSD IN NORTH KOREAN DEFECTORS

Wootaek Jeon, M.D., *Department of Psychiatry, Yonsei University Medical College, CPO Box 8044, Seoul 120-752, Korea;* Sung-Kil Min, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that active screening and intervention of the PTSD high-risk group is important to best allow North Korean defectors to successfully adapt to South Korean society.

SUMMARY:

Objective: Since 1994, the number of North Korean defectors who have escaped from North Korea and entered South Korea has increased rapidly. More recently, it was discovered that defectors have experienced extreme physical and mental difficulties and trauma in North Korea and again during the process of defection. Because of these experiences, PTSD is one of the more prominent mental problems among defectors and seriously disrupts their efforts to successfully adapt to a new society. This study into the risk factors of PTSD was undertaken to allow its early detection and to enable the optimal treatment of defectors with PTSD.

Method: Two hundred North Koreans, who had defected between 1998 and 2000, and now live in Seoul, were randomly sampled and surveyed by field workers. Demographic data, factors related to the defection (route, companions, duration between escape from North Korea, and entry into South Korea), trauma experiences, Beck Depression Inventory (BDI), and items from the PTSD diagnosis checklist were documented.

Results: Of 200 defectors, 59 (29.5%) (28 men, 31 women) were diagnosed with PTSD, and the risk factors of their PTSD were determined to be the following: female, age greater than 50; a high BDI score (more than 16); and of 25 listed trauma items, five specific traumatic experiences in North Korea (e.g., beaten severely, tortured, politically criticized); and of 19 trauma items, four specific traumatic experiences during the process of defection (e.g., danger of being detected while preparing for defection, danger of being shot, separation from family).

Conclusion: PTSD should be included in the screening of newly arrived defectors, and the PTSD high-risk group need to be identified and proactively cared for to assist their successful transition to South Korean society.

Funding Source: Board of Unification, the Korean government

REFERENCES:

1. Jeon WT: Issues and problems of adaptation of North Korean defectors to South Korean society: an in-depth interview study with 32 defectors. Yonsei Medical Journal 2000; 41(3): 362–371.
2. Lee YH, Lee MK, Chun KH, Lee YK, Yoon SJ: Trauma experience of North Korean refugees in China. Am J Prev Med 2001; 20(3):225–229.

SCIENTIFIC AND CLINICAL REPORT SESSION 2—EATING DISORDERS

No. 5
PERFECTIONISM, TRAINING, AND EATING BEHAVIORS IN RUNNERS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the relationship between perfectionism and abnormal eating in community runners.

SUMMARY:

Objective: The authors examined the relationship between community athletes' psychological profiles and their risk of abnormal eating behaviors. We hypothesized that abnormal eating behaviors would correlate with certain dimensions of perfectionism, negative mood states, self-loathing, and low enjoyment of the sport.

Method: Participants were contacted through three running organizations in Hawaii. They completed a self-report survey instrument for demographic information, the Multidimensional Perfectionism Scale, the self-loathing subscale of the Exercise Orientation Questionnaire, the Abbreviated Profile of Mood States, the Commitment to Exercise Scale, and three subscales of the Eating Disorders Inventory.

Results: Forty-one runners completed the survey. Scores on the EDI-2 correlated with overall perfectionism ($p < 0.05$), self-loathing ($p < 0.01$), and commitment to exercise ($p < 0.05$), but not with sport enjoyment or time spent running alone. There was a nonsignificant trend for EDI-2 score and negative mood states ($p = 0.082$).

Conclusion: This study confirms previous findings that perfectionism and commitment to exercise significantly and independently correlate with abnormal eating behaviors, in a population of community athletes. Self-loathing was another personality factor associated with eating abnormalities. Identification of such personality factors opens potential inroads for intervention.

REFERENCES:

1. McLaren L, Gauvin L, White D: The role of perfectionism and excessive commitment to exercise in explaining dietary restraint: replication and extension. Int J Eat Disord 2001; 29(3):307–13.
2. Davis C, Kaptein S, Kaplan AS, Olmsted MP, Woodside DB: Obsessionality in anorexia nervosa: the moderating influence of exercise. Psychosom Med 1998; 60(2): 192–7.

No. 6
SELF-REPORTED HUNGER AND PARASYMPATHETIC TONE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand how gut sensations (stomach growling, cramping, gas) are associated with greater experience of hunger and to explore how these differences may relate to ED risk.

SUMMARY:

Objective: Eating disordered (ED) patients are characterized by increased parasympathetic tone and diminished sympathetic tone. The role of the parasympathetic system in the generation of hunger is complex and controversial. This study, part of a larger study of heart rate variability in ED patients, tests the hypothesis that the level of hunger experienced is related to parasympathetic activity in the enteric division.

Method: Sixty-two college students completed the hunger factor of the Three-Factor Eating Questionnaire (Stunkard & Messick, 1985) and the ANSRI (Autonomic Nervous System Response Inventory, Water et al., 1984) with items added to reflect enteric parasympathetic functions.

Results: Hunger score correlated significantly with total parasympathetic factor; with the three enteric items (stomach growls, cramps, gas), and with two other individual items: cold, sleepy. In addition, the 11 students who reported past or current ED symptoms scored significantly higher on parasympathetic and enteric than did other students, including the 13 students who reported past or present depression but not ED.

Conclusion: Hunger appears related to heightened parasympathetic activity. The increased parasympathetic tone found in ED patients could enhance hunger and make achievement of thinness more difficult.

REFERENCES:

1. Hagan MM, Castaneda E, Sumaya IC, Fleming SM, Galloway J, Moss DE: The effect of hypothalamic peptide YY on hippocampal acetylcholine release in vivo: implications for limbic function in binge-eating behavior. Brain Res 1998; 805:20–8.
2. Kay W, Strober M, Stein D, Gendall K: New directions in treatment research or anorexia and bulimia nervosa. Biological Psychiatry 1999; 15, 1285–1292.
3. Petretta M, Bonaduce D, Scalfi L, de Flilippo E, Marciano F, et al: Heart rate variability as a measure of autonomic nervous system function in anorexia nervosa. Clin Cardiol 1997; 20:219–24.

No. 7
TOPIRAMATE TREATMENT OF BULIMIA NERVOSA

Scott P. Hoopes, M.D., *Mountain West Clinical Trials, LLC, 315 North Allumbaugh Street, Boise, ID 83704-9208;* Frederick W. Reimherr, M.D., Marc Kamin, M.D., Debra Karvois, M.S., Norman E. Rosenthal, M.D., Rezaul Karim, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize and understand the potential efficacy of topiramate in the treatment of bulimia nervosa.

SUMMARY:

Bulimia nervosa (BN) is characterized by binge eating and inappropriate compensatory behaviors to prevent weight gain. Preliminary reports suggest topiramate (TPM), an antiepileptic agent, may be useful in treating eating disorders. This 11-week, randomized, double-blind, placebo-controlled trial included 68 outpatients (mean age 29 years) with DSM-IV diagnoses of BN in the intent-to-treat analysis. Mean baseline weekly binge or purge days was 4.9 ± 1.6 (TPM, n = 34) and 5.2 ± 1.4 (placebo, n = 34). Mean binge or purge days decreased 46% (TPM) from baseline during the last week of study vs 9.5% (placebo) ($p = .002$). Mean binge days decreased 49% (TPM) vs 17% (placebo) ($p = .01$), and binge frequency decreased 50% (TPM) vs 29% (placebo) ($p = .089$). Mean purge days decreased 44% (TPM) vs 16% (placebo) ($p = .014$), and purge frequency decreased 50% (TPM) vs 22% (Placebo) ($p = .012$). Topiramate was associated with significant reductions in CGI Severity ($p = .02$), Bulimic Intensity Scale ($p = .019$), and a significant increase in CGI Improvement ($p = .009$). Median TPM dose was 100mg/day (range 25–400). Three patients (two placebo, one topiramate) discontinued due to adverse events. Topiramate represents a potential treatment for bulimia nervosa.

REFERENCES:

1. Knable M: Topiramate for bulimia nervosa in epilepsy. Am J Psychiatry 2001; 158:322–323.
2. Shapira NA, Goldsmith TD, McElroy SL: Treatment of binge-eating disorder with topiramate: a clinical case series. J Clin Psychiatry 2000; 61:368–372.

No. 8
MIXED ANXIETY DEPRESSIVE DISORDER IN A SAMPLE OF PRIMARY CARE PATIENTS

Risa B. Weisberg, Ph.D., *Department of Psychiatry, Brown University, Box G - BH, Duncan Building, Providence, RI 02912;* Larry Culpepper, M.D., Martin B. Keller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the diagnosis of mixed anxiety-depressive disorder and assess its utility.

SUMMARY:

Objective: Mixed anxiety-depressive disorder (MAD) was included in the DSM-IV research appendix, in part, because it was thought to be prevalent in primary care settings. We seek to examine the occurrence and one-year course of MAD in a sample of primary care patients.

Method: Data are part of the larger, naturalistic, Primary Care Anxiety Project (PCAP). Primary care patients from 15 clinics completed a questionnaire screening for the presence of anxiety symptoms. Of the 3,963 patients screened, 1,560 screened positive and were then interviewed with the SCID-IV. A total of 504 participants were diagnosed with an anxiety disorder and assessed at six and 12 months post-intake using the LIFE.

Results: Only four individuals (0.01% of 1,560 completing the SCID) met full DSM-IV MAD criteria. When we relaxed the historical exclusion criteria, allowing for past MDD, an additional six patients were diagnosed with MAD. At one-year follow-up, the probability of remitting from MAD was 78%. Eight cases remitted, one was in partial remission, and only one case continued to meet full criteria for MAD throughout the year. Further, psychosocial impairment was mild and the overlap with adjustment disorder was great.

Conclusions: Results indicate a very low occurrence of mixed anxiety-depressive disorder across 15 primary care settings. Further, it appears that this syndrome may remit quickly and may often be subsumed under adjustment disorder. Overall, our findings question the utility of the current MAD criteria.

Funded by: An unrestricted grant from Pfizer Pharmaceuticals.

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1. Zinbarg RE, Barlow DH, Liebowitz M, et al: The DSM-IV field trial for mixed anxiety-depression. Am J Psychiatry 1994; 151: 1153–1162.
2. Liebowitz MR: Mixed anxiety and depression: Should it be included in DSM-IV? J Clin Psychiatry 1993; 54 (suppl): 4–7.

No. 9
PSYCHOPATHOLOGICAL ASPECTS IN 86 CHRONIC FATIGUE SYNDROME PATIENTS

Massimo di Giannantonio, M.D., *Department of Psychiatry, University of Chieti, Via Dei Vestini 5, Chieti, IT 66100, Italy;* Anatolia Salone, M.D., Delia Racciatti, M.D., Daniela Mezzano, M.D., Eligio Pizzigallo, M.D., Maria F. Ferro

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the chronic fatigue syndrome for a better diagnosis and therapy.

SUMMARY:

Objective: To describe a specific psychodiagnostical profile in CFS patients vs mood disorders and healthy subjects.

Methods: We examined 86 CFS patients (12 pts have a comorbidity diagnosis of anxiety disorders), 25 patients with major depression, 8 patients with a bipolar disorder, and 28 healthy subjects. The psychiatric evaluation consisted: (1) detailed psychiatric interview, (2) MMPI, (3) Hamilton, (4) Zung tests for anxiety and depression. The psychiatric diagnosis were realized according to DSM-IV. The statistical differences were tested by the ANOVA test estimating differences deriving from all MMPI scores.

Results: The MMPI profiles of 86 CFS patients were similar to the profile of patients with somatoform disorders. The evaluation of discriminant functions showed for CFS patients a great similarity to subjects with hystrionic personality and a difference to the patients with depressive syndromes.

Conclusion: The psychiatric evaluation of 86 CFS patients documented anxiety disorders comorbidity and 86 CFS MMPI profiles with significant difference vs mood disorders (depressive and bipolar) patients. This could reflect an abnormal central pathways stress, with an excessive fatiguability of central origin, probably related to noradrenergic and dopaminergic dysregulation. We suggest a better therapeutic role of SNRI in comparison with the unsatisfactory role of SSRI.

REFERENCES:

1. Holmes et al: Chronic fatigue syndrome, a working case definition. Ann Int Med 1988;108:387–439.
2. Goodnick PJ: Treatment of chronic fatigue syndrome with venlafaxine. Am J Psychiatry 1996 Feb; 153(2): 294.

No. 10
LOW EXPRESSION OF NEGATIVE AFFECT AND DENIAL PREDICT BREAST CANCER RECURRENCE

Karen L. Weihs, M.D., *Department of Psychiatry, George Washington University Medical Center, 2300 Eye Street NW, Ross Hall 612B, Washington, DC 20037;* Timothy Enright, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify coping strategies that contribute to risk of breast cancer recurrence. New empirical evidence of this association will be shown, along with evidence from publications on the subject.

SUMMARY:

Objective: This study tested venting of negative emotions as a protective factor, and denial of the disease as a risk factor for breast cancer progression.

Methods: Seventy-three Stage II breast cancer patients in remission were enrolled 30 +/– 5 months after diagnosis. Disease severity was computed using the Nottingham Prognostic Index (NPI) [2 × tumor size (cm) + lymph node status (1 = node-negative; 2 = 1–3 positive nodes; 3 = ≥ 4positive nodes); + histological grade (1 = good; 2 = moderate; 3 = poor)]. Venting and Denial scores from the Brief Cope, along with NPI, were used to predict time to recurrence, using Cox proportional hazards method.

Results: Eleven subjects had recurrent disease at the end of data collection (4.5 years). Mean scores for Venting and Denial were, 5.6 +/–1.7 and 3.2 +/–1.5 (range: 2–8). Mean NPI was 5.0 (range: 2.5–7.2). A one unit increase on Venting was associated with RR = 0.70[0.50–0.96], p = 0.03, and increased Denial was associated with RR = 1.37[1.01–1.87], p = 0.05.

Conclusion: Denial was a risk and Venting was a protective factor for disease recurrence in women who were assessed at 30 months after the diagnosis of breast cancer.

REFERENCES:

1. Carver CS, Scheier MF, Weintraub JK: Assessing coping strategies: a theoretically based approach. Journal of Personality and Social Psychology 1989;56(2):267–283.
2. Weihs K, Enright T, Simmens S, Reiss D: Negative affectivity, restriction of emotions and site of metastases predict mortality in recurrent breast cancer. J of Psychosomatic Research 2000;49:59–68.

SCIENTIFIC AND CLINICAL REPORT SESSION 4—ISSUES IN CROSS-CULTURAL PSYCHIATRY

No. 11
IS THE WECHSLER INTELLIGENCE SCALE FOR CHILDREN, THIRD EDITION (WISC-III UK) APPLICABLE TO GHANA?

Ama K. Edwin, M.B., *Department of Clinical Psychology, KBU Teaching Hospital, P O Box KB591, Korle-Bu, Accra, Ghana*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the need for using appropriate and culture-fair instruments standardized on the target population and be able to interpret test results cautiously.

SUMMARY:

Objective: To investigate whether the WISC-III^{UK} is applicable to the Ghanaian child; to determine the influence of schooling on test performance, to determine the differences between the performance of girls and boys on the WISC-III^{UK} and the RCPM, and to establish the correlation between the WISC-III^{UK} and the RCPM.

Methodology: This was a 2 (groups) × 12 (age groups) × 2 (measures) multifactorial study designed to derive local norms for the WISC-III^{UK}. A total of 200 Ghanaian children from selected schools between the ages of 6 years, 0 months, and 11 years, 11 months were tested with the WISC-III^{UK} and the RCPM.

Results: Performance on the WISC-III^{UK} is influenced by an individual's cultural milieu, with children from private schools doing better than those from public schools. Males and females did not differ significantly from each other on the tests except on the Mazes subtest of the WISC-III^{UK}. Increasing age did not show a uniform improvement on scores, but children in the upper classes did better than children in the lower classes. Performance on the WISC-III^{UK} correlated strongly with performance on the RCPM.

Conclusion: The WISC-III^{UK} is not applicable to Ghana in its present state without making specific changes and modifications to it.

REFERENCES:

1. Bisanz J, Morrison FJ, Dunn: Effects of age and schooling on the acquisition of elementary cognitive skills. Developmental Psychology 1995;31:221–236.
2. Anum A: A Normative Study of the Raven's Coloured Progressive Matrices Among School Children in Ghana. Master of Philosophy Thesis, Department of Psychology, University of Ghana, Legon, 1996.

No. 12
DISSOCIATION, CHILDHOOD TRAUMA, AND ATAQUE DE NERVIOS

Roberto Lewis-Fernandez, M.D., *New York State Psychiatric Institute, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Pedro J. Garrido, Ph.D., Amaro Lakia, Ph.D., Maricarmen Bennasar, Psy.D., Guoguang Ma, M.S., Elsie Parrilla, L.C.S.W., Eva Petkova, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the relationship between ataque de nervios, dissociation, and childhood trauma. The participant will also learn current methods for identifying and assessing ''culture-bound syndromes'' and their overlap with psychiatric nosology as well as for evaluating dissociative symptomatology and childhood trauma.

SUMMARY:

Objective: This presentation examines the relationships between dissociation, childhood trauma, and ataque de nervios.

Method: Forty Puerto Rican psychiatric outpatients were evaluated for ataque frequency, dissociative symptomatology, traumatic exposure, and mood and anxiety psychopathology, with blind conditions maintained across assessments.

Results: Among female subjects, clinician-rated dissociative symptoms using the SCID-D screener increased with ataque frequency. DES scores, panic disorder, and dissociative disorders were also associated with ataque frequency, before correcting for multiple comparisons. Childhood trauma was uniformly elevated and showed no relationship with number of ataques or dissociation.

Conclusions: This is the first empirical evidence demonstrating a specific relationship between ataque de nervios and dissociation. Frequent ataques may be, in part, a marker for psychiatric disorders characterized by dissociative symptomatology. However, childhood trauma per se did not account for ataque status in this sample. This contradicts previous findings with a different clinical population

and trauma scale that showed an association between ataque and childhood trauma, but is consistent with a multifactorial model of dissociation and ataque. There is no research at present that might inform treatment of this common Latino syndrome. Our study suggests that techniques that address pathological dissociation might be useful.

REFERENCES:

1. Guarnaccia PJ, Canino G, Rubio-Stipec M, Bravo M: The prevalence of ataque de nervios in the Puerto Rico Disaster Study. J Nerv Men Dis 1993; 181:157–165.
2. Lewis-Fernández R: Culture and dissociation, in Dissociation: Culture, Mind, and Body. Edited by Spiegel D. Washington, D.C., American Psychiatric Press, 1994, pp. 123–167.

No. 13
TRAUMA, CREATIVE COGNITION, AND SUCCESS AMONG TRIBAL SOUTH-AFRICAN STUDENTS

Albert Rothenberg, M.D., *Department of Psychiatry, Harvard University, P.O. Box 1001, Canaan, NY 12029*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize emotional and educational trauma and disadvantage in diverse cultural groups; identify a specific type of creative cognition; apply a screening procedure to admission evaluation.

SUMMARY:

There is currently a high early dropout rate among tribal and mixed-race students enrolled in South African medical schools. Many of these students have sustained both educational and emotional trauma and disadvantages during the years of apartheid.

The *objective* of this study was to assess whether identification and facilitation of creative cognitive capacities among entering students overcomes disadvantage and trauma effects and leads to early successful academic achievement.

Method: A timed word association test standardized and scored to assess the tendency for creative thinking was individually administered at the beginning of the academic year to 23 first-year students in an academic development program at the University of Capetown Faculty of Medicine.

Results: Three types of predominant cognitive capacities were identified: linguistic, conceptual, and creative. Subjects were informed of results and counseled in ways of applying their own predominant cognitive capacity to medical school education. Follow-up at the end of the first academic year showed grade score rankings in the upper half of the development group were significantly associated (chi square = 4.91 $p < .05$) with the predominantly creative cognition capacity.

Conclusions: Creative cognition capacity can be identified and facilitated through counseling to produce academic success and overcome effects of educational and emotional trauma and disadvantage.

Funded by the Gladys Ficke Estate.

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1. Rothenberg A: Psychopathology and creative cognition. a comparison of hospitalized patients, Nobel laureates, and controls. Arch Gen Psychiatry 1983;40:937–942.
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SCIENTIFIC AND CLINICAL REPORT SESSION 5—ISSUES IN MID LIFE AND BEYOND

No. 14
LONG-TERM EFFECTS OF DEPRESSION ON SYMPTOMS AND FUNCTION IN MID-LIFE WOMEN

Joyce T. Bromberger, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, WPIC, Pittsburgh, PA 15213;* Charlotte Brown, Ph.D., Adriana Cordal, M.D., Howard M. Kravitz, D.O., Karen Matthews, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be aware (1) of the varying long-term effects of different types of depression histories on women's mental and physical health and functioning during midlife, (2) that these effects may exist whether or not they are currently depressed, and (3) that they have implications for women's experience of the menopausal transition.

SUMMARY:

Objective: To examine the relationship between major depression-recurrent (MDR), single episode (MDS), subsyndromal depression (SSD), or no depression (ND), and health and functioning in middle-aged white, African-American, and Hispanic women.

Methods: We used the SCID-IV to diagnose lifetime and current major and subsyndromal depression in 922 women, aged 42–52, participating at the Chicago, Newark, and Pittsburgh sites of the Study of Women's Health Across the Nation. We used multiple logistic regression adjusting for current depression to assess differences among the diagnostic groups in somatic and mood symptoms, CES-D score, quality of life and functioning, and psychotropic medication use.

Results: Lifetime depression rates were: MDR—16.9%, MDS—14.9%, SSD—14%; 45.8% of the women had no history of depression. Compared with women with no depression, MDR women were at significantly higher risk for medication use (Odds Ratio (OR) = 4.19), somatic symptoms (OR = 1.87), mood symptoms (OR = 1.98), CES-D ≥ 16 (OR = 1.74), and poorer social functioning (OR = 2.59); and MDS women were at higher risk for CES-D ≥ 16 (OR = 1.63), and poorer social functioning (OR = 1.60). SSD women had ORs similar to or lower than those of MDS for most outcomes, but none were significantly different from the ND group.

Conclusions: Results suggest that among mid-life women, those with a history of recurrent depression have the greatest and those with no depression history or an SSD history have the lowest risk of experiencing symptoms and poor functioning.

REFERENCES:

1. Kuh DL, Wadsworth M, Hardy R: Women's health in midlife: the influence of the menopause, social factors and health in earlier life. British Journal of Obstetrics and Gynaecology 1997; 104:923–933.
2. Coryell W, Scheftner W, Keller M, et al: The enduring psychosocial consequences of mania and depression. Am J Psychiatry 1993; 150: 720–727.

No. 15
SOCIOECONOMIC STATUS AND DEPRESSION AMONG OLDER ADULTS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the relationship between socioeconomic status and depression among the elderly, how social stress mediates this process, and how this can inform intervention strategies.

SUMMARY:

Objective: Recently, attention has been directed toward assessing the degree to which the stress process model (Pearlin, 1989) mediates the relationship between measures of position in the social structure and depression. Turner and Lloyd (1999) demonstrate that much of the observed differences in depression across different social groups can be accounted for by stress exposure, psychosocial resources, and social support. One significant limitation in this work, however, concerns the exclusive focus on working age adults. To our knowledge, no one has examined whether the stress process model mediates the relationship between socioeconomic status and depression in older populations. In this study, we examine this question using a sample of adults aged 55 and older.

Method: The data come from the National Population Health Survey (NPHS) by Statistics Canada, collected in 1994. The sample size of adults age 55 and over is 5,093.

Results: We find, consistent with Turner and Lloyd (1999), that a substantial amount of the variation in depression by socioeconomic status can be accounted for by social stress, mastery and self-esteem, and social support.

Conclusions: The identification of social stress, psychosocial resources, and social support as mediating factors in the relationship between socioeconomic position and depression can inform intervention strategies aimed at reductions in depression among the elderly.

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2. Turner RJ, Lloyd DA: The stress process and the social distribution of depression. Journal of Health and Social Behavior 1999; 40: 374–404.

No. 16
PSYCHOTHERAPY WITH THE ELDERLY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the important psychological developmental issues relevant to the elderly, recognize the barriers as well as the opportunities for the use of psychotherapy with the elderly, and identify modifications that may be associated with effective psychotherapy in the elderly.

SUMMARY:

This report is geared toward psychiatrists involved in the treatment of the elderly, usually in an outpatient setting. In spite of advances in the understanding and treatment of mental disorders in the elderly, the modality of psychotherapy tends to be underutilized, particularly by psychiatrists. While the ultimate role of psychotherapy has not been adequately established, it is already clear that the psychiatrist of the 21st century will be faced with growing numbers of elderly patients for whom psychotherapy may be beneficial. Previous cohorts of elderly have not been particularly amenable to psychotherapy, but the baby boomers will undoubtedly bring an increased interest in, and demand for, psychotherapy. This report will identify some current obstacles as well as potential opportunities for the use of psychotherapy with the elderly. The presentation will include discussion of important relevant issues (e.g., psychological development, different types of psychotherapy, modifications in technique for the elderly population), and a review of the relevant literature. Clinical vignettes will be provided, including a brief description of psychoanalysis in an elderly woman. Thinking about psychotherapy with the elderly forces us to confront various assumptions about psychotherapy in general and may lead to important insights that apply to all ages.

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SCIENTIFIC AND CLINICAL REPORT SESSION 6—PSYCHOPHARMACOLOGY OF MOOD DISORDERS

No. 17
FLUOXETINE-INDUCED WEIGHT CHANGE IN DEPRESSIVE SUBTYPES

Christina M. Dording, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Robert L. Gresham, B.A., Heidi D. Montoya, B.A., John J. Worthington III, M.D., Jonathan E. Alpert, M.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the association between depressive subtypes and fluoxetine-induced weight change.

SUMMARY:

Background: Fluoxetine has been associated with weight loss during acute phase treatment. However, in the only two studies reporting on weight changes during fluoxetine continuation therapy, rates of significant (i.e., ≥7%) weight gain for patients taking fluoxetine (10.2%) were no different from patients taking placebo (7.4%) after 38 weeks and were comparable (6.8%) to sertraline (4.2%) and significantly less than paroxetine (25.5%) after 26 to 32 weeks.

Objective: The purpose of this study was to examine any changes in weight during the course of an open trial of fluoxetine for 36 weeks, and to evaluate any possible association between fluoxetine-induced weight changes and the presence of atypical or melancholic features.

Method: We studied 60 (mean age: 41.9 ± 8.5; 29 men and 31 women) major depressive disorder outpatients (for which weights were available at both screen and endpoint) who participated in a study that involved treatment with fluoxetine 20 mg/day for eight weeks and, for remitters only, with fluoxetine 40 mg/day for an additional 28 weeks. Patients were diagnosed as having melancholic, atypical, or neither subtype with the use of the SCID during the screen visit. Changes in weight were examined with an intent-to-treat approach for both the acute and the continuation phases of the trial.

Results: The mean weight change from screen/baseline to end of the eight-week acute phase was a significant ($t: 3.5$; $p < .001$) decrease of 2.2 ± 4.7 pounds; the mean weight change from screen/baseline to end of the 28-week continuation phase was a nonsignificant ($t: -0.8$; $p < .5$) increase of 0.9 ± 8.4 pounds. The percentage of patients with a ≥7% increase in body weight was 6.7%. There was no significant relationship between weight changes during both

phases of treatment and depressive subtypes (atypical or melancholic) or age/gender.

Discussion: These findings confirm that acute therapy with fluoxetine is associated with mild but statistically significant weight loss, and that fluoxetine continuation therapy is associated with a nonsignificant increase in weight.

REFERENCES:

1. Michelson D, et al: Changes in weight during a one year trial of fluoxetine. American Journal of Psychiatry 1999; 156(8):1170–1176.
2. Fava, et al: Fluoxetine versus sertraline and paroxetine in major depressive disorder: changes in weight with long-term treatment. Journal of Clinical Psychiatry 2000; 61:11:863–867.

No. 18
ADJUNCT MODAFINIL FOR FATIGUE AND WAKEFULNESS IN MDD

Karl Doghramji, M.D., *Department of Psychiatry, Thomas Jefferson University, 1015 Walnut Street, Suite 319, Philadelphia, PA 19107;* Matthew A. Menza, M.D., Murray H. Rosenthal, D.O., Ronald R. Fieve, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to treat fatigue and sleepiness associated with major depressive disorder with an antidepressant and modafinil.

SUMMARY:

Objective: Fatigue and sleepiness are primary symptoms of major depressive disorder (MDD) that often do not resolve with antidepressant therapy and may require additional therapeutic measures. Modafinil, a novel wake-promoting agent, improves wakefulness in patients with excessive sleepiness, and reduces fatigue in patients with multiple sclerosis. This study evaluated the effects of modafinil on fatigue and sleepiness in patients with MDD.

Methods: Patients with partial response to antidepressants given for at least six weeks prior to study for a current major depressive episode were enrolled in this six-week, randomized, double-blind, placebo-controlled, multicenter study. Patients received modafinil (100–400 mg/day) or placebo as adjunct treatment to ongoing antidepressant therapy. Changes in fatigue and daytime sleepiness were evaluated using the Fatigue Severity Scale (FSS) and Epworth Sleepiness Scale (ESS), respectively. Adverse events were recorded.

Results: Of 136 patients randomized, 118 (87%) completed the study. Most patients were fatigued (82%), and half (51%) were sleepy. Modafinil rapidly improved fatigue and daytime wakefulness, with significantly greater mean changes from baseline than placebo in FSS scores at week 2 ($p < 0.05$) and ESS scores at week 1 ($p < 0.01$). Modafinil was generally well tolerated.

Conclusions: Modafinil may be a useful adjunct for the management of fatigue and sleepiness in patients who are partial responders to antidepressant therapy.

REFERENCES:

1. Menza MA, Kaufman KR, Castellanos A: Modafinil augmentation of antidepressant treatment in depression. J Clin Psychiatry 2000;61:378–381.
2. DeBattista C, Solvason HB, Kendrick E, Schatzberg AF: Modafinil as an adjunctive agent in the treatment of fatigue and hypersomnia associated with major depression. New Research Program and Abstracts of the 154th Annual Meeting of the American Psychiatric Association; May 9, 2001, New Orleans, LA. Abstract NR532:144.

No. 19
SHORT-TERM USE OF ESTRADIOL AS AN ANTIDEPRESSANT STRATEGY IN PERIMENOPAUSAL AND POSTMENOPAUSAL WOMEN

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the differential antidepressant benefit of estrogen treatment for peri- and postmenopausal women suffering from depressive disorders.

SUMMARY:

Objective: To examine the efficacy of short-term use of transdermal 17 β-Estradiol for the treatment of depression in peri- and postmenopausal women.

Methods: Twenty women (9 perimenopausal, 11 postmenopausal) who met criteria for depressive disorders (mean MADRS scores 21.38 ± 4.66) received four weeks of treatment with 100μg of 17 β-E2 adhesives. Depressive and somatic symptoms were assessed at baseline and at week 4 using the MADRS and Greene Climacteric Scale (GCS), respectively.

Results: All women concluded treatment. Perimenopausal and postmenopausal women were similar in age, marital status, education, and severity of depression. Six perimenopausal women (66.7%) and one postmenopausal woman (9.1%) had full remission of depression (mean MADRS scores <9; $p = 0.017$, Fisher's exact test). Except for menopausal status, remission of depression with E2 was not associated with any variables studied, including severity of depression and somatic symptoms at baseline (all p-values ≥ 0.05). Also, there was no significant correlation between changes in depressive and somatic symptoms (MADRS and GCS scores; $r = 0.17$, $p = 0.453$).

Conclusions: Depression in perimenopausal women may be rapidly and significantly alleviated with short-term use of E2. Postmenopausal women, however, may not benefit from a brief hormone intervention. This response does not seem to be associated with distinct improvement on vasomotor symptoms. Putative explanations for this differential response deserve further investigation.

This study was supported by Forest Laboratories, USA.

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SCIENTIFIC AND CLINICAL REPORT SESSION 7—MANAGEMENT OF BIPOLAR DISORDER

No. 20
A COMPARISON OF THE PREVALENCE AND CORRELATES OF ANGER ATTACKS IN BIPOLAR DISORDER

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02114; Jordan W. Smoller, M.D., Stephanie Racette, B.A., Pamela A. Roffi, B.S., Grace E. F. Rubenstein, B.A., Gary S. Sachs, M.D., Maurizio

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to recognize anger attacks during depressive episodes in both bipolar disorder and major depression, and understand their clinical significance.

SUMMARY:

Objective: Previous studies have reported that anger attacks are prevalent among patients with major depressive disorder (MDD). The purpose of this investigation is to assess the corresponding prevalence among patients with bipolar disorder (BPD).

Methods: We analyzed rates of anger attacks among a sample of outpatients with MDD (N = 50) and BPD (N = 29) administered the SCID-I/P and currently in a depressive (but not mixed, manic or hypomanic) episode. Anger attacks were identified using the questionnaire of Fava et al (1993).

Results: We found that patients with BPD were more likely to have anger attacks during depressive episodes than those with MDD (62% vs 26%; p = 0.002). Among BPD patients, anger attacks were associated with a trend toward earlier onset of affective illness (14.8 ± 5.0 vs 20.0 ± 9.1; p = 0.06) but not with sex, ethnicity, or depressive features.

Conclusion: Our data suggest that anger attacks are prevalent among patients with BPD during depressive episodes, and may be associated with earlier onset of illness.

Funding: Millennium Pharmaceuticals, Inc.; NARSAD

REFERENCES:

1. Fava M, Rosenbaum JF, Pava JA, McCarthy MK, Steingard RJ, Bouffides E: Anger attacks in unipolar depression, part 1: clinical correlates and response to fluoxetine treatment. Am J Psychiatry 1993; 150:1158–63.
2. Tedlow J, Leslie V, Keefe BR, Alpert J, Nierenberg AA, Rosenbaum JF, Fava M: Axis I and Axis II disorder comorbidity in unipolar depression with anger attacks. J Affect Disord 1999;52:217–23.

No. 21
TOPIRAMATE TREATMENT OF RAPID-CYCLING MOOD DISORDER

Fava, M.D. Mohammad Z. Hussain, M.D., *Prince Albert Health District, Mental Health Centre, 2727 2nd Avenue West, Prince Albert, SK S6V 5E5, Canada;* Zabaida A. Chaudhry, M.D., Seema Hussain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate long-term management of rapid cycling bipolar mood disorder and the use of topiramate monotherapy and combination therapy in patients whose illness proved refractory.

SUMMARY:

Bipolar disorder is a serious, debilitating illness affecting over 2% of the population. Up to 20% suffer from rapid cycling. In some, it is transient and associated with antidepressants, whereas for others it is a natural course of their illness that is more severe and treatment resistant. Novel anticonvulsants have increased treatment options. Long-term studies are essential to assess efficacy and patient acceptability.

Sixty patients meeting criteria of rapid cycling disorder received open-label treatment with topiramate monotherapy or in combination. All had history of >2 years of rapid cycling and had been treated with lithium carbonate, valproate, risperidone, and other medications with limited response. Twenty-three were bipolar I, 37 bipolar II, with a mean age of 38.5, range 17–57. They were rated on HAMD, Young Mania scales, and CGI at baseline, 1/2-1-2-3-6-12-18-24-30 and 36-month intervals. Topiramate was given at a starting dose of 25 mg hs, rising every two nights to 200 mg hs and later up to 600 mg hs. All patients completing the 36-month trial were good responders. Thirteen patients required alternative strategies and were intolerant of topiramate. Seven patients have dropped out of follow-up. Combination therapy includes lithium, gabapentin, valproate, novel neuroleptics, and thyroid supplementation, and antidepressants in Bipolar II patients.

Topiramate is clinically effective in rapid cycling mood disorder.

REFERENCES:

1. Kilzieh N, Akiskal HS: Rapid cycling bipolar disorder. An overview of research and clinical experience. Psychiatr Clin North Am 1999;22(3):585–607.
2. Wehr TA, Sack DA, Rosenthal NE, Cowdry RW: Rapid cycling affective disorder: contributing factors and treatment responses in 51 patients. Am J Psychiatry 1988;145(2):179–184.

No. 22
COGNITIVE AND PSYCHOSOCIAL DEFICITS IN BIPOLAR DISORDER AND SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe some of the neuropsychological and psychosocial deficits shared by bipolar disorder and schizophrenia patients.

SUMMARY:

Objective: Executive function and verbal memory impairments in bipolar disorder appear to show some consistency in overlap with neuropsychological deficits found in schizophrenia. However, less is known in bipolar disorder about how these neuropsychological deficits are associated with psychiatric symptoms and psychosocial functioning.

Methods: We conducted psychiatric symptom, psychosocial, and neuropsychological assessments in stable, euthymic bipolar patients (n = 28), stable schizophrenia patients (n = 20), and normal controls (n = 22). The only major difference between the groups was that bipolar patients had more education than did the schizophrenia patients.

Results: Even after controlling for education, we found that bipolar and schizophrenia patients overlapped in deficits on executive function (WCST) and verbal memory (CVLT). The severity of negative symptoms (SANS) was inversely correlated with executive functioning in both bipolar patients ($r = -.41$, $p < .05$) and schizophrenia patients ($r = -.43$, $p < .08$). In bipolar patients, psychosocial functioning was positively associated with executive functions ($r = .59$, $p < .01$) and verbal memory ($r = .39$, $p < .05$).

Conclusion: The overlap in the neuropsychological impairment in bipolar disorder and schizophrenia may include negative symptoms as clinical correlates. Neuropsychological domains associated with poor psychosocial functioning in schizophrenia may also be involved in bipolar disorder. This pattern of findings suggests some overlap in underlying pathophysiology of bipolar disorder and schizophrenia.

SCIENTIFIC AND CLINICAL REPORT SESSION 8—SUICIDE

No. 23
SUICIDES IN YOUTHS INVOLVED WITH JUVENILE JUSTICE AND CHILD WELFARE SERVICES

Johanne Renaud, M.D., *Department of Psychiatry, Ste-Justine, 3100 Ellendale Street, Montreal, QC H3S 1W3, Canada;* Francois Chagnon, Ph.D., Lambert Farand, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the population at high risk of committing suicide in order to improve treatment and promote effective prevention programs.

SUMMARY:

In 1996, suicide accounted for 38.3% of deaths within the 15 to 19 year old population in Quebec, a rate of 20.7/100,000 versus 11.5 for Canada. Effective suicide prevention programs depend on identification of high risk populations. In Quebec, a single type of government agency, called "Youth Centers" (YCs), owns the mandate to provide social services, rehabilitation, and juvenile detention to troubled youths. Recently, suicides in the YC population has brought up media attention. While the prevalence of attempted suicide among YC subjects suggested a high risk of suicide, the extent of the problem had never been quantified.

Suicide records of adolescents under 19 that had occurred from 1995 to 1996 were retrieved from the coroner's office. YC records were retrieved and classified as active or closed at the time of suicide. From a total of 177 suicides, a YC record was retrieved in 32%. For 40% of these, YC record was still active at the time of suicide, for 39% it had been closed one year or less before suicide, and for 21% the record had been closed between one and 3.5 years before suicide. At least one third of adolescents who committed suicide had been involved with the YCs, 80% the year preceding suicide.

REFERENCES:

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2. Kempton T, Forehand R: Suicide attempts among juvenile delinquents: The contribution of mental health factors. Behavior Research and Therapy 1992; 30(5), 537–541.

No. 24
PREDICTORS OF SUICIDE ATTEMPTS IN A PERSONALITY DISORDER SAMPLE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify empirically derived risk factors for suicide attempts in a PD sample.

SUMMARY:

Objective: To describe characteristics of prospectively observed suicide attempts in patients with PDs, and identify precipitants in the month preceding the attempt.

Methods: Subjects from the Collaborative Longitudinal Study of Personality Disorders were reliably assessed for Axis I and II disorders (SCID-I and DIPD-IV), and suicide attempts were ascertained with the LIFE. During the two years of prospective follow-up of 631 subjects, 62 (10%) reported at least one definitive suicide attempt (suicide gestures were excluded from analyses). Predictors that are examined include diagnoses and diagnostic course, significant life events, impulsivity, and childhood abuse/neglect.

Results: Multivariate logistic regression analyses indicate that BPD and PTSD are unique significant predictors of suicide attempt status. While co-occurrent PD/MDD was not a significant predictor of attempter status, survival analyses indicate that course of MDD in the two months preceding the attempt was a significant predictor.

Conclusion: Severe PD disturbance in combination with exacerbation of Axis I conditions, particularly MDD, heightens risk for a suicide attempt.

Funding Source: National Institute of Mental Health.

REFERENCES:

1. Mann JJ, Watermaux C, Haas GL, Malone KM: Toward a clinical model of suicide behavior in psychiatric patients. Am J Psychiatry 1999;156:181–189.
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No. 25
HOSTILITY AND IMPULSIVITY AMONG SUICIDAL BIPOLAR PATIENTS

Benjamin H. Michaelis, M.A., *Department of Psychiatry, New York Presbyterian Hospital -Payne Whitney, 525 East 68th Street, New York, NY 10021;* Glen P. Davis, B.A., Joseph F. Goldberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should familiar with the clinical and diagnostic relationship between impulsivity and hostility among suicidal bipolar patients.

SUMMARY:

Objective: The personality trait of impulsivity has been linked to suicidality in general and with suicidality in patients with bipolar disorder specifically. In addition, aggression has been shown to be associated with suicidal behavior in suicidal bipolar patients. However, the relationship between impulsivity and aggression in suicidal bipolar patients remains unclear. The current study was designed to explore the relationship between impulsivity and hostility in suicidal bipolar patients.

Method: A total of 75 bipolar patients, 40 with a history of suicide attempts and 35 with no history of suicide attempts, were recruited. Patients were diagnosed using DSM-IV criteria, and self-report questionnaires assessing the traits of hostility and impulsivity were administered.

Results: Hostility, but not impulsivity, was significantly higher among patients with a history of suicide attempts. Suicide attempters scored significantly higher on the Non-planning impulsiveness scale than non-attempters. A significant association was found between impulsivity and aggression among suicide attempters, but not among non-attempters.

Conclusion: Suicidality among bipolar patients may not emerge from impulsivity or hostility per se, but rather as a part of the complex interaction of these two personality traits.

REFERENCES:

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tempters and nonattempters. Journal of Affective Disorders 2000; 59, 107–117.
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SCIENTIFIC AND CLINICAL REPORT SESSION 9—BPD

No. 26
BPD, MEDICAL ILLNESS, LIFESTYLE CHOICES, AND HEALTH CARE UTILIZATION

Frances R. Frankenburg, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Mary C. Zanarini, Ed.D., John Hennen, Ph.D., Kenneth R. Silk, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the negative health consequences of a failure to remit from borderline personality disorder.

SUMMARY:

Objective: The purpose of this study was to assess the relationship between remission status of borderline personality disorder (BPD) and rates of physical illness, life style choices affecting physical health, and health care utilization.

Method: A total of 200 patients who no longer met DIB-R and DSM-III-R criteria for BPD and 64 patients who still met our study criteria for BPD were interviewed concerning their physical health, lifestyle choices, and use of nonpsychiatric medical care six years after their initial participation in the McLean Study of Adult Development (MSAD).

Results: Nonremitted borderline patients were found to be significantly more likely than remitted borderline patients to have a history of noninsulin-dependent diabetes, osteoarthritis, hypertension, back pain, and obesity. They were also found to be significantly more likely to drink alcohol, smoke cigarettes, and have household accidents as well as significantly less likely to exercise regularly. In addition, nonremitted borderlines were significantly more likely than remitted borderlines to have had at least one medically related ER visit or medical hospitalization.

Conclusions: The failure to remit from BPD seems to be associated with a heightened risk of suffering from chronic physical conditions, making poor health-related lifestyle choices, and using costly forms of medical services.

Supported by NIMH grants MH47588 and MH62169.

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2. Sansone RA, Wiederman MW, Sansone LA: Borderline personality symptomatology, experience of multiple types of trauma, and health care utilization among women in a primary care setting. J Clin Psychiatry 1998; 59:108–111.

No. 27
IMPULSIVITY, GENDER, AND 5HT IN BPD

Paul H. Soloff, M.D., *Department of Psychiatry, University of Pittsburgh/WPIC, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Thomas M. Kelly, Ph.D., Stephen J. Strotmeyer, M.P.H., Kevin M. Malone, M.D., J. John Mann, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the relationship between gender, impulsivity, and central serotonergic function in patients with borderline personality disorder.

SUMMARY:

Objective: An inverse relationship between impulsivity and the prolactin response to serotonin agonists has been reported in BPD, independent of suicidal behavior, depression, or alcohol use disorders. Many of these studies have been conducted among males in specialized settings. Studies of female BPD subjects, recruited in community settings, report inconsistent findings.

Method: We examined the prolactin responses to d,1 fenfluramine (FEN) in 64 subjects with BPD (20 male, 44 female), and 57 controls (36 male, 21 female), recruited from community sources. Axis I and II disorders and suicidal histories were assessed by structured interviews. BPD was diagnosed by DSM III-R criteria, with exclusion for psychotic disorders, organic mood disorders, bipolar disorders, or substance withdrawal. Controls were free of Axis I and II disorders. Impulsivity and impulsive-aggression were assessed by the BDHI, BIS, MMPI-Pd, and the Brown-Goodwin LHA. The FEN challenge followed a standard protocol, was non-blind, and without placebo control.

Results: Male, but not female, BPD subjects had significantly diminished prolactin responses compared with controls. Impulsivity and impulsive-aggression each predicted prolactin responses. A significant effect of BPD diagnosis on prolactin response was eliminated when impulsivity was covaried. Impulsivity and impulsive-aggression were inversely related to delta-prolactin and peak-prolactin responses among male but not female subjects.

Conclusions: Gender differences in impulsivity contribute to variation in the prolactin responses to FEN in BPD.

Supported by NIMH Grant RO1 MH48463.

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No. 28
DIAGNOSTIC EFFICIENCY OF BPD AND ANTISOCIAL PERSONALITY DISORDER (APD) CRITERIA IN MONOLINGUAL HISPANIC MEN

Daniel F. Becker, M.D., *Mills-Peninsula Medical Center, 1783 El Camino Real, Burlingame, CA 94010;* Carlos M. Grilo, Ph.D., Luis M. Anez, Psy.D., Thomas H. McGlashan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the diagnostic efficiency of the DSM-IV criteria for BPD and APD, and the extent to which these criteria sets may discriminate these disorders.

SUMMARY:

Objective: To examine the predictive and discriminant efficiency of the DSM-IV criteria for borderline personality disorder (BPD) and antisocial personality disorder (APD).

Method: Subjects were 74 men admitted to an outpatient substance abuse clinic for monolingual Hispanic adults. All were reliably as-

sessed with the Spanish-Language Version of the Diagnostic Interview for DSM-IV Personality Disorders. Four conditional probabilities, along with total predictive value (a measure of percent agreement), were calculated in order to determine which of the BPD and APD symptoms were most efficient in diagnosing their respective disorders. In addition, these two criteria sets were examined to determine their discriminant efficiency with respect to the two disorders.

Results: Twenty-five (34%) subjects met diagnostic criteria for BPD, and 16 (22%) met criteria for APD. The diagnostic co-occurrence of these disorders was statistically significant ($p < .001$). While the diagnostic efficiency of the BPD criteria set was comparable to that reported in other studies of outpatients, these criteria were not significantly more efficient than the APD criteria in diagnosing BPD. By contrast, the APD criteria were more efficient than the BPD criteria in diagnosing APD ($p < .001$); this was equally true for the adult and the adolescent APD criteria subsets.

Conclusions: In male Hispanic outpatients with substance use disorders, BPD and APD show significant diagnostic overlap. The APD criteria are useful in discriminating these two disorders, while the BPD criteria are not. These findings also provide support for the value of the conduct disorder criteria in predicting APD in adulthood.

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SCIENTIFIC AND CLINICAL REPORT SESSION 10—TOPICS IN SCHIZOPHRENIA

No. 29
THE RELATIONSHIP BETWEEN NEGATIVE AND POSITIVE SYMPTOMS: A 15-YEAR FOLLOW-UP

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation participants will have gained a better understanding of the link between major biological theories and the observed clinical symptoms (e.g. psychosis and negative symptoms) which the theories are designed to explain.

SUMMARY:

Objective: Major biological theories of schizophrenia by D. Weinberger, K. Davis, and A. Grace have proposed inverse levels of cortical-subcortical dopaminergic (DA) function. In this outlook, viewing DA as an excitatory neuromodulator, mesocortical DA underactivity can lead to DA overactivity in the limbic system. The current longitudinal research studied one symptomatic consequence of this view: a possible positive relationship between negative symptoms (low frontal DA activation) and psychosis (potential mesolimbic DA overactivity).

Method: We assessed, longitudinally, 106 patients from the Chicago Followup Study. The sample included 69 schizophrenic and schizoaffective patients and 37 other types of psychotic patients. We evaluated the patients for negative symptoms, positive symptoms, other types of symptoms, and for psychosocial functioning six times over 15 years. The SADS and other structured interviews were used to assess the patients at each follow-up. Satisfactory inter-rater reliability was obtained for the major measures used ($t = .86$, $p < .001$).

Results: 1. The data at the 15-year follow-up for schizophrenics indicate a positive relationship between negative and positive symptoms ($r = .38$, $p = .001$). 2. At the 15-year follow-up, 65% of the schizophrenics with negative symptoms also showed clear psychosis. 3. In contrast, only 24% of the schizophrenics without negative symptoms showed clear psychosis ($p < .01$). 4. The correlations for the initially psychotic, but nonschizophrenic, patients were not as consistent.

Conclusions: The consistent and significant positive relationship over time between negative and positive symptoms in schizophrenia fits with a major biological theory, with DA underactivity in the frontal cortex linked to DA hyperactivity in the temporal-limbic system, with disinhibition of limbic activity. This relationship between negative and positive symptoms was not as strong for nonschizophrenic psychotic patients.

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2. Davis KL, Kahn RS, Ko G, Davidson M: Dopamine in schizophrenia: a review and reconceptualization. American Journal of Psychiatry 1991; 148:1474–1486.

No. 30
NEUROLOGICAL SOFT SIGNS AND PSYCHOPATHOLOGY IN SCHIZOPHRENIA

Giuseppe Bersani, *Lasapienza University, 3rd Psychiatric Clinic, Via di Torre Argentina 21, Rome, IT 00186, Italy;* Simona Gherardelli, M.D., Professor Paolo Pancheri

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the clinical features of the association of neurological and psychopathological signs.

SUMMARY:

Objective: The aim of this study was to evaluate a possible correlation between neurological soft signs (NSS) and the clinical traits (positive and negative symptoms) in a male schizophrenic sample. So far, several studies seem to be suggestive of correlations between negative symptoms and various neurological deficits.

Method: The study was carried out on 94 male inpatients (mean age 32.7 ± 9.01) with DSM-IV diagnosis of schizophrenia, on neuroleptic stabilized treatment. The NSS evaluation was performed by the Neurological Evaluation Scale (NES by Buchanan et al., 1989) and its subscales (Motor Coordination, Sensory Integration, Sequencing of Complex Motor Acts). The Scale for the Assessment of Negative Symptoms (SANS) and the Scale for the Assessment of Positive Symptoms (SAPS) by Andreasen (1983) have been used for the assessment of psychopathology.

Results: Significant correlations emerged between NES Motor Coordination area and SANS total score ($p = .021$), Alogia ($p = .026$), Anhedonia ($p = .019$), Flat affect ($p = .046$), as well as between NES Sensory Integration area and SANS total score ($p = .017$), Alogia ($p = .007$), Apathy ($p = .037$). No significant correlation was found between SAPS total score and the NES scores. Only one significant correlation emerged between NES Sequencing of Complex Motor Acts and SAPS Thought disorder subscale ($p = .048$).

Conclusion: The results suggest that the correlations between NSS and some negative features in schizophrenia could be considered as a brain functional impairment mostly associated with clinical deficit syndrome.

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1. Buchanan RW, Heinrichs DW: The Neurological Evaluation Scale (NES): a structured instrument for assessment of neurological signs in schizophrenia. Psychiatry Research 1989; 27: 335–350.
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No. 31
HETEROGENEITY IN SCHIZOPHRENIA: COGNITIVE DEFICITS AND BRAIN ABNORMALITIES

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to realize that the nature of cognitive deficits may indicate the nature of the brain pathology in schizophrenia, and that the diagnosis may include subgroups with different underlying diseases.

SUMMARY:

Objective: We identified three subgroups of schizophrenia patients based on marked differences in memory deficits, and determined whether the groups had different brain structure abnormalities.

Method: Forty stable outpatients (mean age 41.4 +/– 9.4 yrs) who met DSM-IV criteria for schizophrenia were divided into groups with good memory, a selective verbal memory deficit, or generally poor memory. Volumes of the lateral ventricles, temporal lobes, and dorsal prefrontal cortex were measured on MRI scans of the 40 patients and 22 healthy subjects in a manner blind to group assignment.

Results: The patient subgroups differed significantly in brain volume abnormalities. Good memory patients had left-lateralized temporal and frontal volume reductions without significant ventricular enlargement. Verbal deficit patients had bilateral cortical volume reductions and moderate ventricular enlargement. Poor memory patients had marked ventricular enlargement and the least remarkable temporal and frontal volume reductions.

Conclusions: Patients who share the diagnosis of schizophrenia but have different cognitive deficits also have different brain structure abnormalities. These findings provide evidence of differences in pathophysiology among the three subgroups, and support suggestions that the diagnosis of schizophrenia may comprise more than one disease process.

REFERENCES:

1. Wexler BE, Stevens AA, Bowers AA, Sernyak MJ, Goldman-Rakic PS: Word and tone working memory deficits in schizophrenia. Arch Gen Psychiatry 1998, 55:1093–1096.
2. Wexler BE, Jacob S, Stevens AA, Donegan NH: Deficits in language-mediated mental operations in patients with schizophrenia. Schiz Res, in press.

SCIENTIFIC AND CLINICAL REPORT SESSION 11—OLANZAPINE: BIPOLAR DISORDERS AND AGITATION

No. 32
EFFECTIVENESS OF RAPID INITIAL DOSE ESCALATION OF ORAL OLANZAPINE FOR ACUTE AGITATION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the relative findings of rapid initial dose escalation versus standard dosing of olanzapine for acute agitation.

SUMMARY:

Objective: Clinical reports suggest dose loading approaches with olanzapine may achieve faster therapeutic effect in acutely agitated patients.

Method: A total of 142 acutely agitated inpatients (Positive and Negative Syndrome Scale [PANSS] Excited ≥ 20) with schizophrenia spectrum or bipolar I disorder were randomized to four days of double-blind oral olanzapine by "Rapid Initial Dose Escalation" (RIDE): 20 mg followed by 2 or 1 10 mg doses as needed on days 1–2 and 3–4, respectively; or "Usual Clinical Practice" (UCP): 10 mg followed by 2 or 1 lorazepam 2 mg dose(s) as needed, days 1–2 and 3–4, respectively. After four days of double-blind treatment, all patients received standard, open-label olanzapine doses (5–20 mg on days 5–7). Primary efficacy measure was PANSS Excited subscale.

Results: PANSS excited ratings improved significantly in both groups ($p < .001$ within group at 24 hours). Over the double-blind phase, RIDE dosing was significantly more effective than UCP ($p = 0.019$) and this difference was first significant at 24 hours ($p = 0.04$). No significant group differences existed in treatment-emergent adverse events or laboratory abnormalities. Final mean olanzapine dose was similar in both groups.

Conclusions: Subjects experienced greater agitation improvement with a RIDE approach than standard dosing. Loading dose strategies merit further evaluation.

REFERENCES:

1. Callahan JT, Bergstrom RF, Ptak LR, Beasley CM: Olanzapine: Pharmacokinetic and pharmacodynamic profile. Drug Disposition 1999; 37:177–193.
2. Meehan K, Zhang F, David S, Tohen M, Janicak P, Small J, Koch K, Rizk R, Walker D, Tran P, Breier A: A double-blind, randomized comparison of the efficacy and safety of intramuscular injections of olanzapine, lorazepam, or placebo in treating acutely agitated patients diagnosed with bipolar mania. Journal of Clinical Psychopharmacology 2001; 21:389–397.

No. 33
OLANZAPINE COMBINED WITH LITHIUM OR VALPROATE FOR RELAPSE PREVENTION OF BIPOLAR DISORDER: AN 18-MONTH STUDY

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M.D., Richard C. Risser, M.S.C., Angela R. Evans, Ph.D., Joseph R. Calabrese, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should be able to determine the benefit of the use of olanzapine in augmentation therapy for mood stabilization in bipolar I disorder.

SUMMARY:

Objective: To determine whether olanzapine cotherapy reduces symptomatic relapse among bipolar patients treated with lithium or valproate.

Methods: Following six weeks of acute therapy, patients remitting on olanzapine combined with lithium or valproate were randomized to olanzapine (5–20 mg/day, n = 30) or placebo (n = 38), concomitant with ongoing valproate (50–125 μg/mL) or lithium (0.6–1.2 mEq/L).

Results: Among patients who achieved symptomatic remission of bipolar disorder at the end of the acute therapy, 55.3% and 36.7% of placebo- and olanzapine-treated patients, respectively, relapsed into either mania or depression (bipolar relapse) during this 18-month trial (P = .149). Time to bipolar relapse, however, was significantly different (P = .023) between groups: 25% of placebo- and olanzapine-treated patients had relapsed into either mania or depression by days 15 and 124, respectively. Relapse to mania was observed in 28.9% and 20.0% of placebo-treated and olanzapine-treated patients, respectively (P =. 574), whereas rates of relapse to depression were 39.5% and 23.3% (P = .197).

Conclusion: In bipolar patients stabilized on olanzapine plus lithium or valproate, continued treatment with olanzapine significantly delayed symptomatic relapse compared with treatment with lithium or valproate alone.

Funding provided by Eli Lilly and Company.

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1. Tohen M, Zarate CA Jr: Antipsychotic agents and bipolar disorder. J Clin Psychiatry 1998; 59:38–49.
2. Tohen M, Sanger TM, McElroy SL, Tollefson GD, et al: Olanzapine versus placebo in the treatment of acute mania. Am J Psychiatry 1999; 156:702–709.

No. 34
OLANZAPINE VERSUS DIVALPROEX SODIUM FOR MANIA: A 47-WEEK STUDY

Robert W. Baker, M.D., *Eli Lilly and Company, Lilly Corporate Center, Drop Code 4133, Indianapolis, IN 46285;* Mauricio F. Tohen, M.D., Lori L. Altshuler, M.D., Carlos M. Zarate, Jr., M.D., Patricia Suppes, M.D., Terence A. Ketter, M.D., Richard C. Risser, M.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss relative findings for olanzapine and divalproex sodium in longer-term use in patients with bipolar disorder.

SUMMARY:

Objective: To compare olanzapine and divalproex for longer-term efficacy and safety in mania.

Method: This 47-week, randomized, double-blind study compared olanzapine (5–20 mg/day) with divalproex sodium (500–2500 mg/day) for bipolar manic or mixed episodes (N = 251). Young-Mania Rating Scale (Y-MRS) ≥ 20 was required for inclusion, with scores ≤ 12 for remission.

Results: Over the 47-week trial, olanzapine-treated patients had better mean Y-MRS improvement ($p < .01$) and shorter time to mania remission ($p = .047$). After three weeks, mania remission rate was significantly higher for olanzapine (47.2%) than divalproex (34.1%) ($p = .039$); among remitters, mania relapse rates did not differ statistically between treatments during the 44-week continuation: olanzapine (40.7%), divalproex (50.0%) ($p = .418$). Median time to relapse was 270 and 74 days for olanzapine- and divalproex-treated patients, respectively ($p = .392$). Treatment-emergent adverse events and laboratory abnormalities more frequent with olanzapine ($p < .05$) were somnolence, dry mouth, increased appetite, weight gain, akathisia, and liver function test (increased ALT), and for divalproex ($p < .05$) were nausea, nervousness, manic reaction, rectal disorder, and decreased platelets. Mean weight increase (LOCF) was olanzapine 3.4 kg vs. divalproex 1.7 kg ($p = .045$).

Conclusion: Compared with divalproex-treated patients, olanzapine-treated patients had significantly greater mania improvement and faster time to remission.

REFERENCES:

1. Bowden CL, Calabrese JR, McElroy SL, Gyulai L, et al: A randomized, placebo-controlled 12-month trial of divalproex and lithium in treatment of outpatients with bipolar I disorder. Divalproex Maintenance Study Group. Arch Gen Psychiatry 2000; 57:481–9.
2. Tohen M, Jacobs TG, Grundy SL, McElroy SL, et al: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. The Olanzapine HGGW Study Group. Arch Gen Psychiatry 2000; 57:841–9.

SCIENTIFIC AND CLINICAL REPORT SESSION 12—HEALTH SERVICES RESEARCH

No. 35
CONSENSUS DEVELOPMENT ON CORE QUALITY MEASURES FOR MENTAL HEALTH CARE

Richard C. Hermann, M.D., *Cambridge Hospital, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA 02139;* Scott E. Provost, M.S.W., Jeffrey Chan, B.S., Greta Lagodmos, B.A., Michael Shwartz, Ph.D., R. Heather Palmer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the role of process measurement in internal and external quality improvement initiatives for health care; measure attributes that characterize their meaningfulness and feasibility in quality improvement activities; describe dimensions of the health care system that should be represented in a core set of mental health quality measures used.

SUMMARY:

Objective: Standardized core measures are needed to compare quality of care across sites and facilitate quality improvement. This research sought to develop a core measure set based on (1) a framework of dimensions of health care delivery, (2) a formal consensus development process among stakeholders, (3) quantitative ratings of measure meaningfulness and feasibility.

Method: Drawing from a national inventory of 308 quality measures, 116 were selected based on their operationalization, data availability, and face validity. A 12-member stakeholder panel, including individuals from major accreditors, clinician and consumer groups, government agencies, and plans, rated measure meaningfulness and feasibility using a two-stage modified Delphi consensus development process. High-ranking measures were mapped to a dimensional framework.

Results: A total of 29 measures were identified as meaningful, feasible, and representative of varied domains of health care process, including treatment (13 measures), access (2), assessment (2), conti-

nuity (4), coordination (2), prevention (1), and safety (5). Measures were balanced among treatment modalities, clinical settings, diagnostic categories, vulnerable populations, and other dimensions. Fifty-nine percent of measures were based on research evidence and 41% on clinical consensus.

Conclusion: A systematic approach to measure assessment and consensus development can be used to select measures for quality improvement activities. Core measures may reduce reporting burden, facilitate comparisons across sites, and focus further measure development in priority areas.

REFERENCES:

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2. Hermann RC, Palmer RH: Common ground: a framework for selecting core quality measures for mental health and substance abuse care: Under review, 2001.

No. 36
IMPROVING THE COMPETENCY OF CLINICIANS TREATING PEOPLE WITH MENTAL ILLNESS

Alexander S. Young, M.D., *VISN22 MIRECC, West Los Angeles Veterans Administration, 11301 Wilshire Boulevard, Building 210A, Los Angeles, CA 90073;* Sandra L. Forquer, Ph.D., Matthew J. Chinman, Ph.D., Melissa Rowe, Ph.D., Anita Miller, Ph.D., Edward Knight, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify clinical competencies that are needed to provide high-quality care to people with severe, persistent mental illness; and understand approaches that can be used to improve the competency of clinicians in publicly financed mental health organizations.

SUMMARY:

Objective: Test the effectiveness of an intervention designed to improve rehabilitation and empowerment competencies in clinicians providing services to clients with severe, persistent mental illness; and increase client use of self-help. The intervention focuses on 15 of 37 competencies previously identified as necessary to provide high quality care to this population.

Method: Twelve-month controlled trial in two western states of intensive education, structured dialogues, and consultation to improve clinical competencies; and support and technical assistance to facilitate the formation of self-help services. Two provider organizations were assigned to the intervention and three to usual care. Clinicians' competencies were evaluated using a new, valid instrument. Organizational changes were characterized. Service provision was measured by record review.

Results: The intervention has been successfully implemented. Clinician participation rates have been high (79%). There was competency improvement at two weeks in rehabilitation ($p < .001$), holistic approach ($p = .045$), optimism ($p = 0.022$), and recovery orientation ($p = .001$); and trends toward improvement in most other competencies and overall competency ($p = .065$). Eleven self-help groups have formed.

Conclusion: Clients often do not have access to effective medical and rehabilitative services. This intervention shows promise for improving clinical competencies that enhance client outcomes.

REFERENCES:

1. Young AS, Sullivan G, Burnam MA, Brook RH: Measuring the quality of outpatient treatment for schizophrenia. Archives of General Psychiatry 1998; 55, 611–7.
2. Young AS, Forquer SL, Tran A, Starzynski M, Shatkin J: Identifying clinical competencies that support rehabilitation and empowerment in individuals with severe mental illness. Journal of Behavioral Health Services & Research 2000; 27, 321–33.

TUESDAY, MAY 21, 2002

SCIENTIFIC AND CLINICAL REPORT SESSION 13—GENDER ISSUES

No. 37
MEAT CONSUMPTION AND RISK OF DEPRESSION: A PROSPECTIVE, POPULATION-BASED STUDY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the importance of nutritive factors in depression.

SUMMARY:

Objective: Fish oil-derived omega-3 fatty acids appear to be beneficial both to physical and mental health. A meat-rich diet may contain considerable amounts of saturated fats, which may counteract the favorable effects of omega-3 polyunsaturated fats.

Method: Subjects were randomly selected and included 2,339 men aged 42 to 60 years who had no current depressive symptoms at baseline examination. The average follow-up time was 12 years (from 1984 to 1999). Meat consumption was estimated with a four-day food record. Depressive episodes were ascertained with the hospital discharge registry.

Results: A total of 48 men had a depressive episode requiring hospitalization during the follow-up. In a Cox model adjusting for covariates, men in the highest tertile of sausage consumption had an increased risk (RR = 2.65, 95% CI's: 1.22–5.74, $p = 0.013$) of depression compared with men in the lowest tertile. Pork, beef, and total meat consumption were not associated with the risk of depression. Heavy sausage users also had a lower proportion of eicosapentaenoic and docosahexaenoic acid of serum concentration of all fatty acids compared with others ($p = 0.028$ and $p = 0.001$ for linearity, respectively).

Conclusion: A high sausage consumption may increase the risk of depression, and this could be due to a reduced availability of omega-3 fatty acids.

REFERENCES:

1. Rissanen T, Voutilainen S, Nyyssönen K, Lakka TA, Salonen JT: Fish oil-derived fatty acids, docosahexaenoic acid and docosapentaenoic acid, and the risk of acute coronary events. The Kuopio Ischaemic Heart Disease Risk Factor Study. Circulation 2000;102:2677–9.
2. Tanskanen A, Hibbeln JR, Hintikka J, Haatainen K, Honkalampi K, Viinamäki H: Fish consumption, depression, and suicidality in a general population. Arch Gen Psychiatry 2001;58:512–3.

No. 38
A MULTINATIONAL STUDY OF THE EMERGENCE OF GENDER DIFFERENCES IN DEPRESSION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the age at which the prevalence of depression escalates among adolescent girls to assist in the prevention, recognition, and treatment of adolescent-onset depression.

SUMMARY:

Objective: While the gender gap in depression among adults is well established, the age when this phenomenon appears during adolescence is less clear. To address this, we present a cross-national examination of the emergence of the gender gap in depression during adolescence using national longitudinal panel data from Canada, Great Britain, and the U.S.

Method: The two-wave 1994–1996 Canadian National Population Health Survey employs a diagnostic measure across a 24-month interval providing 12-month prevalence rates of major depressive disorder. The British Youth Panel measures depressive symptomatology across five annual waves beginning in 1995. The two-wave 1995–1996 National Longitudinal Study of Adolescent Health uses a measure of depressive symptomatology across a 12-month interval.

Results: Females have significantly higher rates of depression for each sample overall. When samples are decomposed by age, the gender gap in depression consistently emerges by age 14 across all three samples irrespective of the measure employed or whether categorical cut-offs or untransformed scale scores are used for depressive symptomatology.

Conclusions: There is a consistent pattern in the onset of the gender gap in depression across all three countries and measures at age 14. This consistency provides important etiologic clues concerning underlying causes of depression and identifies at what age diagnosis, treatment, and intervention strategies should be directed.

REFERENCES:

1. Angold A, Costello EJ, Worthman CM: Puberty and depression: the roles of age, pubertal status and pubertal timing. Psych Med 1998; 28:51–61.
2. Hankin BL, Abramson LY, Moffitt TE, Silva PA, McGee R, Angell KE: Development of depression from preadolescence to young adulthood: emerging gender differences in a 10 year longitudinal study. J Abnorm Psychol 1998; 107:128–140.

No. 39
EFFICACY AND SAFETY OF SILDENAFIL CITRATE IN MEN WITH DEPRESSION AND ERECTILE DYSFUNCTION: SIX-MONTH, OPEN-LABEL TREATMENT

Stuart N. Seidman, M.D., *Department of Psychiatry, Columbia Presbyterian Medical Center, 1051 Riverside Drive, Unit 98, New York, NY 10032;* Steven P. Roose, M.D., Vera J. Stecher, Ph.D., Matthew A. Menza, M.D., Raymond C. Rosen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize some of the factors related to the complicated bidirectional relationship between erectile dysfunction and depression, and the therapeutic implications of long-term treatments.

SUMMARY:

Objective: Despite indications that depressed men are less responsive to treatments for erectile dysfunction (ED), we demonstrated that sildenafil was more effective than placebo in a double-blind trial involving 152 men with ED and minor depression. The current study evaluated the long-term safety and efficacy of sildenafil during an open-label treatment extension.

Method: Entry criteria included ED for ≥ 6 months (mean = 5.7 years), DSM-IV diagnosis of depressive disorder NOS, and HAM-D score ≥ 12 (mean = 16.9). A total of 136 men (mean age, 56 years) entered the 24-week, open-label phase. The 50 mg starting dose of sildenafil could be adjusted based on efficacy and tolerability. At weeks 2, 4, 6, 16, and 24 (or at discontinuation), subjects completed a three-question global efficacy assessment (GEA) on the ability to achieve/maintain an erection.

Results: A total of 111 men completed the 24-week, open-label phase. End-of-study GEA responses indicated that 89% of patients had consistently improved erectile function. Fifty-three percent experienced treatment-related adverse events that were generally mild or moderate, most commonly flushing (21%), dyspepsia (13%), and chromatopsia (7%).

Conclusion: Sildenafil remained effective and well tolerated in men with ED and minor depression for six to nine months.

Funding provided by Pfizer Inc.

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1. Seidman SN, Roose SP, Menza MA, Shabsigh R, Rosen RC: Treatment of erectile dysfunction in men with depressive symptoms: results of a placebo-controlled trial with sildenafil. Am J Psychiatry 2001; in press.
2. Shabsigh R, Klein LT, Seidman S, Kaplan SA, Lehroff BJ, Ritter JS: Increased incidence of depressive symptoms in men with erectile dysfunction. Urology 1998;52:848–852.

SCIENTIFIC AND CLINICAL REPORT SESSION 14—BIPOLAR TREATMENT ISSUES

No. 40
END-STAGE CHRONIC RENAL FAILURE FROM PROLONGED LITHIUM THERAPY

Gregory Braden, M.D., *Baystate Medical Center, 759 Chestnut Street, Springfield, MA 01109;* David L. Honeyman, M.D., Anthony Poindexter, M.D., Jane Garb, M.S., Michael Germain, M.D., Lewis M. Cohen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to diagnose and treat those patients who develop chronic renal failure from lithium.

SUMMARY:

Objective: Although lithium therapy has been associated with renal structural changes and reduced glomerular filtration rate, the effects of long-term Li use >10 years have not been elucidated.

Methods: We analyzed all patients (pts) referred to our center from 1984–1998 for evaluation of possible lithium-induced chronic renal failure (Li CRF). Forty pts were evaluated. The mean age was 51 ± 2 years (yrs) and the mean duration of Li use was 10.6 ± 2 yrs. After ruling out all other causes of CRF by complete serologic and radiographic evaluation, 28 pts (22 female and 6 male) had Li CRF measured as serum creatinine (Scr) > 1.4 mg/dl or sodium iothalamate clearance (IC) < 80 ml/min.

Results: The mean Scr was 1.8 ± 2 mg/dl and the mean IC was 55 ± 6 ml/min at the time of diagnosis. Two pts had nephrogenic diabetes insipidus (NDI) and two pts had at least one episode of Li intoxication. Scr at the time of diagnosis correlated positively with the duration of Li exposure ($r = .62$, $p < .01$). IC correlated inversely with duration of Li ($r = .51$, $p < .05$). Five pts underwent renal biopsy showing classic lesions of Li-CRF with microcystic tubular changes. Li was stopped in 14 pts. After a mean of 61 ± 6 mos, Scr decreased from 1.8 ± .3 to 1.5 ± .5 mg/dl, $p = .007$, and IC increased from 47 ± 5 to 60 ± 10 ml/min, $p = .01$. All 14 pts did

well on valproic acid or carbamazepine. Nine pts who remained on a reduced dose of Li due to psychological dependence had decreased renal function after 63 mos follow up. Scr increased from 1.4 ± .2 to 1.8 ± .3 mg/dl, p < .01 and IC decreased from 63 ± 7 to 57 ± 5 ml/min, p = .19. Five pts treated for 23 ± 2 yrs required dialysis or renal transplantation. Four of nine pts treated for > 20 yrs reached ESRD vs one of 23 pts treated for <20 yrs (p<0.05).

Conclusions: Five years after discontinuing Li therapy, the majority of pts with Li CRF treated for <20 yrs had improved renal function with a significant decrease in Scr and a significant increase in IC. Li use for >20 yrs was associated with a significant risk for ESRD. NDI and episodes of Li intoxication were not associated with Li CRF.

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2. Bendz H, Aurell M, Balldin J, Mathe AA, Sjodin I: Kidney damage in long-term lithium patients: a cross-sectional study of patients with 15 years or more on lithium. Nephrol Dial Transplant 1994; 9:1254.

No. 41
TOPIRAMATE IN THE TREATMENT OF REFRACTORY BIPOLAR DEPRESSION

Mohammad Z. Hussain, M.D., *Prince Albert Health District, Mental Health Centre, 2727 2nd Avenue West, Prince Albert, SK S6V 5E5, Canada;* Zabaida A. Chaudhry, M.D., Seema Hussain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the seriousness and management difficulties of bipolar mood disorder, effectiveness of topiramate as a mood stabilizer, and significance of weight loss in treatment compliance.

SUMMARY:

Bipolar disorder, a serious debilitating illness, affects over 2% of the population. Frequent treatment failure remains a major concern. The novel antiepileptic drugs lamotrigine, gabapentin, and topiramate have been successfully used as mood stabilizers. Most trials have been short-term with limited followup. Long-term studies are essential to assess efficacy and patient acceptability because of the chronic, recurrent nature of this illness.

A total of 135 patients meeting DSM-IV criteria for bipolar I or II disorder, depressed phase, received open-label treatment with topiramate: 46 males, 89 females, mean age 34, mean age of onset 21, mean duration of current episode 11 weeks, bipolar I(62) and bipolar II(73). All were previously treated with mood stabilizers and antidepressants but failed to respond adequately. They were rated on the Hamilton Depression Rating Scale, met criteria for major depression, and were subsequently rated at 1-2-3-6-12-18-24-30-36-month intervals. Topiramate was given at a starting dose of 25 mg/hs, rising every two days to 200 mg/hs, and later up to a maximum of 600 mg/day. All patients completing the 36-month trial were good responders (HDRS score 0–8). Clinically significant responses were seen within two to four weeks. A total of 47 patients discontinued medication. Results support evidence that topiramate is an effective mood stabilizer. Mean weight loss was 17.2 kg by completion of the study.

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1. McElroy SL, Suppes T, Keck PE Jr, et al: Open-label adjunctive topiramate in the treatment of bipolar disorders. Biol Psychiatry 2000;47:1025–33.
2. Marcotte D: Use of topiramate: a new antiepileptic as a mood stabilizer. J Affect Disord 1998;59:245–51.

No. 42
PRESCRIBING PRACTICES IN BIPOLAR DISORDER

Bonnie L. Szarek, R.N., *Institute of Living, 400 Washington Street, Hartford, CT 06106;* John W. Goethe, M.D., Uzma S. Faheem, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe current prescribing practices for bipolar disorder.

SUMMARY:

Objective: Given recent attention to the apparent increase in "polypharmacy," the authors prospectively monitored treatment of inpatients with bipolar disorder to determine the extent to which patients receive concurrent psychotropics.

Methods: Subjects were consecutively admitted patients in fiscal year 2001 with a diagnosis of bipolar disorder (N = 535). For each patient all demographic and treatment data were recorded. For comparison, similar data were retrospectively obtained from 1995. Data were analyzed with chi square and t-tests.

Results: One or more mood stabilizers were prescribed for 80.2% (N = 429) of patients, most commonly valproic acid (N = 200). A total of 62 patients received two or more mood stabilizers concurrently, most commonly valproic acid and gabapentin (24.6%, N = 14). Lithium was used as monotherapy in only 86 patients. Compared with 1995, lithium use has decreased (46% vs 21%). Antipsychotic use was common (70.7%, N = 378), and antidepressants were prescribed for approximately half of all patients (51.1%, N = 273).

Conclusions: These data are consonant with other recent reports indicating that polypharmacy is common in mood disorders. Polypharmacy may improve patient outcomes but also has implications for cost of care and side-effect burden.

Funding Source: author's institution.

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1. Frye MA, Ketter TA, Leverich GS, Huggins T, Lantz C, Denicoff KD, Post RM: The increasing use of polypharmacotherapy for refractory mood disorders: 22 years of study. J Clin Psychiatry 2000; 61:9–15.
2. Post RM, Ketter TA, Denicoff K, Pazzaglia PJ, Leverich GS, Marangell LB, et al: The place of anticonvulsant therapy in bipolar illness. Psychopharmacology 1996; 128:115–129.

No. 43
ONCE-DAILY ADMINISTRATION OF ATOMOXETINE: A NEW TREATMENT FOR ADHD

David Michelson, M.D., *Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, DC 0721, Indianapolis, IN* 46285

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the mechanism of action of atomoxetine, be able to make a judgment about its efficacy and potential place as a therapy for ADHD, and understand some of the pharmacologic mechanisms that could account for persistence of effect despite declining plasma drug levels.

SUMMARY:

Objective: Stimulants are currently the most widely used therapies for ADHD. We assessed the safety and efficacy of atomoxetine, a new, nonstimulant drug being studied as a treatment for ADHD in children and adults, which has previously been assessed using only twice-daily administration.

Methods: Atomoxetine was studied in a six-week, double-blind, placebo-controlled, parallel design in children and adolescents with weight-adjusted, once-daily administration each morning. Outcomes

were assessed with investigator, parent, and teacher reports using an intent-to-treat analysis.

Results: Atomoxetine (N = 86) was superior to placebo (N = 84) as assessed by investigator, parent, and teacher reports, with a treatment effect size of 0.71 for the primary outcome measure. Data from a parent diary suggested that drug-specific effects were sustained into the evening. Discontinuations due to adverse events were low for both groups (atomoxetine 2.3%, placebo 1.2%).

Conclusion: Atomoxetine is a promising therapy for children and adolescents. Once-daily administration of atomoxetine is effective and appears to be safe and well tolerated. The treatment effect size is similar to that observed with twice-daily therapy, and evidence suggests that drug-specific effects are maintained throughout the day. These data also indicate that efficacy associated with atomoxetine may be associated with regulatory changes that persist beyond the drug's plasma half-life.

REFERENCES:

1. Spencer, et al: Effectiveness and tolerability of atomoxetine in adults with attention deficit hyperactivity disorder Am J Psychiatry 1998; 155:693–5.
2. Michelson, et al: Atomoxetine in the treatment of children and adolescents with ADHD: A randomized, Placebo-controlled, dose-response study. Pediatrics, in press.

SCIENTIFIC AND CLINICAL REPORT SESSION 15—DRUG THERAPY OF ADHD

No. 44
ADHD TREATMENT WITH A ONCE-DAILY FORMULATION OF METHYLPHENIDATE HYDROCHLORIDE: A TWO-YEAR STUDY

Timothy E. Wilens, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114;* William E. Pelham, Jr., Ph.D., Mark Stein, Ph.D., C. Keith Conners, Ph.D., Howard Abikoff, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that the OROS® formulation of MPH offers an effective and well-tolerated once-daily therapy option for the longer-term treatment of children with ADHD.

SUMMARY:

Objective: To assess the long-term efficacy and safety of a once-daily OROS® formulation of methylphenidate HCl (MPH) in children with attention-deficit/hyperactivity disorder (ADHD).

Methods: Four hundred seven children with ADHD, ages 6 to 13 years, were enrolled in this open-label, multicenter study. Children received the OROS® formulation of MPH qd for up to 24 months. All children had participated in previous short-term, controlled studies of the OROS® formulation of MPH qd. Efficacy was assessed monthly by parents and teachers during the first year and every three months by parents during the second year, using established measures. Adverse events were recorded from parent reports. In addition, parents assessed their child's tics and sleep quality, and children's vital signs were monitored throughout the study.

Results: Efficacy ratings showed that treatment efficacy was maintained throughout the 24-month study period. Treatment was well tolerated, with a similar safety profile to that seen in shorter-term studies of the OROS® formulation of MPH. Adverse events were characteristic of those seen with short-acting MPH treatment.

Conclusions: Once-a-day dosing with the OROS® formulation of MPH appears to be well tolerated and efficacy was maintained for up to 24 months in this sample of children with ADHD.

This research was funded by ALZA Corporation, Mountain View, CA.

REFERENCES:

1. Pelham WE, Gnagy EM, Burrows-Maclean L, et al: Once-a-day Concerta™ methylphenidate versus three-times-daily methylphenidate in laboratory and natural settings. Pediatrics 2001;107(6):e105.
2. Wolraich M, Greenhill LL, Pelham WE, et al. on behalf of the Concerta™ Study Group: Randomized controlled trial of OROS® methylphenidate qd in children with attention-deficit/hyperactivity disorder. Pediatrics 2001, in press.

No. 45
LONG-TERM SAFETY AND EFFICACY OF ADDERALL EXTENDED RELEASE IN CHILDREN WITH ADHD

Mark C. Chandler, M.D., *North Carolina Neuropsychiatry, 1829 East Franklin Street, Building 400, Chapel Hill, NC 27514;* Frank A. Lopez, M.D., Joseph Biederman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the long-term safety and therapeutic effects of Adderall XR in the treatment of pediatric ADHD.

SUMMARY:

Objective: The efficacy and extended duration of action of Adderall XR in the treatment of children with attention-deficit/hyperactivity disorder (ADHD) has been demonstrated in prior double-blind studies. This study is being conducted to assess the long-term safety and efficacy of Adderall XR therapy.

Method: An 18-month interim analysis of an ongoing, multicenter, open-label extension trial will be presented. Adderall XR treatment was initiated at 10 mg daily and could be titrated up to 30 mg/day. Safety assessments were performed at each visit and efficacy was assessed by the Conners 10-item Global Index Scale—Parent version (CGIS-P).

Results: Twelve-month data available at the time of this submission show 509 subjects in the intent-to-treat (ITT) population. Efficacy was maintained over course of the year: quarterly CGIS-P total scores (mean ± SD) were 11.8 ± 8.2, 8.9 ± 5.3, 8.3 ± 5.8, 8.2 ± 5.8, and 6.9 ± 5.6 for baseline and quarters 1 to 4, respectively. The most commonly reported adverse events were headache (10.6%), anorexia (9.0%), insomnia (6.1%), and abdominal pain (5.9%). Most AEs were mild or moderate in intensity.

Conclusion: Adderall XR was well tolerated at daily doses from 10- to 30-mg, and demonstrated persistent therapeutic effects over one year of therapy.

Supported by Shire Pharmaceutical Development Inc.

REFERENCES:

1. McCracken J, Biederman J, Greenhill L, et al: Analog classroom assessment of SLI381 for the treatment of ADHD. Poster presentation at the 47th Annual Meeting of the American Academy of Child and Adolescent Psychiatry. New York, NY, October 26, 2000.
2. Biederman J, Lopez F, Boeliner S, et al: Once-daily-dosed SLI381 for pediatric ADHD. Platform presentation at the 154th Annual Meeting of the American Psychiatric Association. New Orleans, LA, May 9, 2001.

No. 46
PARTNER VIOLENCE AND RISK OF MAJOR DEPRESSION IN CHINESE-AMERICAN WOMEN

Madelyn H. Hicks, M.D., *Department of Social Medicine, Harvard Medical School, Maudlsey Hospital, Denmark Hill, London SE5 8AZ, United Kingdom*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: (1) recognize that a history of partner violence strongly increases the risk of major depression in Chinese American women, and (2) use this methodology to examine the possible role of partner violence in the epidemiology of depression in other populations of women.

SUMMARY:

Objective: To determine if partner violence is associated with the diagnosis of major depression in a community, probability sample of Chinese-American women. This specific approach was previously not used in women of any ethnicity.

Method: Cross-sectional and retrospective, combining epidemiological and ethnographic methods. A total of 181 Chinese-American women were randomly sampled from households in the Boston census. Outcomes from a structured interview were (1) history of partner violence; (2) lifetime, 12-month, and current major depression identified by the CIDI 2.1; and (3) year of first onset.

Results: Partner violence increased rates of major depression in the lifetime (RR = 4.0, $p < .0001$), previous 12-months (RR = 3.7, $p = .01$), and currently (RR = 5.9, $p = .04$). Partner violence increased severity of depression, with a dose effect. In women with histories of both, twice as many had first onset of major depression during or after violence, rather than before. Adjusted for other factors in multinomial logistic regression, partner violence multiplied the odds of having lifetime major depression by over eight times.

Conclusions: Partner violence is strongly associated with increased risk of major depression in Chinese-American women. This study's methodology could examine the possible causal role of partner violence in the epidemiology of major depression among women of any ethnicity.

Funding Source: A Young Investigator grant from the National Association for Research on Schizophrenia and Depression (NARSAD).

REFERENCES:

1. Straus MA, Gelles RJ: Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families. London, Transaction Publishers, 1990.
2. Giles-Sims J: The aftermath of partner violence, in Partner Violence: A Comprehensive Review of 20 Years of Research. Edited by Jasinski JL, Williams LM, London, Sage Publications, 1998, pp 44–72.

SCIENTIFIC AND CLINICAL REPORT SESSION 16—CULTURAL ISSUES IN VIOLENCE

No. 47
VIOLENCE IN COLOMBIA: MENTAL HEALTH IMPACT IN CHILDREN

Ruby C. Castilla-Puentes, M.D., *Department of Epidemiology, University of Pittsburgh, 3811 O'Hara Street, SWAN-Study, Pittsburgh, PA 15213;* Ivan S. Gomez, M.D., Sandra-Rocio Castilla Puentes, M.D., Wilma-Ines Castilla Puentes, M.D., Miguel Habeych, M.D., Linda McWilliams, M.P.H., Boris Birmaher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should have an understanding of mental health implications of violence in children, awareness of methodological issues related to research, and understanding of mitigating factors that place children at risk of traumatic events.

SUMMARY:

Objective: To examine psychiatric symptoms in children living in rural areas of Colombia, South America, exposed to the stress of civil war.

Methods: A total of 300 school-aged children/adolescents from a stratified, random sample of schools in a rural area in Belen, Boyacá, Colombia, were included in the study. Children and their parents and teachers, were assessed with the Screen for Child Anxiety Related Emotional Disorders (SCARED), Children Depression Inventory (CDI), a screen for alcohol and substance abuse, as well a sociodemographics information and an inventory of traumatic events.

Results: The overall response rate was 97.6%, consisting of 183 girls and 11 boys with a mean age of 12.3 years (range 10–18 years). Among all of the children, 239 (81.56%) reported a total score of > 25 in the SCARED; 205 (69.9%) a total score of >10 in the CDI; 178 children (60.8%) were exposed to traumatic events; 128 (43.7%) have never used alcohol, and surprisingly all 293 (100%) never used drugs.

Conclusions: Our results suggest that these children exposed to dangerous and violent situations in their environment are experiencing higher levels of anxiety symptoms, which is particularly more true for girls. The anxiety symptom scores in our rural population is higher than those reported in similar studies where the SCARED has been used where the children and adolescents were not exposed to the stress and violence associated with a civil war. Remarkably, family factors are protective for use of alcohol and drugs in this population. There is a need for continued monitoring of the mental health situation in Colombia.

REFERENCES:

1. Ahmad A, Mohamad K: The socioemotional development of orphans in orphanages and traditional foster care in Iraqi Kurdistan. Child Abuse Negl 1996; 20:1161–1173.
2. Berman SL, Kurtines WM, Sliverman WK, Serafini LT: The impact of exposure to crime and violence on urban youth. Am J Orthopsychiatry 1996; 66:329–336.

No. 48
EPIDEMIOLOGY, TRAUMA, AND TRANSCULTURAL PSYCHIATRY

Joop De Jong, M.D., *Transcultural Psydsoc, Keizersgracht 329, Amsterdam 101 EE, Netherlands;* Ivan Kompore, Ph.D., Mark Van Ommeren, Daya Somasundaram, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the role of moderators such as coping strategies, social support, and social network size on the effects of lifetime traumatic events on psychopathology, quality of life and disability.

SUMMARY:

Since primary prevention of traumatic stress is impossible once an armed conflict is over, identifying and modifying the effects of protective moderators is essential for the improvement of service provision and for secondary and tertiary prevention.

Methodology: Within the framework of four public mental health programs, we did an epidemiological survey among a random sample

of 3,048 respondents from communities in (post-) conflict situations in Algeria, Cambodia, Ethiopia, and Gaza. The study used nine different instruments for the assessment of demographics, lifetime traumatic events, psychopathology including PTSD and complex PTSD, peritraumatic dissociation, psychological distress, coping, social support, quality of life, and disability.

Results: This lecture will present structural equation models to show the role of moderators such as coping strategies, social support, and social network size on the effects of lifetime traumatic events on psychopathology, quality of life, and disability.

Conclusion: Transcultural aspects of psychosocial moderators must be considered in (post-) conflict populations.

REFERENCES:

1. Jong de JTMV, Komproe IH, Van Ommeren M, El Masri M, et al: Lifetime events and posttraumatic stress disorder in 4 post conflict settings. JAMA 2001;286:555–561.
2. Jong de JTVM (Ed.): War and Violence: Public Mental Health in the Sociocultural Context. New York, Plenum-Kluwer, 2002.

SCIENTIFIC AND CLINICAL REPORT SESSION 17—BIPOLAR DISORDER

No. 49
INCREASED RATES OF ANTIPSYCHOTIC-INDUCED EPS IN MOOD DISORDERS: MYTH OR REALITY?

Patrizia A. Cavazzoni, M.D., *Department of Research, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Paul H. Berg, M.S., Robert W. Baker, M.D., Angela R. Evans, Ph.D., Mauricio F. Tohen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the attendee should be able to determine the relative risk of olanzapine compared with conventional antipsychotics in inducing EPS in bipolar disorder and schizophrenia.

SUMMARY:

Objective: To determine antipsychotic-induced EPS vulnerability in bipolar disorder compared with schizophrenia.

Methods: Acute EPS profiles of olanzapine (5–20 mg/d, n = 125) and placebo (n = 129) were compared in two randomized, double-blind trials of patients with bipolar disorder. EPS profiles of olanzapine (5–20 mg/d, n = 234) and haloperidol (3–15 mg/d, n = 219) also were compared in a trial of similarly diagnosed patients. Findings were compared with those from olanzapine-placebo and olanzapine-haloperidol trials in schizophrenia. EPS was assessed as: (1) extrapyramidal adverse events, (2) objective rating scales, and (3) concomitant use of anticholinergics.

Results: Olanzapine was not significantly different from placebo on any of these EPS assessments. However, olanzapine was associated with significantly less EPS compared with haloperidol on all assessments. These analyses in bipolar patients were compared with findings in placebo- and haloperidol-controlled olanzapine studies for schizophrenia. While the placebo and olanzapine groups exhibited EPS profiles similar to like-treated patients with schizophrenia, the haloperidol group exhibited more severe EPS profiles than like-treated patients with schizophrenia.

Conclusions: These findings support the observation of increased EPS vulnerability in bipolar patients treated with haloperidol, but not olanzapine, which had placebo-like EPS rates across schizophrenia and bipolar disorders.

Funding provided by Eli Lilly and Company.

REFERENCES:

1. Kane JM, Smith JM: Tardive dyskinesia: prevalence and risk factors, 1959 to 1979. Arch Gen Psychiatry 1982;39:473–481.
2. Nasrallah HA, Churchill CM, Hamdan-Allan, GA: Higher frequency of neuroleptic-induced dystonia in mania than in schizophrenia. Am J Psychiatry 1993;145:1455–1456.

No. 50
CYCLOTHYMIA IN ATYPICAL DEPRESSION: THE BORDERLINE-BIPOLAR II CONNECTION

Giulio Perugi, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa 56100, Italy;* Christina Toni, M.D., Chiara Travierso, M.D., Giuseppe Ruffolo, M.D., Hagop S. Akiskal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that mood lability and interpersonal sensitivity traits in atypical depressives may be related to a cyclothimic temperamental matrix, to individuate a common diathesis that will make patients in this realm more accessible to pharmacologic and psychologic approaches geared to their common temperamental attributes.

SUMMARY:

Objective: The constructs of atypical depression, cyclothymia, bipolar II, and borderline personality overlap. We attempt to provide empirically-based answers to the difficulty of separating the shifting affective symptomology of these patients from their long-term temperamental and characterologic attributes.

Method: We examined in a semi-structured format, 107 consecutive patients who met DSM-IV criteria for major depressive episode with atypical features. Patients were further evaluated on the basis of the Atypical Depression Diagnostic Scale (ADDS), the Hopkins Symptoms Check-list (HSCL 90), and the Hamilton Rating Scale for Depression (HRSD), coupled with its modified form for reverse vegetative features, as well as Axis I and II comorbidity, and temperamental dispositions.

Results: Seventy-eight percent of atypical depressives met broad criteria for bipolar II. Forty-five patients who met DSM-IV criteria for cyclothymic temperament, compared with those who did not, were indistinguishable on demographic, familial and clinical features, but were significantly higher in lifetime comorbidity for panic disorder with agoraphobia, alcohol abuse, bulimia nervosa, as well as borderline, narcissistic and dependent personality disorders. Cyclothymics also scored higher on the ADDS items of maximum reactivity of mood, interpersonal sensitivity, functional impairment, avoidance of relationships, other rejection avoidance, and in interpersonal sensitivity, phobic anxiety, paranoid ideation, and psychoticism HSCL-90 factors. The total number of cyclothymic traits was significantly correlated with "maximum" reactivity of mood and interpersonal sensitivity. A significant correlation was also found between interpersonal sensitivity and "usual" and "maximum" reactivity of mood.

Conclusions: Mood lability and interpersonal sensitivity traits appear to be related as part of an underlying cyclothymic temperamental matrix in the complex pattern of anxiety, mood, and impulsive disorders, which atypical depressive, bipolar II, and borderline patients display during young adult life. We contend that conceptualizing these constructs as related with a common diathesis will make patients in this realm more accessible to pharmacologic and psychologic approaches geared to their common temperamental attributes.

REFERENCES:

1. Perugi G., Akiskal HS, Lattanzi L. et al: The high prevalence of soft bipolar (II) features in atypical depression. Compr Psychiatry 1998;39:1–9.

2. Akiskal HS: Subaffective disorders: dysthymic, cyclothymic and bipolar II disorders in the "borderline" realm. Psychiatr Clin North Am 1981;9:25–66.

No. 51
SUBSTANCE USE AND PERCEIVED SYMPTOM IMPROVEMENT IN BIPOLAR DISORDER

Roger D. Weiss, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106;* Monika Kolodziej, Ph.D., Margaret L. Griffin, Ph.D., Lisa M. Najavits, Ph.D., Lara M. Jacobson, B.A., Shelly F. Greenfield, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to understand the relationship between reasons for substance use among patients with bipolar disorder and treatment outcome.

SUMMARY:

Objective: We investigated reasons for substance use and perceived symptom improvement associated with use among patients with current bipolar disorder (BPD) and substance dependence.

Method: Forty-five patients received six monthly assessments, 21 of whom received Integrated Group Therapy (IGT), focusing simultaneously on BPD and substance dependence.

Results: Racing thoughts and depression were the BPD symptoms most frequently associated with perceived improvement from substance use. Among patients reporting BPD symptom improvement from substance use, the IGT cohort reported fewer days of drug use than the non-IGT cohort; this difference was not significant among patients without substance-induced symptom improvement.

Conclusion: Substance-dependent patients who report BPD symptom improvement from substance use may benefit from treatment that focuses simultaneously on both disorders.

This paper was supported by Grants DA-09400, DA-00326, DA-00407, DA-08631, and DA-00400 from the National Institute on Drug Abuse; and a grant from the Dr. Ralph and Marian C. Falk Medical Research Trust.

This symposium is designed for psychiatrists and other clinicians who work with patients with mood disorders, substance use disorders, and those dually diagnosed with this combination of disorders.

REFERENCES:

1. Weiss RD, Kolodziej M, Griffin ML, Najavits LM, Jacobson LM, Greenfield SF: Substance use and perceived symptom improvement among patients with bipolar disorder. Submitted to the American Journal of Psychiatry.
2. Khantzian EJ: The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. American Journal of Psychiatry 1985; 142:1259–1264.

SCIENTIFIC ANC CLINICAL REPORT SESSION 18—PREDICTORS OF OUTCOME

No. 52
OUTCOME OF EARLY-PHASE PSYCHOSIS CONCURRENT WITH SUBSTANCE USE

Carol L.M. Caton, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 56, New York, NY 10032;* Deborah S. Hasin, Ph.D., Michael B. First, M.D., Ellen M. Stevenson, M.D., Robert E. Drake, M.D., Francine Cournos, M.D., Patrick Shrout, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize similarities and differences in the early illness course of psychotic disorders that are substance induced in contrast to primary psychoses with substance use comorbidity.

SUMMARY:

Objective: How different is the early illness course of psychoses that are substance induced compared with primary psychotic disorders that co-occur with the use of alcohol and/or drugs? Comparative data based on state-of-the art diagnostic and longitudinal methods have been lacking.

Method: We are conducting a NIDA-funded longitudinal study of 400 men and women experiencing an early episode of psychotic disorder that is concurrent with substance use. Subjects are psychiatric emergency admissions who give voluntary informed consent. They are interviewed at baseline and six-month intervals with a battery of standardized assessments including a research diagnostic interview for comorbidity (PRISM).

Results: Patients with a baseline PRISM diagnosis of primary psychosis concurrent with substance use had an earlier age of onset of psychotic symptoms, greater PANSS positive and negative symptoms, and less awareness of symptoms using a symptom insight rating scale (SUMD) than patients with a substance-induced psychosis. Alcohol and cannabis use was widespread in both groups, but cocaine and hallucinogen use was greatest in the substance-induced group. At six months, outpatient attendance was low and rehospitalizations exceeded one-third in both groups. Patients with substance-induced psychoses had greater use of substances and were more likely to have been homeless, incarcerated, or suicidal.

Conclusion: Illness course in substance-induced psychoses can be of equal or greater severity as primary psychotic disorders, underscoring the importance of early assessment and treatment of psychosis and substance use comorbidity.

REFERENCES:

1. Kovasznay B, Fleischer J, Tanenberg-Karant M, Jandorf L, et al: Substance use disorder and the early course of illness in schizophrenia and affective psychoses. Schizophr Bull 1997;23: 195–201.
2. Boutros N, Bowers MB: Chronic substance-induced psychotic disorders: state of the literature. J Neuropsychiatry 1996;8: 262–269.

No. 53
PREDICTORS OF SYNDROMAL AND FUNCTIONAL RECOVERY IN PATIENTS WITH FIRST-EPISODE MANIA

Mauricio F. Tohen, M.D., *Department of Research, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* John Hennen, Ph.D., Carlos M. Zarate, Jr., M.D., Stephan M. Strakowski, M.D., Ross J. Baldessarini, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the attendee should be able to identify predictors of recovery and relapse among first-episode manic patients.

SUMMARY:

Objective: To determine predictors of recovery and relapse among first-episode manic patients.

Methods: Patients (n = 173) hospitalized with a first episode of mania were followed during recovery and for two additional years. Syndromal recovery and relapse were defined using DSM-IV criteria and assessed by survival analysis. Symptomatic recovery was defined as a YMRS total score ≤ 5 and functional recovery as gaining

vocational and residential status at or superior to baseline. Clinical and demographic factors were identified by bivariate and multivariate regression.

Results: At the 24-month follow-up, 98.9% and 93.6% of subjects achieved symptomatic and syndromic recovery, respectively. Time-to-syndromal-recovery (median = 11.2 weeks) was shorter in patients who were married, discharged sooner, aged 30 at onset, or female. Functional recovery was attained by only 34.9% of the patients and predictors included short lengths of stay, married, and aged >30. Predictors of relapse/recurrence to depression were psychotic features, mixed episode, comorbidity, high vocational status and aged > 30. Predictors of relapse/recurrence to mania included longer hospital stay, psychotic features, and low vocational status.

Conclusion: Most patients reached symptomatic and syndromal recovery within 24 months; however, only slightly more than one-third attained functional recovery by two years. Predictors varied depending on the specified outcome.

Funding provided by Eli Lilly and Company.

REFERENCES:

1. Tohen M, Hennen J, Zarate CA Jr, Baldessarini RJ, et al: Two-year syndromal and functional recovery in 219 cases of first-episode major affective disorder with psychotic features. Am J Psychiatry 2000; 157:220–228.
2. Tohen M, Stoll AL, Strakowski SM, Faedda GL, et al: The McLean first-episode psychosis project: six-month recovery and recurrence outcome. Schizophr Bull 1992; 18:273–282.

No. 54
HIGH BIRTH WEIGHT AS A PREDICTOR OF SCHIZOPHRENIA: A 31-YEAR FOLLOW-UP

Kristiina Moilanen, M.D., *Department of Psychiatry, University of Oulu, P O Box 5000, Peltolantie 5, Oulu 90014, Finland;* Jari Jokelainen, M.S.C., Anna-Liisa Hartikainen, Ph.D., Marjo-Riitta Jarvelin, Ph.D., Peter B. Jones, Ph.D., Matti K. Isohanni, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that nutritional factors in early life may contribute to the development of schizophrenia.

SUMMARY:

Objective: The Northern Finland 1966 Birth Cohort was studied to determine the association between high birth weight and risk for schizophrenia.

Methods: All subjects (n = 10, 558) whose birth weight was available were included in the study. Psychiatric outcome (DSM-III-R) was ascertained through linkage to a national hospital discharge register. Associations (adjusted odds ratios) between schizophrenia and birth weight were calculated.

Results: An increased risk of schizophrenia was associated with the high birth weight for gestational age (OR 2.7, 95% CI 1.2–6.4) but not with low (OR 1.3, 95% CI 0.2–10.1). Among males increased risk for schizophrenia was significantly associated with large size for gestational age (OR 2.8, 95% CI 1.1–7.2). In females birth weight was not related to risk of schizophrenia

REFERENCES:

1. Wahlbeck K, Forsen T, Osmond C, Barker DJP, Eriksson JG: Association of schizophrenia with low maternal body mass index, small size at birth, and thinness during childhood. Arch Gen Psychiatry 2001; 58: 48–52.
2. Jones PB, Rantakallio P, Hartikainen A-L, Isohanni I: Schizophrenia as a long-term outcome of pregnancy, delivery and perinatal complications: a 28-year follow-up of the 1966 North Finland General Population Birth Cohort. Am J Psychiatry 1998, 155; 355–364.

SCIENTIFIC AND CLINICAL REPORT SESSION 19—BEHAVIOR AND COGNITIVE THERAPY

No. 55
DOES COGNITIVE-BEHAVIORAL GROUP TREATMENT IMPROVE PERSONALITY MEASURES IN PANIC DISORDER PATIENTS?

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognise the impact of cognitive-behavioural group therapy (CBGT) in the personality of panic disorder patients.

SUMMARY:

Objectives: Our work aims to study the result of therapeutic manipulations in the patients' morbid personalities. We hypothesized that cognitive behavioral group treatment (CBGT) improves personality dimensions in patients with panic disorder with agoraphobia (PDA). We believe that personality is subject to alterations through time and that therapeutic formats can influence personality vulnerabilities.

Methods: Patients were selected according to DSM IV criteria for PDA. The experimental group (n = 14) received pharmacotherapy plus CBGT while the control group (n = 14) received pharmacotherapy only.

According to a longitudinal design, two full evaluations were performed before and after a period of three months of treatment. Each evaluation included the following assessment tools: Mini-Mult; SCL-90; HARS; HRSD; BID and the SF-36. The raw data were statistically processed using univariate-repeated measures analysis of variance.

Results: Our results confirmed our initial hypothesis. Indeed, several Mini-Mult dimensions showed a significant decrease, namely hypochondria, psychopathy, psychoasthenia, and depression. The results provided by the Mini-Mult were generally congruent with similar measures obtained with the other scales applied, which gives a certain degree of consistency among our set of results.

Conclusions: CBGT improves some personality dimensions in patients with PDA. A high score in Mini-Mult Psychopathy dimension evidences a strong characterological derangement and transmutes mainly into incapacity to develop normal interpersonal relationships. The improvement seen in psychoasthenia may be consequent to a decrease in phobic fears as a result of CBGT. Our study highlights the importance of CBGT in the treatment of PDA.

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No. 56
VISUALLY ENHANCED PSYCHOSEXUAL THERAPY

Frank G. Sommers, M.D., *406-360 Bloor Street, West, Toronto, ON M5S 1X1, Canada*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should have increased familiarity, comfort, and skill with the modern sex therapy multicultural community.

SUMMARY:

This paper will review 25 years of a psychiatric/sexological practice in a large urban, multicultural community, incorporating the use of film and video. The power of images to move individuals is well recognized by Hollywood, television, and the advertising industry. Their use in medicine in general, and sex education and therapy in particular, is less well established, but no less effective or powerful, if used in the right manner.

We will outline and illustrate the preparation of patient(s) (couples and single men and women), and the careful introduction, setting, and detailed debriefing that must accompany the use of any visual aid in order to promote optimal therapeutic progress.

Cognitive restructuring, behavioral change, and emotional healing are significantly, and often critically, enhanced by the ethical use of appropriate audiovisual aids in modern sex therapy.

In work with patients whose English language skills are deficient, visually enhanced sex therapy may be the most effective tool to promote desired therapeutic progress.

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2. Sommers FG: Use of Videos in Sex Education, Counselling and Therapy. Proceedings of the 13th World Congress of Sexology, Valencia, Spain. ECVSA.

No. 57
DICHOTOMOUS THINKING AND THOUGHT SUPPRESSION IN MANAGING ANGER

David M. Magder, M.D., *University of Toronto, 586 Eglinton Avenue East, Suite 505, Toronto, ON M4P 1P2, Canada*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to utilize the principles of dichotomous thinking and thought suppression in the management of emotion, in particular, anger.

SUMMARY:

Objective: To demonstrate that combining two cognitive principles: dichotomous thinking (polarized, absolutistic or all-or-nothing thinking) and thought suppression has utility in the analysis and management of emotional behavior using anger as a prototypical example.

Method: Observation from a general practice of psychiatry.

Results: Many patients who sincerely wish to control their emotions find themselves confounded because they see emotion in a polarized manner. With anger, for example, individuals see themselves as either completely calm or explosive in their rage. Because the explosive nature of their anger is so repugnant to them, they attempt to suppress all manifestations of anger. This leads to a paradoxical intensification of the anger when it is expressed, validating their (incorrect) view that they must work even harder to subdue the emotion. A vicious cycle is established. Teaching them to recognize the graduations of anger and appropriately express themselves in the low or middle ranges enables the effective management of their emotion.

Conclusion: Patients can effectively cope with emotions when they are taught the significance of dichotomous thinking and thought suppression. Parental modeling is likely the origin of the distorted approach to the management of emotions.

No funding

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SCIENTIFIC AND CLINICAL REPORT SESSION 20—ETHICAL AND EXPLANATORY MODELS IN PSYCHIATRY

No. 58
PRINCIPLES OF CLINICAL EXPLANATION IN 21ST-CENTURY PSYCHIATRY

David H. Brendel, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) understand the conceptual and clinical significance of explanatory models in psychiatry, (2) recognize the need for an explanatory model that is neither reductionistic nor eclectic, (3) appreciate the need in the 21st century for a model that is both rigorous and multifactorial.

SUMMARY:

Objective: The purpose of this report is to outline key principles of clinical explanation in 21st century psychiatry. Explanatory models have deep significance because they reflect what we deem valuable in making people's behavior intelligible, and because they lead us to treat patients with mental illnesses in particular ways. This presentation is for psychiatrists and other clinicians with interests in the conceptual aspects of clinical explanation in the 21st century.

Method: Important works on explanatory models in psychiatry are reviewed critically.

Results: The rigor and utility of our explanatory models can be enhanced by greater consideration of their conceptual underpinnings. Some current explanatory models in psychiatry are reductionistic, while others are eclectic. The former tend to restrict options for diagnostic and therapeutic paradigm choice, while the latter lack a clear and consistent theoretical basis. There is an urgent need for an explanatory paradigm that is neither reductionistic nor vague and eclectic, but rather that is rigorous and multifactorial.

Conclusion: An updated, and more empirically informed, version of the biopsychosocial model represents our best option for an explanatory model that is rigorous, but also flexible and multifactorial. Such a model would allow patients to receive sound clinical care that subsumes explanatory concepts spanning the entire biopsychosocial spectrum. Developing and implementing such an explanatory model ought to be a major focus of the 21st century psychiatrist.

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1. Brendel DH: The ethics of diagnostic and therapeutic paradigm choice in psychiatry. Harvard Rev Psychiatry 2002, in press.
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No. 59
EXPERIENCE OF RESEARCH PARTICIPATION BY PATIENTS WITH SEVERE MENTAL ILLNESS

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EDUCATIONAL OBJECTIVES:

At the conclusion, participants should be able to recognize some of the reasons why inpatients with severe mental illness volunteer to participate in clinical research and their understanding of significant ethical issues and the informed consent process.

SUMMARY:

Objective: A crucial issue facing modern psychiatric research with individuals with severe mental illness is balancing the need to protect a vulnerable population along with respecting their autonomy in making decisions about research participation. Why do they volunteer for clinical research protocols and do they understand what is being asked of them as participants?

Method: A total of 40 inpatients completed a 13-item semistructured interview on their research experience and the informed consent process at the completion of a two- to eight-week blood assay protocol. All patients were diagnosed with either a major effective or psychotic disorder.

Results: Data indicated that most patients expressed an altruistic desire to help others in the future by participating in a study that provided no direct benefit to them ($p < .05$). Trust in their caretakers and belief that their treatment was ethical and had their best interests in mind was the predominant reason why patients felt the informed-consent process was adequate though they were not always sure just what comprises the informed-consent processes. ($p < .05$).

Conclusion: Patients do not consider themselves decisionally impaired and often their participation in clinical research is based, in part, on their willingness to help others and their trust in their caregivers. While they claim they understand the informed-consent process, many patients may not fully appreciate its importance in protecting their rights.

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No. 60
ATTITUDES OF PHYSICIANS TOWARD GIFTS FROM THE PHARMACEUTICAL INDUSTRY: A PILOT STUDY

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EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, participants should be able to recognize the influence of pharmaceutical companies and their drug representatives. After the presentation, clinicians including residents and medical students should be able to formulate some guidelines regarding their working relationship with the drug companies.

SUMMARY:

Objective: To survey physicians' attitudes toward gifts and incentives offered to them by pharmaceutical companies.

Methods: A cross-sectional study was conducted using a self-report questionnaire, given to attending physicians and physicians-in-training (residents and fellows) in eight clinical departments at a community-teaching hospital. Data were analyzed by ANOVA, Post-hoc test: Bonferroni and Tukey, chi-square, and logistic regression using SPSS version 10.0.

Results: Response rate was 80.7% (N = 187). Most physicians (80.8%) said pharmaceutical companies and their representatives (PR) sponsored freebies had no influence on their prescribing patterns, 86.1% reported not receiving any formal guidelines regarding interactions with PRs, and 93.4% were not aware of Web sites catering to indigent patients. Physicians-in-training favored (1) accepting textbooks as compared to faculty (Mean Likert's Scale Value (MLSV) 4.19 vs. 3.58 respectively), (2) having nationally reputed grand rounds speakers (MLSV 4.11 vs. 3.74), and (3) outings for personal enjoyment (MLSV 3.36 vs. 2.56), which were sponsored by PRs. Significant interdepartmental variations were noted in (1) frequency of interactions with PRs ($p<0.05$), (2) receiving promotional items ($p<0.001$), (3) opinions regarding accuracy of medication information provided by PRs ($p<0.001$), (4) views about maintaining the same degree of contact with PRs regardless of gifts ($p<0.001$), and (5) the necessity of guidelines ($p<0.01$). More male physicians (81.3% vs. 18.8% females) reported receiving financial support from Pharmaceutical companies for attending national meetings. Physicians in general agreed to participate with the goal of reducing medication price by refusing freebies, with female physicians more strongly agreeing as compared to male physicians who were either neutral or agreed ($p < .05$).

Conclusions: Despite minimal awareness about ethical guidelines regarding gifts and Web sites that help support indigent patients' medication, physicians at our hospital reported that PR sponsored gifts do not influence their prescribing patterns. Our preliminary study did not indicate a potential for pharmaceutical company influence. We propose to correlate actual physician prescribing pattern and relationship to PRs' visits. Of more immediate concern is the lack of physician knowledge and understanding of ethical issues pertaining to gifts. More immediate attention must be paid to medical students and residents' education.

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2. Hopper JA, Speece MW, Musial JL. Effects of an educational intervention on residents' knowledge and attitudes toward interactions with pharmaceutical representatives. J Gen Intern Med. 1997 Oct;12(10):639–42.
3. Anadaleeb SS, Tallman RF. Relationships of physicians with pharmaceutical sales representatives and pharmaceutical companies: an exploratory study. Health Mark Q. 1996;13(4):79–89.
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SCIENTIFIC AND CLINICAL REPORT SESSION 21—RELIGION, SPIRITUALITY, AND PSYCHIATRY

No. 61
EFFECTS OF FALUN GONG PRACTICE ON PHYSICAL AND MENTAL HEALTH

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Ashwin A. Patkar, M.D., Li-Shan Huang, Ph.D., Daniel A. Monti, M.D., Sue Jiang, M.S., Cuirong Ren, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the concept of Falun Gong, a spiritual practice for both mind and body originating from ancient Chinese traditional culture and recognize the beneficial effects of Falun Gong on physical and mental health.

SUMMARY:

Objective: To evaluate the effects of Falun Gong (FLG) on physical and mental health. FLG is a spiritual practice originating from China, based on qualities of truth, compassion, and tolerance.

Methods: Survey data were collected from 235 volunteers practicing FLG during 2000. FLG consists of five sets of spiritually-based meditative exercises. The survey questions were based on 1997 National Health Survey from the US Center of Health Statistics Studies. Physical and mental health before and after FLG was rated on a five-point scale and impact on smoking cessation was also assessed. Changes in scores were examined using t-tests and relationships between reports of self-health improvement and variables related to FLG were examined via tests of correlation.

Results: A total of 202 respondents were from the U.S. and 32 were from Canada; 58.3% were women, 97% were of Asian background, and the mean age was 39. About 20% had practiced FLG less than one year, 28% between one and three years and the rest above three years. About 30% had master level education, and 16% had doctoral degrees. Significant improvements in self-reports of physical ($p < .01$) and mental health scores ($p < .01$) were observed following FLG. Of the 18 respondents who smoked, a 100% quit rate was observed after FLG practice.

Conclusions: The study found that FLG practitioners noticed significant improvement in their health status. Further controlled studies are needed to evaluate the effectiveness of FLG in psychiatric conditions.

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2. Yang J: Health and Anti-Aging Effects of Falun Gong, Eighth International Conference of Anti-Aging Medicine and Technology, Las Vegas, December, 2000.

No. 62
MORAL CONFLICT AS A COMPONENT OF ANXIETY AND WORRY

Jerome L. Kroll, M.D., *Department of Psychiatry, University of Minnesota, 2450 Riverside Avenue, F282/2A West, Minneapolis, MN 55454-1495;* Kathleen S. Carey, M.S., Paul Erickson, M.D., Elizabeth Egan, Ph.D., Myles Johnson, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to recognize the presence of personal moral concerns as a factor that causes anxiety and worry in their patients.

SUMMARY:

Objective: Psychiatric research and clinical practice rarely inquire whether moral conflicts contribute to a patient's sense of worry and anxiety. The goal of the study was to ascertain the extent to which patients consider worry about moral issues as an important source of anxiety.

Method: One hundred and eleven nonpsychotic adult outpatients were asked to complete the Eysenck Personality Inventory-abridged, Duke Religiosity Scale, and a 20-item Worry Scale adapted from published worry scales by substituting eight new items designed to tap into moral concerns.

Results: Factor analysis of the Worry Scale with Quartermax Rotation produced five worry domains (moral concerns, relationships, health and finances, personal impressions, job) accounting for 61% of the total variance. Factor 1 consisted of seven of the eight a priori moral worry items (e.g., I worry that I have not lived up to my moral responsibilities). A paired t-test revealed that the mean for worry about moral issues was significantly lower than the mean for practical worries. On linear regression analysis, moral worries were not related to neuroticism once the effects of practical worries were partialled out. Canonical correlation analysis with moral and practical worry subscales on the dependent side revealed that the first canonical variable, accounting for 42% of the variability, was highly related to practical worries and neuroticism. The second variable, accounting for 10% of the variability, was highly related to moral worries and to the frequency of church attendance and private devotional activities.

Conclusions: These results suggest that moral worry is a domain distinct from practical worry and cannot be fully explained by its relationship with neuroticism. Personal worry about moral issues is an overlooked topic that deserves further attention and research.

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No. 63
EFFECT OF MODAFINIL ON MOOD AND QUALITY OF LIFE IN PATIENTS WITH NARCOLEPSY

Philip M. Becker, M.D., *Sleep Medicine Association of Texas, 8140 Walnut Lane, Suite 100, Dallas, TX 75231;* Jonathan Schwartz, M.D., Neil Feldman, M.D., Rod J. Hughes, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the effects of untreated mood on quality of life and select a safe and effective treatment option in modafinil.

SUMMARY:

Objective: To assess the effect of modafinil, a novel wake-promoting agent, on fatigue, mood, and health-related quality of life (HRQoL).

Methods: Patients with excessive daytime sleepiness associated with narcolepsy who were dissatisfied with prior treatment with psychostimulants as determined by physician assessment ($N = 151$) discontinued treatment with psychostimulants for two weeks and then received six weeks of open-label treatment with modafinil (Week 1:200 mg/d: Week 2: 400 mg/d; Weeks 3–6: 200 mg/d or 400 mg/d). Efficacy was assessed using the Profile of Mood States (POMS) questionnaire, the 36-item Short Form Health Survey (SF-36), and the Epworth Sleepiness Scale (ESS).

Results: Significant improvements were observed at all three time points in mean total POMS score (all p values <0.0001) and all six POMS subscale scores (all p values <0.05). In particular, mean (±SD) fatigue-inertia scores improved from 13.2 (7.2) to 6.3 (6.0) – 8.2 (6.2) and mean vigor-activity scores improved from 9.8 (6.0) to 13.1 (6.4) – 13.7 (7.1) (all p values <0.0001). Mean SF-36 mental and physical health component scores (assessed only at Week 6) were significantly improved ($p < 0.001$), with the greatest improvements observed in the vitality/fatigue (27.9 [20.4] to 47.4 [24.9]), role physical (34.3 [36.6] to 58.3 [40.6]), and social functioning (57.0 [29.4] to 68.9 [28.8]) domains (all p values <0.0001). Mean ESS scores improved from 17.8 at post washout baseline to 11.3–12.7 at Weeks 1, 2, and 6 (all p values <0.0001).

Conclusions: In patients with narcolepsy, treatment with modafinil resulted in significant improvements in mood and HRQoL by week 1 and the significant improvements lasted at least six weeks.

Study funding provided by Cephalon, Inc.

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SCIENTIFIC AND CLINICAL REPORT SESSION 22—USES OF MODAFINIL

No. 64
LONG-TERM SAFETY AND EFFICACY OF MODAFINIL FOR DAYTIME SLEEPINESS

Mary B. O'Malley, M.D., *Department of Psychiatry, Norwalk Hospital, 24 Stevens Street, Norwalk, CT 06856*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to treat excessive daytime sleepiness with modafinil.

SUMMARY:

Objective: To assess the long-term efficacy and safety of modafinil for the treatment of daytime sleepiness.

Methods: A total of 478 patients with excessive daytime sleepiness associated with narcolepsy entered an open-label study and received modafinil 200–400 mg/d for up to 136 weeks (>2.5 years) in three consecutive open-label studies (40, 48, and 48 weeks duration, respectively). Efficacy was assessed using the Epworth Sleepiness Scale (ESS) and the Clinical Global Impression of Change (CGI-C) Scale.

Results: Following the two-week washout period, mean ± SD ESS scores improved from 16.5 ± 4.6 at open-label baseline to 12.4 ± 5.4 ($p<0.001$) after two weeks of treatment. Mean scores ranged from 11.8 ± 5.1 to 12.9 ± 5.5 for Weeks 8–136. CGI-C scores improved in 74%–84% of patients. The most common treatment-related adverse events (AEs) in the three studies were headache (8%–13%), nervousness (3%–8%), dry mouth (3%–6%), and nausea (2%–5%). Nine percent (9%) of patients discontinued treatment because of AEs during Weeks 0–40 compared with 2% during Weeks 40–88 and 4% during Weeks 88–136. Discontinuations because of insufficient efficacy were low (3%–12%). The percentages of patients completing each of the studies ranged from 71%–84%.

Conclusions: Long-term treatment with modafinil for up to 136 weeks was efficacious and well tolerated.

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2. Besset A, Chetrit M, Carlander B, Billiard M: Use of modafinil in the treatment of narcolepsy: a long-term follow-up study. Neurophysiol Clin 1996;26(1):60–66.

No. 65
MODAFINIL ENHANCES MOTIVATION IN THE ABSENCE OF OVERT SLEEPINESS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the potential clinical benefit of wake-promoting agents in the absence of sleepiness.

SUMMARY:

Objective: Modafinil is a novel wakefulness-promoting agent that improves alertness without promoting significant hyperactivity (Edgar et al, 1996). Modafinil administration results in increased activity of neurons in discrete brain regions, including posterior hypothalamus and cingulate cortex (Scammell et al., 2000). Activation of cingulate cortex by modafinil has led to the hypothesis that modafinil may enhance motivation. This hypothesis was tested in a preclinical model of behavioral despair.

Methods: Sprague-Dawley rats were evaluated in a forced swim behavioral despair model following administration of single doses of modafinil (3–100 mg/kg, ip) or repeat doses of imipramine (3–30 mg/kg, ip). Duration of active efforts to escape from an escape-proof water tank was quantified in a blinded manner. Potential effects of modafinil on locomotor activity were assessed in an automated open field chamber. Functional imaging of discrete brain regions was assessed 2 hrs following modafinil administration by quantitative immunohistochemistry of the immediate early gene cFos.

Results: In awake animals, single doses of modafinil produced dose-related increases in duration of active escape behavior (ED50 = 10 mg/kg, ip). Potency and efficacy of modafinil were similar to that for the traditional antidepressant imipramine dosed repeatedly. Modafinil did not increase wake-associated locomotor activity. Modafinil administration resulted in functional activation of several regions of cerebral cortex, including anterior and posterior cingulate cortex, and orbital cortex.

Conclusions: Single doses of the wakefulness-promoting agent, modafinil, potentiate motivation and goal-oriented behavior in awake animals. This behavior is independent of locomotor effects, but is associated with activation of frontal cortex. Data suggest that wakefulness is a non-discrete state in which individual behavioral components can be pharmacologically modified. Modafinil may have utility in enhancing motivation and other behavioral components of wakefulness in the absence of overt sleepiness.

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SCIENTIFIC AND CLINICAL REPORT SESSION 23—CROSS-CULTURAL PSYCHIATRY: ASIAN ISSUES

No. 66
INTEGRATING PSYCHIATRY AND PRIMARY CARE IMPROVES TREATMENT ACCEPTABILITY AMONG ASIAN AMERICANS

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Grace E. F. Rubenstein, B.A., Henry Chung, M.D., Pamela A. Roffi, B.S., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D., David Mischoulon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand a new model of care, the "Bridge Project," which significantly improves acceptability of psychiatric treatment to Asian Americans.

SUMMARY:

Objective: To investigate whether integrating psychiatry in primary care improves treatment acceptability of mental health services among Asian Americans.

Method: The "Bridge Project," an integrative service model, was introduced in 2000 to a primary care clinic serving low-income Asian immigrants. It includes seminars for primary care physicians to recognize common mental disorders, a primary care nurse to facilitate case referral, and a psychiatrist to provide onsite evaluation and treatment. The number of referrals to mental health service and the rate of successful referral, defined as a patient keeping his/her first mental health appointment, were compared before and after implementation of the integrative model.

Results: In the first 12 months after introduction of the "Bridge Project," primary care physicians referred 64 patients to mental health service, a 68% increase in referrals compared with the previous four years. Fifty-six (87.5%) of referred patients kept their first psychiatric appointments, demonstrating an improvement of 3.65 times the previous rate of successful mental health referral (χ^2 = 28.59, $p < 0.001$). Patients referred before and after implementing the integrative model had similar demographic characteristics (age, gender ratio, and years of education).

Conclusion: Integrating psychiatry and primary care improves treatment accessibility and acceptability for Asian Americans with mental disorders.

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2. Lin KM, Cheung, F: Mental health issues for Asian Americans. Psychiatric Services 1999; 50:774–780.

No. 67
ANGER DISCOMFORT IN JAPANESE, CHINESE, AND CAUCASIAN FEMALES

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize differences between some Asian ethnic groups and examine how these differences relate to ED risk.

SUMMARY:

Objective: To compare women of various ethnicities in terms of anger-discomfort and known risk factors for eating disorder (ED) to see if anger-discomfort is associated with greater ED risk.

Method: A total of 89 Japanese, 44 Chinese, and 79 Caucasian college students in Hawaii were asked about diet/exercise habits, body mass index (BMI), and administered scales of body-dissatisfaction, self-loathing (:SLSS), and anger-discomfort (ADS). ADS measures person's reaction to anger but not frequency or intensity of anger.

Results: ANOVA analyses showed Caucasians had higher levels of exercise but were not more likely to diet than Japanese and Chinese. Caucasian women had considerably higher BMIs than Japanese or Chinese and reported higher body-dissatisfaction than Chinese. Japanese scored higher than Caucasian or Chinese on self-loathing. While there were no ethnic differences on three of the anger perception subscales (anger-positive, anger-emotive, interpersonal), Chinese reported greater intrapersonal anger-discomfort than other groups.

Conclusion: Japanese and Caucasian females appear to relatively high ED risk while Chinese females are at low ED risk but are more threatened by feeling angry. If Chinese women feel more threatened because they express anger more freely than other groups, this may lower their risk for ED. Future study will examine anger expression in Japanese, Chinese, and Caucasian females.

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No. 68
ANATOMY OF JEONG

Christopher K. Chung, M.D., *Department of Psychiatry, Harbor UCLA Medical Center, 1000 West Carson Street, Torrance, CA 90509;* Samson J. Cho, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the different emotional expressions of "jeong" in Korean and Asian patient populations.

SUMMARY:

In Korean culture, "jeong" refers to a special interpersonal bond of trust and emotional attachment. In English, jeong could be translated as interpersonal feeling, empathy, love, affections or compassion. However, jeong has much broader and inclusive meanings than these terms. Thus jeong perhaps is a culture-specific expressions of emotion.

The authors feel it would be useful to consider jeong as it relates to Korean culture and Western psychotherapy. Jeong may be easily mistaken as a form of psychopathology from the vantage of traditional Western theory of psychotherapy, since its manifestation could be interpreted as the blurring of ego boundaries, or passive-dependent behavior. However, jeong has a healthy and desirable side in the context of Asian culture.

When a group of people develop a strong cohesive bond and loyalty to one another, jeong almost appears to be inter-psychic feelings that exist between individuals or among group members. This paper will present the phenomena of jeong, analyze the characteristics of jeong, and compare it with related Western concepts and Japanese expression, such as amae. The role of jeong in individualism and collectivism in the cultural context and its positive vs. negative aspects in the setting of psychotherapeutic relations will also be presented.

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2. Kim U: Individualism and Collectivism: Conceptual Clarification. Individualism and Collectivism: Theory, Method, and Application, Thousand Oaks, London and New Delhi, Sage Publication, 1994, pp 19–40.

SCIENTIFIC AND CLINICAL REPORT SESSION 24—EPIDEMIOLOGY

No. 69
THE BURDEN OF HEPATITIS C AMONG MENTALLY ILL PERSONS IN LONG-TERM CARE

Elsie J. Freeman, M.D., *Central Office, Massachusetts Department of Mental Health, 25 Staniford Street, Boston, MA 02114-2575;* Kenneth S. Duckworth, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the impact of Hepatitis C among those with chronic mental illness, including the effect of infection on medical followup, psychiatric symptoms and management of psychotropic medications. Consideration will also be given to the costs of medical management in publicly funded systems of care.

SUMMARY:

Objective: Of four million people in the United States infected with Hepatitis C, a significant portion will develop chronic hepatitis, cirrhosis, and hepatocellular carcinoma. While it is known that as many as 40% of incarcerated individuals are HCV positive, data on seroprevalence in other special populations, for example, those with chronic mental illness, are limited.

Method: The Massachusetts Department of Mental Health has undertaken HCV screening in its nine inpatient facilities. Each positive patient is entered into a client tracking system, which includes information on demographics, diagnoses, psychiatric medications, risk variables, vaccine history, and laboratory findings.

Results: Preliminary results suggest that the prevalence of HCV antibody ranges from 8% to 23% among inpatients in DMH long-term care. General population estimates of HCV infection are approximately 2%, making the prevalence in DMH inpatients four to 11 times higher than in the general population.

Conclusion: Since DMH cares for as many as 30,000 individuals on a long-term basis, a prevalence of even 10% represents 3,000 individuals at risk of developing chronic hepatitis, cirrhosis, and liver failure. Most internists who treat HCV are reluctant to treat patients with a history of mood instability or psychosis because of the psychiatric symptoms associated with interferon therapy, DMH is creating linkages with medical providers to facilitate the safe treatment of these chronically mentally ill individuals, developing patient and staff education protocols and providing vaccination for HepA and HepB. Given the CNS effects of infection with HCV, DMH is monitoring whether treatment for HCV improves psychiatric symptoms and assessing the effect of even mild degrees of liver failure on levels of psychotropic medications metabolized in the liver.

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1. Forton D, et al.: Evidence for a cerbral effect of the hepatitis C virus. The Lancet 2001; 358:38–39.
2. Musselman DL, et al: Proxetine for the prevention of depression induced by high dose inteferon alfa. N Engl J Med 2001; 344(13): 961–966.

No. 70
DOUBLE JEOPARDY: MENTAL ILLNESS, MEDICAL CONDITIONS, AND EARLY DEATH

Elsie J. Freeman, M.D., *Central Office, Massachusetts Department of Mental Health, 25 Staniford Street, Boston, MA 02114-2575:* Kenneth S. Duckworth, M.D., Robert Goldstein, Ph.D. MaryLou Sudders.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the methodology for collecting mortality data, the literature on mortality and mental illness, and the Massachusetts data regarding premature mortality and mental illness, identify some of the factors contributing to this excess mortality, and appreciate the importance of medical issues in caring for those with serious mental illness.

SUMMARY:

Objective: Research has shown that mentally ill individuals are at increased risk of dying prematurely. The Massachusetts Department of Mental Health has undertaken an analysis of client deaths from 1998 through 2000 in order to develop effective strategies for addressing health issues in this high-risk population.

Method: Data on decreased DMH clients were linked to death certificate data collected by the Bureau of Health Statistics at the Massachusetts Department of Public Health, which uses the same methodology as the National Vital Statistics Center. Information was available on age, sex, race, marital status, education, country of birth, manner of death, underlying cause, and other medical conditions. Summary statistics computed for the DMH clients were compared with the general Massachusetts population.

Results: Natural causes account for 72.7% of all DMH client deaths. The leading natural causes of death for DMH clients are similar to Massachusetts as a whole, but heart disease and pulmonary disease account for a greater proportion of the DMH deaths than in the rest of Massachusetts, even though the DMH population is far younger than the general population. The age-specific death rate for 15- to 64-year-old DMH clients is 1.4 to 3.3 times higher than in the general population, with the most pronounced difference in the 25 to 44 year old groups. There is a six-fold increase in cardiac deaths among 25 to 44 year old DMH clients and a two- to six-fold increase in deaths from pulmonary disease in 25 to 64 year olds.

Conclusion: Analysis of mortality data suggests that individuals with serious mental illness may be at greater risk of mortality at younger ages from cardiac and pulmonary disease than the population at large. The results of this study suggest that addressing medical issues is an important consideration in improving the quality of life for persons with major mental illness.

REFERENCES:

1. Harris EC, Barradough B: Excess mortality of mental disorders. Brit J Psych 1998; 173: 11–53.
2. Brown S, et al: Causes of the excess mortality of schizophrenia. Brit J Psych 2000; 177: 212–217.

No. 71
PREVALENCE AND SYMPTOM PATTERNS OF DEPRESSION AMONG COLLEGE STUDENTS

Shamsah B. Sonawalla, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Nicole B. Neault, B.A., Christina M. Dording, M.D., Megan E. Hughes, B.A., Albert Yeung, M.D., Timothy J. Petersen, Ph.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: (1) recognize that depression is prevalent among college students, (2) understand that it is important to screen for depression and plan effective intervention strategies in this population, and (3) conclude that symptom patterns may differ between student minority groups.

SUMMARY:

Objective: To assess the prevalence and symptom patterns of depressive disorders among minority and nonminority college students.

Method: A total of 707 students at a college in the Boston area (mean age: 20.1 years ± 3.1 years; 54.5% women; 37.6% minority) were screened for depressive symptoms. After obtaining written, informed consent; the Beck Depression Inventory (BDI) was distributed to all students. Students who scored greater than or equal to 16 on the BDI and consented to be interviewed were further assessed using the MDD module of the Structured Clinical Interview for DSM-IV (SCID-P). Spearman rank correlation and unpaired t-tests were used for data analysis. Analysis was focused on evaluation of the difference in BDI Factor 1 and Factor 2 scores among minority and nonminority students. BDI Factor 1 represents psychological/cognitive aspects, whereas BDI Factor 2 represents somatic/vegetative aspects of depression.

Results: 14.1% of the students scored ≥ 16 on the BDI. Age and gender did not predict severity of depression (measured by total BDI score). No differences in BDI Factor 1 scores were found when comparing minority and nonminority students, or when comparing international and non-international students. African-American students scored significantly higher on the BDI Factor 2 scale than Asian-American, Hispanic, and Asian-Indian students ($p = 0.04$, $p = 0.01$, $p = 0.01$). Non-international students scored significantly higher on the BDI Factor 2 scale than international students ($p = 0.02$).

Conclusion: A substantial percentage of students in this sample reported experiencing significant depressive symptoms. This study highlights the importance of screening for depressive symptoms in the college population, and suggests that depressive symptoms may vary with ethnic background.

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2. Sonawalla SB, Kelly KE, Neault NB, Mischoulon D, et al: Predictors of suicidal ideation in a college population. 154th Annual Meeting of the American Psychiatric Association. New Orleans, Louisiana, 2001.

WEDNESDAY, MAY 22, 2002

SCIENTIFIC AND CLINICAL REPORT SESSION 25—TREATMENT OF PERSONALITY DISORDERS

No. 72
RISPERIDONE TREATMENT OF SCHIZOTYPAL PERSONALITY DISORDER

Harold W. Koenigsberg, M.D., *Department of Psychiatry, Mt. Sinai-Bronx VAMC, 130 West Kingsbridge Rd, #116A, Bronx, NY 10468;* Marianne Goodman, M.D., Antonia S. New, M.D., Vivian Mitropoulou, M.A., Robert L. Trestman, M.D., Jeremy Silverman, Ph.D., Larry J. Siever, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify symptom constellations in schizotypal personality disorder which show significant improvement in response to low dose risperidone treatment compared with treatment with placebo.

SUMMARY:

Objective: Patients with schizotypal personality disorder (SPD) often suffer from marked social and occupational impairment, yet they have been difficult to treat with medications because of their unusual sensitivity to side effects. This study is designed to determine whether low-dose risperidone treatment is acceptable to SPD patients and can reduce the positive and negative symptoms of the disorder.

Method: Twenty-five SPD patients were entered into a nine-week randomized, double-blind, placebo-controlled study of low-dose risperidone in the treatment of SPD. Patients were rated with the Positive and Negative Syndrome Scale (PANNS), the Schizotypal Personality Disorder Questionnaire (SPQ), the Hamilton Depression Rating Scale (HDRS), and the Clinical Global Impression Scale (CGI).

Results: Patients receiving active medication had significantly lower scores on the PANNS general symptom scale by week 3 ($p = .018$), on the PANNS positive symptom scale by week 7 ($p = .010$), and showed a trend for a lower PANNS negative score by week 9 compared with patients receiving placebo. Side effects were generally well tolerated.

Conclusion: Low-dose risperdone appears to be effective in reducing positive and general psychopathological symptoms in SPD and may reduce negative symptoms as well.

REFERENCES:

1. Kirrane RM, Siever LJ: New perspectives on schizotypal personality disorder. Current Psychiatry Rep 2000; 2:62–66.
2. Schultz SC, Camlin KL, Berry SA, Jesberger JA: Olanzepine safety and efficacy in patients with borderline personality disorder and comorbid dysthymia. Biol Psychiatry 1999; 46:1429–1435.

No. 73
A PRELIMINARY TRIAL OF OMEGA-3 FATTY ACIDS IN WOMEN WITH BPD

Mary C. Zanarini, Ed.D., *Department of Psychiatry, McLean-Harvard Hospital, 115 Mill Street, Belmont, MA 02478;* Frances R. Frankenburg, M.D., Anna Vujanovic, A.B., Elizabeth A. Parachini, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that omega-3 fatty acids may be an effective agent in the treatment of the aggressive impulsivity commonly found in patients with borderline personality disorder.

SUMMARY:

Objective: The intent of this study was to compare the efficacy and safety of omega-3 fatty acids vs. placebo in the treatment of women meeting criteria for borderline personality disorder (BPD).

Method: We conducted a double-blind, placebo-controlled study of omega-3 fatty acids in 30 female subjects meeting Revised Diagnostic Interview for Borderlines (DIB-R) and DSM-IV criteria for BPD. The subjects were randomly assigned to omega-3 or placebo in a 2:1 manner. Treatment duration was eight weeks. Primary outcome measures were changes on the aggression, irritability, and suicidality subscales of the Modified Overt Aggression Scale (OAS-M).

Results: Twenty subjects were randomized to omega-3 and ten to placebo. Using random effects regression modeling of panel data and controlling for baseline level of severity, omega-3 was associated with a significantly greater rate of improvement over time than placebo in aggression (mostly verbal in nature) but not irritability and suicidality (which was extremely low at baseline). Side effects were few and very mild. In addition, attrition was very low as all but three of the subjects completed the entire trial.

Conclusions: Omega-3 appears to be a safe and effective agent in the treatment of women with criteria-defined borderline personality

disorder, significantly affecting the impulsive aggression that can often destabilize their social and vocational functioning.

Supported by an Independent Investigator Award from NARSAD.

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1. Stoll AL, Severus WE, Freeman MP, Rueter S, et al: Omega 3 fatty acids in bipolar disorder: a preliminary double-blind, placebo-controlled trial. Arch Gen Psychiatry 1999; 56:407–412.
2. Zanarini MC, Frankenburg FR, Gunderson JG: Pharmacotherapy of borderline outpatients. Compr Psychiatry 1988; 29:372–378.

No. 74
IS CHEMICAL IMBALANCE A USEFUL CONCEPT IN TREATING PERSONALITY DISORDERS?

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the balance between psychotherapeutic treatments and psychopharmacologic interventions in patients with personality disorders.

SUMMARY:

The concept of chemical imbalance as being the primary cause of psychiatric disorders is becoming more prevalent in this era of molecular biology and genetics. There is increasing evidence that biological processes underlie all human behavior, thought, and emotions. Yet translating biological theories and discoveries into the concept of chemical imbalance not only simplifies the complexity of human thought and behavior but also can become particularly troublesome in the treatment of patients with personality disorders. We currently are limited in how much success can be achieved through the use of medications for patients with personality disorders. While there is optimism that more specific and effective medications will be developed in the future, we, at the present time, must work with what is available. If we emphasize only the chemical imbalance aspect of psychiatric disorders, especially in patients with personality disorders, then we fail to have the patient assume responsibility for his own behaviors and relationships. Further, we deny the patient the opportunity to develop and strengthen coping mechanisms and strategies and to appreciate how exposure and reaction to stressful situations can become essential testing arenas to practice behavioral control that can lead to personal growth. In addition, we perpetuate the unrealistic expectation that cure can come solely through the manipulation of chemicals within one's body. We must work with our patients to have them appreciate how they can develop the skills to function from their own resources while we await more useful developments and products for the psychopharmacologic treatment of the personality disorders. Interventions related to this particular clinical situation as well as case vignettes will be presented.

REFERENCES:

1. Tasman A, Riba MB, Silk KR: The Doctor-Patient Relationship in Pharmacotherapy: Improving Treatment Effectiveness. New York, Guilford Press, 2000.
2. Gunderson JG: Borderline Personality Disorder. A Clinical Guide. Washington, DC. American Psychiatric Press, 2001.

SCIENTIFIC AND CLINICAL REPORT SESSION 26—ISSUES IN CHILD PSYCHIATRY

No. 75
ADHD COMORBIDITY: AGE AND GENDER DIFFERENCES

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the frequent comorbid disorders associated with ADHD and develop specific treatment alternatives.

SUMMARY:

Objective: ADHD is commonly associated with other disorders, but most of these studies are based on small samples, which do not provide information on gender and age differences. This study with 1,000 patients provided information on comorbidity, age, and gender differences.

Method: The patients were diagnosed according to DSM-IV criteria, DuPaul ADHD Rating Scale, and Offord and Boyle Child Health Study parent and teacher rating scales.

Sample: The sample consisted of 792 males and 208 females ranging in age from three to 18 years who were seen in a university hospital, ADHD clinic, or training and research institute.

Conclusions: For every age group most patients suffered from two or more disorders, and only less than 20% had ADHD alone. For every age group, oppositional defiant disorder (ODD) and conduct disorder (CD) were most common. In the preschool age group communication disorders were common but decreased by age. CD was more common in ADHD Combined type and rare in Predominantly inattentive type. No gender differences were found in anxiety disorders. In preschool age group, ODD was more common in boys. The frequency of mood disorders increased by age and more prevalent in females. Patients with ADHD should be carefully screened for other comorbid disorders. Changes by age should be recorded since additional medications may be required for comorbid disorders.

REFERENCES:

1. Diagnosis and evaluation of the child with ADHD. Pediatrics 2000; 105:1158–1170
2. Biederman J, Newcorn PJ, Sprich S: Comorbidity of ADHD with conduct, depressive, anxiety, and other disorders. Am J Psychiatry 1991; 148:564–577.

No. 76
PSYCHIATRIC DIAGNOSIS FOR CHILDREN UNDER AGE FIVE REFERRED TO A PUBLIC MENTAL HEALTH SYSTEM

Harry H. Wright, M.D., *Department of Neuropsychiatry, University of South Carolina, 3555 Harden Street Extension, Suite 104, Columbia, SC 29203;* Michael L. Cuccaro, Ph.D., Rosetta H. Penny, M.S.W., Tami V. Leonhardt, Ph.D., Kristin M. Wieduwilt, Ruth K. Abramson, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the range of DSM-IV diagnoses observed in a

large population of 0- to 5-year-old children referred to a public mental health system.

SUMMARY:

DSM-IV does not provide adequate coverage for making psychiatric diagnoses in the 0 to 5 age group. Despite difficulties, clinicians must assign diagnoses when young children appeared in their offices for assessment and treatment. There have been several recent reports, using the CBCL, DC:0–3, or modified DSM-IV criteria, that have provided prevalence data about social-emotional and behavioral problems in referred and community samples of 0- to 5-year-old children. There have been no studies of a large sample of young children with DSM-IV diagnoses as the base for prevalence data.

This report describes the range of DSM-IV diagnoses observed in 7,152 children 0- to 5-years-old, who were referred to a public mental health system over a four-year period. There were nearly equal numbers of white (3,722) and black (3,185) children referred. The other category, which was 90% Hispanic, increased from 3% to 4.1% of the total in the four years studied. Referral sources varied with enthnicity. More than 40% of families terminated the intervention by dropping out. The most common services provided to the children and families were family therapy, assessment, individual therapy, psychiatric medical assessment, psychosocial rehab, and case management. The rank order of the top 25 DSM-IV diagnoses for the entire group and by year, for 0- to 5-year-old children and the one and two-year-old children will be provided.

Implications for service, training, and research for this population will be discussed.

REFERENCES:

1. Briggs-Gowman MJ, et al: Prevalence of social, emotional, and behavioral problems in a community sample of 1 & 2 year old children. J Amer Acad Child Adolesc Psychiat 2001; 40:811–819.
2. Keren M, et al: Diagnoses and interactive patterns of infants referred to a community based infant mental health clinic. J Amer Acad Child Adolescence Psychiatry 2001; 40:27–35.

No. 77
MODAFINIL IN CHILDREN WITH ADHD: A DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY

Thomas A. Rugino, M.D., *Department of Pediatrics, Marshall School of Medicine, 6316 Highland Drive, Huntington, WV 25705;* Teresa C. Samsock, M.S., Laura Adkins, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the potential role of modafinil in the management of ADHD in children and adolescents, particularly if low body weight is a concern.

SUMMARY:

Hypothesis: Modafinil, a stimulant indicated for narcolepsy, significantly improves clinical features of children with attention deficit/hyperactivity disorder (ADHD).

Method: Twenty-four children meeting DSM-IV criteria for ADHD participated in a randomized, double blind, placebo-controlled study. Outcome measures included the Test of Variables of Attention (TOVA), Conners' Parent and Teacher Rating Scales - Revised (CPRS, CTRS), ADHD Rating Scale - IV (ADHDRS), and questionnaires.

Results: Eleven control subjects and 11 treatment subjects completed the study with evaluation before medication, and after an average of 5.3 weeks (placebo) or six weeks (treatment). The average TOVA ADHD scores improved by 2.53 standard deviations for the treatment group compared with a decline of 1.03 standard deviations for controls ($p < 0.01$). Compared with controls, the modafinil group showed significant ($p < 0.05$) improvements in several rating scale subscores. Regarding questionnaires, 9/10 subjects taking modafinil were reported as significantly improved whereas 8/10 controls were reported as showing no or slight improvement ($p < 0.001$). One subject withdrew from the study due to emesis, which resolved completely. No subjects required more than one dose daily. No anorexia occurred.

Conclusions: Modafinil may be a useful treatment for children with ADHD, particularly when anorexia limits use of other stimulants.

REFERENCES:

1. Rugino TA, Copley TC: The effects of modafinil in children with attention-deficit/hyperactivity disorder: an open label study. J Am Acad Child Adolesc Psych 2001; 40(2):230–235.
2. Baranski JV, Pigeau RA: Self-monitoring cognitive performance during sleep deprivation: effects of Modafinil, d-amphetamine and placebo. J Sleep Res 1997; 6(2):84–91.

SCIENTIFIC AND CLINICAL REPORT SESSION 27—PSYCHOTHERAPIES

No. 78
MUSIC THERAPY AND MEDICATION COMPLIANCE IN PSYCHOTIC PATIENTS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the important role of group music therapy on medication compliance in psychotic patients.

SUMMARY:

Objective: To assess the effectiveness of group music therapy (GMT) on medication compliance in psychotic patients.

Methods: Eighty five patients with Dx of schizophrenia (n = 38), psychosis NOS (n = 19), bipolar disorder (n = 18), and schizoafective disorder (n = 10) receiving psychotropic medications, were randomized to GMT (n = 42) and control, supportive talking/counseling (ST) (n = 43). Patients and their families completed the Medication Compliance Survey (MCS) before and at the end of eighth session of GMT or ST.

Results: Those patients with GMT showed improvement in the MCS at the end of eighth session compared with the ST group ($p > 0.05$). When compliance was examined by diagnoses, patients with bipolar disorder exhibited the highest rates of improvement in the MCS.

Conclusions: Our results suggest that GMT in psychotic patients using psychotropic medications improves their compliance rates. Particularly marked improvement was seen in bipolar patients. Future studies are needed to confirm this impression.

REFERENCES:

1. Clair AA: Therapeutic Uses of Music With Older Adults. Baltimore, MD, Health Professional Press, 1996.
2. Lane D.: Effects of music therapy on immune function of hospitalized patients. Quality of life 1994; 3:74–80.

No. 79
CONTROLLED STUDY OF NAMI FAMILY-TO-FAMILY EDUCATION PROGRAM

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Room 476, Baltimore, MD 21201;* Joyce Burland, Ph.D., Alicia Lucksted, Ph.D., Bette Stewart, B.S., Leticia T. Postrado, Ph.D., Colleen McGuire, M.A., Marcia Hoffman, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the NAMI Family to Family Education Program and the family member outcomes it improves.

SUMMARY:

Objective: The NAMI Family to Family Education Program (FFEP) is a national, widely disseminated, 12-week program taught by trained family member volunteers. Family caregivers of people with severe mental illnesses receive information, learn self-care and communication skills, problem-solving, and advocacy strategies. Little is known about its effectiveness. This study extends our previous uncontrolled study of FFEP effectiveness by adding a control waiting list period for participating subjects.

Methods: Consenting FFEP participants (N = 95) were evaluated three months prior to FFEP participation (WL), right before the start, of 12-week program (BASELINE), immediate after completing FFEP (POST), and six months later. Mixed effects regression models were used to assess program effectiveness.

Results: Participants had significantly reduced subjective burden (decreased worry and displeasure with ill family member) and increased (1) empowerment (within family, service system and community), (2) self-care and acceptance, (3) illness information, and factors reflecting (4) "reclaiming one's life", and (5) "coming to terms" with mental illness (p's < .001) at post and six months compared with WL and BASELINE). Depression also decreased over the evaluation period.

Conclusion: This study provides evidence of the effectiveness of the NAMI FFEP in improving the well being and coping skills of family members of person with SMI. Future studies should assess whether these improvements enhance consumer outcomes directly.

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1. Dixon L, Stewart B, Burland J, Delahanty J, Lucksted A, Hoffman M: Pilot study of the effectiveness of the Family-to-Family Education Program. Psychiatric Services 2001;52:965–967.
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No. 80
AN ADDITIONAL GUIDELINE FOR CHOOSING APPROPRIATE SUPPORTIVE PSYCHOTHERAPY TECHNIQUES

Frederick S. Mendelsohn, M.D., *Department of Psychiatry, Columbia University, 950 Park Avenue, New York, NY 10028-0320;*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to classify supportive psychotherapy techniques along an inner-outer continuum and use such a classification to choose appropriate techniques for supportive psychotherapy.

SUMMARY:

Objective: When the 21st century psychiatrist does psychotherapy, it is most likely supportive psychotherapy (SP). This paper's objective is to present additional guidelines for choosing specific SP techniques from the many described in the literature. The paper argues that insufficient attention has been paid to choice of techniques in SP.

Method: The various SP techniques described in the literature are arranged on a continuum from those that are most related to the patient's feeling and thinking (the inner pole) to those that include greater degrees of direct intervention on the part of the therapist (the outer pole). Discussing with patients how they can increase their frustration tolerance is toward the inner pole. Taking patients to apply for welfare benefits is toward the outer pole. The continuum differs from the supportive-expressive continuum and does not include interpretation or other psychoanalytic techniques. The paper presents the therapeutic advantages of inner pole techniques.

Conclusion: If several different SP techniques all seem appropriate, the therapist should choose the one closest to the inner pole.

Summary: The literature does not provide clinicians with sufficient guidelines for choosing appropriate SP techniques. The inner-outer continuum attempts to help fill that gap.

REFERENCES:

1. Rockland LH: Supportive Psychotherapy: A Psychodynamic Approach. New York, Basic Books, 1989.
2. Hellerstein DJ, Pinsker H, Rosenthal RN, et al: Supportive therapy as the treatment model of choice. J Psychother Pract Res 1994; 3:300–306.

SCIENTIFIC AND CLINICAL REPORT SESSION 28—ADDICTION PSYCHIATRY

No. 81
ECSTASY: COMPLICATIONS AND NEUROTOXICITY

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SUMMARY:

Background: MDMA ("ecstasy") is a popular "party drug" with a good reputation on the clubbing and dancing scene. However, there is reason to worry. Apart from the increasing reports about acute, serious, and fatal complications, there are more and more clues that ecstasy can cause permanent brain damage with complications over a long period.

Objective: This review will give an up-to-date summary about the psychiatric complications associated with the use of MDMA.

Methods: Articles considering the adverse reactions with ecstasy and its neurotoxicity were selected by means of a search in Medline and Psychlit.

Results: Ecstasy can cause a wide range of psychiatric symptomatology. The MDMA-syndrome, an overlap between the serotonin syndrome and neuroleptic malignant syndrome, can be fatal. MDMA is known to cause serotonergic neurotoxicity in animals. Studies with XTC-users suggest that permanent neurotoxicity is a real risk for people as well.

Conclusions: Ecstasy can cause a diversity of psychopathology. Many of the acute adverse effects are reversible, but the MDMA-syndrome can be fatal. The research of neurotoxicity is in full progress and reinforces the idea that XTC-users are at risk of permanent brain damage with long-term complications as a consequence.

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1. Schifano F, Magni G: MDMA ('Ecstasy) abuse: psychopathological features and craving for chocolate: a case series. Biol Psychiatry 1994;36:763–767.

2. Schmidt CJ: Neurotoxicity of the psychedelic amphetamine methylenedioxymethamphetamine. J Pharmacology and Experimental Therapeutics 1986;240:1–7.

No. 82
PREDICTING TREATMENT OUTCOME OF COCAINE-DEPENDENT PATIENTS

Ashwin A. Patkar, M.D., *Department of Psychiatry, Thomas Jefferson University, 833 Chestnut Street, Suite 210E, Philadelphia, PA 19107;* Raman N. Gopalakrishnan, M.D., Charles C. Thornton, Ph.D., Stephen P. Weinstein, Ph.D., Edward Gottheil, M.D., Wade H. Berrettini, M.D., Kevin P. Hill, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the importance of cocaine-positive admission urine and alterations in serotonin function as possible clinical and biological predictors of treatment-outcome of cocaine patients.

SUMMARY:

Objective: We investigated whether baseline UDS and platelet paroxetine binding, a measure of serotonin uptake sites, were related to outcome measures of cocaine patients.

Methods: Tritiated paroxetine binding sites on platelets were assayed and UDS and measures of drug use and personality were obtained on 105 African-American, cocaine-dependent (DSM-IV) outpatients. Outcome measures included number of clean urines, days in treatment, dropout rates, and number of treatment sessions attended. Relationships between biological and clinical variables and outcome measures were examined.

Results: A significant association was found between a baseline cocaine-positive UDS and clean urines ($r = -.29$, $p < .01$), treatment retention ($r = -.33$, $p < .01$), dropouts ($r = .37$, $p < .001$) and treatment sessions ($r = .25$, $p < .05$), while Bmax of paroxetine binding (number of serotonin uptake sites) was significantly associated with treatment retention ($r = .37$, $p < .001$) and clean urines ($r = .22$, $p < .05$). Moreover, UDS and paroxetine binding combined to provide a strong prediction of retention ($R = .55$, $p < .001$) and abstinence ($R = .45$, $p < .01$).

Conclusions: Although both baseline UDS and paroxetine binding seem to contribute individually in predicting outcome measures of African-American cocaine patients, a combination of the two variables seems to have a stronger effect in terms of predicting treatment retention and abstinence.

Supported by grant KO8DA00340-02 from the National Institute on Drug Abuse.

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1. Alterman AI, Kampman K, Boardman CR, et al: A cocaine-positive baseline urine predicts outpatient treatment attrition and failure to attain initial abstinence. Drug and Alcohol Dependence 1997;46:79–85.
2. Little KY, McLaughlin DP, Zhang L, et al: Cocaine, ethanol, and genotype effects on human midbrain serotonin transporter binding sites and mRNA levels. American Journal of Psychiatry 1998;155:207–213.

No. 83
5HT UPTAKE, IMPULSIVITY, AGGRESSION, AND CRAVING AMONG COCAINE ABUSERS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the role of serotonergic mechanisms in cocaine abuse; understand the possible relationship between serotonergic and measures of impulsivity, aggression, and craving among cocaine abusers; and clarify the clinical implications of this relationship.

SUMMARY:

Objective: We investigated whether platelet tritiated paroxetine binding, a measure of serotonin uptake sites, and behavioral measures of impulsivity, aggression and craving differ between cocaine-dependent subjects and controls, and whether paroxetine binding was related to the behavioral measures.

Method: One hundred and five African-American, cocaine-dependent outpatients and 44 African-American controls were studied. Tritiated paroxetine binding sites on platelets were assayed and standardized assessments of impulsivity, aggression, and craving were performed. Data were analyzed by t-tests (two-tailed). Analyses of Variance and Pearson product moment correlations as appropriate.

Results: Paroxetine binding (Bmax) was significantly reduced among cocaine patients compared with controls ($p < .01$). Also, cocaine patients showed significantly higher scores on certain measures of sensation seeking, impulsivity, and aggression compared with controls. Furthermore, paroxetine binding (Bmax) showed a significant negative correlation with most measures of sensation seeking, impulsivity, and aggression, but not with craving, among cocaine patients. In multiple regression analyses, one behavioral measure of impulsivity, one of sensation seeking, and two of aggression combined to strongly predict low paroxetine Bmax among cocaine patients ($p < .01$).

Conclusion: Our findings indicate that densities of serotonin uptake sites may be reduced among cocaine abusers and may be related to the impulsive-aggressive behavioral dimension.

Supported by grant KO8DA00340-02 from the National Institute on Drug Abuse.

REFERENCES:

1. Coccaro EF, Kavoussi RJ, Sheline YL, et al: Impulsive aggression in personality disorder correlates with tritiated paroxetine binding in the platelet. Archives of General Psychiatry 1996;53:531–536.
2. Yudofsky SC, Silver JM, Hales RE: Cocaine and aggressive behavior: neurobiological and clinical perspectives. Bulletin of Menninger Clinic 1993;57:218–226.

No. 84
CIVIL COMMITMENT IN TURKEY: REFLECTIONS ON A BILL DRAFTED BY PSYCHIATRISTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to gain perspective on the various cultural, social, and legal factors that influence involuntary commitment practices and laws in Turkey, and around the world.

SUMMARY:

Rarely does a country have the opportunity to create mental health law de novo. Turkey, however, has no established criteria regulating the involuntary admission of mentally ill patients, other than the relevant sections of the Turkish constitution and general criminal and civil laws. The nonspecific nature of these laws unavoidably causes confusion and often requires the exercise of individual discretion by mental health professionals. In an effort to provide better

defined guidelines, a task force appointed by the Psychiatric Association of Turkey has drafted a civil commitment bill, titled "Mentally Ill Patients' Bill of Rights," which reflects the general principles of current law and is similar to the civil commitment laws of several other countries. This draft offers psychiatrists of all countries the opportunity to reflect on the proper balance between patients' rights and their needs for treatment, as well as practical aspects of implementation. The authors place the proposal within the broader context of mental health law around the world, while highlighting Turkey's unique cultural, social, and legal structure.

REFERENCES:

1. Appelbaum PS: Almost a revolution: an international perspective on the law of involuntary commitment. J Am Acad Psychiatry Law 1997;25:135–147.
2. Psychiatric Association of Turkey: Psikiyatrik hastalarin haklarini koruma yasa taslagi icin oneri-IV (Draft of mentally ill patients' bill of rights-IV). Work in progress, draft #IV, Ankara, Turkey, Psychiatric Association of Turkey, 2001.

SCIENTIFIC AND CLINICAL REPORT SESSION 29—ISSUES IN PSYCHIATRIC TREATMENT

No. 85
MALPRACTICE LIABILITY IN SHARED TREATMENT

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand legal issues related to physician liability in relationships, (2) deal knowledgeably with potential malpractice liability in shared treatment, and (3) practice risk management in supervision and consultation.

SUMMARY:

Psychiatrists are more and more often working in shared treatments of one sort or another, especially in this era of managed care. The role may be medication backup for other disciplines or a variety of consultative, supervisory, or administrative relationships. In these situations, when a patient is injured, who is liable? Malpractice claims are quite clear when they relate to diagnosis and treatment of patients in one's care but are less so in managed care and other related shared settings. Administrators, directors, supervisors, and clinicians who work in group settings supervising nonphysicians share information and responsibilities. How can one protect oneself in this environment? Traditional legal principles, statutory analysis, and guidelines are examined for clarification and practical risk management.

REFERENCES:

1. Appelbaum PS: General guidelines for psychiatrists who prescribe medication for patients treated by nonmedical psychotherapists. Hospital and Community Psychiatry 1991;42:281–282.
2. Sederer L, Ellison J, Keyes C: guidelines for prescribing psychiatrists in consultative, collaborative and supervisory relationships. Psychiatric Services 1998;49:1197–1202.

No. 86
ASSERTIVE COMMUNITY TREATMENT TEAM PATIENT EMPLOYMENT OUTCOMES

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EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand mechanisms necessary to incorporate vocational rehabilitation in community psychiatry and mitigate the burden of illness.

SUMMARY:

Introduction: Expectations for employment outcomes for severely and persistently mentally ill (SPMI) individuals have increased over the past few years. The modern PACT team philosophy has incorporated employment rehabilitation to facilitate client socialization. Desired vocational outcomes have generally been achieved through progressive vocational processes administered in a step-wise manner. Conversely, therapeutic milieus of social clubs, continuing day treatment, and sheltered workshops tend to retain clients, foster dependence, and do not provide in-vivo skills necessary for employment.

Objective: To describe aspects of vocational rehabilitation of clients engaged in a start-up ACT program.

Methods: Survey of 109 patients enrolled in ACT from the initiation of the Buffalo program in January 2000 until August 2001. Interviews conducted with staff explored previous employment, social clubs, vocational rehabilitation services, hours required for rehabilitation, gainful employment attained, and time of retention of the employment by the client.

Results: During the period of follow up, 3% of patients had attained competitive employment. Over 12% worked "off the books." Such jobs offered security, flexibility, as well as a sense of empowerment and money.

Conclusions: To effectively focus the vocational rehabilitation process of SPMI persons, mechanisms are needed to elicit and reframe the various work and work-like settings in which patients engage. The importance of structured job training, placement, and the patient acceptance of these initiatives will be discussed. Successful outcomes and barriers in this regard will also be discussed.

REFERENCES:

1. Macias C: Massachusetts Employment Intervention Demonstration Project "An Experimental Comparison of PACT and Clubhouse." EIDP Final Report, 2001.
2. Bond G, et al: Implementing supported employment as an evidence-based practice. Psychiatric Services 2001; 52:313–322.

SCIENTIFIC AND CLINICAL REPORT SESSION 30—SOCIAL AND COMMUNITY PSYCHIATRY

No. 87
DEFINING DISABILITY DOWN

Howard W. Telson, M.D., *Department of Psychiatry, New York University, 215 East 24th Street, Suite 321, New York, NY 10010-3804*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand the different definitions of "disability" used

in the U.S., and their relevance to individuals with mental illness; (2) understand the various contexts in which psychiatrists utilize the different definitions of disability; (3) understand the conceptual and practical problems that arise when the different definitions of disability are used interchangably and imprecisely.

SUMMARY:

Over recent decades American society has focused attention on the disabled population. In common usage "disability" means "impairment," and the words are often used interchangeably. However, laws delineating different government programs constructed distinctive, sometimes incongruous definitions of disability. Specifically, Social Security disability benefits are available to individuals who are "unable to work due to a physical or mental impairment, which has lasted or is expected to last at least twelve months, or result in death." Alternatively, the Americans With Disabilities Act defines disability broadly, calling it "a physical or mental impairment that substantially limits one or more of the major life activities."

This paper will discuss the need for psychiatrists to recognize the distinctive definitions of disability when they (1) perform treatment, (2) provide evidence to support benefits applications, (3) offer testimony about psychiatric sequelae of disability discrimination, (4) assess the appropriateness of workplace accommodations, and (5) participate in program development and advocacy. It will examine how psychiatrists view the role of clinical assessments in their determination of employability, discrimination, and disability. The paper will also describe the conceptual and practical problems that commonly arise when definitions of disability are used interchangeably and imprecisely.

REFERENCES:

1. Petrila J, Brink T: Mental illness and changing definitions of disability under the Americans With Disabilities Act. Psych Services 2001; 52:626–630.
2. Moynihan DP: Defining deviancy down. American Scholar 1993; 62:17–32.

No. 88
MARITAL DISRUPTION AND MENTAL HEALTH: A NINE WAVE PANEL STUDY

Terrance J. Wade, Ph.D., *Department of Psychiatry, University of Cincinnati, PO Box 670840, Cincinatti, OH 45267-0840;* David J. Pevalin, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to better understand the complex relationship between marital disruption and mental health over time in relation to competing causation versus selection arguments.

SUMMARY:

Objective: Most research indicates that marital disruption is a precursor for poor mental health, but there is contradictory evidence indicating that poor mental is a selective factor leading to marital disruption. In this analysis, we examine the relationship between mental health and marital transition due to separation or divorce as well as the death of one's spouse.

Method: We utilize the longitudinal British Household Panel Survey containing nine annual waves of data (1991 to 1999). Mental health was measured using the 12-item General Health Questionnaire.

Results: Findings indicate that those transitioning out of marriage have a higher prevalence of poor mental health afterwards. Further analyses indicate that, among those separated or divorced, poor mental health may precede marital disruption. Among those widowed, prevalence of disorder centers around the time of the event.

Conclusions: The ability to examine marital disruption and mental health across multiple waves of the course of mental health and the subsequent risk of marital separation or divorce provides a very different picture than if we confined our examination to a cross-sectional survey or to data collected at just one point prior to marital transition. While these results support the social-causation hypothesis for widows/ers, they provide substantial contradictory evidence for those who separate or divorce.

REFERENCES:

1. Aseltine RH, Kessler RC: Marital disruption and depression in a community sample. Journal of Health and Social Behavior 1993; 34:237–251.
2. Bruce ML, Kim KM: Differences in the effects of divorce on major depression in men and women. American Journal of Psychiatry 1992; 149:914–917.

No. 89
DIVORCE AND MARITAL INSTABILITY IN DIFFERENT SUBTYPES OF MAJOR AFFECTIVE DISORDERS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that marital instability/family breakdown is a common consequence of affective illness that might be particularly frequent among patients with bipolar II disorder

SUMMARY:

The objective of this study was to investigate the prevalence of marital instability in different subtypes of major affective disorders in a community sample of the Hungarian population.

Method: Randomly selected subjects (aged 25 to 65 years) were investigated using the Hungarian version of the Diagnostic Interview Schedule, which generated DSM-III-R diagnoses.

Results: The rate of persons with one or more divorce/separation was 22.9% among those with no lifetime history of major affective disorder (N = 3,173), while the corresponding figures for patients with a history of bipolar II (N = 52), bipolar I (N = 66) disorder and unipolar major depression (N = 357) were 40.4%, 27.3%, and 33.0%, respectively. (Bipolar II disorder versus no affective disorder: $p = 0.01$).

Conclusion: The results confirm the previous finding that family breakdown is a common consequence of affective disorders (Kessler et al. 1998) and suggest that marital instability may be particularly frequent among patients with bipolar II disorder.

REFERENCES:

1. Kessler RC, Walters EE, Forthofer MS: The social consequences of psychiatric disorders, III: probability of marital stability. Am J Psychiatry 1998; 155:1092–1096.
2. Szádóczky E, Papp Zs, Vitrai J, Rihmer Z, Füredi J: The prevalence of major depressive and bipolar disorders in Hungary. J Affect Disord 1998; 50:153–162.

SCIENTIFIC AND CLINICAL REPORT SESSION 31—ISSUES IN MEDICATION MANAGEMENT

No. 90
COMPLIANCE AND TREATMENT DISCONTINUATION IN PANIC-DISORDER PATIENTS

Giulio Perugi, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa 56100, Italy;* Christina Toni, M.D., Franco Frare, M.D., Carlo Torti, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize clinical correlates and predictors of treatment discontinuation in panic disorder patients with the aim at improving long-term treatment strategies.

SUMMARY:

Objective: High percentages of treatment discontinuation are usually recorded among patients with panic disorder-agoraphobia (PD) treated with antidepressants. Poor adherence to treatment has been attributed to "jitteriness syndrome" and to pharmaco-phobia, especially in the first phases of the treatment, and to weight gain, sexual impairment, and anticholinergic symptoms in the long term. In the present study we examined the relationships between long-term treatment response, occurrence of side effects, and noncompliance in a large sample of PD patients treated with antidepressants.

Method: A total of 326 PD patients were naturalistically treated with antidepressants (imipramine n = 127, 39%; clomipramine n = 93, 28.5%; paroxetine n = 76, 23.3%; or "other antidepressants" n = 30, 9.2%) and followed for a period of three years. All patients were evaluated by means of the Structured Clinical Interview for Diagnosis (SCID), the Panic Disorder/Agoraphobia Interview (PDI), and the Longitudinal Interview Follow up Examination (Life-up). ANOVA and Chi-square analysis were utilized for comparative analyses. Survival analysis and logistic regression have been employed to study the relationship between treatment adherence and demographic and clinical characteristics of PD, treatment response, and side effects.

Results: During the three-year follow-up period, 179 patients (54.9%) interrupted pharmacological treatment. Forty-eight patients (26.8%) were not traceable or refused to be interviewed. Among the patients who had been interviewed, 66 (20.2%) had deemed further contact with the psychiatrist unnecessary because of PD remission. Other reasons of interruption were ineffectiveness of the treatment (n = 39, 18.4%), side effects (n = 19, 10.6%), personal reasons (n = 13, 7.3%). Patients who interrupted the pharmachological treatment because of remission of the symptomatology remained in the study for a longer period than patients who interrupted it for inefficacy. Severity of PD and agoraphobia and the length of illness were significantly lower in subjects who interrupted the treatment for remission of PD compared with the other groups, while greater symptomatological severity, and longer duration of illness predicted a better adherence to the medication regimen.

Conclusion: Our data suggest that side effects or inefficacy of the treatment do not represent the only factors of noncompliance in long-term treatment of PD with antidepressants, but also a high percentage of patients who achieved a symptomatological remission tended to default from further treatment. A more severe and long lasting symptomatology predicted a better compliance to long-term treatment with antidepressants.

REFERENCES:

1. Demyttenaere K: Compliance during treatment with antidepressants. J Affective Disorders 1997; 43(1):27–39.
2. Toni C, Perugi G, Frare F, et al: A prospective naturalistic study of 326 panic-agoraphobic patients treated with antidepressants. Pharmacopsychiatry 2000; 33:121–131.

No. 91
META-ANALYSIS OF ANTIDEPRESSANT LEVELS IN LACTATING MOTHERS' BREASTMILK AND NURSING INFANTS

Alicia M. Weissman, M.D., *Department of Family Medicine, University of Iowa, 200 Hawkins Drive, 01105 PFP, Iowa City, IA 52242-1097;* Arthur J. Hartz, Ph.D., Suzanne Bentler, M.S., Micca Donohue, Vicki L. Ellingrodringold, Ph.D., Katherine L. Wisner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify which maternal antidepressants are least likely to produce elevated levels in breastfed infants.

SUMMARY:

Objective: We conducted the first statistical meta-analysis of all available antidepressant levels in nursing mother/infant pairs, in order to identify the antidepressants that lead to minimal infant exposure.

Methods: Electronic and bibliographic searches identified 58 studies, of which 51 provided usable paired plasma and milk levels. We also collected unpublished data from 36 cases. Multiple measurements from the same subjects were deleted. Infant levels were standardized using the average maternal level.

Results: Symptomatic infants and infants with recent prenatal exposure were treated in separate analyses. Except for dothiepin, fluoxetine produces the highest mean standardized infant level and the highest proportion (29.4%) of infant levels that are elevated (> 10% of the average maternal level). Nortriptyline and paroxetine produce infant levels that are usually undetectable, but 7.6% of infant sertraline levels are elevated. Based on smaller numbers, 16.7% of infant citalopram levels are elevated. Prenatal exposure to fluoxetine results in persistently elevated levels that can last beyond six weeks of age.

Conclusions: Nortriptyline and paroxetine are unlikely to produce detectable or elevated infant levels and may be preferred choices in breastfeeding. Fluoxetine is more likely to produce elevated levels, especially following prenatal exposure. Research into effects of antidepressants on infants is needed.

REFERENCES:

1. Yoshida K, Smith B, Kumar R: Psychotropic drugs in mothers' milk: a comprehensive review of assay methods, pharmacokinetics and of safety of breast-feeding. J Psychopharmacol 1999;13:64–80.
2. Burt V, Suri R, Altschuler L, Stowe Z, Hendrick V, Muntean E: The use of psychotropic medications during breast-feeding. Am J Psychiatry 2001;158:1001–9.

No. 92
CLINICAL PROBLEMS IN THE TREATMENT OF ADULTS WITH COMORBID ADD

Marc D. Schwartz, M.D., *26 Trumbull Street, New Haven, CT 06511*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the ADD behaviors that undermine the psychotherapy of patients with comorbid psychiatric disorders and implement

treatment strategies based on an understanding of the neuropsychology of ADD.

SUMMARY:

Many adults being treated for psychiatric disorders such as anxiety and depression have comorbid ADD. These patients often exhibit characteristic behaviors, noted above, that interfere with their therapy. The therapy can be even more disrupted if the therapist mistakes these behaviors for, and treats them as, resistance or poor motivation. ADD (Attention Deficit Disorder) makes it difficult for adults in psychotherapy to

- present information in an organized manner
- formulate a point and make it in a reasonable period of time
- bring to mind important issues that were talked about during sessions
- focus attention flexibly, that is, focus on the topic being discussed yet, when appropriate, shift to another topic
- follow through on plans
- keep track of time, including keeping appointments, being on time, timing treatment sessions, and timing refill requests

This paper details the ways comorbid ADD can interfere with psychotherapy and offers a neuropsychological understanding of the processes underlying the interference. It concludes with a presentation of treatment strategies for dealing successfully with the adverse effects of ADD on psychotherapy.

REFERENCES:

1. Biederman J, et al: Patterns of psychiatric comorbidity, cognition, and psychosocial functioning in adults with attention deficit hyperactivity disorder. Am J Psychiatry 1993; 150:1792–1798.
2. Castellanos F: Towards a pathophysiology of attention deficit/hyperactivity disorder. Clin Pediatrics 1997; 36, 381–393.

SCIENTIFIC AND CLINICAL REPORT SESSION 32—MANAGING SIDE EFFECTS AND DEFICITS

No. 93
BRANCHED-CHAIN AMINO ACID TREATMENT OF TARDIVE DYSKINESIA

Mary Ann Richardson, Ph.D., *Movt. Dis. Division, Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962;* Margaret L. Bevans, R.N., Helen M. Chao, Ph.D., Laura L. Read, Ph.D., Leslie L. Citrome, M.D., James D. Clelland

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to treat tardive dyskinesia in a safe and effective manner with a medical food product consisting of branched chain amino acids. Information will be provided that will allow for full understanding of the mechanism of action.

SUMMARY:

A three-week, placebo-controlled trial of a branched chain amino acid medical food product was conducted to treat tardive dyskinesia (TD) in 48 male psychiatric patients with long treatment histories (mean = 21 years). The mean age for the group was 45. Treatment frequency was three times a day, seven days a week. The efficacy measure was a videotaped frequency count. No differences were seen between the placebo and 200 mg/kg treatment dose groups in age, years on neuroleptics, days since current admission, or type of neuroleptic used. Active treatment was significantly more likely to produce the clinically significant response of a TD symptom decrease of 60% or more. The active treatment group showed a median 37% TD symptom decrease over the trial, which was significantly different than the median increase of 6% seen for the placebo group. No clinically significant differences were seen in laboratory values pre and post trial and minimal complaints were received from participants. There was no relationship seen between plasma glucose and neuroleptic plasma levels and TD change. This study presents a safe, clinically effective TD treatment for men with a well-defined mechanism of action.

Funding: NIMH, NYS Office of Mental Health, Scientific Hospital Supplies, Ltd.

REFERENCES:

1. Richardson, et al: Phenylalanine kinetics are associated with TD in men but not in women. Psychopharmacology 1999; 143(4):347–357.
2. Richardson, et al: Branched chain amino acids decrease TD symptoms. Psychopharmacology 1999; 143(4):358–364.

No. 94
NONADRENERGIC NONCHOLINERGIC SILDENAFIL TREATMENT OF SRI-ASSOCIATED SEXUAL DYSFUNCTION

H. George Nurnberg, M.D., *Health Science Center, University of New Mexico, 2600 Marble Avenue, NE, Albuquerque, NM 87131;* Paula L. Hensley, M.D., Alan J. Gelenberg, M.D., Maurizio Fava, M.D., John Lauriello, M.D., Susan Paine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the efficacy of sildenafil citrate in treating serotonergic antidepressant-associated sexual dysfunction.

SUMMARY:

Objective: To report the first prospective, double-blind (DB), placebo-controlled trial with open-label (OL) extension of nonadrenergic-noncholinergic sildenafil treatment for serotonin reuptake inhibitor-(SRI-) associated erectile/sexual dysfunction (ED/SD). This iatrogenic condition frequently leads to treatment noncompliance.

Method: Study entry required that MDD be in remission (HAM-D/A < 10), with a minimum of six weeks stable SRI dose. Ninety men without preexisting SD, remitted major depression (MDD), and SRI-ED/SD were randomized to six weeks DB sildenafil (50 mg, adjustable to 100 mg) or placebo. Responders from the DB phase received eight weeks OL sildenafil. Nonresponders from the DB phase, who developed a response during an additional six weeks of OL sildenafil, also entered the eight-week extension. Outcome measures: International Index of Erectile Function (IIEF), Arizona Sexual Experience Scale (ASEX), Massachusetts General Hospital Sexual Function Questionnaire (MGH), Sexual Dysfunction Inventory (SDFI), Clinical Global Impression-Sexual Function (CGI-SF), and HAM-D.

Results: Sildenafil demonstrated significant improvement in all IIEF domains ($Ps < 0.01$) except libido. ASEX/MGH/SDFI/CGI-SF measures significantly improved and correlated with IIEF ($Ps < 0.004$); 67% sildenafil and 17% placebo were "much/very much/improved" in DB (CGI≤2). In OL 93% (13/14) sildenafil and 94% (25/26) placebo nonresponders were "much/very much/improved" (CGI≤2). MDD remission continued (HAM-D < 7).

Conclusion: Sildenafil reversed SRI-ED/SD in the domains of erectile function, orgasm, and intercourse/overall satisfaction. Patients maintained compliance with effective SRI-AD MDD treatment without relapse.

Funding provided by Pfizer Inc.

REFERENCES:

1. Rosen RC, Lane RM, Menza M: Effects of SSRIs on sexual function: a critical review. J Clin Psychopharmacol 1999;19:67–85.

2. Nurnberg HG, Hensley PL, Lauriello J: Sildenafil in the treatment of sexual dysfunction induced by selective serotonergic reuptake inhibitors. CNS Drugs 2000;13:321–335.

No. 95
RIVASTIGMINE TARTRATE IN NEUROCOGNITIVE DEFICITS IN SCHIZOPHRENIA PATIENTS TREATED WITH CLOZAPINE

Mohammad Z. Hussain, M.D., *Prince Albert Health District, Mental Health Centre, 2727 2nd Avenue West, Prince Albert, SK, S6V 5E5, Canada;* Zabaida A. Chaudhry, M.D., Seema Hussain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize neurocognitive deficits in schizophrenia illness and effect of acetylcholinesterase activity of clozapine on cognition and its management with rivastigmine tartrate.

SUMMARY:

Many patients with schizophrenia have difficulty in the community functioning even when psychiatric symptoms are well controlled. Deficits in social functioning, vocational outcome, and independent living contribute to a high level of disability and are most often the result of neurocognitive deficits. The novel neuroleptics improve cognition profiles for many patients but there still remain a considerable number of patients with neurocognitive deficits. Clozapine and other neuroleptics with anticholinergic activity lead to adverse effects in visual memory and other cognitive functions. The cholinergic hypothesis of Alzheimer's disease proposes that cognitive deterioration is related to deficits in central cholinergic function and amelioration of the cholinergic deficit leads to improvement. Acetylcholinesterase inhibitiors should produce similar improvement in schizophrenia by neutralizing the anticholinestrase-mediated effects of clozapine and olanzapine.

Twenty-seven patients suffering from schizophrenic illness receiving clozapine or olanzapine and exhibiting neurocognitive deficits were treated with rivastigmine tartrate, 3 mg daily.

Sixteen patients showed significant improvement in their cognitive functions measured on different neurocognitive tests and have shown improvement in attention, memory, and problem-solving with improved social and vocational functioning. Seven showed moderate improvement in motivation and alertness and four discontinued due to ineffectiveness. Acetylcholinestrase inhibitors have beneficial effect on neurocognitive deficits related to medications.

REFERENCES:

1. Kane J: Clinical efficacy of clozapine in treatment of refractory schizophrenia: an overview. British Journal of Psychiatry 1992; 18 (Suppl 17):41–54.
2. M Rosler, R Anand, A Cicin Sain, S Gauthier, Y Agid, P Dal Bianco, HB Stahelin, R Hartman, M Gharabawi on behalf of the B 303 Exelon Study Group: Efficacy and safety of rivastigmine in patients with Alzheimer's disease. International randomized controlled trial. British Medical Journal 1999; 318:633–638.

SCIENTIFIC AND CLINICAL REPORT SESSION 33—MANAGEMENT OF DEPRESSION

No. 96
PSYCHOSOCIAL FUNCTIONING AS A PREDICTOR OF RESPONSE TO NORTRIPTYLINE IN TREATMENT-RESISTANT DEPRESSION

Timothy J. Petersen, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Heidi D. Montoya, B.A., Robert L. Gresham, B.A., George Papakostas, M.D., Andrew A. Nierenberg, M.D., Jonathan E. Alpert, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to gain an understanding of whether baseline LIFE (Longitudinal Interval Follow-up Evaluation) psychosocial functioning scales predict response to nortriptyline in a sample of patients suffering from treatment resistant depression (TRD).

SUMMARY:

Objective: To evaluate whether LIFE psychosocial functioning scales predict response to nortriptyline in a sample of patients suffering from TRD.

Method: A total of 92 patients with TRD were enrolled in an outpatient clinical study to assess the efficacy of a six-week, open trial of nortriptyline. Inclusion criteria were men and women ages 18 to 70 with current major depressive disorder, a score of 17 or greater on the HAM-D-17, and evidence of treatment resistance during the current episode. Four composite LIFE scale scores were calculated and logistic regression was used to evaluate these scores as predictors of nortriptyline response. Response was defined as a 50% or greater reduction in HAM-D-17 total score by week 6.

Results: LIFE composite score #2 (work functioning) was found to be a statistically significant predictor of response status ($p = 0.0268$), while the other three composite scores were not found to significantly predict treatment outcome. Responders were found to be older than nonresponders ($p = 0.049$), but no other demographic or clinical features were found to be significantly different between groups.

Conclusion: In this sample, work functioning significantly predicted response to nortriptyline. It is possible that higher levels of work functioning at treatment outset in some way mediate response to nortriptyline. Further research is needed to elucidate this relationship.

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2. Pyne JM, Bullock D, Kaplan RM, Smith TL, Gillin C, Golshan S, Kelsoe JR, Williams K: Health-related quality of life measures enhances acute treatment response prediction in depressed inpatients. Journal of Clinical Psychiatry 2001; 62:261–268.

No. 97
EFFICACY OF CITALOPRAM AS AN AUGMENTING STRATEGY FOR MENOPAUSAL WOMEN WITH ESTROGEN-RESISTANT DEPRESSION

Claudio N. Soares, M.D., *Department of Psychiatry, MGH Center for Women's Health, 15 Parkman Street, WACC 812, Boston, MA 02114;* Jennifer Poitras, B.A., Jan L. Shifren, M.D., Allison B. Alexander, M.D., Lee S. Cohen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the potential antidepressant benefit of combined treatment for menopausal women suffering from depressive disorders.

SUMMARY:

Objective: Previous studies suggest that treatment with 17 β-Estradiol (E2) may improve depressive symptoms within three to four weeks. This study examined the efficacy of citalopram as an augmenting strategy for menopausal women whose depression persisted after short-term treatment with E2.

Methods: Thirteen women aged 40 to 60 (3 perimenopausal, 10 postmenopausal) who met criteria for depression (mean MADRS scores 21.38 ± 4.66) and failed to show satisfactory response to four-week treatment with 100μg of 17 β-E2 adhesives were selected for a combined eight-week treatment with citalopram (20 to 60 mg/day, orally). Depressive and somatic symptoms were assessed at baseline and after four and eight weeks, using the MADRS and Greene Climacteric Scale (GCS), respectively.

Results: Twelve women (92.3%) concluded the eight-week combined treatment. Eleven subjects (84.6%) showed full remission of depression after using 36.67 ± 14.35 mg/day of citalopram + E2 (LOCF analyses). The mean MADRS score declined from 15.92 ± 5.72 (measured after four weeks of treatment with E2 alone) to 5.00 ± 4.67 (re-evaluation after eight weeks of combined treatment) ($p < 0.01$). Both peri- and postmenopausal women responded to treatment. The combination of E2 + citalopram was well tolerated, and there was no significant ($p = 0.51$) weight gain after adding citalopram.

Conclusions: Citalopram is an effective treatment for peri- and postmenopausal women who persist with depressive symptoms despite the use of estrogens, and can be safely combined with estradiol.

This study was supported by Forest Laboratories, USA.

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No. 98
POLYPHARMACY WITH ANTIDEPRESSANTS

John W. Goethe, M.D., *Department of Clinical Research, Institute of Living-Burlingame, 400 Washington Street, Hartford, CT 06106-3309;* Bonnie L. Szarek, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe current prescribing practices for major depressive disorder.

SUMMARY:

Objectives: Given recent attention to the increase in polypharmacy in the treatment of mood disorders, the frequency and the clinical and demographic correlates of this practice are of interest.

Methods: Subjects were consecutively admitted inpatients (10/1/00-6/30/01) receiving antidepressants. All patients discharged on more than one antidepressant were identified, and relevant demographic, clinical, and treatment data were analyzed using chi square and t-tests.

Results: 25.3% of all patients (419 of 1,656) discharged on an antidepressant received more than one such agent. This proportion is similar (29.4%) with the sample limited to patients with a diagnosis of major depressive disorder (240 of 817). The most common combinations were SSRIs and trazodone (N = 140), SSRIs and buproprion (N = 73), and SSRIs and mirtazepine (N = 56). SSRIs were the most frequently used drug (N = 1124, 67.9%) overall and as monotherapy (N = 789). Patients with depression were significantly more likely to receive multiple antidepressants vs patients with other diagnoses (27.8% vs 18.3%, $p < .001$). Women were more likely than men to receive multiple antidepressants (29.0% vs 20.9%, $p < .001$) but there were no differences by race or ethnicity.

Conclusions: Although less common than found in reports, this study also shows that antidepressants are frequently used in combination therapy.

Funding source: Author's institution.

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THURSDAY, MAY 23, 2002

SCIENTIFIC AND CLINICAL REPORT SESSION 34—FORENSIC PSYCHIATRY

No. 99
MEDICATIONS, STRANGE INTOXICATIONS, AND VIOLENT CRIME

Michael M. Welner, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, Suite 806, New York, NY 10001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should better recognize the relationship of different psychotropic medications and drugs to violence, and specific history taking and laboratory analysis of successful investigation.

SUMMARY:

The proliferation of newer, activating psychotropic drugs has been accompanied by criminal defenses attributing blame to these medicines for violent and other crimes. These cases were popularized by early suggestions that the antidepressant Prozac might increase the likelihood of suicide. The phenomenon of medicine-induced crime inspired consideration of other prescriptions that might also be raised as contributing factors to offenses.

This program explores the role medicines, psychotropic and others, may play in violent behavior. The potentials of single medicines, drug interactions, and idiosyncratic intoxications are reviewed, separating myths and facts. The problem of drug reporting is also raised. Participants learn what confounding factors to consider in their history taking, and what indicators heighten the likelihood of a medicine as a causal influence on a crime.

In recent years, violent crimes have also been reported in individuals who were using illicit drugs not readily identified as causing violence, or to such a degree. The program reviews idiosyncratic behaviors associated with newer man-made drugs, and when to raise clinical suspicion of their influence. Techniques and standards for the laboratory measurement and analysis of suspected drug or medicine-influenced cases are also reviewed.

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2. Welner M: Pill poisoned: the seasoning of medication defenses. The Forensic Echo 1998; 2(3):4–10.

No. 100
TREATING MENTALLY ILL OFFENDERS IN A RESIDENTIAL TREATMENT UNIT

Cristinel M. Coconcea, M.D., *Department of Psychiatry, CWRU University Hospitals, 150 Southwood Road, Akron, OH 44313;* Nicoleta Coconcea, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand specific principles governing the delivery of psychiatric services in prisons.

SUMMARY:

Background: Recent studies are showing that approximately 2.6% of the U.S. population is on parole, probation, or in prisons. Metzner (1993) shows that 8% to 19% of prisoners have significant psychiatric disabilities and another 15% to 20% will at some point need mental health services. The state of Ohio is the first state in the Union to offer mental health services for inmates under the provisions of a consent decree.

Method: This study describes a four-year experience of treating mentally ill offenders in a residential treatment unit (RTU) at Grafton Correctional Institution. It describes the caseload, defines the term RTU, and the admission criteria, the referral process, the incidence and prevalence of psychiatric disabilities treated, and the treatments available since the opening of the unit in 1997. Specific problems related to the practice of psychiatry in a correctional setting are identified and discussed.

Conclusions: The main diagnoses were severe treatment-resistant psychotic disorders, severe mood disorders, and severe personality disorders. An eclectic multidisciplinary treatment team approach is proposed, and models of interaction with the correctional staff are discussed.

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1. Wettstein R: Treatment of Offenders with Mental Health Disorders. New York, NY, The Guilford Press, 1998.
2. Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association. Second Edition. Washington, DC, APA, 2000.

No. 101
PRESIDENTIAL ASSASSINATION SYNDROME REVISITED: NEW UNDERSTANDING

David A. Rothstein, M.D., *Department of Psychiatry, Swedish Covenant Hospital, 55 East Washington, Suite 1649, Chicago, IL 60602*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) understand factors in the history of those who have violent ideation toward the President of the United States; (2) understand how violence plays a role in identity formation; (3) recognize how individual, private determinants of behavior manifest in public behavior.

SUMMARY:

Objective: To apply psychiatric understanding to the phenomenon of presidential assassination.

Method: Shortly after the assassination of President Kennedy, the author studied individuals who were imprisoned at the United States Medical Center for Federal Prisoners for the crime of threatening the President. Subsequently, as a consultant to the Warren Commission, the author reviewed the information obtained by the commission concerning Lee Harvey Oswald. This paper reviews the earlier study, supplemented by the author's more recent studies of the interaction between the assassin and the assassinated.

Results: Based upon similarities between these patients and information about Lee Harvey Oswald, it appeared that a reasonably coherent syndrome could be postulated, with threateners at the less severe end of the same continuum on which an actual assassin represented the most severe example. The author termed this the Presidential Assassination Syndrome.

Conclusion: After reviewing early 20th century psychiatric papers on previous assassins, the author noted, "I cannot help but wonder what psychiatric readers half a century hence will think of our feeble attempts to understand the event of November 1963." This paper shows how some of the developments in theoretical understanding, which have occurred in the almost 40 years since the Kennedy assassination, enrich our understanding and provide additional insights into the resonances between leaders and followers, the role of violence in identity formation, and its implications for warfare and mass violence.

Funding by the author.

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SCIENTIFIC AND CLINICAL REPORT SESSION 35—ISSUES IN TRAUMA AND VIOLENCE

No. 102
PREDICTING CHRONICITY IN VIETNAM VETERANS WITH PTSD: NEW FINDINGS FROM THE NATIONAL VIETNAM VETERANS READJUSTMENT STUDY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize symptoms in an individual with early-onset PTSD that may be predictive of chronic illness, suggesting a need for treatment intervention.

SUMMARY:

Objective: Given the fact that acute symptomatic reactions after trauma are extremely common, an important research goal has been the identification of individuals at risk for chronic illness without intervention. Because clinical presentation varies considerably in PTSD, some symptoms may be more strongly associated with chronicity than others.

Method: The National Vietnam Veterans Readjustment Study conducted in-depth psychiatric interviews with 259 male veterans. Data were analyzed for predictors of chronicity, defined as still having PTSD at the time of interview (15–20 years of illness).

Results: Overall, the avoidance cluster was most predictive of chronicity. Veterans with chronic PTSD had more avoidance ($p = .0016$) and arousal ($p = .035$) symptoms, but not more reexperiencing symptoms, than those whose PTSD had remitted. Among individual

symptoms, flashbacks (p = .006), diminished interest in activities (p = .003), and insomnia (p = .004) were associated with chronicity, as well as the emotional numbing cluster (range p = .003 to p = .09). Veterans with highly chronic PTSD were more likely to seek treatment; thus the higher symptom rates are not due to failure to seek treatment.

Conclusion: Although PTSD is defined as a unitary syndrome, it appears that some symptoms are more strongly associated with severe chronic illness than others. These symptoms may help to distinguish between normative and enduringly pathological responses to trauma, and indicate a need for intervention.

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No. 103
COMMUNITY AND INPATIENT VIOLENCE IN MAJOR PSYCHIATRIC DISORDERS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to contrast psychiatric patients who are assaultive in both community and hospital to patients whose assaults are restricted to the hospital. To recognize differences in psychosis, behavioral disturbances, neurological impairment, and historical risk factors in these two populations.

SUMMARY:

Objective: To compare clinical/historical variables associated with inpatient and community violence in major psychiatric disorders.

Method: A total of 277 inpatients were divided into three groups based on inpatient/community assaults: 70 (CHs) were assaultive in both settings, 133 (INPs) in hospital only, 74 (NVs) were not assaultive. Psychiatric symptoms were assessed with the Brief Psychiatric Rating Scale (BPRS), ward behaviors with the NOSIE upon study entry, and after four weeks. Quantified Neurological Scale (QNS) and psychosocial questionnaires were administered.

Results: Violent patients evidenced more positive psychotic symptoms than NVs (Baseline: $F = 14.8$, $df = 2,275$, $p < .001$; Endpoint: $F = 4.3$, $df = 2,273$, $p < .05$). The groups differed in neurological impairment (QNS: $F = 3.7$, $df = 2,255$ $p < .05$); it was greatest in INPs, least in CHs. Both violent groups were more irritable and had difficulties following rules. At endpoint, CHs were more sociable than INPs (NOSIE Social; $t = 2.3$, $df = 178$, $p < .05$). Violent groups had more disturbed early environment: 20% of CHs and 20% of INPs vs. 7% of NVs were raised in foster homes (Chisq = 6.8, df = 2, $p < .05$). Some factors were worse in CHs: school truancy in 61% of CHs vs. INPs 36% and NVs 32% (Chisq = 16.5, df = 2, $p < .01$); parental alcoholism in 24% of CHs vs. INPs 11% and NVs 6% (Chisq = 13.3, df = 2, $p < .01$)

Conclusions: Community and inpatient violence are associated with different psychiatric, neurological, and historical profiles.

Funding Source: NIMH.

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No. 104
PARENTAL SEPARATION AT BIRTH AND CRIMINALITY IN ADULTHOOD

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that the etiology of criminality may include very early experiences in infancy.

