# SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

# 2003 ANNUAL MEETING


San Francisco, CA ■ May 17-22, 2003

PROCEEDINGS SUMMARY

# FOR YOUR RECORDS

This Certificate of Attendance is for your personal records.

*the American Psychiatric Association certifies that*

*has participated in the*
*156th Annual Meeting of the APA*
*San Francisco, CA, May 17-22, 2003*
*President's Theme: The Promise of Science – The Power of Healing*

*and is awarded _____ category 1 credits.*

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

**DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION, May 17-22, 2003, San Francisco, CA**

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 |
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**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, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209, (703) 907-8662, or on the APA web site at www.psych.org.

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

## Reciprocity with AMA

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

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

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

**APA Report Form**

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

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

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

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

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

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

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

# SYLLABUS
# AND
# SCIENTIFIC PROCEEDINGS

## IN SUMMARY FORM

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

San Francisco, CA
May 17-22, 2003


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1000 Wilson Boulevard, Suite 1825
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May 2003

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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 Carrie Smith-Dent, Carletta Todd, 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.

# 2003 ANNUAL MEETING
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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.

# TOPIC INDEX

## DISORDERS



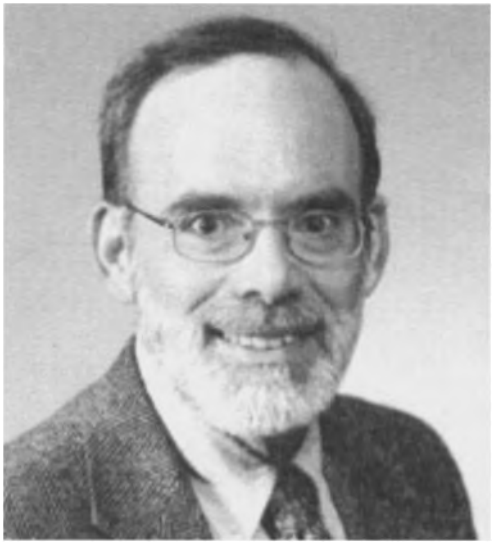
## PRACTICE AREAS/ SETTINGS

## SUBSPECIALITY AREAS OR SPECIAL INTERESTS

## TREATMENTS



## OTHER ISSUES



Paul S. Appelbaum, M.D.

# PAPER NO. 1: PRESIDENTIAL ADDRESS

## THE PROMISE OF SCIENCE—THE POWER OF HEALING

Over the last decade-and-a-half, psychiatric care has been systematically defunded by private payers and government agencies alike. The result has been a marked contraction in the availability of both inpatient and outpatient treatment. In many parts of the United States, we now face a crisis in access to psychiatric care.

This tragic situation contains the nucleus of opportunity within it. What we have been accustomed to speak of as the "psychiatric treatment system" is, in fact, a fragmented and incomplete non-system of care. With this reality now recognized by the President's Commission on Mental Health, and with media attention regularly directed to the unfortunate consequences for persons with mental illness and their families, the time has come for psychiatrists to help define a genuine psychiatric treatment system for the 21st century.

A system of the future must be based on the principles of universal access, comprehensive treatment and rehabilitation, provision of supportive social services and integration of psychiatric and other medical care. Building this system will be facilitated by the impending restructuring of the American health care system as a whole. Funding will be a challenge, but less so when the enormous costs of the current non-system are taken into account.

As psythiatrists, our advocacy trancends merely decrying existing inadequacies or suggesting piecemeal remedies. We call for a renewal of this nation's commitment—launched with the Community Mental Health Act 40 years ago—to provide a comprehensive system of treatment and care to all persons with mental illness.

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# SCIENTIFIC AND CLINICAL REPORT SESSION 1—ADDICTION PSYCHIATRY

## No. 2
## DIFFERENCES IN PERIPHERAL NORADRENERGIC FUNCTION AMONG ACTIVELY DRINKING AND RECENTLY ABSTINENT ALCOHOL-DEPENDENT INDIVIDUALS

Anup M. Desai, M.D., *Department of Psychiatry, Thomas Jefferson Hospital, 833 Chestnut Street, Suite 210E, Philadelphia, PA 19107;* Ashwin Patkar, M.D., Raman Gopalakrishnan, M.D., Stephen Weinstein, Ph.D., Michael Vergare, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that plasma noradrenergic levels may vary with alcohol consumption and abstinence.

### SUMMARY:

*Objective:* We examined whether excessive alcohol consumption was related to changes in plasma levels of norepinephrine (NA) and whether these changes recover following abstinence. We also explored whether differences in NA levels between type I and type II alcoholics and controls existed during active drinking and abstinence.

*Method:* Plasma concentrations of NA were determined in 27 Caucasian alcohol-dependent men who were actively drinking, 29 Caucasian alcohol-dependent men who were abstinent for a minimum of three months, and 28 race-matched and gender-matched healthy controls.

*Results:* NA concentrations were significantly higher in actively drinking subjects than the recently abstinent alcoholics and controls. Notably, severity of alcohol dependence was positively correlated with NA levels. While type I and type II alcoholic individuals differed across clinical measures, NA levels were similar in both subtypes. Both subtypes showed an elevation in NA levels during active drinking compared with controls, but NA levels did not differ between the two subtypes and controls during abstinence.

*Conclusions:* Plasma concentrations of NA are elevated during active drinking, but appear to return to normal after a period of abstinence. However, alterations in NA activity do not seem to be specific for type I or type II subtypes of alcoholism.

*Funding source:* supported by the Trent Regional Health Authority and Upjohn-Duphar Pharmaceuticals.

### REFERENCES:

1. Linnoila M: Alcohol withdrawal and noradrenergic function. Ann Intern Med 1987; 107:875–879.
2. Cloninger CR: Neurogenetic adaptive mechanisms in alcoholism. Science 1987; 236:410–416.

## No. 3
## CHANGES IN PERIPHERAL NORADRENALINE AND 5HT LEVELS AND CRAVING DURING ALCOHOL WITHDRAWAL

Ashwin A. Patkar, M.D., *Department of Psychiatry, Thomas Jefferson University, 833 Chestnut Street, Suite 210E, Philadelphia, PA 19107;* Raman N. Gopalakrishnan, M.D., Heather Murray, B.A., Stephen P. Weinstein, Ph.D., Michael J. Vergare, M.D., Anup Desai, M.D.,

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that plasma noradrenergic and serotonin levels may be related to craving during alcohol withdrawal.

### SUMMARY:

*Objective:* We examined whether peripheral levels of NA and 5HT were altered during alcohol withdrawal, and whether these measures were related to craving. We also explored whether alterations in NA and 5HT activity differ between type I and type II alcoholics during withdrawal.

*Methods:* Plasma measurements of NA and 5HT and assessments of craving were performed longitudinally in 26 Caucasian alcohol-dependent men who were hospitalized for detoxification at baseline (day 0), and at the 1st, 7th, and 14th day of withdrawal. These measures were compared with NA and 5HT levels obtained in 28 controls.

*Results:* During withdrawal, NA levels declined significantly from day 1 through day 14, while 5HT levels and craving declined significantly from day 0 through day 14. The NA levels on days 0 and 1 of withdrawal were significantly higher than the NA levels in controls; however, by day 7 the NA levels were similar to the control values. In contrast, the 5HT levels on day 0 of withdrawal resembled control values; however, the 5HT concentrations on day 1, 7, and 14 were significantly lower than those in controls. There were no significant correlations between NA and 5HT levels or between craving and the biological measures during withdrawal. Type I and type II alcoholics did not differ in NA or 5HT levels during withdrawal.

*Conclusions:* The findings indicate that both NA and 5HT levels change during withdrawal; however the pattern of change is different for the two measures. Also, while alterations in NA activity appear to normalize by late withdrawal, 5HT changes seem to be more persistent. Neither craving nor subtypes of alcoholism seem to be related to alterations in NA or 5HT during withdrawal.

*Funding:* Supported by the Trent Regional Health Authority and Upjohn-Duphar.

### REFERENCES:

1. Bailly D, Vignua J, Racadot N, et al: Platelet serotonin levels in alcoholic patients; changes related to physiological and pathological factors. Psychiatry Research 1993; 47:57–88.
2. Krystal J, Webb E, Cooney N, et al: Serotonergic and noradrenergic dysregulation in alcoholism: m-chlorophenylpiperazine and yohimbine effects in recently detoxified alcoholics and healthy comparison subjects. Am. Journal of Psychiatry 1996; 153:83–92.

## No. 4
## EFFECT OF MODAFINIL ON COCAINE ABSTINENCE AND TREATMENT RETENTION IN COCAINE DEPENDENCE: PRELIMINARY RESULTS FROM AN OPEN-LABEL STUDY

Charles A. Dackis, M.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19104;* Kyle M. Kampman, M.D., Helen Pettinati, Ph.D., Charles P. O'Brien, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the rationale for use of modafinil as treatment for cocaine dependence, based on its hypothesized reversal of known neuroadaptations of this disorder and its effects on cocaine abstinence and treatment retention in an open-label study of cocaine-dependent patients.

SUMMARY:

*Objective:* Cocaine withdrawal is associated with severe sleepiness, fatigue, and psychomotor retardation. Modafinil is a novel wake-promoting agent that is chemically and pharmacologically distinct from psychostimulants and has a low potential for abuse. Modafinil has been shown to rapidly reduce fatigue and improve wakefulness and psychomotor retardation in MDD patients with sleepiness and fatigue. This study assessed modafinil as a treatment foar symptoms associated with withdrawal and as relapse prevention for cocaine dependence.

*Methods:* The first five subjects entering the eight-week outpatient phase (after a one- to two-week inpatient treatment phase) of an ongoing open-label pilot study were assessed. Subjects with severe cocaine withdrawal (Cocaine Selective Severity Assessment >20) were randomized to 200 mg/day or 400 mg/day of modafinil. Cocaine abstinence was assessed with urine benzoylecgonine testing and treatment retention with attendance logs.

*Results:* Modafinil reversed cocaine withdrawal symptoms within hours in all subjects during inpatient treatment. In the outpatient phase, the subjects were abstinent and had attended scheduled meetings at approximately 65% and 95% of total evaluation visits, respectively. Two subjects were completely abstinent; one subject used cocaine once, remaining abstinent for the following eight weeks. The fourth subject withdrew from the study after five weeks of abstinence, and the fifth used cocaine throughout the study but reported a diminution of its euphoric effect. Modafinil was well tolerated. No serious adverse events were reported.

*Conclusions:* Our results are encouraging and indicate that modafinil should be further tested as treatment for cocaine dependence under controlled conditions.

*Acknowledgment:* Supported by NIDA Grants DA P60-05186 and DA P50-12756, and modafinil supplied by Cephalon, Inc.

REFERENCES:

1. Rush CR, Kelly TH, Hays LR, Wooten AF: Discriminative-stimulus effects of modafinil in cocaine-trained humans. Drug Alcohol Depend. 2002; 67:31–22.
2. Menza MA, Doghramji K, Fieve RR, Rosenthal MH: Effect of adjunct modafinil on energy and concentration in depressed patients. Proceedings of the American Psychiatric Association 2002 Annual Meeting. Philadelphia, PA: 45, Abstract III.

# SCIENTIFIC AND CLINICAL REPORT SESSION 2—CONSULTATION-LIAISON AND EMERGENCY PSYCHIATRY

## No. 5
## QUETIAPINE TREATMENT OF HALLUCINATIONS AND AGITATION OF LEWY BODY DISEASE

Andrius Baskys, M.D., *Department of Psychiatry, UCI, 5901 East 7th Street, Long Beach, CA 90822*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should have an understanding of the neurodegenerative nature of Lewy Body dementia (LBD) and how treatment with quetiapine, an atypical antipsychotic, may exhibit neuroprotective properties in patients with LBD without the extrapyramidal symptoms associated with most other antipsychotics.

SUMMARY:

Neurodegeneration underlies many brain disorders and presents clinically as cognitive, behavioral, and emotional disturbances. Lewy Body dementia (LBD) is a neurodegenerative disorder thought to account for approximately 27% of all dementia cases. Psychosis and nighttime agitation are prominent characteristics of LBD. Treatment of LBD psychosis is difficult because of patient intolerance to extrapyramidal symptoms (EPS) and anticholinergic side effects associated with most antipsychotics. Such sensitivity affects approximately 50% of LBD patients and represents a potentially fatal complication. Unlike other typical or atypical antipsychotics, the atypical antipsychotic quetiapine has moderate affinity for $D_2$ receptors, no appreciable affinity for acetylcholine receptors, and a benign EPS profile. We studied quetiapine effects in LBD patients and found a dramatic reduction in psychosis (measured by Neuropsychiatric Inventory, or NPI, and the Brief Psychiatric Rating Scale, or BPRS) without increase in EPS. To understand mechanisms of drug action we studied nerve cell death and neuroprotection in organotypic cultures and used gene microarray technology to link receptors with neuroprotective pathways. Preliminary findings suggest that quetiapine may exhibit neuroprotective properties. Thus, combined clinical and laboratory approaches may provide useful information for rational use of antipsychotics in neurodegenerative disorders.

## No. 6
## SURVEY OF PRACTICE PREFERENCES IN THE PHARMACOTHERAPY OF DELIRIUM

Michael W. Kiang, M.D., *Department of Psychiatry, Toronto General Hospital, 8EN-212 200 Elizabeth Street, Toronto, ON M5G2C4, Canada;* Mark R. Katz, M.D., Susan E. Abbey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: demonstrate familiarity with literature on the relative efficacy and risks of pharmacological treatments for delirium; recognize the limitations of the current evidence base; be aware of trends in the practice preferences of consultation-liaison psychiatrists.

SUMMARY:

*Objective:* To survey consultation-liaison (C-L) psychiatrists' practice preferences in the pharmacological treatment of delirium.

*Method:* A case-based survey was sailed to 836 C-L psychiatrists in the USA and Canada.

*Results:* 284 responses (34%) were received, and 258 (31%) were suitable for analysis. For agitated delirium, 55% chose to treat with haloperidol, 24% with risperidone, 12% with olanzapine, 4% with loxapine, and 3% with quetiapine. All respondents choosing loxapine were in Western Canada, and this effect was statistically significant. Among other regions, there was no significant difference in the percentage choosing haloperidol or atypical antipsychotics. Of those choosing haloperidol, more-recent graduates were more likely to choose the intravenous rather than the oral or intramuscular form, and those preferring the intravenous form were more likely to have experienced a medically ill patient develop prolonged QTc interval on an antipsychotic. Also, 37% of respondents elected to treat a case of hypoactive delirium pharmacologically, all with an antipsychotic. More-recent graduates and those spending more than 20 hours/week in C-L practice were more likely to endorse treating hypoactive delirium pharmacologically.

*Conclusions:* Further controlled studies are needed to determine the relative effectiveness and tolerability of pharmacotherapeutic options in delirium.

*Funding:* internal (university health network).

REFERENCES:

1. American Psychiatric Association: Practice guideline for the treatment of patients with delirium. Am J Psychiatry 1999; 156(5 Suppl):1–20.
2. Schwartz TJ, Masand MD: The role of atypical antipsychotics in the treatment of delirium. Psychosomatics 2002; 43:171–174.

## No. 7
## HYPONATREMIA ASSOCIATED WITH THE USE OF ANTIDEPRESSANTS IN GERIATRIC PATIENTS

Subramoniam Madhusoodanan, M.D., *St. Johns Episcopal Hospital, 327 Beach 19th Street, Far Rockaway, NY 11691;* Olivera J. Bogunovic, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will become familiar with hyponatremia associated with the use of antidepressants, particularly serotonin reuptake inhibitors.

### SUMMARY:

*Objective:* To review the literature on the incidence of hyponatremia associated with the use of antidepressants in geriatric patients.

*Method:* We searched Medline for reports of antidepressant use and development of hyponatremia/SIADH between January 1966 and June 2002, using the following MESH terms: SIADH, hyponatremia, serotonin reuptake inhibitors, tricyclic antidepressants, and other antidepressants. All individual drugs were cross-referenced with syndrome of inappropriate antidiuretic hormone secretion.

*Results:* There were 82 case reports of hyponatremia associated with the use of antidepressants; 59 were associated with the use of selective serotonin reuptake inhibitors, and 23 with tricyclic antidepressants. There were only a few studies on hyponatremia associated with the use of antidepressants in geriatric patients. Advanced age, female gender, use of other medications, and medical comorbidity have been identified as risk factors associated with the development of hyponatremia associated with the use of antidepressants.

*Conclusion:* Hyponatremia associated with antidepressant treatment is not uncommon in elderly patients, particularly with the use of selective serotonin reuptake inhibitors. Hyponatremia can cause confusion, agitation, and lethargy. Any change in the course of illness of a depressed geriatric patient should alert the physician to the possibility of hyponatremia.

*Funding Source:* None.

### REFERENCES:

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2. Strachan J, Shepherd J: Hyponatremia associated with the use of selective serotonin reuptake inhibitors. Aust NZ J Psychiatry 1998; 32:295–308.

# SCIENTIFIC AND CLINICAL REPORT SESSION 3—PERSONALITY DISORDERS

## No. 8
## SEXUAL AVERSION AMONG BORDERLINE PATIENTS AND AXIS II COMPARISON SUBJECTS

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

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that a substantial percentage of borderline patients either avoid consenting sex for fear of becoming symptomatic and/or develop symptoms as a result of consenting sex.

### SUMMARY:

*Objective:* The purpose of this study was to assess the experiences of sexual aversion reported by patients with borderline personality disorder (BPD) and Axis II comparison subjects. For the purposes of this study, sexual aversion was defined as either becoming symptomatic as a result of consenting sex or avoiding consenting sex for fear of becoming symptomatic.

*Method:* The experiences of sexual aversion reported by 290 borderline patients and 72 Axis II comparison subjects followed prospectively for six years were assessed blind to baseline diagnostic status using a reliable semistructured interview.

*Results:* Sexual aversion was found to be significantly more common among borderline patients than Axis II comparison subjects over time (61% vs. 19%). Sexual aversion was also found to be significantly more common among women than men with BPD over time (65% vs. 44%). Rates of sexual aversion declined for both borderline patients and Axis II comparison subjects over time, but the changes were more pronounced for borderline patients, particularly male borderline patients. In addition, three significant predictors of sexual aversion among borderline patients emerged: female gender, childhood history of sexual abuse, and adult history of rape.

*Conclusions:* Taken together, the results of this study suggest that aversion to sexual experiences may be more common among borderline patients than previously recognized. Supported by NIMH grants MH47588 and MH62169.

### REFERENCES:

1. Hurlbert DF, Apt C, White C: An empirical examination into the sexuality of women with borderline personality disorder. Journal of Sex and Marital Therapy 1992; 18:231–242.
2. Zanarini MC, Williams AA, Lewis RE, et al: Reported pathological childhood experiences associated with the development of borderline personality disorder. Am J Psychiatry 1997; 154:1101–1106.

## No. 9
## EFFECTS OF PERSONALITY DISORDERS ON FUNCTIONING AND WELL-BEING IN MDD

Andrew E. Skodol II, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Carlos M. Grilo, Ph.D., Maria E. Pagano, Ph.D., Donna S. Bender, Ph.D., John G. Gunderson, M.D., M. Tracie Shea, Ph.D., Thomas H. McGlashan, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that comorbid personality disorders detract from the social functioning and emotional well-being of patients with major depressive disorder.

### SUMMARY:

*Objective:* This study investigates the effects of comorbid personality disorders (PDs) on the functioning and well-being of patients with major depressive disorder (MDD).

*Method:* Patients with semistructured interview diagnoses of MDD with (N = 117) and without (N = 32) comorbid PD (schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder) were followed prospectively for three years as part of the Collaborative Longitudinal Personality Disorders Study (CLPS). Physical and social/emotional functioning and well-being were assessed using the eight multi-item scales of the Medical Outcomes Study (MOS) SF-36 among patients who met current diagnostic criteria at the 36-month follow-up.

*Results:* Patients with MDD and comorbid PD had significantly more impairment on scales measuring role limitations due to emotional problems, social functioning, vitality, and general health perceptions than patients with MDD and no PD. There were no differences between the groups on scales measuring physical functioning, role limitations due to physical health problems, bodily pain, or

emotional well-being. Patients with MDD and no PD were found to have levels of functioning and well-being comparable to those previously reported on samples of depressed patients recruited from both medical and mental health settings. Patients with MDD and comorbid PD were found to have much lower levels of functioning in most areas than reported samples.

*Conclusions:* Comorbid personality disorders make a significant contribution to the impaired social/emotional functioning and well-being of patients with major depressive disorder.

Supported by NIMH grants MH 50837, MH 50838, MH 50839, MH 50840, MH 50850, and MH 10645

## REFERENCES:

1. Wells KB, Stewart A, Hayes RD, et al: The functioning and well-being of depressed patients: results from the Medical Outcomes Study. JAMA 1989; 262:914–919.
2. Hayes RD, Wells KB, Sherbourne CD, et al: Functioning and well-being outcomes of patients with depression compared with chronic general medical illnesses. Arch Gen Psychiatry 1995; 52:11–19.

## No. 10
## SUPPORTIVE THERAPY FOR BPD PATIENTS WITH SELF-INJURIOUS BEHAVIOR

David J. Hellerstein, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 101, New York, NY 10032;* Ron Aviram, Ph.D., Jessica Gerson, Ph.D., Barbara Stanley, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe how supportive therapy may be adapted for self-injuring borderline personality disorder patients.

## SUMMARY:

*Background:* We have adapted supportive therapy (ST) for an outpatient population of BPD patients with self-injurious behavior (SIB) and chronic suicidal ideation (SI). ST has been described as an active treatment approach that may be efficacious for a wide variety of patients. It emphasizes the mobilization of strengths to minimize deterioration and to enhance self-esteem, the use of adaptive defenses, and positive coping skills.

*Method:* BPD patients who have SIB and SI participate in an ongoing treatment study utilizing ST as a comparison treatment to Linehan's Dialectical Behavioral Therapy. Patients attend weekly psychotherapy sessions for one year and receive fluoxetine or placebo in a double-blind design. As adapted for BPD patients with SIB and SI, ST addresses low self-esteem, use of primitive defenses, and impulsive behavior (Pinsker, et al. 1988;1994; 1998) with techniques such as reframing, encouragement, modeling, and anticipatory guidance.

*Results:* Descriptive data and selected outcome measures will be presented along with qualitative vignettes of clinical material. Our preliminary findings indicate that ST may be efficacious in engaging BPD patients in treatment and in minimizing frequency and intensity of SIB and SI.

*Conclusion:* ST that specifically involves interventions aimed at the three dimensions of self-esteem, adaptive defenses, and psychological functioning appears well tolerated by BPD-SIB patients and may prove to be a useful clinical option.

*Funding source:* National Institute of Mental Health (BH Stanley, PhD, principal investigator) 1R01MH6017

## REFERENCES:

1. Hellerstein DJ, Pinsker H, Rosenthal RN, Klee S: Supportive therapy as the treatment model of choice. Journal of Psychotherapy Practice and Research 1994; 3:300–306.
2. Pinsker H: A Primer of Supportive Psychotherapy. Analytic Press, Hillside NJ, 1997.

# SCIENTIFIC AND CLINICAL REPORT SESSION 4—ANXIETY DISORDERS

## No. 11
## THE PREVALENCE OF PTSD IN CANADA

Michael A. Van Ameringen, M.D., *Department of Psychiatry, McMaster Medical Center, 1200 Main Street, West, Hamilton, ON L8N 3Z5, Canada;* Catherine Mancini, M.D., Beth Pipe, B.S.N., Sandra Balseiro, Michael Boyle, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the prevalence rates of PTSD and related comorbid conditions in Canada; to determine the types of trauma exposure most likely to induce PTSD in Canada.

## SUMMARY:

*Objective:* Epidemiological studies have indicated that posttraumatic stress disorder (PTSD) has become a global health issue. Lifetime prevalence rates of PTSD in selected populations range from 1.3% in Germany to 37.4% in Algeria. In the United States, the National Comorbidity Survey reported a lifetime prevalence rate of PTSD of 7.8%. As there are no national prevalence rates of PTSD in Canada, we conducted an epidemiological study in Canada to determine the current and lifetime prevalence of DSM-IV PTSD and related comorbid conditions.

*Method:* A representative national sample of 3,006 respondents was obtained using a random-digit dialing method. A telephone interview using modified versions of the Composite International Diagnostic Interview PTSD module, the depression, alcohol and substance abuse sections of the Mini International Neuropsychiatric Interview were used to obtain prevalence rates of PTSD.

*Results:* Preliminary analysis revealed prevalence rates of PTSD of 3.1% (94/3,006) current (one month) and 11.3% (340/3,006) lifetime in Canada. Traumatic exposure sufficient to cause PTSD was reported by 75.7% (2275/3,006) of respondents. The most common forms of trauma resulting in PTSD included unexpected death of a loved one, sexual assault, and seeing someone badly injured or killed.

*Conclusion:* PTSD is a common psychiatric disorder in Canada. These rates are surprisingly high given the low rates of crime, a small military, and few natural disasters. Implications of these data will be discussed.

## REFERENCES:

1. Breslau N, Davis GC, Andreski P, Peterson E: Traumatic events and posttraumatic stress disorder in an urban population of young adults. Arch Gen Psychiatry 1991;48:216–22.
2. Kessler RC, Sonnega A, Bromet E, et al: Posttraumatic stress disorder in the national comorbidity survey. Arch Gen Psychiatry 1995; 52:1048–1060.

## No. 12
## A NEW SELF-REPORT SCREENING TOOL FOR DSM-IV AXIS I DIAGNOSIS

Catherine L. Mancini, M.D., *Department of Psychiatry, McMaster Medical Center, 1200 Main Street West, Hamilton, ON L8N 3Z5, Canada;* Michael Van Ameringen, M.D., Beth Pipe, B.S.N., Jonathan Oakman, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the potential use of a new self-report screening instrument (MACSCREEN), for Axis I psychiatric disorders in primary care settings and to examine the reliability and validity of this instrument.

## SUMMARY:

*Objective:* Psychiatric illness often goes unrecognized in primary care. Clinician-administered screening tools require considerable time and training and consequently are seldom used. We report on the development and initial validation of 'MACSCREEN' a paper-and-pencil self-report psychiatric screening instrument for DSM-IV Axis I diagnosis.

*Method:* Validation was conducted on 158 consecutive admissions to the Anxiety Disorders Clinic at McMaster University Medical Centre. All patients completed the MACSCREEN and were interviewed using the Structured Clinical Interview for DSM-IV (SCID). Initial results led to a slight modification of MACSCREEN. Revised MACSCREEN was administered to an additional, 100 admissions, followed by the SCID.

*Results:* Data analysis was limited to disorders that occurred in at least 10 individuals (panic disorder, social phobia, generalized anxiety disorder, posttraumatic stress disorder, obsessive compulsive disorder, specific phobia, major depression, and psychotic disorder). Sensitivity ranged from a low of .59 for specific phobia to a high of 1.00 for psychotic disorder, with an average of .82. Specificity ranged from a low of .53 for generalized anxiety disorder to a high of .95 for psychotic disorder, with an average of .71. The most common reason for false-negatives was that symptoms were denied on MACSCREEN but acknowledged during the SCID.

*Conclusion:* Preliminary validation results suggest that MACSCREEN may be an efficient and clinically useful tool in primary care.

## REFERENCES:

1. Spitzer RL, Williams JBW, Kroenke K, et al: Prime MD: Primary Care Evaluation of Mental Disorders. New York, N.Y., Biometrics Research, 1993.
2. Sheehan D, Janavs J, Baker R, et al: Mini International Neuropsychiatric Interview: English Version 5.0.0. Medical Outcome Systems Inc., 2000.

## No. 13
## SEXUAL AVERSION DISORDERS IN PRIMARY ANXIETY DISORDERS

Chris Watson, B.K.I.N, *McMaster University, 3274 Spruce Avenue, Burlington, ON L7N1J4, Canada;* Michael A. Van Ameringen, M.D., Catherine L. Mancini, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the relationship between sexual aversion disorder and the anxiety disorders and evaluate the prevalence of sexual aversion disorder in an anxiety disorders clinic sample.

## SUMMARY:

*Objectives:* Sexual aversion disorder (SAD) is characterized by an extreme aversion to and avoidance of, sexual contact with a partner. Studies have linked SAD to panic disorder (PD), but its relation to other anxiety disorders has not been elucidated.

*Methods:* We assessed 82 consecutive admissions to an anxiety disorders clinic for SAD using a self-report questionnaire. Patients also completed the Revised Adult Attachment Scale (RAAS), the Maudsley Obsessional Compulsive Inventory (MOCI), the Fear Questionnaire (FQ), and the Sheehan Disability Scale (SDS).

*Results:* Thirteen percent (11/82) met criteria for SAD, with 81.8% (9/11) of the SAD patients attributing the disorder to their anxiety. The percentage of patients who met criteria for SAD was similar in each of the primary anxiety disorder groups (social phobia 13.9%, PD 7.7%, obsessive compulsive disorder 20.0%; $X^2 = 1.487$, df = 2, p = 0.476). Patients with SAD reported significantly lower RAAS Close subscores, higher FQ social phobia scores, and greater social impairment than non-SAD patients.

*Conclusions:* This study does not support a specific relationship between SAD and PD but suggests a general link between anxiety disorders and SAD. Anxiety disorder patients with SAD appear to have greater social and attachment difficulties than non-SAD patients. We will discuss potential treatment implications of these findings.

## REFERENCES:

1. Figueira I., Possidente E., Marques C., Hayes K: Sexual dysfunction: a neglected complication of panic disorder and social phobia. Archives of Sexual Behavior 2001; 30:369–377.
2. Kaplan HS: Sexual Aversion, Sexual Phobias, and Panic Disorder. New York, Brunner/Mazel, 1987.

# SCIENTIFIC AND CLINICAL REPORT SESSION 5—EVOLVING ISSUES IN ATYPICAL ANTIPSYCHOTICS

## No. 14
## EFFECTS ON WEIGHT CHANGE OF SWITCHING FROM OLANZAPINE TO QUETIAPINE

Prakash S. Masand, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3391 Duke South, Room 3050B, Yellow Zone, Durham, NC 27710;* Sanjay Gupta, M.D., Subhdeep Virk, M.D., Thomas L. Schwartz, M.D., Ahmad Hameed, M.D., Bradford L. Frank, M.D., Kari Lockwood, R.N.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: assess the effects of switching from olanzapine to quetiapine because of excessive weight gain in patients who are chronically ill with psychiatric disorders.

## SUMMARY:

*Objectives:* To assess effects of switching from olanzapine to quetiapine on body weight in chronically psychiatrically ill patients.

*Methods:* Sixteen patients who were psychiatrically stable on olanzapine but had gained weight were gradually switched to quetiapine and followed for 10 weeks. Enrollment criteria included body mass index (BMI) greater than 25 and weight gain of at least 20% of body weight on olanzapine. Weight change as both a categorical and a continuous variable was examined using t-test for paired scores. Efficacy was measured using the Positive and Negative Syndrome Scale (PANSS), while the medication related side effects were assessed using the Simpson-Angus Scale (SAS).