SUMMARY:

Objective: We studied the association between very early separation and later criminality in an unique data set.

Method: The index cohort consisted of 3,020 subjects (1,617 males and 1,403 females) born from 1945–1965 in Finland who were temporarily isolated from their family immediately after birth to adequate nursing homes due to tuberculosis in the family. The average separation time was seven months. For every index subject, two reference subjects were matched for sex, year of birth, and place of birth. Data on violent and nonviolent crimes were obtained from Statistics Finland between January 1, 1977, and December 31, 1999.

Results: Altogether, 192 (11.9%) male violent offenders were included in the index cohort, and 226 (7.1%) in the reference cohort (OR 1.89, 95%CI 1.54–2.32). In females the corresponding numbers were 16 (1.1%) and 22 (0.8%), respectively, (OR 1.49, 95%CI 0.78–2.84). Nonviolent crimes were committed by 416 (25.7%) male indexes and 730 (22.8%) male controls (OR 1.27, 95%CI 1.10–1.46), and by 108 (7.7%) female indexes and 140 (5.0%) female controls (OR 1.58, 95%CI 1.22–2.04).

Conclusions: Parental separation at birth in tuberculous households was associated with criminality in the offspring, especially violent offences in sons and nonviolent crimes in daughters.

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SCIENTIFIC AND CLINICAL REPORT SESSION 36—USES OF ANTIPSYCHOTICS

No. 105
POLYPHARMACY IN PATIENTS WITH SCHIZOPHRENIA

Robert E. McCue, M.D., *Department of Psychiatry, Woodhull Hospital, 760 Broadway, Brooklyn, NY 11206-5317;* Rubina Waheed, M.D., Leonel Urcuyo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand how multiple psychotropic drugs are used in patients with schizophrenia and some clinical effects of this practice.

SUMMARY:

Objective: Polypharmacy in patients with schizophrenia is a common practice with little basis in well-controlled studies. Our goal in this report will be to review the possible reasons for using polypharmacy, to survey its use over a five-year period at our institution, and to determine clinical correlates of its use.

Methods: We will critically review the literature on psychiatric polypharmacy. In addition, we will report on the findings of a study done at our institution, a public psychiatric service with over 2,000 discharges per year that serves an economically disadvantaged urban population. We will report on a review of the medical records of all discharges in the years 1995 and 2000 of patients with a diagnosis of a schizophrenia disorder.

Results: The prescribing practices for these patients will be compared between these two periods, during which a number of new psychotropic medications were added to the hospital formulary. We will discuss the relationship between various polypharmacy regimens and specific diagnoses, severity of illness, and time to recovery from acute episode. We will review the main patterns of polypharmacy in patients with schizophrenia: using more than one antipsychotic when an atypical antipsychotic is used, adding a mood stabilizer to an antipsychotic for impulsive aggression, and adding an antidepressant to an antipsychotic for depressive symptoms.

Conclusion: We will review the factors that have possibly affected the prescribing practices for patients with schizophrenia.

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No. 106
THE USE OF ATYPICAL ANTIPSYCHOTICS IN ADULTS WITH DEVELOPMENTAL DISABILITY

Karen J. Shedlack, M.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Christine Magee, M.S., Robert Sisson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to acquire knowledge of the use of standardized behavioral rating scales and the influence of diagnosis and gender on response to atypical antipsychotic medications in adults with MR/DD.

SUMMARY:

Objective: Adults with mental retardation/developmental disabilities (MR/DD) and comorbid psychiatric illness, the so-called dually diagnosed, present challenges to assessment, diagnosis, and medical treatment planning. Antipsychotics are widely prescribed for a variety of indications in this population. At the Adults with Developmental Disabilities Psychiatric Partial Hospital Program (ADDPP) at McLean Hospital, we have investigated the role of gender and diagnosis in the response to atypical antipsychotics among the dually diagnosed.

Method: This unfunded, retrospective, chart-review study of 72 (36M, 36F) dually diagnosed adults treated at the ADDPP from 1/98 to 12/99 examined the relationship between atypical antipsychotic dose and standardized outcome measures including the Aberrant Behavior Checklist (ABC). Total antipsychotic doses were converted to chlorpromazine equivalents and patients were rated at admission and discharge.

Results: Successful outcomes identified by reductions in specific symptoms as measured by the ABC subscales were correlated with atypical antipsychotic dose at discharge. When analyzed by gender and then by diagnosis, the correlation between dose and improvement on the social withdrawal subscale was significant for women ($r = .52$, $p = .02$) but not for men ($r = .23$, $p = .21$) and for patients with diagnoses in the schizophrenia spectrum ($r = 54$, $p = .004$) but not with psychotic depression ($r = .07$, $p = .84$) or mania ($r = .50$, $p = .17$).

Conclusion: Social withdrawal is often a constitutional feature of MR/DD and can easily go unrecognized as a treatable complex of negative symptoms associated with schizophrenia. Our findings indicate that psychiatric diagnosis and gender can affect response to treatment with atypical antipsychotics and influence clinical improvement in patients with MR/DD.

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1. Mikkelsen EJ, McKenna L: Psychopharmacologic algorithms for adults with developmental disabilities and difficult-to-diagnose behavioral disorders. Psychiatric Annals 1999; 29(5):302–314.
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SCIENTIFIC AND CLINICAL REPORT SESSION 37—MOOD DISORDERS IN CHILDREN

No. 107
ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDER

Giulio Perugi, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa 56100, Italy;* Gabriele Masi, M.D., Christina Toni, M.D., Maria Mucci, M.D., Stefania Millepiedi, M.D., Hagop S. Akiskal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize anxious bipolar comorbidity in children and adolescents and to identify the predictors of pharmacological hypomania when considering antidepressant pharmacotherapy in youths with severe, multiple anxiety disorders.

SUMMARY:

Objective: We describe a consecutive clinical sample of children and adolescents with bipolar (BP) disorder, in order to define the pattern of comorbid anxiety and externalizing disorders, and to explore the possible influence of such comorbidity on their cross-sectional and longitudinal clinical characteristics.

Methods: The sample comprised 43 outpatients, 26 males and 17 females, mean age 14.9 ± 3.1 years (range 7–18), either type I or II, according to DSM-IV diagnostic criteria. All patients were screened for psychiatric disorders, using historical information and a clinical interview, the Diagnostic Interview for Children and Adolescents—Revised (DICA-R) (Reich, 1997). To shed light on the possible influence of age at onset, a comparison was conducted among clinical features of subjects whose BP onset was during childhood (< 12 years) or adolescence. We also conducted comparisons among different subgroups, with and without comorbidity with externalizing and anxiety disorders.

Results: BP disorder type I was slightly more represented than type II (55.8% vs 44.2%). Only a minority of patients was not affected by any other psychiatric disorder (n = 5, 11.6%); importantly only 10 subjects (23.5%) did not show any comorbid anxiety disorder. Comorbid externalizing disorders were present in 12 (27.9%) pa-

tients; such comorbidity was related to the childhood onset of type II BP disorder. Patients with comorbid anxiety disorders more often reported pharmacological (hypo)mania compared to the others.

Conclusion: Although comorbidity with externalizing disorders has been studied much more often than that with anxiety disorders, our study suggests that this latter is more prominently represented in out-patient children and adolescents with BP disorder. The frequent report of pharmachologic hypomania in such comorbidity indicates the need to be cautious when considering antidepressant pharmacotherapy in youths with severe, multiple anxiety disorders.

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No. 108
COMORBIDITY IN CHILD AND ADOLESCENT MAJOR DEPRESSION

Atilla Turgay, M.D., *Department of Psychiatry, Scarborough Hospital, 3050 Lawrence Avenue, East, Scarborough, ON MIP 2V5, Canada;* David Ng, M.D., Lillian Mok, M.D., Joanna Blanchard, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the frequent comorbid disorders associated with child and adolescent major depression and develop specific treatment alternatives.

SUMMARY:

Objective: To provide information about the comorbid disorders in child and adolescent major depression.

Sample: This clinical study involved 66 children and adolescents (35 females and 31 males), age range 8–16 years.

Method: DSM-IV criteria were used for major depression. All the patients were expected to exceed the recommended cut-off scores for the Beck, Kovacs, and Hamilton Depression Rating Scales. All patients were screened for comorbid disorders with the use of Offord-Boyle Ontario Child Health Study parent and teacher rating scales.

Findings: A total of 21 patients (31.8%) had only major depression (MD) in the absence of other comorbid disorders; 68.2% had at least one more comorbid disorder. The mean number of diagnostic categories per patient was found to be 2.1 with a standard deviation of 0.98. The number of comorbid disorders increased as a function of age for females, whereas this was not the case for males. For children under 12, males were over-represented. For adolescents age 13 and over, females were over-represented. 32.9% of the patients had ADHD and 34.3% had ODD. The most common comorbid disorder for boys was ADHD and for girls, ODD. 12.9% of the patients had conduct disorder and 12.9% also suffered from associated anxiety disorders.

Conclusions: Children and adolescents with major depression should be carefully screened for ADHD and anxiety disorders. They need a multiple treatment approach and combination drug therapies.

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No. 109
EVALUATION AND INTERVENTION OF PRODROMAL SYMPTOMS OF BIPOLAR I DISORDER

Mohammad Z. Hussain, M.D., *Prince Albert Health District, Mental Health Centre, 2727 2nd Avenue West, Prince Albert, SK, S6V 5E5, Canada;* Zabaida A. Chaudhry, M.D., Seema Hussain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand and diagnose the early symptoms of bipolar mood disorder in children and adolescents, which predate development of full syndrome.

SUMMARY:

Often bipolar mood disorder emerges in childhood or adolescence, but the average interval between prodromal symptoms and diagnosis is 10 or more years. To allow early intervention, we need to define the early symptoms that predate the full syndrome and identify youth during that phase.

Forty-seven children were diagnosed with bipolar I, prodrome state. They had positive family history, episodic mood, and energy symptom fluctuation with anger dyscontrol, irritability, defiance, demanding behavior, conduct problems, sleep disturbance, anxiety, tension, worrying, stubborness, and somatic complaints. A 25-item, four-point prodrome scale was created with items relevant to youth from DSM-IV criteria, Hamilton Depression, and Young Mania scales. The scale reflects the atypical presentation of bipolar disorder in childhood. Comorbidities were recognized, which add another dimension to evaluation. The group of 28 males and 19 females had a mean age of 11.6 years (range 7–16). All received mainstay treatment of topiramate in a dose range 25–100 mg qhs, with some subjects requiring adjunct treatment. Twelve were intolerant of topiramate and received valproate 250–500 mg daily. They were rated at baseline, and 1-2-3-6-9-12-month intervals. They had 68% to 92% symptom reduction on consecutive assessments. Topiramate and valproate are effective treatments in prodromal bipolar disorder.

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SCIENTIFIC AND CLINICAL REPORT SESSION 38—ISSUES IN DEPRESSION

No. 110
DYSTHYMIC DISORDER: INTEGRATING RESEARCH FINDINGS INTO CLINICAL TREATMENT

David J. Hellerstein, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 101, New York, NY 10032;*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe major findings from research on dysthymic disorder (in psychopharmacology, psychotherapy, and combined treatments), and apply effectively in clinical practice.

SUMMARY:

Objective: Dysthymic disorder, a form of chronic depression, has been studied over the past two decades. A variety of forms of research, from epidemiological research to psychopharmacology and psychotherapy outcome studies, now provides data that can help the clinician to effectively treat dysthymic patients.

Method: This paper reviews clinically-relevant research studies and applies their findings to the clinical setting.

Results: Epidemiological research and prospective follow-up studies have defined the risks of untreated and under-treated chronic depression, including impaired work, interpersonal, and health functioning. Studies on the phenomenology of dysthymic disorder can help the clinician define target symptoms, which often include nonvegetative symptoms such as low self-esteem, pessimism, feelings of inadequacy, and social withdrawal. Treatment outcome research can help to guide treatment choices. At least 15 placebo-controlled psychopharmacology studies of dysthymia, including seven studies of "pure" dysthymia (dysthymia without comorbid major depression) have been completed, and consistently indicate the efficacy of a variety of pharmacological agents. The emerging literature on combining medication and therapy can provide goals for treatment at different phases of treatment. Reports from specialized clinics suggest that as many as 75% of dysthymics can achieve and maintain good to superior levels of functioning with targeted treatment.

Conclusion: The clinician has a significantly greater chance of helping dysthymic patients now than only 20 years ago.

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1. Lima MS, Moncrieff J: A comparison of drugs versus placebo for the treatment of dysthymia: a systematic review. (Cochrane Review). The Cochrane Database of Systematic Reviews 2001; Issue 2.
2. Hellerstein DJ: Dysthymic disorder: integrating research findings into clinical treatment. J of Psychiatric Practice 2001, in press.

No. 111
EFFECT OF ADJUNCT MODAFINIL ON ENERGY AND CONCENTRATION IN DEPRESSED PATIENTS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the use of modafinil as an adjunct treatment to antidepressant therapy.

SUMMARY:

Objective: To evaluate the effect of the wake-promoting agent modafinil on energy and concentration in patients with major depression who had a partial response to antidepressant therapy prior to study.

Method: In this six-week, randomized, double-blind, placebo-controlled study, 136 patients received modafinil (100–400 mg/day) or placebo as an adjunct to their antidepressant therapy. Changes in energy and concentration were assessed using the retardation subscale (items 1, 7, 8, and 14) of the Hamilton Depression Rating Scale. A total of 118 patients (87%) completed the study.

Results: Improvements from baseline (n = 118) in mean retardation subscale scores were shown throughout the study with adjunct modafinil; however, no significant between-treatment differences were demonstrated. Subanalysis by various antidepressants showed improvement in energy and concentration versus placebo in those patients taking modafinil with fluoxetine (n = 33), paroxetine (n = 31), or sertraline (n = 21) but not citalopram (n = 21). The differences in the subanalysis did not reach statistical significance. When the fluoxetine, paroxetine, and sertraline groups were combined, a statistically significant overall treatment effect favoring modafinil over placebo was demonstrated.

Conclusions: This study provides evidence that modafinil may improve energy and concentration in patients with depression. Further studies are recommended.

Funding: Supported by Cephalon, Inc.

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1. Menza MA, Kaufman KR, Castellanos A: Modafinil augmentation of antidepressant treatment in depression. J Clin Psychiatry 2000; 61:378–381.
2. Pigeau R, Naitoh P, Buguet A, McCann C, Baranski J, Taylor M, Thompson M, Mac KI: Modafinil, d-amphetamine and placebo during 64 hours of sustained mental work. I. Effects on mood, fatigue, cognitive performance and body temperature. J Sleep Res 1995; 4:212–228.

No. 112
PARENTAL SEPARATION AT BIRTH AND DEPRESSION IN ADULTHOOD

Juha M. Veijola, M.D., *Department of Psychiatry, University of Oulu, P O Box 5000, Peltolantie 5, Oulu 90014, Finland;* Pirjo H. Maki, M.D., Matti Joukamaa, Ph.D., Helina Hakko, Ph.D., Matti K. Isohanni, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that the etiology of depression may include very early experiences in infancy.

SUMMARY:

Objective: Early separation of a child from the mother has been considered as a risk factor for developing later depression. We investigated the association between very early separation and later depression in a unique data set.

Method: The index cohort consisted of 3,020 subjects born from 1945–1965 in Finland and isolated from their family due to tuberculosis in the family into special nurseries, the Christmas Seal Homes, immediately after the birth. The average separation time was seven months. The subjects being alive at January 1, 1971 were identified. For every index subject two reference subjects were chosen; the matching criteria being sex, year of birth, and place of birth. The data on depression was obtained from Finnish Hospital Discharge Register by the end of year 1998.

Results: Of the male index subjects 4.2% and 2.6% of the reference subjects had been treated in hospital due to depressive episode. In females the respective figures were 3.9% for index subjects and 3.6% for reference subjects.

Conclusion: The risk for depression of the Christmas Seal Home boys later in adulthood was elevated. The early separation from the mother possibly had unfavorable effects on later psychological development, especially in some of the male subjects.

REFERENCES:

1. Brown GW, Harris T: Social origins of depression: a study of psychiatric disorders in women. New York, Free Press, 1978.
2. Mäki P, Veijola J, Joukamaa M, Hakko H, Isohanni M: Schizophrenia in the Finnish Christmas Seal Home Children. Schizophr Res Suppl 2001; 49:38.

SCIENTIFIC AND CLINICAL REPORT SESSION 39—CLINICAL APPROACHES IN SCHIZOPHRENIA

No. 113
LOW-FREQUENCY TRANSCRANIAL MAGNETIC STIMULATION CURTAILS MEDICATION-RESISTANT AUDITORY HALLUCINATIONS

Ralph E. Hoffman, M.D., *Department of Psychiatry, Yale University School of Medicine, PO Box 208099, New Haven, CT 06520-8099;* Keith A. Hawkins, Psy.D., Fadddie H. Rachid, M.D., Ralitza Gueorguieva, Ph.D., Kathleen M. Carroll, Ph.D., Nashaat N. Boutros, M.D., John H. Krystal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant shall understand cortical effects of 1-Hz rTMS and its potential usefulness in treating auditory hallucinations.

SUMMARY:

Objective: Studies suggest that auditory hallucinations of spoken speech arise in part from neurocircuitry ordinarily active during speech perception. 1 hertz repetitive transcranial magnetic stimulation (rTMS) produces sustained reductions in cortical activation. In a brief pilot study, we have shown that 1-Hz rTMS to left temporoparietal cortex reduces auditory hallucinations. We wished to determine if a more extended trial of rTMS can produce sustained reductions in auditory hallucinations previously resistant to antipsychotic medication.

Method: Twenty-four schizophrenic patients with medication-resistant auditory hallucinations were randomized to receive active vs sham rTMS consisting of a total of 132 minutes of stimulation delivered over a nine-day period at 90% motor threshold. Neuropsychological assessments were administered at baseline, during, and following the trial.

Results: Active rTMS produced robust improvements in auditory hallucinations relative sham rTMS ($p < .003$). Frequency and attentional disruption were the two aspects of hallucinatory experience showing greatest improvement. Duration of treatment effects ranged widely, with 50% of patients maintaining improvement for at least 12 weeks. rTMS was well-tolerated without evidence of neuropsychological impairment.

Conclusion: 1-Hz rTMS deserves additional study as a potential treatment for medication-resistant auditory hallucinations.

Funding: NIMH grant R21MH63326, NIH/NCRR/GCRC Program Grant RR00125, and the Donaghue Medical Foundation.

REFERENCES:

1. Hoffman RE, Boutros NN, Hu S, Berman RM., Krystal JH, Charney DS: Transcranial magnetic stimulation of left temporoparietal cortex in schizophrenic patients reporting auditory hallucinations. Lancet 2000;355:1073–5.
2. Silbersweig DA, Stern E, Frith C, Cahill C, Holmes A, et al: A functional neuroanatomy of hallucinations in schizophrenia. Nature 1995; 378: 176–179.

No. 114
SIBUTRAMINE TREATMENT OF OBESITY IN SCHIZOPHRENIA

Ljiljana Radulovic, M.D., *Department of Psychiatry, SUNY Downstate, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203;* Peter J. Weiden, M.D., David B. Allison, Ph.D., Catherine Camille, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the mechanism of action of sibutramine, and its safety and efficacy as a treatment for obesity in stable outpatients with schizophrenia

SUMMARY:

Objective: This session is for psychiatrists who are interested in new data on using sibutramine to treat obesity among patients on antipsychotic medication. Sibutramine is an FDA-approved medication for obesity, but its safety and efficacy have not been studied for psychotic patients taking antipsychotic medications.

Method: This is a 16-week, double-blind, placebo-controlled study evaluating the safety and efficacy of adding sibutramine to an antipsychotic regimen for stable, obese (BMI > 27) outpatients with schizophrenia. Exclusion criteria include clozapine treatment, concomitant antidepressants, and untreated hypertension. Enrolled patients are assigned to double-blind sibutramine (up to 15mg per day) or placebo assigned in a 2:1 ratio. All patients also receive behavioral weight counseling.

Results: To date 17 patients have enrolled, and 15 remain in active treatment with a mean baseline BMI is 35.6. The three discontinuations were for hypertension (n = 1), unrelated medical problem (n = 1), and for personal reasons (n = 1). None of the 17 experienced a worsening of psychotic symptoms. Most of the 15 continuations are losing weight, but at this time we are unable to report on the efficacy of sibutramine over and above the behavioral intervention (but will do so at the APA meeting).

Conclusions: The preliminary finding of this study is that it is safe to add sibutramine onto an ongoing antipsychotic regimen. This finding is reassuring because sibutramine's mechanism of action (catecholamine reuptake inhibition) could, in theory, exacerbate psychotic symptoms.

This study was supported by a grant from Knoll Pharmaceuticals (now Abbott).

REFERENCES:

1. Allison D, et al: The distribution of body mass index among individuals with and without schizophrenia. Journal of Clinical Psychiatry 1999; 60(4):215–220.
2. Devlin MJ, et al: Obesity: What mental health professionals need to know. American Journal of Psychiatry 2000; 157:854–866.

No. 115
THE STABILIZATION PHASE OF SCHIZOPHRENIA: A REVIEW OF THE LITERATURE

Peter J. Weiden, M.D., *Department of Psychiatry, SUNY Health Science Center at Brooklyn, 450 Clarkson Avenue, Brooklyn NY 11203;* Judy Greene, B.A., Nina R. Schooler, Ph.D.

EDUCATIONAL OBJECTIVES:

The goal of this paper is to present a meta-analysis of studies that try to define the stabilization period for patients with schizophrenia and report on the course of illness during this time.

SUMMARY:

Schizophrenia is a phasic illness. The major phases of illness identified for schizophrenic disorders are prodromal, acute, stabilization, maintenance, and remission phases. Of these, the stabilization phase is perhaps the least well understood. A review of the current literature yields multiple names describing this phase of illness including: post-acute phase, resolving phase, convalescent phase, healing phase, and partial remission phase. These definitions are hazy at best, and indicate that, as a concept, stabilization in schizophrenia is poorly defined and lacks clear boundaries.

This paper summarizes the last 40 years of research literature on stabilization in schizophrenia. Although this phase of illness has not been the central research focus of maintenance studies, it is operationalized in many studies as a period of time prior to medication randomization. The parameters are subjectively defined depending on the focus of the clinical research. This phase of illness has been conceptualized in various ways including: (1) with relation to symptom severity and stability over time, (2) medication dosage, (3) psychosocial stressors, (4), biologic markers such as changes in dopamine levels or other neurotransmitter systems, (5) acuity of treatment setting. The characterization of this phase of illness has implications for both psychiatric management and clinical research. We will summarize how the studies define stabilization, and present major outcome domains such as the course of symptom response, suicide, and relapse rates. We will also report on the shortcomings of the current literature with the hope of establishing better definitions of this phase of treatment in the future.

REFERENCES:

1. Frank E, et al: Conceptualization and rationale for consensus definitions of terms in major depressive disorders. Archives of General Psychiatry 1991; 48:851–855.
2. Schooler NR, et al: Relapse and rehospitalization during maintenance treatment of schizophrenia: the effects of dose reduction and family treatment. Archives of General Psychiatry 1997; 54:453–463.

SCIENTIFIC AND CLINICAL REPORT SESSION 40—MANAGED CARE AND HEALTH CARE FINDINGS

No. 116
ALZHEIMER'S DISEASE INCREASES COSTS OF COMORBIDITIES IN MEDICARE-MANAGED CARE

Howard Fillit, M.D., *Institute Study of Aging, 767 Fifth Avenue, Suite 4200, New York, NY 10153;* Jerrold W. Hill, Ph.D., Robert Futterman, Ph.D., John R. Lloyd, B.S., Vera Mastey, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that health care costs for patients with AD and comorbid conditions are higher than costs for patients without AD with the same conditions.

SUMMARY:

Objective: To analyze the relationship between comorbid conditions and costs for patients with Alzheimer's disease (AD) in a Medicare-managed care organization (MCO).

Method: Retrospective analysis of administrative data for patients with AD (3,517) and age- and gender-matched controls (17,480) selected from members in a group practice Medicare-MCO. Comorbid conditions were identified from administrative data using diagnostic classifications from the Charlson Comorbidity Index.

Results: The prevalence of AD in the MCO was 3.9%. Annual health care costs were $3,706 higher for AD patients than controls. Costs for comorbid conditions were also higher for AD patients compared with controls. Compared with controls with the same conditions, costs were $5,389 higher for patients with AD and congestive heart failure, $7410 higher for AD and diabetes with chronic complications, and $4,404 higher for AD and diabetes without complications. Increased health care costs for AD patients were attributable to greater utilization of inpatient and skilled nursing facilities.

Conclusions: Costs for AD patients in a Medicare-MCO were 1.6 times higher than for controls and significantly higher for 13 of 16 comorbid conditions examined, including CHF and diabetes. To improve quality of care and reduce health care costs existing disease management programs should be modified to include guidelines for identified dementia patients.

Primary funding source: Pfizer Outcomes Research.

REFERENCES:

1. Gutterman EM, Markowitz JS, Lewis B, Fillit H: Costs of Alzheimer's disease and related dementia in managed-medicare. J Am Ger Soc 1999; 47:1065–1071.
2. Fillit H, Gutterman EM, Lewis B: Donepezil use in managed medicate: effect on health care costs and utilization. Clin Therapeutics 1999; 21:2173–2185.

No. 117
DONEPEZIL IS ASSOCIATED WITH LOWER HEALTH CARE COSTS IN MEDICARE-MANAGED CARE

Jerrold W. Hill, Ph.D., *Institute Study of Aging, 767 Fifth Avenue, Suite 4200, New York, NY 10153;* Howard Fillit, M.D., Robert Futterman, Ph.D., Vera Mastey, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that long-term treatment with the cholinesterase inhibitor, donepezil, results in lower health care costs for AD patients in a large group practice Medicare-managed care organization as compared with costs for untreated AD patients.

SUMMARY:

Objective: To evaluate the impact of the cholinesterase inhibitor donepezil on health care costs associated with Alzheimer's disease (AD) in a large Medicare-managed care organization (MCO).

Method: A retrospective case-control analysis was conducted on 204 patients diagnosed with AD with prescriptions for donepezil and 12 or more months of enrollment in the MCO following the date of the first prescription. A control group of 204 patients with 12 or more months of plan enrollment following the diagnosis of AD was selected. Health care costs were calculated for cases and controls during the 12-month follow-up period and adjusted for age, gender, comorbid conditions, and complications of dementia.

Results: Annual adjusted costs for medical services and prescription drugs were $3,891 lower for patients taking donepezil compared with controls. Adjusted costs were $4,192 lower for patients on longer-term therapy (270 or more days supply of donepezil) and $3,579 lower for patients on shorter-term therapy (less than 270 days supply) when compared with controls.

Conclusions: Donepezil reduced costs for patients with AD in this Medicare-MCO. Longer-term therapy was associated with greater cost savings. The likely mechanism for lower costs associated with donepezil therapy is improved cognitive functioning and associated improvements in medical management.

Primary funding source: Pfizer Outcomes Research.

REFERENCES:

1. Gutterman EM, Markowitz JS, Lewis B, Fillit H: Cost of Alzheimer's disease and related dementia in managed-medicare. J Am Ger Soc 1999; 47:1065–1071.
2. Fillit H, Gutterman EM, Lewis B: Donepezil use in managed medicare: effect on health care costs and utilization. Clin Therapeutics 1999; 21:2173–2185.

No. 118
MANAGED CARE AND MALPRACTICE LIABILITY: UPDATE 2002

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) understand legal issues related to physician liability in managed care, (2) deal with treatment denials in an appropriate manner, and (3) participate in more effective defense should denial lead to a malpractice suit.

SUMMARY:

Managed care has restricted the physician's freedom to determine treatment, while he or she remains susceptible to malpractice liability, a situation aggravated by hold-harmless clauses and gag rules. From the outset, courts held physicians accountable if they did not appeal sufficiently to exhaust all means of overturning utilization review determinations denying or limiting treatment. Several lines of approach to liability in physician/insurer/patient relationships have been considered by the courts, often following principles applicable to hospital settings. Federal ERISA Law pre-empting state laws in managed care further complicates the legal situation and increases physician risk. Public anger over perceived injustices have led many states to legislate allocation of responsibility for malpractice. Federal courts have begun to review ERISA provisions and decide precedent-setting cases; modification of ERISA by Congress is pending. This paper summarizes applicable law and reviews the more recent changes in this rapidly evolving field.

REFERENCES:

1. Lowenkopf EL, Rychik A: Malpractice liability and managed care. Directions in Psychiatry 2001; 20(1):45–54.
2. Mariner WM: Liability for managed care decisions: the unevent playing field and the Employment Retirement Income Security Act (ERISA). Am Jnl Public Health 1996; 86(6):863–869.

SCIENTIFIC AND CLINICAL REPORT SESSION 41—TREATMENT TECHNIQUES

No. 119
MATCHING TREATMENT TO TYPE OF POOR-PROGNOSTIC, SUBSTANCE-DEPENDENT PATIENTS

Edward Gottheil, M.D., *Department of Psychiatry, Jefferson Medical College, 833 Chestnut East, Suite 210E, Philadelphia, PA 19107;* Charles C. Thornton, Ph.D., Stephen P. Weinstein, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify two types of poor-prognosis, substance-dependent patients at intake and assign them to suitable early intervention techniques.

SUMMARY:

Objective: Patients who enter treatment still using positive urinalysis and/or who drop out early have been demonstrated to have poor prognoses (PP). The purpose of this study was to identify characteristics of PP patients, which might suggest approaches to treatment.

Method: A mixed group of 142 PP and non-PP substance-dependent outpatients were compared with respect to demographics and a battery of intake instruments. Significant differences were found between the PP and non-PP patients on measures of psychiatric severity, addiction severity, coping styles, and treatment related attitudes.

Results: Those measures that significantly differentiated the PP and non-PP patients were then entered into a factor analysis. Two profiles emerged: one associated with disengagement and denial (avoidant coping style) and the other characterized by ambivalence toward using or not and the value of treatment, despite admitting to psychiatric and addiction problems.

Conclusion: Based on data available at intake, the provision of specific early treatment interventions such as assertiveness training for the avoidant type and motivational interviewing for the ambivalent might reduce early dropouts and improve outcomes.

Funding Source: NIDA Grant R01 DA08527.

REFERENCES:

1. Gottheil E, Sterling RC, Weinstein SP: Pretreatment dropouts: characteristics and outcomes. Journal of Addictive Diseases 1997; 16:1–14.
2. Onken LS, Blaine JD, Boren JJ: Beyond the Therapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment. NIDA Research Monograph 165, Rockville, MD, 1997.

No. 120
TIAGABINE, A SELECTIVE GABA REUPTAKE INHIBITOR FOR THE TREATMENT OF ANXIETY

Daniel L. Crane, M.D., *130 East 18th Street, New York, NY 10003-2416*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the potential use of tiagabine in the treatment of anxiety.

SUMMARY:

Objective: To assess the efficacy of tiagabine, a selective GABA reuptake inhibitor, for the treatment of anxiety disorders and comorbid anxiety associated with other psychiatric disorders.

Methods: Case-series study of 10 patients considered to be refractory to conventional anti-anxiety medications. Patients initially received 2 mg of tiagabine once daily for one week either alone (N = 5) or in combination with other antianxiety medications (N = 5). The dosage of tiagabine could be increased and administered on a twice-daily basis. Efficacy was assessed after four weeks of treatment using the Clinical Global Impression of Change scale.

Results: Most patients reported markedly reduced anxiety levels within the first week of treatment. After four weeks of treatment, all patients were considered to be "much improved" or "very much improved." Eight of 10 patients were receiving 2–4 mg/d of tiagabine; two patients were receiving 6–8 mg/d. Mean dosages of tiagabine were approximately the same in patients receiving monotherapy (3.6 mg/d) and those receiving polytherapy (4.4 mg/d). All patients have now received tiagabine for ≥ 3 months, with excellent control of anxiety symptoms. Tiagabine has been very well tolerated.

Conclusions: The SGRI tiagabine, alone or in combination with other antianxiety medications, may be effective for the treatment of anxiety in patients refractory to conventional antianxiety medications.

REFERENCES:

1. Nielsen EB, Suzdak PD, Andersen KE, Knutsen LJ, Sonnewald U, Braestrup C: Characterization of tiagabine (NO-328), a new potent and selective GABA uptake inhibitor. Eur J Pharmacol 1991; 196:257–266.
2. Kaufman KR: Adjunctive tiagabine treatment of psychiatric disorders: three cases. Ann Clin Psychiatry 1998; 10:181–184.

No. 121
ADJUNCTIVE USE OF TIAGABINE WITH ANTIDEPRESSANTS IN PTSD

Michael E. Lara, M.D., *Department of Behavioral Medicine, Gardner Family Care, 160 East Virginia Street, Suite 280, San Jose, CA 95112*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to treat posttraumatic stress disorder and comorbid mood disorders with an antidpressant and the selective GABA reuptake inhibitor tiagabine.

SUMMARY:

Objective: To evaluate the efficacy and safety of the selective GABA reuptake inhibitor tiagabine as an adjunct to antidepressant treatment of posttraumatic stress disorder (PTSD).

Methods: This prospective, open-label case series describes six adult patients with PTSD and a comorbid mood disorder who received tiagabine as an augmenting agent to target symptoms of increased arousal. The Davidson Trauma Scale was administered prior to treatment and at each subsequent visit over a six-week period. The Overt Aggression Scale-Modified was used to assess impulsivity and aggression. Results were compared with two control patients (one receiving SSRI therapy alone and one receiving antidepressant and a benzodiazepine).

Results: Final tiagabine doses ranged from 8–16 mg/day. All patients reported a decrease in the PTSD symptoms at a rate similar to that observed with antidepressant plus benzodiazepine therapy and at a more rapid rate when compared with that observed with antidepressant therapy alone. A robust decrease in aggression and impulsivity was seen in those patients on an antidepressant plus tiagabine when compared with other treatment regimens. Side effects were minimal and did not lead to any discontinuation of tiagabine.

Conclusions: Tiagabine may be an alternative to benzodiazepines when used as an adjunct to antidepressants and may be particularly promising in patients who report increased arousal associated with PTSD.

REFERENCES:

1. Nielsen EB, Suzdak PD, Andersen KE, Knutsen LJ, Sonnewald U. Braestrup C: Characterization of tiagabine (NO-328), a new potent and selective GABA uptake inhibitor. Eur J Pharmacol 1991; 196:257–266.
2. Kaufman KR: Adjunctive tiagabine treatment of psychiatric disorders: three cases. Ann Clin Psychiatry 1968; 10:181–184.

SCIENTIFIC AND CLINICAL REPORT SESSION 42—TRENDS IN SUICIDE RATES

No. 122
FEMALE SUICIDES IN TEXAS CITIES: 1994–1998

Veena R. Doddakashi, M.D., *Department of Psychiatry, Austin State Hospital, 4110 Guadalupe, Austin, TX 78751;* Richard Wilcox, Ph.D., Lawrence A. Hauser, M.D.

SUMMARY:

From 1995 to 1997 suicide was the eighth leading cause of death in Texas, claiming 2,137 lives, accounting for 20% of all injury deaths in Texas. Firearm injuries significantly affect mortality rates in many states. From 1976 through 1985, Texas ranked first among states in the proportion of injury-deaths caused by firearms, with an annual rate of 21.2 per 100,000. The rates of suicide have continued to rise, particularly in young adults. The rate of suicide by firearms has also increased significantly.

We have focussed on different methods of suicide by age and race in women from 1994 to 1998. This work extended that of Li and Hauser (May 2001) on suicide in Austin, Texas, from 1994 to 1998. They found that the most common method of suicide in both males and females was by firearms. In the current study, we examined whether the Austin data were unique, or if they were representative of major Texas cities such as Dallas, Houston, San Antonio, and El Paso. Our major finding was that the most common method of suicide among women in all these cities was by firearms. Women in the age group 35 to 44 had the highest incidence of deaths, followed by those 45 to 54.

If easy accessibility to firearms is a common risk factor for suicide, does a state with liberal gun laws such as Texas need to re-examine its laws in order to reduce mortality from suicide? If the most common method of suicide among women across the nation is by overdose, are factors other than easy accessibility to firearms contributing to the more violent method of deaths by suicide for women? Finally, if depression is more common in women than men, and depression is a significant risk factor for suicide, do we need more aggressive intervention, especially for women for the treatment of depression?

No. 123
TRENDS IN SUICIDE RATES IN NEW YORK CITY: IMPLICATIONS FOR A PREVENTION INITIATIVE

Neal L. Cohen, M.D., *New York City Department of Mental Health, 93 Worth Street, New York, NY 10013;* Susan Wilt, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize how trends in suicide and hospitalization for self-inflicted injuries allow for identification of risk factors that can be addressed through a suicide prevention and initiative in a large urban setting.

SUMMARY:

Objective: The authors examine trends in suicide and hospitalization for self-inflicted injuries in the past decade in New York City to inform a city-wide suicide prevention initiative.

Method: New York City vital records data for suicides and state health department data for hospitalizations are each combined for the years 1990, 1991, and 1992 and compared with aggregate data for the years 1998, 1999, and 2000. Aggregate data control for variations that occur from year to year. Suicide and hospitalization rates are calculated including gender, age, ethnicity, method, and neighborhood factors.

Results: Statistical analyses are carried out to highlight trends in self-inflicted injury and suicide in NYC at the start and end of the 1990s decade. With a decline in suicide by 31% and relatively level rates of hospitalization, the report highlights changes in risk factors for suicide. Significant trends in homicide and quality of life measures over the same period are discussed in relation to their relationship to changes in suicide rates.

Conclusions: The authors use data on self-inflicted injury and suicide rates in New York City to propose the components of a suicide prevention initiative relevant to large urban settings.

REFERENCES:

1. The Surgeon General's Call to Action to Prevent Suicide: U. S. Department of Health and Human Resources. Rockville, MD, 1999.
2. Harris EC, Barraclough BB: Suicide as an outcome for mental disorder. Br J Psychiatry 1997;170:205–228.

No. 124

CHANGING SUICIDE RATES IN EUROPE: POSSIBLE CAUSES

Zoltan Rihmer, M.D., *Department of Psychiatry, XIII, National Institute of Psychiatry, Huvosvolgyi Ut 116, Budapest 1021, Hungary;* Annamaria Rihmer

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand, that more widespread and effective treatment of depressive and other psychiatric disorders is one of the contributing factors in decreasing national suicide rates in some European countries.

SUMMARY:

The objective of this study was to analyze the possible causes of changing national suicide rates in Europe during the last two decades.

Methods: National suicide rates, some psychosocial variables (unemployment, alcohol consumption, GDP) and the prescription of antidepressants were analyzed in different countries of Europe between 1980 and 1998.

Results: The great (sometimes more than 10-fold) differences between national suicide rates and the recent changes in them cannot be fully explained either by the former (communist) political-economic systems, or by the recent changes in this respect, since several post-communist countries (Romania, Poland, Bulgaria) have always had a relatively low suicide rate. In addition, after the political changes, with the exception of Hungary, Belarus, and Russia, the suicide mortality of these countries have increased or not changed substantially. The markedly decreased suicide mortality of several European countries (Denmark, Austria, Hungary, Sweden, UK, and Wales, France, and Belgium) can be explained in part with the more widespread treatment of depressive and anxiety disorders (Isacsson 2000, Rihmer et al 2001).

Conclusions: Since more than 90% of suicide victims have (mostly untreated) psychiatric illness (mainly depression), it is not surprising that better care of psychiatric patients is one of the contributing factors in decreasing national suicide rates.

REFERENCES:

1. Isacsson G: Suicide prevention: a medical breakthrough? Acta Psychiatr Scand 2000; 102:113–117.
2. Rihmer Z, Belso N, Kalmár S: Antidepressants and suicide prevention in Hungary. Acta Psychiatr Scand 2001; 103:238.

SYMPOSIUM 1—ADVANCES IN THE DIAGNOSIS AND TREATMENT OF DELIRIUM

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should be able to (1) diagnose delirium in the clinical setting, (2) use diagnostic tests judiciously, (3) appreciate the experience of delirium, and (4) understand the biological and clinical rationale for the use of atypical antipsychotic medications in the treatment of delirium.

No. 1A
THE EXPERIENCE OF DELIRIUM IN CANCER PATIENTS

William Breitbart, M.D., *Department of Psychiatry, Memorial Sloan Kettering Hospital, 1275 York Avenue, Box 421, New York, NY 10021-6007*

SUMMARY:

The authors conducted a prospective survey of the experience of delirium in a convenience sample of 101 hospitalized cancer patients with delirium. Patients were rated systematically with the Memorial Delirium Assessment Scale as well as measures of physical performance status, and sociodemographic and medical variables. After resolution of delirium, patients were administered a Delirium Experience Questionnaire, which assessed recall of delirium episode and distress related to the episode. Spouses/caregivers and nurses were also asked to rate severity of distress. Fifty-four percent (53.5%) of patients remembered being delirious, 93% reported the experience as "distressing." Mean level of patient distress (0-4 NRS) = 3.22 (SD = .86); mean level of spouse/caregiver distress = 3.75 (SD = .47); mean level of nurse distress = 3.09 (SD = .37). Spouses reported greater distress than patients and nurses. Predictors of delirium-related distress in patients included the presence of hallucinations and delusions. Hypoactive delirium was equally as distressing as hyperactive delirium for patients.

No. 1B
THE CLINICAL DIAGNOSIS OF DELIRIUM

John W. Barnhill, M.D., *Department of Psychiatry, New York Presbyterian-PWC, 525 East 68th Street, Box 181, New York, NY 10021*

SUMMARY:

Delirium is a disturbance of consciousness and cognition. While often found in medically ill patients with dementia, delirium is a syndrome of cerebral insufficiency rather than a sign of a dementing process. While it is the most common psychiatric syndrome found in a medical hospital and may have the highest morbidity and mortality of all psychiatric diagnoses, delirium frequently goes undiagnosed. The diagnostic difficulty stems from several factors such as the fact that symptoms fluctuate during the day, the patient may present with dramatically misleading behavior, and inattentive patients are difficult to interview. In addition, delirious patients are often dismissed as having confusion, depression, ICU psychosis, or simple alcohol withdrawal. In hypoactive delirium, the patient may not be noticed at all. This presentation will review the differential diagnosis for delirium and will describe a systematic approach to its evaluation.

No. 1C
CLINICAL UTILITY AND COST-BENEFIT PROFILE OF DIAGNOSTIC TESTING IN DELIRIUM

Christopher I. Kauffman, M.D., *Department of Psychiatry, New York Presbyterian Hospital\Payne Whitney, 525 East 68th Street, Box 140, New York, NY 10021*

SUMMARY:

Objective: The change in mental status consult is among the most common of consultation requests called in to psychiatric consultation-liaison services from the medical/surgical wards. The large number of potential etiologies, as well as the increased morbidity and mortality associated with delirium, makes the rapid and accurate diagnosis of the underlying condition(s) crucial. It is not uncommon for a wide range of diagnostic tests and procedures to be recommended and undertaken, including those that seek to identify relatively rare potential etiologies. This study attempts to examine the clinical usefulness and cost-benefit profile of selected diagnostic tests that are frequently ordered on such consults with the goal of providing a statistical framework that will aid clinicians in assessing the potential utility, and relative costs, of these tests.

Method: A retrospective study of existing psychiatric consultation records for "change in mental status" consults at the New York Presbyterian Hospital-Weill Cornell Center will be carried out with a focus on the classification of the number, rate, and frequency of "positive" findings on commonly ordered laboratory tests.

Results/Conclusions: It is anticipated that the results of this study will help to better define the clinical usefulness and cost-effectiveness of those diagnostic tests that seek to uncover the relatively rare etiologies of delirium.

No. 1D
THE USE OF ATYPICAL ANTIPSYCHOTICS IN THE TREATMENT OF DELIRIUM

Stephen J. Ferrando, M.D., *Department of Psychiatry, New York Presbyterian Hospital, 525 East 68th Street, Box 181, New York, NY 10021*

SUMMARY:

It is well known that antipsychotics are the treatment of choice for delirium. However, with the widespread use of atypical antipsychotic medications in recent years, there is increasing interest in the potential role of such agents in the treatment of delirium. This is particularly because atypical antipsychotics have a different pharmacodynamic profile and a relatively benign adverse effect profile compared with typical antipsychotics, such as haloperidol. Unfortunately, there is little comparative literature on the relative efficacy and safety of atypical versus typical antipsychotics. This presentation will review the relevant literature on the psychopharmacological treatment of delirium, beginning with the typical antipsychotics and ending with the limited literature on atypicals. Following will be a discussion of the potential rationale for the use of atypical antipsychotics in the treatment of delirium subtypes and selected patient populations.

No. 1E
AN OPEN TRIAL OF OLANZAPINE IN THE TREATMENT OF DELIRIUM

William Breitbart, M.D., *Department of Psychiatry, Memorial Sloan Kettering Hospital, 1275 York Avenue, Box 421, New York, NY 10021-6007*

SUMMARY:

The authors conducted an open, prospective trial of olanzapine for the treatment of delirium in a sample of 79 hospitalized cancer patients. Patients all met DSM-IV criteria for a diagnosis of delirium and were rated systematically with the Memorial Delirium Assessment Scale (MDAS) as a measure of delirium severity, phenomenology, and resolution, over the course of a seven-day treatment period. Sociodemographic and medical variables, as well as measures of physical performance status and drug-related side effects were collected. Fifty-seven patients (76%) had complete resolution of their delirium on olanzapine therapy. No patients experienced extrapyramidal side effects; however 30% experienced sedation (usually not severe enough to interrupt treatment). Several factors were found to be significantly associated with poorer response to olanzapine treatment for delirium, including age over 70, history of dementia, CNS spread of cancer and hypoxia as delirium etiologies, "hypoactive" delirium, and delirium of "severe" intensity (i.e. MDAS>23). A logistic regression model suggests that age over 70 is the most powerful predictor of poorer response to olanzapine treatment for delirium (OR=171.5). Olanzapine appears to be a clinically efficacious and safe drug for the treatment of the symptoms of delirium in the hospitalized medically ill.

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2. Work Group on Delirium: Practice Guidelines for the Treatment of Patients with Delirium. Am J Psychiatry 1996; 153:231–237.
3. Kane FJ, Remmell R, Moody S: Recognizing and treating delirium in patients admitted to general hospitals. South Med J 1993; 86:985–988.
4. Sipahimalani A, Masand PS: Olanzapine in the treatment of delirium. Psychosomatics 1998; 39:422–30.
5. Breitbart W, Tremblay A, Gibson C: An open trial of olanzapine for the treatment of delirium in hospitalized cancer patients. Psychosomatics, submitted, 2001.

SYMPOSIUM 2—PLAGUES, PRIONS, AND PARANOIA: THE NEUROPSYCHIATRY OF INFECTIOUS DISEASE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: (1) recognize neuropsychiatric syndromes due to CNS infections; (2) demonstrate knowledge of contemporary infectious diseases relevant to psychiatric practice and public health.

No. 2A
PSYCHIATRIC AND COGNITIVE FEATURES OF LYME DISEASE

Felice A. Tager, Ph.D., *Department of Psychiatry, Columbia University, 622 West 168th Street, Box 427, New York, NY 10032;* Brian A. Fallon, M.D.

SUMMARY:

Objective: This presentation will review the published literature on the psychiatric and neuropsychological aspects of Lyme disease. The goal is to help mental health clinicians by (1) describing the psychiatric and neuropsychological symptoms typical of Lyme disease and (2) analyzing laboratory tests that are useful in confirming or supporting the diagnosis.

Method: All studies found through MEDLINE and PsycINFO (1970—present) focusing on cognitive and psychiatric aspects of Lyme disease were reviewed.

Results: Reports from Europe and the United States suggest that psychiatric symptoms, e.g., irritability, paranoia, anxiety, and mood swings, may be prominent characteristics of Lyme disease. In addition, impairments in memory, attention, language, and motor functioning occur among adults with late-stage Lyme disease.

Conclusions: Patients with disseminated Lyme disease may present with psychiatric and cognitive problems including disturbances of memory, attention, mood, and sleep. Psychiatrists in areas where Lyme is endemic will be referred such patients, sometimes before the disease has been diagnosed. Clinicians need to be aware of the range of features associated with Lyme disease in order to aid in the differential diagnosis and care of these patients.

No. 2B
REGIONAL SPECIFICITY AND THE NEUROPATHOPHYSIOLOGY OF HIV-1 IN BRAIN

Karl Goodkin, M.D., *Department of Psychiatry, University of Miami School of Medicine, 1400 NW 10th Avenue, Room 803A, Dom Tower, Miami, FL 33136;* Frances L. Wilkie, Ph.D., Diana Lee, Psy.D., Robert Lecusay, Teri T. Baldewicz, Ph.D., Deshratn Asthana, Ph.D., Paul Shapshak, Ph.D.

SUMMARY:

HIV-1 causes two cognitive-motor disorders, minor cognitive-motor disorder, and dementia. Their pathophysiologies relate to regional specificity of brain infection. Neuropsychological performance demonstrates deficits associated with ventriculomegaly and a number of subcortical changes—hippocampal atrophy, decreased basal ganglia volume, and deep white-matter lesions. Abnormalities in cellular function can be detected prior to structural lesions using the technique of magnetic resonance spectroscopy. These changes can then be related to the regional pathophysiology of the infection. To date, the more commonly cited mechanisms of brain tissue damage have been related to mediators of the inflammatory response to HIV-1, an indirect pathophysiological effect. From the standpoint of the pathogen itself, HIV-1, studies have related viral load by brain region and viral strain to the likelihood of HIV-1 associated dementia. Brain tissue viral load by region may require several types of measurement to be evaluated fully. Evolution of virus toward a neurovirulent strain and/or toward a strain more likely to escape immunologic monitoring may also contribute to disease pathophysiology. Beyond using currently FDA-approved antiretrovirals, a growing class of binding, fusion, and entry inhibitors will become available. Further, anti-inflammatory therapies including a number of novel candidates merit testing specifically for these disorders.

No. 2C
THE NEUROPSYCHIATRY OF THE TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES

David N. Irani, M.D., *Department of Neurology, Johns Hopkins, 600 North Wolfe Street, Baltimore, MD 21287*

SUMMARY:

Transmissible spongiform encephalopathies (TSEs), also known as prion diseases, are progressive neurodegenerative disorders of animals and humans. These diseases share many clinical and neuropathological features, and recent data suggest that they develop through closely related mechanisms. The TSEs take part of their name from one of the most striking pathological features of these disorders: spongiform ("sponge-like") degeneration of the brain.

As the name also implies, TSEs can be transmitted from one host to another much like any other infectious process. In these situations, however, clinical disease may take months or even years to appear. In rare instances, TSEs can even develop through genetic mutation and therefore occur as familial disorders. Unfortunately, all TSEs worsen over a period of months, inevitably leading to the death of the affected host. From a psychiatric perspective, it is notable that the newly identified variant form of Creutzfeldt-Jakob disease (vCJD) typically occurs in younger adults causing prominent psychiatric and/or behavioral manifestations early in the disease course. This has forced a heightened awareness of vCJD among mental health professionals throughout the United Kingdom where the disease is found. Relevant features of variant and sporadic Creutzfeldt-Jakob disease (CJD) will be reviewed.

No. 2D
PSYCHIATRIC MANIFESTATIONS OF ACUTE VIRAL ENCEPHALITIS

Stanley N. Caroff, M.D., *Department of Psychiatry, University of Pennsylvania VA Medical Center, University Avenue, 116A, Philadelphia, PA 19104;* Stephan C. Mann, M.D., Michael F. Gliatto, M.D., Kenneth A. Sullivan, Ph.D., E. Cabrina Campbell, M.D.

SUMMARY:

Objective: The primary purpose of this presentation is to review the clinical signs, epidemiology, virology, neuropathology, and treatment of psychiatric disorders due to acute viral encephalitis. Specific objectives include identification of reliable clinical and laboratory signs, and a survey of suspected viruses, to facilitate the recognition and diagnosis of encephalitis among patients with abnormal behavior.

Method: Clinical reports of patients with psychiatric disorders due to viral encephalitis were obtained through a literature search from 1955 to 2000. Published cases were included if viral encephalitis was diagnosed based on histopathology, viral cultures, serology, and clinical or epidemiologic findings.

Results: A total of 108 cases of psychiatric disorders due to viral encephalitis were found. A specific virus was identified in only 57% of cases. Mortality was highest among patients infected with HIV, HSV-1, and measles, whereas no deaths were reported with influenza, Epstein-Barr, coxsackie, and mumps. Among patients with unidentified pathogens, 7% died and 65% recovered without sequelae. Psychiatric symptoms clustered into four major syndromes: acute psychosis (35%), catatonia (33%), psychotic depression (16%), and mania (11%). Antipsychotics were beneficial in 12 of 17 (71%) patients but resulted in significant neurotoxicity. ECT was beneficial in seven of 13 (54%) patients.

Conclusions: Viral encephalitis presenting as a psychiatric disorder may be underdiagnosed. Although cognitive deficits, focal neurologic signs, catatonia, and frontal or temporal lobe syndromes are highly suggestive, there is no behavioral syndrome specific for viral encephalitis. The predominance of women is unexplained. Several common viruses that infect the central nervous system can present with behavioral symptoms. Apart from antiviral agents, treatment with psychotropic drugs and ECT can be useful if carefully monitored.

No. 2E
NEUROSYPHILIS: A HISTORY AND CLINICAL REVIEW

Michael F. Gliatto, M.D., *Department of Psychiatry, University of Pennsylvania VA Medical Center, University Avenue, 116A, Philadelphia, PA 19104;* Stanley N. Caroff, M.D.

SUMMARY:

Syphilis was a more virulent infection when it first appeared in Europe in the 15th century, and developed into an epidemic in the 16th century. In the 19th century, French physicians first described general paresis of the insane. These patients presented with mania or depression, but became progressively demented before death. In the late 19th century, general paresis of the insane was linked to syphilis, and this was confirmed in the 20th century.

Psychiatric institutions were once filled with patients, mostly men, who had general paresis. Following the introduction of penicillin, the number of patients admitted with neurosyphilis declined dramatically and general paresis is now rare in the United States. However, syphilis itself is still prevalent, especially among urban, substance abusing populations. Neurosyphilis should be considered in the differential diagnosis of all demented patients, as well as in patients with HIV who present with new psychiatric symptoms. Most patients with neurosyphilis have neurological findings, such as cranial neuropathies, reflex deficits, or pupillary abnormalities.

Penicillin remains the mainstay of treatment. The CDC guidelines for treatment will be discussed. The most effective regimen for patients with syphilis in the context of HIV infection has not yet been established.

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SYMPOSIUM 3—FEAR AND LOATHING IN THE MEDICATION CLINIC
APA Commission on Psychotherapy by Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be to recognize the psychological and social issues relevant to effective pharmacotherapy.

No. 3A
TO MONITOR OR TO RELATE?

Jerald Kay, M.D., *Department of Psychiatry, Wright State University, PO Box 927, Dayton, OH 45401*

SUMMARY:

Managed behavioral health care has placed significant pressure on many psychiatrists to provide brief medication services as well as to participate in split treatment relationships. Both of these forces have spawned the myth that a psychiatrist should not relate psychotherapeutically during medication checks and collaborative treatment. Evidence will be presented to counteract these practices and provide recommendations to the clinician on how to establish thera-

peutic relationships that deepen the doctor-patient relationship and contribute to better medication adherence.

No. 3B
SPLIT-TREATMENT ANGST

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, wherein a psychiatrist or other physician provides the medication and manages medical issues while a non-physician therapist provides the psychotherapy, is a growing and common treatment modality. While the American Psychiatric Association published guidelines in 1980 describing the responsibilities of psychiatrists involved in such collaborative types of relationships, there are no currently recognized best methods or practice guidelines that have been accepted by the field (APA, 1980). Forces that have influenced the growth of split treatment include managed care, increased numbers of social workers and psychologists as compared with psychiatrists, the availability of safer and more efficacious psychotropic medications, increased numbers of primary care physicians who are screening and treating for depression, and financial incentives. While there are certainly positive aspects of split treatment, there are clinical, ethical, and legal challenges that confront the physician and therapist. This presentation will review some of the positive as well as negative aspects of split treatment, legal and ethical issues, and offer practical suggestions for clinicians engaged in this practice.

No. 3C
THE DIVIDED HOUR: PSYCHOTHERAPY IN THE MEDICATION CHECK AND OTHER BRIEF SESSIONS

Jesse H. Wright, M.D., *Department of Psychiatry, University of Louisville, P.O. Box 35070, Louisville, KY 40202*

SUMMARY:

By undervaluing psychotherapeutic interventions, insurers have influenced psychiatrists to de-emphasize and, in some cases, to abandon the practice of psychotherapy. The medication check, with four or more patients scheduled per hour, is now one of the most common forms of clinical activity. Although the traditional 50-minute hour of psychotherapy may be endangered, there are many opportunities for adapting psychotherapy methods for the medication check and other sessions lasting less than 30 minutes.

Questions discussed in this presentation include:

1. How have insurers influenced psychiatrists' attitudes about psychotherapy?
2. What options do psychiatrists have to respond to the pressures of managed care and governmental regulations on provision of psychotherapy?
3. How can psychotherapy be modified for brief sessions?
4. What are the merits of using specific therapy methods (e.g., CBT, brief psychodynamic psychotherapy, IPT) compared with an eclectic approach for short sessions of combined pharmacotherapy and psychotherapy?

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1. Kay J: Integrated treatment: an overview, in Integrated Treatment of Psychiatric Disorders. Edited by Kay J. Washington, DC, American Psychiatric Press, 2001.
2. Riba M, Balon R, eds: Psychopharmacology and Psychotherapy: A Collaborative Approach: Washington, D.C., American Psychiatric Press Inc., 1999.
3. American Psychiatric Association: Guidelines for psychiatrists in consultative, supervisory, or collaborative relationships with nonmedical therapists. Am J Psychiatry 1980; 137:1489–1491.
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SYMPOSIUM 4—HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: CLINICAL APPLICATIONS AND IMPLICATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the audience should be able to understand the history, organization, and implementation dates of HIPAA. Also, they should be able to understand how HIPAA will impact on their clinical practices and how similar guidelines have impacted in the European community.

No. 4A
BASIC HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OVERVIEWS

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

The development of the Health Information Portability and Accountability Act (HIPAA) was motivated by a number of factors, including the need to decrease the cost of the transfer of information and to capitalize on current information technologies. Also, the United States was under pressure from the European community to build standards for the transmission of information so it could be transmitted to them securely, as well as within the United States. These led to the formation of regulations concerning transactions that are to result in the standardization of information transfer, confidentiality, and security. Although originating from issues associated with electronic information, HIPAA regulations extend to all forms of individually identifiable information, even paper-based and oral communications. What are the significant elements that all clinicians will need to know? What will clinician need to do when they are confronted with these regulations and guidelines? How will a private practitioner deal with these issues? What must be provided to patients? How will clinicians verify whether they are compliant? In this symposium, the major components of HIPAA will be reviewed, when these will go into effect, and some of the implications.

No. 4B
CONFIDENTIALITY AND SECURITY CONCERNS UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Charles J. Rainey, M.D., *Department of Psychiatry, Medical College of Wisconsin, P.O. Box 170965, Milwaukee, WI 53217-8086*

SUMMARY:

Although HIPAA was passed in 1996, it has taken until 2000 to develop the regulations necessary to implement its mandates. Most of HIPAA's regulations, especially those with respect to security and transactions will not be fully mandated until 2003.

When mandated, a practitioner must be able to answer the question, "Who has the right to view or have access to this identifiable or private health care information?" The practitioner must also be

prepared to respond to the patient's request for access to such information and his/her demand to "correct" such information contained in the practitioner's chart on them. The mental health provider faces unique challenges due to the variety of information that may be in a patient's medical record and how a patient may react to or use such information.

A second major concern for practitioners is the security required for identifiable or private health care information both in its hard copy (or written) form and in its electronic format. The practitioner will need to develop a plan to safeguard such information, not only while it is in his/her office, but also when it is in the hands of associated contractors and in transit over electronic lines of communication.

No. 4C
DATA PROTECTION IN PRACTICE: THE IMPACT OF THE DATA PROTECTION ACT AND OTHER LEGISLATION IN THE UNITED KINGDOM

Brian Lunn, M.D., *Department of Psychiatry, University of New Castle, Queen Victoria Road, New Castle NE1 4LP, United Kingdom*

SUMMARY:

The European Union is prioritizing bio-informatics with £1.2 billion ($1.7 billion) earmarked for research in this area. Meanwhile since 1984 the United Kingdom Data Protection Act has given the right to individuals to access any data identifiable as theirs and to challenge and have corrected data that are erroneous. More recently the act has been updated and along with legislation allowing access to medical records the U.K. government has legislated extensively on electronic medical records. Clause 65 of the Health and Social Care Act (2001) will controversially allow the health secretary to open computerized medical records to any organization he considers in the public interest. But while this legislation is highly controversial, it is largely unknown by the medical profession and the lay public.

The presenter will give an overview of the duties and responsibilities of health professionals in the U.K. as well as the rights of patients. Particular reference will be made to areas of conflict and similarity with HIPAA and comment made on the stance doctors need to take to protect patient confidentiality while maintaining open and accountable electronic medical records.

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1. Department of Health and Human Services Tentative Regulation Implementation Schedule. http:\\aspe.os.dhhs.gov\admnsimp/pubsched.htm.
2. Department of Health and Human Services Final Rules on Privacy Standards: http://aspe.os.dhhs.gov\admnsimp\bannerps.htm
3. Department of Health and Human Services Proposed Rules on Security Standard: http://aspe.os.dhhs.gov/admnsimp/nprm/seclist.htm
4. Data Protection Act 1998 London: Her Majesty's Stationery Office, 1998.

SYMPOSIUM 5—EATING DISORDERS 2002: BIOLOGICAL, CLINICAL, AND SOCIAL PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the symposium's conclusion, participants should be able to discuss new developments in eating disorders regarding serotonin 1A receptors' possible relation to vulnerability, high death rates and predictors of mortality, dental findings and interventions, cross-cultural high school-level prevention efforts, and e-technology contributing to cause, recovery and treatment.

No. 5A
TRAIT-RELATED 5HT 1A DISTURBANCES IN ANOREXIA NERVOSA: RELATIONSHIP TO SUSCEPTIBILITY

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, #E-724, Pittsburgh, PA 15213;* Guido Frank, M.D., Carolyn C. Meltzer, M.D., Julie Price, Ph.D.

SUMMARY:

Recent family, twin, and physiologic studies suggest that eating disorders are highly heritable. Theoretically, people may inherit traits that make them susceptible to developing an eating disorder. Several lines of data suggest that a disturbance of serotonin activity may create a behavioral vulnerability for developing anorexia nervosa (AN). That is, overactive neuronal serotonin pathways may result in increased satiety and anxious, obsessive traits that may predispose young women to benefit from extreme dietary restriction.

The serotonin 1A receptor ($5HT_{1A}$) has been implicated in modulation of anxiety and feeding behaviors. Recent studies by our group show that people who have recovered from AN have increased binding of [^{11}C]WAY 100635 in the raphe nucleus (pre-synaptic $5HT_{1A}$ autoreceptors) and post-synaptic frontal-limbic cortical $5HT_{1A}$ receptors. Most importantly, $5HT_{1A}$ binding in cortical regions was positively correlated with anxiety and harm avoidance. Thus, increased $5HT_{1A}$ receptor activity may be a trait that is independent of the state of the illness.

Tryptophan, an essential amino acid, is the precursor of serotonin. Extreme dieting, through effects on insulin metabolism, is one method of reducing tryptophan availability to the brain, and thus reduce 5HT concentrations. When ill and recovered women with AN were acutely tryptophan depleted, they had a significant reduction in anxiety. Thus, people with AN may discover that they can reduce dysphoric mood states by starving themselves.

No. 5B
WHO'S DYING FROM AN EATING DISORDER?

David B. Herzog, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, 725 ACC-EDU, Boston, MA 02114;* Pamela K. Keel, Ph.D., David J. Dorer, Ph.D., Debra Franko, Ph.D., Kamryn T. Eddy, B.A., Valerie E. Charat, B.A., Dana Charatan, B.A.

SUMMARY:

Anorexia nervosa (AN) is characterized by a high mortality rate. However, studies are needed to assess predictors of mortality in women with AN and bulimia nervosa (BN). We followed 246 treatment-seeking women with AN and BN for a median of nine years using a prospective longitudinal study design. Data sources for mortality information included death certificates, autopsy reports, medical records, National Death Index searches, and telephone contact. Eleven deaths were detected (10 AN, 1 BN). Of those, four deaths were suicides. Standardized Mortality Ratios (SMRs) were elevated for all causes of mortality (11.6, 95% C.I. = 5.5, 21.3), and suicide (56.9, 95% C.I. = 15.3, 145.7) in women diagnosed with AN at intake. Although SMRs were not elevated for all causes of mortality in women with BN at intake (1.3, 95% C.I. = 0.0, 7.2), seven of the women with intake diagnoses of AN met criteria for BN over the course of their eating disorder. We will report on predictors of mortality both at intake and over the course of the study, including eating disorder symptomatology, comorbid disorders, and treatment

utilization. Implications for clinical treatment and research will be discussed.

No. 5C
THE ROLE OF THE DENTIST IN THE CARE OF EATING-DISORDER PATIENTS

James E. Mitchell, M.D., *NRI, 700 First Avenue, South, P O Box 1415, Fargo, ND 58103;* James Roerig, Pharm. D., Ross D. Crosby, Ph.D., Stephen A. Wonderlich, Ph.D., Melissa Burgard, B.S.

SUMMARY:

It is well known that dental complications are fairly common in patients with eating disorders who vomit. Various research studies have demonstrated a variety of dental complications including impaired saliva flow, dental decay, and, in particular, loss of dental enamel. Such changes tend to correlate with the duration and severity of eating disorder symptoms.

While these changes are fairly obvious on dental examination, very little is known about how dentists approach this problem when they suspect eating disorders in their patients.

In this paper, we will describe the results of a survey (n > 100) of dental practitioners in the upper Midwest who responded to a detailed questionnaire regarding their practices when they suspected a patient of having an eating disorder. The results of the study indicate that while dentists frequently see such problems in their practices they are often reluctant to confront patients about such behaviors given their lack of training in counseling. Also, many are not adequately informed about what treatment resources exist in their area for patients with eating disorders.

No. 5D
PRIMARY PREVENTION OF EATING DISORDERS: A TALE OF TWO COUNTRIES

Katherine A. Halmi, M.D., *Westchester Division, New York Presbyterian Hospital, 21 Bloomingdale Road, White Plains, NY 10605-1504;* Claire V. Wiseman, Ph.D., Suzanne R. Sunday, Ph.D., Francesca Bortolotti, M.D.

SUMMARY:

Numerous eating disorder prevention programs have had little effect in changing attitudes and knowledge of eating disorders. This program was intended to change attitudes that may act as precursors to eating disorders and compare the effect of a prevention curriculum based program in two different countries.

A total of 194 female high school students participated: 138 in Naples, Italy, and 56 in Westchester, New York. Sections of a health class in both locations were randomly assigned to either the control or intervention group. The intervention group completed specialized assignments and projects as part of the intervention curriculum. All students completed the EDI, TFEQ, Rosenberg Self-Esteem Scale, demographic information, and BMI both at baseline and after the program.

Significant differences at baseline existed between Italy and the U.S. on every EDI subscale except for drive for thinness. For the Italian students the intervention had a significant effect on drive for thinness and interoceptive awareness. The intervention had no effects on any variables with the U.S. students.

The clearly ethnic differences in the two samples may account for baseline differences in eating attitudes. Attitudes in high school students may be less amenable to change. A younger target audience may be better for future intervention prevention studies.

No. 5E
E-TECHNOLOGIES AND EATING DISORDERS: PROBLEMS AND PROSPECTS

Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*

SUMMARY:

This presentation will review what is known about the impact of e-technologies including web-based sources on promoting and sustaining eating disorders on the one hand, and in positive activities that may promote prevention and recovery on the other. Globally, the widespread impact of iconic glamour images on the web may further foster unrealistic body-image expectations and lower self-esteem in vulnerable populations. The appearance of pro-anorexia Web sites provides disturbing illustrations of how social reinforcement for maladaptive eating disorder-related attitudes and behaviors may occur via virtual communities that span nations.

At the same time, patients and their families are now able to access considerable practical and emotionally supportive information regarding eating disorders from a number of well established Web sites developed by self-help, advocacy, and professional groups. Research studies using a variety of e-services are examining the feasibility and utility of providing education and services for vulnerable populations and patients via the Web and through other e-technologies. Some clinicians are using e-technology in support of conventional treatments for eating disorder patients.

After describing current developments and available resources, the presentation will consider innovative use of e-technology that may provide further help for patients, families, and clinicians in the future.

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SYMPOSIUM 6—MANAGEMENT OF SCHIZOPHRENIA WITH COMORBID DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be familiar with the current state of knowledge regarding common and challenging comorbid conditions in schizophrenia and able to manage them.

No. 6A
MANAGEMENT OF SCHIZOPHRENIA WITH DEPRESSION

Samuel G. Siris, M.D., *Department of Psychiatry, Hillside Hospital, 75-79 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

This presentation approaches the issue of depression in schizophrenia from the standpoint of making a differential diagnosis. This differential includes comorbid medical conditions and side effects of agents used in their treatment; acute or chronic use and\or discontinuation of substances (including "street" drugs, alcohol, nicotine, and caffeine); acute and chronic disappointment reactions; the "negative symptom" syndrome; "depression" as a component of EPS secondary to neuroleptic use, including akinesia and akathisia; the possibility of other dysphoric or anhedonic reactions to neuroleptic medications; depression as an intrinsic component of decompensation, either on a biological or psychological basis; schizoaffective disorder; and the possibility of an independent coexisting affective diathesis. Treatment strategies considered in relationship to these various situations include reducing or otherwise adjusting neuroleptic dosage; changing antipsychotic agents, including the use of "atypical" antipsychotics; the rational use of adjunctive tricyclic, SSRI, and MAOI antidepressant medications; the potential role of benzodiazepines, lithium, anticonvulsants, and ECT; and the importance of psychosocial approaches. An orderly path for considering diagnosis and treatment will be presented.

No. 6B
MANAGEMENT OF SCHIZOPHRENIA WITH COMORBID ANXIETY DISORDERS

Michael Y. Hwang, M.D., *Department of Psychiatry, East Orange VA Medical Center, 385 Tremont Avenue, East Orange, NY 07018-1095*

SUMMARY:

While the anxiety symptoms such as obsessive-compulsive (OC) and panic symptoms in schizophrenia have long been recognized, its underlying biological and clinical implications remain obscure. Prior to DSM-III-R, diagnostic conventions precluded simultaneously diagnosing schizophrenia and anxiety disorders. As a result obsessive-compulsive disorder (OCD) and panic disorder (PD) in schizophrenia were believed to occur only rarely and carry no significant clinical implications. However, recent epidemiological and clinical studies have shown much greater prevalence rates and significantly worse clinical course among the subgroup of schizophrenia with comorbid OCD and PD. Recent biological research suggest a distinct neurobiological basis and pharmacological treatment for these comorbid disorders. However, clinical management of schizophrenia with co-existing anxiety symptoms continue to challenge practicing clinicians. This subgroup of schizophrenia with co-existing anxiety symptoms may be conceptualized categorically, e.g., as reflecting presence of two distinct disorders, or dimensionally, e.g., as representing one of many phenomenological symptom dimensions in schizophrenia. While further studies are needed, evidence suggests that the schizophrenia patients with comorbid anxiety disorders would benefit from in-depth clinical evaluation and individualized treatment approach for optimal outcome. This symposium will examine the existing clinical, epidemiological, and neurobiological evidence and suggest a novel approaches for their clinical management.

No. 6C
CLINICAL MANAGEMENT OF PERSISTENT AGGRESSIVE BEHAVIOR IN SCHIZOPHRENIA

Leslie L. Citrome, M.D., *Clinical Research\CREF, Nathan Kline Institute, 140 Old Orangeburg Road, Building 37, Orangeburg, NY 10962-2210;* Jan Volavka, M.D.

SUMMARY:

Violent or threatening behavior is a frequent reason for the admission to a psychiatric inpatient facility, and that behavior may continue after the admission. The distinction between transient and recidivistic assaultiveness is clinically important: a small group of recidivistic patients may cause the majority of violent incidents. Patients with persistent aggressive behavior must first be assessed for the possibility of comorbid conditions. Short-term sedation with lorazepam is a safe and effective choice for acute agitation, although the new intramuscular preparations of the atypical antipsychotics may prove to be a better alternative for the acutely agitated psychotic patient. Longer-term solutions include strategies that would decrease impulsivity. Mood stabilizers, especially valproate, are commonly used with neuroleptics to decrease the intensity and frequency of agitation and poor impulse control, but they have not been extensively studied under double-blind, placebo-controlled conditions. Clozapine appears to be more effective than typical neuroleptics, as well as risperidone, in specifically reducing aggressivity in patients with schizophrenia or schizoaffective disorder. Beta blockers, well studied in the treatment of aggressive behavior in brain injured patients, may also be helpful as an adjunctive agent to antipsychotics for aggression and schizophrenia. Adjunctive serotonin-specific reuptake inhibitors are another option for this population. The simultaneous use of multiple psychotropic agents will be discussed.

No. 6D
LONG-TERM OUTCOME AND COMORBID CONDITIONS: WHY DO WE KNOW SO LITTLE?

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

SUMMARY:

The course of schizophrenia is determined by a number of factors, which have been relatively well studied. For example, long-term outcome is usually better for men than for women, a later age of onset predicts a better long-term course; and early cognitive and intellectual impairments are associated with poorer course.

Comorbid psychiatric conditions and syndromes represent another added burden that negatively affect outcome. Methodological problems beset the researcher who studies these questions. First, long-term studies are rare and often patients with comorbid conditions are specifically excluded. Second, with the exception of substance and alcohol abuse and dependence, comorbid syndromes are not routinely identified. Third, examination of differential long-term outcome specifically for patients with and without comorbid conditions is even rarer than long-term studies.

This presentation will review data specifically regarding substance and alcohol abuse as a model for studies that can inform us regarding outcome with comorbid conditions in schizophrenia.

Finally, recommendation regarding strategies to ascertain the influence of comorbid conditions on long-term outcome will be proposed.

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3. Citrome L, Volavka J: Management of violence in schizophrenia. Psychiatric Annals 2000; 30(1):41–52.
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SYMPOSIUM 7—DEPRESSIVE SPECTRUM DISORDER IN LATE-LIFE: IMPLICATIONS FOR CLINICAL CARE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the clinical features of late-life depressive spectrum disorders, and the approaches to diagnosis and treatment.

No. 7A
NONMAJOR CLINICALLY SIGNIFICANT DEPRESSION: THE EXISTING EVIDENCE OF A CONTINUUM

Anand Kumar, M.D., *Department of Psychiatry, UCLA, 760 Westwood Place, Room 37-384, Los Angeles, CA 90095*

SUMMARY:

Non-major forms of clinically significant depression are more prevalent than the more widely recognized major depressive disorder (MDD). This observation has been observed in community samples, ambulatory programs, and more long-term care settings. The psychosocial, medical, and economic impact of non-major depression is considerable and approaches those of MDD. Also, phenomenologic features and risk factors are also comparable in both groups. Despite these findings, non-major depression remains understudied from neurobiological, cognitive, and therapeutic perspectives. We will present data demonstrating an overlap in several clinical and epidemiological domains between these two principal groups. New findings from our laboratory demonstrate a continuity of both neuroanatomical and cognitive aberrations between major and minor depression in the elderly. Impairments in executive functions, working memory, and spatial tasks also show a continuum between between patients with major and minor depression with the minors falling in between patients with MDD and controls on most domains. The neuroimaging and neuropsychological findings will be integrated with the clinical and epidemiological data and an overall picture of the clinical neuroscientific characteristics of all forms of clinically significant depression in the elderly will be presented. This presentation will serve as the broad introduction to the symposium and its primary theme, the concept of spectrum disorders in the elderly.

No. 7B
CLINICAL FEATURES OF A DEPRESSIVE CONTINUUM

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Geriatric depression may contribute to medical morbidity, disability, and compromised quality of life. However, the level of depressive symptoms required in order to influence the clinical picture remains unclear. This study compared the clinical characteristics of syndromic and sub-syndromal depression in a representative sample of patients from primary care practices that participated in the PROSPECT Study.

Randomly selected primary care patients had a telephone interview using the CES-D. All patients with CES-D scores above 20 and 5% of patients with a CES-D score below 20 had an in-person interview using the SCID and other instruments. Of the 699 patients, 71 had a CES-D score above 20, and of these, 26 met DSM-IV criteria for major or minor depression, while the remaining 45 were considered as having "depressive complaints." Only two of the 71 patients with high CES-D were receiving antidepressant treatment. Compared with subjects with "depressive complaints," patients with depression diagnoses had higher severity of depression (HDRS $t=11.0$, $p<0.0001$), lower scores in the Positive Affect Scale ($t=2.4$, $p<0.02$), more current suicidal ideation (SSI $t=3.25$, $p<0.001$), and greater scores of neuroticism (NEO $t=2.64$, $p<0.01$). However, these groups had similar scores in anxiety, history of suicidal ideation, negative affect, disability, social interactions, optimism, and subjective and instrumental social support. Moreover, patients with "depressive complaints" had more symptoms of depression (HDRS $t=2.2$, $p<0.03$) and anxiety (CAS $t=2.26$, $p<0.03$), less positive affect ($t=3.51$, $p<0.0007$), lower optimism (NEO $t=2.06$, $p<0.04$), greater perceived ($t=2.43$, $p<0.02$) and actual disability ($t=2.16$, $p<0.03$) than patients without depressive complaints (CES-D below 21). These observations suggest that elderly patients with major, minor, and subsyndromal depression have more anxiety, personality dysfunction, and disability than patients free of depressive symptoms.

No. 7C
DYSTHYMIC DISORDER IN THE ELDERLY

Davangere P. Devanand, M.D., *New York State Psychiatric Institute, Columbia College of Physicians, 722 West 168th Street, Unit 72, New York, NY 10032-2603*

SUMMARY:

Dysthymic disorder has not been studied extensively in the elderly, and it remains unclear if the phenomenology and treatment response in these patients is similar to that observed in dysthymic disorder in young adults. In a series of 224 consecutive elderly outpatients with dysthymic disorder, the mean age of onset of dysthymia was in middle age, and early-onset was uncommon. Comorbid anxiety disorders were rare, and personality disorders were relatively uncommon with obsessive-compulsive and avoidant personality disorders being the most common subtypes. Elderly dysthymics appear to differ from young adult dysthymics who are known to be mostly female with an early onset and frequently have comorbid Axis I and Axis II disorders. These results suggest that dysthymic disorder in the elderly has unique clinical features that distinguish it from young adult dysthymics, and that elderly dysthymics are not young dysthymics who simply grow older. Research data suggest that this group of patients represents challenges to effective treatment, and that a wide range of treatment options need to be considered.

No. 7D
DEPRESSION AND SYMPTOMATIC ANXIETY

Alastair J. Flint, M.B., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8 EN-238, Toronto, ON M5G 2C4, Canada*

SUMMARY:

Diagnostic classifications have traditionally separated depression from anxiety. In clinical practice, these two conditions frequently coexist, forming a spectrum of disorders between the two extremes. Depression and anxiety can co-exist in a number of ways: concurrent depressive and anxiety disorders, depressive disorder with symptoms of anxiety, anxiety disorder with symptoms of depression, and mixed subsyndromal symptoms of depression and anxiety. Depressive disorder with symptoms of anxiety is the most common manifestation of coexistent depression and anxiety in geriatric psychiatry practice; therefore, the presentation will focus on this entity. When confined to episodes of major depression, anxiety symptoms are best viewed as prognostically significant epiphenomena rather than indicators of an additional disorder or distinct subtype of depression. In depressed

patients, a high level of symptomatic anxiety is associated with greater severity of illness, worse response to treatment, poorer long-term outcome, and increased risk of suicide. Anxiety symptoms can confound the diagnosis of depression, with the result that the underlying depressive illness is frequently missed or inappropriately treated with benzodiazepine monotherapy. This presentation will discuss factors that may impede the recognition of depression with associated anxiety, especially in patients with comorbid medical illness or cognitive impairment. The impact of anxiety on treatment of depression, especially adherence to treatment, time to response, and treatment resistance will be highlighted and the implication of these data for planning management of the patient will be discussed. Finally, the data pertaining to the effect of symptomatic anxiety on the risk of relapse and recurrence of late-life depression will be presented and discussed in the context of maintenance therapy.

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SYMPOSIUM 8—INTERACTION OF STRESS AND PERSONALITY
Association for Research in Personality Disorders

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the listener will be updated on the recent research on the interaction of personality disorders and stress in different populations.

No. 8A
STRESS AND PERSONALITY: BIOLOGICAL IMPLICATIONS

Kenneth R. Silk, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, CFOB B2917, Ann Arbor, MI 48109-0704*

SUMMARY:

Background: The effect of chronic stress upon a person's persistent coping and interpersonal style, that is, upon the person's personality, is beginning to receive attention. Yet only very recently have we begun to appreciate the biological underpinnings of personality and the personality disorders. Biological studies may provide a bridge to understanding the link between trauma, chronic stress, and personality disorders.

Objective: This presentation reviews the most recent literature on the biology of personality disorders and attempts to compare and to integrate these recent findings with biological findings uncovered in studies of chronic stress.

Methods: The results of biological studies of neurotransmitter function, pharmacologic challenge studies, and studies of the hypothalamic-pituitary-adrenal (HPA) axis in patients with personality disorders will be compared with the findings in these areas with respect to chronic stress.

Results: Prolonged stress can lead to permanent biological changes in the brain that may result in either a persistent lack of response to environmental stimuli or to what appears to be chronic hyperreactivity to the environment. The HPA axis is abnormal in some people who suffer prolonged stress as well as in some people with personality disorders regardless of whether or not they have experienced trauma.

Conclusion: When the biological changes that result from chronic stress are incorporated into the overall biological balance or imbalance of a particular individual, then that person may appear to present with many characteristics that we currently attribute to personality disorders.

No. 8B
CLINICAL CHARACTERISTICS OF STRESS-INDUCED PERSONALITY DISORDERS

James H. Reich, M.D., *Department of Psychiatry, Stanford Medical School, 2255 North Point Street, Unit 102, San Francisco, CA 94123*

SUMMARY:

This report starts with the finding that some patients with an Axis I disorder who appear personality disordered when acutely ill may represent a distinct clinical subgroup. It examines the clinical correlates of this "stress induced" personality disorder group. A group of male psychiatric outpatients (n=165) was divided into three groups. The group with life-long personality disorders "Trait PD" group (n=24); the group with personality symptoms under the stress of an Axis I disorder, "Stress Induced PD" or "State PD," group (n=63); and a group that had no personality disorders, "No PD" group (n=78.) These three groups were compared on personality variables by direct comparison and logistic regression. Logistic regression showed a reasonable differentiation between the Trait and State group. The variables of "Reacts Criticism", "Suicide," and "Needs Approval" predicted the Trait group, while the variable "Ashamed" predicted the State group. Logistic regression also showed reasonable differentiation between the State and No PD groups. "Restricted Expression of Affect" predicted the No PD group, while the variables of "Acts Childishly," "Suicide," "Sensitive to Criticism," "Acts Emotionally," "Feelings Change," and "Fearful" predicted the State group. The evidence seems to indicate the previously identified State group can be differentiated from its theoretical near neighbors using clinical criteria.

No. 8C
RELATIONSHIP BETWEEN ADJUSTMENT, ANXIETY, AND DEPRESSIVE DISORDERS

Peter Tyrer, M.D., *Department of Psychiatry, Imperial College School of Medicine, 20 South Wharf Road, London WL1PD, United Kingdom*

SUMMARY:

The Nottingham Study of Neurotic Disorder was initiated in 1982 and recruited 210 patients with anxiety and depressive diagnoses (diagnosed with the SCID Interview Schedule) between 1983 and 1987. These patients were involved in a randomized trial of drug and psychological therapy and subsequently followed up on 10 occasions, the last being on the 12th anniversary of their original presentation. The results showed that most patients improved greatly in the first 10 weeks of treatment irrespective of intervention, and that at 12 years nearly half had recovered entirely. Personality disorder at initial presentation was a major factor in determining a poor long-term outcome (Seivewright et al, 1998). Further analysis of the results suggests that many of the patients, despite having a DSM-III anxiety or depressive diagnosis, behaved clinically as adjustment disorders with rapid resolution associated with a favorable natural history.

However, there is another group, those who develop adjustment disorders because of personality vulnerability, who have recurrent problems. Ways of differentiating the two groups—pure adjustment disorders and adjustment disorders secondary to personality vulnerability—will be described. The findings show that the predictive value of this exercise is both useful in the short and long term.

No. 8D
JOB STRESS AMONG YOUNG PHYSICIANS: WORKING CONDITIONS OR PERSONALITY, A PROSPECTIVE STUDY

Per Vaglum, M.D., *Department of Behavioral Sciences, University of Oslo, P.O. Box 1111 Blindern, Oslo N-0317, Norway;* Reidar Tyssen, M.D., Nina Gronvold, M.D., Oivind Ekeberg, M.D.

SUMMARY:

The relative importance of working conditions and personality features for the level of experienced job stress is explored in a longitudinal study starting out with a nationwide representative sample of medical students in the last term (N=522) and following them to the end of the internship (n=371). The Job Stress Questionnaire-20 (Cooper) was used to measure the dependent variable, sleeping hours when on duty, number of weekly working hours, and learning milieu as measures of working conditions in internship. The Basic Character Inventory (Torgersen), Ways of Coping Checklist, Perceived Clinical Competence, and Perceived Medical School Stress (Vitaliano) in the last term in medical school were used as individual variables.

Results: Multiple regression analysis showed that controlled for age and sex, both clinical competence as student, vulnerability(neuroticism) and wishful thinking, and internship learning climate and number of sleeping hours on duty were independent predictors of job stress (adjusted R square R=.314).

Conclusion: Both personality and job factors are important for level of job stress. Both may be targets for prevention.

No. 8E
SCHEMA-FOCUSED COGNITIVE THERAPY AND STRESS-EXACERBATED PERSONALITY DISORDERS

David P. Bernstein, Ph.D., *Department of Psychiatry, Bronx VAMC\Fordham University, 130 Kingsbridge Road, Dealy Hall, 3rd Floor, Bronx, NY 10568*

SUMMARY:

When personality disordered individuals present for treatment, it is often because their fragile coping mechanisms have been overwhelmed by acute or chronic stress. In this presentation, we will discuss strategies for intervening with stress-exacerbated personality disorders, using Jeffrey Young's Schema-Focused Cognitive Therapy as a conceptual framework. Schematherapy is an integrative form of treatment for personality disorders and severe and persistent mood and anxiety disorders that combines cognitive, behavioral, psychodynamic object relations, and experiential approaches. The Schematherapy model posits that early maladaptive schemas (EMSs) form the cognitive and affective core of personality disorders. EMSs are pervasive, self-defeating patterns or themes, such as abandonment, defectiveness, abuse/mistrust, and deprivation, which develop due to adverse childhood experiences, and are elaborated throughout one's life. When EMSs are triggered by stressful circumstances, they produce intense, disruptive affects, such as anxiety, rage, and depression. In attempting to manage these affects, personality disordered individuals often rely on inadequate, self-defeating coping mechanisms, making matters worse.

Case example: A patient with borderline personality disorder became convinced that he was about to be fired, when his boss began making demands on him (Abuse\Mistrust Schema triggered by work-related stress). In a fit of anxiety and rage, the patient shocked his boss by impulsively handing in his resignation. The patient's resignation was a pre-emptive attempt to protect himself from attack, a self-defeating coping mechanism that precipitated a long period of unemployment.

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5. Young JE: Cognitive Therapy for Personality Disorders: A Schema-Focussed Approach (3rd. Edition). Sarasota, FL, Professional Resource Press, 1999.

SYMPOSIUM 9—EVIDENCE-BASED PSYCHODYNAMIC THERAPY PART I: STUDYING CLINICAL WORK
American Academy of Psychoanalysis and American Psychoanalytic Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to (1) comprehend the difference between research evidence and clinical evidence, (2) identify at least one obstacle to research into dynamic psychotherapy, and (3) discuss at least one technique for transforming clinical intuition into validated therapeutic skills.

No. 9A
THE ANALYTIC PROCESS SCALES II: INTERVENTION QUALITY AND PATIENT PRODUCTIVITY

Sherwood Waldron, Jr., M.D., *1235 Park Avenue, Unit 1B, New York, NY 10128-1759*

SUMMARY:

The Analytic Process Scales (APS) were employed to examine 123 analyst interventions from nine sessions of three psychoanalyses. This research instrument, with an extensive coding manual, assesses tape recorded sessions from a psychoanalytic process viewpoint, enabling psychoanalysts to evaluate the nature and quality of the contributions of both analyst and patient to the psychoanalytic process.

The analytic work by both patient and analyst is characterized in a reliable and systematic way for sessions from these three analyses. The nature of the interventions, the nature and quality of the work by patient and analyst, and the striking differences between the cases are described.

Substantial correlations were found between the core analytic activities of clarification, interpretation, and analysis of resistance; transference and conflict; and the productivity of the patient in the immediately following segment. A multiple regression analysis

showed that the impact of these analytic activities was entirely dependent on the quality of the analyst's intervention. In addition, patient's previous productivity contributed as strongly as intervention quality to subsequent patient productivity. Statistical analysis also demonstrated that the level of work of the analyst and the patient were highly correlated in this sample.

No. 9B
THE ANALYTIC PROCESS SCALES

Anna M. Burton, M.D., *163 Engle Street, Building 2, Englewood, NJ 07631-2530*

SUMMARY:

The presenter reviews the work of this research group in developing the Analytic Process Scales (APS) and bringing them to their present powerful potential, and describes the clinical research value of recorded material. One session and its context in a fully recorded analytic treatment will be summarized and an uncut sequence within one of the sessions will be presented to the audience, in both audiotape and printout formats, to illustrate how the APS identifies and quantifies each element of interaction between patient and therapist in a theory-free manner. On the patient's side, measures can be made of how her feelings have contributed, or how her developmental history enters the work; how she responds to the analyst's intervention, and so forth. On the analyst's side, we can measure his types of intervention, his discernible feelings, how he follows the patient's immediate emotional focus, and how these factors correlate with the patient's useful productivity. The APS measures the interactional characteristics of the process through its applications to conflicts, resistances, and transferences.

The systematic application of these scales to audiotaped sessions has revealed correlations relevant to both short-and long-term psychotherapeutic benefit to this patient.

No. 9C
AN OUTCOME STUDY FOR PSYCHODYNAMIC PSYCHOTHERAPY OF PANIC DISORDER

Barbara L. Milrod, M.D., *Department of Psychiatry, Cornell University, 525 East 68th Street, New York, NY 10021;* Fredric N. Busch, M.D.

SUMMARY:

This talk will describe the methodology necessary to turn psychoanalytic psychotherapy into a reproducible, scientifically believable treatment, as well as to report on the immediate outcome and six-month follow-up on the patients we studied with our method. Twenty-one patients with panic disorder were entered into a trial of twice weekly, 24-session treatment with Panic-Focused Psychodynamic Psychotherapy (PFPP), a psychoanalytic psychotherapy based on core psychoanalytic principles of the central importance of unconscious mental dynamisms and the use of free association. Sixteen of 21 experienced remission of panic and agoraphobia. Treatment completers with depression also experienced remission of depression. Symptomatic and quality of life improvements were substantial and consistent across all measured areas. Symptomatic gains were maintained over six months. Psychodynamic psychotherapy appears to be a promising nonpharmacological treatment for panic disorder.

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3. Milrod B, Busch F, Leon A, et al: An open trial of psychodynamic psychotherapy for panic disorder—a pilot study. American Journal of Psychiatry 2000; 157:1878–1880.

SYMPOSIUM 10—EVIDENCE-BASED PSYCHODYNAMIC THERAPY PART II: WHAT DO THE DATA SHOW?
American Academy of Psychoanalysis and American Psychoanalytic Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should have a clearer idea of central dimensions of analyst and patient work in psychodynamic therapy, how they can be measured, and how the analyst work enhances the patient's productivity.

No. 10A
THE BENEFITS OF INDIVIDUAL PSYCHOTHERAPY FOR SCHIZOPHRENIA PATIENTS: A META-ANALYTIC REVIEW

William H. Gottdiener, Ph.D., *111 Hicks Street, Unit 7N, Brooklyn, NY 11201;* Nick Haslam

SUMMARY:

A comprehensive meta-analytic review was undertaken to determine the efficacy of individual psychotherapy for schizophrenic patients. Mean effect sizes were calculated for seven separate meta-analyses. Use of antipsychotic medication, theoretical orientation of treatment, and changes in diagnostic criteria were examined as possible moderator variables. Improvement in overall functioning was associated with all forms of individual psychotherapy, which included psychodynamic, cognitive-behavioral, and non-psychodynamic supportive therapies. The largest proportion of patients, however, improved with the use of psychodynamic and cognitive-behavioral therapies when combined with antipsychotic medication. Narrowing of diagnostic criteria after publication of DSM-III did not attenuate effect sizes. Implications for treatment and suggestions for future research are discussed.

No. 10B
CONTROLLED TRIALS OF PSYCHOANALYTIC THERAPIES FOR YOUNG PEOPLE

Peter Fonagy, Ph.D., *Psychoanalysis Unit, University College of London, Gower Street, London WC1E 6BT, United Kingdom;* Geoffrey Baruch, M.D., Anthony Bateman, M.D.

SUMMARY:

Psychodynamic approaches have a poor track record with individuals with conduct problems. Insight-oriented treatments are ineffective and in some trials have been found to have iatrogenic effects on young people's behavior. In our formulation the reason for the apparent ineffectiveness of psychoanalytic therapies rests with the limited relevance of understanding unconscious processes to individuals whose capacity to represent mental states is limited, at least in attachment contexts. Psychoanalytic therapy, if it is to be effective for such individuals, needs to be reframed, as an intervention that enables the individual to evolve second-order representations of internal states, what has come to be called: "mentalization." Therapies focused on these ideas have been shown to be effective in the context of partial hospital treatment of borderline states. The present paper will report on two trials, a study of brief psychotherapy involving

juvenile delinquents in London (led by Dr. Geoffrey Baruch) and a violence prevention intervention in Topeka schools (led by Dr. Stuart Twemlow). The paper will explore how the capacity for thinking about one's thoughts and feelings can be improved by psychodynamic interventions that focus on this capacity and how such improvements lead to measurable improvements in adaptations at a behavioral level.

No. 10C
THE LIMITED EFFECTIVENESS OF SHORT-TERM THERAPY FOR ANOREXIA NERVOSA

Authur L. Robin, Ph.D., *1720 Haynes, Birmingham, MI 48009;* Patricia Siegel, Ph.D.

SUMMARY:

This study assessed the importance of a sufficient length of treatment by comparing outcomes after six versus 16 months of Behavioral Family Systems Therapy (BFST) or Ego Oriented Individual Therapy (EOIT) as treatments for teens with anorexia nervosa. Thirty-seven female adolescents with restricting anorexia nervosa were randomly assigned to BFST or EOIT. Each participant received a common medical/dietary regimen and 16 months of BFST or EOIT. BFST consisted of family sessions focusing on a behavioral weight gain program, cognitive restructuring, and family structure. EOIT consisted of individual adolescent sessions focusing on dynamics blocking eating; parents were seen separately. Measures were administered before treatment, six months later, and at post treatment. Twenty-eight percent of the girls attained target weight by six months; 68% by 16 months. Twenty-eight percent of the girls resumed menstruation by six months; 80% by 16 months. Eating habits, depression, and ego functioning did not improve until 16 months. Health was restored in less than a third of the patients after six months of intensive therapy, but in over two-thirds of the patients after 16 months of therapy. Psychological variables did not improve until post assessment. These results emphasize the importance of an adequate length of treatment for anorexia nervosa.

No. 10D
RANDOMIZED CLINICAL TRIAL OF A PSYCHOANALYTIC TREATMENT OF BPD

Anthony Bateman, M.D., *Department of Psychotherapy, Saint Ann's Hospital, Saint Ann's Road, London N15 3TH, United Kingdom*

SUMMARY:

Forty-four patients with borderline personality disorder, diagnosed according to standardized criteria, were allocated either to psychoanalytically oriented partial hospitalization or to general psychiatric care (control group) in a randomized control design. Treatment, which included individual and group psychoanalytic psychotherapy, was for 18 months. Outcome measures included frequency of suicide attempts and acts of self-harm, number and duration of inpatient admissions, use of psychotropic medication, and self-report measures of depression, anxiety, general symptom distress, interpersonal function, and social adjustment. Patients in the partial hospitalization program showed a statistically significant decrease on all measures in contrast to the control group. Improvement in depressive symptoms, decrease in suicidal and self-mutilatory acts, reduced inpatient days, and better social and interpersonal function began after six months and continued to the end of treatment at 18 months.

Gains were not only maintained over 18-months follow-up but also showed a statistically significant continued improvement on most measures, including service utilization, in contrast to the control group of patients who showed only limited change during the same period.

Detailed results will be presented, including cost-effectiveness and the importance of the findings discussed, including the outpatient adaptation of the program, which is presently part of a research trial using a randomized, controlled design.

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2. Robin AL, Siegel PT, Moye AW, Gilroy M, et al: A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa. Journal of the American Academy of Child and Adolescent Psychiatry 1999; 38:1482–1489.
3. Bateman A, Fonagy P: The effectiveness of partial hospitalization in the treatment of borderline personality disorder—a randomized controlled trial. American Journal of Psychiatry 1999; 156:1563–1569.

SYMPOSIUM 11—SOCIAL PSYCHIATRIC ASPECTS OF VIOLENCE AND TRAUMA
American Association for Social Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the biopsychosocial implications of violence and trauma, and how to use this knowledge in diagnosing, treating, and preventing violence and trauma among psychiatric patients.

No. 11A
TRAUMA AND VIOLENCE: A U.S. PERSPECTIVE

Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago, IL 60617-2746*

SUMMARY:

Using data from the Adverse Childhood Experiences (ACE) Study, Dr. Bell will highlight the long-term negative outcomes that violence and trauma are associated with in the United States. The ACE study shows a strong association between psychological abuse, physical abuse, contact sexual abuse, living with a substance abuser, living with a mentally ill person, having criminal behavior in the household while growing up, and growing up in a household where the mother/stepmother was treated violently with increased risk for alcoholism, drug abuse, depression, suicide, smoking, sexually transmitted diseases, severe obesity, sexual intercourse with 50+ people, ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Dr. Bell will discuss the public health implications for childhood exposure to trauma and violence along with various public health strategies designed to correct this major cause of mortality and morbidity in the U.S., most notably constructing a children's mental health and mental wellness infrastructure in the U.S. This is an especially high leverage strategy considering the current infrastructure "sucks."

No. 11B
SOCIAL ASPECTS OF TRAUMA

S. Arshad Husain, M.D., *Department of Psychiatry, University of Missouri, 1 Hospital Drive. N119 UMCH Hospital, Columbia, MO 65212*

SUMMARY:

According to UNICEF at any given time approximately 50 countries are engaged in armed conflict around the world. Children, women, and elderly—the most vulnerable members of the society—are the most common victims of those conflicts. Besides death and injury, the war atrocities take a serious toll on the psychological well-being of victims. In the United States, although there is no state of war, domestic violence and physical and sexual abuse of children are being perpetrated at an endemic proportion and have similar psychological impact as seen in war traumatized children. However, not all children exposed to trauma suffer from traumatic stress reaction. It is now generally accepted that there are sociocultural factors that influence vulnerability and resiliency to trauma. This author, drawing from his experience in working with war traumatized children of Bosnia and Herzegovina, will discuss various social aspects of trauma.

No. 11C
NOSTALGIA AS A DEFENSE AGAINST FULLY EXPERIENCING THE TRAUMA OF IMMIGRATION

Salman Akhtar, M.D., *Department of Psychiatry, Jefferson University, 260 Overhill Road, Balacynwyd, PA 19004*

SUMMARY:

Though its intensity varies, the psychic trauma consequent upon immigration is a palpable and life-long one. It is, of course, more marked in involuntary immigrants, i.e. exiles. The trauma consists of a rupture in the core background of reality constancy. This causes mental pain. In addition, the evolving encounter will-altered superego dictates and newly-found ego freedoms lead to a constant ebb and flow of anxiety. As life unfolds and new development challenges appear on the horizon, the immigration trauma has to be reworked again and again.

Nostalgia is often evoked as a psychic defense against the experience of this inner disaster. It can serve both healthy and pathological aims. The therapist dealing with an immigrant must offer psychic space, respect, and empathy while keeping an eye upon the hidden transference allusions in the nostalgic pleasure as well as upon its defensive aims against aggression in the past and in the here and now. In contrast, the therapist dealing with an exile must empathically reflect the patient's inability to experience nostalgia and interpret the defenses against the emergence of this affect.

In essence, both the immigrant and the exile struggle with defensive alterations of libidinal investment in the memory of their homeland. The immigrant needs to exaggerate the love that the exile is compelled to deny. By helping the former renounce such idealization and the latter reclaim the warded-off good feelings, the therapist facilitates genuine affection for the country of origin in both types of individuals. Paradoxically, it is only with such foundation that true commitment to the country of adoption, where life is now to be lived, becomes possible.

No. 11D
CONSEQUENCES OF PSYCHOSOCIAL INTERVENTIONS: THE POTENTIAL TO HARM AND HELP

Daniel L. Creson, M.D., *Dept of Psychiatry, University of Texas at Houston HSC, 1300 Moursund Street, Houston, TX 77030-3406;* Pedro Ruiz, M.D., Patricia Blakeney, Ph.D.

SUMMARY:

Humanitarian interventions in complex emergencies or crisis situations have serious psychological consequences. Even though this seems obvious, little attention has been given to identifying and quantifying these consequences. One consequence of this type of aid interventions programs is the tendency to equate psychosocial programs with programs whose design is based on a medical trauma model. The medical trauma model tends to focus its attention in individual trauma that requires individual treatments. This Western concept of intervention in emergency situations has little relevance with respect to the acute and chronic stress experienced by community members when they get exposed to shared hardships and shared traumatic experiences.

As professionals acquire more experiences and skills in resolving serious crisis and/or emergency situations, they move away from simplistic, linear models of intervention. In this respect, field experiences have shown that the active participation of community members is an essential and healthy way of achieving success when intervening in emergency situations.

In this presentation, social interventions that promote a sense of worth, that ameliorate feelings of powerlessness, and that enhance cooperation and collaboration will be addressed and discussed. Hopefully, this presentation will help to design more appropriate types of interventions when dealing with serious emergencies.

No. 11E
PTSD AND CULTURAL COMPETENCY

Edward F. Foulks, M.D., *Department of Psychiatry, Tulane University School of Medicine, 1430 Tulane Avenue, TMC-SL97, New Orleans, LA 70112-2699*

SUMMARY:

Cultural competency has recently been included in the requirements of the Accreditation Council for Graduate Medical Education (ACGME) for all U.S. residency training programs. Since Freud and Breuer's Studies in Hysteria, it has been recognized that memories of horrific traumatic events are frequently denied, forgotten, and repressed in patients who suffer from PTSD. Psychiatrists who treat such patients should therefore be prospectively informed about historical events of traumatic nature potentially experienced by patients, particularly from diverse cultural backgrounds, U.S. veterans and Southeast Asian refugees from the Vietnam War will be cited to exemplify this principle.

REFERENCES:

1. Felitti VJ, Anda RF, Nordenberg D, et al: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults—The Adverse Childhood (ACE) Study. American Journal of Preventive Medicine 1998; 14(4):245–258.
2. Husain SA: Hope for the Children: Lessons from Bosnia. IMET, Columbia, Missouri, USA, 2001.
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4. Coldberg L, Breznitz S, (eds): Handbook of Stress, New York, Free Press, 1993.
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SYMPOSIUM 12—SADISTIC PERSONALITY DISORDER: ITS WIDE RANGE AND IMPORTANCE AS A DIAGNOSIS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to grasp the importance of sadistic personality disorder as a

valid diagnosis, understand its wide range and its differences from and overlap with, psychopathy and sexual sadism, and know which forms are treatable—and by what methods.

No. 12A
SADISM AND FORENSIC PSYCHIATRY

Michael M. Welner, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, Suite 806, New York, NY 10001*

SUMMARY:

While sadism lays silently in the clinical psychiatric nomenclature, the implications of sadism are visible in forensic psychiatry. In contemporary forensic psychiatry, the designation sadism is used interchangeably with sexual sadism. Consequently, the entity is often stereotyped as necessarily a sexual fetish. The author provides an example from his own case experiences of how this misconception translates in forensic work.

The forensic psychiatrist who performs assessments for criminal responsibility and capital cases must closely examine the motivation, actions, and attitudes of the perpetrator. Consideration of sadism may be masked by the presence of coincidental major mental illness, or a close relationship with the victim. Included in this framework is an appreciation for the role pathology and forensic sciences play in the investigation of the presence of sadism. Guidelines are proposed for relevant history and workup of these peculiar cases.

The Depravity Scale, a history and evidence driven device being validated to standardize the definition of depravity, incorporates sadism into several of its factors. These factors are reviewed.

Finally, the author discusses the serious implications of the labeling of sadism. Sobriety, caution, and diligent pursuit of forensic evidence are a must for the psychiatrist who must consider this diagnostic possibility.

No. 12B
SADISTIC PERSONALITY DISORDER: THE NEED TO REINSTATE IN FUTURE EDITIONS OF DSM

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, # 114, New York, NY 10024-6027*

SUMMARY:

Sadistic personality disorder [SPD] had been included provisionally in the appendix of DSM-III-R and subsequently omitted, partly for political reasons, lest SPD be misused by defense attorneys as "exculpatory" (as a "mental illness") of crimes involving extreme cruelty. Lack of field studies was another factor, since sadistic persons rarely come for treatment or are treatable—hence the literature on clinical aspects of SPD was sparse. There is a large literature bearing on the subject, however, in the form of full-length biographies of notorious violent offenders. Review of 393 such books and the 395 offenders (two books involved a pair of offenders) reveals that at least four of the eight criteria mentioned in DSM-III-R were applicable to 259 of the offenders, most of whom had committed one or more murders or several rapes. Six books dealt with self-defense homicides, leaving 389 dealing with murder(s). Men [N= 317] outnumbered women [N=72]. SPD applied more often to men [72%] than to women [43%]. Utilizing a scale for ranking the degree of cruelty utilized, offenders were categorized as belonging to one of the 22 gradations. SPD was rare in those committing "crimes of passion." SPD was noted in 40 (females)—65% (males) of those who killed to "get someone out of the way" (e.g., spouse, in order to be with a lover). Sexual sadism was nonexistent in women, but common in male serial killers, almost all of whom showed SPD (70% of those who killed to avoid detection; 100% of those with concomitant sexual sadism). SPD is common in the forensic population, and deserves reinclusion in future editions of DSM. SPD should never be "exculpatory" of violent crime.

No. 12C
PATTERNS OF SADISTIC BEHAVIOR AND VICTIM RESPONSE

Ann Burgess, D.N., *The Forensic Panel, 224 West 30th Street, #806, New York, NY 10001*

SUMMARY:

This presentation will describe the sadistic offender from the perspective of the victim through the analysis of ten adjudicated cases. The dynamics of the interaction and of the motivation for the sadistic offense need to be taken in to consideration in formulating plans for treatment of the sadistic offender.

Additional insights of value in forensic assessment were derived from study of the wives and partners who had been consensually involved with the sadistic offenders, and who had endured from them varieties of psychological, physical, and sexual abuse. Several such examples will be discussed in the presentation, along with the relevance of sadistic personality disorder as a diagnosis pertinent both to the understanding of the offenders and to the proper development of prognostic guidelines and treatment strategies.

No. 12D
THE EMPIRICAL RELATIONSHIP BETWEEN PSYCHOPATHY AND SADISM

J. Reid Meloy, Ph.D., *964 5th Avenue, Suite 409, San Diego, CA 92101*

SUMMARY:

There have been recent studies that demonstrate a significant and strong relationship between the construct of psychopathy and that of the sadistic impulse. The utilization of standardized measures of psychopathy (such as that of Hare's Psychopathy-Checklist/Revised [PCL-R]) and personality measures of sadism (such as Millon's MCMI-II, PAI) suggest that clinicians, especially those engaged in forensic evaluation and treatment, should suspect sadism in the history of the psychopath. Similarly, clinicians should always consider the diagnosis of psychopathic personality when confronted by sadistic behavior or by the paraphilia of sexual sadism. The concepts of sadistic personality disorder and psychopathy have important ramifications in the domain of treatment, since both conditions have a bearing on both the amenability *to* treatment and the limitations *of* the treatments, such as are currently available. Pertinent cases will be presented.

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2. Baumeister R: Evil: Inside Human Violence and Cruelty. NY, WH Freeman, 1999.
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SYMPOSIUM 13—FROM RESEARCH TO PRACTICE: PRIMARY CARE RESEARCH IN SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES FOR ELDERLY (PRISME)
Substance Abuse and Mental Health Services Administration

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the implementation of MH/SA research in primary care from the researcher, provider, consumer, and ethnic minority perspectives.

No. 13A
INTEGRATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES IN PRIMARY CARE FOR THE ELDERLY

John S. McIntyre, M.D., *Department of Psychiatry, Evelyn Brandon Health Center, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*

SUMMARY:

The integration of behavioral health services and primary care has become increasingly popular. This service delivery model has the potential for increasing access, decreasing stigma, increasing recognition of mental health and substance abuse disorders, improving communication among health professionals, and improving the adherence to recommended treatments. However, there are few studies, especially of elder patients, examining the outcome of these treatment models. The PRISME study is a randomized, controlled study addressing these issues for patients with the diagnosis of depression, anxiety, and alcohol abuse. This paper will present information from 50 clinical sites that identifies key factors that influence the success of an integrated model including screening of patients, role of the PCP, information sharing, adaptation of mental health and substance abuse treatments for primary care, and financial/reimbursement issues.

No. 13B
CONSUMERS' AND RESEARCHERS' PERSPECTIVE ON IMPROVING ELDERLY ASIAN-AMERICANS' AND HISPANIC-AMERICANS' PARTICIPATION IN MENTAL HEALTH AND SUBSTANCE ABUSE RESEARCH

Hongtu Chen, Ph.D., *CB Wang Health Center, 125 Walker Street, New York, NY 10013;* Guiseppe Costantino, Ph.D., Sue E. Levkoff, Sc.D., Herman Sanchez, A.B.

SUMMARY:

This presentation explores barriers and strategies in motivating Asian and Hispanic elders to participate in mental health services research programs. Elderly consumer representatives, primary care physicians, and research investigators were involved in identifying these barriers and developing strategies to reduce them.

The barriers include: (1) lack of culturally sensitive/competent mental health providers, (2) stigma associated with mental illness and their related services, (3) denial of mental health problems, (4) poor understanding of treatment and research benefits, (5) unwillingness to sign consent forms, (6) reluctance to spend extra money for research treatment, (7) inability to commit to new activities due to family responsibilities, and (8) poor geographical mobility.

A number of strategies have been identified and implemented to motivate them to participate including (1) community education via multimedia, such as videotapes to publicize the study, (2) monetary compensation for participating time, (3) utilizing bilingual research assistants/clinicians, (4) developing culturally competent MH/SA services, (5) gaining support from primary care providers, and (6) providing transportation and other social services.

In conclusion, there are multifaceted barriers preventing cultural minorities from participating in mental health/substance abuse research. However, they can be reduced by strategies developed through collaboration of consumers, primary care providers, and research investigators.

No. 13C
CONSUMERS AND RESEARCHERS: NEW PARTNERSHIP CHALLENGES AND OPPORTUNITIES

Cynthia Zubritsky, Ph.D., *Department of Managed Care, University of Pennsylvania, 3600 Marker Streetd, 7th Floor, Philadelphia, PA 19104;* Rosa Wims, Trudy Persky, M.S.W., William Faust, Paul Wohlford, Ph.D.

SUMMARY:

Researchers and funders are realizing the value of actively incorporating consumer perspectives in research. Developing effective partnerships between consumers and researchers is challenging, but the benefits and opportunities are becoming clearer. This may be particularly true with older adult and ethnic minority populations. Consumers can help to enhance study subject recruitment, enrollment, retention, instrumentation, and other research procedures. They can help disseminate results to a broader, non-academic audience of policymakers, advocates, and the general public. In 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Veterans Affairs (VA) and the Health Resources Services Administration (HRSA), funded a five-year, multisite study called the Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISMe) Study. The consumer perspective is included in many aspects of multisite study development and implementation. Each study site is also required to develop a Consumer Advisory Council (CAC) and incorporate their feedback on all aspects of site-level protocol development and implementation.

Conclusion: This presentation will briefly review the range of consumer involvement approaches and will report in depth on lessons learned along the way.

No. 13D
IDENTIFICATION AND TREATMENT OF ALCOHOL PROBLEMS IN PRIMARY CARE

David W. Oslin, M.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 790, Philadelphia, PA 19104;* Frederic C. Blow, Ph.D.

SUMMARY:

The treatment of alcohol abuse and dependence among the elderly has traditionally focused on individualized or group psychotherapy delivered in specialized addiction treatment centers. Findings from the PRISMe study confirm that few older adults with alcohol problems have been identified and are being treated in specialty programs. New strategies need to be developed to assist in the identification and early treatment of older patients. Emerging evidence supports a role for mental health providers in identifying and managing late-life problem drinking both in their own practice and in consultation with other colleagues.

This presentation will focus on the effective identification of patients through systematic screening. While screening may be necessary, it is not sufficient for managing patients and thus early intervention options will also be discussed with a focus on brief interventions. Brief interventions can be easily implemented in many health care settings, can assist in getting patients into specialty care, and have been shown to be effective in reducing or stopping consumption of alcohol.

No. 13E
HEALTH POLICY IMPLICATIONS OF (PRISME) AND THE PROMISE OF RESEARCH ON MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT OF OLDER PERSONS IN PRIMARY CARE

Stephen J. Bartels, M.D., *Department of Psychiatry, NH-Dartmouth Res CT, 2 Whipple Place, Suite 201, Lebanon, NH 03766-1360;* Betsy McDonel-Herr, Ph.D.

SUMMARY:

Objective: The objective of this presentation is to provide an overview of the health policy implications of current research on integrated mental health services for older persons in primary care.

Method: Health policy issues of access, treatment effectiveness, and the organization and costs of mental health services in primary care are discussed in the context of PRISMe and two other concurrent multisite studies.

Results: Depression and other mental health disorders affect at least one-third of older adults in primary care, resulting in poorer health outcomes and increased health costs. Integration of services has been proposed as a remedy for inadequate treatment of these problems, yet empirical data are lacking. Over 5,000 older persons with depression and other disorders are currently participating in three different multisite studies in primary care settings. PRISMe compares effectiveness and costs associated with integrated and referral models of mental health and substance abuse (MH/SA) services. Two other studies examine the effectiveness of depression care managers facilitating antidepressant treatment and interpersonal psychotherapy (PROSPECT) or Problem Solving Therapy. (IMPACT).

Conclusions: These studies address different and complementary health policy questions on the effectiveness and costs of integrating mental health and substance abuse services for older persons in primary care.

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2. Rogler LH, Santana-Cooney R, Costantino G; Early BF, Grossman B, Gurak D, Malgady R, Rodriguez O: A conceptual framework for mental health research on Hispanic populations. Monograph No. 10, Hispanic Research Center, New York, NY, 1983.
3. Center for Medicare Education. Building Coalitions. Issue Brief 2001; 2(3).
4. Barry KL, Oslin DW, Blow FC: Prevention and Management of Alcohol Problems in Older Adults. New York, Springer Publishing, 2001.
5. Mechanic D: Approaches for coordinating primary and specialty care for persons with mental illness. General Hospital Psychiatry 1997; 19:395–402.

SYMPOSIUM 14—EXTINCTION VERSUS ADAPTATION: THE FUTURE OF STATE HOSPITAL PSYCHIATRY
APA Caucus of State Hospital Psychiatrists and American Association of Psychiatric Administrators

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the challenges that faced state hospital psychiatrists historically with the vision of application of these "lessons learned" to the future; develop methods to survive internal system and governmental political pressures; appreciate adaptation strategies of state psychiatrists in recruitment retention and medical leadership.

No. 14A
BUILDING, UNBUILDING, AND REBUILDING AMERICA'S STATE HOSPITALS

Jeffrey L. Geller, M.D., *Department of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655-0002*

SUMMARY:

While there have been shifting ideologies in the United States about the care and treatment of individuals with chronic mental illnesses over the past 200 years, one fundamental principle has been a constant: "Do what's right and save money." Throughout much of the 19th century, this principal fueled the construction of state hospitals. After the first half of the 20th century, when the state hospital was seen meeting a cornucopia of unmet needs, i.e., care for the elderly, repository for those with neurosyphillis, etc., the principal again emerged in full forces. This time it fueled the destruction of state hospitals, and the arguments for and against state hospitals were put forward without adequate, accurate data. This presentation examines this history, with a particular focus on how history can inform us of the future. Are state hospitals dinosaurs, Edsels, or bellbottoms?

No. 14B
THE FUTURE OF STATE HOSPITAL PSYCHIATRY PART II: SURVIVING POLITICAL CHANGES

Thomas W. Hester, M.D., *Division MHMRSA, 2 Peachtree Street, N.W., 22nd Floor, Atlanta, GA 30303*

SUMMARY:

From 1955 to 1996 the number of persons served in state hospitals dropped from 560,000 to 77,000 – and acute inpatient care was shifted to general hospitals. In addition to downsizing, state hospitals have been the focus of political forces including privatization campaigns, and highly publicized sentinel events like patient suicides and elopements of patients charged with violent felonies. Also, the U.S. Department of Justice CRIPPA actions, transfer of convicted sexual offenders from prisons in the wake of Kansas v. Hendricks, the 1999 U.S. Supreme Court decision in the case of Olmstead v. L.C. and E.W., and other class action and private law suits have left many state hospitals marginalized, isolated, and stagnant.

State hospitals can use certain successful strategies to manage political adversity, including becoming expert at meeting the needs of those patients who remain in state hospitals, and revitalizing the therapeutic culture of the state hospital to reflect principles of recovery, community integration, best clinical practices, and accountability. Tactics to support these strategies include hiring peer special-

ists, supporting mutual help groups, implementing active anti-stigma campaigns, establishing hospital-operated community programs, and collaborating with universities and community providers in the implementation of medication algorithms.

No. 14C
RECRUITMENT AND RETENTION

Joel S. Feiner, M.D., *Department of Psychiatry, University of Texas at Southwestern, 233 West 10th Street, Dallas, TX 75208*

SUMMARY:

It has been my experience that those state hospital that are most successful in recruiting and retaining psychiatrists have the most developed integration with a medical school department of psychiatry. This integration includes academically oriented psychiatrists in subspecialty areas of the state hospital including research, and forensic and geriatric units. Training should take place in designated units, attended by faculty who are distinguished by their clinical and teaching abilities. The interdisciplinary team should also include nurses, psychiatrists, social workers, mental health technicians, and chemical dependency specialists who display excellence in their field and a comfortable disposition to participate in teams. In addition, the professionals should be capable of supervising trainees in their own disciplines.

This concentration of departmental excellence lends prestige to the state hospital psychiatrist and provides the excitement of state of the art training for residents. All attending psychiatrists benefit from on-site academic exercises.

If the full integration is not possible because of bureaucratic difficulties or geography, then as many of elements should be incorporated, especially residency training. Other dimensions that obviously encourage recruitment and retention are competitive, if not greater, salaries and benefits and hospitals with exemptions from managed care constraints.

No. 14D
MEDICAL LEADERSHIP IN STATE HOSPITAL SYSTEMS

Christopher G. Fichtner, M.D., *Department of Psychiatry, University of Chicago, 160 North La Salle Street, S-1000, Chicago, IL 60601;* Daniel J. Luchins, M.D., Thomas A. Simpatico, M.D., Louis J. Mini, M.D.

SUMMARY:

In the context of a symposium on the future of state hospital psychiatry, posing alternatives of adaptation or extinction, a discussion of medical leadership takes on distinctive dimensions. Numerous authors have written about the close relationship between leadership and the management of change. State hospitals, public mental health systems, psychiatric services in general, and American health care more broadly are all changing. State hospital psychiatrists, and psychiatrists working in related public systems, now face the challenge of providing medical leadership in the context of evolving systems of care. This has often meant taking a strong stance on minimum standards of quality in the face of shrinking resources. It is also characteristic of good leadership to find opportunity in the midst of change, even under conditions of adversity. To be effective leaders, state hospital psychiatrists will need to become adept at envisioning strategies for resource management that integrate patient advocacy and quality standards, while being clear about commitment to maximizing value for the health care dollar. They must lead the implementation of systemic changes that reduce current inefficiencies and optimize use of available resources. This presentation will highlight initiatives in continuity of care, community psychiatry staffing and leadership, information management, public-private sector collaboration, hospital medical staff monitoring, and multidisciplinary team functioning that illustrate opportunities for medical leadership in the context of state hospital practice. The role of academic affiliations in supporting and developing psychiatrist leadership will be addressed.

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1. Geller JL: The last half-century of psychiatric services as reflected in Psychiatric Services. Psychiatric Services 2000; 51:41–67.
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SYMPOSIUM 15—THE SOCIAL BRAIN AND PSYCHOTHERAPY
World Psychiatric Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to define social brain, sociodynamics, and sociophysiology; describe how these form better connections between the brain-cellular-molecular-levels of analysis to those described as experiential-mental-behavioral; list brain features of deception; and note problems for bridging efforts inherent in the development of the science.

No. 15A
CLINICAL SOCIOPHYSIOLOGY

Russell J. Gardner, Jr., M.D., *Department of Psychiatry, Medical College of Wisconsin, 214 Durose Terrace, Madison, WI 53705-3323*

SUMMARY:

Psychiatry needs a basic science in which its ills are phrased as normal function variants. Clinical activities including psychotherapy would gain enhancement from a rational basic science that combines brain data with principal brain functions (parallel to other body systems and their functions, e.g., the gastrointestinal tract and digestion). Brain functions operating in psychopathology and its treatments include those of social relations, such as social rank hierarchy communications, in-out group behaviors, and bonding-separation. Subcortical functions include emotions; cortical elaborations entail story formations that pervade culture and individual development including a greater ability to form allies than animals can with smaller neocortical: whole brain ratios. More cortex enhances competence in social relations including increased ability to enlist allies. Noteworthy, 42% of the variance in therapy effect stems from therapeutic alliance; with human cultural storylines, a genetically unrelated doctor or other therapist assists someone in need, a less likely event with other species. In psychotherapy treatment contracts, metaphors of illness, and treatment gain value by distinguishing human and nonhuman communicational attributes; for instance, patients frequently display ancient propensities in their symptoms. Present neuroscience shows competence in the brain-cell-molecule issues, but we need equal competence with social and communicational factors that influence experiential-mental-behavioral realms.

No. 15B
SOCIODYNAMICS IN PSYCHOTHERAPY

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health Sciences University, 3006 NE Bryce Street, Portland, OR 97212-1718*

SUMMARY:

"Sociodynamics" refers to interactive processes in which the direction of causation proceeds from external social pressures toward internal psychological states. Mutual suggestion is paradigmatic. Often concealed by self-deception, one's brain calculates how best to present oneself to others, then brings one's beliefs, desires, and behaviors into congruence. Others ratify one's projected image, with tacit expectations for reciprocity. "Psychological realities" emerge. Relevant brain functions are to calculate interests, assets/liabilities, and environmental pressures; select preferred life strategies from numerous innate and learned modules; apply them to life contingencies; and modify them with new information throughout the life span. Supporting data come from converging research paradigms on indirect reciprocity, hypnosis, psychological trauma, and the social sciences. To extend neuroimaging to interacting brains also may help to identify otherwise elusive underlying patterns. Central to psychotherapeutic practice, is the extraordinary reframability of psychological realities. Therapeutic implications include looking for social effects of patients' symptoms, utilizing significant others, identifying symptom-reinforcing interactions, and intervening at biopsychosocial focal points in ways that respect, reframe, and build upon patients' basic life strategies toward greater social functionality, behavioral safety, and personal wellbeing.

No. 15C
THE SOCIAL BRAIN AS SITE OF TRUTH AND DECEPTION

Godehard Oepen, M.D., *Department of Psychiatry, University of Alabama, 223 Trace Ridge Road, Birmingham, AL 35244-3926*

SUMMARY:

The ability to understand other people's behavior involves mentalizing and manipulation of other people's mental states. New findings and methods in neuroscience enable us now to see how the brain uses "deception" in its creation of internal conceptual coherence, and external social coherence. The neurobiology of "falling in love," placebo research, cross-cultural psychiatry, and "top-down" effects of social factors shaping neurobiological functions in animals and humans illustrate this point. Deceiving others, as well as detecting deception is seen as basically normal skills. Different cerebral lesions might impair them differentially, leading to both inhibitory and disinhibitory phenomena. Cortical and subcortical as well as laterality factors play an important role in different forms of deception. An intact left cerebral hemisphere (the "storyteller") seems to be required for the ability to actively deceive, while a compromised left hemisphere seems to improve the ability to detect deception in others. Neuroimaging has recently demonstrated different cerebral activation patterns in patients with hysterical limb paralysis and volunteers faking a limb paralysis. Research on "Mirror Cells" and the new "Medial Prefrontal/Superior Temporal Sulcus" system demonstrate additional progress in our understanding of interacting brains and minds, and re-introduce the subject and its relationships into psychiatry.

No. 15D
BIOLOGY OF FAMILY PSYCHOTHERAPY

Douglas A. Kramer, M.D., *Department of Psychiatry, University of Wisconsin, 780 Regent Street, Suite 300, Madison, WI 53715-2635*

SUMMARY:

Sociophysiology constitutes a relationship-based basic science framework that encourages pathogenetic formulations. The Research Committee of the Group for the Advancement of Psychiatry (GAP) suggests that a "social brain — defined by its function, namely, it mediates social interactions while also serving as the repository of those interactions — focuses on the interface between brain physiology and the individual's environment. The brain is the organ most influenced on the cellular level by social factors across development; in turn, the expression of brain function determines and structures an individual's personal and social experience." This symposium suggests that psychotherapy needs focus on sociophysiology to connect the brain to behavioral-experiential domains. This view provides translations of what happens and clinical sociophysiology provides practical implications as well. A second presentation notes that the "sociodynamics" of the therapeutic situation highlights issues of agreed-on deceptions while a third amplifies this discussion by describing current research on brain mechanisms of truthful and deceptive communications. Ethology represents a facet of biology exemplified from family therapy.

No. 15E
A SKEPTIC'S VIEW OF BRIDGING EFFORTS

Alan A. Stone, M.D., *Hauser Hall, Room 400, Harvard University Law School, 1575 Massachusetts Avenue, Cambridge, MA 02138-2996*

SUMMARY:

The profession of psychiatry is still struggling to find its way in the paradigm shift from a psychodynamic model of the mind to a neuroscientific understanding of the brain. This is most problematic for clinicians who no longer have coherent or meaningful explanations to offer patients in psychotherapy. Sociophysiology is one important effort to fill the explanatory void. There are those who believe that insights drawn from evolutionary psychology, ethology, and the new findings of neuroscience will provide a "sociophysiological" foundation for psychotherapy. Another school to which I belong is of the view that neuroscientific advances will require that we construct a new theory of mind whose parameters are not yet available to our outmoded intuitions. There are a melange of techniques but no coherent blueprint for psychotherapy.

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3. Ramachandran VS: The evolutionary biology of self-deception, laughter, dreaming, and depression: some clues from anosognosia. Med Hypotheses 1996; 47:5:347–362.
4. Stone AA: Psychotherapy in the managed care health market. Journal of Psychiatric Practice 2001; 7.

SYMPOSIUM 16—SPECIAL TOPICS IN WOMEN'S MENTAL HEALTH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize gender differences related to some specific psychiatric disorders, and to understand the particularities that may affect the diagnosis and treatment in women.

No. 16A
MOOD DISTURBANCE AND PREGNANCY: PROS AND CONS OF PHARMACOLOGICAL TREATMENT

Adele C. Viguera, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street\WACC 812, Boston, MA 02114;* Claudio N. Soares, M.D., Lee S. Cohen, M.D.

SUMMARY:

Pregnancy has frequently been referred to as a time of emotional well-being conferring "protection" against psychiatric disorder. However, recent data do not support this clinical lore. The management of psychiatric disturbances during pregnancy, particularly depression and bipolar disorders, is complex. While the prevalence of psychotropic drug use during pregnancy is high, data-driven guidelines for their use are sparse. This presentation will review the existing data regarding the impact of an untreated psychiatric illness on the infant's development. In addition, reproductive safety data of psychiatric medications, including antidepressants, mood stabilizers, antipsychotics, and benzodiazepines, will be critically discussed. The focus of the presentation will be a delineation of areas where there is a question regarding "safest" or "best practice" use of these compounds during pregnancy. The ultimate goal is to refine treatment guidelines and then reduce the exposure both to the illness and to the potential teratogenic effects of the treatment. Therefore, clinicians should seek a treatment strategy that poses the least risk for both mother and infant.

No. 16B
PSYCHIATRIC CHARACTERISTICS OF BINGE EATING DISORDER IN OBESE WOMEN

Jose C. Appolinario, M.D., *Department of Psychiatry, University of Rio de Janeiro, Visconde de Piraja 550 CJ 2002, Rio De Janeiro, RJ 22410-001, Brazil*

SUMMARY:

Binge eating disorder (BED) is a very common clinical condition among obese individuals presenting for weight loss treatment and occurs more frequently in women than men (65% female, 35% male). Compared with non-bingeing subjects, BED obese patients commonly report associated eating psychopathology as well as greater frequency of psychiatric comorbid conditions including depression and anxiety. It has been suggested that the clinical recognition of this eating disturbed behavior could facilitate therapeutic management of obesity.

This presentation will critically review associations between dieting, eating behavior, weight loss treatment, weight cycling, body image, and psychiatric morbidity in overweight and obese women. We will also present findings on a Brazilian group of obese women seeking treatment for weight loss. Patients fulfilling DSM-IV criteria for BED (n=32) with a body mass index (BMI)= 35.4 (±3.5) were compared with patients without BED (n=33) but with similar BMI= 36.1 (±3.2). Subjects with BED had higher scores in Binge Eating Scale (p=0.001), reported significant depressive symptoms assessed by Beck Depression Inventory (p=0.001) and were more likely to have a current diagnosis (p=0.03) and a lifetime history of major depressive disorder (p=0.02) when compared with those without BED.

We will discuss the clinical implications of the presence of BED and the associated psychiatric comorbidity for the treatment of obesity in this subgroup of patients.

No. 16C
GENDER AND ADDICTION: WHAT IS NEW?

Monica L. Zilberman, Ph.D., *Addicton Center, University of Calgary, 1403 29th Street NW, Calgary, AB T2N 2T9, Canada*; Hermano Tavares, Ph.D., Nady El-Guebaly, M.D.

SUMMARY:

Substance-related disorders are considered a motive of growing health concern for women in different parts of the world. Male-to-female ratios of prevalence estimates have been narrowing due to a stronger drop in the age of onset of substance use among women, as compared with men. The literature on gender differences in these issues has increased over the past 25 years, documenting a variety of interesting but sometimes contradictory aspects, which could have significant prevention and treatment implications. Changes in women's social role likely influenced the gender gap in substance use. Existing data indicate that women present greater vulnerability to substance effects, with more severe medical consequences, faster development of dependence, and more frequent psychiatric comorbidity. However, important knowledge gaps remain, such as the specific features of subgroups of women (adolescents, elderly women, minority women, dual-diagnosed women, lesbians, and poly-substance users, among others). Moreover, although the importance of craving episodes in relapse to substance use has been recognized, gender has not been systematically taken into account in the available research to date. At last, treatment strategies will be discussed with particular reference to matching to specific subgroups of female substance users.

No. 16D
IMPACT OF ESTROGEN AND OTHER SEXUAL HORMONES ON MOOD DISTURBANCES

Claudio N. Soares, M.D., *Department of Psychiatry, MGH Center for Women's Health, 15 Parkman Street, WACC 812, Boston, MA 02114;* Jennifer Poitras, B.A., Jennifer Prouty, R.N.C., Lee S. Cohen, M.D.

SUMMARY:

Preliminary research suggested that estrogen replacement therapy may improve depressive symptoms for some perimenopausal and postmenopausal women, but these data were limited by methodological problems. More recently, two double-blind estradiol (E2) studies demonstrate efficacy for the treatment of clinically significant major and minor depression in perimenopausal women when compared with placebo. Of note, partial or full remission of depression was observed in more than 70% of women treated with E2. This presentation will review data available on the effect of estrogen replacement (as a monotherapy or augmenting treatment) on mood in perimenopausal and postmenopausal women. The lecture will focus on the potential actions of estrogen in the central nervous system (CNS), particularly the interaction between estrogen and some monoamine-mediated systems, and how hormonal interventions\fluctuations may alter these systems. Additionally, we will emphasize that women are differentially sensitive to the effects of gonadal steroids, and therefore hormone changes may result in dramatically different effects in different individuals. Lastly, existing data on the effects of testosterone and dehydroepiandrosterone (DHEAS) on mood disorders will be critically reviewed.

No. 16E
ESTROGENS AND ALZHEIMER'S DISEASE IN ELDERLY WOMEN

Monica Z. Scalco, M.D., *Department of Psychiatry, University of Toronto, 3560 Bathurst Street, BCGC Room 4W07, Toronto, ON M6A 2E1, Canada;* Robert Van Reekum, M.D.

SUMMARY:

An estimated 15% of older women will develop Alzheimer's disease (AD) during their lifetimes, with a prevalence that is double that of men. Estrogen has important effects over CNS activity. It appears to affect the pathogenesis of AD through its actions on neurotransmitters, nerve growth, synapse morphology, neuromodulin, amyloid precursor protein solubility, glucose metabolism, cerebral blood flow, and as antioxidants. Estrogen also has effects on cognition. It has been shown to enhance learning and prevent the deterioration of short- and long-term memory that occurs with normal aging in peri- and post-menopausal women. A number of studies have examined the role of estrogens in preventing AD. Accumulating evidence indicates that use of estrogen after menopause is associated with a lower incidence of AD. It also may exert influence on the development of dementia by reducing the risk of cardiovascular disease. There is also preliminary evidence from trials that estrogens may enhance cognitive function in AD patients, and may potentiate other antidementia drugs. The role of estrogens in the prevention and treatment of AD has not been established conclusively and final results of two ongoing randomized trials of estrogen replacement therapy for preventing dementia will be very helpful.

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SYMPOSIUM 17—PRACTICING PSYCHIATRY IN 2002

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the main external factors that affect the clinical practice of psychiatry today, the principles and strategies that lead to successfully navigate through current obstacles, and the strategies necessary to survive and thrive.

No. 17A
THE MINNESOTA PHYSICIAN-PATIENT ALLIANCE

Lee H. Beecher, M.D., *Creekside Professional Building, 6600 Excelsior Boulevard, Suite 121, Saint Louis Park, MN 55426*

SUMMARY:

The only way to change the present inequities and discriminations for psychiatric patients and other patients negatively impacted by managed care, as well as the physicians who serve them, is through aggressive public education and citizen political action. MPPA is a group of over 800 physicians of all specialties and citizens (patients) who feel disenfranchised by employer and government funded managed care. MPPA has been very successful in Minnesota exposing managed care physician risk sharing, administrative costs in HMOs, and arbitrary corporate medical necessity utilization review practices. MPPA physician members effectively work within the Minnesota Medical Association and Minnesota Psychiatric Society (APA District Branch), and have supported the actions of Minnesota Attorney General Mike Hatch in his suit against BCBSM for denying necessary psychiatric care to Blue Cross enrollees (see details of the brief and groundbreaking settlement at <www.ag.state.mn.us>). MPPA is called on to comment in the print and broadcast media because we are not a physician trade organization and present views from the perspective of the patient and practicing physician. We have among us the minds and hands of thoughtful and concerned citizens throughout Minnesota. To learn more about MPPA and to download our 2001 MPPA Report: How Health Plan-physician Contracts Influence Patient Care Quality and Privacy, go to www.physician-patient.org.

MPPA is a model for similar organizations in other jurisdictions. After all, sooner or later we all become patients.

No. 17B
SOLO PRACTICE PSYCHIATRY IN THE COMMUNITY

Thomas W. Dodson, M.D., *2187 SW Main Street, Suite 101, Portland, OR 97205-1123*

SUMMARY:

This presentation will discuss the practical aspects of treating a wide range of patients in the community. It is based on the experiences of a solo private practice general adult psychiatrist who practices in a highly managed care environment. Its goal is to provoke discussion of practical approaches to meeting the mental health care needs of the community and how the future psychiatrist can take a leadership role in a community approach with better outcomes in social and occupational functioning and decreased patient suffering. Detailed and comprehensive computerized Axis I and II diagnostic testing results will be available for over 400 patients. An analysis of comorbid conditions and their frequency will be reported along with generally recognized data from the scientific literature as a comparison group. Specific attention will be given to how to collect and maintain records, which reflect the mental disorders in the community served, and how that information can be utilized to adapt to changing future needs if necessary. This presentation will include a discussion of efficiency and effectiveness of psychiatric treatment, the importance of psychotherapy in the treatment of mental disorders, and the importance of systems of care, which are flexible, individualized, accessible, and consistent with the biopsychosocial model.

No. 17C
BRAIN AND MIND IN CLINICAL PRACTICE

Ronald D. Abramson, M.D., *25 Main Street, Suite 7, Wayland, MA 01778*

SUMMARY:

Psychiatry is the only clinical discipline whose main foci of concern are pathologies of the *mind* and the related underlying *brain.* In addition to the complexities offered by this mind/brain interface, psychiatric treatment also takes place in a social and economic milieu that presents special pressures.

This presentation will present the experience of a successful full-time outpatient private practice of adult psychiatry in a managed care milieu, illustrated by case presentations, integrating psychoanalysis, psychoanalytic psychotherapy, and psychopharmacology in a patient population whose payees are mostly managed care companies, Medi-

care, and Medicaid. The success and the satisfactions derived from this practice are based on the following principles:

1. See a broad range of patients who are paid for by a variety of payees.
2. Be well educated in psychopharmacology, but do not allow oneself to be seduced into reductionistic "medication only" thinking.
3. Be well educated in psychoanalytic psychotherapy, but realize that most patients require medications as well as psychotherapy.
4. Be clear as to goals, the agenda of the patient, and the limitations imposed by what the patient and/or insurance company is willing to pay.

These principles facilitate professional satisfaction in the face of the strains imposed by managed care.

No. 17D
PSYCHIATRY IN THE 21ST CENTURY

Garry M. Vickar, M.D., *Eastern Missouri Psychiatry Society, 1245 Graham Road #506, Florissant, MO 63031-8082*

SUMMARY:

Psychiatry is still a very challenging, exciting profession. Advances in science offer qualitatively better outcomes than they did before, but against that background is the interference from managed care companies and the constraints they impose between doctors and patients. However, to practice good medicine one must balance the advocacy for patients, maintaining their confidentiality, yet attempt to maximize all the benefits that you can offer them. This means doing whatever one has to do to prevent any interference with the doctor-patient relationship by a third party.

The extent of the interference from managed care is such that the payment received by the hospital in which this presenter works is so below cost that there has been very serious consideration to dropping all psychiatric services, which would eliminate general private care to a community of over a million people. Fortunately, the decision was made to keep psychiatric services, and the only justification that allowed administration to make that decision was the hiring of a hospitalist to handle all/most of the inpatient work. The logic behind that was since so many doctors find it a money loser to have inpatient care, they would rather concentrate on outpatient/office services. And yet, for those patients who require inpatient care, a hospitalist can provide that service for those who don't want to admit their own patients. This is a very dramatic change in our community. The impact of that on practices will be discussed in some detail.

Each practice setting offers a uniqueness, but there are some principles in developing and maintaining a good private practice with good referrals, good working relationships with referrals regardless of payer source, and there will be an effort to point out all the practical aspects of private practice. As well, comments will be made about the importance of giving back to the community through community service, speakers' bureaus, and relationships with local medical and psychiatric societies as part of a broader medical involvement. There will be opportunity for questions and answers.

No. 17E
PRACTICING PUBLIC PSYCHIATRY IN THE 21ST CENTURY

Roger Peele, M.D., *Department of Mental Health, Montgomery County, 8002 Lions Crest Way, Gathersburg, MD 20879-5637*

SUMMARY:

As we enter the 21st century, the public psychiatric sector is in disarray. For the past 40 years we have moved from one department of the state government being responsible for the psychiatrically ill to many departments of the state, county, and city government being responsible for some aspect of the care and treatment of the psychiatrically ill. Such fragmentation leaves no agent fully responsible for the broad treatment and social needs of patients. Presently, we are going through a phase in which Medicaid is assuming responsibility for treatment, but that responsibility has been narrowed by managed care.

There are two hopes to reverse the tailspin, both of which must be realized. First, while the use Medicaid had been a series of disasters, it does offer the potential of public psychiatric treatment finally being united within the rest of medicine, ultimately an abolishment of public-private split. Adequate psychiatric treatment within medicine, if ever achieved, however, will be inadequate unless the social supports are also available. The *Olmstead* Supreme Court decision (1999) offers the promise that the state will become responsible for those social resources. While almost no progress has been made to implement *Olmstead* in any state, that remains the key: a state-based social support that effectively and humanly interdigitates with the private practitioner.

No. 17F
GENERAL HOSPITAL PSYCHIATRY FOR THE FUTURE

John C. Urbaitis, M.D., *Department of Psychiatry, Sinai Hospital of Baltimore, 2401 West Belvedere Avenue, Baltimore, MD 21215*

SUMMARY:

Psychiatrists need more than medical skills to practice successfully in general hospitals. As hospitals offer a continuum of psychiatric services, psychiatrists will see some patients for several years and even decades, and they must be mindful of the person, not just the illness. They often need to interact with the patient's family, caretakers and significant others, as well as the patient's other physicians, and possibly others, such as the patient's employer.

Hospital psychiatrists encounter significant frustrations in dealing with hospital and government bureaucracies, managed care organizations, and other limiting agencies. To survive and thrive, they need to hone their own skills, continue their education, interact with colleagues, and assure themselves of the opportunity to see patients with a variety of disorders, and to take on a variety of assignments.

Outside sources of support include peers in the community and on the Internet. Because of their familiarity with organizational settings, hospital psychiatrists often can advocate effectively for changes that benefit their patients from within the system. They can participate actively in medical societies and serve as consultants to public advocacy groups, and governmental and private agencies. Teaching provides another source of personal satisfaction and collegiality.

No. 17G
PRACTICING PSYCHIATRY TODAY WITH ENJOYMENT AND INTEGRITY DESPITE MANAGED CARE

Brian Crowley, M.D., *5225 Connecticut Avenue, NW, Suite 215, Washington, DC 20015*

SUMMARY:

At our general hospital (Suburban Hospital, Bethesda) the practice of inpatient psychiatry would be next to impossible without being in several managed care panels. The doctor would not get paid, and in many cases neither would the hospital.

Once in, those same managed care plans refer patients to me in the office, more of them than I could possibly see. Many of these prospective patients are really very desireable, high quality candidates for my particular practice of psychodynamic psychiatry. I

describe my typical office visit as "psychotherapy with or without SSRIs," and it lasts 45 minutes. I hardly ever do "15-minute med checks," and avoid the "split treatment" model unless I know and work closely with the psychotherapist. If a managed care plan won't cover my office service, or pays too badly, I and they gradually part company. I also have some full paying patients with out-of-plan good insurance policies or who self pay, and would like more of those.

I enjoy a gradually increasing amount of private forensic practice, mostly civil but some criminal, with a nice hourly fee of which Managed Care has, thus far, not found a way to steal 30 or 50%.

My public sector work, in DOD's Deployment Health Clinical Center at Walter Reed, is interesting, salaried, and hence resistent to the depradations of managed care. I believe that managed care is the worst disaster ever to befall American psychiatry. I think it deprives patients of their right to adequate treatment, and is a legalized form of theft.

And of course my part-time medical school teaching and serving APA as chair of the Guttmacher Award Board are unpaid voluntary activities, stimulating and rewarding. All in all, while things could be better, I'm much enjoying the practice of psychiatry in 2001–2002.

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SYMPOSIUM 18—LOVE FROM PATHOLOGY TO NORMALITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the role love plays as universal; diagnose cultural restrictions of a free choice; evaluate perverse aspects of personality; interpret love-transference and transference-love; understand the relevance of love for psychiatric assessment.

No. 18A
CHANGE OF HEART BETWEEN ATTACHMENT NETWORK AND ROMANTIC LOVE IN ARRANGED MARRIAGES

Danielle Groleau, Ph.D., *Department of Psychiatry, McGill-Jewish Hospital, 4333 Cote Sainte Catherine, Montreal, QC H3T 1E4, Canada*

SUMMARY:

The Cultural Consultation Service (CCS) at the Sir. Mortimer B. Davis-Jewish General Hospital in Mortimer, Québec, was designed and implemented in 1999 to improve accessibility and cultural appropriateness of regional mental health services. Populations targeted by the service included immigrants, refugees, ethnocultural groups, First Nations and Inuit, as well as Aboriginal peoples. A process evaluation research project adopted a participatory approach using participant-observation by the clinical coordinator, a consultant of the service, and a research anthropologist working in close collaboration with the team. A protocol was developed for summarizing case conferences and cultural formulations. Results of the research presented included a typology of cultural formulations produced by the CCS. Many of these cultural formulations were in relation to the traditional practices of arranged marriages being applied in North America. The aim of the presentation is to illustrate how the notion of "attachment networks" introduced by Travecchio (1987), romantic love, collective identity, and safety are useful concepts to produce "cultural formulations" (DSM-IV) as well as clinical recommendations for cases relative to arranged marriages. To illustrate the usefulness of these concepts and to rethink cases implying traditional arranged marriages in the North American context, a specific case will be presented in relation to a young woman from Afghanistan with a spectacular predicament and outcome.

No. 18B
CLINICAL CONSIDERATIONS ABOUT PEDOPHILIA: LOVE, SEX, AND TRANSGRESSIONS

Roland M. Coutanceau, M.D., *Antenne De Psychiatrie Legale, 22 Rue De Chateaudun, La Garenne Colombe 92250, France;* Arnaud Martorell, M.D., Anne Andronikof, Ph.D.

SUMMARY:

Clinical issues let us know that there are different forms of pedophilia (exclusive, preferential, or secondary ones). The rising frequency of the pedophilic drive can be interpreted as a difficulty for the patient to live an adult sexuality, in a modern society that does not accept any longer "rites of passage" like in traditional ones.

Our experience as clinician and expert allows us to consider that the cristalized stable extreme case of a "pervert" pedophile is actually not frequently encountered. Patients with pedophilic behavior often manifest a hypomaniac mood disorder.

The population of potential pedophiles may correspond to various psychic economies and organizations. Beyond all types of caricature, the group of pedophiles does not refer itself to subjects actively agressive. Nevertheless, their actions can often be interpreted as "moral con tricks" (escroquerie morale). These patients often express a very idealized love expectation, as if they were victim of a type of "self-lure".

To contribute to treatment of pedophilia, it is important to adopt an open position, which allows psychiatrists to take their place in the social field and to improve our understanding of the social and situational factors at work.

We observed that a first step, based on group psychotherapy, may motivate the patient to an individual psychotherapy.

Some rare "pervert" pedophiles, do not express sex but use sexuality in a defensive way, that is to say, in order to impose violence (C. Balier). This type of disorder is not an indication for any psychotherapeutic approach.

When a child molester is taken into treatment, what are the main goals for therapy? Is it to deal with pedophilic fantasy in the field of self-eroticism, or is it to try to help the patient to assume his sexuality without transgression of the social and legal regulations and to live an adult sexual relationship?

No. 18C
THE LOVE LIFE OF MELANCHOLICS

Peter D. Kramer, M.D., *Yale Medical School, 236 Hope Street, Providence, RI 02906*

SUMMARY:

The experience of the author as training and supervising analyst at the Columbia University Center for Psychoanalytic Training and Research and as a professor of clinical psychiatry at Columbia University led her to study the concept of transference-love, first described by Freud.

Erotic feelings engendered in the therapy situation may be interpreted in different ways: "inescapable fate," expression of truthfulness, reedition of the original objects of childhood and specific patterns of love-object, as mentioned by S. Freud in the Dynamics of Transference.

We may also interpret love-transference as a resistance to the discovery of unconscious.

The author will stress upon the differences between love attitudes in men and women. In all human beings, love is at the service of narcissism and identity. Both fate and hazard determine love, sometimes against social frame and familial traditions.

Love transference is often dominated by the straitjacket of repetition to an even greater extent than was romantic love. It is the therapist's role to maintain strictly the rule of abstinence and to stand aside, in the background, in order to let the patient find again his or her own love object-representations.

No. 18D
SKIN DEEP: TRANSSEXUALITY, GENDER IDENTITY, AND THE PSYCHOPATHOLOGY OF LOVE

Nancy M. Blake, Ph.D., *University of Illinois, St Mathews, Urbana, IL 61801*

SUMMARY:

In cases of transsexualism, identification to a sex, in the physical sense, is accompanied by a conviction that one is "really" a member of the opposite gender, man or woman. Here, a recognition of anatomical reality is accompanied by a conviction that another reality exists.

In the classical texts devoted to the subject (Stoller et al.), transsexualism is almost exclusively studied as male to female, whereas more recent evidence shows that female to male transitions are now just as often demanded. In the case of the male to female transition, surgery is capable of providing a functioning sexual organ, although reproductive capacity is of course lacking. For the female to male however, sexual function is not an option. What does it mean to have the conviction that the being of a male is compatible with the exclusion of a functioning sexual organ?

For a transsexual to achieve the acting out of sex change, the demand for hormones and surgery has not historically been enough; a narrative has had to be produced, a story which would result in the clinician pronouncing the diagnosis that would permit treatment. This is one example of a medical act that involves the authorization of a psychiatric opinion.

No. 18E
LOVE AS A MIRROR OF HUMAN DISTRESS: A TRANSCULTURAL PERSPECTIVE

Richard Rechtman, M.D., *Department of Psychiatrie, CHS La Verriere, Institut Marcel Riviere Le Mesnil St. Deni 78327, France;* James K. Boehnlein, M.D.

SUMMARY:

According to the French psychoanalyst Jacques Lacan, love is giving to someone else what the giver does not have. Each partner in a relationship wants what they suppose the other has, but at the same time will pretend and act as if they have what the other partner requires. The process of this fictional exchange is like gambling without knowing the rules, and might come to a standstill if one of the partners discovers the hidden truth. The classical image of a peaceful and shared convergence is frequently unlikely, and love is often a highly stressful experience. Cultural meanings always shape the human experience. Love and its suffering remain a universal, cross-cultural standard of human behavior, and frequently link, at least in language, with pathological conditions. Idioms like love pangs, love sickness, love to death, being mad about, nuts about, crazy about, and so on exist in every language, and illustrate how difficult it is to express rationally the stream of love and its pain. Except in specific delusions, like the classical French erotomania, love has not received much psychiatric attention. While usually considered as a stress factor in various disorders such as anxiety and depression, the authors will demonstrate that love also can be understood as a relevant transcultural idiom of distress that is too rarely considered in clinical practice. From a transcultural and anthropological point of view, the authors will underline the different meanings of love, including its painful aspects, as they appear in clinical practice. The aim is to show with clinical material how love is also a paradigmatic metaphor of human suffering that can be identified as an idiom of distress.

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SYMPOSIUM 19—ADOLESCENCE: THE TUMULTUOUS YEARS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the audience will appreciate the complexity of psychopathology that begins during adolescence and the new hope that innovative treatment interventions may bring to clinicians treating young adults.

No. 19A
MEETING THE NEEDS OF STUDENTS EXPOSED TO VIOLENCE THROUGH SCHOOL-BASED PROGRAMS

Bradley D. Stein, M.D., *RAND, 1700 Main Street, Santa Monica, CA 90407;* Sheryl H. Kataoka, M.D., Lisa Jaycox, Ph.D., Marleen Wong, M.S.W., Arlene Fink, Ph.D.

SUMMARY:

Between 20% and 50% of American children are victims of violence, and an even greater number may be traumatized through witnessing violence. For many, these experiences result in the development of psychological symptoms while others develop full disorders such as posttraumatic stress disorder (PTSD) and depression.

The potential of providing mental health (MH) services in schools has long been recognized. Schools are a particularly promising avenue for providing care to disadvantaged children with poor access to MH care and for many have already become the primary providers of MH services. School MH programs can improve access for children traumatized by violence, but these programs' effectiveness has often not been evaluated. A school-based intervention for traumatized Latino immigrant youth, developed collaboratively with school clinicians, will be presented as one model. The challenges in the program's development and evaluation will be discussed, as will preliminary results showing that children who received the intervention

reported significantly fewer symptoms of PTSD and depression as compared with controls. The program demonstrates that culturally sensitive interventions can ameliorate MH problems in Latino immigrant children exposed to violence, and schools have an important role to play in reducing MH symptoms in their students.

No. 19B
ADOLESCENT ALCOHOL AND DRUG ABUSE: CHALLENGES AND TRANSITIONS

Sandra A. Brown, Ph.D., *Department of Psychiatry, UCSD School of Medicine, 9500 Gilman Drive, La Jolla, CA 92093*

SUMMARY:

Adolescent alcohol and other drug involvement are major societal concerns. By high school graduation the vast majority of teens have experimented with alcohol, half will have become regular drinkers, and one-third hazardous drinkers. Early onset of alcohol involvement (prior to age 14) dramatically increases lifetime risk for alcohol dependence, and a number of risk and protective factors have been identified.

Of particular importance are recent findings on the relationship between alcohol abuse and adolescent development. Findings from longitudinal studies of clinical and community samples of adolescent alcohol abusers will be reviewed. In particular, the psychosocial and neurocognitive consequences of protracted alcohol involvement during adolescence will be highlighted. Further, developmental differences in rates and patterns of remission of alcohol abuse will be discussed. Data from multiple community and clinical samples will be used to highlight important clinical issues (e.g., psychiatric comorbidity) and implications for interventions. Recommendations for increasing the developmental sensitivity of interventions for addictive disorders among adolescents will be provided as well as an example of a novel community based intervention.

No. 19C
TREATMENT IMPLICATIONS OF TEEN-ONSET MANIA

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

SUMMARY:

Mania beginning in adolescents may occur in the context of previously good premorbid functioning (''classical''), or may be superimposed on other psychiatric disorders that began in childhood. In the former case, manic or depressive episodes can be severely psychotic and debilitating, but overall prognosis is good. In the latter case, externalizing disorders (attention deficit hyperactivity disorder, oppositional/conduct disorder) are most common prior disorders, but anxiety disorders, and learning and developmental disorders are also common. These comorbidities not only make bipolar disorder more difficult to diagnose and differentiate, but it also becomes more difficult to treat.

The mood stabilizing medications and strategies for their use for either ''classical'' or ''complicated'' youth-onset mania follow the same as algorithms used in adults. However, the necessity of using strategies for the comorbid disorder, and for the attendant psychosocial difficulties are different. In ''complicated'' bipolar disorder, one is targeting aggression, problems with executive function, and family and educational factors much more so than in classical bipolar disorder. This presentation will describe these differences.

No. 19D
DIAGNOSIS AND TREATMENT OF DYSTHYMIA AND DOUBLE DEPRESSION

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

SUMMARY:

Dysthymic disorder typically has an age of onset before the age of 20. The purpose of this paper is to discuss diagnostic issues in the recognition of dysthymic disorder among adolescents. Dysthymic disorder is frequently complicated by major depressive episodes—so-called double depression. Thus, both disorders are likely to occur among adolescents. The treatment principles for dysthymia and double depression among adolescents involve similar treatment principles as those among adult patients, namely high doses of medication and long periods of treatment are required in order to provide an opportunity for sustained remission. Psychotherapy may be a very important component of the treatment of dysthymia among adolescents, as is education regarding the nature and course of this disorder.

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2. Brown SA, D'Amico EJ, McCarthy D, Tapert SF: Four year outcomes from adolescent alcohol and drug treatment. Journal of Studies on Alcohol, in press.
3. Carlson GA, Bromet EJ, Lavelle J: Medication treatment in adolescents vs adults with psychotic mania. J Child and Adolescent Psychopharmacology 1999; 9:221–231.
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SYMPOSIUM 20—IS THERE A BIPOLAR SPECTRUM?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the evidence for and against the validity of the concept of the bipolar spectrum, and understand the clinical relevance of this subject.

No. 20A
THE VALIDITY OF THE BIPOLAR SPECTRUM

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

SUMMARY:

Kraepelin had envisaged a broad concept of manio-depressive illness that included recurrent depressions. The unipolar-bipolar dichotomy restricted the territory of manic-depression to strictly defined bipolar disorder with mania (bipolar I). Research over the past three decades has shown that bipolarity extends into the severe psychotic domain, as well as into the interface between bipolarity and unipolarity. At the severe end of the spectrum, familial-genetic and course parameters support the extension of bipolar disorder into ''schizo-bipolar.'' At the ''softer end,'' bipolar II, III, and IV have been described. The latter are distinguished from bipolar [by excited periods that are non-psychotic and brief; and sometimes adaptive (hypomania as short as two days), could be occasioned by antidepressants, or constitute temperamental characteristics along cyclothymic and hyperthymic lines. The clinical and familial data in support for

extending the bipolar spectrum have come from U.S. and European centers and community studies. The broadened clinical spectrum does not necessarily imply genetic homogeneiry; indirect evidence supports underlying polygenic or oligogenic inheritance. Finally, the broad spectrum has important therapeutic and public health significance in terms of early intervention and extending the benefit of mood stabilizers to conditions that might otherwise be diagnosed "unipolar" or "impulse control disorders."

No. 20B
PREDICTORS OF UNIPOLAR TO BIPOLAR CONVERSION IN AFFECTIVE DISORDERS

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney-NY Presbyterian Hospital, 525 East 68th Street, New York, NY 10021*

SUMMARY:

Although many bipolar patients present initially with depression, previous studies have estimated that only about 10% of depressed patients eventually manifest a bipolar course of illness. More recent studies, prospectively assessing manias and hypomanias beginning with early, young depressed patients, have revised this estimate to approximately 30% to 40%. Because treatment, prognosis, and longitudinal course differ between unipolar and bipolar disorders, efforts to identify predictors of a bipolar diathesis among ostensibly depressed patients has become a critical focus of clinical investigation.

This presentation will examine data from the current literature along with findings from the Cornell Bipolar Research Program on clinical factors associated with the emergence of mania or hypomania among originally depressed individuals. Early (childhood or adolescent) onset, psychosis, temperamental features, and a bipolar family history may demarcate a high risk subgroup. In addition, manias evoked by sleep deprivation, other circadian dysrhythmias, as well as past psychoactive substance abuse may further predispose vulnerable groups to mood destabilization and cyclicity. The degree to which manias secondary to antidepressants constitute an intrinsic form of bipolar illness will be further considered along with concepts about highly recurrent depressions as a potential forerunner to polarity conversions.

No. 20C
THE BIPOLAR SPECTRUM: THE CLINICIAN'S VIEW

Jacob J. Katzow, M.D., *Department of Psychiatry, George Washington University, 3 Washington Circle NW, Suite 406, Washington, DC 20037-2356*

SUMMARY:

The diagnostic approaches in DSM-III/IV focus completely on polarity: bipolar disorder, which is diagnosed when mood elevation is present, is placed in the diagnostic schema in such a way as to imply it is a totally separate illness. The relationship between bipolar and highly recurrent forms of unipolar depression cannot be conceptualized within the current schema. Phenomenologic studies dating to Kraepelin have put primary emphasis on course of illness, with cycling considered as important as polarity; thus, cases of recurrent depression may be more likely to have treatment responses similar to bipolar disorder. We will discuss some of the major clues to possible bipolarity in patients presenting with mainly depressive symptoms. Some of these clues include antidepressant-induced mania or hypomania, recurrent major depressive episodes, early age of onset of major depressive episodes, and family history of bipolar disorder in a first-degree relative.

No. 20D
CRITICISM OF THE BIPOLAR SPECTRUM AS A CONCEPT

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

The bipolar spectrum is a concept that has many critics. While empirical evidence against it is limited, in this lecture, I will present some of the criticisms that have been presented. A major critique of the concept of the bipolar spectrum is that it extends the diagnostic boundaries so far that the authentic valid disease entity of bipolar disorder is put at risk of being watered down. This may adversely affect research and knowledge about bipolar disorder, especially in genetics. It has also been suggested that recent increasing interest in the bipolar spectrum reflects nonscientific fads in psychiatry, such as previous overdiagnosis of schizophrenia. This cultural/social component of psychiatric diagnosis should not be ignored. It has also been proposed that many patients diagnosed with bipolar disorder receive that diagnosis based on vague "mood swings," while the accurate diagnosis may be borderline personality disorder or other conditions. In this presentation, I will present these viewpoints clearly, and critique them based on available evidence. The limitations of the bipolar spectrum concept are as important as its strengths.

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3. Ghaemi SN, Ko JY, Goodwin FK: The bipolar spectrum and the antidepressant view of the world. Journal of Psychiatric Practice 2001;7.
4. Baldessarini RJ: A plea for the integrity of the bipolar disorder concept. Bipolar Disorders 2000; 2:3–7.

SYMPOSIUM 21—UPDATE ON TREATMENT OF STIMULANT ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize stimulant abuse in patients, diagnose its common psychiatric comorbidities, and treat it effectively using both psychosocial and pharmacologic modalities.

No. 21A
RECOVERY-ORIENTED PSYCHOSOCIAL TREATMENTS

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854;* Jonathan Krejci, Ph.D., Marc Steinberg, M.A., Jill Williams, M.D., Sylvia Atdjian, Jeffrey A. Berman, M.D.

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 including the Matrix/Neurobehavioral Model of Stimulant Treatment and the Pavillon/Integrated Model for Recovery. Participants will learn about resources and training materials on psychosocial treatments for stimulant and other addictions.

No. 21B
THERAPY AND PLACEMENT APPROACHES FOR COCAINE-ABUSE TREATMENT

David R. Gastfriend, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114;* Estee Sharon, Psy.D., Sandrine Pirard, M.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. 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. 21C
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, but not yet rigorously evaluated, include the selective MAO inhibitor selegiline, anticonvulsants such as phenytoin and vigabatrine, and disulfiram (which may act 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 muopiate agonist, has shown promise in the treatment of such patients.

No. 21D
PSYCHIATRIC COMORBIDITY IN STIMULANT ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Saint Luke's Roosevelt, 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 the dually diagnosed after reviewing important epidemiologic and diagnostic issues specific to this population. Stimulant abusers often present for treatment with complaints of psychiatric symptoms, especially depression and anxiety. In addition, stimulants are known to directly cause psychotic symptoms as well as a variety of mood and anxiety symptoms, and as such, diagnosis of non-substance-related (NSR) mental disorders in this group is not straightforward. Yet, it is important to accurately elucidate the present diagnoses in order to provide the most specific and effective treatments. New approaches to behavioral treatment of stimulant abusers with differing NSR psychiatric diagnoses such as schizophrenia, mood disorders, and PTSD will be presented, with information on how traditional addiction approaches have been effectively modified for the mentally ill. In addition, novel pharmacotherapeutic strategies that have been developed for stimulant abusers with differing comorbidity will be reviewed.

No. 21E
METHAMPHETAMINE ABUSE: 2002 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. Relatively little work to date has been done to find medical treatments of methamphetamine abuse and there are no established, effective pharmacotherapies, although a number of medications are theoretically plausible to utilize, and medication 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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1. Ziedonis D, Krejci J, Atdjian J: Integrated treatment of alcohol, tobacco and other drug addictions, in Integrated Treatment of Psychiatric Disorders. Edited by Kay J. Washington DC, APPI, 2001.
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3. Gorelick DA: Pharmacologic therapies for cocaine and other stimulant addiction, in Principles of Addiction Medicine, 2nd edition. Edited by Graham AW, Schultz TK. Chevy Chase, MD, American Society of Addiction Medicine, 1998, pp. 531–544.
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SYMPOSIUM 22—NEW FRONTIERS IN THE NEUROENDOCRINOLOGY OF AFFECTIVE DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize various neuroendocrine aspects of affective disorders and update his/her knowledge of the newest findings in the neuroendocrinology of mood disorders.

No. 22A
ASSESSING VULNERABILITY TO DEPRESSION: ROLE OF HPA AXIS DYSFUNCTION

D. Jeffrey Newport, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive NE Suite 4003, Atlanta, GA 30322.*

SUMMARY:

Depressive episodes are often triggered by stressful life events; nevertheless, many individuals tolerate stress of great magnitude or duration without becoming ill. Furthermore, as many as one-half of those who become depressed may not experience a subsequent episode of depression. Tools to identify those at greatest risk for becoming depressed or experiencing a depressive relapse are critical for the successful implementation of psychiatric preventive care. HPA dysfunction has long been viewed as a state phenomenon that arises only during episodes of depression, but recent clinical and preclinical data now indicate that HPA dysfunction may preexist illness in some individuals especially vulnerable to depression. Heritable (genetic) factors coupled with early adverse experiences may precipitate persistent alterations in HPA axis function that convey this vulnerability to illness. Additional evidence indicates that enduring abnormalities in HPA axis function after resolution of a depressive episode may also be indicative a heightened vulnerability to relapse. Future research implications and the potential clinical utility for assessments of HPA axis function in identifying those most vulnerable to depression will be discussed.

No. 22B
GENDER DIFFERENCES IN THYROID INDICES IN DEPRESSION

Mark A. Frye, M.D., *Department of Psychiatry, University of California at Los Angeles, 300 Medical Plaza, Suite 1544, Los Angeles, CA 90095;* George Klee, M.D., Natasha S. Sane, M.D., Teresa Huggins, Ph.D., Lori L. Altshuler, M.D., Michael J. Gitlin, M.D., Robert M. Post, M.D.

SUMMARY:

Prevalence rates of depressive and thyroid illness clearly have shown a female predominance. However, gender differences in thyroid indices in depressive illness have received little systematic study.

Serum and CSF samples were obtained in 52 medication-free depressed patients for thyroid analyses. There was a correlation between severity of depression (as measured by the Hamilton Scale for Depression) and serum FT4, TT4, TT4-CSF, and serum rT3. There was no correlation between depression and T3 or TSH measures. The positive correlation between mood and various thyroid measures of T4 and RT3 were more prominent in the male vs. female patient group.

In a second retrospective study, medical records of 83 patients hospitalized for depression were reviewed to evaluate whether there was a relationship between antidepressant response time as measured by hospital length of stay (HLOS) and admission thyroid data. Controlling for age and date of hospital discharge within the five-year study period, survival regression modeling including gender and each thyroid function revealed a significant interaction between gender and FT4 index (X2=8.30, df=1, p=0.004). Separate gender analyses revealed an inverse relationship between FT4I and HLOS in men (X2=17.78, df=1, p=0.0001), but not women (X2=0.06, p=.81). Similar results were observed when patients who were medication-free at the time of admission were analyzed separately.

Prospective study is encouraged to clarify the significance of thyroid axis "overdrive," potential gender difference, and its treatment implications for depression.

No. 22C
TESTOSTERONE AND DEPRESSION IN MEN: A CLINICAL REVIEW

Stuart N. Seidman, M.D., *Department of Psychiatry, Columbia Presbyterian Medical Center, 1051 Riverside Drive, Unit 98, New York, NY 10032;* Steven P. Roose, M.D.

SUMMARY:

Background: The relationship between the hypothalamic-pituitary-gonadal (HPG) axis and male depressive illness is poorly understood, and the role of exogenous testosterone (T) in antidepressant treatment is unclear, particularly with regard to age-associated hypogonadism.

Objective: The purpose of this review is to describe and organize the data on these relationships, and to present new data.

Method: We reviewed data from all published, English-language studies that have assessed: T secretion in depressed men, the psychiatric effects of T replacement, and the efficacy of androgen treatment for depression. We collected original HPG axis data from: (1) clinical samples of elderly depressed and non-depressed men, (2) a large epidemiological study, and (3) a T replacement study in depressed men.

Results: In some though not all studies, a subgroup of depressed men (particularly older men with dysthymia) have reduced T levels and blunted T secretion while depressed. Exogenous androgen treatment consistently elevates mood, libido, appetite, and energy in hypogonadal men. In open trials, T administration appeared to be an effective antidepressant for certain subgroups of depressed men (e.g., HIV positive, SSRI refractory). However, in a six-week, ran-

domized trial of T vs. placebo in 32 hypogonadal men with MDD, T replacement was indistinguishable from placebo. Finally, an analysis of epidemiological data from 1,000 middle-aged men suggests that there may exist a vulnerable subgroup of men, marked by an androgen receptor polymorphism, who are susceptible to developing depression at low T levels.

Conclusion: There are indications that in some depressed men there is HPG axis disturbance. There is little support for exogenous T as an effective antidepressant treatment, though data are limited.

No. 22D
ESTROGEN USE, MOOD, AND CEREBRAL METABOLISM IN MENOPAUSAL WOMEN

Natalie L. Rasgon, M.D., *Department of Psychiatry, University of California at Los Angeles, 300 Medical Plaza, Suite 1544, Los Angeles, CA 90095-7057;* Gary W. Small, M.D., Prahba Siddarth, Karen Miller, Linda M. Ercoli, Susan Y. Bookheimer, Michael E. Phelps, M.D.

SUMMARY:

Increased vulnerability to mood disorders has been reported during perimenopause. Fluctuating estrogen levels accompany the perimenopausal transition. Thus, estrogen replacement therapy (ERT) has been proposed as a potentially effective treatment for mood disorders occurring during perimenopause. Similarly, low estrogen levels during postmenopause may cause women to be more susceptible to the development of depression. The purpose of this presentation is to review available data on the role of estrogen use in menopause and to discuss results from ongoing studies on ERT use in our center. Effects of ERT were evaluated in three different paradigms: (1) as a single treatment agent in perimenopausal depressed women, (2) as an open-label add-on to fluoxetine in perimenopausal depressed non-responders, and (3) as a placebo-controlled add-on to sertraline in postmenopausal depressed women. In perimenopausal women, ERT was effective both as a single agent and as an adjunct to fluoxetine. In postmenopausal women, those receiving sertraline with ERT improved more rapidly than women receiving sertraline with placebo, suggesting that ERT may play a role in accelerating the antidepressant response in postmenopausal women with major depressive disorder. In addition, we report the findings of estrogen use on cerebral metabolic rates in aging adults. Beneficial effects of ERT on mood and cerebral metabolism in various populations are discussed.

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1. Rasgen NL, Small GW, Siddarth P, Miller K, Ercoli LM, et al: Estrogen use and brain metabolic change in older adults. Psychiatric Research: Neuroimaging 2001; 107:11–18.
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SYMPOSIUM 23—ADDICTIONS: CUTTING EDGE TREATMENTS FOR GAMBLING AND SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should know the best methods, both pharmacologic and behavioral, for treating the major addictions. In addition, the participant will have an understanding of phenomenology of behavioral and substance-induced addictions.

No. 23A
TREATMENT OF COCAINE DEPENDENCE

Adam M. Bisaga, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 66, 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 the most studied, have yielded inconsistent results. Dopaminergic medications such as pergolide, flupenthixol, amantadine, and bromocriptine have also not been consistently successful. More recently, a dopamine D1 agonist, as opposed to a dopamine D1 antagonist, has shown promise. Other research foci have included NMDA antagonists, the partial opioid agonist buprenorphine, and anticonvulsants such as carbamazepine. A current area of interest is the inhibitory and excitatory amino acids, with gabapentin showing promise as a cocaine pharmacotherapy. Antibody development after vaccination has been shown, and tests of this active immunization approach are currently under way. Several nonpharmacological treatment approaches are also in use. Relapse prevention, a cognitive-based intervention, has been used successfully in pharmacotherapy trials. A behavioral therapy, contingency contracting, used in conjunction with community-based reinforcement is the only nonpharmacological treatment that has been shown to be effective in controlled trials. Although no single treatment is currently suggested, promising approaches will be discussed and new interventions described.

No. 23B
TREATMENT OF HEROIN DEPENDENCE

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032*

SUMMARY:

The increasing number of heroin addicts, secondary to the drug's increased purity and decreased price, has heightened the need to develop improved medications. 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, major difficulty in withdrawal and, with LAAM, increased risk of Torsade de Pointes. The antagonist naltrexone, while blocking heroin use and decreasing alcohol abuse, has low rates of acceptance by addicts and high dropout rates. The partial agonist buprenorphine may have the advantages of these three agents but with much 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. The alpha-adrenergic agonist lofexidine may have better withdrawal efficacy than clonidine, and potential for treatment of craving. An injectable

form of naltrexone has been shown to block heroin for up to five weeks. New approaches to opiate detoxification, including rapid detoxification either under anesthesia or using buprenorphine and naltrexone, and the use of NMDA antagonists hold out hope for less discomfort and higher completion rates.

No. 23C
MARIJUANA AND CLUB DRUGS: CUTTING-EDGE DEVELOPMENTS, NEW AND POTENTIAL TREATMENTS

David M. McDowell, M.D., *Department of Psychiatry, STARS-NYSPI, 600 West 168th Street, Basement, New York, NY 10032*

SUMMARY:

Marijuana is the most commonly used illicit substance in the United States. In addition the use of "club drugs," in particular MDMA, Ketamine, and GHB, are increasing. Contrary to public perception, club drugs cause real and substantial morbidity and even mortality, and heavy and chronic use of marijuana carries with it substantial morbidity as well as the risk of dependence and withdrawal. These issues have far reaching implications for substance abuse treatment, and psychiatric treatment in the future. Pharmacological interventions for marijuana dependence have included mood stabilizers and medication focused on withdrawal symptoms. Treatment strategies for these conditions have focused on prevention measures and psychosocial interventions. These conditions are not as well studied as other substance abuse conditions. In recent years a great deal of work has been completed concerning the basic mechanisms of actions, pharmacology, and neurophysiology of marijuana and its endogenous ligand, anandamide. Given the increasing knowledge about marijuana, new and potential treatments are being studied, and even more can be theorized. Especially promising are various pharmacological interventions for marijuana specifically, 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. 23D
CUTTING-EDGE TREATMENT OF GAMBLING ADDICTION

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029;* Stefano Pallanti, M.D., Erica Sood, B.A., Nicolo Baldini-Rossi, M.D., Sallie J. Hadley, M.D.

SUMMARY:

Pathological gambling (PG) is a rapidly growing public health problem that shares important features with other addictive disorders, including tolerance and withdrawal. Classified as impulse control disorder, it is frequently comorbid with bipolar spectrum disorders, attention deficit hyperactivity disorder, and substance use disorders. PG may serve as a cleaner biological model of other addictive disorders, since the neurocircuitry and neurotransmitter function abnormalities in PG are unaffected by use of exogenous substances. Recent placebo-controlled trials have documented significant reduction of gambling urges and behavior with the SSR1 fluvoxamine. Placebo-controlled trials with the opiate antagonist naltrexone also demonstrate efficacy in PG. Double-blind, placebo-controlled trials with sustained release lithium demonstrate significant improvement in gambling behavior in the bipolar spectrum PG patient. Studies demonstrate specific abnormalities in serotonin, norepinephrine, and dopamine function in PG patients, and failure to activate orbitofrontal lobes on FDG-PET during gambling tasks while wagering in PG patients. The implications of these neurobiological dysfunctions on treatment response will be highlighted.

No. 23E
TREATMENT OF COMORBID CONDITIONS

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, 640 Pomander Walk, Teaneck, NJ 07666*

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, post-traumatic stress disorder, generalized anxiety and panic disorder, 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.

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4. Hollander, et al: A randomized, double-blind fluvoxamine/placebo crossover trial of pathological gambling. Biol Psychiatry 2000; 47:813–817.
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SYMPOSIUM 24—PSYCHOTHERAPY RESEARCH: CHALLENGES FOR THE 21ST CENTURY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize current developments in psychotherapy research and consider the important clinical issues and research goals for the coming decades to improve patient outcomes and therapeutic efficiency.

No. 24A
PATIENT RESPONSE TO THE BRIEF PSYCHODYNAMIC INVESTIGATION

Jean-Nicolas Despland, M.D., *Department of Psychiatry, La Polclinique Psychiatrique Universitaire, Lausanne 1005, Switzerland;* Yves De Roten

SUMMARY:

A recent trend in psychiatry focuses on how to screen and treat psychiatric patients using a brief investigation format. At the end of the investigation, some patients experience sufficient reduction in distress and other symptoms, and enough insight into their presenting problems to require no further treatment. For other patients, the brief investigation may be sufficient to ascertain the nature and severity of diagnoses and problems in functioning and plan subsequent treatment. The presenter will begin with recent research on the effects of brief psychiatric investigation, including his own research on the Brief Psychodynamic Investigation. He will examine the known relationships between patient characteristics and brief investigation treatment response and then outline issues that require further work. Such a brief investigation and treatment model may have a valuable role to play in practice settings, but better differentiation of responders and those requiring further help will increase its value and lessen the likelihood that serious cases may inadvertently be offered no further treatment.

No. 24B
MATCHING PATIENTS TO THERAPY: A REVIEW OF EMPIRICAL STUDIES OF PSYCHOTHERAPY

Per A. Hoglend, M.D., *Department of Psychiatry, University of Oslo, PO Box 85 Vinderen, Oslo N-319, Norway*

SUMMARY:

One of the reasons for the equivalency of outcomes for different types of psychotherapy may be that different types of patients react differently to different styles of therapy, for example, directive versus non-directive therapies. Research in education has led to some consistent findings of aptitude-treatment interactions in learning. In psychotherapy research, the patient characteristics that have been studied to some extent are general mental abilities (IQ), and personality (externalizer versus internalizer, high versus low quality of interpersonal relationships, psychological mindedness, anaclitic versus introjective features, high versus low motivation, etc). Beyond these, the most researched aspect is severity of psychiatric disturbances. The presentation will give an overview of aptitude-treatment interactions in clinical psychotherapy. It will then look forward to the candidate matching characteristics that should be tested to improve patient outcomes with already existing treatments.

No. 24C
MOVING COGNITIVE THERAPY FROM THE RESEARCH CLINIC TO GENERAL PSYCHIATRIC PRACTICE

Robert J. DeRubeis, Ph.D., *Department of Psychology, University of Pennsylvania, 3815 Walnut Street, Philadelphia, PA 19104-6196*

SUMMARY:

In carefully conducted controlled and comparative studies, cognitive therapy has been shown to be an effective treatment for a wide variety of disorders, rivaling the antidepressant medications in the scope of syndromes and disorders effectively treated by it, and equaling or surpassing medications in short-term benefit across many psychiatric conditions. Moreover, evidence is accruing that the effects of even short-term cognitive therapy may be longer lasting, relative to equally short-term medication treatment, and perhaps even relative to long-term medication treatment. However, little is known about parameters that will affect the widespread use and effectiveness of cognitive therapy outside the typical research setting. Issues that will be discussed, with reference to limited existing literatures, as well as to research efforts that can advance our knowledge, are: (1) considerations of quality of delivery of cognitive therapy, its measurement, and its relation to outcome; (2) optimal dose (number of sessions) and regimen (frequency) of therapy, given that most research has involved brief cognitive therapy; including matching dose and regimen to pre-treatment and in-treatment patient characteristics; (3) the potential place of cognitive therapy in sequencing algorithms; and (4) understanding obstacles to the widespread use of cognitive therapy in general psychiatric practice.

No. 24D
ARE RECOVERY AND HEALTHY FUNCTIONING ACHIEVABLE TREATMENT GOALS FOR AXIS II DISORDERS?

John C. Perry, M.D., *Department of Psychiatry, McGill University and Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, QC H3T 1E4, Canada*

SUMMARY:

The psychotherapy of personality disorders has a surprisingly robust number of empirical studies, yet the median treatment duration is about six months and the longest less than three years. Even with such durations, improvement is the rule with sizable within-patient changes. Yet few studies indicate what proportion of patients recovered or became healthy in functioning. The type and severity of disorder, treatment type, frequency or intensity, duration, and especially the selection of target measures of improvement (symptomatic versus fundamental psychopathology) are issues that together influence outcome. The presentation will review this literature. Considering the findings and limitations of current research together, the presenter will suggest what may be needed to achieve higher treatment goals including recovery from both psychiatric symptoms and disordered personality patterns and the attainment of healthy functioning.

No. 24E
LONG-TERM PSYCHOTHERAPY: CURRENT STATUS AND FUTURE DIRECTIONS

Paul Crits-Christoph, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3535 Market Street, Philadelphia, PA 19382*

SUMMARY:

Although numerous research studies have documented the efficacy of short-term psychotherapies of various types, there remains a relatively large number of patients who do not achieve adequate improvement in short-term therapy and should be considered candidates for long-term therapy. Drawing from the empirical literature on psychotherapy, this presentation addresses the following questions related to long-term therapy: (1) How often is long-term therapy currently delivered as a treatment in the community? (2) What do we currently know about the efficacy of long-term therapy? (3) What are the types of patient problems for which long-term therapy might be indicated? (4) What are the methodological issues involved in conducting research on long-term therapy? We conclude that long-term treatment is indicated for sizable numbers of patients who present with recurrent disorders, chronic distress, and characterological problems. The current service delivery system may be providing inadequate treatment for these patients, leading to increased suffering and increased costs to society through higher usage of other medical

services (including hospitalization), reduced productivity at work, and other indirect costs. Research on long-term therapy, therefore, is an important agenda for the future.

REFERENCES:

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2. Hoglend P, Sorlie T, Heyerdahl O, et al: Brief dynamic psychotherapy: patient suitability, treatment length and outcome. Journal of Psychotherapy Practice and Research 1993; 2:230–241.
3. DeRubeis RJ, Crits-Christoph P: Empirically supported individual and group psychological treatments for adult mental disorders. Journal of Consulting and Clinical Psychology 1998; 66:37–52.
4. Perry JC, Bond M: Empirical studies of psychotherapy for personality disorders in Psychotherapy of Personality Disorders (Review of Psychiatry Series Vol 19 Number 3, Oldham JM & Riba MB (Series Eds). Washington, DC, American Psychiatric Press, 2000, pp 1–31.
5. Crits-Christoph P, Barber JP: Long-term psychotherapy, in Handbook of Psychological Change: Psychotherapy Processes and Practices for the 21st Century. Edited by Snyder CR, Ingram RE. New York, John Wiley and Sons, 2000.

SYMPOSIUM 25—A RESEARCH AGENDA FOR DSM-V

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will (1) acquire knowledge about the current DSM research planning process, and (2) learn about the gaps in the current DSM and recommended strategies for addressing these before DSM-V is developed.

No. 25A
NOMENCLATURE RECOMMENDATIONS

Bruce J. Rounsaville, M.D., *School of Medicine, Yale University, 950 Campbell Avenue (151 D), West Haven, CT 06516;* Renato D. Alarcon, M.D., Gavin Andrews, M.D., James S. Jackson, Ph.D., Robert E. Kendell, M.D., Kenneth S. Kendler, M.D., Laurence J. Kirmayer, M.D.

SUMMARY:

While acknowledging the difficulty inherent in defining mental disorder, this workgroup emphasizes the importance of future research to elucidate the boundary between normality and pathology for DSM-V. Various models for defining illness and disorder and research recommendations that may clarify the implications for each model will be presented.

While the DSM-IV and ICD-10 development processes minimized the problems in cross-cultural applications caused by the manuals' distinct classification systems, continuing differences means improving the compatibility of the DSM-V and ICD-11 remains an area in need of future research. A research agenda is recommended to resolve minor differences. To address major distinctions, developing a strategy to compare the validity and reliability of the constructs within the two classification systems is suggested.

As detection and early intervention for mental disorders increasingly occurs outside of traditional psychiatric settings, additional research should explore ways to make the DSM-V less reliant on clinical judgment, thereby facilitating the diagnostic process in non-psychiatric settings. The workgroup recommends investigating the reliability and validity of using self-reported questionnaires to rate diagnostic criteria as well as exploring the viability of enhancing or substituting the current criteria with medical laboratory procedures or psychometric scales.

No. 25B
NEUROSCIENCE RECOMMENDATIONS

Dennis S. Charney, M.D., *National Institute of Mental Health, National Institute of Health, 9000 Rockville Pike, Building 10, Room 3N212, Bethesda, MD 20892;* David Barlow, Ph.D., Kelly N. Botteron, M.D., Jonathan D. Cohen, M.D., Raquel E. Gur, M.D., Keh-Ming Lin, M.D., Eric J. Nestler, M.D.

SUMMARY:

While research in basic and clinical neuroscience has not yet identified neurobiological phenotypic markers or genes that aid diagnosis or predict treatment response, this workgroup asserts that research should be executed that will assist in developing an etiologically and pathophysiologically based diagnostic system. The workgroup chair will review the current status of the field to show why progress has been limited and provide insights into five areas poised to enhance the knowledge base about the etiology and pathophysiology of psychiatric disorders: animal models, genetics, postmortem investigations, brain imaging, and pharmacogenetics.

The workgroup recommends future genetic research to determine biologically meaningful diagnostic subtypes as one method for obtaining clinically relevant information on etiology, pathophysiology, course, therapeutic response, and outcome that may then be incorporated into the diagnostic system. Studies on pharmacogenetic differences are proposed as a way to define new disease subtypes and assist in the development of individualized treatment plans.

A speculative outline for the future diagnostic system is presented. The outline includes a revision of the Axial system to incorporate such areas as genotype, environmental modifiers, and therapeutics, while acknowledging that the integration of advances in biological and clinical neuroscience into the diagnostic system will prove to be a significant challenge for DSM-V.

No. 25C
DEVELOPMENTAL RECOMMENDATIONS

Daniel Pine, M.D., *National Institute of Mental Health, 900 Rockville Pike, 1-B320, Bethesda, MD 20892;* Margarita Alegria, Ph.D., Edwin H. Cook, Jr., M.D., E. Jane Costello, Ph.D., Ronald E. Dahl, M.D., Mina K. Dulcan, M.D., Doreen S. Koretz, Ph.D.

SUMMARY:

Recent research advances in neuroscience, genetics, psychology, and psychopathology, and epidemiology and services research have increased the knowledge base necessary to enhance and refine psychiatric nosology as it relates to developmental issues. The advances in these specialties frame a proposed research agenda to further improve the classification of developmental psychopathology.

The chair of this workgroup will discuss five key areas of research: neuroscience and genetics, prevention and early intervention, infancy and early childhood, the multi-axial approach, and psychiatric assessment. The workgroup asserts the significance of continuing studies on familial and genetic aspects of developmental psychopathology and recommends analyzing the costs and benefits of incorporating routine surveillance of and early intervention for children's emotional and behavioral health into the practice of pediatric primary care. In discussing the multi-axial system as it pertains specifically to children and adolescents, the recommendations are concentrated on the relative lack of focus on development and the questionable clinical utility of all the Axes compared with Axis I in the DSM. Specific problem

areas that would benefit most from future research are targeted. Other examples of recommendations that will be discussed include research on how to effectively and optimally implement assessment methods and tools in clinical practice.

No. 25D
DISABILITY AND IMPAIRMENT RECOMMENDATIONS

Anthony F. Lehman, M.D., *Department of Psychiatry, University of Maryland at Baltimore, 701 West Pratt Street, Suite 388, Baltimore, MD 21201;* George S. Alexopoulos, M.D., Howard H. Goldman, M.D., Dilip V. Jeste, M.D., Dan Offord, M.D., T. Bedirhan Ustun, M.D.

SUMMARY:

The DSM-IV's inclusion of distress and impairment in the definition of mental disorder and the addition of two axes directly related to disability and impairment in the multiaxial approach represent significant advances. Yet, while the diagnostic process was enhanced by this broadened clinical focus, the coupling of disability and diagnosis also poses many new problems for nosology and treatment. For example, early intervention may be hindered because a diagnosis cannot be rendered unless the disorder produces clinically significant distress or impairment. Furthermore, disability and symptoms may necessitate different treatments. This workgroup recommends research that separately explores the etiology, nature, course, and treatment of both mental disorders and disability. The proposed research agenda suggests studying the inclusion of contextual, environmental, lifespan, and cultural considerations in the assessment of disability and impairment. Other examples of recommendations that will be discussed include the importance of research to examine the validity of measures that assess disability and disease.

No. 25E
CROSS-CULTURAL RECOMMENDATIONS

Renato D. Alarcon, M.D., *Atlanta VA Medical Center, 1670 Clairmont Road, Atlanta, GA 30033;* Margarita Alegria, Ph.D., Carl C. Bell, M.D., James S. Jackson, Ph.D., Laurence J. Kirmayer, M.D., Keh-Ming Lin, M.D., T. Bedirhan Ustun, M.D.

SUMMARY:

This workgroup asserts the need to refine the current diagnostic system to ensure its cross-cultural applicability. Progress made in DSM-IV in cross-cultural issues was limited by not allowing for culture's dynamic nature. A research agenda exploring how to develop a diagnostic system that incorporates cultural considerations in a clinically useful way is presented. The research recommendations are organized according to five main topics: methodological issues, epidemiology, clinical and health services/outcomes, culture and neurobiology, and special topics.

The workgroup chair will present recommendations that clinical description, ethnographic research, epidemiological methods, and experimental methods should be combined into any research program. Additionally, developing reliable and valid culturally standardized assessment instruments should be a priority.

Additionally, the need to investigate the clinical utility of cultural formulation guidelines incorporated into DSM-IV and to examine other ways to incorporate cultural information into the diagnostic and treatment process will be discussed.

The research agenda also calls for including participants with diverse cultural backgrounds in neurobiological research as well as elucidating the mechanisms responsible for the documented ethnic variations in response to different psychotropics.

No. 25F
GAPS IN THE CURRENT SYSTEM: RECOMMENDATIONS

Michael B. First, M.D., *Department of Biometrics, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 60, New York, NY 10032-2603;* Carl C. Bell, M.D., John H. Krystal, M.D., David Reiss, M.D., M. Tracie Shea, Ph.D., Thomas A. Widiger, Ph.D., Katherine L. Wisner, M.D.

SUMMARY:

This workgroup developed research recommendations to inform the future development of the classification of personality disorders, the relationship between Axis I and Axis II disorders, and the exploration of relational problems/disorders. The workgroup suggests investigating the reliability and clinical utility of dimensional models to determine whether clinically important aspects of personality disorders could be adequately represented by dimensional models. Additionally, the workgroup proposes a research agenda to explore whether research on the spectrum model may address some of the current problems with boundaries between Axis I and Axis II disorders.

The workgroup chair will also discuss a research strategy to examine the definition of relational disorders and to determine the clinical utility of adding relational disorders as an Axis I or II classification. Other recommendations that will be discussed include the development of valid and reliable assessment modules for relational disorders that are adaptable to different types of relationships.

REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-IV-TR™), Fourth Edition, 2000.
2. American Psychiatric Association. DSM Sourcebooks, 1997; 1–4.

SYMPOSIUM 26—ACADEMIC AND COMMUNITY MENTAL HEALTH: CAN THIS MARRIAGE BE SAVED?

EDUCATIONAL OBJECTIVES:

At the end of this symposium the participant should understand:

(1) how different mechanisms for financing mental health care relate to the potential for collaboration between academic and community mental health organizations;

(2) how to bridge the differing goals of academic and community mental health organizations in order to strengthen both institutions;

(3) how collaboration can strengthen training and recruitment of psychiatrists and improve the retention of psychiatrists in community mental health settings.

No. 26A
PUBLIC ACADEMIC LIAISON: CAN THIS MARRIAGE BE SAVED?

Anita Everett, M.D., *37 Canterbury Road, Charlottesville, VA 22903*

SUMMARY:

The Psychiatrists in Underserved Areas Program was designed to address the problem of recruitment and retention of psychiatrists in the community mental health system in Virginia. A governor's commission identified the lack of access to psychiatrists as a significant problem in many communities in Virginia. As a result of this, the governor appropriated money for this purpose. Based on the idea that psychiatry residency training programs manufacturer a commod-

ity that the community system needed, a task force was set up, which met several times to design the program. This task force included the chairs of each of the four psychiatric residency training programs, as well as two community psychiatrists and representatives from the Department of Mental Health, Mental Retardation and Substance Abuse Services. Two elements were initially developed. These were: financial subsidy to a third or fourth year psychiatric resident in exchange for a commitment to practice within Virginia in an underserved or rural area, and financial subsidy to identified faculty mentors at each training site in exchange for enhanced teaching for all residents in community and rural mental health. The successes and stresses of this program will be discussed in detail.

No. 26B
HOW DO YOU KEEP THEM DOWN ON THE FARM? TRAINING, RECRUITMENT, AND RETENTION

Barbara M. Rohland, M.D., *Department of Psychiatry, Texas Technical Institute, 1400 Wallace Boulevard, Amarillo, TX 79106*

SUMMARY:

The primary community incentive for the organization of the Iowa Consortium for Mental Health was recruitment of psychiatrists to rural community mental health centers. Members of the consortium included the University of Iowa Department of Psychiatry, the State of Iowa Department of Human Services, the state association of community mental health center directors, and the National Alliance for the Mentally Ill. The domains of collaboration were defined as education (training programs for mental health and state agency staff), clinical service delivery (residency placements in community mental health centers), and research (services research projects that provided data in regard to policy issues). Collaborative efforts on education and training programs were modest, but successful. Focused research studies were also successful although statewide service utilization studies were not possible to limited and non-systematic central data collection. Community-based residency placements were not successfully implemented, but opportunities for resident awareness and involvement in public sector programs increased, and several residents were successfully recruited into community programs following residency. An event that had profound impact on the nature of the collaboration was the statewide implementation of Medicaid managed Care. Incentives for collaboration were altered, motivations for collaborative activities became complicated, and intra-agency relationships that had been strong were eroded. Overall, this collaboration was successful, but not necessarily in the ways originally intended or envisioned. This experience demonstrated the importance for state-agency-academic collaborations to be adaptable in the context of a changing and unpredictable economic and political environment in order to endure and to grow.

No. 26C
UC DAVIS AND SACRAMENTO COUNTY: A SHOTGUN WEDDING TURNED SHARED VISION FOR PUBLIC MENTAL HEALTH

Thomas J. Sullivan, M.S.W., *Sacramento County Department of Mental Health, 7001-A East Parkway, Suite 400, Sacramento, CA 95823;* Jonathan Nevfeld, Ph.D.

SUMMARY:

Collaboration between academic departments of psychiatry and public mental health programs presents great potential for mutual benefit, but is difficult to achieve. We present some factors that have contributed to the successful 10-year "marriage" between the UC Davis Department of Psychiatry and the Sacrament County Division of Mental Health. Currently, there are 15 UCD faculty members and 10 residents who serve in various clinical and administrative roles at county facilities. Although the initial collaboration was something of a "shotgun wedding" brought about by mutual crises in 1989, the partners have successfully forged a shared vision for county mental health that is both progressive and successful. This vision includes a high-quality community psychiatry training program, a primary role for UCD in the provision of medical direction, incorporation of a recovery model throughout county service programs, and ongoing involvement of family and consumer groups. UCD faculty psychiatrists and residents have been integrated into the workforces and budges of existing county mental health programs and facilities. This integration results in improved "team" focus, enhancement of the treatment milieu, greater psychiatrists involvement in the daily administration of county programs, and increased overall quality of care, with only minimal incremental costs to the county.

REFERENCES:

1. Faulkner LR, Eaton JS Jr., Bloom JD, Cutler DL: The CMHC as a setting for residency education. Community Mental Health Journal 1982; 18(1):3–10.
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TUESDAY, MAY 21, 2002

SYMPOSIUM 27—NEW TREATMENT TARGET IN SCHIZOPHRENIA: UPDATE ON SOCIAL ANXIETY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be updated on the comorbidity between social anxiety and schizophrenia, and able to clearly define the clinical dimension of social anxiety, the impact on social disability, the assessment of social phobia in schizophrenics, and co-treatments.