*Results:* Twelve patients completed the study. Weight decline after switching to quetiapine was statistically significant (mean change 103 to 101 kg; 2.25 kg per patient; P = 0.03); effect size was small (Cohen's d = 0.12). PANSS variables of Somatic Concern and Guilt Feelings declined significantly after the switch (t = 2.88; P = 0.13 and t = 2.62; P = 0.021, respectively). There was no increase in psychiatric symptoms during the 10-week follow up. There were no statistically significant differences in SAS variables.

*Conclusions:* This pilot study suggests that switching to quetiapine may be a viable strategy for patients who experienced weight gain associated with olanzapine. The switch to quetiapine was well toler-

ated; patients lost weight while taking quetiapine without relapse of symptoms at the 10-week follow up.


## REFERENCES:

1. Worrel JA, Marken PA, Beckman SE, Ruehter VL: Atypical antipsychotic agents: a critical review. Am J Health Syst Pharm. 2000;57:238–255.
2. Masand P, Gupta S: Long-term adverse effects of atypical antipsychotics. Psychiatric Practice. 2000;6:29–309.


## No. 15
## A THREE-WEEK COMPARISON OF OLANZAPINE VERSUS RISPERIDONE IN THE TREATMENT OF BIPOLAR MANIA: IMPROVEMENT IN MANIC AND DEPRESSIVE SYMPTOMS AND TREATMENT ADHERENCE

Robert W. Baker, M.D., *Eli Lilly and Company, Lilly Corporate Center, Drop Code 4133, Indianapolis, IN 46285;* Carlos M. Zarate, Jr., M.D., Eileen Brown, Ph.D., Leslie Schuh, Ph.D., Mauricio F. Tohen, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participant should be able to discuss the relative merits of olanzapine and risperidone for treatment of acute bipolar disorder.


## SUMMARY:

*Objective:* The first prospective, randomized comparison of olanzapine and risperidone in bipolar disorder.

*Method:* The three-week, double-blind study compared olanzapine (5–20 mg/day; N = 165) to risperidone (1–6 mg/day; N = 164) in manic or mixed episodes. Efficacy measures included Young-Mania Rating Scale (Y-MRS) (primary outcome measure), Hamilton and Montgomery-Asberg Depression Rating Scales (HAM-D and MADRS), and global rating of clinical severity (CGI). Analytical techniques included repeated measures analysis of variance on change from baseline and Fisher's exact test for categorical comparisons.

*Results:* Olanzapine-treated patients were more likely to complete the study (p = .015), with more risperidone patients discontinuing by patient decision (p = .023). There was not a statistical separation on the primary outcome (Y-MRS, p = .913); however, those on olanzapine had greater HAM-D (p = .040) and CGI (p = .026) improvement across the study. Risperidone-treated patients experienced greater prolactin elevation (p < .001) and sexual dysfunction (p = .049); olanzapine patients experienced greater liver function elevations. Adverse events more frequent with olanzapine (p < .05) were dry mouth and weight increase and for risperidone (p < .05) were anxiety and joint stiffness.

*Discussion:* Patients had greater global bipolar improvement on olanzapine than on risperidone; though groups did not differ in mania improvement, olanzapine-treated patients had more depressive symptom improvement, better treatment adherence, and less sexual dysfunction.


*Source of Funding:* Eli Lilly and Company


## REFERENCES:

1. Sachs GS, Grossman F, Ghaemi SN, et al: Combination of a mood stabilizer with risperidone or haloperidol for treatment of acute mania: A double-blind, placebo-controlled comparison of efficacy and safety. Am J Psychiatry 2002; 159:1146–1154.
2. Tohen M, Jacobs TG, Grundy SL, et al: Olanzapine HGGW study group: efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. Arch Gen Psychiatry 2000; 57:841–849.


## No. 16
## OLANZAPINE/FLUOXETINE COMBINATION AND OLANZAPINE IN THE TREATMENT OF BIPOLAR DEPRESSION

Mauricio F. Tohen, M.D., *Department of Research, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Eduard Vieta, M.D., Joseph R. Calabrese, M.D., Richard C. Risser, M.S., Robert W. Baker, M.D., Angela R. Evans, Ph.D., Sanjay Dube, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the attendee should be able to determine the effectiveness of olanzapine and the combination of olanzapine plus fluoxetine in treating bipolar depression.


## SUMMARY:

*Objective:* To determine the efficacy of olanzapine and olanzapine/fluoxetine combination compared with placebo for treatment of bipolar depression.

*Methods:* Patients with bipolar depression and MADRS ≥20 were randomized for eight weeks of double-blind treatment with olanzapine (5–20 mg/d, $n$ = 370), placebo ($n$ = 377) or combination ($n$ = 86) of olanzapine (6 or 12 mg/d) plus fluoxetine (25 or 50 mg/d).

*Results:* Response rates were significantly greater for the olanzapine group (48.2%) compared with placebo (36.1%; $P$ = .003) and for olanzapine/fluoxetine combination group (64.8%) compared with both placebo ($P$ = .001) and olanzapine groups ($P$ = .017). Time-to-response was significantly shorter in both olanzapine ($P$ = .007) and olanzapine/fluoxetine combination groups ($P$ < .001) compared with the placebo group. The combination group also had a significantly shorter time-to-response than olanzapine ($P$ = .005). Significantly more olanzapine-treated patients (40.5%) met remission criteria compared with placebo-treated patients (29.1%; $P$ = .004). Significantly more patients in the combination group were in remission (56.3%) compared with olanzapine- ($P$ = .023) and placebo-treated patients ($P$ < .001). Time-to-remission was significantly shorter in both olanzapine ($P$ = .027) and olanzapine/fluoxetine combination groups ($P$ < .001) compared with placebo. The combination group also had a significantly shorter time-to-remission than olanzapine ($P$ = .012).

*Conclusion:* Olanzapine and olanzapine/fluoxetine combination significantly improved depressive symptoms in patients with bipolar depression; the magnitude of effect was significantly greater with olanzapine/fluoxetine.


*Funding:* This study was funded by Eli Lilly and Company.


## REFERENCES:

1. Sachs GS, Koslow CS, Ghaemi SH: The treatment of bipolar depression. Bipolar Disord 2000; Sep; 2 (3 Pt 2):256–60.
2. Tohen M, Jacobs TG, Grundy SL, et al: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled study. Arch. Gen. Psychiatry 2000; 57:841–849.


# SCIENTIFIC AND CLINICAL REPORT SESSION 6—MEASURING MOOD DISORDERS

## No. 17
## ELEVATED MATERNAL CYTOKINE LEVELS AND SCHIZOPHRENIA IN ADULT OFFSPRING

Dost Ongur, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114;* Amy H. Farabaugh, Ph.D., Maurizio Fava, M.D.

## EDUCATIONAL OBJECTIVE:

Participants will gain an understanding of the relationship between features of temperament and anxiety disorder comorbidity among patients with major depression.

## SUMMARY:

*Objective:* We used the Tridimensional Personality Questionnaire (TPQ) to study the relationship between temperamental traits and comorbid anxiety disorders in patients with major depressive disorder (MDD).

*Method:* Patients recruited for a large clinical study on MDD underwent a SCID assessment and were administered the self-rated TPQ (n = 261; mean age = 39.9 ± 10.5 years, female = 138, initial HAM-D = 19.7 ± 3.5). The TPQ was scored for three previously identified factors—harm avoidance (HA), novelty seeking (NS), and reward dependence (RD). Multiple logistic regression methods were used to evaluate the relationship between TPQ factors and each comorbid anxiety disorder, after controlling for age, gender, and initial HAM-D-17 score (when these were related to the dependent variable in simple regressions).

*Results:* Social anxiety disorder was strongly associated with higher scores on HA and lower scores on NS and RD ($p < 0.0001$; $p = 0.009$; $p = 0.045$ respectively). A diagnosis of GAD was significantly related to higher HA scores ($p = 0.006$). Finally, the presence of OCD was associated with lower NS scores ($p = 0.023$) as was that of panic disorder ($p = 0.051$). Simple phobia and agoraphobia were not significantly related to any TPQ factor.

*Conclusions:* These results indicate that features of temperament, as assessed by factors in the TPQ scale, are related to specific patterns of anxiety disorder comoribidity among patients with MDD. As expected, higher levels of harm avoidance and lower levels of novelty seeking were associated with an increased risk of anxiety disorder comorbidity in our sample.

## REFERENCES:

1. Newman JR, Ewing SE, McColl RD, et al: Tridimensional personality questionnaire and treatment response in major depressive disorder: a negative study. J. Affect Disord 2000; 57:241–247.
2. Mulder RT, Joyce PR Cloninger CR: Temperament and early environment influence comorbidity and personality disorders in major depression. Compr. Psychiatry 1994; 35:225–233.

## No. 18
## DIFFERENCE IN SUBJECTIVE/OBJECTIVE SADNESS PREDICTS DRUG RESPONSE

Anand Pandya, M.D., *Columbia University, 215 East 24th Street, #322, New York, NY 10010-3804;* Eric D. Peselow, M.D., Ronald R. Fieve, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the relationship in depressed patients between baseline assessments of subjective and objective sadness and subsequent differences between antidepressant and placebo response.

## SUMMARY:

*Objective:* In rating depressed patients via numerous scales, the rater must depend on the impression of the patient to reliably report his or her symptoms. However, the Montgomery-Asberg depression scale has two items—reported sadness (reported by the patient) and apparent sadness (observed by the rater). The purpose of this presentation is to examine correlations between the two and what effect this has on drug/placebo response.

*Method:* We evaluated 134 patients from two studies—one looking at imipramine vs. paroxetine vs. placebo and the other involving imipramine vs. placebo. Montgomery-Asberg depression scales were done on all patients. We evaluated the first two items to see if there was no difference between reported and apparent sadness (same score or a 1 point difference) or whether there was a difference (two point or greater difference). Patients were rated with the Hamilton Depression Scale, Beck, and CGI. Using these scales we looked at differences in these two items in terms of drug-placebo response.

*Results:* In 88 of the cases, reported sadness and apparent sadness showed no difference. In 15 cases there a two-point or greater difference, with apparent sadness being more than reported sadness, and in 31 cases, reported sadness was two points greater than apparent sadness. When combining both drug groups (imipramine and paroxetine) vs. placebo, the first two groups showed no difference between reported and apparent sadness, or a two-point or greater difference, with apparent sadness being more than reported sadness the drug group showed a statistically significant drug/placebo response. In the third group, where reported sadness was two points greater than apparent sadness, there was no statistically significant drug/placebo difference.

*Conclusion:* Our results, if replicated, indicate observing the patient as part of the rating procedure may be very important in assessing and/or predicting treatment response to drug.

There was no funding for this study.

## REFERENCES:

1. Galinowski A, Lehert P: Structural validity of MADRS during antidepressant treatment. Int Clin Psychopharm 1995; 10:157–161.
2. Mattila-Evenden M, et al.: Determinants of self-rating and expert rating concordance in psychiatric out-patients, using the affective subscales of the CPRS. Acta Psychiatr Scand 1996; 94:386–396.

## No. 19
## IDENTIFYING DEPRESSION IN OLDER INPATIENTS WITH THE GERIATRIC DEPRESSION SCALE AND STRUCTURED CLINICAL INTERVIEW

George Fulop, M.D., DMA, *Merck-Medco, 100 Parsons Pond Drive, F2-2, Franklin Lakes, NJ 07417;* James J. Strain, M.D., Glen Stettin, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant will be able to describe the rate and course of depression in older adults with CHF, and differences noted by using a screening versus a diagnostic instrument.

## SUMMARY:

*Objective:* To observe the course of depression in the six-month period following hospitalization of older adults with congestive heart failure (CHF) using two depression detection instruments.

*Method:* A prospective observational cohort study. A depression screen, the Geriatric Depression Scale (GDS), and a diagnostic instrument, the Structured Clinical Interview (SCID-NP), were administered to 203 older adults (mean age 76.8± 7.8 years) at discharge and four and 24 weeks later.

*Results:* The GDS screen consistently identified a greater percent of older adults with depression than the SCID-NP diagnostic instrument. In a six-month follow-up period, over 25% of elderly patients with CHF who were depressed at discharge remained depressed (persistent). In addition, over 5% of CHF patients who were not depressed at discharge were subsequently identified as depressed over the next six months (incident). The GDS and SCID-NP were concordant in 73% of cases (agreement in identifying adults who were depressed or not-depressed).

| Evaluation | | Hospital discharge | 4 weeks post-discharge | 24 weeks post-discharge |
|---|---|---|---|---|
| | Subjects | N = 203 | N = 166 | N = 113 |
| Depressed GDS | Total Depressed | 73 (36%) | 54 (33%) | 29 (26%) |
| | Persistent | | 39 | 21 |
| | Incident | | 15 | 8 |
| SCID-NP | Total Depressed | 44 (22%) | 34 (20%) | 19 (17%) |
| | Persistent | | 20 | 11 |
| | Incident | | 14 | 8 |
| Not Depressed GDS | | 130 (64%) | 112 (67%) | 85 (75%) |
| SCID-NP | | 159 (78%) | 132 (80%) | 91 (81%) |

*Conclusion:* The ultimate choice of whether to use one instrument versus the other should be determined by the goal of the users—either a wide screen to identify any depressive morbidity (GDS) or a specific diagnostic assessment (SCID-NP) that would drive medical treatment plans.

## REFERENCES:


1. Yesavage JA, Brink TL, Rose TL, et al: Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatry Res 1983; 17:37.
2. Spitzer RL, Williams JBW, Gibbon M, First MB: Structured Clinical Interview for DSM-III-R-Non Patient Edition (SCID-NP, Version 1.0) American Psychiatric Press, Washington DC, 1990.


# SCIENTIFIC AND CLINICAL REPORT SESSION 7—PSYCHIATRIC EDUCATION AND TELEPSYCHIATRY

## No. 20
## PSYCHIATRY TRAINING IN PRIMARY CARE: CURRENT STATUS AND SATISFACTION

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## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the audience should be able to describe the current status of psychiatric training in primary care and the factors associated with program directors' satisfaction with psychiatry training.

## SUMMARY:

*Objective:* The need for psychiatric training for primary care physicians has been well recognized but there is great variability in such training. The purpose of this study is to evaluate the extent of mental health training in primary care residencies and the degree of satisfaction of program directors with their training.

*Methods:* A 16-item questionnaire surveying the amount, specific areas (such as interviewing, psychopharmacology, depression), faculty, and satisfaction with current teaching was distributed to 1,268 U.S. program directors.

*Results:* Of the respondents (40%), 58% of family practice residencies rated their training optimal or extensive compared with 25% for internal medicine, 12% for obstetrics, and 16% for pediatrics ($p < 0.001$). A majority (55%) of all programs were dissatisfied with their psychiatry training ($p < 0.001$). Family practice showed significantly more diversity of training venues, faculty, and specific topics and were more satisfied than other specialties. Satisfaction with current training was associated with diversity of training venues, topics, and faculty across training programs ($p < 0.001$).

*Conclusions:* Our results indicate an overall difference between family practice and all other programs. Across specialties, satisfaction was associated with increased diversity of venues, faculty, and topics taught, indicating the areas of teaching enhancement that may contribute to a more satisfactory training.

*Funding Source:* University

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1. Hodges B, Inch C, Silver I: Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950–2000: a review Am J Psychiatry 2001;158:1579–1586.
2. Gaufberg EH, Joseph RC, Pels RJ, et al: Psychosocial training in US internal medicine and family practice residency programs. Acad Med 2001;76:738–742.


## No. 21
## RETROSPECTIVE EVALUATION OF TELEMENTAL HEALTH CARE SERVICES FOR REMOTE MILITARY POPULATIONS

Brian J. Grady, M.D., *Department of Behavioral Health, National Naval Medical Center, 8901 Wisconsin Avenue, Bethesda, MD 20889-5600;* Ted Meller, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify potential limitations to the use of interactive videoconferencing with patients.

## SUMMARY:

*Objective.* To compare specific treatment and outcome variables between psychiatric care provided to remote rural medical clinics via interactive videoconferencing (VTC) with care provided face to face (FTF).

*Method.* The study was a retrospective, case-controlled record review of psychiatric care provided to two remote military medical facilities during the same one-year period. VTC was conducted at 384 kbps; 63 FTF and 48 VTC records were used. The primary outcome measures were GAF, compliance and various indicators hypothesized to represent the psychiatrists unconscious anxiety with the treatment medium.

*Results.* Groups were well matched for age, gender and military status. Final GAF and full compliance were slightly better for TMH, while time to follow-up was shorter. There were no patients diagnosed with panic, social phobia, or PTSD via TMH. More patients were told to call the psychiatrist if there were problems.

*Conclusions.* TMH may alter assessment, and the interviewers sensitivity in diagnosing anxiety disorders may be diminished. Patients outcome, based on GAF, was no worse utilizing VTC. Providers unconscious uncertainty in utilizing TMH was evident. While only limited generalities can be drawn, practitioners utilizing VTC are encouraged to be aware of these potential diagnostic and treatment issues.

## REFERENCES:


1. Baer L., Cukor P., Jenike, M.A., et al: Pilot studies of telemedicine for patients with obsessive-compulsive disorder. American Journal of Psychiatry 1995; 152: 1383–1385.
2. Zaylor C: Clinical outcomes in telepsychiatry. Journal of Telemedicine and Telecare 1999; 5 (S1): 59–60.


## No. 22
## WHAT INCREASES THE FREQUENCY AT WHICH MEDICAL STUDENTS ASK ADDICTION QUESTIONS?

Kathleen M. Stack, M.D., *Dom Care #18, VAMC, 100 Emancipation Drive, Hampton, VA 23667;* Lisa Fore-Arcand, Ed.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe one way of assessing the effectiveness of curriculum changes; recognize how motivation, education and requirements may encourage medical students to ask substance use questions in the OSCE setting.

## SUMMARY:

*Objectives:* Determine frequencies at which medical students ask addiction questions in an observed, standardized, patient clinical examination (OSCE) given at the end of the M-3 year. Use data as a measurement of the effectiveness of curriculum changes.

*Methods:* Year 1: As a baseline, addiction questions were added to the OSCE without informing the students. Year 2: Students were informed that those doing "well" would have exemption from the M-4 1-week rotation. Year 3: Two didactic hours were added in the M-2 and M-3 years. Students were eligible for exemption only if they attend two AA/NA meetings and completed an addiction patient log. Year 4: Education was unchanged, but the AA/NA and log were requirements.

*Results:* Year 1: 98 students, 30 questions, average 51.9% (s.d. 14.1). OSCE score 69.8%. Year 2: 92 students, 52 questions, average 58.1% (s.d. 10.5). OSCE score 65.3%. Year 3: 31% (28/89) students completed the AA/NA and log. 47 questions, average 59.9% (s.d. 13.7) OSCE score 65.4%. Year 4. 95/100 students completed the AA/NA and log. 48 questions, average 72.6% (s.d. 11.1). OSCE score 70.6%. Scores improved each year compared with both baseline and OSCE score.

*Discussion:* Effects of "motivation," "education," and "requirement" on scores and the limitations of the study are discussed.

## REFERENCES:

1. Geller G, Levine DM, et al: Knowledge, attitudes, and reported practices of medical students and house staff regarding the diagnosis and treatment of alcoholism. JAMA 1989;261:3115–3120.
2. Miller NS, Sheppard LM, et al: Why physicians are unprepared to treat patients who have alcohol and drug related disorders. Acad Med 2001;7:410–418.

# SCIENTIFIC AND CLINICAL REPORT SESSION 8—MOOD AND ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS

## No. 23
## MANAGEMENT OF ADOLESCENT MANIA

Melissa P. DelBello, M.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, Cincinnati, OH 45267-0559*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate challenges in the management of adolescent mania and make informed decisions about treatment options for adolescent patients with bipolar disorder using the current evidence base.

## SUMMARY:

Although the prevalence rate of adolescent bipolar disorder is about 1%, there have been few treatment studies of this population. Children and adolescents with bipolar disorder are more likely than adults to present with rapid-cycling or mixed states, giving rise to the hypothesis that anticonvulsants such as divalproex might be more effective than lithium in such patients. However, open-label studies have found that many children and adolescents with acute mania do not respond to monotherapy with either lithium or an anticonvulsant. Therefore, exploration of pre-adult manias as disease entities is necessary for development of effective treatments. Randomized, controlled clinical trials of atypical antipsychotics suggest their efficacy in adult mania, and several reports indicate that this may be reflected in children and adolescents. The first randomized, controlled trial using an adjunctive atypical antipsychotic in the treatment of pediatric mania will be described. Add-on agents need to possess both efficacy and excellent tolerability, particularly in this patient population. This six-week study enrolled 30 manic or mixed bipolar 1 adolescents (aged 12–18 years) and randomized them to treatment with quetiapine or placebo as an adjunct to divalproex. Subanalyses of patients with underlying psychosis and mixed mania will also be discussed, as will critical issues in the diagnosis and treatment of adolescents with comorbid ADHD.

## REFERENCES:

1. Geller B, Zimerman B, Williams M, et al: Diagnostic characteristics of 93 cases of a prepubertal and early adolescent bipolar disorder phenotype by gender, puberty and comorbid attention deficit hyperactivity disorder. J Child Adolesc Psychopharmacol 2000;10:157–164.
2. Spencer TJ, Biedman J, Wozniak J, et al: Parsing pediatric bipolar disorder from its associated comorbidity with the disruptive behavior disorders. Biol Psychiatry 2001; 49:1062–1070.

## No. 24
## EXPLORATORY FACTOR ANALYSIS OF BPD CRITERIA IN HOSPITALIZED ADOLESCENTS

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

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the components of BPD in adolescent inpatients and understand how these components may relate to various Axis I disorders.

## SUMMARY:

*Objective:* To examine the factor structure of borderline personality disorder (BPD) in hospitalized adolescents and to explore the relationships between Axis I pathology and BPD in this population.

*Method:* Subjects were 123 consecutively admitted adolescent inpatients. All were reliably assessed with structured diagnostic interviews for DSM-III-R Axis I and Axis II disorders. Correlational analyses examined the associations between the BPD criteria, then an exploratory factor analysis (principal components with varimax rotation) identified meaningful components. Finally, logistic regression analyses determined whether these components were predictive of specific Axis I disorders.

*Results:* Coefficient alpha for the BPD criteria was .67. The factor analysis produced a four-factor solution that accounted for 67.0% of the variance. Factor 1 ("suicidal threats or gestures" and "emptiness or boredom") predicted depressive disorders and substance use disorders. Factor 2 ("affective instability" and "uncontrolled anger") predicted anxiety disorders and oppositional defiant disorder. Factor 3 ("unstable relationships" and "abandonment fears") predicted only anxiety disorders. Factor 4 ("impulsiveness") predicted substance use disorders, conduct disorder, and oppositional defiant disorder.

*Conclusions:* This exploratory factor analysis of BPD in adolescent inpatients revealed four BPD factors that appear to differ from those reported for similar studies of adults. The factors represent components of depression, irritability, poorly modulated relationships, and impulsivity—each of which are associated with characteristic Axis I

pathology. These findings shed light on the nature of BPD in adolescents and may also have implications for treatment.


## REFERENCES:

1. Sanislow CA, Grilo CM, McGlashan TH: Factor analysis of the DSM-III-R borderline personality disorder criteria in psychiatric inpatients. Am J Psychiatry 2000; 157:1629–1633.
2. Levy KN, Becker DF, Grilo CM, et al: Concurrent and predictive validity of the personality disorder diagnosis in adolescent inpatients. Am J Psychiatry 1999; 156:1522–1528.


## No. 25
## GENDER DIFFERENCES IN COMORBIDITIES IN CHILD AND ADOLESCENT GAD

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## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize frequently associated comorbid disorders of child and adolescent generalized anxiety disorder and outline the alternative treatment approaches.


## SUMMARY:

*Objective:* To determine frequency, nature, age and gender relations of comorbidity in generalized anxiety disorders (GADs) in children and adolescents (aged 1–19 years).

*Method:* Study included 192 females (37.06%), and 326 males (62.93%) diagnosed by child psychiatrists according to DSM-IV criteria with the support of DuPaul ADHD Rating Scale, Offord-Boyle, Gadow-Sprafkin, and Turgay parent and teacher rating scales providing information for all DSM-IV disorders. The study was completed in a Canadian university-affiliated, general hospital, outpatient population. The male overrepresentation in the sample seemed to be related to the presence of an active ADHD clinic in the same hospital.

*Results:* For only 36% of the cases was GAD the only diagnosis. The most common comorbidities were: ADHD (63.5% in males and 36.97% in females, $p < 0.005$), oppositional defiant disorder (10.4% in males, 27% in females $p < 0.005$), conduct disorder 11.19% in males and 1.9% in females ($p < 0.005$), and mood disorders (33.3% in males and 27% in females). The mood disorder frequency for those aged 13–19 was 54% in males and 72% in females ($p < 0.025$).

*Conclusion:* GAD in children and adolescents is frequently associated with other psychiatric disorders. These patients should be fully screened since treatment differs according to comorbidities.



## REFERENCES:

1. Brown TA, Barlow DH: Comorbidity among anxiety disorders: implications for treatment and DSM-IV. J Consult Clin Psychol 1992; 60:835–840.
2. Bernstein GA, Borchardt CM, Perwien AR: Anxiety disorders in children and adolescents: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry 1996; 35:1110–1119.


# SCIENTIFIC AND CLINICAL REPORT SESSION 9—DEPRESSIVE DISORDERS

## No. 26
## CONTINUATION COGNITIVE-BEHAVIORAL THERAPY MAINTAINS ATTRIBUTIONAL STYLE IMPROVEMENT IN DEPRESSED PATIENTS RESPONDING ACUTELY TO FLUOXETINE

Timothy J. Petersen, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Yasmin Mahal, B.A., Joel Pava, Ph.D., Ella Masson, B.A., Andrew Nierenberg, M.D., Amy Farabaugh, Ph.D., Maurizio, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand of the role of cognitive-behavioral therapy in maintaining attribution style changes experienced by patients responding acutely to fluoxetine.


## SUMMARY:

*Objective:* To evaluate whether the addition of continuation cognitive-behavioral therapy during the continuation phase of antidepressant treatment helps maintain attributional style improvements experienced by patients responding acutely to fluoxetine.

*Method:* 96 patients (mean age = 39.9 years, 54.7% females, mean HamD-17 = 19.7) with major depressive disorder were enrolled in an open, fixed-dose (20mg), eight-week fluoxetine trial, followed by randomization to receive either fixed-dose (40mg) fluoxetine (meds only) or fixed-dose fluoxetine plus 20 sessions of manualized cognitive-behavioral therapy (meds plus CBT) during a six-month continuation treatment phase. The Attributional Style Questionnaire (ASQ) was completed by all patients at three time points—acute baseline visit, end of acute phase, and end of continuation phase. Paired and unpaired tests were used to compare ASQ negative (CN), positive (CP), and combined scores (CPCN) within and between groups.

*Results:* During the acute phase, all patients experienced a significant reduction in CN, increase in CP, and increase in CPCN scores ($p < 0.01$ for all comparisons). Mean Hamilton Depression Scale (17-item) score at the end of acute treatment was 5.1. CP, CN, and CPCN scores differed significantly between treatment groups at the end of the continuation phase of treatment ($p = 0.004$, $p < 0.0001$, $p < 0.0001$), with the meds-plus-CBT group maintaining acute CP and CPCN gains and CN reductions, and the meds-only group exhibiting CP, CN, and CPCN scores at unhealthier levels than found at the acute-phase baseline visit. The two treatment groups did not significantly differ in rates of relapse and final-continuation-phase visit Hamilton scores ($p > 0.05$ for both comparisons).

*Conclusion:* In this sample, the addition of CBT to continuation psychopharmacologic treatment was associated with maintenance of acute-phase attributional style gains. Further research is needed to evaluate the role of such gains in the long-term course of depressive illness.



## REFERENCES:

1. DeRubeis RJ, Evans MD, Hollon SD, et al: How does cognitive therapy work? Cognitive change and symptom change in cognitive therapy and pharmacotherapy for depression. Journal of Consulting and Clinical Psychology 1990; 58:862–869.
2. Michelson LK, Bellanti CJ, Testa SM, Marchione N: The relationship of attributional style to agoraphobia severity, depression and treatment outcome. Behaviour Research and Therapy 1997; 35:1061–1073.


## No. 27
## THE POTENTIAL RELATIONSHIP BETWEEN LEVELS OF PERCEIVED STRESS AND SPECIFIC SUBTYPES OF MAJOR DEPRESSION

Amy H. Farabaugh, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812 Boston, MA 02114;* Pamela Roffi, B.S., Ella Masson, B.A., Dost Ongur, M.D., Timothy Petersen, Ph.D., Rebecca Harley, Ph.D., Maurizio Fava, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants will gain an understanding of the potential relationship between levels of perceived stress and specific subtypes of major depression.

## SUMMARY:

*Objective:* To explore whether major depressive disorder (MDD) subtypes (melancholia, atypical depression, double-depression, and MDD with anger attacks) were related to levels of perceived stress, as measured by the Perceived Stress Scale (PSS). The PSS assesses to what degree an individual perceives himself or herself to be in a stressful situation.

*Method:* Our sample (n = 298; female = 163; mean age 39.9 ± 10.5 years) consisted of depressed outpatients participating in a large single-site clinical trial. The Structured Clinical Interview for DSM-III-R (SCID-P), the 17-item Hamilton Rating Scale for Depression (HAMD-17), the Anger Attack Questionnaire (AAQ), and the PSS were administered prior to initiating treatment.

*Results:* Depressed women had significantly higher levels of perceived stress (mean 37.8±6.2 compared to 36.0 ± 7.0; p = .02) than depressed men. Greater severity of depression at baseline was significantly related to higher levels of perceived stress ($p < .0001$). After adjusting for age, gender, and severity of depression at baseline, higher levels of perceived stress were significantly related to the presence of anger attacks ($p < .0001$; t-value = 4.103) as well as to atypical depression (p = .0013; t-value = 3.26), but not to the presence of melancholia or double-depression.

*Conclusions:* Outpatients with MDD who are more irritable/hostile and/or present with atypical features (including hypersensitivity to rejection) have higher levels of perceived stress, indicating a potential reactive component to their depression, whereas outpatients with melancholic/endogenous and/or chronic depression do not appear to have increased levels of perceived stress.

## REFERENCES:

1. Cohen S., Kamark T., Mermelstein R: A global measure of perceived stress. J Health Soc Behav 1983; 24:385–396.
2. Fava M., Rosenbaum JF., McCarthy M., et al: Correlations between perceived stress and depressive symptoms among depressive outpatients. Stress Medicine 1992; 8:73–76.

### No. 28
### SYMPTOM SEVERITY AND EXCLUSION FROM ANTIDEPRESSANT EFFICACY TRIALS

Mark Zimmerman, M.D., *Department of Psychiatry, Rhode Island Hospital, 235 Plain Street, Suite 501, Providence, RI 02905;* Michael A. Posternak, M.D., Iwona Chelminski, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to describe the variability in exclusion criteria used in antidepressant efficacy trials and the impact of this on the samples included in these studies.