No. 27A
SHYNESS, SOCIABILITY, AND SOCIAL DYSFUNCTION IN SCHIZOPHRENIA

Joel Goldberg, Ph.D., *Department of Psychiatry, McMaster University, 102-350 King Street, East, Hamilton, ON L8N 3Y3, Canada;* La Schmidt, M.D.

SUMMARY:

Recent biodevelopmental models of shyness traits (Schmidt and Fox, 1998, 1999) have proposed that childhood shyness and early sociability troubles may be a precursor to pervasive social dysfunction in adulthood. An important question in testing the vulnerability model is to determine the severity of shyness among adults who

have serious social dysfunction, such as individuals diagnosed with schizophrenia. The Cheek and Buss Shyness and Sociability Scales (Cheek and Buss, 1981) and the Reznick Retrospective Self-Report of Inhibition (Reznick, Hegeman, Kaufman, Woods, and Jacobs, 1992) were administered to 23 schizophrenia outpatients and 23 control subjects matched for age and sex. The results indicated that individuals with schizophrenia showed significantly more shyness ($p < .004$), lower sociability ($p < .02$) and more recollections of childhood social troubles ($p < .007$) compared with the control group. Within the schizophrenia group, both shyness traits ($p < .04$) and limited sociability ($p < .01$) were clearly associated with interpersonal dysfunction, while significant correlations were also found between troubled sociability and negative symptoms ($p < .05$). The findings of shyness traits, impaired sociability, and more recollections of childhood social difficulties among stable outpatients diagnosed with schizophrenia are consistent with predictions based on a biodevelopmental shyness vulnerability model.

No. 27B
COMPARISON AND ASSESSMENT PROCEDURES OF PRIMARY VERSUS COMORBID SOCIAL ANXIETY

Stefano Pallanti, M.D., *Department of Psychiatry, Institute of Neuroscience, Viale Ugo Bassi 1, Firenze 50137, Italy;* Leonardo Quercioli, M.D., Adolfo Pazzagli, Ph.D.

SUMMARY:

Objective: The identification of social anxiety (SA) in schizophrenia (SCH) is difficult. The procedures to detect and assess this comorbid condition are still unexplored. The experiences of social anxious subjects, subjectively extend themselves from the interpersonal sensitivity and active detachment behavior to the passive detachment. On this basis we compared SA patients and schizophrenics with comorbid SA using the most adopted instrument for the assessment of SA.

Method: We compared 24 paranoid schizophrenic patients with comorbid social phobia with 15 patients with social phobia as primary diagnosis. Patients were assessed using SCID-P, SCID-II, SANS and SAPS, SCL90-R Liebowitz Social Anxiety Scale (LSAS), and the Tridimensional Personality Questionnaire (TPQ).

Results: The analysis of LSAS single items, revealed similar profile between the two groups. In SA patients, we found LSAS social anxiety/withdrawal scores and TPQ Harm avoidance subscores positively correlated, LSAS social anxiety/withdrawal and novelty seeking scores negatively correlated. This pattern of correlation was not found in SCH patients with comorbid SA. No significant correlation was found between LSAS scores and SANS and SAPS scores.

Conclusion: Results suggest that the Liebowitz scale could reliably assess SA symptoms in schizophrenic patients.

No. 27C
DETERMINING AND TREATING SOCIAL ANXIETY IN PSYCHOSIS

David Castle, M.D., *Department of Psychiatry, Fremantle Hospital, Alma Street Centre, Fremantle 6160, Australia*

SUMMARY:

It is often erroneously assumed that social anxiety in psychosis is consequent upon or secondary to either positive (eg., persecutory delusions) or negative (eg., apathetic social withdrawal) symptoms of the psychosis itself. In our experience, however, primary social anxiety in psychosis is common but often missed. For example, in a study of patients with psychotic disorders attending a psychiatric living skills program, we found about a third to be experiencing significant social anxiety, which in turn impaired their quality of life and impaired social functioning. Furthermore, the cognitive underpinnings of these symptoms are the same as those in non-psychotic individuals with social phobia (ie., fear of negative evaluation by others); behavioral avoidance of social situations is common, and leads to further marginalization of this patient group. We have developed a successful group-based intervention for the treatment of social anxiety in psychosis; results reveal an enhancement of social functioning, mood, and quality and enjoyment of life. This presentation will outline the studies we have performed so far, and suggest areas for future research.

No. 27D
THE RELATIONSHIP OF SOCIAL ANXIETY TO LEVEL OF FUNCTION OVER TIME IN PATIENTS WITH SCHIZOPHRENIA

Robert G. Stern, M.D., *Department of Psychiatry, UMDNA-RWA Medical School, 189 New Street, New Brunswick, NJ 08901,* Denise Frank, B.A., Suhaila Farook, M.D., Michelle Beyer, B.A.

SUMMARY:

Objectives: The present study tested the hypothesis that in patients with schizophrenia, comorbid anxiety (SA) symptoms have a high prevalence, are stable over time, and have a significant negative impact on the level of functioning of the patients.

Methods: After obtaining informed consent, outpatients meeting DSMHV criteria for schizophrenia or schizoaffective disorder were assessed on the Liebowitz Social Anxiety Scale (LSAS) and on measures of psychosis, depression, level of functioning, and global assessments at two points in time, at least three months apart. In addition, treatment information and demographic data were collected prospectively. Linear regression analysis and student t-tests will be used to assess the correlation between symptom severity and level of functioning using LSAS social anxiety and depression ratings scores demographic and treatment data as covariates.

Results: At the first visit of this ongoing study, schizophrenic and schizoaffective patients were found to have high social anxiety rating scores with more than half of the patients scoring above the empirically-determined cut-off score for social anxiety disorder. Within-subject t-tests will be used to compare social anxiety ratings collected at two different points in time, to assess symptom stability over time. Results will also be presented from two sets of analysis comparing various aspects of functioning between the high and low social anxiety groups among high and low psychosis severity patients.

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3. Halperin S, Nathan P, Drummond P, Castle D: A cognitive-behavioural group based intervention for social anxiety in schizophrenia. Australian & New Zealand Journal of Psychiatry 2000; 34:809–813.
4. Penn, et al: Social anxiety in schizophrenia. Schizophr Res 1994; 11(3):277–284.

SYMPOSIUM 28—PSYCHOTIC SYMPTOMS IN CHRONIC PTSD: PREVALENCE, COMORBIDITY, AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should better understand the potential comorbidity of psychotic symptoms in PTSD and the emerging role of atypical antipsychotics in this population.

No. 28A
PSYCHOTIC FEATURES, ILLNESS SEVERITY, AND ATYPICAL ANTIPSYCHOTICS IN PTSD

Mark B. Hamner, M.D., *Department of Psychiatry, Medical University of South Carolina VAMC, 109 Bee Street, #116A, Charleston, SC 29401;* Christopher B. Frueh, Ph.D., Helen G. Ulmer, M.S.W., George W. Arana, M.D.

SUMMARY:

Psychotic features may be present in up to 40% of patients with chronic combat-associated PTSD. These symptoms include positive symptoms of psychosis that do not necessarily occur only during flashback episodes, e.g. auditory and/or visual hallucinations referable to the trauma. Patients with psychotic features (PTSD-P) may have more severe illness burden as reflected by correlations between PTSD symptom ratings (CAPS) and psychosis ratings (PANSS). In one study, PTSD-P patients had a significant positive correlation between CAPS and PANSS global ratings ($p<0.001$) and between depressive symptom ratings (Hamilton Depression Rating Scale) and PANSS ratings ($p<0.03$), suggesting an interaction between psychotic symptom burden and depression in these patients. In this presentation, we will review prior work investigating and defining psychotic phenomena, illness severity, and associated comorbid disorders including depression in chronic PTSD. We will also present results of two atypical antipsychotic studies in PTSD. One, a controlled study of adjunctive risperidone, investigated the effect of this agent on psychotic features. The other, an open trial of adjunctive quetiapine, investigated the effects of this atypical antipsychotic on core PTSD symptoms.

No. 28B
ADJUNCTIVE RISPERIDONE TREATMENT IN COMBAT VETERANS WITH CHRONIC PTSD

Daniella David, M.D., *Department of Psychiatry, Miami VAMC, 1201 NW 16th Street, Unit 116A12, Miami, FL 33125;* Ludmila Defaria, M.D., Olga M. Lapeyra, M.D., Thomas A. Mellman, M.D.

SUMMARY:

Background: In a recent study of psychotic symptoms in combat veterans with chronic PTSD, 40% reported psychotic symptoms in the preceding six months, which typically reflected combat themes and guilt, were non-bizarre, and were not usually associated with formal thought disorder; they were associated with current major depression, and were more common in minority (black and hispanic) than white veterans. Neuroleptics have been prescribed for treatment-resistant, chronic PTSD with associated psychotic features and agitation, yet little is known about their efficacy in this population. The objectives of this study with the atypical neuroleptic peridone are to preliminarily evaluate its efficacy and to determine its tolerability in refractory PTSD.

Methods: This is a pilot, open-label, 12-week, flexible-dose trial of adjunctive risperidone in male veterans with a primary diagnosis of PTSD, free of alcohol and drugs, medically stable, with only partial response to current psychotropics, as evidenced by symptom persistence and functional impairment. Structured interviews for PTSD (CAPS) and psychosis (PANSS), self-report sleep measures, EKG, and blood tests are obtained at baseline, six, and 12 weeks. Adverse events are assessed every two weeks. Medication efficacy is evaluated by comparing baseline ratings with six- or 12-week ratings by paired t-tests.

Results: Eleven patients completed at least six weeks of the trial to date. Mean age was 53.5 ± 4.6 years, 46% were white, 18% were black, and 36% were hispanic. Mean baseline CAPS was 89.6 ± 8.3 (range 77–100). Comorbidity with a depressive or anxiety disorder was common, and all patients were taking antidepressant, mood stabilizing, and/or anxiolytic medications at stable doses. Ten patients exhibited psychotic symptoms, and mean baseline PANSS was 85.6 ± 16.3 (range 58–115). There was no significant change in total CAPS score, though re-experiencing symptoms improved at a trend level. PANSS scores, and specifically the positive symptom scale, improved significantly ($t=2.5$, $df=10$, $p=.03$ and $t=2.9$, $df=10$, $p=.02$, respectively). Of the sleep variables, the number of nighttime awakenings decreased significantly ($t=2.8$, $df=9$, $p=.02$). No major adverse events occurred. Common side effects were dry mouth, sedation and headaches.

Conclusion: Preliminary results suggests that risperidone as adjunctive treatment in chronic PTSD may have mild to moderate beneficial effects in refractive cases, and is relatively well tolerated.

No. 28C
RACIAL DIFFERENCES IN PSYCHOTIC SYMPTOMS AMONG COMBAT VETERANS WITH PTSD

Christopher B. Frueh, Ph.D., *Department of Psychiatry, VAMC, 109 Bee Street, Charleston, SC 29401;* Mark B. Hamner, M.D., Jason B. Belant, Ph.D., George W. Arana, M.D., Samuel M. Turner, Ph.D., Terence M. Keane, Ph.D.

SUMMARY:

We tested the hypothesis that race may influence clinical presentation and symptomatology in combat veterans with posttraumatic stress disorder (PTSD). African-American and Caucasian veterans were administered the Psychotic Screen Module of the Structured Clinical Interview for DSM, Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and other psychometric measures at a Veterans Affairs outpatient PTSD clinic. Subjects were consecutive referrals who were not matched for level of combat trauma or preexisting trauma; however, there were no group differences in other relevant demographic or diagnostic variables. Significant racial differences, with modest effect sizes, were found on clinician ratings of psychotic symptoms, MMPI-2 scale *6* (paranoia), and a measure of dissociation. No significant differences were found for the MMPI-2 scale *8* (schizophrenia), or on measures that might suggest comorbid depression or anxiety. African Americans with PTSD endorsed more items suggesting positive symptoms of psychosis, without higher rates of primary psychosis, depression, or anxiety than Caucasians.

No. 28D
FAMILIAL AND BIOLOGICAL CHARACTERISTICS OF PSYCHOTIC PTSD

Fredric J. Sautter, Ph.D., *Department of Psychiatry, Tulane University, 1440 Canal Street, New Orleans, LA 70112;* Janet J. Johnson, M.D., Arth Issette, Ph.D., Justin Wiley, Ph.D., John Cornwell, Ph.D., Madeline Uddo, Ph.D., Gina Mire, Ph.D.

SUMMARY:

Objectives: Epidemiological and clinical studies have demonstrated high comorbidity between posttraumatic stress disorder (PTSD) and psychotic symptoms. This series of studies identify the familial and biological characteristics of a homogeneous psychotic PTSD phenotype consisting of cases with primary PTSD and secondary psychotic symptoms.

Method: Three groups were compared for differences in familial psychopathology, CSF catecholamine metabolites, and CSF corticotropin-releasing factor (CRF): PTSD with secondary psychotic symptoms (n=23), nonpsychotic PTSD (n=16), and healthy controls (n=15). Both patients and their first-degree relatives were diagnosed using the SCID and best-estimate procedures.

Results: First-degree relatives of psychotic PTSD patients showed a paucity of familial psychosis (1.1%), and a morbid risk for depression (23.1%) and PTSD (12.8%) that was higher than that evidenced by relatives of healthy controls ($p<.04$). Patients with PTSD and secondary psychotic symptoms showed higher levels of CSF CRF than normal controls ($p<.03$) and a trend toward higher levels of CSF CRF than nonpsychotic PTSD patients. CSF catecholamine assays have not been completed.

Conclusion: These data show that PTSD with secondary psychotic symptoms represents a phenotype that is familially independent of the psychotic disorders, is associated with a family history of depression and PTSD, and is characterized by high levels of CRF and HPA abnormalities.

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SYMPOSIUM 29—NEW DEVELOPMENT IN MEDICATIONS FOR THE TREATMENT OF SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES:

After this symposium, the participant will be able to (1) define the pharmacologic mechanisms employed in a number of new medication options for substance use disorders; (2) relate these mechanisms to potential use in treatment.

No. 29A
OVERVIEW OF MEDICATIONS DEVELOPMENT FOR ALCOHOL AND DRUG DEPENDENCE

Henry R. Kranzler, M.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030-2103*

SUMMARY:

Medications play an increasingly important role in the treatment of substance use disorders. Although the pharmacological treatment of alcohol and drug withdrawal is well established, psychosocial approaches have been the dominant modality for rehabilitation. Efforts to develop and evaluate medications to treat substance dependence have come largely from NIDA and NIAAA. However, recent successes have underscored the commercial potential of such medications and these have generated interest by the pharmaceutical industry. In anticipation of continued growth in the field, this presentation will provide an overview of the preclinical methods that are used to identify compounds with potential clinical utility. The traditional models that use self-administration or place-preference will be described, along with newer pharmacogenetic approaches. The stages of clinical development will also be reviewed and alternatives to the randomized clinical trial will be considered. Specific examples of medications that are FDA approved or that are currently in development for treatment of alcohol and drug dependence will be used to illustrate these methods.

No. 29B
BUPRENORPHINE FOR OPIOID DEPENDENCE

Eric C. Strain, M.D., *Department of Psychiatry, Johns Hopkins University School of Medicine, BPRU, 5510 Nathan Shock Drive, Baltimore, MD 21224-1253*

SUMMARY:

The pharmacological treatment of opioid dependence has primarily occurred in specialty clinics (i.e., methadone treatment programs). Such clinics can be highly effective, but are limited in the geographical regions they serve, often operate at capacity, and have difficulty in expanding. In October 2000 the Controlled Substances Act was amended, allowing office-based treatment of opioid dependence with certain medications. While not specified in the amendment, the primary pharmacological candidate for office-based opioid treatment is buprenorphine. Buprenorphine has an unusual pharmacological profile, reflecting its mu partial agonist and kappa antagonist effects. Since it has poor oral bioavailability, development has focused upon a sublingual tablet. Several clinical trials comparing sublingual buprenorphine with methadone found buprenorphine as effective as moderate-dose methadone. Sublingual buprenorphine could be abused, and a buprenorphine/naloxone product has also been developed. This combination capitalizes upon naloxone's differential bioavailability. When naloxone is taken sublingually, it has poor availability and does not exert an appreciable effect. However, if a combination tablet were dissolved and injected, the naloxone would be expected to precipitate withdrawal. The availability of buprenorphine and buprenorphine/naloxone should provide opportunities to expand treatment capacity for opioid dependence, and integrate substance abuse treatment with other forms of office-based care of patients.

No. 29C
STIMULANT TREATMENT OF COCAINE DEPENDENCE

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, 640 Pomander Walk, Teaneck, NJ 07666*

SUMMARY:

Using the model of methadone maintenance for heroin addiction, there has been a search for medications that might reduce cocaine craving and use by reducing its euphoric effects. One approach has been to use agonist-type medications, such as stimulants, that act by increasing catecholamines intersynaptically. There are some promising preliminary findings with these medications, but there remain concerns regarding the medical safety and potential for abuse of them. What is becoming increasingly clear is that medications designed to treat cocaine abuse may need to target specific subpopulations. One population that may benefit from stimulants is cocaine-dependent patients with attention deficit/hyperactivity disorder (ADHD), a condition characterized by inattention, hyperactivity and impulsivity. Several lines of evidence suggest that adult ADHD and substance abuse may be linked to one another. Adults with ADHD are at greater risk for having a substance use disorder than adults who do not have additional psychopathology. Similarly, adult ADHD is over-represented among substance abusers seeking treatment. Although early open trials with stimulants in cocaine-dependent adults with ADHD appear promising, these studies need to be confirmed by double-blind, placebo-controlled trials. Ongoing work in using stimulants in cocaine-dependent individuals with and without ADHD

and the controversies regarding the use of these agents in cocaine-dependent patients will be discussed.

No. 29D
ONDANSETRON IS EFFECTIVE IN TREATING BIOLOGICAL ALCOHOLISM

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;* Nassima Ait-Daoud, M.D.

SUMMARY:

Method: In a cohort of 321 male and female alcoholics equally divided among early-onset or biological alcoholics (less than 25 years) and late-onset or non-biological alcoholics (greater than 25 years), we studied the effects of ondansetron, a serotonin 3 receptor antagonist, on drinking and craving. Participants received 12 weeks of weekly cognitive-behavioral therapy. The design was a one-week placebo lead-in followed by 11 weeks of double-blind treatment with ondansetron (1, 4, or 16 ug/kg b.i.d.) or placebo. Outcome measures were self-reported drinking, visual analogue scales of craving, and a biochemical marker of alcohol consumption-plasma carbohydrate deficient transferrin (CDT) level.

Results: We previously reported that ondansetron, compared with placebo, was associated with significant decreases in self-reported and the biochemical measure of drinking in early-onset or biological alcoholics. Now, we can report that ondansetron also reduces craving in these individuals. Baseline drinking was a significant predictor of later craving during the study. Craving was also positively correlated with drinking.

Conclusions: Ondansetron reduces drinking, craving, and increases abstinence among alcoholics with a biological disease predisposition.

No. 29E
ANTICONVULSANTS IN SUBSTANCE-USE DISORDERS

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Charleston, SC 29425;* Hugh Myrick, M.D., Robert J. Malcolm, Jr., M.D.

SUMMARY:

Alcohol withdrawal involves an increase in activity in a number of excitatory amino acid neurotransmitter systems, which are impacted by anticonvulsant agents. Additionally, neuronal sensitization or "kindling" has been postulated as one of the processes involved in repeated alcohol withdrawal. Several anticonvulsant agents have demonstrated efficacy in the treatment of alcohol withdrawal. Data from trials using carbamazepine and valproic acid in the treatment of alcohol withdrawal will be presented. Data from preliminary studies exploring the use of newer anticonvulsant agents, such as gabapentin, also will be presented. Preliminary data concerning the use of anticonvulsant agents to prevent relapse and in the treatment of "protracted abstinence" symptoms will also be presented.

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SYMPOSIUM 30—HYPERAROUSAL AND BPD: NEW STUDIES ON ORIGINS, IMAGING, TAXONOMY, AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the pathophysiological significance of affective dysregulation to BPD.

No. 30A
CONSTRUCT VALIDITY OF BPD

Carlos M. Grilo, Ph.D., *Department of Psychiatry, Yale Psychiatric Institute, 301 Cedar Street, PO Box 208038, New Haven, CT 06520-8098;* Charles A. Sanislow, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objective: To report on selected aspects of the construct validity of the borderline personality disorder (BPD) and criteria sets.

Method: Selected psychometric analyses of BPD criteria that speak to convergent validity, discriminant validity, and factor structure will be presented. Analyses will be presented using data obtained for three different study groups (N = 141 adult inpatients; N = 668 mixed in-/outpatient group; N = 100 monolingual Hispanic outpatients). The three study groups were assessed with reliably administered semistructured diagnostic interviews for personality disorders.

Results: BPD criteria demonstrated adequate internal consistency and good discriminant validity (BPD criteria correlated more highly with each other than with criteria for other PD). Exploratory factor analysis revealed three factors (affective dysregulation, disturbed relatedness, behavioral dysregulation) accounting for 57% of the variance. The three-factor structure of BPD was replicated using confirmatory factor analysis in a separate patient group (N = 668).

Conclusion: These data support the construct validity of BPD criteria. The three-factor model of BPD has potential to articulate core dimensions of psychopathology for studies of taxonomy, biological correlates, and treatment.

No. 30B
BORDERLINE SYMPTOMS IN MALTREATED CHILDREN

Joan Kaufman, Ph.D., *Department of Psychiatry, Yale University, 100 York Street, University Towers, New Haven, CT 06511;* Deborah S. Lipschitz, M.D., Seth R. Axelrod, Ph.D., Steven M. Southwick, M.D.

SUMMARY:

Objective: Retrospective studies estimate rates of child maltreatment are approximately 90% among patients with borderline personality disorder (Zanarini et al., 2000). However, there have been no prospective longitudinal investigations conducted to examine this link (Paris, 1997). The goal of the current study is to assess borderline symptomatology in a representative sample of children

removed from their parents' care due to allegations of abuse and/or neglect.

Method: As part of a larger investigation evaluating a new initiative for children who enter out-of-home care, 40 maltreated and 40 demographically matched control children between the ages of 5 and 13 were recruited. Trauma history, clinical symptomatology, family psychopathology, attachment relations, and child temperament assessments were obtained. The majority of the child data for this project was collected in a day camp setting established this summer for research purposes, replicating a methodology used in prior investigations.

Results: Rates of borderline personality disorder, prevalence of borderline symptoms, and other psychiatric diagnoses will be presented, together with predictors of borderline pathology.

Conclusions: The preliminary baseline assessments, the ongoing enrichment of this sample, and the longitudinal follow-up of the cohort will provide valuable information about the link between experiences of child maltreatment and borderline symptomatology.

No. 30C
EXPLORING THE PHENOMENOLOGICAL INTERFACE OF BPD AND PTSD

Seth R. Axelrod, Ph.D., *NC-PTSD, Veterans Administration Medical Center, 950 Campbell Avenue, Suite 151E, West Haven, CT 06516;* Carlos M. Grilo, Ph.D., Charles A. Sanislow, Ph.D., Deborah S. Lipschitz, M.D., Thomas H. McGlashan, M.D., Steven M. Southwick, M.D.

SUMMARY:

Objective: Several theoretical models have linked PTSD and BPD (e.g., Gunderson & Sabo, 1993; Herman, 1992; Southwick et al., 1993). Proposed relationships in the phenomenology of these disorders were empirically evaluated. Specifically, BPD was anticipated to primarily involve PTSD avoidance and hyperarousal.

Method: Associations between the three components of PTSD (intrusive recollections, avoidance, and hyperarousal) and borderline personality were examined in two clinical samples. PTSD and BPD were assessed in 111 male Vietnam veterans enrolled in an intensive PTSD inpatient program, and in 100 male and female adolescent psychiatric inpatients.

Results: BPD was found to be primarily associated with PTSD avoidance in male Vietnam veterans, and with PTSD hyperarousal in adolescent psychiatric inpatients.

Conclusions: The phenomenology of BPD and PTSD appear to be associated in ways that support previous conceptualizations. However, there may be a developmental progression in the relationships of these disorders, with different aspects of PTSD becoming more strongly associated with BPD at different stages of development. Clinical implications of these relationships are discussed.

No. 30D
NEURAL SUBSTRATES OF AFFECTIVE DYSREGULATION IN BPD

Nelson H. Donegan, Ph.D., *Department of Psychiatry, Yale University, PO Box 205602 Yale Station, New Haven, CT 06520;* Charles A. Sanislow, Ph.D., Robert K. Fulbright, M.D., John C. Gore, Ph.D., Pawel Skudlarski, Ph.D., Thomas H. McGlashan, M.D., Bruce E. Wexler, M.D.

SUMMARY:

Objective: To better understand the neuropathophysiology of affective dysregulation in BPD using emotional perturbation procedures during fMRI.

Method: The Ekman and Friesen standardized picture series of emotional facial expressions (fearful, sad, happy, neutral) was presented in eight counterbalanced runs to BPD subjects (n=10) and healthy controls (n=10) during fMRI. Activity response from 20-second blocks to faces displaying the four emotions was contrasted with a fixation point (threshold for activity was set at $p < .05$). Region of Interest (ROI) analyses were performed using ANOVAs and planned contrasts (two tailed).

Results: Compared with healthy controls, BPD subjects evidenced greater levels of left amygdala activation to facial expressions of negative emotion ($p < .001$). In ROI contrasts, BPD subjects demonstrated significantly more left amygdala activation to fearful ($p < .01$), sad ($p < .002$), and neutral ($p < .002$) faces, but not to happy faces ($p = .2$).

Conclusion: Given the amygdala's role in the perception and expression of emotional states, greater excitability demonstrated in BPD individuals begins to elucidate neuropathophysiology of emotional vulnerability for BPD. Interestingly, BPD subjects responded strongly to neutral faces for which the emotional expressions are ambiguous. Debriefing reports suggested that BPD subjects were troubled by the ambiguity.

No. 30E
REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION FOR BPD

Adrian Preda, M.D., *Department of Psychiatry, Yale Medical School, PO Box 208098, New Haven, CT 06520-8098;* Ralph E. Hoffman, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

Repetitive transcranial magnetic stimulation (rTMS) has been studied for the treatment of depression and auditory hallucinations. High frequency rTMS can stimulate and low frequency (lf)rTMS can inhibit the excitability of targeted areas. We used (lf)rTMS to decrease cortical excitability, presumably hyperactive in patients with borderline personality disorder (BPD). Seven patients received (lf)rTMS of the left prefrontal cortex (double-blind, crossover design). Effects were evaluated through a composite scale reflecting the most severe symptoms. Three patients were initially randomized to active. One patient improved during active and continued to improve during sham. One patient improved during active, but discontinued due to side effects. The last one, despite improvement in scores, became unsafe and required hospitalization. Four patients were randomized to sham first. One patient improved during the sham and remained improved during active. One patient became more symptomatic during the sham, then improved during the active. Two patients had similar responses to sham versus active. From the commonly described rTMS side effects (headaches, local tingling, cognitive impairments) one patient experienced headaches. All others tolerated the procedure well. We conclude that (lf)rTMS is a safe intervention for patients with BPD. Further research on its efficacy for BPD is indicated.

No. 30F
THE BPD STATUS CHANGE SCALE: AN INTERVIEW TO ASSESS CHANGE AND FUNCTIONING

Charles A. Sanislow, Ph.D., *Department of Psychiatry, Yale University School of Medicine, 301 Cedar Street, PO Box 208098, New Haven, CT 06520-8098;* Carlos M. Grilo, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objective: To develop an interview-administered anchored rating scale for BPD sensitive to symptomatic and functional change that generates DSM-IV and ICD-10 diagnoses.

Method: Probes and anchors were drafted for DSM-IV and ICD-10 criteria, piloted, reviewed, and revised to develop the BPD-SCS, which was then administered to 73 subjects [BPD (n=29), other-PD (N=18), no-PD/Axis I (n=12) and healthy controls (n=12)]. Two structured interviews that assess BPD (DIPD-IV, I-PDE) were administered to evaluate concurrent validity. Internal consistency was examined for all scales, two-week test-retest performed with a subset of 20 subjects, and inter-rater reliability assessed by five raters scoring four videotaped administrations.

Results: Internal consistency for all scales was good (alpha coefficients were .94 DSM-IV, .92 for ICD-10, and ranged .77–.90 for functioning scales); criterion correlations indicated convergence with established measures (.78–.86 for DIPD-IV; .65–.82 for I-PDE-BOR). Test-retest correlations ranged .47–.85; for inter-rater reliability, raters agreed within two points of the seven-point scale 90% of the time.

Conclusion: The BPD-SCS is characterized by good internal consistency and appears valid based on convergence with established measures. BPD criteria can be reliably assessed using a seven-point anchored rating scale. Modest test-retest values suggest sensitivity to change, thus providing utility for clinical trial research.

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SYMPOSIUM 31—FALSE MEMORY SYNDROME: RECOVERY AND FAMILY RECONCILIATION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to treat families afflicted by false charges of sexual abuse in a fashion that leads to reconciliation and understanding.

No. 31A
THE FALSE MEMORY FOUNDATION AND ITS SURVEY OF FAMILY RECONCILIATIONS

Pamela Freyd, *1955 Locust Street, Philadelphia, PA 19103*

SUMMARY:

The False Memory Syndrome Foundation is a grassroots/establishment organization consisting of professionals and nonprofessionals. It was formed in 1992 in response to a then growing wave of accusations and litigation based on no evidence other than the claim of a repressed memory of childhood abuse recovered in some therapeutic context. Given the amount of research and publicity relating to false and/or recovered memories since its founding, the foundation appears to have had an impact that belies its size. This presentation will describe the history and activities of the FMS foundation with a focus on the results of the foundation's survey research in the areas of families, accusers, legal matters, and most recently family reconciliation.

No. 31B
RECOVERED MEMORY ACCUSERS OF INCEST: INTERACTIONS WITH THEIR FAMILIES

Harold I. Lief, M.D., *Department of Psychiatry, University of Pennsylvania, 987 Old Eagle School Road, Unit 719, Wayne, PA 19087-1708;* Janet M. Fetkewicz, B.A.

SUMMARY:

Families who are members of the False Memory Syndrome Foundation responded to a detailed questionnaire inquiring into the nature of family interactions following the accusations of incest. Three types of interactions were revealed. "Refusers" were accusers who maintained that memories were true and refused to have any contact with their families of origin; "returners" were accusers who returned to family contact while still maintaining the validity of their recovered memories; and "retractors" were accusers who declared that their accusations were false and established relations with their old families. Preliminary results of over 1,000 families show that the accusers were 97% Caucasian, 90% female, and the majority had at least a college education. Fifty-six perent of the accusers were refusers, 36% returners, 7% retractors. Of the returners, 78% refused to discuss the accusations. Still, a frequent trajectory was from returner to retractor; 85% of retractors had first been returners. Further study of family dynamics was helped by interviews with acousers.

No. 31C
MEMORY AND HYPNOSIS: FACTS AND FICTIONS

Herbert Spiegel, M.D., *Department of Psychiatry, Columbia University, 19 East 88th Street, New York, NY 10128-0557*

SUMMARY:

The hypnotic modality, characterized by dissociation, absorption, and suggestibility, can be used to enhance, retrieve, alter, create, or deny memories. Serious use of memory data, especially long term, demands external corroboration. The most reliable observation about memory is that it is only sometimes reliable. Memory is "a relative to truth but not its twin."

Approximately 75% of the population has some degree of hypnotizability. In 8,796 consecutive patients measured for hypnotizability with the Hypnotic Induction Profile (HIP), 55% scored medium to high. These patients readily responded to formal induction procedures. Compared with those who score low or zero, the mid-range and highs are most likely to shift into spontaneous trance, without formal inductions, complying with a persuasive treatment thesis, even when the therapist has no knowledge of hypnosis or intention to use it. In addition, because the therapeutic relationship is bidirectional, emotions and behavioral responses of patients can influence the therapist. "It is a wise hypnotist who knows who is hypnotizing whom."

"Sybil" scored high on the HIP (5 on a 0-5 scale). Her "memories" of childhood abuse, influenced by her high hypnotizability, were never confirmed by external corroboration. This case provides

a model to examine hypnotizability and bidirectional influences on memory in a therapeutic interaction.

No. 31D
RECOVERED MEMORY IN THE COURTS

Alan A. Stone, M.D., *Hauser Hall, Room 400, Harvard University Law School, 1575 Massachusetts Avenue, Cambridge, MA 02138-2996*

SUMMARY:

The clinical and scientific disputes over recovered memory that divided our profession quickly found their way into the courts in a series of remarkable cases. The etiological importance of trauma, the reliability of memory recovered under hypnosis, the tension between professional opinions and scientific evidence, and the ethical duties of psychotherapists would all be argued before the courts. This presentation will outline the critical cases, arguing that in the end what is proving decisive to the courts are legal/jurisprudential not medical/scientific standards. In this process the duties of psychotherapists and the roles of forensic psychiatrists (expert witnesses) were radically revised. A driving force behind these developments was a single psychologist/lawyer, Christopher Barden, whose efforts will be discussed. Much criticized by the psychiatric profession, Barden's litigation strategy was actually based on standards of practice proposed by the distinguished psychiatrist Gerald Klerman and published in the American Journal of Psychiatry.

No. 31E
THE RECOVERED MEMORY CRAZE ONSET AND OFFSET FROM 1990–1998

Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 4-113, Baltimore, MD 21287-7413*

SUMMARY:

This paper will review data collected from questionnaires sent to families who had identified themselves as victims of a false charge of sexual abuse to the False Memory Syndrome Foundation. In this paper the data will demonstrate the remarkable time-limited feature of this phenomenon. The first accusations and claims of recovered memories occurred in the 1980s and were few. An exponential growth of accusations recurred beginning in 1990 and peaked at over 500 per year in 1994. Then there was a prompt falloff of accusations until by 1998 there again were less than 25. This kind of curve of incident claims exactly mirrors the course of "crazes" or social panics described by Lionel Penrose in 1982 where five phases, (1) latent phase, (2) explosive phase, (3) saturation phase, (4) immunity phase, and (5) stagnant phase are defined. The role of hypnotic suggestion and crowd infection in this craze will be reviewed.

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SYMPOSIUM 32—COURSE AND TREATMENT OF BPD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand current principles of recommended treatment for BPD and be familiar with the characteristic longitudinal course of the disorder.

No. 32A
COURSE OF DIAGNOSES AND IMPAIRMENT IN PATIENTS WITH BPD

Andrew E. Skodol II, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Thomas H. McGlashan, M.D., M. Tracie Shea, Ph.D., John G. Gunderson, M.D., Leslie C. Morey, Ph.D., Robert L. Stout, Ph.D., Ingrid R. Dyck, M.P.H.

SUMMARY:

Objective: The purpose of this study was to determine the stability of diagnoses and impairments in psychosocial functioning in patients with borderline personality disorder (BPD) followed prospectively over two years.

Method: A total of 151 rigorously diagnosed patients with BPD were evaluated by trained clinical interviewers using semistructured instruments for diagnosing and following the symptomatic expression of Axis I and Axis II disorders and impairments in psychosocial functioning at baseline and at six-month, one-year, and two-year follow-up assessments.

Results: Diagnoses of BPD showed considerable instability over a two-year interval. 29% of patients exhibited periods of at least two consecutive months with two or fewer criteria manifest during the first year; 42% had similar symptomatic "remissions" over two years. With the periods during which the patients were relatively symptom-free extended to a full year, 26% remitted. Functional impairment, however, changed much less. BPD patients had baseline GAFS scores of 53. At one year, the GAFS had improved to 56, but at two years, it was again 53.

Conclusions: Functional impairment in borderline personality disorder is more stable than the diagnosis itself. More emphasis should be placed on the effect of personality traits on functioning in making diagnoses of BPD than on the behavioral manifestations at any given point in time.

No. 32B
BPD AND MDD: THEIR CO-OCCURRENCE AND IMPLICATIONS FOR TREATMENT

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*

SUMMARY:

Patients with BPD and MDD are sometimes treated with an initial or primary focus on the Axis I, i.e. depressive, condition. This approach is encouraged by the relative simplicity of prescribing medication and the relatively straightforward expectation for adequate reimbursement (i.e. being empirically validated, FDA approved

etc.). This presentation suggests that such a strategy is contraindicated.

Research on BPD has shown that (1) acute depressive symptoms will often resolve (Siever, 1993), and that a significant subgroup (or 10%) of BPD patients will remit (Gunderson et al, unpublished) due to relief of stress (e.g. a "holding environment"); (2) antidepressants and mood stabilizers are usually only moderately helpful (Oldham et al, 2001), and may aggravate agitation or even suicidality (Soloff et al 1986, 1989); (3) resolution of borderline psychopathology is predictive of subsequent remissions of MDD, but not vice versa (Gunderson et al, unpublished); (4) once medications are initiated they are usually maintained with significant risks of misuse (Waldinger & Frank, 1989) and medical complications (obesity, arthritis, diabetes) (Zanarini et al, unpublished). The case is made that treatment planning should center on BPD (meaning long term and multimodal) with the concurrent depressive "disorder" being a secondary consideration. Paradoxically, such an approach is reassuring to most patients and families.

No. 32C
PRINCIPLES OF PSYCHOTHERAPY FOR BPD

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030*

SUMMARY:

A careful review of psychotherapeutic treatments for borderline personality disorder that have been shown to be effective suggests there are several common elements involved in the success of the treatment. These include the use of a multi-treater team, the use of supervision or consultation, and the combination of individual and group approaches. In addition, a number of other overarching principles in the psychotherapeutic relationship are critical to the competent and ethical treatment of patients with borderline personality disorder. Careful consideration of the impact of the patient on the clinician is essential, as is the capacity to maintain professional boundaries that are both firm and flexible at the same time. An ongoing focus on the therapeutic alliance and the goals of treatment is also essential.

No. 32D
A COMPARISON OF COGNITIVE-BEHAVIORAL AND PSYCHODYNAMIC THERAPY FOR BPD

John F. Clarkin, Ph.D., *21 Bloomingdale Road, White Plains, NY 10605;* Ken Levy, Ph.D.

SUMMARY:

Borderline personality disorder (BPD) is characterized by emotional dysregulation, behavioral dyscontrol, and interpersonal hypersensitivity and reactivity. A current model of the disorder includes temperamental characteristics, neurocognitive functioning with related brain mechanisms, and the internalized representations of self and others. In our work, we our gathering data at multiple levels of the organism (i.e., genetics, temperament, neurocognition, and fMRI functioning) in order to empirically investigate a model of the disorder including mechanisms of pathology and change. Temperamentally, the BPD patient is characterized by high negative affect and deficient effortful control. These temperamental characteristics leave the borderline vulnerable to affect storms and disruptions in interpersonal situations. The individual evolves a sense of self that is diffuse and contradictory, with a concomitant poorly integrated sense of others. In this presentation, two treatment approaches to the borderline patient—a dialectical behavioral approach and a transference focused psychotherapy—will be compared in light of the model of the disorder. Both approaches address the borderlines' deficient self-control in the context of negative affect, but in different ways. Implications for treatment planning and focus will be discussed.

No. 32E
DO PATIENTS WITH BPD RECEIVE APPROPRIATE MEDICATIONS

John M. Oldham, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Suite 6700, New York, NY 10032-2603;* Andrew E. Skodol II, M.D., Donna S. Bender, Ph.D., Ingrid R. Dyck, M.P.H.

SUMMARY:

The recently published APA practice guideline for the treatment of borderline personality disorder (BPD) identifies symptom-targeted psychopharmacology as an important adjunctive component of treatment for this condition. Longitudinal studies have shown that, in general clinical practice, most major classes of psychotropic medications are prescribed regularly for these patients (Bender et al., 2001). It is not clear how closely typical practice patterns correspond to the recommendations of the APA guideline, particularly the three algorithms delineated for cognitive/perceptual, affective dysregulation, and impulsive-behavioral dyscontrol symptoms. In a preliminary analysis of data from the NIMH-funded collaborative longitudinal personality disorder study, BPD patients with cognitive/perceptual symptoms could be differentiated from those without these symptoms, and neuroleptics (guideline-recommended for these symptoms) were more commonly prescribed for this subgroup. Almost all patients who had symptoms of affective dysregulation also had impulsive-behavioral dyscontrol, and SSRIs were more commonly prescribed for these patients, consistent with the guideline recommendation. In this presentation, these data will be reviewed, and patterns of medication use predicted by variables such as demographics, comorbidity, and level of functioning will be reported.

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SYMPOSIUM 33—DARWINIAN EVOLUTION: AFFECTIVE TEMPERAMENT AND CLINICAL CONSIDERATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have enriched understanding of the evolution of mood in adaptation and disease.

No. 33A
AFFECTIVE TEMPERAMENTS: EVOLUTIONARY SIGNIFICANCE

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

SUMMARY:

That affective disorders might have adaptive traits with evolutionary survival value is not widely appreciated in conventional psychiatry. This level of analysis is beginning to shed light on how to understand the precursor and intermorbid behavior of individuals suffering from affective disorders. This is easiest to appreciate in the case of the hyperthymic temperament with its high energy and confidence, useful in territoriality, leadership, and entrepreneurial positions. The cyclothymic or moody temperament has its special charm in romantic encounters as well as in risk-taking behavior; artistic creativity also appears linked to this temperament. It is uncertain whether irritable temperamentality subsumes revolutionary or military action; its role in intimate relationships might be to sharply focus on those behaviors of the partner that are problematic. The depressive temperament (and related anxious traits) serves the important role of constraints on behavior in potentially dangerous situations. The forgoing evolutionary perspectives bring together both Freudian and biological psychiatry. I submit that understanding the evolutionary aspect of temperaments contributes to a richer understanding of human behavior in its boundaries to psychopathology, its adaptive role, and therapeutic potential that lies within illness.

No. 33B
EVOLUTIONARY EPIDEMIOLOGY AND THE NEUROPSYCHIATRY OF MANIC DEPRESSION

Daniel R. Wilson, M.D., *Department of Psychiatry, Creighton University, 3528 Dodge Street, Omaha, NE 68131*

SUMMARY:

Vertebrate brain neuromentalities are raised or lowered by signals from conspecifics (Elbi-Eibesfeldt, 1975), via an apparatus for self-esteem that is phylogenetically quite old and deeply rooted in genomic elements that organize general behavior. Modern elements typically overlay but do not wholly replace earlier features (Spencer 1855; Hughlings Jackson 1881; Brown and Schafer, 1888; Goltz, 1892; Sherrington, 1906; Cannon, 1939; Dusser de Barenne, 1920; Kluver and Bucy, 1937; Bard and Mountcastle, 1948; Hayek, 1952; Pribram, 1958; Bucy and Kluver, 1955; Brady, 1958; Harlow, 1958, 1965). Old adaptations can be operationally released, often in pathological circumstances (Thompson, 1942), as when functional tensions arise between R-complex and upper cortical operations to induce pathophenotypies such as mania, depression, and thought disorder. Retentions were modified in the course of integration with newer primatomammalian neuromentalities, e.g., the later limbic, cortical, neo-cortical tissues (and related neuroendocrine innovations). So, concepts of human neuromental phenomena must account not only for reptilian origins but also ongoing retentions. Here, mathematical biology is a useful tool. Intra-species competition stratifies populations in terms of reproductive fitness in each generation with two basic alternatives: escalation, Hawk, or de-escalation; Dove (evolutionary stabilized strategies; or "ESS" Maynard Smith, 1982). Variations on these strategies are part of what defines either an entire species genome, or a polymorphism therein (Krebs and Davies, 1981). The Hawk-Dove ESS exemplifies deeply canalized, successive, and genetically polymorphic triune neuromentalities entirely compatible with both the basic and clinical science germane to manic depression (Price, 1996).

No. 33C
AFFECTIVE DISORDERS AS COMMUNICATIONAL STATE: BRAIN RESEARCH IMPLICATIONS

Russell J. Gardner, Jr., M.D., *Department of Psychiatry, Medical College of Wisconsin, 214 Durose Terrace, Madison, WI 53705-3323*

SUMMARY:

Uttal suggested in Imaging: high tech cannons, phantom targets? (Cerebrum 2001; 3:108–121) that unlike lapidopterists with the simpler task of gathering and classifying insects, imaging researchers possess no physical anchors to organize the deployed psychological constructs that hopefully correlate with brain variables. Behavioral-experiential-mental dimensions of neuroimaging do not even use simple descriptors such as "number of" or "shape of" to classify and organize specimens. Such problems plague psychiatry's interest in a basic science in which disorders—including affective disorders—need to be understood as variations of normal physiology. The problem partly resides in a lack of specified function. Thus, many brain activities subserve social ends, such as social rank, bonding, in-out group differentiation. Ethological observations of manic and depressed patients, moreover, show that these individuals express powerful social rank messages to the person(s) with whom they engage: manics act dominatingly and depressives submissively. Additionally, rank signals exert great power over the emotions and actions of their recipients. Brain states need to be measured with reference to the subject's social rank, especially signals received from others while recording cortically and subcortically imaged registration of the communications received, for instance, boosting signals (anathasis) or put-down deflating signals (catathesis) for functional quantifiable reference points.

No. 33D
EVOLUTIONARY TRAIT VARIATION: IMPLICATIONS FOR CLINICAL CARE AND RESEARCH

Michael McGuire, M.D., *Department of Psychiatry, University of California at Los Angeles, 760 Westwood Plaza, Los Angeles, CA 90024-1759*

SUMMARY:

Clinicians know that no two people with the "same" disorder are the same and rarely treat specific patients in identical fashion. Likewise, physiologists known many of the "so-called" physiological markers of disorders vary considerably from patient to patient; some are normal while some, but not consistently so, are not. So too, pharmacologists know a drug work can be efficacious in many, but not all, patients.

Studies of animal species and humans reveal considerable cross-animal and within-animal-across-environments behavioral variation (*i.e.*, response ranges). Studies of individuals with mental disorders show that response ranges are limited both when environment is held constant and when environments are varied. These findings suggest mental disorders can be characterized as behavioral complexes in which individual variation or response ranges are limited and relatively inflexible.

Implications for interventions and causal explanations are discussed.

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3. Gardner R, Price JS: Sociophysiology and depression, in Interpersonal Approaches to Depression. Edited by Joiner T, Coyne J. Washington, D.C., American Psychological Association Press, 1999, pp. 247–268.
4. McGuire M, Triosi A: Evolutionary Psychiatry. Oxford University Press, 1999.

SYMPOSIUM 34—SUCCESSFUL CLINICAL APPLICATIONS OF TELEPSYCHIATRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the value of using telepsychiatry in clinical practice with various patient populations.

No. 34A
THE INVISIBLE INTERFACE OF TELEPSYCHIATRY: IS IT REALLY?

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

Despite previous publications covering the clinical efficacy and the implemcntation of telepsychiatry systems, rarely are issues dealt with concerning the interpersonal experience that occurs at the telepsychiatric interface. Studies have implied that the interface is adequate and does not vary from the face-to-face clinical experience. Most of the conclusions are based on either patient/provider satisfaction surveys or the application of structured interviews. None have been based on extended clinical care or a psychotherapeutic model.

This presentation will deal with the author's experience in the evaluation and delivery of ongoing care with children and adolescents in a telepsychiatric environment. Unlike consultations or one-time assessments, ongoing care must deal with object relations, perception of affects, and the subtleties of affective expression and communication as a basis of the formation of an interpersonal relationship.

Despite the lack of reported observations and experience in this area, it would appear that the interface is not invisible. It may have a significant impact on influencing patient's perceptions, and affecting the delivery of psychiatric care in a teleconferencing environment. Technical, administrative, and organizational implications of limitations will be identified and discussed.

No. 34B
SUSTAINING AN EXTENSIVE PRISON TELEPSYCHIATRY NETWORK

William M. Tucker, M.D., *New York State Office of Mental Health, 44 Holland Avenue, 8th Floor, Albany, NY 12229;* Gerald Segal, M.S., Steven E. Hyler, M.D.

SUMMARY:

New York State's Office of Mental Health (OMH) operates mental health units in 12 maximum-security facilities operated by the state's department of corrections (DOCs). During its first six months of operation, OMH's telepsychiatry project provided sporadic consultations to four of these units, drawing on faculty from the Columbia College of Physicians & Surgeons. Over the past year these consultations have become routine for all 12 units by providing personal visits by project leadership to the units, by equipping the units with more accessible telemedicine equipment, and by attempting to bridge the "cultural divide" that separates rural, institutional psychiatric practitioners from their urban, research-driven colleagues. Furthermore, the acquisition of support staff both for troubleshooting of equipment problems and for regular scheduling issues, and of further grant funding to compensate consultants, were critical. Finally, it was necessary to resist OMH efforts to redirect the project format from consultation to direct service provision. Successes of the program to date have included: (1) increased access to on-site supervision for Columbia's forensic psychiatry residents; (2) enhanced recruitment of psychiatrists for these units; (3) mainstreaming of the experiences of prison unit psychiatrists; and (4) providing access for university-based psychiatrists to extremely challenging and otherwise inaccessible patients.

No. 34C
TELEPSYCHIATRY: A CANADIAN PERSPECTIVE ON PROGRAM DESIGN AND IMPLEMENTATION

Harry Karlinsky, M.D., *University of British Columbia, 7511 Manning Court, Richmond, BC R3N 4C5, Canada;* James Coyle, M.A., Julian Somers, Ph.D., Elliot M. Goldner, M.D., Susan Quinn, R.N.

SUMMARY:

Operationalizing a sustainable telepsychiatry program is not just about a technical solution but requires conducting a needs assessment; documenting existing clinical processes, technical infrastructure and telehealth projects; establishing local site implementation committees; identifying clear program goals and constructing the relevant clinical and distance educational protocols; developing a viable funding formula; purchasing, installing, testing and ensuring user-training of videoconferencing equipment; establishing a program management model; and implementing a mechanism to collect outcome/evaluation data. Obstacles to implementation will include issues well publicized in the telepsychiatry literature (eg. physician reimbursement) as well as less documented but equally challenging barriers encountered within the remote communities. In our experience, these latter obstacles have included: developing a cohesive community vision for the location of the videoconferencing equipment, constructing workable clinical protocols, assembling the roster of telepsychiatrists, credentialing, balancing the retention of outreach services with telepsychiatry, and naming the new program. Drawing upon the experience of telemental health initiatives in British Columbia and New Brunswick, this presentation will provide a practical and real-world exposure to the challenges of developing a telepsychiatry program. Particular attention will be paid to the "microbarriers"—local issues that can detail successful implementation.

No. 34D
SUCCESS OF TELEPSYCHIATRY WITH GERIATRIC PATIENTS

Beverly N. Jones, M.D., *Department of Psychiatry, Wake Forest University, Medical Center Boulevard, Winston-Salem, NC 27157*

SUMMARY:

The use of telecommunications to provide mental health services to patients at a distance—telepsychiatry—has grown rapidly in the past ten years. Telepsychiatry is especially valuable as a method of reaching patients and populations that traditionally have been underserved, such as nursing home residents and residents of rural communities. Research at Wake Forest University on telepsychiatry assessments of geriatric patients has shown good reliability compared with face-to-face assessments as well as acceptance by patients of the videoconferencing interview. Low bandwidth transmissions (128Kbps) do appear to result in less accurate ratings of movement disorders and behaviors. This presentation will discuss research documenting the accuracy of telemedicine assessments of geriatric patients, review clinical applications of telepsychiatry in geriatric populations, and discuss the current reimbursement framework for telepsychiatry services. Medicare permits reimbursement of telemedicine services for specific mental health service codes when patients are located in non-metropolitan services areas (MSAs). The current evidence supporting telepsychiatry with geriatric patients and the

increased availability of reimbursement are likely to expand the use of telecommunications to provide mental health services.

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SYMPOSIUM 35—DEPRESSION AND THE TRANSITION TO PERIMENOPAUSE: THE HARVARD STUDY OF MOODS AND CYCLES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the relationship between mood disorder and its effect on the transition to the perimenopause

No. 35A
THE METHODS AND CHARACTERISTICS OF WOMEN PARTICIPANTS IN THE HARVARD STUDY OF MOODS AND CYCLES

Bernard L. Harlow, Ph.D., *Department of OB/GYN Epidemiology, Bhigham Women's Hospital, 221 Longwood Avenue, Boston, MA 02115;* Lee S. Cohen, M.D., Michael W. Otto, Ph.D., D. Spelgelman, Daniel W. Cramer, M.D.

SUMMARY:

In an earlier case control study of women 45–54 years of age, we found that those who underwent natural menopause prior to age 48 were twice as likely to self-report a history of depression that required treatment for a year or longer compared with women who were still premenopausal at age 49 or later. Based on these data we could not determine whether depression was a risk factor for early ovarian decline or a marker for a precipitous decline in ovarian function that preceded the cessation of menstruation. To better assess the temporal relationship between major depression and the decline in ovarian function, we identified a population-based sample of 4,164 premenopausal women 36–44 years of age and selected: (1) a cohort of women with a lifetime history of major depression, and (2) a comparison cohort of women with no history of major depression. We compared differences in medical and reproductive histories and early follicular phase estradiol and gonadotropin levels between those with and without a history of major depression at study enrollment and every six months over a 36-month follow-up period. These two cohorts of women comprise the Harvard Study of Moods and Cycles. Study methods and descriptive characteristics of study participants will be presented.

No. 35B
THE IMPACT OF A MOOD DISORDER ON REPRODUCTIVE FUNCTION DURING THE MENOPAUSAL TRANSITION

Lee S. Cohen, M.D., *Department of Psychiatry, MGH Center for Women's Health, 15 Parkman Street, WACC 812, Boston, MA 02114;* Michael W. Otto, Ph.D., Claudio N. Soares, M.D., Bernard L. Harlow, Ph.D.

SUMMARY:

This presentation will describe results from the study that indicate that (1) age at menarche and other events in early reproductive life are associated with risk for depression; (2) women with a lifetime history of major depression are at a greater risk of developing menstrual cycle changes consistent with those that signal an earlier transition into the perimenopause compared with women with no depression history; (3) early follicular phase FSH and LH are higher, and estradiol levels are lower in depressed compared with non-depressed late reproductive aged women as they move toward the climacteric; and (4) women with no prior history of depression who develop new onset of depression during their late reproductive years have a greater cycle-to-cycle variability in FSH and LH compared with those who stay non-depressed.

The clinical implications of these findings will be discussed and further critically reviewed in a subsequent presentation with respect to identification and potential treatment of women at risk for hypoestrogenic states.

No. 35C
DEPRESSION AND ITS INFLUENCE ON MENOPAUSAL TRANSITIONS: CLINICAL AND PUBLIC HEALTH IMPLICATIONS

Claudio N. Soares, M.D., *Department of Psychiatry, MGH Center for Women's Health, 15 Parkman Street, WACC 812, Boston, MA 02114;* Lee S. Cohen, M.D., Michael W. Otto, Ph.D., Bernard L. Harlow, Ph.D.

SUMMARY:

Data available from the Harvard Study of Moods and Cycles suggest that depression may exert an influence on reproductive endocrine function and further development of an early ovarian failure. One could hypothesize that depression may alter more permanently the hypothalamic-pituitary-gonadal Axis regulation as already seen in other neurobiological models of psychiatric disorders, including post-traumatic stress disorder (PTSD). If confirmed by further studies, the association between depression and an earlier transition to the perimenopause would result in significant public health implications given the compounded burden of illness. An earlier transition to the perimenopause (and ultimately an earlier menopause) may result in a prolonged exposure to a hypo-estrogenic state, which has been associated with several medical conditions such as loss of bone density, sexual dysfunction, and a decline in cognitive function. Likewise, there is substantial morbidity and economic burden associated with major depression.

If an earlier transition to the perimenopause would not, in fact, result in an earlier menopause, women with a history of depression could face a longer period of menopausal transition before reaching the menopause. Under this scenario, those women would be exposed to a more prolonged period of hormonal variability—a period shown to be associated with greater vulnerability for new or recurrent depression. Lastly, potential therapeutic strategies for this sub-population will be critically reviewed including the use of estrogen replacement therapy (ERT).

No. 35D
PSYCHOSOCIAL PREDICTORS OF DEPRESSION IN THE HARVARD STUDY OF MOODS AND CYCLES

Michael W. Otto, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114;* Lee S. Cohen, M.D., Bernard L. Harlow, Ph.D.

SUMMARY:

Studies examining a diathesis-stress model of depression have provided fairly consistent support for the role of dysfunctional attitudes, considered alone and in conjunction with levels of negative life events, in predicting levels of depression. In the Harvard Study of Moods and Cycles, we examined the prediction of depression onset in a large, epidemiologically derived cohort of premenopausal women. We found significant prediction for the number of negative life events and degree of dysfunctional attitudes at baseline. For dysfunctional attitudes, we found that a previous episode of depression was associated with residual, elevated dysfunctional attitudes that were not accounted for by residual levels of depressed mood. Moreover, both dysfunctional attitudes and negative life events continued to predict depression when history of depression and subsyndromal depression symptoms at baseline were statistically controlled. We also found that levels of the dimensional personality trait of neuroticism was a significant and unique predictor of depression onset/recurrence, even when controlling for a history of depression, depression symptoms, and the other psychosocial variables. These findings will be critically reviewed, as they encourage the continued application of all of these variables to the prediction and understanding of depression onset in premenopausal women.

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SYMPOSIUM 36—THE PSYCHOLOGICAL WOUNDS OF NATIONAL TRAUMA: CAUSES, CONSEQUENCES, AND TREATMENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should better understand the collective psychology at the heart of ethnic conflict and genocide, the manner in which national trauma is transmitted generationally, and tailored treatment methodologies incorporating personal testimonies, family therapy, and integration with traditional religious practices.

No. 36A
HATE-MONGERING LEADERS AND VULNERABLE FOLLOWERS: THE PSYCHOPOLITICS OF HATRED

Jerrold M. Post, M.D., *Department of Psychiatry, George Washington University, 2013 G Street, N.W., Suite 202A, Washington, DC 20052*

SUMMARY:

The need for enemies is deeply rooted in human psychology. Especially during times of political/economic transition, vulnerable followers are susceptible to the siren song of hatred sung by paranoid leaders. The psychology of the destructive charismatic is described, including the attractiveness of his externalizing perspective to members of traumatized groups. This "sensemaking" diagnosis—"it's not us—it's them; they are responsible for our troubles"—leads to righteous anger, making it legitimate to strike out at them, the hated other in our midst. This dynamic is traced from hate groups, to terrorism and ethnic-nationalist conflict, expressed at its genocidal extremity in ethnic cleansing.

No. 36B
PROCESSING COLLECTIVE TRAUMA: THE ISRAELI SOCIETY AND THE MENTAL HEALTH COMMUNITY

Arie Nadler, Ph.D., *Department of Psychology, Tel Aviv University, Ramat Aviv 69978, Israel*

SUMMARY:

It is now well accepted that traumatic events exert their influence on the traumatized individual long after the trauma itself ended. Yet, we know relatively little of the ways in which whole societies, or communities, process collective traumas. The presentation will analyze the processing of the Holocaust by the Israeli society in which many of the Jewish survivors of the Holocaust have rebuilt their lives. Attention will be given to the reciprocal influences between the societal attitudes toward the survivors of the Holocaust and the mental health community's interpretation of the survivors' posttraumatic pains. The analysis suggests that after a first period in which effort was directed at trying to understand how survivors had survived, attention focused in a second period on the survivors' pains and suffering after the trauma had ended. In a third period the concern shifted to the extended effects of the trauma (e.g., effects on survivors' children). It is suggested that this three-stage model describes processing of collective trauma in general. This analysis highlights the fact that societal interpretation of the collective trauma affects the way in which traumatized individuals "make sense" of their posttraumatic experiences and this inputs into the mental health community's treatment of the victims of traumas.

No. 36C
THE ENEMY'S DAUGHTER: PSYCHOLOGICAL EFFECTS OF STALINISM ON FEMALE CHILDREN OF POLITICAL PRISONERS

Jana H. Svehlova, Ph.D., *5851 Hilldon Street, Mclean, VA 222101*

SUMMARY:

Published literature provides no documented research concerning the psychological effects on the children of Czech Stalinist era political prisoners. The question is why have their stories not been heard in the public sphere. This study illustrates that the psychological consequences of imprisonment far exceed its impact on the arrested individual, the effects on the family are multidimensional, and the experiences of these "daughters of the enemy of the state" indicate that the effects of the Stalinist realm of terror have impact on succeeding generations. The 12 in-depth interviews illuminate three significant issues: as victims of Stalinism—they endured social and political exclusion; they still do not dare to proclaim their victimhood, for fear of diminishing their parents' suffering; their view of themselves as subalterns is validated by the indifference of the post-communist society. By witnessing their narratives, two goals are achieved: an awareness of psychological aspects of Stalinism pre-

viously unexplored, provided by historical actors; and the realization that the indifference to their experiences is not universal. This may be the beginning of a healing process, brought about by the awareness that there is solidarity not only among them but also with the listener who is out there.

No. 36D
TELLING HISTORIES: SURVIVORS' TESTIMONIES OF POLITICAL VIOLENCE

Stevan M. Weine, M.D., *Department of Psychiatry, University of Illinois at Chicago, 8510 West Jackson Street, Suite 400, Chicago, IL 60607*

SUMMARY:

Survivors of torture, genocide, and other forms of political violence, often enough end up telling their stories. We want their testimonies, because we believe that they will bring good. We believe that a restorative power resides there, for the survivors, their families and communities, whole nations, and even for humanity. But what exactly is it about testimony that tells us so? It appears that we also fear that the testimonies may make matters worse. This investigation looks at diverse testimony readings from within four different 20th century socio-historical occurrences of grave violations of human rights. It demonstrates that psychiatry has dominated the approach to testimony, and that with psychiatry, testimony finds itself on a blind, though not entirely unredeemable alley. The concept of the "dialogic," as thoroughly explored by the Russian literary theorist Mikhal Bakhtin in a lifetime of writings, provides an incredibly helpful means for assisting psychiatry in better attending to testimony as a story, which is how testimonies truly want to be used.

No. 36E
COUNTERING SEQUELAE OF CULTURECIDE IN KOSOVO

James L. Griffith, M.D., *Department of Psychiatry, George Washington University Medical Center, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037;* Ferid Agani, M.D., Stevan M. Weine, M.D., Afrim Blita, M.D., John S. Rolland, M.D., Shqipe Ukshini, Ph.D., Melita Kallaba, M.D.

SUMMARY:

During the early 1990s, apartheid (expulsion of Kosovar Albanians from schools and jobs, disruption of institutions, destruction of cultural artifacts) was instituted in Kosovo by the Serbian government, culminating in the 1998 war. This apartheid and subsequent wartime violence (killing male family members, raping women, burning family homes) sought to force migration of Albanian Kosovars from the country and to destroy Albanian culture such that a future return would be impossible. Following the war, the Kosovar Family Professional Educational Collaborative (KFPEC) was organized to counter sequelae of this culturecide through a partnership between American University and professional organizations and mental health professionals at the University of Prishtina School of Medicine. The KFPEC has worked to build a family-centered mental health system and to train Kosovar clinicians in methods that engage the family as the primary unit for mental health treatment. It has proposed that traditional strengths of families can be mobilized to repair societal damage from ethnic violence. Its programs have trained Kosovar professionals in clinical methods that are family-centered, resilience-focused, and community-based. This presentation will describe program accomplishments after its first 18 months and lessons learned that may guide future educational collaborations between American professionals and mental health educators in third world countries.

No. 36F
RECOVERY FROM THE CAMBODIAN HOLOCAUST: THE ROLE OF POLITICAL, RELIGIOUS, AND MEDICAL LEADERS

David S. Liebling, M.D., *Department of Psychiatry, Case Western Reseve University, 4059 Lander Road, Cleveland, OH 44022-1330*

SUMMARY:

Between 1975 and 1979, the Khmer Rouge killed 2,000,000 of the 9,000,000 people in Cambodia. They specifically targeted educated citizens including health care providers. No psychiatrists survived the holocaust and only 43 physicians were alive in 1979. The Buddhist monks initiated a treatment program for survivors who were suffering from psychiatric illnesses, including posttraumatic stress disorder. The author led a delegation of PTSD experts in 1997 to assess both the Buddhist and governmental efforts to deal with the sequelae of mass traumatization in Cambodia. This visit led to a collaboration between the department of psychiatry at Case Western Reserve and the Provincial Hospital of Siem Reap, Cambodia, in rebuilding the mental health infrastructure in this region. This paper will focus on the following topics: (1) the effects of Buddhism and the Buddhist religious infrastructure on the occurrence and response to trauma; (2) the relationship between the central leadership, both political and medical, with the local health care professionals; (3) the role of the current political tensions (Hun Sen vs Prince Ranariddh) in the recovery of the population; and (4) the western efforts to help a third-world Asian country to deal with mass traumatization.

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SYMPOSIUM 37—UNDERSTANDING PSYCHOLOGICAL TRAUMA: MULTIDISCIPLINARY PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have an intellectually diverse overview of important contemporary issues in trauma rescarch and theory.

No. 37A
THE COGNITIVE-AFFECTIVE SCIENCE OF TRAUMA AND DEVELOPMENT

Dan J. Stein, M.D., *Department of Psychiatry, University of Stellenbosch, P.O. Box 19063, Tygerberg, South Africa*

SUMMARY:

Cognitive science, a multidisciplinary approach that is crucially influenced by computational models, is currently a predominant paradigm in academic psychology. Potential advantages of this perspective include useful theoretical constructs and rigorous empirical studies. The distinction between implicit and explicit cognitive processes, for example, may be particularly relevant for a number of areas in psychiatry, including that of trauma and development. Potential disadvantages of the cognitivist perspective include theorizations that are "substrate-neutral" (i.e., independent of their instantiation in brain or silicon), and a relative lack of work on affect. The field of trauma provides cognitivists with a fertile range of exemplars, and arguably encourages a move toward a cognitive-affective science of the brain-mind. An integrative approach to trauma and development that incorporates the best of cognitive science is certainly worth aiming for.

No. 37B
VARIABLE FOR AGING DEMAND REARING IN PRIMATES: RELEVANCE TO TRAUMA

Jeremy D. Coplan, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Eric L. Smith, Ph.D., Bruce A. Scharf, Shirn Baptiste, Altamash I. Qureshi, M.D., Jack M. Gorman, M.D., Leonard A. Rosenblum, Ph.D.

SUMMARY:

Rosenblum developed a primate model of early rearing disturbances in humans, termed variable foraging demand rearing (VFD). He hypothesized that offspring raised by mothers undergoing VFD conditions would develop an anxious temperament in adulthood. Control groups were raised under consistent foraging demands, both low and high demand. Only VFD animals exhibited anxious-like behaviors. Grown VFD animals had increased cerebrospinal fluid (CSF) corticotropin-releasing factor (CRF), and reduced CSF cortisol levels. VFD subjects also displayed CSF elevations of serotonin and dopamine metabolites and somatostatin. And CRF concentrations were stable over a 30-month period, suggesting trait-like stability. In a separate paradigm in which VFD is introduced later in the infant's development, corresponding to late weaning, a significantly different profile (low CRF, high cortisol, high-5-HIAAA) was observed on the above measures, suggesting the timing of the stressor during the infant's development is critical. These and other data to be presented demonstrate pervasive alterations in biological and behavioral functions in the infant of a mother under variable stress, and the persistence of these alterations into adulthood. Relevance to human anxiety and mood disorders is discussed, with emphasis on the developmental phase at which parental/infant stressors occur. Speculations on treatment implications will be presented.

No. 37C
ETHNOCULTURAL FACTORS IN PTSD

Roberto Lewis-Fernandez, M.D., *New York State Psychiatric Institute, 1051 Riverside Drive, Unit 69, New York, NY 10032;* J. Blake Turner, Ph.D., Randall D. Marshall, M.D., Bruce Dohrenwend, Ph.D.

SUMMARY:

Although definitive study is lacking, ethno-cultural factors have been implicated as influencing the development of PTSD in several major ways. For example, ethnicity may impact upon traumatic exposure risk, subjective interpretation of traumatic experience, symptom constellation, and course. Rarely is it possible to assess aspects of ethno-cultural variation empirically using the same methodology across diverse ethnic groups. The National Vietnam Veterans Readjustment Study (NVVRS), a nationwide survey (N=3,016) of Vietnam veterans and non-veterans in which minority veterans were oversampled, permits the simultaneous assessment of social, cultural, and clinical factors that influence PTSD.

The NVVRS found marked differences across ethnic groups in PTSD rates in a subsample evaluated with the SCID (N=343). PTSD was higher in Latinos (27.9%) and African Americans (20.6%) compared with non-Latino whites (13.7%). Ethnic differences on each of the following factors are examined in an attempt to explain these findings: familial/SES vulnerability factors; pre-, during, and post-wartime stressors, including combat exposure; patterns of symptom endorsement; and PTSD course, including time period of onset and degree of persistence/recurrence. Findings will be used to discuss the influence of ethnicity on the experience of trauma and its consequences during childhood, adolescence, and young adulthood.

No. 37D
CONTEMPORARY PSYCHODYNAMIC PERSPECTIVE ON TRAUMA

Arieh Y. Shalev, M.D., *Department of Psychiatry, Hadassah University Hospital, PO Box 12000, Jerusalem 91120, Israel*

SUMMARY:

The last 20 years have revolutionized our knowledge of psychological trauma and its consequences. Specifically, adherence to intuitively, appealing postulates has been replaced by reliance on empirical findings. Studies have, in fact, explored the phenomenology, the epidemiology, and the biology of traumatic stress disorders, and these focused areas of research have shaped the dominant biobehavioral discourse on human traumatization. Forgotten in this hasty course were the major role played by the meaning of events in shaping their consequences, the historical and structural roots of meaning construction, and the permanent changes to personality, emotional life, self-perception, and appraisal of others induced by trauma. These essential ingredients of psychodynamic theory have potent clinical and theoretical implications. Indeed, a comprehensive theorization is badly needed. Yet, in order to become viable again, a psychodynamic approach must consider all empirical knowledge gained, integrate and organize such knowledge, and provide a template for predicting further development. Can this be done? What constrains such development? What are the assets and the challenges ahead? These will be outlined and amply discussed in this presentation.

No. 37E
INTEGRATING THERAPEUTIC MODELS FOR PSYCHOLOGICAL TRAUMA

Randall D. Marshall, M.D., *Department of Anxiety Disorders, NY State Psychiatric Institute-Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

The efficacy of several trauma-focused psychosocial treatments for adults with chronic PTSD is well established. More recently, large clinical trials have shown efficacy for the SSRIs, and previous studies found efficacy for the tricyclic antidepressants and MAO inhibitors. A review of this literature, however, reveals that a substantial proportion of patients are left with residual symptoms in both medication and psychotherapy trials. Despite the widespread practice of combination treatment in chronic PTSD, and its recommendation in recent treatment guidelines, there are no studies that systematically examine combination treatment. However, several lines of reasoning and research attest to the important role of combination therapy in PTSD and will be reviewed in this presentation. The disorder is amenable to both learning models and affect dysregulation models. Psychosocial treatments are likely to exert effects through mecha-

nisms of learning, whereas medications are likely to produce improvement secondary to stabilization and/or restoration of homeostasis of neural networks regulating mood, anxiety, fear, and sleep. Preliminary empirical and theoretical support for a two-phase treatment model in PTSD will be presented. Phase I involves stabilization, formation of an alliance, psychoeducation, and preparation for desensitization. Phase II involves reconstruction of the trauma narrative exploration of individual meaning. The implications for clinical treatment will be discussed.

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SYMPOSIUM 38—BEYOND THE SURGEON GENERAL'S REPORT: PSYCHIATRY FOR A DIVERSE POPULATION
Substance Abuse and Mental Health Services Administration

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the impact of disparities on the disability burden of minorities, appreciate the factors that contribute to ethnic disparities in mental health care, understand the distinct issues of various racial and ethnic groups in gaining access to mental health services, demonstrate a working knowledge of the limitation of current research in minorities and evidence-based treatment.

No. 38A
POLICY IMPLICATIONS OF THE SURGEON GENERAL'S REPORT FOR A DIVERSE POPULATION

Kana Enomoto, M.A., *Center for Mental Health Services, 5600 Fishers Lane, Room 11-C-25, Rockville, MD 20857*

SUMMARY:

Striking disparities in access, quality, and availability of mental health services exist for racial and ethnic minority Americans, according to the latest report from the Surgeon General, Mental Health: Culture, Race, and Ethnicity. The report, a supplement to the 1999 first-ever Surgeon General's report on mental health, highlights the role culture and society play in mental health, mental illness, and the types of mental health services people seek for the four widely recognized racial and ethnic minority groups: African Americans, Americans Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans. It finds that, although effective treatments for mental illnesses are available, racial and ethnic minorities are less likely to receive quality care than the general population. A critical consequence of this disparity is that racial and ethnic minority communities bear a disproportionately high burden of disability from untreated or inadequately treated mental health problems and mental illnesses. The Surgeon General recommends that both researchers and providers turn their attention to understanding how evidence-based treatment can be effectively tailored to accommodate individual factors such as age, race, culture, and language. Key findings of the supplement will be reviewed. Implications for policy and practice will be discussed.

No. 38B
MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY

Jeanne Miranda, Ph.D., *Department of Psychiatry, University of California at Los Angeles, 10920 Wilshire Boulevard, Suite 300, Los Angeles, CA 90024-6505*

SUMMARY:

This report finds that rates of mental disorders in the U.S. community do not vary widely as a result of culture, race, and ethnicity. However, ethnic minorities experience a larger burden of disease because they have poorer access to mental health services, and when services are sought, they often receive poorer quality care. Although the exact cause of this disparity is not known, lack of insurance, culturally associated stigma, and few ethnic appropriate services are leading causes. In addition, a history of racism and discrimination discourage ethnic minorities from trusting systems of care.

This report also finds that ethnic minorities are over-represented in vulnerable groups, including those who are homeless, incarcerated, exposed to violence, and in foster care. These populations have poor access to mental health care, and generally poor outcomes.

One conclusion from this report is that access to culturally appropriate care for ethnic minorities is needed. Furthermore, improving care to vulnerable populations is also important, including services that could prevent minorities from entering these vulnerable groups.

No. 38C
INTERFACE BETWEEN BIOLOGY, PHARMACOLOGY, AND CULTURE

William B. Lawson, M.D., *Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, NW, Washington, DC 20061*

SUMMARY:

Advances in neurosciences, pharmacology, and genetics have improved the treatment outcomes of mental disorders. Often the interaction of culture and ethnic issues are not considered. Failure to consider these factors may contribute to the disparities in mental health care seen in minorities. Research in biological markers and human genetics have led to identification of putative genomic sites for some mental disorders. However, diagnostic issues with minority groups raise questions about the generalizability of these findings. Moreover past history of misuses of genetics and other technological advances has led to suspicion among minorities and general concerns about scientific misuse. Research in the pharmacogenetics and pharmacokinetics of drug metabolism has shown ethnic variability that may have clinical consequences. Some ethnic groups appear to require lower doses of psychotropic medication. However, dosing is also a result of the patient's culture and attitudinal factors of the provider. These findings are not seen with newer agents. Unfortunately, how-

ever, socioeconomic and other factors may limit the availability of new treatments. The underrepresentation of minorities as investigators or subjects further limits the impact of recent developments in mental health research.

No. 38D
ALCOHOL AND DRUG USE IN COLLEGE SAMPLES: RACIAL DIFFERENCES

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

SUMMARY:

College drinking and drug use have become a major concern. Many college students consume alcohol in large quantities and are classified as binge drinkers (five or more drinks in a row in one sitting). The purpose of this study was to explore the extent to which racial differences in the use of alcohol and drugs among adolescent/young adult (<20 years old) college students exit. The Core Survey and the Adolescent Obsessive Compulsive Drinking Scale (A-OCDS) were administered to assess alcohol/drug use and "craving," respectively. Subjects were adolescent/young adult college students at the College of Charleston (C of C) (n=282), predominantly Caucasian and South Carolina State University (SCSU) (n=276), predominantly African American. The average ages for C of C and SCSU were 19.13 ± .77 and 18.8 ± 85, respectively. The C of C sample was comprised of 23% males, while SCSU was comprised of 40.8% males. SCSU students were significantly more likely to have a father with an alcohol or drug use problem. Significantly more of the C of C students engaged in binge drinking two or more times in the two weeks preceding the survey. There were higher rates of clinically significant A-OCDS scores among C of C students than SCSU students. Significantly more of the SCSU students reported never using tobacco, alcohol, marijuana, or cocaine. C of C students were significantly more likely to report daily tobacco use, alcohol use three times/week as well as alcohol use five times/week. There were no differences between the groups for marijuana or cocaine use; there was a low prevalence of marijuana and cocaine use in both groups. Alcohol was the predominant substance of abuse and Caucasian students used alcohol significantly more than African Americans. Overall, the substance use indices indicate that Caucasian college students engage in substance use at greater rates than African American college students.

No. 38E
INFLUENCE OF CULTURE ON CHILD DEVELOPMENT AND EARLY PSYCHOPATHOLOGY IN THE 21ST CENTURY

Harry H. Wright, M.D., *Department of Neuropsychiatry, University of South Carolina, 3555 Harden Street Extension, Suite 104, Columbia, SC 29203*

SUMMARY:

In the first half of the 20th century, there was interest in the influence of culture on child development across several disciplines. More recently, a number of clinicians have moved from an assimilationist orientation regarding culture to one that recognizes and values difference, and they are being expected to know more about the influence of culture on child development and psychopathology. The importance of the influence of culture has been the focus of recent reports by the Institute of Medicine and the surgeon general.

Despite the early cultural foundation for the science of early childhood development, relatively little attention has been focused on translating what is known about the influence of culture, race, and ethnicity on child development and early childhood psychopathology. Child development has been examined from a cross-cultural perspective, but enculturation has not been systematically studied.

This presentation focuses on a small part of what we know about the influences of culture, race, and ethnicity on the mental health of young children between 0 and 5 years of age. We emphasize the interactive nature of the neurobiological and cultural aspects of early childhood development. In addition, as an example, we describe and discuss issues of mental health care access and utilization of children under 5 and their families by ethnicity for a large public mental health system.

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SYMPOSIUM 39—DEFINING EVIL: CLINICAL AND FORENSIC IMPLICATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will gain greater understanding of clinical and forensic psychiatric, and the theological implication defining depravity.

No. 39A
DILEMMAS IN DEFINING DEPRAVITY AT THE CRIMINAL LAW AND PSYCHIATRY INTERFACE

Michael M. Welner, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, Suite 806, New York, NY 10001*

SUMMARY:

In criminal law, psychiatric assessment of depravity relates closely to evaluations of criminal responsibility. The forensic psychiatrist examines evidence and history to determine motivation inspiring the crime in insanity, diminished capacity, and capital cases. The presentation reviews the implications of psychiatry defining depravity in criminal law.

Higher court cases reflect the overcharging and harsher sentencing of defendants on the basis of distorted evidence relating to arbitrarily defined depravity. At the same time, in property and white collar crimes, egregious if nonviolent crimes may be obscured by articulate lawyering that obscures the defendant's motivations and actions.

The author presents case examples of higher court decisions and the dilemmas posed by terminology such as "heinous," "atrocious," and "cruel." The approaches of the forensic psychiatrist are instru-

mental in gathering necessary information to prevent the distortion of these questions.

This discussion includes a review of how psychiatric diagnostic influences have shaped the development of the Depravity Scale, a device being standardized for use in criminal cases and related matters.

No. 39B
SADISTIC MOTHERS AND FATHERS: PARENTS AT THE EDGE OF EVIL

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, #114, New York, NY 10024-6027*

SUMMARY:

A great percentage of the psychiatric disorders that mental health professionals are called upon to treat have as their main predisposing factor sadistic treatment by parents ("parents" here refers to all significant early caretakers). This is true for many cases of personality disorder, depression, social phobia, panic and other anxiety disorders, dissociative conditions, and posttraumatic stress disorders. The small percentage of such parents who are identified, and either treated adequately, or else removed by law from further involvement with their children, represents only the tip of the iceberg. The spectrum of parental cruelty spans a range from excessively harsh but well-meaning and self-aware parents who are amenable to therapy to chronically cruel parents whose personalities fall short of "sadistic personality disorder" and who are scarcely amenable to therapy, on to sadistic parents who relish the torture to which they subject their children. The latter type exemplifies what is usually meant in everyday parlance as "evil." Evil here signifies the conscious desire to hurt another (one's children, in this case) via ego-crippling psychological humiliation and torture, sexual misuse, or physical brutality of torturous proportions. Any combination of these elements may coexist. The histories of many criminals, political sadists, and other sadistic individuals contain in about half the instances examples of violent subjugation, forced witnessing of cruelty to siblings, and violent "coaching" (encouragement to hurt others). Examples will be given from the literature and the author's clinical experience, along with guidelines as to which parents are treatable and which are not.

No. 39C
THEOLOGY CHALLENGES TO DEFINING DEPRAVITY: CAN ACCOUNTABILITY MEET THERAPY AND REDEMPTION?

Lawrence Gesy, M.D., *Archdiocese of Baltimore, Maryland, 113 First Avenue, Brunswick, MD 21716*

SUMMARY:

Defining evil has historically been more readily embraced in theology circles. For this reason, religion's approach to distinguishing evil from error, or evil from illness, can provide guidance to researchers and the courts as they endeavor to do so.

The presenter will review religious perspectives in defining evil, how they differ between religions, and how religious definitions of evil influence justice. Resolving the seeming incompatibility between accountability and religion, the speaker explores how faith can still be respected in quantification of sin. The attendee should develop a further understanding of how religion, law, and psychiatry do interface in this area, and where the three diverge in perspective.

No. 39D
DEPRAVITY AT THE WORKPLACE: CLINICAL AND FORENSIC IMPLICATIONS

Joseph P. Merlino, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, Suite 806, New York, NY 10001*

SUMMARY:

Behavior at the workplace has become the subject of increased psychiatric attention in recent years. With the Americans With Disabilities Act, many employees are referred for psychiatric intervention following workplace incidents that are not necessarily dangerous, yet are still quite remarkable.

In addition, increased sophistication about psychopathy has embraced the reality that depraved actions are not the exclusive province of criminal court and the unemployed.

This is no more visible than executives whose conduct becomes the focus of lawsuits claiming someone has created a hostile work environment, in the context of discrimination.

This lecture focuses on the recognition of depraved actions as they present in the context of psychiatric and psychoanalytic treatment, and their implications for fitness for duty, and employee and supervisor accountability.

No. 39E
THE DEPRAVITY SCALE: VALIDATING A PSYCHIATRIC AND FORENSIC MEASURE OF EVIL ACTIONS

Michael M. Welner, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, Suite 806, New York, NY 10001*

SUMMARY:

In an effort to standardize depravity so as to ensure consistency, fairness, and the inclusion of a full database of evidence into pertinent court cases, the author has developed the Depravity Scale. This device assesses the history of the defendant's motivations, actions, and attitudes, reflecting evidence from forensic psychiatric interviewing, pathology findings, as well as criminalistics and other investigation. In that regard, the Depravity Scale assesses the individual independent of his background and history, is color blind, and does not consider factors otherwise accounted for by other provisions of the statute, such as prognosis.

The most recent research findings of the Depravity Scale are presented, controlling for numerous variables, and with a confirmed sample size that numbers over 2,500. Participants will learn of what aspects of a crime's motivation, actions, and attitudes have achieved consensus appraisal as representative of depravity, as well as interesting findings from subpopulations from the large research sample. Additional research findings relating to the Depravity Scale are presented as well.

The implications of this research and designation of depraved will be further discussed. The role of the examining psychiatrist in these matters is reviewed as well.

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2. Dutton DG: The Abusive Personality. New York, The Guilford Press, 1998.
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SYMPOSIUM 40—THE THERAPEUTIC MISCONCEPTION IN RESEARCH: BARRIER OR NECESSITY?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify elements of the therapeutic misconception in research that impede the process of informed consent; identify prevalence and predictors of the misconception and techniques to overcome it.

No. 40A
AN EMPIRICAL STUDY OF THERAPEUTIC MISCONCEPTION

Charles Lidz, Ph.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue, North, Worcester, PA 01655;* Paul S. Appelbaum, M.D., Thomas Grisso, M.D.

SUMMARY:

We report an empirical study of the frequency of the therapeutic misconception—the belief that research procedures are being conducted with therapeutic intent. Detailed interviews were done with 231 subjects drawn from 41 research projects at two medical centers. The projects ranged from clinical trials for new treatments for depression and cancer to descriptive, interview-based studies of symptomatology. Detailed interviews with participants were coded for the presence of three different indicators of therapeutic misconception: (1) the belief that the study was designed primarily to benefit subjects, (2) the belief that the interventions being studied would be individualized to the specific needs of subjects, and (3) an unreasonable assessment of the therapeutic benefits of participation. Almost 70% of subjects showed evidence of therapeutic misconception on one or more of these criteria. Although previous research had shown high levels of therapeutic misconception among psychiatric patients, the results of this study show no significant differences between subjects in psychiatric and other medical research. Predictors of therapeutic misconception will be described, and the implications for the process of obtaining informed consent discussed.

No. 40B
DECISIONAL CAPACITY AND THERAPEUTIC MISCONCEPTION IN ALZHEIMER'S DISEASE

Scott Y. Kim, M.D., *Department of Psychiatry, University of Rochester, 300 Crittenden Boulevard, Rochester, NY 14642*

SUMMARY:

Therapeutic misconception occurs when research participants come to believe that the purpose of the research is primarily for their own benefit rather than for the benefit of other or future patients. In clinical research involving persons with dementia, this problem may seem particularly relevant since declining cognition may make persons more vulnerable to this misconception. To explore this issue, a post-hoc analysis of data from a competency study involving 37 persons with mild to moderate Alzheimer's disease (AD) will be presented. The AD subjects' capacity was assessed by the MacArthur Competence Assessment Tool-Clinical Research version (MacCAT-CR), containing a hypothetical clinical trial scenario. Two questions assessing the ability to appreciate (i.e., to apply the facts to one's own situation correctly) were examined, viz., the ability to appreciate that the primary purpose of research is not personal benefit and that he or she could indeed receive a placebo in the proposed clinical trial. Outright failure on either question was highly specific for incapacity (as determined by a validated criterion standard); answering either question correctly was correlated with being capable but less specifically. Meaning and implications of these findings for the problem of therapeutic misconception will be discussed.

No. 40C
HISTORICAL PERSPECTIVES ON THE THERAPEUTIC MISCONCEPTION

Gary S. Belkin, M.D., *Department of Psychiatry, Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

The idea of the therapeutic misconception (TM) has become central to discussions of experimentation ethics and emerged in the 1970s as an alleged corrective to unethical and outmoded justifications of research practices. TM organizes thinking about experimentation ethics by emphasizing the degree that research is distinct from usual clinical practice. What makes research ethically unique, in this view, is that it is not of optimal value to persons. Research, even so-called "therapeutic" research, is an artifice created for the benefit of asking questions in rigorous ways, not in meeting patient needs. But before research was thought to risk being dangerously misconceived as treatment, its legitimacy was anchored precisely within a moral vision of treatment. Before writing off such prebioethic era approaches as ethically unsophisticated, we should explore the historical conditions that made them compelling at the time. This paper revisits discussion over experimentation ethics in the roughly 1940s through 1960s period. Rather than being the fruit of ethical maturation, unexamined commitment to the idea of TM may more convincingly be historically understood as concealing larger, concerning, historical changes. In particular, I point to the standardization and commodification of medical practice and knowledge, which may further alienation and suffering.

No. 40D
THERAPEUTIC MISCONCEPTION AND THERAPEUTIC INTENT: WHERE DO THE PROBLEMS LIE?

Donna T. Chen, M.D., *Department of Bioethics, National Institute of Health, 10 Center Drive, 10/1C118, Bethesda, MA 20892*

SUMMARY:

While clinical research frequently has some therapeutic intent, research is not typically designed to maximize the chances of therapeutic benefit for individual research participants. Nevertheless, many individuals are motivated to participate in clinical research by the possibility of therapeutic benefit. As discussed in this symposium, the "therapeutic misconception" refers to a mistaken belief on the part of research subjects that the research is designed to provide them with therapeutic benefit. However, not every belief in the possibility of therapeutic benefit from research participation stems from a therapeutic misconception.

Drawing from experiences assessing the consent of potential research participants at the Clinical Research Center of the National Institutes of Health, practical implications of trying to differentiate therapeutic misconception from desire for therapeutic benefit and other motivations for research participation, such as hope, trust, and desperation will be illustrated. The concept of introducing altruism as a potential method to help manage a therapeutic misconception will be described. Concerns that a form of therapeutic misconception exists in clinical investigators will be raised. The role that all treating psychiatrists can play in helping patients to understand and appreciate the differences between clinical research and clinical care will be discussed.

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SYMPOSIUM 41—COMBINED TREATMENT: DYNAMIC PSYCHOTHERAPY AND MEDICATION

American College of Psychoanalysts and APA Illinois Psychiatric Society

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize and correct problems that arise when medication and dynamic psychotherapy are combined either by a psychiatrist alone or when collaborating with another psychiatrist or non-medical therapist.

No. 41A
DILEMMAS FOR PSYCHIATRISTS DOING SPLIT PSYCHOTHERAPY AND PHARMACOTHERAPY

Malkah T. Notman, M.D., *Department of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02445*

SUMMARY:

Although many participants believe psychotherapy and pharmacotherapy are best done by the same individual, this is increasingly rarer in the context of HMO and other restraints. The psychotherapist, perhaps a non-MD or a psychodynamically trained psychiatrist, may look to a psychopharmacologist to provide medication. This division can create dilemmas for both treaters, whether both are psychiatrists or when the psychiatrist provides the medication back up. These will be described and discussed. They include:

(1) Differences in assessment of the patient such as degree of depression, suicidality, potential for acting out, and violence.

(2) Problems in communication and informing the other therapist of changes in patient's status.

(3) Different approaches leading to a sense of lack of control, a potential problem for each.

(4) Split transference: each may not be aware of transference to the other.

(5) Countertransference may be displaced from the patient to the other therapist.

Strategies for addressing these will be presented.

No. 41B
THE ETHICS OF THE PHARMACEUTICAL DYNAMIC COMPLEX

Brenda C. Solomon, M.D., *Department of Psychiatry, University of Illinois, 150 Park Avenue, Glencoe, IL 60022-1335*

SUMMARY:

The primary purpose of this article is to review the ethical dilemmas psychiatrists confront when recommending the treatment of choice: dynamic psychotherapy and/or psychopharmacologic agents. The dilemmas often involve non-medical therapists while interfacing with managed care or other third-party payers. Psychiatrists feel pulled to please the HMOs, but a "quick fix" is often not in the best interest of the patient. Additionally, young psychiatrists have not had adequate psychodynamic training, which would allow them to address how much anxiety or depression is helpful for patients, and at what point it obstructs treatment and creates needless distress. Some experienced psychiatrists are not up-to-date on new psychopharmacologic options, yet are unwilling to recognize their limitations. To do no harm is the overriding ethic.

Using a psychodynamic model of the mind in parallel with a psychopharmacologic model allows the psychiatrist to adapt to changes in the treatment situation. However, countertransference blind spots can lead to ethical missteps. Typical transferential and countertransferential issues tend to emerge. Case examples will be offered.

No. 41C
THE TEACHING AND LEARNING OF CONJOINT PSYCHOTHERAPY AND PHARMACOTHERAPY

Sidney H. Weissman, M.D., *30 North Michigan Avenue, Chicago, IL 60602*

SUMMARY:

The one area of the practice of mental health in the United States that only psychiatrists can perform is the conjoint or collaborative treatment of a patient in psychotherapy and pharmacotherapy. This paper will examine this treatment process from the initial perspective of how it is taught in residency and then how this joint treatment is supervised. We will examine the implications of the supervision being provided by either a dynamically oriented psychotherapist and a biologic psychiatrist or if the resident has two supervisors.

The paper will address the difficulties in determining which of the two distinct treatments may be responsible for behavioral changes in the patient and how this ambiguity impacts on assessing and validating joint or collaborative treatments.

Finally, we will address the implicit theoretical models involved in these treatments. Do we conceptualize treating one disorder with two methods of treatment or do we conceptualize treating two distinct disorders with two treatments?

No. 41D
WHEN THE WELL-MEANING PSYCHIATRIST BECOMES THE PATIENT'S NEGATIVE OTHER

Jerome A. Winer, M.D., *Department of Psychiatry, University of Illinois Medical Center, 912 South Wood Street, MC 913, Chicago, IL 60612-7325*

SUMMARY:

Many patients with depression seek the help of a psychiatrist. At times, despite what seems to be a reasonable response to drug therapy, the relationship between psychiatrist and patient begins to deteriorate. At other times no medication helps and both patient and psychiatrist become increasingly disappointed with each other. With such patients, it is critical for the psychiatrist to: (1) identify in the patient the unconscious relational pattern that organizes the patient's experience; (2) discover those aspects of the doctor's behavior that prove to the patient that he is once again in the bad situation; (3) work with the patient to demonstrate that the meaning he gives to the

doctor's attitude and behavior is not necessarily the only way to see things. Case examples will be presented to illustrate the technique.

REFERENCES:

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SYMPOSIUM 42—AMERICA ATTACKED: THE AMERICAN PSYCHIATRIC ASSOCIATION AND ITS MEMBERS RESPOND

Committee on Psychiatric Dimensions of Disaster

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify psychiatric intervention strategies following a mass casualty terrorist event. The participant should be able to discuss population-based approaches to intervention.

No. 42A
THE AMERICAN PSYCHIATRIC ASSOCIATION LEADERSHIP RESPONDS TO THE TERRORISM: LESSONS LEARNED

Richard K. Harding, M.D., *Department of Psychiatry, University of South Carolina, 3555 Harden Street, Extension 102, Columbia, SC 29203*

SUMMARY:

The actions taken by the APA leadership and the central office in response to the September 11th terrorist attacks will be reviewed. APA resources that proved helpful in the response will be summarized. Suggestions for future efforts to enhance response activities will be discussed.

No. 42B
THE SAINT VINCENT'S PSYCHIATRIC RESPONSE TO THE SEPTEMBER 11TH TERRORIST ATTACK

Spencer Eth, M.D., *Department of Psychiatry, St. Vincents Hospital and Medical Center, 144 West 12th Street, Room 174, New York, NY 10011*

SUMMARY:

The mental health interventions that took place at St. Vincent's Hospital, New York, in the wake of the World Trade Center attack will be described. Efforts that appeared to be successful and challenges that were encountered will be reviewed. Suggestions for future interventions will be outlined.

No. 42C
NEW YORK CITY RESPONDS TO THE ATTACK ON THE WORLD TRADE CENTER

Neal L. Cohen, M.D., *New York City Department of Mental Health, 93 Worth Street, New York, NY 10013*

SUMMARY:

The mental health intervention activities and plans that Commissioner Cohen directed will be described. Efforts that appeared to be successful and challenges that were encountered will be reviewed. Suggestions for future interventions will be outlined.

No. 42D
PSYCHIATRY AT GROUND ZERO

Vivian B. Pender, M.D., *Department of Psychiatry, Cornell University, 247 West 87th Street, Unit 7F, New York, NY 10024*

SUMMARY:

The actions that were undertaken by the New York County District Branch following the attack on the World Trade Center will be presented. Efforts that appeared to be successful and challenges that were encountered will be reviewed. Suggestions for responding to future events will be outlined.

No. 42E
PSYCHIATRIC INTERVENTION AT THE PENTAGON FOLLOWING THE SEPTEMBER 11TH TERRORIST ATTACK

Stephen J. Cozza, M.D., *Department of Psychiatry, WRAMC, 11524 Gauguin Lane, Potomac, MD 20854-3206*

SUMMARY:

The mental health interventions that took place at the Pentagon will be described. Efforts that appeared to be successful and challenges that were encountered will be reviewed. Suggestions for future interventions will be outlined.

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1. Tucker P, Pfefferbaum B, Nixon SJ, Dickson W: Predictors of posttraumatic stress symptoms in Oklahoma City: exposure, support, peri-traumtic responses. Journal of Behavioral Health Services Research. 2000; 27(4):406–16.
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SYMPOSIUM 43—WHAT'S NEW IN EATING DISORDERS: A CLINICAL RESEARCH TREATMENT UPDATE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be aware of the basic principles of treating the major eating disorders—

anorexia nervosa, bulimia nervosa, and binge eating disorder—and have learned about recent treatment developments currently under study in adults and adolescents.

No. 43A
TREATMENT OF BULIMIA IN A PRIMARY CARE SETTING

B. Timothy Walsh, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia University, 1051 Riverside Drive, Unit #98, New York, NY 10032-2603;* Christopher Fairburn, M.D., Diane Mickley, M.D., Robyn Sysko, B.A.

SUMMARY:

In the last 15 years, effective treatment interventions for bulimia nervosa have been developed and validated in specialized treatment centers. It is generally assumed that these treatments must be provided by highly trained professionals, and cannot be utilized effectively in a primary care setting. This presentation will describe preliminary results of a controlled trial to examine this assumption.

The broad aim of the study is to examine whether treatments known to be effective in specialized centers can be usefully transferred to general health care settings. Specifically, the study examined the relative and combined effectiveness of the two leading treatments for bulimia nervosa: treatment with an antidepressant medication, fluoxetine, and treatment with a form of cognitive-behavioral therapy, guided self-help, designed for use in primary care. Over the last four years, 90 women with bulimia nervosa have been treated in two primary care settings. Patients were randomly assigned to receive (1) either fluoxetine or placebo and (2) either guided self-help combined with medical management or medical management alone. The trial will be completed in 2002, and this presentation will describe the preliminary findings concerning changes in eating behavior and in psychological state.

No. 43B
OPTIMIZING TREATMENT FOR BINGE-EATING DISORDERS

Michael J. Devlin, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia University, 1051 Riverside Drive, unit 116, New York, NY 10032-2603;* Juli A. Goldfein, Ph.D., Pamela S. Raizman, Ph.D., B. Timothy Walsh, M.D.

SUMMARY:

This study was designed to assess the clinical utility of augmenting a standard group behavioral eating/weight management program for binge eating disorder (BED) with individual cognitive-behavioral therapy (CBT) and/or fluoxetine treatment. Ninety-two overweight or obese (BMI >27) patients with BED received a 16-session, five-month group behavioral treatment adapted for BED. Groups were randomly assigned to receive either group treatment only or group plus individual CBT. In addition all subjects received either fluoxetine up to 60 mg/day or placebo.

Outcome variables included binge eating frequency, weight, and self-report measures of depression and body image concern. We examined the effects of the two augmentation treatments (CBT and fluoxetine) using two-way ANCOVA with the post-treatment value as the dependent variable, pre-treatment value as covariate, and individual therapy assignment and medication assignment as independent variables. Analyses were by intent-to-treat using all randomized subjects. Overall, all clinical variables showed significant improvement from pre- to post-treatment assessment. There were significant beneficial effects of individual CBT on binge frequency (p=.012), Binge Eating Scale score (p=.008), and Three Factor Eating Questionnaire disinhibition score (p=.002). There was a significant beneficial effect of fluoxetine on Beck Depression Inventory score (p=.02) and a nonsignificant trend for Body Shape Questionnaire score (p=.064). Individual CBT in the context of group behavioral treatment for BED confers significant additional benefit on the core symptoms of the disorder. Fluoxetine does not, but appears to have, a beneficial effect on depressive symptoms.

No. 43C
PARTIAL HOSPITALIZATION FOR ANOREXIA NERVOSA: WHO GAINS, HOW AND AT WHAT COST?

Angela S. Guarda, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N. Wolfe Street, Meyer 101, Baltimore, MD 21287-7101;* Leslie J. Heinberg, Ph.D.

SUMMARY:

Economic pressures have encouraged partial hospital treatment of anorexia nervosa, although weight gain in outpatient settings has been more difficult to achieve. Since weight normalization is widely believed to be necessary for recovery, cost per pound of weight gained rather than cost per day of treatment is an important index of the cost-effectiveness of partial hospitalization. Methods of safely improving average rates of gain and predicting which patients are likely to gain adequately in a partial hospital setting are needed.

This paper will describe a partial hospital program with average weight gains of over 2lbs/week. Program features include an integrated step-down, inpatient-partial hospitalization design with supervised housing, a behavioral protocol, intensive group therapy, and flexibility in adjusting time-in-program to rate of weight gain. Average cost per pound gained for 62 underweight admissions treated initially as inpatients and transitioned to partial hospitalization was significantly higher for partial hospitalization than for inpatient hospitalization. A median split on cost per pound gained was performed. High versus low cost groups did not differ on most clinical variables examined except for the presence of problematic eating behaviors while on the inpatient unit. Presence of overt eating disordered behavior did not affect inpatient cost per pound gained but did predict lower cost-effectiveness for partial hospital treatment.

This study suggests that partial hospitalization is cost effective in treating behaviorally compliant patients, but that severely underweight or behaviorally disruptive patients are likely to do better and cost less per pound of weight gained if maintained for longer periods on an inpatient unit before transition to partial hospitalization. Randomized studies matching patient characteristics to success of treatment setting in achieving and maintaining weight gain are needed.

No. 43D
FAMILY-BASED TREATMENT FOR ADOLESCENTS WITH ANOREXIA NERVOSA

Katherine L. Loeb, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 74, New York, NY 10032;* Ilene M. Reeman, M.D., B. Timothy Walsh, M.D., James D. Lock, M.D.

SUMMARY:

To date, there has been little evidence available from controlled clinical trials to inform effective treatment planning for children and adolescents with anorexia nervosa, a severe and sometimes deadly disorder. Data from the Maudsley Hospital indicate that for adolescents with recent onset of anorexia nervosa, a family-based intervention is superior to individual therapy, both acutely (Russell, Szmukler, Dare, & Eisler, 1987) and at five-year follow-up (Eisler et al., 1997). However, methodological flaws limit the conclusions that can be drawn from this and related research. Lock, Le Grange, Agras, and Dare (2001) of Stanford University have manualized this

outpatient family treatment, allowing for its dissemination in other clinical settings. We are currently conducting an open trial of the family-based intervention, under the clinical supervision of Dr. Lock, to determine the feasibility of its administration at this center. All patients in the pilot study have exhibited significant clinical improvement, and no families have dropped out. Outcome variables to be reported include: BMI, menstrual status, binge eating, purging, and Eating Disorder Examination (Fairburn & Cooper, 1993) subscale scores.

No. 43E
BULIMIA NERVOSA IN ADOLESCENTS: DO ADULT TREATMENTS TRANSLATE TO TEENS?

Lisa A. Kotler, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive Unit, #74, New York, NY 10032;* Michael J. Devlin, M.D., B. Timothy Walsh, M.D.

SUMMARY:

Eating disorders in children and adolescents are serious conditions that can impede physical, emotional, and behavioral growth, and are an increasingly recognized problem in these age groups. Bulimia nervosa may be expressed slightly differently in children and adolescents than in adults. Consequently, diagnostic procedures and multidisciplinary treatments need to be tailored to the unique developmental needs of children and adolescents with eating disorders. A variety of treatment approaches, including cognitive-behavioral therapy, interpersonal therapy, and antidepressant medications have been used clinically in children and adolescents with eating disorders, but few treatment studies of this population exist in the literature.

We conducted an open clinical trial of fluoxetine for the treatment of adolescents with bulimia nervosa. Eight adolescents, ages 12–18 received eight weeks of fluoxetine 60 mg per day with supportive psychotherapy. Primary outcome measures included frequencies of binge eating and purging, ratings on the Clinical Global Impressions Scale (CGI), and status of bulimia nervosa diagnosis at week 8 using a structured interview. Safety and tolerability of this dose of fluoxetine were also assessed. Average weekly binges decreased significantly from 4.4 ± 4.1 to 0 ($p<.018$). Average weekly purges decreased significantly from 7.4± 5.2 to 0.5± 0.9 ($p<.009$). All patients improved on the CGI scale with 12.5% rated as much improved, 50% improved, and 37.5% slightly improved. All subjects tolerated the 60 mg dose of fluoxetine and there were no dropouts due to adverse effects from the medication. Thus, fluoxetine is generally well tolerated and may be an effective treatment option for adolescents with bulimia nervosa.

REFERENCES:

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SYMPOSIUM 44—EVIDENCE-BASED PSYCHIATRY: PRINCIPLES, EXAMPLES, AND CRITIQUES IN THE U.S. AND FRANCE
French Federation of Psychiatry

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should understand important similarities and differences in the approaches to evidence-based psychiatry in the United States and France.

No. 44A
PRINCIPLES OF EVIDENCE-BASED PRACTICE: U.S. STYLE

Robert A. Rosenheck, M.D., *NEPEC, VA Northeast Program Evaluation Center, 950 Campbell Avenue, Building 8, Unit 182, West Haven, CT 06516*

SUMMARY:

In the U.S., mental health care is increasingly provided through large organizations. As a result organizational process has become an under-examined barrier and potential bridge for the introduction of evidence-based treatment models into mental health practice. Complex organizations of the type in which mental health care is increasingly delivered are characterized by: (1) multiple competing goals, (2) uncertain technologies, and (3) fluid involvement of key participants. Interventions shown to be effective in controlled studies are not as easily introduced into such organizations as researchers expect, because research is conducted in buffered organizational niches quite different from these complex open systems. Key strategies for moving research into practice include constructing decision-making coalitions, linking new initiatives to legitimated goals and values, quantitative monitoring of implementation and ongoing performance, and the development of self-sustaining communities of practice as well as learning organizations.

Conclusion: Effective dissemination of new treatment methods requires attention to, and effective engagement with organizational processes.

No. 44B
EFFECTIVE IMPLEMENTATION OF GUIDELINES: AN EXAMPLE OF SUICIDE PREVENTION IN FRANCE

Jacques Glikman, M.D., *SEP, AMARS, 159 Rue Nationale, Paris 75013, France;* Boland Bouet, M.D., Catherine Mayault, M.D., Jean-Louis Terra, M.D.

SUMMARY:

The Fédération Française de Psychiatrie (FFP) and the Agence Nationale d'Accreditation et d'Evaluation en Sanité (ANAES) have co-organized several clinical guidelines and consensus conferences on psychiatric topics since 1994. International studies have shown that disseminating widely high-quality clinical guidelines recommendation or consensus conference conclusions was not sufficient in itself to improve clinical practice.

Complementary actions should be undertaken to support the effective implementation of recommended practices. We will illustrate improvement actions in France, stemming from the principles of evidence-based-medicine, through the example of an ongoing national public health program devoted to suicide behaviors prevention and care. Clinical guidelines entitled "the hospital care of teenagers after a suicide attempt" have been carried out according to the

ANAES principles with the FFP and widely disseminated. Fifteen standards have been extracted from the guidelines; a clinical audit protocol means to gather and analyze data, identify causes of problems, and propose corrective actions have been set up. A total of 46 voluntary hospitals have been involved. Preliminary result will be presented: With the support of health authorities this clinical audit will soon be proposed to all the French hospitals interested by this topic.

A consensus conference entitled "the suicidal crisis: recognize and treat" has been set up, following the methodology established by ANAES, by the FFP. To enhance the impact of the conclusions, an action plan will be launched based on continued education: in each region an academic psychiatrist and an academic psychologist will be trained on the topic. They will then transfer their knowledge and skills to ground professionals.

No. 44C
ASSERTIVE COMMUNITY TREATMENT AS EVIDENCE-BASED PRACTICE

Robert E. Drake, M.D., *NH-Dartmouth Psychiatric Research Center, 2 Whipple Place, Suite 202, Lebanon, NH 03766;* Kim T. Mueser, Ph.D., Gary R. Bond, Ph.D.

SUMMARY:

Assertive community treatment is a style of organizing community-based services for clients with severe mental illness. It involves a multidisciplinary team, shared responsibility, 24-hour per day availability, outreach, integration of services, and direct service provision rather than brokering. Assertive community treatment has a strong evidence base and the specific forms of treatment as well as the evidence base have evolved over the past 21 years. This presentation will review the current modifications of assertive community treatment that have an evidence base, the limits of the evidence, and the challenge of widespread implementation.

No. 44D
THE FRENCH SECTORIZATION SYSTEM: WHAT EVIDENCE?

Francois C. Petitjean, M.D., *Department of Psychiatry, C. Hospital Sainte Anne, 1 Rue Cabanis, Paris 75674, France;* Valerie Siari, M.D., Jean-Claude Demant, M.D., Denis Leguay, M.D.

SUMMARY:

The sectorization system was set up in France in 1960. It was actually implemented in the 1970s. The basic principles of this organization is to establish a continuity of care, by a multidisciplinary team, for patients treated in the hospital as well as in the community. The term "sector" has always meant two different things: it has an administrative sense, that is catchment area with specific boundaries; it also is a synonym for community psychiatry. A recent report commissioned by the French Ministry of Health shows that this system has led to a gradual deinstitutionalization with a progressive shift of the locus of care, from the hospital to the community.

This presentation will examine how the sectorized system can integrate programs of care that have proved their efficacy on different outcome measures (symptoms, quality of life, etc). The assertive community treatment model can be implemented by mental health teams to meet the needs of high service users. For patients with less severe disabilities, the model of brokered case management seems more suitable.

There is a drive toward the definition of evidence-based practices (EBP) in mental health. This presentation will focus on the issue of effective implementation of EBP by mental health teams within the sectorized framework.

No. 44E
THE EFFICACY-EFFECTIVENESS GAP LIMITS CONFIDENCE IN EVIDENCE-BASED PRACTICES

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Room 476, Baltimore, MD 21201*

SUMMARY:

Confidence in recommendations to implement evidence-based practices hinges on the extent to which the "evidence" is meaningful and relevant to real-world psychiatric practice. A substantive threat to this relevance derives from the nature of the research evidence. Such evidence is far more likely to demonstrate efficacy than effectiveness. Efficacious treatments work under highly restricted research settings. Effective treatments work with the wide range of typical patients, when delivered by typical staff under typical service systems with typical reimbursement schemes. The evidence for "evidence-based treatments" is frequently limited by studies with: (1) restrictive inclusion and exclusion criteria; (2) samples that lack diversity in terms of race and ethnicity, gender, age, educational background, and other characteristics; and (3) incomplete follow-up of significant subsamples of the studied population; (4) atypical or poorly specified control conditions that do not reflect accurate comparisons to actual practice; (5) staff that frequently have special training or are specially selected to provide the program; (6) lack of attention to reimbursement and training issues. Both psychopharmacologic and psychosocial treatment studies must pay attention to the gap between efficacy and effectiveness.

No. 44F
EVIDENCE-BASED MEDICINE IN THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA: A CRITICAL POINT OF VIEW

J. M. Vanelle, *Chu de nantes, 85 Rue Spint-Jacques, Nantes 44035, France;* J. C. Loirat

SUMMARY:

The majority of patients with schizophrenia improve with neuroleptic treatment. Evidence-based medicine (EBM) in mental health can help psychiatrists to better recognize the effective and safe use of new drugs. A recent supplement of the Journal of Clinical Psychiatry examined this important point about five clinical trials of new atypical neuroleptics in the treatment of schizophrenia. However, is EBM in mental health really possible for satisfactory individual psychiatric treatment? Schizophrenia is a heterogeneous disorder with a lifetime duration. Therapeutic strategies should be chosen case by case and all over the outcome of the illness. Finally, we discuss some limits of EBM and propose to put greater emphasis on single case research about the clinical and therapeutic approach of patients with refractory schizophrenia.

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SYMPOSIUM 45—COLLABORATIVE PRACTICE IN PSYCHIATRY: DATA AND PRINCIPLES FOR PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the conceptual basis of the collaborative practice model, be familiar with empirical data that support the model for various mental disorders, and be able to apply basic principles in their practice or research studies.

No. 45A
COLLABORATIVE PRACTICE FOR BIPOLAR DISORDER: A MULTISITE CONTROLLED TRIAL

Mark S. Bauer, M.D., *Department of Psychiatry, Providence VAMC, 830 Chalkstone Avenue, Providence, RI 02908*

SUMMARY:

Bipolar disorder remains a high morbidity and costly illness in general clinical practice, despite the availability of efficacious medications. This "efficacy-effectiveness gap" may be addressed by better organizing systems of care. Department of Veterans Affairs Cooperative Studies Program (CSP) #430 is a nationwide 11-site controlled clinical trial that seeks to improve clinical, functional, and economic outcome in bipolar disorder by addressing this gap. CSP #430 hypothesizes that, compared with usual care, outcomes will be improved by treatment within an integrated, collaborative, clinic-based treatment delivery system that emphasizes (1) algorithm-driven somatotherapy, (2) standardized patient education, and (3) easy access to a single primary mental health care provider to maximize continuity of care. The trial has enrolled 330 subjects using minimal exclusion criteria to maximize the external validity of the study. Subjects are followed for three years. The intervention is highly specified in a series of operations manuals for each of the three components. Several continuous quality improvement (CQI) interventions, process measures, and statistical techniques deal with drift of care in both the intervention and usual care arms to ensure the internal validity of the study. Findings to date are discussed and basic collaborative principles that can be implemented in other health care settings are reviewed.

No. 45B
USING COLLABORATIVE CARE MODELS TO IMPROVE THE TREATMENT OF SCHIZOPHRENIA

Alexander S. Young, M.D., *VISN22 MIRECC, West Los Angeles Veterans Administration, 11301 Wilshire Boulevard, Building 210A, Los Angeles, CA 90073;* Donna L. Bean, M.B.A., Stephen R. Marder, M.D.

SUMMARY:

In schizophrenia, effective treatments include appropriate antipsychotic medication, illness self-management training, caregiver education and support, and assertive management of care. However, usual treatment often does not include delivery of these services, and outcomes are poor. To date, most efforts to improve care have focused on educating clinicians or changing the financing of care, and have had limited success. A more fundamental approach may be needed. Experience in chronic illness and mental health support the efficacy of collaborative care models. They are a blueprint for reorganizing practice, and involve changes in the division of labor and responsibility, adoption of new care protocols, and increased attention to patients' needs.

We have developed a collaborative care model that integrates service delivery approaches that are known to be effective in schizophrenia. We present EQUIP, a 15-month, controlled trial of the feasibility and effectiveness of this care model at two large VA clinics. EQUIP is using a nurse coordinator and health care informatics technology to improve patient-clinician interactions, promote optimal medical management practice patterns, and engage caregivers in the treatment process. Using results from this project, we will discuss strategies for implementing collaborative care approaches in typical treatment organizations.

No. 45C
COLLABORATIVE MANAGEMENT OF DEPRESSION

Gregory E. Simon, M.D., *Center of Health Studies—Group Health, University of Washington, 1730 Minor Avenue, Suite 1600, Seattle, WA 98101-1404*

SUMMARY:

Effective depression care—either psychotherapy or pharmacotherapy—depends on patients' sustained participation in complex and demanding treatments. Unfortunately, organized and sustained treatment is the exception rather than the rule. Many patients discontinue treatment prematurely, and for the few who receive treatments they are often not adjusted or intensified. Most patients are neither aware enough nor empowered enough to seek out higher quality treatment. Collaborative practice models attempt to address these shortcomings by promoting patient activation, enhancing motivation, and fostering more effective self-management. Several recent studies have incorporated elements of collaborative practice into systematic efforts to improve depression treatment. Examples of these successful programs include Katon's Collaborative Care model, Wells' Partner in Care program, Katzelnick's Depression Management Program for high utilizers, and Rost's QUEST program. This research identifies several key elements of effective collaborative practice: patient education programs should promote patient activation and address barriers to treatment adherence. Treatment plans should be guided by an explicit shared decision-making process. All stages of treatment should include specific efforts to assess and enhance motivation. Skills training should focus on effective self-management. The presentation will include specific clinical advice and examples in each of these areas.

No. 45D
IMPROVING DEPRESSION CARE FOR OLDER ADULTS

Jurgen Unutzer, M.D., *Department of Psychiatry, UCLA NPI, 10920 Wilshire Boulevard, Suite 300, Los Angeles, CA 90024*

SUMMARY:

We will review the application of the collaborative care principles to the treatment of older adults with common mental disorders, specifically depression. We will present project IMPACT, a multisite study of a collaborative, stepped care disease management program to improve the care of depression in late life. In this intervention program, a depression clinical specialist based in primary care works with the patients' regular primary care provider to support the use of antidepressant medications and/or to provide a six-session course of Problem Solving Treatment in Primary Care (PST=PPC) for up to

12 months. An important element of the treatment program involves education about depression and available treatments, attention to patients' and providers' treatment preferences, and teaching of skills relevant to the self-management of depression and prevention of future depressive episodes. A total of 1,775 patients are enrolled in the study, half of them randomly assigned to the IMPACT intervention model and half to a care as usual control group. We will discuss the experience with the collaborative care intervention model to date. We will also review a number of similar projects that are applying principles of collaborative care to improving the care for common mental disorders in older adults.

No. 45E
COLLABORATIVE MANAGEMENT OF CHRONIC LOWER BACK PAIN

Benjamin H. K. Balderson, Ph.D., *Center of Health Studies—Group Health, University of Washington, 1730 Minor Avenue, Suite 1600, Seattle, WA 98101*

SUMMARY:

Similar to many chronic illnesses, proper treatment of chronic lower back pain requires sustained efforts on the part of the patient to maintain a number of important self-care activities. Research has shown advice to stay active can be effective in decreasing chronic difficulties for a portion of lower back pain patients. However, two months after seeking care for back pain, a large proportion of primary care back pain patients continue to have significant worries regarding back pain, movement, and re-injury, and a slightly smaller but significant group continues to report activity limitations. Borrowing from previous research with chronic lower back pain, stepped-care, and Lorig's chronic illness management model, a treatment plan has been formulated incorporating shared management of patients between a psychologist and a physical therapist. Treatment includes addressing current worries, fear avoidance, and activity limitations in an effort to enhance motivation and promote patients' gradual activation and self-care. Recent findings of this program will be discussed, highlighting specific clinical examples on how the work is implemented with patients with chronic lower back pain.

REFERENCES:

1. Bauer MS, et al: Principles of effectiveness trials and their implementation in VA Cooperative Study #430, "Reducing the Efficacy-Effectiveness Gap in Bipolar Disorder." J Affective Disorders 2001, in press.
2. Young AS, Sullivan G, Duan N: Patient, provider, and treatment factors associated with poor-quality care for schizophrenia. Mental Health Services Research 1999; 1:201–11.
3. Von Korff M, Gruman J, Schaefer J, Curry SJ, Wagner EH: Collaborative management of chronic illness. Ann Intern Med 1997; 127:1097–1102.
4. Unutzer J, Katon W, Williams JW, Callahan CM, et al: Improving primary care for depression in late life: the design of a multicenter randomized trial. Medical Care 2001; 39:785–799.
5. Von Korff M, Moore JE: Stepped care for back pain: activating approaches for primary care. Annals of Internal Medicine 2001; 134:911–917.

SYMPOSIUM 46—HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART III
APA Committee of Early Career Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to (1) develop their own individual strategy for launching a successful private practice while maximizing strengths and interests; (2) learn techniques that will give them the necessary edge to succeed in a competitive marketplace.

No. 46A
PERSONAL FACTORS LEADING TO A SUCCESSFUL PRIVATE PRACTICE

Ann S. Maloney, M.D., *123 East 37th Street, New York, NY 10016-3030*

SUMMARY:

Dr. Maloney 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. 46B
OFFICE LOCATION AND DESIGN FOR EFFICIENCY AND SUCCESS

Barry W. Wall, M.D., *184 Waterman Street, Providence, RI 02906*

SUMMARY:

Dr. Wall 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 location will also be addressed. The impact of the office on the success of the practice, as well as how well (or not) it represents you will be presented.

No. 46C
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 will be 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. 46D
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 the 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.

REFERENCES:

1. Logsdon L: Establishing a Psychiatric Private Practice. Washington, D.C., American Psychiatric Press, Inc., 1985.
2. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996.
3. Gerber ME: The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About It. Harperbusiness, ISBN 0887307280, 1995.
4. Practice Management for Early Career Psychiatrists. APA Office of Healthcare Systems and Financing, 1998.

SYMPOSIUM 47—MAJOR DEPRESSION: CURRENT GUIDELINES, PRACTICES, AND EFFECTIVENESS RESEARCH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be updated on current evidence-based treatment recommendations for major depressive disorder; understand the extent to which clinicians provide care consistent with these recommendations; be familiar participants with two large-scale research projects studying the effectiveness of treatments and treatment algorithms for major depression: NIMH's large-scale national clinical effectiveness study of different treatment approaches (including medications and/or cognitive therapy) and a quality improvement initiative in the state of Texas.

No. 47A
EVIDENCE-BASED TREATMENT GUIDELINES FOR MDD

Alan J. Gelenberg, M.D., *Department of Psychiatry, University of Arizona Health Science Center, 2320 East Adams, Tucson, AZ 85719-1166*

SUMMARY:

This presentation will provide an overview of key clinical treatment recommendations from the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder. Although the primary focus of the presentation will be to review key treatment recommendations from these guidelines, the session will provide a brief overview of the rationale for developing guidelines and the APA guideline development process. Key recommendations pertaining to psychiatric management, psychopharmacologic treatments psychotherapeutic treatments, electroconvulsive therapy, the formulation and implementation of a treatment plan, and clinical features influencing treatment will be reviewed. The speaker will make observations on developments since the guidelines were approved. Recommendations pertaining to the acute, continuation, and maintenance phases of treatment maintenance will also be addressed. Research gaps in the evidence base that need to be addressed to inform future practice guidelines for the treatment of bipolar disorder will be summarized. Finally, the speaker will editorialize on the role of guidelines and the future of evidence-based medicine.

No. 47B
SEQUENCED TREATMENT ALTERNATIVES TO RELIEVE DEPRESSION (STAR*D)

A. John Rush, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9086*

SUMMARY:

There are many effective treatments for depressed patients, including antidepressant medications and time-limited, depression-targeted psychotherapies. However, only 50% of patients respond to the first antidepressant treatment. How to select the next best treatment is not well known. STAR*D compares several "next-step" treatments following a first treatment, and following even a second or third treatment effort. To generate findings that are directly applicable to practice, STAR*D will enter 4,000 outpatients with nonpsychotic major depressive disorder from roughly 40 primary and specialty care clinical practice sites across the U.S. Patients and family members will receive education about depression. Clinicians follow protocols to implement different treatments, including medications and/or cognitive therapy. A follow-up phase evaluates the longer-term benefits of treatment. Patients and clinicians are not masked to treatments. Masked outcome assessments conducted by telephone interviewers or by the interactive voice response (IVR) system are used to compare the effectiveness of different treatments that are randomly assigned. Outcomes include symptoms, function, side-effect burden, patient satisfaction, service utilization, and treatment costs. Ancillary studies will be conducted using this research infrastructure (for additional information on the project, see www.edc.gsph.pitt.edu/stard).

No. 47C
RESULTS FROM THE TEXAS MEDICATION ALGORITHM PROJECT MDD TREATMENT MODULE

Madhukar H. Trivedi, M.D., *Department of Psychiatry, University of TX Southwestern Medical Center, 5959 Harry Hines Boulevard, Suite 600, Dallas, TX 75235-9101*

SUMMARY:

The Texas Medication Algorithm Project (TMAP) (1) developed consensus guidelines (based on published evidence, whenever available, and on logic and clinical consensus, when evidence was insufficient); (2) developed, with consumers, a patient/family educational package; and (3) compared algorithm-driven treatment combined with the patient/family educational program (ALGO+ED) versus TAU in Texas public-sector patients with major depressive disorder in terms of clinical and service utilization outcomes. All subjects were recruited from the public state mental health system in Texas. Research outcome evaluations were conducted by an independent outcomes assessment team. Assessments were scheduled at baseline and every three months for at least 12 and up to 24 months of follow-up evaluation.

Altogether, 548 outpatients with major depressive disorder entered one of three treatments: ALGO+ED (n=182); TAUnonALGO (n=154); or TAUALGO (n=212). Since ALGO+ED patients had higher baseline depressive symptom severity than TAU patients, 175 ALGO+ED patients were matched with 175 TAU (from either TAU group) patients based on initial symptom severity and length of illness, with 73% providing 12 months of follow-up data. Primary outcomes included symptoms (30-item Inventory of Depressive Symptomatology-Clinician-Rated) (IDS-C_{30}), and function (mental component of the Medical Outcomes Study 12-item Short-Form; SF-12) obtained every three months.

Hierarchical Linear Models estimated effect sizes on change from baseline scores, adjusted for baseline severity, resources, education,

attitudes toward care, and other factors (e.g., gender, ethnicity). All patients improved during the study (p<.0001). However, the ALGO+ED group had significantly greater symptom reduction by an average of 4.55 IDS-C points (p<.004) than the matched TAU group, with the greatest benefit for patients with moderate to moderately severe baseline depressive symptom severity (IDS-C_{30} score 33–49). ALGO+ED also had significantly greater reductions (p<.0001) in self-reported depressive symptoms and better improvement in SF-12 mental function (p ≤ .046) than TAU.

No. 47D
THE TREATMENT OF MDD IN ROUTINE PRACTICE

Joyce C. West, M.P.P., *APIRE, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Farifteh F. Duffy, Ph.D., Steve Marcus, William E. Narrow, M.D., Victoria E. Cosgrove, B.A., Darrel A. Regier, M.D.

SUMMARY:

Objectives: The primary aims of this study were to: (1) characterize clinical features and treatment patterns for adult outpatients with major depressive disorder (MDD) treated by psychiatrists; and (2) assess levels of conformance with key evidence-based practice guideline treatment recommendations.

Methods: Nationally representative, clinically detailed psychiatrist-reported data from the 1999 American Psychiatric Association Practice Research Network (PRN) Study of Psychiatric Patients and Treatments were used. Use of psychosocial, psychopharmacologic, and ECT treatment for 416 adult outpatients with MDD were examined.

Results: The most common severity subtype was moderate, followed by severe without psychotic features, and severe with psychotic features. The majority had comorbid DSM-IV Axis I (49%), Axis II (21%), or Axis III (51%) disorders. A quarter had anxiety disorders; 15% had substance-related disorders. Sexual functioning (59%) and sleep (52%) problems were common. 91% were prescribed antidepressants, 42% antianxiety medications, and 11% antipsychotics. 76% received psychotherapy from the psychiatrist or another provider in the past 30 days. Less than one percent received ECT. Conformance rates for the key APA guideline recommendations (APA, 2000) studied ranged from 74% to 98%.

Conclusions: Most patients received multiple treatment modalities. A significant proportion received treatment that was not consistent with key practice guideline recommendations, including 26% of patients with psychotic depression. Longitudinal research is needed to determine if there is an empirically based clinical rationale for deviating from established treatment guidelines that includes an assessment of treatment effectiveness.

REFERENCES:

1. Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2nd Edition). Washington, DC, American Psychiatric Association, 2000.
2. National Advisory Mental Health Council. Bridging Science and Service: A Report of the National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup: Rockville, MD: NIH Publication, No. 99-4353, 1999.
3. Crismon ML, Trivedi MH, Pigott TA, Rush AJ, Hirschfeld RMA, Kahn DA, et al: The Texas Medication Algorithm Project. report of the Texas Consensus Conference Panel on Medication Treatment of Major Depressive Disorder. J Clin Psychiatry 1999; 60:142–156.
4. Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Second Edition). Washington, DC, American Psychiatric Association, 2000.

SYMPOSIUM 48—DEPRESSION CARE IN MEDICAL SETTINGS: APPROACHES FOR THE FUTURE

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to describe the overall elements as well as the changing role of the psychiatrist in the new integrated systems model of care for depression in primary care as well as for depression in patients with chronic medical illness.

No. 48A
INTER-RELATIONSHIPS OF MENTAL HEALTH AND PRIMARY CARE

Harold A. Pincus, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Suite 230, Pittsburgh, PA 15213;* Constance M. Pechura, Ph.D., Lynn I. Elinson, Ph.D., Amy R. Pettit, B.A.

SUMMARY:

Depression is a serious, often chronic disease that can be managed effectively with a chronic care model in primary care settings. Depressed persons are likely to be seen by a primary care physician, but their condition often goes unrecognized and untreated. There are effective treatment models that consist of efficacious psychotherapeutic and pharmacological interventions, use of evidence-based guidelines for primary care treatment of depression, development of explicit plans and protocols, reorganization of practice, longitudinal follow-up, patient self-management, decision-making support, access to community resources, and leadership commitment. Moving these models into everyday practice requires overcoming both clinical and system barriers. Barriers consist of issues surrounding patients, providers, practices, plans, and purchasers. An understanding of these barriers at each level helps to lay out a framework for the changes required to overcome these barriers.

No. 48B
IMPROVING OUTCOMES OF DEPRESSION WITH STEPPED-CARE PRINCIPLES

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.

SUMMARY:

In this paper, I will review the evidence-based, stepped-care approach that has been found to improve the outcomes of depression in organized health care systems. In this approach, primary care providers provide initial diagnosis and determine whether active treatments are needed or watchful waiting for subthreshold disorders (Step 1). When a diagnosis of major depression is made, nurses and other allied health professionals help support primary care treatment by providing the time and frequency of contacts needed to enhance patient adherence and lifestyle changes (i.e. behavior activation) and to monitor outcomes (Step 2). Psychiatrist supervision of the caseload of allied health professionals may improve outcomes. Psychiatrists provided targeted consultation and brief follow-up (Step 3) to patients with persistent symptoms after acute phase treatment. Selected patients will need referral to specialty mental health clinics (Step 4) for more prolonged treatment.

No. 48C
DEPRESSION BREAKTHROUGH SERIES: QUALITY IMPROVEMENT IN PRIMARY CARE DISSEMINATION PROJECT

David J. Katzelnick, M.D., *Healthcare Technology Systems, Incorporated, 7617 Mineral Point Road, Suite 300, Madison, WI 53717*

SUMMARY:

Objective: Two previous Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) initiatives (sponsored by the Robert Wood Johnson Foundation national program on improving chronic illness care) have successfully reorganized care for diabetes and congestive heart failure producing sustainable change. The goal of the Depression BTS is to discover if the same changes can be achieved for depression care in diverse health care systems.

Methods: Twenty-three ethnically and geographically diverse health care organizations agreed to participate in the BTS focusing on depression care. Many were Bureau of Primary Care clinics. Each team attended three learning sessions that emphasized the ICIC chronic illness care model, key depression change concepts, and how to initiate Plan-Do-Study-Act (PDSA) cycles. An e-mail listserve, monthly reporting of data and progress, and teleconferences were utilized to facilitate collaboration between learning sessions. Most sites used the Patient Health Questionnaire-9 (PHQ-9) for structured depression diagnosis and severity and the MacArthur Foundation Tool-kit. Not all plans used the same patient outcomes. Four outcomes were used by many of the plans.

Results: Seventeen of the 20 plans completing the BTS achieved a faculty assessment of at least a 4 out of 5, indicating significant improvement. Over 2,000 patients initiated depression treatment and were registered in the plan's depression registries. Fifty-eight percent of patients had significant change in their depressive symptoms at 12 weeks, 77% had follow-up assessments, 55% continued antidepressant medication for at least 10 weeks, and 97% completed a structured diagnostic assessment. The Bureau of Primary Care and many of the plans are now spreading the initiative.

Conclusion: The IHI Breakthrough Series is a viable method of disseminating evidence-based depression care in diverse medical settings.

No. 48D
THE MACARTHUR INITIATIVE ON DEPRESSION IN PRIMARY CARE

Thomas E. Oxman, M.D., *Department of Psychiatry, Dartmouth Medical School, One Medical Center Drive, Lebanon, NH 03756;* Allen Dietrich, M.D., Kurt Kroenke, M.D., James E. Barrett, M.D., Paul Nutting, M.D., John Williams, M.D., Kathryn M. Rost, Ph.D.

SUMMARY:

A public health emphasis for addressing mental health needs is enhancing the role of primary care. Excellent care for mental disorders in primary care is achievable with a well-developed system for care. Components of care systems include various combinations of physician and patient education, care management, and an enhanced mental health interface. Probably the key component is the use of physician extenders such as nurses or social workers serving as care managers to systematically assess treatment barriers and measure treatment response. Enhancing the mental health interface is probably the most difficult component to implement. A major problem of system research is the lack of persisting changes after quality improvement or research projects. To disseminate system changes, practice re-engineering requires low cost and implementation without the aid of a research infrastructure. A manualized, widely applicable, easily transported set of web-based toolkits and implementation strategies using a turn-key system is one desirable approach. This presentation will discuss some materials and strategies completed and others currently being tested.

No. 48E
DEPRESSION IN PATIENTS WITH CONGESTIVE HEART FAILURE

Steven A. Cole, M.D., *Department of Psychiatry, Albert Einstein College of Medicine, 10 Chester Court, Huntington, NY 11743;* Nancy Farber, R.N., Joseph S. Weiner, M.D., Michelle Sulfaro, R.N., Alan Silver, M.D., David J. Katzelnick, M.D.

SUMMARY:

This presentation discusses the development, implementation, and outcomes of an innovative telephonic disease-management program for depression in Medicare patients with congestive heart failure. The core elements of the program were developed and implemented according to the "chronic illness care model" elaborated by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement: practice re-design, specialist decision support, patient self-management support, and information system registries.

Thirty-five of 103 CHF patients assessed had a depressive syndrome. After six months, 70% of patients with major depression achieved significant clinical improvement and 50% of patients with other depressive syndromes achieved significant clinical improvement. Of considerable interest, 70% of the patients with major depression who improved significantly were not taking antidepressant medication. The recovery of these patients seemed to result from the activation of patient self-management support through the relationship with the telephonic nurse care coordinator and/or significant improvement in their physical comorbidities. Similarly, 80% of the patients with "other depressive syndromes" who improved significantly did not take antidepressants, but seemed to benefit greatly from the intervention of the nurse care coordinator or from improvement in their physical comorbidities.

REFERENCES:

1. Pincus HA, Pechura CM, Elinson LL, Pettit A: Depression in primary care: linking clinical and system strategies. General Hospital Psychiatry, in press.
2. Katon W, Von Korff M, Lin E, Simon G: Rethinking practitioner roles in chronic illness: the specialist, primary care physician and the practice nurse. Gen Hosp Psychiatry 2001; 23:138–44.
3. Von Korff M, Unutzer J, Katon W, et al: Improving care for depression in organized health care systems: a conference report. J Fam Pract 2000; 50:530–531.
4. Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century, Washington, DC, National Academy Press, 2001.
5. Wagner E: The role of patient care teams in chronic disease management. British Medical Journal 320, no. 7234: 569–572.

SYMPOSIUM 49—GLOBAL PSYCHIATRY AND PATIENTS' RIGHTS: INFORMED CONSENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the principles that have led to federal legislation intended to protect the human subjects participating in research. The presentations explain their application and their extension to international research programs.

No. 49A
OVERVIEW OF INFORMED CONSENT: A PUBLIC PERSPECTIVE

Debra Lappin, M.D., *5235 East Princeton Avenue, Englewood, CO 80220*

SUMMARY:

This session will examine emerging issues concerning informed consent. Particular focus will be drawn from the unique perspective of the participant in human research. This introductory presentation will review: (1) the role of informed consent as part of a matrix of human research protections and the evolution of informed consent, with its historical ethical underpinnings; (2) the purpose and meaning of informed consent as a "moral contract" and an ongoing "process," as opposed to an "event"; (3) the necessary elements of informed consent, with particular focus on "disclosure": as examples, what is the purpose of disclosure, what are the statutory elements of disclosure, what are the emerging demands of participants in terms of disclosure of financial conflicts of interest, of adverse events (in multi-center trials, in novel trials, in animal studies), of new, relevant information requiring re-consent?; (4) where things can go, and have gone, wrong: recent events that raise serious concerns about informed consent, e.g. the Gelsinger case at the Univ. of Pennsylvania, the Roche case at John Hopkins University, the lead paint studies at Hopkins, pediatric research and other relevant case studies.

No. 49B
CONSTRAINED CONSENT: THE LAW AND RESEARCH IN SPECIAL POPULATIONS

Rosemary Quigley, J.D., *Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030*

SUMMARY:

The goal of improved care for patients with mental illnesses is certainly served by the enrollment of human subjects in clinical trials. However, research on individuals with mental illnesses, along with research on other so-called vulnerable populations such as prisoners and children, is governed by special protections under federal regulations on human subjects research. In many cases, research risks raise concern about the capacity for informed consent where mentally ill patients are being enrolled. However, patients may sometimes benefit from participation in clinical research—indeed participation may be a route to optimal therapy—and any barriers to research participation may be unfairly discriminatory. In many instances, decisions about research participation may be made by family members or guardians, or investigators may not even consider enrollment of these populations into trials because of additional regulatory burdens. There are important questions about whether, under the law, the autonomy of these potential human subjects is compromised by the paternalism of the relevant legal and medical communities. This presentation will review the current state of the legal protections in human subjects research on the individuals with mental illness, and will assess proposals for revision of these requirements.

No. 49C
GLOBAL PSYCHIATRY AND PATIENTS' RIGHTS: INFORMED CONSENT

Harold I. Eist, M.D., *10436 Snow Point Drive, Bethesda, MD 20814;* Norman Sartorius, M.D.

SUMMARY:

It has been almost half a century since concerned individuals, researchers, and professional associations started to show enhanced interest in the ethics of human subject research. This presentation presents the evolution of federal regulations that have come to be considered as a standard for the conduct of research.

In 1974, Congress passed the National Research Act. It created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

The commission wrote the Belmont Report (Ethical Principles and Guidelines for the Protection of Human Subjects of Research). This report contains the ethical principles that guide federal regulations for the protection of subjects. Three principles are basic: (1) respect for persons, (2) beneficence, (3) justice. The first principle focuses on the consent process. The second requires a risk/benefit assessment. The third guides the selection of research subjects.

"The Common Rule" is a common set of regulations adopted in 1991 by 17 federal departments and agencies. They addressed protective mechanisms, including review of research by an IRB, informed consent of subjects, and institutional assurances of compliance.

Drs. Eist and Sartorius discuss the national and international application of these regulations.

No. 49D
WORLD PSYCHIATRIC ASSOCIATION COMMITTEE TO REVIEW THE ABUSE OF PSYCHIATRY

Marianne C. Kastrup, M.D., *Center X Tort. Vict., Brondebyosterves 13, PO BOX 21, Copenhagen DK-1014, Denmark*

SUMMARY:

According to the WPA statutes, the Review Committee is a Standing Committee that shall review individual complaints and other issues and initiate investigations of the ethical guidelines for the practice of psychiatry as stated in the Declaration of Madrid.

One of the most important issues recently relates to Falun Gong practitioners and their hospitalization in psychiatric institutions. In the elucidation hereof the review committee has worked in close collaboration with the Chinese Society of Psychiatry as statutory required.

The paper will provide a status of the situation.

No. 49E
CULTURAL FACTORS AND INFORMED CONSENT

Professor Norman Sartorius, M.D., *Department of Psychiatry, Hopitaus University De Geneve, 2 Chemin De Petit-Bel-Air, 1225 Chenebourg, Geneva, Switzerland*

SUMMARY:

The idea that patients should give informed consent before any therapeutic intervention is of recent date. Its introduction into medicine and psychiatry is probably related to the growing influence of medical and other authorities in the U.S. and industrialized countries in the north of Europe. There, the notion was probably inspired by ideas central to the protestant religions such as those of individual's independence, personal responsibility for one's acts and self-reliance in financial, emotional and other matters.

Professional health workers and others that grew up and were inspired by other cultural and religions tenets find the notion of informed consent alien to their understanding of the world. In countries in which interdependence has the place of independence, in which responsibility for one's acts is shared with persons of authority and with one's peers and in which reliance on others is the rule, procedures of informed consent are viewed and used in a different

manner from that in the countries that have been at the origin of the request that they be used. There, but perhaps also elsewhere, the procedures are often used in a ritual way. The understanding that patients have of their rights and the perception of these rights by their family, community, and their doctors makes explanations prior to interventions different from those that are expected and probably often meaningless.

The presentation will discuss these differences and ways to ensure that patients' welfare and rights are safeguarded despite the many differences that exist between the cultures of the world.

REFERENCES:

1. McGuire-Dunn C, Chadwick G: Protecting Study Volunteers in Research. CenterWatch, Inc, Boston, Ma. 1999.
2. Blazar DG, Hays JC: An Introduction to Clinical Research in Psychiatry. Oxford University Press, Oxford, 1998.

SYMPOSIUM 50—THE PSYCHIATRIC TREATMENT OF HIV DISEASE IN THE THIRD DECADE OF AIDS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the current treatment issues concerning HIV, including drug-drug interactions; (2) identify the CNS manifestations; (3) outline the diagnostic criteria for mood and anxiety disorders; and (4) acknowledge the challenges of multiple diagnosis.

No. 50A
HIV TREATMENT UPDATE

Marshal Forstein, M.D., *Harvard University, Department of Psychiatry, 24 Olmstead Street, Jamaica Plain, MA 02130*

SUMMARY:

The availability of an increasing number of antiretroviral agents and the rapid development of new information has introduced and sustained extraordinary complexity regarding the treatment of HIV-infected persons. Potential benefits of such treatments include control or reduction of viral replication, delayed disease progression and prolongation of life, and potential maintenance or reconstruction of a normal immune system. While generating waves of hope and optimism, these treatments also carry significant risks, including the reduction of the quality of life because of toxicity, the potential for early viral resistance and the resulting decrease in treatment options, and the unknown long-term efficacy of combination therapies. These risks pose serious challenges in the treatment of HIV disease. To address the challenges presented by this epidemic, this session will provide information on recent advances in virologic detection and monitoring and explore guidelines and options for the treatment of HIV disease.

No. 50B
CNS MANIFESTATIONS

Karl Goodkin, M.D., *Department of Psychiatry, University of Miami School of Medicine, 1400 NW 10th Avenue, Room 803A, Dom Tower, Miami, FL 33136*

SUMMARY:

Neurologic disease is the first manifestation of symptomatic HIV infection in roughly 10% to 20% of persons, while about 30% to 40% of patients with advanced HIV disease will have clinically evident neurologic dysfunction during the course of their illness. The incidence of subclinical neurologic disease is even higher: autopsy studies of patients with advanced HIV disease have demonstrated pathologic abnormalities of the nervous system in 75% to 90% of cases. This research provides substantial evidence that HIV directly infects the brain, resulting in central nervous system impairment and neuropsychiatric disorders, including HIV-1-associated dementia complex, and minor cognitive-motor disorder. As HIV/AIDS is increasingly treated as a chronic disorder with the improvement of treatments and longer survival times, the incidence of HIV-related neuropsychiatric sequelae is expected to increase. The involvement of psychiatrists in the diagnosis and treatment of HIV/AIDS patients is essential because of the prevalence of HIV-related neuropsychiatric complications, psychiatric comorbidity, as well as the psychodynamic aspects of HIV infection and disease.

This presentation will address primary infection of the central and peripheral nervous systems, cognitive-motor impairment and dementia, and review new developments in psychopharmacologic interventions and treatments.

No. 50C
MOOD AND ANXIETY DISORDERS

Stephen J. Ferrando, M.D., *Department of Psychiatry, New York Presbyterian Hospital, 525 East 68th Street, Box 181, New York, NY 10021*

SUMMARY:

Mood and anxiety disorders represent a broad spectrum of syndromes that can manifest in HIV-positive individuals throughout the course of their infection. While there is a general trend for increased prevalence of mood and anxiety disorders as HIV disease progresses, clinicians need to be familiar with the full spectrum of these disorders, as they may complicate both the medical and psychiatric presentation of HIV infection. Because many mood and anxiety disorders manifest with autonomic and somatic symptoms, their identification may be difficult in medically ill HIV-positive individuals. Treatment for mood disorders (particularly depression and mania) and anxiety disorders in the setting of HIV infection must take into account the full ranges of medications these patients may be taking as well as their compromised medical status. This session will address the epidemiology of mood and anxiety disorders in HIV infection, the symptoms that may be attributed, and the effective treatments to be used with HIV infected individuals impacted by mood and anxiety disorders.

No. 50D
THE MULTIPLY DIAGNOSED HIV PATIENT AND DRUG-DRUG INTERACTIONS

Francine Cournos, M.D., *Department of Psychiatry, NYS Psychiatric Institute-Columbia University, 5355 Henry Hudson Drive, # 9F, New York, NY 10471-2839*

SUMMARY:

The need for multiple diagnoses is becoming increasingly common as HIV-infected patients live longer because of antiretroviral treatments. A number of surveys of persons with HIV infection have shown an elevated premorbid rate of psychiatric disorders when compared with rates in the general population. Psychiatric treatment of patients living with HV infection should include active monitoring of substance abuse, since it is often associated with risk behaviors that can lead to further transmission of HIV and treatment nonadherence.

This session will offer guidelines for the differential diagnosis of the HIV-infected patient, and outline treatment strategies for the multiply diagnosed patient.

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2. Goodkin K, Baldewicz TT, et al: Cognitive-motor impairment and disorder in HIV-1 infection. Psych Annals 2001; 31(1):37–44.
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SYMPOSIUM 51—AMERICAN PSYCHIATRIC ASSOCIATION'S RESPONSES TO THE SURGEON GENERAL'S REPORTS ON MENTAL HEALTH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to say (1) what led to the reports, (2) how they were produced, (3) how their recommendations can be implemented by the APA and Allied Psychiatric Organizations, and (4) how the APA can work with government and citizens as partners.

No. 51A
MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL

Zebulon C. Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, 19 East 93rd Street, New York, NY 10128*

SUMMARY:

In December 1999 the Surgeon General of the United States issued the first report dealing with mental health. It calls for a public health approach, showing that mental disorders are disabling, that mental health and mental illness can be seen as points on a continuum, and with mind and body being inseparable. Stigma has deep roots and remains very strong. Key findings are summarized for neuroscience and treatment research, services reorganization, and the emergence of powerful family and consumer movements. One in five Americans has a mental disorder in any one year: 15% of the adult population and 21% of children use some form of mental health service during any year. Recommendations include: (1) continue to build the scientific base (2) overcome stigma; (3) improve public awareness of effective treatment; (4) ensure the supply of services and providers; (5) ensure delivery of state-of-the-art treatment; (6) tailor treatment to age, gender, race, and culture; (7) facilitate entry; (8) reduce financial barriers. The report was written as a set of findings for organizations to respond with more specific recommendations and plans. This paper will review what has been done since the report was released and propose more specific recommendations.

No. 51B
SUICIDE: AN AMERICAN PSYCHIATRIC ASSOCIATION PLAN OF ACTION

Selby C. Jacobs, M.D., *Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519*

SUMMARY:

This presentation will review the highlights of the Surgeon General's Report on Suicide. In response to the evidence on suicide in our communities and the Surgeon General's plan of action, the presentation will outline an APA plan of action and invite discussion.

No. 51C
CHILD AND ADOLESCENT DISORDERS: TREATMENT AND PREVENTION

G. Pirooz Sholevar, M.D., *Robert Wood Johnson Medical School, 222 Righters Mill Road, Narberth, PA 19072-1315*

SUMMARY:

Mental health problems are prevalent and disabling disorders affecting a significant number of children and adolescents at a very young age. Equally alarming is the number of youth who are vulnerable to subsequent mental disorders due to a range of genetic/familial/environmental factors. Effective and cost-efficient therapeutic modalities are available for such disorders, particularly when instituted at a relatively young age.

It is the goal of this presentation to review the following issues: (1) the prevalence of mental disorders in children/adolescents (2) the prevalence of vulnerability to mental disorders in this population (3) a review of evidence-based treatment modalities with this population (4) an elective review of evidence-based preventive methods with at-risk populations: children of mentally ill parents; children in minority groups with a particular emphasis on Latino populations.

The emphasis of this presentation is on multimodal intervention approaches within a multisystemic context.

No. 51D
YOUTH VIOLENCE: A REPORT OF THE SURGEON GENERAL

Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago, IL 60617-2746*

SUMMARY:

Using official reports and self-reports, Dr. Bell will identify the trends in youth violence. Dr. Bell will highlight research into factors that increase the risk that a young person will gravitate toward violence. Developmental pathways that lead a young person into a violent lifestyle will be outlined by delineating two trajectories for youth violence—an early one in which violence begins before puberty that has long-term consequences, and a late one that begins in adolescence and ends with transition into adulthood. Research on the factors that seem to protect youth from the effects of exposure to risk factors for violence will be presented. Research on the effectiveness of specific strategies to reduce and prevent youth violence will be underscored. Finally, Dr. Bell will present Dr. Satcher's long-range strategic plan to address the problem of youth violence in the society.

No. 51E
MENTAL HEALTH: CULTURAL ISSUES

Altha J. Stewart, M.D., *Detroit-Wayne County CMHC, 640 Temple Street, 8th Floor, Detroit, MI 48201*

SUMMARY:

From differences in help seeking behavior based on culture to selection of and responses to treatment based on culture, many have recognized that "culture counts." The publication of the report by the Surgeon General on "Mental Health: Culture, Race and Ethnicity" as a supplement to the previously published mental health report brings

the problems of providing culturally appropriate treatment to the forefront in the current health care reform debate. The report highlights the impact of additional barriers such as mistrust and fear of treatment, racism, and differences in overall communication styles. This is particularly critical in mental health because the proper diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between patient and clinician. The report identifies specific actions that must be undertaken to reduce or eliminate the disparities and offers six courses of action for the future: expanding the science base, improving access, reducing barriers, improving quality, supporting capacity development, and promoting mental health, all consistent with the goals of the APA. This paper will review these recommendations and describe work under way by the APA to develop more specific recommendations and incorporate them into the organization's overall strategic plan for the future.

REFERENCES:

1. U.S. Dept. of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: US Dept of Health and Human Services Substance Abuse and Mental Health Admin., Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999
2. Surgeon General's Report on Suicide
3. Sholevar GP: Family Interventions with Conduct Disorders. Psychiatric Clinics of North America, 2001.
4. U.S. Department of Health and Human Services: Youth Vilence: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; and National Institutes of Health, National Institute of Health, 2001.
5. U.S. Dept of Health and Human Services. Mental Health: Culture, Race Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Dept of Health and Human Service, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.

SYMPOSIUM 52—SOCIAL ANXIETY DISORDER AND COMORBID MAJOR DEPRESSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose comorbid social anxiety disorder and major depression, and have greater awareness of clinical and biological features and treatments.

No. 52A
PERSPECTIVES ON SOCIAL PHOBIA AND DEPRESSIVE COMORBIDITY

Murray B. Stein, M.D., *Department of Psychiatry, University of CA at San Diego, 8950 Villa La Jolla Drive, Suite 2243, La Jolla, CA 92037*

SUMMARY:

Background: Social phobia is highly comorbid with major depression in psychiatric clinical, primary medical care, and community samples. This paper will review the extent and impact of this commonly observed disorder combination.

Methods: The author reviews several published (and unpublished) studies addressing questions of the prevalence and functional impact of social phobia and depressive comorbidity.

Results: Most studies suggest that it is the generalized form of social phobia that carries the heaviest burden of depressive comorbidity. Although major depression is generally considered to be the more "serious" condition in cases of depressive-social phobia comorbidity, social phobia itself is associated with a remarkably high level of functional impairment and reduced health-related quality of life. In adolescents, social phobia is now recognized as a risk factor for the development of subsequent major depression. Moreover, social phobia in adolescence is predictive of a more severe form of depression in young adulthood.

Conclusions: In aggregate, these findings underscore the importance of appreciating the impact of social phobia when considering the functioning of depressed patients. Treatment of individuals with these comorbid conditions should be undertaken early, and with vigor. The field would benefit from additional information about optimal approaches to treating combined social phobia and major depression.

No. 52B
IMPLICATIONS OF COMORBID SOCIAL PHOBIA FOR MAJOR DEPRESSIVE SUBTYPES AND COURSE

Jonathan E. Alpert, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Megan E. Hughes, B.A., Joel A. Pava, Ph.D., Nicole B. Neault, B.A., Timothy J. Petersen, Ph.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D.

SUMMARY:

Social phobia appears to be the most prevalent comorbid DSM-IV anxiety disorder among adults presenting with major depression in psychiatric outpatient settings, typically with an early age of onset preceding the first depressive episode and extending into adulthood. A relationship between social phobia and particular depressive subtypes and course has been suggested by studies of depressed outpatients. Major depression among adults with social phobia frequently presents with atypical features, including mood reactivity, hypersomnia, hyperphagia, leaden paralysis, and rejection sensitivity. In addition, depressed individuals with social phobia often have a history of juvenile-onset depression as well as a family history of major depression. Axis II comorbidity is also prevalent among these patients. This presentation will focus upon the diagnostic boundaries between atypical depression, social phobia, and avoidant personality disorder in depressed adults. Data will be presented concerning the relevance of comorbid social phobia to the acute and longer-term outcome of depression treatment with respect to core depressive symptoms as well as social functioning. Although the nature of the relationship between social phobia and depression with respect to pathogenesis and treatment implications remains to be elucidated, the emerging literature suggests that early detection and treatment of social phobia may play a role in the primary and secondary prevention of recurrent depression.

No. 52C
INTERPERSONAL SENSITIVITY IN SAD

Gerlinde C. Harb, M.S., *Department of Psychology, Temple University, 1701 North 13th Street, Weiss Hall, Philadelphia, PA 19122;* Richard G. Heimberg, Ph.D., Vito Agosti, M.S.W., Franklin R. Schneier, M.D., Michael R. Liebowitz, M.D.

SUMMARY:

Objectives: Hypersensitivity to interpersonal rejection has been related to depression, as a diagnostic criterion for atypical depression, and a predisposing factor for depressive episodes. The current studies

investigated interpersonal sensitivity in social anxiety and differences between levels of interpersonal sensitivity in atypical depression and social anxiety disorder.

Methods: Study 1 compared 202 treatment-seeking individuals with social anxiety disorder with 34 control participants on the Interpersonal Sensitivity Measure (IPSM). In study 2, two groups of treatment-seeking individuals (atypical depression; n=35, social anxiety disorder, n=35) were compared with each other and the control group (n=34).

Results: In study 1, social anxiety disorder patients scored higher than the control group [$F(2, 225) = 94.65$, $p < .001$]. Further, this pattern remained significant after depression levels were controlled [F (2, 209) = 43.82, $p < .01$]. Study 2 showed that the socially anxious group scored significantly higher than the atypical depression and normal control groups, which did not differ from one another [$F = 26.269$, $p < .001$].

Conclusions: The results demonstrate that interpersonal rejection sensitivity is related to social anxiety disorder. Different aspects of interpersonal sensitivity will further be explored and implications of these findings for the relationship between interpersonal sensitivity; atypical depression, and social anxiety disorder will be discussed.

No. 52D
SOCIAL PHOBIA AND COMORBIDITY WITH DEPRESSION: A DICHOTIC LISTENING STUDY

Gerard E. Bruder, Ph.D., *Department of Biopsychology, New York Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Franklin R. Schneier, M.D., Jonathan W. Stewart, M.D., Patrick J. McGrath, M.D., Paul Leite, M.A., Frederick M. Quitkin, M.D.

SUMMARY:

Objective: Neuroimaging and electrophysiologic studies have found evidence that anxiety disorders are associated with reduced left temporoparietal and greater right frontotemporal activation. This study examined dichotic listening measures of hemispheric asymmetry in social phobia and the effects of comorbidity with depressive disorders.

Method: A 2 x 2 factorial design assessed patients in four groups: (1) social phobia but no depressive disorder (n=18), (2) depressive disorder but no social phobia (n=96), (3) comorbidity of both disorders (n=18), and (4) subjects with neither disorder (n=63). Unmedicated patients and comparison subjects were tested on dichotic fused-words, a consonant-vowel syllable, and complex tone tests.

Results: Social phobia with or without a depressive disorder was associated with reduced right ear (left hemisphere) processing of words or syllables. Patients having comorbidity of social phobia and depressive disorders also had greater left ear (right hemisphere) advantage for perceiving complex tones when compared to patients having either disorder alone.

Conclusions: Social phobia is associated with reduced left temporoparietal processing of verbal information, which may contribute to the stress of public speaking. A additional increase in right temporoparietal processing of tonal information is a distinctive characteristic of comorbidity with depression.

Supported by NIH grant MH36295.

No. 52E
CITALOPRAM TREATMENT OF COMORBID SOCIAL ANXIETY DISORDER AND MAJOR DEPRESSION

Franklin R. Schneier, M.D., *Department of Therapeutics, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Michael R. Liebowitz, M.D., Raphael Campeas, M.D., Carlos Bianco, M.D., Roberto Lewis-Fernandez, M.D., Randall D. Marshall, M.D., J. Arturo Sanchez-Lacay, M.D.

SUMMARY:

Introduction: Although social anxiety and major depression are often comorbid in community and clinical samples, most treatment studies of social anxiety disorder have excluded patients with comorbid major depression.

Objective: To describe a sample of patients with comorbid social anxiety disorder and major depression, and to assess effectiveness and tolerability of citalopram treatment for these patients.

Method: Twenty patients with primary social anxiety disorder and comorbid major depression were treated openly with a flexible dose of citalopram for up to 12 weeks in an anxiety disorders clinic. Principal assessments instruments included the SCID and Liebowitz Social Anxiety Scale for social anxiety subtype and severity; the SCID, Hamilton Depression Scale, and Atypical Depression Scale for depression subtype and severity; and the SF-36 for functional impairment. Treatment outcome assessment also included the Clinical Global Improvement Scale.

Results: The sample will be characterized in respect to demographic features; social anxiety disorder and major depression severity, subtypes, and order of onset; and functional impairment. Symptomatic and functional outcome will be described.

Conclusions: These open-trial findings will provide an impression of citalopram effectiveness and tolerability in these comorbid patients, and will help determine whether further controlled studies are warranted.

Funded by Forest Labs.

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2. Alpert JE, Uebelacker LA, McLean NE, Nierenberg AA, Pava JA, Worthington JJ III, Tedlow JR, Rosenbaum JF, Fava M: Social phobia, avoidant personality disorder and atypical depression: co-occurrence and clinical implications. Psychological Medicine 1997; 27:627–633.
3. Boyce P, Parker G: Development of a scale to measure interpersonal sensitivity. Australian and New Zealand Journal of Psychiatry 1989; 26:156–161.
4. Bruder GE, Wexler BE, Stewart JW, Price LH, Quitkin FM: Perceptual asymmetry differences between major depression with or without a comorbid anxiety: a dichotic listening study. Journal of Abnormal Psychology 1999; 108:233–239.
5. Bouwer C, Stein DJ: Use of selective serotonin reuptake inhibitor citalopram in the treatment of generalized social phobia. J Affect Disord 1998; 49:79–82.

SYMPOSIUM 53—ADAPTATIONS TO SEVERE STRESS: NORMAL RESPONSES AND THERAPEUTIC STRATEGIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize normal coping strategies from early childhood to midlife after severe stresses; recognize commonalities in various cultures after stress, and treat stress, bearing in mind coping strategies.

No. 53A
PRESCHOOL WITNESSES OF DOMESTIC VIOLENCE: PATHWAYS TO RECOVERY

Alicia F. Lieberman, Ph.D., *Department of Psychiatry, University of California at San Francisco, 1001 Potrero Avenue, San Francisco, CA 94110;* Patricia Van Horn, Ph.D., Chandra Ghosh-Ippen, Ph.D.

SUMMARY:

This paper will present the results of a study involving a multiethnic clinical sample of 70 preschoolers who witnessed domestic violence and who were randomly assigned to child-parent psychotherapy with their battered mothers or given referrals for treatment in the community. Results from child and mother assessments conducted at intake and at 12 months will be reported. The paper will focus on the factors that predict improvement in child traumatic stress response symptoms at 12 months, both among preschoolers who received child-parent psychotherapy or other forms of treatment and among those who did not receive treatment. The hypotheses tested postulate that 12-month improvement will be predicted by intake scores on child level of cognitive functioning, child mental representation of attachment figures, maternal level of psychological functioning, and quality of mother-child relationship. Separate analyses will be conducted for children who received treatment and for those who did not to determine similarities and differences in recovery patterns among children who received treatment and those who did not.

No. 53B
THE EFFECT OF TRAUMA ON THE GRIEVING PROCESS IN CHILDREN WHEN ONE PARENT KILLS THE OTHER

Guinevere Tufnell, M.R.C., *Traumatic Stress Clinic, 73 Charlotte Street, London W1T 4PL, United Kingdom;* Dora Black, Tony Kaplan, M.R.C., Jean Harris-Hendriks

SUMMARY:

The Traumatic Stress Clinic is a specialist NHS clinic offering a national assessment and treatment service to children and adults affected by traumatic experiences. The Clinic is afiliated to University College, London. The Child and Family Team at the Clinic has seen over 500 children who were affected by the killing of one parent by the other. Arising out of our research interests in bereaved children, we have studied the ways that witnessing the killing of one parent by the other impacts the normal bereavement process. We find that trauma impedes a child's capacity to mourn. Clinical material illustrating this will be presented and discussed, especially in terms of the effects on a child's ability to form subsequent attachments. We will discuss these natural attempts to guard from further hurts in terms of the approaches we employ in England for helping children affected by parental homicides.

No. 53C
GENDER SIMILARITIES AND DIFFERENCES IN THE STRESS REACTION OF KURDISH AND SWEDISH BOYS AND GIRLS

Viveka Sundelin-Wahlsten, Ph.D., *Department Child and Adolescent, UPPSALA University, S-750 17, Uppsala UAS75017, Sweden;* Abdulbaghi Ahmad, M.D.

SUMMARY:

We studied Kurdistanian refugee children in Sweden and a comparative Swedish group. The Harvard Uppsala Trauma Questionnaire for Children (HUTQ-C), the Posttraumatic Stress Symptoms Instrument for Children (PTSS-C), and the Child Behavior Checklist (CBCL) were administered in oral interview style to 32 children from each sample, controlled for age, gender and trauma levels. No significant differences were found between the two samples regarding types of traumatic events, frequencies of posttraumatic stress disorder, posttraumatic stress symptom scores, or behavioral problem scores. Kurdistanian children reported more war experience and being lost, while Swedish children presented higher frequencies of spare time accidents. We then looked specifically at the gender differences, having to do with how children handled the severe stresses. In the symposium, we will discuss and analyze the new question of "internalization" versus "externalization" of symptoms in the two genders across the Swedish and Kurdistanian groups.

No. 53D
COPING WITH THE DIAGNOSIS AND PROGRESSION OF CANCER

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford, CA 94305-5544;* Lisa Butler, Ph.D., Cheryl Koopman, Ph.D., Matthew Cordova, Ph.D.

SUMMARY:

As medical treatments for cancer, the second most prevalent cause of death in the United States, become more effective, it has become more of a chronic than a terminal illness. Indeed, half of all people diagnosed with cancer will not die of it. Nonetheless, the diagnosis and treatment of cancer constitutes a series of stressors, including fears regarding mortality, arduous and sometimes mutilating treatments, side effects, and alterations in social, vocational, and family functioning. Here we examine populations of women with breast cancer at various points in the course of the disease, and of spouses.

In a study of 124 women within a year of initial diagnosis of breast cancer, we assessed traumatic stress symptoms at baseline using the Impact of Event Scale (IES). On this measure a recommended cut-off score of 20 indicates clinically significant symptoms that may require intervention, and 13.7% of the sample scored at or above this score on the IES intrusion subscale and 29.0% scored at or above this cut-off on the IES Avoidance subscale. At the six-month follow-up, the cut-off score was met or exceeded by 16.9% on the IES intrusion subscale and by 22.6% on the IES Avoidance subscale. Intrusion and avoidance symptoms are even more prevalent among women with metastatic breast cancer. In a study of 125 such women, 34% of the sample scored 20 or above in the IES intrusion subscale, and 28% on avoidance. The mean total score was 31.0 (SD = 14.6, range = 0–71). Increasing age and more time since recurrence were associated with lower IES scores, while other life stressors were related to higher scores. The prevalence of intrusive thoughts, nightmares, and flashbacks as well as numbing and loss of pleasure increases further in the period leading up to death. In a study of the 59 of the 125 metastatic breast cancer patients who had died, we found an increase in both trauma symptoms on the IES and mood disturbance on the POMS prior to death (Profile Of Mood States).

We also were able to study 50 spouses prior to and 33 spouses following the deaths of these women. Thirty-four percent of the 50 spouses experienced clinically significant symptom levels prior to the deaths, and levels of baseline symptoms were uncorrelated within couples. Higher husband/partner symptoms prior to loss of their wives/partners were associated with greater current perceived stress and anticipated impact of the loss; whereas higher symptoms following loss were predicted by higher baseline levels of past family deaths, symptoms, and anticipated impact of the loss.

Thus, a substantial minority of women with breast cancer and their spouses experience PTSD symptoms, and the proportion increases with advancing disease and other life stressors.

No. 53E
NATURAL HEALING PROCESSES IN THE ESSAYS OF 111 COLUMBINE STUDENTS AT 2–3 WEEKS

Lenore C. Terr, M.D., *Department of Psychiatry, University of California at San Francisco, 450 Sutter Street, Room 2534, San Francisco, CA 94108-4204;* Daniel Bloch, Ph.D.

SUMMARY:

Two to three weeks following the April 15, 1999, school shooting at Columbine, a teacher asked each student attending junior-level classes to write about his or her own experience for an ungraded exercise. The teacher later obtained written permissions from 111 of the 118 essayists. The essays were sent to San Francisco, and from the students' writings, it was possible to categorize how close to danger a particular adolescent was and how much personal loss the student endured. From the 2000 yearbook, it was also possible to compare the activities and scholarship of the 111 essayists, now seniors, with the rest of their graduating class. It was our principal goal to search for three coping devices—abreaction, context, and correction—in the essay group. One of us had previously defined these coping styles in over 100 individually traumatized people in psychotherapy. Abreaction (expressing emotion), context (thinking through aspects of the event), and correction (finding new behaviors for the self and/or society), were rated and ranked in each essay by the first author (L.T.) and by five additional psychiatrists or psychologist from the U.S. and E.U. Only seven students showed none of the three processes; 34 used all three. Abreaction was the most commonly employed mechanism, appearing in 86 essays. The correlations between raters and within the student group will be discussed, as well as the implications for treatment. The raters will comment at the end of the presentation.

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2. Harris-Hendriks, J, Black, D, Kaplan T: When Father Kills Mother: Guiding Children Through Trauma and Grief. 2nd edition. London & Philadelphia, Routledge, 2000.
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SYMPOSIUM 54—FAMILY TREATMENT OUTCOMES OF ADOLESCENTS WITH SUBSTANCE USE DISORDERS: CULTURAL ISSUES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand: (1) the critical techniques that are effective in engaging parents and adolescents in adolescent drug abuse treatment, and (2) how to work effectively with individual family members in adolescent drug abuse treatment.

No. 54A
ENGAGEMENT AND RETENTION IN FAMILY THERAPY FOR MEXICAN-AMERICAN ADOLESCENTS

Luis Vargas, Ph.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker Avenue, NE, Albuquerque, NM 87131;* Joan D. Koss-Chioino, Ph.D., Jose M. Canive, M.D.

SUMMARY:

Although engaging and retaining ethnic minority families of substance abusing, problem-behavior adolescents has been discussed as a special challenge, a family systems engagement intervention among Cubans and other Hispanics, developed at the University of Miami, Spanish Family Guidance Center (UMSFGC), has been shown to be effective. This presentation will describe a test of the UMSFGC intervention in a Mexican-American population in the Phoenix metropolitan area. The process of engagement into family therapy as a general process will be discussed. Data on engagement and retention from a test of the Miami engagement intervention among Mexican American and Mexican descent youths in the Phoenix metropolitan area will be presented. Results show that the UMSFGC intervention did not have the same success in the Mexican-American population as in the two Miami studies. Possible reasons for the difference in success rates will be discussed.

No. 54B
OUTCOMES OF TREATING SOUTHWESTERN LATINO YOUTH: SALIENT QUESTIONS

Joan D. Koss-Chioino, Ph.D., *Department of Anthropology, Arizona State University, 6411 South River Drive, Tempe, AZ 85283;* Luis Vargas, Ph.D., Jose M. Canive, M.D.

SUMMARY:

There are very few treatment outcome studies with Latino youth. Studies in Miami, mostly with Cuban youth, show that Structural-Strategic Family Therapy (SSFT) can reduce substance use and psychological symptoms. However, no one has reported on the effects of SSFT in a culturally different Latino population. This presentation reports on a NIDA-funded study that examines the effectiveness of group therapy SSFT among Mexican-American and Mexican youths, 12–18 years of age, who presented with substance use and problem behaviors. Major hypotheses were; (1) family therapy is more effective than group therapy in reducing substance use and problem behaviors, (2) family therapy or group therapy reduces psychological symptoms, and (3) better family functioning mediates treatment outcomes. Results indicate that family therapy and group therapy equally reduce substance use and psychological symptoms and family functioning changes only to a limited extent. Given the contrasting outcomes of the Miami studies, salient questions are raised. These relate to therapy processes, including cultural differences, therapist-patient alliance, treatment adherence, and clinical context.

No. 54C
INVOLVING PARENTS AND ADOLESCENTS IN ADOLESCENT DRUG-ABUSE TREATMENT

Michael S. Robbins, Ph.D., *Department of Psychiatry, University of Miami, 1425 NW 10th Avenue, Miami, FL 33136;* James F. Alexander, Ph.D., Charles W. Turner, Ph.D.

SUMMARY:

Social factors, including family, parent-adolescent, and parent variables are influential in the development and continuation of adolescent substance abuse. Furthermore, research indicates that parents play a critical role in the successful treatment of adolescent

drug problems. However, getting parents and adolescents involved in treatment is a complex and difficult process that has rarely been explored in research studies. This study examined how therapists engaged and retained adolescents and parents in family-based adolescent drug treatment. Specifically, the study aimed to identify (1) the link between the parent-therapist alliance and retention in treatment, (2) the link between adolescent-therapist alliance and retention in treatment, and (3) specific therapist interventions that served to build the therapist's alliance with adolescents and parents. The study found that parental and adolescent alliance were related to dropout and that alliance ratings could be used to differentiate treatment completers from dropouts. However, the pattern of the alliance-dropout relationship was influenced by the mode of delivery (conjoint vs. one person). The results imply that intervention strategies must be tailored to adolescents and parents; simple, unitary strategies may not be effective for building relationships with both roles.

No. 54D
CLINICAL TRIAL OUTCOMES FOR TREATMENT OF ADOLESCENT ALCOHOL AND DRUG ABUSE

Holly B. Waldron, Ph.D., *CFAR, University of New Mexico, 2700 Yale, SE, Suite 200, Albuquerque, NM 87106;* Charles W. Turner, Ph.D., Janet Brody, Ph.D., Thomas R. Peterson, M.S., Sheryl Kern-Jones, Ph.D.

SUMMARY:

This presentation summarizes outcomes from three clinical trials focusing on engaging and intervening with substance abusing adolescents. Study 1 examined the efficacy of a unilateral treatment to engage treatment-refusing youth. Study 1 included 43 parents of treatment-resistant, drug abusing adolescents ranging in age from 15 to 20 years. The findings revealed that 70% of the adolescents refusing treatment were later engaged. Significant improvements in parent functioning and reductions in adolescent substance use were also found. Study 2 (n=120) and Study 3 (n=100), evaluated the efficacy of outpatient treatments for adolescents, aged 13 to 19 years, who were randomly assigned to one of the four intervention conditions: individual cognitive-behavioral therapy (CBT), functional family therapy (FFT), an integrative treatment including both FFT and CBT, or a group intervention. For both Study 2 and 3, treatment outcomes were examined at three follow-up assessments. Study 2 findings showed that adolescents receiving FFT and FFT + CBT significantly reduced substance use from pre- to post-treatment compared with CBT and group ($F(1,78) = 8.33$, $p < .05$). However, the pattern of outcome findings for the four interventions varied over time for both Study 2 and 3. The implications for the findings, taken together, will be discussed.

No. 54E
TRAUMA EXPOSURE AND CONSEQUENCES: THE CASE OF LATINO ADOLESCENTS

Jose M. Canive, M.D., *Department of Psychiatry, New Mexico VAHCS, 1501 San Pedro, SE, # 116A, Albuquerque, NM 87108;* Joan D. Koss-Chioino, Ph.D., Luis Vargas, Ph.D.

SUMMARY:

The high prevalence of trauma exposure among adolescents in treatment for psychiatric disorders is well documented. Factors that influence the risk of exposure to trauma are low socioeconomic status, residence in a neighborhood or family with a high degree of socially deviant behavior, male gender, and ethnic minority status. Despite these risk factors there are no clinical studies of trauma exposure in Mexican-American youths in the literature. This presentation is based on data collected as part of the baseline protocol for a study of family therapy treatment in Mexican origin youths. Of 218 adolescents who completed the K-SADS at baseline, 94 (44%) reported exposure to a traumatic event. However, only seven met criteria for PTSD. Females and subjects with a higher level of acculturation more frequently reported trauma exposure. Adolescents with trauma reported more psychological symptoms, more substance use, and more severe consequences of substance use. A distinction has been drawn between youths who develop BTSD, and those who do not and instead develop a "child abuse syndrome." Since family responses are culturally oriented, differences between trauma exposed youth in immigrant and non-immigrant families are explored as factors in the development of the disorder.

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2. Ozechowski TJ, Liddle HA: Family-based therapy for adolescent drug abuse: knowns and unknowns. Clinical Child and Family Psychology Review 2000; 3:269–298.
3. Alexander JF, Newell RM, Robbins MS, Turner CW: Observational coding in family therapy process research. Journal of Family Psychology 1995; 19:355–363.
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SYMPOSIUM 55—COMBINATION THERAPY FOR BIPOLAR DISORDER: RATIONALES AND CONTROVERSIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the rationale and controversies surrounding the use of mood stabilizer monotherapies, medication combinations, and psychosocial augmentations in bipolar disorder.

No. 55A
THE RATIONALE FOR COMBINING MEDICATIONS IN THE MANAGEMENT OF BIPOLAR DISORDER

Frederick K. Goodwin, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue, N.W., 8th Floor, Washington, DC 20037*

SUMMARY:

The great majority of data on the efficacy of putative mood stabilizers in bipolar disorder is derived from monotherapy studies, while in actual treatment settings, most patients receive more than one medication. Academic psychiatry, unlike the rest of medicine, has traditionally referred to combined treatment as "polypharmacy," a term often viewed as derogatory. The research community's preference for monotherapy trials (they are methodologically "cleaner") is shared by the pharmaceutical industry (the source of most support for clinical trials in psychopharmacology) for an additional reason—FDA policy in the neuropharmacology division has strongly favored monotherapy trials.

This presentation will focus on new data on the effects of mood stabilizers (particularly lithium and the anticonvulsants) involving

the postsynaptic signal transduction cascade, which suggests that lithium and the anticonvulsant divalproex may act synergistically in their beneficial effects. If so, this would further suggest that the lithium-divalproex combination might be effective at doses of each drug well below the usual monotherapy dose. Viewed in this light, the recent report that compliance is greater with the combination of lithium plus divalproex, rather than with either monotherapy, is not counter-intuitive.

No. 55B
COMPLEX COMBINATION THERAPY IN REFRACTORY BIPOLAR ILLNESS

Robert M. Post, M.D., *Biological Psychiatry, NIMH, 900 Rockville Pike, Building 10, Room 3N-212, Bethesda, MD 20892*

SUMMARY:

Lithium, carbamazepine, and valproate are widely recognized mood stabilizers. Yet, even when they are used with antidepressants, benzodiazepines, and typical and atypical neuroleptics as needed, there is still a high incidence of lack of response in bipolar illness. Breakthrough days depressed are approximately two and a half times more frequent than days manic and new antidepressant strategies are sorely needed. Lamotrigine looks promising as an antidepressant modality with little switch liability, while gabapentin does not appear to be a antimanic or mood stabilizing agent, but is widely used adjunctively for a variety of comorbid conditions occurring in bipolar illness. Topiramate is promising as a mood stabilizer based solely on open add-on studies, and it also has the positive side effect of weight loss. The atypical antipsychotics are also being widely used in bipolar illness, but their efficacy in depression and long-term prophylaxis has not been adequately expressed and as a class many have the associated liability of weight gain. Thyroid and many other augmentation strategies such as omega-3 fatty acids are also being widely utilized but are based on an inadequate evidentiary database. Within the intramural program of the NIMH, discharge data from the 1970s to 2000 are highly positively correlated to the number of medications on discharge necessary for achieving acute improvement. This has been associated with an earlier age of onset of illness, greater number of prior depressions, and faster cycling patterns in the patients referred over the past three decades. New methodologies are required to evaluate comparative combination strategies and their most optimal development and sequencing.

No. 55C
THE USE OF ATYPICAL ANTIPSYCHOTICS PLUS STANDARD MOOD STABILIZERS IN BIPOLAR DISORDER

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney-NY Presbyterian Hospital, 525 East 68th Street, New York, NY 10021*

SUMMARY:

Considerable debate surrounds the use of antipsychotics in bipolar disorder, and their role as mono- versus add-on therapies. Current practice guidelines favor short-term use of adjunctive atypical antipsychotics in severe, psychotic, and/or rapid cycling forms of mania or bipolar depression, although recent clinical trials suggest that some atypical antipsychotics possess intrinsic antimanic properties. Some may also reduce depression during mania, diminish agitation, and enhance cognition. Controlled studies further suggest that either olanzapine or risperidone, in conjunction with lithium or divalproex, may accelerate the magnitude of response and time to remission from acute mania. Hence, in routine practice, a broadened and independent role for certain atypical agents is becoming increasingly evident. Rationales for combining standard mood stabilizers such as divalproex or lithium plus atypical antipsychotics stem from their possible complementary mechanisms of action (e.g., GABAergic enhancement by anticonvulsants and 5-HT_2 blockade via atypical antipsychotics), independent of antipsychotic effects per se.

This presentation will review current information about combined treatment with standard mood stabilizers plus atypical antipsychotics across the spectrum of illness phases in bipolar disorder. Issues regarding drug tolerability, side-effect management, and cost-benefit analyses will be described for translating data from controlled studies to office-based practice decisions.

No. 55D
BIPOLAR DEPRESSION: MOOD STABILIZERS ALONE, OR ANTIDEPRESSANT AUGMENTATION?

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

Practitioners often assume that antidepressant drugs become a necessary addition to standard mood stabilizers for the treatment of bipolar depression. Yet, the potential value of adding antidepressant medications to mood stabilizers—above and beyond the effects of therapeutically dosed lithium, divalproex, or lamotrigine alone in bipolar I disorder—remains uncertain. This controversy holds particular significance because of the potential for antidepressant drugs to induce manias or worsen the long-term course of bipolar illness by promoting cycle accelerations. In this presentation, controversies will be reviewed regarding the use of single-agent mood stabilizers relative to mood stabilizers combined with antidepressants for both the acute and prophylactic treatment of bipolar depression. Guidelines will be addressed for making best-practice decisions about when to add particular antidepressants to mood stabilizers, alongside issues regarding the optimal duration and safety of antidepressant augmentation of mood stabilizers during the long-term treatment of bipolar disorder.

No. 55E
AUGMENTING TREATMENT OF BIPOLAR DISORDER WITH PSYCHOTHERAPY

David J. Miklowitz, Ph.D., *Department of Psychology, University of Colorado, Muenzinger Building, Room D244, Boulder, CO 80309*

SUMMARY:

Two decades ago, bipolar disorder was considered a problem solved—and a problem solved purely with somatic treatment. As we enter the 21st century, it is clear that the treatment of bipolar disorder remains a major clinical challenge. While anti-manic medications are effective in a relatively short period of time in most patients, we have become increasingly aware of how long it takes to treat episodes of bipolar depression to full remission. We have also come to recognize how few patients remain well two years after the resolution of an acute manic or depressive episode. When these data first emerged, several research groups set out to test the potential benefit of adding a disorder-specific psychotherapy to the pharmacotherapeutic treatment of individuals suffering from bipolar illness.

It now appears that psychotherapy may have an important role to play in addressing both of these challenges. Researcher in the U.S. Canada, and the United Kingdom have recently shown the benefits of several forms of psychotherapy in the treatment of bipolar disorder, including individual, family, and group interventions using both cognitive and interpersonal approaches. This presentation will describe these new treatments and review emerging data on their impact

as adjunctive treatments of acute bipolar episodes and as strategies for adding to the prophylactic benefit of medications.

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2. Frye MA, Ketter TA, Leverich GS, Huggins T, Lantz C, Denicoff KD, Post RM: The increasing use of polypharmacotherapy for refractory mood disorders: twenty-two years of study. J Clin Psychiatry 2000; 61:9–15.
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SYMPOSIUM 56—PAIN IN THE ADDICTED PATIENT: BASIC SCIENCE, THE LAW, AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to demonstrate understanding of basic neurophysiology of pain and addiction, understand federal regulations for prescribing opioids, prevent diversion of opioids, recognize the difference between addiction and physical dependence, and treat the addicted patient who has pain.

No. 56A
NEUROBIOLOGY OF PAIN

David Borsook, M.D., *Department of Radiology, Massachusetts General Hospital, Building 149 13th Street, 2301, Charlestown, MA 02129-2060*

SUMMARY:

Pain is a critical problem in health care: it affects millions of individuals, costs billions of dollars, and is a major cause of morbidity, suffering, drug abuse, and suicide. The emotional, sensory, and autonomic responses to pain involve a number of CNS networks. Research is beginning to suggest that some of the same circuitry involved in reward is also active with aversive experiences such as pain. Pilot studies from our group suggest that there is a generalized circuitry for reward for humans, which is also active during painful stimuli. We will examine the pain system to evaluate sensory and emotional circuits in the manifestation of the "pain experience" using opioids as a common thread. Such an overlap would help explain why some substances used in pain therapy also have widespread potential for substance abuse. For instance, opioid compounds are a major category of abused substances in this country, at the same time they are the analgesic standard for the treatment of pain. The brain circuitry in humans in opioid reward has not been as well evaluated as control of opioids on descending analgesia. Thus, the commonality of opioid effects on CNS activation of reward and aversive functions remains unknown.

No. 56B
ADDICTION MECHANISMS: RECEPTORS, NEUROTRANSMITTERS, AND PATHWAYS

Eliot L. Gardner, Ph.D., *National Institute on Drug Abuse, 5500 Nathan Shock Drive, Baltimore, MD 21224*

SUMMARY:

The overall goal of this presentation is to present an overview of current understandings of the neurobiology of addiction and its attendant phenomena, including craving, rebound dysphoria, and relapse. The neuroanatomy, neurophysiology, and neurochemistry of the brain's reward/reinforcement circuits will be described. Laboratory paradigms for studying the neurobiology of addiction in laboratory animals will be described, including electrical brain-stimulation reward, *in vivo* brain microdialysis and microelectrochemistry, intravenous and intracranial drug self-administration, conditioned cue preference/aversion, and models of relapse to drug-seeking behavior. Evidence that the brain's reward/reinforcement mechanisms are functionally heterogeneous will be noted, including evidence that these systems are involved in attentional functions, expectancy of reward, disconfirmation of expectancy, and incentive motivational functions. Genetic variation in brain reward activation by addicting drugs will be noted. Current hypotheses relating to the neurobiology of drug craving and relapse will be noted. Implications of addictive drug action on brain reward mechanisms for the development of rational pharmacotherapies for drug action on brain reward mechanisms for the development of rational pharmacotherapies for drug addiction at the human level will be mentioned. The recent discovery of brain circuits governing relapse-to-addictive-behavior will be discussed. Finally, the fact that proper medical management of pain does not in the vast majority of clinical situations, confer vulnerability to addiction will be stressed.

No. 56C
RELIEVING PAIN WHILE PREVENTING DIVERSION

David E. Joranson, M.S.W., *Pain and Policy Studies Group, University of Wisconsin, 406 Science Drive, Madison, WI 53711-1068*

SUMMARY:

This presentation will review democratically achieved public policies that establish the principle of "balance." This principle should guide governmental approaches to addressing the abuse and diversion of controlled pain medications while avoiding interfering in their medical availability. These policies include international treaties, the U.S. Food, Drug and Cosmetic Act, the Federal Controlled Substances Act, and state laws. These laws establish a closed system of distribution that act as a pipeline to deliver needed medications to patients, while preventing diversion and abuse. "Leaks" may develop in the pipeline from the fringes of the health care system through improper prescribing and dispensing or illegal sales by patients, and from external attacks on the pipeline from such other illegal activities as pharmacy theft, forgery, and "doctor shopping." Balanced approaches to stopping diversion will have a high potential for targeting and stopping specific sources of diversion and a very low potential for interfering in patient care. Law enforcement officials have a duty to stop diversion without interfering in patient care, and health professionals have a duty to not contribute to diversion and abuse. If these roles are understood and implemented there could be a rational approach to addressing diversion of controlled substances without interfering in the medical use of medications that are considered essential for the relief of pain and suffering.

No. 56D
ADDICTION, PHYSICAL DEPENDENCE, AND TOLERANCE WITH OPIOID PAIN MANAGEMENT

Howard A. Heit, M.D., *8316 Arlington Boulevard, Suite 232, Fairfax, VA 22031*

SUMMARY:

One of the barriers to opioid pain management is misunderstanding the terms addiction, physical dependence, and tolerance. Physical dependence and addiction can coincide, but dependence does not equal addiction in all cases. Since long-acting/controlled-release opioids are not positive reinforcing, they should be the foundation of opioid pain management. The initial evaluation and follow-up of the pain patient is critical to differentiate between a chronic pain patient and a patient who is drug seeking. Knowledge of federal regulations pertaining to a Schedule II controlled substance is mandatory for prescribing opioids.

No. 56E
APPROACH TO THE PAIN PATIENT WITH THE DISEASE OF ADDICTION

Seddon R. Savage, M.D., *Department of Anethesiology, Dartmouth Medical, 135 East Main Street, Bradford, NH 03221*

SUMMARY:

This lecture will address the principles and practice of pain treatment in individuals with addictive disorders, including alcoholism, opioid addiction, and other types of drug addiction. The multidimensional clinical experiences of pain and addiction will be discussed, and potential synergy between the two conditions when they occur concurrently will be explored. An approach to assessment of the patient with both pain and addictive disease will be presented, with an emphasis on identifying the often multiple contributing components to the pain experience. Principles of pain treatment in the individual with addictive disorder will be discussed and basic tools for addressing pain will be briefly reviewed. Rational approaches to the use of opioids in patients with addiction will be presented with a focus on providing effective relief of pain while structuring therapy to avoid complications of use in patients at risk for medication abuse. An approach to assessing a patient's use of opioids in order to distinguish therapeutic versus dysfunctional use will be suggested. Examples of effective integrated pain management plans will be woven into the discussion.

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2. Gardner EL: The neurobiology and genetics of addiction: implications of the "Reward Deficiency Syndrome" for therapeutic strategies in chemical dependency, in Addiction: Entries and Exits. Edited by Elser J. New York, Russell Sage Foundation, 1999, pp. 57–119.
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4. Consensus Document: Definitions Related to the Use of Opioids for the Treatment of Pain. American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine, 2001.
5. Savage SR: Principle of Pain Treatment in the Addicted Patient, Section 12, Chapter 2, Principles of Addiction Medicine, 2nd Edition, American Society of Addiction Medicine, Chevy Chase, 1998.

WEDNESDAY, MAY 22, 2002

SYMPOSIUM 57—SPORTS THROUGH THE LIFE CYCLE
International Society for Sport Psychiatry

EDUCATIONAL OBJECTIVES:

To understand the pros and cons of a child specializing very early in one sport, the rewards and pitfalls associated with choosing to be your child's coach, the stresses attendant to being the child of a famous sport figure, the unique pressures attendant to elite athletic competition, and the existence and treatment of Axis I disorders and career termination issues that affect this population.

No. 57A
THE PROS AND CONS OF COACHING ONE'S OWN CHILD

Ronald L. Kamm, M.D., *257 Monmouth Road, #A-5, Oakhurst, NJ 07755-1502*

SUMMARY:

As youth sports proliferate, one dilemma facing many of our patients is whether they should coach their own child. By coaching, a parent is spending more time with his or her child, but is it fraught with tension? A parent/coach is demonstrating a committed interest in their child's activities, but are the expectations now higher than if the child were coached by someone else? In the Achievement by Proxy Syndrome, parents try to relive their athletic accomplishments by pushing their children, sometimes to dangerous excess. Over-use injuries, burnout, and eating disorders may be the result.

By the same token, who knows the child better than the parent? Who better to protect the child from the "incompetence" of other coaches, or from the spectre of sexual molestation? (20% of the women on the 1996 Canadian Olympic team had been sexually molested by their coaches at some time in their careers.) Yet a parent who coaches, leaves him or herself open to observation and criticism by other parents, by the child's teammates, and even by the "ungrateful" child. Parental feelings of rejection and underappreciation often result. Can the parent cope with that? Can the noncoaching spouse? What effect will coaching one sibling have on the others who are not coached? In addition, more than the average parent, the coach must also be willing to be a character role model at games, keeping emotions under control. The coach must also guard against the tendency to bring coaching into the house, making every dinner conversation a rehash of that afternoon's practice. Before signing on to coach, a parent should sit down with their spouse and child and go over their expectations for the coaching experience. Checklists, which will be shown at this presentation, should be filled out and compared. If all are not in accord, an open dialogue must ensue.

In the end, the good coach/parent focuses on developing their child's strengths (as opposed to their own), and accepting their child for who he or she is.

No. 57B
THE MID-CAREER ATHLETE: COPING WITH PSYCHIATRIC ILLNESS

Antonia L. Baum, M.D., *Department of Psychiatry, George Washington University, 5522 Warwick Place, Chevy Chase, MD 20815*

SUMMARY:

This presentation will address the athlete who has hit his/her stride, only to be deterred by the rebarbative effects of psychiatric illness. There will be a brief discussion of the gamut of psychopathology, from a premorbid predisposition to illness (such as depression, manic-depression, or attention deficit–hyperactivity disorder), to problems engendered through involvement in the sport itself (such as eating disorders). The ultimate nihilistic act of suicide in the athlete will also be addressed. These phenomena will be illustrated through the testimonial of an Olympic athlete who coped with depression and suicidal ideation.

This symposium is geared towards anyone in the mental health profession with an interest in the psychology and psychopathology of the athlete, and towards anyone in the athletic arena who has an appreciation for the importance of psychiatric illness in the athlete.

No. 57C
WHEN THE CHEERING STOPS: CAREER TERMINATION ISSUES IN ATHLETES

Joshua W. Calhoun, M.D., *Department of Psychiatry, Saint John's Mercy, 615 South New Ballas Road, Saint Louis, MO 63141-8221*

SUMMARY:

It is often said that an athlete dies twice, the first time being when his or her career ends. It's not only athletes, however, who view retirement negatively. As many as one-third of retirees become depressed (Atchley, 1975) and of those who voluntarily retire, a majority re-enter the work force in two years. This, unfortunately, is not true of athletes, who can rarely re-enter the "magic bubble" of elite, high-level competition. The social, psychological, and financial problems associated with termination, for which the athlete has frequently not prepared, then create a major life crisis. Interestingly, one of the most effective ways of helping an athlete deal with career termination is to view it from a death and dying model, first written about by Kubler-Ross (1969).

In this presentation the causes of career termination—age, deselection, injury, etc.—will be discussed. Other issues to be examined are the threat that retirement poses to the athlete's identity, the lack of preretirement planning in sports, and the need for mentoring and career termination counseling, often including anger-management training.

Particularly after a professional career, an important part of therapy is helping the athletes focus on their strengths, helping them see that the attributes that made them successful on the playing field can be applied to their next career in life. Examples of positive and negative experiences from the world of sports will be discussed.

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1. Kamm RL: A developmental and psychoeducational approach to reducing conflict and abuse in little league and youth sports: the sports psychiatrist's role. Child and Adolescent Psychiatric Clinics of North America 1998; 7:891–918.
2. Begel D, Burton RW: (eds) Sport Psychiatry. New York, W.W. Norton, 2000.

SYMPOSIUM 58—COMMUNITY CARE IN GERIATRIC PSYCHIATRY IN THE 21ST CENTURY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the array of clinical issues important in geriatric psychiatry for the coming century.

No. 58A
MENTAL HEALTH DISORDERS AMONG RURAL ELDERS

Kathleen M. Fisher, Ph.D., *Department of Nursing, Penn State University, 1095 Stonegate Road, Hummelstown, PA 17036*

SUMMARY:

Elder adults with psychiatric disorders are less likely to be diagnosed as having a mental disorder or to receive needed mental health treatment than younger adults. Underrecognition by providers, transportation and access difficulties, reluctance of practitioners to diagnose psychiatric illness, and difficulties disentangling coexisting medical, psychiatric and social morbidities all have been offered as explanations for this dilemma.

Depressive disorders and cognitive impairment are two of the most relevant disorders for aging populations, and left untreated they can herald worsening health or nursing home placements. Rural elderly are at added risk since mental health professionals and resources needed to maintain those with mental health disorders in their home are often lacking. Issues related to rural elderly including their "work" ethic, sense of rugged individualism, isolation, fear of institutionalism, and the stigma associated with mental illness will be presented.

Nursing assessment and intervention can be a valuable source of care for elders. A review of mental health needs for rural elders living in public housing shows a high rate of depressive disorders and dementia. These data will also be presented.

No. 58B
PRIMARY CARE MANAGEMENT OF LATE-LIFE DEPRESSION

Ira R. Katz, M.D., *Department of Geriatric Psychiatry, University of Pennsylvania, 3535 Market Street, Room 3001, Philadelphia, PA 19104*

SUMMARY:

Most older patients who receive treatment for depression receive it from their primary care physicians (PCPs). The prevalence of antidepressant use among older people in the community has been estimated as over 10%, and, therefore, the rates of treatment are comparable to estimates for the rates of depression. However, there are concerns about the effectiveness of PCP treatment; available evidence suggests that the outcomes from usual care for major depression by PCPs is comparable to that for placebo treatment in randomized clinical trials. A number of current initiatives are testing models for bridging the gap between the known efficacy of treatments for geriatric depression and the limited effectiveness of usual care in the community. These include the NIMH-supported PROSPECT study evaluating the effectiveness of care management versus usual care in reducing depression and indicators of suicidal risk in older primary care patients; the Hartford Foundation-supported IMPACT study evaluating a similar model; and the SAMHSA and VA-supported PRISMe study evaluating site-specific models for integrating

mental health with primary care for older adults versus referral to mental health specialists. For PROSPECT, early findings suggest robust effectiveness. This presentation will review the issue, the designs of the ongoing research, and early findings.

No. 58C
MANAGING THE BEHAVIORAL COMPLICATIONS OF DEMENTIA

Robert P. Roca, M.D., *Sheppard Pratt Health System, 6501 North Charles Street, Baltimore, MD 21285-6815*

SUMMARY:

While dementia is defined in terms of changes in cognitive functioning, it is the so-called noncognitive behavioral features that are most disturbing to caregivers and most likely to lead to institutional placement and even psychiatric hospitalization. These features include aggressiveness, motor agitation, sexual disinhibition, depression, anxiety, irritability, persecutory delusions, and hallucinations. Since most persons with dementia exhibit these or related manifestations, psychiatrists are often consulted to assist in their management. A systematic approach involves examining problem behaviors from the empathic, behavioral, and medical perspectives. The empathic perspective involves "standing in the patient's shoes" and appreciating how this individual, with a unique biography, now demented, comes to exhibit the problem behavior in response to particular environmental circumstances. The behavioral perspective asks whether the environment is reinforcing or providing a model of the undesirable behavior. The medical perspective asks if a superimposed medical condition might account for the problem behavior. Each perspective yields unique opportunities for intervention. Specific pharmacologic approaches are available when problem behaviors are related to depression, anxiety, insomnia, delusions, or hallucinations. When empirical trials of psychotropics are needed, it is desirable to try the safest drugs first and to select agents that might do "double duty."

No. 58D
CARING FOR ELDER DEPRESSION IN THE 21ST CENTURY

Paul A. Kettl, M.D., *Department of Psychiatry, Pennsylvania State University, P O Box 850, Hershey, PA 17036*

SUMMARY:

Epidemiologic surveys suggest that major depression in community-dwelling elders occurs at rates lower than in the general population. However, depression remains a common clinical problem in geriatric psychiatry.

Special populations of elders with accompanying brain disorders such as Parkinson's disease, stroke, or Alzheimer's disease are especially likely to suffer from depression. Also, those with heart disease or other chronic conditions are more likely to suffer from depression. Grief, an undertreated condition can frequently evolve into major depression.

The cost of depression includes increased rates of death in those with heart disease or placement in nursing homes. Suicide rates in elders with depression are high, with older males having the highest suicide rates of any group.