## SUMMARY:

*Background:* It is the standard practice in antidepressant efficacy trials (AETs) to exclude potential participants with major depressive disorder (MDD) who score below a threshold on the Hamilton Rating Scale for Depression (HRSD). It is unknown to what extent various cutoff scores impact on the generalizability of these trials. In this study we sought to determine how many patients with MDD presenting to an outpatient practice would fail to qualify for an AET because their symptoms were not sufficiently severe, and to what extent the variability in HRSD cutoff scores impacts on exclusion rates.

*Methods:* Fifteen hundred individuals presenting for an intake at a psychiatric outpatient practice underwent an evaluation with semistructured diagnostic interviews. A total of 503 patients received a principal diagnosis of nonbipolar, nonpsychotic MDD. Thirty-nine AETs published in five leading journals during the past seven years were reviewed, 36 of which required a minimum score on the HRSD for inclusion. We applied the HRSD cutoffs used in these AETs to the 503 depressed patients to determine how many would qualify for each AET.

*Results:* Based on the least and most restrictive cutoff scores, between 11.3% and 71.0% of the depressed patients from our practice had an insufficient HRSD score to qualify for an AET. The two most commonly used cutoff scores would lead to the exclusion of almost half of our sample.

*Conclusions:* AETs tend to include the subset of depressed individuals with moderate to severe MDD, and exclude a significant proportion of depressed patients who have mild MDD. Thus, the use of a minimum symptom severity rating in AETs greatly impacts the generalizability of these studies.

## REFERENCES:

1. Posternak M. Zimmerman M, Keitner G, Miller I: A reevaluation of the exclusion criteria used in antidepressant efficacy trials. American Journal of Psychiatry 2002; 159:191–200.
2. Zimmerman M, Mattia JI, Posternak M: Are subjects in pharmacological treatment trials of depression representative of patients in routine clinical practice? American Journal of Psychiatry 2002; 159:469–473.

# SCIENTIFIC AND CLINICAL REPORT SESSION 10—NEUROPSYCHIATRY

### No. 29
### DYSLEXIA AS A POTENTIAL INDEX OF NEUROCOGNITIVE IMPAIRMENTS IN PATIENTS WITH SCHIZOPHRENIA

Giuseppe Bersani, *Lasapienza University, 3rd Psychiatric Clinic, Via di Torre Argentina 21, Rome, IT 00186, Italy;* M. Laura Maneschi, Carlo Leone, M. Maddalena Cacioppo

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that in the learning-disabled population there may be individuals whose deficits result from undiagnosed schizoprenia.

## SUMMARY:

*Objective:* This study reviews research on dyslexia and brain neurodevelopmental abnormalities in schizophrenic patients, aiming at verifying the hypothesis of a subgroup of patients whose neurocognitive impairment could be related in higher degree to language disorder.

*Method:* The study group consisted of 30 male subjects with DSM-IV schizophrenia, undergoing neuropsychological assessment by: Wechsler Bellevue Intelligence Scale (verbal and non verbal QI); Rey-Auditory Verbal Learning Test and Benton-Visual Retention Test (working memory, visual and spatial memory, slow and long memory); Sartori-Auditory Visual Learning Test (reading and listening comprehension phonemes, words and abstract words); Learning History Check List (schooling and working difficulty).

*Results:* 22 subjects, 73.33%, had significantly higher scores of dyslexia, with alteration of visual retention and attention level. Twelve had phonological superficial dyslexia; two semantic deficit; seven superphicial phonolocical attention deficit; one deep dyslexia.

*Conclusion:* These findings suggest that some pathogenetic factors could be shared in the origin of dyslexia, language disorder, and neurocognitive impairment in schizophrenics. The data are still preliminary and will be verified in a larger semple of subjects undergoing MRI examination.

## REFERENCES:

1. Wetterberg L: Mental disease a heritage. Lakartidningen 2000; 1:97:558–62, 565–7.
2. Elvevag B, Egan MF, Goldberg TE: Paired-associate learning and memory interference in schizophrenia. Neuropsychologia 2000; 38:1565–75.
3. Letten F, Saugstad: A lack of cerebral lateralization in schizophrenia is within the normal variation in brain maturation but indicates late, slow maturation. Schizophrenia Research 1999; 39:183–196.

## No. 30
## PREVIOUS HEAD INJURIES IN PSYCHIATRIC INPATIENTS

Edward Kim, M.D., *Department of Psychiatry, Robert Wood Johnson, 671 Hoes Lane, Piscataway, NJ 08855-1392;* Michael Gara, Ph.D., Shula Minsky, Ed.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the prevalence of various types and severities of head injuries in psychiatric inpatients and their influence on clinical course.

## SUMMARY:

*Background:* Head trauma has long been thought to predispose individuals to psychiatric symptoms. The prevalence of prior head injuries in psychiatric populations has not been systematically studied.

*Objective:* To assess the prevalence of various types of prior head trauma in psychiatric inpatients using an instrument that is designed to quantitate cumulative head injuries acquired.

*Method:* We surveyed 127 consecutive patients admitted to an acute psychiatric inpatient service using a rater-administered instrument that inquired about histories of 1) discrete head injuries (DHI), 2) repetitive head injuries without altered consciousness (RHIWO), and 3) repetitive head injuries with altered consciousness (RHIW).

*Results:* Eighty percent of the subjects reported a history of DHI, 40% reported prior RHIWO, and 28% reported prior RHIW. RHIW and RHIWO tended to start in childhood and adolescence and was either short-lived (<5 years) or chronic (>15 years). RHIW was significantly ($p < .05$) associated with increased admission scores on the psychosis subscale of the Behavior and Symptom Identification Scale (BASIS-32). Factor analysis of the instrument yielded three separate factors as intended.

*Conclusion:* A history of head injuries is common among psychiatric inpatients and may affect clinical presentation. Accumulation of head trauma throughout life separates into distinct types of injuries.

## REFERENCES:

1. Burg JS, Williams R, Burright RG, Donovick PJ: Psychiatric treatment outcome following traumatic brain injury. Brain Inj 2000; 14:513–533.
2. McGuire LM, Burright RG, Williams R, Donovick PJ: Prevalence of traumatic brain injury in psychiatric and non-psychiatric subjects. Brain Inj 1998; 12:207–214.

## No. 31
## NEUROFEEDBACK TO INCREASE REMISSION RATES IN DEPRESSION

Leo I. Jacobs, M.D., *Department of Psychiatry, Advocate Good Shepherd, Hospital 450 West Highway 22, Building II, Barrington, IL 60010;* Shannon Doyle, Ph.D., Dan McDonnell, R.N.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the diagnostic significance of QEEG to identify the loss of brainwave variability and an autonomic sympathetic dysfunction as a source of nonremission; realize how neurofeedback treatment can bring major depression into remission.

## SUMMARY:

*Purposes:* To identify and correlate the clinical and QEEG profiles in unremitting major depression patients; demonstrate bilateral neurofeedback's effectiveness; relate functional impairments to the loss of brain wave variability inducing autonomic sympathetic dysfunction, HPA axis activation, and possibly cingulate dysfunction.

*Method:* Assess clinical functioning, GAF scores, and a 1–45 Hz spectrum QEEG pre, intra, and post neurofeedback over 10–20 weekly sessions in 30 patients with pretreatment 50 GAF.

*Results:* Absence of variability and QEEG profile were identified pre-test. Post-treatment QEEG profile showed increased QEEG variability. This correlated highly with 12 mind-brain related processes. Low beta (16–20 Hz) was correlated highly with impaired attention and alertness; increased high beta (22–37 Hz) with obsessive, preoperational and self-condemning cognition intolerant of ambiguity and inability initiating corrective action in conflict; high delta (1–3 Hz) and theta (4–7 Hz) with traumatic memories, autonomic arousal, flashbacks, terror or anger, low energy and motivation, intolerance for agony, and impaired short-term memory and sleep. Post-treatment GAF: 75 in 80% of cases.

*Conclusion:* Neurofeedback is an effective therapy method to increase cerebral flexibility and resilience to attain remission. Further research regarding effectiveness of neurofeedback for other psychiatric diagnoses is warranted.

*Funding source:* Advocate Good Shepherd Hospital, Barrington, IL

## REFERENCES:

1. Othmer S, Othmer SF, Kaiser DA: EEG biofeedback: an emerging model for its global efficacy: introduction to quantitative EEG and neurofeedback. San Diego, California Academic Press 1999; 243–310.
2. Jacobs LI: Unremitting depression: cingulate dysfunction and the cleft-self on trial. Journal of Advocate Healthcare 2002; 4:7–17.

# SCIENTIFIC AND CLINICAL REPORT SESSION 11—ADULT ADHD

## No. 32
## EFFICACY AND SAFETY OF ATOMOXETINE IN ADULTS WITH ADHD

Thomas J. Spencer, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, Boston, MA 02114*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the design of well-controlled trials of adult ADHD; to understand the short-term and long-term efficacy of atomoxetine

in adults with ADHD; to understand the short-term and long-term safety of atomoxetine in adults with ADHD.

## SUMMARY:

*Objective:* Attention-deficit/hyperactivity disorder (ADHD) is a common neurobiological disorder of childhood, with symptoms that frequently persist into adulthood. ADHD has been less studied in adults than in children. Atomoxetine is a nonstimulant medication being studied as a treatment for ADHD in children, adolescents and adults. Atomoxetine is classified as a highly specific inhibitor of the presynaptic norepinephrine transporter.

*Methods:* Atomoxetine has been studied in two identical, acute, randomized, double-blind, placebo-controlled studies (Study 1: n = 141, Study 2: n = 129) and one long-term, open-label extension study (n = 384) in adults with ADHD. Efficacy was measured utilizing the Conners' Adult ADHD Rating Scale and Clinician Global Impression of Severity. Safety was assessed by adverse events, vital signs, ECG, and laboratory testing.

*Results:* Atomoxetine was superior to placebo in reducing core ADHD symptoms in acute studies, and patients who continued atomoxetine treatment in the open-label trial continued to experience symptom improvement. Atomoxetine was well-tolerated with a low rate of discontinuations due to adverse events (7.8%) in the open-label extension study.

*Conclusion:* These studies represent the largest and longest multicenter, systematic clinical trials conducted for any drug intended for the treatment of adult ADHD. Atomoxetine appears to be efficacious and safe in the treatment of ADHD in adults.

*Funding:* Research funded by Eli Lilly and Company, Indianapolis, Indiana.

## REFERENCES:

1. Spencer TJ, Biederman J, Wilens TE, et al: Effectiveness and tolerability of atomoxetine in adults with attention deficit hyperactivity disorder. Am J Psychiatry 1998; 155:693–695.
2. Michelson D, Faries DE, Wernicke J, et al: Atomoxetine in the treatment of children and adolescents with attention-deficit/hyperactivity disorder: a randomized, placebo-controlled, dose-response study. Pediatrics 2001; 108:e83.

## No. 33
## ADDERALL XR DOSED ONCE DAILY IN ADULT PATIENTS WITH ADHD

Richard H. Weisler, M.D., *Department of Psychiatry, Duke University, 2841 Plaza Place #100, Raleigh, NC 27612;* Allan K. Chrisman, M.D., Timothy E. Wilens, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the efficacy and safety of Adderall XR in the treatment of adults with ADHD.

## SUMMARY:

*Objective:* This randomized, double-blind, forced-dose titration study assessed the efficacy and safety of Adderall XR (20, 40, or 60 mg once daily) compared with placebo in 255 adults (≥16 years) with a diagnosis of ADHD.

*Methods:* Patients met DSM-IV criteria for ADHD and also had to have a history of ADHD prior to age 7. The intent-to-treat (ITT) population included 248 subjects (mean age 39 years). Primary efficacy was assessed using the 18-item ADHD Rating Scale (ADHD-RS) for adults.

*Results:* Mean ADHD-RS total scores for each treatment group ranged from 31.1 to 33.0 at baseline. At study endpoint, all doses of Adderall XR significantly reduced mean ADHD-RS total scores compared with placebo: 19.2 for 20 mg, 18.6 for 40 mg, and 18.0 for 60 mg compared with 25.5 for placebo ($p \leq 0.001$ for all doses). Safely measures were performed throughout the six-week study. The most commonly reported adverse events were dry mouth (27.5%), anorexia (25.5%), insomnia (23.5%), headache (22.7%), and nervousness (12.5%) and are consistent with those noted in pediatric patients.

*Conclusion:* Adderall XR administered once daily in doses of 20, 40, or 60 mg appears to be safe and efficacious in the treatment of adult ADHD.

*Funding:* Supported by Shire Pharmaceutical Development Inc.

## REFERENCES:

1. Faraone SV, Biederman J, Spencer T, et al: Attention deficit hyperactivity disorder in adults: an overview. Biol Psychiatry 2000;48:9–20.
2. Spencer T, Biedeman J, Wilens T, et al: Efficacy of a mixed amphetamine salts compound in adults with attention-deficit/hyperactivity disorder. Arch Gen Psych 2001;58:775–782.

## No. 34
## ALPHA-1 AGONIST PRAZOSIN FOR ADHD: THE ROLE OF NOREPINEPHRINE IN ADHD PATHOLOGY

Fletcher B. Taylor III, M.D., *Rainier Associates, 5909 Orchard Street, West, Tacoma, WA 98467-3824;* Nancy Allison, P.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to understand the effects of d-amphetamine on alpha-1 adrenoceptors and their potential role in the pathophysiology of ADHD.

## SUMMARY:

*Objective:* To explore the role of norepinepherine in the pathophysiology of ADHD and how D-amphetamine works for its treatment.

*Methods:* This double-blind, placebo-controlled study enrolled 16 ADHD adults, nine receiving ongoing d-amphetamine and seven not. They each received in a randomized fashion both placebo (lactose) and prazosin increased at .25 mg every one to two days to achieve optimal response. Measures included the ADHD Behavior Checklist for Adults (ADHD Checklist), the Clinical Global Impression of Improvement Scale (CGI), and the Stroop Color-Word Interference Test (Stroop). Adverse events were recorded.

*Results:* For the prazosin-only group, the final mean dosage was 1.04 mg/day (range .5–2 mg). Patient-rated CGI scores ($p < .05$) and Stroop performance scores ($p < .05$) were significantly improved on prazosin as compared with placebo. ADHD Checklist and Stroop performance improvements were significantly correlated. For the prazosin with d-amphetamine group, the mean dosage was 1.40 mg/day (range 5.0–2 mg). Prazosin offered no benefit over the placebo condition, and in fact all measures tended to worsen.

*Conclusions:* These preliminary data suggest that 1) noradrenergic alpha-1 receptor activity may be important in ADHD pathophysiology, and 2) the change in alpha-1 receptor activity provided by d-amphetamine may be important in its efficacy for this disorder.

## REFERENCES:

1. Shi WX, Pun CL, Zhang XX, Jones MD, Bunney BS: Dual effects of d-amphetamine on dopamine neurons mediated by dopamine and nondopamine receptors. J Neurosci 2000; 20:3504–11.
2. Arnsten AF, Mathew R, Ubriani R, Taylor JR, Li BM: Alpha-1 noradrenergic receptor stimulation impairs prefrontal cortical cognitive function. Biol Psychiatry 1999; 45:26–31.

# SCIENTIFIC AND CLINICAL REPORT SESSION 12—TREATMENT OPTIONS IN ADHD

## No. 35
## PLACEBO-CONTROLLED STUDY OF ONCE-DAILY ATOMOXETINE IN THE SCHOOL SETTING

Christopher J. Kratochvil, M.D., *Psychopharmacology Research Center, University of Nebraska Medical Center, 985581 Nebraska Medical Center, Omaha, NE 68198-5581*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of the use of atomoxetine in pediatric ADHD; discuss teacher ratings of pupils treated with atomoxetine for ADHD.

### SUMMARY:

*Objective:* Several studies have demonstrated the efficacy of atomoxetine compared with placebo in reducing symptoms of ADHD based on parent reports. This recently completed clinical trial assessed the efficacy of once-daily atomoxctine compared with placebo, based on teacher reports of ADHD symptoms at school. It is the first atomoxetine trial to use teacher ratings as the primary efficacy measure.

*Methods:* 153 patients aged 8 to 12 enrolled in this seven-week, double-blind, placebo-controlled trial were randomized to receive either once-daily atomoxetine or placebo (2:1 ratio). ADHD symptoms at school were primarily assessed by change from baseline to endpoint in ADHD-RS: Teacher scores.

*Results:* Teachers of children receiving atomoxetine reported significant reduction in ADHD-RS Total scores compared with placebo ($p = .001$). Similar results were observed for the Inattentive ($p = .016$) and Hyperactive/Impulsive ($p < .001$) ADHD-RS subscales, CGI-S ($p = .001$), Conners Global Index-Teacher Total Index ($p = .008$), and CPRSR:S ADHD Index T-Score ($p < .001$). Discontinuations due to adverse events were low for both groups (atomoxetine 5.9%, placebo 0%).

*Conclusions:* This study extends previous results showing that once-daily administration of atomoxetine is safe and effective in improving ADHD symptoms in children and demonstrates that outcomes are similar when symptoms are rated by teachers.

### REFERENCES:

1. Kratochvil CK, Heiligenstein JH, Dittman R, et al: Atomoxetine and methylphenidate treatment in children with ADHD: a prospective, randomized, open-label trial. J Am Acad Child Adolesc Psychiatry 2002; 41:776–784.
2. Michelson D, Faries D, Wernicke J, et al: Atomoxetine in the treatment of children and adolescents with attention-deficit/hyperactivity disorder: a randomized, placebo-controlled, dose-response study. Pediatrics 2001; 108(5).

## No. 36
## MODAFINIL IMPROVES ADHD SYMPTOMS IN CHILDREN IN A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY

Joseph Biederman, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 55 Fruit Street, WACC 725, Boston, MA 02114;* James M. Swanson, M.D., Frank A. Lopez, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the role of modafinil in the treatment of children with ADHD.

### SUMMARY:

*Objectives:* The novel wake-promoting agent modafinil works selectively through the sleep/wake centers of the brain to activate the cortex. Modafinil has been shown to improve ADHD symptoms in children in an open-label study. This study evaluated modafinil given in different dose regimens in ADHD children. We report results of different dose regimens of 300-mg modafinil.

*Methods:* After one-week washout, children with moderate-severe ADHD received four weeks of treatment with placebo or modafinil in split morning/midday dosages of 100/200-mg, 200/100-mg, a single 300-mg morning dose, or 200/200-mg. Randomization called for equal distribution of children by weight except for the 200/200-mg arm, which contained only children ≥30 kg. We report the four treatment groups with similar weights (placebo/300-mg dose groups). The primary efficacy measure was the teacher-rated ADHD Rating Scale-IV.

*Results:* The study enrolled 248 children; 198 are included in this subanalysis (average age, 9-y; average weight, 35.5-kg). Modafinil significantly improved ADHD symptoms for the primary outcome measure for the 200/100-mg and 300 once-daily doses ($P < 0.05$). Modafinil was well tolerated. Adverse events that occurred in at least 10% of patients and more frequently in the modafinil than placebo group were insomnia, abdominal pain, anorexia, cough, fever, and rhinitis. Most adverse events were mild-moderate in nature. Modafinil did not adversely affect white blood cells and absolute neutrophil counts compared with placebo.

*Conclusions:* Modafinil significantly improved ADHD symptoms in children and was well tolerated.

Funded by Cephalon, Inc.

### REFERENCES:

1. Scammell TE, Estabrooke IV, McCarthy MT, et al: Hypothalamic arousal regions are activated during modafinil-induced wakefulness. J Neurosci 2000;20:8620–8.
2. Rugino TA, et al: Effects of modafinil in children with attention deficit/hyperactivity disorder: an open-label study. J Am Acad Child Adolesc Psychiatry 2001;40:230–5.

## No. 37
## SAFETY AND EFFICACY OF OROS MPH IN ADOLESCENTS WITH ADHD

Laurence L. Greenhill, M.D., *Department of Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, Box 78, New York, NY 10032*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that once-daily OROS® MPH improves symptoms and is well tolerated in adolescents with ADHD.

### SUMMARY:

*Objective:* To evaluate the safety and efficacy of once-daily OROS® MPH (up to 72 mg daily) in adolescents with ADHD—an understudied population.

*Methods:* This multicenter study included four phases: screening; titration; a randomized, double-blind phase; and an open-label follow-up. The study was designed to enroll 200 patients (aged 13–18 years) in the titration phase and to target 126 eligible patients at completion of the double-blind phase. During the titration phase an individualized dose of OROS® MPH (18, 36, 54 or 72 mg) was identified for each patient. Patients were then randomized to receive

either their individualized OROS® MPH dose or placebo for the two-week double-blind phase. Patients who successfully completed the double-blind phase were then eligible to receive OROS® MPH for the eight-week, open-label follow-up phase. Efficacy was primarily assessed using the ADHD Rating Scale (parent and investigator). Secondary measures included Conners-Wells Self-Report Scale (CASS-L) (adolescent), Clinical Global Impression (CGI) scale (investigator), and Child Conflict Index (parent report).

*Results:* Analysis of the results suggests that OROS® MPH was well tolerated and controlled symptoms in adolescent patients with ADHD, which lasted through 12 hours.

*Conclusion:* Once-daily OROS® MPH is a safe and effective treatment for the management of ADHD in adolescents.

*Funding:* McNeil Consumer & Speciality Pharmaceuticals, Fort Washington, PA

## REFERENCES:

1. Baren M: ADHD in adolescents: will you know when you see it? Contemporary Pediatrics 2002; 19:124–143.
2. AACAP practice parameter for the use of stimulant medications in the treatment for children, adolescents and adults. J Am Acad Child Adolesc Psychiatry 2002; 41(2 suppl.):26S–49S.

# SCIENTIFIC AND CLINICAL REPORT SESSION 13—PHARMACOTHERAPY OF DEPRESSION

## No. 38
## ONSET AND MAINTENANCE OF ANTIDEPRESSANT EFFICACY FOR DULOXETINE 60 MG QD

Stephen K. Brannan, M.D., *Eli Lilly and Company, Drop Code 4103 Lilly Corporate Center, Indianapolis, IN 46285;* Craig H. Mallinckrodt, Ph.D., Gary D. Tollefson, M.D., Michael J. Detke, M.D., John G. Watkin, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the potential benefit that early onset and subsequent maintenance of antidepressant efficacy may offer to the patient, describe some of the analytical methods that may be employed to assess the onset of antidepressant action, and identify areas of controversy currently existing in this field.

## SUMMARY:

*Objective:* Rapid onset of clinically meaningful efficacy is a highly desirable attribute for an antidepressant medication. However, significant improvements in depressive symptoms are often delayed until two to four weeks of therapy. We examined the temporal pattern of antidepressant efficacy for duloxetine at its recommended starting dose.

*Methods:* Efficacy data were pooled from two identical nine-week, randomized, double-blind, clinical trials of duloxetine 60 mg QD (N = 244) and placebo (N = 251). Efficacy measures included the 17-item Hamilton Rating Scale for Depression ($HAMD_{17}$) total score, $HAMD_{17}$ items 1 (mood), 3 (suicide), 7 (work and activities), and 10 (anxiety), $HAMD_{17}$ subfactors (Maier, Core), Clinical Global Impression of Severity (CGI-S), and Patient Global Impression of Improvement (PGI-I).

*Results:* Mean changes for duloxetine-treated patients were significantly greater than for placebo-treated patients at Week 1 of treatment and at all visits thereafter for all assessed outcomes except $HAMD_{17}$ total score, where statistical significance began at Week 2. The estimated probabilities of improvement based on ≥ 1-unit change in HAMD Items 1, 3, 7, and 10 as well as CGI-S and PGI-I scores were significantly greater for duloxetine-treated patients at Week 1 and at all visits thereafter. Estimated probabilities of remission ($HAMD_{17} \leq 7$) and response (50% improvement) at Week 9 were 43% and 63% for duloxetine-treated patients, respectively, approximately double the corresponding placebo rates.

*Conclusion:* In these studies, duloxetine (60 mg QD) demonstrated rapid onset of robust and sustained antidepressant efficacy across a wide range of symptom measures.

*Funding:* This work was funded by Eli Lilly and Company.

## REFERENCES:

1. Montgomery SA, Bech P, Blier P, et al: Selecting methodologies for the evaluation of differences in time to response between antidepressants. J Clin Psychiatry 2002;63:694–699.
2. Stahl SM, Nierenberg AA, Gorman JM: Evidence of early onset of antidepressant effect in randomized controlled trials. J Clin Psychiatry 2001;62(suppl 4):17–23.

## No. 39
## DEPRESSIVE SUBTYPES AND RESPONSE TO AUGMENTATION OR DOSE INCREASE AMONG OUTPATIENTS RESISTANT TO FLUOXETINE 20 MG A DAY

Roy H. Perlis, M.D., *Department of Psychiatry, Massachussetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114;* Jonathan E. Alpert, M.D., Julie L. Ryan, B.A., Jessica L. Murakami, B.A., Andrew A. Nierenberg, M.D., Jerrold F. Rosenbaum, M.D., Maurizio Fava, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to distinguish between clinical subtypes of major depressive disorder and recognize the limitations and strengths in their application as response predictors in psychopharmacologic treatment.

## SUMMARY:

*Objective:* To determine the association between depressive subtype and response to next-step treatments among patients with major depressive disorder who fail to respond to fluoxetine treatment.

*Method:* In a randomized, double-blind investigation of next-step treatments in 101 outpatients (49 women; mean age: 41.6 ± 10.6) who had been either partial (n = 49) or non-responders (n = 52) to eight weeks of treatment with fluoxetine 20 mg/day, we examined the impact of depressive subtype on likelihood of treatment response following dose increase or lithium or desipramine augmentation using logistic regression, controlling for baseline depression severity.

*Results:* Atypical depression defined by DSM-IV criteria identified subjects significantly more likely to respond to any next step treatment (OR = 2.84, 95% CI 1.09–7.40; $p < 0.05$). Among individual features associated with atypical depression, presence of rejection sensitivity appeared to significantly and independently predict treatment response (OR = 2.84, 95% CI 1.08–7.51; $p < 0.05$). Melancholic, hostile/irritable, and anxious depressive subtypes, as well as double-depression, were not associated with treatment outcome.

*Conclusion:* For patients who fail to respond to initial antidepressant treatment, atypical depression or the presence of rejection sensitivity alone may identify a subgroup more likely to respond to next-step interventions.

*Sources of Funding:* NIMH grant # R01MH48483-05 (Dr. Fava), NARSAD Young Investigator Award (Dr. Perlis).

## REFERENCES:

1. Fava M, Alpert J, Nierenberg A, et al: Double-blind study of high-dose fluoxetine versus lithium or desipramine augmentation of fluoxetine in partial responders and nonresponders to fluoxetine. J Clin Psychopharmacol 2002; 22:379–87.

2. Sotsky SM, Simmens SJ: Pharmacotherapy response and diagnostic validity in atypical depression. J Affect Disord 1999; 54:237–47.

## No. 40
## TREATMENT-RELATED ADVERSE EVENTS IN A 20 MG OPEN-TRIAL OF FLUOXETINE: PREDICTORS OF EMERGENCE AND IMPACT ON THE COURSE OF TREATMENT

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

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the relationship between 1) somatic symptoms of depression and anxiety at baseline with the risk of developing side effects to treatment with fluoxetine and 2) the significance of side effects on treatment outcome.

### SUMMARY:

*Objective:* The significance of treatment-related adverse events (TRAEs) on the treatment of major depressive disorder (MDD) is complex. Higher levels of an antidepressant may increase the likelihood of clinical response or of side effects, resulting in higher dropout rates. Anxiety and somatization have been linked to developing side effects among patients treated for medical problems. In this study we examine the relationship between the degree of anxiety and somatic symptoms before treatment, with the subsequent spontaneous report of TRAEs, and the relationship between TRAEs and outcome in 384 depressed patients enrolled in an eight-week, open-label trial of fluoxetine 20 mg/day.

*Methods:* 170 patients completed the Symptom Questionnaire (SQ) at baseline. We tested whether SQ anxiety, somatic symptoms, and somatic well-being scores predicted the number of TRAEs during the trial or during each two-week interval, and the number of TRAEs during the trial or each interval predicted response to, or discontinuation of, fluoxetine.

*Results:* None of the above SQ scores predicted the number of TRAEs during the trial or during each interval. The overall number of TRAEs did not predict either outcome measure.

*Conclusion:* Fluoxetine was well tolerated regardless of the degree of baseline anxiety or somatic symptoms. There was no relationship between the emergence of side effects and outcome.

### REFERENCES:

1. Barsky AJ, Saintforth R, Rogers MP, Borus JF: Nonspecific medication side effects and the nocebo phenomenon. JAMA. 2002; 287:622–627.
2. Beasley CM Jr, Nilsson ME, Gonzales JS: Efficacy, adverse events, and treatment discontinuations in fluoxetine clinical studies of major depression: a meta-analysis of the 20mg dose. J Clin Psychiatry 2000; 61:722–728.

# SCIENTIFIC AND CLINICAL REPORT SESSION 14—MOOD DISORDERS AND SOMATIC ILLNESS

## No. 41
## CARDIOVASCULAR RISK FACTORS PREDICT TREATMENT OUTCOME IN MDD

Dan V. Iosifescu, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Nicoletta Clementi-Craven, M.D., Julie L. Ryan, B.A., Andrew A. Nierenberg, M.D., George I. Papakostas, M.D., Jonathan E. Alpert, M.D., Maurizio Fava, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the significance of cardiovascular risk factors in major depressive disorder and their impact on the outcome of antidepressant treatment.

### SUMMARY:

*Objective:* We examined the impact of cardiovascular risk factors on treatment outcome in MDD.

*Method:* 348 subjects meeting DSM-III-R criteria for MDD, ages 19 to 65, (192 females, 55.2%) enrolled in an eight-week treatment study with fluoxetine 20 mg/day. We recorded for each subject the age, gender, smoking status, family history, cholesterol, arterial hypertension, diabetes status and concomitant medications. We calculated a cumulated cardiovascular risk score (range = 0–6) following the NIH ATP III guidelines (based on the Framingham Heart Study). The 17-item Hamilton Rating Scale for Depression (Ham-D) was administered five times during the treatment to assess changes in depressive symptoms. The outcome variables were treatment response (Ham-D reduction $\geq$ 50%) and remission (final Ham-D $\leq$ 7). We used logistic regression to assess the relationship between cardiovascular risk factors and clinical outcome.

*Results:* Subjects with cardiovascular risk scores $\geq 4$ (n = 38) had significantly lower rates of treatment response (44.7%, p = .023) and remission (39.5%, p = .038), compared with subjects with cardiovascular risk scores of 2 or 3 (n = 116; response: 53.4%; remission: 47.4%), and those with cardiovascular risk scores of 0 or 1 (n = 194; response: 62.4%; remission: 55.7%). The total cardiovascular risk score was significantly related to treatment nonresponse (p = .021) and lack of remission (p = .044). Among individual cardiovascular risk factors, elevated total cholesterol was a significant predictor of nonresponse ($p < .01$) and lack of remission (p = .011).