Treatment for depressive disorders, including medications, ECT and psychotherapy is quite good, but stigma, availability of providers and problems in Medicare payment limit access.

The special problems in treating elders for depressive disorders will be reviewed in this presentation.

No. 58E
DEPRESSION IN PATIENTS WITH RECENT-ONSET,BILATERAL-AGE-RELATED MACULAR DEGENERATION

Barry W. Rovner, M.D., *Department of Geriatric Psychiatry, Wills Eye Hospital, 900 Walnut Street, 8th Floor, Philadelphia, PA 19107;* Robin Casten, Ph.D.

SUMMARY:

Age-related macular degeneration (AMD) is a highly prevalent, disabling disease of aging that compromises independence and quality of life. Because it lacks symptoms that overlap with depression, AMD provides a useful model to study the interrelationships of disease severity, disability, and depression. In this prospective study, we report the prevalence and incidence rates of, and risk factors for, depression in older patients with recent-onset bilateral AMD (N= 51). Seventeen patients (33%) were depressed at baseline and they had worse visual acuity (p=.038) and greater levels of vision-specific (p=.031) and general clinical disabilities (p=.002) than nondepressed patients. The incidence rate of depression was 33% over six months. Risk factors were higher baseline CES-D (p=.01) and neuroticism (p=.04) scores. Only two patients (4%) were treated for depression.

We conclude that the prevalence and disabling effects of depression in older patients with AMD are substantial. The personality variable of neuroticism predicts depression and excess disability. Recognizing that depression is a treatable disorder that exacerbates the effects of AMD and other chronic diseases will lead to improved outcomes. Innovative interventions to prevent or treat depression in older patients with chronic disease will be discussed.

REFERENCES:

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2. Schulberg HC, Bryce C, Chism K, et al: Managing late-life depression in primary care practice: a case study of the health specialist's role. Int J Ger Psych 2001; 16:577–84.
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SYMPOSIUM 59—BRAIN STIMULATION IN NEUROPSYCHIATRIC ILLNESS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to englighten psychiatrists about the exciting area of brain stimulation, which has both investigational and therapeutic possibilities. At the end of the symposium participants will be familiar with much neuroanatomy and with mechanisms of stimulation.

No. 59A
BRAIN STIMULATION FROM ABOVE AND BELOW: THEORETICAL ISSUES

Mark S. George, M.D., *Department of Psychiatry, Medical University of South Carolina, 52 President Street, Roomn 502 North 10P,*

Charleston, SC 29425; Ziad H. Nahas, M.D., Andrew F. Kozel, M.D., Xingpao Li, M.D., Jeong-Ho Chae, M.D.

SUMMARY:

Transcranial magnetic stimulation (TMS) and vagus nerve stimulation both involve depolarizing nerves with electrical currents. However, they otherwise differ radically in many ways.

TMS is performed by passing a powerful but brief electrical current through a hand-held electromagnet. This creates a powerful magnetic field that in turn passes unimpeded through the skull, inducing current to flow in superficial cortex. Currently, TMS cannot stimulate deep brain structures directly. However, cortical stimulation has indirect effects on other brain regions through transynaptic connections. PET and fMRI studies now reveal how cortical TMS can be used as a window to stimulate subcortical and limbic regions.

VNS is accomplished by a generator implanted under the skin in the chest, which sends intermittent signals through a wire to the vagus nerve in the left neck. This signal is transmitted through sensory fibers in the vagus nerve to brainstem areas involved in alertness and regulatory functions. Recent PET and fMRI studies have shown how these regions in turn communicate to other 'higher' limbic and cortical regions.

Psychiatry thus now has the tools to build on the knowledge gained through traditional functional imaging. TMS and VNS allow us to access important brain regions through different routes. The next 20 years should be exciting ones as we learn more about the mechanisms by which these tools affect the brain and then refine their use as therapies.

No. 59B
SEIZURES, ECT, AND TRANSCRANIAL MAGNETIC STIMULATION: THERAPEUTIC OPTIONS AND NEW DIRECTIONS

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

SUMMARY:

There is substantial evidence that the antidepressant efficacy of ECT is highly contingent on electrode placement and stimulus dosage. These findings indicate that the current paths and the current density within those paths are critical in determining therapeutic outcome, implying that specific neural circuits must be stimulated to obtain response. Brain imaging data converge in suggesting that suppression of functional activity in prefrontal cortex following ECT is associated with superior clinical outcome. ECT is inherently limited in localizing the electrical stimulus due to the impedance of the skull, which results in variability and widespread current distribution. Transcranial magnetic stimulation (TMS) can overcome these limitations since the scalp and skull are transparent to the magnetic field. After preliminary work with nonhuman primates demonstrating the feasibility of magnetic induction of seizures, we have successfully induced seizures in depressed patients using high-intensity repetitive TMS. The results of a within patient crossover study (n=10) will be presented. The findings indicate that the TMS treatments showed superior effects in acute postictal assessments of recovery of orientation, attention, and memory.

No. 59C
BRAIN STIMULATION, MOOD, AND EPILEPSY

Michael R. Trimble, M.D., *National Hospital for Neurology, 23 Queen Square, London WCIN 3BG, England*

SUMMARY:

In this presentation an overview of the relationship between depression and epilepsy will be given, biological associations, such as seizure location (temporal lobe), seizure type (complex partial) and neuroanatomical circuits (temporal-frontal) being noted. The possibilities of treating seizures with TMS will be reviewed, and some early studies on the use of TMS in evaluating psychiatric disorders of epilepsy presented. We have used TMS for example to examine changes in excitability thresholds in patients prescribed psychotropic drugs. The lecture will then review the role of VNS in the management of epilepsy, noting its comparable anticonvulsant activity to other new-generation antiepileptics. The results of VNS on mood in the epilepsy studies will be summarized, as will the data on a small number of patients who have become seizure free with VNS but whose behavior has deteriorated, an example of forced normalization, a topic that sits at the interface between epilepsy and psychiatry.

No. 59D
VAGUS NERVE STIMULATION IN AFFECTIVE DISORDERS: NEW FINDINGS

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

SUMMARY:

Vagus nerve stimulation (VNS) is currently being evaluated in a randomized, controlled, double-blind trial for treatment-resistant depression. However, ongoing open trial data are available that describe the course of medication-resistant mood disorders treated with VNS. As reported by Rush, et al, (2000), after 10 weeks of fixed dose VNS, the response rate was 40% (50% reduction in $HRSD_{28}$ scores) in the initial cohort of 30 patients. We recently evaluated the naturalistic outcome data from this cohort following an additional nine months of VNS treatment. The response and remission rates increased 46% and 29%, respectively, after the additional nine months of longer-term VNS. There were significant additional improvements in function, as measured by several Medical Outcomes Study (MOS) Short Form-36 (SF-36) subscales. Acute study responders had near-normal emotional role, physical function, physical role, social function, general health, and mental health SF-36 subscale scores after nine months of continued VNS treatment. Additional longer-term symptomatic and functional outcomes of VNS will be described, based on all available open-trial data. If ongoing improvement is noted with longer-term VNS, the use of chronic intermittent stimulation of the central nervous system, as occurs with VNS, might be of mechanistic and clinical importance for the development of novel treatments

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SYMPOSIUM 60—LIFE-THREATENING HYPERTHERMIC SYNDROMES IN PSYCHIATRY

EDUCATIONAL OBJECTIVES:

To diagnose, differentiate, and manage hyperthermic syndromes that may develop in patients; to recognize contrasting theories concerning the underlying pathophysiology.

No. 60A
5HT SYNDROME

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

SUMMARY:

The serotonin syndrome is an uncommon but potentially fatal complication of treatment with serotonergic agents. The authors reviewed 111 cases reported since 1991 and found that combinations of MAOIs and tricyclics, MAOIs and SSRIs, and MAOIs and venlafaxine have been most commonly implicated. The former two combinations were involved in 10 of the 12 fatal cases reported. Numerous other agents have been implicated as well during the course of monotherapy, combination therapy, or as a result of drug overdose.

The syndrome is distinguished from more common side effects of these agents by the severity, duration, and co-occurrence of a constellation of specific serotonergically mediated systemic and central nervous system effects. Hyperthermia was observed in 34% of cases and was associated with the severity and lethality of the syndrome. In many cases, the syndrome is mild and self-limited when serotonergic agents are discontinued. In severe cases, aggressive intervention with supportive measures may be required, including use of serotonin receptor antagonists.

As the use of serotonergic medication has expanded, an increasing number of cases of serotonin syndrome have been reported in the literature. The operational criteria to define the syndrome, incidence, risk factors, differential diagnosis, and treatment options will be presented and discussed.

No. 60B
STIMULANT-INDUCED HYPOTHERMIA

Una D. McCann, M.D., *Department of Psychiatry, Johns Hopkins University, 5510 Nathan Shock Drive, Baltimore, MD 21224*

SUMMARY:

Stimulants, including amphetamines, can induce life-threatening toxic hyperthermic reactions. More than 40 years ago, it was first reported that animals in crowded housing conditions were more sensitive to the lethal hyperthermic effects of amphetamine (aggregation toxicity). Later it was determined that a variety of amphetamine analogs lead to selective destruction of brain monoamine neurons and that increased temperatures were associated with more severe neurotoxicity. Over the past decade, the popularity of the amphetamine analog 3,4-methylenedioxymethamphetamine (MDMA) has increased significantly, along with reports of potentially lethal MDMA-induced hyperthermic reactions, typically in the setting of all-night dance parties known as "raves." Raves involve many of the factors associated with aggregation toxicity: high ambient temperatures, crowded conditions, dehydration, and increased physical activity. Emerging data also indicate that any MDMA user who takes enough drug to experience the desired psychoactive effects also is at risk for incurring brain serotonin neurotoxicity, a phenomenon that is likely to be exacerbated by increased temperature. Clinical signs of acute MDMA toxicity will be reviewed, along with currently favored treatment options. Data regarding the selective serotonin neurotoxic effects of MDMA will also be discussed, along with long-term implications.

No. 60C
NMS: STILL A SYNDROME AFTER ALL THESE YEARS?

Ronald J. Gurrera, M.D., *Department of Psychiatry, Brockton DVAMC, 940 Belmont Street, # 116A, Brockton, MA 02301*

SUMMARY:

Objective: To critically assess current knowledge regarding the causes, recognition, and management of neuroleptic malignant syndrome (NMS).

Method: Published clinical studies of NMS containing data pertinent to risk factors, differential diagnosis, management, and prognosis were critically evaluated and summarized. Proposed etiologies were appraised in light of stable, reproducible observations.

Results: High-potency typical antipsychotic medications may entail greater risk than low-potency typical and newer atypical agents, but controlled studies have not been done. Clinical condition at time of neuroleptic exposure (e.g., severe agitation or dehydration) appears more important than the pharmacologic agent itself, but may interact with a high rate of dosage increase to heighten risk. NMS is increasingly viewed as a spectrum disorder, but there is no consensus on specific diagnostic criteria. Knowledgeable clinicians concur that a strong suspicion of NMS should prompt immediate discontinuation of the offending agent, close medical monitoring of widely recognized clinical parameters, and prompt supportive intervention including hydration and minor tranquilizers; but previous enthusiasm for aggressive treatment with bromocriptine and/or dantrolene is waning.

Conclusions: Both state and trait factors appear to influence risk for NMS. The epidemiology, clinical morphology, and course of NMS show remarkable congruities with malignant hyperthermia (MH), but there are also notable differences. The hypothesis that NMS is caused by distinct, genetically transmitted defects affecting intracellular calcium metabolism provides a plausible model for reconciling these observations.

No. 60D
THE MALIGNANT CATATONIA SYNDROME

Stephen C. Mann, M.D., *Department of Psychiatry, University of Pennsylvania, University Avenue, 116A, Philadelphia, PA 19104;* Stanley N. Caroff, M.D., E. Cabrina Campbell, M.D., Henry R. Bleier, M.D., Robert A. Greenstein, M.D.

SUMMARY:

Malignant catatonia (MC) represents a life-threatening neuropsychiatric disorder characterized by hyperthermia, catatonic stupor or excitement, altered consciousness, and autonomic dysfunction. Prior to the introduction of modern psychotropic agents, MC was widely recognized in this country and abroad as a complication of acute psychotic illness. A comprehensive review of the modern world literature indicates that although the prevalence of MC may have declined, it continues to occur, now reported primarily in foreign publications. Lack of recognition probably accounts for the scarcity of recent North American reports. Furthermore, MC is a syndrome rather than a specific disease. While it is more commonly recognized as an outgrowth of idiopathic psychiatric disorders, MC may also develop in association with a wide array of general medical conditions or be substance induced. From this perspective, NMS may be

conceptualized as a toxic or iatrogenic subtype of MC. Evidence implicates reduced central dopaminergic neurotransmission in the pathogenesis of MC. Regarding management, antipsychotic drugs have been shown to aggravate or complicate MC episodes. Electroconvulsive therapy is an effective and practical treatment for MC resulting from psychiatric and neuromedical conditions, including NMS. Both recognition of MC and an understanding of this disorder as a syndrome are essential in avoiding a catastrophic outcome.

No. 60E
HEATSTROKE, HEATWAVES, AND PSYCHIATRIC ILLNESS

Nigel M. Bark, M.D., *Department of Schizophrenia, Bronx Psychiatric Center, 1500 Waters Place, Ward 19, Bronx, NY 10461*

SUMMARY:

Heat stroke is an often lethal condition with considerable morbidity in those who survive. Psychiatric patients are at increased risk of heatstroke, both because of their illness and their medication, which involve the same neurotransmitters as thermoregulation. However only 5 percent of the excess deaths during heat waves are caused by heatstroke, but the risk factors are the same.

Results of studies of heat waves in New York City and local psychiatric hospitals will be presented. They show greatly increased mortality in the hospitals (relative risk (RR) 1.49 compared with 1.19 in the city in the 1970s), large effects of acclimation (RR in hospitals 1.5 in first heat waves in a year and 1.15 in third), and dramatic effects of preventive measures (RR from 1.49 to 1.13, the same as in NYC, in 1980–4). In one hospital the RR was high, 1.36, before the introduction of psychotropic medication.

Another study showed that heat waves during the third to sixth months of pregnancy and in the month before conception increased the relative risk of schizophrenia to 1.1. The last perhaps related to genetic damage to sperm before fertilization.

The role of heat shock proteins in mediating all these phenomena will be discussed.

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SYMPOSIUM 61—COURSE OF PSYCHOPATHOLOGY AND FUNCTIONING IN PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand how psychopathology and psychosocial functioning change over time in patients with different types of personality disorders.

No. 61A
SIX-YEAR SYMPTOMATIC AND FUNCTIONAL COURSE OF BPD

Mary C. Zanarini, Ed.D., *Department of Psychiatry, McLean-Harvard Hospital, 115 Mill Street, Belmont, MA 02478;* Frances R. Frankenburg, M.D., John Hennen, Ph.D., Kenneth R. Silk, M.D.

SUMMARY:

Objective: The purpose of this study was to assess the symptomatic and functional course of a sample of carefully diagnosed borderline patients followed prospectively for six years.

Method: The symptomatic status and psychosocial functioning of 362 former inpatients participating in the McLean Study of Adult Development (MSAD) was assessed using semistructured interviews of demonstrated reliability. Two hundred and ninety met both DIB-R and DSM-III-R criteria for BPD, and 72 others met DSM-III-R criteria for another Axis II disorder (and neither criteria set for BPD). Over 95% of the surviving subjects were reinterviewed at two, four, and six years after their index admission.

Results: At two-year follow-up, 35% of the borderline patients experienced a remission of their BPD, and 57% attained good psychosocial functioning. At four-year follow-up, 49% of the borderline patients experienced a remission of their BPD, and 60% attained good psychosocial functioning. At six-year follow-up, 69% of the borderline patients experienced a remission of their BPD, and 65% attained good psychosocial functioning. All told, 74% of the 275 borderline patients reinterviewed at least once experienced a remission of their BPD, and 78% attained good psychosocial functioning.

Conclusions: The results of this study suggest that both symptomatic remissions and the attainment of a good level of psychosocial functioning are common among even the most disturbed borderline patients. These results also suggest a more hopeful prognosis for BPD than previously recognized. Supported by NIMH grants MH47588 and MH62169.

No. 61B
TWO-YEAR DIAGNOSTIC STABILITY OF FOUR DSM-IV PERSONALITY DISORDERS: SCHIZOTYPAL PERSONALITY DISORDER, BPD, AVOIDANT PERSONALITY DISORDER, AND OCD

Thomas H. McGlashan, M.D., *Department of Psychiatry, Yale University, 301 Cedar Street, P O Box 208098, New Haven, CT 06520-8098;* John G. Gunderson, M.D., Andrew E. Skodol II, M.D., M. Tracie Shea, Ph.D., Robert L. Stout, Ph.D., Charles A. Sanislow, Ph.D., Carlos M. Grilo, Ph.D.

SUMMARY:

Background: Personality disorders (PD) are enduring patterns of maladaptive traits/behaviors, though few data support this definition. In this study we examined two-year diagnostic stability of four PDs schizotypal (STPD), borderline (BPD), avoidant (AVPD), and obsessive-compulsive (OCPD).

Methods: PD diagnoses were reliably established using semistructured interviews (DIPD-IV, SCID-I); 571 subjects met required DSM-IV thresholds. Follow-up assessments at six, 12, and 24 months included monthly ratings of all study PD criteria. *Diagnostic* remission we define as no longer meeting DSM-IV thresholds for diagnosis or "features" (one less than threshold) at 24 months. *Disorder* remission we define as meeting two or fewer disorder criteria for 12 successive months. We report on 473 subjects (83% of the intake samples) with follow-up data.

Results: The following diagnostic and disorder remission rates, respectively, were observed at 24 months: STPD (49%, 27%), BPD (40%, 26%), AVPD (37%, 29%), OCPD (41%, 24%).

Conclusion: What would be considered high rates of remission (37%–49%) occurred over two years in four PDs. The rates may be determined by DSM-IV's categorical diagnostic system, but only in part since applying a very conservative definition of remission failed to reduce rates dramatically. The findings challenge assumptions of PD stability and persistence.

No. 61C
USING FACTOR ANALYSIS TO TEST DIMENSIONAL STABILITY OF PERSONALITY DISORDER CONSTRUCTS

Charles A. Sanislow, Ph.D., *Department of Psychiatry, Yale University School of Medicine, 301 Cedar Street, P O Box 208098, New Haven, CT 06520-8098;* Carlos M. Grilo, Ph.D., Leslie C. Morey, Ph.D., M. Tracie Shea, Ph.D., Andrew E. Skodol II, M.D., Robert L. Stout, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objective: To test stability of the latent constructs implied by borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders using factor analytic methods.

Method: A four-disorder model of DSM-IV PD criteria (borderline, schizotypal, avoidant, and obsessive-compulsive) with a stable factor structure (Sanislow et al., in press) was utilized to derive factor scores for each of these PD constructs with data from reliable diagnostic assessments conducted at four time-points (baseline, six-month, 12-month, and 24-month) as well as a "blind" (i.e., interviewers blind to baseline diagnosis) assessment conducted at two years. The factor scores were examined across four CLPS cell-assigned groups (borderline, schizotypal, avoidant, obsessive-compulsive).

Results: Pearson correlations between the various assessment time points for the factor-derived scores (baseline/six-month, six-month/12-month, 12-month/24-month) were uniformly high ($p < .0001$ for all correlations) for all disorders, ranging from .72–.83 for borderline; .83–.88 for schizotypal; .75–.83 for avoidant; and .69–.84 for obsessive-compulsive. Correlations for "blind" retest at two years were slightly lower, but all remained significant ($p < .0001$) ranging from .54–.68 for all disorders.

Conclusions: The factor structure for borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders demonstrated significant stability over a 24-month period, suggesting that, in contrast to findings using criterion cut-offs, these PD constructs are stable.

No. 61D
COURSE OF FUNCTIONAL IMPAIRMENT IN PERSONALITY DISORDERS OVER TWO YEARS

Andrew E. Skodol II, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* John G. Gunderson, M.D., Thomas H. McGlashan, M.D., Leslie C. Morey, Ph.D., M. Tracie Shea, Ph.D., Robert L. Stout, Ph.D., Donna S. Bender, Ph.D.

SUMMARY:

Objective: The purpose of this study was to determine the stability of impairments in psychosocial functioning in patients with four types of personality disorders followed prospectively over two years.

Methods: 668 rigorously diagnosed patients with borderline, schizotypal, avoidant, or obsessive-compulsive personality disorders or with major depressive disorder and no personality disorder were evaluated by trained clinical interviewers using the Longitudinal Interval Follow-Up Evaluation (LIFE) for impairments in psychosocial functioning at baseline and at six-month, one-year, and two-year follow-up assessments. Patients also completed the self-report Social Adjustment Scale (SAS-SR) at each time point. The course of Axis I and Axis II psychopathology was simultaneously tracked.

Results: Personality disorder diagnoses show considerable instability over a two-year interval, as do many Axis I disorders. Functional impairment improves over two years, but more modestly, and improvements are greater for the types of patients who had less impairment initially. Those with severe personality disorders, i.e., borderline or schizotypal, continue to show more persistent impairment despite overall improvements in their levels of psychopathology.

Conclusions: Functional impairment in personality disorders is more stable and persistent than the diagnoses themselves. In diagnosing personality disorders, emphasis should be placed on the effect personality psychopathology has on functioning in addition to absolute number of descriptive criteria exhibited at any particular time.

No. 61E
PERSONALITY DISORDERS AND AXIS I DISORDERS: LONGITUDINAL ASSOCIATIONS OF COURSE

M. Tracie Shea, Ph.D., *Department of Psychiatry, Brown University-Butler Hospital, 700 Butler Drive, Duncan Building, Providence, RI 02906;* Robert L. Stout, Ph.D., Thomas H. McGlashan, M.D., John G. Gunderson, M.D., Andrew E. Skodol II, M.D., Shirley Yen, Ph.D., Leslie C. Morey, Ph.D.

SUMMARY:

Background: There is abundant evidence of diagnostic co-occurrence between Axis I disorders and personality disorders (PDs), but little is known about their longitudinal associations. This presentation will address the time-varying associations between the course of schizotypal (STPD), borderline (BPD), avoidant (AVPD), and obsessive-compulsive (OCPD) PDs and the course of co-occurring Axis I disorders.

Methods: Diagnoses were established at baseline using semi-structured interviews. Follow-up interviews at six, 12, and 24 months assessed the course of the four PDs and Axis I disorders yielding monthly ratings of all PD criteria and weekly ratings of the diagnostic status of all co-occurring Axis I disorders. Proportional hazards regression with time-varying covariates examined the prediction of change in PD status by change in Axis I disorder status, and vice versa, in 538 PD subjects.

Results: The strongest associations, which worked in both directions, were found for BPD and mood disorders and for AVPD and anxiety disorders. There were few associations for STPD and none for OCPD.

Conclusions: Our findings suggest that the Axis I/II associations are not uniform. Whereas there are strong links in the longitudinal course of BPD and AVPD with specific Axis I disorders, OCPD and STPD appear to have a more independent course.

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SYMPOSIUM 62—CIRCUITRY OF FAILED COGNITIVE STRATEGIES IN ADDICTION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand that drug dependent individuals manifest brain abnormalities and neurocognitive deficits in the prefrontal cortex that could be related to aberrant decision making and perpetuation of addictive behaviors.

No. 62A
BRAIN METABOLISM DURING EARLY ABSTINENCE FROM METHAMPHETAMINE ABUSE

Edythe London, Ph.D., *Department of Neuroimaging, University of California at Los Angeles, 760 Westwood Plaza, Suite 60, NPIC8-532, Los Angeles, CA 90024;* Yun Dong, M.D., Sara Simon, Ph.D., Steven Berman, M.P.H., Ann Shinn, Ph.D., Mark Mandelkern, Ph.D., John A. Matochik, Ph.D.

SUMMARY:

Methamphetamine (MA) is an abused drug that produces severe behavioral sequelae, including cognitive impairments and mood disturbances. The present work focuses on brain function during early abstinence, corresponding to times when MA abusers commonly present for treatment. MA abusers and matched, non-drug-abusing control subjects underwent two assays of regional cerebral glucose metabolism (rCMRglc) by positron emission tomography (PET) while performing a continuous performance task. Tests were done four to seven days and five weeks after stopping MA use. Compared with control subjects, MA abusers showed metabolic deficits at the first PET assay and increased cerebral metabolism during continued abstinence. Increases in global metabolism were noted, as were increases of rCMRglc in orbitofrontal, middle frontal, and superior parietal regions. When data were normalized to global metabolism, increases in orbitofrontal, superior frontal, and middle frontal regions were seen (i.e., regional increases > global), but thalamus and caudate showed apparent decrements (i.e., global increases > regional increases). SPM analysis corroborated these findings. The findings suggest that with abstinence (~ 1 mo.) there is substantial recovery in cortical areas while the caudate nucleus, a dopaminergic terminal area, and the thalamus, which receives striatal projections, demonstrate less recovery. Ongoing studies evaluate the relationship of these metabolic changes to cognitive functions.

No. 62B
IMPAIRED DECISION MAKING AND IMPULSE CONTROL ASSOCIATED WITH DRUG MISUSE AND PERSONALITY DISORDERS

Robert D. Rogers, M.D., *Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, United Kingdom*

SUMMARY:

Accumulating evidence suggests that patients with a history of chronic drug misuse exhibit a range of neuropsychological difficulties (Rogers & Robbins, 2001). These cognitive difficulties may be clinically important because of their tendency to interfere with rehabilitation and, particularly, because of their tendency to increase the risk of relapse through, for example, heightened impulsivity. In this presentation, I present new evidence that individuals with acknowledged impulse control problems—patients diagnosed with borderline and/or antisocial personality disorder (without current major affective disorder)—exhibit a complex of neurocognitive impairments that might help mediate impulsive behavior including drug misuse. These include difficulties in resolving between competing courses of action associated with reward, and deficient inhibitory control in situations requiring the suppression of strongly activated or prepotent behaviors. Importantly, the same individuals also show difficulties with rapid stimulus-reinforcement learning that might index wider difficulties in affective function. These deficits are consistent with significant dysfunction in circuitry encompassing the orbital prefrontal cortex, amygdala, and striatum, as well as the modulation of this circuitry by the monoaminergic neurotransmitter systems (Rogers et. al, 1999).

No. 62C
NICOTINE AND CEREBRAL BLOOD FLOW DURING A WORKING MEMORY TASK

Monique Ernst, M.D., *Department of Brain Imaging, National Institute of Drug Abuse, 1550 Nathan Shock Drive, Baltimore, MD 21224;* John A. Matochik, Ph.D., Stephen J. Heishman, Ph.D., John D. Van Horn, Ph.D., Jack E. Henningfield, Ph.D.

SUMMARY:

Nicotine enhances vigilance and improves cognitive performance, whereas nicotine withdrawal impairs performance on tasks of memory and attention (Heishman et al., 1994). Cognitive activation (increases in relative regional cerebral blood flow) during a working memory task was measured in 11 abstinent smokers (31.8±6.8 y.o.) and 11 ex-smokers (30.2±7.1 y.o.) using positron emission tomography (PET). Each subject participated in two independent PET sessions on two separate days one week apart. In one session, the subject received nicotine gum (4mg), and in the other session placebo. Smokers were abstinent from nicotine for 12 hours at the start of each PET session and experienced nicotine withdrawal. The pattern of brain activation during the working memory task was overall consistent with findings in the literature. The administration of nicotine reduced activation in smokers but enhanced it in ex-smokers. The lack of enhancement of activation after nicotine administration in smokers is interpreted as tolerance and would represent the first evidence of this effect in the human brain. Of note, a lateralization effect may have resulted from the state of nicotine withdrawal, where activation during the placebo condition predominated in the left hemisphere in ex-smokers and in the right hemisphere in smokers.

No. 62D
DIFFERENCES IN CEREBRAL GLUCOSE METABOLISM IN PATIENTS ON AND OFF OPIATE REPLACEMENT THERAPY

Igor I. Galynker, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, Room 6K42, New York, NY 10003;* Christian R. Miner, Ph.D., Donald C. Des Jarlais, Ph.D., John A. Matochik, Ph.D., Carlo Contcregg, M.D., Alane S. Kimes, Ph.D., Monique Ernst, M.D., Richard N. Rosenthal, M.D., Edythe London, Ph.D., Carrie Weaver, M.A., Enid C. Gertmenian-King, B.A., Varughese Kurian, M.P.H.

SUMMARY:

Background: The presence of neurochemical imbalance in brains of opiate-dependent patients would suggest that such patients could benefit from long-term opiate replacement therapy. The goal of this study was to determine whether subjects with histories of opiate dependence have persistent brain abnormalities and whether methadone maintenance alleviates these abnormalities.

Methods: Positron emission tomographic (PET) [F-18]flourodeoxyglucose (FDG) method was used to compare the regional cerebral metabolic rate for glucose (rCMRglc) in three groups of subjects: 1) a methadone-withdrawn (MW) group; 2) a methadone-maintained (MM) group; and 3) a comparison (C) group. The MM subjects were maintained on a stable methadone dose for at least two months. None of subjects used illicit drugs for at least six months.

Results: Normalized rCMRglc was lower in the MW compared with the MM and C groups in the anterior cingulate gyrus and in the superior frontal cortex and higher in right ventral striatum. The rCMRglc in the right vermis and right temporal lobes was abnormal in both MM and MW groups. The MW subjects showed abnormalities in a number of executive function tests, which were attenuated in the MM subjects.

Conclusions: The results of this study suggest that neurobiological abnormalities are present in several brain areas of untreated opiate users after methadone detoxification, which that are alleviated with methadone maintenance. Neuroanatomical, neuropsychological, and clinical implications of these findings will be discussed.

No. 62E
PREFRONTAL LOBE FUNCTIONING IN COCAINE USERS

Karen I. Bolla, M.D., *Department of Neurology, John Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224;* Monique Ernst, M.D., Maria Mouratidis, M.A., John A. Matochik, Ph.D., Dana Eldreth, B.A., Kent Kiehl, Varughese Kurian, M.P.H.

SUMMARY:

Cocaine use is a significant public health concern. The Office of National Drug Control Policy estimates that there are 3.6 million chronic cocaine users in the U.S. Cocaine changes the brain, and there are functional consequences of these changes. Previous neurochemical, neuroanatomical, neurobehavioral, and neuroimaging investigations have reported abnormalities in prefrontal brain regions (PFC). Alterations in these brain regions have been associated with changes in drive, control, decision making, affect, the ability to inhibit inappropriate behavior, planning ability, concentration, insight, judgment, mental flexibility, and obsessive-compulsive behaviors. Difficulty with any of these behaviors could make it problematic for a cocaine abuser to discontinue self-destructive, drug-seeking behavior. Thus, it is important to investigate PFC functioning in chronic cocaine users to understand brain mechanisms in order to develop successful drug prevention and treatment programs. The PFC in chronic, 24-day-abstinent cocaine users who use primarily cocaine is being studied using a multidisciplinary approach. Neurobehavioral testing, PET O_{15} activation while performing the Stroop Interference Task, and measures of brain volume (MRI) are used to investigate prefrontal lobe function. The integration of results from multiple methods will be discussed.

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SYMPOSIUM 63—PERSONALITY AND PERSONALITY DISORDERS IN THE COMMUNITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the prevalence and correlates of personality disorders in the community and the utility of the Five-Factor Model in abnormal personality.

No. 63A
PREVALENCE AND CORRELATES OF PERSONALITY DISORDERS IN A COMMUNITY SAMPLE

Jack F. Samuels, Ph.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 4-181, Baltimore, MD 21287;* William W. Eaton, Ph.D., Oscar J. Bienvenu III, M.D., Clayton Brown, Ph.D., Paul T. Costa, Jr., Ph.D., Gerald Nestadt, M.D.

SUMMARY:

Aims: To estimate the magnitude of personality disorders in a community sample and to identify demographic subgroups with especially high prevalence.

Methods: Clinical psychologists used the IPDE to assess DSM-IV and ICD-10 personality disorders in a sample of 742 subjects residing in Baltimore.

Results: The estimated overall prevalence of DSM-IV personality disorders was 9%. Cluster A disorders were most prevalent in men who had never married. Cluster B disorders were most prevalent in young men without a high school degree, and Cluster C disorders in high school graduates who had never married.

Conclusions: Approximately 9% of this community sample has a DSM-IV personality disorder. Personality disorders are over-represented in certain demographic subgroups of the community. These subgroups may be useful for investigating the determinants and consequences of these disorders, and the service needs of people suffering from them. (Supported by NIH grants R01 MH50616 and MH47447.)

No. 63B
THE FIVE-FACTOR MODEL OF PERSONALITY AND PERSONALITY DISORDERS IN A COMMUNITY STUDY

Paul T. Costa, Jr., Ph.D., *Department of Gerontology, National Institute on Aging, 5600 Nathan Shock Drive, Baltimore, MD 21224;* Jeffrey H. Herbst, Ph.D., Jack F. Samuels, Ph.D., Gerald Nestadt, M.D., Oscar J. Bienvenu III, M.D., Irving M. Reti, M.D., William W. Eaton, Ph.D.

SUMMARY:

Objectives: Of the several alternatives to the categorical classification system for personality disorders (PDs) in DSM-IV, the Five-Factor Model of personality (FFM) contains both broad and specific dimensions in which PDs are mapped in terms of extremes of empirically derived, normally distributed personality traits. Widiger, Trull, Clarkin, Sanderson, and Costa (2001) proposed specific NEO-PI-R facet profiles for each of the DSM-IV PDs. This proposal was tested in a community sample.

Methods: The Hopkins Epidemiologic Study of PDs was used to test the predictions for five IPDE PD classifications (schizotypal n = 9; antisocial n = 31; borderline n = 8; avoidant n = 9; OCPD n =

9); 18 subjects who were absent on all PD criteria served as the control group.

Results: For all but OCPD, more than three-quarters of the hypothesized facets were supported. Conscientiousness facets were low for the total sample and may have contributed to the failure of OCPD predictions. All of the hypothesized facets for borderline (eight out of eight) and antisocial (nine out of nine) were supported. The hypothesized facets accounted for 59% of the variance for borderline and 50% for antisocial diagnosis.

Conclusions: The FFM is useful for understanding the personality features of these PD diagnoses.

No. 63C
DIMENSIONS OF DSM-IV PERSONALITY DISORDERS AND THEIR RELATIONSHIP TO THE NEO-PI-R

Gerald Nestadt, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 4-181, Baltimore, MD 21287;* Fang-Chi Hsu, Ph.D., Jack F. Samuels, Ph.D., Oscar J. Bienvenu III, M.D., Paul T. Costa, Jr., Ph.D., Irving M. Reti, M.D., William W. Eaton, Ph.D.

SUMMARY:

Objectives: To evaluate the construct validity of the 10 personality disorders as operationally defined in the DSM-IV.

Methods: As part of the Hopkins Epidemiology of Personality Disorders Study, all DSM-IV personality disorder criteria were assessed by psychologists using the IPDE; the NEO-PI (R) also was administered to these 742 subjects. Confirmatory dichotomous factor analysis was conducted for each disorder using the M-PLUS program.

Results: A single latent factor was identified for avoidant personality disorder, but not for any of the other disorders. Exploratory factor analysis suggested five personality disorder factors: compulsive, avoidant, callous, egocentric, and asocial. These personality disorder factors resemble those extracted by other investigators in the field.

Conclusions: Abnormal personality may be construed as five personality disorder factors.

(Supported by NIH grants MH50616 and MH47447).

No. 63D
COMORBIDITY OF ANXIETY AND DEPRESSIVE DISORDERS AND NORMAL PERSONALITY TRAITS

Oscar J. Bienvenu III, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 4-181, Baltimore, MD 21287;* Jack F. Samuels, Ph.D., Kung-Ye Liang, Ph.D., Paul T. Costa, Jr., Ph.D., William W. Eaton, Ph.D., Gerald Nestadt, M.D.

SUMMARY:

Objective: High comorbidity among anxiety and depressive conditions is a consistent but not well-understood finding. The current study examines how normal (five-factor model) personality traits relate to this comorbidity.

Method: In the Hopkins Epidemiology of Personality Disorders Study, psychiatrists administered the full Schedules for Clinical Assessment in Neuropsychiatry to 648 subjects, all of whom completed the Revised NEO Personality Inventory. The disorders of interest were lifetime panic disorder, agoraphobia, social phobia, simple phobia, obsessive-compulsive disorder, generalized anxiety disorder, major depression, and dysthymia.

Results: Neuroticism, introversion, and low conscientiousness (especially the facet, self-discipline) were significant predictors of prevalence of anxiety and depressive disorders. Adjusting for the relationships between these personality predictors and the disorders themselves, the associations among disorders were substantially weaker. Given the possibility of state-trait confounding, the effect of acuity of Axis I disorders on results will be presented and discussed.

Conclusions: High neuroticism, low extraversion, and low conscientiousness (in decreasing order of importance) are associated with increased comorbidity due to relationships in common with the prevalences of the different anxiety and depressive disorders.

NIMH grants R01-MH47447 and R01-MH50616, as well as a Johns Hopkins University School of Medicine Clinician Scientists Award (Dr. Bienvenu) supported this work.

No. 63E
THE ROLE OF PARENTING IN THE DEVELOPMENT OF PERSONALITY

Irving M. Reti, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 3-181, Baltimore, MD 21205;* William W. Eaton, Ph.D., Jack F. Samuels, Ph.D., Gerald Nestadt, M.D., Paul T. Costa, Jr., Ph.D., Oscar J. Bienvenu III, M.D.

SUMMARY:

Aim: To evaluate the role of parenting in the development of personality.

Method: A total of 742 subjects in the Hopkins Epidemiology of Personality Study were assessed for normal measures of personality, in particular adult antisocial personality disorder traits. Subjects also were assessed for various measures of parental behavior experienced as children, including the Parental Bonding Instrument (PBI).

Results: Three fundamental dimensions of parental behavior—care, behavioral restrictiveness, and denial of psychological autonomy—were derived by factor analysis of the PBI. These dimensions significantly correlated with other measures of parental behavior also considered influential in later personality. The PBI dimensions were significantly correlated with normal measures of personality, especially neuroticism and self-directedness. Adult antisocial traits in males were associated with low maternal care and high maternal behavioral restrictiveness and, in females, with low paternal care and high maternal denial of psychological autonomy. These dimensions, however, did not explain all variance that parental behavior has on adult antisocial traits.

Conclusions: Parenting is associated with both normal and abnormal personality measures. Understanding how these associations are mediated may shed further light on the etiology of personality disorders.

(Supported by NIH grants MH50616 and MH47447).

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3. Bienvenu OJ, Brown C, Samuels JF, et al: Comorbidity among phobic, panic, and major depressive disorders and the five-factor model of personality. Psychiatry Research 2001; 102:73–85.

SYMPOSIUM 64—LESSONS LEARNED: LOOKING BACK TO MOVE FORWARD
Association of Women Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize and understand and be able to actively participate

in the improved status and opportunities for women physicians professionally and personally.

No. 64A
RETROSPECTIVE CAREER AND FAMILY TRANSITIONS FOR A CLEARER VISION INTO THE 21ST CENTURY

Marion Z. Goldstein, M.D., *Department of Psychiatry, SUNY at Buffalo - ECMC, 462 Grider Street, Buffalo, NY 14215-3021*

SUMMARY:

We can learn a great deal from the changing demographics of the physician population when we review the years during which those of us now 60 and over have had our varied experiences as administrators, researchers, educators, and clinicians. Pertinent AMA statistics will be reviewed, with emphasis on shifts of women:men ratios over those decades. Women physicians have enlightening stories to tell about yearning for a soulmate, companionship, shared responsibilities at home, paid help at home, mentoring, appreciation, rewards, and equal professional choices, pay, and opportunities for advancements, grants, presentations, publications, office space, and secretarial help. We want to cope with the present and plan for the future. We want to pace and balance what pleases us and what we are good at, without exhausting ourselves and having to move from place to place. When we are ill, we want to be taken care of and have time to get well. We want time to care for others. A retrospective of career and family transitions will be presented with present outcomes in the light of the above.

No. 64B
LOOKING BACK TO MOVE FORWARD: THE AFRICAN-AMERICAN EXPERIENCE

Altha J. Stewart, M.D., *Detroit-Wayne County CMHC, 640 Temple Street, 8th Floor, Detroit, MI 48201*

SUMMARY:

Psychiatric administration is at a significant crossroad in its historical development. Much of the literature on psychiatric administration explores the differences between management styles utilized for bureaucratic and clinical activities.

White males have always been trained for leadership of both sexes and races, and some few African-American males have enjoyed opportunities to lead racially mixed groups, but African-American women have historically been limited to leadership of other African-American women. The combined obstacles presented by racism and sexism at work has resulted in the leadership potential of African-American females being a relatively untapped and most certainly underutilized resource.

Since the late 1970s numerous authors have reviewed the common myths and misperceptions regarding African-American women in positions of leadership. Because of the high visibility and charged position they occupy in society, African-American women are more likely to be at the focus of irrational unconscious group processes. These are particularly strong when focused on an African-American female psychiatrist in the leadership position. Issues confronting African-American women in administrative positions in psychiatry have been the basis for little discussion and even less research.

This presentation will explore the symbolic role imposed on African-American women and the nature and scope of their functions and power in the organizations in which they work.

No. 64C
WOMEN AND NATIONAL LEADERSHIP ROLES: GETTING THERE, FUNCTIONING EFFECTIVELY

Carol C. Nadelson, M.D., *Director's Office of Women's Careers, Brigham and Women's Careers, 75 Francis Street, PBB5-503, Boston, MA 02115*

SUMMARY:

In the long and distinguished history of the American Psychiatric Association, there have been three women elected to presidential office. In other national psychiatric organizations there have been proportionally few women who have held the office of president. Because this highest role offers the holder opportunities to affect policy, patient care, and professional issues for all psychiatrists, increased understanding is mandatory for all women and men members seeking this office or seeking to help others attain this position of power and responsibility.

This presentation will enable the presenter to offer insights gained over several decades from within and without the systems of concern.

No. 64D
ACADEMIC LEADERSHIP OPPORTUNITIES, GENDER, ASSUMPTIONS, AND OUTCOMES

Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 South Preston, Suite 214, Louisville, KY 40292*

SUMMARY:

Although women psychiatrists have been ready and competent to assume senior leadership roles in academic psychiatry and academic administration in the dean's offices, for more than two decades, only a small fraction have attained positions they sought.

This presentation will review major factors impacting lack of opportunities. Furthermore, the presenter, involved in national academic leadership issues for more than two decades, will offer insights and recommendations for effective changes. In particular, factors such as the paucity of "men of good conscience," the author's 1991 epithet for men with power willing to professionally advise, encourage, and facilitate gender fair opportunities, will be discussed in detail.

Specific examples of successes and failures will be discussed, carefully disguised as appropriate, in order for the audience to gain knowledge and understanding to become actively involved in specific situations where changes can and should take place.

No. 64E
THE HAND THAT ROCKS THE CRADLE ROCKS THE BOAT: THE EMPOWERMENT OF WOMEN

Ann R. Turkel, M.D., *350 Central Park West, New York, New York 10025*

SUMMARY:

Abstract: In 1980, my paper on "The Power Dilemma of Women" was published. It dealt primarily with the interpersonal aspects of women's difficulties in achieving power. Women are in a vastly different place from where they were 20 years ago and from where they will be 20 years from now. I am referring now not to the external obstacles in the professional and corporate worlds that restrict women's career advancement, but to the psychological glass ceiling, which is now far more important than external restrictions.

The psychodynamic factors that enhance the empowerment of women will be examined, as well as the negative elements that inhibit ambition and success. The internal conflicts for women are mostly invisible: sex-role socialization, low self-esteem, coping with

aggression and anger—both their own and that of others—fear of failure, fear of success, and fear of deviance. The dynamics of power relationships between men and women, role conflicts, and the particular difficulties women experience around issues of leadership, authority, and influence will be examined.

REFERENCES:

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2. Delgado AK, Griffith EEH, Ruiz P: The black woman mental health executive: problems and perspectives. Administration in Mental Health Vol. 12, No. 4, Summer 1985.
3. Grey ZH: An international study of female leaders, locus of control, and gender role conflict organizations; Dissertation Abstracts International: Section B: the Sciences and Engineering 2000; 60:3605.
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SYMPOSIUM 65—TAKING CONTROL OF THE FUTURE: ACADEMIC PSYCHIATRY AND 21ST-CENTURY PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand key repositioning strategies for professional success, particularly those that are emerging from selected departments of academic psychiatry.

No. 65A
PSYCHIATRY OF THE 21ST CENTURY: THE ROLE OF ACADEMIC HEALTH SYSTEMS

Leighton Y. Huey, M.D., *Department of Psychiatry, University of Connecticut, 263 Farmington Avenue, Farmington, CT 06030-1410*

SUMMARY:

Continuing concerns about our overall health care system are pervasive, highlighted most recently by the scathing indictment from the Institute of Medicine in its monograph, "Crossing the Quality Chasm: A New Healthcare System for the 21st Century." Academic health systems and therefore academic psychiatry have a mandate to understand recent changes—why they have occurred and what professional adaptations are required. In particular, it is important to begin establishing not only standards of care based on evidence, outcomes, and research, but also relevant standards of prevention, training, financing, and health system organization. This presentation provides an historical perspective on academic health systems, how they have succeeded in certain ways, but failed in others, to be fully part of the national dialogue on health system reform. Ideas will be offered about how the strengths of academic health systems can be utilized to improve practice, outcomes, and organizational process, and about how to relate better to the larger community.

No. 65B
SHAPING THE FUTURE THROUGH EDUCATION

Michael A. Hoge, Ph.D., *Department of Psychiatry, Yale University, 25 Park Street, Room 604, New Haven, CT 06519*

SUMMARY:

In the past decade and a half we have witnessed dramatic changes in the field of psychiatry. Traditional approaches to care have been challenged by demands for services that are evidenced-based, safe, cost-efficient, culturally relevant, and heavily influenced by consumer choice. Education systems have been limited in their ability to assist providers in adjusting to this new environment, since education programs have also struggled to adapt to changes in the field. In this presentation, education is discussed as a key tool for shaping the future of the behavioral health care system. Psychiatrists and other professionals will only be able to survive, thrive, and mold the future if they understand the economic and political forces that shape our field and possess the practical skills necessary to compete in the current health care environment. Recommendations will be outlined on the optimal knowledge base and skill set that professionals should acquire through education to be both effective practitioners and leaders within their states and communities, shaping the health care systems in which they work. Educational strategies that are both innovative and of demonstrated effectiveness will be highlighted. The role of behavioral health professionals as both life-long students and as educators will be discussed.

No. 65C
CHRONIC ILLNESS MANAGEMENT AND THE DEATH OF THE CARVEOUT: MODELS FROM ACADEMIC PSYCHIATRY

Thomas Carli, M.D., *Department of Psychiatry, University of Michigan, 2401 Plymouth Road, Suite D, Ann Arbor, MI 48105*

SUMMARY:

The most powerful demographic and economic forces shaping health care in the near future will be an increased focus on caring for people with chronic illnesses. This has major implications for psychiatry. Redesigning health care services for people with chronic illnesses will require the end of the "carve-out" and a reintegration of psychiatry with the rest of medicine. The "carve-in" will require new financing, administrative, and clinical models. Reintegration will be grounded in care management for complex cases, disease management programs, evidence-based guidelines, quality and performance-based contracts, and benefit parity. The prototype for these reintegration models currently exists in a number of settings, including some academic health centers and their respective psychiatry departments. Experiences at the University of Michigan Health System will be reviewed that demonstrate: the mental health "carve-in" for both major employer purchasers as well as the public Medicaid system; "managing" a parity benefit; bringing psychiatric and psychosocial expertise to all disease management and complex care management programs; and being financially accountable for quality and outcomes. These models can form a basis for psychiatrists to reclaim authority and control over how clinical care is organized and delivered.

No. 65D
THE USE OF PERFORMANCE INDICATORS IN QUALITY IMPROVEMENT AND FINANCIAL REIMBURSEMENT

Allen S. Daniels, Ed.D., *Department of Psychiatry, University of Cincinnati, 222 Peidmont, Suite 8800, Cincinnati, OH 45219*

SUMMARY:

Increasingly, purchases of care are seeking evidence of quality and demonstrable value to justify their expenditures for mental health and substance abuse services. The behavioral health care field has had a difficult time establishing a standard set of measures to evaluate

the process and outcomes of care. The resulting problems have been three-fold: a) an inability of payers, public and private, to determine with confidence the correct allocation of resources necessary to meet the health needs of specific populations; b) a steady decline in insurance premium dollars devoted to behavioral health care; and c) payer reluctance to establish genuine parity within health care benefit plans. This presentation will describe the recent focused effort to examine the evaluation of treatment services through a methodology that measures "core" and "common" indicators of provider performance, typically expressed as a ratio, to foster meaningful comparisons between service providers and organizations. The difference between these indicators will be described, as will the burdens associated with their use. Finally, the reimbursement implications of these national quality-improvement and performance-measurement initiatives will be examined for psychiatrists in independent practice and in leadership roles in large health systems.

No. 65E
ACADEMIC PSYCHIATRY MANAGING MANAGED CARE

Joseph M. Schwartz, M.D., *Department of Psychiatry, Johns Hopkins, 5007 Morello Road, Baltimore, MD 21214;* Peter J. Fagan, Ph.D., Chester W. Schmidt, Jr., M.D.

SUMMARY:

Facing the reality of managed care today and the risks to academic psychiatry both financially and with regard to the availability of patients for medical education, the Johns Hopkins department of psychiatry made a strategic decision to engage in the administration of a variety of managed care programs beginning in 1995. Implemented through numerous intra-institutional collaborations, these care management partnerships have resulted not only in improved clinical services but also enhanced opportunities for health services research and career development opportunities.

There are now three main managed care product lines covering more than 140,000 subscribers. One is a state-funded product (substance abuse only), one is a private ERISA-type product (mental health and substance abuse), and one is the federally funded TRICARE product for military families and retirees (mental health and substance abuse). This presentation will describe the history of the department's various partnerships, the systems in which the programs operate, the benefits to education, research, and faculty development, and the clinical and economic outcomes that have emerged from them.

REFERENCES:

1. Institute of Medicine: Crossing the Quality Chasm: A New Healthcare System for the 21st Century. National Academy Press, Washington, DC, 2001.
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4. Eisen SV, Shaul JA, Clarridge B, et al: Development of a consumer survey for behavioral health services. Psych Serv 1999; 506:793–798.
5. Reifler B, Briggs J, Uncapher H, et al: A managed behavioral health organization operated by an academic psychiatry department. Psychiatr Serv 2000; 51:1273–1277.

SYMPOSIUM 66—RECENT PERSPECTIVES ON BEHAVIORAL ADDICTIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose various behavioral addictions, recognize their similarities and differences, and treat them appropriately.

No. 66A
APPLICATION OF DEPENDENCE CRITERIA TO UNCONTROLLED BEHAVIORS

Jean Ades, M.D., *Department of Psychiatry, H. Louis Mourier, 178 Rue des Renouillers, Colombes 92700, France*

SUMMARY:

Impulse control disorders (ICDs) are characterized by the repetitive occurence of impulsive behavior. Other clinical characteristics of ICDs are failure to resist an impulse, drive, or temptation to perform some act harmful to oneself and/or to others, an increasing sense of tension or excitement before acting out, a sense of pleasure, gratification, or release at the time of committing the act or shortly thereafter. The pathological types of behavior included in the group of ICD are intermittent explosive disorder, kleptomania, trichotillomania, pyromania, and pathological gambling. We have demonstrated that compulsive and bulimia are often associated with other ICDs, especially in depressed patients. Deviant sexual behaviors, "love addiction," and Internet-use dependence can also be considered as ICDs. Criteria of dependence (i.e., social impairment, craving, great deal of time spent, important activities given up or reduced, loss of control, tolerance, and withdrawal) can be applied to ICDs and to other related behaviors. Considering ICDs as a form of addiction inditates to propose to the patients an abrupt cessation of the behavior (equivalent of withdrawal) followed by a long-term treatment preventing relapses.

No. 66B
PATHOLOGICAL GAMBLING: RELATIONSHIP TO SUBSTANCE ABUSE

David A. Gorelick, M.D., *Department of Clinical Pharmacology, NIH NIDA IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224-0180*

SUMMARY:

Pathological gambling (PG) and substance abuse (SA) have both been considered addictive disorders or disorders of impulse control. They share phenomenological similarities, such as progressive loss of control over the behavior and high rates of comorbidity. Occurrence rates for PA among SA patients in treatment are at least three times higher than among the general population. There is also substantial additional psychiatric comorbidity among pathological gamblers (e.g., affective disorder). The South Oaks Gambling Screen can be validly used in substance-abusing patients, although a structured diagnostic interview remains the gold standard. There is relatively little published data on the order of onset of PG and SA or on the influence of the former on treatment response. One recent study of cocaine- and opiate-dependent outpatients found that PG usually developed earlier than drug dependence, but had little influence on the short-term outcome of addiction treatment. The benefits of explicit treatment directed at the PG seem plausible, but remain unproven. Several medications being studied for the treatment of

PG (e.g., naltrexone, selective serotonin reuptake inhibitors) may also be useful for comorbid SA.

No. 66C
NEUROBIOLOGY OF PATHOLOGICAL GAMBLING

Marc N. Potenza, M.D., *Department of Psychiatry, Yale University, CMHC, 34 Park Street, New Haven, CT 06519*

SUMMARY:

Although pathological gambling (PG) represents a growing public health concern, little is known about its biological substrates. PG shares phenomenological features with drug dependence, and may share biological mechanisms. No neuroimaging studies directly exploring this hypothesis and involving subjects with PG have been published to date. Our group has been using functional magnetic resonance imaging and videotaped cues of happy, sad, or addiction-related scenarios to investigate the neural mechanisms underlying "craving" states in drug and behavioral addictive disorders. Compared with controls, PG subjects reported more robust urges to gamble during viewing of gambling scenarios and displayed relatively decreased activities in limbic (specifically ventral anterior cingulate) and frontal cortical brain regions during viewing of the gambling but not the emotion-related scenarios. The same brain regions distinguished cocaine-dependent from control subjects during viewing of cocaine scenarios, although differences in the timecourse and pattern of neural activities were observed. These findings suggest that abnormal function of limbic-driven motivation and frontal cortical control underlie both cocaine cravings and gambling urges in the affected groups, and are consistent with emerging data suggesting that gambling-related processes (e.g., decision-making and expectancies of monetary reward or punishment) are mediated through neural circuits central to drug addiction.

Support: APA, NIDA, NARSAD, and NCRG.

No. 66D
COMPULSIVE BUYING: CLINICAL ASPECTS AND COMORBIDITY

Michel Lejoyeux, M.D., *Department of Psychiatry, H. Louis Mourier, 178 Rue des Renouillers, Colombes 92700, France*

SUMMARY:

Compulsive buying is defined by the presence of repetitive impulsive and excessive buying episodes leading to personal and familial distress. It represents an important form of behavioral dependence. Patients typically experience repetitive, irresistible, and overpowering urges to buy items, uncontrollable needs, and mounting tension, which may only be relieved by buying. The tension temporarily assuaged by the purchase is quickly replaced by a feeling of guilt. The disorder regularly induces large debts, inability to meet payments, feedback from acquaintances, and legal and financial consequences. Among students, prevalence of compulsive buying is 20%. Compulsive buyers spend significantly more money on gambling, smoke more often, and drank higher amounts of alcohol every day. We also showed that prevalence of compulsive buying in depression is 31.9%. Patients presenting with compulsive buying were younger, more often women, and unmarried. They presented more often than others with recurrent depression, impulse control disorders such as kleptomania or bulimia, benzodiazepine abuse or dependence disorder, and associations of dependences. We also showed that compulsive buying is not especially related to sales or to advertising, items to be bought are more invested by compulsive buyers. They consider them more often as occasions not to be passed up and as personally essential. Most purchases represent gifts to oneself or others and are considered as an obligation due to social status.

No. 66E
ARE DEVIANT SEXUAL BEHAVIORS A FORM OF ADDICTION?

Florence Thibaut, M.D., *Department of Psychiatry, Rouen University, 2 Rue de Germont, Rouen 76031, France*

SUMMARY:

The two most frequent deviant sexual behaviors seen in clinical practice are pedophilia and exhibitionism. Evolution of the clinical concept of dependence allows us to diagnose these patients as dependent. Such a nosographic evolution permits us to include deviant sexual behaviors in general and especially pedophilia and exhibitionism in the field of dependence. These sexual disorders are understood as a repetitive occurrence of impulsive and uncontrolled sexual acts. Other clinical characteristics are failure to resist the impulse, drive, or temptation to perform a sexual act harmful to oneself and/or others, an increasing sense of tension or excitement before acting out, and a sense of pleasure, gratification, or release at the time of the behavior or shortly thereafter. Some patients present their desire to accomplish their sexual sequence as "hot flashes" and excitement that was likened to "falling in love with a product" or "like taking cocaine." Impulse urges toward immediate gratification discourage consideration of the behavior's potential consequences. The subject only seeks to reduce his psychological tension. Treatment of these forms of behavior necessitates a recognition of the pathological behavior, help during withdrawal, and a long-term treatment preventing relapses.

REFERENCES:

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3. Potenza MN, Kosten TR, Rounsaville, BJ: Pathological gambling. JAMA 2001; 286:141–144.
4. Lajoyeux M, Haberman N, Solomon J, Ades J: Comparison of buying behavior in depressed patients presenting with or without compulsive buying. Comprehensive Psychiatry 1999; 40:51–56.
5. Goodman A: Sexual addiction: an integrated approach. Madison, Connecticut, International Universities Press, 1998.

SYMPOSIUM 67—DIAGNOSIS AND TREATMENT OF ADHD IN YOUNG CHILDREN

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding of the clinical issues and complexities regarding the diagnosis of ADHD in preschool children, and the use of pharmacotherapies to treat this disorder in young children. This objective will be met as each presenter discusses the current literature as well as their own ongoing research.

No. 67A
A POPULATION PERSPECTIVE ON PSYCHOPHARMACOLOGIC TREATMENT OF ADHD IN YOUTH: REVIEW AND UPDATE

Julio M. Zito, Ph.D., *Department of Pharmacology, University of Maryland, 100 North Greene Street, Room 5-13, Baltimore, MD 21201*

SUMMARY:

Community-based studies of the treatment experience for emotional or behavioral problems, e.g., ADHD, have advanced by applying methods from pharmacoepidemiology (Safer and Zito, in Greenhill and Osman (ed.), Ritalin: Theory and Practice). This approach uses administrative claims and computerized treatment records from large health systems to characterize practice patterns in order to illuminate national trends and generate hypotheses for additional clinical study. Critical data from ADHD treatment-related epidemiological studies of the past decade will be presented with respect to the following outcomes: 1) prevalence of stimulant use; 2) occurrence of multiple psychotropic medications; 3) prevalence variations based on patient factors (age, gender, race, and geographic area); health system factors (Medicaid subpopulations, e.g., foster care, SSI-covered youths, and poor youths); and group model HMO and clinical specialties (primary care versus psychiatry). Also, time in treatment, particularly the duration of stimulant and the time to additional psychotropic medication, will be discussed in terms of their implications for continuity of treatment, quality of care, and satisfaction with medications. The review should help to crystallize gaps between clinical trial study findings and typical clinical practice patterns.

No. 67B
DIAGNOSTIC CHALLENGES IN PRESCHOOL CHILDREN

Helen L. Egger, M.D., *Developmental Epidemiology Program, Duke University Medical Center, Box 3454, Durham, NC 27701*

SUMMARY:

Establishing the diagnosis of ADHD in the preschool population, and the diagnosis of psychiatric disorders in this age group in general, remains a significant challenge. To date limited instruments have been available to assist in the diagnosis of mental illness in young children. Few of the available algorithms or structured diagnostic assessments are developmentally appropriate for preschool children. The Preschool Age Psychiatric Assessment (PAPA) has been designed to meet this need and is being assessed in a test-retest reliability study. In this presentation Dr. Egger, a developer of the PAPA, will review the development and potential utility of this instrument. The presentation will include an overview of diagnostic considerations in evaluating preschool children with ADHD, discuss general diagnostic challenges in this population, and review the initial data, which are available regarding the PAPA.

No. 67C
DEVELOPMENT AND INITIATION OF THE PRESCHOOL ADHD TREATMENT STUDY (PATS)

Laurence L. Greenhill, M.D., *Department of Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, Unit 74, New York, NY 10032*

SUMMARY:

There is a lack of data regarding the safety and therapeutic value of medications being used for the treatment of ADHD in young children. The use of pharmacotherapies in this population has continued to grow, however, despite the lack of efficacy evidence. Increased awareness of this trend has led to several initiatives to learn more about psychotropic medications being used in preschool children. Dr. Greenhill is the chief architect of a groundbreaking study assessing the efficacy and safety of methylphenidate in preschool children with ADHD. There are many challenging issues regarding the design and implementation of clinical trials in preschool children, with specific challenges involved in the study of ADHD. This presentation will provide insights into the design and development of the PATS study, as well as an update on the implementation of this important project.

No. 67D
PHARMACOTHERAPIES IN YOUNG CHILDREN WITH ADHD

Christopher J. Kratochvil, M.D., *Psychopharmacology Research Center, University of Nebraska Medical Center, 985581 Nebraska Medical Center, Omaha, NE 68198-5581*

SUMMARY:

The early age of onset of ADHD results in many children being treated with pharmacotherapies at a young age, despite a lack of data to support the safety and efficacy of their use. The Preschool ADHD Treatment Study (PATS) will collect data on the use of methylphenidate, but few studies have sought to assess other pharmacotherapeutic options in this age group. This presentation will provide an overview of available data on the use of psychotropic medications in young children with ADHD, then will review new data on a selective noradrenergic reuptake inhibitor being studied for use as a treatment for pediatric ADHD. Safety and efficacy data on 255 6- and 7-year-old children who have been treated with atomoxetine will be presented. Future studies with atomoxetine in younger children, modeled after the PATS study, will also be discussed.

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SYMPOSIUM 68—CLUB DRUGS: TRENDS, TOXICITIES, AND TREATMENTS
Substance Abuse and Mental Health Services Administration

EDUCATIONAL OBJECTIVES:

Individuals attending this symposium will have a greater understanding of the newest research on the epidemiology, toxicity, and need for treatment of club drugs.

No. 68A
TRENDS AND PATTERNS IN CLUB-DRUG USE

Jane C. Maxwell, Ph.D., *ATTC, University of Texas, 1711 Barn Swallow, Austin, TX 78746*

SUMMARY:

Objective: The club-drug phenomenon is characterized by an increasing variety of drugs and changing patterns of use. This presentation will review the latest trends and patterns in the use of MDMA

(ecstasy), GHB, ketamine, and other club drugs, often in combination with alcohol and marijuana, as well as the "normalization" of heroin.

Method: Reports from members of the National Institute on Drug Abuse's Community Epidemiology Work Group, surveys, the Drug Abuse Warning Network of emergency rooms, treatment programs, poison control centers, price and purity, and ethnographic field studies will be summarized. This presentation will also look at the role of the Internet in the spread of various club drugs.

Results: Synthesis of these various data sources shows increases and decreases in use as well as characteristics of the users.

Conclusions: New patterns of use and new groups of users are emerging, and a variety of epidemiological data sources provide confirmation of current trends and an early warning of coming trends. Knowledge of these trends and patterns can help inform clinicians of problems that may be faced in treating club-drug users.

No. 68B
NEUROTOXIC EFFECTS OF 4-METHYLENEDIOXYMETHAMPHETAMINE (ECSTACY)

George A. Ricaurte, M.D., *Department of Neurology, Johns Hopkins Medical Institute, 5501 Hopkins Bayview Circle, Baltimore, MD 21224*

SUMMARY:

The amphetamine analog (±) 3,4-methylenedioxymethamphetamine (MDMA, "Ecstasy") has become increasingly popular as a recreational drug of abuse. In animals, MDMA is a potent and selective brain serotonin (5-HT) neurotoxin, as evidenced by the fact that MDMA produces long-lasting reductions in a variety of brain 5-HT neuroaxonal markers. Doses of MDMA used by humans overlap those that produce neurotoxicity in animals. Hence, efforts have been underway to develop and validate methods for detecting possible MDMA neurotoxicity in the human brain. To date, two such methods have been developed. CSF studies have shown that 5-HIAA, the major metabolite of 5-HT, is reduced in abstinent MDMA users, as it is in primates with documented brain 5-HT neurotoxicity. Similarly, PET studies using a radioligand that binds to the 5-HT transporter have shown reductions in abstinent MDMA users similar to those seen in baboons with known MDMA lesions. Functional consequences of MDMA neurotoxicity remain largely unknown. However, there is growing evidence that MDMA users have abnormalities in cognitive function. The possibility that altered cognitive function in abstinent MDMA users may be related to brain 5-HT neurotoxicity is under investigation as part of a broader effort to better define the risks that MDMA pose to human health.

No. 68C
CLUB DRUGS: EMERGENCY MANAGEMENT ISSUES

Brett A. Roth, M.D., *Department of Emergency Medicine, University of Texas at Southwestern, 1805 Foxborough Trail, Floaer Mound, TX 75028*

SUMMARY:

Club drugs represent a combination of the classic, i.e., cocaine, phencyclidine, marijuana, opiates, and LSD, and "in vogue" drugs of abuse such as methylenedioxy-methamphetamine, MDMA; gamma-hydroxybuteric acid, GHB; ketamine; and flunitrazepam. Medical management of acute complications of the "in vogue" drugs of abuse will be provided in this review.

The management of complications from club-drug abuse demands a variety of skills from airway management to control of seizures and shock. A general treatment approach based on the symptoms complex (i.e., seizures, coma, hyperthermia) may be most appropriate, since initial management decisions frequently have to be made without the benefit of a reliable history. When such a history is available, however, knowledge of complications associated with the specific drugs abused will help guide acute care management issues.

Ketamine is the prototypical "psychostimulant" associated with agitated delirium, psychosis, and rhabdomyolysis. Medical complications from MDMA include severe electrolyte abnormalities, hyperthermia, and personality disorders. GHB, like flunitrazepam, is associated with deep sedation and coma. Unlike flunitrazepam, acute GHB overdose has a distinctive bradycardia. Withdrawal syndromes associated with both GHB and flunitrazepam may be life threatening and require aggressive inpatient therapy. Nitrous oxide induced respiratory arrest and neuropathy is also described.

No. 68D
A REVIEW OF PSYCHIATRIC SYMPTOMS AND TREATMENT FOR CLUB-DRUG USE

Karen A. Miotto, M.D., *Department of Psychiatry, University of California at Los Angeles NPI, 760 Westwood Plz, Los Angeles, CA 90024*

SUMMARY:

Objective: GHB and Ecstasy use often begin under an illusion of safety, without awareness of drug toxicity. Many users obtain prodrug information from friends and the Internet. This study reviews the literature on psychiatric toxicity and treatment for GHB and Ecstasy use.

Methods: Adverse events associated with GHB from case series and prospective studies are reviewed.

Results: Overdose, seizures, and amnestic episodes are associated with GHB use. Users and clinicians are not aware of the risk of GHB dependence. Treatment for acute and protracted GHB withdrawal will be reviewed. Symptoms of protracted GHB withdrawal include anxiety, insomnia, and depression. In contrast to GHB, Ecstasy users generally do not seek treatment with complaints of withdrawal. However, multiple psychiatric symptoms have been associated with Ecstasy use. The most well-recognized are depression and memory impairments.

Conclusion: Pharmacotherapy and behavioral treatments for these emerging drug problems will be suggested in this session.

No. 68E
CLUB DRUGS: CURRENT AND POTENTIAL TREATMENTS

David M. McDowell, M.D., *Department of Psychiatry, STARS-NYSPI, 600 West 168th Street, Basement, New York, NY 10032*

SUMMARY:

Contrary to the perception by a substantial portion of the public, the group of drugs commonly referred to as club drugs, MDMA or Ecstasy, ketamine or "Special K," and "G," gamma hydroxybuterate, as well as the marijuana can be quite harmful both in the long and short run. These drugs of abuse cause real and substantial morbidity and even mortality. These issues have far reaching implications for substance abuse treatment and psychiatric treatment in the future. This is especially true because these drugs appear to be rising in popularity, especially among young people. 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. As more and more young people use them, a knowledge of their physiological properties and effects is essential for all clinicians. This seminar will focus on what is cur-

rently known about these drugs and what treatments for those who abuse them are available.

These conditions are not as well studied as many 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 these drugs as well as of marijuana. This greater understanding has led to further evaluation of various treatments. The psychosocial treatments that have been studied will be discussed, as will those treatments that seem most translatable. In addition, pharmacological strategies will be a focus of this talk. Treatment of acute intoxication and overdose will be discussed as will long-term pharmacological measures. Pharmacological interventions for marijuana dependence have included mood stabilizers and medication focused on withdrawal symptoms. Potential treatments that are now being studied or may be in the future will be discussed.

This 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.

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4. Roth BA et al: Emergency management of drugs of abuse. In Drugs of Abuse, edited by Karch SB, Boca Raton, CRC Press, 1998.
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SYMPOSIUM 69—NALTREXONE TREATMENT OF ALCOHOLISM: A DECADE OF CLINICAL PROGRESS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will be able to recognize current empirical support for naltrexone use in alcoholism treatment, to effectively treat patients with special consideration for patients with comorbid psychopathology, and to understand the value and limitations of the pharmacotherapy for alcoholism treatment.

No. 69A
EFFICACY OF NALTREXONE IN THE TREATMENT OF ALCOHOLISM

Charles P. O'Brien, M.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19104-6178;* Helen Pettinati, Ph.D., David W. Oslin, M.D.

SUMMARY:

In the 1980s naltrexone was first studied in human alcoholics because of convincing results from animal models showing a reduction in alcohol preference when opiate receptors were blocked. The first human study was conducted by Volpicelli, et al. (1990, 1992) in male veterans in a day-treatment center. Those randomized to naltrexone showed less alcohol craving, less reported reward from alcohol, less drinking, and less relapse. This study was followed by a replication of positive results in a different population that included females and less-intense psychosocial intervention (O'Malley, et al. 1992). Since that time there have been 15 published or presented trials of naltrexone in various populations with different protocols. Thirteen of these trials showed significant benefits for patients randomized to naltrexone, but medication adherence was an issue in several of them. The protocols and the results of the published studies will be analyzed and compared. The proportion of positive naltrexone trials will be compared with the literature for antidepressant medication (Robinson and Rickels 2000). The argument will be made that naltrexone is clearly effective for a subsample of alcoholic patients, but as yet there are no reliable criteria that predict treatment response.

No. 69B
OPTIMIZING NALTREXONE TREATMENT OF ALCOHOL DEPENDENCE

Joseph R. Volpicelli, M.D., *Department of Psychiatry, University of Pennsylvania, 40 West Evergreen Avenue, Suite 106, Philadelphia, PA 19118;* Ronald R. Ulm, Ph.D.

SUMMARY:

In the past decade, clinical research has suggested various strategies to optimize the effectiveness of naltrexone for alcoholism treatment. For example, the use of compliance-enhancing techniques improves medication adherence and treatment retention. The BRENDA approach utilizes motivational enhancement techniques that can be easily integrated into an office-based practice to improve compliance with pharmacotherapy. Clinical research also had identified patient characteristics that are likely to have a positive response to naltrexone. For example, patients who experience high initial levels of alcohol craving or a strong family history of alcoholism have better clinical outcomes when taking naltrexone compared with similar placebo patients. Clinical research studies have typically used a dose of naltrexone of 50mg per day taken orally. Recent studies show that higher doses of naltrexone are well tolerated and, given the considerable patient variability in naltrexone metabolism, some patients respond better to higher doses. Also, results of clinical trials over the past decade show that, like the treatment of other chronic medical disorders, pharmacological treatment of alcoholism depends on patients remaining compliant with treatment and on identifying subgroups of patients who respond well to naltrexone treatment.

No. 69C
NALTREXONE: ALCOHOLISM IN PATIENTS WITH COMORBID MENTAL ILLNESS

Stephanie S. O'Malley, Ph.D., *Department of Psychiatry, Yale University Medical School CMHC, 34 Park Street, Room S202, New Haven, CT 06519;* Rajita Sinha, Ph.D., Ismene L. Petrakis, M.D., John H. Krystal, M.D., Bruce Rousaville, M.D.

SUMMARY:

Alcohol dependence is a common co-occurring disorder among patients diagnosed with other serious psychiatric disorders. Naltrexone, an approved pharmacotherapy for alcohol dependence, may be useful for these patient populations. This presentation will review the prevalence of alcohol dependence among patients who have another major psychiatric disorder. Evidence for the safety and efficacy of naltrexone for the treatment of alcoholism in four patient groups will be presented: women with and without eating disorder diagnoses, patients with major depression, and patients with schizophrenia. The results describe the effects of naltrexone on measures of alcohol consumption as well as measures related to the concurrent psychiatric disorder. To date, the results of these studies suggest that naltrexone can be used safely in these patient populations.

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No. 69D
INTERNATIONAL STUDIES WITH NALTREXONE

Philip Morris, Ph.D., *Gold Coast Integration District, 60 High Street, 2nd Floor, Queensland 4215, Australia*

SUMMARY:

Two controlled trials of naltrexone in alcoholism have been completed in Australia. Morris, et al. (2001) compared naltrexone 50 mg daily with placebo in 111 alcoholics over 12 weeks of therapy. The psychotherapy component was a weekly education support group. In the intent to treat analysis, those randomized to naltrexone had a lower relapse rate and reduced consumption of alcohol. A second controlled trial was conducted in alcoholic patients receiving treatment by primary care physicians in a standard medical outpatient clinic (Latt, et al. 2001). A total of 107 patients were randomly assigned to naltrexone or placebo for 12 weeks. While the patients were encouraged to strive for abstinence and attend counseling and AA meetings, this was not mandatory. Those patients randomly assigned to naltrexone had significantly fewer relapses than those assigned to placebo. The relative risk of relapsing compared to placebo was 0.55. In both studies naltrexone was well tolerated, with few adverse side effects. The treatment of alcoholism in Australia is largely conducted in the medical model, and naltrexone has been found to be quite useful.

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3. Maxwell S, Shinderman MS: Use of naltrexone in the treatment of alcohol use disorders in patients with concomitant major mental illness. J Addictive Disorders 2000; 19:61–69.
4. Morris PLP, Hopwood M, Whelan G, et al: Naltrexone for alcohol dependence: a randomized controlled trial. Addiction 2001; (in press).

SYMPOSIUM 70—STATE OF THE ART ADOLESCENT SUBSTANCE ABUSE TREATMENT
Substance Abuse and Mental Health Services Administration

EDUCATIONAL OBJECTIVES:

At the end of this symposium the participant will be familiar with: the risk factors associated with the development of substance abuse and pharmacological interventions appropriate for adolescents with dual diagnosis; science-based guidelines for designing intervention strategies and implementing programs that will maximize attainment of prevention outcome objectives; the key findings of the CYT study in terms of comorbidity, response to treatment, and affordability in an outpatient setting; pre-treatment, in-treatment and post-treatment factors that are most predictive of treatment success in residential treatment programs.

No. 70A
EFFECTIVE PREVENTION: CENTER FOR SUBSTANCE ABUSE PREVENTION'S NATIONAL STUDY OF HIGH-RISK YOUTH PROGRAMS

J. Fred Springer, Ph.D., *EMT Associates, Incorporated, 4175 Clovercroft Road, Franklin, TN 37067;* Soledad Sambrano, Ph.D.

SUMMARY:

The paper summarizes findings from the Center for Substance Abuse Prevention's National Cross-Site Evaluation of High-Risk Youth Programs concerning the effectiveness of prevention programs in reducing rates of increase in substance use among youth aged 9 to 18. The study sample included 48 separate programs and 10,610 racially and culturally diverse youth in treatment and comparison groups. Treatment youth attended the 48 CSAP-funded prevention programs in high-risk communities in 23 states; comparison youth were drawn from youth in the community who were not participating in CSAP-funded prevention. Self-report data on substance use and risk and protective factors were collected at four points in time including six and 18 months after the youth completed the programs. Detailed data on services received by each youth and on program environment, strategies and implementation are used to explain cross-site differences in program outcomes. Extensive analyses of the large data set combine meta-analytic analyses of program effectiveness (as indicated by statistical effect sizes) and cross-level statistical analyses of differences in substance use trajectories as youth age (hierarchical linear modeling).

The study demonstrates a significant overall treatment effect across the study programs, with significant variation in effectiveness of individual programs. Importantly, the study identifies features of intervention design and program implementation that contribute to stronger prevention effects.

No. 70B
PSYCHIATRIC COMORBIDITY AND PHARMACOLOGY AMONG ADOLESCENTS PRESENTING TO TREATMENT

Deborah R. Simkin, M.D., *Office of the Co-Chairman, AACAP Substance Abuse, 4641 Gulf Starr Drive, Suite 106, Destin, FL 32541*

SUMMARY:

Many children are at risk for the development of substance abuse disorders due to such factors as parent modeling, peer influence, learning disorders, chaotic family life, and undiagnosed psychiatric disorders. This presentation will present research that focuses on risk factors and undiagnosed psychiatric and neurological disorders that may put children and youth at risk for development of substance abuse. These psychiatric disorders may include learning disorders, affective disorders, anxiety disorders, attention deficit-hyperactivity disorder (ADHD), conduct disorder, and neurological disorders such as fetal alcohol syndrome.

In addition, the presentation will discuss how educational testing may miss specific other learning problems in children with ADHD, which, if undetected, may result in the development of substance abuse. The presentation will also include the psychopharmacological interventions most appropriate to use with adolescents who present with dual diagnosis.

No. 70C
MAIN FINDINGS OF THE CANNABIS YOUTH TREATMENT RANDOMIZED EXPERIMENT

Michael L. Dennis, Ph.D., *Chestnut Health Systems Lighthouse, 720 West Chestnut, Bloomington, IL 61701*

SUMMARY:

Cannabis is the leading drug mentioned in adolescent arrests, emergency department admissions, autopsies, and substance abuse treatment admissions. This presentation will present the results of two randomized field experiments in which adolescents were assigned to one of five outpatient interventions between 1998 and 2000 and assessed quarterly for 12 months and again at 30 months. Each experiment was replicated in a community-based clinic and a medical center. Of the 600 adolescents, 98% completed interviews at three months, and 94% did at 12 months. Participants had an average age of 16 and tended to be male (83%), white (61%), and referred by juvenile justice (62%). They reported using cannabis weekly or more often (71%), and 80% had one or more co-occurring psychiatric disorders. During the three-month treatment phase, all interventions reduced days of cannabis use from 36 to 22 (−37.0%, $p<.05$) and number of substance problems from 3.8 to 2.4 (−37.3%, $p<.05$). Reductions were sustained through month 12 (22 days and two problems, respectively). All five interventions produced better effects than those reported for existing interventions. Though there were short-term effects by intervention, the differences were not sustained. The best predictor of long-term outcomes was initial response.

No. 70D
OUTCOMES FROM THE ADOLESCENT TREATMENT MODEL PROGRAMS

Marc Fishman, M.D., *Department of Psychiatry, Johns Hopkins School of Medicine, 3800 Frederick Avenue, Baltimore, MD 21229*

SUMMARY:

There has been increased attention to the national problem of substance abuse in adolescents, but very little is known about the effectiveness of its treatment. There has been very little examination of the broad range of treatment modalities and differing program models. Little is known about the differential effectiveness of various treatment strategies and treatment program components.

In an effort to address these and other issues, the federal Center for Substance Abuse Treatment (CSAT) has funded a multisite collaborative grant project called the Adolescent Treatment Models (ATM). Ten community adolescent treatment sites across the country, representing various levels of care and various treatment approaches, have been selected as exemplary models for evaluation and documentation. Part of the evaluation process at each program site includes an outcome study. Across the various sites, treatment was shown to be effective, with rates of sustained abstinence at six and 12 months well within averages from previously published literature reviews. Just as importantly, *reductions* in substance use severity and frequency were associated with improvement in psychosocial function in a variety of domains.

This presentation will feature an overview of the ATM project, descriptions of the various exemplary ATM program models, and a survey of outcome study data, emphasizing those factors most predictive of treatment success, including pre-treatment variables (e.g., aspects of baseline severity), in-treatment variables (e.g., treatment engagement and completion) and post-treatment variables (e.g., family and peer influences).

REFERENCES:

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SYMPOSIUM 71—TREATMENT OF VIOLENCE AND CONDUCT DISORDERS IN CHILDREN AND ADOLESCENTS

EDUCATIONAL OBJECTIVES:

To describe the range of treatment modalities used with conduct disordered youth; and to review the treatment principles and outcome with multiple treatment modalities.

No. 71A
FUNCTIONAL FAMILY THERAPY IN THE TREATMENT OF YOUTH WITH CONDUCT DISORDER

Ellen H. Sholevar, M.D., *222 Righters Mill Road, Narberth, PA 19072*

SUMMARY:

Conduct disorder has a devastating impact on the lives of affected youth, their families, and the communities in which they live. Without effective treatment, the disease may progress to adult antisocial personality disorder, involvement with the criminal justice system, and inability to function as a productive citizen, parent, or employee. There has been a lack of empirically validated therapies to effectively address the symptoms of conduct disorder. Functional family therapy, developed by Dr. James Alexander and colleagues, has been extensively replicated and applied in different settings. A description of this treatment method will be given as well as a comparison with other empirically validated, short-term treatment interventions. A critical assessment of the treatment modality will be presented.

No. 71B
COMMUNITY-BASED TREATMENT OF CONDUCT DISORDER

G. Pirooz Sholevar, M.D., *Robert Wood Johnson Medical School, 222 Righters Mill Road, Narberth, PA 19072-1315*

SUMMARY:

Conduct disorders are serious and treatment-resistant behavioral conditions that can lead frequently to antisocial personality disorder in adulthood. The prolonged treatment of this chronic condition can begin in an outpatient setting but continue through wraparound services, multisystemic therapy, residential treatment centers (RTF), court-affiliated group homes, and community-based residential programs. A knowledge of such programmatic options and their therapeutic outcome with people with conduct disorders can help the psychiatrist select the most promising intervention option in different stages of the disorder.

This presentation describes the characteristics and outcome data with a range of community-based programs. Multisystemic therapy, residential treatment centers, community-based programs, court-affiliated programs, and preventive programs will be reviewed and briefly described.

No. 71C
MEDICATION USAGE IN CONDUCT DISORDERS

Jacquelyn M. Zavodnick, M.D., *Beneto Center, Devereux Foundation, 655 Sugartown Road, Box 297, Malvern, PA 19355-0297*

SUMMARY:

Conduct-disordered children and youth often present with aggression, which can seriously impair their ability to be in the community. While there are limited data on effective treatment, there are some evidenced-based studies that hold promise for effective amelioration of aggression. In addition, there are uncontrolled studies, case reviews, and inferences from adult studies in aggression, which can guide appropriate pharmacological interventions in aggressive children.

The presentation will review available literature, and a retrospective analysis of residentially treated children will be presented. A treatment algorithm will be described. The algorithm will look at effectiveness in the light of the risk-benefits ratio of different medications. The role of no medication, single agents, and polypharmacy will be reviewed.

Residential treatment provides a unique opportunity for careful pharmacological review. Ideally a placebo phase can be instituted before trials for medications in a timely way to create the most impact with the least possible intervention.

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SYMPOSIUM 72—AFFECTIVE INSTABILITY IN BPD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be to better understand the role of affective instability in borderline personality disorder, including factors that contribute to affective instability, its psychological sequelae, and its treatment.

No. 72A
AFFECTIVE INSTABILITY AND BORDERLINE SYMPTOMS AND DEFENSES

Harold W. Koenigsberg, M.D., *Department of Psychiatry, Mt. Sinai-Bronx VAMC, 130 West Kingsbridge Rd, #116A, Bronx, NY 10468;* Philip D. Harvey, Ph.D., Marianne Goodman, M.D., Antonia S. New, M.D., Vivian Mitropoulou, M.A., Larry J. Siever, M.D.

SUMMARY:

Objective: This study examines the degree to which two putative biologically influenced personality traits, affective instability and impulsive-aggression, are associated with some of the interpersonal and intrapsychic disturbances of borderline personality disorder and with choice of defense mechanism.

Methods: Affective instability and impulsive-aggression were measured in 152 patients with personality disorders. Defense mechanisms were assessed in 140 of these patients using the Defensive Style Questionnaire (DSQ). The correlations between the traits of affective instability and impulsive-aggression and the eight DSM-III-R criteria for borderline personality disorder and 20 DSQ defenses were examined.

Results: Affective instability was significantly correlated with the DSM-III-R criteria of identity disturbance, chronic emptiness or boredom, inappropriate anger, suicidality, and the affective instability criteria. It also was associated with the defenses of splitting, projection, acting-out, passive-aggression, undoing, and autistic fantasy. Impulsive aggression was related to unstable interpersonal relationships, inappropriate anger and impulsiveness, and with the defense of acting-out. It was negatively correlated with the defenses of suppression and reaction formation.

Conclusion: A number of the interpersonal and experiential disturbances and defense mechanisms that are features of BPD are associated with the traits of affective instability and impulsive-aggression among patients with personality disorders.

No. 72B
THE RELATIONSHIP BETWEEN CHILDHOOD TRAUMA AND AFFECTIVE INSTABILITY IN BPD

Marianne Goodman, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 1 Gustave L. Levy Place, Box 1230, New York, NY 10029;* Harold W. Koenigsberg, M.D., Antonia S. New, M.D., Vivian Mitropoulou, M.A., Tenko Raykov, Ph.D., Larry J. Siever, M.D.

SUMMARY:

Affective instability is theorized to be a core dimension of BPD pathology; however, little has been written on its relationship with childhood trauma. Figueroa et al, (1997) noted that interpersonal sensitivity was more closely associated with BPD diagnosis than with trauma history.

In order to investigate the effect of childhood trauma, borderline diagnosis, and affective instability and intensity, we evaluated 61 subjects who meet criteria for BPD and 114 with other personality disorder (OPD). All subjects received structured diagnostic interviews and filled out the Childhood Trauma Questionnaire, Affective Lability Scale (ALS), and Affective Intensity Measure (AIM) self reports.

In a multivariate analysis of variance, childhood emotional abuse was a significant covariate for affective intensity ($F[1,194]=8.19$, $p<.01$), but not for affective lability ($F[1,194]=1.8$, p=ns). No effects of gender or a diagnosis by gender interaction were found. Furthermore, in female borderlines only, there was a positive correlation between ALS-total and history of childhood sexual abuse ($p<.01$).

In summary, recalled childhood traumas appear to be associated with aspects of affective instability in personality disorders.

No. 72C
TREATING THE AFFECTIVE INSTABILITY DOMAIN IN BPD

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029;* Daphne Simeon, M.D., Andrea Allen, Ph.D., Jennifer Greenberg, B.A.

SUMMARY:

Affective instability is a core symptom domain in borderline personality disorder (BPD), which contributes to other symptom domains, such as impulsivity/aggression, as well as to morbidity, mortality, and functional impairment. Mood stabilizers such as lithium and carbamazepine have been studied with some success in diagnostic forerunners of borderline personality disorder. We have conducted two double-blind, placebo-controlled trials with the anticonvulsant mood stabilizer divalproex sodium (DS) in BPD. In the first, a 10-

week, parallel-design trial of valproate vs. placebo in 16 outpatients with BPD, preliminary evidence for improvement in global functioning, aggression, and affective instability was found. The study was limited by a high drop-out rate for impulsive BPD patients on placebo. The second trial was a multicenter, double-blind, placebo-controlled trial of DS/placebo in impulsive-aggression, including patients with cluster B personality disorders, intermittent explosive disorder, and posttraumatic stress disorder, where all subjects had frequent explosive outbursts. Data on OAS-M as well affective instability measures for DS vs. placebo will be presented.

No. 72D
EARLY MALTREATMENT AND THE NEUROBIOLOGY OF AFFECTIVE INSTABILITY

Martin H. Teicher, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Susan Andersen, Ph.D., Ann M. Polcari, R.N., Carl M. Anderson, Ph.D., Caryl P. Navalta, Ph.D.

SUMMARY:

Research in our laboratory and in other programs has shown that childhood maltreatment is associated with alterations in brain structure and function. We have specifically identified four major findings, which include: (1) limbic irritability and abnormalities in frontotemporal electrophysiology; (2) attenuated development of the left hemisphere including the neocortex, hippocampus, and amygdala; (3) reduced size of the corpus callosum (CC) and impaired intrahemispheric integration, and (4) diminished functional activity of the cerebellar vermis. Together, these provide a testable model for the role of early maltreatment in the genesis of borderline personality disorder and affective instability. First, limbic irritability is associated with enhanced fight-flight reactions and low threshold for development of anger. Second, diminished left cortical development and reduced CC size leads to impaired integration between the two hemispheres. Recollection of emotional memories can trigger a switch from left to right hemisphere dominance and powerful shifts in mood and affect. Third, the cerebellar vermis is gaining recognition as a critical site for the regulation of attention, cognition, and affective balance. The most consistent structural abnormality in attention-deficit hyperactivity disorder (ADHD) is reduced size of the cerebellar vermis, and rapid mood swings to events is characteristic of this disorder. Early maltreatment can lead to enduring problems in the regulation of affect through any or all of these pathways.

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SYMPOSIUM 73—CLINICAL AND TREATMENT CHALLENGES WITH HISPANIC PATIENTS
Inter-American Council of Psychiatric Organizations

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium participants will better understand cultural, diagnostic, and therapeutic aspects when dealing with Hispanic patients.

No. 73A
THE HISPANIC PATIENT AND THE DSM-IV

Carlos Berganza, M.D., *Department of Psychiatry, San Carlos University Hospital, Ave Reforma 13-70, Zona 9, # 11B, Guatemala City 01009, Guatemala;* Miguel R. Jorge, M.D.

SUMMARY:

Recently a wide discussion has started about the inclusion of a cultural axis in the new version of the DSM. The intimate structure of diagnostic systems in its semantic categories has in itself a cultural dimension. The discussion on the use of certain terminologies that were originally technical showed the need to maintain under a permanent watch the relationship between classification and diagnosis in order to define terminology. To classify is not the same as to diagnose. A diagnostic process in medicine involves predictive moments and a precision of objective criteria, which in our field is so difficult. The difficulty goes even further when an attempt to make a diagnosis excludes the cultural aspect. This presentation will underline the experience that we have today with Hispanic patients within the DSM-IV and will propose changes for DSM-V.

No. 73B
PERCEPTION OF ILLNESS IN THE HISPANIC PATIENT

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Casilla 17 16 127 C EQ, Quito, Ecuador;* Nestor F. Marchant, M.D.

SUMMARY:

It is frequent to find in our field a call for help because communication between the attending doctor and the patient has stalled. A patient lives his illness based upon his development, his cultural background and the use of defense mechanisms. Intervention of one sort or another can be applied depending on the needs of the patient, the nature of the institution and the surrounding cultural background.

We will demonstrate in this paper that the sensibility of the psychiatrist to the patient's perception of his illness will enhance rapport, shorten the period of treatment, and improve the quality of life. Hispanic patients carry with them the culture from which they stem and therefore the perception of illness, which has to be kept in mind independently of the patient's national background.

No. 73C
PERSONALITY AND HISPANIC PATIENTS

Andres Heerlein, M.D., *Department of Psychiatry, Society of Psychiatry, Carlos Silva 1292-22 Providence, Santiago, Chile;* Roberto E. Chaskel, M.D.

SUMMARY:

The classification of personality has generated innumerable controversies all along the history of psychiatry. In Chapter V of the revision of the ICD-10 by the WHO, many terms that were usually of common usage by psychiatrists disappeared. A similar process has happened along the history of the DSM. If both classifications want to represent multicultural populations, a disadvantage in the subcategorization of the personality axis seems to have happened. Although the ICD-10 seems to be more efficient in classifying certain personality traits, many aspects that involve cultural behavior might fall equivocally as a personality trait, therefore being analyzed as pathological.

The development of new clinical studies will be shown in this presentation in order to clarify doubts and suggest the necessary modifications to create clearer limits in this difficult area of diagnosis in our field, particularly when it comes to Hispanic populations.

No. 73D
PSYCHOTHERAPEUTIC INTERVENTION WITH THE HISPANIC PATIENT

Amelia Mvsacchio, M.D., *Salud Mental, Dep University Buenos Aires, Sant Fe 3802, 7A, Buenos Aires 1425, Argentina;* Rodolfo D. Fahrer, M.D.

SUMMARY:

In the 20th century psychotherapy in Latin America closely followed its counterparts in Europe and the U.S. mostly from psychoanalysis. Freud developed an entire theory of personality development from the reminiscences of free associations and dreams. Hispanic patients have been fortunate to be treated with psychodynamic therapies, which as well as systemic and behavioral therapies seem to relieve mental illnesses. The theories of psychotherapy at the turn of the century will include more than the developmental models that influence cognition and behavior. The ethological paradigm that originated in Darwin's naturalistic studies has been useful in applying different psychotherapies to patients in different cultures.

With so many divergent cultures and psychotherapies, therapists might find themselves and their patients in opposing camps. Many Hispanic patients will be unfamiliar with the work their psychotherapists apply. In this paper individual psychotherapy and its cultural aspect will be compared with other psychotherapeutic interventions and the benefit that innovative therapists can have on their patients.

No. 73E
PSYCHOPHARMACOLOGICAL ISSUES WITH HISPANIC PATIENTS

Antonio Pacheco, M.D., *Department of Psychiatry, Central University of Venezuel, PO Box 17344, Caracas 1010-A, Venezuela;* Ruben J. Hernandez-Serrano, M.D.

SUMMARY:

Psychopharmacology in Hispanic patients is a relatively young clinical and research discipline. Although the use of psychotropic medication to treat Hispanic patients was already reported in the 1930s, scientifically rigorous clinical research in this area did not appear until the 1970s. Broad-based enthusiasm among practitioners for psychopharmacological treatment in patients did not really emerge until the 1980s. Most psychiatrists assume that primary and secondary effects of medications are similar across races and cultures. This paper will review the scientific literature on sound clinical and ethical standards that appears to show that Hispanic patients, as one of the minorities, need to be screened carefully. Prescribing and adherence to treatment are influenced by culture. Reactions to medication are influenced by genes. To be sensitive about these aspects will result in a better quality of treatment.

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SYMPOSIUM 74—PATIENTS WITH CHRONIC PAIN: MULTIDISCIPLINARY TREATMENT APPROACHES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the appropriate utilization of different treatment techniques with chronic pain patients; to demonstrate improved facility with pharmacologic and psychologic treatment modalities.

No. 74A
PAIN AND PSYCHIATRY: A GENERAL OVERVIEW

Matthew B. Smith, M.D., *Department of Psychiatry, New York University Medical Center, 333 East 34th Street, # 10, New York, NY 10016-4977*

SUMMARY:

The purpose of this presentation is to present a formulation of physical pain such that in its biological, psychological, and social dimensions, it comes to overlap significantly with psychiatric models and conditions, thus becoming a disorder within the purview of the psychiatrist. Additionally, different approaches to integrating pain syndromes in a psychiatric practice will be addressed. The presentation will include a critical review of the DSM-IV somatoform diagnostic criteria, particularly as they relate to chronic pain patients. The relationship of emotional pain to physical pain will be discussed. Specific psychiatric practice issues will be reviewed, such as the interface with multidisciplinary pain-team members, as well as difficulties inherent in working with chronic pain patients. Specific case examples will be used to highlight these points.

No. 74B
AN INTEGRATIVE MODEL OF THE PSYCHOBIOLOGY OF PAIN

Jeffrey D. Rome, M.D., *Department of Psychiatry, Mayo Clinic, 200 First Street, SW, Rochester, MN 55905-0001*

SUMMARY:

The association between chronic pain, emotional distress, and behavioral dysfunction has garnered much attention from clinicians, researchers, and psychosomatic theorists. Although this association has long been recognized phenomenologically and epidemiologically, it has not been well described at the neurobiologic level. Prevailing theories have primarily addressed short-term/state-related considerations or have focused on "psychogenic" etiologies for obscure pain complaints. The complex processes of neuroplasticity are key to developing a valid biopsychosocial model of the psychobiology of chronic pain. The heuristic construct of a limbically augmented pain syndrome (LAPS) is introduced to describe chronic pain syndromes that are the result of kindling-induced sensitization in corticolimbic structures that subserve both nociception and emotion. The hallmark features of LAPS include pain that is chronic and resistant to analgesic treatments, in association with disturbances of mood, affect regulation, sleep, energy, libido, and memory/concentration. Behavioral dysfunction, along with generalized intolerance of stressful life events, are also features of the complex chronic pain disorders that are labeled LAPS.

No. 74C
THE USE OF ANALGESICS IN CHRONIC PAIN

Michel Dubois, M.D., *Department of Anesthesiology, New York University Medical Center, 530 First Avenue, Suite 9T, New York, NY 10016*

SUMMARY:

In light of newly emerging analgesic medications, the selection of analgesics often presents a dilemma to the practicing clinician. This presentation will review the latest findings regarding the clinical use and selection of analgesics and will present guidelines for the psychiatrist working with patients with chronic pain. The pharmacotherapy of pain relies primarily on central and peripheral analgesics and is based on the concept of nociceptive pain. The primary peripheral analgesics (which also have considerable central effect) are the nonsteroidal anti-inflammatory drugs (NSAIDs). The variety of subclasses that comprises the NSAIDs will be reviewed. Efficacy and side effects vary not only between different subclasses but also within the subclass itself. Ceiling dose as well as guidelines for selection will be discussed. Central analgesia is primarily accomplished through opiates, which appear to stimulate an endogenous system for analgesia. Pharmacologic factors strongly influence selection of drug. Opioid class, weak versus strong opioids, drug toxicities, pharamacokinetic differences, and duration of effect will be outlined. The indications for chronic opiate therapy in nonmalignant pain will also be addressed as well as the newer pharmacologic agents used for analgesia, such as the Cox-2 inhibitors.

No. 74D
CHRONIC PAIN: NONANALGESIC AND ADJUVANT PHARMACOLOGICAL OPTIONS

Michael R. Clark, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Osler 320, Baltimore, MD 21287-5371*

SUMMARY:

Psychiatrists offer special skills, particularly the opportunity of innovative applications of their psychiatric knowledge, in the care of patients with chronic pain syndromes. A large body of research now supports the use of traditional psychiatric treatments in the management of chronic pain. Pharmacological treatments have proven effective for many different pain syndromes, especially neuropathic conditions. For any specific disease, no single algorithm can dictate the modalities of treatment to be prescribed. Several classes of medications, including the antidepressants, anticonvulsants, antiarrhythmics, and calcium channel blockers, have proven efficacy for the treatment of neuropathic pain. These medications are traditionally referred to as nonanalgesic or adjuvant but should be recognized as first-line choices in the pharmacological management of chronic pain. However, relief provided by these medications is usually incomplete and difficult to predict in advance. The selection of a particular medication, or combination of medications, will depend on multiple factors. The disease itself may change over time such that the efficacy of a treatment is altered, or one treatment may be selected over another based on the response to previous treatments and the patient's psychiatric comorbidity, temperament, coping skills, and life story cannot be neglected.

No. 74E
COGNITIVE-BEHAVIORAL APPROACHES TO CHRONIC PAIN

Allen Lebovits, Ph.D., *Department of Anesthesia and Psychiatry, New York University Medical Center, 530 First Avenue, Suite 9T, New York, NY 10016*

SUMMARY:

The psychological intervention with the patient who has chronic pain is an integral part of a multidisciplinary approach to pain management. This presentation will outline the most commonly utilized approach, the cognitive-behavioral approach. The general goal of cognitive-behavioral treatment strategies is to assist the patient in reconceptualizing the belief about pain as an uncontrollable medical symptom to a belief that the patient's response to pain can be under his/her control The mainstay of this approach is relaxation training, which helps patients by distracting them from their pain, reducing autonomic reactivity, and enhancing a sense of self-control. Relaxation training, can be accomplished through several techniques: guided imagery, progressive muscular relaxation, biofeedback, and hypnosis.

In addition to relaxation training, an essential part of the cognitive-behavioral approach is cognitive restructuring. With this technique, patients are taught to identify maladaptive negative thoughts that pervade their thinking and to replace them with more adaptive positive thoughts. The maladaptive thoughts often take the form of statements about oneself or illness that are negative, overgeneralizing, or catastrophizing.

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4. Clark MR: Pharmacological treatments for chronic non-malignant pain. International Review of Psychiatry 2000; 12:148–156.
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SYMPOSIUM 75—PHYSICIAN DISABILITY: TREATMENT, INDEPENDENT EVALUATION, INSURANCE, AND CONFLICTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the key concepts behind disability products and their importance, both in the treatment and evaluation of disabled physicians and for psychiatrists themselves, treat disabled physicians with enhanced ability to recognize potential therapeutic, ethical, and legal pitfalls; conduct an independent psychiatric disability evaluation of a physician.

No. 75A
AREA OF CONFLICT BETWEEN DISABLED PHYSICIAN PATIENTS AND DISABILITY INSURERS

Richard F. Limoges, M.D., *111 North 49th Street, Philadelphia, PA 19139-2718*

SUMMARY:

The extent of the problem of physician illness and disability will be reviewed. It is often difficult for early career physicians to recog-

nize their need for disability insurance coverage, for a variety of reasons that will be discussed.

The treating psychiatrist's relationship with the disability insurance company is fraught will problems. The degree of dissonance between the views of the treater and the physician/patient regarding how disabled the patient is or when he or she should return to work can create a variety of problems for the treatment. Failure to complete the insurer's paperwork may threaten the benefits received by the patient. Communication from the insurance company may seem to question the diagnosis, treatment, or professionalism of the psychiatrist. Requests for medical records or the psychiatrist's notes are not uncommon. It is generally not appropriate to send these to insurers, and to do so, even with the patient's permission, may create legal and ethical problems. Management of these difficulties will be discussed. Resources for helping the psychiatrist manage the legal and ethical issues will be reviewed. Case vignettes will be used to illustrate central points.

No. 75B
DISABILITY INSURANCE: TECHNICAL AND LEGAL ASPECTS

Mark F. Seltzer, Esq., *1710 Spruce Street, Philadelphia, PA 19103-6716*

SUMMARY:

The physician considering the purchase of disability insurance coverage, the physician facing illness and/or disability, and the physician treating disabled patients should become familiar with the important concepts related to disability insurance policies. These concepts include total and residual disability, "own occupation" policies, material and substantial duties, and "regular and appropriate" medical care for the disabling condition. Legal issues will be discussed, including those involving pre-existing conditions (including the failure to disclose), incontestability clauses, legal versus factual disability, social disability, general versus specialty specific, and the issues of risk of relapse from certain disorders. Which psychiatric disorders may be considered the cause of disability will be reviewed. Emphasis will be placed on how this information may enable psychiatrists to better help their disabled patients. The importance of both the legal and medical positions regarding disability will be addressed.

No. 75C
TREATING THE DISABLED PHYSICIAN

Michael F. Myers, M.D., *2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada*

SUMMARY:

In treating the disabled physician one must begin with understanding what has driven the application for disability benefits—the physician/patient, their family, their employer, the psychiatrist, or another physician. It is important to advocate for one's patient, but not to let the patient's wish to be on disability overrule clinical judgment. The clinical importance of whether the disability is short- or long-term will be addressed.

Transference and countertransference feelings of the psychiatrist, and their management, will be discussed in detail, including the potential for boundary blurring and crossing. Feelings of therapeutic failure and the importance of accepting one's limits as a treating psychiatrist will be addressed. The management of secondary gain associated with the patient receiving disability benefits is essential and involves understanding the patient's premorbid attitudes about work, the nature of the workplace itself (toxic versus supportive), and whether the benefits in fact thwart the effort to return to work. Return to work plans will be discussed. The importance of Axis II pathology will be addressed. The place of independent medical evaluations and their impact on the health and treatment of the patient will be discussed. Clinical vignettes will be employed to illustrate essential points.

No. 75D
PERFORMING AN INDEPENDENT PSYCHIATRIC DISABILITY EVALUATION AS A PHYSICIAN

Michael H. Gendel, M.D., *3300 East First Avenue, Suite 590, Denver, CO 80206-5808*

SUMMARY:

The independent evaluation of physicians with respect to whether or not they are psychiatrically disabled differs fundamentally from the psychiatric treatment of such physicians or their evaluation in a treatment context. The difference has to do with the absence of a doctor-patient relationship, limited confidentiality, and the narrow purpose of the evaluation—that of understanding whether the physician is ill, and how that illness impacts the ability to do his or her work.

The lack of doctor-patient relationship may run counter to the expectations, consciously or unconsciously, of both the evaluee and evaluator. Problems of informed consent and its complexities in the IME situation will be reviewed. Certain transference and countertransference experiences for the evaluating psychiatrist are common in working with physicians; these and their management will be discussed. Disability evaluation requires that the evaluating psychiatrist be knowledgeable of the work duties of the physician and be able to demonstrate the relationship of the evaluee's illness and symptoms to those duties. The evaluator must also understand the specific insurance policy definition of disability. The use of collateral sources of information will be addressed. Related topics in forensic aspects of disability will be addressed, including implications for medical licensure.

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THURSDAY, MAY 23, 2002

SYMPOSIUM 76—CULTURALLY COMPETENT MENTAL HEALTH CARE: IDENTIFYING AND REDUCING DISPARITIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will have a better understanding of the extent to which racial and ethnic disparities exist in psychiatric services and standards that facilitate culturally competent care.

No. 76A
BIPOLAR DISORDER IN AFRICAN AMERICANS

William B. Lawson, M.D., *Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, NW, Washington, DC 20061*

SUMMARY:

African Americans (AA) with bipolar disorder (BD) are understudied. Historically, AA with BD were more likely to be misdiagnosed with schizophrenia. Recent findings suggest clinician factors including bias, lack of cultural awareness, and insufficient history contribute to misdiagnosis. Patient factors include more symptoms, perhaps because of treatment delay, and different symptom presentation, i.e., more irritable or psychotic symptoms or suspiciousness. Differences in treatment setting, i.e., primary care or correctional facilities, further complicate diagnosis. A database from the NIMH Genetic Study of Bipolar Disorder was examined. AA showed a different distribution of bipolar spectrum disorders than Caucasians, with the depressive disorders occurring less frequently. Consistent with other studies, African Americans showed more hallucinations and delusions, and were more likely to be treated with neuroleptics. Other recent studies show AA are less tolerant of lithium, which may contribute to excessive neuroleptic use. Together these findings show that AA continue to be at risk for misdiagnosis and under-treatment, more research should be done in AA spectrum disorder and alternatives to lithium, and phenotypic differences suggest caution in interpreting genetic studies.

No. 76B
MENTAL HEALTH CARE IN HISPANIC POPULATIONS: CLINICAL AND THERAPEUTIC ISSUES

Renato D. Alarcon, M.D., *Atlanta VA Medical Center, 1670 Clairmont Road, Atlanta, GA 30033*

SUMMARY:

Standing as the ethnic minority population group on the verge of becoming the largest in the U.S. within the next three decades, Hispanics confront a variety of challenges in the mental health care arena. Heterogeneous in regards to national origin, geographic location, cultural and educational background, and socioeconomic profile, Hispanics present some unique clinical/cultural characteristics vis-à-vis the main psychiatric diagnoses, (psychoses, and mood and anxiety disorders, substance abuse, and cognitive disorders) and equally distinctive responses to medications and psychotherapeutic approaches. The most prominent aspects of this health care picture, however, is the repeated observation of disparities in accessibility, availability, affordability, utilization, and accountability of existing mental health services for Hispanic populations. On the basis of a critical examination of literature and research findings, this presentation formulates an agenda of policy and clinical approaches to alleviate current pressures on the diagnosis, management, efficiency, and quality of mental health care for Hispanics in the U.S.

No. 76C
CULTURAL COMPETENCE STANDARDS FOR MENTAL HEALTH SERVICES

Francis G. Lu, M.D., *Department of Psychiatry, University of California, San Francisco, 1001 Potrero Avenue, SFGH Suite 7M, San Francisco, CA 94110*

SUMMARY:

Cultural competence standards for mental health services have emerged in the past two years to provide guidance in providing services for culturally diverse populations. First, in 2000, the federal Center for Mental Health Services (CMHS) issued its report Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups. It provided guidance at system-network, agency, and individual provider levels to enable provision of services across cultures. The CMHS has also supported the work on Cultural Competence Performance Measures originating from the work of the Center for the Study of Issues in Public Mental Health (New York State). Finally, in December 2000, the U.S. Department of Health and Human Services Office of Minority Health issued National Standards for Culturally and Linguistically Appropriate Services for Healthcare Organizations. All of the 14 key standards are relevant to mental health services.

No. 76D
RACE, ETHNICITY, AND VARIATIONS IN PSYCHIATRIC DIAGNOSIS AND TREATMENT

Diane M. Herbeck, M.A., *APIRE, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Carl C. Bell, M.D., Diana J. Fitek, B.A., Joyce C. West, M.P.P.

SUMMARY:

Objective: to examine variation in psychiatric diagnosis and treatment patterns in a large, nationally representative sample of racial-ethnic minority and nonminority adult patients treated by psychiatrists.

Method: Psychiatrists participating in the American Psychiatric Institute for Research and Education's Practice Research Network provided sociodemographic and clinical data on 2,564 patients. Weighted bivariate Wald Chi-square and Wald F-test assessed diagnostic and treatment factors associated with patients' race/ethnicity. Forward selection logistic regression analyses adjusted for sociodemographic and diagnostic and clinical differences between racial/ethnic groups.

Results: After adjusting for patient sociodeomographic factors, African Americans were more than twice as likely to be diagnosed with a psychotic disorder (OR=2.4, 95% CI=1.5, 3.9) and half as likely to be diagnosed with a mood disorder (OR=.5, 95% CI=3, .8) compared with white patients. Regarding treatments, after adjusting for patient sociodemographic, diagnostic, and clinical factors, African Americans were 49% less likely to receive an antidepressant (OR=.5, 95% CI=.3,.7) compared with white patients. Use of atypical antipsychotic medication varied by race/ethnicity; African Americans were half as likely to receive an atypical APM (OR=.5, 95% CI=.3,.8) compared with white patients.

Conclusions: Although there may be residual confounding in the sociodemographic and clinical case mix adjusters used in these analyses, these findings indicate significant racial/ethnic disparities in the diagnosis and treatment of psychiatric patients.

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SYMPOSIUM 77—HIV TREATMENT DIMENSIONS AMONG DIVERSE ETHNIC AND CULTURAL POPULATIONS
APA Commission on AIDS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify specific treatment perspectives from personal testimony from individuals from Latino and African-American communities, (2) outline the major points of culturally sensitive HIV psychiatry, (3) detail factors specific to African-American and Latino communities.

No. 77A
HIV-POSITIVE PATIENT PANEL

Altha Stewart, M.D., *Department of Psychiatry, Detroit-Wayne County CMHC, 640 Temple Street, 8th Floor, Detroit, MI 4820.*

SUMMARY:

Many times cross-cultural treatment issues can become theoretical and detached from actual patient experiences. Personal testimony from HIV-positive individuals can further add a dimension of learning that can confirm or build on theory.

During this session, individuals from African-American and Latino communities will present personal comments on how cultural differences have affected their HIV psychiatric treatment. After listening to personal patient comments, clinicians are invited to understand how powerful differing cultural aspects can affect the therapeutic alliance and treatment.

No. 77B
CULTURAL CONSIDERATIONS FOR TREATING HIV-INFECTED AFRICAN-AMERICAN PATIENTS

Eric G. Bing, M.D., *9435 Beverlywood Street, Los Angeles, CA 90034-1821*

SUMMARY:

In the United States, the impact of HIV and AIDS in the African-American community has been devastating. Through December 1999, CDC had received reports of 733,374 AIDS cases, of which 272,881 cases occurred among African Americans. Representing only an estimated 12% of the total U.S. population, African Americans make up almost 37% of all AIDS cases reported in this country.

In order to address the growing disproportion of HIV-infected African Americans, this session will outline some of the cultural differences and barriers that can surface when treating African-American patients with HIV, especially men who have sex with men, women, lesbians, transgendered persons, and substance using patients. Suggestions for conducting culturally sensitive psychiatric evaluations and treatment of HIV-infected African Americans will also be presented.

No. 77C
CULTURAL CONSIDERATIONS FOR TREATING HIV-INFECTED LATINO PATIENTS

Milton L. Wainberg, M.D., *Department of Psychiatry, New York Psychiatric Institute-Columbia University, 404 Riverside Drive, Unit 5B, New York, NY 10025*

SUMMARY:

Constituting nearly 12% of the U.S. population, Latinos are expected to become the second-largest ethnic group by 2010. This growth emphasizes the increasing importance of understanding the cultural factors affecting the psychiatric treatment of Latino patients living with HIV. Integrating culture-specific treatments with more traditional interventions, such as medication and psychotherapy, is crucial to achieving successful outcomes for HIV-infected Latino patients.

This session will outline some of the cultural considerations that can surface when treating Latino patients with HIV, especially men who have sex with men, women, lesbians, bisexual and transgendered persons, and substance using patients. Suggestions for conducting culturally sensitive psychiatric evaluations and treatment with HIV-infected Latinos will also be presented.

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SYMPOSIUM 78—BRAIN SUBSTRATES OF ADDICTION: NEUROIMAGING AS A TOOL OF CHOICE IN THE 21ST CENTURY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the utility of imaging tools (PET perfusion, PET neuroligand, structural MRI, BOLD fMRI, and Perfusion fMRI) in studying the brain substrates of addiction.

No. 78A
USING PET TO IMAGE THE NEUROANATOMICAL AND NEUROCHEMICAL SUBSTRATES OF COCAINE CRAVING

Anna R. Childress, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19104;* Paul Acton, Ph.D., Kyle M. Kampman, M.D., Teresa R. Franklin, Ph.D., Anna Fornash, Charles P. O'Brien, M.D.

SUMMARY:

Cue-induced drug desire (craving) is a cardinal feature of addictive disorders, and may precede drug use/relapse. Our hypothesis is that cue-induced, appetitive craving states are characterized by increased activity in the mesocorticolimbic dopamine (DA) system. We have used drug-related videos to evoke cocaine craving in the brain imaging setting, enabling study of its brain substrates. Our initial neuroanatomical studies used PET with O-15 water as the perfusion tracer. These studies demonstrated that appetitive cocaine craving was accompanied by limbic (amygdala, anterior cingulate) activation in cocaine patients (n = 14, vs. 6 controls) viewing a 25-minute cocaine (vs. nature) video. As GABA B agonists may help reduce endogenous DA release, we recently tested whether the familiar GABA B agonist baclofen (up to 20 mg b.i.d.) could blunt or eliminate the characteristic response to cocaine cues. Initial results show blunting of craving and limbic activation by baclofen, when administered less than two hours prior to the PET session. Recently, we have begun testing directly for DA release by cocaine cues, using PET and the neuroli-

gand C-11 raclopride (a D2/D3 antagonist) in a competition paradigm. These complementary neuroanatomical and neurochemical approaches do support DA activation, and additionally underscore the power of neuroimaging tools.

No. 78B
BOLD FMRI VERSUS SPIN-TAGGING IN CUE-INDUCED COCAINE CRAVING (4T)

John M. Listerud, M.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19104;* Jionjiong Wang, Ph.D., J. Defre, M.D., Jason Gray, B.A., Charles P. O'Brien, M.D., Anna R. Childress, Ph.D.

SUMMARY:

Preliminary work by several neuroimaging groups into the brain activation signature for cue-induced cocaine craving has demonstrated encouraging consistency (e.g. limbic activation), despite different imaging (PET O-15, PET F-18 FDG, BOLD fMRI) and cue presentation methodologies. Reported discrepancies potentially reflect difficulty in uncoupling cue-induction paradigms from the several imaging technologies. In our previously reported O-15 PET paradigm, continuous infusion lends itself naturally to "long continuous" video segment intervals, a nice "match" between the infusion technique and the presumed temporal pattern of a craving state (~20 min,). However, such cue-induction paradigms can be expected to be more sensitive to the well known "pink noise" artifact associated with BOLD imaging. "fMRI-style" short, alternating interval paradigms (e.g. ~2 min intervals in a working memory task activating dorsolateral prefrontal cortex) would seem intuitively to not correspond well to the temporal characteristics of limbic states. In our recently completed fMRI study (controls n = 12, cocaine patients = 13; 4 Tesla), "long continuous" versus "short alternating" cue-induced craving paradigms were compared. Our preliminary experience with spin-tagging perfusion fMRI, (subtraction interval ~2 sec.) suggests that it may be a potential solution to decoupling the temporal properties of craving induction from an fMRI method's technical requirements. R25 MH60490, NIDA RO1 DA10241

No. 78C
FUNCTIONAL MRI DURING HEROIN CRAVING IN METHADONE-MAINTAINED SUBJECTS

Daniel D. Langleben, M.D., *Department of Psychiatry, University of Pennsylvania, TRC, 3900 Chestnut Street, Philadelphia, PA 19104;* Jionjiong Wang, Ph.D., Jason Gray, B.A., John M. Listerud, M.D., Charles P. O'Brien, M.D., Anna R. Childress, Ph.D.

SUMMARY:

Background: Heroin abuse by patients on methadone maintenance (MM) is a major cause of relapse and morbidity. Cue-induced craving for heroin may contribute to relapse and continued heroin abuse in MM patients. Research on the brain substrates of craving in opiate-dependent subjects has been limited.

Methods: We are using Arterial Spin Labeling (perfusion) functional Magnetic Resonance Imaging (perfusion fMRI) on a 4 Tesla scanner to study the effects of heroin cues on the regional cerebral blood flow (rCBF). Perfusion fMRI is performed while a "heroin" (simulated use of heroin) or "neutral" (nature) video is presented to MM subjects and controls. Statistical parametric mapping (SPM) is used to compare rCBF during heroin and neutral cues and to correlate rCBF with subjective and physiological measurements of opiate craving.

Results: In MM subjects (N = 4), heroin cues induced craving and a differential rCBF response in the ventral tegmental Area, a component of the mesolimbic reward system.

Conclusions: If confirmed in a larger sample, our results indicate that opiate craving in the absence of physical withdrawal and cocaine craving engage the same brain reward mechanism. Perfusion fMRI at 4 Tesla is a promising technique for imaging of sustained states (e.g. mood or craving).

Supported by *NIDA ROI 10241.*

No. 78D
FMRI OF CUE-INDUCED NICOTINE CRAVING

Teresa R. Franklin, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19105;* Jason Gray, B.A., Charles P. O'Brien, M.D., Anna R. Childress, Ph.D.

SUMMARY:

Relapse to smoking is often precipitated by exposure to environmental cues that lead to craving. Research suggests that nicotine, like other reinforcing drugs, activates the mesocorticolimbic dopamine system. Studies suggest that nicotine effects on dopamine, on observable behaviors, and on self-administration are more pronounced in females, implying that nicotine is more rewarding to this gender. The present study uses smoking videos in the fMRI setting to characterize the substrates of cigarette craving. Male and female smokers (>15cigs/day) and a matched nonsmoking group (n = 12/grp) were imaged while viewing nicotine or non-nicotine videos. Preliminary data suggest that the brain response to nicotine cues mimics findings of regional hyperactivity during cue-induced cocaine craving (orbitofrontal cortex, amygdala, anterior cingulate) and may be greater in women. To our knowledge, this study is the first to use brain imaging to examine gender differences during cue-induced drug craving and as such is a significant contribution to the field.

No. 78E
BRAIN SUBSTRATES FOR SELF-CONTROL MAY BE DEFECTIVE IN ADDICTION

John R. Monterosso, Ph.D., *Department of Psychiatry, University of Pennsylvani-TRC, 3900 Chestnut Street, Philadelphia, PA 19104;* Ronald Ehram, Ph.D., Kimberly Napier, B.A., Anna R. Childress, Ph.D., Charles P. O'Brien, M.D.

SUMMARY:

Addicted populations perform poorly on tasks related to delay tolerance and to risk. These tasks include (1) the Delay Discounting Procedure (DDP), in which choices are made between smaller-sooner and later-larger rewards; (2) the Gambling Task (GT), in which good performance requires avoiding immediately tempting alternatives; and (3) the Rogers Decision-Making Task (RDMT), in which good performance may require adopting and persisting with a globally dominant strategy rather than assessing choices individually. In a population of cocaine-dependent patients (n = 32), we have shown performance on these tasks to be modestly intercorrelated, suggesting some overlap in the construct they assess (Monterosso et al., 2001). Interestingly, in an independent sample of patients, structural MRI analysis revealed deficits in gray matter in brain regions that are active during performance on the above tasks including the orbitofrontal region and the insula (Franklin et al., 2001). We hypothesize that these structural and behavioral deficits are related. We will report on the results from a study currently under way that will allow this hypothesis to be tested by collecting both behavioral and imaging measures within the same cohort.

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SYMPOSIUM 79—OPTIMAL STRATEGIES FOR IDENTIFYING AND TREATING TRAUMATIZED CHILDREN

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize screening instruments for childhood traumatic exposure and PTSD, describe empirically proven trauma-focused CBT interventions, recognize neurobiological abnormalities in child PTSD, demonstrate knowledge about current pharmacologic interventions for traumatized children, and identify emerging standards for treating this population as exemplified by the new California guidelines.

No. 79A
SCREENING FOR TRAUMATIC EXPOSURE AND PTSD SYMPTOMS IN PEDIATRIC SETTINGS

Anthony P. Mannarino, Ph.D., *Department of Psychiatry, Allegheny General Hospital, 4 Allegheny Center, 8th Floor, Pittsburgh, PA 15212;* Judith A. Cohen, M.D., Daphne Ruben, L.C.S.W.

SUMMARY:

Objective: Community, school, and domestic violence; child abuse; natural and man-made disasters; motor vehicle accidents; and traumatic loss of a close family member are unfortunately events that affect the lives of many children. Despite recent high-profile school shootings and other dramatic examples of childhood trauma, most children impacted by such experiences are underidentified and undertreated. There is growing evidence that untreated childhood posttraumatic stress disorder (PTSD) predisposes children to significant psychiatric, medical, and functional impairments that may persist into adulthood. However, there have been few efforts to improve the early screening of children for traumatic exposure and PTSD symptoms. This presentation describes an ongoing project intended to conduct widespread screening for childhood trauma in pediatric primary care settings, including a public hospital clinic, an ob-gyn clinic, and private practices.

Method: One hundred seventy-five children 8 to 16 years old have been screened in a primary care setting using the TESI-C and UCLA PTSD Index instruments.

Results: Over 80% of the screened children reported experiencing at least one traumatic life event. Approximately 20% met criteria for at least moderate PTSD symptoms.

Conclusion: Screening for traumatic exposure and PTSD in pediatric settings is a feasible method for improving identification and referral for traumatized children.

No. 79B
COGNITIVE-BEHAVIORAL THERAPY FOR TRAUMATIZED CHILDREN AND THEIR PARENTS

Esther Deblinger, Ph.D., *Center for Child Support, University Medical Dentist, 42 East Laurel Road, Suite 1100, Stratford, NJ 08084*

SUMMARY:

Objective: In recent years, there has been a growing number of psychosocial treatment studies for traumatized children. Most of these have been conducted in sexually abused children, but there have also been controlled treatment outcome studies for children exposed to physical abuse, single-episode traumas, and natural disasters. To date, trauma-focused cognitive-behavioral therapy (TF-CBT) has the most convincing evidence of efficacy.

Method: This presentation will describe the major components of TF-CBT. These include cognitive processing (exploration and correction of cognitive errors regarding causation, responsibility, and meaning of the traumatic event), gradual exposure (direct discussion of the details of the traumatic event including the thoughts and feelings related to those experiences), stress management (cognitive coping and relaxation techniques), psychoeducation (including safety skills), and parental treatment.

Results: The results of several randomized clinical trials indicate that TF-CBT is superior to wait-list control, community treatment as usual, and nondirective supportive comparison conditions in improving PTSD, and depressive and other symptoms in traumatized children.

Conclusions: TF-CBT is an efficacious treatment for children exposed to a variety of traumatic life events. The need for dismantling studies and efforts to transport TF-CBT for broader use in community settings will also be discussed.

No. 79C
DEVELOPMENTAL TRAUMATOLOGY: NEUROBIOLOGICAL DEVELOPMENT IN CHILDHOOD PTSD

Michael D. DeBellis, M.D., *Department of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213;* Matcheri S. Keshavan, M.D., Sue R. Beers, Ph.D., Neal D. Ryan, M.D.

SUMMARY:

Objective: A series of studies will be presented in which we examined brain development of maltreated children and adolescents with posttraumatic stress disorder (PTSD).

Methods: In the main study, 61 maltreated children and adolescents with PTSD and 122 nonabused controls underwent comprehensive diagnostic assessments and anatomical magnetic resonance imaging brain scan.

Results: As reported in our earlier studies, PTSD subjects had smaller intracranial volumes (ICV) than controls. Cerebral volumes and midsagital area of corpus callosum were smaller than controls, while lateral ventricles were proportionally larger after adjustment for ICV. However, these findings were more prominent in the maltreated males with PTSD. There were significant interactions between age and gender for cerebral white matter and corpus callosum area. PTSD subjects also differed from anxious non-maltreated children and adolescents, whose major findings were of a larger right amygdala.

Conclusions: These data suggest that childhood maltreatment is associated with adverse brain maturation.

No. 79D
PHARMACOLOGICAL TREATMENTS FOR TRAUMATIZED CHILDREN

Judith A. Cohen, M.D., *Department of Psychiatry, Allegheny General Hospital, 4 Allegheny Center, 8th Floor, Pittsburgh, PA 15212*

SUMMARY:

Objective: Several neurotransmitter systems have been implicated in the development and maintenance of childhood posttraumatic stress disorder (PTSD). PTSD in children also has a high rate of comorbidity with other psychiatric disorders. Although numerous controlled pharmacologic trials have been conducted for adults with PTSD, and pharmacologic interventions are being increasingly utilized for treating childhood PTSD, there are currently no published controlled studies evaluating pharmacologic treatments for this population.

Methods: This presentation will review the main neurotransmitter systems involved in childhood PTSD, and will present and critique all of the published open-medication trials for this population, including adrenergic blocking agents, mood stabilizers, antidepressants, novel antipsychotics, opiates, and opiate antagonists.

Results: Several medication classes may hold promise for the treatment of traumatized children, but controlled treatment trials are needed for this population.

Conclusions: Suggestions for the pharmacologic management of childhood PTSD, including treatment of children with comorbid psychiatric conditions will be presented. Future directions for practice, research, and policy also will be addressed. Participants will be encouraged to present clinical cases during the discussion period.

No. 79E
TREATING CHILD AND ADOLESCENT VICTIMS OF CRIME: THE NEW CALIFORNIA GUIDELINES

Graeme Hanson, M.D., *Department of Child & Adolescent Psychiatry, Langley Porter UCSF, 401 Parnassus Avenue, San Francisco, CA 94143*

SUMMARY:

In every state, victims of crime programs fund mental health treatment for child and adolescent victims of crime. Few standards and guidelines have been promulgated to assist clinicians in their treatment of these victims; in addition, the state agencies have had little formalized guidance in assessing the appropriateness and success of such treatments. The California Victims of Crime program convened a task force of child and adolescent mental health specialists to develop such guidelines. These guidelines were published in the spring of 2001. These guidelines address a wide range of pertinent topics, including a description of the victims of crime programs, qualifications for therapists, special populations such as children with disabilities, cultural issues, ethical issues, and legal and documentation issues.

This presentation will review key elements in the California guidelines, especially those that apply to clinicians providing individual therapy and treatment for child and adolescent victims of crime.

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SYMPOSIUM 80—OPIATE-SUBSTITUTION TREATMENT: INTERNATIONAL TRENDS AND PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be acquainted with European approaches to opiate-substitution pharmacotherapy, and understand the issues related to testing effectiveness.

No. 80A
BUPRENORPHINE: EXPERIENCES WITH OFFICE-BASED SUBSTITUTION TREATMENT IN EUROPE

Marc Auriacombe, M.D., *Department of Addiction, Psychiatry Carreire, 121 Rue De La Bechade, Bordeaux 33076, France;* Pascale Franques, M.D., Jean-Pierre Daulouede, M.D., Jean L. Tignol, M.D.

SUMMARY:

Buprenorphine has been in use within the department of psychiatry of the University of Bordeaux, France, since 1987 as a substitution treatment for opiate addiction. It is available both through a center-based setting and office-based practice. Evaluation of the services provided was carried out and demonstrated the benefits of substitution treatment, which encouraged authorities and physicians to treat more patients with buprenorphine. A prospective follow-up evaluation was then performed, which confirmed that buprenorphine treatment had a positive effect on reducing illicit drug use and related quality of life. No shift to the use of other drugs was observed within these treatment settings. These benefits can be attributed to the use of buprenorphine and the setting in which it is given. Based on this study, and studies by others, there have been major changes in France and in 1996, buprenorphine was made widely available: it is now estimated that close to 60,000 patients receive this treatment. During the same time, overdose deaths have dramatically decreased: an overview of buprenorphine status in Europe will be given.

The authors acknowledge financial support from the Ministry of Research (grant MESR-94V to M. Auriacombe) and the Ministry of Health (grant PHRC-1994 to J. Tignol and grant PHRC-2000 to M. Auriacombe).

No. 80B
MORPHINE MAINTENANCE IN THE TREATMENT OF HEROIN ADDICTION

Gabriele Fischer, M.D., *Department of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna 1090, Austria;* Romana Ortner, M.D., Shiro Schindler, M.D., Harald Eder, M.D.

SUMMARY:

Treatment of oplate addicts is still difficult and often has limited success. There is general agreement that opioid dependence is a chronic relapsing disorder and long-term psychopharmacological treatment with synthetical opioids is effective. The efficacy of methadone has been proven for a long time. Regarding diversification of treatment, LAAM and buprenorphine, and other opioid receptor

interacting substances were introduced, both in the U.S. and Europe. To complete the list of substances that are used for maintenance therapy, oral slow-release morphine (SH-morphine) has been applied for many years in European countries. SR-morphine has a high acceptance in the target population; however, there is a lack of evidence-based scientific study trials. A controlled study (methadone/SR-morphine maintenance) in pregnant opioid addicts over 13 weeks until delivery found no differences in the duration and intensity of the neonatal abstinence syndrome in the newborns; however, a significant fewer benzodiazepine and opiate consumption in the SR-morphine maintenance group was found. Results of a double-blind, double-dummy, cross-over maintenance study (methadone/SR-morphine) in opioid-dependent subjects over 14 weeks showed no significant differences in retention rate (85%) in contrast to supervised urinalyses toxicology data. Besides the individual benefits of having a variety of substances available for the treatment of heroic dependence, special awarness needs to be addressed regarding diversion on the street.

No. 80C
IS THERE A GOLD STANDARD MEDICATION IN OPIATE-SUBSTITUTION TREATMENT?

Robert G. Newman, M.D., *Continuum Health Administration, 555 West 57th Street, 18th Floor, New York, NY 10019*

SUMMARY:

There is much about the treatment of addiction that is unique. Thus, governments (in the United States, Germany, and most countries of the world) impose unparalleled restrictions and requirements on physicians active in this field of medicine. However, treatment providers themselves bring an orientation to the management of addiction that in other medical disciplines would be unthinkable—an orientation that is so inherently paradoxical and contradictory that it defies comprehension. Most reject treatment that cannot promise a predictable "cure" of this chronic, notoriously relapsing illness; refuse to prescribe medication in dosages universally accepted as optimal for most patients; and impose sanctions (including termination of care) in response to signs and symptoms that are pathognomonic of the disease being managed. One distinguishing characteristic of the attitude toward addiction treatment that is widely shared by government and by physicians is that methadone (and its active isomer, polamidon) are "bad," and should be discarded as soon as another medication is found to have similar effectiveness. And yet, there are many dozens of analgesics, of anti-inflammatory agents, of chemotherapeutic drugs, of antibiotics, etc.—and no one suggests that a particular member of each therapeutic group be identified as the "gold standard," against which all others must be measured. When dealing with illnesses as complex and difficult to treat as addiction, physicians must demand availability of the broadest possible spectrum of treatments, *and* the authority to apply them according to the individual needs of their patients.

No. 80D
HEROIN-ASSISTED TREATMENT APPROACHES IN EUROPE

Wim Van Den Brink, M.D., *Heroin (CCBH), Central Committee, Universiteitsweg 100, Utrecht 3548C6, Netherlands;* Vincent Hendriks, Ph.D., Peter Blaken, M.A., Jan Van Ree

SUMMARY:

Illicit opiate use is a considerable health problem in all established market economies in the world, with prevalence estimates ranging from 94 to 400 persons per 100,000 adult population in the European Union to 540 to 750 persons per 100,000 in Australia. They constitute a serious public health problem due to the high rate of physical and psychiatric morbidity, the high level of disability (including high rates of criminality), and high mortality.

Extensive treatment systems have been developed in many countries. In some of the European countries (e.g., Denmark, Germany, Netherlands, Spain, Switzerland) the vast majority of all heroin-dependent people are now in regular contact with the treatment system. However, a substantial proportion are still not in treatment and a sizable number of those in treatment are still highly dysfunctional with high levels of illicit drug use. Given the limitations of the current treatments and the severe public health consequences of untreated illicit opiate use, several European countries have taken the initiative to test the effectiveness of the medical prescription of heroin to chronic treatment-resistant, heroin-dependent patients or to heroin-dependent people currently not in treatment. In this program, the results of the British, Swiss, and Dutch trials will be presented.

No. 80E
OUTCOME CRITERIA AND GUIDELINES FROM AN INTERNATIONAL POINT OF VIEW

Richard N. Rosenthal, M.D., *Department of Psychiatry, Saint Luke's Roosevelt, 1090 Amsterdam Avenue, 16th Floor, Suite G, New York, NY 10025*

SUMMARY:

Giving heroin to heroin addicts can be viewed as a response to a social ill created by government policies. However, if one frames this as a medical response to a medical problem, then the structures of modern scientific validation of these treatments must be brought to bear. In this light, substance dependence is a disorder, not just a social ill created by prohibitionist states. Regardless of the politics around criminalization and its negative social effects, persons demonstrate symptoms of substance dependence irrespective of the legal environment (where alcohol is legal in developed nations, it the #1 cause of years lived with a disability). There is a paucity of evidence for safety and efficacy of i.v. opiate treatment, but there have been recent European attempts to increase the delivery of i.v. opioids to addicts to assist treatment and reduce harm, usually in clinics, and under the framework of clinical studies. Studies have shown that i.v. opiate maintenance programs are at least feasible, albeit expensive. There has been controversy about the intention and methods by which some of the European research on i.v. opiates maintenance has been conducted. It is therefore sensible to reason out a baseline of design elements, subject characteristics, and outcome measures, such that future research can answer questions of efficacy to a high degree of certainty, and satisfy the standards of the international scientific community. Some of these would include: randomized, controlled trials of sufficient duration, operationalized approaches to non-study medications and psychosocial interventions, and standard cost-effectiveness measures, such as the Quality-Adjusted Life Year. This talk will evaluate some of the approaches, and hopefully begin the process of consensus building.

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SYMPOSIUM 81—ALCOHOL INTERVENTIONS ACROSS THE SPECTRUM FOR COMMUNITY PRACTITIONERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to identify and apply methods to influence communities' attitudes on underage drinking, improve ability to diagnose fetal alcohol effects, and understand the strategies used in implementing three forms of intervention for alcohol problems in community health care settings.

SUMMARY:

Alcohol-related disorders remain the most prevalent and costly of the nation's abuse problems, both in personal and societal cost. Recent advances in the diagnosis and treatment of these disorders have not always been easily translated into effective programs at the level of community health care. Likewise, well-intentioned laws and regulations enacted to reduce alcohol-related problems have often proved difficult to operationalize.

This symposium is intended to help psychiatrists and other health professionals who work in community clinical settings to understand and implement measures that will decrease alcohol problems. Strategies will be presented for the implementation of current knowledge in the real world of contemporary health care.

Participants will learn which strategies have worked in changing attitudes toward adolescent drinking, and how to overcome obstacles in developing naltrexone treatment in community alcoholism programs. Strategies for improving the identification and diagnosis of fetal alcohol effects in community settings will be discussed. Motivational enhancement interviewing will be described and the participant will learn how the method can be applied in a wide variety of treatment settings. Finally, multisystemic therapy, an intensive family-based treatment method for seriously troubled adolescents, will be discussed, and outcome data presented from randomized trials in alcohol abusing youths.

No. 81A
UNDERAGE DRINKING: CHANGING COMMUNITY NORMS

Robert Voas, Ph.D., *Pacific Institute, 11710 Beltaville Drive, Calverton, MD 20706*

SUMMARY:

Federal laws providing for a uniform minimum legal drinking age and lower BAC limits for drivers younger than 21 testify to the general acceptance of the principal that young people require protection from the risks associated with alcohol consumption. Passing such laws at the national or state levels does not, however, guarantee their implementation at the community level. Among the barriers to effective implementation of theses laws are (1) the belief of police department managers that they are not strongly supported by local citizens, (2) the belief by individual officers that underage drinking is not a really significant problem, (3) the special issues that arise in taking minors into custody resulting in extra time to complete processing, (4) the lack of specific training and appropriate breath-testing equipment, and (5) the difficulty in detecting drinking in underage youth. To ensure adequate enforcement of underage drinking laws, media advocacy programs must be implemented that make clear a community's support for enforcement of underage drinking laws and for the police department's efforts to enforce them. Examples of such community efforts that have been successful are described.

No. 81B
IDENTIFICATION OF FETAL ALCOHOL SYNDROME: DIFFERENTIATING DEVELOPMENTAL DISORDERS FROM FETAL ALCOHOL SYNDROME

Larry J. Burd, Ph.D., *Department of Pediatrics, University of North Dakota, 501 North Columbia Road, Grand Forks, ND 58203;* Jacob Kerbeshian, M.D.

SUMMARY:

Strategies for the delineation of neuropsychiatric correlates in children and adults with FAS and a brief review of management recommendations will be presented. Specific strategies for use in clinical and community settings to identify and diagnosis fetal alcohol syndrome and related disorders (FAS-RD) will be presented (Burd et al., 2000). Three linked tools will be discussed:

(1) The FAS Screen, a tool to screen for FAS-RD in community settings. The tool takes 10 to 12 minutes to complete and has satisfactory epidemiologic performance characteristics (Burd et al., 1999).

(2) The second tool is a screening tool for FAE or alcohol-related neurodevelopmental disorder.

(3) Diagnosis of FAS-RD is completed by use of The Diagnostic Checklist for FAS and Related Disorders with weighted scores for signs of FAS-RD. These data are used to develop an intervention plan for people with FAS-RD and can be used to develop a patient registry for longitudinal followup and prevalence studies.

No. 81C
IMPLEMENTING NALTREXONE IN ALCOHOL TREATMENT IN COMMUNITY SETTINGS

Sherrie Gillette, M.A., *Saint Mary's Hospital, 427 Guy Park Avenue, Amsterdam, NY 12010*

SUMMARY:

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) sponsored a unique program in which alcohol researchers went on-site to alcoholism treatment providers in the state of New York to offer technical assistance on implementing the most advanced and scientifically sound treatment methods. One collaboration involved a leading researcher on the use of naltrexone paired with the service providers at St. Mary's Hospital in Amsterdam, New York. The director of alcoholism at St Mary's Hospital will present an overview of the project and a basic strategy in the implementation of naltrexone into common practice. She will discuss the anticipated barriers to pharmacotherapy treatment in an alcoholism treatment setting as well as an outline of application. The initial outcome, spanning the first year of the project, will be reviewed.

No. 81D
MULTISYSTEMIC TREATMENT OF ALCOHOL-ABUSING ADOLESCENTS: OUTCOMES

Scott W. Henggeler, Ph.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Suite CPP, Charleston, SC 29425;* Colleen A. Halliday-Boykins, Ph.D., Philippe B. Cunningham, Ph.D., Jeff Randall, Ph.D.

SUMMARY:

Multisystemic therapy (MST) is an intensive, family-based treatment for youths presenting serious clinical problems and at imminent risk of out-of-home placements. This paper will present the theoretical rationale of MST as well as an overview of MST clinical procedures, especially those applying to the treatment of adolescent alcohol abuse. Substance abuse, mental health, crime, and psychosocial outcomes have been examined in several of the published MST randomized trials, and these will be reviewed as well as the corresponding service outcomes (i.e., treatment completion, out-of-home placements) achieved in these trials. In addition, current randomized trials aiming to enhance MST outcomes with alcohol abusing juvenile offenders will be described, and preliminary data regarding substance use will be presented.

No. 81E
IMPLEMENTING MOTIVATIONAL ENHANCEMENT THERAPY

Allen Zweben, D.S.W., *Department of Social Welfare, University of Wisconsin, P O Box 786, Milwaukee, WI 53201*

SUMMARY:

Motivational Enhancement Therapy (MET) is based on the principles of motivational psychology and the stages of change model. MET was originally developed in Project MATCH, a multi-site, collaborative alcohol treatment-matching study, as a contrast to more intensive treatment modalities such as cognitive-behavioral therapy (CBT) and Twelve-Step Facilitation (TSF). There is now strong evidence that MET is at least as effective as more intensive treatments (CBT and TSF) in treating alcohol problems. In Project MATCH MET had equivalent efficacy to CBT and TSF even though it was less intensive (four sessions) than the other two interventions (12 sessions). However, the cost savings associated with MET may make it the preferable approach for treating alcohol problems than more intensive interventions. The presentation will describe the background and rationale for MET; provide an overview of the treatment components such as feedback on personal risk, development of personal change plan, and patient monitoring; and describe the various strategies found to be effective such as decisional balancing, deploying discrepancy, reframing, and eliciting "change" talk. In addition, therapist roles, format of sessions, therapist style, and mechanisms of change will be discussed. Issues arising in the implementation of the approach, such as therapist training and monitoring of therapist performance, will be examined. The presentation will be conclude with a discussion of how MET can be incorporated into the repertoire of interventions currently employed in managed care settings.

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SYMPOSIUM 82—THE SCHIZOPHRENIA PRODROME: UPDATE OF RESEARCH 2002

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with the current status of diagnostic, psychometric, propsychologic, MRI, MRS, and intervention research in the schizophrenia prodrome.

No. 82A
INTERVENTION IN THE SCHIZOPHRENIC PRODROME: RATIONALE, STUDIES, AND ETHICS

Thomas H. McGlashan, M.D., *Department of Psychiatry, Yale University, 301 Cedar Street, P O Box 208098, New Haven, CT 06520-8098;* Robert B. Zipursky, M.D., Diana O. Perkins, M.D., Jean M. Addington, Ph.D., Mauricio F. Tohen, M.D., Alan Ereier, M.D., Scott W. Woods, M.D.

SUMMARY:

Clinical trials have begun of antipsychotic treatment in persons who are prodromally symptomatic and at high risk for schizophrenia but who have not yet become psychotic. Schizophrenia is usually chronic, and much of this chronicity appears to develop before psychosis onset. As such, pre-onset treatment not only may target prodromal symptoms but also may delay or prevent onset, improve course and prognosis, and possibly minimize neuropsychological deficits and the structural losses of brain matter seen in first-episode schizophrenia. The development of reliable and valid assessments of this clinical state plus the emergence of atypical antipsychotic drugs with fewer side effects (especially those that are irreversible) have rendered such intervention studies feasible. Two treatment studies have been conducted with encouraging results, an open trial of stress management in a primary care setting (Falloon, 1992), and a non-blind, randomized trial of an atypical antipsychotic plus psychotherapy versus follow-along control (McGorry, et al, 2000). These issues and studies will be discussed in detail. In our opinion, such developments render a double-blind, placebo-controlled clinical trial of atypical antipsychotic medication both ethical and scientifically imperative.

No. 82B
DIAGNOSIS AND SYMPTOM ASSESSMENT IN THE SCHIZOPHRENIA PRODROME

Tandy J. Miller, Ph.D., *Department of Psychiatry, Yale Medical School, 301 Cedar Street, P O Box 208098, New Haven, CT 06520-8098;* Thomas H. McGlashan, M.D., Joanna L. Rosen, Ph.D., Jaak Rakfeldt, M.D., Shelly Nyman-Rose, M.S.W., Phillip Markovich, B.A., Scott W. Woods, M.D.

SUMMARY:

Investigations of patients at imminent risk for developing psychosis require the ability to diagnose the prodrome, rate its severity, and rate changes in symptoms over time.

Methods: We have developed the SIPS (Structured Interview for Prodromal Symptoms) and the SOPS (Scale of Prodromal Symptoms). We have conducted preliminary studies concerning rater training, reliability, validity, and sensitivity to change.

Results: The interrater reliability among fully trained raters using the SIPS was tested, and diagnosis agreement among raters was 93% (kappa = 0.82). The SIPS demonstrated predictive validity for the conversion to psychosis, predicting the onset of psychosis within

one year in up to 54% of identified cases. The SOPS intraclass correlation was 0.93 for the total score and above 0.80 for all four subscales. In addition, the SOPS demonstrated good construct validity and superior sensitivity to change compared with competing instruments. Data from 21 trainees yielded agreement with the consensus diagnosis of 76% before a training workshop (chance = 50%, kappa = 0.52, in the fair range), and 88% after (kappa: 0.762, in the excellent range).

Discussion: Our studies show that a valid, high-risk, prodromally symptomatic state can be identified with satisfactory psychometric precision using the SIPS and SOPS.

No. 82C
A TRIAL OF OLANZAPINE VERSUS PBO IN THE PRODROME: PROTOCOL AND BASELINE SAMPLE

Alan F. Breier, M.D., *Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Robert B. Zipursky, M.D., Diana O. Perkins, M.D., Jean M. Addington, Ph.D., Mauricio F. Tohen, M.D., Stacy R. David, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

In 1997 Lilly launched an investigator-initiated, randomized, double-blind, parallel study of outpatients meeting diagnostic criteria for high-risk, symptomatic, prodromal states. Study design calls for one year of DB medication (PBO or olanzapine 5–15 mg/d) followed by one year of no medication. Patients meeting diagnostic criteria for psychosis at any time enter a rescue arm and receive open-label olanzapine 5–20 mg/d for six months. The study aims are to: (1) prevent or delay the onset of psychosis, (2) treat prodromal symptoms, (3) reduce the severity/chronicity of any emerging psychosis, and (4) reduce deficits in neurocognitive performance. Side effects and safety of drug compared with PBO also will be assessed.

Subject recruitment began in New Haven, Conn. in 1998. Three additional sites in Chapel Hill, N.C.; Toronto, Ontario; and Calgary, Alberta, were added in 1999–2000. Intake was stopped in July, 2001, following the randomization of 60 outpatients meeting inclusion criteria.

No. 82D
NEUROPSYCHOLOGICAL STATUS OF THE FIRST-EPISODE PRODROME

Keith A. Hawkins, Psy.D., *Department of Psychiatry, Yale University, 34 Park Street, CMHC Room 530, New Haven, CT 06519;* Diana O. Perkins, M.D., Jean M. Addington, Ph.D., Robert B. Zipursky, M.D., Kimberly B. Edwards, Ph.D., Stacy R. David, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Subjects in the prodromal state at the Yale site (N = 34) exhibit neuropsychological performances that lie between the deficient level commonly reported for schizophrenia (both first episode and chronic schizophrenia samples, e.g., Goldberg et al, 1990) and the normal performance of healthy subjects. Since neuropsychological decline appears to accompany first-episode psychosis (possibly related to the typical lengthy duration of illness before treatment initiation), this finding lends hope to the notion (1) that the prevention of first-break psychosis by treatment in the prodrome could possibly result in a relative preservation of neuropsychological competence, (2) that the neuropsychological decline associated with the first episode of psychosis might possibly be attentuated by the early identification and treatment of frank psychosis (facilitated by close monitoring of the prodrome), and (3) that the presence of neuropsychological weaknesses may possibly aid diagnosis of the true prodromal state. The Yale findings will be updated by the addition of subjects from three additional Canadian and U.S. sites (total N = 60), and preliminary analyses related to conversion prediction, early course, and the effect of treatment will be presented.

No. 82E
MRI AND MRS FINDINGS IN SUBJECTS WITH PRODROMAL SYMPTOMS

Diana O. Perkins, M.D., *Department of Psychiatry, Univ. of North Carolina, School of Medicine, 101 Manning Drive, Campus Box 7160, Chapel Hill, NC 27599;* Robert B. Zipursky, M.D., Guido Geric, Ph.D., Cecil Charles, Ph.D., Hongbin Gu, Ph.D., Jeffrey A. Lieberman, M.D.

SUMMARY:

When compared with healthy controls, individuals with schizophrenia are repeatedly reported to have alterations in the volume of various brain structures, including ventricular, prefrontal cortical, and limbic areas. The timing of these alterations (fixed during early brain development or progressive as clinical symptoms develop) is uncertain, however. While alterations in specific brain structures are found in patients at first psychotic break, recent studies have found progressive increases in ventricular volume associated with clinical progression, suggesting that there may be a neuroprogressive component in some individuals with schizophrenia. In order to provide further information regarding the timing of structural brain changes associated with the development of psychosis, we report an MRI and MRS investigation of 25 individuals identified in the prodromal stage of illness compared with a similar group of 25 healthy controls. Baseline data will be reported for the entire sample, with follow-up data available for part of the sample.

No. 82F
OLANZAPINE VERSUS PLACEBO FOR PRODROMAL SYMPTOMS

Scott W. Woods, M.D., *Department of Psychiatry, Yale University, 34 Park Street, Room 38, New Haven, CT 06519;* Robert B. Zipursky, M.D., Diana O. Perkins, M.D., Jean M. Addington, Ph.D., Tandy J. Miller, Ph.D., Alan F. Breier, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

In the past few years, symptom-based diagnostic criteria have emerged that permit prospective identification of patients in a putative prodromal phase of schizophrenia. Although many such patients are treatment seeking for their symptoms, thus far there have been no intervention studies specifically targeting symptoms in this group. We therefore conducted a randomized treatment study comparing olanzapine vs placebo.

Methods: A total of 60 patients were randomized to olanzapine or placebo at four centers in North America. Olanzapine was initiated at 5 mg/d and could be increased as high as 15 mg/d. Patients were followed with Scale of Prodromal Symptom (SOPS) evaluations every one to two weeks for eight weeks during acute treatment. Patients worsening to the point of psychosis were exited to rescue treatment.

Results: Interim analyses showed that blinded completion, drop-out, and rescue rates were 68%, 19%, and 14% at eight weeks. Unblinded endpoint analysis of SOPS results will be presented.

Discussion: This will be the first study to report treatment response for current symptoms in prodromal patients, as well as the first to report on placebo response in this group.

Funded by an investigator initiated grant from Eli Lilly.

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SYMPOSIUM 83—THE DUTY TO WARN AND PROTECT FOR THE 21ST-CENTURY PSYCHIATRIST

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand (1) trends in duty to warn/protect jurisprudence; (2) court responses to duty to warn/protect statues; (3) how the duty to warn/protect jurisprudence has encroached on the therapist/patient privilege; and (4) an approach to assessing the risk of verbal threats.

No. 83A
THE FIN DE MILLENAIRE: DUTY TO WARN OR PROTECT?

Alan R. Felthous, M.D., *Department of Psychiatry, SIU School of Medicine, Chester Mental Health Center, P O Box 31, Chester, IL 62233-0031;* Claudia A. Kachigian, M.D.

SUMMARY:

At the turn of the millennium, the authors summarize the evolution of the clinician's duty to protect third persons from a patient's violent acts over the past half century, with special emphasis on jurisprudential developments in the last decade. Four evolutionary periods are identified: pre-Tarasoff, inception, diversification, and retreat. The period of retreat from Tarasoff in the 1990s is characterized by the following approaches to Tarasoff: adoption, statutory containment, rejection of a duty to warn, rejection of a duty to control voluntary patients, and proactive circumscription of any protective duties. A more rational jurisprudential approach would permit some measure of flexibility for the proper exercise of clinical discretion.

No. 83B
JUDICIAL RESPONSES TO TARASOFF STATUTES

Claudia A. Kachigian, M.D., *Department of Psychiatry, SIU School of Medicine, Chester Mental Health Center, P O Box 31, Chester, IL 62233-0031;* Alan R. Felthous, M.D.

SUMMARY:

In 1988, Appelbaum et al., analyzed the 12 Tarasoff-type statutes then in existence. By encouraging a legislatively defined duty to third parties who might be harmed by the actions of their patients, mental health clinicians hoped to better define such a duty, which courts in various jurisdictions had inconsistently established.

Since that time, more than half the states have enacted Tarasoff statutes, and courts in many of those states have considered mental health clinicians' liability for their patients' acts of violence toward third parties. Although some courts, as anticipated by proponents of such legislation, have interpreted the statute as clearly delineating the only circumstances under which a duty to third party exists, this has not been the only judicial approach.

Despite the existence of Tarasoff statutes in some states, courts have not referenced the statute at all, or have noted the existence of the statute, but, for various reasons, have not applied it.

In my presentation, I will review the approaches courts in states with Tarasoff statutes have taken regarding mental health clinicians' duties to third parties, emphasizing the courts' reasoning in cases where they acknowledged the statute, but chose not to apply it.

No. 83C
NOVEL APPROACHES TO TARASOFF

Ralph Slovenko, L.L.B., *Department of Law, Wayne State University, 471 West Palmer, Detroit, MI 48202*

SUMMARY:

Professor Ralph Slovenko examines the concepts of "duty" and "special relationship," and he sets out novel approaches of Tarasoff.

The court in Tarasoff took a novel definition of "special relationship," which Professor Slovenko describes in his presentation. Later application of the Tarasoff principle included cases of domestic abuse, HIV infection, and genetically transmitted tumors.

No. 83D
ENCROACHMENTS ON PSYCHOTHERAPIST-PATIENT PRIVILEGE

Robert Weinstock, M.D., *Department of Psychiatry, University of California at Los Angeles, 1626 Westwood Boulevard, Suite 105, Los Angeles, CA 90024*

SUMMARY:

In a series of cases following the Tarasoff decision, California courts have used the Tarasoff reasoning and a privilege exception for civil commitment to undermine psychotherapist-patient privilege. Initially, this was done to enable victims to sue patients who harmed them by obtaining treatment records without the patient's permission. More recently, in the early 1990s, the California Supreme Court in a series of decisions extended this reasoning to criminal cases. The Court ignored the intent of Tarasoff to protect future victims by creating liability for failing to do so. Instead, it used a civil commitment exception for dangerousness as a rationale to find therapeutic privilege did not exist for a dangerous patient. It used this rationale after a crime occurred to enable therapist testimony to help punish a patient and even obtain a death penalty. The need for a Tarasoff warning provided evidence for this privilege exception. A footnote in the U.S. Supreme Court Jaffee v Redmond decision stated a privilege exception could exist if therapist disclosure was needed to stop harm by a patient. If other jurisdictions follow the California precedent, this exception could be used to punish patients. In at least one case, this exception already was used.

No. 83E
RISK ASSESSMENT IN TARASOFF SITUATIONS

Randy Borum, Psy.D., *Department of Mental Health, University of South Florida, 13301 Bruce B. Downs Boulevard, MHC2636, Tampa, FL 33612-3807*

SUMMARY:

Although significant advances in risk assessment research and practice have been made in recent years, there has not been any analysis in the professional literature regarding how and whether the emerging practice recommendations apply in Tarasoff-type situations. In this presentation, I suggest that when faced with a Tarasoff-type situation, the appraisal of risk should be guided by a method that is primarily fact-based and nomothetic risk assessment approach for general violence recidivism, which is guided primarily by base rates and historical risk factors. I will review the principles underlying a fact-based, or threat assessment, approach and outline six areas of inquiry that can guide the appraisal of risk: A-attitudes that support or facilitate violence, C-capacity, T-thresholds crossed, I-intent, O-other's reactions, and N-noncompliance with risk reduction interventions.

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SYMPOSIUM 84—CLINICAL CHALLENGES IN TREATING SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be (1) familiar with recent neuro-imaging data and special issues in treating the first-episode schizophrenic patient and the violent schizophrenic patient, and (2) familiar with augmentation strategies in schizophrenia and management of long term side effects.

No. 84A
FROM FIRST PSYCHOTIC EPISODE TO LONG-TERM OUTCOME IN SCHIZOPHRENIA

John L. Waddington, D.Sc., *Department of Clinical Pharmacy, Royal College for Surgeons, 123 St. Stephen's Green, Dublin 2, Ireland;* Paul J. Scully, M.D., David J. Meagher, M.D., John F. Quinn, M.D., Patizia A. Baldwin, M.D., Maria G. Morgan, M.D., Anthony Kinsella, M.S.C.

SUMMARY:

Considerable controversy has arisen as to whether it is possible to improve the trajectory of schizophrenia by earlier intervention following the onset of psychosis or even intervening at a yet earlier stage in the disease process. One critical issue is the extent to which reducing duration of untreated psychosis (DUP) at the first episode might be associated with better outcome in the long term; in particular, do those associations reported to date reflect preexisting adverse prognostic features that lead to prolongation of DUP, rather than prolongation of DUP leading to poorer outcome. Thereafter, the trajectory of schizophrenia can be variable, though whether such diversity of outcome reflects heterogeneity of pathobiology remains unclear. In the very long term, outcome in late life can encompass marked debilities in cognition and social-adaptive functioning. This presentation will review these issues, and then describe two studies: firstly, an epidemiologically complete population of first-episode psychosis, and circumstances associated with reduced incidence primarily among females; secondly, a large population of inpatients, many of whom have experienced essentially a lifetime of schizophrenia, in which the relationships of DUP and overall illness duration to psychopathology, cognition, and social-adaptive functioning have been examined.

No. 84B
PET IMAGING STUDIES OF ATYPICAL ANTIPSYCHOTICS: IMPLICATIONS OF DOSING AND MECHANISM OF ACTION

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

SUMMARY:

The talk will focus on how examining the brain receptors occupied by antipsychotics has enhanced our understanding of how these drugs act and also provided clues for new therapeutic strategies. The talk will review recent data relating the antipsychotic efficacy as well as side effects of typical and atypical antipsychotics to their effects on the dopamine D_2 receptors and serotonin 5-HT_2 receptors as measured in patients in clinical-PET studies. The data argue for a central role for dopamine D_2 blockade in the actions of typical as well as atypical antipsychotics. These data at the "bedside" level will be related to models used at the "bench" level and will show a high level of similarity in the mechanisms via which drugs work in animal models and patients. However, these findings give rise to several new questions—can a selective D_2 blocker be an atypical antipsychotic? Do receptors need to be blocked 24 hours a day or is a brief high occupancy be sufficient? Can some drugs be given every other day? Finally, it will be suggested that antipsychotics treat dimensions of schizophrenia, not the disease. Therefore, one should look for specific pharmacotherapies targeted at specific dimensions (positive, cognitive, affective) of the illness of schizophrenia—rather than the current strategy of a single molecule, with many receptor actions, aimed at the entire DSM-IV diagnosis of schizophrenia.

No. 84C
MANAGING VIOLENT BEHAVIOR IN PATIENTS WITH SCHIZOPHRENIA: EMERGING STANDARDS OF CARE

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

SUMMARY:

Violence and schizophrenia is a major contributor to stigma. Although recent research shows that, overall, people with schizophrenia have a higher rate of violent behavior, accumulating evidence holds that this modest propensity toward violence is related to active illness. Additionally, there are preliminary data that the newer antipsychotics may be particularly helpful in people with schizophrenia who are aggressive. Recent guidelines (APA, Expert Consensus, TMAP, and Schizophrenia PORT) have begun to define standards of care for people with schizophrenia. Thus far, these guidelines have not been used to assess management or care delivery for patients who incur legal complications. This presentation will review current data on best practices, pharmacotherapy, and nonpharmacological approaches to the management of aggression in patients with schizophrenia. The presentation also will describe findings from a study evaluating the standard of care for individuals with schizophrenia

who commit violent acts as compared with nonviolent patients with schizophrenia receiving community care. Thus far, 45 violent and 55 nonviolent patents have been evaluated. Among the violent patients, the most common offense was felonious assault; one-third of all offenses were committed against a law enforcement officer. Violent patients were characterized by significantly more positive and general psychopathology and exhibited significantly less insight into their illness. Insight into forensic complications was also uniformly low in the violent patients.

No. 84D
AUGMENTATION STRATEGIES IN TREATMENT-REFRACTORY SCHIZOPHRENIA

Robert R. Conley, M.D., *Spring Grove Hospital Grounds, Maryland Psychiatric Research Center, Maple and Locust Streets, P.O. Box 21247, Baltimore, MD 21228;* Deanna L. Kelly, Pharm.D.

SUMMARY:

A systematic approach to the evaluation and characterization of treatment resistance in schizophrenia has become increasingly important since the introduction of second-generation antipsychotics. People with schizophrenia may manifest a poor response to therapy secondary to intolerance of medication, poor compliance, or inappropriate dosing, as well as true resistance of their illness to antipsychotic drug therapy. This is particularly critical in regard to adjunct medication. What added medicine should be used, and when? What are the parameters of an adequate drug trial? Data regarding the use of added medications to antipsychotics as well as antipsychotic polypharmacy will be reviewed. Emphasis will be placed on the use of agents that have supporting data and critical evaluation of putative improvement in people treated with more than one drug. Clinicians facing the decision of when to change from one antipsychotic to another must clearly understand the appropriate length of a trial and what target symptoms respond to antipsychotics in order to maximize the response in patients with treatment-resistant schizophrenia.

No. 84E
MANAGEMENT OF LONG-TERM SIDE EFFECTS OF NOVEL ANTIPSYCHOTICS

Prakash S. Masand, M.D., *Department of Psychiatry, SUNY Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Novel antipsychotics differ from the conventional neuroleptics, particularly in the areas of tolerability and side-effect profile. However, the novel agents can also cause several long-term adverse events. The talk will address side effects of concern to the clinician including tardive dyskinesia, weight gain, diabetes mellitus, cardiovascular side effects, and prolactin-associated side effects. The relative prevalence of these side effects amongst the different atypical antipsychotics will be discussed and practical strategies to manage this side effect in the treatment setting including both nonpharmacological and pharmacological strategies will be discussed. New data on the use of melatonin and double-blind randomized trials using atypical antipsychotics to treat tardive dyskinesia, particularly in patients with preexisting TD on conventional neuroleptics, will also be discussed. The talk will enable the clinician to weight the risk/benefit ratio from the tolerability and side-effects standpoint when choosing atypical antipsychotics.

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SYMPOSIUM 85—COGNITIVE THERAPY VERSUS MEDICATIONS FOR SEVERE DEPRESSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to summarize the results of a study that compared the relative efficacy of cognitive therapy versus medications in the treatment of severely depressed outpatients with respect to both acute response and the prevention of relapse.

No. 85A
BACKGROUND AND DESIGN OF A PLACEBO-CONTROLLED COMPARISON

Robert J. DeRubeis, Ph.D., *Department of Psychology, University of Pennsylvania, 3815 Walnut Street, Philadelphia, PA 19104-6196;* Jay D. Amsterdam, M.D., John P. O'Reardon, M.D., Paula R. Young, Ph.D.

SUMMARY:

Cognitive therapy of depression has fared well in most randomized comparisons with pharmacotherapy, even in the short run, and even among severely depressed outpatients. However, in the more severely depressed subsample of a large, widely cited, placebo-controlled trial, the Treatment of Depression Collaborative Research Program (TDCRP), cognitive therapy was outperformed by imipramine on the primary outcome measure, the Hamilton Rating Scale of Depression (HRSD). In the more severely depressed subsample of the TDCRP, imipramine outperformed placebo, and cognitive therapy did not outperform placebo. Since the publication of the TDCRP findings, its results have formed the basis for influential treatment guidelines, which have called for the use of medications, and not cognitive therapy, in the treatment of severely depressed patients. However, the adequacy with which cognitive therapy was implemented in the TDCRP has been called into question. This presentation provides an overview of a placebo-controlled comparison between cognitive therapy versus medications among severely depressed patients that seeks to replicate and extend the earlier TDCRP by ensuring that both modalities were implemented by expert therapists.

No. 85B
RESPONSE TO ACUTE TREATMENT

Jay D. Amsterdam, M.D., *Department of Psychiatry, University of Pennsylvania School of Medicine, 3535 Market Street, Philadelphia, PA 19104;* Robert J. DeRubeis, Ph.D., John P. O'Reardon, M.D., Paula R. Young, Ph.D.

SUMMARY:

This presentation presents the findings from the acute treatment phase of the study. At two sites, 240 severely depressed outpatients were randomly assigned to: (1) 16 weeks of cognitive therapy, (2) 16 weeks of pharmacotherapy plus clinical management (a double-sized condition), or (3) eight weeks of placebo plus clinical management. At the eight-week assessment, pharmacotherapy yielded a significantly higher rate of response (50%) than did placebo (27%), with the rate for cognitive therapy in between (38%). By the 16-week posttreatment assessment, response rates were identical (57%) for both pharmacotherapy and cognitive therapy. Thus, these findings suggest that cognitive therapy may work more slowly in effecting change than does pharmacotherapy, but that by the end of a four-month course of treatment, patients who receive cognitive therapy fare as well as those who receive pharmacotherapy. These results were obtained in a sample that appears to have been responsive to pharmacotherapy, as evidenced by the superior performance of active medications, relative to placebo, at the end of the placebo comparison period. Differences in the patients sampled and treatment implementation appear to have contributed to some minor differences in outcomes between the sites.

No. 85C
PREVENTION OF RELAPSE

Steven D. Hollon, Ph.D., *Department of Psychology, Vanderbilt University, 306 Wilson Hall, Nashville, TN 37240;* Richard C. Shelton, M.D., Richard Salomon, M.D., Margaret Lovett, M.Ed.

SUMMARY:

Prior studies have suggested that cognitive therapy may have an enduring effect that protects patients from symptom return following treatment termination and that this effect is about the same as that typically found for continuation medication. However, no such effect was found in the NIMH TDCRP and the belief that cognitive therapy has an enduring effect is still not widely held in the field. The current study examined whether cognitive therapy has an enduring effect by following responders to either medication or cognitive therapy across a 12-month continuation phase. Patients who responded to four months of medication were randomly assigned to either continuation medication or withdrawn onto pill-placebo; patients who responded to cognitive therapy discontinued treatment following remission. Results indicate that patients who were kept on medications did considerably better than patients withdrawn onto pill-placebo and that patients initially treated to remission with prior cognitive therapy did better still. This suggests that cognitive therapy has an enduring effect that protects against subsequent relapse following treatment termination, and that this effect extends to severely depressed outpatients. Moreover, the magnitude of this effect is such that it may have profound implications for the relative cost-efficacy of the interventions.

No. 85D
WHO RESPONDS AND WHO RELAPSES

Richard C. Shelton, M.D., *Department of Psychiatry, Vanderbilt Univesrity, 1500 21st Avenue South, #2200, Nashville, TN 37212;* Steven D. Hollon, Ph.D., Richard Salomon, M.D., Margaret Lovett, M.Ed.

SUMMARY:

Both cognitive therapy and medications appear to be effective in the treatment of severe depression and both appear to reduce the risk for subsequent relapse—cognitive therapy through an enduring effect and medications if they are continued. However, some patients respond better to one intervention than the other and other patients respond to neither. This presentation describes patient characteristics that predict differential response to cognitive therapy versus medications, both with respect to acute response and the prevention of subsequent relapse, and suggests mechanisms behind that differential response. For example, patients with comorbid GAD responded better to medications than they did to cognitive therapy, perhaps due to the former's anxiolytic effects, whereas patients without comorbid GAD responded better to cognitive therapy than they did to medications. Similarly, high-risk patients with histories of chronic depression or multiple recurrences were most likely to require either continuation medication or prior cognitive therapy. These findings suggest that it was not so much severity that places patients at risk for relapse as chronicity or comorbidity. It should prove possible to predict in advance who most needs protection from subsequent relapse and to supplement those predictions with information regarding the extent to which residual symptoms persist following initial treatment.

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SYMPOSIUM 86—REDUCING AGGRESSIVE BEHAVIOR: CHANGING THE TRAJECTORY FOR DRUG USE
Substance Abuse and Mental Health Services Administration

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the pathways linking substance abuse aggression, (2) learn about methods that are best able to identify high-risk youth, (3) acquire familiarity with empirically documented prevention and strategies, and (4) learn about ethnic and demographic variation regarding substance abuse and violence.

SUMMARY:

The symposium examines the prevalence of substance use and violence among white, black, and Hispanic youth and their families. Factors predicting violence behaviors and substance use are discussed in conjunction with a review of screening procedures. The developmental antecendents and patterns of psychiatric comorbidity are summarized. The efficacy of intervention during middle and late childhood is reviewed. Overall, this symposium encompasses a review and integration of current information pertaining to the epidemiology, risk factors, psychiatric patterns of comorbidity and intervention, strategies pertaining to youth violence, and substance use.

No. 86A
INTIMATE PARTNER VIOLENCE AMONG WHITES, BLACKS, AND HISPANICS

Raul Caetano, M.D., *Dallas MPH, School of Public Health, 5323 Harry Hines Boulevard, Room V8112, Dallas, TX 75390-9128;* Craig

Field, Ph.D., Scott Nelson, B.A., Susie Miller, Ph.D., John Schafer, Ph.D.

SUMMARY:

Objective: The research aim is to assess the prevalence and predictors of intimate partner violence (IPV) among white, black, and Hispanic couples. Attention is paid to the association of drinking and alcohol problems to IPV.

Methods: A national probability sample (N=1440) of white, black, and Hispanic couples 18 years of age of older was interviewed in 1995 (response rate=85%). Data were collected during face-to-face interview in respondents' homes. Intimate partner violence was assessed with items adapted from the Conflict Tactics Scale, Form R.

Results: Rates of male to female and female to male partner violence were highest among black couples (23% and 30%), follow by Hispanics (17% and 21%), and white couples (12% and 16%). Between 27% and 41% of the men and 4% and 24% of the women were drinking at the time of the violent incident. Other factors associated with intimate partner violence are alcohol-related problems, depression, victimization by violence during childhood, impulsive personality, acculturation, and witnessing violence between parents during childhood. Individuals with alcohol problems who report intimate partner violence are twice as likely of having had past treatment experiences than others with alcohol problems. This creates the need to address issues related to intimate partner violence during alcohol treatment.

No. 86B
MODIFYING AGGRESSIVE BEHAVIOR VIA STRATEGIC PEER INVOLVEMENT

Gerald August, Ph.D., *Department of Psychiatry, University of Minnesota, 2450 Riverside Avenue, F256-2B West, Minneapolis, MN 55346;* George M. Realmuto, M.D., Joel Hektner

SUMMARY:

We report the results of two complementary studies derived from a mediational model of adolescent drug abuse that links early aggression to drug abuse via deviant peer affiliation.

Study #1. Objective: To test two explanatory models of the origins of deviant peer affiliation (e.g., a selective process vs. default process due to peer rejection) within the context of an intervention trial that afforded us the opportunity to assess temporal changes in patterns of peer affiliation (e.g., peer association, peer interaction, friendship selection) in an environment where peer rejection could be minimized and social interaction between aggressive and non-aggressive children encouraged.

Method: The behavior and affiliation patterns of highly, moderately, and non-aggressive 7-year old children were examined over the course of a six-week summer school program component of the Early Risers "Skills for Success" Program. Implemented across all summer program activities was a "buddy system" intervention that was designed to promote cooperative peer interactions and foster friendship building.

Results: During free play, participants did not selectively associate on the basis of behavioral similarity, but initial mutual friendship choices did show a preference for similarly behaved peers. Over the course of the summer program, moderately aggressive children increased their number of mutual friendships and their association with non-aggressive peers during free play, whereas highly aggressive children lost mutual friendships. The aggressiveness of a child's playmates predicted the likelihood of that child behaving inappropriately during free play.

Conclusion: Deviant peer affiliation may be the result of peer rejection rather than an active process of seeking similarly aggressive peers. Prosocial peer affiliation is malleable among moderately aggressive children.

Study #2. Objective: To test the hypothesis that prosocial peer affiliation provides a protective influence for aggressive children.

Methods: The behavior of buddy dyads and non-buddy dyads was observed while playing foosball, a table-soccer game that requires teammates' cooperation and inspires strong competitiveness. Each child played the game three times: once with a buddy, once with a non-buddy with the same aggressive status, and once with a non-buddy with a different aggressive status.

Results: Overall levels of conflict in each dyad were related to level of aggressiveness of the pair, but this relationship was weaker for buddy-pairs.

Conclusion: Affiliations between aggressive and non-aggressive children can have a protective impact on the aggressive child without producing iatrogenic effects for the non-aggressive children.

No. 86C
COGNITIVE-BEHAVIORAL INTERVENTION FOR AGGRESSIVE PREADOLESCENT CHILDREN (AGES 9–11)

John E. Lochman, Ph.D., *Department of Psychology, University of Alabama, 348 Gordon Palmer Hall, Box 870348, Tuscaloosa, AL 35487;* Karen C. Wells, Ph.D.

SUMMARY:

Characteristics of children and their families that contribute to the development of adolescent substance use and delinquent behavior include the domains of poor self-regulation, poor social competence, weak school bonding, and poor parental involvement. The Coping Power Program has been developed to influence these domains of risk factors among children who are making the transition from elementary to middle school (9 to 11 years of age) (Lochman & Wells, 1996). The Coping Power Program has cognitive-behavioral intervention components for children and for parents, and lasts for 18 months. In the current study, 245 children were identified as aggressive according to teacher ratings, and were randomly assigned to one of four conditions: Coping Power plus a universal intervention, Coping Power alone, universal intervention alone, and an untreated control condition. The universal intervention consisted of a teacher training component and broad parent meetings for all parents of children in the universal classrooms. At the one-year follow up, children who had received the Coping Power and universal interventions had lower substance use rates and lower self-reported delinquency rates than did children in the control condition. Children who had received both interventions had the lowest rates of delinquent behaviors by the one-year follow up.

No. 86D
DIAGNOSTIC-SPECIFIC TREATMENTS FOR ADOLESCENTS WITH SUBSTANCE-USE DISORDERS AND COMORBIDITY

Oscar G. Bukstein, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Objective: The presentation will review recent data from the Pittsburgh Adolescent Alcohol Research Center (PAARC) and related studies regarding the nature of comorbidity in adolescents and preliminary studies about the effects of diagnosis-specific treatments on this population.

Methods: The subjects are 395 adolescents with a lifetime history of an AUD. Psychiatric diagnoses and alcohol and substance use were assessed by means of semistructured interviews. We examined the effects of the most common comorbid psychiatric disorders on alcohol and other substance use variables.

Results: CD has the greater association on the number of other drugs used, the age of onset of SUD symptoms, number of AUD symptoms and stressors, and the level of functioning. Having AUD with both major depressive disorders (MDD) and CD, increased the risk of having a cannabis use disorder by a factor of five. A diagnosis of ADHD adds significantly to a model predicting a diagnosis of alcohol dependence. Onset of a dependence diagnosis, and of other SUDS, was significantly reduced by ADHD.

Conclusions: The comorbidity of MDD, CD, and ADHD with AUDs and/or SUDs can have important associations with substance use and functioning in adolescents. Diagnostic-specific treatments may have great potential in improving treatment outcomes.

No. 86E
FAMILY, PSYCHIATRIC, DRUG USE, AND SOCIAL PREDICTORS OF VIOLENCE BETWEEN ADOLESCENCE AND ADULTHOOD

Ralph E. Tarter, Ph.D., *Department of Pharmacological Sciences, University of Pittsburgh, 711 Salk Hall, Pittsburgh, PA 15261*

SUMMARY:

Objective: Predicting violent behavior is difficult due to the many factors that could precipitate this behavior and its relatively low occurrence. Using information obtained in the course of diagnostic evaluation, it is possible, however, to screen for future violence in children. This study reports findings predicting violence outcome at age 19 from information at ages 12-14.

Method: Structured diagnostic interview and the Drug Use Screening Inventory were administered to 112 boys. The parents were also administered the Structured Clinical Interview Diagnosis (DSM-III-P).

Results: In six- to eight-year follow-up, the information obtained from children and their parents predicted a violence event in the children with 77% accuracy. Sensitivity was 81% and specificity was 76%. The most common violence events were outbursts in school (11.3%), simple assault (9.9%), displaying a weapon (6.6%), and violence toward the teacher (5.7%).

Conclusion: The findings suggest that routinely acquired clinical information can be used to screen for youth who are at high risk for future violence. The implications for selective prevention are discussed.

Supported by a center grant from NIDA (P50-DA05605).

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3. Lochman JE, Wells KC: A social-cognitive intervention with aggressive children: prevention effects and contextual implementation issues, in R. Dev. Peters & R.J. McMahon (Eds.). Preventing Childhood Disorders, Substance Use, and Delinquency. Edited by Peters RD, McMahon RJ. Thousand Oaks, CA, Sage, 1996 pp 111–143.
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SYMPOSIUM 87—NEW DEVELOPMENTS IN INTERPERSONAL PSYCHOTHERAPY RESEARCH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand recent research developments in and applications of IPT.

No. 87A
MAINTENANCE INTERPERSONAL PSYCHOTHERAPY IN RECURRENT DEPRESSION: APPROPRIATE FOR WHICH PATIENTS?

Ellen Frank, Ph.D., *Department of Psychiatry, Western Psychiatric Inst./Univ. of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* David J. Kupfer, M.D., Holly A. Swartz, M.D., Kate Harkness, Ph.D., Patricia Houck

SUMMARY:

While maintenance pharmacotherapy appears to be the optimum strategy for preventing recurrence of major depressive episodes in mid-life (Frank et al., 1990) and late-life patients, not all patients can or should be maintained on long-term antidepressant treatment. In the Pittsburgh Study of Maintenance Therapies in Recurrent Depression, we found a modest effect ($p = .05$) for monthly sessions of interpersonal psychotherapy (IPT) alone in preventing new episodes of major depression. A similar effect was observed in our study of maintenance therapy in late life. Among those patient-therapist dyads in our mid-life study that maintained a high level of focus on interpersonal themes, survival time without a new episode was significantly ($p < .0001$) increased approaching that of patients treated with pharmacotherapy. We then tested a treatment strategy involving acute IPT followed by maintenance IPT among women of child-bearing age, a group thought to be especially appropriate for non-pharmacologic maintenance treatment. We found that the majority of women who achieve remission with IPT alone are effectively protected for a two-year period against new episodes of major depression with maintenance IPT. In contrast, patients who require the addition of SSRI pharmacotherapy to achieve remission are highly vulnerable to relapse and recurrence. We discuss moderators and mediators of effective prophylaxis with maintenance IPT.

No. 87B
TREATMENT STRATEGIES FOR DYSTHMIC DISORDERS

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical College, 525 East 68th Street, Room 1322, New York, NY 10021;* Kathryn L. Bleiberg, Ph.D., James H. Kocsis, M.D.

SUMMARY:

Chronic depression accounts for a third of all mood disorders, yet its treatment has until recently received little study. This randomized, controlled, 16-week study, one of the first to systematically evaluate the psychotherapy of dysthymic disorder, compared an adaptation of IPT for dysthymic disorder (IPT-D), sertraline, supportive psychotherapy (SP), and combined IPT-D/sertraline. Patients had "pure" dysthymic disorder: that is, no major depression within six months of presentation.

Of 106 subjects randomized, 93 entered the study and 71 completed treatment. In intent-to-treat analyses, scores fell for all treatment groups on the 24-item Hamilton Depression Rating Scale (baseline 19.6 ± 5.4; week 16 10.6 ± 7.1) and Beck Depression Inventory

(from 19.0 ± 9.0 to 9.7 ± 8.6). There were no statistically significant differences across groups, but medication appeared more efficacious than psychotherapies in symptom reduction. These preliminary results of an underpowered study show improvement of dysthymic disorder when treated with psychotherapies, medication, and combined treatment. Further analyses will address social functioning, quality of life, and other outcomes.

No. 87C
INTERPERSONAL PSYCHOTHERAPY GROUPS FOR LOW-INCOME WOMEN WITH PTSD

Janice L. Krupnick, Ph.D., *Department of Psychiatry, Georgetown University, 3800 Reservoir Road, NW, 311 Kober Cogan, Washington, DC 20007;* Bonnie L. Green, Ph.D., Jeanne Miranda, Ph.D.

SUMMARY:

This presentation will describe the adaptation of interpersonal psychotherapy, in a group format, to the treatment of posttraumatic stress disorder (PTSD) in a sample of low-income women with histories of interpersonal traumas, i.e., physical or sexual assault or abuse, sexual molestation, and/or domestic abuse. Women were recruited at various public-sector medical clinics and, if they met criteria for current PTSD following interpersonal trauma experiences, randomly assigned to a therapy group or a wait-list control condition. All subjects were assessed on a battery of measures, including the Clinician-Administered Scale for PTSD (CAPS), the Social Adjustment Scale, and the Inventory for Interpersonal Problems, as well as others, at the outset of treatment, at the mid-point of therapy, at termination, and at four-month follow up. Women in the control condition became eligible for treatment if they continued to have PTSD after completing the four-month follow up. Preliminary results suggest that women who completed the IPT groups were more likely than those in the wait-list group to no longer meet criteria for PTSD, both at termination of treatment and at follow-up. They also gained skills in setting limits with others and in assessing the safety of relationships.

No. 87D
INDIVIDUAL INTERPERSONAL PSYCHOTHERAPY FOR PTSD

Kathryn L. Bleiberg, Ph.D., *Department of Psychiatry, Cornell University Medical College, 525 East 68th Street, Box 140, New York, NY 10021;* John C. Markowitz, M.D.

SUMMARY:

This presentation describes the pilot adaptation of interpersonal psychotherapy (IPT) as a treatment for posttraumatic stress disorder (PTSD) in a sample of men and women. Since IPT is a life-event-based, time-limited treatment empirically validated in treating mood disorders, and PTSD is a life-event-based disorder that compromises interpersonal and social functioning, it seems intuitive to treat PTSD with IPT. This work represents an exciting extension of IPT as an individual treatment of anxiety disorders. Unlike most PTSD treatments, IPT is not exposure based. Subjects (n=8), recruited via clinical referral and local advertising, were treated in an open, 14-week IPT trial. Assessments included the Clinician-Administered PTSD Scale (CAPS), Posttraumatic Stress Scale-Self Report (PSS-SR), Social Adjustment Scale-Self Report Version (SAS-SR), Inventory of Interpersonal Problems (IIP), and other measures, at baseline, mid-treatment, end of treatment, and six-month follow up.

Preliminary results: Treatment was well tolerated. Most subjects who completed 14 weeks of IPT reported a decline in PTSD symptoms in all three symptom clusters and improved interpersonal functioning. Follow up and treatment of several patients are ongoing, and therefore, it is premature to draw conclusions. Nevertheless, the preliminary data are promising.

No. 87E
INTERPERSONAL THERAPY VERSUS SUPPORTIVE THERAPY FOR SOCIAL PHOBIA

Joshua D. Lipsitz, Ph.D., *Department of Psychiatry, NYSPI Columbia University, 1051 Riverside Drive #69, New York, NY 10032*

SUMMARY:

Social phobia (social anxiety disorder) is now recognized as a prevalent and often debilitating anxiety disorder. Available treatments include cognitive-behavior therapy and medications such as phenelzine and paroxetine. We modified interpersonal psychotherapy for treatment of social phobia (IPT-SP) and have achieved promising results in a small pilot study.

We now report on the progress of a randomized, controlled trial comparing IPT-SP with supportive therapy for treatment of social phobia. To date, 53 patients have been randomly assigned to one of the two treatments: 31 have completed treatment, 12 have dropped out, and 10 are currently in treatment. Ease of enrollment and rates of retention thus far suggest that these treatments are appealing and reasonably well tolerated.

The presentation will focus on conceptual and clinical aspects of IPT-SP. We will discuss changes in IPT technique based on experience with patients with social phobia. Case summaries of two successful treatments with IPT-SP will be presented.

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4. Weissman MM, Markowitz JC, Klerman GL: Comprehensive Guide to Interpersonal Psychotherapy. New York, Basic Books, 2000.
5. Lipsitz JD, Markowitz JC, Cherry S, Fyer AJ: An open trial of interpersonal psychotherapy for social phobia. American Journal of Psychiatry 1999; 156:1814-1816.

SYMPOSIUM 88—TREATING MENTAL ILLNESS AND SUBSTANCE ABUSE IN THE CRIMINAL JUSTICE SYSTEM

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand how he/she can effectively treat patients who become involved with the criminal justice system and to help decriminalize mental illness.

No. 88A
FAMILY DRUG COURTS: EARLY EVALUATION FINDINGS

Nancy Young, *Family Futures Incorporated, 4940 Irvine Boulevard, Suite 202, Irvine, CA 92620*

SUMMARY:

Since 1997 the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment

(CSAT), has been investigating the effectiveness of family drug treatment courts. In family drug treatment courts, alcohol and other drug treatment combined with intervention and support services for child and family, are integrated with the legal processing of the abuse or neglect case against the parents. CSATS's initiative has included evaluation, sponsorship of the annual Juvenile and Family Drug Court Conference, technical assistance to developing programs, support for the development of a few key publications, and small grants for clinical interventions in family drug treatment court settings. CSAT works closely with the Drug Court Program Office, Department of Justice, on this issue. The presenter is the project director for the National Family Drug Treatment Court Evaluation. She will describe the program and early evaluation findings that using family drug treatment courts reduce the time taken for final disposition of abuse and neglect cases, and will also increase the percentage of family reunifications.

No. 88B
PELICAN BAY SUPER MAX: TREATMENT IN CORRECTIONAL SETTINGS

David Archambault, Ph.D., *Pelican Bay State, Crescent City, CA 95531*

SUMMARY:

Dr. Archambault will describe the psychiatric services unit (PSU) at the Pelican Bay State Prison. The PSU is a treatment program for inmates with serious mental illnesses, who have a supermax classification and have received an infraction resulting in a Security Housing Unit (SHU) term. The SHU is a 23-hour per day lockdown housing unit with very severe property and movement restrictions. The Madrid class-action litigation resulted in inmates with serious mental illnesses being excluded from the SHU. The PSU was developed in order to house inmates with serious mental illnesses who had a SHU classification.

Dr. Archambault is a senior supervising psychologist at PBSP and has been instrumental in the development of the PSU. For purposes of the symposium application, his title will be "A description of a residential treatment program in a supermax prison facility: the mental health-correctional staff interface."

No. 88C
JAIL DIVERSION: MECHANISMS AND SERVICES

Hank Steadman, *Gains Center, 345 Delmar Avenue, Delmar, NY 12054*

SUMMARY:

Criminal justice, mental health, and substance abuse professionals and advocates have called for diversion efforts to link offenders with mental illness to community-based services to break their continued cycling through the criminal justice, mental health, and substance abuse treatment systems. The presenter will describe jail diversion in the context of two broad interlocking areas of intervention. First is the diversion mechanisms, or the means by which an individual is identified at some point in the arrest process and linked to mental health and substance abuse services. Second is the system of integrated mental health and substance abuse services to which the client is diverted. Diversion services may either prevent incarceration or cut it short.

Available research suggest that at least two core elements are necessary for diversion programs: aggressive linkage to an array of community services, especially those for co-occurring mental health and substance use disorders, and nontraditional case managers.

Data now coming out of the SAMSHA nine-site jail diversion project are informing for the first time the key policy questions of: whether any single definitive model for organizing a criminal justice-mental health-substance abuse diversion program exists; what types of programs are effective for detainees with co-occurring disorders; and whether programs actually benefit the targeted recipients, especially in terms of symptom stabilization, reduced jail time, higher levels of community adjustment, and stable participation in community mental health and substance abuse services.

No. 88D
SUCCESSFUL COMMUNITY REINTEGRATION OF OFFENDERS WITH MENTAL ILLNESS

Fred C. Osher, M.D., *Department of Psychiatry, University of Maryland, 8490 Dorsey Run Road, Jessup, MD 20794*

SUMMARY:

There are more than 10 million adults booked into U.S. jails each year with greater than 2.0 million people already incarcerated. Current estimates suggest that as many as 700,000 of those adults entering the criminal justice system have active symptoms of serious mental illness and three-quarters of them will meet criteria for a co-occurring addictive disorder. Almost all of these individuals will leave incarcerated settings and return to our communities. In a review of jail services, Steadman and Veysey (1997) identified discharge planning as the least frequent service provided within jail settings. In fact, the larger the facility, the less frequent attention was placed on what follows release of the detainee into the community. Hartwell and Orr (2000) highlight important differences in transition planning for offenders with mental illnesses from longer-term prison stays compared with that of short-term jail stays. Shorter stays require more rapid assessment and planning activity, but to a greater degree involve offenders who have existing community mental health care providers, and will be released under correctional supervision. Inadequate transition planning strategies often leave offenders without the necessary supports in the community. The outcomes of these poorly implemented re-entry processes include the compromise of public safety, an increase incidence of behavioral health symptoms, homelessness, and re-arrest. Arrest can be viewed as a public health opportunity and efforts to identify needs and link detainees to appropriate services can be achieved. This presentation will discuss a model for transition planning that addresses critical elements required for succesful community re-integration

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SYMPOSIUM 89—TRAUMATIC RESPONSE TO DISASTER: NEUROBIOLOGY AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the range of human response to catastrophic trauma, recognize posttraumatic stress disorder and its psychiatric comorbidities, and apply knowledge about risk for postdisaster problems and their course to direct interventions in the event of a major catastrophe.

No. 89A
NEUROBIOLOGICAL MECHANISMS OF PTSD

Dennis S. Charney, M.D., *National Institute of Mental Health, National Institute of Health, 9000 Rockville Pike, Building 10, Room 3N212, Bethesda, MD 20892*

SUMMARY:

There is evidence that patients with PTSD have abnormalities in brain, noradrenergic, benzodiazepine, and CRF systems. The hypothalamic-pituitary-adrenal axis is dysregulated in PTSD patients. Recent research has focused on identification of the role of endogenous anxiolytic peptides such as neuropeptide Y and galanin as protective factors. Novel pharmacologic therapies are being tested for PTSD. This presentation will review recent research pertaining to the neurobiology and treatment of PTSD.

No. 89B
THE RANGE OF HUMAN RESPONSE TO CATASTROPHIC TRAUMA

Carol S. North, M.D., *Department of Psychiatry, Washington University School of Medicine, Campus Box 8134, 660 South Euclid, St. Louis, MO 63110*

SUMMARY:

Disasters seem to be on the rise, if gauged by the frequency of natural catastrophes, technological accidents, and terrorism in recent national and international news headlines. Oklahoma City made us realize that no place is immune. Clinicians anywhere may wake up one day to find themselves in the wake of a major disaster in their own community with many traumatized individuals needing psychiatric evaluation and treatment. Preparation for this likelihood will aid their ability to respond to meet the demand. Disasters also provide unique opportunities for understanding psychological sequelae of the most severe kinds of traumas in their purest form. Striking randomly and unexpectedly, these catastrophic events affect populations unselected for pre-existing risk factors confounding individual traumas in communities. Posttraumatic response to extreme traumas such as disasters is complex, involving a range of reactions and psychopathologies, all represented in neurobiological brain processes that are increasingly being clarified with research findings in recent studies of posttraumatic stress disorder. Newer pharmacologic agents provide invaluable treatment options for the clinician facing mass psychopathology in the wake of a major disaster as well as for physicians treating posttraumatic stress disorder in victims of increasing violence and trauma that is endemic in communities.

No. 89C
DISASTER OVERVIEW: CLINICAL PRESENTATION NATIONAL AND INTERNATIONAL PERSPECTIVES

David Benedek, M.D., *Department of Psychiatry, Walter Reed Army Medical Center, Building E, Washington, DC 20307-5001*

SUMMARY:

The study of disaster and response to disaster now has a long history beginning in the early 20th century. Disasters have been subdivided into three types: natural disasters such as floods, and famines; technological disasters such as nuclear accidents; and willful human acts such as biological terrorism. The stages of disaster response by individuals and communities have also been well documented. The first response is courage and bravery. This honeymoon period after a disaster lasts for about two months. During the second phase denial is prominent. Symptoms such as sleeplessness, substance abuse, and anorexia or overeating emerge. During the third phase disillusionment with responders begins to occur. Victims feel the government, friends, and family have not done enough. Finally, victims, the family, the community begin to rebuild and reconstruct their lives. It is important to remember that victims of a disaster include those affected primarily such as those directly in the path of the disaster, and those affected secondarily, such as family members and friends. The third group, often forgotten, are rescuers and emergency workers. The community at large is also a victim. The most effective psychiatric response to disaster also has been studied in the last 20 years and will be discussed. The federal government and national voluntary organizations such as the American Psychiatric Association and the Red Cross have developed effective partnerships.

No. 89D
PSYCHOPHARMACOTHERAPY OF PTSD IN CHILDREN AND ADOLESCENTS

Elizabeth B. Weller, M.D., *Department of Psychiatry, University of Pennsylvania, 34th and Civic Center Boulevard, Philadelphia, PA 19104;* Arman K. Danielyan, M.D., Ronald A. Weller, M.D.

SUMMARY:

PTSD is a relatively new diagnosis. It was not until 1987 that its criteria were modified in DSM-III-R for use in children. There is less research done in children and adolescents than in adults. As the FDA has encouraged the psychopharmacologic studies in children and adolescents, there has been some interest in open-labeled and some placebo-controlled studies in this field. The following psychopharmacologic agents have been used in preschool children and adolescents: benzodiazepines, carbamazepine, clonidine, guanfacine, lithium carbonate, citalopram, nefazodone, and propranolol.

In this presentation the psychopharmacological agents used to treat preschoolers, children, and adolescents will be reviewed and an evidence-based approach will be presented to help the clinicians with the judicious use of these agents. Directions for future research will be emphasized.

No. 89E
PSYCHOPHARMACOLOGY OF TRAUMATIC RESPONSE IN ADULTS

Richard Balon, M.D., *Department of Psychiatry, Wayne State University Psychiatric Center, 2751 East Jefferson, Suite 200, Detroit, MI 48207*

SUMMARY:

Management of response to trauma is a complex issue complicated by numerous factors, including comorbidity with various disorders. The usual focus of research and clinician's attention is the treatment of acute response to trauma, such as acute stress disorder and the early stage of PTSD. However, the treatment of response to trauma could frequently become long term. Pharmacotherapy is an important component of this treatment process, which also includes various psychosocial approaches. Pharmacotherapy of PTSD has been the most studied area of psychopharmacology of traumatic response. There are several pharmacological treatment options for PTSD.

Several earlier studies demonstrated response of PTSD to tricyclic antidepressants and MAO inhibitors. Selective serotonin reuptake inhibitors, especially fluoxetine, paroxetine, and sertraline, have been the most studied and used group of psychopharmacological agents in the treatment of PTSD. However, other agents such as nefazodone, benzodiazepines, buspirone, anticonvulsants, beta blockers, and even antipsychotics have been used and studied in the treatment of PTSD.

This presentation will review the current status of psychopharmacology of traumatic response. It will also provide a rational guidance for treatment of acute and chronic traumatic response, including a differential approach to various comorbidities.

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SYMPOSIUM 90—PSYCHIATRY AND THE PHARMACEUTICAL INDUSTRY: WHERE IS THE BOUNDARY?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the effectiveness of the pharmaceutical industry in shaping psychiatric education and practice and to discuss some responses to this influence.

No. 90A
PHARMACEUTICAL PROMOTION: THERE IS NO FREE LUNCH

Amy C. Brodkey, M.D., *Department of Psychiatry, University of Pennsylvania, 644 West Ellet Street, Philadelphia, PA 19119-3427*

SUMMARY:

The pharmaceutical industry is the most profitable business in the United States, with domestic sales of well over $100 billion for U.S. "ethical" (brand-name) drug companies alone. Marketing costs currently exceed 30% of revenues, far surpassing outlays for both research/development and production. An estimated $10–$20,000 per doctor per year is spent on detailing, gifts, speakers, journals, sampling, and other forms of promotion, and this figure continues to rise at an exponential rate. A substantial literature demonstrates that, despite many physicians' protestations to the contrary, their opinions and prescribing practices are impacted by such promotion. In addition, a number of studies demonstrate bias and inaccuracy in industry-sponsored advertising, detailing, promotional materials, continuing medical education seminars, published symposia, and sponsored research. The ethical issues inherent in accepting gifts from drug companies (including higher costs of pharmaceuticals), existing guidelines, and studies on the public's perceptions of this relationship will be reviewed. Reliance on readily available industry funding has limited the development of alternative sources of continuing education, and has helped to redefine the scope of our profession. We need to establish a firm barrier between commercial and professional aspects of psychiatry to safeguard the profession and our patients.

No. 90B
ACADEMIA, MEDICAL EDUCATION, AND THE PHARMACEUTICAL INDUSTRY

Frederick S. Sierles, M.D., *Department of Psychiatry, Finch University, 3333 Green Bay Road, North Chicago, IL 60064*

SUMMARY:

Drug company gifts and sponsored events permeate the educational landscape of residents and students. An overwhelming majority of trainees meet with detailers and obtain information and gifts from them, attend sponsored CME events and drug lunches, and are taught by faculty who receive industry funds. Many of the best residents receive industry-sponsored fellowships and awards. Like attending MDs, trainees widely perceive—despite strong evidence to the contrary—that they are "objective" and thus immune to influence of promotions.

The once-clear boundary between academic medicine and industry has become increasingly blurred. As other sources of medical education funding have waned, the pharmaceutical industry has secured a prominent role in medical education. Further, published research tends to favor drug-company sponsored products, and some clinically important research goes unpublished or is delayed. Fortunately, the vast majority of trainees want to learn more about drug company-MD relationships, and there is preliminary evidence that education programs and guidelines influence trainee attitudes.

We will review the literature on (1) trainee-industry interactions and their associated problems and (2) modest educational interventions and policies that have been shown to affect trainee attitudes. We will also comment on recent initiatives by psychiatric educators organizations to address the above-mentioned problems.

No. 90C
THE PHARMACEUTICAL INDUSTRY AND PUBLIC PSYCHIATRY

Robert M. Factor, M.D., *Department of Psychiatry, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703-2639*

SUMMARY:

Over the past ten years, there has been a dramatic change in the medications used to treat persons with serious and persistent mental illness. New generation antipsychotic and antidepressant drugs have replaced many older medications. Antiepileptic drugs are being used with greater frequency as mood stabilizers. Newer benzodiazepines have replaced older ones. In many of these cases, the newer drugs offer the promise of greater efficacy and fewer side effects. These newer drugs are also significantly more expensive than the drugs that they have replaced. Almost all of them are on patent. With these increased medication options, there is a greater need for information about how to choose them, how to prescribe them, and how they may interact. This information is available from a variety of sources, some from sources obviously related to industry and others apparently not. These facts raise particular questions for practitioners in the public sector. How do we choose drugs when the costs are being paid by public funds? When do we prescribe a generic drug? What use do we make of educational and other materials offered by the pharmaceutical industry? Upon what sources of information can we rely? How do we relate to industry representatives, make use of samples and patient assistance programs? How do we relate to pharmacies? I will discuss these questions using national data and local case examples.

No. 90D
INDUSTRY-SUPPORTED MEDICAL EDUCATION: WHEN EDUCATORS SERVE TWO MASTERS

Diana M. Koziupa, M.D., *Pennsylvania Foundation, 807 Lawn Avenue, Sellersville, PA 18960*

SUMMARY:

Industry-sponsored educational activities have an enormous influence on the prescribing practices of physicians. This presentation discusses the issues that industry-sponsored speakers face when providing educational experiences for clinicians, both for CME credit and not for credit. A large number of non-credit educational activities are funded by the pharmaceutical industry, ranging from lectures to roundtable discussions, on subjects directly or indirectly related to their products.

This presentation will address some dilemmas that speakers face when providing these educational experiences, including the overt and covert influence of the sponsors to promote their specific product. Highlighted will be ways that speakers can ensure that they provide balanced, objective educational experiences, including appropriate discussion of positive and negative research, off-label or investigational usage, as well as discussion of other pharmaceutical products.

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SYMPOSIUM 91—THE EMPLOYMENT INTERVENTION DEMONSTRATION PROJECT: OUTCOME OF BEST PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the key evidence-based features of vocational and psychiatric services that improve competitive employment outcomes for people with disabling psychiatric disorders.

No. 91A
BEST PRACTICE IN EMPLOYMENT RESEARCH: VIEWS FROM THE EMPLOYMENT INTERVENTION DEMONSTRATION PROGRAM COORDINATING CENTER

Judith A. Cook, Ph.D., *Department of Psychiatry, University of Illinois at Chicago, MHSRP, 104 South Michigan, Suite 900, Chicago, IL 60603*

SUMMARY:

Objective: This session will present cross-site findings from the Employment Intervention Demonstration Program (EIDP), a five-year, multisite evaluation of vocational rehabilitation services for people with mental illness.

Method: This presentation will provide an overview of multivariate and longitudinal statistical analyses of EIDP data, address conceptualization of employment outcomes, and report on the ways in which EIDP findings have been used to inform local, state, and federal policymakers about best practices in vocational rehabilitation services, research, and evaluation.

Results: Findings will describe specific outcomes regarding competitive employment, including the (1) proportion of mental health consumers who ever held a paying job, (2) proportion of consumers achieving competitive employment according to criteria defined by the EIDP steering Committee, (3) proportion of consumers working 40 or more hours in one month, and (4) total amount of money earned by working EIDP participants.

Conclusions: This presentation will highlight the ways in which different models of vocational rehabilitation services outcomes, identified with rigorous multivariate statistical analyses, can be used throughout the field to promote the development, implementation, and evaluation of best practices in employment services. Furthermore, the ways in which outcomes from the EIDP have been used to influence important employment, mental health, and public policy initiatives will be described.

No. 91B
THE HARTFORD STUDY OF SUPPORTED EMPLOYMENT FOR SEVERE MENTAL ILLNESS: EMPLOYMENT AND NONVOCATIONAL OUTCOMES

Kim T. Mueser, Ph.D., *Department of Psychiatry, NH-Dartmouth PRC, 1051 Pleasant Street, Main Building, Concord, NH 03301;* Robin E. Clark, Ph.D., Michael Haines, M.A., Robert E. Drake, M.D., Gary R. Bond, Ph.D., Deborah R. Becker, M.Ed., Gregory McHugo, Ph.D., Susan M. Essock, Ph.D., Rosemarie Wolfe, M.A., Anjana Sengupta, Ph.D.

SUMMARY:

Background: We compared three approaches to vocational rehabilitation for persons with severe mental illness: (1) the Individual Placement and Support (IPS) model of supported employment, which emphasizes rapid job search and support by employment specialists who are members of clients' treatment teams, (2) a psychiatric rehabilitation center (PSR) that focused on improving work outcomes through a transitional employment program, and (3) standard services (Standard), which involved the brokering of vocational services to off-site vendors.

Methods: Two hundred and four unemployed inner-city clients (46% African American, 30% Latino) with severe mental illnesses who were interested in competitive work were randomly assigned to IPS, PSR, or Standard and followed for two years. Clients' symptoms, quality of life, self-esteem, and social functioning were assessed at baseline, and 6, 12, 18, and 24 months later. Employment outcomes were tracked weekly.

Results: Over the two years clients in IPS had better employment outcomes than clients in PSR and Standard, including more hours worked, more wages earned, and more likely to obtain competitive work (73.9% vs. 18.2% vs. 27.5%) and any paid work (73.9% vs. 34.8% vs. 53.6%). Clients in PSR reported more satisfaction with social relationships. Few other program differences were found in non-vocational outcomes.

Conclusions: The IPS model of supported employment is more effective than either the PSR model or standard brokered vocational services for improving employment outcomes among inner-city African American and Latino clients.

No. 91C
EFFECTS OF FACT AND AN EMPLOYERS CONSORTIUM ON EMPLOYMENT IN SEVERE MENTAL ILLNESS

William R. McFarlane, M.D., *Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102;* William Cook, Ph.D., Richard Balser, Cindy Boyak, M.D., Renee Leavitt, O.T.

SUMMARY:

Introduction: Employment involves a two-sided relationship: characteristics of the employment setting combine or interact with employee characteristics to produce employment outcomes. The experimental condition in this study involved the participation of a group of 15 companies (the Mental Health Employers Consortium (MHEC)) who worked closely with employment specialists to optimize the ability of the company to provide accommodations to employees with serious mental illness. Participants in both conditions received Family-aided Assertive Community Treatment (FACT), which combines assertive community treatment with psychoeducational multifamily support groups and cognitive assessment.

Methods: Random assignment was to the MHEC condition or the comparison condition, which employed more conventional methods of supported employment. The assessment and data analysis compared employment outcomes, quality of life, satisfaction, social functioning, clinical outcomes, cost of services, and work environments between the two groups (MHEC+FACT vs. FACT).

Results: A total of 132 subjects with disabling psychiatric disorder were randomly assigned to the two rehabilitation conditions. While there was no difference for employment between conditions, both conditions achieved end-point employment rates above 55% for subjects with schizophrenia. Effects of baseline variables, key elements of the Mental Health Consortium and FACT, and personal and family characteristics on employment rates and their interaction with rehabilitation methods will be presented.

Conclusions: FACT achieved high rates of sustained employment, regardless of the level of participation of the employer. The key elements of FACT were developed for schizophrenia, which is reflected in especially promising employment outcomes for those with that disorder.

No. 91D
IMPROVING EMPLOYMENT OUTCOMES FOR PERSONS WITH SEVERE MENTAL ILLNESS

Anthony F. Lehman, M.D., *Department of Psychiatry, University of Maryland at Baltimore, 701 West Pratt Street, Suite 388, Baltimore, MD 21201*

SUMMARY:

Unemployment remains a major consequence of schizophrenia and other severe mental illnesses. This study assesses the effectiveness of the Individual Placement and Support (IPS) model of supportive employment relative to usual psychosocial rehabilitation services for improving employment among inner-city patients with these disorders.

A total of 219 outpatients with severe mental illnesses, 75% with chronic psychoses, from an inner-city catchment area were randomly assigned to either IPS or a comparison psychosocial rehabilitation program. Participants completed a battery of assessments at study enrollment and every six months for two years. Employment data, including details about each job, were collected on a weekly basis. IPS participants were more likely than the comparison patients to work (42% vs. 11%, $p < .001$, Odds Ratio = 5.96)) and to be employed competitively (27% vs. 7%, $p < .001$, odds ratio = 5.58).

Employment effects were associated with significant differences in cumulative hours worked and wages earned. Among those who achieved employment, however, there were no group differences in time to first job or in number or length of jobs held. Also, both groups experienced difficulties with job retention.

As hypothesized, the IPS program was more effective than the psychosocial rehabilitation program in helping patients achieve employment goals. Achieving job retention remains a challenge with both interventions.

No. 91E
EFFECTIVENESS OF LONG-TERM EMPLOYMENT SUPPORT FOR INDIVIDUALS WITH SEVERE MENTAL ILLNESS

Laura E. Bianhertz, Ph.D., *Matrix Research, 100 North 17th Street, Philadelphia, PA 19103*

SUMMARY:

Objective: The objective of this study was to determine if the provision of long-term employment focused supports improves economic and noneconomic outcomes and reduces the use of other mental health services.

Method: This was a randomized field trial with an experimental group that received long-term supports and a control group that did not. The study was conducted in Philadelphia with workers providing contact at least once a week, with some periods of daily contact. A total of 182 entered and 132 completed. Individuals were followed for a minimum of 24 months and a maximum of 36 months. The experimental condition involved a variety of activities that help participants to maintain employment and to develop career plans. Outcome measures were: (1) economic—days and hours worked, total money earned, career advancement (2) non-economic—life satisfaction, mastery.

Results: The experimental condition worked more standardized hours than the control condition ($p = .12$). Non-economic indicators did not change significantly over time because of the participants internalized stigma.

Conclusions: Work often has a different meaning for individuals with severe mental illness and their attachment to the labor force follows a different pattern. Major factors are the level of jobs as well as loss of benefits.

No. 91F
RURAL-BASED SUPPORTED EMPLOYMENT APPROACHES: RESULTS FROM THE SOUTH CAROLINA SITE OF THE EMPLOYMENT INTERVENTION DEMONSTRATION PROJECT

Neil Meisler, M.S.W., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425*

SUMMARY:

We propose to present the employment and psychiatric symptom outcomes from the South Carolina site of the CMHS-sponsored Employment Intervention Demonstration Program (5 UD7 SM51823-02). We compared a new program at a rural CMHC that blended two evidence-based community mental health service models for persons with severe and persistent mental illness: (1) the Program of Assertive Community Treatment—PACT and (2) Individual Placement and Support—IPS (ACT-IPS) to the usual services available to clients of the CMHC. Study participants were unemployed adult clients of the CMHC with severe mental illness.

A total of 144 participants enrolled in the study, 65 in the experimental condition and 79 in the comparison condition. The diagnostic profile of the participants was 50% schizophrenia related disorders, 17% major affective disorders, and 33% other. The majority of the participants were African American and female. The mean age was 36 years. The mean educational level was 11th grade. Employment status and CMHC service utilization were tracked continuously. Participants were interviewed at baseline and six-month intervals for two years. The interview included the Structured Clinical Interview for the Positive and Negative Syndrome Scale and client's self report on a broad range of psychosocial domains.

A total of 115 (80%) participants completed two years of participation in their assigned study conditions, 53 in ACT-IPS and 62 in the comparison condition. Statistical analyses were conducted based

on the intent to treat sample. Significance differences in favor of the experimental ACT-IPS condition were found for the following employment outcomes: any jobs held, competitive jobs held, time employed in any job, time employed in competitive employment, and employment earnings. The ACT-IPS group experienced 90.5% placement in at least one job, had a total of 205 jobs (90.9% competitive), and spent 39.0% of its time employed. The comparison group experienced 70.9% placement in at least one job, had a total of 145 jobs (31% competitive), and spent 22.6% of its time employed. No significant between group differences were found for PANSS scores. The results of the study are consistent with the findings of other IPS studies and are the first obtained for a rural, mostly female, and African-American population. Our study suggests that a proportion of adults with severe and persistent mental illness can get and keep employment if they are provided encouragement, job finding assistance, and ongoing support in accordance with the IPS model.

No. 91G
THE TEXAS EARNS SUPPORTED EMPLOYMENT DEMONSTRATION PROJECT

Marcia Toprac, Ph.D., *Department of Medical Services, Texas Department of MHMR, P O Box 12668, Austin, TX 78711-2668;* Sue K. Hoppe, Ph.D., Pamela Daggett, M.A., Kate Wambach, Ph.D., Steven Onken, Ph.D., Susan Burek, Shelley Blozis, Ph.D.

SUMMARY:

The Texas EARNS Project was one of eight sites funded through SAMHSA's Employment Intervention Demonstration Program. The project compared the effects of two forms of supported employment on competitive employment outcomes for people with serious mental illnesses. The control intervention (STANDARD) involved "place-train" supported employment strategies similar to those used in Individual Placement and Support (IPS—Becker & Drake, 1994) programs. The experimental intervention (EARNS) provided the same supported employment strategies along with intensive interventions aimed at building and strengthening natural support networks. It was hypothesized that the EARNS intervention would result in better employment outcomes (i.e. number of weeks and hours of employment and total earnings).

Two hundred forty-seven individuals receiving services at a public mental health center in San Antonio, Texas, were randomly assigned to STANDARD (N = 122) or EARNS (N = 125). Subjects were followed for at least 24 months. Across groups, 64% had been employed at some point during the 24-month research period. Hierarchical Linear Modeling (HLM) techniques were utilized to examine between-group and individual differences. After demographic, clinical and other covariates were taken into account, there were no statistical differences between the intervention groups in employment outcomes. Associated findings and implications of the results will be discussed.

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SYMPOSIUM 92—TREATMENT OF ADHD: FROM CLINICAL TRIALS TO ROUTINE CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES:

This symposium will update clinicians and researchers on current evidence-based recommendations in the use of stimulant medications for the treatment of attention-deficit/hyperactivity disorder (ADHD), based on the American Academy of Child and Adolescent Psychiatry Practice Parameters. Participants will become familiar with large national clinical trials and community-based studies of somatic and psychosocial approaches in treatment of ADHD.

No. 92A
THE AACAP STIMULANT MEDICATION PRACTICE PARAMETER FOR TREATMENT OF ADHD

Laurence L. Greenhill, M.D., *Department of Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, Unit 74, New York, NY 10032*

SUMMARY:

More than 60 years ago, serendipitous observation revealed that the drug d,l-amphetamine reduces the disruptive symptoms of hyperkinetic children. Today, there are four stimulant medications available for clinical use: methylphenidate (MPH), dextroamphetamine (DEX), mixed-salts amphetamine (AMP), and pemoline (PEM). They are the most widely prescribed psychotropic medications for children, primarily in the treatment of attention-deficit/hyperactivity disorder (ADHD). Long thought of as a childhood disorder, ADHD is now known to persist into adolescence and adulthood, and adults are increasingly being treated with stimulants for this condition. Stimulants are also indicated for the treatment of narcolepsy, based on controlled studies.

The AACAP practice parameters: (1) review the literature pertinent to the clinical use of stimulants, including data derived from the NIMH MTA study; (2) describe indications and contraindications for stimulant treatment, with an emphasis on judicious use; (3) describe the initiation and dosing of the various stimulant agents; (4) describe the side effects encountered in stimulant treatment; (5) discuss long-term maintenance using stimulant agents; and (6) discuss the combination of stimulants and other psychotropic agents in the treatment of comorbid conditions.

No. 92B
TREATMENT OF ADHD: FROM MULTIMODAL TREATMENT ADHD TRIALS TO ROUTINE PSYCHIATRIC PRACTICE

Peter S. Jensen, M.D., *Child Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 78, New York, NY 10032*

SUMMARY:

Despite decades of efficacy research on psychostimulants and behavior therapy (BT) in ADHD, little research has been helpful in the day-to-day decisions of providers. Answers to practice-relevant questions, e.g., "Which treatment works best? When should they

be combined? Can one match patients to treatments?'' remained elusive until 1999–2000, when the results of a large-scale NIMH-funded clinical trial were released. Known as the MTA Study (Multimodal Treatment of ADHD), this 14-month trial demonstrated the superiority of medication over BT for ADHD symptoms and modest advantages of their combination over either treatment alone in other outcome domains. The MTA medication approach was superior to medications in a ''treatment-as-usual'' condition, differences explainable by quality of care parameters. Comorbid subgroups responded selectively to specific treatments, offering better patient-to-treatment matching. Despite these findings' clinical relevance, substantial gaps exist between ''what we know'' vs. ''what we do'' in clinical practice. These gaps result from multiple obstacles, not just in providers, but also in consumers/parents, payors, and policymakers; studies are under way to test methods to address these various obstacles. Tested methods include web-based tools, parent-to-parent empowerment training, academic detailing based on self-efficacy theory; and business change models adapted to clinical practice (CQI). Next steps for researchers and practitioners are outlined.

No. 92C
STIMULANT AND PSYCHOSOCIAL TREATMENT OF ADHD IN LATINO CHILDREN

Glorisa Canino, Ph.D., *Department of Behavioral Science Research I, University of Puerto Rico, GPO Box 365067, San Juan, PR 00936-5067;* Jose J. Bauermeister, Ph.D., Maritza Rubio-Stipec, Sc.D.

SUMMARY:

Objective: To examine to what extent Latino children with a diagnosis of ADHD are receiving appropriate stimulant medication and psychosocial treatment.

Method: A probability community sample of 1900 children ages 4 to 17 from Puerto Rico was obtained. Lay interviewers administered the Diagnostic Interview Schedule for Children (DISC-IV), the Service Assessment for Children and Adolescents, and the Children's Global Assessment Scale (CGAS), among other research instruments. Data for children with a DISC diagnosis of ADHD and a CGAS score of 60 or less, and for those with ADHD not otherwise specified (NOS) were examined to ascertain types of treatment received during the last year.

Results: Approximately 18% of the children with ADHD and 6% of those with ADHD NOS were prescribed stimulant medications. About half of children with ADHD receive school-based, outpatient or residential/hospitalization services. The overall stimulant prescription rate was 1.17%.

Conclusion: In this non-referred community sample, Latino children with a diagnosis of DSM-IV ADHD or that partially meet diagnostic criteria for this disorder are not receiving appropriate medication nor psychosocial treatment. The data also support the findings of Jensen et al. (1999) that significant stimulant overtreatment is not occurring across communities.

No. 92D
THE ROLE OF COMORBIDITY IN THE TREATMENT OF ADHD IN ROUTINE PSYCHIATRIC PRACTICE

Farifteh F. Duffy, Ph.D., *APIRE, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* William E. Narrow, M.D., Donald Rae, M.A.

SUMMARY:

Objective: Examine comorbidity and variations in psychiatric treatment for children and adolescents with attention-deficit/hyperactivity (ADHD).

Methods: A total of 300 patients with ADHD ages 5 to 14, from the 1996 APA Practice Research Network Child and Adolescent Treatment Study on ADHD, and the 1997 and 1999 Study of Psychiatric Patients and Treatments, were sampled.

Results: 71% of patients had one or more comorbid psychiatric or general medical conditions. The most frequent comorbidities were disruptive behavior disorders (31%) and depressive disorders (18%). ADHD patients with comorbid depressive or disruptive disorders had lower GAF scores and more Axis IV problems than ADHD patients without comorbidity. For those receiving pharmacologic interventions, the mean number of medications were higher among patients with comorbidity than those without. A higher percentage of ADHD patients with comorbid depressive or disruptive disorders, or both, received combined psychopharmacology and psychotherapy treatment, in contrast to ADHD patients without comorbidity (49%, 51%, 75% versus 34%, respectively). Conversely, a higher percentage of ADHD patients without comorbidity received medications alone (66%) compared with other comorbid groups (46%, 44%, 20% respectively). Analysis for classes of medications will be presented.

Conclusions: ADHD patients with comorbid conditions represent a more complex clinical profile. These findings demonstrate variations in patterns of treatment for ADHD associated with the presence of comorbid conditions.

No. 92E
INSURANCE FACTORS AND ADHD TREATMENT IN PSYCHIATRIC PRACTICE

William E. Narrow, M.D., *APIRE, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Donald Rae, M.A., Farifteh F. Duffy, Ph.D.

SUMMARY:

Objective: To determine whether children with ADHD differ in their clinical and treatment characteristics according to type of insurance/payment source.

Method: Demographic, clinical, and insurance information was gathered for 300 children with ADHD, age 5 to 14. Data sources were 1996, 1997, and 1999 surveys of the APA Practice Research Network.

Results: There were no differences in age or sex between children using Medicare/Medicaid vs. private insurance vs. self-pay as payment source. Close to 40% of children covered by Medicare/Medicaid were nonwhite; self-pay patients were overwhelmingly white. Self-pay and privately insured patients were most frequently seen in solo or group office settings for the index visit, while Medicare/Medicaid patients were seen most frequently in clinic or inpatient settings. Compared with privately insured and self-pay patients, children with Medicare/Medicaid had more Axis II diagnoses, more psychosocial problems, and lower GAF scores. While there were no differences in overall service modalities (e.g., medication management, psychotherapy) provided to the three groups in the previous month, children with Medicare/Medicaid were more likely to have received an antipsychotic medication in this period.

Conclusions: Children with ADHD using Medicare/Medicaid have high treatment needs in terms of symptomatology and disability. Covered services for this group should include multimodal forms of treatment.

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SYMPOSIUM 93—VIRTUAL REALITY AND MENTAL HEALTH: STATE OF THE ART AND FUTURE DIRECTIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the audience should be able to appreciate the concept of VR as well as its potential benefits, and ethical and cost-benefit issues in psychiatric research and practice.

No. 93A
VIRTUAL ENVIRONMENTS: USING A DRIVING SIMULATOR TO UNDERSTAND CONSCIOUSNESS

Henry J. Moller, M.D., *Department of Psychiatry, University of Toronto, 399 Bathurst Street, Toronto Western, Toronto, ON M5T 258, Canada*

SUMMARY:

Simulated or virtual environments (VEs) are the cornerstone of virtual reality (VR) therapy. These environments allow the user to become immersed in a separate environment from the one he physically occupies, allowing for a sense of "presence." The behavior of an individual in a VE may give the clinician and researcher an understanding of his behavior in a more naturalistic environment. The VE may also be manipulated for diagnostic or therapeutic purposes, making it a viable research tool in a wide variety of psychiatric contexts.

One of the earliest computerized VEs used in assessing cognitive states and performance was the flight simulator used to train pilots as early as the 1930s. Technological advances and media convergence trends in telecommunications have allowed for a wide variety of VEs to emerge in more recent years.

This presentation focuses on the computerized driving simulator as a means of assessing and treating disorders of impaired consciousness and cognition in a sleep disorder population. Psychiatric and public health implications of this research are discussed.

No. 93B
EMBRACING THE REAL WORLD: VIRTUALLY FMRI AND VIRTUAL REALITY

Konstantine K. Zakzanis, Ph.D., *Department of Life Sciences, University of Toronto, 1265 Military Trail, Toronto, ON M1C 1A4, Canada*

SUMMARY:

Neuropsychology has proceeded as a science by reducing complex behaviors to component cognitive domains. One example of these domains includes visual memory, which can be viewed as the ability to take material that was visually attended to and store it in the brain for a longer period of time.

Older paper-and-pencil tests, which attempt to measure this domain, include measures such as the Rey-Osterrieth Complex Figure and the Wechsler Memory Scale. These tests are administered in controlled environments, where they are often highly contrived and lack ecological validity (i.e., degree of relevance to the "real" world).

We have developed a virtual reality (VR) environment called "Sunnybrook City," a virtual town that provides a realistic, yet controlled testing environment. We present brain activations using an event-related *f*MRI design during immediate and long delay route recall and recognition for five healthy older adults. Our marriage of immersive VR and functional brain imaging may prove useful in the development of ecologically sound neuropsychological measures, while also providing a unique opportunity to relate the constituent cognitive behavior involved in the task to its specific neuroanatomic underpinning.

This should allow the clinician to infer quite accurate brain-behavior relations from performance on virtual reality-type tasks, such as "Sunnybrook City."

No. 93C
VIRTUAL REALITY NEUROPSYCHOLOGICAL ASSESSMENT AND REHABILITATION: PRESENT AND FUTURE

Albert A. Rizzo, Ph.D., *Department of Gerontology, University of Southern California, 3715 McClintock Avenue, MC0191, Los Angeles, CA 90089*

SUMMARY:

Virtual environment (VE) technology has undergone a transition in the past few years that has taken it out of the realm of expensive toy and into that of functional technology. Recently, in the field of neuropsychology, the considerable potential of VEs has been recognized for the scientific study, neuropsychological assessment, and cognitive rehabilitation of persons with acquired brain injury, neurological disorders, and learning and developmental disabilities. This technology offers the potential to develop sophisticated human testing and training environments that allow for the precise delivery and control of complex, dynamic 3D stimulus presentations in which human cognitive and functional performance can be assessed and rehabilitated. The use of virtual environments could serve to revolutionize the study of brain/behavior relationships as well as produce assessment and treatment options unavailable with traditional methods.

My presentation will provide a general introduction to neuropsychological assessment and cognitive rehabilitation and present a rationale for the use of VEs in these areas. I will present data on our applications using VEs with ADHD and for the assessment and training of visuospatial abilities. I will also present a headmounted display demo of some new work developing panoramic 360-degree video for anxiety disorders and anger management.

No. 93D
APPLICATION OF ADVANCED INFORMATION TECHNOLOGIES IN THE CREATION OF VIRTUAL HUMANS

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

Advances in information technology allow the characterization of psychiatric illnesses unlike ever before. These technologies allow the bringing together of psychiatry, animation, and biomechanics in unique ways that allow the understanding of the somatic impact of psychiatric disorders and their representation through the creation of photo-realistic, animated characters or avatars. In this presentation, two areas will be covered: how motion-capture technology can be

used to analyze somatic/gait alterations in those with depression; and, to create a virtual human or avatar with the same motion-capture data. From these data an increased understanding of the somatic and biomechanical alterations associated with depression will be covered, in particular, those that might lead to musculoskeletal injury including low-back pain. Also, the virtual human or avatar will allow the concealment of the original identity of the patient, assuring confidentiality, yet preserving and allowing the demonstration of the psychopathology. These techniques have the potential to revolutionize psychiatry by allowing that which has never been seen to be seen and that which is unquantifiable to be quantified utilizing objective, accurate, and reproducible data, unlike anything that has ever been done before.

The creation and use of virtual humans or avatars have the potential to become a unique frontier with mental health virtual reality applications.

No. 93E
VIRTUAL REALITY THERAPY: A COST-BENEFIT ANALYSIS

Mark D. Wiederhold, M.D., *10260 Campus Point Drive, San Diego, CA 92121*

SUMMARY:

Over the past decade the use of virtual reality and other forms of computer simulation for the diagnosis and treatment of a variety of mental health disorders has been seen. Several controlled clinical trials have demonstrated the effectiveness of virtual environments in the treatment of anxiety disorders and eating disorders. Many new applications in other areas of psychiatry are being tested and developed at the present time. Overall patient satisfaction and acceptance seem high, and the rate of negative effects, such as "cybersickness" are low, (estimated at less than 2%). Before wider acceptance of this technology is possible, an economic analysis is necessary. This analysis is unfortunately a moving target, since unlike the cost of most other medical devices and equipment, the cost of computer simulation tools including peripherals drops every year. Ten years ago, system prices close to $1 million were not uncommon. Today high-quality graphics can be delivered on desktop PCs and over the Internet. As costs decrease however, training, equipment maintenance, and other costs remain, which must be factored to present a realistic view of the economics of virtual reality therapy. This presentation will focus on the economic factors that will govern the successful growth and acceptance of virtual reality therapy.

REFERENCES:

1. Arnedt JT, Acebo C, Seifer, R, Carskadon MA: Assessment of a simulated driving task for sleep research. Sleep 2000; 24; Abstract Suppl. A413.
2. Burgess N, Maguire EA, Spiers HJ, O'Keefe J: A temporoparietal and prefrontal network for retrieving the spatial context of lifelike events. NeuroImage; 2001 (14): 439–453.
3. Rizzo AA, Buckwalter JG, Bowerly T, McGeeJ, van Rooyen A, et al: Virtual environments for assessing and rehabilitating cognitive/functional performance: a review of projects at the USC Integrated Media Systems Center. Presence: Teleoperators and Virtual Environments 2001; 10(4): 359–374.
4. Alessi N, Huang M: The evolution of virtual humans in psychiatry. Cyberpsychology and Behavior 2000; 321–325.
5. Wiedehold BK: Virtual reality in the 1990s: what did we learn? CyberPsychology and Behavior 2000; 3: 311–314.

TELECOMMUNICATION SESSION 1— APPLICATIONS OF ADVANCED INFORMATION TECHNOLOGIES

No. 1
THE USE OF DIGITAL STREAMING VIDEO FOR DISTANCE EDUCATION IN TELEPSYCHIATRY

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 Medical Center Drive, Ann Arbor, MI 48109-0390;* Gregory L. Barker

EDUCATIONAL OBJECTIVES:

At the completion of this symposium, an audience participant will understand and appreciate the components necessary for the creation of "webstreaming video" for distance education.

SUMMARY:

Advances in streaming digital video are making it possible to make digital video based, educational materials available via the Web. To bring such efforts to light in a format, which is not only accessible, but also of reasonable quality, takes a knowledge of a broad range of technologies, including video production, digital video, the Internet, videostreaming, and digital video storage. In addition, to make such information of value, it is important to consider the possibility of creating searchable, structured video. By this we mean video that is structured, so that a user can search using terms for segments of the video to be reviewed. This facilitates a "just in time" experience that facilitates the use of a video recruiting a Grand Rounds series. In our presentation we will cover the basics involved with digital video production for "webstreaming video" distribution. As well the basics involved in creating "structured searchable video" for Grand Rounds media will be reviewed.

REFERENCES:

1. Barker, G.L. and Alessi, N.E.: Webcasting Alessi, N.E. and Video Streaming Basics: Applications in Telepsychiatry. Telemedicine Journal and e-Health, 2001: 149.
2. Quinlan, P., Huang, M. and Alessi, N.: A Model for Developing Web Sites at Academic Medical Institutions. Cyberpsychology and Behavior,; 1(4):361–369, 1998.

No. 2
DAVID: DEPRESSION ANIMATION VIDEO IMAGE DATABASE

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 Medical Center Drive, Ann Arbor, MI 48109-0390;* Earl C. Lawrence, M.A., Mike Ward, B.A.

EDUCATIONAL OBJECTIVES:

At the completion of this presentation, a participant will understand how digital capture information can be used to create a digital, animated human.

SUMMARY:

Advances in Information Technology, especially digital capture technologies allow information, which is beyond our visual perceptive ability, to be utilized, both for quantitative and qualitative purposes. Quantitatively, it can be used to characterize alterations in velocity, acceleration, or the forces of individual joints. Qualitatively, it has been used to create animated figures that incorporate features of psychopathology, yet sparing a "patient" their confidentiality. As part of our Virtual Human Project, we are working on the development of motion capture technologies and their "use" both for the quantification of psychomotor alterations in depression and the creation of animated figures that allow the representation and display of psychopathology. Our first attempt of an animated figure is the creation of DAVID (Depression Animation Video Image Database), a digital phenomenologically based animated figure, based on three dimensional data, captured in our laboratory and used to create a depressed "animation" patient.

This presentation will allow a review of the technologies required for the creation of the this animated figure and the potential uses and utility of such animated figures both for education and clinical care.

REFERENCES:

1. Alessi, N. and Huang, M.: The Evolution of Virtual Humans in Psychiatry. Cyberpsychology and Behavior. (2000)
2. Alessi, N. and Huang, M.: Digital Motion Phenomenology of Depression. Proceedings: Medicine Meets Virtual Reality 2001, pp. 30–37, IOS Press, 2001.

No. 3
OPEN INFRASTRUCTURE FOR OUTCOMES: FROM PLUG AND PLAY WEB FORMS TO EVIDENCE-GUIDED TREATMENT

Andrew P. Ho, M.D., *Department of Psychiatry, Harbor-UCLA, 1000 West Carson Street, Box 498, Torrance, CA 90509*

EDUCATIONAL OBJECTIVES:

Recognize the merits and limitations of open vs. closed information systems; describe the components of an information infrastructure that supports web-based data collection and analysis.

SUMMARY:

Objective: The collection and management of clinical outcome data require user-friendly and flexible information systems. Quantitative evidence of treatment effectiveness from ordinary clinical services will more likely be known when the cost of data collection, management, and analysis is lowered. *Method:* Since 1998, we have been developing the Open Infrastructure for Outcomes (OIO) software to support low cost, web-based data collection and analysis. The OIO system has been in use at Harbor-UCLA since March 2000 to track over 2000 dually diagnosed patients. The software was released in August 2000 under the Gnu General Public License and is available as a free download from *www.TxOutcome.Org*. The user community is supported through online documentation library and mailing lists. *Results:* The OIO system allows thru-the-browser creation of web-forms that are plug-and-play via XML. Forms can be uploaded to an online forms library for sharing and re-use. An integrated data analysis module allows rapid generation of contingency table, drill-down query, and statistical calculations via statistical routines from the R statistics environment. *Conclusion:* A low-cost, user friendly, and flexible information infrastructure is essential for evidence-guided treatment. The development and dissemination of the OIO system is a step towards the realization of that goal.

REFERENCES:

1. Ho AP, Tsuang JW, Liberman RP, Wang R, Wilkins JN, Eckman TA, Shaner AL: Achieving Effective Treatment of Patients with Chronic Psychotic Illness and Comorbid Substance Dependence, American Journal of Psychiatry 1999; 156:1765–1770.
2. Zielstorff RD: Capturing and Using Clinical Outcome Data: Implications for Information System Design. JAMIA 1995; (3):191–196.

TELECOMMUNICATIONS SESSION 2—EVIDENCE-BASED MEDICINE AND TELEPSYCHIATRY

No. 4
INTRODUCTION TO EVIDENCE-BASED MENTAL HEALTH

Gregory E. Gray, M.D., *Department of Psychiatry, Charles R Drew University, 1720 East 120th Street, AFH 1021, Los Angeles, CA 90059*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: formulate answerable clinical questions; describe the best sources for obtaining answers; critically appraise reports of clinical trials, systematic reviews, and practice guidelines for validity, importance, and clinical applicability; and apply the results to individual patients.

SUMMARY:

Evidence-based medicine has been defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." This course provides an introduction to evidence-based medicine for psychiatrists and other mental health professionals. The course covers both the philosophy and methods of evidence-based medicine, including criticisms of the approach. Participants will learn how to ask answerable clinical questions and where to find the best evidence to answer these questions. Participants will learn about the hierarchy of evidence and the most appropriate type of study to answer particular types of questions. They will also learn about lesser-known pre-filtered sources of information, including the *Cochrane Library, DARE, Clinical Evidence, and Evidence-Based Mental Health.* They will also learn about search filters to more efficiently search MEDLINE for particular types of studies. Considerable emphasis will be placed on learning how to critically appraise various types of papers, including reports of clinical trials, systematic reviews, and practice guidelines. In appraising papers, they will learn a systematic method that focuses on validity, importance, and clinical applicability. They will also learn how to electronically store their search and evaluation results for future retrieval. Lastly, there will be a resident's perspective on learning and practicing evidence-based psychiatry.

REFERENCES:

1. Collins R, MacMahon S. Reliable Assessment of the Effects of Treatment on Mortality and Major Morbidity, I: clinical trials. *Lancet* 2001; 357:373–380.
2. Dawes M, Davies P, Gray A, Mant J, Seers K, Snowball R. *Evidence-Based Practice: A Primer for Health Care Professionals.* New York: Churchill Livingstone, 1999.

No. 5
INDIVIDUAL AND GROUP PSYCHOTHERAPY VIA TELEPSYCHIATRY

Brian J. Grady, M.D., *Department of Behavioral Health, National Naval Medical Center, 8901 Wisconsin Avenue, Bethesda, MD 20889-5600*

EDUCATIONAL OBJECTIVES:

Recognize issues of self image experienced by some patients treated via telepsychiatry, recognize transference/counter transference issues experienced via telepsychiatry.

SUMMARY:

Interactive video for individual and group psychotherapy was first studied in the early 1960's, with scattered reports of its use over the past four decades. The author has conducted individual dynamic, supportive and cognitive behavioral psychotherapies beginning in 1998 and group psychotherapy since 2000 via video teleconferencing at various communications bandwidths (128 to 384 kilobits per second) both within the US and overseas. Issues of setting, transference and counter transference will be discussed including several issues unique to the video teleconferencing setting such as self-image and the "safety" of therapy at a distance and will include both patient and provider experiences. Telepsychiatry has been found to be safe and effective for delivery of individual and group psychotherapy of selected patients by this author. Research into the use and nuances of psychotherapy via video teleconferencing is ongoing and needed.

REFERENCES:

1. Wittson, CL, Benschoter R: Two-Way Television: Helping the Medical Center Reach Out. Amer J. Psychiat 1972; 129(5):136–9.
2. Baer L, Elford D.R., Cukor P: Telepsychiatry at Forty: What Have we Learned? Harv Rev Psychiatry 1997 May; 5(1) 7–17.

Component Workshop 1
HOW TO CONVINCE CORPORATE CEOS THAT MENTAL HEALTH IS A GOOD INVESTMENT
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,* Lloyd I. Sederer, M.D., *Division of Clinical Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*
Participants: Leonard T. Sperry, M.D., Paul W. Heck

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to demonstrate by the use of a traditional business case approach that providing quality, accessible mental health treatment, including substance abuse care, to employees delivers a medical good, a social good, and an economic good.

SUMMARY:

Mental disorders, including substance abuse, are highly prevalent in the workplace. Many employees report that workplace performance suffers from mental health problems and that few employees seek treatment. Mental and substance use disorders impact workplace performance by reducing productivity, creating or sustaining disability, and generating absenteeism and turnover. They also increase corporate medical costs and other workforce expenses. The terrible irony is that psychiatric treatment is effective and could be made available.

This workshop will review the human stories and business and clinical data that provide a compelling business case for quality mental health care. Participants will be presented a model corporate message that could be delivered to business decision-makers and to people who suffer with mental illness and their families. Participant feedback will aid in testing and strengthening the message.

REFERENCES:

1. Rosenheck RA, Druss BG, Stolan M, et al: Effect of declining mental health service use on employees in a large corporation. Health Affairs 1999; 18:193–203.
2. Mental Health: A Report of the Surgeon General. Washington, DC, Department of Health and Human Services, December 1999. (www.surgeongeneral.gov)

Component Workshop 2
JUSTICE AND HEALTH EQUITY IN GLOBAL PSYCHIATRY
APA Commission on Global Psychiatry

Chairperson: Arthur M. Kleinman, M.D., *Harvard University, 330 William James Hall, 33 Kirkland St, Cambridge, MA 02138-2044*
Participants: Benedetto Saraceno, M.D., Steven E. Hyman, M.D., Ahmed M.F. Okasha, M.D., Carl C. Bell, M.D., Vikram Patel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the end of the session, the participants should be able to demonstrate knowledge of health disparities in the global mental health field, including both burden of disease and availability of health services. The participant also should be able to identify the core ethical issues of justice and equity and identify key policy issues for global psychiatry and for APA in particular.

SUMMARY:

Sponsored by APA's Commission of Global Psychiatry, this workshop will address the practical, policy, research, and ethical issues embedded in the growing disparity between mental health problems and resources globally. Mental health problems are most prevalent among the poor who in turn have the least amount of resources with which to address these problems. Moreover, the gap between rich and poor continues to widen. The majority of the world's mental health resources are accessible to only 20% of the world's population. Ethical considerations demand that the global psychiatric network address these inequities.

The proposed workshop will address questions of ethics and policy via a panel of leading psychiatrists from the U.S., the World Health Organization, and the World Psychiatric Association. Presentations will focus on the disparity between the burden of disease and health resources, the development of global mental health policy, and critical ethical issues for psychiatry such as psychopharmacological research and testing conducted on developing world populations that cannot afford or have access to effective treatments. Attention will be devoted to poor societies, the poorest strata of wealthy societies, and the unique position of APA to foster change.

REFERENCES:

1. World Health Report, 2001. Geneva, Switzerland, World Health Organization.
2. Neurological, Psychiatric, and Developmental Disorders in the Developing World. Washington, DC, Institute of Medicine, National Academy of Sciences, 2001.

Component Workshop 3
THE AMERICAN PSYCHIATRIC ASSOCIATION AND ITS ALLIANCE GO TO AMERICA'S SCHOOLS
APA Alliance

Chairperson: Alicia A. Munoz, B.S.C., *APA Alliance, 3130 Fifth Avenue, San Diego, CA 92103*
Participants: Carol Skiljan, Jorge A. Zapatel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the impact of the essay project as a tool to address mental health heeds and learn the value of the Yellow Ribbon Program as a resource for youth suicide prevention.

SUMMARY:

This workshop discusses the next steps to follow in enhancing our already successful drive to improve mental health in high schools. The essay project, "When Not to Keep a Secret," originated by the Colorado Psychiatric Society and taken to the rest of the country by the APA Alliance as a annual project, is sponsored by the American Psychiatric Foundation. The project is in its fourth year and has become a national success. Educators in many states recognize the essay project as a primary strategy for youth violence prevention.

Many of the early essays were focused on depression and suicide. As a result, a mutual collaboration with the Yellow Ribbon Youth Suicide Prevention Program, an outreach of the Light for Life Foundation, has become an important component of the essay project. The Yellow Ribbon Card is an effective resource to prevent teen suicide. This year, as more students have felt freer to express themselves, issues of loneliness, self image, sexual life, social interaction, antagonism within the schools, bullying, and many others have come to life. This workshop will present strategies to sharpen the efforts of APA and APA Alliance members to address mental health concerns on campus.

REFERENCES:

1. Psychiatric News, Vol. 36, #13, p. 21.
2. Psychiatric News, Vol. 36, #8, p. 1.

Component Workshop 4
WHEN YOUR PHYSICIAN PATIENT IS FROM AN ETHNIC MINORITY: A CROSS-CULTURAL APPROACH TO TREATMENT
APA Committee on Physician Health, Illness, and Impairment

Co-Chairpersons: Carmen T. Webb, M.D., *4409 Sorrel Court, Flowermound, TX 75028,* Patti Tighe, M.D., *2800 North Lake Shore Drive, Chicago, IL 60657*
Participants: William B. Lawson, M.D., Raymond M. Reyes, M.D., Hagit Bat-Avi, M.D., Jimmie C. Holland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to describe treatment issues (sociocultural, psychological, and psychopharmacological) to consider when working with physician patients from African-American, Asian, Hispanic, and other ethnic minority groups; describe three strategies toward more effective outcomes with ethnic minority physicians.

SUMMARY:

Psychiatrists caring for physicians must be alert to the difficult and frequently hidden concerns prevalent in this subpopulation. Physicians struggle with denial of the illness, difficulty accepting the patient role, loss of control, and an inability to deal with emotional issues. When one is working with those from ethnic-minority groups, the issues become even more complex. These physicians may experience internal pressures of traditional cultural views toward mental illness, bicultural identity, need to prove themselves professionally, survival guilt, and language barriers. Also common are external pressures from professional isolation, racism, stereotypes, and the push to serve only certain communities. Further, the psychiatrist must consider differing responses to medication across ethnic groups. Effective treatment must not only candidly address these issues, but do so in the context of cultural similarities or differences between psychiatrist and patient.

This workshop is designed to highlight cultural issues that may arise when treating physicians who are members of minority groups. Psychiatrists working with those in the African-American, Asian, and Hispanic communities will discuss these factors and will offer practical considerations for appropriate psychotherapeutic and psychopharmacologic approaches.

REFERENCES:

1. Goldman LS, Myers MF, Dickstein LJ, eds: The Handbook of Physician Health: The Essential Guide to Understanding the Health Care Needs of Physicians. Chicago, American Medical Association, 2000.
2. Post DM, Weddington WH: Stress and coping of the African-American physician. J Natl Med Assoc. 2000; 92:70–5.

Component Workshop 5
THE PSYCHIATRIST AND MIGRATION IN THE 21ST CENTURY
APA Rhode Island Psychiatric Society

Co-Chairpersons: Shahbaz A. Khan, M.D., *Dept. of Child and Family Psychiatry, Brown University Rhode Island Hospital, 593 Eddy Street, Potter Basement, Providence, RI 02903,* Thomas O. Osinowo, M.D., *700 Kenyon Drive, Springfield, IL 62704-2102*
Participants: Alison M. Heru, M.D., Kazi M. Salahuddin, M.D., Madelyn H. Hicks, M.D., Deji Ayonrinde, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to gain an increased awareness of the challenges and opportunities facing psychiatrists who move from one geographical location to another; discuss these issues as they relate to the U.S. and the U.K.

SUMMARY:

The "medical carousel" in which some physicians move to a different country appears to be a universal phenomenon. In the United States, 40% of psychiatry residents are estimated to be international medical graduates (IMG). In the United Kingdom, 29% of senior house officers and 27% of specialist registrars are from overseas. IMGs and overseas physicians represent a diverse population in terms of language, race, and culture. The challenges they face during migration range from loss of friends, family, economic burden, immigration, and examination requirements and adjustment to a different culture. Both public-sector psychiatry and rural areas have experienced the positive impact of IMG and overseas physicians. However, IMG and overseas physicians may feel less welcome in academic arenas. They may perceive less mentorship and can have less involvement in local and national professional organizations. This workshop will provide case scenarios to help address the challenges faced by IMG and overseas physicians. In addition, opportunities available to them in academic arenas and professional organizations will be discussed. This workshop will provide a forum for exchange of ideas among attendees and U.S. and U.K. psychiatrists with expertise in the area.

REFERENCES:

1. Mullan F, et al: Medical migration and the physician workforce: international medical graduates and American medicine. JAMA 1995; 273: 1521–27.
2. Welsh, Christopher (editorial): Training overseas doctors in the United Kingdom: they must be given accurate information about their job prospects. BMJ 2000; 321: 253–254.

Component Workshop 6
RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE
APA 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.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize diagnostic categories that reflect the highest risk for suit; be familiar with risk management issues presented by organized systems of care, supervisory relationships, cybermedicine, the HIPAA privacy regulations, and other risk areas in the practice of psychiatry.

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 will present data from the APA-endorsed Professional Liability Insurance Program, identifying common sources of malpractice actions against psychiatrists. The nature of malpractice lawsuits will be described, and data will be presented on the cause and outcome of such lawsuits. Special emphasis will be placed on malpractice as it relates to the process of supervision and working

with nonpsychiatrist providers, the changes managed care brings to psychiatric practice, the impact of the HIPAA privacy regulations on psychiatrists, and the risks associated with new forms of telecommunication and cybermedicine. Information will be 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 will be discussed.

REFERENCES:

1. Meyer DJ, Simon RI: Split treatment: clarity between psychiatrists and psychotherapists. Psychiatric Annals (Part I - May, 1999 & Part II - June 1999).
2. Gostin LO: National health information privacy: regulations under the Health Insurance Portability and Accountability Act, JAMA 2001; 285: 3015–3021.

Component Workshop 7
THE PHILADELPHIA STORY: A VA UNIVERSITY OF ADDICTION RESEARCH COLLABORATION
APA Consortium on Organized Service Systems

Chairperson: Laurent S. Lehmann, M.D., *Department of Veterans Affairs, (111C) VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420-0002*
Participants: George E. Woody, M.D., Charles P. O'Brien, M.D., Laura F. McNicholas, M.D., A. Thomas McLellan, Ph.D.

EDUCATIONAL OBJECTIVE:

To understand the importance of addressing comorbidity in addiction treatment.

SUMMARY:

Early data from the Philadelphia VA/Penn Addiction Research Center showing the complex relationship between psychiatric symptoms and substances of abuse will be described, as will data showing the negative influence of untreated psychiatric and medical disorders on the outcome of addiction treatment. Studies that have shown benefits of antidepressant pharmacotherapy and psychotherapy for substance abuse patients with psychiatric disorders will be presented, as will studies that have shown little or no effect. The role of additional psychiatric treatments for persons with substance use disorders will be reviewed, as will benefits that have been shown from studies providing on-site medical treatments in substance abuse programs. Discrepancies between data on how to best address comorbidities, and current funding pressures will be reviewed. Suggestions on what clinicians might do to better align reimbursement models with patients' needs will be discussed.

REFERENCE:

1. Brady KT, Halligan MD, Malcom MD: Dual diagnosis, In: Textbook of Substance Abuse Treatment: 2nd Edition, Washington, DC American Psychiatric Press Inc, 1999, pp. 475–483.

Component Workshop 8
SUBSTANCE ABUSE IN SPECIAL POPULATIONS
APA Council on Addiction Psychiatry

Chairperson: Ramon Solhkhah, M.D., *Department of Psychiatry, New York University Medical Center, 550 First Avenue, NB20N29, New York, NY 10016*
Participants: Richard T. Suchinsky, M.D., Seeth Vivek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of identifying and treating substance abuse and dependence in specialty populations. These specialty populations include adolescents, the severe and persistently mentally ill ("dually diagnosed"), and those people exposed to trauma and disasters.

SUMMARY:

Despite recent studies that show that drug and alcohol use have remained essentially stable, substance abuse in special populations remains a concern. In particular, adolescents and the chronic and persistently mentally ill ("dually diagnosed") show different substance abuse patterns than the general population, and they often have different treatment needs. Moreover, those patients that have experienced trauma and/or disasters often use alcohol and other drugs to self medicate. It is hard to claim victory in "the war on drugs" without addressing the needs of these special populations. In this workshop, the speakers will present information on the unique features of substance use disorders (SUD) in these populations. Dr. Ramon Solhkhan will discuss screening, identification, and treatment of SUD in adolescents; Dr. Richard Suchinsky will discuss the treatment needs of the dually diagnosed; and Dr. Vivek Seeth will discuss the role of substance abuse in patients who have been exposed to trauma and/or disasters, particularly those who go on to develop posttraumatic stress disorder (PTSD). Participants will be encouraged to discuss their own clinical experiences in working with these populations and to share ideas for developing treatment strategies. The discussion will highlight how the participants can incorporate this information into their own clinical practice.

REFERENCES:

1. Weinberg NZ, Rahdert E, Colliver JD, Glantz MD: Adolescent substance abuse: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry 1998; 37: 252–261.
2. Jacobsen LK, Southwick SM, Kosten TR: Substance use disorders in patients with posttraumatic stress disorder: a review of the literature. American Journal of Psychiatry 2001; 158: 1184–1190.

Component Workshop 9
AGING AND MOURNING IN THE GAY AND LESBIAN COMMUNITY
APA New York County District Branch's Committee on Gay and Lesbian Issues

Co-Chairpersons: Benjamin H. McCommon, Jr., M.D., *467 Central Park W #10B, New York, NY 10025-3886,* Jordan F. Karp, M.D., *Department of Psychiatry, Columbia University-NYSPI, 1051 Riverside Drive, Box 94, New York, NY 10032*
Participants: Alan Schwartz, M.D., Robert M. Kertzner, M.D., Duane D. Shubert, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify issues that may complicate the process of mourning in the gay and lesbian community, and identify patterns that are common in middle-aged and older midlife gay men and lesbian women.

SUMMARY:

Despite the recent progress in describing successful aging of heterosexual men, there is still paucity of data on the developmental issues facing middle-aged and older midlife gay men and lesbian women. It has been suggested that gay men experience significant variation from the dominant model of adult developmental stages. This workshop will help identify the different pathways that gay men and lesbian women must travel in later adulthood.

The literature will be briefly reviewed and critiqued. Preliminary results will be presented from a qualitative and quantitative study of middle-aged and older gay men. Audience members will be encouraged to compare these observations with their experiences treat-

ing middle-aged gay men and lesbian women. Perspectives of a geriatric psychiatrist will be included. Finally, issues of mourning will be discussed using a clinical case. The panel will suggest some of the unique challenges facing lesbian women and gay men in the process of bereavement.

REFERENCES:

1. Vaillant GE, Mukamal K: Successful aging. Am J Psychiatry 2001; 158:839–847.
2. Peacock JR: Gay male adult development: some stage issues of an older cohort. J Homosexuality 2000; 40:13–29.

Component Workshop 10
PSYCHIATRY IN THE NEUROSCIENCE CURRICULUM: PROMISE AND PERIL
APA Committee on Medical Student Education

Chairperson: Carl B. Greiner, M.D., *UNMC Department of Psychiatry, 600 South 42nd Street, P.O. Box 985575, Omaha, NE 68198-5575*
Participants: Jonathan Polan, M.D., Linda F. Pessar, M.D., Surender P. Punia, M.D., Michael J. Vergare, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify both "best practices" and errors in integrated curriculum design.

SUMMARY:

Developing an integrated curriculum has been a major issue in health science education. "Best practices" included significant preparatory work by faculty and students. Faculty attended lectures by other presenters and participated in team teaching. Student test scores were monitored for learning success.

Psychiatry is increasingly being taught as part of a neuroscience curriculum. The integrated teaching of brain and mind with improved clinical correlations is promising. However, the perils include poorly considered curricular formulations, such as combining psychiatry and orthopedics teaching.

Dr. Polan will review the neuroscience curriculum at Cornell Medical School, which has effectively included psychiatry. Dr. Pessar will discuss the challenges of designing a new neuroscience curriculum. Dr. Punia will present learning concerns from a resident's perspective. Dr. Greiner will provide a critique of "wrong directions" taken in curriculum development and "warning signs" for educators. Dr. Vergare will host the discussion. Although a prime audience will be current educators, medical students and residents would find this a helpful way to conceptualize their learning experiences. Significant time for group discussion will be available.

REFERENCES:

1. Polan JH: Acquired immunodeficiency syndrome: a biopsychosocial paradigm of illness, in Behavioral Science for Medical Students, edited by Sierles FS, Baltimore, Williams and Wilkins, 1993.
2. Lewin LO: Performance of third-year primary-care-track students in an integrated curriculum at Case Western University. Acad Med 1999; 74(1 Suppl):S82–89.

Component Workshop 11
THE ROLE OF THE GERIATRIC PSYCHIATRIST IN PALLIATIVE CARE
APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly

Chairperson: Judith H. W. Crossett, M.D., *Department of Psych, University of Iowa Hospital and Clinic, 200 Hawkins Drive, Iowa City, IA 52242*
Participants: Julian Offsay, M.D., Colleen J. Northcott, M.D., Jaime M. Benitez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the relationship of palliative and psychiatric care and be better prepared to treat these patients.

SUMMARY:

The importance of pain and its management are increasingly recognized. Psychiatrists are asked to inquire about pain and include it in treatment plans, but have little training to do so. Palliative care addresses the psychological, social, and spiritual values of the patient to provide active total care when disease is not responsive to curative treatment. These are traditional psychiatric concerns, but when the patient is elderly, additional barriers to such care may exist. As psychiatrists, we need to learn more about the evaluation and treatment of pain and offer our special skills to those involved. In this workshop we will discuss the concept of palliative care as it applies to geriatric patients. The barriers to use of palliative care and evaluation of pain in the geriatric psychiatry patient will be explored. Psychotherapeutic management of pain and the boundaries between palliative care and the care of the patient with somatoform disorders will be discussed. A psychiatric viewpoint on pharmacological management of patients with pain will be presented. Throughout, we invite participants to look at ways our skills in confronting our own and others' fears in encountering pain and death can help us and our patients, students, and colleagues.

REFERENCES:

1. Ferrel BA: Pain evaluation and management in the nursing home. Ann Int Med 1995; 123:681–7.
2. Bloch S, Kissane D: Psychotherapies in psycho-oncology: an exciting new challenge. British Journal of Psychiatry 2000; 177:112–6.

Component Workshop 12
NAVIGATING GERIATRIC PSYCHIATRY RESEARCH: ISSUES FOR THE BEGINNING RESEARCHER
APA Committee on Ethnic Minority Elderly and APA Council on Aging

Chairperson: Josepha A. Cheong, M.D., *Department of Psychiatry, University of Florida Health Science Center, PO Box 100256, Gainesville, FL 32610-0256*
Participants: Arturo G. Quiason, M.D., Warachal E. Faison, M.D., Michael J. Pratts, M.D., Jacobo E. Mintzer, M.D.

EDUCATIONAL OBJECTIVES:

Following this presentation, the participant will be able to demonstrate knowledge of the opportunities available in geriatric psychiatry research training and understand the need for increased participation in research to improve the care for all geriatric patients, especially the ethnic minority elderly.

SUMMARY:

As the U.S. population continues to age, the issues of geriatric mental health are becoming more and more an issue to be addressed

in clinical care as well as in research. Within the U.S. geriatric population, an increasing percentage is non-Caucasian. This demographic presents its own unique needs and issues. Despite the gradually increasing numbers of graduates entering postgraduate training in psychiatry, only a small percentage enter geriatric psychiatry as a specialty. Within this group, an even smaller number enter research careers in geriatric psychiatry. Although the concern over the "research pipeline" pervades all of academic medicine, it is of particular concern in the area of geriatric psychiatry given the increasing need for such activity. This workshop is targeted to the early career and mid-career psychiatrist interested in entering the field of geriatric psychiatry. An emphasis will be placed on three issues: the perspective of a trainee, different kinds of research being conducted, and specific opportunities for entering research careers through established programs. The focus of the program will be the recruitment of researchers into the field of geriatric psychiatry toward the goal of improving care for all geriatric psychiatry patients, including the ethnic-minority elderly.

REFERENCES:

1. Halpain MC, Harris J, McClure FS, Jeste DV: Training in geriatric mental health: needs and strategies. Psychiatr Serv 1999; 50:1205–8.
2. Halpain MC, Jeste DV, Katz IR, Lebowitz BD: The first summer research institute in geriatric psychiatry. Am J Geriatr Psychiatry 1997; 5:238–46.

Component Workshop 13
EXPERTS OR PAWNS? PSYCHIATRIC CONSULTATION FOR GOVERNMENT AGENCIES
APA Committee on Misuse and Abuse of Psychiatry and Psychiatrists

Chairperson: Robert P. Cabaj, M.D., *Mental Health Services, Community Mental Health Services, 1380 Howard Street, 5th Floor, San Francisco, CA 94103*
Participants: Jerry M. Wiener, M.D., Jose E. de La Gandara, M.D., Abraham L. Halpern, M.D., Juan E. Mezzich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the potential benefits and problems inherent in psychiatric consultation to government agencies, including the risk of abuse or misuse of psychiatry, and the attention needed in regards to ethical issues and human rights concerns.

SUMMARY:

Psychiatrists have played an active role in consultation with all types of government agencies—ranging from federal, state, and local entities, to the international level. There are many exciting benefits to such consultation—a sense of accomplishment, serving a greater cause, recognition, financial, and so on—but there are also potential risks. Government agencies may have specific agendas that could compromise objective psychiatric consultation, and the psychiatrist may not be aware of the specific purpose the governmental agency has in mind. Some legally sanctioned situations may be morally illegitimate, and psychiatrists involved in consultation around such situations may face human rights concerns and potential abuse or misuse of psychiatry. Action taken by the consultant may also involve situations that raise ethical concerns. This workshop will focus on two specific situations: 1) the psychiatrist's role with the Immigration and Naturalization Service and the placement of a child with family versus relatives; 2) the role of psychiatrists and psychiatric hospitals in government attempts to intervene with religious-based groups (Falun Gong in mainland China).

REFERENCES:

1. Costa E. Silva JA: World aspects of psychiatry. In Comprehensive Textbook of Psychiatry, Seventh Edition, edited by Sadock BJ Sadock VA, Philadelphia, Lippincott Williams & Wilkins, 2000, pp. 3333–3342.
2. Dyer AR: Ethics and psychiatry. In Textbook of Psychiatry, Third Edition, edited by Hales RE, Yudofsky SC, Talbott JA. Washington, DC, America Psychiatric Press, Inc., 1999, pp. 1599–1615.

Component Workshop 14
LEGAL AND PSYCHIATRIC CONTROVERSIES IN INTERFERON TREATMENT OF HEPATITIS-C
APA New York County District Branch's AIDS Committee

Co-Chairpersons: Kristina L. Jones, M.D., *Department of Psychiatry, St. Vincents Hospital, 153 West 11th Street, New York, NY 10011,* Scott Burris, J.D., *Temple Law School, 1819 Broad Street, Philadelphia, PA 19122*
Participants: Silvia Hafliger, M.D., John A.R. Grimaldi, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and treat Interferon-induced depression using evidence-based pharmacologic interventions; understand legal issues in prescribing antidepressants during interferon treatment, despite "black box" PDR warnings; and to understand clinical aspects of hepatitis-C.

SUMMARY:

This session is for psychiatrists interested in consultation-liaison issues surrounding Interferon treatment for hepatitis-C. Audience members will hear four 10-minute presentations, followed by 50 minutes of discussion.

Psychiatrists are being asked to give "psychiatric clearance" for patients with hepatitis-C who will be treated with Interferon. Interferon is known to cause severe depression, resulting in suicide attributed to Interferon treatment in a very small number of patients. The drug manufacturer strongly cautions against giving Interferon to patients with a history of depression. Since many hepatitis-C patients are also HIV-positive, and many have a history of IV drug abuse, psychiatric recommendations are complex.

A liver-transplant psychiatrist will discuss clinical presentations of hepatitis-C and Interferon-induced depression. An attorney will discuss medico-legal issues, including "black box" warnings on Interferon. Two psychiatrists who are HIV experts will discuss clinical presentation of hepatitis-C and strategies for safe antidepressant treatment.

REFERENCES:

1. Musselman D, et al: Paroxetine for the prevention of depression-induced by high-dose interferon alfa. New England Journal of Medicine 2001; 1344:961–966.
2. Hauser P, et al: A prospective study of the incidence and treatment of interferon-induced major depressive episodes in patients with hepatitis-C.

Component Workshop 15
THE GOOD-ENOUGH MENTOR: PERSPECTIVES ON MENTORING IN PSYCHIATRIC TRAINING
APA/Glaxo Wellcome Fellows

Chairperson: Paul E. Holtzheimer III, M.D., *3809 North Whitman Avenue, #32, Seattle, WA 98103*
Participants: Laurel L. Williams, D.O., Seema Malhotra, M.D., Lyle B. Forehand, Jr., M.D., John B. Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: describe the history and current definitions of mentoring as it

relates to psychiatric training, describe several key qualities of successful mentoring relationships, recognize practical ways to initiate or improve mentoring in psychiatric training.

SUMMARY:

Mentoring is an important aspect of psychiatric training. This workshop will explore the concept of mentoring from a number of different perspectives in an effort to clarify what constitutes a successful mentoring relationship and how psychiatry residents and their teachers might foster better mentoring. Through a literature review, the historical and current understandings of mentoring will be explored; an effort will be made to distinguish mentoring from other types of teaching and supervision. The results of separate focus groups of psychiatry residents and faculty will provide insight into some current practices of mentoring in psychiatric training programs. A discussion of the results of interviews with several prominent psychiatrists will further explore the role of mentoring in the development of a successful psychiatric career. During the workshop, significant time will be allotted for audience discussion of these various perspectives in an effort to describe key qualities of good mentoring and practical ways for participants to initiate or improve their own mentoring relationships. While the primary focus of the workshop will be how to improve mentoring for psychiatry residents, it will also begin the process of teaching residents how to become good mentors for others.

REFERENCES:

1. Dunnington GL: The art of mentoring. Am J Surg 1996; 171:604–607.
2. Mark S, Link H, Morahan PS, et al: Innovative mentoring programs to promote gender equity in academic medicine. Acad Med 2001; 76:39–42.

Component Workshop 16
TALKING ON YOUR FEET: SURVIVAL TIPS AND TECHNIQUES FOR MEDIA INTERVIEWS
APA Joint Commission on Public Affairs

Co-Chairpersons: Michael Blumenfield, M.D., *Department of Psychiatry, New York Medical College, 16 Donellan Road, Scarsdale, NY 20853,* Sandra C. Walker, M.D., *1120 Cherry Street, Suite 240, Seattle, WA 98104*
Participants: William E. Callahan, Jr., M.D., James M. Maier, M.D., John B. Blamphin

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate a media opportunity, prepare a communications objective and speaking points, and participate effectively in a television or other media interview.

SUMMARY:

News media—newspapers, magazines, radio, television, and the new Internet media—offer psychiatry an unprecedented opportunity to reach millions of people daily with positive messages about the reality of mental illness and the effectiveness of psychiatric diagnosis and treatment. The APA Divisions of Communications and Marketing reports a significant increase in requests from media for formal and informal interview with psychiatric experts on a variety of subjects. District branches report a similar increase in interview requests. In this session, participants will gain experience in evaluating media opportunities, identifying their communications objective, and developing effective speaking points or "soundbites." Using workshop participant volunteers, professional media trainers will demonstrate the following appropriate interview techniques: how to deliver a brief 10-second soundbite, handle hostile questions, dress appropriately for the situation, and how to do effective radio and television interviews. Interview topics will focus on these key APA issues: scope of practice, stigma, advocacy, privacy, and the insanity defense.

REFERENCES:

1. Blamphin J: How to handle the news media, Psychiatric Research Report, 1996; 12:3.
2. Meeting with the media and staying out of trouble, San Francisco Medicine, 1999 (reprint); in Spokesperson Training Program Manual, AMA.

Component Workshop 17
PSYCHIATRY WITHOUT BORDERS: BREAKING THE BARRIERS
APA Committee on International Medical Graduates

Co-Chairpersons: Gopalakrishna K. Upadhya, M.D., *Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456,* Godehard Oepen, M.D., *Department of Psychiatry, University of Alabama, 223 Trace Ridge Road, Birmingham, AL 35244-3926*
Participants: Bruce Singh, M.D., Deborah Spitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: identify issues for career development and research in the international practice of psychiatry; develop strategies to address issues in the treatment of patients with diverse cultural backgrounds; minimize bureaucratic impediments to cross-national practice.

SUMMARY:

The 21st century will see massive migration of patients and increased movement of doctors from country to country. The psychiatrist who moves from one nation or culture to another confronts differences in diagnostic approaches, clinical practice, patient expectations, and professional styles. Even countries with a dearth of psychiatrists may set up complex impediments to practice for immigrant doctors. Yet the international practice of psychiatry offers thought-provoking, cross-cultural experiences that enrich our understanding of mental health, mental illness, and character. Bruce Singh, M.D., a Fiji-born Indian, trained in Australia and practices across the Pacific Rim with people in aboriginal and Western cultures. Deborah Spitz, M.D., a U.S.-trained psychiatric educator, recently moved to the United Kingdom and now works for the National Health service there. The panel will share their cross-cultural experiences and invite participation from attendees. Discussion will focus on the implications for psychiatric understanding of disorders, the use of ICD and DSM systems, the meaning of cultural competence, and the management of bureaucratic and emotional impediments that arise in the international practice of psychiatry.

REFERENCES:

1. Bhugra D, Jones P: Migration and mental illness. Advances in Psychiatric Treatment 2001; 7:216–223.
2. Kleinman A: Anthropology and psychiatry—the role of culture in cross-cultural research on illness. British Journal of Psychiatry 1987; 151:447–454.

Component Workshop 18
PSYCHIATRIC CASUALTIES IN THE MENTAL HEALTH OF HISPANIC IMMIGRANTS
APA Committee of Hispanic Psychiatrists

Co-Chairpersons: Ana E. Campo, M.D., *4330 Surrey Drive, Coconut Grove, FL 33133,* Eugenio M. Rothe, M.D., *275 Glenridge Road, Key Biscayne, FL 33149-1311*
Participants: Rodrigo A. Munoz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn both risk factors and protective factors that play a role in

either causing or ameliorating the incidence of psychiatric illnesses associated with the immigration process; to describe postraumatic symptomatology and other psychiatric comorbidity that arises as a direct sequelae of the immigration process in three different groups of Hispanic immigrants.

SUMMARY:

Hispanics now constitute the largest minority in the United States. One out of two Hispanics living in the United States was born in Latin America. The process of migration carries with it a series of stressors that impact the mental health of the immigrant and his or her family. However, there are also protective factors that play a role in the mental health maintenance of the immigrant.

Often, immigrants from Latin America leave their country of origin not only because of financial reasons but because they are fleeing situations of political turmoil, war, kidnappings, or political persecution. Many of these immigrants suffer from posttraumatic stress disorder, which is often undiagnosed and untreated. The stress of the migration superimposed on PTSD puts the Hispanic immigrant at a higher risk of developing psychiatric psychopathology as well as alcohol and substance abuse problems. The clinicians treating these populations should not only become familiar with the literature on PTSD in Hispanic immigrants so that they can accurately diagnose and effectively treat these patients, but they should also be sensitive to the individual's personal history of migration and the legalization process. The audience will also learn which barriers of access to care affect these populations, so that clinicians treating these patients can adequately give them the care they need and refer them to the appropriate agencies and mental health facilities.

REFERENCES:

1. Pumariega A, Swanson JW, Holzer CE, et al: Cultural context and substance abuse in Hispanic adolescents. J Child and Family Studies 1992; 1:75–92.
2. Rothe EM, Castillo Matos H, Busquets R: Posttraumatic stress in Cuban adolescent refugees during camp confinement. Adolescent Psychiatry 2001; Volume 26.

TUESDAY, MAY 21, 2002

Component Workshop 19
HEALTH CARE LEGISLATION: THE ROLE FOR THE 21ST-CENTURY BLACK PSYCHIATRIST
APA Committee of Black Psychiatrists

Co-Chairpersons: Michelle O. Clark, M.D., *P.O. Box 347189, San Francisco, CA 94134-7189,* Lishan Workeneh, M.D., *American Psychiatric Association CMHS Fellow, 4139 Via Marina Avenue, #704, Marina Del Ray, CA 90292*
Participants: Bethany J. Tucker, M.D., Honorable Louis Stokes

EDUCATIONAL OBJECTIVES:

At the conclusion of this session participants will be conversant with the recommended goals of the U.S. Surgeon General for improvement of mental health in the U.S. black community. They will also learn strategies for collaboration with their political representatives to support legislation to meet these goals.

SUMMARY:

This workshop is intended as a forum for psychiatrists who are interested in learning or improving skills for collaboration with elected officials and others involved in health care legislation. It is specifically intended to respond to the recent U.S. Surgeon General's Supplement to the Report on Mental Health for Minority Mental Health. In the supplement report specific concerns of African Americans were identified. Our presenters will briefly review the history of African-American politicians' involvement in health care legislation. They will also review the recommendations in the report and comment on current issues. Following the presentations the participants will be encouraged to share their experiences, ask questions, and make suggestions to the Committee of Black Psychiatrists for their work during this upcoming year.

REFERENCES:

1. Satcher D: Mental Health: Culture, Race and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General 1999. U.S. Department of Health and Human Services. Rockville, Maryland, 2001.
2. Stokes L: 2002 Solomon Carter Fuller Award Lecture: The Congressional Black Caucus Health Braintrust. Unpublished.

Component Workshop 20
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART I
APA Committee of Early Career Psychiatrists

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., Martin G. Tracy, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to know 10 key tips to avoiding lawsuits and malpractice; know the three most frequent reasons why psychiatrists are successfully sued; and understand different types of malpractice insurance and which one is best for each practitioner.

SUMMARY:

This is part one in a three-part comprehensive session that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day. Offered for the last three years, it is directed by faculty who have succeeded using this information. Even if you are not in private practice this workshop will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices.

In part one we focus on risk management, avoidance of malpractice suits, ways to maximize quality, and high-risk issues that you must address in your practice. Drs. Callahan and Young are joined by experts in the field Jackie Melonas, R.N., J.D., Vice President, Risk Management, Professional Risk Management Services, and Martin Tracy, J.D., President/CEO, Professional Risk Management Services. Other sessions cover coding for maximum billing, marketing, office location and design, streamlining your 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. APA: Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, Washington, D.C., 1998.

Component Workshop 21
MEDICAL STUDENT EDUCATION IN ADDICTION: COMPETENCIES AND RESOURCES
APA Committee on Training and Education in Addiction Psychiatry and American Academy of Addiction Psychiatry

Co-Chairpersons: Jonathan I. Ritvo, M.D., *Department of Psychiatry, University of Colorado, 4200 East 9th Street, Denver, CO 80262,* Richard S. Schottenfeld, M.D., *Yale University, CMHC/SAS 205, 34 Park Street, New Haven, CT 06519*
Participants: William M. Greenberg, M.D., Timothy W. Fong, M.D., Christopher J. Welsh, M.D., Marjorie E. Waldbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to articulate core clinical competencies in addiction appropriate to the medical student level and identify mechanisms and resources for teaching and assessing these competencies and fostering attitudinal change at the medical student level.

SUMMARY:

Addiction is a major public health issue. All physicians encounter patients with substance use disorders in the course of practice; but many of these patients go unrecognized and untreated. It is imperative that medical students develop skills for recognition of and initial intervention with patients with substance use disorders. In promoting this goal, the Committee on Training and Education in Addiction Psychiatry has drafted goals and objectives for medical student education in addiction including core clinical competencies. The draft will be distributed for discussion and feedback in the workshop. Participants will be invited to share their experiences in medical student education and techniques and resources they have found useful in teaching medical students. Presenters will share resources including video material they have found useful. This session is intended for psychiatrists and mental health professionals involved in medical student education.

REFERENCES:

1. Dove HW: Postgraduate education and training in addiction disorders: defining core competencies. Psychiatric Clinics of North America 1999; 22: 481–488.
2. D'Onofrio G, Bernstein E, Bernstein J: The Emergency Physician and the Problem Drinker: Motivating Patients for Change (video), Marino & Co. Productions, 1997.

Component Workshop 22
DISCUSSION: SURGEON GENERAL'S REPORT ON AMERICAN INDIANS AND ALASKA NATIVES
APA Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists

Co-Chairpersons: Frank W. Brown, M.D., *1899 E Gate Dr, Stone Mountain, GA 30087-1912,* Yvonne L. De Cory-Woronoff, M.D., *79 Bramhall Street, #2F, Portland, ME 04102*
Participants: Mary H. Roessel, M.D., Richard L. Livingston, M.D., R. Dale Walker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge of the historical context, sociocultural factors that relate to mental health, need for mental health care, identification of barriers to the delivery of culturally competent mental health services.

SUMMARY:

The Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists will present an in-depth review and discussion of the 2001 Surgeon General's Report on Mental Health Care for American Indians and Alaska Natives. The presentation will include an overview of the historical context, the current status of geographic distribution, family structure, education, income, and physical health status of American Indians and Alaska Natives. Mental disorders in children, youth, adults, and older adults will be reviewed. Major mental health problems will be discussed including suicide, alcohol and drug, incarcerated individuals, those exposed to trauma, and children in foster care. References to traditional medicine will be included. The panel will review and discuss the availability and accessibility of mental health services and issues of preventing and promoting mental health. Active audience participation will be encouraged especially concerning ways to improve access to treatment, reduction of barriers to treatment, and ways to improve the quality of care.

REFERENCES:

1. U.S. Department of Health and Human Services: Mental Health: Culture, Race and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Dept. Of Health and Hum Serv, Sub Abuse and Men Health Serv Admin, 2001.
2. Manson SM: The wounded spirit a cultural formulation of post-traumatic stress disorder. Culture, Medicine and Psychiatry 1996; 20:489–498.

Component Workshop 23
MENTAL HEALTH CARE FOR ASIAN AMERICANS AND PACIFIC ISLANDERS
APA Committee of Asian-American Psychiatrists

Co-Chairpersons: Nang Du, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Unit 7C, San Francisco, CA 94110-3518,* Surinder S. Nand, M.D., *Psychiatric Services, VA Chicago Health Care Systems, 820 S Damen, Chicago, IL 60612*
Participants: Francis G. Lu, M.D., Keh-Ming Lin, M.D., Kana Enomoto, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the diversity of AA/PIs, their needs for mental health services, availability, access, utilization of services, and cultural appropriateness and outcomes of mental health services and treatment for AA/PIs.

SUMMARY:

Asian Americans are the third-largest and the fastest-growing minority group in the U.S., with a population of 10.2 millions in 2000. It is a heterogeneous group that includes at least 43 ethnic subgroups with different languages and dialects, immigration patterns, religious beliefs, socioeconomic statuses, and traditional patterns of seeking health care. These social and cultural variables affect Asian Americans' help-seeking behaviors, development of psychiatric disorders, manifestation of psychiatric symptoms, treatment strategies, compliance and outcomes.

The report "Mental Health: Culture, Race, And Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General" in August 2001 showed that AA/PIs have the lowest rate of utilization of mental health services among ethnic populations. This avoidance of mental health service is attributable to stigma, shame, different cultural beliefs, lack of financial resources and cultural appropriateness of services and treatments.

Participants in this workshop will learn about the diversity in the Asian-American population, as well as the different rates of social, health, and mental health problems, the barriers and issues regarding the availability, access, utilization, and cultural appropriateness of mental health services and treatment in this population.

REFERENCES:

1. Gaw AC (ed.): Culture, Ethnicity, and Mental Illness. Washington, DC, American Psychiatric Press, 1993.
2. Mental health care for Asian-Americans and Pacific Islanders. In Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report to the Surgeon General. Department of Health and Human Services. U.S. Public Health Service, 2001, pp 105–126.

Component Workshop 24
SURVIVOR MUR: WHO GETS VOTED IN?
APA Assembly Committee of Representatives of Minority/Underrepresented Groups

Chairperson: Jeffrey Akaka, M.D., *PO Box 11780, Honolulu, HI 96828-0780*
Participants: Ana E. Campo, M.D., Donna M. Norris, M.D., Rodrigo A. Munoz, M.D., Pedro Ruiz, M.D., Nada L. Stotland, M.D., R. Dale Walker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize barriers to professional achievement that are unique to their status as minorities; implement strategies to overcoming these barriers; learn methods to rise in their psychiatric professional organizations.

SUMMARY:

Minorities remain underrepresented in psychiatric leadership positions in many settings including academic centers, professional organizations, and business. In a study done by the AAMC, underrepresented minority faculty professors were less likely to be promoted than other faculty. Important issues in the development of psychiatrists who will be in leadership positions include mentoring, training and education, administrative experience, and knowledge of cultural factors. These will help to break the organizational bias that constitutes the "glass ceiling."

This workshop will use the expertise of minority psychiatrists who have succeeded in rising in their professional organizations. They will share their insights and experiences to help others accelerate their professional development.

REFERENCES:

1. Fang D, Mov E, Colbur L, Hurley J: Racial and ethnic disparities in faculty promotion in academic medicine. JAMA 2000; 284:1085–92.
2. Lazarus A: Breaking the glass ceiling. Physician Executive 1997; 23:8–13.

Component Workshop 25
AMBULATORY DETOXIFICATION FROM ALCOHOL: HOW TO DO IT WELL AND GET PAID TOO
APA Committee on Treatment Services for Addicted Patients

Co-Chairpersons: George F. Kolodner, M.D., *Kolmac Clinic, 1003 Spring Street, Suite 2, Silver Spring, MD 20910-4016,* Samuel M. Silverman, M.D., *643 Prospect Avenue, West Hartford, CT 06105-4202*
Participants: Brealyn M. Sellers, M.D., Victor Sierra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to safely conduct outpatient detoxification from alcohol and to contract and bill for services.

SUMMARY:

The use of alcohol complicates the treatment of many psychiatric disorders, and detoxification is sometimes required for effective treatment to proceed. Pressures continue to build to move the detoxification phase of addiction treatment away from inpatient toward ambulatory settings. Treatment models to accomplish this move safely and effectively have been available for many years. Clinical and administrative barriers persist, however, for clinicians wanting to become proficient in this area. A recent survey of APA members regarding outpatient detoxification practices identified alcohol as the most commonly detoxified substance. Respondents expressed both doubts about the feasibility of the procedure as well as a desire for more information.

The workshop will focus on practical "nuts and bolts" issues with presentations of clinical protocols including screening guidelines, medication regimens, and ancillary supports, as well as billing code suggestions for both office and facility-based models. The audience will be encouraged to respond to these protocols and to present their own experiences with effective models. The goals regarding ambulatory detoxification will be: 1) to dispel misconceptions about its clinical feasibility and difficulty; 2) to increase awareness of its clinical advantages; 3) to explore billing and contracting issues; and 4) to establish an ongoing network of clinicians interested in sharing their expertise.

REFERENCES:

1. Feldman D, Pattison E, et al: Outpatient alcohol detoxification: initial findings on 564 patients. Am J Psychiatry 1975; 132:407–412.
2. Hayashida M, Alterman AI, et al: Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome. NEJM 1989; 320:358–365.

Component Workshop 26
THE TERRORIST CRISIS OF 2001: USE AND IMPACT OF ELECTRONIC COMMUNICATION
APA Committee on Information Technology, APA New York County District Branch, and the Psychiatric Society for Informatics

Co-Chairpersons: Ronnie S. Stangler, M.D., *1425 Western Avenue, Suite #101, Seattle, WA 98101-2036,* Julie K. Schulman, M.D., *516 East 83rd Street, #4W, New York, NY 10028*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, psychiatrists will understand the use and impact of electronic communication during the terrorist crisis of 2001.

SUMMARY:

40 years after it was conceived as a means to maintain communication in the event of an attack on the United States, the Internet was tested in a magnitude its originators could never had foreseen. The disaster of September 11, 2001 produced an uproar for information and personal connection, as people throughout the world struggled to access and comprehend an incomprehensible disaster. Beyond providing real-time news, the Internet served as a key communication vehicle for government, the corporate sector, and individuals. The use of the Internet during this crisis, for both beneficial and destructive purposes, as well as its service as a therapeutic medium, will be addressed.

REFERENCES:

1. Tedsechi B: The Internet Surpasses its Original Goal. New York Times e-Commerce Report September 17, 2001. http://www.nytimes.com/2001/09/17/technology/17ECOM.html

2. Walker L: The Medium Meets the Emergency. Washington Post e-News Report. September 12, 2001. http://www.washingtonpost-.com/wp-dyn/articles/A21572-2001 Sep12.html

Component Workshop 27
KIDS, SCHOOLS, AND PARENTS: FROM THE 20TH CENTURY INTO THE 21ST CENTURY
APA Committee on History and Library

Chairperson: Richard J. Thurrell, M.D., *17 Beach Street, Madison, WI 53705-4405*
Participants: David F. Musto, M.D., James P. Comer, M.D., Elissa P. Benedek, M.D., Jack C. Westman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize change, progress, and continuing problems in social position and educational development of American children, particularly disadvantaged children, over the past one-half century against the background of worldwide events as reflected in the media.

SUMMARY:

Did the children in your family watch the destruction of the World Trade Center towers on TV? Depending on your current age, did you, as a child, hear about Pearl Harbor on the radio and see the subsequent newsreels and the voluminous WW-II film footage? Or as a kid, did you get in on the Korean War via the media?—Or the Vietnamese "conflict"?—Or the Gulf War?—Or Bosnia?—Or—?

In your early years did your parents, your teachers, and your peers help you to understand? The workshop panel will react to Dr. James Comer's Benjamin Rush lecture and will also discuss how changes in the American culture have impacted children through the second half of the 20th century and into our new millenium.

This workshop is directed at those concerned about how world events, the public culture, and other factors affecting the intellectual and emotional lives of children. Panelists will briefly discuss the issues among themselves. A large portion of the workshop time will involve comments and questions from the audience.

REFERENCES:

1. Comer JP: Waiting for a Miracle: Why Schools Can't Solve Our Problems, and How We Can. New York, Dutton, 1997.
2. Westman JC: Childrens' rights, parents' prerogatives, and society's obligations. Child Psychiatry and Human Development 1999; 29:315–328.

Component Workshop 28
THE MENTAL HEALTH CARVEOUT: STRATEGIES TO ERASE THE STIGMA
APA Work Group on Carveouts

Co-Chairpersons: Lawrence B. Lurie, M.D., *57 Post Street #601, San Francisco, CA 94104-5023* Jonathan E. Gudeman, M.D., *Medical College of WI Milwaukee, 2808 N Shepard Avenue, Milwaukee, WI 53211-3432*
Participants: Janis G. Chester, M.D., Norman A. Clemens, M.D., Jerome H. Rogoff, M.D., Kenneth R. Silk, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, participants will be able to identify the most important ways that mental health carveouts are discriminatory and will have information on how they can work both as individuals as well as members of APA strategically to oppose them.

SUMMARY:

The carving out of mental health care leads to stigmatization of psychiatric patients and marginalizes psychiatric treatment. Only in highly specialized circumstances (most frequently in some sectors of public psychiatric care) can these problems caused by carveouts be sufficiently mitigated to provide reasonable clinical care. The pathway to receive psychiatric treatment should be the same as the pathway taken to seek other medical-surgical care, with no barriers imposed on psychiatric treatment that are different from any other kind of medical treatment. Precertification, UR requirements, denial rates, administrative costs, and access should not differ. There should be no barriers to our collaborative, integrated, and consultative care with our medical-surgical colleagues. This workshop will review and discuss strategies developed by the work group to end these carveouts, and leaders of the workshop will solicit reactions from the participants to the work group's strategies and encourage the participants to suggest additional strategies designed to promote and implement an end to mental health carveouts. APA and its membership must ally with other interested organizations and must work in governmental settings, with insurance companies, with employers, and with the business community to educate everyone as to the detrimental cost of carveouts to our patients, to their workers and policyholders, and to all people who are vulnerable to psychiatric illness. More specific strategies and model legislation will be proposed, and suggestions from the participants will be encouraged.

REFERENCES:

1. Allen TE: Mental health carveouts: part I. Maryland Medicine 2001; 2:26–8.
2. Trabin T, Freeman MA: Managed Behavioral Healthcare: History, Models, Strategic Challenges and Future Course. Tiburon, CA, CentraLink Publishers, 1995.

Component Workshop 29
MISSION IMPOSSIBLE II: WHEN THE DISORDERED CHILD BECOMES AN ADULT
APA Committee on Children with Mental or Developmental Disorders

Chairperson: Roxanne C. Dryden-Edwards, M.D., *Department of Psychiatry, Kennedy Krieger, 1750 East Fairmouth Avenue, Baltimore, MD 21231*
Participants: Paula J. Lockhart, M.D., Donald J. Mordecai, M.D., Lisa J. Nelson, M.D., Lee M. Price, L.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the specific challenges associated with transitioning chronically developmentally and emotionally disabled adolescents from the child mental health system to the adult system.

SUMMARY:

Of thousands of children with learning disabilities, approximately 60% are mentally ill. Psychiatrists who treat this population face unique challenges as patients enter adulthood. The purpose of this workshop is to describe these challenges and to explore ways of supporting these patients. Challenges include adaptive skills training, "aging out" of conventional school settings, living arrangements, and legal and educational issues and changes in systems of care.

Dr. Lockhart will present the case of a young man with fetal alcohol syndrome followed from 15 to 24 years of age. Dr. Mordecai will review federal mandates related to entering adulthood. Dr. Nelson will describe how a county system transitions clients from the child mental health system to the adult system. Ms. Price will describe the role of a state agency. Dr. Dryden-Edwards will be the moderator.

Children with these issues require long-term care. Therefore, it is imperative for child psychiatrists to become familiar with these issues

and for adult psychiatrists to know the patterns of care these patients have received. After the presentation there will be a period for presenters and the audience to discuss questions and share experiences and approaches to assisting these patients.

REFERENCES:

1. National Council on Disability: A Decade of Progress in Disability Policy: Setting an Agenda for the Future. Washington, DC, National Council on Disability, July 1996.
2. McConaughy SH, Wadsworth ME: Differential outcomes in young adults previously referred for mental health services. Journal of Emotional Disorders 2000; 8:202–215.

Component Workshop 30
CLINICIAN SAFETY
APA Task Force on Psychiatric Aspects of Violence

Chairperson: Arthur Z. Berg, M.D., *60 Cedar Street, Wenham, MA 01984-1534*
Participants: Carl C. Bell, M.D., Bradley R. Johnson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to know the extent and seriousness of assaults on psychiatrists; recognize danger signs and safety procedures; and understand denial and ineffective self-defense concepts.

SUMMARY:

Psychiatry is a high-risk profession. Assaults on psychiatrists and other mental health professionals are greatly underreported. The assaults include include serious injury, rape, and homicide. Denial causes underreporting, harmful outcomes in otherwise preventable assaults and inadequate clinician training in residency and postgraduate programs. Many psychiatrists believe they are safe because they work in private offices or with nonviolent patients. That, too, is denial.

The panel will review the alarming statistics of injury and homicide in the mental health professions. Several cases will be presented. Methods of overcoming denial and increasing awareness of potential violence will be discussed. The skill of de-escalation and safety procedures for private offices as well as hospital units will be reviewed. New concepts about self-defense will be suggested. Some motor skills will be practiced by the audience while seated. A question-and-answer period will follow each presentation.

REFERENCES:

1. Berg AZ, Bell CC, Tupin J: Clinician safety: assessing and managing the violent patient. In Psychiatric Aspects of Violence: Issues in Prevention and Treatment, edited by Bell CC, San Francisco, 2000, pp 9–31.
2. Berg AZ: Survival and the ultimate threat. Psych Times 1997; 14:33–36.

Component Workshop 31
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART II
APA Committee of Early Career Psychiatrists

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 presentation, the participant should be able to understand the use of codes for insurance to accurately reflect work with patients; understand documentation requirements consistent with the codes; know where to go to get updated information on coding.

SUMMARY:

This is part two in a three-part comprehensive session that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day. Offered for the last four years and directed by faculty who have succeeded using this information. Even if you are not in private practice, this workshop will offer lots of useful information that will assist you in launching your career. Our material is updated with up-to-the-minute solutions from our faculty with thriving practices. In part two we focus on the complexities of using the insurance industry's procedure codes to accurately reflect your work with patients. Even if you intend to have a fee-for-service cash-based practice many patients will require "superbills" for insurance so they can get reimbursed. There are documentation requirements for each code, and not understanding them and following them can leave you prosecuted for fraud. Drs. Callahan and Young are joined by the two nationally recognized experts on coding who work with APA and AMA to make these codes and guidelines work. Chester Schmidt, M.D. and Tracy Gordy, M.D. will present and answer questions.

REFERENCES:

1. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, Washington, D.C., 1998.
2. Logsdon L: Establishing A Psychiatric Private Practice, Washington, D.C., American Psychiatric Press, Inc., 1985.

WEDNESDAY, MAY 22, 2002

Component Workshop 32
COMPETENCE REQUIREMENTS IN RESIDENT EDUCATION: PROGRESS AND PROBLEMS
APA Committee on Graduate Education

Chairperson: Sherwyn M. Woods, M.D., *P.O. Box 1417, La Quinta, CA 92253*
Participants: Lisa A. Mellman, M.D., Eugene V. Beresin, M.D., Stephen C. Scheiber, M.D., Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the six core and five psychotherapy competencies required by the Residency Review Committee for Psychiatry, understand aspects of cultural competence, and discuss the activities of the APA Task Force on Competency in Graduate Education.

SUMMARY:

As psychiatric educators begin to implement the new requirements of the Residency Review Committee that residents develop competency in six core areas and five specified psychotherapies, the APA Task Force on Competency in Graduate Education serves as a convening body for psychiatric education organizations involved in competency. The workshop presenters will 1) describe the six core competencies (patient care, medical knowledge, professionalism, interpersonal and communication skills, practice-based learning, systems-based practice) and five psychotherapies (supportive, psychodynamic, cognitive-behavioral, brief, combined psychotherapy and psychopharmacology); 2) discuss the complexities of assessing evidence-based competencies, including limitations in time, faculty resources, and methods of assessment; 3) address issues in sociocultural competency; and 4) summarize the competency activities of the APA Task Force on Competency in Graduate Education and a variety of psychiatric education organizations, including American Association

of Directors of Psychiatry Residency Training, American Academy of Child and Adolescent Psychiatry, and American Board of Psychiatry and Neurology.

REFERENCES:

1. Leach DC: The ACGME competencies: substance or form? Accreditation Council for Graduate Medical Education. Journal of American College of Surgeons 2001; 192:396–8.
2. Bienenfeld D, Kylkylo W, Knapp V: Process and product: development of competency-based measures for psychiatry residency. Academic Psychiatry 2000; 24:68–76.

Component Workshop 33
QUALITY INDICATORS FOR CHILDREN AND ADOLESCENTS: WHO CARES?
APA Council on Quality Improvement

Chairperson: James C. MacIntyre II, M.D., *44 East Bayberry Road, Glenmont, NY 12077-3027*
Participants: John M. Oldham, M.D., Rhonda Joyce R. Beale, M.D., Richard C. Hermann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the importance of defining quality indicators for children and adolescents, identify five meaningful domains of quality indicators for children and adolescents, and discuss controversies and complexities of defining indicators and holding health plans accountable.

SUMMARY:

The Institute of Medicine's Committee on Quality of Health Care in America, as well as accrediting and regulatory organizations, are seeking measurable assurance that health facilities, practitioners, and plans are providing quality care. Many meaningless and "easy to succeed" measures have surfaced in recent years. In 1997, psychiatry began looking for ways to influence the development and selection of meaningful indicators that ultimately might gain national use. APA published the Report of the Task Force on Quality Indicators in 1999, followed by the publication of the Report of the APA Task Force on Quality Indicators for Children in 2002. This workshop will examine the environment and contexts in which quality indicators for psychiatric services for children and adolescents can be useful. The workshop will provide a theoretical framework for development and selection of indicators and offer examples of indicators with measures and standards.

REFERENCES:

1. Crossing the Quality Chasm: A New Health System for the 21st Century, Committee on Quality of Health Care in America, Institute of Medicine, Washington, D.C., National Academy Press, 2001.
2. American Psychiatric Association: Report of the Task Force on Quality Indicators for Children, American Psychiatric Publishing, Inc. Washington, D.C.

Component Workshop 34
PRACTICING REWARDING PSYCHIATRY IN JAILS AND PRISONS: A PRACTICUM
APA Council on Psychiatric Services

Chairperson: Henry C. Weinstein, M.D., *Department of Psychiatry, New York University, 1111 Park Avenue, New York, NY 10128*
Participants: Kathryn A. Burns, M.D., Cassandra F. Newkirk, M.D., Annette L. Hanson, M.D., John S. Zil, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to appreciate and understand the basic practical issues of practicing psychiatry in jails and prisons.

SUMMARY:

The opportunities of practicing in a jail or a prison can be interesting and satisfying, rewarding as well as remunerative. This interactive workshop on correctional psychiatry, a presentation of the APA Caucus of Psychiatrists Practicing in Criminal Justice Settings, will focus on the practical realities of working in correctional settings—from basic and simple to complex and perplexing. Topics to be discussed will include the challenges presented by the unique rules and routines of a correctional environment, how the correctional psychiatrist can work within such constraints, and how new practitioners should be oriented to these issues. This workshop will also cover various types of careers in correctional psychiatry (e.g., part time versus full time), the legal context of correctional psychiatry, psychopharmacology in correctional settings, special populations, and "burnout." If the participants so wish, this workshop may cover more advanced topics such as systems issues in correctional facilities, (e.g., integrating medical and mental health services,) managed care issues, accreditation issues, cross-training with security personnel, cultural competency issues, and ethical issues in correctional psychiatry. The faculty for this course are all members of the executive board of the caucus.

REFERENCES:

1. American Psychiatric Association: Psychiatric Services in Jails and Prisons, Second Edition, Washington DC, American Psychiatric Press, 2000
2. Wettstein R (editor): Treatment of Offenders with Mental Disorders. New York, Guilford, 1998.

Component Workshop 35
WHOSE CHILDREN?: PSYCHIATRY IN THE CULTURAL MOSAIC OF AMERICA'S SCHOOLS
APA Committee on Psychiatry and Mental Health in the Schools

Chairperson: Mary E. Schwab-Stone, M.D., *224 St Ronan Street, North Haven, CT 06511-2312*
Participants: Trina B. Allen, M.D., Eugenio M. Rothe, M.D., Hong Shen, M.D., Nichole D. Grier, M.D.

EDUCATIONAL OBJECTIVES:

For each of the four sociocultural groups discussed, identify at least two salient aspects of cultural experience that can lead to barriers to identification of youth mental health problems. For these groups, to understand culturally typical psychiatric presentations in school settings.

SUMMARY:

Culturally competent school-based intervention is a critical avenue for helping our increasingly diverse child and adolescent population. The U.S. Surgeon General's report "Mental Health: Culture, Race and Ethnicity" provides a compelling analysis of ethnic and cultural issues that result in serious barriers to recognizing mental health needs and to accessing treatment. Increasingly, schools have become a critical institution for identifying mental health problems in young people, as well as for facilitating evaluation and treatment. Psychiatrists are being asked to help address the pressing needs of our diverse young population in school settings. The capacity to view clinical issues through the lenses of culture and of ethnic legacy has never been more central to providing effective treatment. This workshop will discuss unique factors that affect African-American, Hispanic-American, and Asian-American students' problem-solving and coping, help-seeking, treatment access, and utilization of school-based services. Intergenerational tensions will be examined as challenges for Hispanic-American youth. Unique issues for Asian-American young people will be presented, with special reference to fears of stigma from identifying and referring troubled family members.

While not customarily identified as a unique cultural group, rural youth commonly face distinctive social-contextual issues that result in barriers to self-revealing and access to care.

REFERENCES:

1. Cultural and Societal Influences in Child and Adolescent Psychiatry. M Belfer (Guest Editor) Child & Adolescent Psychiatric Clinics of North America 2001; 10:4.
2. Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. Department of Health and Human Services, U.S. Public Health Service, 2001.

Component Workshop 36
IT'S NOT GAY ENOUGH: INTERPRETING ANTIGAY BIAS IN THE 21ST CENTURY
APA Committee on Gay, Lesbian, and Bisexual Issues

Chairperson: Jack Drescher, M.D., *420 West 23rd Street, #7D, New York, NY 10011-2174*
Participants: Kenneth B. Ashley, M.D., Daniel W. Hicks, M.D., Howard C. Rubin, M.D., Julie K. Schulman, M.D., Susan A. Turner, M.D., Serena Yuan Volpp, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and critically assess common misbeliefs and stereotypes about gays and lesbians and to provide accurate information to patients and families about current knowledge of human sexuality.

SUMMARY:

This interactive workshop will feature a screening of "It's Not Gay," a video in documentary format prepared by a politically conservative religious organization. Produced as if it were a medical "infomercial," the video's message is to discourage its viewers from "entering the homosexual lifestyle." However, in contrast to most conventional, contemporary public health measures, the video uses fear tactics that distort the known health risks affecting gay male populations. Because the video also draws upon numerous denigrating stereotypes of homosexuality that are found in the general culture, the workshop will invite its audience to focus on the potential harm such stereotypes can have, not only in perpetuating stigma and antihomosexual bias against gay patients, but also in undermining the genuine public health needs of gay male populations.

REFERENCES:

1. Cabaj R, Stein T, eds: Textbook of Homosexuality and Mental Health. Washington, D.C., American Psychiatric Press, 1996.
2. Butler J: Gender Trouble: Feminism and the Subversion of Identity. New York, Routledge, 1990.

Component Workshop 37
DYNAMIC DUEL: DILEMMAS OF SPLIT TREATMENT
APA Consortium on Treatment Issues

Co-Chairpersons: Sally L. Godard, M.D., *3300 N.W. Hill Road, McMinnville, OR 97128-8113,* Richard J. Kessler, D.O., *395 Chestnut Drive, Roslyn, NY 11576*

At the conclusion of this session, the participant should be able to gain awareness of clinical issues that arise in split treatment; to identify possible ethical dilemmas that may be a part of split treatment; and to recognize the importance of close communication in implementation of effective split treatment.

SUMMARY:

The splitting of psychiatric treatment between a psychiatrist prescriber and a nonphysician mental health professional who conducts psychotherapy is a widespread practice. The manner is which the psychiatrist discharges his/her ethical, medical, and legal responsibilities to the patient in a split treatment situation was addressed formally in APA's 1980 Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Non-Medical Therapists. In the last two decades, changes in psychiatric practice have made adherence to those guidelines problematic. Managed care companies add another level of complexity to the issue of split treatment. In addition, residents in psychiatry have had less teaching in psychotherapy in recent years, so that psychiatrists may be less able to collaborate with nonmedical therapists as the guidelines suggest. However, the issues that arise with split treatment, and the discussions that ensue, have not diminished.

This workshop will introduce the dilemmas of split treatment as developed by the consortium members. After a brief introduction, five vignettes will be role-played that will illustrate a common example of a clinical or ethical issue that may present itself in split treatment. After each vignette, a guided discussion by the audience will identify the major points that have been raised. Possible solutions to each dilemma will be outlined. Although definitive answers may not be available for each dilemma, it is anticipated that the discussions will improve a clinician's approach to addressing these issues in his/her own practice. A brief summary will close the workshop.

This workshop encourages attendance by psychiatrists and other mental health professionals who practice within a split-treatment model.

REFERENCES:

1. American Psychiatric Association: Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Non-Medical Therapists, 1980.
2. Riba MB, Balon R: Psychopharmacology and Psychotherapy: A Collaborative Approach. Washington DC, American Psychiatric Publishing Inc., 1999.

Component Workshop 38
TALKING WITH THE TERMINALLY ILL ABOUT DEATH AND DYING
APA Committee on End-of-Life Issues

Co-Chairpersons: Maurice D. Steinberg, M.D., *Department of Psychiatry, Long Island Jewish Medical Center, 270-05 76th Avenue, New Hyde Park, NY 11040,* Edwin H. Cassem, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Fruit Street, Bulfinch 3, Boston, MA 02114*
Participants: Ira R. Byock, M.D., Samuel C. Klagsbrun, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants will feel better prepared to do psychotherapeutic work with dying patients through increased understanding of the psychological concerns of the terminally ill. Participants will learn how to address these needs so as to help patients achieve their best possible death.

SUMMARY:

Current interest in improving the quality of end-of-life care has led to increased attention to the role of the psychiatrist in the care of the terminally ill. The importance of psychiatric diagnosis and treatment of depression and other major psychiatric syndromes has received appropriate recognition. The purpose of this workshop is to focus on the equally important role psychiatry has always played in easing the suffering of dying patients through talking and listening to them. The presenters will discuss major issues of concern to dying patients and their families that the psychiatrist should address in working with the terminally ill. The evolving concept of dying well will be examined, with particular attention to how psychiatry can

help patients achieve this goal. Emphasis will be placed on understanding how the experience of dying and the needs of dying patients have been affected by the greatly expanded role of hospice and palliative care in the care of the terminally ill. This session is intended for psychiatrists who work with dying patients in general hospital, outpatient, geriatric hospice, or palliative-care settings. It will allow for considerable opportunity for audience members to interact with experts in end-of-life treatment.

REFERENCES:

1. Cassem N: Care and management of the patient at the end of life. In Handbook of Psychiatry in Palliative Medicine, edited by Chochinov HM, Breitbart W, Oxford, Oxford University Press, 2000, pp. 13–23.
2. Byock I: Dying Well: The Prospect for Growth at the End of Life. New York City, Riverhead/Putnam Publishing, 1997.

Component Workshop 39
PSYCHOLOGIST PRESCRIPTION PRIVILEGES: IS IT COMING? SHOULD IT?
APA Commission on Public Policy, Litigation, and Advocacy

Co-Chairpersons: Amin N. Azzam, *940 Duncan Street #D204, San Francisco, CA 94131-1868,* Raymond J. Kotwicki, M.D., *850 Piedmont Avenue, #2605, Atlanta, GA 30308*
Participant: Frederick Y. Huang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the current status of psychologist prescription movements in several states; rationally weigh the benefits and risks of granting psychologists prescription privileges; and have an understanding of steps that psychiatrists can take in their state to express an opinion on this issue to legislators.

SUMMARY:

Over the past few years, several states have seen bills introduced into their legislative bodies that would grant psychologists limited prescription privileges. This alarming trend has escalated recently, and several more states (FL, GA, HI, IL, MD, NM, OK, TN, OR, and LA) expect to face this issue in the next two years.

The goal of this workshop is to educate APA members, and especially resident members, about this issue. The format will be a panel discussion. Panelists will include resident fellows from the APA Commission on Public Policy, Litigation, and Advocacy (CoPPLA), as well as members of APA who have been active participants in the struggle to prevent psychologist-prescription bills from reaching legislative floors. Audience members will learn specific steps they can take to be active in the effort to keep prescriptions in the hands of physicians.

REFERENCES:

1. Edited results of the CoPPLA Scope of Practice Readiness Survey.
2. Edited minutes from the CoPPLA Fall Component Meeting on 9/7/01.

Component Workshop 40
COMBINED RESIDENCY TRAINING: YOU WANT TO DO WHAT?
APA Committee on Consultation-Liaison Psychiatry and Primary Care Education

Co-Chairpersons: Shannon T. Suo-Chan, M.D., *2707 Lillard Drive, Davis, CA 95616-4885,* Susan L. Padrino, M.D., *6302 Forest Ridge Drive, Durham, NC 27713*
Participants: Quinton E. Moss, Jodi E. Star, Dylan P. Wint, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to describe what types of combination residency training are available, the benefits and drawbacks of combined programs, and ways in which combined training can be improved in the future.

SUMMARY:

Training programs in traditionally "medical" disciplines combined with psychiatry have expanded significantly in the past 10 years. Currently there are 56 such programs in the United States. Combined training programs face unique challenges but also provide unique opportunities for patients as well as the medical and psychiatric communities. This workshop will focus on identifying the barriers to an integrated curriculum, the strengths of combined psychiatric residencies, and future directions of these programs in the 21st century. Anyone interested in combined training programs is encouraged to attend, but this workshop will be of particular interest to combination residents, training directors, and medical students considering a combined residency. Training programs represented will be family practice/psychiatry, internal medicine/psychiatry, neurology/psychiatry, and pediatrics/psychiatry/child psychiatry. Training directors from several of the presenters' programs will be invited to participate in the discussions as well.

REFERENCES:

1. McCahill ME, Palinkas LA: Physicians who are certified in family practice and psychiatry: who are they and how do they use their combined skills? J Am Board Fam Pract 1997; 2:111–5.
2. Servis ME, Hilty DM: Psychiatry and primary care: new directions in education. Harv Rev Psychiatry 2000; 4:206–9.
3. Wulsin L, Cantor L: The current status of combined family practice and psychiatry residency training programs. Fam Med 1999; 9:606.

Component Workshop 41
THE RULES OF THE CLUB: CAREER ADVANCEMENT FOR WOMEN
APA Committee on Women

Co-Chairpersons: Donna E. Stewart, M.D., *Women's Health, University of Toronto, 200 Elizabeth Street, M/L-2-004, Toronto, ON M5G 2C4, Canada,* Anu A. Matorin, M.D., *UT-HSC-Houston, 1300 Moursund, Houston, TX 77030*
Participants: Deborah Spitz, M.D., Leslie H. Gise, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to have a greater awareness of the factors that influence career advancement for women psychiatrists. Additionally, the workshop will promote a forum for exchange of ideas in order to identify and implement creative and practical strategies for overcoming barriers to career advancement.

SUMMARY:

By the year 2010, women are expected to account for approximately one-third of American physicians. However, the "glass ceil-

ing effect'' as described in corporate America is seen in the medical field as well, with women physicians underrepresented in positions of authority and leadership. For example, according to the AAMC faculty statistics, in 2000 only 186 women faculty attained the rank of professor, while 1,198 men had achieved this distinction. Women physicians face unique challenges in their quest for access to positions of leadership, including lack of role models and inadequate mentoring, professional stereotypes, exclusion from informal network systems, and special issues related to family needs. Many women physicians, especially early career psychiatrists, may lack the tools, background, and experience necessary to advance in their career path. This presentation will critically assess and identify these key challenges including: why women psychiatrists may receive inadequate mentoring, may be uncertain how to seek out leadership positions, or may lack a clear framework for ''what counts'' to progress and succeed in their careers. Utilizing personal and professional experiences, this workshop will promote an exchange of ideas focusing on practical and creative strategies to ameliorate historical and internal barriers, with a special emphasis on the unwritten rules that dictate career advancement.

REFERENCES:

1. Matorin AA, Collins DM, Abdulla A, Ruiz P: Women advancement in medicine and academia: barriers and future perspectives. Texas Medicine 1997; 93:60–64.
2. AAMC Faculty Statistics, 2000.

Component Workshop 42
EDUCATING THE COURTS: RECENT APA AMICUS CURIAE BRIEFS
APA Commission on Judicial Action

Chairperson: Renee L. Binder, M.D., *Department of Psychiatry, Langley Porter Institute, 401 Parnassus Avenue, Box F, San Francisco, CA 94143*
Participants: Howard V. Zonana, M.D., Richard G. Taranto, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the issues in two amicus briefs prepared for the courts by the APA Commission on Judicial Action. One case involves sexually violent predators and the other involves involuntary medication.

SUMMARY:

The purpose of this workshop is to discuss two of the amicus curiae briefs that were recently prepared by APA's Commission on Judicial Action. One of the briefs relates to Kansas v. Crane, a United States Supreme Court case involving the civil commitment of a sexually violent predator. The other brief was prepared at the invitation of the U.S. Court of Appeals for the Second Circuit in reference to U.S. v. Gomes. The latter case involves the issue of whether defendants found incompetent to stand trial can be involuntarily medicated.

These amicus curiae briefs represent efforts of APA to educate and influence the courts about important psychiatric issues. In Kansas v. Crane, the APA brief presents data to help the court decide about whether there must be a finding of a ''lack of control'' before an offender can be found to be a ''sexual predator.'' In U.S. v Gomes, the APA brief argues that medical appropriateness should be used in making decisions about the use of involuntary psychotropic medications and discusses the therapeutic benefits of the newer atypical antipsychotics. This is important because the courts have traditionally seen antipsychotics as extraordinarily intrusive and dangerous.

REFERENCES:

1. Brief for the American Psychiatric Association as Amicus Curiae by invitation of the US Court of Appeals for the 2nd Circuit, U.S. v. Gomes.
2. Brief for the American Psychiatric Association and American Academy of Psychiatry and the Law as Amici Curiae in support of respondent Crane in Kansas v. Crane, US Supreme Court.

Component Workshop 43
MEDICARE UPDATE 2002
APA Medicare Advisory Committee

Chairperson: Edward Gordon, M.D., *388 Hardscrabble Road, North Salem, NY 10560*
Participants: Irvin L. Muszynski, J.D., Ellen Jaffe, Seth P. Stein, J.D., Gerald Rogan, M.D., Lloyd I. Sederer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand changes at the Centers for Medicare and Medicaid Services (formerly HCFA) and how they affect the Medicare program; to understand APA's activities to help unify national coverage; to understand how to solve billing coding problems.

SUMMARY:

The panel and the audience will interact in a ciscussion of how the new regime at the Centers for Medicare and Medicaid Services will change the way Medicare is being administered and how this will affect the practice of psychiatry under Medicare. Panelists will respond to attendees' questions about complying with Medicare regulations; interactions with Medicare carriers and fiscal intermediaries; and about how to navigate the Medicare system with as much ease as possible.

This workshop is intended for individuals in private practice or others in part B billing situations who are responsible for the treatment of Medicare beneficiaries.

REFERENCES:

1. Schmidt C: CPT Handbook for Psychiatrists, 2nd Edition.
2. AMA: CPT, 2002.

Component Workshop 44
CRITICAL ISSUES FOR TREATING DOMESTIC VIOLENCE SURVIVORS AND THEIR CHILDREN
APA Committee on Family Violence and Sexual Abuse

Co-Chairpersons: Carole L. Warshaw, M.D., *Primary Care, Cook County Hospital, 1900 W Polk Street, Room 930, Chicago, IL 60612,* Graeme Hanson, M.D., *Department Child & Adolescent Psychiatry, Langley Porter UCSF, 401 Parnassus Avenue, San Francisco, CA 94143*
Participants: Susan M. Ditter, M.D., Sandra L. Bloom, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to address key issues in treating adult survivors of domestic violence and their children; to understand and address clinicians' needs in treating victims of domestic violence.

SUMMARY:

A growing body of research demonstrates that domestic violence has serious mental health consequences for adult victims and children who witness the abuse. Increased rates of depression, PTSD, substance abuse, and suicidality have all been well documented among domestic violence survivors. Not surprisingly, significant numbers of women 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 physical and emotional abuse; 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 confidentiality. 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 will address the psychological and practice needs of clinicians working with domestic violence survivors and their children. The group will discuss questions raised by the presentations and issues arising from participants' clinical experience.

REFERENCES:

1. Domestic Violence and Children: The Future of Children. The David and Lucille Packard Foundation. Los Altos, CA, 1999.
2. Warshaw C: Women and violence. in Psychological Aspects of Women's Health Care: The Interface Between Psychiatry and Obstetrics and Gynecology, edited by Stotland N, Stewart D. Washington, DC. American Psychiatric Press, Inc., 2001.

Component Workshop 45
PSYCHIATRY'S RESPONSE TO THE DATA: SPIRITUALITY AS A RELEVANT CLINICAL FACTOR
APA Committee on Religion, Spirituality, and Psychiatry

Chairperson: Irving S. Wiesner, M.D., *Swarthmore Medical Center, Yale Avenue and Chester Road, Swarthmore, PA 19081*
Participants: Harold G. Koenig, M.D., Francis G. Lu, M.D., S. Atezaz Saeed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to be aware of published research concerning spirituality as a patient-relevant factor, as a research-relevant factor, as a potentially harmful as well as beneficial factor in illness prevention, coping and treatment outcomes, and be aware of recent psychiatric training interest and emphasis concerning spirituality as residency training relevant factor.

SUMMARY:

A new focus on understanding the relevance of patients' spiritual or religious worldviews and recognizing how it may help or harm patients is now changing the once prevalent clinical tradition of overlooking spiritual issues in psychiatric care, training, and research. Patient spirituality can become particularly important during times of personal crisis, stress, or medical or psychiatric illness and may influence treatment outcomes, sometimes beneficially when it provides strength and support and at other times adversely when it's a source of conflict or distress.

This workshop will follow-up the Oskar Pfister Award lecture and address research findings concerning: 1) spirituality and mental health diagnoses and care, 2) spirituality as a relevant factor for patients with mental health problems and disorders, 3) recent changes in residency training to help address patients' spiritual and religious issues, 4) the need for greater psychiatric collaboration with chaplains and clergy for religious patients, and 5) religious-sector deficits in recognizing and referring patients with psychiatric disorders.

Issues in improving future training and research will be discussed, including taking a spiritual history and recognizing clinical harms or benefits. Psychiatry has this field-opening opportunity to more systematically think through issues of management of spiritual factors in mental health care.

REFERENCES:

1. Koenig HG, McCullough ME, Larson DB: The Handbook of Religion and Health. New York, Oxford University Press, Inc., 2001.
2. Larson DB, Lu FG, Swyers JP: Model Curriculum for Psychiatry Residency Training Programs; Religion and Spirituality in Clinical Practice. Rockville, MD, National Institute for Healthcare Research, 1996. (Rev. 1997).

Component Workshop 46
LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED RESIDENTS: CHALLENGES IN TRAINING
APA Northern California Psychiatric Society's Committee on Lesbian, Gay, Bisexual, and Transgender Issues

Chairperson: Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco, CA 94110*
Participants: Ellen Haller, M.D., Rodney J. Erwin, M.D., Kristin P. Riley-Lazo

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify needs of lesbian, gay, bisexual, and transgendered psychiatry residents and ways to improve the training experience for these residents.

SUMMARY:

This workshop will identify needs of lesbian, gay, bisexual, and transgendered (LGBT) psychiatry residents and discuss how training programs can foster a supportive and effective learning environment. Challenges LGBT psychiatry residents may face, such as isolation and stigmatization, will be presented. Essentials in curriculum in LGBT issues will be discussed. Issues arising in supervision and concerning disclosure will be addressed. The presenters will share their experiences as residents and faculty using clinical and personal vignettes. Audience members will be asked to discuss issues facing LGBT residents at their training programs and the varied responses of these programs. Strategies for residents and faculty to improve the residency training experience will be identified from this discussion.

REFERENCES:

1. Polansky JS, Karasic DH, Speier PL, et al: Homophobia: therapeutic and training considerations for psychiatry. Journal of the Gay and Lesbian Medical Association 1997; 1:41–47.
2. Townsend MH, Wallick MM, Combre KM: Gay and lesbian issues in residency training at U.S. psychiatry programs. Academic Psychiatry 1993; 17:67–72.

Component Workshop 47
NEW TRENDS AND CHALLENGES IN RESIDENCY EDUCATION
APA Committee on Graduate Education

Co-Chairpersons: Joyce A. Tinsley, M.D., *Department of Psychiatry, University of Connecticut, 263 Farmington, Farmington, CT 06030,* Paul E. Holtzheimer III, M.D., *3809 North Whitman Avenue, #32, Seattle, WA 98103*
Participants: Leighton Y. Huey, M.D., Laura B. Dunn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge about three challenges for residency education: teaching residents to teach other residents and medical stu-

dents; teaching an evidence-based curriculum; and integrating residency education with a plan for lifelong learning.

SUMMARY:

This workshop is for participants who are directly involved with psychiatric education as learners or teachers. The Committee on Graduate Medical Education predicts that three areas will receive greater attention in the future. Teaching residents to teach continues to be a challenge. Studies show that even top residents have varying aptitudes for teaching. Why and how to improve resident teaching will be explored. The presenters are residents and faculty, which should spark the audience to discuss the issue from both points of view.

Evidence-based medicine is a term that may be used to a greater extent than it is understood. Its basic concepts, strengths, and weaknesses will be discussed. The audience will participate in a discussion of how evidence-based curricula can enhance psychiatric education.

The American Board of Medical Specialties is actively discussing the possibility of linking lifelong learning to maintenance of board certification, not only in psychiatry but also in medicine as a whole. The workshop will serve as a forum for discussion about ways to help residents develop a plan for lifelong learning before they enter practice.

REFERENCES:

1. American Board of Medical Specialties and the Council of Medical Specialty Societies: Lifelong Learning and Self-Assessment: The Relationship to Maintenance of Certification. Chicago, 2001.
2. Geddes J, Carney S: Recent advances in evidence-based psychiatry. Canadian Journal of Psychiatry 2001; 46:403–406.

Component Workshop 48
HIPAA PRIVACY RULE: WHAT EVERY PSYCHIATRIST NEEDS TO KNOW
APA Council on Psychiatry and Law and APA Committee on Confidentiality

Chairperson: Jeffrey L. Metzner, M.D., *Department of Psychiatry, University of Colorado, 3300 East First Avenue, Suite 590, Denver, CO 80206-5808*
Participants: Margo P. Goldman, M.D., William M. Reinhart

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be knowledgeable about the requirements of HIPAA, with specific reference to psychotherapy notes and the "minimum necessary" disclosure requirements.

SUMMARY:

This presentation will provide a basic overview of the the HIPAA regulations with a focus on issues relevant to the practice of psychiatry. The definition of psychotherapy notes under these regulations will be highlighted due to the extra privacy protections available for such notes. An attorney from the Office of Civil Rights within HHS, which is the agency responsible for enforcement of the privacy regulations under HIPAA, will present this overview. Issues pertinent to the minimum necessary disclosure requirements and APA's efforts to provide guidelines concerning such a requirement will be presented by Margo Goldman, M.D. (Chair, Committee on Confidentiality). These efforts had been coordinated with many components within APA including the Council on Psychiatry and Law, Committee on Confidentiality, Joint Commission on Government Relations, and the Assembly.

REFERENCES:

1. Gostin LO: National health information privacy: regulations under the Health Insurance Portability and Accountability Act. JAMA 2001; 285:3015–3021. http://www.hhs.gov/ocr/hipaa

Component Workshop 49
MEETING THE MENTAL HEALTH NEEDS OF MINORITIES IN THE 21ST CENTURY
APA/Center for Mental Health Services Minority Fellows and APA/AstraZeneca Minority Fellows

Chairperson: Michael J. Pratts, M.D., *P.O. Box 1054, New York, NY 10113-1054*
Participants: Alvaro Camacho, M.D., Cherry Chevy, M.D., Denise De Guzman, M.D., Nancy Sheng-Shih Wu, M.D., Bethany J. Tucker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that culture may influence patients' signs of mental illness.

SUMMARY:

David Satcher, M.D., writes: "With a seemingly endless range of subgroups and individual variations, culture is important because it bears upon what all people bring to the clinical setting. It can account for minor variations in how people communicate their symptoms, and which ones they report. Some aspects of culture may also underlie culture-bound syndromes—sets of symptoms much more common in some societies than in others. More often, culture bears on whether people seek help in the first place, what types of coping styles and social supports they have, and how much stigma they attach to mental illness. Culture also influences the meanings that people impart to their illness. Consumers of mental health services, whose cultures vary both between and within groups, naturally carry this diversity directly to the service setting.

What becomes clear is that culture and social contexts, while not the only determinants, shape the mental health of minorities and alter the types of mental health services they use. Cultural misunderstandings between patient and clinician, clinician bias, and the fragmentation of mental health services deter minorities from accessing and utilizing care and prevent them from receiving appropriate care. These possibilities intensify with the demographic trends highlighted at the end of the chapter."

REFERENCES:

1. Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services; 2001.
2. Peifer KL, Hu T, Vega W: Help seeking by persons of Mexican origin with functional impairments. Psych Serv 2000; 51:1293–98.

THURSDAY, MAY 23, 2002

Component Workshop 50
CAREER CHOICES IN PSYCHIATRY
APA Assembly Committee of Area Member-in-Training Representatives

Co-Chairpersons: Shauna P. Reinblatt, M.D., *263-10 74th Avenue, #C6, Glen Oaks, NY 11004,* Pamela J. Petersen-Crair, M.D., *6324 Mercer Street, Houston, TX 77005-3346*
Participants: Blaine S. Greenwald, M.D., Keith W. Young, M.D., Scott Masters, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will recognize several pros and cons of a career in general private practice, child and adolescent, geriatric and community psychiatry, the benefits and drawbacks to different practice settings, how choosing a fellowship might impact their career.

SUMMARY:

Psychiatric residents are faced with increasingly diverse career choices in the currently evolving health care climate. Not only are more specialty training programs available to psychiatric residents, but the types of practice settings continue to grow as well. Residents must ask themselves whether they should specialize or not, and in which work settings their goals would be best achieved. This workshop will: 1) help residents learn more about several specialty areas in psychiatry (general private practice, child and adolescent, geriatric, and community psychiatry), 2) inform residents about the decision between a general psychiatric practice and a subspecialty, 3) help members-in-training formulate questions regarding which work setting suits them (private, community, academic), and 4) give suggestions about what residents can do now to help them make an informed decision for their career pathway. After a brief introduction, several early career psychiatrists will describe their respective fields and how they made their career choices. They will review the reasons for their career choices, including the post-residency training they pursued and the pros and cons of their field. Panelists will discuss what drew them to their current work settings and the daily practice realities of their area of interest. Next, there will be an interactive question period. During the final half-hour, attendees will separate into four groups led by each of the four panelists. Participants will join the group that interests them for a more targeted exploration of that field. At the end of this workshop, residents will be better prepared to choose their future career path.

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 51
CODING AND DOCUMENTATION UPDATE
APA Committee on RBRVS, Codes, and Reimbursements

Co-Chairpersons: Chester W. Schmidt, Jr., M.D., *Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, A4C, Baltimore, MD 21224-2735,* Tracy R. Gordy, M.D., *1600 West 38th Street, #321, Austin, TX 78731-6406*
Participants: Ronald A. Shellow, M.D., Gerald Rogan, M.D., Joseph M. Schwartz, M.D., Edward Gordon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants will: be given a practice expense update, be knowledgeable about documentation developments, and have questions answered about their coding problems.

SUMMARY:

The goals of the workshop are to inform practioners about developments in the RBRVS payment system, CPT coding, and documentation guidelines that effect their practices. This years update will focus on APA's efforts to preserve the practice expense component of RBRVS medicare payments, current and future changes in CPT coding, and documentation guideline developments. Time will be reserved for questions about the above topics as well as issues and problems facing the individual participants.

Component Workshop 52
PSYCHOLOGICAL ISSUES OF PEOPLE LIVING LONGER WITH HIV
APA Commission on AIDS

Chairperson: Warren M. Liang, M.D., *Department of Psychiatry, University of Cincinnati, PO Box 670559, Cincinnati, OH 45267*
Participants: Karl Goodkin, M.D., Robert S. Stasko, M.D.

EDUCATIONAL OBJECTIVES:

To be able to outline the impact of HIV-related changes in cognitive functioning, to list some of the complex considerations regarding reproductive decision-making, and to understand the impact of changes in the physical appearance and systemic functioning of HIV-infected patients.

SUMMARY:

During the early history of HIV, an HIV-positive diagnosis was for many people equivalent to a death sentence. HIV-infected individuals examined their lives and made changes in their relationships, finances, and careers in light of the context of impending illness and death. As more and more HIV-infected patients experience longer life spans because of recent treatment advances, the psychosocial issues can become even more complex compared with the early days of HIV. Ambiguity regarding long-term treatment success and toxic side effects, the possibility of cognitive impairment well before an AIDS diagnosis might be given, the choices and stigma attached to reproductive decision-making, and the psychological and social consequences of changes in physical appearance and functioning can greatly affect HIV-infected patients and present particular challenges for the psychiatrist.

This workshop will focus on these important issues and present a forum for open as well as clinical case discussion.

REFERENCES:

1. Clay D: Mental health and psychosocial issues in HIV care. Lippincotts Prim Care Pract 2000; 4: 74–82
2. Cournos F, Forstein M (eds.): What Mental Health Practitioners Need to Know about HIV and AIDS. New Dir Ment Health Serv 2000; (87).

Component Workshop 53
INFORMATION TECHNOLOGY: CORE COMPETENCIES FOR PSYCHIATRISTS
APA Committee on Information Technology

Chairperson: Ronnie S. Stangler, M.D., *1425 Western Avenue, Suite #101, Seattle, WA 98101-2036*
Participants: Thomas A.M. Kramer, M.D., Zebulon C. Taintor, M.D., David F. McMahon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, physicians will have developed a functional perspective to their ongoing development of personal technology skills.

SUMMARY:

The simultaneous explosion of new kinds and sources of medical information coupled with technology and telecommunications advances require every physician to contend with a dizzying amount of information, often not well integrated or synthesized, and to utilize that information in a safe and private manner to effect best patient care. Certainly there must exist a set of core competencies for those of us who practice medicine, a kind of information technology toolkit that will help us negotiate and effectively utilize this entropic mass.

We propose a functional perspective to consider technology and its place in medicine. Technology can support the fundamental roles

of physicians as lifelong learner, clinician; educator/communicator; researcher; manager; and participant in systems. This context will drive what we agree to be a minimal set of competencies. The psychiatrist's toolkit will consist less of hardware or software specifics, but more about principles and applications. In that context, we will describe proposed components of an information technology toolkit for psychiatrists.

REFERENCES:

1. American Association of Medical Colleges: Medical School Objectives Project. Report II. Contemporary Issues in Medicine: Medical Informatics and Population Health. 1998. http://www.aamc.org/meded/msop/report2.htm
2. Institute of Medicine: Crossing the Quality Chasm: A New Health Care System for the 21st Century. National Academy Press, 2001.

Component Workshop 54
SURGEON GENERAL'S REPORT ON CULTURE, RACE, AND ETHNICITY: CLINICAL IMPLICATIONS
APA Council on National Affairs

Co-Chairpersons: Sylvia W. Olarte, M.D., *Department of Psychiatry, New York Medical College, 37 East 83rd Street, #1, New York, NY 10028,* Theresa M. Miskimen, M.D., *Department of Psychiatry, UMDNJ, Newark Campus, 215 South Orange Avenue, Newark, NJ 07103*
Participants: Robert P. Cabaj, M.D., Nang Du, M.D., R. Dale Walker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand issues related to health-seeking behavior and recognize appropriate treatment modalities for racial and ethnic minority groups.

SUMMARY:

The Surgeon General's supplement on the interaction of culture, race, and ethnicity on mental health made it clear that a challenge for clinicians in the near future will be to eliminate disparities that affect mental health care of psychiatric patients from minority groups. These disparities, including less likelihood to seek and receive good quality mental health treatment, need to be understood and addressed not only by researchers but also by clinicians who will ultimately confer services. To this purpose we have assembled a panel of clinicians to discuss how this report could and should be translated into the daily delivery of mental health services for minority populations. The panelists will address the impact of culture, race, and ethnicity on health-seeking behaviors and will discuss results of evidence-based research on treatment modalities. In particular, health-seeking behavior and treatment modalities will be discussed for each of the four major racial and ethnic minority groups according to federal classifications: African Americans; American Indians, Alaska Natives and Native Hawaiians; Asian Americans and Pacific Islanders; white Americans; and Hispanic Americans. This presentation is geared toward clinicians in a position to provide direct patient care to minority populations and to any person interested in understanding how culture, race, and ethnicity affect the clinical practice of psychiatry.

REFERENCES:

1. Mental Health: Culture, Race, and Ethnicity-A supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001
2. Gallo JJ, Marino S, Ford D, Anthony JC: Filters on the pathway to mental health care, II. sociodemographic factors. Psychological Medicine 1995; 25:1149–1160.

Component Workshop 55
BAD BOYS, BAD GIRLS: THE DEMONIZATION OF ADOLESCENCE
APA Committee on Juvenile Justice Issues

Chairperson: Louis J. Kraus, M.D., *Department of Psychiatry, Evanston NW Healthcare, 2650 Ridge Avenue, Evanston, IL 60201*
Participants: Wade C. Myers, M.D., Michael G. Kalogerakis, M.D., Daphne Dorce, M.D., Lois Flaherty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand minority over-representation in juvenile justice; understand zero tolerance in school systems; understand concerns of placing youth in adult corrections facilities.

SUMMARY:

Adolescent development is complex. Our society's tolerance and response to delinquent behavior has been variable. Concern at present is that we are focusing more on punitive than rehabilitative approaches. This workshop will focus on society's demonization of adolescence. This session is for residents and attending psychiatrists who have a particular interest in child advocacy, education, and juvenile court. Each topic will be presented for 15 minutes through a slide or power-point presentation. We will allow one-half hour for discussion of questions and topics. The workshop will start with a historical perspective on adolescent violence in America, followed by a presentation on zero-tolerance policies within school systems towards substance abuse and violent behavior. The third speaker will present a discussion of cultural competency, the understanding of different ethnic, cultural, and minority groups as they present to juvenile court and over-representation of African Americans in juvenile detention facilities. The last presentation will focus on the increased numbers of youth placed in adult corrections and the lack of practice parameters to assist with children in adult facilities at this time.

REFERENCES:

1. Surgeon General's Report on Youth Violence.
2. Hamparian D, Leiber M: Disproportionate confinement of minority juveniles in secure facilities: 1996 National Report. Champaign, IL., Community Research Associates, 1997.

Component Workshop 56
GUIDELINES FOR THE TREATMENT OF SUICIDAL BEHAVIORS
APA Steering Committee on Practice Guidelines

Chairperson: John S. McIntyre, M.D., *Department of Psychiatry, Evelyn Brandon Health Center, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*
Participants: Douglas G. Jacobs, M.D., Yeates Conwell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to provide an update concerning the overall progress of the APA practice guidelines effort and obtain feedback on a wide variety of issues relating to the Suicide Management Practice Guideline.

SUMMARY:

APA has published 12 guidelines using an evidence-based process resulting in documents that are both scientifically sound and clinically useful to practicing psychiatrists. A work group has begun to develop a guideline on suicidal behaviors. Although this guideline is not disorder specific as are the other APA practice guidelines, we are

proceeding because of the seriousness of these behaviors and the importance of identifying clinically useful strategies.

In this workshop members of the work group will present key recommendations in the guideline and identify the evidence that supports these recommendations. Case vignettes will be used to demonstrate these principles, and audience participation will be encouraged to discuss the implementation of the guideline. Dissemination and evaluation strategies for this guideline will also be discussed.

REFERENCES:

1. Hirschfeld RM, Russel JM: Assessment and treatment of suicidal patients. N Engl J Med 1997; 337:910–5.
2. The Harvard Medical School Guide to Suicide Assessment and Intervention, edited by Jacobs DG. San Francisco, Jossey-Bass, 1999.

Component Workshop 57
ASIAN AMERICANS IN INTERMARRIAGES: PSYCHOSOCIAL ADJUSTMENT AND IDENTITY
APA Caucus of Asian-American Psychiatrists

Chairperson: Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, Southern Illinois University, Choate Mental Health Center, Anna, IL 62906*
Participants: Prakash N. Desai, M.D., Kathleen M. Kim, M.D., Francis G. Lu, M.D., Cynthia M. Nguyen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be able to learn of important issues regarding Asian Americans in intermarriages such as potential areas of conflict, personal identity, effective ways towards psychosocial adjustment, child rearing, and children's identity.

SUMMARY:

Asian Americans comprise about 4.2% of the population in the United States, and they come from heterogenous backgrounds. The countries of origin of Asian Americans vary considerably. Major faiths of Asian Americans include Buddhism, Christianity, Hinduism, and Islam. There are differences in their races and ethnicity, and they speak numerous different languages. Asian intermarriages are becoming commonplace in the American melting pot. Potential areas of difficulty in intermarriages include problems in communication, including nonverbal communication, prejudices and stereotypes, surrounding family, concept of marriage, language barrier, differences in values, differing cultural objectives for marriage, intimacy, identity, child rearing, division of labor and responsibility, nature of love, degree of acculturation, and religious and racial differences. Following the introduction of the subject matter by the chair, the four intermarried faculty, a naturalized citizen of Asian-Indian origin and one each of first-generation Americans of Korean, Chinese, and Vietnamese origin will share from personal experience and common wisdom about personal identity the challenges involved in effective adjustment to intermarriage as well as rearing children and their identity. Audience participation will be strongly encouraged.

REFERENCES:

1. Pathy Salett E, Koslow D: Race, Ethnicity and Self: Identity in Multicultural Perspective. NCMI Publications, Washington DC, 1994.
2. Spickard PR: What must I be? Asian Americans and the question of multiethnic identity. Amerasia Journal, 1997; 23:43–60.

MONDAY, MAY 20, 2002

Issue Workshop 1
HOW TO GET THE MOST OUT OF SUPERVISION: WHAT RESIDENTS NEED TO KNOW

Chairperson: Sarah M. Whitman, M.D., *9 Tohopeka Lane, Philadelphia, PA 19118-3823*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to maximize the benefit of their psychotherapy supervision by understanding 1) pros and cons of different types of supervision, 2) useful characteristics of supervisees, 3) what to expect of their supervisors, and 4) how to address problems in supervision. Residents will also set goals for supervision and learn how to meet them.

SUMMARY:

Psychotherapy supervision is one of the most important avenues through which residents learn psychotherapy. However, instruction on how to effectively use supervision is minimal. This workshop will help students prepare for and maximize their learning in supervision. Participants' experiences will be reviewed, focusing on what types of supervision are available and what contributes to either a positive or negative outcome. Why supervision is hard for trainees will be discussed, and ways to decrease anxiety will be presented. Included in this section will be a discussion of professional versus personal issues in supervision. Residents will learn what the characteristics of good supervisees and good supervisors are, including what is reasonable to expect from supervisors. Students will set goals for their supervision and learn how to meet them. Problems that occur in supervision and how to address them will be reviewed. The workshop will be highly interactive, with most examples drawn from participants' supervision experiences. Personalized worksheets for supervision goals and supervision agreements will be used.

REFERENCES:

1. Whitman SM: Teaching residents 'an introduction to supervision'. Academic Psychiatry, in press.
2. Berger SS, Buchholz ES: On becoming a supervisee: preparation for learning in a supervisory relationship. Psychotherapy: Theory, Research, Practice and Training 1993; 30:86–92.

Issue Workshop 2
NURSING HOME PSYCHIATRY: PROBLEMS AND SOLUTIONS

Chairperson: Marc I. Rothman, M.D., *Department of Psychiatry, Hampton Hospital, 650 Rancocas Road, Westhampton, NJ 08060*
Participants: Istvan J.E. Boksay, M.D., David L. Snyder, M.D., Nancy O'Dowd

EDUCATIONAL OBJECTIVES:

To improve geropsychiatric care skills of nursing home staff; effectively utilize psychotropic medicines in the nursing home within federal guidelines; manage marital and intimacy issues in nursing home residents; and intervene with families experiencing a crisis due to the nursing home experience.

SUMMARY:

The workshop will address difficult challenges commonly encountered by psychiatrists working in nursing home settings. These are:

1) enhancing the psychiatric assessment and management skills of all levels of personnel interacting with nursing home residents to increase problem prevention and make psychiatric consultation efforts more effective; 2) understanding the manner of optimizing use of psychotropic medicines while practicing in accordance with federal "OBRA '87" prescribing guidelines; 3) reconciling issues of privacy, safety, and autonomy in working with both married couples in nursing homes and intimate behaviors between nonmarried residents; 4) assisting family members through the emotional and behavioral crises that they and their elderly relatives in the nursing home often experience; and 5) adhering to Medicare and managed care billing policies in achieving payment for rendered services. Each problem area will be introduced with a vignette designed to elicit approaches from the audience. The audience's comments and responses will be integrated into the discussion of potential approaches and solutions by each workshop presenter.

REFERENCES:

1. Manual of Nursing Home Practice for Psychiatrists, Washington, D.C., American Psychiatric Association, 2000.
2. Reichman WE, Katz IR: Psychiatric Care in the Nursing Home New York, Oxford University Press, 1996.

Issue Workshop 3
COGNITIVE-BEHAVIORAL THERAPY TRAINING FOR RESIDENTS: HOW TO TEACH, MEASURE, AND ATTAIN RESIDENT COMPETENCY

Chairperson: Donna M. Sudak, M.D., *Psychiatry Residency Training Department, MCP Hahnemann University, 3200 Henry Avenue, Philadelphia, PA 19129*
Participants: Judith S. Beck, Ph.D., Jesse H. Wright, M.D., Hinda F. Dubin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to: 1) review model curricula for training in CBT, 2) observe and participate in demonstrations of models and methods for training, 3) use the Cognitive Therapy Rating Scale for evaluating competency, 4) use nationally available resources to improve faculty expertise.

SUMMARY:

In January 2001 ACGME requirements for residency training in psychiatry mandated that training programs demonstrate that residents achieve competency in five forms of psychotherapy, including cognitive-behavioral therapy. Given that CBT has a rich literature regarding therapist training and evaluation of therapist competency, a fairly uniform standard of resident training could be disseminated and evaluated. This workshop will be designed to teach participants key features of a curriculum in cognitive therapy that have been discussed with noted educators in the field and adapted for residency training. The audience will review key features of a didactic program, participate in a demonstration of some of the educational methods available for training residents, and be shown the usefulness of the Cognitive Therapy Rating Scale as one method of assessing resident competence. We anticipate substantial discussion of the barriers to the use of this model in specific residency situations and to problem solve with the audience about these, as well as discussing the difficulty of measuring psychotherapy competence in general. Additionally, the audience will receive information about national resources available to enhance the training of faculty members in CBT. This session is for all interested attendees.

REFERENCES:

1. Shaw et al. Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. J Consulting and Clinical Psychology 1999; 67:837–846.
2. Shaw and Dobson: Competency judgments in the training and evaluation of psychotherapists. J Consulting and Clinical Psychology 1998; 56:666–672.

Issue Workshop 4
SUPERVISION 101: SEX, LIES, AND VIDEOTAPE?

Chairperson: Chelsea L. Chesen, M.D., *University of Arizona, P O Box 245002, Tucson, AZ 85724-5002*
Participants: Francisco A. Moreno, M.D., Gayle Masterson, M.D., John C. Racy, M.D.

EDUCATIONAL OBJECTIVES:

1) To discuss positive aspects of the supervisory relationship as it applies to supervisee education and development, 2) incorporate techniques into supervision that will expand the skill-sets of supervisees, 3) appreciate the centrality of the supervisory relationship as a model for the therapeutic relationship, and 4) discuss potential pitfalls in the supervisory relationship and ways these may be addressed.

SUMMARY:

For psychiatry residents and other trainees, apprenticeship takes place within the supervisory relationship. The supervisor is immensely important to the supervisee's education and training, and their supervisory relationship acts as a model for the supervisee's future therapeutic and supervisory relationships. In this highly interactive workshop, led by members of the University of Arizona department of psychiatry, the supervisory relationship will be explored from the perspectives of the resident/trainee, the recent-residency-graduate turned junior-faculty supervisor, the psychiatry residency training director, and the experienced senior-faculty supervisor. Brief presentations presented by members of the panel will be used to stimulate discussion with workshop attendees. We will look at the positive aspects of the supervisory relationship, including a description of an appropriate supervisory frame. Tips for new and experienced supervisors will be discussed, with a focus on innovative and "tried-and-true" techniques for use in supervision. The panel will also present information related to "parallel process" in supervision and the ways in which this can be used as a tool to improve the outcomes of both supervision and the supervisee's therapeutic work with patients. The panel will discuss some of the potential pitfalls within the supervisory relationship, including boundary violations within the supervisory frame, issues related to the impaired supervisor and/or supervisee, and deception within the supervisory relationship. Case examples will be used to illustrate these concepts and their potential effects on the supervisee's short-term and long-term personal and professional development.

REFERENCES:

1. Hantoot MS: Lying in psychotherapy supervision: why residents say one thing and do another. Academic Psychiatry 2000; 24:179–187.
2. Igartua KJ: The impact of impaired supervisors on residents. Academic Psychiatry 2000; 24:188–194.

Issue Workshop 5
CHILDREN OF PSYCHIATRISTS: 21ST-CENTURY INSIGHTS

Co-Chairpersons: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 South Preston, Suite 214, Louisville, KY 40292,* Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0704, Ann Arbor, MI 48109-0704*
Participants: Gail M. Barton, M.D., Zachary Myers, Elizabeth Bakalar

EDUCATIONAL OBJECTIVES:

To recognize and understand how children think and feel about their psychiatrist-parents.

SUMMARY:

This annual workshop, which enables children of psychiatrists to share personal anecdotes and advice with the audience of psychiatrist-parents and parents-to-be, has been offered to standing-room audiences for five years. While stigma toward psychiatry in general has diminished, psychiatrists, because of training and professional work, bear emotional fears and concerns of how they will and do function as parents. The four presenters will speak for 15 minutes each about their personal experiences and also offer advice to attendees. There will be a brief introduction by Dr. Dickstein to set the tone for the audience, and she and Dr. Riba will lead the 30-minute discussion to follow.

REFERENCES:

1. Dickstein LJ: An interview with Stella Chess, M.D., in Women Physicians in Leadership Roles, edited by Dickstein L, Nadelson C., American Psychiatric Press, Inc., pp. 149–158.
2. Mueller-Kueppers M: The Child Psychiatrist as Father, The Father as Child Psychiatrist (German), Praxis der Kinderpsychologie und Kinderpsychiatrie, Vol. 34(8), Nov.-Dec., 1985, pp. 309–315.

Issue Workshop 6
THE POLICING OF PHYSICIAN-PATIENT BOUNDARIES: SOME INTERNATIONAL PERSPECTIVES

Chairperson: Gail E. Robinson, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada*
Participants: Werner Tschan, M.D., Carolyn Quadrio, M.D., Linda M. Jorgenson, J.D.

EDUCATIONAL OBJECTIVES:

Describe trends in mandatory reporting; list at least three areas of controversy about the Canadian changes; differentiate statutes applying to psychotherapists vs. all physicians.

SUMMARY:

Throughout the 1990s the policing of physician-patient boundaries in psychiatry and other medical specialities has become a major international topic. Major studies in Ontario and British Columbia examined these issues, and the changes in Canadian law and rules attracted attention from the AMA and other groups. The Ontario Task Force recently reviewed and examined the impact of these changes in Canada in a major report. At present some of these issues are under evaluation by the Canadian Supreme Court. Issues of physician rights vs. regulations have come under examination.

Simultaneously, research and regulatory debate was taking place throughout the world. The various Australian and New Zealand medical councils, for example, focused on their own research findings and disciplinary experience and re-examined the role of their institutions and their disciplinary processes. Parallel events took place in Europe with special task forces set up in some countries, a major governmental study and report in Germany, new laws in the Netherlands, and a major Swiss effort. In Switzerland an interdisciplinary approach has led to two major conferences sponsored by a new organization named AGAVA. The attorney member of the panel will present a legal perspective on the evolution of regulatory standards, criminal and civil statutes, and civil litigation. But the focus of our discussion will be on the larger picture—how these developments fit togther, or fail to fit together. We also hope to examine similarities and differences between the USA, Canada, Europe, and Asia.

REFERENCES:

1. Bloom JD, Nadelson CC, Notman, MT: Physician Sexual Misconduct. Washington, DC, American Psychiatric Press, 1999.
2. Bisbing S, Jorgenson LM, Sutherland P: Sexual Abuse by Professionals: A Legal Guide. Charlottesville, Va., Michie Co., 1995 (with 1997 & 1999 updates).

Issue Workshop 7
PERSONALITY DISORDERS IN THE MENTAL RETARDATION AND DEVELOPMENT DISORDERS POPULATION

Co-Chairpersons: Harvey Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504,* Susan Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504*
Participant: Michael M. Scimeca, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop, participants will begin to be able to distinguish elements of traditional personality disorders in the MRDD population.

SUMMARY:

Although all diagnoses of mental retardation and development disorders are diagnosed on Axis II according to DSM-IV TR, we have generally ignored the traditional Axis II diagnoses, personality disorders, in this population. When the behavioral disturbances so frequently manifested by this population are examined this is hardly ever focused upon. Instead, if a behavior is not felt to be susceptible to pharmacological treatment, it is labeled "behavioral," and the discourse ends. Why are we not then pursuing the possibility of traditional personality disorders?

This workshop will focus on the subject of mental retardation and development disorder patients with apparent "dual Axis II diagnosis,"—one of them appearing to have a personality disorder. The audience will be asked to draw on its own specialized experience in the field. This workshop will continue discussions about the need for mental retardation and development disorder treatment to be considered part of mainstream psychiatry.

REFERENCES:

1. Xenit, Ides, KI, et al: An inpatient treatment model for adults with mild intellectual disability and challenging behavior. J. Intellectual Disability Research 1999; 43 (Pt. 2):128–34.
2. Maughan B, et al: Mild mental retardation: psychosocial functioning in adulthood. Psychol Med 1999; 29:351–66.

Issue Workshop 8
THE IMPACT ON CLINICIANS OF SUICIDE

Co-Chairpersons: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262,* Jane G. Tillman, Ph.D., *Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262*
Participants: Edward R. Shapiro, M.D., Edward K. Rynearson, 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 steps in coming to grips with such tragic but often inevitable events.

SUMMARY:

It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. Mental health clinicians often have less contact with death in their work with patients than clinicians from other medical 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, as well as the intentional empathic attunement and emotional availability to patients that is part of mental health clinical work. This workshop offers an initial half-hour presentation from a pilot study that found seven thematic clinician responses to the suicide of a patient: 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. Exploring therapist responses offers an opportunity to anticipate and avoid professional isolation and disillusionment and may help professionals provide and receive help during such crises. The remainder of the workshop will be a highly interactive opportunity for participants to discuss their own experiences with patient suicides.

REFERENCES:

1. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138–148.
2. Powell J, Geddees J, Deeks J, et al.: Suicide in psychiatric hospital patients. British Journal of Psychiatry 2000; 176:266–272.

Issue Workshop 9
CAREER DEVELOPMENT FOR INTERNATIONAL MEDICAL GRADUATES

Chairperson: Renato D. Alarcon, M.D., *Atlanta VA Medical Center, 1670 Clairmont Road, Atlanta, GA 30033*
Participants: Nyapati R. Rao, M.D., Norma C. Panahon, M.D., Gabrielle F. Beaubrun, M.D., Jennifer I. Downey, M.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to identify unique needs of IMGs in setting up a practice, developing careers in public psychiatry, and treating ethnically diverse populations.

SUMMARY:

Statistics from the American Medical Association show that 42 percent of all general psychiatry residents are international medical graduates (IMGs). Research also shows that IMGs practice more frequently in the public sector, and as a result serve more ethnically diverse populations. This workshop, geared toward resident and early career IMGs, will serve to identify and discuss the special needs of IMGs, including challenges surrounding acculturation, cultural competency training, overcoming barriers to setting up a practice, and issues and challenges in public sector psychiatry.

REFERENCES:

1. Salsberg E, Nolan J: The posttraining plans of international medical graduates and US medical graduates in New York State. JAMA 2000; 183:1749–1750.
2. Fiscella K, Frankel R: Overcoming cultural barriers: international medical graduates in the United States. JAMA 2000; 183:1751.

Issue Workshop 10
EVALUATION OF TELEPSYCHIATRY SERVICES IN AN INTEGRATED HOSPITAL SYSTEM IN THE VETERANS ADMINISTRATION AND DEPARTMENT OF DEFENSE

Co-Chairpersons: Paul E. Ruskin, M.D., *5700 Ridgedale Road, Baltimore, MD 21209-4220,* Stephen J. Cozza, M.D., *Department of Psychiatry, WRAMC, 11524 Gauguin Lane, Potomac, MD 20854-3206*
Participants: Brian J. Grady, M.D., Stephen I. Deutsch, M.D., James J. Nocks, M.D.

EDUCATIONAL OBJECTIVES:

Participants will learn of the status of telepsychiatry in integrated health care delivery systems in the VA and DoD. Telepsychiatry can deliver services in "real-time" to remote and inaccessible sites (e.g., outpatient clinics, ships, and overseas). Outcome measures for utilization and effectiveness, applications to children, and original research will be presented.

SUMMARY:

Telepsychiatry is a novel means of providing expert psychiatric treatment to patients at a distance from the source of care. It has been suggested for the treatment of patients in remote locations or in areas where psychiatric expertise is unavailable. The use of telepsychiatry raises a number of issues that are not encountered in routine, face-to-face clinical care. These include (1) technical issues such as the cost and quality of equipment; (2) staff training in the use of the equipment; (3) staff buy-in/utilization; (4) determining which clinical problems are appropriate for telepsychiatric intervention; (5) performance monitors—how to measure interventions to determine success; (6) unique ethical/legal issues pertaining to telepsychiatry; (7) patient and provider satisfaction; (8) licensing and reimbursement issues.

This workshop is designed as an opportunity for clinicians who are currently using telepsychiatry to share experiences and problem solve solutions, as well as for those who have not used this treatment modality but might want to do so. The presenters will describe clinical and research experiences with telepsychiatry in an integrated network of VA hospitals and in Army and Navy military facilities, which should serve as a jumping off point for a discussion of the issues named above. Importantly, telepsychiatric services in each of the three examples are at different stages of implementation and serve unique clinical niches. There will be a discussion of the use of telepsychiatry in child as well as adult populations.

REFERENCES:

1. Ruskin PE, Reed S, Kumar R, et al: Reliability and acceptability of psychiatric diagnosis via telecommunication and audiovisual technology. Psychiatric Services. 1998; 49:1086–1088.
2. Baer L, Elford R, Cukor P: Telepsychiatry at 40: What have we learned? Harvard Rev Psychiatry. 1997; 5:7–17.

Issue Workshop 11
ACCESS TO PSYCHOTHERAPY TRAINING IN RESIDENCY: A CURRENT PERSPECTIVE

Chairperson: Robert W. Guynn, M.D., *Department of Psychiatry, 1300 Moursund Street, Suite 206, Houston, TX 77030*
Participants: Sandra Sexson, M.D., Anu A. Matorin, M.D., Vinay Kapoor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the audience will have a greater appreciation of the challenges faced by academic centers in providing access to psychotherapy training. Discussions will identify creative strategies and solutions with the hope developing training modules to address this issue.

SUMMARY:

The importance of psychotherapy training as a core aspect of psychiatry residency cannot be underestimated. Until recently, psychiatry residents were reimbursed by third-party payors for providing services. However, currently most third-party payors are unwilling to pay for resident-driven services. This has placed an undue burden on psychiatry departments to fund resident training through other means. Despite the fact that most training programs require psychiatry residents to achieve competency in different modalities of psychotherapy, because of the current situation some residency training programs have cut back on psychotherapy training or considered eliminating it altogether. An unintended consequence may be that a generation of psychiatric trainees believes that they will not be prac-

ticing psychotherapy. Highly tuned skills of listening and observation and a sensitivity to the subtleties of interpersonal interactions are important in every aspect of the treatment process. In addition, psychiatrists in hospital and community settings provide consultation services for other staff and leadership in a multidisciplinary treatment team. The current situation offers unanticipated challenges for academic psychiatry and provides the opportunity to come up with creative strategies and solutions in training residents in the area of psychotherapy. A survey of residency programs regarding this issue will be highlighted.

REFERENCES:

1. Hoge M, Jacobs S, Belitsky R: Psychiatric residency training, managed care, and contemporary clinical practice. Psychiatric Services 2000; 51:1001–1005.
2. Panzarino P: Psychiatric training and practice under managed care. Administration and Policy Mental Health 2000; 28:51–59.

Issue Workshop 12
USE OF THE PERSONAL DIGITAL ASSISTANT IN PSYCHIATRY
Psychiatric Society of Informatics

Chairperson: John Luo, M.D., *Department of Psychiatry, University of California Davis Health Systems, 2230 Stockton Boulevard, Sacramento, CA 95817*
Participants: Daniel A. Deutschman, M.D., Sol Herman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, physicians will better understand ways that the personal digital assistant (PDA) can support the practice of psychiatry.

SUMMARY:

The practice of medicine depends upon information to make decisions that affect the health and quality of life of our patients. Due to the organizational demands to manage such information, personal digital assistants (PDAs) have been extremely useful in transmitting, storing, and retrieving the information needed for the patient care. PDAs are more than an organizational tool, as more medical applications have been developed in recent years. In this workshop we will review some essential PDA applications in medicine and psychiatry. We will address the finding and downloading of medical software programs, synchronizing information (such as abstracts to the American Journal of Psychiatry), using the PDA for writing progress notes, and utilizing the various pharmaceutical information software packages available. In addition, we will demonstrate the use of PDAs to give presentations, access e-mail, surf the Internet, and write prescriptions. There will also be reviews of Internet references, patient tracking and billing software, and accessory features, such as keyboards and cameras.

REFERENCES:

1. Luo J, Hales R, Hilfy D, Brennan C: Clinical computing: electronic sign-out using a personal digital assistant. Psychiatr Serv 2001; 52:173–4.
2. Grasso BC, Genest R: Clinical computing: use of a personal digital assistant in reducing medication error rates. Psychiatr Serv 2001; 52:883–6. Abstract.

Issue Workshop 13
SCHIZOPHRENIA WITH COMORBID CONDITIONS: CLINICAL AND RESEARCH ISSUES

Co-Chairpersons: Michael Y. Hwang, M.D., *Department of Psychiatry, East Orange VA Medical Center, 385 Tremont Avenue, East Orange, NJ 07018-1095,* Miklos F. Losonczy, M.D., *Department of Mental Health, VA NJ Health Care System, 151 Knollcroft Road, Lyons, NJ 07939*
Participants: Lewis A. Opler, M.D., Naveed Iqbal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will be familiar with the current state of knowledge in some of the common and challenging comorbid conditions of schizophrenia and better able to manage these patients.

SUMMARY:

Schizophrenic spectrum disorder has been known to encompass diverse clinical phenomena. Recent psychiatric research has demonstrated varying neurobiological abnormalities in schizophrenic illness. This clinical and biological diversity in schizophrenia continues to challenge researchers as well as practicing clinicians in terms of assessment and treatment. Recent epidemiological and clinical evidence suggests that schizophrenics with comorbid conditions such as depression, OCD, substance abuse, and impulsive-aggressive behaviors may account for considerable part of schizophrenic heterogeneity and require specific pharmacological and behavioral treatment intervention. The proposed workshop will review recent research findings and discuss the clinical management and research approaches of schizophrenia patients with comorbid conditions. Dr. Opler will review and discuss the psychometric issues of comorbidity in schizophrenia. Dr. Iqbal will review the current clinical and neurobiological considerations of schizophrenic comorbidity. Dr. Hwang will discuss the diagnostic and treatment challenges of comorbid anxiety symptoms in schizophrenia. Dr. Losonczy will discuss the psychosocial rehabilitation in schizophrenia with comorbid conditions. At end of the presentation participants will be encouraged to share their clinical experience.

REFERENCES:

1. Hwang MY (Guest Editor): Management of schizophrenia with comorbid conditions. Psychiatric Annals, January 2000.
2. Hwang MY, Bermanzohn PC (Editors): Schizophrenia with Comorbid Conditions: Diagnosis and Treatment. APA Clinical Monograph Series, Washington, DC, APPI, 2001.

Issue Workshop 14
PSYCHOTHERAPY TRAINING FOR THE 21ST-CENTURY PSYCHIATRIST

Co-Chairpersons: Diane M. Roston, M.D., *6 South Park Street, Lebanon, NH 03766-1300,* Rebecca R. Neal, M.D., *New Hampshire Hospital, 36 Clinton Street, Concord, NH 03301*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the psychotherapy fundamentals necessary for the competent 21st-century psychiatrist.

SUMMARY:

With the explosion of evidence demonstrating the benefit of many psychotherapeutic interventions, it is imperative to define a lexicon of psychotherapy concepts and practices necessary for the psychiatrist of the 21st century. The Accreditation Council for Graduate Medical Education requires that a residency program demonstrate that residents have achieved competency in at least the following forms of treatment: brief therapy, cognitive-behavioral therapy, combined psychotherapy and psychopharmacology, psychodynamic therapy, and supportive therapy (ACGME Program Requirements, 2001).

With limited time for training or continuing education, what key components of psychotherapy practice are fundamental for all psychiatrists? In this workshop, the co-presenters will briefly review recent psychotherapy outcomes research and published psychotherapy guidelines. They will present as a catalyst for discussion a summary of the psychotherapy didactic seminar that they have co-taught for several years at Dartmouth Medical School. Participants will have

the opportunity to collaborate toward the goal of identifying what components of psychotherapy theory and practice are vital to the future of psychotherapy in the psychiatric profession.

REFERENCES:

1. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice: The DSM-IV Edition. Washington, DC, American Psychiatric Press, 1994.
2. Sabo A, Havens L: The Real World Guide to Psychotherapy Practice. Cambridge, MA, Harvard University Press, 2000.

Issue Workshop 15
TRAINING A CULTURALLY COMPETENT PSYCHIATRIC WORKFORCE

Co-Chairpersons: Janet E. Osterman, M.D., *21 Ocean View Drive, Hingham, MA 02043-1224,* Albert C. Gaw, M.D., *San Francisco Mental Health Rehab. Facility, 887 Potrero Avenue, San Francisco, CA 94110*
Participant: Joop De Jong, M.D.

EDUCATIONAL OBJECTIVES:

The participant will demonstrate attitudes, knowledge, and skills about transcultural psychiatry and be able to develop a transcultural curriculum, complete a culturally competent assessment and treatment plan, including appropriate ethnopsychopharmacology.

SUMMARY:

The United States has a multicultural population with increasing diversity as more refugees enter from war-torn areas of the world, more people immigrate, and through growth of the existing minority populations. Health organizations and residency training programs require that psychiatrists and trainees be educated in transcultural psychiatry to effectively function in this multicultural society. The Surgeon General's recent report indicates that we have not yet met the goal of cultural competency in meeting the mental health needs of patients from diverse cultural backgrounds. The practice of culturally competent mental health care requires that psychiatrists develop certain attitudes, knowledge, and skills to enhance their effectivencss in working with patients from different cultures. This workshop will present an educational curriculum in transcultural psychiatry that can be adapted for residency training or continuing education to reach the goal of cultural competent psychiatric practice. Participants will be asked to explore and discuss their experience, knowledge, and attitudes about treating patients from diverse cultural backgrounds. The presenters will teach in an interactive style how to perform a culturally competent assessment and develop a culturally competent treatment plan including a special section on ethopharmacology. The session will end with the panel responding to participants' questions.

REFERENCES:

1. Gaw A: Cross-cultural psychopharmacology. In Concise Guide to Cross-Cultural Psychiatry, Washington, DC, American Psychiatric Press.
2. de Jong J: (Ed.) War and Violence: Public Mental Health in the Sociocultural Context. New York, Plenum-Kluwer, 2002.

Issue Workshop 16
TRANSGENDER CARE: NEW PERSPECTIVES

Chairperson: Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco, CA 94110*
Participants: Daniel Garza, M.D., Vernon A. Rosario, M.D., Melanie E. Spritz, D.O.

EDUCATIONAL OBJECTIVES:

To better assess gender identity and gender dysphoria; understand consequences of transitioning, cultural issues, and issues facing transgendered youth.

SUMMARY:

Psychiatrists now recognize the utility of a respectful, nonpathologizing approach to the spectrum of transgendered patients seeking treatment for disorders related or unrelated to transgenderism. This workshop will present general principles of care of these patients, as well as presenting perspective on care of diverse transgendered populations, including youth, diverse ethnicity, and those whose gender identity falls outside binary male/female categorization.

Clinical issues to be presented include approaches to the presentation of gender dysphoria in psychotherapy, assessment of gender identity in patients considering transitioning, and discussion of consequences of hormonal and surgical therapy. Differences in clinical issues for female-to-male transgendered people versus male-to-female will be discussed. The psychiatric and medical protocols of a clinic for transgendered youth will be presented, with psychological and medical issues illustrated by case vignettes. The articulations of ethnicity, culture, gender identity, and sexuality will be discussed, with presentation of case material from the psychotherapy of a transgendered Latina. A discussion of trends in clinical care, controversies in diagnosis in DSM-IV-TR, and questions for future research will include a look ahead to DSM-V. Audience participation will be encouraged, with ample time allotted for questions and discussion of issues raised.

REFERENCES:

1. Karasic DH: Progress in health care for transgendered people. Editorial. Journal of the Gay and Lesbian Medical Association, 2000; 4:pp. 157–8.
2. Rosario VA: Trans [homo] sexuality? double inversion, psychiatric confusion, and hetero-hegemony. In Queer Studies: A Lesbian, Bisexual, Gay, Transsexual Anthology, ed. Brett Beemyn and Mickey Eliason, New York, New York University Press, 1996, pp. 35–51.

Issue Workshop 17
HOW TO EFFECTIVELY INTEGRATE MENTAL HEALTH SERVICES IN GENERAL CARE SYSTEMS

Chairperson: Ann Marie T. Sullivan, M.D., *14 Stuyvesant Oval #9F, New York, NY 10009-2229*
Participants: Neal L. Cohen, M.D., Martin H. Maurer, M.D., Juan E. Mezzich, M.D., Amy S. Hoffman, M.D., Richard A. Young, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of integrating mental health services in general care systems; understand the implementation of several successful models; and learn how policy shapes practice. Participants will also learn the impact of culture issues and how to address them.

SUMMARY:

This workshop will focus on effectively integrating mental health services in general care systems. Presentations will provide a basis for discussions beginning with policy development, e.g., the effects of the merger of the New York City Department of Health and Mental Health, to the very practical integration of depression treatment on site in a busy primary care clinic. The collaborative care model for treating mental illness in primary care will be presented, including preventive services, screening procedures and tools, treatment protocols, and how to train primary care physicians. Presenters and audience will be invited to share how to implement such programs, the problems, pitfalls, and successes. A comprehensive care management program for substance-abusing women will be of particular interest to those who work with mentally ill chemical abusers. This program coordinates psychiatric, medical, and psychosocial services and provides continuing comprehensive support to women and their families.

Cultural factors affecting successful integration of and access to services will be outlined, and models for addressing cultural issues presented. All programs will present specific measured outcomes. Throughout, audience and presenters will share ideas, problems, and solutions.

REFERENCES:

1. Katon W, et al: A multifaceted intervention to improve treatment of depression in primary care. Archives of General Psychiatry 1996; 53:924–932.
2. Olfson M, Sing M et al: Mental health/medical care offsets: opportunities for managed care. Health Affairs 1999; 18:79–90.

Issue Workshop 18
BREAKING THE CYCLE OF MATERNAL ADDICTION: AN INTEGRATED TREATMENT PROGRAM MAKING A DIFFERENCE
Substance Abuse and Mental Health Services Administration

Chairperson: Cynthia C. Crone, A.P.N., *University of Arkansas, 4301 W Markham Suite 711-1, Little Rock, AR 72205-1990*
Participants: Linda L.M. Worley, M.D., Leanne Whiteside-Mansell, Ed.D., Veronica L. Williams, M.D.,

EDUCATIONAL OBJECTIVES:

The participant will be able to identify common psychiatric diagnoses of mothers and children affected by substance abuse; interrelationships between maternal substance abuse and child welfare; positive outcomes of family treatment; rationale for integrated treatment over sequential, parallel, or linked treatment strategies; and financing strategies for interdisciplinary, integrated care.

SUMMARY:

A majority of women with substance abuse disorders have concurrent psychiatric disorders. Yet, fewer than 4% of our nation's dually diagnosed persons receive comprehensive, integrated treatment. When the dually diagnosed woman is a mother, her condition negatively affects her children, and barriers to treatment increase. The University of Arkansas for Medical Sciences department of psychiatry operates Arkansas CARES, an innovative, interdisciplinary prevention and treatment program serving pregnant and parenting, dually diagnosed women and their children. Mothers receive comprehensive behavioral health care, life-skills development emphasizing parenting, and social-support services. Children receive quality, developmentally appropriate child care and mental health services. Ongoing outcome studies show statistically significant improvements in maternal substance use, mental health symptoms, birth outcomes, employment, legal status, parenting stress, and family cohesion. Young children show developmental gains, while older children exhibit greater alcohol and drug refusal skills. Begun with SAMHSA demonstration funding, the program is now self-sufficient. This interactive workshop is designed to facilitate dialogue between Arkansas CARES staff and others interested in providing this type of service, in order to share lessons learned about program development and financing, client and program evaluations, and implications for behavioral health care of the future.

REFERENCES:

1. Whiteside-Mansell L, Crone CC., Conners NA: The development and evaluation of an alcohol and drug prevention and treatment program for women and children: the AR-CARES program. Journal of Substance Abuse Treatment, 1999; 16:265–275.
2. Conners NA, Bradley RH, Whiteside-Mansell L, Crone CC: The Impact of a Comprehensive Substance Abuse Treatment Program: An Initial Evaluation. Journal of Substance Abuse Treatment, (in press).

Issue Workshop 19
TREATING PSYCHOSIS ACROSS DIAGNOSIS

Chairperson: Lewis A. Opler, M.D., *Department of Psychiatry, Columbia University, 765 Gramatan Avenue, Mt. Vernon, NY 10552*
Participants: Ian E. Alger, M.D., Clarice J. Kestenbaum, M.D., Eric R. Marcus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will better understand how and why biological and psychosocial interventions need to be combined in treating psychosis.

SUMMARY:

Four senior clinicians will discuss treatment of patients with psychosis, including the need to combine the following interventions: psychodynamic, biological, social, experiential, building on strengths, teaching skills, and providing support. The audience will then join the faculty in exploring two general principles as they apply to treating psychosis across a number of different diagnostic categories, including schizophrenia, mood disorders, anxiety disorders, and personality disorders: 1) As clinicians, treatments target dimensions of psychopathology (e.g., psychosis) more often than discrete diagnostic entities; and 2) Psychiatry needs to reaffirm a holistic approach informed by knowledge of biological, psychological, and social factors.

REFERENCES:

1. Marcus E: Psychosis and Near Psychosis: Ego Function, Symbol Structure, Treatment. International Universities Press, Madison, CT, in press.
2. Opler LA: Schizophrenia and other psychotic disorders, Primary Care Psychiatry and Behavioral Medicine: Brief Office Treatment and Management, Pathways, edited by Feinstein RE, Brewster A, Springer Publishing Company, N.Y., 1999.

Issue Workshop 20
CHALLENGES OF THE CHIEF RESIDENT IN PSYCHIATRY

Chairperson: Sadiq H. Al-Samarrai, M.D., *Education Research Building, 401 Haddon Avenue, 3rd Floor, Camden, NJ 08103*
Participant: Thomas S. Newmark, M.D.

EDUCATIONAL OBJECTIVES:

The objective of this session is to define the role of chief resident in a psychiatry training program.

SUMMARY:

The position of chief resident in any residency program is important; however, it is surrounded by uncertainty and lack of clarity. The identity of the chief resident must be established at the beginning of his term if he or she is to be an effective role model. A strong identity facilitates clarity regarding the crucial issues of boundaries, power, and authority. Early opportunities to participate in workshops, specific administrative supervision by an experienced faculty person, and directed readings about the management process are necessary tools that help reinforce this identity. The workshop will address the history of chief residencies and the role as a leader, administrator, teacher, educator, researcher, therapist, and politician. An open discussion with workshop participants will enable the audience to share

similar experiences, discuss the character of a chief resident, and offer their ideas of what makes a chief resident successful.

REFERENCES:

1. Bemis C, Fehr R: The psychiatric chief residency. Am J Psychiatry 1989; 146:943–4.
2. Lowy FH, Thornton JF: To be or not to be a psychiatric chief resident. Can J Psychiatry 1980; 25:121–127.

Issue Workshop 21
NONSEXUAL BOUNDARY VIOLATIONS: SPECIAL PROBLEMS IN SMALL COMMUNITIES

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., Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to understand and assess the potential problems, both legal and clinical, arising from nonsexual boundary crossings in therapeutic relationships, particularly in small communities. They will also be familiar with strategies for dealing with these conflicts.

SUMMARY:

Sexual boundary violations have received considerable attention. Nonsexual boundary violations are more difficult to define, and sometimes it is difficult to distinguish unethical conduct from poor clinical judgment. A particular challenge is faced by those in small communities where relationships between psychiatrists and patients unavoidably overlap. This presents problems involving dual roles, conflict of interest, and embarrassment. The psychiatrist as a parent with children in the same school as patients' children and the psychiatrist as a member of the same visible minority, religious group, or professional organization are examples of situations with potential boundary conflicts. Invitations to weddings and gifts also provide problems. Traditional solutions concerning separation of roles may not be possible in these settings.

This workshop will address the assessment of these situations and discuss strategies for dealing with them. It will also examine the forensic implications of such boundary crossings.

A videotape will present vignettes of actual dilemmas encountered by a psychiatrist. Two forensic psychiatrists will describe situations where boundary crossings have occurred and their resolution. Clinical implications will be considered. An attorney will discuss how the professional needs to document actions taken in response to patients' challenges to boundaries.

REFERENCES:

1. Gabbard GO, Nadelson C: Professional boundaries in the physician-patient relationship. JAMA 1995; 273:1445–1449.
2. Gutheil T, Gabbard GO: Misuses and misunderstandings of boundary theory in clinical and regulatory settings. Am J Psychiatry 1998; 155:409–414.

Issue Workshop 22
COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Chairperson: Judith S. Beck, Ph.D., *Beck Institute for Cognitive Therepy and Research, One Belmont Avenue, Suite 700, GSB Building, Bala Cynwyd, PA 190041610*

EDUCATIONAL OBJECTIVES:

To conceptualize personality disorder patients according to the cognitive model; recognize therapeutic alliance issues in treatment of personality disorders; set goals and plan treatment for patients with characterological disturbance; combine pharmacotherapy and cognitive therapy for personality disorder patients.

SUMMARY:

Cognitive therapy, a short-term, structured, problem-solving psychotherapy, has been shown in more than 120 trials to be effective in treating Axis I disorders. In the past 10 years cognitive therapy methods have been developed for Axis II disorders, and outcome research has verified the utility of this treatment approach. Cognitive therapy for personality disorders requires substantial variation from Axis I treatment. A far greater emphasis is placed on developing and maintaining a therapeutic alliance, modifying dysfunctional beliefs and behavioral strategies, and restructuring the meaning of developmental events.

In this workshop, a variety of case examples of patients with personality disorders will illustrate the principles of cognitive therapy, conceptualization of individual patients, developing the therapeutic relationship, planning treatment, and the adjunctive use of medication. Roleplays will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout, and a final segment will instruct participants in the steps they can take to learn about this empirically validated approach for a difficult patient population.

REFERENCES:

1. Beck AT., Freeman A: Cognitive Therapy of Personality Disorders. New York: Guilford, 1990.
2. Beck JS: Cognitive approaches to personality disorders. In American Psychiatric Press Review of Psychiatry, Vol. 16, edited by Dickstern LJ, et al., Washington, D.C., American Psychiatric Press, 1997.

Issue Workshop 23
ASSESSING PSYCHOTHERAPY COMPETENCIES OF RESIDENTS

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*
Participants: David A. Goldberg, M.D., Lisa A. Mellman, M.D., Jerald Kay, M.D., Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVES:

By the end of the workshop participants should be able to discuss the five specific psychotherapy-related treatment competencies required by the Residency Review Committee for Psychiatry, as well as practical approaches and limitations in assessing them during residency.

SUMMARY:

New requirements issued by the Residency Review Committee for Psychiatry of the Accreditation Council on Graduate Medical Education in January 2001 specify that residency programs must demonstrate effective plans for assessing resident performance and for utilizing assessment results to improve resident performance. These plans must be applied to six basic competencies common to all medical specialties, as well as to competencies in the following specific forms of psychiatric treatment: brief therapy, cognitive-behavioral therapy, combined psychotherapy and psychopharmacology, psychodynamic therapy, and supportive therapy. As a group of experienced psychiatric educators who have grappled with these issues for decades, the workshop panelists will consider conceptual and theoretical issues pertinent for assessing clinician competency in these specific treatment methods, review literature on contemporary approaches for assessing competencies for these therapies, discuss efforts currently being field-tested in training programs across the

country, and suggest realistic strategies and expectations for educators and regulators. The panelists will attempt to outline what may be feasible with regard to assessing competency in these treatments during residency training, and what may realistically be beyond the scope of practical methods.

REFERENCES:

1. McClelland DC: Testing for competence rather than for "intelligence." American Psychologist 1973; 28:1–14.
2. Carroll KM, Nich C, Sifry RL, et al: A general system for evaluating therapist adherence and competence in psychotherapy research in the addictions. Drug & Alcohol Dependence 2000; 57:225–38.

Issue Workshop 24
PROFESSIONALISM IN THE TEACHER/LEARNER RELATIONSHIP

Chairperson: Alison M. Heru, M.D., *Department of Psychiatry, Brown University/Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906-9980*
Participants: Marilyn Price, M.D., Patricia R. Recupero, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify when self-disclosure will be helpful and when it is inappropriate; to understand the importance of maintaining good boundaries between teacher/learner.

SUMMARY:

The process of imparting knowledge and wisdom to medical students and residents has occurred for centuries, seemingly through a process of osmosis. Since 1962, when medical student mistreatment was first formally identified as a problem, more attention has been given to providing a good learning environment for all students and residents. This workshop will review the legal and ethical principles associated with teacher/learner boundaries and will explore the boundaries between teacher and learner, with particular focus on self-disclosure during supervision—when it aids learning and when it is self-serving for the supervisor. The results of surveys of trainees and faculty concerning perceptions of what constitutes boundary violations in supervision will be presented. Videotapes will be used to illustrate appropriate supervisor self-disclosure and self-disclosure experienced by residents as a boundary violation. The discussion will focus on the skills needed to provide excellent supervision and to avoid the pitfalls of bad supervision and boundary violations.

REFERENCES:

1. Shanfield SB, Hetherly VV, Matthews KL: Excellent supervision: the resident's perspective. J Psychother Prac Res 2001; 10:23–7.
2. Gutheil TG, Gabbard GO: Misuses and misunderstandings of boundary theory in clinical and regulatory settings. Am J Psychiatry 1998; 155:409–414.

Issue Workshop 25
PSYCHOTHERAPY TERMINATION: A CHALLENGE IN PSYCHIATRIC RESIDENCY TRAINING

Chairperson: Anu A. Matorin, M.D., *UT-HSC-Houston, 1300 Moursund, Houston, TX 77030*
Participants: Pedro Ruiz, M.D., Vinay Kapoor, M.D., David W. Preven, M.D., Madhuri V. Kamble, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusions of the workshop, the audience will have a greater appreciation of the challenges in the termination of psychotherapy in training settings. Discussions will highlight issues from both the residents' and supervisors' perspective with the hope of impacting curriculum development and increasing awareness of this issue in residency training.

SUMMARY:

The importance of psychotherapy training as a core aspect of psychiatry residency training cannot be underestimated. However, despite the fact that most psychiatric training programs require residents to achieve competency in different modalities of psychotherapy, certain aspects of psychotherapy, particularly termination of long-term psychotherapy patients, are not well addressed during training. The challenges that arise during the transfer/termination process as the residents finish their training or move on to the next rotations are generally handled in an ad-hoc manner, thereby losing important therapeutic as well as learning opportunities. The common problems encountered during the termination phase of psychotherapy include patients' psychodynamic response, therapists' psychodynamic responses, lack of awareness of the process and planning of termination, and inadequate supervision. Within this context, this workshop will address the clinical issues that are most relevant to the termination of psychotherapy during psychiatric residency training and discuss ways in which the didactic curriculum and supervisory methods could help avoid pitfalls in this area. The presenters, both residents and supervisors, will illustrate these issues by sharing their individual clinical experiences. Discussion and interaction with the audience will be encouraged. We hope that this discussion will stimulate research and educational efforts on this subject, and increase awareness of its significance in psychiatric residency training.

REFERENCES:

1. Kapoor V, Matorin A, Ruiz P: Termination of psychotherapy: a training perspective. Journal of Psychiatric Practice 2000; 6:334–40.
2. Bostic FQ, Shadid LG, Blotcky MJ: Our time is up: forced terminations during psychotherapy training. Am J Psychotherapy 1996; 50:347–59.

Issue Workshop 26
CONFIDENTIALITY ISSUES AND LEGAL ESSENTIALS IN SEXUAL HARASSMENT CASES

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., *247 Sunset Avenue, Englewood, NJ 07631-4414*
Participants: Diane K. Shrier, M.D., Margaret F. Jensvold, M.D., David W. Garland, Esq., Francine Weiss, Esq.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to be better able to deal with confidentiality issues in consultations and treatment of patients claiming sexual harassment, and should better be able to understand the legal aspects of discovery issues in harassment.

SUMMARY:

This workshop will examine the critical and sensitive aspects of confidentiality in psychiatric consultations and treatment of individuals seeking professional help for sexual harassment. While it is expected and assumed that all that is disclosed to the consulting psychiatrist or mental health specialist is under the umbrella of patient confidentiality, the consultant is now aware that legal methods exist to discover the content of consultations and therapy sessions. The experienced clinician knows that providing the opposing attorney with such records can backfire and re-traumatize the patient, and that if the patient is worried about any lack of confidentiality, he or

she may clam up and not be willing or able to provide a full history or engage in meaningful therapy.

Patients need guidance in self-protection—whom to talk to, and what the risks are. They need to understand what can happen within institutions when an individual reports having been sexually harassed either to the EEOC or internally, and what measures they may take to reduce the risks of retaliation.

These issues will be addressed by the psychiatrists on the panel. The attorneys will discuss techniques on how psychiatrists may best interact with the lawyer for the patient and for the employer/harasser, and how best to avoid the common mistakes made by psychiatrists. The attorneys will also discuss recent cases demonstrating court-approved and court-sanctioned techniques used by psychiatrists.

REFERENCES:

1. Shrier D: Sexual Harassment in the Workplace and Academia-Psychiatric Issues, Wash. D.C., American Psychiatric Press, Inc., 1995.
2. McDonald R: Forensic aspects of sexual harassment [Review] [31 refs], Psychiatric Clinics of North America 1999; 22:129-45.

Issue Workshop 27
PSEUDODEMENTIA IN THE 21ST CENTURY

Chairperson: Maurice Preter, M.D., *Department of Psychiatry, The University of MS Medical Center, 6295 Old Canton Road, 9A, Jackson, MS 39211*
Participants: Randolph B. Schiffer, M.D., Robin C. Hilsabeck, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participant should have a better understanding of modern concepts of "pseudodementia," gain insight into the relationship between cognitive changes and mental illness, and be familiar with the clinical assessment of cognitive changes in different neuropsychiatric populations.

SUMMARY:

We propose a fresh look at the concept of pseudodementia in neuropsychiatric disorders—in depression, post-traumatic stress disorder, and psychosis. Awareness that the presentation of reversible neuropsychiatric conditions may mimic irreversible disorders goes back to the mid-19th century. However, pseudodementia's use as a clinical term continues to engender criticism because it seems to imply that the presenting cognitive dysfunction is somehow not "real" (because it may be treatable and potentially reversible). Moreover, longitudinal data on depressed patients with comorbid cognitive impairment seem to blur the boundaries between "pseudo" dementia and true cognitive decline.

This workshop contains four segments. An introduction and overview of the concept of pseudodementia is followed by a presentation of data on psychiatric diagnoses in a memory disorders clinic. Third, possible links between cognitive dysfunction and massive psychological trauma will be discussed using the example of a rural population. A fourth segment reviews cognitive-assessment skills for psychiatrists in different neuropsychiatric populations. The workshop is led by two neurologists-psychiatrists and a neuropsychologist. There will be ample time for discussion and questioning; group participation, especially in form of short clinical vignettes, is highly encouraged.

REFERENCES:

1. Nebes RD, Vora IJ, Meltzer CC, et al: Relationship of deep white matter hyperintensities and apolipoprotein E genotype to depressive symptoms in older adults without clinical depression. Am J Psychiatry 2001; 158:878–884.
2. Schiffer RB, Caloe ED: The interaction between depressive affective disorder and neuropsychological test performance in multiple sclerosis patients. J Neuropsychiatry Clin Neurosci 1991; 3:28–32.

Issue Workshop 28
WHAT WORKS IN SUBSTANCE ABUSE TREATMENT?
Substance Abuse and Mental Health Services Administration

Chairperson: A. Thomas McLellan, Ph.D., *Pennsylvania/VA Center, Building 7, University Avenue, Philadelphia, PA 19104*
Participants: D. Dwayne Simpson, Ph.D., Joseph C. J. Finney, M.D., Shelly F. Greenfield, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to implement empirically derived treatment components in substance abuse treatments.

SUMMARY:

There has been substantial progress in the treatment of alcohol and drug dependence over the past decade, and this symposium will review this progress with particular emphasis upon distilling those medications, therapies, treatment approaches, and treatment components that have shown evidence of efficacy from controlled clinical trials and effectiveness from large-scale field evaluations in real-world settings. Dr. Dwayne Simpson from TCU will review the results of field evaluations of drug abuse treatments (particularly from his DATOS study of more than 10,000 patients) and will discuss an empirically derived model of addiction treatment process that derives from those evaluations. Dr. John Finney from the Palo Alto VA Medical Center and Stanford University will discuss his longitudinal literature reviews and meta-analyses of all published studies of alcohol treatment, highlighting components of treatment that have been effective in multiple sites and studies. Dr. Thomas McLellan from the University of Pennsylvania and the Treatment Research Institute will discuss the application of "best practices" learned from effective substance abuse treatments and their application in new settings and populations (drug courts, emergency rooms, family practice settings, welfare to work populations, and chronic, multiple detoxification users). Presentations will include ample time for questions and discussion.

REFERENCES:

1. McLellan AT, Kleber HD, Lewis D, O'Brien CP: Drug Addiction as a Chronic Medical Illness, 2000.
2. McLellan AT, McKay JR: The treatment of addiction: what can research offer practice? In Lambas., Greenlick M. and McCarty D. (Eds). Bridging the Gap: Forging New Partnerships in Drug Abuse Treatment. National Academy Press, 1998.

TUESDAY, MAY 21, 2002

Issue Workshop 29
WORKING WITH PARENTS DURING THEIR BABY'S FIRST YEAR OF LIFE

Chairperson: James M. Murphy, M.D., *30 West 60th Street, Apartment 12B, New York, NY 10023-7913*

EDUCATIONAL OBJECTIVES:

To recognize parents' and their baby's nonverbal messages to each other; develop criteria for diagnosing troubled parent-infant relationships; and understand why and how to use experiential methods in interventions with infants.

SUMMARY:

This workshop presents a pilot project that suggests that 21st-century psychiatrists may expand their interventions to include work with parents and their infant (under one year of age) in order to prevent some infants from becoming adults with mental disorders. The project was a series of 10 workshops with four to six families with a baby. The leaders led parents in guided activities in 10 parenting-skills areas, including feeding and dressing their baby. The project was based on theories that early childhood relationships with parents affect adult mental health. Since infants were nonlinguistic, techniques of using nonverbal communication and interaction were used. Through questionnaires, parents' verbal reports, and leaders' observations, it was found that parents improved their communication, interaction, and relationship with their baby. This workshop begins with a lecture, then participants will role-play a parent and a baby in doing guided activities, and it ends with discussion.

REFERENCES:

1. Murphy JM: Nonverbal interventions with infants and their parents. Am J Dance Therapy 1998; 20:37–54.
2. Stern D: The First Relationship: Mother and Infant. Cambridge, Harvard University Press, 1977.

Issue Workshop 30
THE NEUROBIOLOGY OF LEARNING: IMPLICATIONS FOR TEACHING

Chairperson: Janet E. Osterman, M.D., *21 Ocean View Drive, Hingham, MA 02043-1224*

EDUCATIONAL OBJECTIVES:

The participant will describe the neurobiology of developing new long-term memory and learning, discuss the application of these concepts to the practical application of teaching to enhance their effectiveness in teaching, and develop teaching methods to enhance their effectiveness as a teacher.

SUMMARY:

The goal of teaching is to help the student learn and retain new knowledge, concepts, and skills. Learning requires that the student develop new long-term memories and as such is a complex neurobiological process that involves neuronal growth and long-term potentiation. Multiple brain systems are involved in the encoding of memories for facts and skills and for the development of concepts. Individuals have variations in how they organize learning using auditory, visual, tactile regions to varying degrees. Using an interactive teaching method, this workshop will demonstrate effective teaching methods. Participants will be asked to examine and discuss their individual learning styles to develop concepts that there are variations in learning that mandate a multimodal teaching method to maximize effectiveness. A review of the types of memories involved in learning and the processes involved in encoding of semantic, episodic and procedural memories will be presented. The role of planned repetition for long-term memory formation and the function of the hippocampus will be discussed. The application of the advances in knowledge of the neurobiology of learning and memory encoding to enhance teaching skills and for improved curriculum development will be discussed. Thc workshop will conclude with a question-and-answer session.

REFERENCES:

1. Turnball J: Bench to bedside in medical education. Academic Medicine 1999, 74:664–666.
2. Stark CE, Squire LR: Functional magnetic resonance imaging (fMRI) activity in the hippocampal region during recognition memory. J Neuroscience 2000, 20:7776–7781.

Issue Workshop 31
EXPLORING THE MEDIA'S ROLE IN IMITATION VIOLENCE

Chairperson: Paul A. Kettl, M.D., *Department of Psychiatry, Pennsylvania State University, P O Box 850, Hershey, PA 17036*
Participant: Kathleen Jamison, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand the concept of media-fueled imitation violence and how best to manage it.

SUMMARY:

Suicides and episodes of violence can be newsworthy events. Suicide, especially if it occurs to a celebrity or is connected with a newsworthy event, can attract press attention. Episodes of violence, such as the mass killings at Columbine High School in Colorado can also bring vast amounts of attention to a tragic event.

The press, in their reporting of these events, can make public how tragic mental illness can be, but unfortunately, the press can also sensationalize these events through their coverage and make an already bad situation worse.

In this workshop, we will examine the behavior of the press in reporting suicides and episodes of violence. We will review what would be appropriate and responsible behavior by the press as well as incidences of inapropriate behavior. The cost of inappropriate behavior by the press is imitation of the original event by susceptible individuals who may already be considering suicide or violence. In addition, we will review "tips" for psychiatrists on how to handle the media in these situations.

REFERENCES:

1. Kostinsky S, Bixler EO, Kettl PA: Threats of school violence in Pennsylvania after media coverage of the Columbine High School massacre. Arch Pediatr Adolesc Med 2001; in press.
2. Kettl PA, Christ MJ, Bixler EO: Imitation suicides after a live televised suicide. Abstract. Program and Papers On New Research in Summary Form, 145th Annual Meeting of the American Psychiatric Association, Washington, D.C., May 4, 1992, Washington, D.C. American Psychiatric Press, Inc.

Issue Workshop 32
WE CAN IMPROVE CARE FOR THOSE WITH MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS

Chairperson: Katherine E. Watkins, M.D., *Rand Corporation, 1700 Main Street, Santa Monica, CA 90407*
Participants: John Sheehe, M.S.W., Dina Daleo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify barriers to setting up programs for clients with co-occurring mental health and substance abuse disorders, strategies to overcome them, and components of effective mental health and substance abuse interagency collaborations.

SUMMARY:

Despite the availability of effective treatments and treatment models for both mental illness and substance abuse, most persons who have co-occurring disorders are not receiving effective care. While integrated treatment programs appear to be superior for individuals

with severe mental illness and substance abuse, parallel treatment with effective service coordination may be appropriate and less costly for the majority of individuals with co-occurring disorders. However many clinicians are unfamiliar with how to set up effective interagency collaborations. This workshop is for psychiatrists and other mental health and substance abuse professionals who wish to set up effective treatment programs and interagency collaborations for the dually diagnosed.

This workshop will introduce participants to three examples of successful collaborations between public substance abuse and mental health agencies. Small-group discussions of participants' experiences with systemic barriers will allow participants to identify barriers and potential solutions. We will also discuss our own reactions to working with individuals with co-occurring disorders, how to identify problems, and techniques to address issues of countertransference. A large-group discussion at the end will give participants the opportunity to share other examples of successful strategies and collaborations between public mental health and substance abuse agencies.

REFERENCES:

1. Sciacca K: Program development and integrated treatment across systems for dual diagnosis: mental illness, drug addiction, and alcoholism (MIDAA). J of Mental Health Administration 1996; 23:288–297.
2. Watkins KE: A national survey of care for persons with co-occurring mental and substance use disorders. Psychatric Services 2001; 52:1062–1068.

Issue Workshop 33
COUPLES TREATMENT BY PARALLEL COORDINATED INDIVIDUAL PSYCHOTHERAPY

Chairperson: Michael C. Hughes, M.D., *Hughes Family Psychiatric Center, 2801 Ponce de Leon Boulevard, Suite 430, Coral Gables, FL 33134*
Participant: Eva C. Ritvo, M.D.

EDUCATIONAL OBJECTIVE:

To recognize indications for couples therapy, describe conjoint and individual approaches to couples therapy, compare and contrast those couples most appropriate for traditional conjoint therapy to those more appropriate for a coordinated individual approach, and treat more effectively patients whose significant other is also in individual psychotherapy by coordinating the parallel individual therapies.

SUMMARY:

Couples therapy is understood as the treatment modality that utilizes the presence of a couple, generally husband and wife, to treat interpersonal conflict. This workshop describes another approach to treating couples through parallel, coordinated, individual psychotherapy, with separate therapists for each member of the dyad. The couple does not meet together for treatment. Rather, the therapists confer regularly to consider diagnostic issues, partners' unrealistic perceptions of each other, heretofore unshared secrets, and the like. Patients are counseled to initially avoid contentious issues but to focus on rebuilding their relationship. Later, sharing knowledge about themselves is encouraged rather than propounding problems perceived in their spouse. Progress in individual therapy parallels development of a more successful dyadic relationship.

Traditional couples therapy is a long-established, valuable treatment approach. However, at times it is not acceptable to the couple, clinically inappropriate, or may end prematurely. Parallel coordinated individual psychotherapy offers an alternative to conjoint treatment, a contemporaneous supplement, or sometimes a more appropriate approach. It also allows therapists who are unprepared to perform traditional conjoint treatment to treat couples as well as affording couples already in individual psychotherapy an opportunity to have their treatment coordinated to better encompass dyadic difficulties. Case illustrations will also be presented, strengths and limitations of the procedure considered, and methodology elaborated. Audience participation and contributions are emphasized, for the concluding 30 minutes, toward the ongoing development of this treatment modality.

REFERENCES:

1. Glick I, Berman E, Clarkin J, Rait D: Marital and Family Therapy. 4th Edition. Washington, DC, American Psychiatric Press, 2000.
2. Lewis JW: Marriage as a Search for Healing: Theory, Assessment and Therapy. New York, Brunner/Mazel, Inc. 1997.

Issue Workshop 34
MOTION PICTURES: THE THERAPEUTIC MODALITY OF THE 21ST CENTURY

Chairperson: M. Fuat Ulus, M.D., *406 Rockhill Circle, Bethlehem, PA 18017-1702*
Participant: Conni Sharp, Ed.D., Eda Ulus, B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to appreciate the simplicity, practicality, and applicability of the therapeutic qualities of movies in any given inpatient, partial hospitalization, or outpatient settings.

SUMMARY:

Many educators and therapists have been using commercial movies in their academic and therapeutic settings in recent years. This modality, identified in various ways such as cinema therapy, movie therapy, reel therapy, motion picture therapy, and other such names, has already been gaining its popularity among both professionals and the public alike. The presenters will discuss many themes, including the chronological development of this movement; its different formats; the consolidation potential into other therapies provided in the inpatient, partial hospitalization, and outpatient settings; and finally, its complementary application to education efforts. Handouts will be distributed. Furthermore, the audience is expected to participate at the end of each portion of the presentation, and lively discussion among colleagues will be encouraged. This workshop is of interest to all mental health providers and other mental health liaison professionals. There are no special background requirements for this workshop. It will be a stimulating and enjoyable 90 minutes, during which the participants are expected to have a good time while exchanging ideas about this valuable treatment tool.

REFERENCES:

1. Berg-Cross L, Jennings P, Baruch R: Cinematherapy: theory and application. Psychotherapy in Private Practice 1990; 8:135–156.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy. John Wiley & Sons, 1998.

Issue Workshop 35
INNOVATIVE STRATEGIES IN THIRD-YEAR MEDICAL STUDENT PSYCHIATRIC EDUCATION

Chairperson: Molly J. Hall, M.D., *University of Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814-4799*
Participants: Timothy J. Lacy, M.D., Brenda J. Roman, M.D., Donald A. West, M.D., Stephen B. Shanfield, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify approaches to the changing requirements of medical student

education today and describe teaching and evaluation strategies, including strengths and weaknesses.