*Conclusion:* In MDD patients, the total burden of cardiovascular risk factors significantly predicts lack of response and remission after antidepressant treatment with fluoxetine.

### REFERENCES:

1. Alexopoulos GS, Meyers BS, Young RC, et al: Clinically defined vascular depression. Am J Psychiatry 1997; 154:562–5.
2. Wilson PW, D'Agostino RB, Levy D, et al: Prediction of coronary heart disease using risk factor categories. Circulation 1998; 97:1837–47.

## No. 42
## PREVALENCE AND CHARACTERISTICS OF PATIENTS WITH DEPRESSION AND/OR CHRONIC PAIN

Bruce A. Arnow, Ph.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 1326, Stanford, CA 94305-5722;* Enid M. Hunkeler, M.A., Christine Blasey, Ph.D., Bruce Fireman, Ph.D., Janelle Lee, Ph.D., Rebecca Robinson, M.S., Chris Hayward, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that a very high proportion of depressed patients seen in primary care have comorbid chronic pain and that these factors need to be taken into account when planning treatment.

### SUMMARY:

*Objective:* Despite substantial data on depression, little is known about depressed patients with pain. We examined prevalence, quality of life (QOL), and qualifiers of pain among primary care patients with depression only, pain only, depression + pain, and neither condition.

*Method:* 12,000 patients were surveyed within one week of a primary care visit in a large HMO. We assessed major depressive disorder and physical symptoms with the Patient Health Questionnaire, QOL with the SF-8, and pain intensity and disability with the Graded Chronic Pain Scale.

*Results:* Overall prevalence of depression was 7.6% of depressed patients, 67% reported chronic pain (pain for at least months) and 54.5% were "bothered a lot" by three or more physical symptoms vs. the overall sample with rates of 40% and 15%, respectively. MANCOVA analyses comparing controls, pain, depression, and pain + depression revealed progressive and significant decrements in QOL and burden from physical symptoms after covarying for age ($p < .001$ for all comparisons). Compared with pain alone, depression + pain was associated with significantly greater disability ($p < .001$).

*Conclusion:* Chronic pain is highly prevalent in depressed primary care patients and is associated with substantial disability and reduced QOL. Physicians might consider incorporating these data when planning treatment.

*Funding source:* Eli Lilly & Company

## REFERENCES:

1. Arnow BA, Hart S, Hayward C, et al: Severity of child maltreatment history, pain complaints & medical utilization among women. J Psychiatr Res 2000; 34:413–421.
2. Ohayon MM, Schatzberg AF: Chronic pain is highly predictive of depressive morbidity in the general population. Arch Gen Psych, in press.

### No. 43
### EFFECTIVENESS OF COLLABORATIVE CARE IN A DEPRESSED, POOR, PRIMARY CARE SAMPLE

Lawson R. Wulsin, M.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, ML0559, Cincinnati, OH 45267;* Shelley A. Evans, M.S., Terrance J. Wade, Ph.D., Orson Austin, M.D., Martha McCarthy, B.A., Heidi Meyer, B.A., Victoria E. Wells, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the clinical effectiveness of the collaborative care model applied to major depression in a sample of uninsured working poor in a family practice.

## SUMMARY:

*Objective:* To compare the clinical effectiveness of collaborative care with usual care in a low-income, family-practice sample.

*Method:* Sixty uninsured, working, poor adults with major depression were enrolled in the intervention group and assessed with the Patient Health Questionnaire (PHQ), the Short Form 36, and a Utilization Index. A depression care manager and a part-time psychiatrist delivered monitoring, adherence, patient education, and treatment interventions over nine months in a large group family-practice center. Depression was monitored with the PHQ9. A usual-care group matched for age, sex, and income was assessed at baseline and at nine months.

*Results:* Of the 60 intervention subjects enrolled, 48 (80%) completed nine-month follow-up. Mean PHQ9 total score improved from 20.5 to 7.4 over nine months ($t = 13.4$, $p < .001$), reflecting an 82% remission rate. Though physical functioning remained unchanged and nearly normal, mental functioning improved markedly from a Mental Component Score (MCS) of 21.4 (severely impaired) to 42 (nearly normal, $t = 11.4$, $0 < .001$). The usual-care group began the study somewhat less depressed (mean PHQ9 total = 16) and less mentally impaired (mean MCS = 30.5). The intervention group showed trends toward greater rates of improvement in depressive symptoms and mental functioning than the usual-care group.

*Conclusions:* Collaborative care can effectively treat an uninsured family practice sample of severely depressed adults. This study demonstrates the need for cost-effectiveness research on the economic value of collaborative care in this population.

*Funding:* The Health Foundation of Greater Cincinnati.

## REFERENCES:

1. Katon W. Robinson P, VonKorff M, et al: A multifacted intervention to improve treatment of depression in primary care. Arch Gen Psych 1996; 53:924–932.
2. Schoenbaum M, Unutzer, J. Sherbourne C, et al: Cost-effectiveness of practice-initiated quality improvement for depression. JAMA 2001; 286:1325–1330.

# SCIENTIFIC AND CLINICAL REPORT SESSION 15—CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY

### No. 44
### MODAFINIL IN CHILDREN WITH ADHD: A RANDOMIZED, PLACEBO-CONTROLLED STUDY

James M. Swanson, M.D., *Child Development Center, University of California at Irvine, 19722 MacArthur Boulevard, Irvine, CA M.D. 92612;* Laurence L. Greenhill, M.D., Joseph Biederman, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the role of modafinil in the treatment of children with ADHD.

## SUMMARY:

*Objectives:* Attention deficit/hyperactivity disorder is associated with cortical/striatal dysfunction. The novel wake-promoting agent modafinil works through the sleep/wake centers to activate the cortex. Modafinil significantly improved ADHD symptoms in an open-label study. This study evaluated different doses of modafinil given once-daily in children with ADHD.

*Methods:* Children with ADHD were enrolled in this double-blind, randomized, placebo-controlled, crossover study in an analog classroom setting (Laboratory School Protocol [LSP]). Patients received placebo or modafinil 100, 200, or 300/400 mg (300 mg in children <30 kg or 400 mg children ≥30 kg) during study weeks 1–4. The ADHD Rating Scale-IV (Home version) was the primary efficacy measure. Outcome measures used during the LSP day included the Swanson, Kotkin, Agler, M-Flynn and Pelham (SKAMP) rating scale.

*Results:* 48 children (aged 6–13 years) were enrolled. Modafinil significantly improved ADHD symptoms in the 300/400 mg group ($P < 0.05$), as measured by the ADHD Rating Scale total score and subscale scores. Modafinil 200 mg/day also demonstrated a trend of improvement on the inattention subscale. Patients receiving modafinil 300/400 mg also tended to improve in SKAMP attention and deportment subscales over the course of the day. Adverse events that occurred in at least 10% of patients and more frequently in the modafinil than placebo group were abdominal pain and headache. Modafinil did not appear to adversely affect lab values, nor were there clinically significant changes in vital signs, ECG, or physical exam results. Six patients withdrew because of adverse events.

*Conclusions:* Modafinil significantly improved ADHD symptoms and was well tolerated in children with ADHD.

Funded by Cephalon, Inc.

## No. 45
## QUETIAPINE USE IN CHILDREN AND ADOLESCENTS: A LITERATURE REVIEW

Brian J. McConville, M.D., *Department of Psychiatry, University of Cincinnati Medicine, 231 Bethesda Avenue #ML559, Cincinnati, OH 45267-0559;*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to critically evaluate the existing medical literature regarding the use of quetiapine in children and adolescents and to recognize quetiapine as a safe and effective treatment for psychotic disorders.

### SUMMARY:

*Objective:* To evaluate data regarding the safety and effectiveness of quetiapine as a treatment for psychotic disorders in children and adolescents.

*Method:* Clinical studies and case reports published between January 1997 and April 2002 on the use of quetiapine in children and adolescents were identified by Medline searches (English language). Keywords included quetiapine, children, and adolescents. Research presented at conferences was also included in the review.

*Results:* Although there is a paucity of published data on the use of quetiapine in children and adolescents, study results indicate that quetiapine is effective and well tolerated in this patient population. Children who received quetiapine achieved statistically significant improvement in psychotic symptoms after short-term (eight weeks) and long-term (mean duration of treatment 445 days) treatment, compared with placebo. Additionally, quetiapine effectively reduced the symptoms of bipolar disorder and comorbid attention deficit hyperactivity disorder in adolescents. Quetiapine is well tolerated in children and adolescents with minimal to no extrapyramidal symptoms or increased prolactin levels.

*Conclusions:* In multiple studies of various methodological rigor, treatment with quetiapine was reported to be effective and safe in children and adolescents and has shown a low propensity to induce side effects like weight gain and EPS.

### REFERENCES:

1. McConville BJ, Arvanitis LA, Thyrum PT, et al: J Clin Psychiatry 2000; 61:252–260.
2. Finding RL, McNamara NK, Gracious BL: Expert Opin Pharmacother 2000; 1:935–945.

## No. 46
## CLINICAL REVIEW OF OROS MPH IN CHILDREN, ADOLESCENTS, AND ADULTS WITH ADHD

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

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that OROS® MPH, a once-daily, oral formulation of methylphenidate is effective and well tolerated in children, adolescents, and adults.

### SUMMARY:

*Objective and Methods:* To review the clinical trials program for OROS MPH, a once-daily, controlled-release, oral formulation of MPH, in more than 1,500 children, adolescents, and adults with ADHD.

*Results:* Two laboratory school studies (children aged 6–12 years; $n = 64$, $n = 70$) demonstrated that OROS® MPH was significantly better than placebo at controlling core ADHD symptoms, with control similar to MPH tid. A four-week, pivotal multicenter, double-blind, efficacy study ($n = 206$, 6–12 years) showed OROS® MPH was effective both at school and at home, and was well tolerated with a safety profile similar to IR MPH tid. A total of 1,082 subjects (6–12 years, $n = 682$; 13–17 years, $n = 264$, ≥18 years, $n = 136$) participated in the nine-month, multicenter, community use setting study in which OROS® MPH was shown to be well tolerated and effective. Long-term efficacy and tolerability was maintained for up to 24 months in a multicenter, open-label, nonrandomized study (6–13 years, $n = 407$). Ongoing studies include efficacy and safety evaluations in 6–16 year-olds, and a 14-week, multicenter study evaluating efficacy and safely with dosing up to 72 mg per day in the understudied adolescent population (13–18 years).

*Conclusions:* The clinical trials program demonstrates that OROS® MPH is well tolerated and provides effective control through 12 hours.

*Funding:* This study was supported by McNeil Consumer & Specialty Pharmaceuticals, Fort Washington, PA

### REFERENCES:

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2. Wolraich M, Greenhill LL, Pelham W, et al: Randomized, controlled trial of OROS® methylphenidate once a day in children with attention-deficit hyperactivity disorder. Pediatrics 2001; 108:883–892.

# SCIENTIFIC AND CLINICAL REPORT SESSION 16—PREDICTORS OF SUICIDE

## No. 47
## PERSONALITY TRAITS AS PREDICTORS OF SUICIDALITY IN YOUNG WOMEN

Joel F. Paris, M.D., *Department of Psychiatry, Sir Mortimer B Davis Jewish General Hospital, 4333 Cote SteCatherine Road, Montreal, PQ H3T 1E4, Canada;* Gustavo Turecki, M.D., Mark Zoccolillo, M.D., Richard Tremblay, Ph.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to present data on the relationship between personality traits and suicidality.

### SUMMARY:

*Objectives:* To test the hypothesis that personality trait profiles are predictive of suicidal attempts and of suicidal ideation.

*Methods:* The sample consisted of 477 women, aged 20–21, drawn from a community-based, longitudinal follow-up study of children. The measures included the Suicidal Intent Scale, Suicidal Ideation Scale, and the Diagnostic Assessment for Personality Pathology (DAPP-BQ).

*Results:* Subjects with a history of suicidal attempts (n = 50) had significantly different scores on 12 out of the 18 DAPP-BQ scales; logistic regression showed that three scales had independent contributions to the discrimination between attempters and nonattempters: identity problems ($p < .008$), rejection ($p < .05$), and self-harm ($p < .0001$). When subjects who reported significant suicidal ideation on the Suicidal Ideation Scale (n = 226) were compared with those who did not, 16 out of 18 DAPP-BQ scales were significantly related to higher levels of ideation. Logistic regression showed that four scales had independent contributions to this discrimination conduct disorder ($p < .0001$), social avoidance ($p < .001$), and self-harm ($p < .0001$) were related to higher levels of ideation, while narcissism ($p < .03$) was related to lower levels.

*Conclusions:* The results indicate that specific personality trait profiles are associated with both suicidal attempts and ideation in young women.


## REFERENCES:

1. Fergusson DM, Woodward LJ, Horwood LJ: Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early childhood. Psychological Medicine 2000; 30:23–39.
2. Livesley WJ, Jang KL, Vemon PA: Phenotypic and genetic structure of traits delineating personality disorder. Archives of General Psychiatry 1998; 55:941–948.


## No. 48
## SUICIDAL BEHAVIOR IN VIOLENT AND NONVIOLENT PSYCHIATRIC PATIENTS

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 identify psychiatric, neurological, and historical correlates of suicidal behavior in schizophrenic, schizoaffective, and bipolar patients; to contrast correlates of suicide in violent and nonviolent patients.

## SUMMARY:

*Objective:* To identify clinical/historical variables associated with suicidal behavior in violent and nonviolent psychiatric patients.

*Method:* 76 out of 216 (35%) violent and 27 (33%) out of 81 nonviolent patients had a history of suicide attempts (SA's); the others did not (NSA's). Psychiatric symptoms were assessed with the Brief Psychiatric Rating Scale (BPRS) upon entry and after four weeks. Neurological and psychosocial assessments were also done.

*Results:* More women than men had attempted suicide in the violent ($\chi^2$ = 5.8, df = 1, p = .02) and nonviolent ($\chi^2$ = 18.4, df = 1, p < .01) groups; gender was used as a covariate in all analyses. SA's, violent and nonviolent, had more severe depression/anxiety than NSA's (ANCOVA; BPRS Anxiety/Depression. baseline: F = 13.1; df = 1,286; p < .001; endpoint: F = 12.0; df = 1,291; p < .001). For frontal impairment, there was an interaction between violence and suicide classifications (F = 4.4; df = 1,245, p = .04). In the nonviolent group, SA's were more impaired; in the violent group, NSA's were more impaired. Multivariable logistic regression indicated that suicide attempts were related to substance abuse ($\beta$ = .80; $\chi^2$ = 5.0; p = .02), school truancy ($\beta$ = .53; $\chi^2$ = 3.6; p = .05), and mother's psychiatric illness ($\beta$ = 1.0; $\chi^2$ = 7.4, p < .01) and alcohol abuse ($\beta$ = .66; $\chi^2$ = 3.5, p = .06). Violence status was independently associated with these factors.

*Conclusions:* There is an overlap in factors associated with suicidal behavior in violent and nonviolent patients.

*Funding Source:* NIMH


## REFERENCES:

1. Harkavy-Friedman JM, Restifo et al: Suicidal behavior in schizophrenia: characteristics of individuals who had and had not attempted suicide. American Journal of Psychiatry 1999; 156:1276–1278.
2. Krakowski M, Czobor P, Chou JC: Course of violence in patients with schizophrenia: relationship to clinical symptoms. Schizophrenia Bulletin 1999; 25:505–17.


## No. 49
## OBSTETRIC COMPLICATIONS AND SUICIDE RISK IN ADOLESCENCE AND YOUNG ADULTHOOD

Richard Neugebauer, Ph.D., *Brain Disorder #53, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* M. Lynne Reuss, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to summarize the literature on the association between prenatal and perinatal factors and risk of suicide in offspring, together with the most recent findings on the role of obstetric complications in violent suicide among males.