SUMMARY:

The shift from inpatient care to outpatient treatment in psychiatry has altered the educational milieu for third-year clerkships. Programs often have to train students at a variety of different clinical sites, ensure sufficient, comparable key clinical learning opportunities across sites, and objectively evaluate core areas of knowledge and skill acquisition. This workshop presents four innovative education and evaluation models, implemented in psychiatric clerkships at four medical schools to address the changing requirements of medical student education and the changing available patient populations shaped by managed care. Each clerkship will present a brief overview of its program, the goals and objectives, and the strengths and weaknesses of the initiative. The audience will participate in an evaluation of these efforts and share their approaches to similar concerns in their programs. In one program, a pilot course in clinical psychiatric assessment and diagnosis was developed using standardized patients in a medical simulation center and in a clinical outpatient setting. Clinical scenarios were developed, and sufficient standardized patients trained so that each student individually interviews a patient weekly, followed by a post-encounter class. Another program will present a one-day focused curriculum in diagnosing and treating substance abuse using standardized patients and role playing. Two programs will focus on evaluation. In one program a system of written and oral "Mini-OSCEs" using videotaped psychiatric interviews was developed to ensure an objective evaluation of fundamental skills. In the fourth program, an overview of the complexities of the evaluation of medical student clinical performance will be discussed. Strategies for dealing with the clinical teachers, the actual evaluators, will be presented. Curriculum, format, videotapes, evaluation, and data will be shared with workshop participants.

REFERENCES:

1. Pessar LF: Ambulatory care teaching and the psychiatric clerkship. Academic Psychiatry 2000; 24:61–67.
2. Distlehorst LH, Dunnington GL, et al: Teaching and Learning in Medical and Surgical Education: Lessons Learned for the 21st Century. Lawrence Erlbaum Associates, Inc., 2000, pp 217–234.

Issue Workshop 36
NATIONAL COMMISSION ON MARIJUANA AND DRUG ABUSE REPORT: 30 YEARS LATER

Chairperson: J. Thomas Ungerleider, M.D., *16800 Adlon Road, Encino, CA 91436-3811*
Participant: Michael R. Sonnenreich, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should be able to critically examine and better understand how mythology and misunderstanding have hindered our approach to the persistent problem of substance abuse.

SUMMARY:

This proposed issue workshop will examine the Report of the National Commission on Marijuana and Drug Abuse—Marijuana: Signal of Misunderstanding, on its 30th anniversary. Some of the crucial issues and deliberations of the commission will be presented in retrospect by Presidential appointee J. Thomas Ungerleider, M.D. and Executive Director Michael Sonnenreich, J.D. At the time of the commission's report there were a little over 200,000 marijuana arrests annually, which then seemed alarming. (Today the annual marijuana arrest figure approaches 700,000.) The abuse potential and threat to the public health and safety from marijuana were major considerations for us. THC, the active ingredient of marijuana, had only recently been synthesized, and the double-blind studies of its efficacy had yet to be done, so medical marijuana was not a focus of the commission's deliberations. However, should the audience discussion lead to this topic, Sonnenreich and Ungerleider are qualified to address this issue, Sonnenreich, as former chief deputy counsel of the Bureau of Narcotics and Dangerous Drugs, the predecessor of the D.E.A., was the major architect of the Controlled Substances Act, placing marijuana in schedule 1 along with LSD and heroin. Dr. Ungerleider has had an IND for marijuana and THC research for over 20 years and has published on its efficacy in spasticity of multiple sclerosis patients, antiemetic effects in cancer chemo/radiation therapy and bone-marrow transplant patients, and reduction of intraocular pressure in glaucoma patients. The audience may also choose to focus on issues of marijuana prevention/education, therapy of abusers, and/or social policy issues.

REFERENCES:

1. National Commission on Marihuana and Drug Abuse: Marihuana: A Signal of Misunderstanding, First Report, U.S. Government Printing Office, Washington, D.C., Appendix, Volumes 1 and 2, 1252, 1972.
2. Ungerleider J: Marijuana: still a signal of misunderstanding. Proc. of Assoc. of American Physicians 3:173–181:1999 (#2). Thematic Review Series V: Substance Abuse Research and Clinical Practice.

Issue Workshop 37
BRIDGING THE GAP: DEPRESSION, CHRONIC MEDICAL DISEASE, CULTURE, AND ETHNICITY

Chairperson: Annelle B. Primm, M.D., *Department of Psychiatry, Johns Hopkins, 600 N. Wolfe Street, Meyer 144, Baltimore, MD 21287-7180*
Participants: William T. Regenold, M.D., Evelyn L. Lewis, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the interactions of depression, diabetes, and hypertension/cardiovascular disease, and culture/ethnicity in the clinical setting; explain the public health impact of depression and chronic disease comorbidity; and understand the implications for disease management from a cultural/ethnic perspective.

SUMMARY:

Depression remains underdiagnosed and undertreated in the U.S., contributing to major health, economic, and societal costs. A significant portion of those with depression avoid specialty mental health services due to stigma and present to primary care where education about mental illness and time for evaluation are limited. Help-seeking in primary care is even more common among racial and ethnic minorities for whom treatment of depression is associated with higher levels of stigma. Cultural and ethnic differences in health beliefs and practices are often poorly understood by health providers of all types, further complicating the delivery of adequate depression care. In response to recommendations in the Surgeon General's Report on Mental Health, an initiative called Bridging the Gap has been developed to educate clinicians about depression, chronic disease comorbidity, and cultural/ethnic influences. Workshop presentations will draw from Bridging the Gap curricula on 1) depression, hypertension/cardiovascular disease, and culture/ethnicity and 2) depression, diabetes, and culture/ethnicity. The audience will be asked to provide feedback on the usefulness of this integrative approach to medical education about depression. This session is designed for specialty mental health and primary care clinicians and residents who have a basic understanding of depression and chronic disease.

REFERENCES:

1. Cooper-Patrick L, Gonzales JJ, Rost KM, et al: Patient preferences for treatment of depression. International Journal of Psychiatry in Medicine 1998; 28:382–383.
2. Hirschfeld RMA, Keller MB, Panico S: The National Depressive and Manic-Depressive Association Consensus Statement on the Undertreatment of Depression. Am J Psychiatry 1997; 277:333–340.

Issue Workshop 38
OLFACTORY DYSFUNCTION IN PSYCHIATRY AND NEUROLOGY

Co-Chairpersons: Teodor T. Postolache, M.D., *2225 Nees Lane, Silver Spring, MD 20905-4541,* Richard L. Doty, Ph.D., *Smell and Taste Center, University of Pennsylvania, 3400 Spruce Street, Philadelphia, PA 19104*
Participants: Paul J. Moberg, Ph.D., Marilyn Jones-Gotman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand that olfactory deficits may precede other symptoms in patients with schizophrenia and Alzheimer's dementia; to recognize that increased olfactory acuity may be a trait in patients with major depression; learn the neurocircuitry involved in olfactory processing.

SUMMARY:

Testing olfactory performance may have a potential to contribute to early diagnosis and detection of vulnerability for debilitating and prevalent neuropsychiatric disorders such as Alzheimer disease (AD) and schizophrenia. The goal of this workshop is to present the state of the art in understanding olfactory dysfunction in neuropsychiatric disorders and to familiarize the audience, using an interactive hands-on approach, with certain olfactory tests.

Dr. Doty will discuss the anatomy and physiology of the olfactory system and review modern means for quantitatively assessing smell function.

Dr. Moberg will demonstrate that patients with schizophrenia have significant early olfactory deficits. Similarly, olfactory deficits are present at the first signs of AD and may actually precede other cognitive symptoms of this disorder. The olfactory deficits in schizophrenia and AD will be reviewed and their neuroanatomical basis will be discussed.

Dr. Postolache will describe a relationship between increased olfactory acuity and ample seasonal emotional rhythms and will present data suggesting that increased olfactory acuity may be a trait-like finding in patients with depression.

Dr. Jones-Gotman will present a functional neuroimaging study of cerebral blood flow during odorant-pleasantness judgment and review the neuroimaging of olfactory processing.

The workshop targets clinicians and researchers with an interest in integrating olfactory methods in evaluating and treating neuropsychiatric disorders. No prior knowledge in chemoreception is required.

REFERENCES:

1. Moberg PJ, Agrin RN, Gur RE, et al: Olfactory dysfunction in schizophrenia: a qualitative and quantitative review. Neuropsychopharmacology 1999; 21:325–340.
2. Zatorre RJ, Jones-Gotman M, Rouby C: Neural mechanisms involved in odor pleasantness and intensity judgments. NeuroReport 2000; 11:2711–2716.

Issue Workshop 39
NEUROBEHAVIORAL SEQUELAE OF TRAUMA TO THE FRONTAL LOBES

Chairperson: Marilyn F. Kraus, M.D., *Department of Psychiatry, Loyola University Medical Center, 2160 South First Avenue, Maywood, IL 60153*
Participants: Harvey Levin, Ph.D., Thomas Gualtieri, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the neuropathology of traumatic brain injury and the range of neurobehavioral disorders that can result; understand the neuropsychologic profile of frontal lobe dysfunction; and know the role of neuropharmacology in the treatment of these disorders.

SUMMARY:

This workshop is intended to familiarize the practitioner with the neurobehavioral sequelae of frontal lobe injury and the diagnostic dilemmas posed by patients with these symptoms. The incidence of traumatic brain injury (TBI) in the population is sufficiently high to constitute a major health care problem. Over 2,000,000 people per year in the U.S. sustain a TBI. These individuals sustain significant injuries that result in billions of dollars in both health care costs and lost revenue. Of those who survive, up to 90,000 have chronic disability. This disability, regardless of level of brain injury severity, is often due to the attendant neurobehavioral sequelae (cognitive, mood, and behavioral changes). These deficits are often related to dysfunction of the prefrontal cortex, since the frontal lobes are very commonly damaged in traumatic injuries. Chronic brain injured patients often fall between the cracks in the general psychiatry setting and do not get appropriate assessment or treatment. Basics of neuropathology of brain injury will be presented and will be related to the neurobehavioral sequelae often encountered. Neuropsychologic features of frontal lobe damage and correlation with imaging findings will be presented. Pharmacologic management of frontal lobe dysfunction will also be discussed, including the role of dopaminergic agents.

REFERENCES:

1. Levin HS, Kraus MF: The frontal lobes and traumatic brain injury. Journal of Neuropsychiatry and Clinical Neurosciences 1994; 6:443–454.
2. Bohnen NI, Jolles J, et al: Late neurobehavioral symptoms after mild head injury. Brain Injury 1995; 9:27–33.

Issue Workshop 40
CULTURAL COMPETENCE IN PSYCHIATRIC RESIDENCY TRAINING PROGRAMS

Chairperson: Francis G. Lu, M.D., *Department of Psychiatry, University of California, San Francisco, 1001 Potrero Avenue, SFGH Suite 7M, San Francisco, CA 94110*
Participants: Renato D. Alarcon, M.D., Pedro Ruiz, M.D., James W. Thompson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the June 2001 ACGME special requirements for psychiatry residency programs that involve cultural competence.

SUMMARY:

Cultural competence and diversity are increasingly important issues in American psychiatry as seen in the Surgeon General's Report on Mental Health: Culture, Race and Ethnicity (2001), and the APA Position Statement on Diversity (May, 1999). With the new ACGME special requirements for psychiatry residency training programs that came into effect January 2001, it is very important that the implementation of the new special requirements (including the six core competencies and the five specific psychiatry competencies) incorporate explicit attention to cultural competence and diversity. This workshop will begin with a report on a June 2001 American Psychiatric Association conference, supported by the federal Center for Mental Health Services, on cultural competence in residency training. The conference brought together representatives from 10 psychiatric organizations including APA, AADPRT, ACGME-ABMS, ABPN, CMHS, Association for Academic Psychiatry (AAP), American Association of Community Psychiatry (AACP), the GAP Cultural Psychiatry Committee and the Society for the Study of Psychiatry and Culture (SSPC), and the Association of the Directors of Medical Student Education in Psychiatry (ADMSEP). In addition, prominent experts from the four ethnic minority cultures, women, and gay/lesbian individuals as well as residents participated. Discussion will follow as to how both organizations and individual programs can begin to implement its recommendations.

REFERENCES:

1. American Medical Association: Cultural Competence Compendium. Chicago, Ill: American Medical Association, 1999.
2. U.S. Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, Md: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.

Issue Workshop 41
A LEGAL PRIMER FOR PSYCHIATRISTS INVOLVED IN ISSUES OF SEXUAL ORIENTATION

Co-Chairperson: John E. Fryer, M.D., *Temple University, 138 W Walnut Lane, Philadelphia, PA 19144-2612,* Mark-Allen Taylor, J.D., *Temple University, 3440 North Broad Street, Philadelphia, PA 19140*
Participants: Nancy J. Knauer, J.D., David L. Scasta, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this session, participants should be able to articulate an understanding of the particular legal issues of violence and abuse faced by gay and lesbian victims; the areas of overlap with law and psychiatry; and the disparity among jurisdictions in the legal treatment of gays and lesbians.

SUMMARY:

Abusive treatment of gays and lesbians, through violence or harassment, has been tolerated or even encouraged in the health care, legal, and spiritual spheres. Reporting violence or abuse has been problematic because of the victim's fear of public exposure and/or further discriminatory treatment (e.g., physical harm or death; loss of employment; social condemnation; and even criminal prosecution). This workshop will consist of four presentations (with time for discussion between the audience and the presenters) discussing the interplay between psychiatry and the law in addressing responses to violence and abuse of gay and lesbian people. Nancy Knauer, J.D. will present "Same-Sex Domestic Violence" outlining the legal system's response and the current status of this tragic problem both within law and society at large. David Scasta, M.D., will present "Disability Due to Harassment and a Hostile Working Environment Because of Sexual Orientation" focusing on psychological assessment due to sexual orientation abuse in the work place. John Fryer, M.D., will present "Sanctions of Gay and Lesbian Psychiatrists" focusing on sexual boundaries. Finally, Mark-Allen Taylor, J.D., will present: "Homosexual-Panic Defense and the Criminal Law" tracking its legal use by defense attorneys.

REFERENCES:

1. Knauer N: Same-sex domestic violence: claiming a domestic sphere while risking negative stereotypes. Temple Pol & Civ Rights Law Rev 1999; 8:325–350.
2. Wang, L: The complexities of "hate." Ohio St Law J 1999; 60:799–900.

Issue Workshop 42
TEN YEARS OF TEACHING ABOUT BOUNDARIES: WHAT HAVE WE LEARNED?

Chairperson: Gregg E. Gorton, M.D., *Department of Psychiatry, Jefferson Medical, 1201 Chestnut Street, Suite 1400C, Philadelphia, PA 19107*
Participant: Steven E. Samuel, Ph.D., Gail Zivin, Ph.D.

EDUCATIONAL OBJECTIVE:

To design and implement an educational program for trainees regarding boundary issues in the treatment relationship, with special emphasis on management of sexual feelings and prevention of sexual misconduct.

SUMMARY:

For 10 years we have provided a course on sexual and other boundaries in the treatment relationship to PGY-III psychiatric residents at Jefferson Hospital. In addition, we have integrated teaching about boundaries and other ethical and professional conduct issues across all four years of the training curriculum. We have also served as in-house experts on these issues within our department, providing grand rounds, consultations, and faculty-developmental educational sessions for clinical supervisors of our residents. Finally, we have also engaged boundary issues clinically—evaluating and treating both victims and offenders, and providing expert forensic evaluations and testimony. The current highly interactive workshop will draw upon what we have learned from all of these diverse clinical and pedagogical experiences. We have certainly learned that it is crucial for potential teachers and clinicians working in these areas to have safe professional venues within which to reflect upon and grapple with a host of sensitive and even controversial issues, including the range of normative feelings of attraction toward patients; the appropriate containment, understanding, and therapeutic management of erotic transference and countertransference; the known phenomenology of sexual misconduct and other forms of exploitation of patients; ethical, legal, and administrative issues in this realm; and primary, secondary, and tertiary prevention of sexual exploitation. Ideally, in the 21st century, this sort of professional discussion can lead to a professional culture-of-awareness regarding this formerly "taboo" realm, with the ultimate goal of developing an open, inclusive attitude toward all boundary issues whenever they arise. We will also present pre- and post-course knowledge and attitude data gathered from trainees over the ten years of our course, and we will discuss possible long-term outcome measures of educational efficacy.

REFERENCES:

1. Gotton GE, Samuel SE, Zebrowski S: A pilot course for residents on sexual feelings and boundary maintenance in treatment. Academic Psychiatry 1996; 20:43–55.

2. Samuel SE, Gorton GE: Sexual exploitation: an extreme of professional deception. American Journal of Forensic Psychiatry 2001; 22:63–81.

Issue Workshop 43
EVIDENCE-BASED TREATMENT FOR MARIJUANA DEPENDENCE
Substance Abuse and Mental Health Services Administration

Co-Chairperson: Thomas F. Babor, Ph.D., *University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030,* Kathleen M. Caroll, Ph.D., *Department of Psychiatry, Yale University, New Haven, CT 06520*
Participants: Roger A. Roffman, D.S.W., Ronald Kadden, Ph.D., David M. McDowell, M.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to demonstrate brief marijuana-dependence-therapy techniques that combine cognitive-behavioral and motivational-enhancement therapies, be familiar with the research evidence supporting them, and be familiar with the products supporting the dissemination of this treatment including the clinician manual and videotape.

SUMMARY:

Overview: This workshop will (a) review of the importance of treatment for marijuana dependence and its relevance to clinical psychiatry, (b) provide an summary of findings from CSAT's Marijuana Treatment Project (MTP), and (c) highlight the products that have been developed to disseminate this effective treatment from research to practice, including a CSAT-published therapist manual and training videotape.

Treatment implementation: The second section of the workshop will provide a review of clinician training procedures, supervision experiences, MTP psychotherapy process data, and their relevance to psychiatric practice.

Demonstration of brief marijuana-dependence-therapy techniques: This section will include a brief review of the treatment manual and training tapes and use videotaped examples from our training package and role plays involving audience members to demonstrate critical therapeutic techniques used in MTP.

Open discussion: The final section of the workshop will consist of discussion by audience members of clinical, training, and research issues.

REFERENCES:

1. MTP Research Group: Treating cannabis dependence: findings from a multisite study. Under review, 2001.
2. Carroll KM, Steinberg K, Roffman R, et al: Process and outcome in a multisite trial of treatments for marijuana dependence. Under review, 2001.

Issue Workshop 44
ENHANCING AND FUNDING MENTAL HEALTH SERVICES: NEW FREEDOM INITIATIVE
Substance Abuse and Mental Health Services Administration

Co-Chairpersons: Mary Jane England, M.D., *Regis College, 235 Wellesley Street, Weston, MA 02493-1571* and Eileen Elias
Participants: Charles G. Currie, M.A., Shelley E. Bishop, Vincent J. Hughes, Eileen C. Wolkstein, Ph.D., Marilyn L. Eckley, M.P.A.

EDUCATIONAL OBJECTIVES:

To demonstrate understanding of the impact of the President's New Freedom Initiative on states' delivery of community services to individuals with disabilities, including those with mental disabilities; to demonstrate understanding on the importance of a statewide inclusionary planning process and its impact on funding community services through the state Medicaid plan and facility consolidation.

SUMMARY:

This workshop is targeted to public and private sector psychiatrists, helping them understand their key role in ensuring integrated community services for individuals with mental disabilities. The President's NFI provides an opportunity, supported by federal regulatory changes and funding in conjunction with civil rights expectations, to address the challenges in providing community mental health services for individuals with mental disabilities. Dr. England will host the panel discussion consisting of primary stakeholders who helped direct Pennsylvania's nationally recognized response to the President's executive order for individuals with mental disorders: Charles Currie (Pennsylvania's mental health director/nominated administrator to the federal agency of SAMHSA), Vincent Hughes (Pennsylvania Senator), and Shelley Bishop director of the state's mental health consumer organization. Mr. Currie will explain the NFI and civil rights linkage with the Supreme Court's Olmstead decision. Each panelist will explain his/her role in developing and financing Pennsylvania's mental health plan. Barriers and solutions will be identified, with specific attention to the fiscal impact of state hospital consolidations and effective use of the state Medicaid plan.

REFERENCES:

1. President Bush's Executive Order 13217 (New Freedom Initiative/NFI) on Community-Based Alternatives for Individuals with Disabilities issued on June 18, 2001.
2. U.S. Supreme Court ruling in L.C. v. Olmstead, 138 F.3d 1485 (11th Cir. 1998).

Issue Workshop 45
BUPRENORPHINE: A NEW OFFICE-BASED TREATMENT FOR OPIOID DEPENDENCE
Substance Abuse and Mental Health Services Administration

Co-Chairpersons: Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032,* H. Westley Clark, M.D., *Center for Substance Abuse Treatment, 5600 Fishers lane, Suite 615, Rockville, MD 20857*

EDUCATIONAL OBJECTIVES:

To understand the legal, pharmacologic, and clinical aspects of this new treatment.

SUMMARY:

On October 17, 2000, legislation was passed that allows physicians to apply for a waiver of separate registration from the CSA requirements if the physician meets certain conditions. This new law, the Drug Addiction Treatment Act of 2000 (DATA), provides waiver authority for physicians who dispense or prescribe narcotic drugs in schedule III, IV, or V or combinations of such drugs for substance abuse maintenance or detoxification treatment. Though there are currently no medications meeting the criteria for this new treatment paradigm, buprenorphine and a combination of buprenorphine/naloxone are currently under FDA review, with approval anticipated in 2002. As designated authority over DATA, SAMHSA/CSAT will receive physician notifications of intent to prescribe or dispense these medications and notify the Attorney General of these requests. The pharmacology and clinical aspects of these new medications as well as the legislative requirements will be discussed with the audience at this workshop. The audience will discuss their ideas as to how such medications could fit into various models of psychiatric practice, and what problems they anticipate.

REFERENCES:

1. O'Connor PG: Editorial: treating opioid dependence—new data & new opportunities. New England Journal of Medicine 2000; 343:1332–1333.
2. Bickel WK, et al: Buprenorphine dosing every 1, 2, or 3 days in opioid dependent patients. Psychopharmacology 1999; 146:111–118.

Issue Workshop 46
IMPROVING THE QUALITY OF SERVICE IN A MEDICAID HMO

Chairperson: James M. Schuster, M.D., *4721 McKnight Road, Pittsburgh, PA 15237*
Participants: Deborah Wasilchak, Frank Ghinassi, Kelly Kelleher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participants will understand how a managed behavioral health care organization utilizes data in quality processes to improve the services available to its members.

SUMMARY:

This workshop will help participants understand how a managed behavioral health organization (MBHO) uses specific and aggregate population data to help providers improve the quality of their services. It will describe a provider-owned MBHO, explain how the organization assesses the quality of service, and explore an application of these principles. The presentation will include: 1) a description of the MBHO and its quality and outcomes programs, 2) a discussion of the opportunities for outcomes management and performance management in MBHOs, along with the types of data necessary to impact quality, 3) a review of specialized services for children that are funded under the Pennsylvania Medicaid program and the quality issues inherent to these services, and an analysis of these intensive services and how the MBHO has worked with providers to improve the quality of these services.

REFERENCES:

1. Guidelines for Best Practice in Child and Adolescent Mental Health Services, Pennsylvania Department of Public Welfare, 2001.
2. Nash D, Childs G, Kelleher K: A cohort study of resource use by Medicaid children with asthma. Pediatrics 1999; 104 (2Pt 1):310-312.

Issue Workshop 47
IMPLEMENTATIONS OF DBT IN CORRECTIONAL ENVIRONMENTS

Chairperson: Robert L. Trestman, M.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030-1410*
Participants: Daniel Bannish, Psy.D., M. Paul Chaplin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the benefits of DBT implementation in a corrections environment. Participants will understand who may benefit from DBT within the system, how DBT's skills-training component may help reduce risk for maladaptive, problem behaviors in inmates, and how to address potential theoretical and administrative challenges realted to its use.

SUMMARY:

DBT is a manual-driven, cognitive-behavioral treatment model initially conceived as a treatment for borderline personality disorder. With its emphasis on treating life-threatening and therapy-interfering behaviors, DBT has the potential ability to serve as an invaluable tool for those working with mentally ill populations in a prison environment. The experiences and perspectives of clinicians from Connecticut working to operationalize DBT in correctional settings will be shared. This workshop will focus on four main topics in relation to DBT and the prison system: logic supporting the use of DBT with a forensic population, issues of implementation, potential benefits of DBT for both inmates and correctional staff, and a more global perspective of DBT and its role in community mental health. Discussion sessions after each speaker will allow audience members to confer with the speaker regarding implications of each topic.

REFERENCES:

1. McCann, RA, Ball EM, Ivanoff A: DBT with an inpatient forensic population: The CMHIP forensic model. Cognitive and Behavioral Practice 2000; 7:447–456.
2. Scheel KR: The empirical basis of dialectical behavior therapy: summary critique and implications. Clinical Psychology: Science & Practice 2000; 7:68–86.

Issue Workshop 48
HEPATITIS C IN ADDICTION PSYCHIATRY

Chairperson: Vasant P. Dhopesh, M.D., *Department of Psychiatry, VA Medical Center/116A, University & Woodland Avenue, Philadelphia, PA 19104*
Participants: Kyong-Mi Chang, M.D., Robert M. Weinrieb, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants will be knowledgable in epidiomiology, diagnosis, complications, and treatment of hepatitis C.

SUMMARY:

This issue workshop is for people working in the addiction field. This will be an informal review of hepatitis due to A, B, and C viruses with the main focus on hepatitis C. Active participation by the audience is encouraged. Some general knowledge of internal medicine is sufficient. As per the NIH consensus conference in April 1997, about 4 million in the U.S. and 100 million worldwide are infected with hepatitis C, and 30,000 new cases per year occur. Eight to 10 thousand die each year due to hepatitis C; 20% will develop cirrohsis within 20 years, and of these 2%–3% will develop hepatic carcinoma.

Injection drug users account for half the new cases a year; 80% to 90% of injection drug users are positive for hepatitis C antibody. Treatment and complications will be discussed by Dr. Chang. Characteristics of the patients undergoing liver transplant will be discussed by Dr. Weinrieb. Dr. Weinrieb will discuss the management of psychiatric complications of alfa-interferon 2b plus ribavirin in the treatment of hepatitus C infection.

REFERENCES:

1. Lauer GM, Walker BD: Review article: hepatitis C viral infection. New Engl J Med 2001; 345:41–52.

2. Dhopesh VP, Taylor KR, Burke WM: Survey of hepatitis B and C in addiction treatment unit. Am J Drug Alcohol Abuse 2000; 26:703–707.

Issue Workshop 49
GROUP PSYCHOTHERAPY FOR SUBSTANCE ABUSERS

Co-Chairpersons: David W. Brook, M.D., *Community Medical, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1044A, New York, NY 10029,* Henry I. Spitz, M.D., *Columbia University, 101 Central Park W, New York, NY 10023-4204*

EDUCATIONAL OBJECTIVES:

To understand the developmental, neurobiological, and psychosocial bases for the use of a variety of group psychotherapeutic approaches in the treatment of substance abusers; evaluate which group approaches are most appropriate; and treat substance abusers using a variety of group psychotherapeutic techniques.

SUMMARY:

Group psychotherapeutic approaches form a major method of treatment for substance abusers and 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, interpersonal group therapy, harm-reduction groups, psychoanalytically oriented groups, self-help groups, and others. 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. The presenters will utilize specific clinical examples and material from group sessions as illustrations.

Active audience participation will be encouraged. Participants will be asked to present specific clinical examples or problems for discussion. This issue workshop is co-sponsored by the American Group Psychotherapy Association.

REFERENCES:

1. Flores P: Group Psychotherapy with Addicted Populations. New York, Haworth Press, 1997.
2. Brook DW, Spitz HI (Eds.): Group Psychotherapy of Substance Abuse. Washington, D.C., Haworth Press, (In press).

Issue Workshop 50
WORLD FEDERATION OF PSYCHIATRIC TRAINEES: SATISFACTION AND INTERNATIONAL EXCHANGE IN PSYCHIATRIC EDUCATION

Co-Chairpersons: Victor J.A. Buwalda, M.D., *Department of Psychiatry, Free University, Parnasusweg 28-III, Amsterdam 1076-AR, Netherlands,* Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0704, Ann Arbor, MI 48109-0704*

EDUCATIONAL OBJECTIVES:

To recognize the changes and challenges in the education; be familiar with satisfaction surveys of different countries; learn about the IMSEP, a possible procedure to start an international exchange of trainees; learn about the aims and goals of the WFPT.

SUMMARY:

The purpose of this workshop is to familiarize participants with the changes in psychiatric education in different countries today and the challenges to reform the programs for tomorrow. Residents and medical students in countries as different as Canada, The Netherlands and Finland are working on satisfaction surveys and are formulating the requirements that educational programs should meet. The goals of this second workshop of the World Federation of Psychiatric Trainees are:

1. Provide a forum in which residents and medical students can discuss topics, ideas and thoughts concerning international worldwide psychiatric training programs, and where they can learn about the diversity and the richness of the current training of psychiatrists in the world;
2. Stimulate and expand the use of the educational networks for psychiatric training;
3. Explore ways in which residents can promote and improve their own training and professional development worldwide;
4. Promote and facilitate international exchange among training programs;
5. Learn about the satisfaction surveys of different countries;
6. Discuss the possibility of establishing an international medical student exchange program.

REFERENCES:

1. Robinowitz, CB: Psychiatric education for the new millennium. In Psychiatry in the New Millennium edited by Weissman S, Sabshin M and Eist H, Washington DC, American Psychiatric Press, 1999, pp 301-315.
2. Buwalda VJA, Veenhof CHN, Jacques LB, Curt GA: International Medical Student Exchange Program (IMSEP): The Challenge of the New Millennium. New Research Abstracts, American Psychiatric Association, 2001 Annual Meeting.

Issue Workshop 51
SPIRITUAL DIMENSION AND RELIGIOUS ISSUES IN AN URBAN CMHC CLINICAL PRACTICE
Haitian-American Psychiatric Association

Chairperson: Jean B. Tropnas, M.D., *121 Midwood St, Brooklyn, NY 11225-5060*
Participants: Ophie Franklin, Yvette Sealy, Ph.D., Meeta Gandhi, M.S.W., Donna M. Serrant, M.S.W.

EDUCATIONAL OBJECTIVE:

To recognize the influence of religion and spirituality in the clinical presentation psychiatric illnesses and in treatment as practiced in a community mental health center that serves an inner-city mostly African-American population.

SUMMARY:

The basic striving of humans, as expressed in our thinking, feeling, and behavior, is made manifest by the universal force of spirit. Spirit is the essence of the substance that makes all elements of the universe. The therapist's appreciation of a patient's spiritual experience along with the therapist's openness to his/her own subjective state of being, facilitates and constitutes a precondition for an optimally responsive therapeutic experience for the patient.

Clearly religious and spiritual traditions powerfully shape the identities and worldviews of patients. These traditions inform the patient's views on the meaning of sickness, suffering, and life itself. Understanding the role that spiritual factors play in the onset and prognosis of disease is key to achieving optimal responsiveness in psychotherapeutic work. For example, in our Bedford-Stuyvesant CMHC population, depression is subject to more stigmatization than somatic complaints. Depression means personal weakness, while somatization has a spiritual meaning. Our patients will minimize the psychological

aspects of their depression in favor of more socially and spiritually acceptable somatic symptoms.

This workshop will provide alternative ways to understand spiritual processes that influence psychopathology and promote healing through interventions based upon principles of spirituality and religion in a community mental health center.

REFERENCES:

1. Alarcon R: The Psychiatric Clinics of North America: Cultural Psychiatry, September 1995.
2. Pierre J: Faith or delusion? at the crossroads of religion and psychosis. Psychiatric Practice 2001; 7:163–172.

Issue Workshop 52
ETHICS OF PHARMACEUTICAL INVOLVEMENT IN PSYCHIATRIC EDUCATION

Chairperson: Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*
Participants: Jeffrey M. Levine, M.D., Uday K. Mukherjee, M.D., Huma K. Khan, M.D., Mikhail Y. Ziskin, M.D.

EDUCATIONAL OBJECTIVE:

To recognize ethical vs. unethical involvement of pharmaceutical companies in education, research, and clinical practice of psychiatry.

SUMMARY:

In recent years pharmaceutical companies have become dominant funders of several activities such as grand rounds, biomedical research, and speakers to present at residents' lunches. Pharmaceutical representatives frequently visit doctors to promote their drugs and in return for their time give them some material things, take them out for dinners, etc. These activities raise several ethical issues, and residency training directors have struggled with the concept of how to utilize pharmaceutical involvement in training while maintaining ethical standards. In this workshop we present findings of a survey of residents and psychiatrists regarding these professional-ethical issues. We will demonstrate how we educate residents as well as pharmaceutical reps to maintain educational-ethical standards. Participants will share their experiences for a lively discussion. Through the workshop we expect to develop some clarity on what would be considered ethical pharmaceutical involvement in education and clinical practice of psychiatry. We will also present a review of literature about what other physicians have experienced and how other training programs are addressing this issue. We will present a survey of pharmaceutical reps to identify how they see their role and where conflicts arise.

REFERENCES:

1. Physicians and the pharmaceutical industry: is a gift ever just a gift? JAMA 2000; Vol. 283, No. 3.
2. Pharmaceutical marketing: implications for medical residency training: Pharmacotherapy 1996; 16:103–7.

Issue Workshop 53
THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILMS

Chairperson: Steven E. Pflanz, M.D., *68A Fort Warren Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to critically examine contemporary films with mental health 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 Americans. Often, mental health professionals pay more attention to films that achieve critical acclaim for their artistic merits. The value of these films is undeniable. However, to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the facilitator will discuss briefly the portrayal of psychiatry in contemporary films during the 1990's, focusing on "The Prince of Tides," "Basic Instinct," "As Good As It Gets," "Good Will Hunting," "Analyze This," and "Grosse Pointe Blank." Each of these films achieved both critical acclaim and box office success and was seen by millions of Americans. To generate discussion, short film clips from these movies will be viewed. The majority of the session will be devoted to audience discussion of these and other films and how we understand contemporary film to influence the image of psychiatry in America.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, D.C., American Psychiatric Press, Inc., 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Films in Psychotherapy. New York, John Wiley & Sons, Inc., 1998.

Issue Workshop 54
HIV, AIDS, HEPATITIS-C, MENTAL ILLNESS, AND SUBSTANCE ABUSE: CONVERGING ILLNESS
Substance Abuse and Mental Health Services Administration

Chairperson: Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*
Participants: Marvin S. Swartz, M.D., Lawrence Brown, M.D., Jennifer F. Havens, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, attendees will be able to recognize risky behaviors and ideation that puts patients with SMI and addictions at increased risk for Hepatitis C and HIV/AIDS; determine treatment readiness for individuals living with HIV/AIDS who also have confirmed DSM-IV and addictive disorders; identify culturally based treatment interventions for African Americans and Hispanics with multiple occurring patterns of drug abuse, mental health, and HIV/AIDS.

SUMMARY:

This workshop will open with three short presentations on comorbidity of HIV/AIDS and mental illness and/or substance abuse, and hepatitis C. Dr. Swartz will discuss findings from a recent article that suggests that people living with HIV/AIDS who also have severe mental illness are at much greater risk for hepatitis C than for HIV/AIDS, though their mental illness places them at increased risk for both. He will discuss underlying patterns of behavior, such as victimization, that are associated with this risk. Dr. Havens will discuss innovative strategies for preparing and keeping in treatment those individuals with co-occurring HIV/AIDS and substance abuse and/or mental disorders. She will provide suggestions for engaging this hard to reach population. Dr. Brown will examine cultural considerations for treatment with African Americans and Hispanics with

multiple occurring patterns of drug abuse, mental health, and HIV/AIDS. He will discuss the importance of issues such as rites of passage and cultural restoration. Dr. Forstein then will lead a 45-minute discussion, inviting the audience to share their ideas and experiences.

REFERENCES:

1. Havens JF et al: Psychiatric morbidity in school-age children with human immunodeficiency virus infection. J Dev Bev Pediatri 1994; 15:S18–25.
2. Rosenberg SD, et al: HIV, hepatitis B, and hepatitis C in people with severe mental illness. Am J PubH 2001; 9:31–7.

Issue Workshop 55
ADDICTION TREATMENT 2002: NEW DIRECTIONS

Chairperson: Richard J. Frances, M.D., *Silver Hill Foundation, 208 Valley Road, New Canaan, CT 06840*
Participants: Sheila B. Blume, M.D., Sheldon I. Miller, M.D., Marc Galanter, M.D., Robert B. Millman, M.D., Lionel P. Solursh, M.D., Frances R. Levin, M.D.

EDUCATIONAL OBJECTIVES:

The participant will learn about new directions addiction treatment is taking, including psychotherapy and psychopharmacologic approaches.

SUMMARY:

This will be the 35th year of the EWING Group meeting at the annual APA meeting. This group has met annually to lead a wide ranging discussion around issues related to alcohol and addiction treatment and its relationship to psychiatry. In keeping with this year's theme of "Psychiatry in the 21st Century," the discussion is centered around new directions in addiction treatment and how best to integrate and explain new treatment strategies. As new treatments are being developed, they often are slow to find their way into practice. This workshop will focus on new treatment strategies and how to implement them and how to integrate them into practice. The workshop provides an opportunity for young and experienced therapists to have their questions answered by master clinicians and teachers.

REFERENCES:

1. Mack A, Franklin J, Frances R: Concise Guide to Treatment of Alcoholism & Addiction, 2nd ed.
2. Clinical Textbook of Addictive Disorders, 2nd ed., Edited by Frances RJ, Miller SI.

Issue Workshop 56
TARASOFF REVISITED: CHANGING TRENDS IN DUTY TO WARN THIRD PARTIES

Chairperson: Chowallur D. Chacko, M.D., *2718 North Orange Avenue, Suite C, Orlando, FL 32804*
Participants: Robert L. Sadoff, M.D., Liz M. Chacko

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the participants will learn about the Tarasoff duty to warn third parties of threats from their patients and the evolution of the Tarasoff doctrine over the years, with a recent trend led by Texas and Florida courts declaring psychiatrists have no duty to warn third parties.

SUMMARY:

The original Tarasoff decision by the California Supreme Court (1974) created a duty of psychiatrists to warn third parties of their patients' threats of violence against them. During the ensuing quarter century, courts and legislatures in various states have created Tarasoff-like duty to warn third parties. However, there is now a change of trend with Texas Supreme Court (Thapar v. Zezulka 1999) and Florida Appellate Courts (Boynton v. Burglass, 1991, Santa Cruz v. Northwest Dade Community Mental Health Center, 1992 and Green v. Ross, 1997) declaring in an unambiguous language that psychiatrists in those states have *no duty* to warn third parties of a patient's threats. Copies of the court decisions on these cases will be distributed to the participants for review and discussion with the panelists.

The panel is made up of a senior forensic psychiatrist with an academic background, a solo practitioner of general psychiatry, and a law student. They will review their personal experiences as well as information gathered from legal research on the current status of duty to warn third parties. The participants would be encouraged to share their own experiences and concerns regarding the duty to warn third parties.

REFERENCES:

1. Rosner R: Principles and Practice of Forensic Psychiatry, New York, NY, Chapman & Hall, 1994.
2. Spring RL, Lacoursiere RB, Weissenberger G: Patients, Psychiatrists and Lawyers: Law and the Mental Health System. Cincinnati, Anderson Publishing Co., 1997.

Issue Workshop 57
IMPLEMENTING AN EFFECTIVE TRUANCY-REDUCTION PROGRAM

Participants: Mary Jo Davoren, M.Ed., David Mahrer, Ph.D., Edward Taylor, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how to pull together community resources to develop and implement programming to effectively impact truancy in their community. To be familiar with what data to measure in order to produce meaningful outcomes for key stakeholders.

SUMMARY:

Reduction of truancy rates is currently a major priority of schools and departments of juvenile justice (DJJ) as they work to improve educational outcomes and reduce juvenile crime. Mental health professionals are increasingly being asked to assist in these efforts and sometimes to take the lead. In this highly interactive workshop, attendees will learn about a successful effort by the South Carolina Department of Mental Health (SCDMH) to reduce truancy in youth with chronic absenteeism. Four programs were developed with joint SCDMH/DJJ funding, while a fifth was started with grant money. A range of interventions were provided in the programs, including case-management services, psycho-educational groups, and individual therapy. Of 428 children served only eight (2%) had further problems that resulted in eventual DJJ incarceration, while 467 children from the same counties who did not participate in the program had 28 incarerations (6%). Approximately 40% had no Axis I diagnosis. Workshop topics will included how the programs are structured and funded, how the staff work with the children and their families, and the outcomes of the program. Workshop participants will be encouraged to share situations they have faced in dealing with chronic absenteeism.

REFERENCES:

1. Mattison RE: School consultation: a review of research or issues unique to the school environment. J Am Acad Child Adolescent Psychiatry 2000; 39:402–413.

2. Bostic JQ, Rauch PIT: The 3 R's of school consultation. J Am Acad Child Adolescent Psychiatry 1999; 38:339–341.

Issue Workshop 58
PSYCHODYNAMICS IN TREATMENT-REFRACTORY DEPRESSION

Co-Chairpersons: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262,* Edward R. Shapiro, M.D., *Admissions, Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262*
Participant: David L. Mintz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enumerate components of a psychodynamic approach to the treatment-refractory patient and have an enhanced understanding of and ability to use psychodynamic formulations to advance treatment of patients with treatment-refractory depression comorbid with prominent Axis II pathology.

SUMMARY:

Although algorithms help 21st-century psychiatrists select biological treatments for patients with treatment-refractory depression, the subset of these patients presenting with prominent Axis II pathology often fail to respond to medications alone. Treatment relationships with these patients often become chronic crisis management, with frustration common for both parties. Since training programs and the field currently de-emphasize psychodynamic notions like transference and countertransference, which may be useful in integrating a treatment approach to these patients, clinicians may be at a disadvantage in usefully framing the overall problem. This workshop describes an effective approach to this subset of treatment-refractory patients. The approach uses a psychodynamic formulation to integrate biological and psychotherapeutic treatments. Essential elements of a psychodynamic formulation are reviewed, including attending to the patient's life context and its repeating metaphors, and identifying transference-countertransference paradigms likely to be contributing to treatment refractoriness. The formulation is used to guide interpretation in the psychotherapy, but also to guide adjunctive family work, integrate the psychopharmacologic approach, and maximize medication compliance. After a half-hour presentation, sample cases will be offered to initiate an interactive discussion with workshop participants, who will be encouraged to present their own cases for group discussion.

REFERENCES:

1. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure and clinical application. American Journal of Psychiatry 1987; 144:543–550.
2. McLaughlin J: Clinical and theoretical aspects of enactment. Journal of the American Psychoanalytic Association 1991; 39:595–614.

Issue Workshop 59
THE ART OF THE UNCONSCIOUS: SHAKESPEARE, POETRY, FILM, AND PSYCHIATRY

Co-Chairpersons: Steven E. Pflanz, M.D., *68A Fort Warren Avenue, Cheyenne, WY 82001* Charles R. Joy, M.D., *4406 Sunnydale Boulevard, Erie, PA 16509-1651*

EDUCATIONAL OBJECTIVES:

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 for ourselves and our patients.

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 us understand from a different perspective the difficult issues that our 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 will listen to readings of poetry and view short film clips, discussing each piece as it is presented. The material chosen will contain universal themes touching on human lives. The poetry readings will include selections from our own writings as well as from our favorite poets. The coup de grace will be a short performance of a classic scene from Shakespeare by the two facilitators. Throughout the workshop, we will lead the audience in a lively discussion exploring the connection between art and the unconscious for both ourselves and our 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 60
USE OF RESTRAINTS IN PSYCHIATRIC PRACTICE: PROS, CONS, AND ALTERNATIVES

Chairperson: Ann Marie T. Sullivan, M.D., *14 Stuyvesant Oval #9F, New York, NY 10009-2229*
Participants: William Fisher, M.D. Charles T. Barron, M.D., Janet Bezmen, R.N., John O'Brien, M.D., Yuange Hu, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the appropriate use of restraints and learn effective alternatives to their use. Participants will understand how to implement programs to decrease the use of restraints while maintaining patient safety in medical and psychiatric settings, including particular issues affecting the management of the aggressive youngster.

SUMMARY:

This workshop will provide an in-depth discussion of the appropriate use of and alternatives to the use of emergency restraints in the psychiatric and medical setting. An overview of the appropriate use of restraints will be followed by a discussion of successfully implemented programs that provide a safe environment while reducing restraint use in acute and intermediate care psychiatric units. A presentation of how and when to use "behavioral restraints" in the medical setting will focus on ways to reduce their use with safe, effective alternatives. Alternatives to restraint use will include learned staff and patient skills in de-escalation; patient contracts; environmental adaptation; peer-advocate support; and family and caregiver involvement. Impediments will be discussed, including staff and systems attitudes and fears regarding safety for themselves and patients. Specific skills and approaches for working with the aggressive youngster will be presented. Throughout the workshop the audience will participate in the discussion and share ideas, experiences and approaches to working with the acutely aggressive patient.

REFERENCES:

1. Harris G, Rice M: Risk appraisal and management of violent behavior. Psychiatric Services 1997; 48:1168–1176.
2. Nijman H, et al: Prevention of aggressive incidents on a closed psychiatric ward. Psychiatric Services 1997; 48:694–698.

Issue Workshop 61
METHAMPHETAMINE TREATMENT: WHAT PSYCHIATRISTS NEED TO KNOW
Substance Abuse and Mental Health Services Administration

Chairperson: Richard A. Rawson, M.D., *Matrix Center, 10350 Santa Monica Boulevard, #330, Los Angeles, CA 90025*
Participants: William F. Haning III, M.D., Walter Ling, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to effectively understand and communicate: 1) the NIDA medications development effort for methamphetamine pharmacotherapy, 2) behavioral approaches on methamphetamine treatment, 3) the current state of information on methamphetamine psychosis.

SUMMARY:

Pharmacotherapy clinical trials for methamphetamine treatment have targeted issues of dependence, intoxication/overdose, and cognitive impairment, with the development of the infrastructure for clinical studies encompassing Phase I, clinical/pharmacological inpatient studies, cue cravings, and Phase II and III outpatient studies; while preclinical animal models have provided data on locomotion, drug discrimination/substitution, and reinforcement. NIDA medications trials have examined the efficacy of drugs such as sertraline and desipramine. Future trials may explore new study designs focusing on withdrawal and relapse prevention, rapid medication screens, large Phase III studies, pipeline drugs, and examination of subpopulation issues for biomarkers.

The treatment of methamphetamine-related disorders is currently dependent upon the application of psychosocial and counseling strategies. There is an evolving literature that is developing an empirically supported foundation to this work. The work done on the model of outpatient treatment referred to as the Matrix Model represents the most substantial data set with methamphetamine users on an outpatient basis. The Matrix approach combines a set of strategies into a four-month outpatient protocol that has been standardized in a treatment manual. Outcome data have been collected on a substantial cohort of methamphetamine users treated with this approach. By the time of the APA meeting the results of a large CSAT-funded, multisite trial will be available for presentation. This trial includes over 1000 participants treated in seven community-based programs using a random assignment design in which individuals are randomly assigned to the Matrix approach or the agency's treatment-as-usual approach. In addition to a review of the Matrix approach, information will be provided on other psychosocial approaches that have demonstrated efficacy for the treatment of cocaine use disorders.

REFERENCES:

1. Rawson R: Treatment for stimulant use disorders. CSAT Treatment Improvement Protocol 33; DHHS Publication No. (SMA) 99-3296, 1999.
2. Special Methamphetamine Edition of Journal of Addictive Diseases, Spring 2002.

Issue Workshop 62
FROM PSYCHOANALYTIC PSYCHOTHERAPIST TO PSYCHOANALYTIC ORGANIZATIONAL CORPORATE CONSULTANT: AN INTRODUCTORY WORKSHOP

Chairperson: Howard E. Book, M.D., *2900 Yonge Street, Suite 101, Toronto, ON M4N 3N8, Canada*
Participant: Jeffrey P. Kahn, M.D.

EDUCATIONAL OBJECTIVES:

To list the differences between individual psychotherapy and corporate consulting; recognize the applications of psychodynamic concepts to corporate consultations; list common reasons why corporations might seek consultations.

SUMMARY:

This highly interactive workshop begins by: (1) defining "organizational consulting;" (2) overviewing the applications of a psychoanalytic perspective to such consultations; and (3) discussing the differences between the role of psychoanalytic therapist and the role of psychoanalytic organizational consultant.

The second and major portion of this workshop focuses on offering participants a case-study format to explore this case; to tease out the latent issues that prompted the consultation; to formulate the issues; and to conceptualize the phases involved in the consultation. The overarching emphasis throughout this workshop will be to encourage participants to view all these issues from a psychodynamic perspective. The workshop will close with the moderators facilitating a 15-minute summary of manifest and latent themes and issues that emerged from this workshop.

REFERENCES:

1. de Board R: The psychoanalysis of organizations: a psychoanalytic approach to behaviour in groups and organizations. Tavistock Publications, London, U.K., 1985.
2. Sperry L: Corporate Therapy and Consulting. Brunner/Mazel, New York, NY, 1996.

Issue Workshop 63
ROLE OF AMYTAL IN CONVERSION DISORDER

Chairperson: Sadiq H. Al-Samarrai, M.D., *Education Research Building, 401 Haddon Avenue, 3rd Floor, Camden, NJ 08103*
Participant: Thomas S. Newmark, M.D.

EDUCATIONAL OBJECTIVE:

The objective of this session is to demonstrate by videotape and discussion the role of amytal as a useful tool in the management of conversion disorders.

SUMMARY:

Conversion disorder is a psychologically produced alteration or loss of physical functioning suggestive of a physical disorder. According to DSM-IV-TR, the essential diagnostic feature, criterion A, is the presence of "symptoms or deficits affecting voluntary motor or sensory function that suggests a neurological or other general medical condition." Management of conversion disorders include allowing the symptoms to remit spontaneously, use suggestion, psychotherapy, hypnosis, an amytal interview, environmental manipulation, electromyographic, biofeedback, and functional electric stimulation. Bleckwenn introduced the amytal interview in 1930 as a specific technique for treating psychotic patients. In 1932, Linde-

mann demonstrated possible benefits of subnarcotic doses of the drug in interviews with nonpsychotic population as well. Since then, amytal has had a valid role in the assessment and initial management of catatonia, hysterical stupor, and unexplained muteness, as well as in distinguishing between depressive, schizophrenic, and organic stuporous states. The audience will see two videotaped cases and discuss the topic with the speakers.

REFERENCES:

1. Fackler SM, Anfinson TJ: Serial sodium amytal interviews in the clinical setting. Psychosomatics 1997; 38:558–564.
2. Maldonado JR, Spiegel D: Conversion disorder. Chapter 4, somatoform and factitious disorders. Edited by Phillys KA, Washington, DC, London, England, APPI 2001, pp. 95–128.

Issue Workshop 64
MINORITY PSYCHIATRISTS WHO HAVE SUFFERED MENTAL ILLNESS: OVERCOMING STIGMA
National Alliance for the Mentally Ill

Co-Chairpersons: Michael F. Myers, M.D., *2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 South Preston, Suite 214, Louisville, KY 40292*
Participants: Michelle O. Clark, M.D., Raymond M. Reyes, M.D., Suzanne E. Vogel-Scibilia, M.D.

EDUCATIONAL OBJECTIVES:

To understand the challenges of being both a minority psychiatrist and a patient; overcome internalized stigma toward colleagues living with psychiatric illness.

SUMMARY:

Surgeon General Dr. David Satcher's report "Mental Health: Culture, Race, and Ethnicity" highlights glaring disparities in access, quality, and availability of mental health services faced by racial and ethnic minority citizens. How relevant is this to minority psychiatrists who themselves have suffered a psychiatric illness? In this workshop, following introductory comments by Drs. Myers and Dickstein, the presenters will give first-person accounts of mental illness. Issues addressed include self-recognition and self-response to becoming ill; perceived stigma and its consequences in considering treatment; availability of culturally competent psychiatrists to consult; quality of treatment received; thoughts about disclosure to (and reactions of) training directors, licensing boards, insurance companies, hospital credentialing committees, and patients; impact of their illness on work colleagues, friends, and families; and issues that are unique to the individual psychiatrist's minority reference group, including specific types of stigma. Discussion will be given by Dr. Suzanne Vogel-Scibilia, who is a NAMI board member and a psychiatrist living with bipolar illness.

REFERENCES:

1. Satcher D: Mental Health: Culture, Race and Ethnicity. Office of the United States Surgeon General. Washington, DC., 2001.
2. Gaw AC: Concise Guide to Cross-Cultural Psychiatry Washington, DC. American Psychiatric Publishing, Inc, 2001.

Issue Workshop 65
THE CHALLENGE OF PARENTAL MENTAL ILLNESS
Substance Abuse and Mental Health Services Administration

Chairperson: Judith Katz-Leavy, M.Ed., *5600 Fishers Lane, Room 17C-02, Rockville, MD 20857*
Participants: Beth Hinden, Ph.D., Lucinda Mallen, William R. Beardslee, M.D., Joanne Nicholson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to: identify the critical issues facing parents with mental illness and their children, describe hospital- and community-based treatment and prevention approaches, and adapt clinical practices to meet the needs of families.

SUMMARY:

The majority of women and men in the U.S. who meet criteria for psychiatric disorder during their lifetime are parents. Children of these parents are at increased risk for the development of serious mental health problems, though many are resilient. However, children diagnosed with serious emotional disturbance evidence high rates of parental psychiatric hospitalization, mental illness, and substance abuse. These families face many challenges; their needs cross service systems and adult and child funding streams. The scope of the issue and needs of these families will be described (Ms. Katz-Leavy). National interview and site-visit data on comprehensive, family-centered treatment approaches will be presented (Dr. Hinden). The Invisible Children's Program will be described by its founder, whose work is informed by her own family experiences (Ms. Sloan Mallen). An empirically based, preventive intervention will be placed in the context of family narratives (Dr. Beardslee). Implications for family-centered practice will be discussed (Dr. Nicholson), with audience participation focusing on real-life problems and pragmatic solutions.

REFERENCES:

1. Nicholson J, Sweeney EM, Geller JL: Mothers with mental illness: I. The competing demands of parenting and living with mental illness. Psychiatric Services 1998; 49:635–642.
2. Beardslee W, Versage E, Wright E, et al: Examination of preventive interventions for families with depression: evidence of change. Development & Psychopathology 1997; 9:109–130.

Issue Workshop 66
AFTERMATH OF PROFESSIONAL BOUNDARIES VIOLATIONS: TREATMENT OF VICTIMS

Chairperson: Gail E. Robinson, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada*
Participants: P. Susan Penfold, M.D., Werner Tschan, M.D., Gary R. Schoener, Psy.D.

EDUCATIONAL OBJECTIVES:

To be able to identify at least three treatment issues with such clients; compare victims of psychiatric vs. nonpsychiatric professionals; discuss mediation options.

SUMMARY:

The growing awareness of the problem of boundary violations, including but not limited to sexual involvement between professional

and patient, has led to an increasing number of patients coming for assistance in the aftermath of such relationships. Whereas early work focused on the problems of the sexually exploited patient, in recent years a much broader group of former patients has come under this umbrella. Our panelists, from eastern and western Canada, Europe, and the U.S. will examine follow-up therapy, mediation, and implications for professional training and regulation. The panel will explore a number of issues relative to helping such patients. Our first speaker will examine what has been learned about these situations and helping such victims over the past 20 years in Canada. She will also examine the evolving regulatory framework in Ontario and what advances there have been in understanding and preventing this problem. Our second panelist will present a view from British Columbia, examining the data from the most extensive study of consumer views and experiences done to date. She will examine the sometimes uneven playing field for both the patient and the professional, and how this impacts on recovery from such bad experiences.

Our third panelist will examine the situation from the perspective of European experience, reviewing what has been learned in German studies and his own work in Switzerland. The frameworks being used overlap with North American ones, but also provide some new ideas and approaches. Our final panelist will examine some unique group approaches, processing sessions, and other remedies.

REFERENCES:

1. Penfold S: Sexual Abuse by Health Professionals: A Personal Search for Meaning and Healing, Toronto, Ontario, U. of Toronto Press, 1998.
2. Notman MT, Nadelson C: Psychotherapy with patients who have had sexual relations with a previous therapist. In Physician Sexual Misconduct, edited by Bloom JD, Nadelson CC, Notman, MT, Wash., DC, American Psychiatric Press, pp. 247–262.

Issue Workshop 67
A RECIPE FOR ACADEMIC/PERSONAL SUCCESS: SOME KEY INGREDIENTS
Association for Academic Psychiatry

Chairperson: Linda L.M. Worley, M.D., *Department of Psychiatry, UAMS, 4301 W Markham Slot 789, Little Rock, AR 72205-1990*
Participants: Josepha A. Cheong, M.D., Robert J. Boland, M.D., Donald M. Hilty, M.D., Michelle B. Riba, M.D.

EDUCATIONAL OBJECTIVES:

Participants will understand the role of the AAP while they learn to recognize important life-balancing strategies, become familiar with cutting edge technology utilized in teaching, understand the critical role that remaining passionate on a day-to-day basis plays, and appreciate the role that effective mentorship plays in career development.

SUMMARY:

Succeeding in ones' personal and professional life seems to be increasingly challenging given the current pace of academic medicine in this rapidly changing medical climate. The Association for Academic Psychiatry is dedicated to furthering the growth and success of its members who are passionate about psychiatric education. Leaders in the AAP, many of whom are well-recognized academicians, take great pride in nurturing the career development of junior faculty and residents. The collective energy and enthusiasm for passionate teaching, combined with a love for psychiatry, rapidly rejuvenates the weary educator. This workshop will serve as an interactive resource for understanding several key ingredients for success: 1) The critical role that teaching with passion plays in recruitment into psychiatry; 2) How utilizing the latest in educational technology keeps the learner (and the teacher) effectively engaged; 3) How mentoring relationships serve as the scaffolding for successful careers; and 4) Life-balancing tips as seen through the eyes of an inspirational, successful academician. Participants will gain an appreciation for their own career development and will have the opportunity for an active interchange of ideas.

REFERENCES:

1. Bakhai Y, Halbreich U. Development of Junior Faculty in Resource Poor Departments of Psychiatry. Academic Psychiatry 1993;17:84–90.
2. Bland CJ, Schmitz CC, Stritter FT, et al. Sucessful Faculty in Academic Medicine: Essential Skills and How to Acquire Them. Springer Publishing Company, New York, NY, 1990.
3 Gruber N, Cherry LM. Grassroots, "bottom-up" strategies for a successful Academic career. Acad Med 1996;71:218–219.
4. Riba M. Women in Mwedicine: The Balancing Act. In Victor L, Ed. The Residency Handbook, The Parthenon Publishing Group, 1994, pp 107–116.

Issue Workshop 68
THE BODY IN 21ST-CENTURY PSYCHIATRY: DIAGNOSTIC DIMENSIONS AND THERAPEUTIC CHALLENGES

Co-Chairpersons: Elena B. Bezzubova, M.D., *Medical Department, University of California at Irvine, 2990 Zurich Court, Laguna Beach, CA 92651,* Barton J. Blinder, M.D., *Department of Psychiatry, University of California, 400 Newport Center Drive, Suite 706, Newport Beach, CA 92660-7608*
Participants: Jon E. Grant, M.D., Donca Vianu, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the expanding focus in psychiatry on body appearance, self-appraisal and body regulation; to appreciate increasing somatic/somatoform diagnostic dilemmas and to apply the evolving understanding of the body in mental health care for more effective treatment.

SUMMARY:

In the 21st century the psychiatrist faces a fascinating paradox. Psychiatry, originally formed as a mind-oriented science, in contrast to a body-oriented internal medicine, has discovered the body as an important object and dimension of mental health. The substantial presence of body-related categories in the psychiatric diagnoses—somatoform, dissociative, factitious, eating and gender disorders—is magnified by social influences. Philosophy, art, media, and business have established a view of the body as a valuable component of personal and social achievement. The body with its aesthetic, physical, and gender characteristics is considered not as immutable but as a challenging changeable image, subject to modification. The goal of our workshop is to explore how this perspective of the role-of-body challenges the psychiatrist and what should be done to update psychiatric education and services in response. From physiological base that exerts a demand upon the mind for action, the body epitomizes biological psychiatry. On the other hand, "the body-image" paradigm as a "representational" entity symbolizes dependence of the body on mind. Body-centered concepts in psychoanalysis, psychosomatics, behaviorism, and feminism are reviewed. Presentations on dysmorphophobia, anorexia, hypochondriasis, and depersonalization will examine the relationship between personal identity and body image, dissociation and conversion, and clinical and social features as a background for diagnosis and therapy. The audience will be guided into discussion of dilemmas encountered in somatic/somatoform symptoms in daily practice. Participants will be encouraged to share clinical experiences and their ideas on the role of the body in psychiatry for input to DSM-V. Case studies

illustrating "the self-made body" and self-initiated transforming behaviors, including change of biological sex, will be explored. The role of psychiatrists' commitment/engagement in the high-tech body-altering interventions of aesthetic surgery, organ transplantation, and reproductive medicine will be examined.

REFERENCES:

1. Meermann R, Napelski C, Vandereycken W: Experimental body image research in anorexia nervosa patients. In The Eating Disorders, edited by Blinder BJ, Chaitin BF, Goldstein R. New York, PMA Publishing Corp, 1988 pp. 177–194.
2. Grant JF, Kim SW, Crow SJ: Prevalence and clinical features of body-dysmorphic disorder in adolescent and adult psychiatric inpatients. J Clin Psychiatry 2001; 62:517–522.

WEDNESDAY, MAY 22, 2002

Issue Workshop 69
CHALLENGES IN TREATING GAY AND LESBIAN YOUTH AT RISK

Co-Chairpersons: William Resnick, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1124 W Carson Street, B4 South, Torrance, CA 90502,* Steven Sokoll, M.D., *1911 Panama Street, Philadelphia, PA 19103-6609*

EDUCATIONAL OBJECTIVES:

The participant will be able to identify risk factors for suicide, mental illness, and sexually risky behaviors; to understand the developmental differences and challenges inherent in treatment of gay and lesbian teens; to recognize social etiologies for difficulties in gay and lesbian teens.

SUMMARY:

The workshop is intended for the general psychiatrist who would like to be more informed about the developmental differences and challenges in treating gay and lesbian youth as well as the more experienced clinician who would like to review his or her clinical challenges in working with this population. Presentations will be clinically relevant and will review up-to-date epidemiological studies that provide information about risk factors for suicide, depression, substance abuse, eating disorders, and sexually risky behaviors. A review of sampling issues will outline the difficulties obtaining relevant information about this population. The following therapeutic issues will be discussed: the context of clinical evaluation and treatment; a model for gay and lesbian adolescent development, including the concept of "coming out"; social contributions to difficulties for gay and lesbian teens including societal and medical homonegativity, lack of affiliative group, possible lack of supportive community and family, and lack of safety at school. A case presentation will review the ongoing treatment of a gay male from age 8 to 12 including individual work, parent guidance, and intervention with the school. Ample time for discussion will address the attendees' thinking about the epidemiological data, developmental and social formulations, and clinical material.

REFERENCES:

1. Garofalo R, Wolf RC, Kessel S, et al: The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. Pediatrics 1998; 101:895–902.
2. D'Augelli AR, Hershberger SL, Pilkington NW: Lesbian, gay and bisexual youth and their families disclosure of sexual orientation and its consequences. Am J Orthopsychiatry 1998; 68:361–371.

Issue Workshop 70
GRIEVOUS BODILY HARM AND CLUB DRUGS: TREATMENT AND OTHER CONSIDERATIONS

Chairperson: Jeffrey N. Wilkins, M.D., *23273 Red Rock Road, Topanga, CA 90290-3948*
Participants: Waguih W. Ishak, M.D., Romana Markvitsa, M.D., Katherine Mellott, M.D., Lewis Nelson, M.D.

EDUCATIONAL OBJECTIVES:

To become familiar with the clinical features of club drug intoxication, learn basic management principles in treating club-drug intoxication and gain insight into the social factors involved in club-drug use.

SUMMARY:

The workshop will discuss the clinical presentation of club-drug intoxication and the social factors involved in drug use and raves. Clinical scenarios will be presented with audience members proposing what they would do next. An informative session will follow of the emergency room presentation of club-drug users. Discussion of potential medical and psychiatric complications with treatment options in both the acute and subacute period will follow. A panel supplemented by audiovisual material will explore raves as a modern manifestation of the search for spirituality and community among youth. Interviews will be provided of rave participants including their reasons for using or not using drugs. A discussion of harm-reduction strategies will follow, and the audience is invited to share their opinions. Does harm reduction legitimize drug use or is it a realistic alternative to the difficult goal of abstinence?

The audience will be invited to further discuss: the spread and popularity of club drugs in their community, the popularity of raves as a reflection of larger social issues, how we can create raves that do not involve drug use, and how psychiatrists can best steer their young patients away from club-drug use.

REFERENCES:

1. Weir E: Raves: a review of the culture, the drugs and the prevention of harm. [Review] CMAJ: Canadian Medical Association Journal 2000; 162:1843–1848.
2. Milroy CM: Ten years of 'ecstasy'. JR Soc Med 1999; 92:68–72.

Issue Workshop 71
RECENT STUDIES ON PARITY AND EMPLOYER-SPONSORED INSURANCE
Substance Abuse and Mental Health Services Administration

Chairperson: Darrel A. Regier, M.D., *Office of Research, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*
Participants: Jeffrey Buck, Ph.D., Mady Chalk, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, attendees will understand current trends and issues with the coverage of MH/SA services in employer-sponsored health insurance, and the effects of laws designed to require the coverage of such services at the same level as other health benefits.

SUMMARY:

This session will present information on trends in employer-based insurance coverage for mental health and substance abuse treatment services. It also will review the most recent data on the effects of

parity mandates on insurance costs and services utilization. Studies over the past several years have shown that state parity laws have had a small effect on premiums, costs have not shifted from the private to public sector, and most state parity laws are limited in scope and application. This workshop will update studies released in the late 1990s and will feature the results of a broad evaluation of Vermont's parity law, one of the most comprehensive such laws in the nation. An audience discussion following the presentation will focus on implications of the findings for psychiatric practice and future of insurance coverage. Attendees will be encouraged to discuss their experiences and concerns.

REFERENCES:

1. Buck B, et al: Behavioral health benefits in employer-sponsored health plans, 1997. Health Affairs 1999; March/April pp. 67–78.
2. Sing M, et al.: The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits. USDHHS (SAMHSA), March 1998.

Issue Workshop 72
PSYCHOPHARMACOGENETICS AND ETHNICITY: CURRENT PERSPECTIVES

Co-Chairpersons: Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030,* Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street/B4 South, Torrance, CA 90002*
Participants: William B. Lawson, M.D., Edmond H.T. Pi, M.D., Ricardo P. Mendoza, M.D., Tarek A. Okasha, M.D.

EDUCATIONAL OBJECTIVES:

To understand and recognize the role and functions of psychopharmacogenetic mechanisms in treating ethnic minority patients who suffer from psychiatric disorders.

SUMMARY:

Research efforts have greatly advanced the field of ethnopsychopharmacology in recent years. As a result of these efforts, much knowledge has been developed with respect to the role and mechanisms of pharmacogenetics, pharmacokinetics, and pharmacodynamics in the psychopharmacological treatment of psychiatric disorders and conditions among ethnic minority patients. The Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has underlined the importance of culture, race, and ethnicity when diagnosing and treating multiethnic populations who suffer from psychiatric conditions.

In this workshop, we will address and discuss the role of psychopharmacogenetics in the psychopharmacological treatment of African Americans, Hispanic Americans, Asian Americans and Pacific Islanders, and Native Americans. Particular attention will be given to the metabolic mechanisms, diet patterns, and drug-elimination pathways among the different ethnic minority groups residing in the United States. Hopefully, this workshop will stimulate further thinking and research efforts in this very important field.

REFERENCES:

1. Ruiz P (ed.): Ethnicity and Psychopharmacology. Washington, D.C. American Psychiatric Press, Inc., Review of Psychiatry Series, Volume 9, No. 44, 2000.
2. Lin K-M, Cheung F: Mental health issues for Asian-Americans. Psychiatric Services 1999; 50:774–780.

Issue Workshop 73
PRACTICAL PHARMACOTHERAPY OF MOOD DISORDERS

Co-Chairpersons: Gary E. Miller, M.D., *530 Wells Fargo Drive, Suite 110, Houston, TX 77069-3338,* Richard L. Noel, M.D., *530 Wells Fargo Dr #110, Houston, TX 77090-4026*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will have gained an improved understanding of practical and theoretical issues in the diagnosis and treatment of mood disorders including techniques for managing difficult patients whose symptoms fail to fit DSM-IV categories and whose illnesses fail to respond to conventional pharmacotherapy.

SUMMARY:

The workshop is directed to practicing psychiatrists and other clinicians involved in pharmacological treatment of mood disorders. The moderators are clinical psychopharmacologists who have treated over 10,000 unselected patients (adults, adolescents, and children) over the last 10 years. They will present vignettes of actual patients, each illustrating a problematic issue facing clinicians. Attendees will be encouraged to discuss the cases presented and to convey their own clinical experience and views. The focus will be on crucial issues, both practical and theoretical, in the diagnosis and treatment of mood disorders. Questions to be explored include the following: Are some antidepressants more effective than others? Are antidepressants really dangerous for bipolar patients? Are most early-onset recurrent depressions really bipolar variants? Are topiramate, lamotrogine, and the atypical antipsychotics authentic mood stabilizers? When is it appropriate to initiate treatment of a depressed patient with a mood stabilizer? Is the unipolar/bipolar distinction the fundamental dichotomy in mood disorders, or does clinical experience favor something more in line with the DSM I and II conceptualization—involutional depression vs. manic-depression? What is the proper role of thyroid-hormone augmentation in mood disorders? How can we know when the impulsive aggressive child has more than just ADHD?

REFERENCES:

1. Akiskal Hagop S: The prevelant clinical spectrum of bipolar disorders: beyond DSM-IV. Journal of Clinical Psychopharmacology 1996; 16:45–145.
2. Nassir Sachs GS, et al: Is bipolar disorder still underdiagnosed? are anti-depressants overutilized? Journal of Affective Disorders 1999; 52:135–144.

Issue Workshop 74
MINDFULNESS AND AWARENESS PRACTICE IN THE MEDICINE BUDDHA TRADITION OF TIBET

Chairperson: James T. Sacamano, M.D., *c/o Gorge Road Hosp, 63 Gorge Rd E, Victoria, BC V9A 1L2, Canada*

EDUCATIONAL OBJECTIVES:

The participant will understand mind, mindfulness, and awareness as described in the Tibetan practice of Medicine Buddha as a traditional method for self help that can train attention, increase appropriate social awareness, and optimize learning of positive life strategies.

SUMMARY:

This workshop will present a brief discussion of the Buddhist psychology of mind and the tranquility practice of calm abiding,

which leads to increased self-awareness, the basics of the theory and practice of empathetic compassion, and the use of mantra and visualization in Medicine Buddha practice. There will be guided meditations in these practices and discussion with an emphasis on the participant's personal experience. We will discuss possible applications in work with patients, to reduce burnout in health care providers, and as a way to enhance life satisfaction. This workshop will be appropriate for anyone who is interested in understanding mind and ways to work with mind from a meditative perspective. No previous study is necessary. The goal of the course is to provoke new questions and suggest options for working with mind, emotions, and behavior in an open, nondogmatic dialogue.

REFERENCES:

1. Loizzo J: Meditation and psychotherapy, stress, allostasis, and enriched learning. In, Review of Psychiatry, Complementary and Alternative Medicine and Psychiatry, edited by Muskin PR, Vol. 19, 2000.
2. Thondup T: Boundless Healing, Meditation Exercises to Enlighten the Mind and Heal the Body. Shambhala, Boston, 2000.

Issue Workshop 75
DRUG THERAPY FOR FUNCTIONAL SOMATIC SYNDROMES

Chairperson: Peter Manu, M.D., *Hillside Hospital Medical Services, 75-79 263rd Street, Glen Oaks, NY 11004*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be familiar with advances in the pharmacotherapy of chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, and premenstrual syndrome.

SUMMARY:

The workshop will present and discuss advances in the drug therapy of four common functional disorders (chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, and premenstrual syndrome). These conditions have been diagnosed in at least 10% of the U.S. population and are commonly associated with mood, anxiety, and somatoform disorders. The workshop will allow the participants (consultation-liaison and community/outpatient-based psychiatrists) to evaluate the existing controlled therapeutic trials for these conditions. The goal of the session is to reach consensus regarding effective and ineffective interventions and ways of integrating the pharmacological treatment with other therapeutic modalities. The audience's participation will be encouraged.

REFERENCES:

1. Manu P (Editor): Functional Somatic Syndromes: Etiology, Diagnosis and Treatment. Cambridge University Press, 1998.
2. Manu P: The Pharmacotherapy of Common Functional Syndromes. Haworth Medical Press, 2000.

Issue Workshop 76
IN SEARCH OF THE EMPATHIC HEALER

Chairperson: Michael J. Bennett, M.D., *11 Dunbarton Road, Vermont, MA 02478-2458*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of empathy to the process of healing as it takes place both within the clinical context and within the patient's life structure, and appreciate the value of empathic knowing in developing personalized, focused treatment.

SUMMARY:

Empathy has long been regarded as central to the art of medicine and especially the practice of psychotherapy. The ability of a therapist to appreciate the patient's state of mind and frame of reference is the foundation of a therapeutic alliance and key to the process of healing. These subjective aspects of practice, however, are rendered suspect by today's emphasis on objectivity. Basing interventions on diagnosis alone, medical psychotherapists increasingly rely upon treatment methodologies that appear aimed more at disease than at the person who suffers from it. Pressured by the practice climate and misled by the false dualism between mind and brain, practitioners have abandoned their traditional role as healers.

In this workshop we will consider how the psychotherapist may balance objective and subjective data through the use of empathically derived knowledge and contribute to the healing process through personalized, focused interventions. Drawing upon recent discoveries about genetic plasticity, the biology of memory and learning, and the byplay between the environment and cellular events in the brain, a new dualism will be proposed and its implications for the psychotherapist explored. Participants will be asked to share their clinical experience with the use of empathic knowing to bridge rifts in therapy, focus treatment, and prepare the patient to heal. Examples from literature as well as clinical vignettes will be used to stimulate discussion. Background experience as a psychotherapist, of any discipline, is required.

REFERENCES:

1. Bennett MJ: The Empathic Healer: An Endangered Species. New York: Academic Press, 2001.
2. Bohart AC, Greenberg LS: Empathy reconsidered: new directions in psychotherapy. Washington, DC, American Psychological Association, 1997.

Issue Workshop 77
UNDERSTANDING THE SOCIAL SECURITY DISABILITY PROGRAM

Chairperson: Bernard J. Arseneau, *D.O., 805 Briergreen Court, Bel Air, MD 21015*
Participant: Henry G. Conroe, M.D., Cathy Lively, Ph.D.

EDUCATIONAL OBJECTIVE:

To articulate the SSA definitions of disability, impairment, and functional limitation, understand the disability determination process, understand the role of the psychiatrist, effectively communicate medical evidence.

SUMMARY:

The Social Security Administration (SSA) administers two programs that provide benefits based on disability: the Social Security Disability Insurance (SSDI) and Social Security Income (SSI) programs. Each year, over 2 million people apply for disability on the basis of functional limitations resulting from a medically determinable impairment. During CY 2000, one-half million people applied on the basis of a primary mental disorder alone. Psychiatrists and other practitioners play a vital role in the disability determination process. This workshop will provide a fundamental knowledge base concerning definitions of impairment, functional limitation, and disability, the disability determination process, medical evidence requirements, the role of psychiatrists and other practitioners, and effective reporting of medical information in compliance with HIPAA. The format will include lecture with slides, Q&A panel, and case discussion using case scenarios. Participants should be experienced in the clinical evaluation and treatment of psychiatric disorders. The focus of the workshop will be the 'adult' population.

REFERENCES:

1. U.S. Government Printing Office: Disability Evaluation Under Social Security, 1998.
2. American Medical Association: Guides to the Evaluation of Permanent Impairment, 5th edition, Chicago, AMA Press, 2000.

Issue Workshop 78
NEW DIRECTIONS IN MENTAL HEALTH RESPONSE TO DISASTERS AND LARGE-SCALE CRISES
Substance Abuse and Mental Health Services Administration

Chairperson: Mary E. Nelson, M.S.W., *5600 Fishers Lane, Room 17-C20, Rockville, MD 20857*
Participants: Elissa P. Benedek, M.D., Matthew J. Friedman, M.D., Sharon E. Carpinello, Ph.D., Farris Tuma, Sc.D., Chip J. Felton, M.S.W.

EDUCATIONAL OBJECTIVE:

Workshop participants will understand the conceptual model behind federal mental health programs for response to disaster and criminal events, and will have an improved understanding of existing service models for short and long term response to community crises.

SUMMARY:

Disasters create elevated levels of stress throughout impacted communities and in some instances may produce severe traumatic stress reactions. The workshop will explore existing models of crisis response and the challenges of developing effective programming with inconclusive research on effectiveness. The workshop will include extensive group discussion of appropriate mental health responses to a variety of events ranging from natural disasters, to school violence, to mass casualty traumas such as bombings. The workshop will also discuss existing federal programs for disaster mental health as well as new federal interagency partnerships designed to ensure high-quality disaster mental health services and establish better connections between disaster services and research findings.

REFERENCES:

1. Friedman MJ: Post-Traumatic Stress Disorder: the Latest Assessment and Treatment Strategies. Kansas City, Compact Clinicals, 2000.
2. Flynn BW, Nelson ME: Understanding the needs of children following large-scale disasters and the role of government. Child and Adolescent Psychiatric Clinics of North America. 1998; 7:1.

Issue Workshop 79
CHILDHOOD TRAUMA INTERVENTION AND AFTERMATH: ACCESS TO QUALITY CARE
Substance Abuse and Mental Health Services Administration

Chairperson: Malcolm A. Gordon, Ph.D., *CMHS, 5600 Fishers Lane, Rockville, MD 20857*
Participants: Judith A. Cohen, M.D., Mary Beth Williams, Ph.D., Chris M. Kirchner, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will understand current treatment approaches and service access for children and adolescents who have experienced trauma.

SUMMARY:

This workshop is intended for child and adolescent psychiatrists and other mental health professionals interested in treatment services for children who experience trauma. The workshop presenters will focus on the issues of effective treatment approaches for child traumatic stress reactions and how effective treatment approaches are or can be delivered. Dr. Cohen will focus on models of effective intervention for traumatic stress in children, the strength of evidence of their effectiveness, and her experience working in a hospital-based child trauma clinic and consulting with community-based child service programs. Dr. Williams will discuss service delivery to traumatized children in trauma treatment clinics and in school-based assessment and service-referral programs, including issues of program operation, referral systems, and financing of services. Ms. Kirchner will discuss childrens advocacy centers, which are centralized investigative, referral, and treatment gateways for children reported for abuse in many communities, and the role of child psychiatrists and other mental health professionals in such centers. Each presenter will have approximately 25 minutes for a mixture of presentation, discussion, and interaction with attendees. The chairperson in his introductory remarks will briefly describe a new CMHS-funded initiative to develop a national network of child trauma centers.

REFERENCES:

1. Cohen JA, Berliner L, Mannarino AP: Treating traumatized children: a research review and synthesis. Trauma, Violence and Abuse 2000; 1:29–46.
2. Williams MB, Nurmi LA: Creating a Comprehensive Trauma Center: Choices and Challenges, New York, Plenum, 2001.
3. Blush GJ, Ross KL: Investigation and case management issues and strategies. Issues in Child Abuse Accusations 1990; 2:152–160.

Issue Workshop 80
TEACHING BEHAVIORAL SCIENCES TO FAMILY DOCTORS

Chairperson: Jonathan S. Davine, M.D., *East Region Mental Health, 2757 King Street East, Hamilton, ON L8G 5E4, Canada*

EDUCATIONAL OBJECTIVE:

To understand exposure to a longitudinal method of teaching behavioral sciences to family medicine residents, and exposure to CME initiatives in a shared-care family medicine/psychiatry program.

SUMMARY:

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

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

There will be question-and-answer periods with the audience after the presentation of each of these two models. Participants will be encouraged to share their own experiences in this educational area.

REFERENCES:

1. Kates N, et al: Psychiatry and family medicine: the McMaster approach. Can J Psychiatry 1987; v. 32.

2. Strain J, et al: The role of psychiatry in the training of primary care physicians. General Hospital Psychiatry 1986; 8.

Issue Workshop 81
MUSIC AS MIRROR: REFLECTIONS OF THE PSYCHE IN WORKS BY THE GREAT COMPOSERS

Chairperson: Chelsea L. Chesen, M.D., *University of Arizona, PO Box 245002, Tucson, AZ 85724-5002*
Participant: Eli S. Chesen, M.D.

EDUCATIONAL OBJECTIVE:

To recognize some of the processes by which musicians/composers shape the emotional reactions and experiences of an audience, and discuss the ways in which the experiences of an individual musician/composer (affective states, attachments, illnesses, interests, culture and personality features) find reflection in his/her music, using specific examples from Europe over the past 400 years.

SUMMARY:

Much has been written about the ways in which artists transform their environments expressively to reflect their particular experiences, especially when known to suffer from mental illness. Likewise, many clinicians and artists extol the virtues of creative activities as a therapeutic form of processing for us all. This workshop will use a multimedia approach, including live violin performance, to experientially demonstrate the affective power of music on the listener. After participating in the workshop, attendees will better appreciate the relationship between the life experiences and intrapsychic make-up of a musician/composer and his/her creation of music. Some techniques used by composers and musicians to elicit emotional responses in listeners will be revealed. We will also peer into the inner worlds of several composers by learning about their lives and listening to excerpts of their compositions. One might think of this concept as a "musical projective identification" of sorts. In order to actively participate in this workshop, attendees need only an open mind and curiosity about music, human experience, and creativity. Knowledge of musical theory and terminology is unnecessary. Content will focus on the European composers of "serious" (or "classical") music over the last 400 years. The stimulation of an affectively rich internal experience for each attendee while listening to chosen excerpts of music and attendee participation in an interactive discussion will be the primary goals of the workshop.

REFERENCES:

1. Meyer LB: Emotion and Meaning In Music. Chicago, University of Chicago Press, 1956.
2. Schonberg HC: The Lives of the Great Composers, 3rd Ed. New York, W.W. Norton and Company, 1997.

Issue Workshop 82
ASSISTING PHYSICIANS AND OTHER PROFESSIONALS WHO VIOLATE BOUNDARIES

Chairperson: Werner Tschan, M.D., *Psychiatrist FMH, Nevensteiner Strasse 7, Basel 4053, Switzerland*
Participant: Michael F. Myers, M.D., Carolyn Quadrio, M.D., Gary R. Schoener, Psy.D.

EDUCATIONAL OBJECTIVE:

To be able to described the connection between mood disorders and boundary violations; identify five types of offending professionals; describe remedial boundaries training.

SUMMARY:

In recent years work with professionals who sexually exploit their clients has broadened to include a broader range of professionals who have broken doctor-patient boundaries. This goes beyond sexual contact and includes a variety of types of misconduct in practice. By the same token, this work and literature has begun to find some point of overlap with traditional work with impaired professionals—those with mood disorders, substance abuse and alcohol abuse disorders, etc.

Our first panelist will discuss clinical aspects of boundary crossing and mood in physicians. He will examine when an unrecognized, untreated, or undertreated mood disorder contributes to boundary crossing; when boundary crossing and its many sequelae cause depression in the physician; and when mood disorders and boundary crossing are separate DSM-IV conditions. Our second panelist will comment on the situation as seen from Australia and also examine some emerging issues with female offenders in the professional ranks. The chair, who will be our third panelist, will discuss the evolving work in Switzerland and Europe as regards assessment of those who violate boundaries, various treatment options, and some innovative work with boundaries training.

Our final panelist will examine the overlap between the work of physicians and that of other types of helping professionals and present a system for describing the origins of boundary violations. He will also examine preventive and remedial boundaries training.

REFERENCES:

1. Gabbard GO: Psychodynamic approaches to physician sexual misconduct. In Physician Sexual Misconduct, edited by Bloom JD, Nadelson CC, Notman, MT, Wash., DC, American Psychiatric Press, pp. 205–223.
2. Schoener GR: Assessment of professionals who have engaged in boundary violations. Psychiatric Annals 1995; 25:95–99.

Issue Workshop 83
WOMEN AND SMOKING

Co-Chairpersons: Sarah M. Whitman, M.D., *9 Tohopeka Lane, Philadelphia, PA 19118-3823,* David Rubenstein, Psy.D., *MCP-Hahnemann, 1427 Vine Street, 8th Floor, Philadelphia, PA 19102*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to state epidemiological facts about smoking in the U.S. and smoking cessation efforts, recognize gender differences in smoking, including rates of smoking, medical problems due to smoking, use of nicotine, and quitting, and use counseling strategies, including stages of change assessment and motivational interviewing to promote smoking cessation.

SUMMARY:

Smoking is a significant national medical problem, causing heart disease, cancer, stroke, and pulmonary disease, and is attributed to or associated with 1 in 5 deaths. While 25% of Americans smoke, tobacco use is particularly problematic for females. More girls start smoking, and women are less likely to quit and more likely to relapse. Medical consequences are more severe, with greater lung cancer and cardiovascular risk and quicker development of airway disease. Additional medical problems include cervical cancer, osteoporosis, peptic ulcer disease, and lower fertility and other obstetrical problems. Cigarette use differs in that women use fewer and lower nicotine cigarettes, inhale less deeply, and are more affected by social and sensory factors. Difficulty in quitting is related to more intense withdrawal, lower response to nicotine replacement therapies, higher risk of weight gain and depression, and premenstrual factors.

Despite these discouraging factors, smoking cessation interventions can be effective. Participants will learn how to ask about tobacco use, advise patients to quit smoking, and assist in developing a plan to quit. Participants will learn how to assess a patient's stage of

change, which evaluates a patient's readiness to change behavior. Participants will then learn how to use motivational interviewing techniques tailored to each stage of change.

REFERENCES:

1. Perkins KA: Smoking cessation in women: special considerations. CNS Drugs 2001: 15:391–411.
2. Miller WR, Rollnick S: Motivational Interviewing: Preparing People to Change Addictive Behavior. New York, NY, Guilford Press, 1991.

Issue Workshop 84
CLOZAPINE USE IN HIV

Chairperson: Richard H. McCarthy, M.D., *Department of Psychiatry, Cornell University, 21 Bloomingdale Road, White Plains, NY 10605-1504*
Participant: Mara J. Fiorentino, M.D.

EDUCATIONAL OBJECTIVE:

Participants will be aware of the rational for the use of clozapine in the treatment of HIV seropositive, seriously mentally ill patients, as well as the attendant risks and benefits of treatment.

SUMMARY:

The seriously mentally ill, treatment-refractory, psychotic patient population is the group for whom clozapine is the indicated treatment. Moreover, this same population has been identified as a group at relatively high risk to become HIV positive. Since routine screening for HIV is not done prior to clozapine initiation, it is likely that there are many seropositive patients who are presently receiving clozapine without our being aware of it.

In this workshop, we will present the case of a seropositive individual who was placed on clozapine for the treatment of her psychosis. We will discuss the rationale for the use of clozapine in this and other cases. Potential unique benefits and risks will be discussed. In particular, we will discuss the potential risk of clozapine-induced agranulocytosis, in terms of what is known about both the likelihood and the mechanism for this adverse effect.

REFERENCES:

1. Kelly JA, Murphy DA, Bahr GR, et al: AIDS/HIV risk behavior among the chronic mentally ill. Am J Psychiatry 1992; 149:7–886.
2. Alvir MJ, Liebeman JA, Safferman AZ, et al: Clozapine-induced agranulocytosis: incidence and risk factors in the United States. New England Journal of Medicine 1993; 135:162–167.

Issue Workshop 85
INTERGENERATIONAL ASPECT OF TRAUMA AND TRAUMA-RELATED BEHAVIORAL PATTERNS

Chairperson: Andrei Novac, M.D., *Department of Psychiatry, University of California, 400 Newport Center Drive, Suite 309, Newport Beach, CA 92660-7604*
Participants: Rita R. Newman, M.D., Rachel Yehuda, Ph.D.

EDUCATIONAL OBJECTIVES:

To become familiar with the biopsychosocial model and mechanisms at play in intergenerational transmission of trauma; understand the relationship between risk factors of PTSD and those related to aggressive/violent behavior; and familiarize oneself with the concept of dehumanization/depersonification.

SUMMARY:

Ongoing victimization among humans in spite of enhanced education, progress in mass media communication, and travel has raised the question of "stagnating factors" in prevention of trauma, violence, and consequent psychopathology. Among such stagnating factors are: primitive psychological defenses, a propensity towards aggression, the presence of the dehumanization/depersonification paradigm, and biopsychosocial consequences of PTSD. All of the above will be explored in this presentation. A comparison between the risk factors of PTSD and those associated with violent and aggressive behavior will be drawn.

The presentors are members of the Special Interest Area Group on Intergenerational Transmission of Trauma at the International Society of Traumatic Stress Studies (ISTSS). The workshop will be presenting in-progress research findings of intergenerational transmission since the presentation at last year's APA annual meeting. This year, additional emphasis will be placed on biological markers, factors of vulnerability, and psychometric investigation of intergenerational transmission of trauma and PTSD. Clinical examples drawn from different populations (victims of childhood trauma, Holocaust families, violent offenders) will be discussed with audience participation.

REFERENCES:

1. Novac A: Traumatic stress and human behavior. Psychiatric Times, 2001; 18:41–43.
2. Yehuda R: Biology of posttraumatic stress disorder, J. Clin. Psychiatry 2001; 62(Suppl 17):41–46.

Issue Workshop 86
DO RESTRICTED FORMULARIES SERVE AS BARRIERS TO CARE?

Co-Chairpersons: Mitchel J. Stein, M.D., *129 Boerum Place, Apartment 6A, Brooklyn, NY 11201,* Joseph R. Mawhinney, M.D., *Mental Health Association, 1959 Grand Avenue # A, San Diego, CA 92109-4511*
Participants: Stephen M. Goldfinger, M.D., Kenneth S. Duckworth, M.D., Peter L. Forster, M.D.

EDUCATIONAL OBJECTIVES:

To understand the nature and scope of restricted formularies in both the public and private sectors and their potential in creating major barriers to the provision of timely, state-of-the-art psychiatric treatment.

SUMMARY:

The rapid growth of managed care organizations and their theoretical underpinnings has been a dominant influence in the practice of psychiatry in the United States during the past decade. The main focus of cost control began in the arena of highest cost, inpatient care, but has now has moved to encompass outpatient services including the range of available psychopharmacologic agents. The ability of a psychiatrist to exercise best judgment in selecting the most appropriate psychopharmacologic agent for a patient is now often compromised. The problem of restricted formularies has moved beyond carveout managed behavioral health plans in the private sector and now includes many public-sector programs in various states. This workshop is designed for psychiatrists, program administrators, representatives of the pharmaceutical industry, and consumers. Panel and audience will discuss their experiences of the impact that formulary restrictions have on the care of patients, the nature of psychiatric practice, and the financial well being of public and private behavioral health care programs. Strategies that have been successful in removing restrictions will likewise be explored.

REFERENCES:

1. Horn, et al: Financial incentives and drug spending in managed care. Health Affairs, 1998.

2. Horn, et al: Intended and unintended consequences of HMO cost-containment strategies: results from managed care outcomes project. American Journal of Managed Care, 1996.

Issue Workshop 87
ADVOCACY 101: INFLUENCING MENTAL HEALTH POLICY

Chairperson: Jay B. Cutler, J.D., *Government Relations, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*
Participant: Helen M. Foster, M.D., Heather Whyte, John E. Kraus, Jr., M.D., Jason Pray

EDUCATIONAL OBJECTIVES:

To recognize current state and federal legislative issues that affect patients and the practice of psychiatry and how to effectively engage in legislative advocacy.

SUMMARY:

If you are registered to vote, you possess the most important qualification needed to be a successful advocate on legislative issues affecting your patients and your profession. Participants will learn about current state and federal legislative issues, the legislative process, and resources available to stay on top of the issues. Attendees will learn how to shape the future of psychiatric practice through relevant legislative advocacy and be briefed on current state and federal legislative issues that affect patients and the practice of psychiatry.

APA's Division of Government Relations offers many resources to encourage and assist APA members to become successful advocates. For example, APA's Web-based advocacy tool "Write to Congress" will be explained as well as other tools developed for APA members to enhance and increase the impact of their advocacy efforts. Psychiatric practitioners who have been successful lobbyists at both the state and federal levels will describe their experiences as advocates and explain why psychiatric practitioners' participation in the legislative process is crucial to the development of mental health public policy. Attendees will learn about legislative activity in the 107th Congress, pressing legislative issues in key states, and their influence as constituents in the development of mental health policy in the 21st century.

REFERENCES:

1. Redman E: The Dance of Legislation. University of Washington Press, 2000.
2. What have medical lobbyists done for you lately? Organized medicine has clout, but practicing physicians are more effective at the influence game. Medical Economics 2000; pp. 46–60.

Issue Workshop 88
CAREER DEVELOPMENT AND RISK MANAGEMENT

Chairperson: Barry W. Wall, M.D., *184 Waterman Street, Providence, RI 02906*
Participants: Martin G. Tracy, J.D., Jacqueline M. Melonas, J.D., Joseph M. Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

To understand and discuss the major professional liability risks in psychiatric practice and the emerging trends in practice that reflect the highest risk for malpractice lawsuits, including risk issues related to nontraditional areas of practice. The participant will learn risk-management strategies for preventing risks associated with suicide, supervisory relationships, cybermedicine, the Health Insurance Portability and Accountability Act (HIPAA), and forensic psychiatry, among others.

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 early career psychiatrists understand some of the sources of malpractice lawsuits and become aware of malpractice risks inherent in a variety of practice areas, whether clinical, academic, or administrative. This workshop will present data from claims statistics and professional liability literature that identify common sources of malpractice lawsuits against psychiatrists. Examples from clinical case studies and applicable lawsuits will be used to demonstrate high-risk areas of psychiatric practice and to demonstrate various strategies for preventing or minimizing the related professional liability risks. Topics to be presented include liability risks associated with suicidal patients, supervisory relationships, forensic practice, the HIPAA privacy regulations, cybermedicine and new forms of telecommunications, and nontraditional psychiatric practice. Participants will be encouraged to ask questions about the case studies and lawsuits presented and to be involved in a discussion about a variety of related risk-management strategies. Resources for the early career psychiatrist about obtaining risk-management information for the prevention of professional liability lawsuits will be presented.

REFERENCES:

1. Gostin LO: National health information privacy: regulations under the Health Insurance Portability and Accountability Act, JAMA 2001; 285:3015–3021.
2. Kane B, Sands DZ: Guidelines for the clinical use of electronic mail with patients; the AMIA Internet working group, task force on guidelines for the use of clinic-patient electronic mail; J Am Med Inform Assoc 2001; 5:104–11.

Issue Workshop 89
ASSESSING EDUCATIONAL EXPERIENCES IN PSYCHIATRY

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*
Participants: Paula L. Hensley, M.D., Deepa N. Nadiga, Michael A. Hollifield, M.D.

EDUCATIONAL OBJECTIVES:

By the end of this workshop, participants will be able to describe various methods for assessing psychiatric trainee performance and learning experiences on specific clinical rotations, for comparing the types information they provide, and for using this information as feedback for improving educational activities.

SUMMARY:

This workshop for psychiatric educators will review methods used to assess learning experiences of psychiatric residents and medical students. Focusing on three groups, we examine trainees' assessments of their learning about psychiatric disorders and problems, evaluation skills, and therapeutic interventions, and their assessments of educational processes and ambience in different settings: 1) Third-year medical students on core clerkships: How do the experiences of medical students on a psychiatric clerkship vary by primary rotation site (e.g., general inpatient versus VA inpatient versus geriatric unit) and by order of rotation during the academic year? How do medical students' assessments relate to scores on shelf exams? 2) PGY-2 psychiatric residents rotating through a general outpatient clinic. 3) PGY-3 psychiatric residents rotating through a special problems

clinic that concentrates on mood, anxiety, and behavioral medicine problems and cognitive-behavior therapy.

We consider how students' assessments correlate with stated educational goals and objectives of these rotations, types of learning that occur above and beyond those specifically targeted, and how feedback provided by these assessments can help faculty redesign training experiences or validate current rotations. We also discuss a variety of other methods and issues regarding evaluating trainee performance and proficiencies, including the assessment of psychotherapy competence.

REFERENCES:

1. Strauss G, Yager J, Liston EH, Strauss G: Testing psychiatric knowledge with in-house examinations. Am J Psychiatry, 1981; 138:636–649.
2. Yager J, Elliott RL, Smith N, et al: The quality of psychiatric residency programs: the assessment of programs and options for distributing psychiatric residents in the service of health care reform. Academic Psychiatry 1999; 23:61–70.

Issue Workshop 90
THE PSYCHIATRIC FITNESS-FOR-DUTY EXAM

Chairperson: Robert C. Larsen, M.D., *1390 Market Street, Suite 301, San Francisco, CA 94104*

EDUCATIONAL OBJECTIVES:

At the session's conclusion, the participant should be able to understand the role of the examining psychiatrist performing fitness-for-duty examinations. Situations triggering such exams with illustrative case examples will be presented. Discussion between participants and the presenter will include exam information exchange and a framework for conducting these specialized psychiatric assessments.

SUMMARY:

This workshop will address the topic of fitness for duty as a specialized forensic psychiatry assessment. Participants will be presented with guidelines used by occupational medicine physicians for conducting medical evaluations. Limits of medical confidentiality in such examinations will be delineated with attention given to the Americans with Disabilities Act. Situations justifying psychiatric examination include pre-employment assessment, the disruptive employee, the post-disability leave status, a failed return to work, and threat assessment. Participants will discuss case examples for each of these five situations. The concept of work function assessment will lead to reports of greater value in assisting employees back to work and allowing employers to make decisions regarding workplace accommodations. The topic of information exchange between the examiner and the referral source will be addressed. Obtaining informed consent from the examinee will also be detailed. Potential "administrative minefields" should assist the psychiatrist in avoiding involvement in unnecessary examinations as well as make recommendations to a referral source regarding circumstances that justify a fitness-for-duty examination. The presenter will make available a sample release-of-information form to participants interested in taking on these types of occupational medicine evaluations within the mental health field.

REFERENCES:

1. Latsen RC: Ethical issues in psychiatry and occupational medicine. In Larsen RC, Felton JS (eds): Psychiatric Injury in the Workplace. Philadelphia, Hanley & Belfus, 1988, 719–726.
2. Industrial Medical Council, State of California: Confidentiality of Medical Information: Information for Physicians. Department of Industrial Relations, 1999.

Issue Workshop 91
YOUTH VIOLENCE: A REPORT OF THE SURGEON GENERAL
Substance Abuse and Mental Health Services Administration

Co-Chairpersons: Marilyn B. Benoit, M.D., *3033 New Mexico Ave, NW #201, Washington, DC 20016,* Norma Hatot, CMHS/SAMHSA, *5600 Fishers Lane, Rockville, MD 20857*
Participants: Delbert Elliott, Ph.D., Carl C. Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the developmental dynamics of youth violence; understand risk and protective factors by domain (individual, family, school, and peers); identify model, promising, and ineffective youth violence prevention programs and strategies; and develop informed decisions to ensure the safe and healthy development of children.

SUMMARY:

This session will highlight the findings in a report that integrates and summarizes what is known about youth violence and its magnitude, corrects many myths about this problem and barriers to the ability to address the problem successfully, and provides direction for future research. It focuses on perpetration of interpersonal physical assault by youth; reviews the developmental dynamics of youth violence (the first two decades of life); and addresses risk and protective factors including early forms of violence and continuity into adulthood to include adult consequences of youth violence. This report identifies the causes of youth violence and highlights prevention and intervention with a focus on promoting healthy nonviolent children, methods of identifying best practices, and scientific standards for determining program effectiveness (model, promising, and does not work). This session concludes with a vision for the future with potential next steps. The key conclusion is that an array of intervention programs with well-documented effectiveness exist to reduce and prevent youth violence. Youth violence is not an intractable problem.

REFERENCES:

Youth Violence: A Report of the Surgeon General (Copies of this report will be available for dissemination)

Issue Workshop 92
SELF-MUTILATION IN PRISON

Co-Chairpersons: Lee H. Rome, M.D., *Department of Psychiatry, University of Michigan, 3511 Bemis Road, Ypsilanti, MI 48197,* James E. Dillon, M.D., *Huron Valley Center, 3511 Bemis Road, Ypsilanti, MI 48197*

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participant should have an increased understanding of the dynamics, assessment, and management strategies regarding self-mutilation of prisoners.

SUMMARY:

Although not unique to the prison setting, self-mutilation is a common and notoriously challenging behavior faced by clinicians practicing in correctional facilities. Few, if any, behaviors of inmates have more powerful impact on correctional institutions than self-injury. Although distinguishable, self-mutilation and suicidal behavior are not mutually exclusive. Both types of self-injurious behavior

can cause serious injury or death and can occur in the same individual. In addition, self-mutilation is associated with complications including program disruption, staff conflict and splitting, high transportation and medical costs, and substantial medical-legal risk.

This workshop will focus on the type of self-injurious behavior identified as self-mutilation. A definition, brief overview of published scientific literature, integrated descriptive and functional typology models, evaluation issues, and treatment/management approaches will be presented by the workshop chairpersons. In addition, case vignettes illustrating various presentations of self-injurious behavior of incarcerated individuals will be offered by the chairpersons and solicited from the workshop participants. Interventions emphasizing an integrated effort of all staff will be explored. A substantial amount of time will be reserved for attendees to share their experiences and insights.

REFERENCES:

1. Favazza AR: The coming of age of self-mutilation. J Nerv Ment Dis 1998; 186:259–268.
2. Suyemoto KL: The functions of self-mutilation. Clinical Psychology Review 1998; 18:531–554.

Issue Workshop 93
PSYCHIATRIC ILLNESS AND THE WORKPLACE

Chairperson: Steven E. Pflanz, M.D., *68A Fort Warren Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

To understand the relationship between work stress and mental health and the role of the psychiatrist in minimizing the impact of job stress on the emotional health of workers.

SUMMARY:

Increasingly, both industry and mental health professionals are recognizing that work stress is a major factor in determining the mental health of employees. Psychiatrists and mental health professionals are often faced with patients suffering from emotional distress that is attributed to job stress. Importantly, 15% of American workers experience at least one episode of psychosocial disability every year. Mentally ill workers exhibit decreased productivity, increased workforce turnover, higher absenteeism, and increased medical care utilization. These combined factors cost industry $150 billion annually. The relationship between the work environment and the mental health of employees has received little research attention. Nonetheless, 10% of American workers report exposure to mental stress at work, and 5% believe that their experience of work stress could be deleterious to their mental health. At work, both exposure to sudden traumatic events and to chronic daily stress can produce or exacerbate psychiatric symptoms. In this workshop, the audience will discuss the complex relationship between the work environment and mental health. We will examine the common sources of job stress and the mechanisms by which work stress can lead to psychiatric illness. Lastly, we will explore how the mental health professional can forge a partnership with patients and employees to reduce work stress and ameliorate or eliminate psychiatric illness in working patient populations.

REFERENCES:

1. Pflanz SE: Occupational stress and psychiatric illness in the military: investigation of the relationship between occupational stress and mental illness among military mental health patients. Milit Med 2001; 166:457–462.
2. Pflanz SE: Psychiatric illness and the workplace: perspectives for occupational medicine in the military. Milit Med 1999; 164:401–406.

Issue Workshop 94
ELECTRONIC MEDICAL RECORDS ENHANCE QUALITY AND PRODUCTIVITY: THE TIME HAS COME

Chairperson: Daniel A. Deutschman, M.D., *Department of Psychiatry, Case Western Reserve University, 18051 Jefferson Park Road, Middleburg Heights, OH 44130*
Participant: Joshua E. Freedman, M.D.

EDUCATIONAL OBJECTIVES:

To understand the power and value of electronic medical records (EMR), recognize features of EMR that contribute to enhanced function, and understand how to select, customize, and implement an EMR.

SUMMARY:

Health care is under assault. Medical knowledge is growing exponentially. While demanding more comprehensive data to meet NCQA requirements, managed care payors steadily decrease reimbursements. Medicare's rigid data criteria tied to reimbursements threaten MDs with fraud and abuse charges. Electronic medical records (EMR) may hold the answer since they readily provide comprehensive data, MD decision support, quality of care enhancement, and increased productivity.

Three such EMR in university-affiliated mental health facilities more than meet the challenges outlined above. They represent years of work by leaders in EMR design and implementation from Columbia University, University of Louisville, and Case Western Reserve University. In aggregate, these EMR offer: 1) prompting data input forms, 2) automated data entry, 3) printouts of interviews, treatment plans, and prescriptions, 4) MD decision support for diagnostically complex and treatment-resistant patients, 5) electronic scheduling, 6) billing, 7) naturalistic studies, 8) multisite capacity, and 9) seamless inpatient and outpatient data integration. The data systems will be demonstrated. Costs, implementation issues, patient/MD satisfaction, and future developments will be discussed. Our discussant, the past president of the Psychiatric Society for Informatics, will contrast and critique these EMR. The workshop will be interactive with ample opportunity for questions and answers.

REFERENCES:

1. McDonald CJ: The barriers to electronic medical record systems and how to overcome them. J. American Medical Informatics Assoc 1997; 4:213–221.
2. Tang PC, LaRosa MP, Gorden SM: Use of computer-based records, completeness of documentation, and appropriateness of documented clinical decisions. J. American Medical Informatics Assoc 1999; 6:245–251.

Issue Workshop 95
DILEMMAS OF MELANCHOLIA: LET PHILOSOPHY HELP
Association for the Advancement of Philosophy and Psychiatry

Chairperson: Michael F. Myers, M.D., *2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada*
Participants: Jennifer Radden, Ph.D., Deborah Spitz, M.D., Leah J. Dickstein, M.D., Zachary Myers

EDUCATIONAL OBJECTIVES:

To appreciate the complexity of melancholic states in our patients and institute treatment with greater understanding and success.

SUMMARY:

In DSM-IV the only reference to melancholia is as a specifier for mood disorders, i.e., "with melancholic features." Yet historically and clinically melancholia is more than its narrow DSM definition. And the many melancholic patients who consult psychiatrists each year elude our nosology and thereby challenge our ability to help. In this interactive workshop, the presenters (both philosophers and psychiatrists) will review definitions of melancholia and outline its history and rich philosophical underpinnings; raise and consider philosophical and theoretical considerations when conducting both a descriptive and etiological analysis of melancholic states versus clinical depression; outline the various ways the canon on melancholy can be seen through contemporary epistemological, gender-sensitive, and other frames; present some clinical paradoxes and discuss how philosophical distinctions can guide the clinician in understanding and treating patients with melancholia; and examine the myriad countertransference issues that occur in treatment, particularly patients with refractory illness. Thirty minutes will be protected for discussion with the audience.

REFERENCES:

1. Radden J: The Nature of Melancholy: From Aristotle to Kristeva. New York, Oxford University Press, 2000.
2. Marinoff L: Plato, Not Prozac! New York, Harper Collins, 1999.
3. Jackson S: Melancholia and Depression. New Haven, Yale University Press, 1986.

THURSDAY, MAY 23, 2002

Issue Workshop 96
STIGMA STAYED: THE COST OF PREJUDICE IN HIGH PLACES

Chairperson: Karl S. Burgoyne, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson Street, Box 498, Torrance, CA 90509*
Participants: Milton H. Miller, M.D., *Marvin J. Southard,* D.S.W. James Allen, M.B.A.

EDUCATIONAL OBJECTIVES:

To 1) list examples of the exploitation of prejudice to forward business or political interests; 2) describe effective programs to combat stigma; 3) understand steps needed to assure the long-term effectiveness of individualized treatment programs; 4) describe the historical and contemporary overlap/repetition of the consequences of prejudice in high places.

SUMMARY:

Twenty-five years ago, First Lady Rosalyn Carter said that she had been surprised by the price extracted in the lives of individuals with mental illness because of prejudice. She was shocked that at such a late point in history prejudicial attitudes were still so damaging.

Progress notwithstanding—especially Surgeon General David Satcher's report and some gains in insurance coverage—acts reflecting entrenched prejudice in high places and/or acts that exploit community fear of mental illness are still common. With audience participation actively sought, the presenters will outline multiple examples of the effects of stigma. For instance, a hospital blocks construction of a halfway house "on their street." Or a prominent medical school delays the appointment of a psychiatry chair for a full decade (with dire consequences for patients, families and health professionals). Governments use jails and prisons to replace hospitals for treatment of mentally ill citizens. Perhaps most damaging, the mix of stigma and cost-cutting time strictures imposed by health insurance companies make effective treatment for millions almost impossible. Patients receive short shrift in terms of education, family participation, and face-to-face time with psychiatrists. Patients lose hope, stop treatment, and symptoms return. Critics question efficacious treatments, pointing to "all the relapses."

REFERENCES:

1. Jones AH: Mental illness made public: ending the stigma? The Lancet, 1998; 352:1060.
2. Sartorius N: Stigma: what can psychiatrists do about it? The Lancet, 1998; 352:1058–1059.

Issue Workshop 97
THE OTHER SIDE OF THE MOUNTAIN: FROM RESIDENCY TO REALITY

Chairperson: Stephen M. Goldfinger, M.D., *Department of Psychiatry, SUNY, Downstate, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*
Participants: Deborah J. Hales, M.D., Mary Kay Smith, M.D., Ronald C. Albucher, M.D.

EDUCATIONAL OBJECTIVES:

To understand the challenges involved in the transition from resident to early career psychiatrist, and acquire skills to cope with these challenges.

SUMMARY:

Increasingly, APA and academic medical centers have been focusing on recognizing and addressing the needs of recent residency graduates or early career psychiatrists (ECPs). Sponsored APA-based fellowships have begun to bring together ECPs and offer continuing structured learning and individual mentoring experiences. This forum will focus on an interactive discussion between ECPs and senior psychiatrists in an exploration of how we have, and have not, met young professionals' needs in our current training paradigms. Residents in every program learn the basics of differential diagnosis, psychotherapies, and pharmacotherapeutics, and other aspects of clinical psychiatry. Many programs, however, address only peripherally, or not at all, essential needs to translate this information into practice. Ranging from operational assistance in such essentials as joining provider panels, purchasing office equipment, or deciding on malpractice insurance to discussions on how best to continue one's ongoing medical education after formal training is over, we often provide young professionals with inadequate tools to face the challenges ahead. Hopefully, drawing on the real world expertise of both junior and senior panel members, we will be able to help further the discussion of what is most needed and how best to meet these needs as we prepare ourselves, our field, and our residents for the millennium ahead.

REFERENCES:

1. The American Psychiatric Association: Practice Management for Early Career Psychiatrists, Washington DC, 1999.
2. The Association for Women Surgeons: The Pocket Mentor: A Manual for Surgical Interns and Residents, Westmont IL, 1997.

Issue Workshop 98
TOWARDS GLOBAL DECRIMINALIZATION OF DRUG ADDICTION

Co-Chairpersons: Rodrigo A. Munoz, M.D., *University of California at San Diego, 3130 5th Avenue, San Diego, CA 92103,* Guido Belsasso, M.D., *3130 5th Avenue, San Diego, CA 92103*
Participants: Gretchen Bergman, Pedro Ruiz, M.D., Jorge A. Zapatel, M.D., Harold I. Eist, M.D., Maria C. Bayon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to recognize the conflicting interests among the many participants

in the struggle against addictive drugs' production, transportation, and use. Clinicians should emphasize opportunities for early diagnosis of chemical dependency, treatment, and rehabilitation.

SUMMARY:

California implemented Proposition 36, which mandates treatment instead of incarceration for nonviolent drug offenders on July 1, 2001. Arizona passed a similar law in 1996, saving millions of dollars and improving the public safety through therapeutic rather than punitive measures. Florida, Michigan, and Ohio are slated to pass similar laws, and a sea change of thinking is sweeping across the states. Citizens are aware that the war on drugs has failed and that it is time to focus on the demand for, rather than the supply of, drugs. And too many people have seen first-hand not only the devastation of the disease of addiction, but the further damage done to the addicted individual and their families by our practices of punitive incarceration.

On the international front, The Netherlands has long maintained more of a harm-reduction position, and Portugal just became the latest European country to decriminalize drugs. And what is happening in Latin America? Interdiction and confiscation of drugs have failed to reduce production, and drug traffic has actually increased. Drugs are now cheaper and more potent than ever before, and we are warehousing a generation of young adults behind bars.

The panelists, witnesses to the problems created by drug cultivation, transportation, and use in the Americas, discuss new initiatives emerging in many countries. Can a fresh approach be more successful than the current one? It is time to take an honest look at this public health problem of epidemic proportions. Will an educated approach with early diagnosis and effective treatment serve our global community?

REFERENCES:

1. Appleby L, Dyson V, Luchins DJ, Cohen LS: The impact of substance use screening on a public psychiatric inpatient population. Psychiatr Serv 1997; 48:1311–1316.
2. Havassy B, Arns PB: Relationship of cocaine and other substance dependence to well-being of high-risk psychiatric patients. Psychiatr Serv 1998; 49:935–940.

Issue Workshop 99
POEMS ON PSYCHIATRY

Chairperson: Charles R. Joy, M.D., *4406 Sunnydale Boulevard, Erie, PA 16509-1651*

EDUCATIONAL OBJECTIVES:

To appreciate the extent to which poetry can express insights related to psychiatric practice; recognize powerful emotions related to the identifications with poems on psychiatry; and express personal experiences of practicing psychiatry in a highly refined fashion through the use of poetic technique.

SUMMARY:

The dynamic energies, the interpersonal relationships, and the sublimations and other distortions inherent in the practice of psychiatry provide a fertile substrate for the creation of poetry. Moreover, poems about psychiatry written by a psychiatrist and shared with an audience of psychiatrists provide a unique opportunity to identify and express powerful insights into the practice of psychiatry. The 21st-century psychiatrist will benefit from an increased appreciation for the power of poetry as a method for considering issues of importance to both patients and practitioners. In this workshop participants will have the opportunity to hear such poetry, discuss their associations to the poems, and then create their own poems in a structured writing exercise. Participants at this workshop in 2001 particularly enjoyed the writing exercise. The chair of this workshop has extensive experience writing and presenting original poetry inspired by the practice of psychiatry. Selections will include "Something Different," first-place winner at the APA Arts Association Exhibition in 1991, and "At The Preschool," (Mediphors, 1998). Themes will include the price of empathy, the risks of intervention, the experience of assessment, and more. Emotions will be engaged as participants experience psychiatry through the modality of poetry.

REFERENCES:

1. Joy CR: What if Lashika. The Pharos 1999;1:8.
2. Joy CR: This work. West Virginia Medical Journal 1999;95:205.

Issue Workshop 100
HOW TO GIVE A MORE EFFECTIVE LECTURE: PUNCH, PASSION, AND POLISH

Chairperson: Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106*

EDUCATIONAL OBJECTIVE:

To improve techniques for holding audience attention, involving the audience, and using slides effectively.

SUMMARY:

This workshop will provide practical advice on how to make a psychiatric presentation with punch, passion, and polish. Instruction will be given on planning a scientific paper presentation and a half-day course. The workshop leader will cover the selection of a title through to the choice of closing remarks. Teaching techniques to hold the audience's attention include the use of humor, anecdotes, and vivid images. Participants will be taught to involve the audience by breaking them into pairs to solve problems by applying recently acquired knowledge.

Participants will be told that they should never read while lecturing, display their esoteric vocabulary, or rush through their talk, no matter what the time constraints. Tips will be given for making traditional word slides and innovative picture slides. Pitfalls of Powerpoint will be illustrated. Advice will be given on the effective use of videotape vignettes. A videotape will be used to illustrate common errors made by lecturers. The workshop will also cover preparation of handouts. Finally, participants will be encouraged to make a three-minute presentation with or without slides and receive feedback from workshop participants.

REFERENCES:

1. Anholt RR: Dazzle 'Em With Style: The Art of Oral Scientific Presentation, WH Freeman & Co., 1994.
2. St. James D: Writing and Speaking for Excellence. Sudbury, Massachusetts, Jones and Bartlett Publishers, 1996.

Issue Workshop 101
TEACHING PRIMARY CARE RESIDENTS ABOUT DEPRESSION AND SUICIDE: CAN TECHNOLOGY ALTER OUTCOMES?

Chairperson: Donna M. Sudak, M.D., *Psychiatry Residency Training Department, MCP Hahnemann University, 3200 Henry Avenue, Philadelphia, PA 19129*
Participants: Rory P. Houghtalen, M.D.

EDUCATIONAL OBJECTIVE:

To understand the need for teaching primary care residents skills in recognizing and managing suicide and depression, evaluate an interactive computer-based program to teach these skills, and discuss methods to measure outcomes in patient-care settings.

SUMMARY:

Suicide is the eighth-leading cause of death in the United States. Specific requirements for nonpsychiatric primary care residents in the recognition and management of depression and suicide are inconsistent and variably applied. Despite the availability of guidelines for diagnosing and treating major depression and recognizing suicide risk, recognition rates and treatment to remission rates are poor and educational efforts have been of limited success. A survey found that 83%–94% of primary care residents and training directors nationally expressed a desire for standardized curricular materials on depression and suicide. This workshop will review studies of training programs to improve outcomes in primary care and present a computer-based, interactive program to teach the diagnosis and treatment of major depression to trainees. The audience will participate in a demonstration of the program, learn what resources were chosen as critical to present to primary care trainees, and discuss methods proposed to measure outcomes in actual future practice of these trainees. We anticipate substantial discussion of the difficulties involved in implementing this program, as well as the difficulties of evaluating actual outcomes of training efforts.

REFERENCES:

1. Bongar B, Harmatz M: Clinical psychology graduate education in the study of suicide: availability, resources and importance. Suicide Life Threatening Behavior 1991; 21:231–243.
2. Weissbarg M: The meagreness of physicians' training in emergency psychiatric evaluation, Academic Medicine 1990; 65:747–750.

Issue Workshop 102
RELIGIOUS AND SPIRITUAL ASSESSMENT IN CLINICAL PRACTICE

Chairperson: Francis G. Lu, M.D., *Department of Psychiatry, University of California, San Francisco, 1001 Potrero Avenue, SFGH Suite 7M, San Francisco, CA 94110*
Participant: Christina M. Puchalski, M.D.

EDUCATIONAL OBJECTIVE:

To understand the importance of incorporating history taking and assessment of religious/spiritual issues in clinical work and understand the practical methods of utilizing the assessment in treatment planning.

SUMMARY:

According to the APA Practice Guideline on the Psychiatric Evaluation of Adults and the DSM-IV Outline for Cultural Formulation, cultural issues including religion/spirituality should be incorporated in history taking, assessment, and treatment planning. Yet clinicians may be unfamiliar with methods of religious/spiritual assessment. This workshop will review cases that demonstrate methods of interviewing, assessment, and treatment planning. Participants will be invited to critique and comment on these issues and use them as a stimulus for discussion of their clinical work. Specific issues discussed will include the importance of respectful rapport, the use of the DSM-IV Outline for Cultural Formulation, the DSM-IV diagnosis of religious or spiritual problem, and the use of religious/spiritual consultations and interventions such as with chaplains.

REFERENCES:

1. Puchalski C., Larson DB: Developing curricula in spirituality and medicine. Academic Medicine 1998; 73:970–974.
2. Larson D., Lu F., Swyers J (Eds.): Model Curriculum for Psychiatry Residency Training Programs: Religion and Spirituality in Clinical Practice. Rockville, MD: National Institute for Healthcare Research.

Issue Workshop 103
LITHIUM REVISITED: INTEGRATING RECENT FINDINGS INTO CLINICAL PRACTICE

Co-Chairpersons: Robert T. Dunn, M.D., *55 I Street #1, Boston, MA 02127,* Eric G. Smith, M.D., *16 Kingsbury Street, Framingham, MA 01702-8112*
Participant: Frederick K. Goodwin, M.D., Michael J. Gitlin, M.D.

EDUCATIONAL OBJECTIVE:

To demonstrate an increased awareness of the primary factors to consider when starting or maintaining a patient on lithium, including the most recent data concerning long-term side effects and benefits of lithium treatment.

SUMMARY:

This workshop considers lithium's current role in treating bipolar disorder by integrating recent and past findings concerning lithium's efficacy, risks, and benefits, and engaging the audience in a wide-ranging discussion of the factors they consider when deciding whether to use lithium. Indications for using lithium, especially in relation to other mood stabilizers, will be reviewed, along with contraindications and precautions for initiating lithium treatment. Length-of-stay data for mania will be reviewed, suggesting lithium may compare favorably with even-loading doses of valproate. In addition, several adverse effects particularly relevant to the maintenance use of lithium will be reviewed, emphasizing the recent literature on the long-term renal, thyroid, and parathyroid effects of lithium. Lithium's cognitive effects, which account for a surprising percentage of nonadherence, will also be highlighted. To foster a more complete sense of when lithium's benefits outweigh its risks, additional benefits from lithium use will be considered, including mortality and suicide reduction and potential neuroprotection. Audience participation will be solicited regarding whether lithium is currently an overused or underused part of our psychotropic armamentarium. The session's goal is to provide thought-provoking data and discussion concerning lithium's role entering the 21st century.

REFERENCES:

1. Sachs, GS, Printz DJ, Kahn DA, et al.: Medication treatment of bipolar disorder 2000, April 2000; The Expert Consensus Guidelines series. Postgraduate Medicine (Special Report) pp. 1–104.
2. Gitlin MJ: Lithium and the kidney; and updated review. Drug Safety 1999; 20: 231–243.

Issue Workshop 104
THE DISRUPTIVE PHYSICIANS AND HOSPITAL CULTURE

Co-Chairpersons: Glenn N. Siegel, M.D., *Professionals at Risk, Elmhurst Memorial, 183 North York Road, Elmhurst, IL 60126,* Mary Pittman, M.S., *Elmhurst Memorial, 183 North York Road, Elmhurst, IL 60126*

EDUCATIONAL OBJECTIVES:

To identify barriers to effective leadership in hospital settings, identify effective interventions to prevent escalation of behavioral disruption in a hospital setting, and implement a paradigm for creating a healthy hospital culture.

SUMMARY:

Physicians identified as disruptive in the workplace present challenges to professional colleagues, hospital administrators, state pro-

fessional assistance programs, and state medical licensure boards. As the delivery of cost-effective health care relies increasingly on the collaborative efficacy of multidisciplinary teams, those physicians with significant interpersonal difficulties become readily and overtly apparent. This workshop will address the range of etiologies of such behavioral difficulties and explore how different types of hospital cultures can affect both the development and resolution of these problems. Administrative and medical staff leadership philosophies are central determinants in the creation of a culture that can either contain and minimize systemic effects of disruptive behaviors or invite and exacerbate them. A paradigm for the development and maintenance of a healthy professional culture within a hospital setting will be presented. Participants will be asked to use examples from their own hospital setting to broaden the discussion and encourage mutual consultation. This workshop targets those in hospital and medical-staff leadership positions.

REFERENCES:

1. Pfifferling J-H: The disruptive physician: a quality of professional life factor. The Physician Executive 1999; Mar/April: 56-61.
2. Sotile W, Soltile MO: How to shape positive relationships in medical practices and hospitals. The Physician Executive 1999: July/Aug 51-60.

Issue Workshop 105
EVIDENCE-BASED TABLES OF SIDE EFFECTS OF PSYCHOTROPIC MEDICATIONS: USEFUL?

Co-Chairpersons: David N. Osser, M.D., *Taunton State Hospital, 60 Hodges Avenue Extension, Taunton, MA 02780,* Andrew A. Sassani, M.D., *Brockton VA Medical Center, 940 Belmont Street, Brockton, MA 02401*
Participants: Alfredo Martija, M.D., Alexandrina Darabus, M.D., Michael J. Kittay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be more able to differentiate the side-effect liabilities of psychotropic medications based on a mixture of literature-based evidence. The participant will be able to compare medications with similar indications and with placebo.

SUMMARY:

Due to the ever-growing advances in the pharmacological treatment of psychiatric disorders, clinicians today are equipped with a far greater and improved armamentarium of medications to treat these conditions. However, it has become correspondingly difficult to choose the medication most likely to be well tolerated by the patient. The busy clinician frequently turns to textbooks and journal articles (notably those in journal "supplements") where it is easy to find tables of comparative side effect liabilities. These tables generally rate the side effects as "+," "++," or "+++" or similar comparisons, based on the authors' educated guesses. The fuzzy nature of this qualitative rating system brings the risk that bias and other errors may occur.

This workshop will present an ongoing project to construct quantitative, evidence-based side-effect tables for the medications used to treat depression, schizophrenia, and bipolar disorder. The panel members reviewed numerous placebo-controlled, peer-reviewed studies and performed meta-analyses of the available data on important side effects. The data are being entered into tables. However, it is clear that the evidence is, to varying degrees, flawed by study design problems. The goal of this workshop is to engage in a dialogue with participants about the process of deciding what the "evidence" tells us about side-effect propensities and to discuss the reliability of this source of information in comparison with expert opinion and what is presented in the media and advertising.

REFERENCES:

1. Berg AO: Dimensions of evidence. In Evidence-Based Clinical Practice: Concepts and Approaches. Edited by Geyman JP, Deyo RA, Ramsey SD. Boston, Butterworth Heinemann, 2000, pp 21–25.
2. Bowden CL, Calabrese JR, McElroy SL, et al: A randomized, placebo-controlled 12 month trial of divalproex and lithium in treatment of outpatients with bipolar I disorder. Arch Gen Psychiatry 2000; 57:481–489.

Issue Workshop 106
USING YOUR PSYCHIATRIC SKILLS TO BUILD A PRODUCTIVE TEAM AT WORK

Chairperson: Saul M. Levin, M.D., *Access Consulting International, 1901 Penn Avenue NW, Suite 705, Washington, DC 2006*
Participant: Judy L. Stange, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand innovative ways to get staff to function together in a productive manner while appreciating differences.

SUMMARY:

During medical school, residency, and full-time practice, physicians may realize they are not trained to "team build" in the business sense of the word. While socialized to function as a team, physicians do so within strict clinical roles and duties focusing on patient care, knowing the patient suffers if responsibilities are neglected.

However, physicians have not learned how to identify the strengths and weaknesses individual personalities bring to the team milieu. Time-sensitive environments, like managed care, leave little time for addressing interpersonal aspects of the team environment, and additional stresses ensue when different personal styles are not effectively integrated. A more efficient, productive working team can be built by utilizing the strengths of team members, while using the team structure to deemphasize weaknesses.

Upon conclusion of the session, participants will be able to: 1) identify their personal style as a team member, 2) use a quantitative instrument to determine if "team-building" is needed in their organization, 3) articulate strategies for enhancing communication among people of differing communication styles, 4) describe techniques for resolving conflicts within teams and organizations.

This will be an interactive presentation. Participants will form small groups and practice utilizing assessment and communications strategies.

REFERENCES:

1. Schermerhorn, J., Hunt, J, Osborn, R: Organizational Behavior. John Wiley & Sons Inc, 1997.
2. Kilmann R, Thomas K: Thomas-Kilmann Conflict Resolution Instrument; XICOM Inc., 1996.

Issue Workshop 107
THE FRONTIER OF PUBLIC HEALTH PSYCHIATRY: PREVENTING SUICIDE
Substance Abuse and Mental Health Services Administration

Chairperson: Eric D. Caine, M.D., *Department of Psychiatry, University of Rochester Medical Center, 300 Crittenden Boulevard, Rochester, NY 14642-8409*
Participants: David A. Litts, O.D., Madelyn Gould, Ph.D., Yeates Conwell, M.D.

EDUCATIONAL OBJECTIVES:

To develop an understanding of the public health challenges involved in preventing suicide in the U.S. with specific awareness of

the problems encountered among youth, where the rate has increased dramatically during recent decades, and among elders, where the rates remain highest.

SUMMARY:

The number of deaths annually from suicide always exceeds those from murders. While violent crime has been a riveting focus for the national consciousness, the mortality and morbidity associated with suicide and suicidal behaviors largely has escaped public notice until recently. Most psychiatrists and mental health clinicians deal with concerns regarding suicide when evaluating or treating imminently or persistently suicidal individuals. But clinical therapeutic perspectives have shown little discernable impact on the overall suicide rates in the United States or in other countries during the 20th century. The status of suicide prevention *today* is comparable to preventive cardiology *more than 50 years ago,* and the experience of the past half-century has demonstrated that individually specific clinical approaches do not reduce suicide rates among larger populations. We shall consider the challenge posed by the U.S. Surgeon General, who declared that suicide and attempted suicide are serious public health threats in his "Call to Action" to develop, implement, and evaluate a national strategy to prevent suicide by the year 2005. The National Strategy was released in May 2001. To meet the Surgeon General's challenge, barriers to a nationwide suicide prevention effort must be identified and removed.

In addition to a specific presentation regarding the development of the National Strategy for Suicide Prevention, presenters will consider the unique challenges posed by prevention among youth and elders. The former experienced the greatest increase in rates over the second half of the 20th century, while the latter continue to have the highest death rates from suicide among all age groups.

REFERENCES:

1. Pearson JL, Conwell Y: Suicide and Aging: International Perspectives. New York, Springer Publishing Company, 1996.
2. Silverman MM, Davidson L, Potter L: National Suicide Prevention Conference Background Papers. Reno, NV, October 1998. Supplement to Suicide and Life-Threatening Behavior 2001; 31.

Issue Workshop 108
MEDICATION USE FOR CHILDREN IN SYSTEMS OF CARE
Substance Abuse and Mental Health Services Administration

Co-Chairpersons: Gary De Carolis, M.Ed., *CMHS, SAMHSA, 5600 Fishers Lane, Room 11C-16, Rockville, MD 20857,* David Fassler, M.D., *c/o Otter Creek Associates, 86 Lake Street, Burlington, VT 05401-5297*
Participants: Wayne Holden, Ph.D., Andres J. Pumariega, M.D., Peter S. Jensen, M.D., Gayle Porter, Psy.D.

EDUCATIONAL OBJECTIVES:

To understand the uses of medication to treat children in systems of care and their impact on outcomes, apply concepts from ethnopsychopharmacology to children in community settings, and apply the evidence base from efficacy trials to interpret effectiveness of medications.

SUMMARY:

Despite the increasing use of pharmacotherapy for children's mental health disorders, limited attention has been paid to understanding the effectiveness of pharmacological interventions in community settings and the role of these interventions as one treatment component of a coordinated care plan within a larger, integrated systems of care approach. This workshop will address the use of pharmacotherapy as an important treatment component within community-based systems of care for children and youth with serious emotional disturbance.

The first 45 minutes of the workshop will be devoted to three presentations. The workshop will begin with a presentation by E. Wayne Holden, Ph.D., describing the use of pharmacotherapy and its influence on outcomes within a longitudinal comparison study conducted as part of the National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families program. This will be followed by a presentation by Andres Pumariega, M.D., and Gayle Porter, Psy.D., that reviews community level effectiveness of pharmacotherapy for children's mental health disorders and introduces ethnopsychopharmacology as an important perspective for addressing effectiveness. A final presentation by Peter Jensen, M.D., will provide an overview of the evidence base for the use of pharmacotherapy with children and interpret community-level effectiveness within this evidence base. The latter 45 minutes of the workshop will be devoted to discussion and questions and answers.

REFERENCES:

1. Hoagwood K, Jensen PS, et al: Medication management of stimulants in pediatric practice settings: a national perspective. J Developmental & Behavioral Pediatrics. 2000; 21:322–331.
2. Jensen PS, Hoagwood K, Petti T: Outcomes of mental health care for children and adolescents: II. literature review and application of a comprehensive model. J American Academy Child & Adolescent Psychiatry 1996; 35:1064–1077.

Issue Workshop 109
WORKING THROUGH IN PSYCHOTHERAPY

Chairperson: Steven H. Lipsius, M.D., *Department of Psychiatry, George Washington University, 2141 K Street, N.W., Suite 404, Washington, DC 20037-1810*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize a second mode of transference, introjective identification, and understand the unique interventions to employ them for this inner working through process; be able to more effectively treat patients within the diagnostic categories for whom this approach is indicated.

SUMMARY:

"The greatest enigma in psychoanalysis" is the concept of "working through" as expressed by psychoanalyst Peter Giovacchini. A proposed solution to this enigma for psychotherapy is the subject of this workshop. What has been recognized as the traditional transference is only one mode of the transference, namely projective identification. Furthermore, the traditional psychotherapy interventions of interpretation and confrontation, useful in managing this recognized mode are counterproductive to the other mode of transference, namely, introjective identification—often resulting in impasses in psychotherapy. When the therapist is taken within, rather than projected onto, less intrusive interventions are required. The most internalized object relations contain an element of the subject's self. These subject relations processes enable therapeutic facilitation of innermost dialogues between self and others. Reworking psychic structure is correlated with Damasio's neuroscience underpinnings, nearly seamless mind-brain union. Case examples in depth will help participants silently resonate with that inner working-through process. Extensive audience participation with demonstration by role-playing will help members recognize different countertransference signals and coordinate and integrate the two modes of transference. Experienced therapists are most likely to appreciate the advantage of having two cylinders to drive the engine of the working-through process.

REFERENCES:

1. Giovacchini P: Working through: a technical dilemma. reprinted in Classics in Psychoanalytic Technique, edited by Lange R. Northvale NJ, Jason Aronson, Revised Edition, 1990, pp. 475–490.
2. Rucker NG, Lombardi KL: Subject Relations; Unconscious Experience and Relational Psychoanalysis, New York, Routledge, 1998.

Issue Workshop 110
ALPHA-DOWN EEG BIOFEEDBACK: A NOVEL TREATMENT FOR ANXIETY

Chairperson: Thomas M. Brod, M.D., *Department of Psychiatry, University of California, LA, 12304 Santa Monica Boulevard, #210, Los Angeles, CA 90025-2551*
Participants: William M.W. Scott, M.D., Meredith L. Sagan, M.D.

EDUCATIONAL OBJECTIVE:

At the end of this workshop participants should be able to differentiate anxiety disorders from syndromic anxiety reactions, be familiar with "reactive alpha states" in anxiety production, be familiar with EEG biofeedback protocols for anxiety syndromes, and understand the indications for down-training vs. up-training alpha EEG.

SUMMARY:

After introducing alpha-theta biofeedback to workshop participants, we will describe a new therapy for anxiety syndromes. We will explain (and demonstrate on video) Wm. Scott's refinement of traditional alpha/theta brainwave biofeedback, namely down-training of excess alpha activity. Abnormalities in alpha activity in anxiety states have been discussed in the literature for several decades, but this is the first protocol to address the correlation between "reactive alpha" states and syndromic anxiety. Whereas some anxiety states respond to traditional alpha frequency up-training, the Scott protocol deals with conditioned *increases* in alpha frequencies in response to anxiety-provoking situations. The protocol secondarily builds in a volitional component as patients track their anxious cognitions and modulations of response through the feedback. We will briefly review the latest data on 46 subjects' EEG changes correlated with anxiety measures from the MMPI. The workshop will then turn to a discussion of illustrative successful applications of this new protocol for in the following conditions: PTSD startle response and flashbacks, panic, test anxiety, "white coat" hypertension and other phobias, various sleep disturbances, ruminations (isolation of affect), substance abuse, and generalized apprehensive expectation. Workshop participants are invited to bring clinical anecdotes for discussion.

REFERENCES:

1. Peniston EG, Marinam DA, Kulkosky PG, et al: EEG alpha-theta brainwave synchronization in Vietnam theater veterans with combat related PTSD and alcohol abuse. Advances in Medical Psychotherapy 1993; 6:37–50.
2. Schwartz JM: A role for volition and attention in the generation of new brain circuitry, in The Volitional Brain, Libet B (ed), Imprint Academic, Exeter U.K. ISBN 0907845509, 1999.

Issue Workshop 111
JOINING FORCES: WORKING WITH LAW ENFORCEMENT TO SERVE THE MENTALLY ILL

Chairperson: Debra A. Pinals, M.D., *Forensic Service, Worcester State Hospital, 305 Belmont Street, Worcester, MA 01604*
Participants: Heidi S. Vermette, M.D., Richard M. Stanley, Kamlyn R. Haynes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the value of improved communication with law enforcement agencies, identify the challenges police face when managing the mentally ill person in crisis, identify the issues that must be considered when working with police.

SUMMARY:

Establishing a good working relationship with local law enforcement professionals is essential for the mental health professional interested in providing quality care in the community setting. Police provide up to one-third of emergency mental health referrals. They see more mental illness than any occupational group outside of mental health. Due to the competing priorities of community safety versus individual care, establishing this working relationship is often difficult to achieve. In this workshop, we will use case examples to raise awareness of the importance of working with law enforcement professionals and the challenges police officers and mental health providers face when working together to determine the best disposition for the mentally ill offender. Topics to be covered include police perspective on working with persons with mental illness, role responsibility, custody, and confidentiality. The audience will participate in a discussion about how to establish a working relationship with community law enforcement agencies and the future directions of police liaison.

REFERENCES:

1. Cordner GW: A community policing approach to persons with mental illness. Journal American Academy of Psychiatry and the Law 2000; 28:326–31.
2. Teplin LA, Pruett NS: Police as streetcorner psychiatrist: managing the mentally ill. International Journal of Law and Psychiatry 1992; 15:139–156.

Issue Workshop 112
ERIK ERIKSON EPIGENESIS AS DEPICTED IN ANDREW LLOYD WEBBER'S MUSICALS

Co-Chairpersons: Hani Raoul Khouzam, M.D., *5 Terrace Road, Concord, NH 03301-3138,* Robert W. Hierholzer, M.D., *Veterans Administration, 2615 East Clinton Avenue, Fresno, CA 93703*

EDUCATIONAL OBJECTIVES:

To review Erikson's epigenetic eight stages of the life cycle; recognize Webber's biography and its correlation with his musical productions; elicit opinions about the assumptions of linking the musical pieces to the epigenetic life cycle.

SUMMARY:

Erik Erikson's eight stages of the epigenetic life cycle are summarized. Following each stage description, a selected theatrical musical piece will be heard with its corresponding lyrics projected on a screen. The selected music has been chosen to correlate an Erikson's stage with Webber's epigenetic life cycle as described in his biography. The workshop participants will then be invited to express their opinions about the presented materials. The presenters will then encourage the participants to reach a conclusion statement regarding the possibility of incorporating Erickson's epigenesis and the creative works of Webber, as well as other contemporary musicians in their clinical interventions with patients who are musically inclined and who are experiencing transitional developmental crises.

REFERENCES:

1. Erikson E: Childhood and Society, 2nd college edition, New York, W.W. Norton and Company Inc., 1963.

2. Webber AL: biography, created by Amy Hafner, http://www.angelfire.com/wa/alw/bio.html, last modified 08/08/2001.

Issue Workshop 113
BRIDGES FOR HEALING: INTEGRATING FAMILY THERAPY AND PSYCHOPHARMACOLOGY

Chairperson: Roy O. Resnikoff, M.D., *Department of Psychiatry, University of California, 1104 Pearl Street, La Jolla, CA 92037-4211*

EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants should be able to use a dimensional "bridging" model for integrating four main schools of family therapy (strategic, structural, psychodynamic, and existential) and the varied application of psychopharmacology for each. Psychopharmacology will be understood both within a medical model problem-solving model and a humanistic expression and relational enhancing model.

SUMMARY:

Four dimensions, or "bridges," will be outlined from the presenter's new book Bridges for Healing to help integrate family therapy and pharmacotherapy. They are: (1) foreground versus background stages of therapy, (2) instrumental versus expressive-relational methods, (3) biological versus environmental causes, and (4) therapist versus family interaction. Clinical examples will be presented from each stage (school) of family therapy (surface problem solving, communication/boundary issues, personality issues and polarities, life transition/spiritual). Participants will be invited to present clinical situations for supervision and discussion. (Intended for practitioners with some interpersonal therapy and pharmacotherapy experience.)

REFERENCES:

1. Resnikoff R: Bridges for Healing: Integrating Family Therapy and Psychopharmacology. Philadelphia, PA, Brunner-Routledge, 2001.
2. Resnikoff R, Lapidus D: Psychopharmacology in conjunction with family therapy. Journal of Family Psychotherapy 1998; 9:1–18.

Issue Workshop 114
VIDEO CASE STUDIES OF COUPLES IN TREATMENT

Chairperson: Ian E. Alger, M.D., *500 East 77th Street, #132, New York, NY 10162*

EDUCATIONAL OBJECTIVES:

To identify critical stages of couples therapy and develop an increased awareness and understanding of his/her style as a couples therapist.

SUMMARY:

Participants will have the opportunity to role-play clinical examples of couples treatment with the leader, and through the use of video playback, to identify issues of engagement, problem identification, change facilitation, and closure. Workshop participants will have the opportunity to compare their own clinical experiences relating to problems of dual-career couples; struggles during separation and divorce; issues in second marriages; sexuality and intimacy; and issues involving children as well as extended family members, and peer and friendship networks.

REFERENCES:

1. Alger I: Marital therapy with dual-career couples. Psychiatric Annals 1991; 21:8.
2. Glick I: Marital and Family Therapy, 4th Edition, Washington, D.C. American Psychiatric Press, 2000.

Issue Workshop 115
OUTPATIENT COMMITMENT: KENDRA'S LAW AND THE NEW YORK CITY EXPERIENCE

Co-Chairpersons: David A. Trachtenberg, M.D., *8 Independence Drive, Manhasset Hills, NY 11040,* Michael S. Lesser, M.D., *Medical Director, NY City Department of Mental Health, 93 Worth Street, Room 414, New York, NY 10013-3412*
Participants: Scott D. Rogge, M.D., Daniel Garza, M.D., Robert H. Berger, M.D.

EDUCATIONAL OBJECTIVES:

To understand the various clinical, legal, policy, and ethical questions that arise in the debate over outpatient commitment as well as review how the law has been applied and actualized in New York City (through the eyes of those who are responsible for implementing it).

SUMMARY:

"Kendra's Law" is named for the 32-year-old Buffalo native who was pushed to her death in front of a Manhattan subway train by Andrew Goldstein, a schizophrenic man who had a history of noncompliance with treatment. Her death in January 1999 revived the New York State legislature's interest in a program to provide for court-ordered assisted outpatient treatment for certain mentally ill persons found "unlikely of surviving safely in the community without supervision."

A number of important conceptual issues have been raised by various stakeholders that the workshop would like to explore. This law highlighted the general public's fear of psychiatric patients and their perception of the mentally ill to be significantly more violent than other persons in the community. This perception has been rejected by most research studies that show either a minimal or negligible independent effect of mental illness on acts of violence. Why then was the law passed? Was it intended as a public safety measure or was it intended to enable treatment for those in need of it? Other commentators take a "rights"-driven approach and analyze whether the government's police and parens patriae powers are sufficiently balanced against the individual's liberty interest in determining his or her own course of treatment.

Nowhere in the country has the implementation of outpatient commitment been more controversial than New York City, site of the death of Kendra Webdale and home to the controversial pilot program upon which the law was modeled. In addition, some critics have commented that New York City overemphasizes the obtaining of court orders at the expense of seeking voluntary or alternative treatment agreements. To that end, this workshop brings together the directors from the four New York City borough teams along with the medical director from the New York City Department of Mental Health to discuss and debate issues pertinent to the law and its implementation. Since some form of outpatient commitment currently is available in over 40 states and the District of Columbia (but often not utilized), the workshop will also address the different standards that exist in different jurisdictions.

REFERENCES:

1. Appelbaum P: Thinking carefully about outpatient commitment. Psychiatric Services 200; 52:3.

2. Telson H: Outpatient commitment in New York: from pilot program to state law. George Mason University Law Journal, Winter 2001; Vol 41.

Issue Workshop 116
CREATING EFFECTIVE ALLIANCES WITH PHARMACEUTICAL INDUSTRY PHYSICIANS

Chairperson: Arthur L. Lazarus, M.D., *6830 Windham Parkway, Prospect, KY 40059*
Participants: Paul E. Keck, Jr., M.D., David L. Garver, M.D., Rajiv Tandon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to familiar with the diverse roles of physicians working at pharmaceutical companies, recognize the value of establishing and maintaining alliances with pharmaceutical physicians, and understand the current and future issues involved in the conceptualization, design, conduct, and reporting of clinical trials.

SUMMARY:

Interactions between psychiatrists and pharmaceutical company representatives other than salespeople—industry physicians, for example—have not been well documented or studied. Given that 80% of department chairs and senior academic administrators consider the challenges facing them to be urgent or extremely urgent, it is important to understand the value of pharmaceutical physicians in leveraging research, enhancing scientific communications, and developing medical partnerships.

Psychiatrists may collaborate with pharmaceutical physicians in many ways, for example, by conducting clinical trials and participating in outcomes research. Increasingly, psychiatrists have teamed with pharmaceutical physicians to carry out pharmacoeconomic studies. Research related to e-health and disease state management constitute other emerging areas of importance.

Pharmaceutical companies may offer workshops to promising young investigators to impart skills for writing grants and conducting clinical trials. Senior investigators may acquire a deeper understanding of regulatory requirements and the drug discovery and development process through additional specialized programs offered by some pharmaceutical companies.

This workshop will discuss ways in which psychiatrists can develop effective alliances with their physician counterparts in industry. The discussion will be facilitated by an industry "insider" and psychiatrists who have enjoyed positive working relationships with several pharmaceutical companies. The focus will be on strategies to optimize pharmaceutical alliances rather than interactions intended to affect the prescribing and professional behavior of practicing psychiatrists.

REFERENCES:

1. Campbell EG, Weissman JS, Moy E, Blumenthal D: Status of clinical research in academic health centers: views from the research leadership. JAMA 2001; 286:800–806.
2. Rudnick SA, Rosenthal AS: Research-organization and management philosophies: their impact on physicians in academia and industry, in Future Practice Alternatives in Medicine, second edition. Edited by Nash DB. New York, Igaku-Shoin, 1993, pp. 191–202.

Issue Workshop 117
SUBSTANCE ABUSE PREVENTION AND TREATMENT: A PSYCHIATRIC PERSPECTIVE
Substance Abuse and Mental Health Services Administration

Chairperson: Sheila Harmison, *D.S.W., Center for Substance Abuse Treatment, 5600 Fishers lane, Suite 615, Rockville, MD 20857*
Participants: Ruth Sanchez-Way, Ph.D., H. Westley Clark, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify and apply current scientific and practice-based research findings in substance abuse prevention and treatment.

SUMMARY:

The Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse. Treatment (CSAT) provide national leadership in the development of policies, programs, and services to prevent the onset of and to effectively treat those involved in illegal drug use and underaged alcohol and tobacco use. CSAP and CSAT apply prevention and treatment strategies to a wide variety of problems related to substance abuse with the goal of reducing the demand for and having adequate treatment for the use of illicit drugs and the underage use of alcohol and tobacco. This workshop will share with the audience current prevention and treatment research and evaluation findings that examine the trends and patterns of substance use, the precursors of substance abuse, and the scientific and practice-based treatment knowledge that can be used by medical practitioners. A comprehensive review of CSAP's and CSAT's programs, which provide the field with science-based prevention and treatment modalities, will be discussed. Evaluation results on prevention and treatment effectiveness will be presented as well as how these results are incorporated by the field to enhance prevention, treatment, and recovery approaches.

REFERENCES:

1. Research to practice, in Szapocznik J, Sambrano S, Tolan P, (eds.): Bringing Effective Substance Abuse Prevention Strategies to Youth and Their Families: Lesson Learned from Center for Substance Abuse Prevention's Predictor Variable Initiative. (In press)
2. Center for Substance Abuse Treatment (CSAT): Changing the Conversation: The National Treatment Plan Initiative to Improve Substance Abuse Treatment. DHHS PUB (SMA) 00-3480, Nov. 2000.

Issue Workshop 118
HOW TO DEVELOP A LECTURE

Co-Chairpersons: Marianne T. Guschwan, M.D., *155 E. 31st Street, Suite 25-L, New York, NY 10016,* Susan Tapert, Ph.D., *Department of Psychiatry, Veterans Affairs Medical Center, 3350 La Jolla Village Drive, Room 116A, San Diego, CA 92161*
Participant: Christopher J. Welsh, M.D., Donna L. Londino, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants should be able to effectively prepare and deliver a lecture using Power Point slides and resources on the Internet.

SUMMARY:

This workshop is geared toward residents, fellows, and early career psychiatrists as well as anyone interested in learning more about developing lectures. The workshop will begin by discussing the following: how to prepare a lecture, how to deliver a lecture, how to handle questions, and how to close a lecture.

The workshop will then demonstrate how to prepare effective slides on Power Point showing dos and don'ts. The presenters will also demonstrate the use of Web sites to prepare a lecture or lecture series. The attendees will be provided with Web resources for outlines, slides, and other information. The final portion of the workshop will be a discussion of how to tailor lectures to different audiences and other issues.

REFERENCES:

1. Tufte ER: The Visual Display of Quantitative Information. Cheshire, Ct, Graphics Press, 1997.
2. Bakshian AB: The American Speaker. Washington DC, Georgetown Publishing House, 1997.

Issue Workshop 119

A CLINICIAN'S GUIDE TO SUBSTANCE ABUSE TREATMENT FOR GAY, LESBIAN, BISEXUAL, AND TRANSGENDER PERSONS

Substance Abuse and Mental Health Services Administration

Chairperson: Saul M. Levin, M.D., *Access Consulting International, 1901 Pennsylvania Avenue NW, Suite 705, Washington, DC 20006*
Participants: Frank Y. Wong, Ph.D., Michele J. Eliason, Ph.D.

EDUCATIONAL OBJECTIVES:

To learn how to treat LGBT persons for substance abuse in a culturally appropriate manner; know LGBT demographics and differences in treatment issues between gay, lesbian, bisexual, and transgendered persons.

SUMMARY:

The session will be in four parts: introduction; issues for lesbians and gay men; issues of color; and a discussion period.

Using the SAMHSA/Center for Substance Abuse Treatment (CSAT) publication titled "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals," participants will hear and participate in a presentation focusing on LGBT demographics, cultural issues of treatment, and clinical issues for lesbians, gay men, and persons of color.

Participants will be provided with case vignettes and asked to discuss their methods of analysis of appropriate treatment and issues that may arise in the therapeutic relationship. HIV/AIDS issues will be addressed in terms of clinical and medication issues. Glossary of terms will be discussed, so that participants are familiar with language that may be discriminatory for the treated individual. Participants will be given the reference book free of charge to consult during the talk, make notes, and take back to the office to use as a reference guide.

REFERENCES:

1. U.S. Department of Health and Human Services: A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Tarnsgender Individuals; SAMHSA/CSAT DHHS Publication No. (SMA) 01-3498, 2001.
2. Cabal P, Stein TS: Textbook of Homosexuality and Mental Health. Wash. D.C., American Psychiatric Press Inc. 1996.

RESEARCH ADVANCES IN PSYCHOPHARMACOLOGY

ADVANCES IN PSYCHOPHARMACOLOGY: AN UPDATE ON THE ESSENTIALS OF CLINICAL PSYCHOPHARMACOLOGY

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5717,* Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to apply recent data to key areas of psychopharmacologic treatment including: antidepressants; nonbenzodiazepine anxiolytics; anticonvulsant mood stabilizers; antipsychotics; and management during pregnancy.

SUMMARY:

In 2001, we published the Essentials of Clinical psychopharmacology, a shortened version of the Textbook of Clinical psychopharmacology. In this symposium several key chapters are updated by their primary authors. The areas to be covered represent important aspects of daily psychiatric practice. Ranga Krishnan will discuss new antidepressants in development, emphasizing recent studies on CRH and NK-1 antagonists. Basic biology of depression as it relates to the development of these new strategies is reviewed. Phil Ninan will review nonbenzodiazepine anxiolytics exploring the use of pregabalin, SSRIs and SNRIs in a range of anxiety disorders, including social phobia. Michael Owens will present recent developments in atypical antipsychotics, discussing not only atypical agents but the soon to be approved partial agonists. An update on the antiepileptic mood stabilizers will be provided by Susan McElroy discussing valproate, oxcarbazepine, lamotrigine, etc. Last, Zachary Stowe will discuss psychopharmacologic strategies in pregnant or lactating women. Clinical implications of recent findings are emphasized.

REFERENCE:

1. Schatzberg AF, Nemeroff CB (eds): Essentials of Clinical Psychopharmacology. Washington. American Psychiatric Press, 2001.

RESEARCH ADVANCES IN PSYCHIATRY

UNDERSTANDING THE BRAIN AND BODY IN THE TREATMENT OF DEPRESSION AND SCHIZOPHRENIA

Chairperson: Herbert Pardes, M.D.
Co-Chairperson: Philip R. Muskin, M.D.
Participants: Robert Carney, Ph.D., Alexander Glassman, M.D., Carol Tamminga, M.D., and Herbert Meltzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be informed about the importance of depression on the long-term mortality following a myocardial infarction and the impact of treatment on that outcome. Participants will also review the current understanding of the neurophysiology of patients with schizophrenia and review the current pharmacologic treatments for the illness.

SUMMARY:

One of the great puzzles of Psychiatry is the interaction between the mind and the brain. That interaction has always been thought to influence the body. While it is convenient to think along these lines, the evidence to support such thinking has not always been convincing. This symposium will address the mind-brain-body interaction directly. There is robust evidence that depression is a risk factor for mortality following a myocardial infarction. Dr. Carney will speak about the impact of psychotherapy on depression following a myocardial infarction. Dr. Glassman will address the effects of psychopharmacologic treatment of depression on morbidity and mortality after a MRI. Continuing the exploration of how the mind and brain interact, Dr. Tamminga will speak about the current understanding of the neurophysiology in the brain in patients with schizophrenia. As our understanding of schizophrenia has followed the mechanism of action of the antipsychotic medications, Dr. Meltzer will address the current medications from the perspective of how they differ and what is important to know about their side effect profiles. He will speak about the controversy regarding their mechanism of action, and address how clinicians can approach the decision-making process regarding the choice of medication.

REFERENCES:

1. Frasure-Smith N, Lesperance F, Gravel G, Masson A, Juneau M, Talajic M, Bourassa MG: Social Support, Depression, and Mortality During the First Year After Myocardial Infarction. Circulation 2000;101:1919–1924.
2. Geddes J, Freemantle N, Harrison P, Bebbington P: Atypical Antipsychotics in the Treatment of Schizophrenia: Systematic Overview and Meta-Regression Analysis. British Medical Journal 2000; 321:1371–1376.

CONTINUOUS CLINICAL CASE CONFERENCES

1. LIVES AND TREATMENTS: TWO PATIENTS, TWO THERAPISTS: PARTS I AND II

James W. Lomax, M.D., *Department of Psychiatry, One Baylor Plaza, Houston, TX 77030-3411,* Glen O. Gabbard, M.D. and Irma J. Bland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will learn to recognize core elements of the treatment process in psychoanalysis and in psychotherapy including manifestations and evolution of transference phenomena, the effect of gender and ethnicity on the therapeutic process, and the integration of pharmacotherapy into psychotherapy. Two presentations will compare and contrast elements from a more classical (albeit with a somewhat unusual clinical problem) psychoanalytic treatment to those of an encounter where the therapist must blend psychotherapeutic and pharmacological strategies. Issues related to patient therapist similarities and differences and gender and racial background will be manifest in the presentation.

SUMMARY:

On day one of the program, Dr. Lomax will present a case with discussion initiated by Drs. Glen Gabbard and Irma Bland. The subtitle of the presentation is "Transference Love: An Artificial Rose." The emphasis is on the forms and evolution of transference phenomena in a particular clinical course involving the treatment of recurrent major depression.

On day two, Dr. Bland will present a psychotherapy case involving both pharmacotherapy and psychotherapy in which different constellation of patient and therapist gender and racial background are evident in the treatment process. Drs. Lomax and Gabbard will initiate the discussion.

The two cases can be attended separately and educational objectives will be met on either day. However, the opportunity to compare the two cases would be particularly valuable for those participants able to attend both days.

REFERENCES:

1. Person E.: Dreams of Love and Faithful Encounters, 1988.
2. Freud Sigmund: Observations on Transference Love, Standard Edition, 1915.

2. MANAGING NEGATIVE OUTCOMES IN GENERAL PSYCHIATRY: PARTS 1 AND II

Richard G. Hersh, M.D., *100 Riverside Drive, #16B, New York, NY 10024-4822,* Mary S. Sciutto, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have an overview of management strategies for a variety of common untoward events in general psychiatric practice. Strategies for comprehensive assessment and intervention in clinical situations including suicide attempts, medication adverse reactions and overdoses, and treatment elopements will be reviewed.

SUMMARY:

Clinical case material from an academic medical center's general outpatient psychiatry clinic will be used to review strategies for management of untoward events. Specific cases involving suicide attempts, adverse reactions to medication and treatment elopements will be uses to underscore the importance of such strategies. Key elements including attention to medico-legal issues, preservation and maintenance of treatment alliances will patients and families, and negotiation of medical and mental health systems will be discussed using specific clinical examples. In addition, clinicians' fears and countertransferential anger will be a focus of discussion as common barriers to effective management of these events.

REFERENCES:

1. Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law: Baltimore, Williams and Wilkins, 1991.

CLINICAL CASE CONFERENCES

1. CONTRASTING PSYCHOPATHOLOGY IN ADOLESCENTS AND ADULTS

Lynda A. Tenhundfeld, M.D., *Georgetown University Hospital, 3800 Reservoir Road, NW, Cober-Cogan 64, Washington, DC 20007.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will have an increased understanding of the impact of normal adolescent development on the presentation and treatment of psychopathology.

SUMMARY:

Normal adolescent developmental tasks impact the presentation and treatment of psychopathology. The differences in symptomatology between adolescents and adults of common psychiatric conditions such as major depression, self-injurious behavior, and suicide will be examined. It will be proposed that adjustments to generally accepted protocols used in the treatment of adults must be made by the general psychiatrist when treating similar conditions in adolescents. Awareness of normal adolescent developmental issues, including secondary separation individuation, risk taking behavior, and dependency upon peer acceptance as a step preceding further identity consolidation, should be used to inform treatment planning and decrease potential detrimental impact of hospitalization of adolescents. Case presentations will highlight how exposure to patients with significant substance abuse or self-injury histories, including eating disorders, can have a contagion effect on susceptible adolescents.

REFERENCES:

1. Self-Mutilative Behavior in Adolescents Who Attempt Suicide by Overdose, Journal of the American Academy of Child and Adolescent Psychiatry; Volume 40, Number 9, September, 2001.
2. Multimethod Assessment of Suicidality in Adolescent Psychiatric Inpatients: Preliminary Results", Journal of the American Academy of Child and Adolescent Psychiatry, Volume 40, Number 9, September, 2001.

2. DEPRESSION IN THE MEDICAL SETTING REVISITED: THE PROBLEM OF THE DEPRESSIVE SPECTRUM DISORDERS

Robert Boland, M.D., *Department of Psychiatry, The Miriam Hospital, 164 Summit Avenue, Providence, RI, 02906-2853,* Colin Harrington, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the different depressive disorders and explain how they differ, recognize the limitations of such distinctions, and develop a treatment algorithm for such difficult medical-psychiatric cases.

SUMMARY:

Through the categorization of major depression in DSM has greatly increased the reliability of the diagnosis, problems of validity remain.

These problems can become particularly acute in the medical setting. To highlight these concerns, a case will be presented in which, though depressive symptoms are clearly evident, the clinician must distinguish between idiopathic depression, adjustment disorders, and secondary mood disorders. Such distinctions, though of great theoretical importance to the psychiatrists, may appear arbitrary and meaningless to our medical colleagues, who often view depression more from a syndromal standpoint. The burden of treating medical illness in the primary care setting, the pressure from managed care companies to diagnose and treat quickly, and the message from pharmaceutical companies as to the role of various treatment all compound the confusion that the primary care doctor feels from the consulting psychiatrist, who may be viewing depression in a much different way. In the discussion of the case, current concepts of the spectrum of mood disorders, the history of such distinction, and the limitations of the validity of these distinction will be reviewed. Practical suggestions, both for the clinical and consulting role, will be suggested.

REFERENCES:

1. Boland RJ, Keller MB: Diagnostic Classification of Mood Disorders: Historical Context and Implications for Neurobiology, Neurobiology of Mental Illness, edited by Charney DS, Nestler EJ and Bunney BS, New York, Oxford University Press, 1999, pp 291–298.
2. Harrington C, Boland RJ: Depression in the Medical Setting, Medicine and Health, in press, Rhode Island, 2001.

3. MOTIVATIONAL ENHANCEMENT THERAPY FOR THE MEDICALLY ILL, SUBSTANCE ABUSE PATIENT WITH DEPRESSION

Robert M. Weinrieb, M.D., *The Research Treatment Center, The University of Pennsdsylvania, 3900 Chestnut Street, Philadelphia, PA, 19104-3120,* Deborah H.A. Van Dorn, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be familiar with the Stages of Change Model of behavioral change and Motivational Enhancement Therapy in the treatment of alcoholism and drug addiction; be aware of the incidence, relevance and medical-psychiatric disease processes of both alcoholism, drug addiction and hepatitis C infection the United States; and be able to discuss the decision making process involved in choosing various treatment options in the medically ill substance abuser with psychiatric illness.

SUMMARY:

We will focus on the case of a middle-aged man with chronic medical conditions compounded by psychiatric illness and addictions. This patient suffers from chronic hepatitis C infection, a chronic pain syndrome, Major Depressive Disorder and alcohol dependence. He is representative of a complicated but uncommon referral for psychiatric consultation. We will describe conjoint treatment of his disorders with special emphasis on Motivational Enhancement Therapy for alcoholism. We will also review how psychiatrists can assist patients in navigating multiple caregivers. In this case, multiple opinions resulted in confusion for the patient, but also challenged and stimulated his progress in psychotherapy. Dr. Weinrieb will present the case from his perspective as a psychiatrist who specializes in treating addictions in the medically ill. He will describe how antidepressants and opioid pain medications enhanced this patient's progress and quality of life. He will also discuss adjunctive pharmacotherapeutic options for the treatment of alcoholism. Dr. Van Horn is an expert in the use of Motivational Interviewing in addictions. She will provide the background and clinical relevance of the Stages of Change model to the theory and practice of Motivational Enhancement Therapy for this case and patients with similar disorders.

REFERENCES:

1. Miller WR, Rollnick S: Motivational Interviewing: Preparing People for Change. New York: Guilford Press, 1991.
2. Thase ME, Salloum IM, Cornelius JD: Comorbid Alcoholism and Depression: Treatment Isseus. Journal of Clinical Psychiatry 2001; 20:32–41.

DEBATE

RESOLVED: POLITICAL CORRECTNESS HAS NO PLACE IN MEDICINE?

Moderator: Patricia I. Ordorica, M.D.
Affirmative: Sally Satel, M.D.
Negative: Paul Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, participants will be able to identify issues relevant to the discussion of "political correctness" in medicine; identify political issues influencing health care; explore future challenges facing the delivery of medical and psychiatric services; be aware of the potential impact of "political correctness" in the medical enterprise; and consider the ways in which a greater sensitivity to the needs of minority and under-represented groups, sometimes derived as "political correctness", may have a positive impact on the practice of menicine in general and of psychiatry in particular.

REFERENCES:

1. Satel SL: PC, M.D.: Political Correctness Is Corrupting Medicine. New York: Basic Books, 2000.
2. Appelbaum, PS: Almost a revolution: Mental health law and the limits of change. New York: Oxford University Press, 1994.
3. Nuland SB: Indoctrinology. The New Republic. February 19, 2001.

FORUMS

1. THE MENTAL HEALTH COMMUNITY RESPONSE TO THE WORLD TRADE CENTER DISASTER

Chairperson: Randall Marshall, M.D.
Participants: Rachel Yehuda, Ph.D., Marilene Cloitre, Spencer Eth, M.D., and Harold Koplowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to review the responses of major medical and academic centers in New York City to the September 11 attack.

SUMMARY:

Since September 11, 2001, the landscape of mental health, not only in greater New York, but across the U.S. has been dramatically altered. Surveys demonstrated the presence of significant symptomatology in a strikingly large number of individuals weeks after the WTC attack. Both new onset psychiatric disorders and relapse of preexisting disorders occurred. In addition, the scope of normative reactions to serious and ongoing threats such as bioterrorism and poor air quality presented challenges to the mental health community never before encountered in the U.S. on such a large scale.

In response to the anticipated need a number of research and treatment and treatment efforts were launched by various academic centers in New York. This panel will present a summary of completed and ongoing efforts by five Manhattan Centers: New York State Psychiatric Institute/Columbia University (Dr. Marshall); Weill Medical College/Cornell University (Dr. Cloitre); Mt. Sinai Hospital (Dr. Hehuda); St. Vincent Catholic Medical Center/New York Medical College (Dr. Eth); and New York University Hospital (Dr. Koplowitz). An Overarching goal has been to provide services *and* learn from our experience so that future victims of terrorism may benefit from the knowledge gained through these efforts.

REFERENCES:

1. North CS, Nixon SJ, Shariat S, Mallonee S, McMillen JC, Spitznagel EL, Smith EM: Psychiagtric Disorders Among Survivors of the Oklahoma City Bombing. JAMA 282:755–762, 1999.
2. Kendler KS, Karkowski LM, Prescott CA: Auasal Relationship Between Stressful Life Events and the Onset of Major Depression. Am J Psychiatry 156:837–841, 1999.

Copy to Come

2. LEADERSHIP CHALLENGES IN MENTAL HEALTH AND SUBSTANCE ABUSE: A MEETING OF THE MINDS

Chairperson: Charles G. Curie, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will have gained an understanding of the Federal Government's agenda and policies for mental health services, addiction treatment, and substance abuse prevention, including such issues as co-occurring disorders, bridging the research-to-practice continuum, and reducing the treatment gap in substance abuse and mental health services, among others.

SUMMARY:

A March 2001 Institute of Medicine report observed that it can take from 15–20 years between the discovery of an effective treatment or intervention and its adoption as part of the state-of-the-art care. Perhaps nowhere is this of greater concern in the interest of the public health than in the fields of mental health and substance abuse treatment. With the near doubling of the Federal health research commitment in the past few years, the gap between knowledge and its application in practice may grow still wider without a fundamental change in how scientific advances are incorporated into community care. This forum will explore ways in which the current Administration is approaching this challenge in the science-to-practice gap in mental health and substance abuse; it also will explore such issues as the Administration's New Freedom Initiative (including the proposed Commission on Mental Health), faith-based activities, proposed mechanisms to close the substance abuse treatment gap, and ways to promote community-centered, evidence-based practices in the treatment of mental and addictive disorders.

REFERENCES:

1. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington DC: National Academy Press, 2001.
2. Office of Applied Studies. *Summary of Findings from the 2000 National Household Survey on Drug Abuse.* Rockville MD: Substance Abuse and Mental Health Services Administration, 2001.

3. EVIL

Chairperson: Samuel C. Klagsbrun, M.D.
Participants: Professor Robert Pollack and Dr. Carl Goldberg

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant will have a clearer concept of evil. Evil will be defined from a psychiatric as well as a philosophic and moral point of view. The goal is to quality the way the mental health professional can deal with the presence of evil.

SUMMARY:

A description of the historical evolution of the understanding of evil will be presented. The Judeo Christian origins for understanding evil will be presented and the evolution of that understanding into modern times will describe the problem for the mental health professional confronting a moral dilemma when exposed to behavior which might be considered evil will be explored. The psychological origins of people who have behaved in a hurtful evil fashion will be discussed and the issue will be raised of whether an understanding of the origins and influences upon such a person can and should provide mitigation circumstances, there by in a way diminishing the consequences of judging these behaviors. Finally, in the face of current times, an invitation to rethink the role of evil in our society and the responsibility of the mental health community to revisit the concept will be discussed.

REFERENCES:

1. Goldberg C: Speaking with the Devil: A Dialogue with Evil. Viking 1996.
2. Buber M: Good and Evil. Scribner 1953.

4. MUSIC AND MOOD DISORDERS: TCHAIKOVSKY

Chairperson: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will appreciate the connection between Tchaikovksy's mental illness and his musical output and will understand some fundamental concepts about creativity.

SUMMARY:

There is a longstanding tradition associating creative genius with mental illness. The glorious music of Peter Ilyich Tchaikovksy (1840–1893), considered by some to be history's greatest composer of melodies, does little to dispel this notion. Tchaikovsky suffered from severe depressive episodes and had suicidal impulses through his adult life. His music alternates between anguished cries to inconsolable grief *(Pathetique Symphony)* and ethereal beauty (*Swan Lake* and the *Nutcracker*), but it is always intensely personal, either describing his intrapsychic torment or creating an idealized fantasy world into which he could escape.

Psychiatrist and award-winning concert pianist Richard Kogan (first prize-Chopin Competition) will perform Tchaikovsky's beloved *Piano Concerto No. 1* and other musical examples in an attempt to demonstrate the connection between the composer's music and his psyche. Dr. Kogan will discuss the psychological and artistic impact of Tchaikovsky's conflicts over his homosexuality, his brief, disastrous marriage, and his fascinating epistolary relationship with a benefactor whom her never met. There will also be an exploration of the controversy over whether or not Tchaikovsky committed suicide. Dr. Kogan will speculate on what forces conspired to make Tchaikovsky's music so emotionally powerful.

REFERENCES:

1. Holden A: *Tchaikovsky: A Biography,* Random House, 1995.
2. Neumayr A: *Music and Medicine,* Volume 3, Medi-Ed Press, 1997.

5. HOMOSEXUALITY AND RELIGION: HEALING THE WOUND

Chairperson: Daniel W. Hicks, M.D.
Participants: David L. Scasta, M.D., Stuart M. Sotsky, M.D., and Thomas P. Welch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will understand and recognize the role religion has played in causing homophobia and emotional distress in gay men and lesbians, have learned ways to help gay and lesbian patients access and explore their spirituality, and understand how religions are working to broaden their acceptance and outreach to homosexuals.

SUMMARY:

As our scientific understanding of human behavior has dramatically increased over the last 50 years, homosexuality is being recognized as a normal variation of human sexual expression rather than pathology. Religions have played a major role in socialization and continue to exert a great deal of influence in our society. Some religions preach vehemently against homosexuality as a mortal with sin, advocating severe punishment and campaigning against basic human rights for homosexuals. This influence helps to maintain a repressive and homophobic attitude in our society, which often leads to psychological and emotional distress in persons who recognize same sex attractions in themselves. Depression, substance abuse, and even suicidal behavior are linked to this internalized and societal homophobia, especially in adolescents.

During this session, we sill discuss some of the mental health problems experienced by gay and lesbian patients as a result of their religious upbringing. Psychiatrists from a broad array of religious backgrounds will discuss their religions' historical stance on homosexuality, current perspectives in their faith, and how they have been able to integrate their sexuality and spirituality into their own lives. This will hopefully help the audience in working with their gay and lesbian patients to resolve their spiritual conflicts.

REFERENCES:

1. Aaron L: *Prayers for Bobby,* Harper San Francisco, 1995.
2. Heminiak DA: *What the Bible Really Says About Homosexuality,* San Francisco, Almo Square Press, 1994.

6. THE DEATH PENALTY AND THE ROAD TO EXECUTION: PSYCHOLOGICAL ISSUES FOR CORRECTIONAL OFFICERS; APPROPRIATE AND INAPPROPRIATE ROLES FOR PSYCHIATRISTS

Chairperson: Robert Michels, M.D.
Co-Chairperson: Philip Zimbardo, Ph.D.
Participants: Michael J. Osofsky, Howard Osofsky, M.D., and Warden Burl Cain

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be aware of how correctional officers deal with their roles in the execution process with focus on how their views and behaviors are influenced by senior prison administration. Several important ethical/legal issues related to the death penalty will also be clarified for psychiatry.

SUMMARY:

Dr. Michael Osofsky will describe and present new data from his ongoing seminal work at Louisiana State Penitentiary at Angola and at Holman Penitentiary in Alabama, both maximum security facilities. At Angola, executions are carried out by lethal injection. Correctional officers who work with executions consider themselves professionals focused on maintaining security and carrying out the laws of the land. Raising profound questions, they stress their desire to be humane and decent while describing worries about their roles in the killing of another human being, the fairness of the execution process, the importance of prevention program for high risk youth, and deterrence versus punishment. Findings will be compared with those from Holman Prison where officers who work directly with the executions are committed to secrecy about their work and where executions are carried out via electrocution with the warden himself being the executioner.

Warden Burl Cain has helped change Angola from the bloodiest prison in the country to one which stresses openness, mutual respect, religion, and rehabilitation. He stresses his primary commitment to security and his concern for victims and their families as well as his concern for inmates and his commitment to their appropriate care. Warden Cain requested that Dr. Howard Osofsky, senior mental health consultant for Angola, evaluate a number of inmates on Death Row where there are ongoing and possibly severe mental health problems. The aim is to help the penitentiary to plan their overall treatment, including taking the unprecedented step, if warranted, of requesting that their sentences be commuted to life in prison.

Dr. Howard Osofsky will describe his evaluations of these Death Row inmates. The evaluations extend the ethical debate about psychiatrists' roles in the process. They point to the need for further clarification of when severe psychiatric symptoms, including those developing post-conviction, should result in a death sentence being commuted. They further mandate the need for specifying whether executions should be forbidden as an "allowable complication" when psychiatric medications, prescribed to alleviate suffering, result in restoration of competence.

REFERENCES:

1. American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) adopted by The AMA as policy, entitled, Physician Participation in Capital Punishment: Evaluation of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed . . . Report, 1995.

2. Johnson R: *Death Work: A Study of the Modern Execution Process.* Wadsworth Publishing Company, Belmont CA, 1998.

7. CANCELLED

8. THE CHALLENGES OF IDENTIFYING AND INTERVIEWING POTENTIAL SUBSTANCE ABUSERS

Chairperson: Joseph H. Autry III, M.D.
Co-Chairperson: H. Westley Clark, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to demonstrate an understanding of the basic DSM-IV diagnostic criteria for illicit substance abuse and/or dependency and assess a patient for illicit drug use, as well as alcohol abuse and alcoholism.

SUMMARY:

Both standardized clinical assessments and drug/alcohol testing can be of value in diagnosing substance abuse and confronting patient denial.

Recent analysis of the FY 2000 National Household Survey on Drug Abuse shows that there are at least XX million people in the US population who meet the DSM-IV diagnostic criteria for substance abuse and/or dependency on illicit drugs. An additional XX million meet the criteria for "heavy alcohol use" (5 or more drinks on 5 or more occasions in the past 30 days).

Most of these people do not see themselves as having a drug or alcohol problem. Denial of a substance abuse problem is a strong impediment to seeking treatment. The use of standard assessment instruments such as the DAST and AUDIT in combination with drug/alcohol testing and standardized clinical interview can be critical for diagnosing these problems.

This is particularly important for primary care physicians who see the vast majority of these people for other health problems.

REFERENCE:

1. National Household Survey on Drug Abuse, 2000.
2. DSM-IV, 1994.

9. KILLING IN THE NAME OF GOD: OSAMA BIN LADEN AND RADICAL ISLAM

Chairperson: Jerald Post, M.D.
Participants: Ambassador Nat Howell, Jessica Stern, Ph.D., and Vamik Volkan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be informed about the cultural basis of suicidal terrorism and will better understand the relationship between the "true believer" follower of al Qaeda and their destructive charismatic leader, Osama bin Laden.

SUMMARY:

An attempt to understand the tragic events of September 11, 2001, this forum will consider the psychology and cultural basis for suicidal terrorism, differentiating between the suicide bombers in Israel and the perpetrators of the attacks on the World Trade Center and the Pentagon. It will discuss the characteristics of religious fundamentalist terrorism and will clarify the power of the destructive charismatic relationship between Osama bin Laden and his "true believer" followers, as well as addressing the broader context in which this terrorist organization emerged, that of radical Islam.

REFERENCES:

1. Robins R and Post J: *Political Paranoia: The Psychopolitics of Hatred;* Yale University Press, 1997.
2. Volkan V: *Blood Lines: From Ethnic Pride to Ethnic Terrorism;* Farrar Strauss and Giroux, 1997.

10. ABPN UPDATE: REQUIREMENTS FOR ABPN EXAMINATION

Chairperson: Stephen C. Scheiber, M.D.
Participants: Glenn c. Davis, M.D., Michael H. Ebert, M.D., Larry Faulkner, M.D., Burton V. Reifler, M.D., Pedro Ruiz, M.D., James Scully, M.D., Elizabeth Weller, M.D., and Daniel K. Winstead, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants will 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 the young career psychiatriststs.

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 psychiatry, geriatric psychiatry, clinical neurophysiology, and pain management.

REFERENCES:

1. Shore J and Scheiber SC: *Certification, Recertification, and Lifetime Learning,* APPI Press, Washington DC, 1994.
2. American Board of Medical Specialization: *Recertification for Medical Specialists,* ABMS, Evanston IL, 1987.

11. LATIN AMERICA

Chairperson: Rodrigo A. Munoz, M.D.
Participants: Harold Eist, M.D., Miguel Jorge, M.D., Gerardo Heinze, M.D., Juan Mezzich, M.D., Gonzalo Viale, M.D., and Rodrigo J. Munoz T, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will have learned about current initiatives to enhance communications among all the countries in the Americas.

SUMMARY:

APA, especially through the Commission on Global Psychiatry and the Membership Committee, has made rapid progress in increasing scientific contacts about training, certification, career development, continued education, and international research among countries in North, Central, and South America. Recent examples are the international project on the genetics of schizophrenia and affective disorders, and the APA Paraguay project. Two new projects are permitting fast interaction on scientific news, changes in clinical practice strategies, and new discoveries. We plan on discussing initiatives for the years to come.

REFERENCES:

1. Commission on Global Psychiatry—Mission Statement, APA BOT, December, 2001.
2. Paraguay Initiative, APA BOT, December, 2001.

12. PSYOP: PSYCHOLOGICAL OPERATIONS IN THE WAR AGAINST TERRORISM

Chairperson: Ronnie S. Stangler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be better informed of the military PSYOP, its recent operations in Afghanistan. They will also hear a perspective about its likely transformation in the Information Age.

SUMMARY:

The catastrophic events of September 11, 2001, catapulted the United States into an international war against terrorism. In an array of powerful and sophisticated weaponry, psychological operations (PSYOP), the use of information for its powers of influencing thoughts and emotions, were as key to the campaign as bullets or missiles.

REFERENCES:

1. The Creation and Dissemination of all Forms of Information in Support of Psychological Operations (PSYOP) in Time of Military Conflict. Report of the Defense Science Board Task Force. United States Department of Defense. Office of the Undersecretary of Defense for Acquisition, Technology, and Logistics, May 2000.
2. Elite Army Team Opens New Front: The Afghan Mind. WSJ, 2001.

13. THE PHARMACEUTICAL INDUSTRY AND THE APA: CONTROVERSIES AND APPROACHES

Chairperson: Stephen M. Goldfinger, M.D.
Co-Chairperson: Charles R. Goldman, M.D., Philip R. Muskin, M.D., Nyapati Rao, M.D., James W. Thompson, M.D., Troy L. Thompson II, M.D., David Wahl, M.D., Paula Panzer, M.D., William B. Lawson, M.D., and Anand Pandya, M.D.

EDUCATIONAL OBJECTIVE:

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.

INDUSTRY-SUPPORTED SYMPOSIUM 1—PSYCHIATRY PRACTICE PARADIGM: THE EMERGING ROLE OF THE PSYCHIATRIST IN TREATING ALZHEIMER'S DISEASE

Supported by Eisai Inc., Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to define the role of the psychiatrist and allied health care professionals in the diagnosis and management of Alzheimer's disease: identify the long-term goals of managing patients with Alzheimer's disease; provide appropriate expectations for patients' families; develop an understanding, via a series of video case studies, of the various ways the patient with AD may present.

No. 1A
MILD COGNITIVE IMPAIRMENT VERSUS EARLY ALZHEIMER'S DISEASE

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

SUMMARY:

This presentation features a case study video that will demonstrate how a patient with mild cognitive impairment may present. The diagnosis of Alzheimer's disease requires assessment of memory, cognitive abilities, neuropsychiatric symptoms, and daily functioning. These characteristics can be classified based upon their severity as normal aging, mild cognitive impairment, or probable Alzheimer's disease.

Early diagnosis of Alzheimer's disease and appropriate pharmacologic intervention are critical to slowing progression and preserving function and give patients and families time to learn about the disease. Mild cognitive impairment likely represents an important transitional stage between normal aging and dementia. However, early diagnosis can be difficult for a number of reasons, including patient and family denial, lack of physician awareness, subtle presentations, comorbid conditions, and other constraints. A focused approach to assessment of patients with cognitive impairment will be reviewed, including early clues, cognitive and neuropsychiatric signs/symptoms, and functional status.

No. 1B
MILD TO MODERATE ALZHEIMER'S DISEASE

Pierre N. Tariot, M.D., *435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

A case video will demonstrate how a patient with mild to moderate Alzheimer's disease may present, which includes insidious onset and gradual progression of cognitive functional decline, usually in the absence of prominent behavioral or neurological changes early on. Risk factors for AD include age; family history; mutations on chromosomes 1, 14, 21; increased frequency of ApoEε4 alleles; and, possibly, female gender, head trauma, and Down's syndrome. Putative protective factors against AD include estrogen use, higher education, anti-inflammatory use, antioxidant use, and increased ApoEε2 allele frequency. Cholinesterase inhibitors including donepezil, rivastigmine, and galantamine are modestly effective in improving cognition and maintaining functional status in patients with AD. Evidence is accruing that the likelihood of symptomatic benefit is increased by giving maximally tolerated doses, and that early and long-term treatment may be beneficial. The emerging data illustrating these conclusions will be reviewed in the context of the case presented.

No. 1C
DEPRESSION IN ALZHEIMER'S DISEASE

William E. Reichman, M.D., *185 South Orange Avenue, MSB C671, Newark, NJ 07103*

SUMMARY:

A case video will demonstrate how AD patients with depression may present. As many as 60% of Alzheimer's disease patients have depressive symptoms; however, these symptoms are generally underrecognized because of their variability over time and within patients. The symptoms of depression include sadness; apathy; withdrawal; changes in sleep, appetite, and energy; and, in some cases, anxiety, irritability, and somatic concerns. Nonpharmacologic approaches to managing depression include open communication, involvement in pleasurable activities, education for caregivers, adult daycare, and grief counseling. Pharmacologic approaches include antidepressants, possibly cholinesterase inhibitors, and, although clinical trials data are generally lacking, combinations of SSRIs and cholinesterase inhibitors.

No. 1D
DEMENTIA WITH ABNORMAL NEUROLOGICAL FEATURES

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

SUMMARY:

A patient case video will be used to demonstrate how patients with dementias other than Alzheimer's disease may present. In the evaluation of suspected dementia, the initial step is to rule out delirium caused by an active medical problem. In patients with delirium, cognitive deficits fluctuate, the development is abrupt, duration is short, and cognitive symptoms typically do not progress. By contrast, in patients with dementia, cognitive deficits are relatively consistent, onset is slow, duration is prolonged, and symptoms inevitably progress.

Approximately 70% of dementia cases are due to Alzheimer's disease. The remainder are sometimes referred to as non-Alzheimer's dementias. This is a diverse group that may present with atypical features including rapid onset and progression, younger age at onset, early neurologic abnormalities, fluctuating consciousness, change in social conduct, focal deficits, and prominent psychopathology. The most common diagnoses in this group include dementia with Lewy bodies, frontotemporal dementia, and vascular dementia. Patients may also present with a mixed picture including these conditions plus AD.

Some common diagnostic pitfalls include over-reliance on test scores such as MMSE, over-diagnosis of vascular dementia, over-reliance on imaging and other diagnostic tests, mistaking apathy for depression, mistaking delirium for dementia, and overlooking comorbidities.

No. 1E
SEVERE DEMENTIA WITH AGITATION AND NURSING HOME ISSUES

William E. Reichman, M.D., *185 South Orange Avenue, MSB C671, Newark, NJ 07103*

SUMMARY:

A case video will demonstrate how patients with severe dementia may present, illustrating agitation in its typically multifaceted forms. Her case also provides a glimpse of the issues we confront in the long-term care environment. Behavior disturbances associated with dementia occur in up to 90% of patients at some point, and often fall into "subsyndromal" clusters. These symptom clusters include disturbed mood and affect, altered ideation, altered perceptions, agitation, aggression, anxiety, and passivity. Medical and psychiatric evaluations are recommended.

Nonpharmacologic approaches for managing patients at this stage of illness include increasing the patient's social and physical stimulation, assessing aggravating factors, adapting to limitations, educating patients and caregivers, and employing behavior management principles. When pharmacologic therapy is deployed, an algorithmic approach can be used. The class of medication prescribed is generally selected to match the predominant target symptoms. Dosing should start low and increase until efficacy without toxicity is achieved. If the medication is effective, the same dose is continued for weeks to months and then tapered so the need for ongoing treatment can be assessed. If the medication is ineffective, empirical trials of alternative agents are usually in order.

New information is emerging that addresses the potential role of antidementia therapy in more advanced stages of illness and in nursing home residents, of whom approximately 70% have dementia. Two-thirds of all dementias in this setting are considered severe. A placebo-controlled, six-month, multicenter nursing home study of donepezil showed less clinical decline among patients taking active treatment than those taking placebo. This is supported by smaller open-label studies of this and other cholinesterase inhibitors, and is consistent with results from an outpatient study of patients with moderate to severe AD.

This growing body of evidence suggests that patients in advanced stages of illness have recognizable needs that can be addressed with sensible use of nonpharmacologic as well as pharmacologic strategies to help the common behavioral manifestations of illness as well as the cognitive and functional impairment.

No. 1F
PSYCHOSIS IN ALZHEIMER'S DISEASE

William E. Reichman, M.D., *185 South Orange Avenue, MSB C671, Newark, NJ 07103*

SUMMARY:

A case video will demonstrate how patients may present with psychosis in dementia. This patient, for instance, initially became indifferent to hygiene and lost her initiative. After her husband died, she experienced increased cognitive impairment, visual hallucinations, and functional decline. She was eventually placed in a nursing home where she exhibited socially inappropriate behavior and had fixed delusions. As she illustrates, patients with psychosis in dementia generally have delusions regarding theft, an unfaithful mate, or abandonment. They can have visual and, less commonly, auditory hallucinations. Some experience misperceptions that TV characters are real, or they may not recognize themselves in a mirror. Effective pharmacologic therapy includes atypical antipsychotics and high-potency conventional antipsychotics. Emerging data regarding atypical antipsychotics suggest that they are associated with fewer side effects in the short and long term and may become the new standard of therapy. Low-potency conventional antipsychotics are not recommended. Anecdotal evidence suggests occasional benefit of cholinergics and SSRIs. These options will be reviewed within the context of the case presentation.

No. 1G
PRACTICE MANAGEMENT

Gary S. Moak, M.D., *21 Longmeadow Rd, Westborough, MA 01581-2419*

SUMMARY:

Psychiatrists have an opportunity to fill the void in the diagnosis and treatment of Alzheimer's disease. By managing the disease, psychiatrists can enhance their professional role and image. Psychiatrists can also expand their practice by visiting other facilities such as nursing homes and assisted-living facilities.

The skills needed to manage Alzheimer's patients include an understanding of the neurology of dementia, managing of the seven Is (incontinence, insomnia, instability, immobility, iatrogenesis, involvement, intellectual) as well as pain, behavior interventions for agitation, ethics and end-of-life care, legal aspects, and individual and family psychology of dementia. Psychiatrists also need to know the DSM-IV and CPT billing codes for AD services. They also need to understand how to bill for ALF services and know the regulations for Medicare reimbursement within their area.

Psychiatrists can market themselves as dementia experts by writing articles for the lay press, offering in-services and lectures, and providing screening at clinics. Networking through various professional organizations and community organizations is also a great way to make key contacts.

REFERENCES:

1. Petersen RC, Smith GE, Waring SC: Mild cognitive impairment: clinical characterization and outcomes. Arch Neurol 1999;56:303–308.
2. Cummings JL, Donohue JA, Brooks RL: The relationship between donepezil and behavioral disturbances in patients with Alzheimer's disease. Am J Geriatric Psychiatry 2000;8:134–140.
3. Visser PJ, Verhey RJ, Ponds RWHM, et al: Distinction between preclinical Alzheimer's disease and depression. JAGS 2000;48:479–484.
4. Kaye JA: Diagnostic challenges in dementia. Neurology 1998;51(Suppl 1):S45–S52.
5. Tariot PN: Treatment of agitation in dementia. J Clin Psychiatry 1999;60(Suppl 8):11–20.
6. Rosenquist K, Tariot PN, Loy R: Treatment for behavioral and psychological symptoms in Alzheimer's disease and other dementias, in Dementia, 2nd edition. Edited by Ames D, Burns A, O'Brien J. Chapman & Hall, 2000, pp 571:601.
7. Geriatric Psychiatry Practice Management Handbook. American Association for Geriatric Psychiatry, Bethesda, MD, 1997.

INDUSTRY-SUPPORTED SYMPOSIUM 2—MOLECULES AND MOOD DISORDERS: DRUG DISCOVERY AND THE TREATMENT OF DEPRESSION
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the process of antidepressant drug discovery and development, the refinement of existing therapeutic options, and the state of the art of antidepressant treatment.

No. 2A
ANTIDEPRESSANT DRUG DISCOVERY: THE WAYS, MEANS, AND NEEDS

Michael J. Owens, Ph.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Following the serendipitous discovery of the MAOI iproniazid and the TCA imipramine in the 1950s, a great deal of research on the pharmacologic action of these drugs formed the basis of subsequent refinements, particularly with respect to their safety and tolerability. In the late 1980s, the introduction of the SSRIs revolutionized and redefined the treatment of depression, bringing relief to millions of depression sufferers without troublesome side effects or danger from overdose. In the new millennium, further refinements in antidepressant drugs are under way that may bring the care of patients afflicted with depression to another level of efficacy and tolerability. The preclinical selection of antidepressant molecules using in-vitro screening and animal models is a crucial process to insure the quality of the antidepressant compounds that will be moved forward. Although animals exhibit complex social and emotional behaviors for which well-defined and standardized measures exist, a precise replica of human depressive disorder cannot be expected in a single model. An accurate interpretation of the type of therapeutic response each behavioral model predicts is crucial for quality antidepressant drug discovery. Efficacy and tolerability in human clinical trials will ultimately decide which of the new molecules will be used in clinical practice.

No. 2B
THE PHENOMENON OF SINGLE ISOMER DRUGS

Joseph Gal, Ph.D., *4200 East Ninth Avenue, Box C237, Denver, CO 80220*

SUMMARY:

Interest in single-isomer (ie, single-enantiomer) compounds has intensified greatly during the past 20 years, and the great deal of research conducted on the basic and clinical aspects of these drugs has demonstrated unequivocally that the two mirror-image forms of a chiral molecule often differ significantly in their effects. However, single-isomer drugs are not new; indeed some of the oldest drugs in use have been single isomers. The consensus today is that, in most cases, a single-isomer form of a chiral drug is advantageous over the corresponding racemic mixture, and as a result single-isomer development has evolved as a leading strategy to refine current therapies. There are three mechanisms for the development of new single-isomer drugs: chiral switches (CS), chiral metashifts (CM), and new single-isomer chemical entities (NSICEs). In a CS, one of the two enantiomers of an established racemate is developed as a new drug, with the expectation that the single-isomer form has advantages over the racemic parent in terms of efficacy and/or adverse effects. Many new CS drugs were recently launched or are close to launch, all improved compounds over their racemic counterpart, e.g., the antibacterial levofloxacin, levalbuterol for asthma, and escitalopram for depression. In a CM, a chiral metabolite of a drug is developed, in single-isomer form, as an agent with advantages over the parent. Among CM drugs in development are (*S*)-desmethylzopiclone (antianxiety agent, metabolite of the sedative-hypnotic zopiclone) and (+)-norcisapride (gastrointestinal prokinetic metabolite of cisapride). Many NSICEs are on the market or in development, e.g., atorvastatin as an antihypercholesterolemic, pregabalin as an anticonvulsant, abarelix as an antineoplastic, etc. As in the development of any new drug, not every single-isomer candidate will reach the clinic, but there is no doubt that the move to single-isomer agents is an important step forward in the search for better and safer drugs.

No. 2C
REFINING CURRENT THERAPIES: CLINICAL IMPLICATIONS TO THE TREATMENT OF DEPRESSION

C. Lindsay DeVane, Pharm.D., *171 Ashley Avenue, Charleston, SC 29425-0742*

SUMMARY:

The clinical importance of stereochemistry for antidepressants lies in the recognition that stereoisomers or enantiomers often show substantial differences in their pharmacokinetic and pharmacological properties. For example, fluoxetine is a serotonin selective reuptake inhibitor marketed as the racemic mixture (50:50 mixture of its enantiomers). The potential disadvantages of racemic mixtures include the possibility that one of the enantiomers may not contribute substantially to the therapeutic effects of the administered drug yet might contribute to either adverse events or participate in drug-drug interactions. While fluoxetine's enantiomers have similar potency with regard to inhibition of serotonin reuptake, the enantiomers of norfluoxetine, the active metabolite, have five- to ten-fold differences in their activity as inhibitors of the uptake of serotonin. With recent advances in separating and manufacturing enantiomers, some formulations in current clinical use may be improved with further development of a pure enantiomeric formulation. Racemic citalopram is a pertinent example. Escitalopram is approximately twice as potent as racemic citalopram as an inhibitor of 5-HT reuptake. Use of escitalopram should result in lower doses and/or an improved safety profile with no increase in drug interaction liability. Clinical trial data support this advantage.

No. 2D
THE STATE OF THE ART IN TREATING DEPRESSION: 2002

Andrew A. Nierenberg, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

The treatment of depression is rapidly evolving with the development or availability of new antidepressants, antidepressant single isomers, and new somatic and psychotherapeutic treatments. Treatments in development or newly on the market include escitalopram, reboxetine, vagus nerve stimulation, repetitive transcranial magnetic stimulation, and several modifications of cognitive-behavioral therapy. Each new advance has its benefits and risks, advantages and disadvantages relative to established treatments. How these new treatments might fit into treatment algorithms is yet to be determined.

This talk will update participants on these latest treatment options and review anticipated advantages of these newest advances.

REFERENCES:

1. Owens MJ, Knight BS, Nemeroff CB: Second generation SSRIs: humanmonoamine transporter binding profile of escitalopram and R-fluoxetine. *Biological Psychiatry.* 2001. In press.
2. Eichelbaum M, Gross AS: Stereochemical aspects of drug action and disposition. Adv Drug Res 1996;28:1–64.
3. DeVane CL, Boulton DW: Great expectations in stereochemistry: focus on antidepressants. J Clin Psychiatry 2001, in press.
4. DeVane CL: Pharmacologic characteristics of ideal antidepressants in the 21st century. J Clin Psychiatry 2000;61:4–8.

INDUSTRY-SUPPORTED SYMPOSIUM 3—BIPOLAR DISORDER: NEW NATIONWIDE DATA ON MISDIAGNOSIS AND COMMUNITY COSTS
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the nature and extent of bipolar spectrum disorder in the com-

munity and in the clinic and have increased awareness of the degree of under-recognition of bipolar disorder.

No. 3A
PREVALENCE AND BURDEN OF DEPRESSION IN THE COMMUNITY AND PRIMARY CARE

Myrna M. Weissman, Ph.D., *1051 Riverside Drive, Unit 24, New York, NY 10032-2603*

SUMMARY:

Since it is widely recognized that depressed patients can be treated in primary care settings, there have been numerous studies of the prevalence, detection, and burden of major depression in primary care. These studies show that the rates of major depression are far higher in primary care than in epidemiologic surveys of community samples. While rates differ, the characteristics of depression—namely, increased rates in women, early onset, and high rates in the young—are comparable in both epidemiologic and primary care settings. Increasingly, primary care practitioners are being taught to detect and treat these patients. One problem with primary care studies, in contrast to the epidemiologic surveys, is that the rates obtained in the former are usually based on screening instruments and only focus on current illness. Therefore, personal or family history of manic episodes are rarely obtained. Since patients with bipolar illness are more likely to come for treatment during the depressed phase, their manic illness may not be detected or properly treated. Current epidemiologic and primary care studies, including new data from a primary care study of 1,000 patients in New York City, will be examined in light of their implication for detecting bipolar illness.

No. 3B
THE TRUE PREVALENCE OF BIPOLAR SPECTRUM DISORDER

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

SUMMARY:

Although the prevalence of bipolar I disorder is approximately 1%, the prevalence of bipolar spectrum disorders is far higher. Previous studies have suggested that it is in the range of 3% to 6%. Many of those suffering from bipolar spectrum disorder present for treatment in an episode of depression, and are unrecognized as having bipolar disorder. New prevalence data from a 127,000-person, population-based epidemiologic study conducted in 2001 will be discussed. Of the 2,869 individuals meeting diagnostic criteria for bipolar disorder, a relatively small number indicated that a doctor had diagnosed them with bipolar disorder or manic depression, and roughly half indicated that they had been diagnosed with depression. In a follow-up impact study, approximately three-quarters of individuals contacted completed and returned a bipolar disorder screening instrument, the Mood Disorder Questionnaire. A representative subsample of this group was contacted and assessed for bipolar disorder, including bipolar I and bipolar II. The details and significance of these landmark surveys will be examined.

No. 3C
HUMAN SUFFERING AND ECONOMIC BURDEN IN A LARGE COMMUNITY SAMPLE

Joseph R. Calabrese, M.D., *11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*

SUMMARY:

The burden of bipolar disorder to society and the health care system has not been previously assessed from a national perspective. This presentation will discuss new findings, based on results of a U.S. population-based survey of 127,000 individuals, regarding the prevalence and burden of bipolar disorder. This information will be cross-referenced against other survey data, including medical coverage and prescription medications used to provide a further gage on the magnitude of human suffering due to unmet needs of bipolar disorder patients. A family history of bipolar disorder was present among a relatively high number of respondents meeting diagnostic criteria for bipolar disorder compared with fewer respondents not meeting diagnostic criteria. Problems with alcohol and drug use were reported by more than six-fold of respondents meeting criteria for bipolar disorder compared with respondents not meeting the criteria. A subset of 2,400 individuals responding to the initial prevalence survey were administered a second survey on the impact of bipolar disorder on functional ability and well-being. This sample was stratified by MDQ score and included positive and non-positive cases. These data, currently being analyzed, will be presented in full at the symposium.

No. 3D
NEW DEVELOPMENTS IN THE TREATMENT OF BIPOLAR DEPRESSION

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

SUMMARY:

Depression is the primary challenge in managing outpatients with bipolar disorder, and these patients usually consult during the depressed phase. Significant numbers of patients with bipolar depression fall to achieve satisfactory control with lithium—a mainstay of treatment of bipolar disorder for years. This presentation will review new developments in the treatment of bipolar depression that show the possibility of improving outcomes. The primary goal in the treatment of bipolar disorder is mood stabilization without induction of mania or rapid cycling. Mood stabilizers including lithium, lamotrigine, divalproex sodium, and carbamazepine are effective in treating the manic and depressive phases of bipolar illness and do not induce switching or rapid cycling. Unimodal antidepressants including monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, and tricyclic antidepressants have been prescribed and shown effective in controlling depression. However, antidepressants may induce mania and rapid cycling and therefore should be used cautiously. New data from well-controlled studies suggest that the mood stabilizer lamotrigine is effective in controlling bipolar depression. Compared with lamotrigine, the benefits of older mood stabilizers including lithium, divalproex, and carbamazepine are modest. Besides pharmacotherapy, electroconvulsive therapy has been shown effective in alleviating acute bipolar depression although data are inconsistent across studies.

No. 3E
THE CHALLENGE OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *301 University Boulevard, Galveston, TX 77550-0188*

SUMMARY:

Bipolar disorder in children and adolescents has significant adverse effects on a child's academic, social, and family functioning. Unfortunately, bipolar disorder in children is often unrecognized or misdiagnosed. Comorbid conditions frequently complicate the course of

this illness in youth. Children with bipolar disorder are at increased risk for suicide and substance abuse. Despite the severity of this illness in youth, there is very little controlled data regarding pharmacotherapy for this disorder. Mood stabilizers, such as lithium and divalproex, remain the mainstay of treatment; however, there is increased interest in the use of atypical antipsychotics and newer anticonvulsants. This presentation will focus on recognition and diagnosis of bipolar disorder in children as well as comorbid conditions and will discuss the course of this illness in youth. New research findings regarding the safety and efficacy of pharmacological agents will be presented. Treatment strategies and psychosocial interventions will be discussed.

REFERENCES:

1. Weissman MM, Bland RC, Canino GJ, et al: Cross-national epidemiology of major depression and bipolar disorder. JAMA 1999;276(4):293–299.
2. Hirschfeld MA, Williams JB, Spitzer RL, et al: Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. Am J Psychiatry 2000;157(11):1873–5.
3. Tohen M, Hennen J, Zarate CM Jr, et al: Two-year syndromal and functional recovery in 219 cases of first episode major affective disorder with psychotic features. Am J Psychiatry 2000;157:220–8.
4. Calabrese JR, et al: A double-blind placebo-controlled of lamotrigine monotherapy in outpatients with bipolar I depression. J Clin Psychiatry 1999;60: 79–88.
5. Geller B, Zimerman B, Williams M, et al: Six-month stability and outcome of a prepubertal and early adolescent bipolar disorder phenotype. J Child and Adolescent Psychopharmacology 2000;10:165–173.

INDUSTRY-SUPPORTED SYMPOSIUM 4—IMPROVING PATIENT OUTCOMES ACROSS THE SPECTRUM OF BIPOLAR DISORDER
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the challenges associated with the diagnosis of bipolar disorder; discuss gender differences in the manifestation of bipolar disorder; review treatment strategies for acute mania and breakthrough depression in bipolar disorder; discuss pharmacological and psychotherapeutic strategies for treating bipolar disorder.

No. 4A
MANAGING THE PENDULUM OF MOOD IN BIPOLAR DISORDER

Jack M. Gorman, M.D., *1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Even with optimal mood stabilizing therapy, patients with bipolar disorder will still exhibit mood shifts. Treating hypomania and mania generally involves adjusting the dose and plasma levels of the mood stabilizer, adding benzodiazepines, and/or prescribing antipsychotic medications. A more difficult problem is the treatment of breakthrough depression. Clinicians have been warned that prescribing antidepressants to bipolar patients may precipitate rapid cycling. In fact, the evidence for this is much weaker than originally promulgated and antidepressant therapy can usually be offered to patients with bipolar depression. Before that step, however, it is important to consider increasing doses of mood stabilizers like lithium or valproate because this step alone may often be sufficient. If this does not work, antidepressants can be prescribed. Common wisdom has asserted that bupropion is less likely to cause hypomania in bipolar patients, but there is little empirical validation for this contention. Patients should be dosed conservatively and watched carefully. Antidepressant medication should be withdrawn as soon as there is any sign of mood elevation. An alternative or adjunct to antidepressant medication is anticonvulsant or atypical antipsychotic medication. Lamotrigine, an anticonvulsant as well as ziprasidone, an atypical antipsychotic, each appear to have specific antidepressant properties and therefore may be attractive options.

No. 4B
ACUTE MANIA: PHARMACOLOGIC TREATMENT STRATEGIES

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

SUMMARY:

Recent advances in the pharmacologic treatment of bipolar disorder have primarily focused on the treatment of acute mania. Historically, lithium has been the treatment of choice for patients with bipolar disorder. The search for new mood-stabilizing compounds with comparable or superior efficacy and reduced toxicity has led to the introduction of two major drug groups (atypical antipsychotics and novel anti-epileptics) as key therapeutic strategies. Several clinical trials support the efficacy of atypical antipsychotics for treatment of acute bipolar mania. Although preliminary findings are promising, further research is necessary to establish the clinical efficacy of recently developed anti-epileptics for the treatment of acute mania associated with bipolar disorder and to examine the efficacy of atypical antipsychotics and antiepileptics in patients with mixed bipolar states. Furthermore, combined treatment with atypical antipsychotics and anti-epileptics may prove more effective than treatment with either drug type alone. The increasing availability of these new agents underscores the need for targeted guidelines for outcome measures, including assessment of functional recovery. In addition, the development of flexible, treatment-based guidelines is necessary to optimize the treatment of individuals with bipolar disorder.

No. 4C
PHASE-SPECIFIC PSYCHOTHERAPY FOR BIPOLAR DISORDER

Holly A. Swartz, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Since the introduction of lithium in 1949, clinicians and researchers have focused on somatic approaches to the treatment of bipolar disorder. It has become increasingly clear, however, that treatment with pharmacotherapy alone fails both to prevent recurrence in a substantial proportion of individuals with bipolar disorder and to address the significant residual functional deficits associated with its long-term course. It seems increasingly likely that combining psychotherapy with medication represents an optimal strategy for improving functional and symptomatic outcomes for patients suffering from bipolar illness. This presentation will focus on an adjunctive psychotherapy for the treatment of bipolar disorder—interpersonal and social rhythm therapy—which, when combined with pharmacotherapy leads to a reduction in low-grade depressive symptoms and may hasten recovery from a depressive episode. We will discuss our hypothesis that most bipolar-specific psychotherapies exert their effects primarily during the depressive phase of the disorder (Swartz & Frank, 2001) and articulate a proposal for deploying targeted psychosocial strategies for bipolar disorder in variable se-

quences, linked to fluctuating mood states, across the phases of the disorder.

No. 4D
GENDER VARIATIONS IN BIPOLAR DISORDERS

Ellen Leibenluft, M.D., *10 Center Drive, MSC 1255, Bethesda, MD 20892*

SUMMARY:

In recent years increasing attention has been paid to gender variation in the course of psychiatric illnesses, including bipolar disorder (BPD). Several findings are well established: bipolar women in the postpartum period are clearly at high risk for recurrences; rapid cycling BPD is more common in women than men (although the exact magnitude of the effect is disputed); and, while some bipolar women experience a systematic relationship between menstrual cycle phase and mood, most do not. The implications of each of these findings for the treatment of patients with BPD will be discussed.

Other questions regarding the impact of gender on BPD have received considerably less attention. For example, possible gender differences in the prepubertal onset of BPD require further study. As the discussion will highlight, both this epidemiological question and the clinical management of early-onset BPD are complicated by the high comorbidity between BPD and attention deficit/hyperactivity disorder, and by the phenomenological overlap between the two illnesses. Other unresolved but important questions include the impact of menopause on the course of BPD, gender differences among bipolar patients in the ratio of depressive to manic episodes, the pathophysiologic implications of the observation that exogenous androgens may induce mania, the impact of mood-stabilizing medication on reproductive function and parent-of-origin effects in genetic susceptibility to BPD.

No. 4E
THE LONGITUDINAL COURSE OF BIPOLAR DISORDER ACROSS THE LIFE CYCLE

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

SUMMARY:

Bipolar disorder is a longitudinal, often lifelong illness, that is marked by recurrent episodes of illness and sometimes chronicity. It usually presents during adolescence or young adulthood in a variety of ways. These include impulsivity, substance abuse, risk taking behavior, depression, anxiety problems, and psychoses. Not surprisingly, in light of these seemingly unrelated expressions, too often bipolar disorder is unrecognized and misdiagnosed. Treatment received is often inappropriate. Many patients are symptomatic for over a decade before the correct diagnosis is made. In adulthood bipolar disorder is characterized by several different clinical states, including mania, hypomania, mixed states, depression, and rapid cycling. Psychosocial problems associated with these episodes are extensive and often devastating. According to the World Health Organization bipolar disorder is the sixth leading cause of health-related disability in the world. Bipolar disorder also occurs in older adults, and is misdiagnosed in this population as well. Onsets in later life are often due to organic factors that must be addressed.

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INDUSTRY-SUPPORTED SYMPOSIUM 5—NEW APPROACHES FOR TREATING ADHD: THE WHOLE-LIFE PERSPECTIVE
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss new approaches for treating ADHD along the lifespan, including being able to describe cognitive impairments associated with ADHD, the relationship between ADHD phenotypes and cognitive functioning, recognize and treat ADHD in adults, and discuss treatment options on the horizon for ADHD.

No. 5A
ADHD: DSM-IV AND BEYOND

Thomas E. Brown, Ph.D., *P.O. Box 6694, Hamden, CT 06517*

SUMMARY:

For decades ADHD has been seen primarily as a behavior disorder affecting only young children, primarily boys, causing them to be inattentive and disruptive in school. Research has now established that ADHD affects females as well as males and that impairing symptoms, for most, persist into adulthood. It has also been shown that this disorder impacts many aspects of life that extend well beyond problems in school. This disorder impairs not only one's ability to sit still and listen, but also the capacity to organize tasks and materials, to sustain effort on tasks, and to utilize short-term memory for daily activities.

Studies of children, adolescents, and adults with ADHD indicate that many suffer from a variety of cognitive impairments that extend beyond symptoms listed in the DSM-IV diagnostic criteria for ADHD. These include chronic problems in regulating alertness, in reading comprehension, and in modulating emotions that occur more frequently in persons with ADHD than in the general population. This presentation will describe recent research findings demonstrating the wide range of cognitive impairments associated with ADHD. These will be related to a new model of ADHD as developmental impairment of executive functions of the brain.

No. 5B
ADHD: PHENOTYPES AND PATHOPHYSIOLOGIES

Albert J. Allen, M.D., *Lilly Corporate Center, Indianapolis, IN 46285;* David Michelson, M.D.

SUMMARY:

Objective: A number of ADHD phenotypes have been described and/or postulated. The relationship of these phenotypes to various theories of ADHD, if any, is of interest as it may improve treatment and guide future research.

Method: The literature on ADHD phenotypes and proposed pathophysiologies was reviewed.

Results: ADHD phenotypes may be divided into two groups, those relating to core symptoms of ADHD (hyperactive/impulsive vs. inattentive) and those relating to comorbid conditions and symptoms. Proposed pathophysiologies of ADHD are mainly focused on genetic

mechanisms, neuroanatomical pathways, and the neurotransmitters dopamine and norepinephrine. Data linking specific phenotypes to specific pathophysiologies are currently limited.

Conclusions: The relationship between ADHD phenotypes and proposed pathophysiologies is of great interest. As our knowledge of specific pathophysiologies increases, it may help to refine the current phenotypes and improve treatment selection.

No. 5C
NEW ADHD TREATMENT OPTIONS ON THE HORIZON

Christopher J. Kratochvil, M.D., *985581 Nebraska Medical Center, Omaha, NE 68198-5581*

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common psychiatric disorders of childhood, yet there have historically been few pharmacological treatment options available. Sixty-five years after Bradley first treated children with benzedrine, stimulants remain the primary pharmacological interventions for ADHD. Methylphenidate was introduced in 1958, and has been the mainstay of treatment for several decades. Although safe and effective, a short duration of action and side effects common to the stimulants have been problematic for some requiring treatment. Recent technological advances in delivery systems will afford many the option of fewer doses throughout the day.

Efforts have also focused on developing nonstimulant treatment options for ADHD. Some patients do not respond to stimulants, some do not tolerate them, and despite the proven safety of these drugs some chose not to use stimulants because of their status as controlled substances.

This presentation will review recent developments in delivery systems for the stimulant medications, as well as nonstimulant treatment options under development.

No. 5D
FROM CHILDHOOD TO ADOLESCENCE: DIAGNOSIS AND COMORBIDITY ISSUES

Thomas J. Spencer, M.D., *Fruit Street 725 ACC Building, Boston, MA 02114*

SUMMARY:

The clinical picture of ADHD changes with age. Children with ADHD have the prototypic features of inattention, distractibility, and often hyperactivity/impulsivity. In adolescence, motoric hyperactivity diminishes though it may persist as subjective restlessness. With age, there are increasing challenges that demand executive function abilities, such as the ability to plan and become independent. With the persistence of ADHD, academic and social skill deficits from childhood may progress to profound failures with more dire consequences. Such failures may generalize into other domains. Potential domains of ADHD impairment include academic, social, legal, injuries, motor vehicle accidents, occupational failure, unwanted pregnancies, poor financial management, and poor health habits. In adolescents with persistent ADHD, cognitive deficits in vigilance, response inhibition, organization, and set shifting do not catch up with that of peers. In addition, there remains a higher risk of comorbid psychiatric disorders throughout the lifespan of the ADHD individual. Such disorders include comorbid learning disorders, conduct disorder, smoking and substance abuse, anxiety, depression, bipolar, and tic disorders. In this presentation, Dr. Spencer will discuss the changing symptom pattern of ADHD and comorbid disorders from childhood through adolescence with data from the MGH longitudinal follow-up studies.

No. 5E
ISSUES IN DIAGNOSING AND TREATING THE ADULT ADHD PATIENT

Lenard A. Adler, M.D., *301 East 10th Street, Suite 1101, New York, NY 10003*

SUMMARY:

The adult ADHD presents a unique set of issues as ADHD symptoms tend to occur in more complex and less structured social and work/school settings than in childhood. Additionally, adult ADHD requires the presence of both symptoms and impairment as a child and as an adult, the ability to make retrospective diagnosis can obviously be complicated. There are unique treatment issues for the adult patient, given their longer day and need for treatment of longer duration, than their child counterparts. This presentation will cover topics related to: (1) establishing an accurate diagnosis of ADHD in an adult, (2) diagnosing comorbid conditions with adult ADHD, and (3) tailoring an individualized treatment plan for an adult ADHD patient. Specific tools to assist in making the diagnosis, include rating scales and the role of neuropsychological testing, will be reviewed. It is critical to appropriately recognize and treat comorbid psychiatric conditions as they occur in at least 60% of ADHD adults. The symptom presentation and medication treatment of comorbid anxiety, mood, and substance abuse disorders will be detailed. The substantial advances that have occurred in the pharmacology of ADHD have led to marked improvements in the quality of life for ADHD patients secondary to improved tolerability and sustained duration of effect of medications. The utility of newer sustained-released stimulant preparations and norepinephrine re-uptake inhibitors in adults will be discussed. Finally, there will be a review of the role of coaching and cognitive behavioral therapies.

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INDUSTRY-SUPPORTED SYMPOSIUM 6— ANTIPSYCHOTIC THERAPY AND CARDIOVASCULAR DISEASE: THE UNFOLDING STORY
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to assess cardiovascular health risk in psychiatric patients (e.g., factors contributing to the development of micro- and macrovascular

disease), and develop an informed opinion on using particular antipsychotics based on relative risks and benefits for individual patients.

No. 6A
ANTIPSYCHOTIC THERAPY IN PATIENTS WITH COMORBIDITIES: ISSUES AND POLYPHARMACY

Donald C. Goff, M.D., *25 Staniford Street, Boston, MA 02114*

SUMMARY:

Age-adjusted mortality rates in patients with schizophrenia are consistently elevated compared with the normal population and in several studies the increase in mortality rates have ranged from two-to-four-fold. Cardiovascular disease and accidental death (including suicide) appear to make the largest contributions to this increased mortality. Results from surveys of medical illness and mortality in patients with schizophrenia will be reviewed, including a recent study of over 30,000 patients in Massachusetts. Medical risk factors associated with schizophrenia that may contribute to this increase in mortality will be also be reviewed, including cigarette smoking, comorbid substance abuse, and suicide. Experience with clinical approaches to smoking reduction and cessation in schizophrenia patients will be discussed as well as substance abuse treatment. Strategies to reduce mortality from suicide will also be discussed, including identification of risk factors, strategies for preventing self-injurious behavior, and approaches to minimize lethality of overdose.

No. 6B
TORSADE de POINTES, QT, AND ANTIPSYCHOTIC DRUGS

Walter V. Vieweg, M.D., *Box 0710, Richmond, VA 23298*

SUMMARY:

Certain drugs, including psychotropic drugs, may cause clinically significant electrocardiographic QT interval prolongation and lead to dizziness, palpitations, and syncope. Cardiac arrhythmias associated with QT interval prolongation include ventricular tachycardia of the torsade de pointes type and ventricular fibrillation. Recent withdrawal and reclassification of numerous non-psychotropic and psychotropic drugs has raised concern for the practicing psychiatrist about drug-induced cardiac arrhythmias and sudden death.

The electrical circuits within the heart coordinate chamber contractions to optimize ejection of blood into the system and pulmonary circulations. The QT interval consists of both ventricular depolarization and repolarization with time to repolarize making up the major part of the QT interval.

Many psychotropic drugs may disturb cardiac potassium ion channels during repolarization, lengthen the QT interval, provoke serious cardiac arrhythmias of the torsade de pointe type, and be associated with sudden cardiac death.

No. 6C
A FOCUS ON HEALTH: METABOLIC CONSEQUENCES OF ANTIPSYCHOTIC THERAPY

Donna A. Wirshing, M.D., *11301 Wilshire Boulevard, Building 210 B151, Los Angeles, CA 90073*

SUMMARY:

The novel antipsychotic drugs (NAPDs) offer significant advantages over conventional antipsychotic drugs (CAPDs) due to their favorable extrapyramidal side effects (EPS) profiles. Unfortunately these medications are associated with other side effects, such as weight gain. Compounding obesity onto serious mental disorders such as schizophrenia, schizoaffective disorder, and manic depressive illness increases our patients' morbidity and mortality. Obesity can negatively impact treatment adherence. This session aims to provide the participant with up-to-date information about the relative liabilities of novel antipsychotic medications on weight gain, diabetes, hypercholesterolemia, and hypertriglyceridemia. Additionally, this session will provide some guidelines for monitoring these side effects.

No. 6D
ANTIPSYCHOTICS AND DIABETES: A CURRENT PERSPECTIVE ON EPIDEMIOLOGY

Michael J. Sernyak, M.D., *950 Campbell Avenue, #116A, West Haven, CT 06516*

SUMMARY:

There have been reports describing the development of diabetes following initiation of some of the atypical neuroleptics. These have consisted primarily of case reports and a few relatively small studies comparing the rates of diabetes in patients treated with atypical neuroleptics and controls. This presentation will report on data obtained from 38,632 patients with schizophrenia treated in the VA system, which demonstrated that the risk of diabetes was significantly increased for clozapine, olanzapine, and quetiapine, but not risperidone. Data comparing the rates of diabetes observed both by specific neuroleptic and age will also be presented. In addition, recent data in a smaller group of patients on rates of impaired glucose metabolism in the absence of frank diabetes will be reported. The historical context of observed rates of diabetes with typical neuroleptic treatment and prior to the introduction of neuroleptics will be reviewed.

No. 6E
MECHANISMS OF ANTIPSYCHOTIC-INDUCED GLUCOSE DYSREGULATION AND INSULIN RESISTANCE

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

SUMMARY:

Abnormalities in glucose regulation, including type 2 diabetes mellitus, are more common in schizophrenic patients than in the general population. New diagnostic criteria and screening recommendations for diabetes target early identification and treatment in an effort to limit health complications associated with hyperglycemia. Complications of hyperglycemia include retinopathy and nephropathy, and increased cardiovascular disease risk (eg, myocardial infarction and stroke). Plasma glucose thresholds for diagnosing diabetes are set to reflect glycemic thresholds for increased risk of retinopathy and nephropathy. However, cardiovascular disease risk increases continuously with increasing plasma glucose, beginning well below the diabetic threshold. Treatment with antipsychotic medications, particularly certain newer agents, has been associated with abnormalities in glucose and lipid metabolism, including diabetic ketoacidosis (DKA), hypertriglyceridemia, new-onset type 2 diabetes, and aggravation of preexisting type 1 and type 2 diabetes. Sensitive and validated assessments from several laboratories indicate differences in insulin resistance associated with different antipsychotic treatments. Antipsychotic effects on plasma glucose may be related in part to effects on glucose transport at the cellular level. Patients taking antipsychotics should be monitored for hyperglycemia, dyslipidemia, and weight gain, along with other risk factors for diabetes and cardiovascular disease.

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INDUSTRY-SUPPORTED SYMPOSIUM 7—DIAGNOSIS AND TREATMENT ISSUES IN CHILD AND ADOLESCENT BIPOLAR DISORDERS
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) diagnose bipolar disorder in children and distinguish it from other common childhood psychiatric disorders. (2) implement current treatments for bipolar disorder in youth, including mood stabilizers, antipsychotics, newer anticonvulsants, and electroconvulsive therapy.

No. 7A
DIAGNOSIS AND COURSE OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *301 University Boulevard, Galveston, TX 77550-0188*

SUMMARY:

The diagnosis of bipolar disorder in youth, particularly young children, is a clinical challenge. Children with bipolar disorder often present with mixed mania and rapid cycling. Bipolar disorder may be mistaken for other childhood psychiatric disorders such as attention deficit hyperactivity disorder. There are clinical differences in the features between bipolar disorder in young children and in adolescents. These diagnostic and clinical issues will be the focus of this presentation. Bipolar disorder has serious adverse consequences on children's social, academic, and family functioning. Illness duration, recovery and relapse rates, and suicidality associated with this disorder will be presented. The role of the family, school, and social supports that have impact on the outcome of this illness in childhood will be included in this presentation.

No. 7B
GENETIC AND ENVIRONMENTAL EFFECTS OF BIPOLAR DISORDER ON FAMILIES AND OFFSPRING

Kiki D. Chang, M.D.

SUMMARY:

A family history of bipolar disorder appears to be a risk factor for developing bipolar disorder (BD), vying with schizophrenia as being most tied to genetic causes. Studies have shown an approximate 67% concordance rate of BD for monozygotic twins and 25% for dizygotic twins, demonstrating that BD is highly heritable. While having a close relative with BD does not itself create a significant risk, a biological *parent* with BD may cause up to 27% of offspring to develop BD. Therefore, child and adolescent bipolar offspring may shed light on the development of BD, demonstrating early symptoms of prodromal BD; with longitudinal assessment, revealing the natural progression of BD; determining the impact of drug/alcohol use on the presentation of BD; elucidating the environmental effects of BD, although it is difficult to parse environmental from genetic factors; and determining the efficacy of various interventions in preventing the onset of full BD.

We will discuss the genetics of BD as it applies to children of parents with BD and review phenomenological, biological, psychosocial studies, and intervention studies of bipolar offspring. Finally, we will discuss the effects of BD on the family environment and how that may contribute to the exacerbation or improvement of bipolar symptoms and course of illness.

No. 7C
PHARMACOLOGIC TREATMENT OF CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDERS

Robert A. Kowatch, M.D., *231 Bethesda Avenue, P O Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Pediatric bipolar disorders are equally prevalent in children and adolescents with an estimated prevalence of 1%. These disorders are very difficult to treat pharmacologically, perhaps due to the complicated initial presentation and clinical course. The overall response rate to mood stabilizers is fairly low, even by adult standards. These patients often have comorbid disorders that complicate their diagnosis and treatment response. These comorbid disorders include attention-deficit/hyperactivity disorder (ADHD), and anxiety and conduct disorders. ADHD is the most common comorbid disorder among these patients with comorbidity rates as high as 98%. Other causes of treatment resistance may be because they often present with a mixed or "dysphoric" picture characterized by frequent short periods of intense mood lability and irritability rather than classic euphoric mania.

We have recently completed two Stanley funded treatment studies in children and adolescents with bipolar disorders. The first study was a continuation of our acute eight-week study in open, prospective treatment for another 16 to 18 weeks to determine treatment response. The objective of our second study was to determine the safety and efficacy of adjunctive treatment with a low-dose amphetamine vs. placebo in pediatric subjects with bipolar I or II disorder first treated with sodium divalproex. The results of these studies will be discussed.

No. 7D
NOVEL AND MAINTENANCE TREATMENT APPROACHES IN PEDIATRIC BIPOLARITY

Robert L. Findling, M.D., *11100 Euclid Avenue, Cleveland, OH 44106-5000*

SUMMARY:

Lithium, divalproex, and carbamazepine are the most commonly used pharmacologic agents for the treatment of juvenile bipolarity. There is, however, a small but growing body of evidence that suggests that other medications may be useful in the treatment of bipolar illness in this population. Thus far, the primary empirical evidence supports use of the atypical antipsychotics. However, other medications that are currently marketed as anticonvulsants may also be

efficacious in the treatment of pediatric bipolarity. Furthermore, there are data to suggest that omega-3 fatty acids, calcium channel blockers, and other somatic interventions may eventually have a role in the treatment of these patients. Although acute treatment data are available for both the established and novel approaches in the treatment of pediatric bipolarity, relatively few maintenance data exist beyond a few weeks of therapy. Considering that bipolar illness is a severe and chronic condition, the issue of maintenance pharmacotherapy is important; the empirical evidence for pharmacologic intervention in this phase of the illness will be reviewed. In addition, interim results from an ongoing maintenance treatment study in pediatric bipolarity will be considered.

No. 7E
DIAGNOSTIC AND TREATMENT IMPLICATIONS OF PSYCHIATRIC COMORBIDITY IN JUVENILE BIPOLAR DISORDER

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

SUMMARY:

While there is increasing recognition of bipolar disorder (BPD) in youth, controversy and clinical confusion exist surrounding comorbidity with other psychiatric conditions. In this symposium, data-based work on psychiatric comorbidity with BPD and its treatment will be reviewed. One of the most well replicated findings in BPD is its extensive overlap with attention-deficit hyperactivity disorder (ADHD). Data indicate a high risk of ADHD with prepubertal-onset BPD, an intermediate risk with adolescent onset BPD, and low risk with adult-onset BPD. In contrast, adolescent-onset BPD, but not prepubertal-onset BPD, is associated with a high risk for substance abuse. Anxiety and obsessive-compulsive disorders are overrepresented in BPD in all age groups. Similarly, the disruptive disorders including oppositional and conduct disorder are overrepresented in juvenile BPD and may represent a separate subtype or symptom overlap with BPD.

Emerging literature suggests sequencing BPD and comorbidity treatment based on clinical presentation. In youth with ADHD and depression within BPD, data indicate improved outcome in both domains with minimal manic activation when initially sequencing BPD treatment prior to the respective comorbidity. However, recent controlled data suggest immediately treating BPD in adolescents with comorbid substance abuse. Novel pharmacological strategies and recent findings with comorbid BPD groups will be discussed.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 8—LATE-LIFE DEPRESSION: OLD MYTHS AND NEW DATA
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should appreciate that the neurobiology of late-life depression difers from depression in younger patients, and that involvement of vascular illness and other medical comorbidities can complicate treatment; evaluate the effectiveness of pharmacotherapy and psychotherapy in the treatment of late-life depression, including parameters such as speed of onset and time to response.

No. 8A
LATE LIFE DEPRESSION: NEURO-ANATOMY AND MEDICAL COMORBIDITY

Anand Kumar, M.D., *760 Westwood Place, Room 37-384, Los Angeles, CA 90095*

SUMMARY:

Both cardiac disease and depression are frequent and highly debilitating conditions. More than 12 million individuals in the United States have coronary artery disease and the prevalence of depression has been reported to range up to 17%. The association between these two common conditions has been studied in numerous epidemiological and clinical settings. In this brief review, we will consider three important aspects of the relationship between depression and coronary artery disease. First, we will examine the prevalence of the associations between these two conditions. Second, we will evaluate the notion that depression in the context of coronary disease affects morbidity and mortality. Third, that depression can be a risk factor for development of cardiac disease. We will also discuss the concept of a subtype of depression, i.e., vascular depression, and the potential management of this condition.

No. 8B
DEPRESSION: PSEUDODEMENTIA AND EXECUTIVE DYSFUNCTION

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

SUMMARY:

The relationship of aging related brain changes and depression has been the focus of numerous investigations. Early studies developed diagnostic methods for identifying depression-dementia syndromes. "Pseudodementia," a syndrome thought to be benign, has been shown to be heterogeneous including patients with a dementing disorder at a preclinical level, severe depression interfering with cognitive assessment, depression interacting with aging related lesions and compromising cognition, and depression and cognitive dysfunction resulting from common or related brain dysfunctions.

These observations guided investigators to study the relationship of specific cognitive abnormalities to distinct outcomes of geriatric depression. In non-demented, depressed elderly patients, memory impairment has been shown to predict dementia. In contrast, executive dysfunction may be associated with poor or slow antidepressant response and early relapse and recurrence. Persistent executive dysfunction in geriatric depression may be explained in part by microstructural white matter abnormalities. We have hypothesized that these abnormalities compromising the reciprocal regulation of ventral limbic and dorsal cortical structures contribute to chronicity of geriatric depression and persistent disability. As this circuitry is modulated

by dopamine, acetylcholine or opioid neurotransmitters, findings related to this hypothesis can generate novel pharmacological approaches. Nonpharmacological interventions should target depressive symptoms and functional impairments contributed by executive dysfunction.

No. 8C
HOW LONG SHOULD ANTIDEPRESSANT TRIALS BE IN GERIATRIC DEPRESSION?

Harold A. Sackheim, Ph.D., *1051 Riverside Drive, Unit 126, New York, NY 10032*; Steven P. Roose, M.D.; Tal Burt, M.D.

SUMMARY:

Conventional recommendations are that elderly patients should be started at lower doses of medications, and they require longer trials to attain remission. Thus, six- to eight-week trials are often recommended in younger adults, while many advocate 12-week trials in geriatric depression. The issue of differential trial length has never been put to empirical test. There are two issues in considering trial duration: when should the clinician stop the trial because the patient has shown insufficient response, and how long should trials continue in patients who show initial improvement. Using databases of elderly patients treated with different antidepressant agents in 12-week trials, new data will show that early determination can be made that patients will not respond to long-duration trials. If after four weeks of treatment there is less than a 25% reduction in symptom scores, there is an 80% probability that elderly patients will not remit in a 12-week trial. Alternatively, elderly patients may achieve remission status late in treatment if they are above threshold levels of improvement earlier on. This suggests that some elderly patients may require longer trials, informed by signs of improvement earlier in the course, while non-remitters may be identified much earlier in treatment.

No. 8D
TREATMENT OF DEPRESSION IN THE OLD AND OLD-OLD

Steven P. Roose, M.D., *1051 Riverside Drive, Box 98, New York, NY 10032*

SUMMARY:

There is still a paucity of randomized controlled trials of antidepressant treatments in late-life depression, particularly placebo-controlled studies. Recently two large RCTs in late-life depression have been completed. One study included 752 depressed patients with a mean age of 70, randomized to sertraline or placebo for an eight-week trial. Seventy-nine percent of patients completed the trial and there was a statistically significant drug placebo difference that was, however, less than two points on the HRSD in an LOCF analysis.

Though the "old-old," over age 75, are the most rapidly expanding segment of the population, they have been the least studied. To date, the many studies of late-life depression (over age 60) include few patients 75 to 80 and fewer still over 85. The lack of data is understandable: narrow criteria excludes those with comorbid medical conditions, or concomitant medication use, and most studies will exclude patients with mini-mental scores below 24. However, studies have shown that in older patients, significant cognitive impairment improves when depression is effectively treated.

Recently, a consortium of geriatric researchers has completed the largest RCT in the depressed "old-old" to date. In this study, 178 patients over the age of 75 were randomized to citalopram or placebo in an eight-week trial. The completion rate was 82%. The results will be presented.

No. 8E
INTERPERSONAL PSYCHOTHERAPY THERAPY IN LATE-LIFE DEPRESSION: WHO BENEFITS?

Charles F. Reynolds III, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Interpersonal psychotherapy (IPT) in combination with antidepressant medication leads to a high rate of remission in elderly patients with major depressive disorder. IPT addresses problems that occur commonly in late-life depression: bereavement, major role transitions, interpersonal conflict, and interpersonal deficits. Treatment outcomes are similar in both suicidal elderly and non-suicidal elderly. The combination of IPT and antidepressant medication is more effective than medication alone in prolonging recovery from major depressive episodes, and IPT alone is more effective than placebo in maintaining wellness. Patients who respond rapidly to combined treatment, attaining remission within four to six weeks, are generally able to remain well on maintenance IPT alone.

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INDUSTRY-SUPPORTED SYMPOSIUM 9—DEPRESSIVE SUBTYPES: THE MULTIPLE FACES OF DEPRESSION
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize various subtypes of major depressive disorder and be familiar with the management options available to clinicians, (2) summarize the results of the studies comparing the efficacy of different antidepressant classes in the treatment of these depressive subtypes.

No. 9A
ATYPICAL DEPRESSION: AN OFTEN UNDER-RECOGNIZED CONDITION

Jonathan W. Stewart, M.D., *1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Atypical depression is a disorder characterized by significant reactivity of mood associated with hyperphagia, hypersomnia, extreme fatigue, and significant sensitivity to interpersonal rejection. Compared with depressed patients having melancholic features, those with atypical features have earlier age of onset, more chronic illness, more family history of depressive disorder but less family history

of severe depressive illness, and more typically normal biology. These differences argued for the inclusion of the atypical features modifier of major depression and dysthymic disorder in DSM IV. Differences also exist between depressed patients with atypical features and those with melancholic features in expected response to pharmacological therapy. The history of the concept, as well as the arguments that atypical depression is a separate entity with specific clinical picture, course of illness, family history, biology, and treatment responsiveness, will be presented.

No. 9B
TREATMENT CHALLENGES IN ANXIOUS DEPRESSION

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

SUMMARY:

Anxious depression is typically defined as either unipolar depression with high levels of anxiety (using dimensional measures of anxiety) or unipolar depression with comorbid anxiety disorders. In either case, approximately 40% of patients with major depressive disorder are diagnosed with anxious depression. This subtype of depression has been found to be associated with greater severity of both illness and functional impairment, chronicity, and delayed or poorer response to antidepressants. In addition, anxiety disorders often precede the onset of major depressive disorder, and some researchers believe that anxiety disorders may predispose patients to depression or increase their vulnerability toward it. Although most treatment studies have failed to show significant differences in response across antidepressant classes or within antidepressants of the same class, concerns about the possibility of activation and agitation as treatment-emergent side effects often lead clinicians to use relatively more sedating agents in "real-world" settings. In addition, despite the fact that antidepressant monotherapy seems to work well in clinical trials, the concomitant use of antianxiety drugs and/or cognitive-behavioral therapy in clinical practice is quite common. Finally, many clinicians favor starting patients with anxious depression on lowedoses of the antidepressant, assuming that dosage titration may avoid any initial worsening of the anxiety symptoms.

No. 9C
MELANCHOLIC DEPRESSION: ARE DUAL-ACTION ANTIDEPRESSANTS SUPERIOR TO SELECTIVE

J. Craig Nelson, M.D., *20 York Street, EP-10-835C, New Haven, CT 06504*

SUMMARY:

Almost from the initial introduction of the first SSRI, fluoxetine, there has been debate about whether melancholic or endogenous depression responds better to a selective antidepressant or to a dual-action agent. Sometimes the debate has pitted the SSRI against the tricyclics (TCAs), but the first TCA showing superiority was clomipramine, a dual-action agent. The controversy has also considered whether "severe depression" is a better distinction than melancholia. Ian Anderson, in a review of 103 studies comparing SSRIs and TCAs, concluded that the only patient characteristic related to response was "inpatient status." This presentation will review these diagnostic concepts. Their diagnostic value in inpatients and outpatients will be considered. In fact, it appears that these are overlapping concepts and that severe melancholic inpatients may be the group most likely to show treatment differences. Within individual outpatient studies, the melancholic distinction and the severe distinction have seldom been useful in predicting treatment differences. Although relatively few inpatient comparison studies have been conducted, several of these studies have reported differences favoring the dual action agent. Recently meta-analyses have been reported suggesting that the dual action agents venlafaxine and mirtazapine are each more effective than a selective serotonin agent. These meta-analyses included outpatient studies. It is possible that the size of the difference between treatments is smaller in outpatients and requires the pooled data and a meta-analysis to detect a difference. The implications of these findings for the clinician treating depressed patients will be addressed.

No. 9D
VASCULAR DEPRESSION

Ranga K. Krishnan, M.D., *Box 3950, Durham, NC 27710*

SUMMARY:

The concept of vascular depression is not a new idea. What is new is the technology to demonstrate subtle but surprisingly widespread structural brain change in vivo by MRI and other imaging techniques. Gaupp (1905) (as quoted by F. Post) described 45 elderly patients with depression secondary to arteriosclerosis. Based primarily on soft neurological signs and symptoms, other early studies also tended to classify elderly patients with depression as arteriosclerotic depressions. In our first study of 35 depressed patients, 72% of LOD subjects had leukoaraiosis. The prevalence was 85% between the ages of 59 and 66, and 100% after age 74. We examined the association between number of white and gray matter lesions and white matter grade (a measure of severity) and reported depressive symptoms using a modified version of the Centers for Epidemiological Studies Depression (CES-D) scale in a sample of 3,660 men and women from the cardiovascular health study. The subjects underwent a standardized interview, physical examination, and magnetic resonance imaging (MRI) scan. We controlled for a variety of demographic and medical variables as well as functional status and modified Mini Mental Stale Exam score. We found that number of small (less than 3 mm) basal ganglia lesions and severity of subcortical white matter lesions were significantly associated with reported depressive symptoms. In subsequent logistic regression models, number of basal ganglia lesions remained a significant predictor (odds ratio = 1.401, $p = 0.0041$) after controlling for non-MRI variables. We have also shown that the lesions localization is to the medial orbital frontal cortex in depression. We have also demonstrated a relationship between lesions and outcome.

No. 9E
PRACTICAL APPROACH TO PSYCHOTIC DEPRESSION

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

SUMMARY:

Numerous studies in the past three decades have characterized the subtype of major depression that is accompanied by delusions or other psychotic features. The presence of psychosis in depression is associated with longer episode lengths and higher rates of relapse and recurrence, distinct abnormalities in hypothalamic-adrenocortical (HPA) axis function, and a variety of other biological findings from neuroendocrine, brain imagining, and sleep studies. Treatment studies have shown psychotic depression predicts infrequent response to placebo, poor response to antidepressant monotherapy, and good response to ECT or an antidepressant plus an antipsychotic. Taken together, these findings support the notion that psychotic depression represents a unique disorder with a high level of morbidity.

Until recently, there were only two prospective, double-blind, controlled trials investigating the efficacy of antidepressant-antipsy-

chotic combination pharmacotherapy, yet this constitutes the currently accepted and most universally applied "standard of care" for psychotic depression. Established treatment guidelines have been based on uncontrolled studies of ECT and studies using tricyclic antidepressants (TCAs) and conventional antipsychotic drugs, which are not frequently chosen as first-line agents today. A growing literature from Italy suggests preliminary efficacy of selective serotonin reuptake inhibitor (SSRI) monotherapy for psychotic depression, but questions have been raised about the role of diagnostic heterogeneity as a possible confound in recent research on psychotic depression. A multicenter, controlled trial investigating the efficacy and safety of combination fluoxetine-olanzapine was recently completed. A multicenter, controlled trial of the glucocorticoid receptor antagonist mifepristone is currently under way. The results from these and other clinical research regarding psychotic depression will be critically reviewed.

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1. Stewart JW, McGRath PJ, Rabkin JG, Quitkin FM: Atypical depression. a valid clinical entity? Psychiatr Clin North Am 1993; 16(3):479–495.
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INDUSTRY-SUPPORTED SYMPOSIUM 10—RECOVERY FROM DEPRESSION: NEW PERSPECTIVES TO IMPROVE OUTCOMES

Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should learn about the process of recovery from depression, both in terms of risk factors and therapeutic strategies.

No. 10A
RECOVERY FROM DEPRESSION: CONCEPTUAL UNDERPINNINGS

Michael E. Thase, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Syndromal episodes of major depressive disorder may last from a few weeks to a number of years and, for each depressed person, the temporal course from illness to recovery presents both unique challenges and opportunities. As the number and type of effective treatments for depression continue to grow, more attention can be devoted to ensuring a progression of favorable outcomes from response, to remission, and, subsequently, sustained recovery. This presentation will address the psychosocial, clinical, and neurobiological factors that are known to influence the trajectory of recovery from depression. Many of these factors can be viewed as targets for therapeutic intervention and risk factors that cannot be changed can be, at the least, addressed with education, ongoing support, and, if possible, acceptance. Such focused treatment will, in turn, increase the probability of recovery and reduce the considerable risks of chronicity, relapse, recurrence, and diminished quality of life associated with depressive disorders.

No. 10B
AUGMENTATION AND COMBINATION STRATEGIES FOR THE NEWER ANTIDEPRESSANTS

Andrew A. Nierenberg, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

To decrease relapse rates and to decrease longer-term morbidity and mortality, symptomatic and functional remissions are essential in the treatment of major depression; a minority of patients, however, reaches full remission after an acute trial of an antidepressant. Better treatment strategies are clearly needed to improve the acute and long-term outcomes of patients with major depression. One such strategy is to add a second agent to the initial antidepressant—to add a medication other than another antidepressant is referred to as augmentation and to add a second antidepressant is called combination treatment. This presentation will evaluate selected augmentation and combination strategies to improve response and remission rates for patients with major depression. Data from randomized, control trials will be presented to the extent that these data are available. Open data from published studies will be critically examined. Factors such as the adequacy of initial response, side effects, drug interaction potentials and ease of use will influence the choice of an agent, and will also be discussed. Since limited data that compare add-on treatments are available, the Sequential Treatment Alternatives to Relieve Depression (STAR*D) study will also be described.

No. 10C
COMBINING PSYCHOTHERAPY AND MEDICATION FOR DEPRESSION

John C. Markowitz, M.D., *525 East 68th Street, Room 1322, New York, NY 10021*

SUMMARY:

Antidepressant pharmacotherapy has so clearly demonstrated its efficacy that psychotherapy has been relatively neglected. Yet research has also shown the benefits of particular psychotherapies, particularly interpersonal psychotherapy (IPT) and cognitive-behavioral therapy (CBT), as treatments for acute major depression. Growing evidence suggests that IPT, CBT, and cognitive-behavioral analysis system for psychotherapy (CBASP) may also efficaciously treat chronic forms of depression. The combination of psychotherapy and pharmacotherapy may for some patients work better than either alone.

Most studies, however, have shown only slight advantages for combined antidepressant treatment over monotherapies. In an era of constrained health care resources, it is crucial to know which patients need combined treatment and which will fare well with a monomodal intervention. This presentation will review current evidence on the utility of psychotherapy, alone and especially in combination with pharmacotherapy, as a treatment for unipolar mood disorders.

No. 10D
MAXIMIZING EFFICACY IN THE TREATMENT OF CHRONIC DEPRESSION

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

SUMMARY:

As many as 30% to 35% of individuals with depressive disorders experience a chronic course lasting two years or longer, characterized by prolonged episodes of illness and incomplete remission between episodes. Chronic forms of depression include chronic major depressive disorder, dysthymic disorder, double depression, and recurrent major depressive disorder with incomplete interepisode recovery. These disorders tend to be underrecognized and undertreated, and are associated with substantial personal and societal costs. The psychosocial impairment with chronic depression spans marital, family, and social roles, as well as occupational functioning and overall quality of life. High rates of comorbidity and physical impairment are also common, along with high levels of health care utilization.

Recent studies have demonstrated the efficacy of several antidepressant medications in the treatment of chronic depression. Response rates to pharmacotherapy are in the 50% to 60% range, with about 30% to 40% of patients achieving a full remission by the end of 12 weeks. Combination treatment with pharmacotherapy and psychotherapy may improve response rates to as high as 85%. Patients who achieve remission show significant improvement in psychosocial functioning that approaches the levels of nondepressed community samples. The benefit of continuation and maintenance treatment for chronic depression, both in improving remission rates and in preventing relapse and recurrence of depression, has clearly been demonstrated. This presentation will provide an overview of chronic depression and its treatment.

REFERENCES:

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2. Thase ME, Howland RH, Friedman ES. Treating antidepressant nonresponders with augmentation strategies: an overview. Journal of Clinical Psychiatry 59(Suppl 5):5–12, 1998.
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4. Dunner DL: Acute and maintenance treatment of chronic depression. J Clin Psychiatry 2001;62(supp 6):10–16.

INDUSTRY-SUPPORTED SYMPOSIUM 11—TREATING PSYCHOTIC ILLNESS ACROSS THE LIFE SPAN: ARE DRUGS ENOUGH?
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize that the age of onset of a psychotic illness can have a profound effect on the course of the patient's life; (2) understand that treatment will need to be tailored to the age of the patient; and (3) understand how early intervention can effect the course of life for the patient.

No. 11A
PSYCHOTIC ILLNESS IN CHILDREN

Jean A. Frazier, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Introduction: This presentation will review the benefits of pharmacological and nonpharmacological interventions in children with psychotic disorders.

Methods: Medline over the past 20 years was utilized to find literature documenting the efficacy of pharmacological and nonpharmacological interventions as adjuvant approaches to medication treatment in youth with psychosis.

Results: Several open and one double-blind study indicate that atypical antipsychotics are helpful in reducing psychotic symptoms in children and that they may have long term benefits in terms of improved cognition. Additionally, several studies indicate that cognitive behavioral approaches, psychoeducation, and reduction of expressed emotion in the child's environment may promote the healing process in those suffering from psychosis.

Conclusion: Although pharmacotherapy is the cornerstone of treatment for psychosis (positive and negative symptoms) in children, optimal healing may be further promoted by attending to the "milieu" surrounding the child.

No. 11B
FROM GETTING BY TO GETTING BETTER

Gerald A. Maguire, M.D., *51 Whitman Court, Irvine, CA 92612*

SUMMARY:

Early recognition and treatment of psychosis in the elderly is key to optimizing patient outcome. Psychosis and behavioral disturbances associated with dementia often lead to earlier caregiver burnout and institutional placement. A goal of therapy is to improve patient functioning and quality of life, and the treatment of psychosis and behavioral disturbances is of high priority. Treatment should include non-pharmacologic interventions, but often, pharmacologic agents are needed to augment. Ideal pharmacologic treatment would be agents with a broad efficacy profile and a benign side-effect profile. While no agent is ideal, our newer-generation antipsychotic medications provide many advantages being a safer, more effective means of improving quality of life in our patients. Early intervention and long-term stabilization are the goals of therapy in not only getting our patients well, but keeping them well.

No. 11C
RAISING THE BAR OF EXPECTATIONS

Ralph Aquila, M.D., *New York, NY 10025*

SUMMARY:

New technologies and advocacy have raised the bar of expectations for persons with serious and persistent mental illness. The notion of reintegration, or recovery have become obtainable goals for many patients with schizophrenia and its related disorders. Efficacy, first and foremost, is what many clinicians are seeing both from the data and from their clinical experiences. The atypicals have shown to be equal to or superior to the traditional antipsychotics for both positive and negative symptoms. Improved cognition, quality of life enhancements, and meaningful employment are therefore the next step for outcome measures in schizophrenia. Elimination of EPS and improved mood stability are improvements from a side-effect profile that lead toward greater compliance. The next important step is that we as clinicians begin to really believe that our patients can achieve more. Hargreaves showed that about half of all patients with schizophrenia improve and require minimal assistance. Blending rehabilita-

tion and state of the art psychiatric services are an important step in the process of reintegration.

No. 11D
MADNESS AND THE REST OF A LIFE

Anne Alonso, Ph.D., *17 Lakeview Avenue, Cambridge, MA 02138*

SUMMARY:

The problem with madness, be it dementia, psychotic depression, or any feeling state that is out of control, is that the individual is left with a serious diminished sense of hope, a reduced set of real-life options, and strained relationships with caretakers. To the extent that these problems remain silent and unacknowledged, they become a sources of festering shame and lead to even greater deterioration. It remains true that the body remembers what the mind tries to forget. While these problems are universal and existential, they nonetheless lend themselves to psychosocial interventions. It is a common error to think that psychotherapy is only suitable for dealing with neurotic reparations or developmental deficits. Psychotherapy can offer a life-saving platform for sustaining the individual in relationship with a therapist or a therapy group. The corrosive isolation that is driven by shame can be relieved enough to allow a far greater quality of life, both for the afflicted individual and for those who are involved as caretakers, be they professionals or family members. This talk will explore some psychosocial interventions and offer situational possibilities for providing that treatment.

No. 11E
BEST PRACTICES IN PSYCHOSOCIAL REHABILITATION FOR PSYCHOTIC ILLNESSES

Paul J. Barreira, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Studies investigating the effectiveness of psychosocial interventions have proliferated over the last 10 years. This presentation will review the results of recent studies of the major psychosocial interventions in the treatment of psychotic illnesses. Interventions that will be discussed include family interventions, assertive community treatment, vocational rehabilitation models, skills training, cognitive-behavior therapy, and case management. Based on the current literature, the presenter will discuss the implications for best practices in psychiatric rehabilitation interventions. Also, the transferability and cost-effectiveness of various interventions will be presented. Areas for future research will be identified.

No. 11F
IS THE CHEAPEST ALTERNATIVE THE MOST ECONOMICAL?

Sumer Verma, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

The increasing costs of health care have been under close scrutiny for the past decade. The costs of the newer drugs have threatened to overwhelm the most liberal budget. Yet these drugs offer substantial advantages in the immediate and long-term outcomes from psychiatric illness across the life span. Should costs be measured strictly in terms of the costs of the pharmaceutical intervention, or are there other measures of cost effectiveness. Does a higher investment of dollars in the initial phase of a chronic debilitating psychiatric illness offset a greater saving years in the future—savings that are obtained through the prevention of side effects, of social and cognitive decline, and of caregiver burden. This discussion looks at pharmacoeconomics from the perspective of cost savings through reintegration.

REFERENCES:

1. Bustillo JR, Lauriello J, Horan WP, Keith SJ: The psychosocial treatment of schizophrenia: an update. American Journal of Psychiatry 2001; 158: 163–175.
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INDUSTRY-SUPPORTED SYMPOSIUM 12—ADVANCES IN THE TREATMENT OF PSYCHOSIS: MINIMIZING THE BURDEN OF DISEASE
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe strategies for minimizing the burden of disease for patients with psychotic disorders through advances in the understanding and treatment of psychosis.

No. 12A
THE PUBLIC HEALTH IMPACT OF SCHIZOPHRENIA

Norman Sartorius, M.D., *2 Chemin de Petit-Bel-Air, 1225 Chenebourg, Geneva, Switzerland*

SUMMARY:

Despite its relatively low incidence, schizophrenia remains a problem of major public health importance because of its long duration and the severe consequences that it has for the individuals concerned, their families, and their communities. Nearly half of the beds in mental hospitals are occupied by people whose primary diagnosis is schizophrenia, and a large proportion of people disabled because of mental illness have the diagnosis. The World Health Organization's studies predict that schizophrenia will remain among the ten main causes of disability well into the 21st century.

The criteria for the assessment of public health importance of a problem include (1) the frequency of the problem; (2) its severity in terms of suffering and disability; (3) the availability of effective solutions that are acceptable to patients, their families, and society; and, (4) the likelihood that the problem will remain stable or grow in the years to come. In recent years, the impact of the disease on the quality of life of the persons concerned—the people who have the disease, their families, and the caregivers—has been added to these criteria of public health importance. Problems that are found to have high public health importance using these criteria should deserve priority in public health allocations, in research funding, and in the education about public health matters. During this presentation, I will show that schizophrenia satisfies the definition of a major public health problem on the basis of an examination of the four

criteria listed above. I will also present possible reasons for the unacceptably low priority that has been given to action regarding the problem of schizophrenia by public health authorities in most countries of the world.

No. 12B
THE EVOLUTION OF ANTIPSYCHOTIC THERAPIES: OVERCOMING TREATMENT BARRIERS

Daniel R. Weinberger, M.D., *10 Center Drive, Building 10, Room 4S-235, Bethesda, MD 20892-1379*

SUMMARY:

While it can be stated with confidence that schizophrenia is a disorder of abnormal brain microstructure and function, the nature of the underlying pathology at the neuronal level has not been clearly delineated. No single lesion has yet been identified. Rather, schizophrenia is evolving as a complex of disorders that have diverse origins but overlapping clinical symptomatology. Be that as it may, by combining research on the neurochemical basis of psychosis and the molecular pharmacology of antipsychotic medications, we have reached a point where we can deliver effective treatments with tolerable levels of side effects. The identification of specific neurotransmitter systems and receptors that are involved with the complex of disorders that is schizophrenia and the amelioration of the associated symptoms provides a rationale for the development of new compounds with even more specific pharmacologic properties. Current medications provide less than the desired therapeutic responses in most patients. Ongoing research holds promise of newer medications with a broader range of therapeutic benefits and milder, more acceptable, side effects. During this presentation, I will give an historical perspective on the neurobiological basis of and clinical experience in schizophrenia that has paved the way for the development of these significantly improved medications.

No. 12C
OPTIMIZING MANAGEMENT OF SCHIZOPHRENIA: BRIDGING THE GAP BETWEEN CLINICAL RESEARCH AND REAL WORLD CLINICAL PRACTICE

Andrew J. Cutler, M.D., *807 West Morse Boulevard, Suite 101, Winter Park, FL 32789*

SUMMARY:

The treatment of schizophrenia has advanced with the recognition that palliative measures are not enough—that in our care for patients with psychotic disorders, we must go beyond positive symptom control and strive to improve a patient's overall ability to function in a meaningful fashion. This effort has meant optimizing and individualizing existing therapies and looking for new ways and new medications that can improve function and quality of life. With the development of newer antipsychotics, a broader range of treatment options has emerged that have shown promise in reducing positive and negative symptoms as well as cognitive and mood disturbances associated with psychotic psychopathology. Part of the gain has come from improvements in the side-effect and safety profiles of the newer agents such that the introduction of untoward deficits or burdens has been reduced. During this presentation, I will review evidence-based strategies for improving outcomes in the treatment of schizophrenia by broadening the domains of care to yield increased function and quality of life. Data from recent studies showing comparative effects of some of the newer agents on mood and cognition will also be reviewed. Throughout this presentation, the need for new research tools and paradigms to measure and investigate quality of life and function with be highlighted. The discovery of newer agents should lead to a broader understanding of how we evaluate, understand, and help our patients lead more worthwhile and fulfilling lives.

No. 12D
CARING FOR A FAMILY MEMBER WITH SCHIZOPHRENIA: A PERSONAL ACCOUNT

Martin S. Willick, M.D., *970 Lincoln Place, Teaneck, NJ 07666-2636*

SUMMARY:

Clinical research is carried out and reported on groups of patients, and treatment guidelines are built around an aggregate of patients with schizophrenia. Treatments, however, are applied to individuals, and schizophrenia is an illness of individual patients. Although of necessity, clinicians treat patients as though they were this "average," there is in fact no such average person with schizophrenia. Each individual person with schizophrenia has a unique history, personality, and circumstance. While the medical literature tells us a great deal about the illness, it is difficult to convey the experience of an individual or his or her family in a scientific presentation. During this presentation, you will hear insights from a physician caregiver and others, describing their families' struggles and triumphs as they have lived with a family member with schizophrenia.

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INDUSTRY-SUPPORTED SYMPOSIUM 13—RECENT DEVELOPMENTS IN THE SCIENCE AND TREATMENT OF PTSD
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify risk and resiliency factors in PTSD, differentiate biologic differences in trauma victims who develop PTSD and those who do not; describe familial risk factors and developmental neurobiologic factors associated with PTSD; understand the clinical implications of the above.

No. 13A
RISK AND RESILIENCE FACTORS IN PTSD

Rachel Yehuda, Ph.D., *130 West Kingsbridge Road, #116A, Bronx, NY 10468*

SUMMARY:

More than half the population has experienced a traumatic event severe enough to give rise to posttraumatic stress disorder (PTSD), but only 15% to 25% exposed to such events actually develop the chronic disorder. This observations has raised numerous questions regarding the factors that increase the risk for developing PTSD following trauma exposure, and increase recovery from, or promote resiliency to, this disorder. In the last several years, prospective and retrospective studies of trauma survivors have identified a variety of factors that contribute to the development of PTSD (versus the development of other psychiatric conditions, or no disorder following trauma exposure). These factors, which include age of traumatization, prior history of stress, and family history of either traumatic stress or PTSD, have known biologic concomitants that may influence specific biologic responses to traumatic stress. Longitudinal studies have demonstrated that PTSD may result from an inadequate termination of the acute stress response, manifested by elevated heart rate and low cortisol levels, which over time can lead to a cascade of biologic changes and associated chronic symptoms. Depressed cortisol levels (and increased number of glucocorticoid receptors) may fail to blunt the adrenergic response, which can lead to progressive sensitization of the stress response and a prolonged arousal state. An inherited tendency for low cortisol levels may be an important risk factor for PTSD. This presentation will address these compelling issues and discuss their clinical implications.

No. 13B
WHAT CAN NEUROIMAGING TEACH US ABOUT PTSD?

Scott L. Rauch, M.D., *Building 149, 13th Street, Charlestown, MA 02129*

SUMMARY:

Paralleling the literature on fear conditioning, neurocircuitry models of posttraumatic stress disorder (PTSD) have focused on a triad of brain regions: the amygdala, the hippocampus, and medial frontal cortex (e.g., anterior cingulate cortex). Specifically, it has been hypothesized that the pathophysiology of PTSD might entail hyperresponsivity of the amygdala to threat-related stimuli as well as insufficient "top-down" modulation of the amygdala response by medial frontal cortex and/or the hippocampus. The current presentation will provide a general review of neuroimaging findings in PTSD, highlighting the various experimental paradigms that have been used. In addition to morphometric studies that have suggested abnormalities in hippocampal volume, functional studies employing symptom provocation and cognitive activation methods will be presented. In particular, recent cognitive activation studies of PTSD have provided convergent evidence for dysfunction involving the amygdala, hippocampus and anterior cingulate cortex. Finally, future directions will be addressed, including the promise of research designed to clarify the specificity of findings in PTSD vs. other psychiatric disorders and to identify predictors of treatment response.

No. 13C
MEDICATION STRATEGIES IN PTSD

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

SUMMARY:

There are many challenges in the treatment of posttraumatic stress disorder (PTSD). There is marked interpatient variability in clinical response to medications. Although a variety of medications have been evaluated, the selective serotonin reuptake inhibitors (SSRIs) are considered first-line therapy. The SSRIs are effective, well-tolerated, and conveniently administered once daily. Additionally, the SSRIs are not associated with potential for abuse, which is important in this population. The SSRIs are also effective for many of the comorbidities associated with PTSD, including mood and anxiety disorders. Suicidality is very common, and the SSRIs are safe in overdose situations. Other agents that have been demonstrated in controlled trials to be useful in PTSD include the monoamine oxidase inhibitors (MAOIs) and the tricyclic antidepressants (TCAs). However, the MAOIs and TCAs are associated with more toxicity and more severe adverse-effect profiles and may be reserved for treating patients who do not respond initially to SSRIs. A number of other agents, including antipsychotics and anticonvulsant agents, show promise in controlled trials. Psychotherapy is an important component of the overall treatment strategy for PTSD. Appropriate treatment of patients with PTSD significantly improves their quality of life. This presentation will review current medication strategies for treating PTSD.

No. 13D
TREATMENT OF PTSD WITH EXPOSURE THERAPY

Barbara O. Rothbaum, Ph.D., *1365 Clifton Road, NE, Atlanta, GA 30322*

SUMMARY:

The psychotherapy literature for PTSD will be succinctly reviewed and discussed, focusing on cognitive-behavioral treatments (CBT), and the various CBT techniques will be briefly described. The results of the Treatment Guidelines for PTSD commissioned by the International Society for Traumatic Stress Studies (ISTSS) will be reviewed. In those guidelines, due to the strength of the literature base in this area, only peer-reviewed empirical studies were included. Exposure therapy involves assisting patients in recalling their traumas in their imaginations and recounting them repeatedly in a therapeutic manner until discomfort decreases. The evidence is very compelling from many well-controlled trials with a mixed variety of trauma survivors that exposure therapy is effective. In fact, no other treatment modality has this strong of evidence for its efficacy. Stress Inoculation Training (SIT), an anxiety management training package of techniques, Cognitive Processing Therapy (CPT) developed for rape victims, cognitive therapy, and combination approaches all have some evidence for their efficacy, as well. Data on EMDR and virtual reality exposure therapy will be presented. The Expert Consensus Guidelines for PTSD recommendations for psychotherapy also will be briefly reviewed.

No. 13E
USING ASSESSMENT TOOLS IN CLINICAL PRACTICE: WHEN, WHY, AND HOW?

Kathryn M. Connor, M.D., *Box 3812 DUNC, Durham, NC 27710*

SUMMARY:

Posttraumatic stress disorder (PTSD) may be considered as a hidden diagnosis, as is it a common condition but frequently unrecognized by health care professionals. Current prevalence rates for PTSD in medical settings may exceed 10% of patients. Certain medical disorders are often associated with PTSD and, therefore, may be viewed as a signal for greater likelihood for the disorder and indicating greater need for PTSD screening. PTSD also has characteristic ways of presenting. These clinical situations will be described.

The importance of assessing for PTSD lies in its associated chronicity, morbidity, comorbidity, and societal costs. Approaches to assessment of PTSD include empathic and accurately focused emotions, elicitation of a trauma history, and use of rating scales. A

variety of psychometrically validated rating instruments have been developed to assess PTSD. These include structured and semi-structured diagnostic interviews (e.g., SCID, MINI, CAPS, SIP), as well as very brief, self-rated screening questionnaires (e.g., SPAN). Other scales also exist for the measurement of PTSD severity and its response to treatment (e.g., SPRINT, CAPS, TOP-8, DTS, PDS), as well as for the measurement of resilience (e.g., SVS, CD-RISC).

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INDUSTRY-SUPPORTED SYMPOSIUM 14—CUSTOMIZING CARE FOR PATIENTS WITH BIPOLAR DISORDER
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand factors that may be useful in the process of selecting agents to customize care for individuals at critical decision points in the course of bipolar illness.

No. 14A
INTERVENTION FOR REFRACTORY PATIENTS

Patricia Suppes, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Treatment interventions for refractory patients have entered into a new era of therapeutics based on a greater appreciation of the range of presentation in bipolar disorder and increased recognition of the potential for severe morbidity and mortality without adequate medication management. Limited well-controlled data are currently available on the use of combination medication therapies for patients with partial response to monotherapy treatments. Yet, as illustrated by multiple treatment guidelines, including the Expert Consensus, Texas Medication Algorithm Project, and Veterans Administration Guidelines, the next step following monotherapy is combination treatment. Recent studies evaluating combination treatments will be presented. Treatment for this illness requires knowledge of the new therapeutic options together with strong clinical management skills. Recent studies on newer medications for mood stabilization and depression will be presented. Treatment management strategies, using recent controlled studies and expert consensus, will be discussed.

No. 14B
SIGNIFICANCE OF PSYCHOSIS

Charles L. Bowden, M.D., *7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

SUMMARY:

Psychosis frequently accompanies acute manic episodes. Less well recognized is evidence that a substantial portion of bipolar patients retain some psychotic features for years; and that such symptoms continue during periods without syndromal mania or depression. Studies of this phenomenon have not been routinely incorporated into psychiatric management plans, in part because terminology of thought disorders varies widely. Also, thought disorder exists on a spectrum, with evidence that among patients with persisting psychosis, approximately half have severe thought disorders and half have milder indications of idiosyncratic thinking. What is commonly viewed as impaired insight in bipolar disorder may in part be driven by psychosis.

Bipolar patients with psychotic features have consistently been reported to have poorer outcomes with maintenance treatments. Although antipsychotic drugs have been studied extensively in acute mania, few controlled studies of antipsychotic drugs, or any other mood stabilization treatments for prophylaxis, have been conducted in this subgroup of bipolar disorders.

No. 14C
CHOOSING INITIAL MOOD STABILIZER AFTER ACUTE MANIA

Guy M. Goodwin, M.D., *Headington, United Kingdom OX3 7JX*

SUMMARY:

There is probably a consensus that any patient with bipolar I disorder is likely to benefit from maintenance treatment after acute mania with an appropriate and effective drug. While for many years there was no choice and it had to be lithium and/or a classical antipsychotic, we have now moved into an era of considerable uncertainty. We are spoiled for choice by a large menu of possible drugs claiming to stabilize mood in continuing and/or maintenance treatment of bipolar I disorder. Ideally, the clinical picture, the past history, our knowledge of drug efficacy, and the potential burden from side effects should allow an optimal choice to be made. In practice we have a limited evidence base on which to make an informed choice for the long term. Instead we have growing evidence for the effectiveness of continuation of drugs used in acute treatment, some post-hoc evidence that particular clinical states, specifically mixed mania, may respond preferentially to particular mood stabilizers, and the pragmatic fact that while monotherapy may be the ideal, combined pharmacological treatment is increasingly the rule. It will be argued that instead of a choice based on the force of competing marketing claims, there is a need for pragmatic comparative studies of different mood stabilizers individually and in combination. The BALANCE trial in the U.K. is an example of such a trial and its progress will be reviewed.

No. 14D
SELECTION OF AN ACUTE TREATMENT STRATEGY: SEQUENTIAL VERSUS STRATIFIED APPROACH

Gary S. Sachs, M.D., *15 Parkman Street, WACC 815, Boston, MA 01773*

SUMMARY:

Individualized therapeutic approaches to the treatment of bipolar disorder can be chosen based on a risk-benefit analysis that takes

into account severity of symptoms and the available resources in the treatment setting. In instances of milder symptomatology, for instance subsyndromal mood elevation, treatment generally takes place in an outpatient setting. Selection of interventions will generally favor a strategy that starts with the most tolerable intervention and sequentially offers less well tolerated options until therapeutic results are achieved. This is analogous to beginning the treatment of mild hypertension with diet and exercise.

For patients with more severe symptoms, for instance inpatients with acute mania, preference is given to strategies that maximize immediate safety and offer rapid restoration of behavioral control. While monotherapy is an attractive option for practical reasons, several recent studies of acute mania find a significant advantage for combined treatment with a mood stabilizer and an antipsychotic medication compared with monotherapy with either class of medication. Furthermore, for the strata of extremely ill patients, there is a premium on reaching an effective dose of each medication as quickly as tolerable. Evidence from clinical trials suggests acutely manic patients tolerate more aggressive dosing strategies than less severely ill outpatients.

No. 14E
DEALING WITH COMMON PROBLEMS DURING ONGOING TREATMENT IN BIPOLAR DISORDER

W. Gordon Frankle, M.D., *1051 Riverside Drive, Unit #2, New York, NY 10032*

SUMMARY:

This talk will review the various difficulties that arise during the maintenance treatment of bipolar disorder. Specific attention will be given to common issues for which consultations are requested. These include the management of common side effects arising during treatment with mood stabilizers as well as the management of subthreshold symptoms. It is not uncommon for individuals with bipolar disorder who have recovered from a mood episode to develop symptoms that fall short of the DSM-IV criteria for either depression or mania/hypomania. One of the most difficult issues facing the clinician is whether or not to intervene when these subthreshold symptoms arise. This talk will review the relevant literature on this topic as well as discuss strategies for choosing an intervention to address these symptoms.

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INDUSTRY-SUPPORTED SYMPOSIUM 15—THE AGING BRAIN AND VULNERABILITY TO DEPRESSION
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be provided a framework for understanding why depression in the elderly differs in clinical features, biology, and treatment response from major depression as seen in younger patients.

No. 15A
AGE, NEUROBIOLOGY, AND TREATMENT RESPONSE

Madhukar H. Trivedi, M.D., *5959 Harry Hines Boulevard, Suite 600, Dallas, TX 75235-9101*

SUMMARY:

Risks of depression vary across the life span and there is evidence that age affects the symptomatic expression of depressive syndromes and, perhaps, response to specific therapies. For example, prior to age 40 the so-called reverse vegetative symptoms (overeating, weight gain, and oversleeping) are not so atypical and may reflect the brain's capacity to respond to the chronic stress via serotoninergically mediated, conservative adaptations. With aging and repeated bouts of affective illness, however, these inhibitory response systems appear to become dysfunctional and there is evidence of dysregulated or exaggerated central nervous system stress responses (e.g., loss of deep sleep, hypercortisolemia, and increased limbic glucose metabolism). These neurobiological correlates are more typically observed among patients with melancholia. Individual differences in vulnerability, including systemic disease (e.g., diabetes or hypertension), heredity, and exposure to various forms of trauma can accelerate this process. Decreasing estrogen levels also may hasten the shift toward melancholia among perimenopausal women. This model predicts that the benefits of selectively serotominergic medications are greatest earlier in life and that medications that affect noradrenergic or peptidergic systems may be more advantageous in later life. Evidence for and against an "age-informed" model of differential therapeutics will be examined.

No. 15B
THE IMPACT ON COGNITION OF PHARMACOLOGICAL TREATMENT FOR LATE-LIFE DEPRESSION

Ruth O'Hara, Ph.D., *401 Quarry Road, C-305, Stanford, CA 94305;* Alan F. Schatzberg, M.D.; Greer M. Murphy, M.D.

SUMMARY:

While impairment in cognitive function is a noted concomitant of late-life depression, little is known about the impact of pharmacological treatments for depression on cognitive function in the elderly. Yet, enhanced cognition in depressed elderly could have significant benefits for functional behaviors, quality of life, and medication and treatment compliance. We report on the findings of a double-blind, randomized, multicenter investigation of 255 subject 65 years and older, with major depression, treated with mirtazapine or paroxetine. Cognitive performance on measures of attention, information processing, visuo-spatial ability, visual and verbal memory, and executive function was assessed at baseline, eight weeks, and 24 weeks. Modest improvements in cognition were observed. Also, our findings suggest that APOE genotype may moderate the impact of treatment on attention. Methodological considerations for our and other investigations of the impact of pharmacological treatment on cognitive performance are discussed. Additionally, we will provide a comprehensive review of the cognitive impairments often associated with geriatric depression, the cognitive domains most affected, the variability in cognitive function according to the subtype, severity and onset of depression, the neurophysiological basis speculated to underlie these impairments, and the impact of depression-associated cognitive impairments on treatment and prognosis in older depressed patients.

No. 15C
PHARMACOGENETICS IN GERIATRIC DEPRESSION

Greer M. Murphy, M.D., *MSLS P-104 Psychiatry Neuroscience Lab, Stanford, CA 94305-5485*

SUMMARY:

Prediction of antidepressant response in individual patients based on DNA sequences holds great promise for clinical psychiatry. In elderly depressed patients a method for identifying those individuals at risk for medication side effects or for poor therapeutic response would be especially valuable. However, the practical association of genetic variants with drug efficacy and tolerability is not straightforward. Pharmacogenetic trials designed to identify markers for drug tolerance and efficacy are complicated by issues of informed consent, ethnic differences in the frequency of genetic variants, and the difficulties in assigning patients to treatment groups based on genetic profile. Technologies for determining genotypes at hundreds of polymorphic loci in large numbers of patients are currently available, but data analytic methods for testing the reliability of genotype-clinical associations are not well developed. Nevertheless, studies performed to date have demonstrated that genetic markers can be used to predict plasma drug levels, side effects, and efficacy of certain antidepressants in elderly patients. Results from large-scale pharmacogenetic trials in the elderly will be reviewed and implications for practice will be discussed.

No. 15D
TREATMENT OF THE DEPRESSED: OLD-OLD IN OUTPATIENT AND LONG-TERM CARE SETTINGS

Steven P. Roose, M.D., *1051 Riverside Drive, Box 98, New York, NY 10032*

SUMMARY:

The age group over 80 is the most rapidly growing segment of the population. The prevalence of depression and the association with increased mortality in patients with medical illness and in people living in residential facilities, make it compelling that we develop effective treatment for depression in this age group. Unfortunately, there is a paucity of data on treatment of depression in the "old-old." The narrow inclusion and exclusion criteria in most randomized clinical trials exclude many older patients because of comorbid medical conditions, concomitant medication use, or cognitive impairment.

Recently, two large studies have contributed to our knowledge in this area. In the largest RCT to date in patients over the age of 75, 178 patients meeting DSM IV criteria for MDE, baseline HRSD ≥ 20 and MMSE ≥ 18, were randomized to citalopram or placebo in an eight-week trial. Completion rate was 82%. The rates of response and adverse events are currently being analyzed and will be presented.

An open trial of mirtazapine has been conducted for treatment of depression in a long-term care facility. In this study, long-term care residents 70 and older, with a diagnosis of depression and MMSE ≥ 10 are treated with mirtazapine in an open-label, 12-week trial. This study uses a novel assessment procedure in which efficacy was evaluated by a composite HRSD and CGI improvement scale contributed to by all the caregivers involved in the patient care (e.g. day/night nurse, activity therapist, etc.). Results of this study will also be presented.

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INDUSTRY-SUPPORTED SYMPOSIUM 16—LONG-TERM MANAGEMENT OF MOOD DISORDERS
Supported by Cyberonics, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the evidence for the longer term efficacy of medication, electroconvulsive therapy, psychotherapy, and vagus nerve stimulation in the management of mood disorders and consider the implications of this evidence for developing both an acute and a long-term treatment plan for chronic/recurrent mood disorders.

No. 16A
DOES MEDICATION CHANGE THE LONG-TERM COURSE OF MOOD DISORDERS?

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

SUMMARY:

It is now virtually certain that people with recurrent depression who respond to antidepressants will have a better chance of sustained recovery if they remain on antidepressant medication. It is also a fact that between 40% and 60% of these same people will suffer a relapse or recurrent episode of depression within six months of stopping an effective antidepressant. Even a 50% reduction in antidepressant dose has been associated with a significant increase in relapse risk. The risk of post-discontinuation relapse appears to be relatively constant across the first 18 months of recovery and might even persist across years of maintenance therapy. By contrast, those who remain on active maintenance therapy face a steady risk of relapse/recurrence of about 5% to 10% per year *if* there is good adherence.

When considered together, these data indicate that maintenance antidepressant with currently available medications will improve the long-term course of recurrent depression as long as the treatment is provided and accepted. However, prophylactic pharmacotherapy has no enduring benefits once treatment is stopped. Analogous to pharmacotherapy of hypertension, adherence to maintenance antidepressant therapy is the cornerstone of long-term risk reduction.

It is not known if the risk of post-discontinuation relapse declines after five, 10, or 15 years of successful prophylaxis. Therefore, until more truly curative treatments are developed for recurrent depression, antidepressants should never be stopped without a clear-cut justification and, whenever possible, medication should be slowly tapered downward.

No. 16B
DOES PSYCHOTHERAPY CHANGE THE LONG-TERM COURSE OF MOOD DISORDERS?

Robin B. Jarrett, Ph.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-9149*

SUMMARY:

The early studies of cognitive therapy, behavior therapy, and interpersonal psychotherapy were designed to evaluate, rather intensive,

"short-term therapy" over a 10 to 16 week acute phase. Most studies showed the therapies reduced symptoms of adults with major depressive disorder. Naturalistic follow-up studies, using varied methods, produced a wide range of relapse and recurrence rates raising questions about what influences durability and how best to optimize the longer-term effects of these psychotherapies. Where the data were positive, innovators have adapted these therapies, for new populations such as depressed elders, children, adolescents, and adults with specific unipolar subtypes and bipolar illness.

The review will focus on randomized controlled trials that evaluate continuation and maintenance phase psychotherapy following acute phase psychotherapy, pharmacotherapy, and combination therapy for unipolar and bipolar depression. The implications of these data for addressing where psychotherapy fits in the long-term management of mood disorders will be discussed.

No. 16C
DOES ECT ALTER THE LONG-TERM COURSE OF MOOD DISORDERS?

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

SUMMARY:

Electroconvulsive therapy (ECT) is widely considered the most effective treatment for major depression. However, several issues remain about its effects on the long-term course of mood disorders. First, like other antidepressants, ECT can provoke hypomania or mania. This presentation will address the relative incidence of this phenomenon and its clinical management. Second, while ECT produces high rates of remission, there is concern that relapse rates are high with conventional continuation therapy, suggesting only a temporary benefit from ECT. Progress in preventing relapse following ECT will be reviewed, focusing on new strategies to sustain remission. Third, there has been controversy regarding potential long-term effects of ECT in suicide prevention. Generally, the evidence indicates that ECT has a rapid beneficial effect on suicidality, but no long-term effect. In contrast, there is evidence that ECT exerts a positive long-term effect on overall rates of mortality. Finally, the issue has been raised that ECT accelerates depressive illness, resulting in a shortening of the period between episodes. It will be argued that the evidence in support of this view is flawed, and that most likely patients who receive ECT have the most severe form of mood disorders, which at times shows an accelerating course.

No. 16D
VAGUS NERVE STIMULATION FOR DEPRESSION: METHODS AND MECHANISMS

Mark S. George, M.D., *52 President Street, Roomn 502 North 10P, Charleston, SC 29425*

SUMMARY:

Vagus nerve stimulation (VNS) has been a research tool for almost 70 years. In 1982, scientists discovered that stimulating the vagus nerve in the neck could abort a seizure. Today, well over 10,000 patients with epilepsy have the FDA-approved NeuroCybernetic Prosthesis (NCP) implanted for seizure control. Several lines of evidence have suggested that VNS also has beneficial effects on pathological mood and anxiety disorders. The sensory fibers in the vagus nerve coming from the viscera terminate in several key brain regions long implicated in mood regulation (e.g., locus ceruleus, amygdala, hypothalamus, orbitofrontal cortex). VNS studies in animal models of epilepsy and depression, along with human studies of CSF and brain activity (measured by PET and fMRI), all converge on the idea that stimulation of the vagus nerve is an important new way to alter the pharmacology and behavior of the visceral/emotional brain. Recent open acute study results of 59 patients with mood disorders characterized by a recurrent or chronic course and inadequate unsustained responses to prior treatments revealed a 30% response rate (≥50% reduction in baseline HRS-D_{28} total score) and substantial functional improvement. If available, additional acute phase findings will be presented.

No. 16E
DOES VAGUS STIMULATION CHANGE THE LONG-TERM COURSE OF MOOD DISORDERS?

Lauren B. Marangell, M.D., *6655 Travis, Suite 560, Houston, TX 77030*

SUMMARY:

Vagus nerve stimulation (VNS) is currently being evaluated in a randomized, controlled, double-blind trial for treatment-resistant depression. However, ongoing open-trial data are available that describe the course of medication-resistant mood disorders treated with VNS. As reported by Rush et al (2000), after 10 weeks of fixed dose VNS, the response rate was 40% (50% reduction in $HRSD_{28}$ scores) in the initial cohort of 30 patients. We recently evaluated the naturalistic outcome data from this cohort following an additional nine months of VNS treatment. The response and remission rates increased 46% and 29%, respectively, after the additional nine-months of longer-term VNS. There were significant additional improvements in function, as measured by several Medical Outcomes Study (MOS) Short Form-36 (SF-36) subscales. Acute study responders had near normal emotional role, physical function, physical role, social function, general health, and mental health SF-36 subscale scores after nine months of continued VNS treatment. Additional longer-term symptomatic and functional outcomes of VNS will be described, based on all available open-trial data. If ongoing improvement is noted with longer-term VNS, the use of chronic intermittent stimulation of the central nervous system, as occurs with VNS, might be of mechanistic and clinical importance for the development of novel treatments

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INDUSTRY-SUPPORTED SYMPOSIUM 17—THE ADHERENCE CHALLENGE: CHRONIC ISSUES AND EMERGING SOLUTIONS WITH ANTIPSYCHOTIC THERAPY
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with rates of nonadherence in psychotic disorders and con-

tributing factors. Attendees will also be familiar with data on long-acting injectable medications and their potential role in facilitating adherence and enhancing outcome.

No. 17A
APPROACHING THE ADHERENCE CHALLANGE

Stephen R. Marder, M.D., *11301 Wilshire Boulevard, Building 210A, Los Angeles, CA 90033;* Donna A. Wirshing, M.D.; William C. Wishing, M.D.

SUMMARY:

As many as 30%, and perhaps an even higher proportion of patients with schizophrenia, have serious problems with medication adherence. Moreover, there is evidence that noncompliance with medication regimes may be the most common reason for rehospitalization in schizophrenia. This report will focus on factors that can contribute to nonadherence such as medication side effects, lack of insight, substance abuse, and an inadequate continuity of care. A number of interventions have been found to improve adherence. Pharmacological approaches include managing medication side effects and the use of long-acting formulations of antipsychotics. Psychosocial approaches include forms of psychoeducation for both patients and families, specialized programs for patients who have comorbid substance abuse disorders, the use of behavioral skills training methods such as the Community Re-entry Module, and intensive case management strategies. The data supporting the effectiveness of each of these methods will be reviewed. Taken together, the findings from controlled studies indicate that there are effective strategies that can be individualized to the needs of patients who are at a high risk for nonadherence.

No. 17B
PHARMACOLOGIC OPTIONS FOR SCHIZOPHRENIA: IMPLICATIONS FOR COMPLIANCE

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

SUMMARY:

The introduction of second-generation or "atypical" antipsychotics has provided a range of valuable new treatment options to enhance efficacy, tolerability, and adherence. Despite these advances nonacceptance and nonadherence of optimum treatment recommendations pose a serious challenge and have enormous public health implications.

Though there are clear advantages to long-acting antipsychotic medications, they have not been widely utilized in the U.S. Contributing factors may include the side-effect profiles of these drugs. A typical antipsychotics have been associated with lower relapse rates than conventional antipsychotics. The availability of a new generation antipsychotic in a long-acting alternative should go a long way toward taking better advantage of this option.

Many clinical trials have had difficulty determining the potential benefits of long-acting medications because they were not utilized under "real world" circumstances. The appropriate consideration and utilization of this approach requires an optimum patient clinician relationship.

No. 17C
RESEARCH EXPERIENCE WITH A LONG-ACTING ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Samuel J. Keith, M.D., *2400 Tucker N.E., Suite 404, Albuquerque, NM 87131*

SUMMARY:

Long-acting antipsychotics have the potential to improve treatment adherence, which helps to sustain symptom remission, prevent relapse, and improve level of functioning in patients with schizophrenia and related disorders. Specific treatment protocols that maximize this potential are still under investigation. The effect of different dosing strategies of fluphenazine decanoate in conjunction with family intervention was assessed in a large, multicenter, randomized, double-blind study. Acutely ill patients (N = 528) were enrolled; 313 stable patients were then randomized to receive one of two family interventions and either a continuous low dose (2.5–10 mg), standard dose (12.5–50 mg), or targeted dose (vehicle), delivered by injection every two weeks for two years. Rescue medication and relapse were more frequent with low-dose and targeted therapy, while rehospitalization was increased only with targeted therapy. There were no differences between family interventions.

The first long-acting newer antipsychotic, a microspheres formulation of risperidone, has now been evaluated in Phase III trials. Data from a 12-week study in patients with schizophrenia and schizoaffective disorder show that this formulation was effective and well tolerated. As it appears to offer the same advantages as the newer oral antipsychotics, this medication may have increased potential to improve treatment adherence and overall outcome.

No. 17D
VIEWS FROM THE NURSING PERSPECTIVE: PROBLEMS AND SOLUTIONS

Kathleen Jarboe, R.N., *1903 North Druid Hills Road, Atlanta, GA 30319*

SUMMARY:

As nurses who treat individuals taking antipsychotic medications, we are keenly aware of the problems associated with patient compliance. New medications are being constantly developed and introduced that not only offer effective treatment to many who had not responded earlier in their lives, but also offer hope to patients and families. And yet something is still missing. Can we eliminate the three-way medication struggle between patients, family members, and clinicians? This presentation will explore the general compliance issues dealt with by nurses, and the possibility of successfully altering negative experiences associated with antipsychotic medications. Information and clinical experience with the administration of a new long-acting formulation of risperidone, including patient acceptance and concerns, staff training, and other topics will be presented. Finally, can nurses and patients form a collaborative alliance through patient and family education, understanding, and emotional support to improve the quality of life for patients?

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INDUSTRY-SUPPORTED SYMPOSIUM 18—CHALLENGES AND OPPORTUNITIES IN THE MANAGEMENT OF PSYCHOTIC DISORDERS

Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the challenges and opportunities in the management of psychotic disorders

No. 18A
INTERVENING EARLY IN THE EVOLUTION OF SCHIZOPHRENIA: NEED FOR NOVEL APPROACHES DURING THE PRODROMAL PHASE

Patrick D. McGorry, Ph.D., *35 Popular Road, Parkville Victoria, Australia 3052;* Lisa Phillips, M.S.C.; Alison R. Yung, M.D.; Paul Amminger, M.B.; John Koutsogiannis, M.D.; Jannine Ward, B.A.; Phillipe Conus, M.D.

SUMMARY:

Most episodes of first-episode psychosis, especially nonaffective psychosis, are preceded by a phase that, in retrospect, can be labeled "prodromal." This period is typically lengthy and is associated with substantial disability and a disruption to lifestyle and life trajectory. However, the symptom picture is typically subtle and confusing, characterized by multiple comorbidities and nonspecific features. It is usually clear that the person presenting to the clinician, or alternatively languishing at home and of great concern to relatives, is clinically compromised. The dilemma becomes what can be done; how to do it; and, what is happening biologically during the transition.

To create a situation in which accurate predictors and markers of transition to psychosis can be identified, requires the creation of a two-stage strategy. Criteria must be developed that "enrich" the level of risk substantially so that secondary predictors can be "identified." Ultra high-risk (UHR) criteria as well as several secondary features have been defined based on a series of studies, which have increased the power and characterization of the predictors. A positive predictive value of 0.8 has been achieved in a sample of 104 UHR cases. Given this very high level of symptoms, disability, and risk, the questions become (1) What interventions should be considered? and (2) How do they impact on the early course of illness? Psychosocial strategies are relatively safe, well accepted, and have a definite place. Biological treatments, including atypical antipsychotics and neuro-protective agents, may prove to have a crucial role. Emerging evidence in relation to treatment efficacy will be presented as well as neurobiological data.

No. 18B
NEW ADVANCES IN SCHIZOPHRENIA PHARMACOTHERAPY: MANAGEMENT OF ACUTE EPISODES

Diana O. Perkins, M.D., *101 Manning Drive, Campus Box 7160, Chapel Hill, NC 27599*

SUMMARY:

The treatment of schizophrenia has made several important advancements. Since their introduction, atypical antipsychotic medications result in fewer side effects than conventional neuroleptics and they have broader efficacy. Research on first-episode psychosis has shown that the initial treatment intervention is a critical opportunity to influence the long-term course and outcome of the illness. Studies have demonstrated improved outcomes with shorter durations of psychosis and fewer relapses. These studies present compelling arguments for early and adequate treatment.

A first episode of psychosis typically causes great distress with treatment contact often being precipitated by a crisis. Initial clinical interactions are directed at reducing the patient's acute distress. The immediate goal of pharmacologic therapy is a reduction of the acute psychotic symptoms. Unlike chronic schizophrenia, appropriate pharmacological treatment of the first episode of schizophrenia typically requires lower doses of medication. Complete or near complete symptom remission can be expected, although the time course for symptom response varies. Long-term maintenance treatment will reduce the risk of relapse and of the patient developing disabling chronic symptoms. An important treatment goal is to minimize persistent medication side effects in order to maximize maintenance treatment adherence. During this presentation, I will review strategies for optimizing and individualizing pharmacological and psychotherapeutic interventions for first episode and acute exacerbations of psychosis.

No. 18C
IMPROVING LONG-TERM OUTCOMES IN PATIENTS WITH SCHIZOPHRENIA

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

SUMMARY:

Historical Overview: Treatment priorities for patients with schizophrenia have evolved since the discovery of effective antipsychotic medications during the 1950s. We learned in the 1960s about the need for maintenance medication to prevent relapse; in the 1970s, we recognized the burden of EPS and TD; in the 1980s, we renewed our awareness of negative symptoms; and, in the 1990s, we were introduced to the "atypical" antipsychotics. These newer medications have helped solve many treatment problems (eg, the burden of EPS), but, in turn, have focused attention to other kinds of outcomes that had not previously been a high priority for most clinicians.

Better cognitive functioning as a new priority: There will be more of a focus on cognitive problems. New outcome data show that persistent cognitive problems are often the limiting factor in preventing patients from "getting their life back." The presentation will cover new pharmacologic and psychosocial methods for helping improve cognitive functioning.

Better physical health as a new priority: The limitations of older medications made it very hard for clinicians to address medical risk factors. Now, as treatments improve, excess medical morbidity and mortality is becoming a major public health concern. The newer medications can be a two-edged sword. They can help patients reduce certain high-risk behaviors (eg, cigarette smoking) but may exacerbate others (eg, obesity). During this presentation, I will discuss new data on the relationship between the newer antipsychotics and medical outcomes.

Summary: The current treatment advances have solved some problems but have opened the door to new challenges. Clinicians can incorporate these newer outcome priorities in helping their patients live more fulfilling and longer lives.

No. 18D
THE IMPACT OF SAFETY AND TOLERABILITY ON PATIENTS SATISFACTION WITH THERAPY

Joseph P. McEvoy, M.D., *1003 12th Street, Building 32, Butner, NC 27509-1695*

SUMMARY:

In psychiatry, how a patient's quality of life is defined and measured has been approached in many different ways. Objective measures have focused on either general standards of living (levels of sustenance and security) provided by patients' environments or on the richness of patients' social networks and daily activities. Subjective measures have focused on patients' reports of satisfaction with their lives.

For patients above the threshold for poverty, as defined by the United Nations, general standards of living are not significantly related to subjective reports of satisfaction with life. Among patients treated with conventional antipsychotics, the severities of persistent psychopathology and of unwanted side effects (in particular, extrapyramidal side effects) have been the most powerful determinants of reported dissatisfaction. Only if these medication-related issues can be successfully managed do social interactions and daily activities contribute significantly to an improved subjective quality of life. In reality, the objective and subjective aspects of quality of life are indeed related and both need to be assessed and addressed.

During this presentation, I will briefly review the available measures of quality of life for patients with schizophrenia, focusing upon their relative capacities for addressing objective standards of living, social interactions, and daily activities, as well as on their ability to measure subjective satisfaction. Recent studies examining quality of life among patients treated with first-generation, novel antipsychotics will be discussed, with particular attention being paid to the questions: (1) Do patients treated with these drugs report more subjective satisfaction than patients treated with the older, conventional antipsychotics? and, (2) Do the different, but still important, side effects and safety issues related to the first-generation, novel antipsychotics, (eg, weight gain, sexual dysfunction) affect a patient's quality of life?

No. 18E
MECHANISM OF ACTION AS PREDICTOR FOR CLINICAL UTILITY: LESSON FROM SCHIZOPHRENIA RESEARCH

Jeffrey A. Lieberman, M.D., *Room 7025, Neurosciences Hospital, CB7160, Chapel Hill, NC 27599*

SUMMARY:

Much remains to be learned about the etiology and pathophysiology of schizophrenia, yet the efficacy of treatments for this disorder has been clearly demonstrated. Although all available treatments have limitations in their effectiveness and are associated with adverse side effects, it has been established that antipsychotic medications can alleviate the psychotic symptoms of the disorder and prevent their recurrence. Moreover, in doing so, antipsychotic drug treatment, strategically used, appears to reduce the degree of clinical deterioration that occurs from progression of the illness.

Until recently, most pharmacologic treatments for schizophrenia were based on synaptic modulation of dopamine neuronal systems mainly by antagonism of postsynaptic D_2 receptors. With the advent of the novel antipsychotics, this focus has broadened to include other neurotransmitters as well as neuropeptides and neurosteroids. These compounds have either low ratios of affinities for the D_2 and 5-HT_{2A} receptors or possess affinities for some combination of multiple neuroreceptors and reuptake sites. At present, all effective treatments appear to possess some threshold level of D_2 receptor antagonism. Schizophrenia researchers have historically used pharmacology in a bootstrap approach to simultaneously develop treatments and pathophysiological disease models. This productive process of cross-fertilization continues as we see experimental treatments and drug development strategies derive from the results of the emerging neuroscience of schizophrenia. These research findings provide new opportunities and new challenges to understanding and treating schizophrenia. During this presentation, I will discuss the mechanism of actions of novel antipsychotics and discuss how a drug's profile may affect the selection of an appropriate agent.

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INDUSTRY-SUPPORTED SYMPOSIUM 19—TREATMENT OF ANXIETY DISORDERS: WHERE ARE WE, AND WHERE ARE WE GOING? Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the prevalence of comorbid conditions and their clinical implications in anxiety disorders; the management of depression and sleep disturbance in the patient with anxiety disorder; the impact of anxiety disorders on patients' quality of life; and the efficacy and tolerability of current and investigational therapies for anxiety.

No. 19A
COMORBIDITIES AND ISSUES TO CONSIDER IN THE MANAGEMENT OF ANXIETY DISORDERS

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

SUMMARY:

Anxiety disorders are the most common psychiatric disorders in the United States. More than 23 million people are afflicted by these debilitating illnesses each year, approximately one out of every four individuals, yet they remain underdiagnosed and undertreated. The anxiety disorders are also highly correlated with one another, and approximately one-quarter to one-half of individuals with each of the anxiety disorders report a lifetime history of an alcohol or substance use disorder. Anxiety disorders rarely exist alone, with several studies reporting that more than 90% of individuals with anxiety disorders have a lifetime history of other psychiatric problems. Anxiety disorders are frequently comorbid with depression, panic disorder, social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, and alcohol and other substance abuse. These disorders often present in the primary care setting, commonly with somatic symptoms; therefore, it is important for primary care physicians to be aware of their prevalence. Comorbidity among anxiety disorders is associated with greater symptom severity and a considerably higher incidence of suicidality. This presentation will address the prevalence of anxiety disorders, the rates of recognition, and the diagnostic difficulties associated with their comorbidities.

No. 19B
MANAGEMENT OF DEPRESSION AND DEMORALIZATION IN ANXIETY DISORDERS

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

SUMMARY:

Depression occurs commonly in patients with primary anxiety disorders. The presence of comorbid depression has been associated with higher levels of distress, greater impairment in quality of life, and higher risk of suicide than uncomplicated anxiety disorders. The presence of more than one anxiety disorder may further impair function and outcome. Chronic anxiety symptoms can also be associated with feelings of shame, frustration, and demoralization, which may worsen the patient's ability to function in work or school settings and potentially interfere with treatment seeking and compliance. Thus, it is critical to screen anxiety patients for comorbid disorders, particularly mood disorders, and to aim treatment at the full spectrum of symptoms present. Such comprehensive treatment is necessary to achieve a full remission of symptomatology, improve quality of life, and reduce morbidity, including risk of suicide. This presentation will address the prevalence of depression and other comorbidities across the spectrum of anxiety disorders and focus on effective diagnosis and management strategies for this condition.

No. 19C
MANAGING THE DISORDERED SLEEP ASSOCIATED WITH ANXIETY AND MOOD DISORDERS

John W. Winkelman, M.D., *1400 Center Street, Suite 109, Newton Center, MA 02459*

SUMMARY:

Sleep difficulties and mood/anxiety disorders are inextricably entwined. Untreated insomnia and hypersomnia have been repeatedly shown to be predictive of new-onset depressive episodes and anxiety disorders. Once such disorders develop, they are present in roughly 80% of patients with mood disorders and about half of those with an anxiety disorder. Unfortunately, treatment with antidepressant agents may precipitate sleep difficulties in up to 15% of patients. During the course of treatment of depression with an SSRI, hypersomnia and insomnia are the most common refractory symptoms. However, sleep deprivation may either alleviate depression or precipitate mania in individuals with bipolar disorder. Finally, the most common type of chronic insomnia, psychophysiologic (or conditioned) insomnia is, in effect, an anxiety disorder, characterized by somatic and cognitive hyperarousal. These connections suggest that psychiatrists should pay sufficient attention to sleep complaints among their anxiety and mood disorder patients and aggressively treat them. This presentation will address the prevalence and morbidity of sleep disorders, discuss the specific features of sleep disorders that predict risk, and outline the appropriate behavioral and pharmacological management of these disorders.

No. 19D
GAD: LONG-TERM TREATMENT TO IMPROVE OUTCOME

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

SUMMARY:

An expanding body of research as well as extensive clinical experience suggests that generalized anxiety disorder (GAD) is a typically chronic condition associated with significant distress, morbidity, and dysfunction. With onset relatively early in life, GAD may exert a pernicious influence over the lives of affected individuals for decades. Longitudinal studies in the past of patients receiving naturalistic treatment reported rates of recovery for GAD lower than that seen in major depression; moreover, many who recovered ultimately relapsed. Labeling and recommendations to use benzodiazepines for short-term treatment did not resonate with the empiric data and clinical observation demonstrating the chronic nature of anxiety. In addition, with the growing recognition of the frequent comorbidity of anxiety and depression and the availability of a new generation of better tolerated agents, there has been a gradual shift toward greater use of the newer antidepressants for GAD. A number of large randomized, controlled studies demonstrate the efficacy of venlafaxine XR, as well as paroxetine, for the treatment of GAD, both acutely and over the long term. Rates of recovery increase over time; severely ill patients may achieve comparable rates of improvement to mildly ill individuals, after long-term treatment. Thus, maintenance treatment over the long term may be critical to optimize outcome for patients with GAD. In addition, a variety of other pharmacologic and psychosocial strategies can improve long-term outcome and will be discussed.

No. 19E
CURRENT AND FUTURE TREATMENTS FOR ANXIETY: EFFICACY AND TOLERABILITY

R. Bruce Lydiard, M.D., *1 Poston Road, Suite 150, Charleston, SC 29407*

SUMMARY:

There is increasing awareness of the importance of optimal treatment of anxiety. Based on recent epidemiological studies, anxiety disorders, commonly precede and represent a risk factor for developing comorbid major depression and additional anxiety disorders. Substantial evidence suggests that these comorbid states confer more disability, chronicity, and resistance to treatment. Women appear to be at approximately twice the risk for pre-existing anxiety than men, which explains why the risk for major depression in women is greater than in men. Up to 40% of patients with only one disorder fail to respond to any particular agent, and of those who do respond, a substantial number derive only short-term benefits. Remaining problems with current anxiolytics include unwanted side effects and a limited range of efficacy across the anxiety-depression spectrum. Thus, there is a critical need for the development of new anxiolytics that provide greater short- and long-term efficacy and/or better tolerability in the treatment of both uncomplicated anxiety, and anxiety that co-exists with other psychiatric or medical conditions. Several clinical trials, which are currently underway, are examining novel therapeutic strategies to treat anxiety disorders. With an emphasis on generalized anxiety disorder, this presentation will review the efficacy and safety of current therapies as well as give an update on new treatments in the pipeline.

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INDUSTRY-SUPPORTED SYMPOSIUM 20—ATYPICAL DEPRESSION: OVERVIEW AND NEW DEVELOPMENTS

Supported by Somerset Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, attendees will be able to discuss the neurobiology, characteristics, diagnosis, and treatment of atypical depression. The attendee will recognize new diagnostic findings, and new agents in development for the treatment of atypical depression.

No. 20A
THE BIOLOGY OF ATYPICAL DEPRESSION

Ranga K. Krishnan, M.D., *Box 3950, Durham, NC 27710*

SUMMARY:

Emerging evidence indicates that atypical depression may have a characteristic biology. New data from studies of twins indicate that atypical depression may be categorized as a distinct subtype of depression.

Other data indicate that the symptoms of atypical depression are associated with concomitant hypofunction of the corticotropin releasing hormone (CRH) and norepinephrine (NE) systems. When compared with patients diagnosed with other forms of depression, patients with atypical depression exhibit a significant difference in cortisol response to desipramine injection. In addition, depression has been associated with both suppression and enhancement of various aspects of immune function. In a study of patients with atypical depression, plasma ACTH levels were elevated and cortisol levels were reduced when compared with those in a control population. Interleukin-2 (IL-2) production was reduced, but to a smaller extent, among patients with atypical depression when compared with patients diagnosed with classic major depression or dysthymia. Interestingly, IL-2 production in the depressive groups was directly related to plasma NE levels. Unlike the pathophysiology observed in melancholic depression, atypical depression is associated with a series of biological changes that are inverse to those of typical depression. The possibility of different treatment modalities for atypical depression is thus raised.

No. 20B
THE BIOLOGY OF PTSD AND ATYPICAL DEPRESSION: THE ROLE OF EARLY-LIFE TRAUMA

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

SUMMARY:

Numerous lines of research have documented the importance of hyperactivity of the hypothalamic-pituitary-adrenal (HPA) system in the pathophysiology of mood and anxiety disorders. Preclinical investigations have shown that exposure to stressful conditions during the early postnatal period followed by normal rearing conditions into adulthood induces long-lasting changes in laboratory animals, manifested by increased behavioral and HPA responsivity to stressful stimuli in adulthood. Biologic findings in animals exposed to early stress resemble the abnormalities observed in the HPA axis of individuals with major depression, while the exaggerated behavioral response to a stressful "trigger" seen in these adult animals is reminiscent of posttraumatic stress disorder (PTSD) in humans.

Recent research efforts have been designed to translate hypotheses from these animal studies to relevant investigations in humans. While the biology of PTSD in human patients exposed to adulthood is less consistently characterized, an emerging body of research suggests that HPA axis hyperactivity, presumably due to hypersecretion of corticotropin-releasing factor (CRF), is a persistent consequence of exposure to significant stress during childhood. Similarities and differences in the biology of PTSD and atypical depression will be reviewed, with special focus on the role of early trauma in the predisposition for development of adult psychopathologic conditions.

No. 20C
DIAGNOSTIC ISSUES IN ATYPICAL DEPRESSION

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

SUMMARY:

Although incorporated into DSM-IV as a feature specifier of major depression, atypical depression exhibits a broader manifestation in the clinical setting. Characterized by mood reactivity and reverse vegetative symptoms of hyperphagia, hypersomnia, and leaden paralysis, atypical depression should be considered as part of the differential diagnosis in patients presenting with a major depressive disorder.

The use of psychometric instruments, such as Ham D-21 and -29 (-21 item scale plus 8-item addendum for atypical symptoms), the Inventory for Depressive Symptomatology (self-report and clinician-rated), the Columbia Atypical Depression Diagnostic Scale, SADS, and ISI will be discussed. The effects of demographic, clinical, and family variables will be addressed. Specific diagnostic measures, including new developments in neurobiology, to differentiate atypical depression from other psychiatric conditions will be discussed.

No. 20D
PSYCHOTHERAPY IN THE TREATMENT OF MAJOR DEPRESSION

Barbara O. Rothbaum, Ph.D., *1365 Clifton Road, NE, Atlanta, GA 30322*

SUMMARY:

Psychotherapy, alone or in combination with pharmacotherapy, is an integral part of the treatment of depressed patients. Cognitive-behavioral therapy for the treatment of major depression has been extensively studied; more than 80 trials have been conducted in the past 20 years. A 1999 study of 108 patients with atypical depression found that treatment with cognitive therapy or pharmacotherapy were equally efficacious.

This session will focus on the cognitive-behavioral-analysis system of psychotherapy as a treatment for atypical depression. This analysis system utilizes behavioral, cognitive, and relationship techniques used in other forms of psychotherapy; patients are taught to focus on behavioral consequences and to use problem-solving algorithms to attempt to resolve interpersonal conflicts. A study of patients with chronic depression treated with nefazodone, cognitive-behavioral-analysis, or both, found that response rates of the monotherapies were equivalent; however, the combination was significantly more efficacious. Innovations in the treatment of depression-related anxiety, such as the use of virtual reality (VR), also will be discussed.

No. 20E
NEW TREATMENTS FOR ATYPICAL DEPRESSION

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

SUMMARY:

Monoamine oxidase inhibitors (MAOIs) and selective serotonin reuptake inhibitors (SSRIs) have been the treatments of choice for atypical depression. Guidelines recommend their use as first-line pharmacologic therapy. There has been no systematic controlled clinical research to address whether SSRIs and newer antidepressants such as nefazodone, mirtazepine, venlafaxine, or bupropion have efficacy comparable to MAOIs in the treatment of atypical depression. The use of MAOIs has been limited by apprehension of the potential for hypertensive reactions resulting from concomitant ingestion of dietary tyramine or sympathomimetic amines (such as nonprescription decongestants or appetite suppressants). Newer selective reversible inhibitors of monoamine oxidase-A (RIMAs) may offer therapeutic potential, but few studies have been conducted. Patients with major depressive disorder and atypical features demonstrate preferential response to phenelzine compared with imipramine in placebo-controlled trials. Oral administration of selegiline failed to demonstrate significant efficacy in the treatment of atypical depression in a 1989 trial; the authors concluded that the maximum 40-mg daily dose was subtherapeutic. When administered transdermally, however, selegiline shows great promise as an antidepressant agent and offers the potential to deliver CNS-targeted antidepressant doses of selegiline without the potential for dietary tyramine or sympathomimetic interaction. Recent trials of this formulation will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 21—NEW DEVELOPMENTS IN THE TREATMENT OF BIPOLAR DISORDER
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to implement treatment strategies for bipolar illness based on recent guidelines, focusing on acute mania, bipolar depression, maintenance treatment, rapid cycling and mixed mania, and psychosocial issues.

No. 21A
ADVANCES IN THE TREATMENT OF MANIA

Gary S. Sachs, M.D., *15 Parkman Street, WACC 815, Boston, MA 01773*

SUMMARY:

Treating bipolar disorder is complex due to acute episodes of different polarity and longitudinal management of patients with fluctuating severity and widely varying rates of recurrence. Recent guidelines offer a systematic iterative approach to management. The Expert Consensus Guidelines recommend the use of a mood stabilizer in every phase of the illness. This recommendation, coupled with systematic record keeping and mood charting, allows efficient management longitudinally. The initial decision to select a mood stabilizer can often be made in collaboration with the patient. While the efficacy of mood stabilizers appears to be equivalent, the selection most often rests on matching the side-effect profile to an individual patient's needs and preferences.

While monotherapy is theoretically advantageous, most patients will benefit from multiple medications both acutely and prophylactically. Still, not all combinations are supported by equivalent evidence: Combination treatment with mood stabilizers and antidepressants has not been proven more effective than mood stabilizer monotherapy overall. In addition, combinations of mood stabilizers have not been well studied. However, mood stabilizers in combination with antipsychotics have produced consistent robust benefits over mood stabilizer or antipsychotic therapy alone. These therapeutic approaches to the treatment of mania will be discussed.

No. 21B
UPDATE ON THE TREATMENT OF BIPOLAR DEPRESSION

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

SUMMARY:

Most patients with bipolar disorder, especially those with bipolar II, present for treatment with a depression. However, most of the emphasis for treatment of bipolar disorder has focused on mania. The consequence of this is that many patients with bipolar disorder are unrecognized and mistreated. Recently, a number of new developments have occurred to help the clinician in the treatment of depression in patients with bipolar disorder. There are several studies of lamotrigine, suggestive evidence for topiramate, new data on divalproex, and several new studies of new-generation antidepressants, including fluoxetine, citalopram, and venlafaxine. This presentation will overview these new data and will present overall strategies for approaching and managing the patient with bipolar depression.

No. 21C
STABILIZING THE COURSE OF REFRACTORY BIPOLAR ILLNESS: MEETING THE CHALLENGES OF DYSPHORIC STATES AND MIXED MANIA

Patricia Suppes, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Bipolar illness is a severe, heterogeneous disorder that presents clinicians with numerous challenges. Up to one-fourth of bipolar patients may develop rapid-cycling disorder, in which four or more episodes occur within a year. In addition, mixed episodes occur more frequently later in the course of bipolar disorder and often fall conventional treatments. These patients exhibit substantial functional impairment both when in episode and remission, which also can be complicated by a less robust response to treatment. Empirical evidence available to guide treatment decisions will be examined, including careful consideration of drug combinations along with appropriate treatment strategies and their impact on the course of illness. Recent guideline approaches and empirical evidence for the treatment

of rapid-cycling bipolar disorder and mixed episodes will be reviewed.

No. 21D
UPDATE ON PSYCHOSOCIAL TREATMENTS OF BIPOLAR DISORDER

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

SUMMARY:

During the past decade, it has become clear that a majority of patients with bipolar affective disorder have multiple affective episodes and, at the least, periods of significant vocational and psychosocial disability. For such patients, a medication clinic model of care is usually insufficient. Investigators have, therefore, begun to evaluate the role of various forms of psychotherapy as an adjunct to pharmacotherapy. Such therapies have been evaluated in group and individual modalities, and the focus has ranged from psychoeducation and adherence training to family management, interpersonal difficulties, and cognitive models of relapse prevention. There is now sufficient evidence to conclude that the addition of a focused form of psychotherapy can improve the course of bipolar disorder when compared with medication management alone. In this presentation, the common elements of empirically supported psychosocial treatment for bipolar disorder will be reviewed and exemplified, with attention to intervention that can be integrated within standard pharmacotherapy.

No. 21E
THE MULTIPLE GOALS OF MAINTENANCE TREATMENT

Charles L. Bowden, M.D., *7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

SUMMARY:

Earlier views on maintenance treatment for bipolar disorder emphasized prevention of relapse into a manic or depressive episode. With the expanded group of mood stabilizing drugs available, a more ambitious and realistic set of goals aimed at remission and relatively unimpaired social function is needed. Sub-threshold symptoms of bipolar should be kept to a minimum, as these are highly associated with functional impairment. Patients who stop treatment are at high risk of relapse and greatly increased direct and indirect medical costs. Therefore, patients need to be in active, collaborative treatment, and the treatment regimen must be well tolerated. With the expansion of treatments beyond lithium, there has been justified interest in combined drug regimens. One reason for this is that divalproex and lithium appear to benefit principally the manic components of bipolar disorder, whereas lamotrigine may principally benefit depressive components. Similarly, though less well studied, antipsychotic drugs and other drugs with a role in bipolar, may have benefits limited to one or two dimensions of this complex disorder. Psychiatrists need to avoid unwarranted complex medication combinations which may worsen side-effect burden, reduce the likelihood of benefit due to competing drug properties, and complicate the assessment of the patient.

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INDUSTRY-SUPPORTED SYMPOSIUM 22—TREATMENT OF MOOD AND ANXIETY DISORDERS IN WOMEN: WHAT IS EVIDENCE AND WHAT IS ART? Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

At the end of the symposium, the audience should have an increased understanding of the components of treatment for women with mood and anxiety disorders that are evidence based.

No. 22A
TREATMENT OF MOOD DISORDERS IN PREGNANCY AND THE POSTPARTUM PERIOD

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

SUMMARY:

Major depression is a highly prevalent illness and is twice as common in women compared with men. Depression clusters during the childbearing years despite clinical lore that pregnancy is a time of emotional well-being for women providing protection against psychiatric disorder. Data supporting this impression are sparse. In fact, a growing body of evidence suggests that women are at risk for both new onset and relapse of major depression during pregnancy. For example, in at least one study, discontinuation of maintenance antidepressant medication during pregnancy was associated with early and severe relapse of depressive disorder.

This presentation will describe the course and treatment of major depression in women during pregnancy and the postpartum period. Relative risk of fetal exposure to psychiatric medications will be reviewed, as will risks to mother and fetus associated with untreated mood disturbance. Treatment guidelines for identification and management of puerperal mood disturbance will also be discussed given the growing literature describing functional recovery following adequate treatment of postpartum depression.

No. 22B
COURSE AND TREATMENT OF BIPOLAR ILLNESS DURING PREGNANCY AND THE POSTPARTUM PERIOD

Adele C. Viguera, M.D., *15 Parkman Street/WACC 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 essentially unknown. The management of bipolar women who plan to conceive or who are pregnant poses significant challenges for clinicians who care for these patients. Recent data suggest that pregnancy is not protective and the risk for relapse after lithium discontinuation is similar in pregnant and nonpregnant women with 50% relapsing within six months. This presentation reviews the major clinical dilemmas in

managing pregnant bipolar patients as well as recent data on the course of bipolar disorder during pregnancy and the postpartum period. Treatment guidelines for the management of bipolar illness during pregnancy and the postpartum period also will be presented.

No. 22C
NEW STRATEGIES IN MANAGING PMDD

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

SUMMARY:

Over the past few years, clinicians have come to realize the impact that premenstrual mood disorders exact on the lives of women suffering from these conditions. Fortunately, this has been accompanied by an ever increasing literature on effective treatments. At this point, it is clear that selected agents are useful for PMDD including agents that block the serotonin transporter, calcium and perhaps alprazolam. Exciting new information supports the efficacy of serotonin blockers when administered only during the luteal phase of the menstrual cycle. However, a large number of treatment strategies remain untested even though they are common in clinical practice. For example, little study has been conducted on the use of oral contraceptives in this disorder even though it is common in clinical practice. Similarly, a number of clinicians recommend that treatment with benzodiazepines or serotonin transporter blockers be commenced when symptoms begin even though this approach has yet to be systematically evaluated. This presentation will review evidence-based treatment of PMDD but also outline areas where more information is needed.

No. 22D
GENDER AS A FACTOR IN THE TREATMENT OF PANIC AND ANXIETY DISORDERS

M. Katherine Shear, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Over the past few years, clinicians have come to realize the impact that premenstrual mood disorders exact on the live of women suffering from these conditions. Fortunately, this has been accompanied by an ever increasing literature on effective treatments. At this point it is clear that selected agents are useful for PMDD including agents that block the serotonin transporter, calcium and perhaps alprazolam. Exciting new information supports the efficacy of serotonin blockers when administered only during the luteal phase of the menstrual cycle. However, a large number of treatment strategies remain untested even though they are common in clinical practice. For example, little study has study has been conducted on the use of oral contraceptives in this disorder even though it is common in clinical practice. Similarly, a number of clinicians recommend that treatment with benzodiazepines or serotonin transporter blockers be commenced when symptoms begin even though this approach has yet to be systematically evaluated. This presentation will review evidence-based treatment of PMDD but also outline areas where more information is needed.

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INDUSTRY-SUPPORTED SYMPOSIUM 23—PRIMARY MOOD STABILIZERS AS THE CORNERSTONE OF TREATMENT FOR BIPOLAR DISORDER
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should critically understand the most current data regarding the efficacy and safety of medications used to treat all aspects of bipolar disorder.

No. 23A
MANIA AND MOOD STABILIZATION: WHAT'S NEW?

Lauren B. Marangell, M.D., *6655 Travis, Suite 560, Houston, TX 77030*

SUMMARY:

Mood stabilizing agents are ideally conceptualized as possessing antimanic and antidepressant properties. An ideal agent would be effective, easy to use, and relatively free of major toxicities. Despite the many recent advances in the treatment of bipolar disorder, existing therapies continue to be limited by treatment failures in a substantial subset of patients. It is increasingly clear that no one agent will be effective for all patients. This presentation will provide a comprehensive review of the available data regarding the use of medications to treat mania, including the use of lithium, valproate, carbamazepine, and olanzapine. Other agents that are currently being studied for use in mania will also be included, such as risperidone, ziprasidone, lamotrigine, and topiramate. Comparative clinical trials will also be discussed. The fact that not all anticonvulsants are effective mood stabilizers, as illustrated by the recent negative trials of gabapentin in the treatment of bipolar disorder, is an important clinical point. Practical applications of these data will be emphasized.

No. 23B
PRACTICAL APPROACHES TO RECOGNIZING AND MANAGING SIDE EFFECTS

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

SUMMARY:

Medication side effects are among the most common causes of treatment non-adherence for patients with bipolar disorder. The availability of a wide variety of thymoleptic agents, including lithium, divalproex, carbamazepine, antidepressants, and new atypical antipsychotics and antiepiletpics for patients with bipolar disorder brings the hope of improved efficacy but also the problem of recognizing and managing new side effects. The prevalence and severity of common and rare side effects of these agents will be presented along with their association with rates of non-adherence. All available data regarding preventing, minimizing, and treating these side effects

through dosage optimization, alternative treatment options, and medications to counteract side effects will be discussed.

No. 23C
TREATING DEPRESSION AND SUICIDALITY

Michael E. Thase, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Although manic episodes are often more the emergent and notorious phase of bipolar affective disorder, depressive episodes last longer, are typically harder to treat, and result in the high ultimate risk of suicide. Rapid cycling, mixed states, and antidepressant-induced mania are additional complications. Whereas the identification of new treatments for mania has been given high priority over the past decade, treatment of bipolar depression remains more a matter of expert opinion and clinical "art" than an application of evidence-based medication. This presentation will focus on bipolar depressive episodes and suicidality and will cover the major pharmacologic options as well as new data on the use of adjunctive focused psychotherapies. The presentation will also include consideration of ECT and novel, experimental therapies (i.e., vagal nerve stimulation and rTMS). Each method discussed will be "graded" on the basis of evidence of efficacy and placed within the comprehensive treatment algorithm used in the nationwide STEP-BD treatment program.

No. 23D
UPDATE ON THE TREATMENT OF RAPID-CYCLING BIPOLAR DISORDER

Joseph F. Goldberg, M.D., *525 East 68th Street, New York, NY 10021*

SUMMARY:

Rapid cycling, originally defined over a quarter century ago as ≥ 4 annual affective episodes, was originally viewed as a marker for lithium prophylaxis failure. It has since become recognized in DSM-IV as a distinct course specifier for bipolar illness, likely occurring in at least one-fifth of bipolar patients. More common in women than men and potentially linked with subclinical hypothyroidism, debates persist about its nosology and appropriate treatment. Is rapid cycling a transient or persistent phenomenom? To what extent is it the istrogenic result of antidepressant overuse? How does it manifest in bipolar I vs. II patients, or those with comorbid forms of illness? What pharmacotherapies best treat or prevent rapid cycling, and which might aggravate it? This presentation will review existing data from controlled and large open trials of lithium, divalproex, lamotrigine, olanzapine, antidepressants, and related psychotropics for bipolar rapid cycling. Data will be reviewed on the phenomenology of affective switching and the vicissitudes of mania or depression among rapid cycers. Controversies surrounding the use of antidepressants will be examined, alongside the roles of contemporary pharmacotherapies and novel treatments for optimal outcomes.

No. 23E
COMPLIANCE AND OPTIMIZING FUNCTION

Guy M. Goodwin, M.D., *Headington, United Kingdom OX3 7JX*

SUMMARY:

Optimizing pharmacological treatment in the treatment of bipolar disorder only starts with the prescription. Successful treatment requires a further alliance between doctor and patient and the other supporting cast in the management of this complex disorder. At present there are important emerging studies on the impact of non-pharmacological interventions in bipolar disorder. These include psychoeducation, personal rhythm therapy, and broadly focussed cognitive-behavior therapy. There is a consensus around the need for self-monitoring and education without which it is hard to imagine any specific treatment making an impact. The existing trials suggest that intensive psychological input can have an important impact on short-term remission rates, especially in mania. At present, we are uncertain what the critical ingredient in any of such treatments is. None are based on a fully convincing theory of the social, psychological, and behavioral contributions to mood disorder. The most promising leads to more specific behavioral intervention may lie in the area of sleep disturbance, which provides an important symptom at the interface between worsening disease and modifiable behavior. Understanding the findings that favor non-pharmacological strategies and their application in everyday practice is a major challenge for the better management of bipolar affective disorder.

No. 23F
THE DOCTOR/PATIENT RELATIONSHIP: HOW TO GET HELP FOR THE ONE YOU LOVE

Mary R. Worthen, *9308 Cynthia Drive, Little Rock, AR 72205*

SUMMARY:

While new and exciting treatments lie within our reach in the 21st century, it is still difficult to obtain treatment for family members with mental illness. There are several obstacles in the way of treatment. The illness itself, age, stigma, insurance coverage, the shortage of available beds in mental hospitals, or open slots available in day treatment programs. There is also the need of educating doctors and patients about newer mood stabilizers to treat bipolar disorder. Some practical approaches for patients and families to get help are: Asking the family doctor to recommend a therapist, counselor, day treatment program, or hospital for treatment; calling mental health organizations for information to obtain help; being totally honest with one's doctor or therapist; and adherence to prescribed treatment and medicine regimens. Families should show they care but let the patient be in control of his/her own treatment program, giving their loved one a feeling of independence. With each new day comes the promise of better treatment, better medication, and more understanding by the public about mental illness. My daughter and I continue to win the "battle" against bipolar disorder, while we wait for science to win the "war," thus giving tomorrow's psychiatrists the vision and the knowledge of not just finding the treatment, but finding the cure!

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INDUSTRY-SUPPORTED SYMPOSIUM 24—MOLECULES OF THE MIND: THE SCIENCE OF SCHIZOPHRENIA
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the genetic link to schizophrenia and evaluate neurobiological data on the subject.

No. 24A
THE NEUROBIOLOGY OF COGNITIVE DYSFUNCTION IN SCHIZOPHRENIA

David A. Lewis, M.D., *3811 Ohara Street, W1650 BST, Pittsburgh, PA 15213-2593*

SUMMARY:

Cognitive deficits are among the most persistent and debilitating features of schizophrenia and appear to be the best predictor of long-term outcome for individuals with the illness. They may also reflect dysfunction of neural networks that include the dorsal prefrontal cortex. Consequently, understanding the neurobiological basis for the prefrontal dysfunction in schizophrenia is critical for the development of more effective treatments for this illness. This presentation will review recent findings that address this issue. For example, gene expression profiling of postmortem brain tissue has revealed that of 250 functional gene groups surveyed, the gene group encoding proteins involved in synaptic neurotransmission showed the most consistently altered levels of expression in the prefrontal cortex of subjects with schizophrenia. Consistent with these observations, neural circuitry studies have provided evidence of disturbances in the synaptic connections between the thalamus and dorsal prefrontal cortex in subjects with schizophrenia. Together these observations provide insight into the neurobiological basis for cognitive dysfunction in schizophrenia and they may reveal novel targets for pharmacological intervention in this illness.

No. 24B
NICOTINIC RECEPTORS AND THE GENETICS OF SCHIZOPHRENIA AND BIPOLAR DISORDER

Robert Freedman, M.D., *4200 East 9th Avenue, C-268-7, Denver, CO 80262*

SUMMARY:

Genetic studies of schizophrenia and bipolar disorder, once characterized by contradictory results and failure of confirmation, have now yielded replicable information that suggests that several genes contribute to the risk for each of these illnesses. The pool of genes appears to be overlapping between the two illnesses, and each gene by itself contributes only a modest amount to the risk for the illness. One of the candidate genes is the alpha nicotinic acetylcholine receptor gene, located on chromosome 15. The genetic research involving this gene will be discussed, as well as its physiological role, which includes activation by nicotine in tobacco products (a part of the psychotic patient's well characterized heavy smoking behavior).

No. 24C
GLUTAMATERGIC TRANSMISSION IN SCHIZOPHRENIA

Carol A. Tamminga, M.D., *Maple and Locust Street, Box 21247, Baltimore, MD 21228*

SUMMARY:

Glutamate is the neurotransmitter for a family of ionotropic and metabotropic glutamate receptors in mammalian brain. These mediate the bulk of excitatory transmission in human brain and, as such, have a role in many neurophysiologic processes in CNS. Also, changes in glutamatergic transmission have been implicated in several pathologic processes underlying brain diseases. Several lines of evidence suggest an involvement of glutamatergic transmission in schizophrenia, particularly that transmission mediated by the NMDA-sensitive glutamate receptor. The NMDA-sensitive glutamate receptor has several distinguishing psychophysical characteristics (*e.g.*, gating the passage of CA ions into the cell), increasing its overall importance in brain. In the hippocampus in schizophrenia, rCBF is characteristically abnormal and subunits of the NMDA receptor are expressed at abnormal levels. Overall, glutamate-mediated transmission may be diminished in the neuronal pathways exiting the hippocampus and innervating other limbic structures. These abnormalities can be speculatively linked to schizophrenia symptoms, and some of these associations are being tested.

No. 24D
WHITE-MATTER ABNORMALITIES IN SCHIZOPHRENIA

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

SUMMARY:

Whitematter abnormalities in schizophrenia have been suggested, however such abnormalities have never been intensively explored. Twelve schizophrenics and 12 relatively age-matched controls, with postmortem intervals of approximately 10 hours, were selected for studies utilizing the Affymetrix microarray system. All samples were taken from the prefrontal cortex, Brodman area 46. Sixty-five hundred genes were screened with the oligonucleotide Affymetrix chip. Each patient and control sample was done in duplicate. Correlations between replicate samples ranged between 0.94 and 0.99. Eighty-nine genes met criteria for expression levels differentiating patients and controls. These criteria showed a statistically significant difference in expression between the two study populations as well as at least a 1.4-fold difference in expression. The vast majority of these genes displayed a significantly higher expression in these schizophrenics. However, less than 10 genes showed decreased expression in schizophrenia. Six of these genes were related to myelin and the process of myelination in the brain. The specific genes were MAL, 2′3′ cyclic nucleotide 3′ phosphodiesterase, MAG, transferring, gelsolin, HER3 (Hakak Y, et al. PNAS, 2001). The microarray chip contained a total of 35 myelin-related genes. The likelihood of these six genes showing the lowered expression values was less than $p = .008$, as calculated by a Monte Carlo analysis. Confirmation of these changes in expression levels confirmed the results from the microarrays.

No. 24E
MOLECULAR BIOLOGY AND GENETICS OF CORTICAL FUNCTION IN SCHIZOPHRENIA

Daniel R. Weinberger, M.D., *10 Center Drive, Building 10, Room 4S-235, Bethesda, MD 20892-1379*

SUMMARY:

Explication of the molecular interactions in prefrontal cortical microcircuitry and intracellular signal processing has led to an understanding of a mechanism of genetic susceptibility for schizophrenia. There is abundant evidence from clinical neurocognition studies and from neuroimaging studies that prefrontal malfunction is a core

feature of the biology of schizophrenia. Recent studies in experimental animals, including nonhuman primates, have shown that interactions between glutamatergic pyramidal neurons and GABAergic local circuit neurons are critical for tuning the response of prefrontal circuits during executive cognition. Dopaminergic inputs to prefrontal glutamate and GABA neurons participate in this tuning process, by biasing pyramidal neurons to respond to sustained associative inputs and not to respond to transient inputs. This facilitates responses that are in the service of a behavioral goal and avoids responding to distracting stimuli. A genetic variation in the gene for COMT, which has a unique impact on the tuning function of prefrontal dopamine, predicts the efficacy and efficiency of prefrontal function during executive cognition, and increases risk for schizophrenia. Thus, the mechanism by which the COMT allele associated with poorer prefrontal tuning conveys increased risk is presumably because it affects this aspect of prefrontal function.

No. 24F
NEUROPLASTICITY AND CELLULAR RESILIENCE IN MOOD DISORDERS

Husseini K. Manji, M.D., *49 Convent Drive, Room B1EE16, MSC4405, Bethesda, MD 20892*

SUMMARY:

Recent studies demonstrating adult human neurogenesis has highlighted the degree of neuroplasticity that can persist into senescence, and generated considerable excitement about the possibility of attenuating and perhaps even reversing disease-associated neuronal atrophy and death. Intriguingly, the mood stabilizing agents lithium and valproate have recently been demonstrated to robustly increase the expression of a completely unexpected target—the major neurotrophic and neuroprotective protein, bcl-2. Consistent with these effects, valproate and particularly lithium, exert neurotrophic effects in a variety of paradigms. Valproate also activates the ERK MAP kinase pathway, a signaling pathway utilized by many endogenous neurotrophic factors. In prospective human studies, chronic lithium was shown to significantly increase NAA (a marker of neuronal viability and function) levels, effects localized almost exclusively to gray matter. Examination of brain tissue volumes using high-resolution 3-D MRI revealed an extraordinary finding that lithium significantly increases total gray matter content in patients with bipolar disorder. Together, these results suggest that a reconceptualization about the pathogenesis and optimal long-term treatment of the severe psychotic disorders is warranted. Optimal long-term treatment for these severe illnesses may only be achieved by the early use of agents with neurotrophic/neuroprotective effects, irrespective of the primary, symptomatic treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 25—CLINICAL CHALLENGES IN DEPRESSION, PART 1
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should understand the issues associated with treating the depressive component of bipolar disorder and depression in the patient with psychosis; recognize symptoms of depression in children and adolescents and discuss treatment strategies; understand the medical management of depression in cardiovascular patients; recognize sexual dysfunction in depressed patients and implement management strategies; and be able to design treatment strategies to improve long-term outcome in depressed patients.

No. 25A
SPECIAL CHALLENGES IN TREATING BIPOLAR DEPRESSION AND PSYCHOTIC DEPRESSION

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

SUMMARY:

Bipolar depression and psychotic depression are distinct subtypes of depressive illness and pose significant clinical challenges. Treatment of bipolar depression is remarkably understudied. Patients are at greatly increased risk of treatment resistance, suicide, and a prolonged, difficult course. Antidepressants are effective, but they all can induce a switch mania. The SSRIs and bupropion are believed to be less likely to cause switching than other agents. Lithium and the anticonvulsants may have some antidepressant efficacy, particularly in refractory patients. Psychotic depression, another clinical challenge, is associated with more frequent, severe, and treatment-refractory depressive episodes and possibly an increased suicide risk. Psychosis in a young adult with major depression may herald the onset of bipolar disorder. Acutely psychotic patients may need hospitalization or intensive social support. Treatment of psychotic depression requires both an antidepressant and an antipsychotic. The choice of therapy must be guided by the efficacy and safety of combination therapy, the drug-drug interaction potential of the combination, and the differential diagnosis. Bipolar disorder must be ruled out because antidepressants can exacerbate mania in patients whose symptoms are mistaken for psychosis. Treatment refractory patients may require electroconvulsive therapy. This presentation will review these data and provide clinically useful management strategies.

No. 25B
GROWING UP DEPRESSED: THE UNDERSERVED CHILD AND ADOLESCENT

Neal D. Ryan, M.D., *3811 O'Hara Street, Room ERC-720, Pittsburgh, PA 15213*

SUMMARY:

Major depression is common in children and adolescents, yet significantly underdiagnosed and undertreated. Major depression adversely affects social, family, and academic function. Symptoms of depression in youth can include depressed mood, irritability, diminished interest in activities, and changes in appetite or sleep. Suicidality remains an important consequence of adolescent depression. Nearly one in five high school students has seriously considered suicide in the past year. Comorbidity, including a switch to bipolar depression, substance/alcohol abuse, cigarette smoking, and teenage pregnancy also complicate adolescent depression. Depressed adoles-

cents tend to grow up to be depressed adults. It is important to identify efficacious treatment for this serious disorder of youth. There is increasing evidence to support the use of selective serotonin reuptake inhibitors in the treatment of depression in this population. Psychotherapy, particularly cognitive-behavioral therapy, has been shown to improve depressive symptoms in adolescence. Further controlled trials of medications and psychotherapy are warranted for this underserved population.

No. 25C
CARDIOVASCULAR DISEASE AND DEPRESSION: A DEADLY COMORBIDITY

Dominique L. Musselman, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Major depression is an independent risk factor for, rather than a psychological response to, the progression of cardiovascular disease. Persons who experience mental stress during daily life are at twice the risk of myocardial ischemia following that stress. Patients with clinical depression following a myocardial infarction have higher mortality rates than nondepressed controls. These observations suggest a psychophysiologic mechanism underlying the vulnerability of depressed patients to ischemic heart disease. The platelet response to psychological stress and/or depression is one hypothesis that has been explored. Inhibition of platelet function prevents coronary disease, but platelet activation leads to thrombosis and acute coronary events in patients at risk. Depressed patients exhibit exaggerated platelet reactivity compared with nondepressed subjects, which may be one mechanism underlying depression as a risk factor for ischemic events. Therefore, increased susceptibility to platelet activation may be one way in which depression increases the risk for ischemic heart disease and fatal events after myocardial infarction. It is not known if antidepressant treatment will break the link between depression and cardiovascular disease, but this is an area of active investigation. This presentation will review the literature and present findings of studies assessing the role of depression in patients with comorbid heart disease.

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INDUSTRY-SUPPORTED SYMPOSIUM 25—CLINICAL CHALLENGES IN DEPRESSION, PART 2
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should understand the issues associated with treating the depressive component of bipolar disorder and depression in the patient with psychosis; recognize symptoms of depression in children and adolescents and discuss treatment strategies; understand the medical management of depression in cardiovascular patients; recognize sexual dysfunction in depressed patients and implement management strategies; and be able to design treatment strategies to improve long-term outcome in depressed patients.

No. 25A
CAN LONG-TERM OUTCOME BE IMPROVED IN DEPRESSION? THE ROLE OF SIDE EFFECTS AND COMPLIANCE

Prakash S. Masand, M.D., *Box 3391, Durham, NC 27710*

SUMMARY:

There is currently a large and diverse pharmacopeia of medications for the treatment of depression. Most of the available antidepressants are equally effective when administered at therapeutic doses. The choice of antidepressant therapy, therefore, is often guided by patient preference and side-effect profile. Regardless of drug efficacy, patients must comply with their medication regimen in order to respond, remit, and remain well. There are many pathways to antidepressant noncompliance. Side effects are an important factor in noncompliance. In addition, many patients do not fill their prescription, and others intentionally underdose in an attempt to avoid side effects. Inconvenient dosing schedules and cost also contribute to noncompliance. Poor compliance or premature treatment discontinuation due to side effects can result in relapse and recurrence. Suboptimal response can also be erroneously interpreted as treatment resistance, which can lead to a search for alternate therapies. Such therapeutic misadventures unnecessarily expose the patient to potential adverse effects, further delays in response and continued functional impairment, inconvenience, and associated cost. This presentation will address the issue of noncompliance and adverse effects associated with antidepressant therapy and provide management strategies for improving long-term outcome in depression.

No. 25B
HELPING PATIENTS WITH SEXUAL DYSFUNCTION DURING ANTIDEPRESSANT TREATMENT

Lori Calabrese, M.D., *1330 Sullivan Avenue, South Windsor, CT 06074*

SUMMARY:

Sexual dysfunction (SD) is associated with most antidepressant medications, and may involve decreased libido, inhibited sexual excitement, diminished genital sensation, erectile dysfunction, failure to achieve or maintain vaginal lubrication, orgasmic delay, anorgasmia, pain, or decreased satisfaction. At least 37% of patients treated with newer antidepressants experience significant sexual dysfunction. Risk factors for antidepressant-associated SD include patients over 50 years of age, who are married, with less than a college education, not employed full time, who smoke six to 20 cigarettes per day, who are taking a higher daily dose of the antidepressant or any concomitant medication, with a comorbid illness known to cause sexual dysfunction, a prior history of antidepressant-induced sexual dysfunction, or poor lifelong psychosexual adjustment. Prescribing an antidepressant with few negative effects on sexual functioning in patients with any of these risk factors may avoid the problem. Management of antidepressant-induced SD once it occurs could involve waiting for tolerance to develop, reducing the medication dose or modifying the timing of the dose, taking a drug holiday, using antidotes/adjunctive agents, or substituting another antidepressant less likely to cause sexual dysfunction. The success of these strategies and who might benefit from each of these strategies will be discussed.

REFERENCES:

1. Masand PS: Weight gain associated with psychotropic drugs. Expert Opinion on Pharmacotherapy 2000;1:377–389.

2. Clayton A, Leadbetter R, Bass K, et al: Antidepressant-Associated Sexual Dysfunction: Risk Factors. Proceedings of the Annual Meeting of the American Psychiatric Association 2001, New Orleans, LA.

INDUSTRY-SUPPORTED SYMPOSIUM 26—NOVEL ANTIPSYCHOTIC DRUGS: ADVANCES IN THE TREATMENT OF PSYCHOTIC SPECTRUM DISORDERS, PART 1
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

Upon completion of this symposium, attendees should be able to discuss current theories about why antipsychotics are effective and how lessons learned in the laboratory may apply in the clinic; review strategies for the long-term management of patients with chronic and treatment-refractory schizophrenia; discuss the advantages and disadvantages of using novel antipsychotic medications in the treatment and stabilization of bipolar disorder, review important clinical challenges and potential strategies for managing psychotic disorders in elderly patients.

No. 26A
BENCH TO BEDSIDE: RATIONAL SELECTION OF MEDICATIONS IN TREATING SCHIZOPHRENIA

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

SUMMARY:

Although the biological basis of schizophrenia remains unknown, positive symptoms are believed to be linked to overactivity of dopaminergic pathways, especially the mesolimbic dopamine pathway. The behavioral deficits in negative symptoms of schizophrenia suggest underactivity of other neurotransmitter systems, and are believed to involve other regions of the brain such as the dorsolateral prefrontal cortex. How, then, do antipsychotics work? Why do novel agents appear to have a broader spectrum of effectiveness and an improved side-effect profile compared with the so-called conventional antipsychotics that preceded them? What have we learned about the chemical properties and clinical actions of older drugs that can help us choose safer and better-tolerated medications for our patients today? Understanding the pathophysiology of psychosis at the laboratory level will be discussed in the context of what this may mean for the rational selection of pharmacotherapeutic agents for optimizing the treatment of schizophrenia and for developing pharmacotherapies for the future.

No. 26B
WHAT HAVE WE LEARNED ABOUT THE LONG-TERM MANAGEMENT OF SCHIZOPHRENIA: WHAT CONSTITUTES TREATMENT REFRACTORINESS

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

SUMMARY:

To optimize the management of schizophrenia, strategies must be employed that maximize symptomatic improvement, functional outcome, and treatment adherence. One of the most critical goals in the long-term management of schizophrenia is the prevention of relapse and rehospitalization. Hard-won gains lost because medication is inappropriately discontinued or taken erratically should be viewed as a preventable negative outcome. To overcome such losses, medication strategies must be well understood and accepted by patients; side effects need to be kept to a minimum and managed appropriately, and other potential causes of nonadherence must be addressed.

Patients who relapse despite taking adequate doses of antipsychotic medication could be considered treatment refractory; yet, they are fundamentally different from patients who derived little or no benefit from acute treatment. We need to change the way we approach treatment refractoriness, and we need better treatments. In the ideal world of treatment, patients should experience improvements in positive and negative symptoms, cognition, and quality of life over the course of their therapy. To this end, we must have effective, well tolerated, and safe pharmacotherapy in addition to psychosocial, cognitive, and rehabilitative support. During this presentation, I will review the effectiveness and tolerability profiles of our current armamentarium of antipsychotics for the long-term management of schizophrenia, and preview the efficacy, safety, and tolerability profiles of the next generation of agents, which appear to have a different spectrum of effects and an improved safety and tolerability profile compared with the conventional and early atypical antipsychotics.

Unfortunately, community standards are often vague or inconsistently applied, with the result that rates of nonadherence, relapse, and rehospitalization are substantially higher than if best practices were routinely followed. The availability of newer and better medications, coupled with appropriate clinician and patient education regarding evidence-based treatment approaches, should go a long way toward improving outcome for a large percentage of patients with schizophrenia.

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INDUSTRY-SUPPORTED SYMPOSIUM 26—NOVEL ANTIPSYCHOTIC DRUGS: ADVANCES IN THE TREATMENT OF PSYCHOTIC SPECTRUM DISORDERS, PART 2
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

Upon completion of this symposium, attendees should be able to discuss current theories about why antipsychotics are effective and how lessons learned in the laboratory may apply in the clinic; review strategies for the long-term management of patients with chronic and treatment-refractory schizophrenia; discuss the advantages and disadvantages of using novel antipsychotic medications in the treatment and stabilization of bipolar disorder; review important clinical challenges and potential strategies for managing psychotic disorders in elderly patients.

No. 26A
THE ROLE OF ANTIPSYCHOTICS IN ACUTE MANIA

John M. Zajecka, M.D., *1725 West Harrison Street, # 955, Chicago, IL 60612*

SUMMARY:

Initially, conventional antipsychotics were used to treat a variety of disorders, including mania. Unfortunately, the adverse effects associated with these older antipsychotics, including extrapyramidal symptoms, tardive dyskinesia, and hyperprolactinemia, caused them to fall into disfavor for the treatment of mania. Clinicians were also bothered by the depressogenic effects of many of the conventional antipsychotics. Further erosion of the use of conventional antipsychotics for bipolar disorder followed the introduction of lithium and other putative mood stabilizers because of the apparent beneficial effects of these agents on both mania and depression.

Ideally conceptualized, a mood-stabilizing agent possesses antimanic and antidepressant properties. An ideal mood stabilizer is not only effective, but is easy to use and free of major toxicities. Despite many recent advances toward this goal, a substantial subset of patients fail to respond to the existing mood stabilizers or incur adverse effects that impede longer-term medication adherence.

Recently, novel antipsychotics have been studied for their properties as antimanic agent and as mood stablizers. Olanzapine is the first of these antipsychotics to be approved by the FDA for the treatment of acute mania. It is being further tested for potential beneficial effects on depression. Studies with other novel agents, including risperidone, quetiapine, and ziprasidone have recently been completed. Aripiprazole, the newest and most mechanistically distinct of the novel agents, has also undergone evaluation for its antimanic and mood stabilizing properties. During this presentation, I will review the rationale behind the renewed interest in antipsychotic medications for the treatment of bipolar disorder and introduce data. In addition, I will cover barriers to the successful management of bipolar disorder with novel antipsychotics, including their risk-to-benefit ratios, longer-term side effects, and adverse health consequences. Strategies to improve long-term outcomes will also be discussed.

No. 26B
CLINICAL CHALLENGES IN MANAGING PSYCHOSIS IN THE ELDERLY

Dilip V. Jeste, M.D., *3350 La Jolla Village Drive, San Diego, CA 92161*; Christian Dolder, Pharm.D.; Hoang A. Nguyen, M.D.; Laura B. Dunn, M.D.; Jorge F. Porras, M.D.; Enid Rockwell, M.D.

SUMMARY:

Preclinical and clinical studies of antipsychotic agents used for the treatment of schizophrenia have increased our understanding of the pathophysiology of psychosis in general and have helped us identify some drug characteristics that may predict desirable as well as undesirable clinical effects. Improving the understanding of these drugs in the treatment of schizophrenia has pointed us in the direction of more effective and tolerable pharmacotherapies for patients with other psychoses, such as those due to Alzheimer's disease. During this presentation, I will examine the profiles of antipsychotic medications and put into perspective their relative safety and efficacy for improving symptoms associated with psychotic illnesses. Discussion will also include the reason to hope for improvements in function, cognition, and quality of life with some of the newer agents. Antipsychotic medications in development with new mechanisms of action have shown promise in benefiting older patients with psychotic symptoms. I will conclude with a preview of the early data from recently completed clinical trials that have evaluated antipsychotics in this population.

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2. Yudofsky SC, Hales RE: What's new in neuropsychiatry. J Neuropsychiatry Clin Neurosci. 1999;11:1–4.
3. Tohen M, Jacobs TG, Feldman PD: Onset of action of antipsychotics in the treatment of mania. Bipolar Disord 2000; 2(3 PT 2):261–8.
4. Jeste DV, Finkel SI: Psychosis of Alzheimer's disease and related dementias. Diagnostic criteria for a distinct syndrome [editorial]. Am J Geriatr Psychiatry 2000;8:29–34.

INDUSTRY-SUPPORTED SYMPOSIUM 27—ANTIPSYCHOTIC PHARMACOTHERAPY AND THE HIPPOCRATIC OATH: ABOVE ALL DO NO HARM, PART 1
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize that the new generation of antipsychotics are essentially of equivalent efficacy in the treatment of psychosis, but they differ in their side-effect profiles. The medical morbidities of antipsychotics and the bioethics of pharmacotherapy will be discussed.

No. 27A
MEDICAL MORBIDITY AND MORTALITY IN PATIENTS WITH SCHIZOPHRENIA

S. Charles Schulz, M.D., *2450 Riverside Avenue, Minneapolis, MN 55454-1495*

SUMMARY:

Medical illness is more common in psychiatric patients than in the general population, occurring in more than 50% of the cohort. Schizophrenic patients die on an average at least 10 years earlier than age-matched counterparts. Several medical conditions have an increased prevalence in schizophrenia including irritable bowel syndrome, osteoporosis, polydipsia and hyponatremia, substance use disorders, type II diabetes mellitus, and sudden death, amongst others. In addition, schizophrenic patients may also suffer the complications like obesity as a side effect of psychotropic medications including certain antipsychotics, mood stabilizers, and antidepressants. Interestingly enough, some medical illnesses like rheumatoid arthritis are less prevalent in schizophrenic patients than in the general population. Schizophrenic patients are less likely than those in the general population to receive adequate medical care, partly because of the stigma associated with having the illness and partly because patients themselves may be reluctant to spontaneously report physical signs and symptoms. A comprehensive treatment approach to the schizophrenic patient should include not only a structured psychiatric interview, but a structured interview to diagnosis medical problems, which should be treated aggressively using psychotropics with the most favorable risk/benefit ratio and the least amount of drug/drug interactions.

No. 27B
MINIMIZING ACUTE AND LONG-TERM MOVEMENT DISORDERS WITH ATYPICAL ANTIPSYCHOTICS

Lilli Kopala, M.D., *5909 Jubilee Road, QEII, Halifax, NS Canada B3H 2E2;* David Whitehorn, Ph.D.; Hazel Woodley, R.N.; Connie Hault, M.D.; Heather Milliken, M.D.; S. Devarajan, M.D.; Uttam J. Wadhwa, M.D.

SUMMARY:

Kraepelin (1915) observed that some patients with psychosis had movements reminiscent of Parkinson's disease. After the introduction of neuroleptics, clinicians assumed that the treatment of psychosis necessarily resulted in extrapyramidal signs (EPS) and regrettably few patients were examined for abnormalities of basal ganglia function prior to being treated with antipsychotics.

We (Kopala et al, 1998; Lang et al, 2001) have documented pre-existing motor abnormalities in 28% to 40% of drug naïve, first-episode psychotic patients. Such abnormalities of basal ganglia function may be masked by typical antipsychotics. Prior studies have indicated that treatment of a drug-naïve sample with an atypical antipsychotic medication actually improved motor function. However, the effect of quetiapine on these abnormalities has not been previously explored. Recently, we studied the effect of quetiapine on pre-existing EPS. Preliminary results indicate that quetiapine does not induce EPS, and in addition, appears to correct pre-existing motor dysfunction. The results suggest that, unlike typical antipsychotics, which cause motor impairment, atypical antipsychotics are a safe treatment option for vulnerable patient groups such as those at a first episode of psychotic illness.

No. 27C
WEIGHT GAIN AND OBESITY SECONDARY TO ATYPICALS: IMMEDIATE AND LONG-TERM HEALTH THREATS

Diana O. Perkins, M.D., *101 Manning Drive, Campus Box 7160, Chapel Hill, NC 27599*

SUMMARY:

The atypical antipsychotic medications, including risperidone, olanzapine, quetiapine, ziprasidone, and clozapine offer important advantages over older antipsychotic medications, particularly improved effectiveness and a decreased liability to extrapyramidal side effects. Weight gain, however, has emerged as a troublesome and potentially serious side effect of some of the atypical antipsychotics, with clozapine and olanzapine apparently having the greatest weight gain liability. In addition, alterations in lipid metabolism, especially serum triglyceride levels, have recently been reported with clozapine and olanzapine. Weight gain and lipid abnormalities are associated with health risks, including heart disease, joint disease, diabetes, cancers, and sleep apnea. In addition, weight gain may impact on a patient's quality of life and willingness to take antipsychotics. This presentation will summarize the impact of atypical antipsychotics on weight change and the potential adverse health consequences of this side effect. The potential mechanism that may underlie antipsychotic-related weight gain is reviewed. Finally, nonpharmacological and pharmacological interventions to minimize weight gain and adverse effects on lipid metabolism will be briefly discussed.

REFERENCES:

1. Goldman LS. Medical illness in patients with schizophrenia. Journal of Clinical Psychiatry 1999;60:10–15.
2. Kopala L, Good K, Fredrikson D, Whitehorn D, Lazier L, Honer W: Risperidone in first-episode schizophrenia: improvements in symptoms and pre-existing extrapyramidal signs. Int J Psychiat Clin Pract 1998; 2:S19–S25.
3. Devlin MJ, Yanovski SZ, Wilson GT: Obesity: what mental healthy professionals need to know. Am J Psychiatry 2000;157:854–866.

INDUSTRY-SUPPORTED SYMPOSIUM 27—ANTIPSYCHOTIC PHARMACOTHERAPY AND THE HIPPOCRATIC OATH: ABOVE ALL DO NO HARM, PART 2
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize that the new generation of antipsychotics are essentially of equivalent efficacy in the treatment of psychosis, but they differ in their side-effect profiles. The medical morbidities of antipsychotics and the bioethics of pharmacotherapy will be discussed.

No. 27A
AVOIDING NEUROENDOCRINE DISRUPTIONS WITH ATYPICAL ANTIPSYCHOTIC AGENTS

David C. Henderson, M.D., *25 Staniford Street, Boston, MA 02114*

SUMMARY:

Recently, atypical antipsychotic agents have been linked to a negative impact on endocrine and metabolic systems including effects on serum prolactin levels, leptin, lipids, and glucose metabolism. In a five-year naturalistic study, we found that 30 of 82 (36.6%) clozapine patients were diagnosed with diabetes during the five-year follow-up. Patients experienced significant weight gain that continued until approximately month 46. Other studies have yielded similar results with olanzapine. Additionally, there have been a number of deaths in clozapine- and olanzapine-treated patients from diabetic ketoacidosis. A number of other reports have focused on increased scrum leptin levels as well as hypertiglyccridemia in atypical antipsychotic agent-treated patients. There have also been reports of hyperprolactinemia associated with the conventional agents and risperidone. This talk will review recent studies examining the impact of atypical antipsychotic agents on serum prolactin levels, leptin, lipids, and glucose metabolism in subjects with schizophrenia. Potential interventions to minimize risks and to avoid such complications will be discussed.

No. 27B
EMERGING BIOETHICAL ISSUES IN ANTIPSYCHOTIC PHARMACOTHERAPY: DO UNTO OTHERS

Henry A. Nasrallah, M.D., *1500 East Woodrow Wilson Drive, Jackson, MS 39216*

SUMMARY:

Bioethical issues are gaining increased emphasis in the pharmacotherapy of psychosis. The recent rapid developments in antipsychotic treatments have spawned a plethora of ethical considerations that require the attention of researchers and practitioners alike. This presentation will raise and discuss several bioethical issues that may be intertwined with antipsychotic pharmacotherapy including:

1. For *researchers:* In light of the possible risks of untreated psychosis, what are the ethical considerations of requiring placebo-treated controls in establishing efficacy? Is capacity to give informed

consent being adequately established for research participation of psychotic subjects? Why are negative findings in pharmaceutical research rarely published? How objective are the in-house pharmaceutical studies or those sponsored by proprietary companies?

2. For *clinicians:* Are there conflicts of interest in the selection of antipsychotics by physicians? Do clinicians balance marketing messages with peer-reviewed, controlled studies? What are the ethics of off-label uses of novel antipsychotics? Do physicians do unto patients what they would do unto close family members who become psychotic? Do patients receive adequate information about possible short and long-term health hazards of certain iatrogenic morbidities such as obesity, dyslipidemia, diabetes and tardive dyskinesia?

The goal of this presentation is not to arrive at "the right answer" but to sensitize the physicians and health care professionals in attendance to these nagging bioethical issues that demand our attention in the course of managing psychosis or conducting research with psychotic disorders.

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1. Henderson DC, Cagliero E, Gray C, Nasrallah RA, Hayden DL, Schocnfeld DA, Goff DC: Clozapine, diabetes mellitus, weight gain, and lipid abnormalities: a five year naturalistic study. Am J Psych 2000;(6).
2. Carpenter WT, et al: Decisional Capacity for informed consent in schizophrenia research. Arch Gen Psychiatry 2000;57:533–538.

INDUSTRY-SUPPORTED SYMPOSIUM 28—UNDERSTANDING SLEEP MEDICINE: WHAT THE PSYCHIATRIST NEEDS TO KNOW, PART 1

Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize previously undiagnosed sleep disorders, appreciate the role of insomnia in psychiatric comorbidity, understand mechanisms of action of hypnotics, and treat sleep problems effectively.

No. 28A
SLEEP, SAFETY, AND PUBLIC POLICY

Mark R. Rosekind, Ph.D., *20111 Stevens Creek Boulevard, Cupertino, CA 95014*

SUMMARY:

Technology has dramatically evolved to support, and increase, 24/7 global operations. However, basic human design and our vital need for sleep and a stable circadian clock has not evolved at all. Around-the-clock operations create significant physiological challenges to the human operators that involve sleep loss and circadian disruption, which result in degraded performance, alertness, and safety. It is estimated that fatigue is a significant causal factor in 15% to 20% of all transportation accidents, surpassing the role of alcohol and drugs. This presentation will elaborate the physiological factors that underlie fatigue and how their disruption degrades performance, alertness, and safety. Specific operational factors related to schedules will be described and how they influence physiological disruption. Finally, examples of alertness strategies and how they can be applied to improve patient alertness and safety when working in 24/7 settings will be described. The presentation will provide extensive empirical data from research and examples from NASA aerospace operations, aviation, and other 24/7 environments (e.g., health care).

No. 28B
SLEEP DISORDERS: WHAT THE PSYCHIATRIST NEEDS TO KNOW

Lois Krahn, M.D., *200 First Street, S.W., Rochester, MN 55905*

SUMMARY:

The objective is to review the sleep disorders about which psychiatrists need to know. This session will complement the other topics in this symposium by providing a larger context within the field of sleep medicine. No specific background is required other than an interest in sleep issues.

Psychiatrists' expertise in assessing amotivation, inattention, fatigue, and irritability is an excellent preparation for identifying sleep issues and disorders. Psychiatrists need to be familiar with sleep physiology and pathophysiology in order to develop a comprehensive differential diagnosis and treatment plan. Excessive daytime sleepiness is caused by many conditions, including obstructive sleep apnea, restless legs syndrome/periodic limb movement disorder, narcolepsy, insufficient sleep syndrome, and circadian rhythm disturbances. Likewise insomnia may be a potential manifestation of all the same disorders listed above as well as many medical disorders, chemical dependency states, and several psychiatric disorders. Furthermore, psychotropic drugs may cause or exacerbate undesired restlessness as well as sedation. A description of the major sleep disorders relevant to psychiatrists including the typical symptoms, diagnostic tests, and treatment will be provided.

No. 28C
INNOVATIVE STRATEGIES IN THE MANAGEMENT OF INSOMNIA

Karl Doghramji, M.D., *1015 Walnut Street, Suite 319, Philadelphia, PA 19107*

SUMMARY:

Seventy percent of depressives, 90% of psychotic patients, and 80% of C/L patients complain of disturbed sleep. Persistent insomnia is associated with an increased risk of psychosocial and occupational decline, cognitive impairments, accidents, suicide, and an increased risk for the emergence of new psychiatric disorders. This paper will review pharmacologic and behavioral options for the management of insomnia: hypnotic agents, antidepressants, other sedatives, anxiolytics, over-the-counter medications, dietary supplements, sleep hygiene education, phototherapy, sleep restriction, cognitive therapy, stimulus control, and psychotherapy, among others. Special issues in the use of hypnotic agents will also be addressed, such as length of administration, as-needed vs. nightly use, middle-of-night vs. prophylactic use, and use in the elderly. Treatment options that have been recently introduced or which are still in development will be compared with traditional therapies and will be discussed regarding effectiveness and adverse effects. A multimodal approach that integrates these treatment methods will be presented. The need for the formulation of a differential diagnosis prior to treatment, and tailoring the treatment to the underlying disorder, will be emphasized.

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1. Rosekind MR, Gander PH, Gregory KB, et al: Managing fatigue in operational settings 1: physiological considerations and countermeasures. Journal of Behavioral Medicine 1996;21:157–165.
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INDUSTRY-SUPPORTED SYMPOSIUM 28—UNDERSTANDING SLEEP MEDICINE: WHAT THE PSYCHIATRIST NEEDS TO KNOW, PART 2
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

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No. 28A
MECHANISM OF ACTION OF HYPNOTICS

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

SUMMARY:

Several mechanisms of action differentiate one hypnotic agent from another. In terms of pharmacodynamics, various neurotransmitter receptors mediate the sedative hypnotic properties of a wide variety of agents, ranging from histamine 1, alpha 1 and muscarinic cholinergic, serotonin 2A and GABA-A/ benzodiazepine receptors. Although many sedating antidepressants are employed as hypnotics "off-label," the majority of well-characterized hypnotics act at the GABA-A/benzodiazepine/chloride channel receptor complex. Recent advances have characterized this complex as multiple different isoforms that configure benzodiazepine binding sites. Different behavioral actions correlate with different molecular isoforms, thus potentially allowing separation between the anxiolytic and sedative actions of these receptors and the drugs that act at them. Current agents that act at these receptors, however, differ more in their pharmacokinetics than in their pharmacodynamic interactions. Thus, nonbenzodiazepine hypnotics range from the rapid-onset/short-acting agent zaleplon, to rapid-onset/intermediate-acting zolpidem and zopiclone. Also various benzodiazepines have a range of pharmacokinetic actions, from rapid-onset/short-acting triazolam, to somewhat delayed-onset long-acting temazepam to rapid-onset, long-acting flumazepam. Understanding the pharmacodynamic and pharmacokinetic properties of the range of available hypnotics will optimize the matching of a specific agent to the needs and responses of individual patients.

No. 28B
MORBIDITY OF INSOMNIA

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

SUMMARY:

Research on the morbidity of insomnia has historically focused on laboratory measures of performance. This approach was based on the assumption that insomnia-related decrements are parallel to those of sleep deprivation. Virtually all of these studies were negative. However, work over the past decade has identified significant insomnia morbidity. These studies have been primarily epidemiological and have focused on quality of life. The primary results on insomnia morbidity relate to work productivity, health care utilization, and risk of depression. Patients with insomnia have been shown to have decreased work output, higher rates of absenteeism, and greater rates of accidents. Studies on health care utilization have demonstrated that insomnia patients use more health care services. This is true for both medical as well as psychiatric services. The area with the most consistent findings is insomnia as a risk for depression. In six separate studies, insomnia has been shown to represent a significant risk factor for incident depression. A significant risk has been demonstrated in a variety of insomnia populations with follow-up periods ranging from one to 40 years. Clearly, insomnia therapy should not simply focus on improving sleep but on reversing and preventing insomnia-related morbidity.

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1. Stahl SM: Essential Psychopharmacology, 2nd Edition, New York, Cambridge University Press, 2000.
2. Vgontzas AN, Kales A: Sleep and its disorders. Annual Review of Medicine 1999; 50:387–400.
3. Chang PP, Ford DE, Mead LA, et al: Insomnia in young men and subsequent depression. American Journal of Epidemiology 1997; 146:105–114.
4. Simon GE, VonKorff M: Prevalence, burden, and treatment of insomnia in primary care. American Journal of Psychiatry 1997; 154:1417–1423.

INDUSTRY-SUPPORTED SYMPOSIUM 29—ONE SIZE DOESN'T FIT ALL: DEPRESSION THERAPIES FOR THE 21ST CENTURY, PART 1
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the available treatments for depression and fit them as best as possible into an individualized treatment plan for the patient.

No. 29A
THE PHYSICAL MANIFESTATIONS OF DEPRESSION

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

SUMMARY:

At bottom, there is no pure-form depression. Recognized depression subtypes broaden our awareness of depression's myriad presentations and our ability to select appropriate remedies. But as Korayb-ski reminded us, "The map is not the territory it seeks to describe." Even today's global-position systems need regular updating if they are to guide us accurately to our destination.

Beyond depression subtypes and their commonly recognized symptoms and signs there are several physical manifestations of depression that can confound its recognition and treatment. While we must be eternally vigilant against the false dichotomy between physical and psychological manifestations of illness, because all that is psychological has physical underpinnings in neurotransmitters and neuromodulators that permit physical perceptions and psychological experience, the shorthand distinction is commonly used and convenient.

This presentation will emphasize physical manifestations of depression that can delay diagnosis, confuse treatment selection, interfere with management, and produce suboptimal outcomes.

No. 29B
IMPROVING OUTCOMES IN THE LONG-TERM TREATMENT OF DEPRESSION: GIVING PATIENTS A CHOICE

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

SUMMARY:

Major depressive disorder (MDD) is a medical condition that includes abnormalities of affect and mood, neurovegetative functions, cognition, and psychomotor activity. Affected individuals display quite a wide variation in clinical symptoms and course. For most people, MDD is a life-long episodic disorder with multiple recurrences (averaging one episode in every five-year period), with approximately 20%–25% of major depressive disorder patients experiencing a chronic, unremitting course. While continuation antidepressant therapy for six to nine months after obtaining remission is recommended for all depressed patients in order to reduce the risk of relapse, maintenance therapy is typically indicated for patients with a relatively higher risk for recurrences. All antidepressant classes have been shown to be more efficacious than placebo in preventing relapses and recurrences, but poor adherence to long-term treatment is a major issue in the long-term treatment of depression. This presentation focuses on some of the new strategies in the long-term treatment of depression that have been developed in the past few years. These strategies range from the use of polypharmacy or combined pharmacotherapy and psychotherapy with the goal of eliminating residual symptoms and consolidating response, to the use of antidepressant formulations aimed at enhancing treatment adherence and improving outcomes in the long-term treatment of depression. This presentation will also discuss other common approaches to minimizing the risk of nonadherence during long-term treatment with antidepressants.

No. 29C
ADAPTING PSYCHOTHERAPIES TO A PATIENT'S INDIVIDUAL NEEDS

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

SUMMARY:

The development of short-term, disorder-specific psychotherapies has represented a major advance in the treatment of mental disorders; however, the essential empirical validation of these treatments through clinical trials requiring strict adherence to the treatment model in terms of focus and duration has led to inappropriate impression about how these treatments should be conducted in community practice. The true utility of these treatments comes in their adaptation to the specific needs of individual patients.

This presentation will focus on modifications of one depression-specific psychotherapy, interpersonal psychotherapy (IPT), as an example of how such treatments can be adapted to individual patient needs. Our research group has focused on adaptation of IPT for depressed patients with both syndromal and subsyndromal panic comorbidity and for patients with practical need for briefer courses of therapy. We will describe our methods for identifying patients with treatment-relevant panic comorbidity, the nature of the specific treatment challenges they present, and the ways in which we are addressing them. We will also describe our efforts to "concentrate" a full course of IPT into an eight-session intervention. Finally, we will review other types of patient variability and suggest treatment adaptations of IPT, CBT, and other interventions that might be relevant to them.

REFERENCES:

1. Cornelius JR, Salloum IM, Ehler JG, et al: Fluoxetine in depressed alcoholics: a double-blind, placebo-controlled trial. Arch Gen Psychiatry 1997; 54:700–705.
2. Parker G, Roy K, Wilhelm K, Mitchell P: Assessing the comparative effectiveness of antidepressant therapies: a prospective clinical practice study. J Clin Psychiatry 2001; 62:117–125.
3. Fava M, Kaji J: Continuation and maintenance treatments of major depressive disorder. Psychiatric Annals 1994; 42:281–290.
4. Kroenke K: Depression screening is not enough. Ann Intern Med 2001; 134:418–20.
5. Frank E, Grochocinski VJ, Spanier CA, et al: Interpersonal psychotherapy and antidepressant medication: evaluation of a sequential treatment strategy in women with recurrent major depression. J Clin Psychiatry 2000; 61:51–57.

INDUSTRY-SUPPORTED SYMPOSIUM 29—ONE SIZE DOESN'T FIT ALL: DEPRESSION THERAPIES FOR THE 21ST CENTURY, PART 2
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the available treatments for depression and fit them as best as possible into an individualized treatment plan for the patient.

No. 29A
LOST IN DEPRESSION: THE TREATMENT-RESISTANT PATIENT

Holly A. Swartz, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Despite advances in the pharmacological and psychotherapeutic treatments for depression, approximately 10%–30% of individuals treated for major depressive disorder do not achieve a full remission of their symptoms following a course of therapy. These individuals often experience a long, protracted course of illness characterized by psychological suffering, functional impairment, and a relatively high risk of suicide. Sources of treatment resistance include misdiagnosis, psychiatric comorbidity, suboptimal treatment doses, inadequate treatment duration, individual variation in medication metabolism, and stressful socioeconomic circumstances. This talk will focus on novel approaches to the treatment-resistant patient. We will consider three broad categories of intervention: 1) optimizing current treatment(s), 2) augmentation strategies, and 3) switching strategies. We will pay particular attention to the role of psychotherapy in the management of these patients, including recent evidence suggesting that sequenced treatments (interpersonal psychotherapy followed by an SSRI) may contribute to improved rates of remission among women with recurrent major depression.

No. 29B
DEPRESSION AND SUBSTANCE USE

Kathleen T. Brady, M.D., *67 President Street, Charleston, SC 29425*

SUMMARY:

Depression and substance use disorders commonly co-occur. The relationship between depression and substance use disorders is complex and can vary in any individual case. In some cases, the substance use disorder may develop as an attempt to self-medicate depressive symptoms. On the other hand, depressive symptoms are often seen with the use of substances of abuse and during withdrawal states.

Cognitive-behavioral therapies have been demonstrated to be efficacious in the treatment of both substance use disorders and depressive disorders. The idea of blending the strategies used in the treatment of both disorders to create a treatment specifically tailored to dually diagnosed individuals is one that has received attention in recent years. In one study, depressed alcoholic individuals treated with a specially tailored cognitive-behavioral therapy manual showed

more improvement and less relapse compared with those individuals who received treatment as usual.

Serotonin reuptake inhibitors (SRIs) have demonstrated efficacy in the treatment of depression. Clinical studies of SRIs in the treatment of alcohol dependence have had less consistent results. In a double-blind trial, Krantzler and colleagues (1995) showed no benefit when fluoxetine was compared with placebo. Cornelius and colleagues (1996) demonstrated a robust effect of fluoxetine in decreasing alcohol-use and reducing depressive symptoms in a group of alcoholics with major depression. New developments in pharmacotherapeutic and psychotherapeutic treatments of substance use disorders will be discussed.

No. 29C
PUTTING THE PIECES TOGETHER: TREATMENTS FOR THE PRESENT AND FUTURE

David L. Dunner, M.D., *4225 Roosevelt Way NE, 306C, Seattle, WA 98105-6099*

SUMMARY:

The purpose of this talk will be to present a synthesis of material related to treatment of depression. We will focus on newer and upcoming therapies for depression, including psychotherapies and medication. Some of the psychotherapies to be mentioned will include cognitive-behavioral analysis system of psychotherapy and behavioral activation. Some of the medications of interest for the future include newer augmentation strategies, medications in the "pipeline," such as reboxetine and duloxetine, CRF antagonists, and substance P antagonists. Physical treatments such as vagal nerve stimulation and rapid transcranial magnetic stimulation will also be mentioned. We will emphasize trying to select the appropriate treatment for the individual patient in order to improve adherence.

REFERENCES:

1. Cornelius JR, Sallourn IM, Ehler JG, et al: Fluoxetine in depressed alcoholics: a double-blind, placebo-controlled trial. Arch Gen Psychiatry 1997;54:700–705.
2. Parker G, Roy K, Wilhelm K, Mitchell P: Assessing the comparative effectiveness of antidepressant therapies: a prospective clinical practice study. J Clin Psychiatry 2001;62:117–125.
3. Fava M, Kaji J: Continuation and maintenance treatments of major depressive disorder. Psychiatric Annals 1994;42:281–290.
4. Kroenke K: Depression screening is not enough. Ann Intern Med 2001;134:418–20.
5. Frank E, Grochocinski VJ, Spanier CA, et al: Interpersonal psychotherapy and antidepressant medication: evaluation of a sequential treatment strategy in women with recurrent major depression. J Clin Psychiatry 2000;61:51–57.

INDUSTRY-SUPPORTED SYMPOSIUM 30—BREAKING THE SILENCE OF CHILDREN'S MENTAL ILLNESS: NATIONAL INITIATIVES, EARLY DETECTION, AND NEW PHARMACOTHERAPIES, PART 1
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to become familiar with clinically relevant information from recently completed research pertaining to the treatment of pediatric patients with psychotropic agents.

No. 30A
MENTAL ILLNESS IN CHILDREN: DIAGNOSING OUTSIDE THE BOX

Hans Steiner, M.D., *401 Quarry Road, Room 1136, Stanford, CA 94305-5340*

SUMMARY:

Background: Children and adolescents have two characteristics that make ordinary diagnostic practices problematic: They are extremely context dependent. The social context strongly influences their behavior, mentation, and symptoms; and they are evolving organisms that change at a rapid rate. This can lead to varied manifestations of symptoms. The DSM-IV diagnostic criteria themselves are also somewhat problematic, having been defined in adults.

Method: Summarizing findings from recent prevalence studies of psychopathology in youth, we will discuss the importance of high levels of comorbidity and non-isomorphic manifestations of adult disorder. The example of bipolar offspring is given.

Results: The findings suggest that in order to diagnose children accurately and validly, we always need to consider social context, developmental phase, and trajectories of functioning. The example of the continuum from ODD to CD to APD is given.

Conclusion: If we are to understand longitudinal outcomes of psychopathology better we need to be prepared to modify our diagnostic practices.

No. 30B
ATYPICAL ANTIPSYCHOTICS IN PEDIATRIC PSYCHIATRY: EFFICACY IN WELL-DESIGNED TRIALS

Christopher J. McDougle, M.D., *541 Clinical Drive, Room 299, Indianapolis, IN 46202*

SUMMARY:

A number of double-blind, placebo-controlled studies of atypical antipsychotics have been conducted in children and adolescents with various neuropsychiatric disorders. These include investigations of clozapine (childhood-onset schizophrenia), risperidone (conduct disorder with and without comorbid mental retardation, autistic disorder) and ziprasidone (Tourette's disorder). Open-label studies of these and other agents have also been published, including risperidone (childhood-onset schizophrenia, other pervasive developmental disorders, Tourette's disorder, attention deficit/hyperactivity disorder, bipolar disorder), olanzapine (childhood-onset schizophrenia, autistic disorder, Tourette's disorder, bipolar disorder) and quetiapine (autistic disorder, psychotic disorders). In general, these studies have found the atypical antipsychotics to be efficacious for the treatment of a number of these disorders, with generally good tolerability. Additional controlled trials are necessary to replicate and extend the results of these preliminary findings. Atypical antipsychotics will likely play a significant role in the treatment of psychotic and nonpsychotic disorders in children and adolescents for a number of years to come. Determination of short- and long-term safety data will be essential.

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1. Steiner H: Developmental approaches to consultation-liaison psychiatry. Clinical Child Psychiatry and Psychology 1999;4:309–324.
2. McDougle CJ, Scahill L, McCracken JT, et al: Research units on pediatric psychopharmacology (RUPP)–autism network: background and rationale for an initial controlled study of risperidone, In Child and Adolescent Psychiatric Clinics of North America, Vol 9(1), edited by Martin A, Scahill L. Philadelphia, WB Saunders Co., pp. 201–224, 2000.

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INDUSTRY-SUPPORTED SYMPOSIUM 30—BREAKING THE SILENCE OF CHILDREN'S MENTAL ILLNESS: NATIONAL INITIATIVES, EARLY DETECTION, AND NEW PHARMACOTHERAPIES, PART 2
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to become familiar with clinically relevant information from recently completed research pertaining to the treatment of pediatric patients with psychotropic agents.

No. 30A
EVOLVING TREATMENTS FOR PSYCHIATRIC DISORDERS IN YOUNG PATIENTS WITH EVIDENCE FROM BIPOLAR AND OTHER CONDITIONS

Janet Wozniak, M.D., *15 Parkman Street, WACC 725, Boston, MA 02114;* Joseph Biederman, M.D.; Jennifer Richards, B.A.

SUMMARY:

Background: Although controversial, an increasing literature of systematic research has challenged the traditional view that pediatric-onset bipolar disorder is a rare condition.

Method: This paper summarizes current research regarding pediatric-onset bipolar disorder including work delineating its atypical presentation, its overlap with attention deficit-hyperactivity disorder (ADHD) and other comorbid conditions, and family-genetic and treatment data.

Results: When examining structured interview data, cases of pediatric mania made up 16% of referrals to our outpatient clinic. Presentation is atypical by adult standards, with irritability, chronicity, and mixed state. Family-genetic data and treatment data help to establish the validity of the diagnosis.

Conclusion: Pediatric bipolar disorder is not a rare condition. Treatment requires a combined pharmacotherapy approach to address issues of comorbidity, especially with ADHD. Atypical antipsychotic medications have thus far provided the most promising results, but there is a need for additional controlled clinical trials.

No. 30B
ANTIPSYCHOTIC PHARMACOTHERAPY IN CHILDREN AND ADOLESCENTS: WHAT IS THE EVIDENCE FOR LONG-TERM SAFETY?

Robert L. Findling, M.D., *11100 Euclid Avenue, Cleveland, OH 44106-5000*

SUMMARY:

Pharmacological treatment with antipsychotics in pediatric patients has moved from conventional agents toward "atypical" antipsychotics (clozapine, risperidone, olanzapine, and quetiapine), which have a reduced risk of extrapyramidal side effects (EPS). Open-label clinical studies have shown promise for use of these atypical compounds in a wide range of neuropsychiatric disorders in young patients. Well-designed, controlled studies of antipsychotics in children are few, and most have been completed within the past five years. Large, long-term studies are now available for risperidone, an antipsychotic with a high serotonergic to dopaminergic binding ratio in the central nervous system. More modest data are available on other newer antipsychotics.

Conduct disorder is one of the most commonly diagnosed disorders in outpatient psychiatric clinics, frequently occurring with comorbid attention deficit/hyperactivity disorder (ADHD) or learning disorders. Treatment typically involves both pharmacological and behavioral therapies. This presentation will focus on data from an open-label, long-term extension study and the two newly completed long-term (one-year) international open-label studies of safety and efficacy of risperidone in children with severe conduct disorders with or without ADHD and subaverage intelligence. Available long-term safety data from studies with other atypical antipsychotics will also be discussed.

No. 30C
A PARENTS PERSPECTIVE ON INTERVENTIONS FOR CHILDREN'S MENTAL HEALTH

Ellen Kingsley, M.A., *1720 Bissonnet, Houston, TX 77005*

SUMMARY:

When clinicians tell parents their children have a mental illness, parents often regard it less as a diagnosis and more as an indictment. While social stigma accounts for a large part of this response, clinicians must also do a better job of communicating what the diagnosis means, and how brain disorders impact behavior. Many parents operate under outdated notions about psychiatric disorders and frequently distrust psychiatrists and medications.

Parents are too often left on their own to find community support, information, and advice, often with damaging results. Parents of children with ADHD, for example, frequently turn to unproven therapies such as dietary interventions, or become involved with antipsychiatry fringe groups touting their own remedies.

In order to achieve greater compliance and more successful treatment outcomes, clinicians need to make psychiatry more user-friendly. They need to better explain the psychiatric disorder, make themselves available to answer parent questions as they arise, describe the medication—how it works and what side effects to expect—and provide continuing support for parents as well as their children. Parents need clinicians to provide more literature, targeted parenting strategies, and legitimate networking opportunities.

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INDUSTRY-SUPPORTED SYMPOSIUM 31—BIPOLAR DEPRESSION AND RAPID CYCLING: CURRENT MANAGEMENT STRATEGIES
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to differentiate between and diagnose patients with bipolar depression and to become knowledgeable about the most current data on strategies for addressing unmet needs in bipolar disorder and improving the quality of care for these patients.

No. 31A
THE UNDERESTIMATED NEED AND TREATMENT CHALLENGES OF BIPOLAR DEPRESSION

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

SUMMARY:

It is of concern that a disease with such large humanistic and economic burdens as bipolar disorder remains inadequately diagnosed and treated. This presentation will discuss unmet needs in the management of bipolar disorder as a means of setting the stage for subsequent presentations that consider strategies for improving the management of this disease. Bipolar disorder often goes unrecognized. Hypomania is often overlooked, and bipolar depression is frequently not differentiated from unipolar depression. Moreover, when psychiatric morbidity is identified in a patient with bipolar disorder, symptoms may be misattributed to other illnesses. In one survey including 400 patients with bipolar disorder, 69% of patients with bipolar disorder had not been diagnosed initially with bipolar disorder, which was most commonly mistaken for depression, anxiety, and schizophrenia. More than one-third of respondents had suffered symptoms of bipolar disorder for at least 10 years before they were diagnosed. Beside being under-recognized and misdiagnosed, bipolar disorder is often inadequately treated. In particular, it is often treated as unipolar depression—a problematic strategy in light of the fact that standard unimodal antidepressants may destabilize bipolar depression. These considerations highlight the need for improvement in approaches to diagnosing and managing the patient with bipolar disorder.

No. 31B
STABILIZING MOOD IN BIPOLAR DISORDER FROM BELOW BASELINE OVER LONG PERIODS

Joseph F. Goldberg, M.D., *525 East 68th Street, New York, NY 10021*

SUMMARY:

Mood stabilization over long periods without the induction of mania or cycle accleleration is the primary objective for the treatment of bipolar disorder. Treatment options include: typical mood stabilizers (MSs) such as lithium, divalproex, and (possibly) the atypical antipsychotics that tend to stabilize mood "from above" baseline (primary efficacy in mania); the conventional use of antidepressant medication; and novel MSs, such as lamotrigine, which have been shown to stabilize mood "from below" baseline (primary efficacy in depression) during 18-month maintenance studies. This presentation will explore the pharmacologic management of bipolar depression, with particular focus on data with newer pharmacotherapies. While numerous placebo-controlled studies have been conducted in bipolar mania, few have been conducted in bipolar depression. Unimodal antidepressants including MAOIs, SSRIs, and tricyclic antidepressants have been shown effective in controlling depressive symptoms over the short term; however, evidence of long-term efficacy is lacking. Furthermore, the benefit of combining a MS with an antidepressant, as opposed to continued treatment with a MS alone or a second MS in combination, has not been demonstrated. Unimodal antidepressants should be used cautiously as some of them—particularly the tricyclic antidepressants—have been implicated in the induction of mania and rapid cycling.

No. 31C
RAPID CYCLING: CLINICAL PRESENTATION AND TREATMENT APPROACHES

Robert M. Post, M.D., *900 Rockville Pike, Building 10, Room 3N-212, Bethesda, MD 20892*

SUMMARY:

While rapid cycling was once viewed as being a rare presentation of bipolar disorder, recent data suggest that it may present in as many as 20% to 30% of patients with bipolar II disorder. This presentation will analyze the phenomenology of rapid cycling with an emphasis on hallmark symptoms and will discuss pharmacotherapeutic strategies. Generally, clinical outcome in patients with rapid cycling is often poor, and these patients may be nonresponsive or only partially responsive to lithium therapy. In some cases, rapid cycling may be associated with antidepressant use and improve upon discontinuation of antidepressant therapy, but clinical outcome for these patients may be inadequate when treatment is limited to antimanic agents that stabilize mood "from above" baseline. These treatment strategies result in marked improvement in the symptoms of hypomania and mania, but most show only modest improvement in the depressed phase of the illness. This presentation will evaluate the spectrum of activity of new agents in monotherapy or in combination with typical mood stabilizers. Newer agents will be discussed, including anticonvulsants and the atypical antipsychotics. Combination treatments, including evolving clinical strategies to effectively manage patients with rapid cycling will be examined.

No. 31D
MANAGING COMMON BENIGN AND UNCOMMON SERIOUS ADVERSE EFFECTS

Terence A. Ketter, M.D., *401 Quarry Road, Room 2124, Stanford, CA 94305-5723*

SUMMARY:

Pharmacotherapies for bipolar disorders include the mood stabilizers (MSs) lithium, divalproex, and carbamazepine; antidepressants (ADs); antipsychotics (APs); and anticonvulsants (ACs). These agents have adverse effects (AEs) ranging from common-but-benign to uncommon-but-serious. Combination therapies may increase the risk of AEs. Also, bipolar depression often entails hypersomnia, hyperphagia, anergia, psychomotor slowing, and decreased concentration, which overlap with medication AEs. Psychotropic agents commonly yield central nervous system and gastrointestinal AEs. The former include tremor (lithium, divalproex), sedation (APs, high-dose MSs, some ACs), concentration difficulties (lithium, some ACs), and extrapyramidal symptoms (APs). The latter include nausea (lithium, divalproex, some ADs), diarrhea (lithium, divalproex, some ADs), constipation (some APs, some ADs), and appetite increase/weight gain (lithium, divalproex, some APs, some ADs). ADs may cause mania, cycle acceleration, and sexual dysfunction. Older APs may increase risk of depression. Uncommon AEs include serious rash (carbamazepine, lamotrigine) and blood dyscrasias (carbamazepine, clozapine). Distinguishing these and avoiding more common benign rashes and leukopenia facilitates long-term management. Other strategies will be described. The risk of AEs should be weighed against illness morbidity and mortality and expected benefits of therapy.

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INDUSTRY-SUPPORTED SYMPOSIUM 32—THE NEW NEUROBIOLOGY OF MOOD AND ANXIETY DISORDERS
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the biological basis for mood and anxiety disorders; understand novel mechanisms of antidepressants; recognize the uses of functional brain imaging in research and clinical practice; relate changes in sleep architecture to the pathophysiology of depression; describe the role of adverse early life events in the onset, course, and pathophysiology of depression; and relate the effect of stress on neural function and growth.

No. 32A
CLINICAL RELEVANCE OF NOREPINEPHRINE IN MOOD DISORDERS

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

SUMMARY:

The biological underpinnings of depression are complex and result, at least in part, from disturbances in specific neurotransmitter systems. Neural circuits utilizing the monoamine neurotransmitters, serotonin (5-HT) and norepinephrine (NE), are pathologically altered in depression. There is considerable evidence indicating that the noradrenergic and serotonergic systems subserve distinct, but interrelated, functions. For example, the noradrenergic system appears to be involved in drive and motivation, whereas the serotonergic system modulates mood, appetite, and libido. Antidepressants that exert effects on both noradrenergic and serotonergic systems may have particular efficacy in anxiety disorders, severe depression, and comorbid conditions. Agents that modulate both systems have shown promise in clinical trials (e.g., mirtazapine, venlafaxine, nefazodone). In contrast, the selective serotonin reuptake inhibitors (SSRIs) have proven efficacy and safety in a wide range of therapeutic indications. There is now evidence to suggest that paroxetine may specifically affect the noradrenergic, as well as the serotonergic, system. The dual receptor activity of paroxetine is unique among the SSRIs and has been demonstrated both in vitro and in vivo. This presentation will review the neurobiology of depression and provide an update on the role of norepinephrine in the pathophysiology and treatment of this disorder.

No. 32B
CHILDHOOD TRAUMA AND THE NEUROBIOLOGY OF MOOD DISORDERS

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

SUMMARY:

Early untoward life stresses, including child abuse or neglect, are associated with an increase in the prevalence of depression in adulthood. Results of a series of preclinical studies in rodents and nonhuman primates and a clinical study suggest that corticotropin-releasing factor (CRF) containing neurons are rendered persistently supersensitive to stress after exposure to neonatal stress. Studies have documented CRF neuronal hyperactivity in drug-free depressed patients as evidenced by hypothalamic-pituitary-adrenal (HPA) axis hyperactivity, increased cerebrospinal fluid CRF concentrations, and a reduced number of CRF receptors in the frontal cortex, the latter finding presumably due to CRF receptor down regulation in response to CRF hypersecretion. Results of animal studies confirm these findings. A clinical study of depressed women with a history of sexual abuse in childhood or adolescence compared with early abused women without depression reveals an increased HPA-axis response to stress in the early stress-depressed group. These data support the CRF hypothesis of depression and suggest that alterations in CRF neurons mediate the effects of early trauma and increase an individual's vulnerability to depression. The therapeutic implications of these findings will be discussed.

No. 32C
ADVANCES IN FUNCTIONAL BRAIN IMAGING IN DEPRESSION AND ANXIETY

Clinton D. Kilts, Ph.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

The clinical use of CT and MRI is primarily limited to the detection of neurological abnormalities that are suspected to cause psychiatric manifestations (secondary causes). The mental status exam remains the primary method of assessing psychiatric illness by elucidating signs and symptoms of clinical syndromes. However, neuroimaging has begun to be applied to research questions about the very nature of psychiatric diseases. As the technology develops, increasing information is available that is further elucidating the relationship of neuroanatomy and psychiatric illness.

MRI, CT, SPECT, and PET techniques have improved over the past two decades permitting noninvasive examination of brain structure and function. In addition use of functional MRI and the development of theories about the neural and cognitive substrates of anxiety and depression has led to an explosion of knowledge on some of these changes in anxiety and depression. Both implicit and anticipatory fear have been localized to the amygdala. Similarly there is increasing evidence implicating the medial orbital frontal cortex in mood regulation. For example, there is evidence of negative performance deficit in depression and that this deficit is related to OFC dysfunction. In this review we will evaluate the cognitive elements of anxiety and depression and their neuroanatomical substrates and then relate these to findings in patients with depressive and anxiety disorders.

No. 32D
NEUROBIOLOGY, SLEEP, AND MOOD DISORDERS: A NEW LOOK

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

SUMMARY:

While clinical neuroscience tools in depression research are providing important leads in our understanding of the pathophysiology of depression, the specific application of neuroimaging in sleep physiology as related to depression may provide a significant advance. Indeed, the convergence of neuroimaging and improved measures of sleep, such as spectral analysis, provides a set of toolbox strategies that could shed light on the relationship between sleep and mood disorders. While it has been shown that affective disturbance may be associated with alterations in specific limbic and paralimbic systems, neuroimaging studies during NREM and REM sleep in patients with depression are providing further support for this assumption. For instance, patients with depression fail to show the

pattern of decreased relative glucose metabolism in thalamus and frontal cortex normally observed in healthy subjects. In healthy subjects, REM sleep is associated with global increases in metabolism and blood flow, and with relative regional increases in limbic and paralimbic cortex. Patients with depression fail to demonstrate this pattern of activation from waking to REM sleep, and instead, show increased activation of specific limbic and paralimbic areas. Thus, depression is associated with alterations in both regional deactivation patterns during NREM sleep and regional activation patterns during REM sleep. This presentation will review the emerging body of neuroimaging data as it relates to depression and sleep physiology, and the potential clinical application of this technology will be reviewed.

No. 32E
STRESS, NEUROGENESIS, AND THE ADULT BRAIN

Elizabeth Gould, Ph.D., *Washington Road at William Street, Princeton, NJ 08540*

SUMMARY:

The hippocampus has been implicated in mood disorders and is also a region that is sensitive to hormones and stress. The hippocampus undergoes a substantial amount of structural change in adulthood. In particular, neurogenesis and the ensuing structural changes including synapse formation, axon elongation, and dendritic elaboration occur in the dentate gyrus throughout life. This has been demonstrated in virtually all mammalian species, ranging from rodents to primates. The production and survival of new neurons are under the influence of experiential cues. Aversive experiences have been shown to decrease the production of new neurons by inhibiting the proliferation of granule cell precursors. Acute and chronic subordination stress decreases the number of new hippocampal neurons. The survival of newly born neurons is dependent on environmental complexity. Living in a naturalistic environment enhances the survival of adult-generated cells and accentuates the structural differences between dominant and subordinate animals. These results suggest that adult-generated neurons are an important substrate for experience-dependent structural and perhaps functional change.

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INDUSTRY-SUPPORTED SYMPOSIUM 33—MANAGING AGGRESSION ACROSS THE LIFE SPAN: FROM THE PEDIATRIC TO THE GERIATRIC PATIENT
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize aggression as a common symptom for many psychiatric disorders across the lifespan and to evaluate efficacy and safety of newer antipsychotics for the treatment of aggression in psychiatric patients of all ages.

No. 33A
MANAGING THE AGGRESSIVE PATIENT

Douglas H. Hughes, M.D., *78 Monmouth Street, Brookline, MA 02446*

SUMMARY:

Aggression is a common symptom in many psychiatric disorders. While most people with psychiatric disorders are not violent, those who are seriously mentally ill are associated with significantly higher rates of aggression compared with the general population (odds ratio 2.4 to 3.6 times higher). The annual prevalence rates of aggression among psychiatric patients in the community ranges from a low of 3% to a high of 25%. The prevalence rate of inpatient violence (7% to 27%) is also of concern for those in the mental health field. Comparison characteristics of female and male violence shows rates of assaults (30% to 26%) and injuries (12% to 7%) that are roughly equivalent.

Etiology of aggression is highly complex and involves multiple contributing factors, from neurobiological to social. However, research shows that among neurotransmitters, serotonin plays a major inhibitory role in aggressive behavior, and dopamine abnormalities may play a role in a patient's vulnerability to aggressive episodes. Atypical antipsychotic medications, which affect both serotonin and dopamine activities, may have primary antihostility properties (lacking in traditional antipsychotic medications), and their use is becoming more common in controlling symptoms of aggression and hostility in psychiatric patients across various diagnoses and age groups.

No. 33B
EVIDENCE-BASED APPROACH TO PHARMACOTHERAPY OF THE AGGRESSIVE CHILD

Jorge L. Armenteros, M.D., *1695 N.W. 9th Avenue, Suite 1404J, Miami, FL 33136*

SUMMARY:

Aggressive behaviors are extremely common in the lives of many children. Several researchers have attempted to define the phenomenology of human aggression and its subtypes. Two types of aggressive behaviors have emerged. The first type is considered to have a significant affective component and to be more impulsive. This impulsive aggression is viewed as an overreaction to a minor provocation often accompanied by disinhibition and behavioral dyscontrol. The second type of aggression is considered to be nonimpulsive; an instrumental or predatory behavior prompted by its anticipated benefits. As an independent entity, impulsive aggression does not comprise a separate diagnostic category. Various psychiatric disorders, however, are frequently accompanied by impulsive aggressive behavior. These include conduct disorder, attention-deficit/hyperactivity disorder, mental retardation, mood disorders, substance abuse,

and psychoses. Thus, impulsive aggression is considered as a dimensional behavioral disturbance. Impulsive aggression is believed to respond to pharmacological interventions. This presentation will describe clinical trial evidence for the pharmacological treatment of impulsive aggression in children across several diagnostic categories.

No. 33C
AGGRESSION AND PSYCHIATRIC DISORDERS: CONFRONTING THE WAR WITHIN

Robert R. Conley, M.D., *Maple and Locust Streets, P.O. Box 21247, Baltimore, MD 21228*

SUMMARY:

Aggression can occur in more than 60% of patients with chronic psychiatric illnesses. Aggressive symptoms have a complex psychopathology in which primary psychiatric disorders, side effects, substance abuse, psychosis, affective disorders, personality disorders, and medical illnesses play overlapping roles. They are a source of significant personal and caregiver stress and are often the primary causes of poor outcomes. One of the most challenging aspects of care involves the management of people who are aggressive to themselves or others. Symptoms such as threats, physical aggression against persons and objects, self-directed aggression, anxiety, agitation, and depression have often been clinically managed with a variety of psychotropic drugs such as conventional antipsychotics, antidepressants, antiepileptic drugs, and benzodiazepines. Studies suggest that the second-generation antipsychotics clozapine, risperidone, olanzapine, quetiapine, and ziprasodone may exert therapeutic effects on hostility as well as on psychosis and also may reduce suicidality in people with schizophrenia. These therapeutic actions appear to represent additional advantages of second-generation antipsychotics compared with other pharmacotherapies. This presentation will focus on the approach to managing people with aggressive behavior and complex mental health issues. Specific diagnoses are discussed as well as the optimal assessment of new-onset violent behavior.

No. 33D
STRATEGIES AND INTERVENTIONS FOR LATE-LIFE AGGRESSION

Soo Borson, M.D., *1959 N.E. Pacific Street, Box 356560, Seattle, WA 98195*

SUMMARY:

Aggression in older adults occurs in dementia, delirium, psychoses, affective illness, pain, and situations of conflict with a partner or caregiver. Murder-suicide, a catastrophic form of double aggression, is more common in older than younger adults and is associated with untreated mental disorder (especially depression or substance abuse) and/or a history of violence. In some cases, hopelessness associated with declining health of one or both partners may precipitate a murder-suicide. Geriatric aggression is most common in dementia, where predictors include more severe cognitive deficits, male gender, episodes of hands-on caregiving, and distinctive psychopathology, including psychosis, depression, and anxiety. These findings underscore the importance of assessing and intervening in the antecedents and clinical psychopathology associated with aggressive behavior. Caregiver training, activity programs, and other nonpharmacological interventions can modulate risk, but drug therapy is required for severe or persistent aggression. Antipsychotics, antidepressants, and mood-stabilizing anticonvulsants are all first-line drugs, with initial choice suggested by specific psychopathologic features; estrogen or antiandrogens, beta blockers, and benzodiazepines can be helpful in specific situations for selected patients. Atypical antipsychotics, the best-studied medications for aggression, have a broad spectrum of action and may prevent the later emergence of psychosis in aggressive demented patients.

No. 33E
LONG-TERM ADVERSE EFFECTS OF ANTIPSYCHOTIC THERAPY

Prakash S. Masand, M.D., *Box 3391, Durham, NC 27710*

SUMMARY:

Pharmacological treatment of aggression, as with other symptoms and disorders, requires a thorough diagnostic evaluation and weighing of the risk/benefit ratio of effective agents. Newer atypical antipsychotics have demonstrated efficacy in the treatment of symptoms of aggression across the age spectrum. These agents offer safety advantages over conventional antipsychotics, particularly in the incidence of motor disturbances. However, newer antipsychotics may have other side effects of note, which are of particular importance in vulnerable populations.

Safety considerations include extrapyramidal symptoms, weight gain, and metabolic disturbances, as it is very likely that these patients will continue on antipsychotic treatment for the long term. Treatment of geriatric patients is complicated by various comorbidities, sensory deficits, and cognitive impairment, suggesting that such liabilities of atypical antipsychotics as somnolence, gait disturbances, and falls will be of concern in this age group. Metabolic disturbances and cardiac sequelae will also impact the choice of an antipsychotic for older individuals. Appropriate dosing of these medications for specific age groups is recommended to minimize potential problems and ensure the best treatment outcomes.

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INDUSTRY-SUPPORTED SYMPOSIUM 34—TREATING FEAR: PERSPECTIVES ON THE BIOLOGY AND THERAPY OF ANXIETY DISORDERS
Supported by Solvay Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, a participant should be able to understand the factors associated with optimal response.

No. 34A
NEUROBIOLOGY OF FEAR AND SOCIAL ANXIETY

Justine M. Kent, M.D., *1051 Riverside Drive, Unit 41, New York, NY 10032*

SUMMARY:

Is conditioned fear an appropriate model for understanding social anxiety? Are the neural pathways activated during conditioned fear experiments the same as those activated during social anxiety-producing tasks? How can this information further our understanding of social anxiety disorder? These questions will be discussed in the context of the presentation of recent data from clinical, neurobiological, and neuroimaging investigations in social anxiety. Research into the neurobiology of social anxiety is yielding information regarding potential abnormalities in brain chemistry, with neuroimaging techniques currently yielding some of the most exciting advances. Functional magnetic resonance imaging (fMRI) is being used to identify the basic neural pathways responsible for the association of fearful affect with social cues. Positron emission tomography (PET) techniques are being used to identify potential abnormalities in neurotransmission, focusing on the monoamines as well as other systems of interest. The importance of this recent research in forming an emerging model of the neurobiology of social anxiety will be discussed in terms of its impact on pharmacologic research and the development of improved treatments for social anxiety disorder.

No. 34B
DEVELOPMENTAL ANTECEDENTS OF ANXIETY DISORDERS

Daniel Pine, M.D., *900 Rockville Pike, 1-B320, Bethesda, MD 20892*

SUMMARY:

Objective: This presentation reviews recent studies on childhood antecedents of three anxiety disorders: social phobia, generalized anxiety, and separation anxiety disorders. The presentation reviews data on associations between childhood and adult anxiety disorders, considering the manner in which childhood precipitants predispose to anxiety in general as well as to specific anxiety disorders in both children and adults.

Method: Data are reviewed from a series of prospective, family-based, biological and treatment studies. These studies outline both commonalities and differences among distinct anxiety disorders in children and adults.

Results: Among adults, most chronic anxiety disorders develop after a history of significant anxiety during childhood. Studies reveal evidence for both specific and nonspecific correlates of individual anxiety disorders. Correlates of childhood generalized anxiety disorder are similar to correlates of adult generalized anxiety disorder. Across ages, these correlates relate to various other anxiety disorders and to major depression. Correlates of childhood social phobia, as in adults, appear more specific for this condition. Finally, correlates of separation anxiety disorder are similar to those for panic disorder, with both conditions showing relationships to respiratory factors.

Conclusions: Most adult anxiety disorders are preceded by childhood anxiety. Individual anxiety disorders exhibit unique associations with biological and phenomenological factors.

No. 34C
NEW DEVELOPMENTS IN PHARMACOTHERAPY OF ANXIETY DISORDERS

Jonathan R. T. Davidson, M.D., *Trent Drive, Room 4082B, Box 3812, Durham, NC 27710*

SUMMARY:

After five decades of treating anxiety disorders with pharmacotherapy it has become evident over the past five to 10 years that "antidepressant" drugs that predominantly inhibit serotonergic reuptake are the treatments of first choice and optimum efficacy in all major forms of chronic anxiety (GAD, PTSD, panic, OCD, SAD). Other drugs such as benzodiazepines, antiepileptic drugs, beta-blockers, buspirone, and MAOIs are niche drugs with more limited applications. Moreover, the prognosis can be good, and full remission attainable, after long-term treatment. Relapse occurs more often if medication is discontinued within 12 months of recovery. Evidence is now accumulating to compare the relative advantages of pharmacotherapy and CBT. These trends will be described, along with the potential for other forms of pharmacotherapy.

No. 34D
ACCELERATING RESPONSE AND TREATING COMORBIDITY IN ANXIETY

Eric Hollander, M.D., *One Gustave Levy Place, Box 1230, New York, NY 10029*; Sallie J. Hadley, M.D.; Stefano Pallanti, M.D.; Sherie L. Novotny, M.D.; Erica Sood, B.A.; Nicolo Baldini-Rossi, M.D.; Jennifer Friedberg, B.S.

SUMMARY:

Anxiety disorders are common, long-lasting, and associated with considerable functional impairment. Current treatment approaches include cognitive-behavioral therapy (CBT), selective serotonin reuptake inhibitors (SSRIs), dual-mechanism agents (SNRIs) such as mirtazapine and venlafaxine, older antidepressants, and benzodiazepines (BZD) such as clonazepam. Two problems complicate the management of many patients: 1) a therapeutic-lag time of approximately four weeks, and 2) comorbid illness. This presentation will focus on current and experimental approaches to accelerate treatment response and manage comorbidity in anxiety disorders. The following methods may accelerate response in anxiety: co-administration of the BZD clonazepam plus SSRI resulted in rapid antipanic response; use of controlled-release formulation fluvoxamine initiated at 100 mg/d resulted in persistent antiobsessional response by week 2 in OCD; SNRI venlafaxine resulted in rapid separation from placebo in GAD; presynaptic inhibitory autoreceptor alpha-2 antagonist mirtazapine had a high proportion of early persistent response by week 2; presynaptic autoreceptor 5HT1a antagonists, such as pindolol, accelerated the therapeutic effects of SSRIs. Methodological shortcomings of the above include prospective definition of rapid response, aggressive dosing strategies, and impact of side effects on early response. Comorbid illness, especially anxiety, depressive, bipolar, psychotic, substance-use, and personality disorders complicate the treatment of anxiety disorders, and practical and effective strategies for these comorbid conditions are highlighted.

No. 34E
MINIMIZING SIDE EFFECTS AND ENHANCING COMPLIANCE OF ANTIANXIETY TREATMENTS

Francisco A. Moreno, M.D., *1501 North Campbell Avenue, Suite 7303, Tucson, AZ 85724*

SUMMARY:

Patient noncompliance represents a great clinical challenge for practitioners and a major contributor to the undertreatment of anxiety disorders. Although adherence problems are multifactorial including psychological, cultural, and behavioral factors, it is commonly the adverse events associated with pharmacological interventions that primarily limit treatment adherence and ability to dose adequately, compromising long-term outcome and quality of life.

During this presentation, general strategies to facilitate compliance with antianxiety treatments will be discussed, including early patient and family education about the presence and meaning of collateral effects, opportune detection, early intervention to minimize unwanted side effects, and adequate monitoring of outcome and progress. Side effects will be presented in relation to the neurotransmitter systems thought to be involved in triggering or facilitating their presence. As an example of the application of these principles, sexual dysfunction will be discussed in greater detail. This will include the relationship between anxiety and sexual function, incidence of sexual dysfunction during treatment, and the use of the Arizona Sexual Experiences Questionnaire, a practical validated scale for measurement of sexual dysfunction secondary to psychotropic medication. Strategies for dealing with these side effects in the anxiety disorder population that will be discussed include optimization, antidote, and substitution strategies.

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INDUSTRY-SUPPORTED SYMPOSIUM 35—RAISING EXPECTATIONS IN SCHIZOPHRENIA: ENHANCING LONG-TERM OUTCOMES

Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should describe the risk factors for cardiovascular morbidity in patients with schizophrenia, and identify strategies for minimizing these factors during the management of schizophrenia; discuss the data from controlled studies, and review the evidence on typical and atypical antipsychotics with regard to long-term outcomes, efficacy for negative symptoms, tolerability, EPS side-effect profiles, and relapse prevention; recognize patients who present in the emergency setting with acute psychosis, and discuss their assessment, treatment, and the possible role of antipsychotic medications; identify potential mechanisms of medication-associated glucose metabolism impairment and review several medications' effects on glucose metabolism; review the clinical and public health burdens of cardiovascular disease among patients with schizophrenia and suggest effective antipsychotic drug regimens.

No. 35A
ACUTE PSYCHOTIC AGITATION: CHALLENGES AND TREATMENT

Alan J. Mendelowitz, M.D., *7559 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

Assessment and treatment of agitated psychiatric patients in the emergency department and crisis center are some of the most important clinical contacts that mental health practitioners make with patients. Beyond treatment in the emergency room, successfully facilitating the transition to long-term treatment is also a key factor in optimizing patient outcome.

Initial evaluation of patients with acute psychosis requires rapid evaluation, assessment, and quick decision-making regarding diagnosis, issues of safety, and use of an optimal medication regimen in the least restrictive clinical setting. The decision regarding whether a patient requires medication or can respond to support and limit setting must be carefully weighed. Clearly, initiation of medication to treat acute psychosis is an important clinical decision that impacts the patient in the emergency setting and after the patient is discharged.

For many years, intramuscular treatment with benzodiazepines and/or conventional antipsychotics, such as haloperidol, has been the mainstay of treatment for acute psychosis. However, the poor tolerability of conventional antipsychotics compromises their usefulness for both short and long-term treatment. Atypical antipsychotics have more favorable side-effect profiles, but the transition from an intramuscular formulation of an atypical antipsychotic is problematic. Fortunately, the development of intramuscular formulations of olanzapine and ziprasidone offers promising new treatment options for patients experiencing an acute psychotic episode and will also help to facilitate the transition to the outpatient setting.

No. 35B
LONG-TERM TREATMENT GOALS

Nina R. Schooler, Ph.D., *75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

The goals of maintenance treatment in schizophrenia are to preserve the gains made during acute treatment, prevent symptom exacerbation, seek further improvement in psychopathology, enhance social functioning, and improve quality of life for the patient. Meeting these goals remains an elusive target.

Clinicians now have greater options for treating schizophrenia with antipsychotic medications. Treatments are being developed that can be tailored to the cognitive deficits of individuals, that target specific symptoms such as persistent delusions or hallucinations, and that address limitations in the environments in which these patients live. Second-generation atypical antipsychotics promise to improve long-term outcomes through several mechanisms, including enhanced efficacy for negative symptoms, improved tolerability and EPS side-effect profiles, and improved relapse prevention. But all treatment decisions must involve an awareness of data from carefully controlled research and a clinical assessment of the needs of the individual patient.

After a review of the evidence regarding first-generation antipsychotics in long-term treatment, this presentation will examine second-generation antipsychotics. Three comparisons will be examined: new antipsychotics versus placebo, new antipsychotics versus first-generation medications, and new antipsychotics versus each other. Although new antipsychotics offer great potential, only limited information is currently available regarding efficacy from controlled clinical trials. The presentation concludes with a review of long-term studies that compares clozapine with typical and atypical antipsychotics.

No. 35C
ADVERSE EFFECTS PROFILE OF NEW ANTIPSYCHOTIC AGENTS

Daniel E. Casey, M.D., *3710 SW U.S. Veterans Hospital Road, Portland, OR 97201*

SUMMARY:

Antipsychotic drugs are the mainstay for treating both the acute and chronic phases of the lifetime course of schizophrenia. However, these compounds have many side effects that have imposed an additional burden on patients who are already impaired by their psychosis. All the conventional, or typical, neuroleptic drugs have the particular troublesome neurological adverse effects of acute extrapyramidal syndromes (akathisia, dystonia, and parkinsonism) as well as the late-onset tardive dyskinesia. These syndromes are often cited by patients as reasons for noncompliance with drug therapy because the neurological symptoms of both motor (objective) and mental (subjective) symptoms are intolerable. Other side effects involve the autonomic nervous system, sexual dysfunction, and health problems with weight gain. The new, novel atypical antipsychotic agents have substantially improved the side effect profile by decreasing or not causing extrapyramidal symptoms and tardive dyskinesia, but some of these new agents still have a range of side effects that patients may find unacceptable and negatively impact compliance. Some of the newest antipsychotic agents have further improved the adverse effect profile so that even the difficult and common side effects of weight gain may not occur with some of these new agents. The presentation will compare and contrast the wide range of adverse effects for the conventional neuroleptics with those of the new novel agents. Further, a comparison will be made between the new and novel agents to characterize the unique adverse effect profiles for each of these new medicines for managing the lifelong course of psychosis.

No. 35D
MECHANISMS OF MEDICATION-ASSOCIATED GLUCOSE METABOLISM IMPAIRMENT

David C. Henderson, M.D., *25 Staniford Street, Boston, MA 02114*

SUMMARY:

Several medications may potentially impair glucose metabolism, including centrally acting alpha-blockers, beta-blockers, corticosteroids, cyclosporine, phenytoin, phenothiazines, atypical antipsychotic agents, thiazide diuretics, and oral contraceptives containing norgestral. Glucocorticoids are thought to impair glucose utilization with insulin resistance occurring at both receptor and postreceptor sites. Valproate has been shown to induce a metabolic syndrome characterized by centripetal obesity, hyperinsulinemia, lipid abnormalities, polycystic ovaries and hyperandrogenism in women with epilepsy. Patients receiving human immunodeficiency virus-1 protease inhibitors often develop impaired glucose tolerance or diabetes, that may be attributed to insulin resistance. Patients treated with clozapine and olanzapine have developed elevated fasting serum insulin levels that suggests insulin resistance. Insulin resistance can be due to abnormalities at any step in the entire insulin action sequence (e.g., receptor defects or postreceptor defects in insulin action). Agents may decrease insulin-sensitive glucose transporters (GLUT). GLUT 4 is a transporter that mediates the bulk of insulin-stimulated transport activity. Chronic exposure to high concentrations of glucose and insulin reduces the subsequent ability of insulin to maximally stimulate glucose transport by inhibiting transporter translocation. Alternatively, antagonism at serotonin 5-HT 1A receptors by atypical antipsychotic agents may decrease pancreatic B-cell responsiveness to blood sugar levels. This presentation will review several medications, including atypical antipsychotic agents, and their effects on glucose metabolism along with possible mechanisms.

No. 35E
SCHIZOPHRENIA AND THE RISK OF CARDIOVASCULAR DISEASE

Charles H. Hennekens, M.D., *2800 South Ocean Boulevard, Boca Raton, FL 33432*

SUMMARY:

Cardiovascular disease (CVD) is far and away the leading cause of mortality in the United States, accounting for 40% of deaths. Schizophrenia affects about one percent or about three million patients in the U.S. Whereas the average life expectancy in the general population of the U.S. is about 76 years, that among patients with schizophrenia is 20% shorter, or 61 years. While 50% of patients with schizophrenia attempt suicide and about 10% succeed, CVD remains far and away their leading cause of death. In the general population, cigarette smoking, blood cholesterol, hypertension, obesity, and diabetes mellitus are major risk factors, which are far more pronounced among patients with schizophrenia. Thus, there is an enormous clinical and public health burden of CVD among patients with schizophrenia. While greater emphasis on favorable modification of risk factors is important, lifestyle changes are far more difficult to achieve in patients with schizophrenia than among the general population. Efforts aimed at the primary prevention of major risk factors for CVD assume even greater importance among patients with schizophrenia. This strategy should include choice of particular antipsychotic drug regimens of comparable efficacy and with less tendency to adversely affect the major risk factors for CVD.

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INDUSTRY-SUPPORTED SYMPOSIUM 36—CLINICAL DIFFERENCES IN SEROTONIN AND NOREPINEPHRINE DRUGS IN DEPRESSION
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the role of serotonin and norepinephrine in antidepressant response and the differences that characterize their clinical effects.

No. 36A
SEROTONIN AND NOREPINEPHRINE MECHANISMS IN DEPRESSION

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

SUMMARY:

Both serotonin and norepinephrine have been implicated in the neuropathology of depression and the mechanism of antidepressant action. Two challenge techniques were developed that deplete the brain of either norepinephrine (NE) or serotonin (5-HT). Tryptophan depletion lowers 5-HT levels and has been shown to cause return of depressive symptoms in patients successfully treated with antidepressants specific for serotonin. Alternatively, catecholamine depletion using AMPT lowers norepinephrine levels and causes return of depressive symptoms in patients treated with drugs specific for NE. Depletion studies in asymptomatic subjects or untreated depressed

patients demonstrated little effect. These findings taken together indicate that NE and 5-HT play a role in mediating antidepressant response, but these data do not inform us about the pathophysiology of depression. The findings raise interesting questions. If both NE and 5-HT mediate antidepressant action, do they treat the same patients? Do they treat the same symptoms? In a recent study, the latter question was investigated. A large sample of more than 100 patients who had participated in previous studies was pooled. The effects of NE and 5-HT depletion were examined using symptom ratings from the Hamilton Depression Scale and the Hamilton Anxiety Scale. The findings indicated some overlap in the symptoms affected, but also some differences. The implications of these findings for antidepressant selection for treatment of depressed patients will be discussed.

No. 36B
CLINICAL EFFICACY OF SEROTONIN AND NOREPINEPHRINE ANTIDEPRESSANTS

J. Craig Nelson, M.D., *20 York Street, EP-10-835C, New Haven, CT 06504*

SUMMARY:

Both serotonin (5-HT) and norepinephrine (NE) mediate antidepressant response, and it is reasonable to question if antidepressants selective for NE and 5-HT have similar efficacy. Several reviews have compared response to tricyclic antidepressants and SSRIs, but the TCAs represent a heterogeneous group of agents. Sixteen studies have now been published comparing response to a selective 5-HT agent and a NE selective agent. The NE selective agents included desipramine, nortriptyline, reboxetine, lofepramine, and maprotiline. Approximately 2,000 patients were included in these studies. Response rates were similar, 65% and 61%, for the SSRIs and NRIs. Predictors of response were examined. In studies that examined response predictors, there were few symptoms identified and no consistent findings across studies. These data are consistent with a recent meta-analysis that found that anxiety did not predict response to either sertraline or bupropion during treatment of depression. The findings are somewhat different with respect to how symptoms respond during treatment. If all patients had a 100% remission of symptoms, this would be a moot point. In fact, only about 50% of all patients starting treatment reach a 50% improvement criterion. Thus there is considerable room for symptoms to respond differently during treatment. In a prior study of desipramine we found eight symptoms that were directly responsive to therapeutic levels of desipramine. Depressed mood, loss of interest, loss of pleasure, loss of energy, and loss of appetite were among those items and suggested that the NE-selective agent desipramine had a prominent effect on symptoms related to motivation. But there was no comparison with effects of a 5-HT agent. Other studies have found loss of interest and poor social functioning improved more with reboxetine than fluoxetine. This presentation will review comparisons of NE and 5-HT selective agents with respect to their efficacy and the question of whether these agents treat the same patients and symptoms.

No. 36C
TREATMENT IMPLICATIONS OF THE SEROTONIN SPECTRUM DISORDERS

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

SUMMARY:

Serotonin (5-HT) has been implicated as a mechanism of action for treatment of depression. Since the introduction of the SSRIs, however, interest in a number of other disorders that respond to the SSRIs has grown. Some of these disorders comprise a group sometimes referred to as the anxiety spectrum. In a some cases, SSRIs have been approved for use in these disorders. This group of disorders includes obsessive-compulsive disorder (OCD), panic disorder (PD), social anxiety disorder (SD), generalized anxiety disorder (GAD), and post-traumatic stress disorder (PTSD). Two other disorders, bulimia and premenstrual dysphoric disorder (PMDD), also appear to respond to 5-HT agents. It is not clear that all of these disorders share a common diathesis, and in fact, that seems unlikely. Yet, they all display some degree of response to 5-HT agents. In some cases, particularly OCD and PMDD, it appears well established that antidepressants acting primarily on norepinephrine (NE) are not effective for treatment. This presentation will review and define these disorders and summarize our current knowledge about treatment. The question of specificity, that is, do these disorders only respond to 5-HT agents or to both 5-HT and NE agents, will be addressed. The implications of the treatment data will be considered both with respect to the treatment of the disorders themselves but also as they occur concomitantly with depression. Finally, the question of whether these data inform use about treatment of specific symptoms or dimensions will be considered.

No. 36D
TREATMENT IMPLICATIONS OF THE NOREPINEPHRINE SPECTRUM DISORDERS

James J. Hudziak, M.D., *Given Room B229, Burlington, VT 05405-0001*

SUMMARY:

Serotonin (5-HT) and norepinephrine (NE) have both been implicated as mechanisms of action for treatment of depression. Since the introduction of the SSRIs, however, interest in a number of other disorders that respond to the SSRIs has grown; for example, OCD, panic disorder, social anxiety disorder (SD), and others. Most of these disorders are well known to psychiatrists. Recently, there has been increased interest in disorders that respond preferentially to norepinephrine agents rather than agents acting on 5-HT. For example, smoking cessation responds to agents acting on the catecholamines. Bupropion and nortriptyline both are effective treatments for smoking cessation. Unpublished studies suggest that the SSRIs are not effective for this condition. ADHD, a common disorder in children and adults, responds to agents acting on catecholamines. The agents used in this case include those directly acting to release dopamine, but NE-specific agents such as desipramine and tomoxetine are effective treatments for ADHD. This presentation will review these NE-responsive disorders and summarize our knowledge about treatment. The question of specificity, do these disorders only respond to NE as opposed to 5-HT, will be addressed. If these disorders are comorbid with depression, they may guide antidepressant selection. In addition, the larger issue of whether there are symptom clusters or dimensions that respond preferentially to NE agents will be considered, and the question of how this might guide the clinician will be addressed.

No. 36E
COMBINING SEROTONIN AND NOREPINEPHRINE ACTIONS TO IMPROVE OUTCOME

Gerard Sanacora, M.D., *21 Arrowhead Drive, Guilford, CT 06437-3137*

SUMMARY:

Serotonin (5-HT) and norepinephrine (NE) both have been shown to mediate antidepressant response. Antidepressants with selective NE or 5-HT action appear to have equivalent efficacy. Yet it is not

known if agents with NE and 5-HT actions treat the same patients or the same symptoms. If the clinical effects differ, combining these actions may improve the speed of response or the final outcome. Two different approaches have been taken to achieve this end. Dual-actions agents such as clomipramine, venlafaxine, mirtazapine, and duloxetine have been developed and appear to have greater efficacy than do selective drugs. The other approach is to combine a NE agent with a 5-HT agent. These strategies include the use of an SSRI with desipramine, bupropion, mirtazapine, and reboxetine. This presentation will review the efficacy data for dual-action agents and augmentation strategies that combine NE and 5-HT mechanisms with reference to the question of whether NE/5-HT combinations are more effective than selective agents. For clinicians interested in the administration of these strategies, issues related to dosing, drug interactions, and safety will be reviewed.

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INDUSTRY-SUPPORTED SYMPOSIUM 37—BEHAVIORAL DISTURBANCES IN DEMENTIA: DIAGNOSTIC AND TREATMENT GUIDELINES

Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an in-depth knowledge of the behavioral disturbances observed in dementia, explain the pathophysiology behind the illness, recognize the clinical manifestations, and effectively treat the dementias.

No. 37A
THE PATHOPHYSIOLOGY OF ABNORMAL BEHAVIOR AND MOOD IN DEMENTIA

Mustafa M. Husain, M.D. *5161 Harry Hines Boulevard, Dallas TX 75232*

SUMMARY:

Over the past couple of decades, knowledge of the pathophysiologic changes occurring in Alzheimer's disease (AD) has increased substantially. In the normal central nervous system (CNS), the generation and breakdown of acetylcholine is in equilibrium. In AD, however, the balance is disrupted. This alteration within the cholinergic system, caused by various changes within the neural circuitry, is believed to be responsible for the cognitive and behavioral symptoms associated with the dementia. Depletion of acetylcholine, loss of cholinergic neurons, decrease in acetylcholinesterase activity, and increase in butyrylcholinesterase activity are some of the changes recently identified. Neuropsychiatric symptoms are frequently observed in dementia with Lewy bodies (DLB). Interestingly, studies of brain tissue in patients with a history of DLB reveal that cholinergic activity is more severely depleted in this dementia than in AD. Whether this is the reason for the high incidence of behavioral disturbances remains under investigation.

This presentation will provide a review of normal cholinergic function followed by a description of the changes encountered in the AD or DLB brain. Current theories correlating the CNS alterations with dementia symptoms, particularly the behavioral and mood disturbances, will be discussed.

No. 37B
IMPACT OF CHOLINESTERASE INHIBITORS ON SLEEP DISTURBANCE IN ALZHEIMER'S DISEASE

P. Murali Doraiswamy, M.D., *1521 East Franklin Street, Chapel Hill, NC 27514*

SUMMARY:

Two common problems observed in moderate and advanced Alzheimer's disease are sleep disturbances and nocturnal agitation, "sun-downing." Acetylcholine is believed to play a role in mediating various aspects of both sleep and cognition. This presentation will review the impact of acetylcholine and the relationship between cognitive impairment and sleep. Anecdotal evidence implies that cholinergic and anticholinergic drugs may influence sleep. Preliminary evidence suggests that REM sleep disorders may improve with cholinergic drugs, whereas some clinical experience suggests that these drugs can cause sleep-cycle changes or agitation. This presentation will review these data as well as additional cholinesterase inhibitor research. Practical relevance of the findings as well as examination to determine whether there are differences among pharmacological agents will be discussed.

No. 37C
DEMENTIA WITH LEWY BODIES: THE FRONTIERS OF EFFECTIVE TREATMENT AND DIAGNOSIS

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

SUMMARY:

Until recently, dementia with Lewy bodies (DLB) was considered a rare disorder. As it is now understood to be one of the more common dementias, clinicians and researchers realize the importance of accurately diagnosing the condition. To this end, the Consortium on Dementia with Lewy Bodies was convened to establish guidelines for the clinical and pathologic diagnosis of DLB. These criteria will be summarized and discussed during this presentation.

Cognitive, extrapyramidal, and neuropsychiatric symptoms as well as fluctuations characterize DLB. This dementia is rapidly progressive, and the symptoms are often difficult to manage. Although DLB patients present with substantial behavioral problems, these patients tend to suffer severe adverse reactions following administration of

neuroleptic medications. Many medications commonly used to treat psychiatric disturbances should be avoided in this population.

Cholinesterase inhibitors, effectively used in the treatment of AD, have also demonstrated substantial efficacy in treating the neuropsychiatric disturbances associated with DLB. A randomized, double-blind, placebo-controlled trial with the cholinesterase inhibitor rivastigmine resulted in positive findings in terms of behavioral outcomes, tolerability, and safety. In addition to discussing this trial, further clinical experience with cholinesterase inhibitors, and general recommendations for the successful management of DLB patients will be explored during the presentation.

No. 37D
TREATING BEHAVIORAL DISTURBANCES OBSERVED IN ALZHEIMER'S DISEASE: PHARMACOLOGIC AND NONPHARMACOLOGIC INTERVENTIONS

Steven G. Potkin, M.D., *101 City Drive, South Rt. 88, Orange, CA 92868*

SUMMARY:

The symptoms of Alzheimer's disease (AD) that cause the most patient and caregiver stress are behavioral. Behavioral symptoms can be variable but tend to worsen as the disease advances. Paranoia and depression are often observed early on, while agitation, wandering, and delusions generally occur later in the disease. In order to minimize their otherwise devastating impact, a primary goal for those caring for AD patients should be effective treatment of these symptoms. Antipsychotic and antidepressant medications are frequently prescribed for behavioral problems. The potential for adverse events in this elderly population is a serious concern. Trials of cholinesterase inhibitors provide a useful alternative to antipsychotic and antidepressant medications in treating the behavioral disturbances with AD. Cholinesterase inhibitors have demonstrated impressive results in the treatment of AD patients with disruptive behavior. The cholinesterase inhibitors currently available have different pharmacological profiles, leading to differences in efficacy outcomes, particularly in the domain of behavior. Results from cholinesterase inhibitor clinical trials will be discussed during this presentation.

Many effective, nonpharmacological/behavioral modification strategies can be employed either as first-line therapy or as an adjunct to drug therapy. This talk will present an overview of the pharmacologic and nonpharmacologic approaches currently available to manage the behavioral disturbances associated with AD.

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INDUSTRY-SUPPORTED SYMPOSIUM 38—CHRONIC EPISODIC DISORDERS: COMORBIDITY AND COMPREHENSIVE INTEGRATED TREATMENT, PART 1
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the shared features and pathophysiologic links between depressive disorders and pain syndromes, irritable bowel syndrome (IBS), and obesity; to identify the unique and similar treatment strategies for each predominantly female comorbid disorder with a focus on serotonin dysregulation and the impact of the sex steroids.

No. 38A
UNRAVELING THE COMPLEXITY: COMORBIDITY, MECHANISTIC LINK, AND PHARMACOLOGIC RESPONSE

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

SUMMARY:

Depression, irritable bowel syndrome (IBS), pain syndromes such as migraine and fibromyalgia, and obesity share several features. All of these disorders are more prevalent in women than in men, all have both psychological and medical components, and all have been linked to abnormalities of serotonin function. Pathophysiologic linkage between these disorders is supported by epidemiologic evidence of comorbidity in clinical and population-based studies, particularly between depression and migraine, depression and IBS, depression and obesity, and migraine and irritable bowel syndrome. A physiologic abnormality common to all the disorders is serotonin dysregulation related to hypothalamic-pituitary-adrenal (HPA) axis hyperactivity, which may represent a common etiologic factor necessary, but not sufficient to produce these separate disorders. Effects of sex steroids, particularly estrogen, on serotonin and HPA axis function may explain the predominance of women affected and the specific disorder manifested. Additional evidence for a linkage is that migraine, depression, IBS, and obesity all respond to medications that affect serotonergic function. Thus, the neurobiologic evidence supports phenomenologic and pathophysiologic links among depression, migraine, irritable bowel syndrome, and obesity.

No. 38B
NEW DEVELOPMENTS IN OBESITY

Donna H. Ryan, M.D., *6400 Perkins Road, Baton Rouge, LA 70820*

SUMMARY:

Obesity, defined by worldwide consensus to mean body mass index >30 Kg/m^2, currently effects more than 22% of American adults. The health and economic implications of this are sobering when one considers the comorbidities associated with obesity (type 2 diabetes, hypertension, cardiovascular disease, and increased risk for some cancers). Relatively modest weight loss (–5% from baseline) can produce improvement in glycemic control, blood pressure reduction, and lipid-profile improvement. The Finnish Diabetes Prevention Study recently demonstrated reduced risk for developing diabetes with modest weight loss and lifestyle changes.

Recent progress has been made in understanding the pathophysiology underlying the association of obesity with diabetes and cardiovascular disease, and there are new insights from energy balance biology that inform our understanding of the etiology of obesity. Studies are underway to evaluate the health effects of modest weight

loss sustained over the long term. After a hiatus of more than 20 years, two new pharmaceuticals targeting long-term treatment for obesity have reached the marketplace, and virtually every pharmaceutical company has a research program targeting weight management.

This lecture will focus on new developments in the field of obesity that are of interest to the primary care physician and the psychiatrist.

No. 38C
COMORBID PHYSICAL SYMPTOMS ASSOCIATED WITH FEMALE-SPECIFIC MOOD DISORDERS

Julia K. Warnock, M.D., *4502 East 41st Street, Tulsa, OK 74135*

SUMMARY:

Women suffer mood disorders twice as often as men. Women have higher rates of physical and psychiatric conditions that are comorbid with depression. From the onset of menarche until well after menopause, women are at increased risk of specific mood disorders during reproductive life events. Female-specific mood disorders such as premenstrual dysphoria, depression associated with the postpartum period, and mood disorders associated with perimenopause, suggest the possibility that the fluctuations of estrogen may contribute to greater risk for depression in women. Evidence of the neuromodulatory effects of estrogen on the serotonergic system is accumulating and suggests that estrogen might alter the risk for depression through its effects on serotonergic function. Women undergoing significant declines in estrogen are hypothesized to report an increase in both depressive and physical symptoms. Several studies examining the mood and physical symptoms of female patients undergoing GnRH agonist therapy (Lupron) for endometriosis will be discussed. Thirty-four female patients were evaluated at baseline, prior to GnRH agonist therapy, and again at several time intervals. Physical symptoms increased significantly by the second week ($t(33)=4.3$; $p<.001$), and by a factor of 3 by month four. Treatment strategies for women on GnRH agonist therapy may also be effective for women suffering during other reproductive life events.

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INDUSTRY-SUPPORTED SYMPOSIUM 38—CHRONIC EPISODIC DISORDERS: COMORBIDITY AND COMPREHENSIVE INTEGRATED TREATMENT, PART 2
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

To describe the shared features and pathophysiologic links between depressive disorders and pain syndromes, irritable bowel syndrome (IBS), and obesity; to identify the unique and similar treatment strategies for each predominately female comorbid disorder with a focus on serotonin dysregulation and the impact of the sex steroids.

No. 38A
THE RELATIONSHIP BETWEEN PSYCHIATRIC ILLNESS AND IRRITABLE BOWEL SYNDROME

R. Bruce Lydiard, M.D., *1 Poston Road, Suite 150, Charleston, SC 29407*

SUMMARY:

Irritable bowel syndrome is a functional gastrointestinal syndrome that affects an estimated 10%–22% of the population. Only 14%–50% of IBS patients seek medical care; those who do have a high prevalence of psychiatric illness, notably mood and anxiety disorders. Patients seeking care for psychiatric illness also have a high prevalence of IBS. The prevalence is 19% in patients with schizophrenia, 29% in patients with major depression, and 46% in patients with panic disorder among others. In terms of the etiology of IBS, there is considerable evidence to suggest that a link exists between the CNS and the ENS. At a neurophysiologic level, the locus ceruleus (LC), which is known to mediate fear and arousal states, receives afferent input from the gut. Moreover, 90% of the serotonin in the human body is found in the GI tract, primarily in the gut enterochromaffin cells and in myenteric interneurons. The talk will focus on the comorbidity of IBS in psychiatric illness, common links in etiology and pathophysiology, and treatments including the use of tricyclic antidepressants, SSRIs, SNRIs, as well as nonpharmacological therapies in treatment of this chronic disorder.

No. 38B
MANAGEMENT OF PAIN SYNDROMES: FIBROMYALGIA, MIGRAINES, AND CHRONIC PAIN

Diane S. Thompson, M.D., *1356 Lusitana Street, Honolulu, HI 96813*

SUMMARY:

Fibromyalgia is a common and chronic musculoskeletal pain disorder frequently accompanied by other chronic episodic disorders. The prevalence is 4%, with a female:male ratio of 7:1. Fibromyalgia is defined as pain to palpation in at least 11 of 18 particular sites. The pain is frequently accompanied by specific changes in the sleep electroencephalogram; alpha waves intrude into non-REM sleep with poor progression into Stages 3 and 4.

The relationship to depression is quite striking; rates are as high as 50%–70%. Between 36% and 60% of fibromyalgia patients have irritable bowel syndrome, and up to 80% are also diagnosed with headaches. All occur more frequently in women; however, fibromyalgia appears to increase with age, while IBS and migraines peak in the reproductive years. Regardless, these "pain disorders" are all associated with serotonergic functioning. Serotonin receptor agonists are standard therapy for migraines. Antidepressant agents that enhance central serotonin function are also used to treat migraines. Treatment for fibromyalgia is yet unclear; however, medications that affect serotonin function appear to be the most useful. Cyclobenzaprine, tricyclics, SSRIs, and 5-hydroxytryptophan have had varying degrees of success with pain modulation.

While information on the physiologic linkages between these pain disorders is inadequate, identification of temporal and pathophysiologic mechanisms will enhance our understanding and future management of pain syndromes.

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1. Hudson JI, Pope HG: Affective spectrum disorder: does antidepressant response identify a family of disorders with a common pathophysiology? Am J Psychiatry 1990;147:552–564.

2. Dinan TG: Serotonin and the regulation of the hypothalamic-pituitary-adrenal axis function. Life Sci 1996;48:1683–1694.
3. Drossman DA, Richter JE, Talley NJ, et al: Functional gastrointestinal disorders: diagnosis, pathophysiology, and treatment. McLean, Va., Degnon and Associates, 1994, 115–173.
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INDUSTRY-SUPPORTED SYMPOSIUM 39—AGE, GENDER, AND DIAGNOSIS: INFLUENCES ON DRUG RESPONSE, PART 1
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the course of illness of anxiety disorders associated with major depression in children and adolescents and assess possible treatment strategies, evaluate the therapeutic potential of the SRIs and TCAs in women, review the safety and efficacy of treating depression in the immediate postinfarction period and recognize that treatment changes the risk of morbidity and mortality, review the diagnostic and treatment implications of comorbid mood and anxiety disorders.

No. 39A
CAN TREATING DEPRESSION ALTER CARDIOVASCULAR DISEASE?

Alexander H. Glassman, M.D., *1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Although the relationship between depression and cardiovascular disease has been discussed since antiquity, scientific support has been lacking. Now compelling evidence shows that individuals who suffer from depression are at increased risk of developing cardiovascular disease, and individuals who suffer from an MI and become depressed are at increased risk of dying. The crucial question is whether treating depression would decrease the risk of dying.

SSRIs are safe in stable heart disease; however, no antidepressant had been tested in the postinfarction period. Many physicians felt that postinfarction depression was a natural reaction and would not respond to antidepressants. Demonstrating a reduction in mortality would require a large number of postinfarction patients when it was not clear if the drugs were either efficacious or safe. As a result, we began a trial of the safety and efficacy of sertraline in the immediate postinfarction period. This trial involved the psychiatric examination of 10,000 patients after heart attack of whom 1,800 developed major depression, and slightly fewer than 900 met inclusion criteria. Approximately half of the patients were enrolled, and almost 400 have completed this double-blind, placebo-controlled trial. Evidence is now available that sertraline is safe and efficacious in post-MI patients, and data on mortality will be available shortly.

No. 39B
COMORBIDITY AND ITS IMPLICATION ON TREATMENT: CHANGE OVER THE LIFE SPAN

Tana A. Grady-Weliky, M.D., *Box 601, Room G7644Q, 601 Elmwood Avenue, Rochester, NY 14642*

SUMMARY:

Most clinicians are familiar with the clinical presentations of individual mood and anxiety disorders. However, overlapping symptoms and comorbid disorders present additional clinical challenges. Patients with comorbid depression and anxiety disorders tend to experience more severe symptoms, use more health care resources, and have a worse prognosis than those with a single diagnosis. Clinically, it is not uncommon for a patient with a primary diagnosis of depression to report symptoms of anxiety or vice versa; 90% of depressed patients exhibit symptoms of anxiety. Results from the National Comorbidity Survey demonstrate that in a 12-month period, 51% of patients with major depressive disorder were additionally diagnosed with an anxiety disorder, such as posttraumatic stress disorder (PTSD), generalized anxiety disorder, social anxiety disorder, or panic disorder. Conversely, many patients with an anxiety disorder develop major depression. For example, approximately half of all patients with PTSD also have major depression at some time in their lives. The greater impairment experienced by patients with comorbid diagnoses can manifest as a heightened severity of symptoms, severely reduced quality of life, and longer time to recovery. This presentation will discuss the treatment implications of comorbid mood and anxiety disorders as well as review current clinical findings.

REFERENCES:

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2. Kessler RC, Neslon CB, McGonagle KA, et al: Comorbidity of DSM-III-R major depressive disorder in the general population: results from the US National Comorbidity Survey. Br J Psychiatry 1996;30(suppl):17–30.

INDUSTRY-SUPPORTED SYMPOSIUM 39—AGE, GENDER, AND DIAGNOSIS: INFLUENCES ON DRUG RESPONSE, PART 2
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the course of illness of anxiety disorders associated with major depression in children and adolescents and assess possible treatment strategies, evaluate the therapeutic potential of the SRIs and TCAs in women, review the safety and efficacy of treating depression in the immediate postinfarction period and recognize that treatment changes the risk of morbidity and mortality, and review the diagnostic and treatment implications of comorbid mood and anxiety disorders.

No. 39A
EPIDEMIOLOGY, COURSE, AND DRUG RESPONSE: HOW ARE MOOD AND ANXIETY DISORDERS DIFFERENT IN CHILDREN?

John S. March, M.D., *P.O. Box 3527, Durham, NC 27710*

SUMMARY:

Major depression and anxiety disorders negatively impact a child's development. Often, comorbid anxiety disorders are unrecognized

when a child is diagnosed with major depression. These comorbid anxiety disorders worsen the course of depression in children. Also, there is increasing evidence that the development of anxiety disorders precedes the development of major depression; therefore, early identification of anxiety disorders in children is essential. Unfortunately, there are few controlled data regarding treatment of anxiety disorders and depression in children. Pharmacological agents, such as the selective serotonin reuptake inhibitors, and cognitive-behavior therapy hold promise. This presentation will focus on recognition of anxiety disorders associated with major depression and the course of these illnesses in children. Treatment strategies for these disorders will be discussed.

No. 39B
TREATMENT OF MOOD DISORDERS IN WOMEN

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

SUMMARY:

Women are susceptible to a number of mood disorders, including those occuring around the time of pivotal reproductive events (e.g., the postpartum period, premenstrual phase of the menstrual cycle, and perimenopause). While the relatively more benign side-effect profile of serotonin reuptake inhibitors (SRIs) made treatment possible for a number of patients who could not tolerate TCAs, an additional benefit is that they are efficacious for some conditions, and some patients, in whom TCAs were not as effective. For example, some work suggests that SRIs are more effective than TCAs for women with major depressive disorder and depression during the immediate postpartum period. It is also clear that agents that block the serotonin transporter are useful treatments for premenstrual dysphoric disorder, while non-SRIs are less beneficial. This presentation will review these data and recent neurobiological findings that might shed light on the different gender effects of SRIs versus TCAs.

REFERENCES:

1. Pine DS, Cohen P, Gurley D, et al: The risk for early-adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. Arch Gen Psychiatry 1998;55:56–64.
2. Kornstein S, Schatzberg A, Thase M, et al: Gender differences in treatment response to sertraline versus imipramine in chronic depression. Am J Psychiatry 2000;157:1445–1452.
3. Steiner M: Premenstrual syndrome and premenstrual dysphoric disorder: guidelines for management. Psychiatry & Neurosci 2000; 25:459–468.

INDUSTRY-SUPPORTED SYMPOSIUM 40—THERAPEUTIC CHALLENGES, NOVEL APPROACHES: ANTIPSYCHOTICS IN THE MANAGEMENT OF MOOD AND ANXIETY DISORDERS, PART 1
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to use new strategies to more effectively manage the increasingly complex caseload that psychiatrists face in practice.

No. 40A
PHARMACOLOGICAL PROPERTIES OF ANTIPSYCHOTICS: TEASING OUT POTENTIAL MECHANISMS OF ACTION

Michael J. Owens, Ph.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

The last 20 years have seen a large increase in the armamentarium of research tools available to scientists to elucidate the biological underpinnings of mood and anxiety disorders. This has led to considerable evidence implicating a number of neurotransmitter systems in the pathophysiology and therapeutics of these disorders. Some of these neurotransmitter systems include classical transmitters such as 5-HT, norepinephrine, and dopamine, as well as the neuropeptides corticotropin-releasing factor (CRF) and substance P. These same tools have also enabled researchers to characterize, in great detail, the targets for antipsychotic drugs on both short and long time frames. Many of these targets may turn out to be related to the physical structure and cytoarchitecture of the neuron and not just chemical neurotransmission. Very recently, "gene chip" technologies have allowed investigators to examine a host of new targets that are dysregulated in mood and anxiety disorders and/or targets for antipsychotic drugs. Based upon this knowledge base, one can hypothesize that certain brain systems are likely to be implicated in the mechanism(s) of action of antipsychotic drugs in the treatment of mood and anxiety disorders.

No. 40B
RESTORING THE BALANCE IN MANIC OR DEPRESSIVE BIPOLAR PATIENTS THROUGH THOUGHTFUL PHARMACOTHERAPY

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

SUMMARY:

In the last decade, treatments other than lithium have emerged as important in the management of bipolar disorder. Among the novel drug treatments, valproate benefits manic symptomatology both acutely and in prophylaxis. Lamotrigine has demonstrated efficacy in acute bipolar depression and maintenance efficacy in rapid-cycling bipolar patients. Atypical antipsychotic drugs have demonstrated efficacy in reducing acute manic symptoms, and there is emerging evidence for efficacy in depressive symtoms. Randomized, double-blind, placebo-controlled studies provide good evidence that regimens of risperidone or olanzapine in combination with lithium or valproate provide greater improvement in acute mania than the mood stabilizers alone. Valproate combined with antipsychotics provides greater improvement in mania than antipsychotic medication alone resulting in the need for lower dosage of antipsychotics. Though differences in efficacy have not been established, differences in weight gain may be more relevant in bipolar disorder than in schizophrenia due to the need to use standard mood stabilizers that often potentiate such weight gain. The treatment of the depressed phase of bipolar disorder is understudied and remains a common clinical dilemma for clinicians. Compared with the manic phases, episodes of bipolar depression are more frequent and of longer duration, yet the literature on this problem is minimal.

No. 40C
AUGMENTATION STRATEGIES TO EXPAND PHARMACOTHERAPEUTIC POTENTIAL IN TREATMENT-REFRACTORY MAJOR DEPRESSION

Richard C. Shelton, M.D., *1500 21st Avenue South, #2200, Nashville, TN 37212*

SUMMARY:

Depression isn't what it used to be. Psychiatrists are being required to treat depressed patients of greater severity and complexity, and yet with fewer resources than ever before. That means that each psychiatrist must be equipped with the best strategies the field has to offer to manage his or her patients. This presentation will present a mechanistic view of treatment resistant depression. Furthermore, newer treatment strategies, including psychotherapies, vagal nerve stimulation, novel antipsychotics, and others will be presented. These new treatments will be put into an overall context of resistant depression to produce a therapeutic heuristic that can be applied to clinical practice immediately.

REFERENCES:

1. Owens MJ, Mulchahey JJ, Plotsky PM: Molecular and neurobiological mechanisms in the treatment of psychiatric disorders. In: Psychiatry, edited by Tasman A, Kay J, Lieberman JA. WB Saunders Co., Philadelphia, pp. 210–257.
2. Shelton R, Tollefson GD, Tohen M., et al: A novel augmentation strategy for treatment-resistant major depression. Am J Psychiatry 2001;158:131–134.
3. Psychotic features in illness severity in combat veterans with chronic posttraumatic stress disorder. Biological Psychiatry 1999;45:846–852.

INDUSTRY-SUPPORTED SYMPOSIUM 40—THERAPEUTIC CHALLENGES, NOVEL APPROACHES: ANTIPSYCHOTICS IN THE MANAGEMENT OF MOOD AND ANXIETY DISORDERS, PART 2
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to use new strategies to more effectively manage the increasingly complex caseload that psychiatrists face in practice.

No. 40A
PROGNOSIS AND PHARMACOLOGICAL MANAGEMENT OF MEN AND WOMEN WITH PTSD

Frederick Petty, M.D., *3528 Doge Street, Omaha, NE 68131*

SUMMARY:

Posttraumatic stress disorder (PTSD) is a common and debilitating mental illness with lifetime population prevalence in the United States of 8% to 12%. Although, PTSD is traditionally considered to be an anxiety disorder, recent evidence suggest that perhaps up to 40% of patients with PTSD have psychotic symptoms. These psychotic symptoms can include hallucinations, delusions, and bizarre behavior.

The causes of posttraumatic stress disorder are most commonly ranked in domestic violence in women and accidents and assault in men. Symptoms of PTSD include intrusive thoughts, avoidant behavior, and hyperarousal. The serotonin reuptake inhibitor antidepressants are generally considered to be the first-line treatment of posttraumatic stress disorder. However, over half of patients do not demonstrate a complete or robust response to the SSRIs, thus a role for a typical antipsychotic in the treatment of PTSD may exist.

Several small studies in case reports suggest that the atypical antipsychotics risperidone, olanzapine, and quetiapine may alleviate symptoms of PTSD. Whereas the SSRIs appear to have their greatest effect in symptom reduction in the avoidant and hyperarousal symptoms, it may be that the typical antipsychotics have a preferential or selective effect upon the intrusive symptoms of PTSD, which are often considered the hallmark of this condition.

No. 40B
INTERPLAY BETWEEN DISEASE AND TREATMENT REGIMEN: SPECIAL SAFETY CONSIDERATIONS

Olga Brawman-Mintzer, M.D., *PO Box 250861, Charleston, SC 29425-0001*

SUMMARY:

As fears of extrapyramidal side effects traditionally associated with the use of antipsychotics lessened following the emergence of the new atypical antipsychotic drugs, practitioners became increasingly more comfortable using these compounds in the treatment of nonpsychotic patients, such as those suffering from mood and anxiety disorders. The use of these compounds in less impaired and higher functioning individuals has raised the attention of clinicians to previously ignored side effects and their potential impact in this population.

This lecture will address the potential risks that these compounds pose to the development of metabolic disorders such as glucose dysregulation and diabetes, dyslipidemias, hormonal disturbances (e.g., hyperprolactinemia), and potential risk for cardiac disturbances, such as QT interval prolongation. Further, the potential impact of these side effects on quality of life, compliance, and cost of care will be discussed.

REFERENCES:

1. Zarate CA Jr: Antipsychotic drug side effect issues in bipolar manic patients. J Clin Psychiatry 2000;61:52–61; discussion 62–3.
2. Ghaemi S: New treatments for bipolar disorder: the role of atypical neuroleptic agents. Journal of Clinical Psychiatry 2000;61 (suppl 14):33–42.

INDUSTRY-SUPPORTED SYMPOSIUM 41—THE PATHOPHYSIOLOGY AND TREATMENT OF IMPULSIVITY AND AGGRESSION IN PSYCHIATRIC DISORDERS, PART 1
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand mechanisms of impulsive behavior, their adaptations over time, and their role in major psychiatric disorders including bipolar cluster B personality, substance use, and stress-related disorders, and disruptive behavior disorders of childhood and adolescence. Learn the role of pharmacologic and other strategies in the physiologically based treatment of disorders where impulsivity is prominent.

No. 41A
MECHANISMS OF IMPULSIVITY

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

SUMMARY:

Before conscious consideration of an act can occur, a screening process involving the prefrontal cortex, amygdala, and other brain regions takes place. Impulsivity occurs when this behavioral filter fails or is bypassed. Impulsivity can lead to destructive or self-destructive acts including violence and suicide, but no specific behav-

ior is innately impulsive; any act can be impulsive or planned. Impulsive behavior, including aggression and suicide, is distinguished by lack of reflection or regard for the consequences of the behavior. There is increasing evidence that impulsivity can occur through at least two interrelated mechanisms: the filter can be defective, or an otherwise normal filter can be overloaded by overstimulation or by the generation of excessive "spontaneous" behavior. These mechanisms have different pharmacologies and time courses. Impulsivity appears to have state- and trait-sensitive components that may correspond in part to disturbances in generation or filtering of behavior. The balance between the components varies across disturbances of impulsivity. Behavioral sensitization may increase susceptibility to impulsivity, contributing to the apparent overlaps among bipolar disorder, substance abuse, and stress-related disorders. The pharmacologic and behavioral management of impulsivity depends on the balance between relatively trait-related deficits in the behavioral filter and more state-related problems of overstimulation or hypermotivation. Successful treatment requires complementary behavioral and pharmacologic strategies.

No. 41B
MOOD STABILIZERS AS ADJUNCTIVE TREATMENT IN SCHIZOPHRENIA

Daniel E. Casey, M.D. *P-7 MHDC, 3710 SW US Veterans Hospital Rd., Portland, OR 97201*

SUMMARY:

Psychotic disorders, particularly the schizophrenias, are primarily characterized as disorders of thought and perception. However, many patients with psychosis also have disturbances in affect, which is a cardinal feature of the schizoaffective subtype of schizophrenia. Additionally, disturbances in impulsivity, hostility and aggression are common clinical features across the entire range of psychotic diagnoses. Thus, mood stabilizers are increasingly being used as adjunctive treatment in both the acute and long-term management strategies for psychoses. Lithium was the first mood stabilizer to be regularly used in this setting, and now divalproex is the most commonly prescribed adjunct to manage mood disturbances as well as impulsivity and aggression in psychosis. While these drugs are best studied in the bipolar disorders, increasing evidence is supporting the use of these drug strategies in other areas. Mood stabilizers are most commonly used in the maintenance phase of schizoaffective disorder. While these drugs are best studied in bipolar disorders, they are also commonly used to treat schizoaffective psychosis. Additionally in a large randomized, well-controlled study of patients with an acute exacerbation of schizophrenia, divalproex, when added to olanzapine or risperidone, significantly improved symptoms of psychosis as early as day 3 and was well tolerated compared to antipsychotic monotherapy. Data regarding the use of mood stabilizers in psychosis will be reviewed and treatment recommendations will be proposed.

No. 41C
AGGRESSION, VIOLENCE, AND PSYCHOPATHOLOGY: A DEVELOPMENTAL APPROACH

Hans Steiner, M.D., *401 Quarry Road, Room 1136, Stanford, CA 94305-5340*

SUMMARY:

We will focus on how subtypes of aggression (i.e., affective and predatory) develop in children and can be derailed by pathological events to form certain syndromes. Of particular interest are disruptive behavior disorders (oppositional defiant disorder, conduct disorder, intermittent explosive disorder) and trauma-related syndromes (PTSD, dissociative disorders), which have a high likelihood of manifesting as adolescent delinquency and adult criminality. The link to adult personality disorders (antisocial personality, borderline personality) will be elucidated. These disorders can be conceptualized as a continuum of disturbances of the aggression system under the impact of genetic, constitutional, and environmental factors. We will elucidate maximally effective intervention strategies in different phases of development, including preventive measures, psychotherapy, and psychopharmacology. By matching methods to intervention targets according to developmental principles, we can maximize our chances of being successful in treating these conditions characterized by a high persistence of pathology. Treatment strategies and methods will be discussed.

REFERENCES:

1. Swann AC, Anderson JC, Dougherty DM, Moeller FG: Measurement of inter-episode impulsivity in bipolar disorder. Psychiatr Res 2001;101:195–197.
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INDUSTRY-SUPPORTED SYMPOSIUM 41—THE PATHOPHYSIOLOGY AND TREATMENT OF IMPULSIVITY AND AGGRESSION IN PSYCHIATRIC DISORDERS, PART 2
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should understand mechanisms of impulsive behavior, their adaptations over time, and their role in major psychiatric disorders including bipolar cluster B personality, substance use, and stress-related disorders, and disruptive behavior disorders of childhood and adolescence; learn the role of pharmacologic and other strategies in the physiologically based treatment of disorders where impulsivity is prominent.

No. 41A
VIOLENCE, SUBSTANCE-USE DISORDERS, AND PTSD

Kathleen T. Brady, M.D., *67 President Street, Charleston, SC 29425*

SUMMARY:

The connection between aggression, impulsivity, and substance use disorders (SUDs) is complex, with many violent crimes and acts of aggression committed when individuals are intoxicated. The disinhibition caused by substances may make violence and acts of aggression more likely to occur. Also, it is possible that the personality characteristics and risk factors that predispose to violence also predispose to the development of SUDs. A number of studies exploring the relationship between SUDs, impulsivity, and aggression will be reviewed. In addition, the relationship and commonality of impulsive aggression and SUDs in individuals with PTSD will be examined. In the clinical arena, many psychiatric disorders that are commonly associated with impulsivity and aggression, such as impulse dyscontrol disorders and bipolar disorder, are often comorbid with SUDs. Studies show that comorbid SUDs are a risk factor for violence in chronically mentally ill individuals and are often implicated in self-directed violence and suicide. There are many common neurobiologic systems implicated in violence, impulsivity, and SUDs, such as the serotonergic, opiate, and noradrenergic systems. Data concerning

the use of pharmacologic interventions such as SRIs and anticonvulsants in the treatment of impulsive aggression and SUDs, as well as psychosocial approaches, will be discussed.

No. 41B
THE IMPULSIVE-AGGRESSION SYMPTOM DOMAIN IN PERSONALITY DISORDERS

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

SUMMARY:

Personality disorders are common, lifelong and associated with substantial morbidity, mortality and functional impairment. Impulsivity/aggression is a core behavioral symptom domain that cuts across several of the personality disorders, particularly the cluster B personality disorders such as borderline personality disorder (BPD). Conceptualizations of BPD have changed over the years due to different theoretical viewpoints of this disorder. A symptom-based approach to BPD focuses on the impulsive-aggresive symptom domain and the affective instability symptom domain, which may be linked to novel findings with regard to brain circuits, neurotransmitter systems and genetic mechanisms. Various psychosocial and medication treatment approaches have been studied in BPD. Medication approaches for the amelioration of core symptoms have included SSRIs, MAO inhibitors, atypical neuroleptics, and mood stabilizers. Recent double-blind, placebo-controlled trials with anticonvulsants have documented improvement in the impulsive-aggressive and affective instability symptom domains, as well as improvement in global functioning in BPD. New data from a large multicenter, placebo-controlled trial in cluster B personality disorders as well as new data in BPD will be presented, and the impact of this data on revising our conceptualization of BPD and practical management of these difficlut patients will be highlighted.

REFERENCES:

1. Brady KT, Myrick H, McElroy S: The relationship between SUD, impulse control disorders and pathologic aggression. Am J Addictions 1998;7:221–230.
2. Chrome L, Levine J, Allingham B. Changes in use of valproate and other mood stabilizers for patients with schizophrenia from 1994 to 1998. Psychiatr Serv. 2000 May;51(5):634–8.
3. Hollander E, Allen A, Lopez RP,Bienstock CA, Grossman R, Siever LJ, Merkatz L, Stein DJ. Apreliminary double-blind, placebo-controlled trial of divalproex sodium in borderline personality disorder. J Clin Psychiatry 2001;62(3):199–203.

INDUSTRY-SUPPORTED SYMPOSIUM 42—NEW PERSPECTIVES ON SCHIZOPHRENIA SPECTRUM DISORDERS AND THEIR TREATMENT, PART 1
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

The objectives of this symposium are to familiarize the participants with the schizophrenia spectrum disorders, to aid them in the recognition of these subjects in a clinical setting, and update them with the latest information regarding pharmacologic treatment options in these disorders.

No. 42A
VALIDATING SCHIZOTAXIA CRITERIA FOR FUTURE PREVENTION OF SCHIZOPHRENIA

Ming T. Tsuang, M.D., *74 Fenwood Road, Boston, MA 02115*

SUMMARY:

In this presentation, the nature of schizotaxia (a predisposition to developing schizophrenic psychosis) will be discussed. Based originally on Paul Meehl's conception of schizotaxia, we have operationalized a putative syndrome that includes neuropsychological deficits, negative symptoms, manifestations of social dysfunction, and positive treatment responses to low doses of atypical neuroleptic medications. For this presentation, our continued attempts to validate our operational criteria for schizotaxia and to understand its relationship with the current DSM-IV definition of schizotypal personality disorder will be presented. It is very important to identify a subgroup of homogeneous subjects who have not received neuroleptic medication because they have not demonstrated prodromal symptoms, yet are at high risk for schizophrenia because they manifest cognitive deficits, negative symptoms, and social dysfunction. By studying relatives of schizophrenic patients with schizotaxia, it is our hope to prepare for the early intervention in, and prevention of, schizophrenia.

No. 42B
THE SCHIZOPHRENIA PRODROME: EARLY TREATMENT FINDINGS

Barbara Cornblatt, Ph.D., *75-59 263rd Street, Glen Oaks, NY 11004;* Todd Lencz, Ph.D.; Michael Obuchowski; Christopher Smith, M.S.; Manoj R. Shah, M.D.

SUMMARY:

Introduction. Evidence supporting the prevention of schizophrenia has dramatically increased interest in the prodrome—the phase just preceding the onset of psychosis. The prodrome, frequently identified in adolescents, resembles schizotypal personality disorder. In this report, we present preliminary treatment findings from the Hillside Hospital Recognition and Prevention (RAP) Program, one of the first prospective studies of the schizophrenia prodrome.

Methods: The RAP treatment strategy is naturalistic and symptom based. An initial interest is to determine how prodromal symptoms are treated in standard practice. Findings are reported for 61 adolescents, characterized by attenuated negative, disorganized, and/or positive symptoms, who completed at least six months of treatment.

Results: 80% of the RAP patients received pharmacotherapy, in most cases, either a novel antipsychotic (NAP; primarily olanzapine and risperidone), an antidepressant (a selective serotonin reuptake inhibitor, SSRI), or a combination of the two. Over 85% of these adolescents either improved or stabilized, with SSRIs as effective as NAPs in improving symptoms.

Discussion: Early intervention thus appears potentially effective in slowing clinical deterioration in adolescents considered to be at risk for schizophrenia. Moreover, although based on non-random assignment, it appears that medications other than NAPs should be considered when intervening prior to the onset of psychosis.

REFERENCES:

1. Cornblatt B, Lencz T, Kane J: Treatment of the schizophrenia prodrome: is it presently ethical? Schizophrenia Research 2001.
2. Tsuang MT, Stone WS, Faraone SV: Towards the prevention of schizophrenia. Biol Psychiatry 2000;48:349–356.

INDUSTRY-SUPPORTED SYMPOSIUM 42—NEW PERSPECTIVES ON SCHIZOPHRENIA SPECTRUM DISORDERS AND THEIR TREATMENT, PART 2
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

The objectives of this symposium are to familiarize the participants with the schizophrenia spectrum disorders, to aid them in the recognition of these subjects in a clinical setting, and update themselves with the latest information regarding pharmacologic treatment options in these disorders.

No. 42A
NEUROBIOLOGY AND PHARMACOLOGIC TREATMENT OF SCHIZOTYPAL PERSONALITY: IMPLICATIONS FOR PHARMACOLOGY

Larry J. Siever, M.D., *One Gustave Levy Place. Box 1230, New York, NY 10029;* Harold W. Koenigsberg, M.D.; Vivian Mitropoulou, M.A.; Marianne Goodman, M.D.; Monte S. Buchsbaum, M.D.

SUMMARY:

Schizotypal personality disorder (SPD) is closely related to more severe schizophrenic disorders. It is often underrecognized in clinical settings as its anhedonia and flat affect are mistaken for refractory depression, and it is treated often unsuccessfully with antidepressants. It may be characterized by significant social/occupational impairment but does not easily respond to psychosocial treatments and often has unusual sensitivity to medication side effects. Neurobiologically, patients show some similarities to schizophrenic patients, but appear better buffered in terms of cognitive and dopaminergic function. In a nine-week, randomized, double-blind, placebo-controlled study of low dose of risperidone (0.25 mg/per day to 2 mg per day), 25 SPD patients receiving active medication had lower scores on the general symptom scale, PANSS positive symptom scale, and a trend for a lower PANSS negative score as well as for cognitive improvement compared with subjects receiving placebo. Side effects were generally well tolerated, and there was no group dropout rate for side effects. Thus, the low-dose risperidone appeared to be efficacious in reducing positive and general psychopathologic symptoms and might, by virtue of indirect effects by 5-HT_2 blockade, reduce negative symptoms as well.

No. 42B
COGNITIVE ENHANCERS IN THE SCHIZOPHRENIA SPECTRUM

Marianne Goodman, M.D., *1 Gustave L. Levy Place, Box 1230, New York, NY 10029;* Vivian Mitropoulou, M.A.; Harold W. Koenigsberg, M.D.; Antonia S. New, M.D.; Liza Maldari, M.A.; Larry J. Siever, M.D.

SUMMARY:

Introduction: Cognitive impairment in the schizophrenia spectrum disorders is a critical determinant of their functional outcome. Individuals with schizotypal personality disorder (SPD) are prototypic of the schizophrenia spectrum and do not show the global cognitive deterioration of patients with schizophrenia; however, they have selective impairments in working memory, verbal learning, and sustained attention. These cognitive impairments in SPD may be more readily reversible, less contaminated by medication confounds, and more likely to demonstrate benefit from pharmacologic interventions than in subjects with schizophrenia.

As cognition is modulated in part by catecholamines, pharmacologic agents acting on the dopaminergic and/or noradrenergic system may improve cognition in impaired populations such as those with schizophrenia, attention deficit disorder, and aging.

Methods: We studied cognitive function using a single dose (30mg) of amphetamine administration and four-week trials of a dopaminergic (mixed D_1-D_2) agent, pergolide, and a noradrenergic agent, guanfacine, utilizing a comprehensive cognitive battery.

Results: Results of the attention and verbal learning indicate that all three agents significantly improved performance in working memory ($p<0.05$) and related cognitive functions.

Discussion: These findings suggest that cognitive enhancement may be achieved in the schizophrenia spectrum and by dopaminergic and noradrenergic agents.

No. 42C
THE PROMISE OF ATYPICAL ANTIPSYCHOTICS FOR BORDERLINE DISORDERS

S. Charles Schulz, M.D., *2450 Riverside Avenue, Minneapolis, MN 55454-1495;* Kelly L. Camlin, M.S.W.; Sally A. Berry, M.D.; Yanjee Adit, M.D.; Lee Friedman, Ph.D.

SUMMARY:

Introduction: Borderline and schizotypal personality disorders often present substantial challenges in treatment. One part of management can include reduction in symptoms through use of medications; however, some medications, although efficacious, are not well tolerated. The purpose of this paper is to summarize three studies of atypical antipsychotic medications.

Methods: Risperidone, olanzapine, and quetiapine have all been evaluated utilizing objective rating scales in eight-week trials. Risperidone was tested versus placebo, while the other two compounds were evaluated in an open-label design. Patients were seen in a research clinic designed to be therapeutic for BPD and SPD patients.

Results: Risperidone led to substantial improvement in GAF and reduction in SCL-90 symptoms; however, those patients assigned to placebo also improved. Olanzapine also led to decreased SCL-90 scores and reduced impulsivity. Six patients have completed the quetiapine study, with some substantial improvement in symptoms. All the medications tested have been well tolerated.

Discussion: These three studies, although preliminary in nature, indicate a usefulness in BPD and SPD. Not only were symptoms reduced, nearly all patients completed the studies. Further controlled trials are clearly indicated to assist the field in choosing appropriate medication treatment for these patients.

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1. Kirrane RM, Siever LJ: New perspectives on schizotypal personality disorder. Current Psychiatry Reports 2000;2:62–66.
2. Friedman JI, Temporini H, Davis KL: Pharmacologic strategies for augmenting cognitive performance in schizophrenia. Biol Psychiatry 1999;45:1–16.
3. Schulz SC, Camlin KL. Treatment of borderline personality disorder: potential of the new antipsychotic medications. J Pract Psychiatry Behav Health 1999;5:247–255.

INDUSTRY-SUPPORTED SYMPOSIUM 43—NONCHOLINERGIC TREATMENTS FOR ALZHEIMER'S DISEASE: PRESENT KNOWLEDGE, FUTURE HOPE
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand existing cholinergic treatments of AD; better

comprehend the neuroanatomy of AD; recognize options that may be used alone or in combination with existing treatments; and consider the future of AD treatments.

No. 43A
THE DIAGNOSIS AND TREATMENT OF ALZHEIMER'S DISEASE: AN OVERVIEW

Barry D. Liebowitz, Ph.D., *18-101 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857*

SUMMARY:

Since 1984, standardized clinical criteria have existed to facilitate the diagnosis of Alzheimer's disease (AD). New criteria have been proposed for psychosis, depression, and sleep disturbance in AD. All of these are appropriate targets for therapeutics. Several cholinesterase inhibitors are approved by the FDA for AD. They may provide limited symptomatic improvement in cognition and may enhance activities of daily living in patients with mild to moderate AD. Data on long-term treatment and effects on patients with more severe disease are lacking. Studies are ongoing with other cholinergic agents, as well as with estrogen, NSAIDs, and botanical agents. Vitamin E and selegiline have been shown to delay adverse outcomes of AD. The NMDA antagonist memantine has been shown effective for more severe disease.

Successful patient management incorporates pharmacological and nonpharmacological approaches. Behavioral manifestations of AD are important considerations. Depression is common in patients with AD. The choice of antidepressant should be based on its adverse effects. Aggression and agitation also are common and increase caregiver burden, and many drugs have been evaluated in open trials. Sleep disturbances and wandering also should be addressed. Nonpharmacological approaches, including caregiver support, must be integral to any successful treatment plan.

No. 43B
CURRENT TREATMENTS FOR ALZHEIMER'S DISEASE: CHOLINESTERASE INHIBITORS

Rachelle S. Doody, M.D., *6550 Fannin, Suite 1801, Houston, TX 77030*

SUMMARY:

Cholinesterase inhibitors, often in conjunction with high-dose vitamin E, represent the current standard of care for treating Alzheimer's disease (AD). The three agents in common use have been shown to benefit cognition, function, and behavior in short-term, placebo-controlled studies, and in longer, placebo-controlled studies up to one year. The open-label extensions of studies with several agents suggest that the benefits to patients may extend well beyond one year, but the absence of placebo control for these long-term observations reduces our ability to generalize the results. Cholinesterase inhibitors were developed for symptomatic treatment of mild to moderate AD. Subsequent studies support the likelihood that these drugs benefit patients with severe AD, as well as patients with other forms of dementia, such as dementia with Lewy bodies. It is unlikely that any currently conceived approach to AD would completely prevent the disease from occurring in all members of the population. Cholinesterase inhibitors will, therefore, remain part of the treatment of AD for the foreseeable future.

No. 43C
THE NEUROANATOMY OF ALZHEIMER'S DISEASE

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

SUMMARY:

Alzheimer's disease (AD) is characterized by degenerative changes in a variety of neurotransmitter systems. These include, but are not limited to, alterations in the function of the monoaminergic neural systems that release glutamate, norepinephrine, and serotonin, as well as a few neuropeptide-containing systems. In addition to the changes observed in these neurotransmitter systems, AD is characterized by degenerative changes in selected brain regions, including the temporal and parietal lobes and restricted regions within the frontal cortex and cingulate gyrus. The degeneration of these systems may underlie specific aspects of the dementia associated with AD. A major problem in AD research today is that none of the hypothesized mechanisms currently in vogue are able to explain the cellular and regional distribution pattern that characterizes the neuropathology of AD. For example, the mechanisms underlying the degeneration of cholinergic neurons within the basal forebrain are unknown. This presentation will summarize our understanding of the nature and extent of the changes associated with these neural systems and discuss possible treatment approaches and a potential mechanism involving chronic neuroinflammation to explain the pattern of neuropathological changes seen in AD.

No. 43D
BEYOND ACETYLCHOLINE: THE SEARCH FOR BETTER TREATMENT OPTIONS (PART 1)

Jacobo E. Mintzer, M.D., *5900 Core Road, Suite 203, North Charleston, SC 29406*

SUMMARY:

The biological processes that underlie the steady progression of Alzheimer's disease (AD) are complex and involve a disruption of multiple neurochemical pathways. Even so, research and treatments relating to AD have long focused on the cholinergic pathway. Accordingly, the cholinesterase inhibitors are the only established drugs available for the symptomatic treatment of mild to moderate AD. Although newer generation cholinergic agents have a more favorable side-effect profile, they are limited by marginal efficacy. Two alternative therapies that involve mechanisms other than cholinergic augmentation will be discussed in this presentation.

There is growing evidence that glutamate, the most prevalent excitatory neurotransmittor in the brain, is involved in, if not central to, the pathology of AD. Promising data indicate that NMDA receptor antagonists may provide neuroprotection and enhanced cognition in AD patients. Clinical data on the efficacy and safety of memantine, a noncompetitive NMDA receptor antagonist, will be reviewed. Additionally, Ginkgo biloba is proposed to have antioxidant, neurotrophic, and anti-inflammatory properties. Studies on the potential efficacy of Ginkgo biloba in slowing the progression of AD will be reviewed.

No. 43E
BEYOND ACETYLCHOLINE: THE SEARCH FOR BETTER TREATMENT OPTIONS (PART 2)

Mary Sano, Ph.D., *630 West 168th Street, New York, NY 10032*

SUMMARY:

To date, approved treatments for Alzheimer's disease (AD) have focused primarily on cholinergic enhancement, although other approaches are being explored. Other classes of agents that may have a benefit in AD treatment include antioxidants such as vitamin E,

anti-inflammatory agents, and estrogens. With this broader set of agents questions will be raised about their use alone or as adjuncts to current therapies. In addition, enthusiasm has been raised for the development of agents for slowing decline and for primary and secondary prevention of dementia. Evaluating treatments for these purposes, however, requires different approaches to trial design. This presentation will review current knowledge about these classes of agents in the treatment of AD. Recent studies will be used to illustrate safety issues as well as efficacy. Also, treatment effects on noncognitive outcomes such as function and behavior will be reviewed. The need to rely on randomized clinical trials to support treatment decisions will be discussed. The challenge of drug development is to focus on protection from decline, possibly in the absence of observable benefit, to encourage screening for the earliest detectable changes, and to raise awareness and commitment to the task of clinical trials designed to assess disease prevention.

REFERENCES:

1. Small G, et al: Diagnosis and treatment of Alzheimer's disease and related disorders. JAMA. 1997;278:1368–1371.
2. Doody RS, Geldmacher JS, et al: Open-label, multicenter, phase 3 extension study of the safety and efficacy of donepezil in patients with Alzheimer disease. Arch Neurol 2001;58:427–33.
3. Wenk GL, Barnes CA: Regional changes in the hippocampal density of AMPA and NMDA receptors across the lifespan of the rat. Brain Res 885:1–5.
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INDUSTRY-SUPPORTED SYMPOSIUM 44—SLEEP DISORDERS AND PSYCHIATRIC ILLNESSES: SCIENTIFIC FOUNDATIONS
Supported by Sepracor, Inc

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should understand insomnia and sleep disorders in relation to psychiatric illnesses, the economic and psychosocial burden imposed by insomnia, and important differences among current therapeutic modalities.

No. 44A
SLEEP AND PSYCHIATRIC ILLNESSES

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

SUMMARY:

Insomnia/disordered sleep may be both a symptom and a cause of behavioral illness and mood disorder. As many as 60% of psychiatric outpatients complain of disturbed sleep. Studies of depressives indicate as many as 85% will at some point experience insomnia. Unresolved insomnia that impairs daytime function may be associated with significant psychiatric morbidity, predominantly major depression. In young adults with no history of mood disorders, insomnia of more than two-weeks' duration is a risk factor for onset of major depression within three years. Sleep complaints have been found to predict relapse in remitted depressed patients.

Patients with bipolar disorder also may suffer from sleep disturbance. Sleep changes may even precipitate mania in these patients. Sleep disturbance has also been associated with post-traumatic stress disorder (PTSD). U.S. prevalence of PTSD has been estimated at 8%; in two-thirds of these patients the condition becomes chronic. Recurrent nightmares and sleep-disturbance episodes are key criteria for PTSD diagnosis and are among the most commonly reported symptoms. Clinicians aware of the frequent co-existence of these disorders will be able to make more appropriate and timely diagnoses and pharmacotherapeutic interventions. Since antidepressant therapies may impair sleep quality, insomnia in depressed patients may need to be addressed separately.

No. 44B
EPIDEMIOLOGY AND ECONOMIC BURDEN OF INSOMNIA

James K. Walsh, Ph.D., *232 South Mills Road, Chesterfield, MO 63017*

SUMMARY:

An estimated 60 million Americans suffer from insomnia. Work-related difficulties (decreased job performance, absenteeism) and a greater likelihood of comorbid physical and mental health conditions have been associated with the disorder. Just the direct economic costs of insomnia in the U.S., including prescription and nonprescription medications and physician visits related to insomnia, have been estimated to exceed $14 billion per year. Though indirect costs are more difficult to measure, insomnia no doubt contributes to the cost of lost productivity and workplace accidents. But the economic burden is only a part of the issue. Insomnia also contributes to psychosocial disability, increased utilization of health care resources, and adds to the risk of mortality. Because insomnia may be correlated with a number of physical and psychiatric illnesses, improved recognition and diagnosis, followed by the appropriate intervention, might prevent or mitigate those conditions, which would otherwise increase health care expenditures.

However, establishing the most appropriate therapy/intervention for insomnia may be problematic. Insomnia is associated with many underlying illnesses, and patients have varying therapeutic needs. The best therapeutic approach tailors treatment to patient-specific clinical criteria.

No. 44C
CURRENT THERAPEUTIC APPROACHES TO SLEEP

Ruth M. Benca, M.D., *6001 Research Park Boulevard, Madison, WI 53719-1176*

SUMMARY:

A variety of pharmacological agents are currently used in the treatment of insomnia and other sleep problems encountered in psychiatric patients. These include sedating hypnotics, anxiolytics, antihistamines, antidepressants, and melatonin. Behavioral therapies and bright light have also been effective in treating sleep disturbances. The mechanisms of these therapies will be discussed in relation to the neurobiology of sleep, the circadian system, and stress. Sedative hypnotics, anxiolytics, and barbiturates bind to the GABA(A) receptor complex, resulting in such effects as sedation, anxiolysis, muscle relaxation, and increased seizure threshold. Specific clinical effects may be mediated by benzodiazepine receptor subtypes. That has led to the development of more selective hypnotic agents with receptor-subtype specificity.

Antidepressants may variously affect sleep, producing both sedative and/or sleep-disturbing effects, as well as effects on specific sleep stages. Melatonin and light therapy appear to have primary effects on the circadian pacemaker, and so may be more beneficial for insomnia secondary to inappropriate timing of sleep.

REFERENCES:

1. Roth T: The relationship between psychiatric diseases and insomnia. International Journal of Clinical Practice 2001;Suppl (116):3–8.
2. Walsh JK, Engelhardt CL: The direct economic costs of insomnia in the United States for 1995. Sleep 1999;22 Suppl2:S386–393.
3. Obermeyer WH, Benca RM: Effect of drugs on sleep. Neurological Clinics of North America 1996;14:827–840.

INDUSTRY-SUPPORTED SYMPOSIUM 45—THE BURDEN OF SCHIZOPHRENIA: WHY PATIENTS DON'T GET BETTER Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate state-of-the-art assessment and available treatment strategies to deal with treatment-refractory schizophrenia.

No. 45A
DEFINING NONRESPONSE IN SCHIZOPHRENIA: WHY PATIENTS DON'T DO WELL

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

SUMMARY:

The newer generation of (atypical) antipsychotics has seemingly revolutionized the treatment of psychotic disorders with their superior efficacy in treating negative and neurocognitive symptoms, substantially reduced risk of EPS and tardive dyskinesia, and greater efficacy in otherwise refractory patients. Despite these advantages, a significant number of patients appear to respond suboptimally, and complete functional recoveries in patients suffering from schizophrenia are still uncommon. How does the functional and social outcome in schizophrenia in the past decade of atypical antipsychotics compare to prior decades? Have some measures of outcome been impacted to a greater extent by the newer generation of antipsychotics than others? What aspects of the "disease" of schizophrenia contribute to poor outcome? What treatment factors contribute to poor functional outcome? What patient factors are associated with poor treatment response? How does one assess treatment refractoriness, and how do aspects of refractoriness (nature, degree, timing, etc.) and possible causes (noncompliance, substance abuse, etc.) guide treatment selection? This presentation will attempt to define the nature of inadequate treatment response and describe the several ways in which "patients don't do well." This presentation will then focus on the state-of-the-art assessment and differential diagnosis of this difficult clinical problem of treatment-refractory schizophrenia.

No. 45B
WHEN PSYCHOSIS DOESN'T IMPROVE

Alan J. Mendelowitz, M.D., *7559 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

The treatment of patients with schizophrenia continues to be a clinical challenge for patients, family, and clinicians. With a new generation of antipsychotics, clinical expectations have increased for patients, families, and clinicians as to the level of improvement that patients should manifest. Often times in clinical settings, patients' psychotic symptoms do not improve to the level that they or their treatment team would like. The question of why a psychotic episode does not improve in some of these cases will be examined. The considerations of inadequate treatment of positive symptoms, negative symptoms, and mood symptoms will be considered. The question of what "treatment response" means and whether our expectation is realistic will also be considered. The question of what other factors may complicate treatment response will be evaluated as well. Considerations of what to do when patients do not improve will be discussed.

No. 45C
NEGATIVE AND COGNITIVE FUNCTION

Michael D. Jibson, M.D., *1500 E Medical Center Drive, Ann Arbor, MI 48109-0016*

SUMMARY:

Negative symptoms and cognitive impairments are important treatment targets in patients with schizophrenia, as these symptoms substantially contribute to functional disability and are subjectively distressing. Negative and cognitive symptoms have multiple potential etiologies, may be primary to the underlying illness, or secondary to antipsychotic drug side effects—a comorbid major depression, demoralization, or self-stigma. Clinicians must determine the severity and etiology of negative symptoms based on clinical exam and information from family and other care providers. New bedside strategies are becoming available to aid the clinician in directly assessing and monitoring cognitive impairments. Atypical antipsychotics potentially target negative and cognitive symptoms and may offer distinct advantages over older agents. The relative advantage of the atypical antipsychotics theoretically may relate to interactions with dopamine receptors or other neurotransmitter systems. Other adjunctive pharmacological interventions are being investigated that may further address residual negative and cognitive symptoms. In addition, new therapeutic treatment strategies such as cognitive remediation have been developed that may benefit cognitive function in selected patients with schizophrenia.

No. 45D
COMORBIDITIES IN SCHIZOPHRENIA: DEPRESSION AND SUBSTANCE ABUSE

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

SUMMARY:

The management of schizophrenia is often complicated by the presence of physical and psychiatric comorbidities. Chief among the latter are mood disturbances and substance abuse. Approximately 50% of patients with schizophrenia experience comorbid depression. This is associated with poorer outcome, more frequent relapses, and markedly elevated risk of suicide in these patients. Until recently, recommended practice for treating comorbid depression was to add an antidepressant to the conventional antipsychotic medication. However, recent data suggest that atypical antipsychotics—now in the mainstream for treatment for schizophrenia—may have thymoleptic and mood-stabilizing effects for patients with schizophrenia and in mood disorders.

Substance abuse is also extremely common and is associated with recidivism, noncompliance, violent behavior, and poor long-term outcome. Management consists of accurate assessment, tailored dual-diagnosis programs, and assertive case management. Also, the impact of atypicals upon substance abuse in schizophrenia is of considerable heuristic interest.

In accordance with a broader appreciation of domains of outcome in schizophrenia, this presentation will focus on the impact of novel antipsychotic medications on depressive symptoms in schizophrenia and on comorbid substance abuse. Emerging data suggest that these

agents may have (direct) beneficial effects on these domains of outcome. The extent to which the atypical antipsychotics differentiate between each other on these two outcomes will also be explored.

No. 45E
WHY PATIENTS STOP THEIR ANTIPSYCHOTICS AND WHAT TO DO ABOUT IT

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

SUMMARY:

As treatments for schizophrenia continue to improve, noncompliance becomes an increasingly important barrier to achieving the best outcomes. Unfortunately, research on medication noncompliance in schizophrenia has lagged behind the other advances in the psychopharmacology of schizophrenia. This presentation will review recent work in this area, including:

1.) Theoretical issues: Risk factor models will show how medication nonresponse and medication noncompliance are interrelated. Also, nomenclature (e.g., noncompliance vs. nonadherence) has theoretical and political implications; 2.) Assessment issues: Helpful assessment techniques will be covered; 3.) Psychosocial management: There is growing data on psychosocial interventions that improve medication adherence, such as certain forms of psychoeducation and cognitive-behavioral therapy; 4.) Pharmacologic management: The first step in pharmacologic management is to select an antipsychotic that is most likely to help the patient remain compliant. Medication characteristics that will be reviewed include efficacy considerations, side-effect assessment, and route of administration. For antipsychotics, extrapyramidal symptoms have been the most common cause of noncompliance and still are a problem even with the newer medications. More recently, weight gain has been associated with noncompliance. The advantages and disadvantages of oral conventional, depot conventional, and newer "atypical" antipsychotics will be reviewed.

REFERENCES:

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2. Conley RR, Buchanan RW: Evaluation of treatment-resistant schizophrenia. Schizophr Bull 1997;23:663–674.
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4. Siris SG: Depression in schizophrenia: perspective in the era of atypical antipsychotic agents. Am J Psychiatry 2000; 157:1379–1389.
5. Fenton W: Determinants of medication compliance in schizophrenia: empirical and clinical findings. Schizophr Bull 1997;23:637–651.

INDUSTRY-SUPPORTED SYMPOSIUM 46—IDENTIFICATION AND MANAGEMENT OF DAYTIME FATIGUE AND SLEEPINESS IN PSYCHIATRY
Supported by Cephalon Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the differential diagnoses and intervention options for daytime fatigue and sleepiness in patients with psychiatric disorders.

No. 46A
SLEEPINESS AND FATIGUE: NEUROBEHAVIORAL AND PHYSIOLOGICAL FEATURES

David F. Dinges, Ph.D., *1013 Blockley Hall, 423 Guardian Drive, Philadelphia, PA 19104*

SUMMARY:

Sleepiness and fatigue are among the most prevalent nonspecific symptom complaints associated with impaired functional capability and reduced waking capacity. They can result from a wide range of behavioral and medical conditions including acute or chronic cumulative sleep debt, nonrestorative sleep, disturbed sleep and difficulty sleeping, primary sleep disorders, and disturbed circadian rhythms. Sleepiness involves an elevated propensity to fall asleep and an increased instability of waking vigilance, both of which can be assessed with objective neurobehavioral performance and physiological measures. Sleepiness is the product of an increasingly well-delineated neurobiological interaction of the homeostatic drive in sleep and endogenous circadian pacemaker. In contrast, subjective fatigue refers to a mismatch between the desire or drive to achieve certain goal-directed behaviors and the effort required over time to achieve those behaviors. Its etiology is much less well understood, and its objective assessment is problematic, although the same factors that produce sleepiness can produce fatigue. Fatigue can have a number of other meanings and hence is not used in sleep disorders medicine, although it is the term widely use throughout government, industry, labor, and the public to indicate the effects of working too long, getting too little rest, etc. Evaluation and treatment of sleepiness and fatigue are critical to ensure safety, since their origin in sleep disorders or in medical and neuropsychiatric conditions poses a risk to persons who drive or operate in safety-sensitive environments.

No. 46B
PRIMARY SLEEP DISORDERS ASSOCIATED WITH EXCESSIVE DAYTIME SLEEPINESS

Mary B. O'Malley, M.D., *24 Stevens Street, Norwalk, CT 06856*

SUMMARY:

Somnolence is a common complaint in psychiatric patients. Symptoms of sleepiness can masquerade as mood or cognitive complaints, complicating psychiatric diagnosis and treatment. This presentation will describe the primary sleep disorders that can manifest as excessive daytime sleepiness, their diagnosis, and the specific treatments they require.

Acute and chronic sleep deprivation represents the most common cause of sleepiness in the general population. The cognitive effects of such sleepiness has been shown to greatly decrease work performance, impair mood and judgment, and significantly increase the risk of driving and work-related accidents. Sleep apnea syndrome, which has an especially high prevalence among schizophrenic patients, adds sleepiness as well as cardiovascular consequences to the burden any psychiatric illness already imposes. Patients with narcolepsy frequently experience ancillary symptoms along with sleepiness that may be confused with psychiatric disorders. A variety of other sleep disorders such as periodic limb movement disorder and circadian rhythm or jet lag/shift work syndromes are also common and can present particular problems in managing the treatment of the mentally ill. Diagnostic testing used to assess sleepiness, and the characteristic findings related to these specific sleep disorders, will be explained. Finally, pharmacologic and nonpharmacologic treatment strategies for each of these disorders will be reviewed.

No. 46C
FATIGUE AND EXCESSIVE DAYTIME SLEEPINESS IN PSYCHIATRIC DISORDERS

Karl Doghramji, M.D., *1015 Walnut Street, Suite 319, Philadelphia, PA 19107*

SUMMARY:

The complaints of fatigue and excessive daytime sleepiness (EDS) abound in psychiatric settings. Several demographic surveys suggest, for example, that tiredness, fatigue, and reduced energy are expressed by 75% to 95% of patients with major depressive disorder (MDD). Conversely, 46% of individuals in the general population having a complaint of hypersomnia suffer from at least one psychiatric disorder, including, in order of prevalence, anxiety, affective, substance use, and other disorders. Longitudinal studies also suggest that persistent hypersomnia, in the absence of identifiable comorbid psychiatric disturbance, strongly predicts the future emergence of Axis I disturbances, suggesting the possibility of a bi-directional relationship between these entities. Recent studies also suggest that disturbed sleep and fatigue are the most commonly reported residual symptoms in MDD patients who have achieved remission with antidepressant treatment. Additionally, the persistence of these residual symptoms is associated with impaired daytime performance, accidents, the increased use of concomitant medications, and recurrence.

This presentation will review the differential diagnosis of fatigue and EDS in the psychiatric setting. Emphasis will be given to affective disorders, which have received greater research attention regarding sleep/wake disturbances than any other psychiatric syndrome. The presentation will also review strategies to address these symptoms. They include monotherapy (e.g., activating antidepressants), polytherapy (e.g., antidepressants and alerting agents, thyroid hormone, other antidepressants, etc.), and behavioral management techniques (sleep hygiene, restriction of time in bed, circadian alignment, phototherapy, etc.).

No. 46D
CLINICAL MANIFESTATIONS OF FATIGUE IN CHRONIC FATIGUE SYNDROME

Anthony L. Komaroff, M.D., *10 Shattuck Street, Suite 602, Boston, MA 02115*

SUMMARY:

The condition of being chronically tired is common and is most often caused by overwork or major depression. A relatively small percentage of chronically tired individuals fulfill the Centers for Disease Control (CDC) case definition for chronic fatigue syndrome (CFS), a severely debilitating illness of unknown cause characterized by at least six months of exceptional fatigue, with several associated chronic symptoms.

Several objective laboratory findings distinguish patients with CFS from control subjects who are healthy or have fatiguing diseases: abnormalities of the hypothalamic-pituitary axes; white-matter abnormalities on MRI scans of the brain; defects of perfusion and/or metabolism on brain SPECT; evidence of sympathetic and parasympathetic autonomic neuropathy; impaired function of natural killer cells and increased numbers of activated CD8+ T cells; reactivation of human herpesvirus-6, a neurotropic and immunotropic virus; and increased activity of an anti-viral enzymatic pathway in lymphocytes (the 2-5A pathway).

Sleep disorders have been reported in 33% to 80% of patients with CFS. Interestingly, for most patients treatment provides only a modest benefit, indicating that the sleep pathology is a secondary reflection of the underlying disorder, and not the cause of the chronic fatigue. Most patients with CFS have suffered no psychiatric disease *prior to* the onset of CFS. However, at least 50% of patients develop psychoneurotic disorders in the years *after* the onset of CFS. One randomized, placebo-controlled, double-blind trial of fluoxetine therapy in patients with CFS found no evidence of improvement in either fatigue or coexisting depression.

This presentation will discuss the manifestations of CFS, options for therapy, and hopes for treatments in the future.

No. 46E
NOVEL MOLECULAR TARGETS IN DEFICIT SYNDROMES

Daniel R. Weinberger, M.D., *10 Center Drive, Building 10, Room 4S-235, Bethesda, MD 20892-1379*

SUMMARY:

Abnormalities of executive cognition, working memory, cognitive control, and deficits in motivation, attention, and goal-directed behavior are common features of chronic psychiatric disability. Such abnormalities are especially common in conjunction with schizophrenia, bipolar disorder, alcoholism, and brain trauma. As the neuronal systems and functions associated with such deficits are increasingly being explicated, novel molecular targets for therapeutic intervention will likely be identified. This presentation will focus on several potential targets that have emerged from studies of genetic variations that impact on prefrontal information processing. A functional polymorphism in the COMT gene explains 4 percent of the variance in prefrontal function. As such, COMT inhibition is a potential therapeutic target, especially in genetically selected individuals. Genetic variations in dopamine and serotonin transporter genes also appear to impact on prefrontal information processing assayed with fMRI, and these also may be targets based on individual genotype. Strategies for selecting drug targets, for selecting patient samples, and for assaying therapeutic effects with neuroimaging will be reviewed.

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2. Chokroverty S, ed: Sleep Disorders Medicine: Basic Science, Technical Considerations, and Clinical Aspects. 2nd ed. Boston, Butterworth-Heineman, 1999.
3. Komaroff AL, Buchwald DS: Chronic fatigue syndrome: an update. Annu Rev Med 1998;49:1–13.
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5. Egan MF, Goldberg TE, Kolachana BS, et al: Effect of COMT $Val^{108/158}$ Met genotype on frontal lobe function and risk for schizophrenia. PNAS, 2001;12:6917–6922.
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INDUSTRY-SUPPORTED SYMPOSIUM 47—ADULT ADHD: FROM RESEARCH TO CLINICAL PRACTICE
Supported by Shire Richwood

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with the neuropsychology, genetics, imaging in adults with ADHD, and be able to recognize essential features of the comorbidity and principles of treatment of ADHD in adulthood.

No. 47A
OVERVIEW AND PATTERNS OF COMORBIDITY IN ADULTS WITH ADHD

Joseph Biederman, M.D., *15 Parkman Street, WACC-725, Boston, MA 02114*

SUMMARY:

It is well known that a wide range of additional psychiatric disorders co-occur with attention-deficit/hyperactivity disorder (ADHD) throughout the lifecycle. These comorbid disorders greatly complicate diagnosis and affect prognosis and treatment. Dr. Biederman will present longitudinal data in adolescents and retrospective data in adults to illustrate the course and nature of comorbid disorders. Methodologic issues of ascertainment, symptom overlap, and the use of family-based data will be used to explain the complexities of comorbidity. The individual importance of depression, bipolar disorder, anxiety disorders, antisocial disorders, and substance abuse in ADHD will be discussed as will the effect of gender. This discussion will provide clinically relevant data on the clinical dilemma of conceptualizing and diagnosing comorbidity within ADHD.

No. 47B
THE NEUROPSYCHOLOGY OF ADULT ADHD

Larry J. Seidman, Ph.D., *74 Fenwood Road, Boston, MA 021115;* Joseph Biederman, M.D.; E. Valera, Ph.D.; Allysa Doyle, Ph.D.; Michael Monoteaux, B.A.; Stephen V. Faraone, Ph.D.

SUMMARY:

Follow-up studies show that ADHD persists into adolescence and young adulthood in 10% to 60% 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 fronto-striatal 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. 47C
A GENETIC PERSPECTIVE OF THE VALIDITY OF ADULT ADHD

Stephen V. Faraone, Ph.D., *750 Washington Street, Suite 255, South Easton, MA 02375*

SUMMARY:

Because the validity of adult ADHD has been questioned in the psychiatric literature, there is much uncertainty about the nosological status of adults who present with a history of ADHD symptoms. Genetic studies are useful for addressing the validity of adult ADHD because family, twin, and adoption studies show ADHD to be a highly heritable disorder. These studies have addressed the validity of adult ADHD in several ways. 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 rather than being an invalid diagnosis, 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. We also review psychometric studies that assess the possibility that findings of familial transmission in adult ADHD are due to reporter biases.

No. 47D
FUNCTIONAL AND STRUCTURAL NEUROIMAGING IN ADHD

George Bush, M.D., *725 Fruit Street, ACC Building, Boston, MA 02114*

SUMMARY:

Attention-deficit/hyperactivity disorder is characterized by developmentally inappropriate symptoms of inattention, impulsivity, and motor restlessness. ADHD affects approximately 5% of school-age children and persists to a lesser degree into adulthood. Given the great morbidity associated with the disorder, including persistent neuropsychological impairments, determining the underlying neurobiology of ADHD is of great importance.

Recent reviews of data from neuroimaging, neuropsychological, genetic, and neurochemical studies have generally implicated fronto-striatal network abnormalities as the likely cause of ADHD. In particular, dorsal anterior cingulate cortex, dorsolateral prefrontal cortex, caudate, corpus callosum, and cerebellum have been shown to display morphological and functional abnormalities that may lead to the clinical pathology observed in this disorder.

This presentation will review the convergent evidence from structural and functional neuroimaging studies relevant to ADHD. For the clinician, this presentation will also place the neuroimaging work in the context of other forms of research to provide an understanding of how functional, biochemical, and structural imaging tools may be used now and in the future for diagnostic purposes and drug development.

No. 47E
PHARMACOTHERAPY OF ADULTS WITH ADHD

Thomas J. Spencer, M.D., *Fruit Street 725 ACC Building, Boston, MA 02114*

SUMMARY:

While adults with attention deficit/hyperactivity disorder (ADHD) are often treated with medication, guidelines are usually extrapolated from studies in children. However, there are a number of controlled trials in the adults with ADHD that document response and tolerability of medical treatment as well as the moderating effects of comorbidity. Controlled trials have revealed that adults with ADHD respond to the same stimulant and nonstimulant medications as children with ADHD. Agents with catecholaminergic activity—dopamine and norepinephrine in particular—have efficacy in ADHD, whereas those with predominately serotonergic properties are not effective for ADHD. Medications with cholinergic activity appear promising. Dr. Spencer will present data from eight controlled medication trials in adults that were conducted at his center. In addition to available compounds, new research on medications for ADHD will be presented.

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1. Seidman LJ, Biederman J, Weber W, et al: Neuropsychological function in adults with attention-deficit hyperactivity disorder. Biological Psychiatry, 1998;44:260–268.
2. Faraone SV, Biederman J, Spencer T, et al: Attention deficit hyperactivity disorder in adults: an overview. Biological Psychiatry 2000;48:9–20.
3. Bush G, Frazier JA, et al: Anterior cingulate cortex dysfunction in attention deficit/hyperactivity disorder revealed by fMRI and the counting stroop. Biological Psychiatry 1999;45:1542–1552.
4. Biederman J, Faraone SV, et al: Gender differences in a sample of adults with attention deficit/hyperactivity disorder. Psychiatry Research 1994;53:13–29.
5. Spencer T, Biederman J, et al: Pharmacotherapy of ADHD: a life span perspective. In, American Psychiatric Press Review of Psychiatry, edited by Oldham J, Riba M. Washington, APPI, 1997, pp. 87–128.

INDUSTRY-SUPPORTED SYMPOSIUM 48—ADVANCES IN THE UNDERSTANDING AND TREATMENT OF BINGE-EATING DISORDER
Supported by Ortho-McNeil Pharmaceutical

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the diagnosis, features, and epidemiology of binge eating disorder, and to know about the use of pharmacologic and psychological treatments in binge eating disorder.

No. 48A
BINGE EATING DISORDER: DIAGNOSIS AND BEHAVIOR

B. Timothy Walsh, M.D., *1051 Riverside Drive, Unit #98, New York, NY 10032-2603*

SUMMARY:

Syndromes of binge eating were clearly elucidated by Stunkard in 1959. However, significant interest in the psychiatric community in the creation of the new diagnostic category binge eating disorder occurred only in the early 1990s during discussions of DSM-IV. Because of uncertainty about the need for this diagnostic category and about the most appropriate diagnostic criteria, binge eating disorder appears in DSM-IV in Appendix B, which provides criteria sets for future study. In fact, substantial study of binge eating disorder has occurred in the last decade, providing new information relevant to its status in the next incarnation of the DSM.

This presentation will review the concept of binge eating disorder and the current criteria used for its diagnosis. Information will then be presented on differences in eating behavior between individuals of similar body weight with and without binge eating disorder. These data provide objective evidence that, at least under certain circumstances, individuals with binge eating disorder exhibit clear behavioral disturbances. These findings are relevant both to the status of the disorder in the psychiatric nomenclature and to our understanding of its clinical features and treatment.

No. 48B
EPIDEMIOLOGY AND RISK FACTORS

William P. Carter, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

This presentation will review the epidemiology of binge eating disorder. It will cover studies of the prevalence and course of this disorder in the United States and Europe and the association between the risk of binge eating disorder and age, gender, and ethnicity.

The talk will move on to a consideration of factors associated with binge eating disorder, including other psychopathology, being overweight, societal influences, and family features. Potential risk factors will be discussed.

Finally, the public health importance of binge eating disorder will be discussed in relationship to its prevalence, its morbidity, and the opportunities for prevention and treatment.

No. 48C
TREATMENT WITH ANTIDEPRESSANTS

James I. Hudson, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

This presentation will review the use of antidepressants in the treatment of binge eating disorder. It will begin with a discussion of the theoretical rationale for the use of this class of medications, including possible links between binge eating disorder and mood disorders; the response of the related eating disorder, bulimia nervosa, to antidepressants; and neurotransmitter dysfunction in binge eating disorder.

The talk will then discuss studies of antidepressants in binge eating disorders, including mention of open-label studies and more emphasis on placebo-controlled trials. Placebo-controlled studies have thus far suggested that the tricyclic antidepressant desipramine and the serotonin uptake inhibitors fluvoxamine and sertraline are superior to placebo in the treatment of binge eating disorders.

Finally, the presentation will consider practical issues in the management of binge eating disorder with pharmacotherapy generally, and with antidepressants in particular. It will offer guidelines for pharmacologic treatment of binge eating disorder based on research findings and clinical experience.

No. 48D
TREATMENT WITH APPETITE SUPPRESSANTS AND ANTIEPILEPTICS

Susan L. McElroy, M.D., *231 Bethesda Avenue, Cincinnati, OH 45267-0559*

SUMMARY:

Although antidepressants are the medications most often used to treat binge eating disorder, both appetite suppresant and antiepileptic agents have also been studied in this disorder. A placebo-controlled study of d-fenfluramine (which has since been removed from the market) and an open trial of sibutramine suggest appetite suppressants reduce binge eating in binge eating disorder. Also, a placebo-controlled study of topiramate and open data with zonisamide—antiepileptics both associated with weight loss in patients with epilepsy—suggest these agents may reduce binge eating and induce weight loss in patients with binge eating disorder. In this presentation, studies of appetite suppressants and antiepileptics in binge eating disorder will be reviewed. Practical guidelines for the treatment of binge eating disorder with these agents will then be provided.

No. 48E
PSYCHOLOGICAL TREATMENT

Denise E. Wilfley, Ph.D., *6363 Alvarado Court, Suite 100, San Diego, CA 92120*

SUMMARY:

Individuals with binge eating disorder typically present to treatment with the multiple problems of binge eating, varied eating disorder psychopathology (such as overeating in general, and extreme concerns about eating, shape, and weight), psychiatric symptoms, and overweight. Accordingly, evaluation of treatments for binge eating disorder need to take into consideration the impact of the intervention on these multiple problems in both the short and long term.

Recently, a number of controlled studies have been completed on the psychological treatment of binge eating disorder. Promising short-term findings have accrued for several conceptually and procedurally distinct psychological treatments including specialist treatments, behavioral weight loss treatment, and self-help approaches. Positive long-term outcomes have also been demonstrated for two of the specialist treatments: cognitive-behavioral therapy and interpersonal psychotherapy. Nevertheless, central questions regarding the specificity of treatment effects and whether patients with binge eating disorder require intervention beyond behavioral weight loss treatment remain unanswered.

This presentation will review the state-of-the-science in psychological treatment research for binge eating disorder, with a focus on the implications of this research for clinical practice. Recommendations will be offered regarding the selection of evidence-based treatments in clinical practice with a special consideration of factors that may moderate treatment outcome.

REFERENCES:

1. Walsh BT: Diagnostic criteria for eating disorders in DSM-IV: work in progress. Int J Eat Disord 1992; 11:301–304.
2. Fairburn CG, Doll HA, Welch SL, et al: Risk factors for binge eating disorder. Arch Gen Psychiatry 1998; 55:425–432.
3. Hudson JI, Carter WP, Pope HG Jr: Antidepressant treatment of binge-eating disorder: research findings and clinical guidelines. J Clin Psychiatry 1996; 57[suppl 8]:73–79.
4. Shapira NA, Goldsmith TD, McElroy SL: Treatment of binge-eating disorder with topiramate: a clinical case series. J Clin Psychiatry 2000; 61:368–372.
5. Wilfley DE: Psychological treatment of binge eating disorder. In Eating Disorders and Obesity, edited by Fairburn CG, Brownell KD, New York, Guilford Press, in press.

INDUSTRY-SUPPORTED SYMPOSIUM 49—EXPLORATIONS IN DEMENTIA: NEW AND CURRENT PERSPECTIVES
Supported by Eisai Inc., Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify methods of early detection and genetic risk factors in AD; use effective differential diagnosis techniques to pursue optimal patient management; recognize the existence of mild cognitive impairment and its implications; identify strategies to diagnose vascular dementia and its emerging pharmacotherapies; recognize the impact of cholinesterase inhibitors in the management of AD.

No. 49A
EARLY DETECTION AND GENETIC RISK ASSESSMENT IN ALZHEIMER'S DISEASE

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

SUMMARY:

Along with greater awareness of the impact of dementia during the last few decades, psychiatrists have been bombarded with numerous developments in medical technology that offer promise of more effective diagnostic and treatment interventions. Genetic discoveries have determined several mutations that cause a rare form of early-onset (beginning before age 60 years) Alzheimer's disease in families, and for the common late-onset form of Alzheimer's, the apolipoprotein E-4 genetic risk is now verified. Because this latter genetic variation is neither necessary nor sufficient to cause dementia, uncertainty persists about when the results of such genetic assessments may be useful and when they may be misleading. Other potential environmental risks, such as head trauma and lack of educational achievement, are emerging, as well as potential protections, including low-fat diets and aerobic exercise. Research on neuroimaging technologies such as positron emission tomography and functional magnetic resonance imaging, used in combination with information about risk factors, indicates that the brain changes seen in full-blown Alzheimer's disease begin decades before families and clinicians recognize the obvious symptoms. This presentation will provide an overview of current information on early detection of Alzheimer's disease and provide a practical approach to using diagnostic information from new technologies and risk assessment.

No. 49B
DIFFERENTIAL DIAGNOSIS OF DEMENTIA SYNDROMES: A PSYCHIATRIC PERSPECTIVE

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

SUMMARY:

The older patient presenting with changes in cognitive functioning and behavior can pose a difficult diagnostic challenge. The clinical dementia syndrome can encompass alterations in memory, language, mood, motivation, recognition, praxis, executive function, visuospatial skills, and motor function. While Alzheimer's disease (AD) is clearly the most prevalent diagnosis, other considerations include vascular dementia, dementia with Lewy bodies, and frontotemporal dementias. The latter two typically present with prominent neuropsychiatric symptoms that would prompt psychiatric consultation. The advent of new pharmacotherapies for AD has highlighted the need for early and accurate diagnosis of these disorders. This trend will continue as specific treatments for other dementias become available. Accurate diagnosis of dementia remains a clinical endeavor, since there is no reliable laboratory diagnostic test. This can be accomplished by performing a concise but thorough examination that combines assessment of neurologic, psychiatric, cognitive, and functional status. The presentation will focus on practical skills needed for developing a dementia differential diagnosis in geriatric patients. Topics to be covered will include clinical phenomenology, cognitive screening instruments, focused neurologic examination, and pertinent laboratory testing.

No. 49C
CONTEMPORARY ISSUES IN MILD COGNITIVE IMPAIRMENT: FACT OR FICTION?

Bradley F. Boeve, M.D., *200 First Street, SW, Rochester, MN 55905*

SUMMARY:

Mild cognitive impairment (MCI) refers to the transitional stage of cognitive impairment between normal aging and early Alzheimer's

disease (AD) in which memory impairment exists in the absence of frank dementia. The clinical criteria for the diagnosis of MCI include: a) memory complaint by patient and/or informant, b) objective evidence of memory impairment, c) normal general cognitive functioning, d) preserved activities of daily living, and e) not demented. Individuals with MCI are at increased risk for developing dementia or AD, and treatment trials using various agents are in progress to potentially delay the rate of progression from MCI to AD. Consensus now exists that evaluating and monitoring individuals with MCI is recommended, and it will be increasingly important for psychiatrists to evaluate and monitor suspected cases. Recent analyses have shown that not all individuals with MCI progress to dementia or AD, nor do all autopsied individuals with MCI have Alzheimer pathology. Future studies may allow better identification of those patients with MCI who indeed have evolving AD, which will be particularly important for future intervention trials.

No. 49D
CHARTING THE COURSE IN CEREBROVASCULAR DEMENTIA

Gustavo C. Roman, M.D., *7703 Floyd Curl Drive, San Antonio, TX 782297833*

SUMMARY:

Historically, vascular lesions were the first recognized cause of dementia in the elderly (''atherosclerotic dementia''). In the 1970s, Alzheimer's disease (AD) became the most common cause of senile dementia. More recently, small-vessel disease, causing leukoaraiosis and lacunar strokes, has been recognized as an important contributor to the clinical expression of dementia in late-onset AD. The frequent association of stroke and AD complicates the diagnostic process of vascular dementia (VaD).

This presentation will review current diagnostic criteria for VaD, including the recently proposed research criteria for the subcortical form of VaD. Results of control clinical trials in the use of anticholinergic medications in VaD are becoming available and will be reviewed. The behavior of the placebo group in these trials provides evidence in favor of the independence of VaD as a clinical entity—separate from AD—since the progression of the disease and the slope of cognitive decline is quite different from that of AD.

Prevention of dementia by control of risk factors of cerebrovascular disease is an encouraging area of public health intervention. Recent data indicate that appropriate control of hypertension and hyperlipidemia decreases the incidence of VaD.

No. 49E
ALZHEIMER'S DISEASE THERAPY IN THE 21ST CENTURY: EXAMINING THE EVIDENCE

Pierre N. Tariot, M.D., *435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

Dementia is so common that it has been predicted to be the next century's pandemic. It is recognizable, diagnosable, treatable, but sadly underrecognized and undertreated. Through medical research, important advances have been made in the treatment of dementia, especially Alzheimer's disease (AD). Clinical trials have demonstrated meaningful therapeutic benefit that can ameliorate the progressive cognitive and functional decline to which patients have historically been resigned. Data from these controlled clinical trials will be reviewed, along with new information expanding our appreciation of what effects available antidementia therapies can be expected to yield. Most information exists regarding cholinesterase inhibitors, which were developed primarily for relief of cognitive dysfunction in AD. Observational data suggest that they may show some promise in altering progression of symptoms as well. This conclusion is supported by data from one-year, placebo-controlled studies. These findings in turn are consistent with laboratory studies indicating that there may cholinoprotective or neuroprotective effects of chronic administration of such agents, and that early and prolonged therapy may be rational. There are other options as well: It is likely that in the foreseeable future we will be deploying rational combinations of therapeutic agents (''cocktails''), some of which will be prerated. The newest research is paving the way to future treatments for this devastating illness.

No. 49F
MANAGING BEHAVIORAL DISTURBANCES IN DEMENTIA: PRACTICAL APPROACHES TO TREATMENT

Donna Masterman, M.D., *710 Westwood Plaza, Box 951769, Los Angeles, CA 90095*

SUMMARY:

Neuropsychiatric symptoms are frequent in patients with dementia and represent a major source of the disease's morbidity. They have been associated with more rapid cognitive decline, increased caregiver burden, increases in patient care costs due to earlier institutionalization of the dementia patient, greater medication use, more adverse side effects, and more extensive institutional staffing needs. Nearly all patients with Alzheimer's disease (AD) develop neuropsychiatric symptoms sometime during the course of their illness, with estimates of disruptive agitated behaviors ranging from 70%–90%. A longitudinal study found that of 235 patients with early AD, only 8.5% remained free of psychopathology during the first three years of follow-up, and it is not uncommon for multiple behavioral symptoms to coexist. Both nonpharmacological and pharmacological interventions are frequently required. While the precise neurobiological substrate for the neuropsychiatric disturbances remains unclear, there are known alterations in several neurotransmitter systems (cholinergic, noradrenergic, serotonergic, dopaminergic, and others), which may contribute in an important way to behavioral disturbances in these patients and may be a further target for improved therapies. Clinical research into the treatment of these noncognitive symptoms have only recently become a subject of major investigation. Finding effective therapies to significantly reduce the neuropsychiatric symptoms is likely to have an important impact on patient care, caregiver distress, and the rate of institutionalization.

REFERENCES:

1. Small, GW: Genetics of Alzheimer's disease: apolipoprotein E in research and practice. International Journal of Geriatric Psychopharmacology 2000;2:109–112.
2. Geldmacher DS, Whitehouse PJ Jr: Differential diagnosis of Alzheimer's disease. Neurology 1997;48(5 Suppl 6):S2–S9.
3. Petersen RC, Stevens JC, Ganguli M, et al: Practice parameter: early detection: mild cognitive impairment (an evidence-based review). Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2001;56:1133–1142.
4. Roman GC: Vascular dementia today: Rev Neurol. 1999;155 Suppl 4:S64–72.
5. Schneider LS, Tariot PN: Drugs for Alzheimer's disease: In: Psychopharmacology of Cognitive and Psychiatric Disorders in the Elderly, edited by Wheatley D, Smith D. London, Chapman & Hall Medical, 1998, pp. 92–115.
6. Cummings JL, Knopman D: Advances in the treatment of behavioral disturbances in Alzheimer's disease. Neurology 1999; 53:899–901.

LECTURES

LECTURE 1
APA/APPL MANFRED S. GUTTMACHER AWARD RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE

John Monahan, Ph.D., *Doherty Professor of Law, University of Virginia School of Law, 580 Massie Road, Charlottesville, VA 22903-1789*

SUMMARY:

The presumed link between mental disorder and violence has been the driving force behind mental health law for centuries. Legislatures, courts, and the public have come to expect that psychiatrists and psychologists will protect them from violent acts by persons with mental disorders. Yet for three decades research has shown that clinicians' unaided assessments of "dangerousness" are barely better than chance. *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence,* winner of the 2002 Manfred Guttmacher Award, tells the story of a pioneering investigation that challenges preconceptions about the frequency and nature of violence among persons with mental disorders—and suggests an innovative approach to the topic—demonstrate how clinicians can use a "decision tree" to identify groups of patients at very low and very high risk for violence. This dramatic new finding, and its implications for the every day clinical practice of risk assessment and risk management, is showcased in this Guttmacher Lecture. Taken to heart, its message will change the way clinicians, judges, and others who must deal with persons who are mentally ill and may be violence will do their work.

REFERENCE:

1. Monahan J, Steadman H, Silver E, Appelbaum P, Robbins P, Mulvey E, Roth L, Grisso T, Banks S: Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York: Oxford University Press, 2001.

LECTURE 2
PERSONALITY DISORDERS: NEW FINDINGS AND CURRENT CONTROVERSIES

John M. Oldham, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Suite 6700, New York, NY 10032-2603*

SUMMARY:

Patterns of adaptive and maladaptive behavior have been described for centuries. Broad personality types have been identified, yet each person has a personality as unique as a set of fingerprints. Each individual's specific temperament is determined by genes and biology, influencing how the individual navigates crucial developmental milestones. In turn, environmental circumstances, such as supportive caretaking vs. neglect and abuse, shape character and directly affect the developing psychobiology of the child. By late adolescence and early adulthood, an individual's unique, recognizable personality has been formed. In some ways, this personality is lifelong; though the tempestuousness of youth may be replaced by mellowing in later life, the remarkably universal experience of recognizing old friends, even after years of no contact and despite changes in appearance, owes a fair amount to familiar patterns of behavior.

How to classify maladaptive behavior, and whether it fits within familiar medical models of pathology or disease, remains controversial. Does personality pathology, like hypertension, represent an excess of otherwise useful and adaptive traits? Is a personality disorder, as we claim, enduring over time? Is it something one unluckily obtains, and if so is it there effective treatment for the condition, either to eradicate it, like an infection, or to stabilize it, like diabetes? Or, instead of something one contracted somehow, is a personality disorder inextricable from one's essential personality, unlikely to change very much no matter what? These controversies will be reviewed, in the context of recent neurobiological research and clinical, longitudinal studies, of DSM-IV-defined personality disorders.

REFERENCE:

1. Oldham, JM, Skodol AE: Charting the Course of Axis II. J Personal Disorders 2000; 14:17–29.

LECTURE 3
APA'S GEORGE TARJAN AWARD ACCESSING CARE: A CHALLENGE TO THE POOR AND DISADVANTAGED

Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030*

SUMMARY:

Despite the overall improvement in the socioeconomic conditions of this country during the last decade, major gaps still exist in our current health/mental health delivery system. For instance, in 1997 there were 43.4 millions of Americans without health insurance, amounting to 16.1% of the total USA populations. Among the populations groups severely affected were: African Americans (21.5%), Hispanic Americans (34.2%) and Asian/Pacific Islander Americans (20.7%). Additionally, among the uninsured, there were 10 million of children and adolescents or 13.9% of this population subgroup. The children and adolescents ethnic groups more affected were: Hispanic Americans (27.7%), African Americans (17.9%) and Asian/Pacific Islander Americans (16.7%).

Obviously, the sector of the American population most affected with respect to the lack of access to health/mental health care is the poor and disadvantaged. For this group, the only alternatives to this health/mental health care problem of crisis proportion is to seek help and assistance via emergency centers, or to be exposed to high morbidity factors and even death. Additionally, frustration, aggressive behaviors, and even violence can also be the outcome of denied health/mental health care access; particularly, when it happens to member of the family network, especially children. Finally, potential solutions will be addressed and discussed as a way of improving such a serious gap in this country's healthcare system.

REFERENCE:

1. Ruiz P, Alarcon RD: How Culture and Poverty Exclude People from Care. American Journal of Forensic Psychiatry, 17(4):61–73, 1996.

LECTURE 4
NEUROSCIENCE IN THE NEW MILLENNIUM

Gerald D. Fishbach, M.D., *Dean and Vice President for Health Science, Columbia University College of Physicians and Surgeons, 630 W. 168th Street, New York, NY 10032*

SUMMARY:

Advances at all levels of neuroscience have brought traditional sub-disciplines closer together than they were just a few years ago. It is easier to clone a gene or to record from individual nerve cells or to record from large populations with noninvasive techniques, and it is also easier to study particular aspects of behavior than ever before. Advances in brain science continue to revolutionize the theory and practice of psychiatry. Studies of particular brain disorders ranging from anxiety and depression through dementia and other degenerations, have produced some of the most exciting science in recent years. Indeed it is clear that old clinical classifications will be re-

placed by more accurate functional and molecular characterizations. With each refinement in diagnosis, opportunities become available for new approaches to therapy.

REFERENCES:

1. Fischbach, GD, McKhann, GM: Cell Therapy for Parkinson's Disease. N Engl J Med 2001, Mar8;344(10):763-5.
2. Hall Z, Bloom, FE, Fischbach, G: Introduction: Where Neuroscience Has Been and Where It Needs to Go. Neurobiol Dis 2000, Oct 7(5):495-8.

LECTURE 5
OPIOIDS AND SINGLE-NUCLEOTIDE POLYMORPHISMS: IMPLICATIONS FOR HEROIN AND COCAINE ADDICTIONS

Mary Jeanne Kreek, M.D., *Professor, The Rockefeller University, 1230 York Avenue, New York, NY 10021*

SUMMARY:

There is increasing evidence from both laboratory-based and clinical research that specific components of the endogenous opioid system play a major role in each of several specific addictive diseases, including heroin and cocaine addictions, as well as alcoholism. Specific components of the endogenous opioid system interacting with the classical neurotransmitter systems, as well as other neuropeptides, have been shown to contribute to both many of the so-called ''rewarding'' effects of drugs of abuse, as well as to counter-regulatory events that serve to modulate drug-induced changes in the molecular neuobiology of the brain. Many of these effects both continue to occur or persist during drug exposure as well as remain for extended periods of time after cessation of exposure to a drug of abuse. There is also evidence of a ''relative endorphin deficiency'' in both abstinent heroin and cocaine addicts, a state which may contribute to drug hunger, craving and relapse. Numerous polymorphisms of the endogenous opioid system, including SNPs, have identified, some of which may alter gene expression and others alter the actual peptides, which may yield differences in functions. Thus, ''physiogenetic,'' as well as pharmacogenetic factors, may therefore contribute to some of the effects of drugs of abuse, as well as possibly to the genetics of addictions.

REFERENCE:

1. K. Steven LaForge, Vadium Yuferove, Mary Jeanne Kreek: Opioid Receptor and Peptide Gene Polymorphisms: Potential Implications for Addictions. European Journal of Pharmacology. Volume 410, pp 249–268, December, 2000.

LECTURE 6
ALZHEIMER'S DISEASE: THE CHALLENGES OF BIG RISKS AND SMALL GAINS

Richard Mayeux, M.D., *Director, Sergievsky Center, Columbia Medical Center, 622 W. 168th Street, New York, NY 10032*

SUMMARY:

Over the last five decades industrial societies have experienced a dramatic rise in the number of elderly and have become concerned about the resulting increase in the prevalence of Alzheimer's disease and related disorders of the aging brain. The risk of Alzheimer's disease nearly triples between ages 60 and 80 years of age making projected estimates of the frequency of Alzheimer's disease during the next few years staggering. Important clues to the etilogy of Alzheimer's disease have come from the genetic and epidemiological investigations of patients and their families. Possession of mutant alleles in three genes cause the disease in autosomal dominant pattern before the age of 55, while a common variant allele in another results in a striking increase in disease susceptibility. Several new putative chromosomal loci have been identified indicating that this is a polygenic disease. This far, all genetic variations identified appear to directly, or indirectly, affect the metabolism of the beta amyloid peptide. A history of previous head trauma, heart disease, smoking and certain socioeconomic factors may also increase disease risk, while the use of anti-inflammatory medications and estrogen appear to decrease disease susceptibility. The knowledge gained from understanding how these genes and risk factors modify disease risk has lead to new concepts concerning its treatment and prevention.

REFERENCE:

1. Tang M-X, Cross P, Andrews H, Jacobs DM, Small S, Bell K, Merchant C, Lantigua R, Costa R, Stern Y, Mayeux R: Incidence Rates for Alzheimer's Disease Among Black, Caribbean Hispanic and White Elderly Living in Northern Manhattan. Neurology 2000; 56:49–56.

LECTURE 7
APA'S WILLIAM C. MENNINGER MEMORIAL AWARD
PSYCHIATRY AND THE MEDICAL CONSUMER MOVEMENT

Rodger McFarlane, *779 Riverside Drive, New York, NY 10032*

SUMMARY:

The effect of consumer impowerment on psychiatric practice, as well as the impact of information available on the Internet, in broadcast, and in print advertising is the theme of the lecture. Consumers have a new power in influencing directly FDA approval of new drugs, Congressional appropriations for research at NIH (and NUMH), their influence with America's largest employers, and the handful of giant companies that compete to underwrite employee health. New legislation could benefit both mental health practittioners, as well as the consumer/patient. Specific alliances between medical professional associations and organized consumer advocacy have been created in order to pursue mutual goals in the new century.

LECTURE 8
YOU ARE TWENTY-FOUR AND YOU HAVE WHAT?

Mary Jane Massie, M.D., *Department of Psychiatry, Memorial Sloan-Kett, 1275 York Avenue, New York, NY 10021-6007*

SUMMARY:

Increasingly psychiatrists will be evaluating and treating very young women with breast cancer. Although psychological issues of women with breast cancer have been described, little attention has been given to the special issues faced by young women with this disease that affects school, work, and career, body image, relationships, self-image, sexuality, childbearing and rearing. In this lecture, Mary Jane Massie, M.D., will provide a brief overview of the risk factors and treatment of breast cancer in young women and will describe the special issues that arise in the psychiatric treatment of these women.

REFERENCE:

1. Rowland JR, Massie MJ: Psychosocial Issues and Interventions. In: JR Harris, ME Lippman, M Morrow, CK Osborne, eds. *Diseases of the Breast,* Second Edition. PA: Lipincott Williams & Wilkins, 2000, 1009–1031.

LECTURE 9
APA'S BENJAMIN RUSH AWARD
PROBLEMS FACING INNER-CITY SCHOOL EDUCATORS AND THE ROLE OF PSYCHIATRY IN ADDRESSING THEM

James P. Comer, M.D., *230 South Frontage Road/PO Box 207900, New Haven, CT 06520-7900*

SUMMARY:

Dr. comer will discuss the insights that lead to his belief that school underachievement is not due primarily to student deficits. He will then describe how pilot project observations suggest that underachievement among such students is due largely to underdevelopment along the critical developmental pathways—physical, social, interactive, psychoemotional, ethical, linguistic, intellectual-cognitive. It has been found that school staff are generally not prepared to support student development. An approach, the School Development Program, was then developed that recreated community in school in a way that enable all the adult stakeholders to support student development. This led to improved teaching and learning and reduced behavior problems. This program was disseminated to over 700 schools across the country.

The School Development Program provides a structure as well as a process for mobilizing adults to support students' learning and overall development. It is a different way of conceptualizing and working in schools and replaces traditional school organization and management with an operating system that promotes good psychological and social functioning among staff, parents, and students.

REFERENCE:

1. Comer JP: Schools that Develop Children; The American Prospect, April, 2001.

LECTURE 10
CANCELLED

LECTURE 11
APA/NIMH VESTERMARK PSYCHIATRY EDUCATOR AWARD
HEALING THROUGH SOCIAL AND SPIRITUAL AFFILIATION

Marc Galanter, M.D., *Department of Psychiatry, New York University Medical Center, 550 First Avenue, New York, NY 10016*

SUMMARY:

Two very different approaches can promote recovery from psychiatric disorders: both are of value, but only one has been effectively integrated into conventional practice. Biomedically-grounded techniques are clearly central to contemporary care. Social and spiritual affiliation, however, can also be valuable in promoting recovery, but they have been eclipsed by widespread acceptance of the biomedical approach, where associated phenomena can be more readily observed and measured.

Research on the treatment of substance abuse will be highlighted to show how social and spiritual affiliation can be effective in promoting relief from illness. The response of highly compromised addicted patients to Alcoholics Anonymous' spiritual orientation will be used to illustrate the potent impact of its spiritual message when imparted in a cohesive social group. An absence of such approaches in contemporary medical care, on the other hand, has led many patients to turn to alleviate medicine and away from standard medical care. Furthermore, behavioral changes observed in cultic, terrorist and mental health support groups can be understood better by considering the model of ideologically-grounded affiliation. Circumstances which prevent useful application of such influence modalities in general psychiatry will be examined, along with options for improved psychiatric training.

REFERENCE:

1. Galanter M: Network Therapy for Alcohol and Drug Abuse, Expanded Edition. New York: Guilford Press, 1999.

LECTURE 12
DYING WELL: BEYOND SYMPTOMS AND SUFFERING, HUMAN DEVELOPMENT AT THE END-OF-LIFE

Ira R. Byock M.D., *The Palliative Care Service, 341 University Avenue, Missoula, MT 59801*

SUMMARY:

Care of dying patients has recently garnered increased attention within medicine including psychiatry. To date end-of-life care has principally been examined through the symptoms and suffering. Indeed, within the problem-based practice of contemporary medicine, often patients must "earn" clinical attention through suffering. Yet dying is, fundamentally, a personal experience, not a set of medical problems to be managed.

Narratives of people confronting life's end provide empiric evidence of the range of human experience that can occur during the time of life termed "dying". Although suffering among dying patients remains all-too-common, the ability to make meaning, review one's life, complete relationships, express love and explore spiritual realms all exist within the human endowment. The phenomenology of positive personal experience associated with illness, progressive disability and dying challenges the prevailing medical model.

A developmental conceptual framework and taxonomy facilitates understanding the nature of suffering and the nature of opportunity at the end of life. Human development provides a powerful tool for working with patients and families regarding issues of life completion and life closure. In counseling and offering anticipatory guidance, psychiatric specialists can alleviate suffering and preserve the opportunity for people to grow, individually and together through the very end of life.

REFERENCE:

1. Byock I: The Nature of Suffering and the Nature of Opportunity at the End of Life, Clinics Ger Med, V.12:2, 237–252, May 1996.

LECTURE 13
WHAT CAN LATE-LIFE TEACH US ABOUT DEPRESSION?

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Late-life depression occurs in the context of ill health and disability. Studies of the medical comorbidity of geriatric depression have provided information on the pathophysiology and treatment response of depressed elderly patients. This research has been organized by three hypotheses: Late-Onset Depression Hypothesis, Depression-Executive Dysfunction Hypothesis, and Vascular Depression Hypothesis.

Late-onset depression is heterogeneous and encompasses patients with brain disorders that may or may not be clinically evident when the depression first appears. Late-onset depressives have more cognitive and neuroradiological abnormalities, medical morbidity and mortality and lower familial prevalence of mood disorders than elderly early-onset depressives. Research on late-onset depression has provided a conceptual step for identifying more homogeneous groups of geriatric depression.

A late-life syndrome characterized by depression and executive dysfunction (DED) has been described. The DED syndrome has a clinical presentation consistent with frontostriatal dysfunction and a slow, poor, and unstable response to antidepressant drugs.

Patients with depression occurring in the context of vascular disease have clinical manifestations, neuropsychological abnormalities, structural neuroimaging and functional neuroimaging findings suggestive of frontostriatal dysfunction.

REFERENCE:

1. Alexopoulos GS, Meyers BS, Young RC, Kalayam B, Kakuma T, Gabriele M, Hull J, Sirey JA: Executive Dysfunction and Long-Term Outcomes of Geriatric Depression. Arch Gen Psychiatry 57:285–290, 2000.

LECTURE 14
APA'S ALEXANDRA SYMONDS AWARD WOMEN'S LEADERSHIP IN MEDICINE AND PSYCHIATRY

Carol C. Nadelson, M.D., *Director, Office of Women's Careers, Brigham and Womens Careers, 75 Francis Street/PBB5-503, Boston, MA 02115*

SUMMARY:

Throughout history women have been caretakers, healers and more rarely, leaders, and policy makers in mental health. Their instrumental roles, however, have often been forgotten or ignore. This lecture will review the history of women health care roles and describe some of their important contributions throughout the ages. Although in contemporary medicine and psychiatry, women have achieved leadership positions this not occurred at a rate that would have been predicted from their early presence and their achievements. This talk will consider some of the obstacles that have been and continue to be encountered by women. It will review the current data on women's roles in medicine and psychiatry, arguing that the future of psychiatry will be seriously compromised if it does not avail itself of women's talent and abilities. Finally, solutions will be proposed to advance women's leadership especially as psychiatric practice and responsibilities change, and as research findings continue to lead to enhanced patient care.

REFERENCE:

1. Nadelson CC: Women in Psychiatry, in Smelser NJ and Baltes PB (eds). International Encyclopedia of the Social & Behavioral Sciences. Pergamon and Science Direct, 24:16522–8, 2001

LECTURE 15
EVIL IN THE WORLD AND TERROR IN OUR NATION: TRANSFERRING VULNERABILITIES INTO RESILIENCE

Philip G. Zimbardo, Ph.D., *Professor of Psychology, Stanford University, Building 420, Jordan Hall, Stanford, CA 94305-2130*

SUMMARY:

On September 11, the well-coordinated, devastating terrorist attacks on the World Trade Center and the Pentagon plunged the United States into grief and terror. Our country, with its traditions of democracy and openness as well as its world wide prestige, found it almost inconceivable that an organized group would be so willing to kill thousands of innocent individuals and that members of this group could be so brainwashed as to methodically plan their roles and then calmly suicide as they piloted the hijacked planes to destruction. This presentation will focus on the psychology of evil, how ordinary men and women can be induced to commit sadistic and even heinous acts that are alien to their usual behaviors. Drawing on knowledge obtained from studying the Inquisition and the Holocaust, the presenter will describe how situational forces contribute to evil behaviors and how propaganda and mind control are utilized effectively to shape the beliefs of a culture. A number of related laboratory and field studies that deal with social expectations, de-individuation, aggression and criminal behavior will be discussed, including the presenter=s well known Stanford Prison Experiment. The presentation will then focus on the response of New York, Washington DC, and our country in general B the anguish, the stress and mood-related symptoms and the panic related to concerns about future and unpredictable terrorist acts. Next, positive components of our national response, including the ensuing patriotism, cohesion, and self-reflection will be discussed. Finally, perspectives will be offered on how mental health professionals and the community at large can contribute to increasing the resilience of our citizens while drawing on our traditional national strengths.

REFERENCE:

1. Zimbardo, PG: The Psychology of Evil: A Situationist Perspective on Recruiting Good People to Engage in Anti-Social Acts. Research in Social Psychology [Japanese journal], 11, 125–133, 1995.

LECTURE 16
APA'S OSKAR PFISTER AWARD THE NEARLY FORGOTTEN FACTOR IN PSYCHIATRY: WHAT A DIFFERENCE A DECADE MAKES

David B. Larson, M.D., *National Institute of Health Research, 6110 Executive Boulevard, #908, Rockville, MD 20852-4213*

SUMMARY:

During the past decade a quiet but constructive transformation has been evolving within the field of psychiatry. This paradigm shift has precipitated a new field of interest in more frequently addressing patient-relevant spiritual and religious factors in clinical research, education and care. Reviews of the research revealed the early neglect of these factors and also documented the relevance and significance of these factors for many of the patients psychiatrists serve. The number of published studies examining the relationship between religious/spiritual factors and mental health continues to grow, elucidating clinical benefits that may have been overlooked in the past, as well as clinical harms. Future research has the opportunity to build on these studies and also to improve measurement and methodology of spirituality and religion in psychiatric contexts.

In clinical education, a growing number of psychiatric residencies have developed curricula for addressing religious and spiritual factors in psychiatric treatment, management, and care. These courses bridge a previous gap in psychiatric training. Although often important to patients, spiritual factors that might either help inpatient coping to add to patient conflict or distress historically drew scant attention to residency training, increasing the potential for either overlooking or misunderstanding these factors in clinical care.

This presentation will highlight where we have been, what changes have taken place, and what steps are still needed to improve the recognition and clinical understanding of spiritual and religious factors in patients' lives.

REFERENCE:

1. Larson DB, Swyers JP, McCullough ME, eds. Scientific Research on Spirituality and Health: A Consensus Report. Rockville, MD: National Institute for Healthcare Research Research, 1998.

LECTURE 17
APA'S MARMOR AWARD
TERROR, HORROR, AND FRIGHT: PAST AND CURRENT PERSPECTIVES

Lenore C. Terr, M.D., *Department of Psychiatry, University of CA at San Francisco, 450 Sutter Street, Room 2534, San Francisco, CA 94108-4204*

SUMMARY:

I began studying the effects of trauma in 1962 when my first patient as a psychiatric resident begged me to stop her from killing her child. Initially, I observed ten young survivors of physical abuse (including my patient's child) at the University of Michigan; and later at CWRU, I studied children who had been neglected and abused. I began to wait for an even that would traumatize a number of children. When the Chowchilla school bus kidnapped occurred in California in 1976, I studied the children within a few months. I found it possible from the Chowchilla group to characterize the effects of trauma in 5–7 months and after 4–5 years. I added a comparison group of normal children to the long-term Chowchilla study and discovered considerable trauma in the so-called "normals," too.

Gradually, I began wondering, "How co entire societies get through terrible events?" In 1986, when the spaceship *Challenger* exploded on lift-off, I studied children of Concord, New Hampshire who watched the tragedy "live" on TV or at Cape Canaveral, as compared to a matched group of children who were riding school buses in California and thus were temporarily masked from the explosion in space. I learned that older children thought more about *Challenger* than did younger ones. Adolescents altered their attitudes about government, manufacturing, and space over a 14 month period; while younger children developed more symptoms, most of which (except trauma-related play) declined over time. Memories remained vivid and conscious in both groups.

In the year 2000, a schoolteacher from Columbine High School sent me 111 essays from juniors. Their compositions had been written 2–3 weeks after the suicidal assault by Dylan Klebold and Eric Harris that killed 12 additional students and the one teacher. By this time, I was interested in how adolescents naturally recovered from horror and fright. I had noted in patients from my psychiatric practice that three factors seem to be necessary: emotional expression, thinking the trauma through, and making behavioral changes for the self and/or society. I analyzed the 111 Columbine essays for these factors—and the 5 international colleagues ranked them, as well. We have presented the results at these APA meetings. The Columbine essays did indeed demonstrate the importance of the three post-traumatic healing factors.

Finally we come to the World Trade Center and Pentagon attacks of 9-11-01. My colleagues and I are studying a number of normal adolescents in New York and New England, this time watching for changes in healing mechanisms over a one-year period (using 3 essays written over the school year). As psychiatrists, we must be increasingly knowledgeable about how the American population withstands the psychological effects of wars waged by terrorists. In order to successfully treat the psychological challenges to our nation, we must allow ourselves and our patients to abreact, to see to the various horrifying events in context, and to find positive changes in our individual behaviors or in the actions of society. We will suffer frights over the coming months and perhaps, years. But we will endure.

REFERENCE:

1. Terr L: Too Scared to Cry, New York, Harper & Row, 1990. Paperback New York: Basic Books, 1992.

LECTURE 18
APA'S PATIENT ADVOCACY AWARD
MENTAL HEALTH: A PERSPECTIVE FROM THE SURGEON GENERAL WHO LISTENS

David Satcher, M.D. *Department of Health and Human Services, Office of the Surgeon General, Rockville, MD 20857*

SUMMARY:

The United States leads the world in understanding the importance of overall health and well-being to the strength of a Nation and its people. With the publication of the first Surgeon General's Report on Mental Health, we are poised to take what we know and to advance the state of mental health in the Nation. This lecture will highlight the Pre-Surgeon General's Report on Mental Health; will share major concerns expressed to the Durgeon General from the community; and will define the major challenges and opportunities of the future.

REFERENCES:

1. Satcher, David: Mental Health: A Peport of the Surgeon General, US Public Health Service, 1999.

LECTURE 19
CAN THE THIRD MILLENNIUM PSYCHIATRIST HELP PERSONS AT THE END-OF-LIFE?

Edwin H. Cassem, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Fruit Street, Bulfinch 3, Boston, MA 02114*

SUMMARY:

In the Netherlands, the 5 top reasons for requesting euthanasia demonstrate that these factors are psychiatric, psychosocial, cultural, existential, and spiritual. These persons experienced illness as robbing their lives of dignity and meaning. Stripped of independence, they felt overwhelmed. They felt that they no longer mattered.

The psychiatrist must not only be able to diagnose and treat major psychiatric illness in terminally persons but also find a way to rehabilitate their self-esteem. Despite the ravages of illness and its treatments, each person is still the same person she or he was at the top of her game. Three strategies will be described by which the clinician can help sick persons define themselves in this manner.

For the time remaining in life persons can find new goals that enhance self-respect, quality of life, and make this time not only meaningful but also a time that the person can be proud of. Likewise the family can be helped to define goals that will celebrate the gift given them in the life of the dying person and forever recall this time as one they too can be proud of.

To do this the clinician must be a healer, that is, one who with compassion and honesty truly cares about and cares for the sick person.

REFERENCE:

1. Cassem NH: The Person Confronting Death. In AM Nicholi, Jr. (Ed), The Harvard Guide to Psychiatry. 3rd Edition. The Belknap Press of Harvard University Press, 1999, pp. 699–734.

LECTURE 20
APA'S KUN-PO SOO AWARD
JOURNEY TO THE WEST: REFLECTIONS ON CULTURE AND PSYCHIATRY ENTERING THE NEW CENTURY

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street/B4 South, Torrance, CA 90002*

SUMMARY:

Rooted in Western intellectual and cultural traditions, psychiatry nevertheless managed to find its niche in practically every corner of the earth in a time span of less than a century. Such remarkable success, transcending enormous sociocultural divides, reflects the ubiquity and inclemency of behavioral problems, and testifies to the power of our therapeutic armamentaria. At the same time, accumulated "cross-cultural" experiences have challenged the presumption of "universality" of prevailing psychiatric concepts and practices, and highlighted the importance of culture and ethnicity in psychiatric assessment and care. Based on my clinical research experiences over he past three decades, I will discuss the influence of culture on vulnerability, resilience, phenomenology and intervention responses. Recent findings derived from pharmacogenetics and psychopharmacology will be used to show the importance of integrating cultural and biomedical perspectives in examining such issues. I will then attempt to summarize the challenges and promises that are awaiting us, and discuss the continuing need of embedding psychiatric research in the context of diversifying patient populations, but also is indispensable for the future development of theories and practices in general.

REFERENCES:

1. Lin KM and Cheung F: Mental Health Issues for Asian Americans, Psychiatric Services, 50:6, 774–780, June 1999.

LECTURE 21
HEALING THE SOUL IN THE AGE OF THE BRAIN: REFLECTIONS ON THE MEANING OF PSYCHIATRY AFTER SEPTEMBER 11

Elio J. Frattaroli, M.D., *168 Gramercy Road, Bala Cynwyd, PA 19004-2905*

SUMMARY:

The root meaning of the word "psychiatry" is "healing the soul," but few psychiatrists today would endorse that meaning. Psychiatry today is about fixing rather than healing, focusing exclusively on the physical and the external—brain and behavior—and ignoring the emotional and spiritual, the inner life of the soul. Society generally shows the same dehumanizing trend. In our compulsive pursuit of material possessions, creature comforts, physical appearances and addictive pleasures, we use the physical and the external as a quick fix to distract us from our deper emotional and spiritual needs. Our society is big on doing but short on feeling, and this promotes a serious imbalance in our lives.

Since the breakdown we suffered on September 11, we've become much more aware of the tension and the choice between doing and feeling. Despite the encouragement of public officials, we've had less interest in doing "business as usual" and have becoe more attuned to inner feelings and values, and to the needs and concerns of our fellow human beings.

Psychiatric breakdowns too can make us aware of the imbalance between doing and feeling. They interrupt our personal world of business as usual. They make us feel things we would rather not feel. They provoke an urgent desire for a quick fix to get us back to the way things used to be—our premorbid level of functioning. At the same time, by shifting our inner balance from doing to feeling, they present an opportunity for something new, for emotional and spiritual growth.

To be able to use this precious opportunity, we need a psychiatry—and a society—that can *recognize* the opportunity, that values feeling over doing and can understand a breakdown as the beginning of a deeper healing process.

REFERENCE:

1. Frattaroli, E: Healing the Soul in the Age of the Brain: Becoming Conscious in an Unconscious World. New York: Viking, 2001.

LECTURE 22
INTERNATIONAL PSYCHIATRIST AWARD LECTURE
GLOBAL IMPLICATIONS ON THE WORLD HEALTH ORGANIZATION'S WORLD HEALTH REPORT 2001 ON MENTAL HEALTH

Benedetto Saraceno, M.D., *World Health Organization, 20 Avenue Appia, CH-1211, Geneva 27 SWITZERLAND*

SUMMARY:

The World Health Report raises awareness of the real burden of mental disorders and their costs in human, social and economic terms. It helps to dismantle the barriers, particularly of stigma, discrimination and inadequate services, which prevent millions of people from receiving the treatment they need. Finally, the Report describes core actions to be undertaken to improve mental health in countries in a manner compatible with the reality of individual country development.

The Report defines both mental health and mental disorders and describes the key findings in neuroscience and in behavioral medicine, highlighting the psychosocial factors which influence physical illness. Key elements of care delivery are discussed and an updated overview of cost effective treatment for mental disorders and substance dependence, is provided. Prevention strategies are discussed with emphasis on suicide prevention. Mental health policies are also comprehensively addressed.

REFERENCE:

1. The World Health Report 2001: "Mental Health: New Understanding, New Hope," World Health Organization, 2001.

LECTURE 23
MANIA IN YOUTH: A TRANSITION FROM IGNORANCE TO ENLIGHTENMENT TO CONFUSION

Elizabeth B. Weller, M.D., *Department of Psychiatry, University of Pennsylvania, 34th and Civic Center Boulevard, Philadelphia, PA 19104*

SUMMARY:

Bipolar disorder has not been well studied in children and adolescents. Historically it was assumed children and adolescents had immature ego development and thus could not suffer from mood disorders. Childhood depression was officially recognized in 1975 following an nimh conference where researchers and clinians declared that youth could suffer from depression similar to adults and the depression could be diagnoised by asking age relevant and developmentally appropriate questions. Since then the field has advanced due to nimh funding of some studies. The fda ruling that any medication that can be used in children needs to be studied in children and offering pharmaceutcal industry a 6 month patent extension of stimulated initiation of these studies. Thus, there has been a mushrooming of studies. Some have been properly done but unfortunatly some have been poorly designed. These studies provide scientific basis of our treatments targeting depressed children and adolescents. An nimh funded multicenter study: treatment for adolescents with depression study (tads) is the current ultimate study that combines cognitive behavioral therapy, fluoxetine, combination treatment, and placebo. However, studies of bipolar disorder continue to lag. Our first study: "mania, has it been overdiagnosed" was published in 1986 and raised a lot of eyebrows. A review of the literature on severly disturbed children revealed 50% of children who satisfied criteria for mania were given a different diagnosis. At that time we noted that even kraeplin had identifed prepubertal onset of mania in his adult manics. Hence initally the child psychiatrists were not diagnosing mania because they were not thinking of it.

With time passing the pendulum swung and a large number of children who had severe symptom complexes were given the diagnosis of mania and treated with pharmacological agents used in adults. A recent meeting at nimh that included leaders in the field had a round table conference where it was emphasized that bipolar disorder clearly exisited in children and adolescents. In prepubertal children it is rare but does exsist. It was also agreed that children who have severe psychopathology who do not fulfill the classical bipolar diagnosis but instead fall into the nos category should also be studied. Our european colleagues stillthink that the diagnosis of mania is an american fad! In some instances they may be true. With the advance of diagnostic tools and the progress in genetic studies with research monies from the nimh and industry we hope to move forward to the age of enlightment.

REFERENCE:

1. Weller EB, Weller RA, Fristad, MA: Bipolar Disorder in Children: Misdiagnosis, Underdiagnosis, and Future Directions. Journal of the American Academy of Child and Adolescent Psychiatry, 34(6):709–714, 1995.

LECTURE 24
APA'S ADMINISTRATIVE PSYCHIATRY AWARD DOES THE PSYCHIATRIC HOSPITAL HAVE A FUTURE?

Steven S. Sharfstein, M.D., *Sheppard Pratt Health System, 6501 N. Charles Street, Baltimore, MD 21204*

SUMMARY:

The Sheppard and Enoch Pratt Hospital, a not-for-profit, well known psychiatric hospital in Baltimore confronted a crisis ten years ago which threatened its existence. The concept of hospital treatment was challenged by managed care approaches and average lengths of stays decreased by almost 90 percent. It was at this time that I became the fifth director in the history of the 100-year old Quaker hospital and together with trustees and staff began to re-imagine a present and future for ourselves. This lecture is a description of Sheppard's reinvention as a continuum of care and from this experience, and extrapolation of what will be likely shape of future opportunities for psychiatric hospitals to provide quality care. Concerns about patient and community safety and the need for intensive biopsychosocial evaluation of individuals with mental disorders prove a compelling rationale for short-term patient care within the context of a comprehensive behavioral health system. Long-term treatment requires a range of residential, day and outpatient settings—a "hospital with walls." This talk will also describe a personal odyssey for a psychiatrist/administrator who has had to confront a range of decisions and emotions in the face of crisis and intensive change.

REFERENCES:

1. Schreter RK, Sharstein SS, Schreter CA (eds): Managing Care, Not Dollars: The Continuum of Mental Health Services. Washington, DC: American Psychiatric Press, Inc., 1997.

MEDIA SESSIONS

SUNDAY, MAY 19, 2002

1. OUR CHILDREN

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should obtain more immediate understanding of the cultural-historical context of the Shoah, as well as of the impact of massive traumatization on children and families and general.

PROGRAM DESCRIPTION:

This media session illustrates the impact of massive psychological traumatization on childhood and adult development. In the discussion part, we will address general ethical and therapeutic issues involved in treating victims of massive childhood trauma when they present many years later as adults. In this last Yiddish-language feature made in Poland, part docu-drama, part melancholic comedy, famous Yiddish comedians Dzigan and Shumacher visit an orphanage near the city of Lodz to perform for an audience of Jewish orphans who survived the Holocaust. Their performance, although well-intentioned, stirs up painful memories of recent events, but also offends the children by the sentimentalized and naïve depiction of wartime conditions. Having all lived through the reality of separation and loss, the children take over the stage, outdo the performers, and tell their stories. The little actors in *Our Children* - among them the proposer's father, C. Preter - were all residents of the Helanowek orphanage, many of them sole survivors of their families. The following have agreed to participate in the expert panel: Psychiatrist and psychoanalyst Dori Laub, co-founder of the Yale Fortunoff Video Archives, psychiatrist Yehuda Nir, child survivor and author of "The Lost Childhood", and forensic psychiatrist and psychoanalyst Harold Bursztajn active in integrating analysis of the Shoah and its aftermath into postgraduate medical and mental health education.

REFERENCES:

1. Grynberg H.K.: The Victory. Northwestern University Press, 1993.
2. Bowlby J.: Loss: Sadness and Depression, Vol. 3. Perseus Books, 1982.

2. MEMENTO

PROGRAM DESCRIPTION:

"Leonard Shelby wears expensive, tailored suits, drives a late model Jaguar sedan, but lives in cheap anonymous motels, paying his way with thick wads of cash. Although he looks like a successful businessman, his only work is the pursuit of vengeance: tracking and punishing the man who raped and murdered his wife. His suspicions dismissed by the police, Leonard's life has become an all consuming quest for justice.

The difficulty, however, of locating his wife's killer is compounded by the fact that Leonard suffers from a rare untreatable form of memory loss. Although he can recall details from his life before the "accident" Leonard cannot remember what happened fifteen minutes ago, where he is, where he's going, and why."

MONDAY, MAY 20, 2002

3. TIME FRENZY

PROGRAM DESCRIPTION:

Time Frenzy, produced by Bob Gliner, a multi-award-winning documentarian and Professor of Sociology at San Jose State University, is a thought-provoking documentary that explores the psychological, sociological, philosophical, and cultural ramifications of our increasingly fast-paced lives. *Time Frenzy* examines this new "24-7" reality, compares the American "work and consume" lifestyle with that of other countries, and probes the impact of technology on personal relationships, education, health, and the environment.

4. THE PUPPETS OF DI CORI: NEW PSYCHODRAMA APPROACH

PROGRAM DESCRIPTION:

The presenter is an innovator of many therapeutic techniques which combine the arts and various theoretical approaches with problems of people in relationships throughout the life cycle. In this demonstration, two adolescent students from the "therapeutic theater course", which Dr. di Cori gives to an audience of over 100 student at the University of Rome, volunteer to participate. They are invited to throw to the floor two loosely articulated, amorphous "rag doll" figures which land in unanticipated positions vi-a-vis eachother on the floor. Professor di Cori then directs the students in pairs, and small groups in an imaginative discourse as they project themselves into the lives of the rag-doll figures on the floor. This involvement leads to an emerging recognition by them of their personalities, ambitions and conflicts as through their projections onto the rag-doll dramas they interact with each other, and the therapist-director.

REFERENCES:

1. Greene, M: Releasing the Imagination. San Francisco: Jossey-Bass Publishers, 1995.
2. Damasio, A: The Feeling of What Happens. New York, Harcourt Brace & Co, 1999.

5. CARVED FROM THE HEART: A PORTRAIT OF GRIEF, HEALING, AND COMMUNITY

PROGRAM DESCRIPTION:

One man loses his son to a cocaine overdose. Grieving, Stan Marsden, a Tsimshian wood carver decides to create a totem pole and invites the town of Craig, Alaska to help. The project grows; it brings persons of diverse ages and backgrounds together, acknowledges common problems of drug abuse and violence and promotes healing within the community. *Carved from the Heart,* produced by Ellen Frankenstein, a filmmaker and community artist and Louse Brady, a member of the Tlingit Tribe of Southeast Alaska, acknowledges the intergenerational grief tat grows out of rapid changes in lifestyles and interruptions to the passage of tradition and knowledge within Alaska Native and American Indian communities.

Screening/Awards: Sundance Film Festival, American Indian Film Festival *Best Documentary Short,* Institute of Noetic Sciences *Elda Hartley Award,* National Educational Media Network *Bronze Apple* Award, Red Earth American Indian Film Competition *Will Sampson Award for Best of Show,* Harvard Medical School, Mind/Body Medical Institute.

REFERENCES:

1. Borowsky IW, Resnick MD, Ireland M, Blum RW, *Suicide Attempts among American Indian and Alaska Native Youth: Risk and Protective Factors,* Archives of Pediatric Adolescent Medicine 153(6): 573–580, 1999.

2. Brave Heart MY, DeBruyn LM, *The American Indian Holocaust: Healing Historical Unresolved Grief,* Am Indian Alaska Native Mental Health Res 8(2): 56–78, 1998.

6. HOMELAND

PROGRAM DESCRIPTION:

Set against the stunning backdrop of the Northern Plains, *Homeland* is a rich and engaging documentary that weaves together the stories of four Lakota Indian families on the Pine Ridge Indian Reservation in South Dakota. Shot over several years, the film provides an inspiring and intimate portrait of contemporary Native American life, as well as a unique and compelling depiction of the strength and vitality of Native culture as it unfolds to the viewer over the course of the years. Ultimately, the film balances the many troubles that beset the reservation system with the resilience and fortitude of Lakota culture and spirituality. In doing so, it challenges viewers to recognize and appreciate the power of family, the immense spirit of the natural world, and the healing potential of humor and faith.

7. BETWEEN WORLDS

PROGRAM DESCRIPTION:

Between Worlds explores over a period of six years the lives of several Vietnamese Amerasians and their families who left Vietnam in 1992. Each of the families was sent to a refugee camp in the Philippines for six months of cultural orientation, before resettling in the U.S. The film details their experiences in camp and follows their lives for five years as they struggle to learn English, find jobs, and pursue their education.

8. M & M SMITH: FOR PROSPERITY'S SAKE

PROGRAM DESCRIPTION:

M & M Smith: For Posterity's Sake eloquently explores the lives and work of Morgan and Marvin Smith, twin brothers and prolific African-American artists. The Smiths moved from Kentucky to New York in 1933 to pursue careers unavailable to them in the segregated South. In 1937, they opened a studio next to Harlem's Apollo Theatre and began 50 year-long careers as artists and still and motion film photographers. The Smiths and their cameras covered events in Harlem such as political rallies, street corner orators, the training ground of Joe Louis, and the exciting nightclub scene. They documented the celebrated and common citizens of their community and opened doors for models and actresses as they sought careers in the white dominated media. The film features Marvin and Morgan Smith, performer Eartha Kitt, and photo historian Deborah Willis.

9. IN THE MIX

PROGRAM DESCRIPTION:

Three reports from the Surgeon General (mental health, suicide and youth violence prevention) describe the timeliness and relevance to produce a video that will convince teens to share information when they hear talk of violence or other mental health concern affecting their peer group, friend or community. "When Not to Keep a Secret," has a four year history of a project that promotes civic responsibility and mental health education within a literacy framework. The APA Alliance is collaborating with the APA Committee on Psychiatry and School Mental Health, the American Academy of Child & Adolescent Psychiatrists, Yellow Ribbon Suicide Prevention Program and In The Mix a PBS weekly series—For Teens by Teens) to produce this guide.

REFERENCES:

1. Surgeon General Report on Youth Violence Prevention.
2. Facts for Families American Academy of Child and Adolescent Psychiatry.

10. SOUTHERN COMFORT

PROGRAM DESCRIPTION:

"Southern Comfort" is the story of the last year of life of Robert Eades, a female-to-male transsexual in rural Georgia, and his found family of transgendered people. Eades is a pipe-smoking, self-proclaimed hillbilly, comfortable in his country environs. But the intolerant world in which he lives is evident in his difficulty obtaining medical care when he develops ovarian cancer. The film is named after a highlight for Eades and his friends, an annual convention for transgendered people in Atlanta.

Through the film's series of interviews and observations over a year with its subjects, "Southern Comfort" is able to demonstrate many truths about their lives and about the lives of transgendered people in general. The film is exemplary in its exploration of relationships, social networks, and family. In the observations on living with a terminal illness, the filmmaker, Kate Davis, finds that courage and love cross all boundaries of gender identity.

Despite the serious subject matter, the film is imbued with the good humor of its subjects, and does not fail to entertain. The film won the Grand Jury Prize for best documentary at the 2001 Sundance Film Festival.

REFERENCES:

1. Devor H: (Female-to-male transsexuals in society). Foreword by Jamison Green. Indiana University Press, Bloomington, IN, 1997.
2. Karasic DH: Progress in health care for transgendered people. Editorial. Journal of the Gay and Lesbian Medical Association, 4(4):157–158, 2000.

11. JUST CALL ME KADE

PROGRAM DESCRIPTION:

Kade Farlow Collins is a 16-year old female-to-male transgendered person residing in Tucson, Arizona. Kade's parents maintain a supportive and nurturing relationship to help their teenage child face many challenges. As Kade's body began to transform during puberty, he became nearly suicidal. Realizing that the issue was more complex than Kade being a tomboy or lesbian, the family searched for information. Through a local support group and the internet, Kade's mother found books and other resources pertaining to transgenderism. The family agreed to have their lives documented in order to bring awareness to the subject.

12. SOPRANOS

PROGRAM DESCRIPTION:

HBO series, *The Sopranos* is a complex drama built around a mobster, Tony Soprano, who struggles with two families; his wife and kids, and his gun-toting gang. The first season was built around what Tony learns when, whipsawed between those two worlds, he finds himself plunged into depression and seeks psychotherapy. With analysis built into the very spine of the show's elaborate episodic structure, creator/writer David Chase, produces an unpredictable se-

ries of parallel plots that twist from tragedy, to farce, to social realism.

TUESDAY, MAY 21, 2002

13. SIX BILLION AND BEYOND

PROGRAM DESCRIPTION:

Half of the world's six billion people are under the age of 25. The decisions they make about how many children to have and when to have them will be critical in shaping life on earth in the next 50 years. This thought-provoking documentary is perhaps the most comprehensive introduction available on video to the interconnected issues of population growth, economic development, equal rights and opportunities for women, and environmental protection around the world.

14. SLIPPERY BLISSES

PROGRAM DESCRIPTION:

Kissing is one of our most complex and delicate forms of communication. It brings our senses of touch, smell, and taste together with a variety of powerful emotions and behavioral messages. *Slippery Blisses* interweaves the commentary of ordinary people who recall their best and worst kisses with a quirky cast of behavioral experts who discuss the "science" of kissing and raise numerous discussion-inducing questions. The film depicts a visit to Paris, the world's most romantic city, and along the way explores the turbulent history of kissing in the movies, interviews a sex therapist, and features a socialite hairdresser who show how cheek-kissing bonds high-society together. *Slippery Blisses* demonstrates ultimately that, as with all human behavior and communication, there is nothing simple about a simple kiss.

15. PERSONAL SPACE: EXPLORING HUMAN PROXEMICS

PROGRAM DESCRIPTION:

Space is a silent language, and we all speak it, whether consciously or not. *Personal Space: Exploring Human Proxemics* is a fascinating and frequently funny video that portrays the effects of space on everyday human behavior in an engaging and dramatic manner. Topics covered in the video include: 1) individual reactions to invasions of personal space; 2) the powerful effect of cultural differences and strong habitual patterns in how individuals use space; 3) family spatial arrangements; 4) how spatial factors affect our perceptions of relationships; and 5) hierarchical space in organizations. The video blends student testimony and often amusing field experiments to illuminate the use of space, territory, and touching in virtually every facet of life.

16. LONG NIGHT'S JOURNEY INTO DAY

PROGRAM DESCRIPTION:

This film captures some of the pain with outpouring of emotions during the hearings before the Truth and Reconciliation Commission (TRC), which was a process chosen by South Africa to facilitate healing from Apartheid trauma. Nobel Prize Laureate Archbishop Desmond Tutu said of this film: "This is an impressive, heartrending film and it deserves wide circulation." In the film he describes a sharp contrast between "Retributive" and "Restorative" justice; it is the latter, he says, that South Africa chose.

The directors of this film, Frances Reid and Deborah Hoffman, have attempted to explore the workings of the "restorative justice" in a dramatic presentation accompanied by rich, emotionally arousing S. African music. The four studies covered include: the Amy Biehl story, the Cradock 4, the McBride Story and the Gugulethu 7. Although no amount of remorse by itself resulted in forgiveness, the four cases explored the divergent views about the possibility of forgiveness and healing. These four cases exemplify the TRC-heard stories on 22,000 victims and 7,000 perpetrators.

This film won the Grand Jury Prize for Best Documentary at the 2000 Sundance Film Festival.

REFERENCES:

1. Durham, M.S. *The Therapist Encounters with Revenge and Forgiveness.* London and Philadelphia: Jessica Kingsley, 2000.
2. Tutu, Desmond. *No Future without Forgiveness.* New York: Random Press, 1999.

17. MAKING VISIBLE THE HIDDEN: SERVING CHILD VICTIMS IN THE HEALTHCARE COMMUNITY

PROGRAM DESCRIPTION:

Healthcare providers are often the first to respond to child victims of violence, but their focus on treating the physical wounds sometimes causes them to overlook children's emotional and mental (the hidden) needs. Without timely and appropriate intervention, the effects of trauma can last a lifetime. *Making Visible the Hidden: Serving Child Victims in the Healthcare Community* highlights three programs in which professionals in medical settings are incorporating victim-oriented practices into the service they provide. The stories of child victims vividly illustrate the importance of early intervention.

18. TAKE THIS HEART

PROGRAM DESCRIPTION:

For the nearly one million American children who are compelled to live in foster care, daily life is a forbidding venture. Cast adrift at an early age, dispossessed of everyone they have known or loved, they are left to grow up in a world that has proven deeply unreliable, with strangers who may or may not offer comfort and protection. *Take This Heart* is the story of three boys who struggle to make sense of their harsh fates, each in his own way. Their stories reveal the remarkable resiliency and the tough-minded will with which they go on with their lives, not utterly consoled, but not broken. The film explores the experiences of a few children in one foster home in Seattle, and in so doing gives voice to an invisible population of children otherwise consigned to silence at the margins of society.

19. A WORLD OF FOOD: TASTES AND TABOOS IN DIFFERENT CULTURES

PROGRAM DESCRIPTION:

From vegans to cannibals, human beings consume an infinite variety of foods. They also form fiercely emotional views about people who follow food practices unlike their own. Many Americans, for example, are horrified by the consumption of dog meat in certain Asian countries. But staples of the American diet may be equally horrifying to others. *A World of Food* is the perfect antidote to ethnocentrism, the all too common assumption that one's own culture is superior to others. This video will teach the critical lesson that all cultures consume foods that people in other cultures see as highly debatable, inherently disgusting, or simply too bizarre to eat at all. It will help develop an enhanced understanding of food practices in

other cultures and a deeper awareness of the need for cross-cultural understanding in an increasingly interconnected world.

20. WORLD TRADE CENTER AND PENTAGON DISASTERS

PROGRAM DESCRIPTION:

From the first horrifying images of lower Manhattan and the Pentagon on September 11, 2001, through the war that followed, the media refocused America, if not much of the world, on a common enemy. How did the media's choice of imagery affect the meaning of the course of events since that dark day? In addition to clips on the September 11th attack, Dr. JoAnn Difede will give a presentation on virtual reality enhanced prolonged exposure therapy for PTSD following the attack. The presentation will enable the audience to view the virtual world of the World Trade Center attack as well as to see a brief segment of a patient undergoing "virtual reeality therapy."

21. STANDING ON MY SISTERS' SHOULDERS

PROGRAM DESCRIPTION:

Never before has a documentary film so dramatically portrayed the involvement of both black and white women working together during the Civil Rights period. Their efforts helped to change the rules of race relations in the South forever. Issues relating to voter registration, desegregation of schools, individual, family and community involvement will be experienced through the words and feelings of women who were there and who participated in these historical events. Archival footage is blended beautifully with current interviews of women such as Annie Devine, Victoria Gray and footage of Fannie Lou Hamer who helped create a new political force in the South.

The title evolves from the words of many interviewed who said they would not be as far along had it not been for their older sisters paving the way. All alluded to the fact that women could do more than men in certain areas because of the fear that men would be killed if they acted as openly as the women.

"Standing on my Sisters' Shoulders" will touch lives and promote discussion by those who view it. Targeted audiences include mental health professionals concerned about the effects of racism on mental health; individuals interested in the Civil Rights Movement; students of Civil Rights who need to know the role of women in the Movement as well as high school and junior high school students, libraries and public and other television channels, film festivals and community organizations.

22. WOMEN OF THE WALL

PROGRAM DESCRIPTION:

In 1989, a group of Jewish women marched toward the Western Wall in Jerusalem carrying a Torah scroll, determined to pray openly as women without male leadership or approval. Violently attacked by right-wing opposition, the *Women of the Wall* filed a petition with the Supreme Court asserting their right to pray openly. This documentary is an insightful exploration of the women's struggle for free spiritual expression in a climate of increasing governmental control over religious practice.

23. LOYALTIES

PROGRAM DESCRIPTION:

Loyalties is the poignant story of two women who discover they share two halves of a common past in the painful lineage of slave and slave holder. Carmelita Robertson, a black graduate student who worked at a museum of national history and her co-worker, Dr. Ruth Holmes Whitehead, a white ethnologist, met for a professional lunch. They soon discover that they have a strange common thread. Almost certainly, one of Ruth's ancestors owned one of Carmelita's as a slave. As a result of this discovery, the pair decide to travel to South Carolina to unravel their linked heritage. This video shows their journey through pain, resentment, embarrassment, and ultimately acceptance, as each woman, in her own way, comes to terms with their shared history.

24. REMEMBER THE TITANS

PROGRAM DESCRIPTION:

Next to a family, a team is one of the most influential groups to which an individual ever belongs. *Remember the Titans* tells the true story of the 1971 integration of a previously all-white Alexandria, Virginia, high school and its football team, the Titans. Not only are black students bussed to the school over the objection of the white community, but also a black coach, played by Denzel Washington, is brought in to replace a beloved, white coach. Washington's character, Herman Boone, is faced with the daunting task of creating a cohesive, winning team when half his squad is racially at war with the other. The coach's strengths are his unwavering commitment to win, his caring relationship with players of both races, and the evolving willingness of his white counterpart, Bill Yoast, to take a subordinate role for the sake of the team. The film is a classic study of how to form a cohesive group to all those trying to bridge the racial divide that still exists in this nation. Bill Yoast, the Titans white coach, and Jerry "Rev" Harris, the Titans black quarterback, will be present to participate in the discussion.

WEDNESDAY, MAY 22, 2002

25. LEONA'S SISTER GERRI

PROGRAM DESCRIPTION:

Leona's Sister Gerri is the story of Gerri Santoro, the real person in the police photograph of an anonymous woman collapsed on a motel room floor, dead from an illegal abortion. Reprinted thousands of times in newspapers, magazines, and books, this image has become a symbol for reproductive freedom. Addressing issues of reproductive rights and domestic violence, this video is the dramatic and engrossing story of a woman's life and society's response to her death.

26. BLINK

PROGRAM DESCRIPTION:

This powerful and thought-provoking documentary examines the dramatic story of one-time white supremacist leader Gregory Withrow, and in so doing, explores the underlying strains of violence and domination in American life and culture. Withrow's flight from the militant white Aryan resistance captured the attention of the national media when Withrow was found beaten and his hands nailed to a board. Now, more than a decade later, Withrow is married to a Mexican-American woman and lives a low-key, semi-isolated rural existence. *Blink* explores the complex middle ground where Withrow

still battles his demons and questions the possibility of fundamental personal change.

27. "IN THE LIFE" TELEVISION NEWS MAGAZINE

PROGRAM DESCRIPTION:

"In the Life" is a national television series in a newsmagazine format that reports on gay and lesbian issues and culture. Episode 701, "Back to School", addresses multiple issues relevant to the education and mental health of gay and lesbian youth and to the families of gay and lesbian youth. The first segment focuses on adolescent suicide. A review of the film "Trevor" describes the isolation, rejection and harassment experienced by a gay adolescent. A lengthy series of interviews follow with the parents of a teenager who committed suicide. Following segments review the process involved in establishing a Gay Students Rights Bill and gay-straight alliances; support and activism for parents; curriculum for educators; and the presence of gay conversion organizations and response by gay and lesbian youth. Final segments report on model Gay and Lesbian support centers; homeless self-identified homeless gay and lesbian youths; and the day of a teen outreach worker who assists youth through the community outreach program at a center in New York City dedicated to the health and welfare of gay and lesbian youth. The target audience is general psychiatrists and psychotherapists who recognize the need to learn about the issues relevant to and barriers to health for gay and lesbian youth. This video has been used with great praise in various teaching venues for those who work with adolescents, including psychiatry residency programs.

REFERENCES:

1. James Lock, M.D., Ph.D., and Hans Steiner, M.D., Gay, Lesbian and Bisexual Youth. Risks for Emotional Physical and Social Problems: Results From a Community Survey. Journal of the American Academy of Child and Adolescent Psychiatry, 38(3):297–304, 1999.
2. Victor Carrion and James Lock, The Coming Out Process: Developmental Stages for Sexual Minority Youth. Clinical Child Psychology and Psychiatry, 2(3);369–377, 1997.

28. WEST 47TH STREET

PROGRAM DESCRIPTION:

West 47th Street, a documentary film for theatrical release this year, offers an unprecedented window in the lives of people who are often feared, ignored, and seldom understood. This warm and intimate film follows five people with serious mental illness, off the streets and out of homeless shelters, in and out of the hospital, and at home and at work, over a three-year period. The resulting film presents a story about people who approach tremendous obstacles with humor, optimism, and grace, and offers considerable insight about psycho-social rehabilitation and the effects of deinstitutionalization.

29. BUBBEH LEE AND ME

PROGRAM DESCRIPTION:

What can a grandchild discover through a grandparent? When the filmmaker of *Bubbeh Lee and Me* arrives in Florida to visit his feisty, 87-year old Jewish grandmother and speaks with her heart-to-heart about love, death, and sexuality, their two worlds collide and the strength of their bond emerges. A spirited reflection on aging, identity, diversity, and acceptance, this classic film examines the legacies passed through families and generations, and shows that the journey of self-discovery can begin at any age.

30. THE FROG IN THE WELL: THE LIFE AND WORK OF HOH-KUN YUEN

PROGRAM DESCRIPTION:

This video chronicles the life and work of Hoh-Kun Yuen, physicist, father, ice skater and radical documentarian. Yuen, a Chinese American immigrant, recorded decades of social movements in and around Berkeley and the Bay Areas beginning in 1963 with the Free Speech movement, including the Black Panther movement, the Women's Movement, the Anti-VietNam War Movement and the Anti-Apartheid struggles of the '80's. His work, inspired by a radical view of science and history, is described using photos, tape recordings, newsprint, and film from Yuen's archives which he named *The Frog in the Well* after a Chinese fable.

The producer and director, David Martinez, and his father, APA member Cervando Martinez, Jr., M.D., will be present to answer questions and lead a discussion. The relationship of personal development and creativity; the immigrant experience in America; the boundary between productivity and obsessional dysfunction; and other salient issues raised by the video will be discussed.

The target audience for the video are mental health professionals and students, particularly students of the Asian American experience, cold war history, and radical politics.

31. A BEAUTIFUL MIND

PROGRAM DESCRIPTION:

A Beautiful Mind is the true story of John Forbes Nash, Jr., a man whose formulas established the mathematical principles of the "Game Theory" of economics. The theory eventually won Nash the Nobel Prize. By the age of 30, Nash was diagnosed with paranoid schizophrenia. He had a varied sexual life, which included an arrest for indecent exposure in a men's restroom, and fathering a child out of wedlock. The film focuses on Nash's relationship with his wife, and the path his life took from success to mental illness to recovery.

32. KING OF MASKS: GENDER AND TRADITION IN CHINA

PROGRAM DESCRIPTION:

The King of Masks is a proud artist, who knows his own value even if no one else does. But behind the old man's pride we see the shadows of his loneliness. In a Sichuan Province shaken by war and ravaged by floods he has the chance to buy a child. Starving parents are selling their sons, and they will give their daughter to anyone who promises the child a home. The difference between the child who has and does not have a "teapot spout" is measured by the market price and its import is sanctified by centuries of patriarchal tradition. The King of Masks does not want the daughters who are thrust at him by their mothers; he wants a son. He turns on his heels, about to give up, when a child's voice cries out "Yeh Yeh," grandfather in Chinese. "Yeh Yeh" is the word one takes away from the film. It will echo in your mind as Doggie utters it with every different emotion of which a child is capable. This first "Yeh Yeh" causes the King of Masks to turn back and behold just the little boy (really a girl) he wanted. Here is the miracle of love at first sight. A price is agreed upon and, after buying Doggie new clothes, he triumphantly takes the child to his little houseboat on the riverbank. Part of Doggie's irresistible charm is that she is both naïve and indignant as to why a "teapot spout" should make such a difference. The director, Wu sets her innocent conviction against China's patriarchal tradition and its history of female infanticide that echoes into this century. Wu's film is the story of how this indignant little girl conquers that age-old tradition to the benefit of everyone.

REFERENCES:

1. Alan A. Stone, "The Artist as Survivor; King of Masks is an allegory about the possibility of human connection," Boston Review 24(6), 1999.
2. Elizabeth Lloyd Mayer, "Toward Female Gender Identity," Journal of the American Psychoanalytic Association, 43:17–38, 1995.

MEDICAL UPDATES

1. MIGRAINE: DIAGNOSIS, TREATMENT, AND COMORBIDITY

Stephen D. Silberstein, M.D., *111 S. 11th Street, Gibbon Building, Suite 8130, Philadelphia, PA, 19107.*

2. CARDIAC EFFECTS OF OPIOID ADDICTION PHARMACOTHERAPY

Elinore F. McCance-Katz, M.D., *Department of Psychiatry, Montefiore, 111 E. 210th Street, Rosenthal 169, Bronx, NY 10467.* Robert Maslansky, M.D., *Bellevue Hospital NYC, 27 E. 65th Street, New York, NY 10021.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have an overview of 1-acetyl-methadol (LAAM) pharmacotherapy for opioid dependence. Topics will include clinical pharmacology of LAAM, effectiveness of LAAM treatment, effect of LAAM on cardiac conduction, reported adverse events with LAAM therapy, review of US FDA black box warning, and proposed new guidelines for LAAM treatment. Participant will also be informed of the benefits of methadone treatment found in clinical research.

SUMMARY:

LAAM is a long-acting opiate agonist drug that is marketed as a treatment for heroin and other opioid addiction. As an alternative to methadone, LAAM has the benefit of a longer duration of action enabling thrice weekly dosing as compared to daily methadone administration. LAAM has recently been associated with a number of serious cardiac adverse events including fatal Torsades de Pointes. These events have resulted in withdrawal of the drug from the European market and a review by the US FDA. The drug remains available for the treatment of opioid dependence in the US, but is now a second line treatment. New guidelines are being developed for initiation and ongoing treatment with LAAM. The events surrounding the relabeling of LAAM and new clinical treatment guidelines will be reviewed.

The work of Gross et al and Kato et al in the rat model have shown that several opiate agonist ligands provide significant cardioprotection during ischemic episodes. This protection is mediated through the activation of a Delta opioid receptor on individual cardica myocytes. This in turn opens the Katp channel which then affords the protection.

In humans this has not been studied. There is however a population of patients who are chronically exposed to circulating opiate mu/delta ligand. These are patients in methadone maintenance treatment programs. Additionally, they are at exceptionally high risk for manifestations of coronary artery disease (CAD). 90% smoke, 25% use the ischemogenic drug cocaine one or more times a year. Few maintain heart healthy diets.

We have reviewed the clinical records from a well-established MMTP with an average census of 350 patients. There is a noteworthy paucity of acute cardiac ischemic events as well as ECG changes reflecting ischemic heart disease. We believe we have demonstrated the cardioprotective effects of methadone in a human population. Additional works should be undertaken to explore the potentially important pharmaceutical implications of these findings.

REFERENCES:

1. Leavitt SB: LAAM and Cardiac Health. Background Document for OPAT Meeting. Center for Substance Abuse Treatment, Rockville MD, July 2001.
2. Schultz JJ, Hsu AK, Gross GJ: Ischemic Preconditioning and Morphine-Induced Cardioprotection Involve the Delta-Opioid Receptor in the Intact Rat Heart. J Mol Cell Cardiology 29: 2187–2195, 1997.

3. STRATEGIC UPDATE OF ALZHEIMER'S DISEASE: LINKING DISEASE WITH THERAPEUTICS

Carol F. Lippa, M.D., *Professor and Chief, MCP Neurology, MCP-Hahnemann University, Philadelphia, PA 19129.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be aware of the underlying disease mechanisms for Alzheimer's disease, as it relates to future therapies. Following the presentation the attendee will understand the rationale for medications in development for meaningful prevention or stabilization of Alzheimer's disease.

SUMMARY:

Alzheimer's disease (AD) is the most common degenerative disease that affects cognitive function in the elderly. At this time, disease stabilization is sought through the use of cholinergic enhancers (cholinesterase inhibitors). However, these treatments do not address the underlying mechanism of neural death in AD subjects. Recent evidence supports the notion that processing of the amyloid precursor protein (APP) is central to the neuronal loss that underlies the dementia of AD. Extracellular beta-amyloid plaques characterize AD from a histopathologic perspective. The beta-amyloid in plaques is a metabolite of the APP that forms when an alternative (B-secretase and then Y-secretase) enzymatic pathway is utilized for processing. One theory is that the beta-amyloid in plaques leads to AD through a direct toxic effect on adjacent neurons. Other theories advance the notion that neuronal death is triggered by intracellular events that occur during APP processing. In the later model, beta-amyloid plaques are a byproduct of the disease process, rather than the direct case of neuronal death. A direct correlation between beta-amyloid plaque burden and neuronal (or synaptic) loss should occur in AD if beta-amyloid plaques cause AD through a direct toxic effect. However, histopathologic studies indicate that the correlation between beta-amyloid plaque burden and neuronal (or synaptic) loss is poor. A vaccine that eliminates beta-amyloid plaques is under study. Other treatments in development include agents that influence APP metabolism so plaque formation is prevented. Understanding the pathologic AD cascade enables a more informed choice of therapeutic agents.

REFERENCES:

1. Citron M: Secretases As Targets for the Treatment of Alzheimer's Disease, Mol Med Today, 6:392–397, 2000.
2. Selkoe DJ: Alzheimer's Disease: Genotypes, Phenotypes, and Treatments. Science, 275:630–631, 1997.

4. COMPREHENSIVE HIV PRIMARY CARE: TREATMENT AND SERVICE UPDATE

Marla J. Gold, M.D., *Chief, HIV/AIDS Medicine, MCP Hahnemann University, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to describe the epidemiology of HIV infection in the United States, describe the HIV pathogenesis and its relation to treatment principles, recognize the comprehensive nature of HIV disease and various models of care, describe the relationship between the HIV infection and mental illness, recognize current antiretroviral agents used to

treat HIV infection, and describe the relationship of stage of immunosuppression with treatment decisions.

SUMMARY:

HIV primary care continues to rapidly evolve. The number of persons with HIV/AIDS and co-morbid conditions including mental illness and substance abuse continues to rise. It is thus important for the mental health clinician to be familiar with HIV medical care. This session will provide an update as to the current standard of HIV care. Areas to be covered include a brief update on epidemiology and HIV pathogenesis, the clinical course of disease, and the current treatment recommendations. The principles of antiretroviral therapy will be reviewed.

Communication between mental health workers and HIV primary care clinicians is often critical to achieving desired health outcomes among patients. Linkage and delivery of HIV primary care and behavioral health care services including substance abuse counseling have been shown to improve retention in medical care and adherence to both medication and healthier behaviors.

In addition to reviewing medical care, comprehensive models of HIV service delivery will be addressed. New knowledge concerning when and how to prescribe antiretroviral agents coupled with increasing numbers of HIV-infected individuals presenting with complicated psychosocial situations, have contributed to the creation of new modes of care. The impact of substance abuse and mental illness on provision of HIV care will be discussed.

REFERENCES:

1. Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents. Centers for Disease Control and Prevention/Department of Health and Human Services (US) Henry J. Kaiser Foundation, 1998 Dec 1 (updated 2002 Feb4).
2. 2001 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus. Centers for Disease Control and Prevention/Public Health Service (US)/Infectious Diseases Society of America, 1999 August (updated 2001 Nov 28).

PRESIDENTIAL SYMPOSIUM

WHAT WILL THE 21ST CENTURY BRING TO THE TRAINING OF PSYCHIATRISTS?

Chairperson: Lisa Mellman, M.D.
Co-Chairperson: Ronald Rieder, M.D.
Participants: Richard Harding, M.D., Carol Bernstein, M.D., David Leach, M.D., Steven Hyman, M.D., Juan Mezzich, M.D., Sheldon Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to discuss current problems and challenges for psychiatric education, including assessing residents for competency, and training residents in general psychiatry and for subspecialties. Participants will also be able to discuss potential solutions.

SUMMARY:

The scientific basis of psychiatry has advanced and the clinical practice of psychiatry has changed, especially over the past decade. In addition to these factors, there are currents within psychiatric education itself related to accountability (e.g., demonstration of competence), and the development of subspecialties, with their associated training programs. This Presidential Symposium will examine these issues and the challenges they pose to psychiatric education, as well as potential solutions.

REFERENCES:

1. Leach DC: The ACGME Competencies: Substance or Form? Accreditation Council for Graduate Medical Education. Journal of American College of Surgeons 192(3): 396–8, 2001.
2. Lieberman JA, Rush AJ: Redefining the role of psychiatry in medicine. Am J of Psychiatry 153(11): 1388–97.

RESEARCH ADVANCES IN MEDICINE

LONG-TERM MECHANICAL CIRCULATORY SUPPORT
Frontiers of Science Lecture

Chairperson: Peter A. Shapiro, M.D.
Co-Chairperson: James L. Levenson, M.D.
Lecturer: Eric A. Rose, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to illustrate the survival and quality-of-life benefit of mechanical circulatory support devices in patients with end-stage heart failure and speculate on future developments.

SUMMARY:

We have implanted left ventricular assist devices (LVADs) in 227 patients as bridges to cardiac transplantation over an 11-year period at a single institution. 158 patients (69.6%) survived to cardiac transplantation after implant durations of 4 to 397 days. Increasing experience allowed evolution from primarily in-patient intensive care unit management to prolonged periods of out-of-hospital support. Similar experience at collaborating institutions raised the question of the potential usefulness of wearable LVADs as a long-term destination therapy for end-stage heart disease patients ineligible for cardiac transplantation.

From 1996 to 1998, we randomized 21 patients to receive either LVAD (n=10) therapy or state-of-the-art optimal medical management (OMM, n=11) at 7 centers. One-year survival in LVAD patients was 40% compared to 20% in the control group (p=NS) while no device patients survived beyond 21 months. This preliminary experience generated modifications of the device employed (Thoratec VE Heartmate), and refinements of patient management protocols. We therefore initiated a 20-center randomized trial (N=129) of LVAD versus OMM management with the primary hypothesis that LVAD therapy would reduce all-cause mortality by 33% over a 2-year observation period.

Kaplan-Meier survival analysis showed a 48% reduction in all cause mortality in the LVAD group) RR = 0.52 (0.34-0.78; p= 0.001). The probabilities of one and two-year survival were 52.1% vs. 24.7% (p=0.002) and 22.9% vs. 8.1% (p=0.09) in LVAD and OMM patients, respectively. The frequency of serious adverse events was 2.35 (1.86-2.95) times greater in the LVAD group with a predominance of infection, bleeding, and device malfunction. Quality of life, as measured by the SF-36, the Beck depression inventory and NYHA functional classification, was significantly improved in the LVAD group at one year. This experience illustrates the rapid evolution of LVAD therapy as a highly effective bridge to transplantation and a clearly effective, complicated, and improving approach to long-term definitive management of end stage heart failure.

REFERENCES:

1. Rose E, Gelijns AC, Moskowitz AJ, Heitjan DF, Stevenson LW, Dembitsky W, et al: Long-Term Use of a Left Ventricular Assist Device for End-Stage Heart Failure; New England Journal of Medicine 2001; 345:1435–1443.
2. Goldstein DJ, Oz MC, Rose EA: Medical Progress: Implantable Left Ventricular Assist Devices; New England Journal of Medicine; 339:1522–1533, 1998.

REVIEW OF PSYCHIATRY

SESSION I OF THE REVIEW OF PSYCHIATRY

EMERGENCY PSYCHIATRY

Chairperson: Michael H. Allen, M.D.

1. **The Structure and Function of Psychiatric Emergency Services**
   Richard E. Breslow, M.D.
2. **Medical, Psychiatric and Cognitive Assessment in Psychiatric Emergencies**
   Glenn W. Currier, M.D.
3. **Assessment and Treatment of the Suicidal Patient**
   Peter L. Forster, M.D.
4. **Emergency Treatment of Agitation and Aggression**
   Jean-Pierre Lindenmayer, M.D.
5. **Psychosocial Interventions in the Psychiatric Emergency Service: A Skills Approach**
   Ronald C. Rosenberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to describe the important elements of psychiatric emergencies and emergency care systems; select appropriate assessments in situations with a wide differential diagnosis including medical, psychiatric, substance use and cognitive disorders; describe the interaction of multiple risk factors for suicide, agitation and aggression and apply a framework for risk assessment and management; and discuss psychotherapy and skills that may be adapted to work in emergency settings.

SUMMARY:

Emergencies occur in all settings and, as access to mental health and substance abuse treatment have declined, psychiatric emergencies have increased in number and complexity. Efforts to prevent hospitalization and manage acute patients in the community require more care including more thorough diagnostic and risk assessment and more intensive treatment, pharmacologically and psychologically. This program will provide a framework for understanding psychiatric emergencies and effective response systems. The first task in an emergency is to determine the nature and severity of the problem, whether medical or psychiatric. A systematic approach to emergency medical, psychiatric and substance abuse assessment will be provided. Available tools for cognitive assessment will be reviewed. Levels of assessment will be described with attention to the goals, efficiency, reliability and requirements of different assessment procedures. A detailed review of the phenomenology of the most common and serious emergencies, suicide, agitation and aggression, is provided. These reviews support an evidence-based approach to risk assessment and management of these problems in any setting. The recommendations and rationale for pharmacologic intervention in emergencies is presented. However, the most challenging aspect of emergency work is interacting in a time limited fashion with severely disturbed patients. Interpersonal processes occur while necessary procedures are accomplished and these interactions yield data and can be used to improve care. This program will illustrate the adaptation of a number of psychotherapeutic theories and techniques to emergency situations. Tools for understanding and utilizing interactions therapeutically are conceptualized. Even in hectic emergency settings, skilled clinicians can facilitate engagement, provide meaningful assistance and promote change.

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4. Rosenberg R: The Therapeutic Alliance and the Psychiatric ER: Crisis As Opportunity. Psychiatric Annals 24: 610–613, 1994.

SESSION II OF THE REVIEW OF PSYCHIATRY

THE MANY FACES OF DEPRESSION IN CHILDHOOD ADOLESCENCE

Co-Chairpersons: David Shaffer, M.D. and Bruce D. Waslick, M.D.

6. **Depression in Children and Adolescents: An Overview**
   Bruce D. Waslick, M.D., Rachel Kandel, Aprhodite Kakouros
7. **Psychotherapy for Depression and Suicidal Behavior in Children and Adolescents**
   Laura Mufson, Ph.D., Drew M. Velting, Ph.D.
8. **Pharmacological Treatment of Children and Adolescents with Major Depressive Disorder**
   Boris Birmaher, M.D. and David Brent, M.D.
9. **Bipolar Disorder in Youth: A Critical Review**
   Gabrielle A. Carlson, M.D.
10. **Child and Adolescent Suicide and Suicidal Behavior**
    David Shaffer, M.D., Ted Greenberg, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be informed about recent research into the causes of youth depression. Participants will also be able to describe the groups who are at greatest risk of depression; present information on the prevalence of depression and suicidal behavior; review what is known about the treatment, both pharmacological and psychotherapeutic, of depressed and suicidal adolescents; provide information about the characteristics of teen depression and how these can be identified; and provide information about the different strategies that have been considered to prevent adolescent suicide.

SUMMARY:

Dr. Bruce Waslick (Depression in Children and Adolescence: An Overview) will present important research regarding the clinical description, diagnosis, epidemiology, etiology, and natural history of depressive disorders by youth. Important concepts emerging from recent empirical efforts to describe and understand the cause of depressive illness in children will be highlighted.

Dr. Laura Mufson (Psychotherapy for Depression and Suicidal Behavior in Children and Adolescents) will provide an overview of the major clinical-trial studies evaluating outpatient psychotherapy for depressed children and adolescents, as well as psychotherapy treatments for suicidal youth.

Dr. Boris Birmaher (Pharmacological Treatment of Children and Adolescents with Major Depressive Disorder) will outline current pharmacological management for the acute, continuation, and maintenance treatment phases for children and adolescents with major depressive disorder.

Dr. Gabrielle Carlson (Bipolar Disorder in Youth: A Critical Review) will present a review of recent findings in the epidemiology,

etiology, natural history, clinical features, and treatment of youth bipolar disorder.

Dr. David Shaffer (Child and Adolescent Suicide and Suicidal Behavior) will outline the epidemiology, etiology, clinical manifestations, assessment and treatment, and prevention of youth suicidal behavior.

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1. Kessler RC, Rubinow DR, Holmes C, Abelson JM and Zhao S: The Epidemiology of DSM-III-R Bipolar I Disorder in a General Population Survey. *Psychological Medicine,* 27(5), 1079–1089, 1997
2. Lewinsohn PM, Hops H, Roberts RE, Seeley JR and Andrews JA: Adolescent Psychopathology: I. Prevalence and Incidence of Depression and other DSM-III-R Disorders in High School Students. *Journal of Abnormal Psychology,* 102(1), 133–144, 1993.
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4. Kashani J and Simonds JF: The Incidence of Depression in Children. *American Journal of Psychiatry,* 136(9), 1203–1205.

SESSION III OF THE REVIEW OF PSYCHIATRY

PSYCHIATRY IN MEDICINE

Chairperson: Nada L. Stotland, M.D.

11. Psychiatric Disorders and the Menstrual Cycle
Laura J. Miller, M.D.

12. Psychiatric Factors in Solid Organ Transplantation
Catherine Crone, M.D.

13. Gastroenterology
Thomas Wise, M.D.

14. Mind and Heart: The Interplay Between Psychiatric and Cardiac Illness
Theodore Stern, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be acquainted with the cutting-edge, clinically relevant information about transplantation, gastrointestinal disease, cardiovascular diseases, and the menstrual cycle.

SUMMARY:

Psychiatry is a medical specialty, and psychiatrists in all practice venues need to refresh and update their knowledge of other medical specialties on a regular basis so as to render the most informed care to their patients. Patients may be referred from other specialists or from primary care physicians for evaluation and management of the psychosocial aspects of their diseases; they may present directly to psychiatrists; and non-psychiatric medical symptoms and syndromes may arise in patients already in psychiatric care. This session comprises presentations about four medical issues affecting great numbers of patients, attracting a great deal of media attention, and benefiting from greatly increased knowledge.

Organ transplantation is a burgeoning field much in the public eye. While the heroically saved lives of transplant recipients are heralded, the psychiatric and social sequelae they suffer from the original organ failure, the wait for donor organs, and their intense postoperative immunosuppresive regimens are not. Gastrointestinal symptoms are ubiquitous, leading to considerable distress and disability across the population. Syndromes associated with known anatomic and pathophysiologic changes interfere with patients' work and family lives. Those whose etiology is less poorly understood leave patients without either explanations or definitive treatments. Cardiovascular disease remains a major killer; many patients with non-fatal conditions struggle with disability and anxiety. Increasing evidence of the efficacy of selective serotonin reuptake inhibitors for premenstrual symptoms has brought the diagnosis of premenstrual dysphoric disorder to the fore. The authors of each of these papers will share with the audience a definitive review of the literature in the area.

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3. Shapiro PA: Psychiatric Aspects of Cardiovascular Disease. Psychiatric Clinics of North America 19:613–629, 1996.
4. Whitehead WE: Psychosocial Aspects of Functional Gastrointestinal Disorders. Gastroenterol Clinics of North America 25:21–34, 1996.

SESSION IV OF THE REVIEW OF PSYCHIATRY

MENTAL HEALTH ISSUES IN THE LESBIAN/GAY/BISEXUAL/TRANSGENDER COMMUNITIES

Co-Chairpersons: Billy E. Jones, M.D. and Marjorie Hill, Ph.D.

15. Gay, Lesbian, Bisexual and Transgender Youth
Jeffrey S. Akman, M.D., Garry Fisher, M.D.

16. Aging and Sexual Orientation
Douglas C. Kimmel, Ph.D.

17. Psychiatric Evaluation of Gay or Lesbian Identified Persons for Legal Proceedings
Richard G. Dudley, Jr., M.D.

18. History and Update on Sexual Conversion (Reparative) Therapies
Jack Drescher, M.D.

19. The Intersection of Transgender Mental Health with Homosexuality and Race
Donald E. Tarver II, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be informed about specific mental health issues related to youth, aging, transgender, legal proceedings, and reparative therapy in the Lesbian, Gay, Bisexual and Transgender communities.

SUMMARY:

There continues to be a widespread lack of understanding and concern about many of the issues affecting the mental health of the members of the LGBT communities. The presentations in this symposium strive to teach mental health professionals how to understand, evaluate and treat LGBT members.

The rarely addressed subject of aging and sexual orientation presents an historical background of the current cohorts of older adult lesbians, bisexuals and gay men. Theoretical models and empirical data on aging as a stigmatized sexual minority are presented. The similarities and differences of aging in the sexual minority communities as compared to the heterosexual community are discussed, including ageism and heterosexism. Special issues in working with aging sexual minorities are also discussed.

Legal proceedings involving individuals with same sex sexual orientation often require psychiatrists to offer a psychiatric opinion. The presenter discusses many of the issues, false assumptions and lack of knowledge involved when lesbians and gay men are involved

in child custody and/or visitation proceedings; workplace harassment and other discrimination cases; criminal law and same-sex domestic violence cases; and immigration and asylum cases.

In the presentation *History and Update on Sexual Conversion ("Reparative") Therapies* there is a discussion of the three types of etiological theories on homosexuality presented in the scientific literature and an historical overview of clinical attitudes toward homosexuality up to the present time. It reports on some adverse side effects of sexual conversion treatments and raises important clinical and ethical concerns.

Transgender Mental Health presents the argument that the increased visibility of successfully functioning transgender persons confronts and undermines the rationale for a specific designation of diagnoses of Transvestism, Transsexualism, or Gender Identity Disorder. The presenter explains that just as the concepts of psychiatric disease and remedy are no longer based on racial or sexual identity they should not be based on gender identity.

Some mental health issues of lesbian, gay, bisexual and transgender youth will also be presented.

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2. Eskridge WN, Hunter ND: Families We Choose. In Sexuality, Gender, and the Law. Westbury, New York: The Foundation Press, Inc., pp 828–848, 1997.
3. Drescher J: What Needs Changing? Some Questions Raised by Reparative Therapy Practices. New York State Psychiatric Society Bulletin, 40(1):8–10, 1997.
4. Israel GE, Tarver DE: Transgender Care: Recommended Guidelines, Practical Information, and Personal Accounts. Philadelphia: Temple University Press, pp 14–17, 1997.

ROUNDTABLE

GOVERNMENT RESPONSE TO TERRORISM

Moderator: Randall Marshall, M.D.
Participants: John J. Worthington III, M.D., Mary Jane England, M.D., Sharon Carpinello, Ph.D., Regina Dolan-Sewell, Ph.D., Chip J. Felton, M.D.,Matthew Friedman, M.D., Peter Jensen, M.D., Robert Pynoos, M.D., Jane Plapinger, M.P.H., and Arieh Shalev, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, participants will be aware of local, state, and federal governmental responses to terrorism, including research and services.

SUMMARY:

The vast majority of citizens in the Greater New York Area, as well as the rest of the U.S., are currently grappling with the consequences of terrorist attacks and threats of attack for the first time. In times of disaster and crises, people often look to government for solutions. Because such events of this scale were unprecedented, however, the infrastructure for addressing the vast new need for outreach and treatment was largely nonexistent. This has required the creation of a myriad of new efforts to establish mental health community infrastructure, information dessemination mechanisms, research studies, and educational programs throughout the U.S. and particularly in the Greater New York Area. This roundtable gathers together individuals who have played important roles in responding to terrorism at the city, state, federal, and international level. Agencies and efforts represented include the New York City Department of Mental Health (*Plapinger*), New York State Office of Mental Health (*Carpello, Felton, and Jensen*), National Institute of Mental Health (*Dolan- Sewell, RAPID Program*), National Center for Child Studies (*Pynoos*), and National Center for PTSD (*Friedman*). Dr. Shalev is a world authority on trauma, Chairman of Hadassah University Hospital in Jerusalem, and has been working with various U.S. agencies for a number of years. The goal of the discussion is to illustrate the various partnerships that have formed at multiple levels between government and community. In addition, the discussion may help to identify important unmet needs in the ongoing efforts to date.

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