## SUMMARY:

*Objectives:* Suicidal behavior has received scant attention in research on the prenatal and perinatal origins of psychiatric illness. Based on an a priori hypothesis supported by previous findings (Jacobson and Bygdeman, 1998) we examined the association between specific obstetric complications and risk of suicide by violent means among the adolescent and young-adult male offspring.

*Methods:* Cases comprised males aged 15–22 years, born and committing violent suicide in New York City between 1985–1991 (n = 139). Cases were identified from death certificates and then linked to the birth certificates. For each case, we selected two controls constituting the hospital birth immediately preceding and following that of the case, matched with the case on ethnicity. Cases were compared with controls on frequency of non-vertex presentation and instrumental delivery, with the associations of interest assessed using conditional logistic regression.

*Results:* In analyses adjusted for patient service (public/private), the odds ratios for non-vertex presentation and instrumental delivery were substantially and significantly elevated, OR = 3.1 (95%CI 1.5–4.4) and OR = 2.7 (95% CI 1.3–4.1), respectively.

*Conclusion:* Based on this independent replication of prior findings, further research is warranted to eliminate alternative explanations, for example, intervening mechanisms, and to search for neurobiological pathways.


## REFERENCES:

1. Salk L, Lipsit LP, Sturner WQ, et al: Relationship of maternal and perinatal conditions to eventual adolescent suicide. Lancet 1985; i:624–627.
2. Jacobson B, Bygdeman M: Obstetric care an proneness of offspring to suicide as adults: case-control study. BMJ 1998; 317:1346–1349.


# SCIENTIFIC AND CLINICAL REPORT SESSION 17—SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

## No. 50
## ELEVATED MATERNAL CYTOKINE LEVELS AND SCHIZOPHRENIA IN ADULT OFFSPRING

Alan S. Brown, M.D., *Department of Psychiatry, Columbia University-NYSPI, 1051 Riverside Drive, Unit 2, New York, NY 10032;* Jonathan Hooton, Ph.D., Eva Petkova, Catherine A. Schaefer, Ph.D., Vicki Babulas, M.P.H., Jack M. Gorman, M.D., Ezra S. Susser, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the role of maternal cytokine levels in the etiology of schizophrenia.

SUMMARY:

*Objective:* To determine whether second trimester levels of four cytokines that are plausible candidates for schizophrenia—interleukin-8, interleukin-1β, interleukin-6, and tumor necrosis factor-α—are increased in individuals who later developed schizophrenia.

*Method:* We conducted a nested case-control study of a large birth cohort, born from 1959–1967 and followed up for psychiatric disorders 30–38 years later. Cases were diagnosed with schizophrenia spectrum disorders (mostly schizophrenia/schizoaffective disorder) with available second trimester maternal serum samples (N = 59); controls (N = 105) had not been diagnosed with a schizophrenia spectrum or major affective disorder, and were matched to cases on date of birth, gender, length of time in the cohort, and availability of maternal scra. The main outcome measures were maternal second trimester serum levels of interleukin-8, interleukin-1β, interleukin-6, and TNF-α. Assays were conducted blind to case/control status.

*Results:* Second trimester maternal interleukin-8 in schizophrenia/schizophrenia spectrum disorder cases was significantly increased as compared with controls (p = .02). There were no differences between cases and controls with respect to interleukin-1β, interleukin-6, or tumor necrosis factor-α.

*Conclusions:* Infectious or inflammatory processes associated with increased levels of interleukin-8 during the second trimester may play a role in the etiology of schizophrenia.

REFERENCES:

1. Brown AS, Hooton J, Schaefer CA, et al: Elevated maternal interleukin-8 levels and risk of schizophrenia in adult offspring (submitted for publication).
2. Brown AS, Susser ES: In utero infection and adult schizophrenia. Ment Retard Dev Disabil Res Rev 2002; 8:51–57.

## No. 51
## ASSOCIATION BETWEEN PSYCHOTIC SYMPTOMS AND SEIZURES IN A COMMUNITY SAMPLE

Christine L. Baker, M.P.H., *453 Halstead Avenue Apartment 6, Mamaroneck, NY 10543;* Richard Neugebauer, Ph.D., Robert Kohn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify limitations of previous studies that investigated the association between psychotic symptoms and history of seizures; recognize the strength of association between psychotic symptoms and history of seizures; compare the strengths and weaknesses of this study design with the limitations of previous studies.

SUMMARY:

*Objective:* The possible association of psychosis with seizures has been a subject of considerable interest in neuropsychiatry. In previous research, reliance on cases from clinical settings, absence of control groups, and inconsistent findings have precluded any confident conclusions to date. The present study is the first to investigate this question in a randomly selected, community-based sample.

*Methods:* Using the Epidemiologic Catchment Area survey, we examined the association of seizure history with both a history of psychotic symptoms and of schizophrenia. Differences in survey methods required that the New Haven site be analyzed separately from the other four sites.

*Results:* After adjustment, a history of psychotic symptoms and of schizophrenia was associated with a raised odds of having a seizure history in the four-site sample, OR = 2.00 (95% CI: 1.1–3.6) and OR = 2.1 (95% CI: 0.7–5.7), respectively. Similar findings were found in the New Haven sample OR = 1.6 (95% CI: 0.8–3.4) and OR = 2.5 (95% CI: 0.9–7.6), respectively.

*Conclusions:* While these effect sizes are small overall, these findings lend support to previous studies using alternative designs that reported a positive association between psychotic disturbance and seizures. Prospective studies using community-based samples are needed for further elucidation of this association.

REFERENCES:

1. Hyde TM, Weinberger DR: Seizures and schizophrenia. Schizophrenia Bulletin 1997; 23:611–622.
2. Mendez MF, Grau R, Doss RC, Taylor JL: Schizophrenia in epilepsy: seizure and psychosis variables. Neurology 1993; 43:1073–1077.

## No. 52
## BIOLOGICAL MECHANISMS IN SCHIZOPHRENIC THOUGHT DISORDER AND DELUSIONS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants should have a better understanding of biological mechanisms proposed to account for schizophrenic delusions and thought disorder, and of the data bearing on these proposed mechanisms.

SUMMARY:

*Objective:* The current research was designed to study the symptomatic consequences of a major biological theory advanced by M. Spitzer to account for schizophrenic thought disorder and schizophrenic delusions. In this theory, based on views about neural networks and about dopamine as an excitatory neuromodulator, *low* frontal dopamine leads to a more diffuse spread of activation, and to a wider and less-focused spread of associations, with resulting thought disorder. In contrast, *high* frontal dopamine leads to more narrow, sharply focused cognition, with potential delusional ideation.

*Method:* 78 schizophrenic and schizoaffective patients and 50 other psychotic patients were assessed at the acute phase and then followed up five times over the following 15 years. Patients were assessed at each follow up (using structured interviews, cognitive tests, and other performance tests) for thought disorder and delusions, for other psychopathology, and for major aspects of functioning.

*Results:* 1) The results indicate a strong positive relationship between thought disorder and delusions at each of the five follow ups over 15 years ($p < .05$). 2) At the 15-year follow up, 90% of the thought disordered patients also were delusional. 3) The relationship between thought disorder and delusions was not as strong for the other psychotic (but nonschizophrenic) patients.

*Conclusions:* The strong, consistent, and significant positive relationship between thought disorder and delusions provides negative evidence on M. Spitzer's biological theory of the link between dopamine activity and major psychotic symptoms. In addition, it does not support simple three-factor models of schizophrenic symptom dimensions. The data suggest common underlying mechanisms play a role in different types of psychotic symptoms and reality distortions in schizophrenia.

REFERENCES:

1. Spitzer M: A cognitive neuroscience view of schizophrenic thought disorder. Schizophrenia Bulletin 1997; 23:29–50.
2. Spitzer M: The mind within the net. Cambridge, Massachusetts, MIT Press, 1999.

# SCIENTIFIC AND CLINICAL REPORT SESSION 18—EPIDEMIOLOGY

## No. 53
## DIAGNOSES IN BEHAVIORAL HEALTH CLINICS: IMPACT ON PERCEIVED BURDEN OF MENTAL HEALTH

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### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that the burden of mental health care on outpatient clinics is greater than shown by conventional nosology. The participant should also be able to demonstrate limitations of the ICD-9 or other standardized coding systems when researching a specific health problem.

### SUMMARY:

*Objective:* Studies of mental disorders focus largely on ICD-9 290-319, to the exclusion of other mental health problems. In the active-duty U.S. armed forces, a large, young-adult, employed population similar to civilians in overall health care utilization, ICD-9 290-319 mental disorders accounted for almost 5.5% of all outpatient visits in 2000, including approximately 56% of all 891,132 visits to military behavioral health clinics. The purpose of this study was to characterize the remaining 44% of outpatient behavioral health visits.

*Method:* All active-duty U.S. armed forces visits to outpatient clinics in 2000 were included. Primary diagnoses were grouped according to mental health relevance in the following categories: mental disorders (ICD-9 290-319), residual mental health (mainly counseling v-codes), screening and observations, and all other diagnoses. Data were obtained from the Defense Medical Surveillance System.

*Results:* The rate (per 1,000) of military visits for mental disorders in behavioral health clinics increased from 370.0 to 525.0, and in all clinics from 426.6 to 591.3 when residual mental health diagnoses were included. This represents an approximate 40% increase in burden of care.

*Conclusions:* Focusing on ICD-9 290-319 to the exclusion of other mental health problems underestimates the true burden of mental health care on outpatient clinics.

### REFERENCES:

1. Angold A, Costello EJ, Farmer EM, et al: Impaired but undiagnosed. J Am Acad Child Adolesc Psychiatry 1999; 38:129–137.
2. Siddique CM, Aubry T: Use of mental health resources in the treatment of adult outpatients with no diagnosable mental disorders. Acta Psychiatrica Scandinavica 1997; 95:19–25.

## No. 54
## THE TREATMENT GAP IN MENTAL HEALTH CARE

Robert Kohn, M.D., *Department of Psychiatry, Brown University, 345 Blackstone Boulevard, Providence, RI 02906;* Shekhar Saxena, M.D., Itzhak Levav, M.D., Benedetto Saraceno, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that the treatment gap presents a significant public health challenge; the majority of individuals with mental illness are untreated.

### SUMMARY:

*Objectives:* Mental disorders are highly prevalent and cause considerable disease burden. To compound this public health problem, many individuals with psychiatric disorders go untreated, although effective treatments do exist. The extent of this treatment gap is the subject of this report.

*Methods:* We conducted a review of community-based psychiatric epidemiology studies that used standardized diagnostic instruments and that provided data on the percentage of individuals receiving services for schizophrenia and other nonaffective disorders, major depression, dysthymia, bipolar disorder, generalized anxiety disorder (GAD), panic disorder, obsessive-compulsive disorder (OCD), and alcohol abuse/dependence. The median rates of these disorders were calculated across studies, and examples of the estimation of the treatment gap for WHO regions is presented.

*Results:* Thirty-seven studies had information on service utilization. The median treatment gap for schizophrenia, including other nonaffective psychosis, across studies was 32.2%. For the other disorders the gap was: depression 56.3%; dysthymia 56.0%; bipolar disorder 50.2%; panic disorder 55.9%; GAD 57.5%, and OCD 57.3%. Alcohol abuse and dependence had the largest treatment gap, 78.1%.

*Conclusion:* The treatment gap may be under-represented due to the lack of studies from developing countries where services are scarcer. The extent of the gap represents a significant public health challenge if the burden of mental illness is to be reduced.

*Funding Source:* World Health Organization

### REFERENCES:

1. World Health Organization: The World Health Report 2001 Mental Health: New Understanding New Hope. Geneva, World Health Organization, 2001.
2. World Health Organization: Atlas: Mental Health Resources in the World 2001. Geneva, World Health Organization, 2001.

## No. 55
## PROJECTING NATIONAL SURVEY PREVALENCES TO POPULATIONS OF INTEREST

Stephen C. Messer, Ph.D., *Department of Psychiatry, Walter Reed Army Medical Center, 503 Robert Grant Avenue, Silver Spring, MD 209107500;* Xian Liu, Ph.D., Charles W. Hoge, M.D., David N. Cowan, Ph.D., Charles C. Engel, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand state and community needs for methods to estimate mental disorder prevalence when direct prevalence data is unavailable and/or resources are limited; and appreciate the utility of indirect/synthetic estimation methods and their applications.

### SUMMARY:

*Objective:* To illustrate an efficient method for the estimation of mental disorder prevalence in population groups where no direct prevalence data are available. This study demonstrated a new method to extrapolate prevalences from a national calibration survey to a target population where no observations are available, and sociodemographic differences are prominent.

*Method:* We restricted the ECA sample to full-time employed participants (≈10,500) and used the total active-duty U.S. Army population (≈460,000) for illustration. Sociodemographic data for the Army came from the official military database (mid-year 2000). Our logistic regression projections represented an extension of sociodemographic-driven synthetic methods used among demographers. Outcomes were lifetime prevalences for 13 DIS/DSM disorders.

*Results:* Compared with the ECA employed population, extrapolations to the Army revealed lower/similar estimates for nine of 13 DIS/DSM disorders. Projections were twice as high for alcohol abuse/

dependence and antisocial personality, and 1/3 higher for social phobia and schizophrenia in the Army. Estimates compared favorably to limited military prevalence data and to results derived using traditional standardization.

*Conclusions:* The indirect estimation techniquc using ECA data to project lifetime prevalences for the U.S. Army generated sound estimates while offering an attractive method to extrapolate national data to demographically diverse communities seeking policy-relevant data.

### REFERENCES:

1. Liu X, Engel CC, Cowan D, McCarroll JE: Using general population data to project idiopathic physical symptoms in the U.S. Army. Mil Med 2002; 167:1–5.
2. Robins LN, Regier DA (eds.): Psychiatric Disorders in America: The Epidemologic Catchment Area Study. New York, Free Press, 1991.

## SCIENTIFIC AND CLINICAL REPORT SESSION 19—DIAGNOSTIC ISSUES

### No. 56
### THE DEVELOPMENT OF A BRIEF ADULT MENTAL HEALTH SCREENING TOOL FOR JAILS

Robert L. Trestman, M.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030-1410;* Juhan Foro, Ph.D., Janelle Mallet, Valerie Hogan, M.A.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to understand the need for and issues surrounding the development of a mental health screening tool for offenders.

### SUMMARY:

*Introduction:* Reliable early identification of psychiatric disorders and suicide risk factors is a critical step toward addressing the public health and safety concerns associated with the increase of mentally ill offenders in this nation's correctional facilities. The present study is designed to develop and validate an efficient brief mental health screening protocol, which can be used nationally in jails for clinical, research, and program development and evaluation purposes.

*Method:* After empirically identifying items from a number of psychiatric screening instruments designed to identify the principal signs and symptoms of Axis I and II psychiatric disorders, the resulting "composite screen" was administered to N=1,370 offenders in Connecticut (N = 700 in four male jails and N = 670 in the female jail).

*Results:* Preliminary statistical analyses reducod the number of items in the composite screening interview from 174 to 64. The validation plan is described, and results are reported from a series of exploratory factor analyses (EFA) done with 700 male and 670 females, using principal components and oblimin rotation.

*Discussion:* Initial results reveal a brief subset of items with potential sensitivity and specificity in predicting both psychiatric disorders and major prospective behavioral or custody problems.

### REFERENCES:

1. Ditton PM: Mental health treatment of inmates and probationers. Bureau of Justic Statistics Special Report. July 1999, NCJ 174463.
2. Teplin LA: Psychiatric and substance abuse disorders among male urban jail detainees. American Journal of Public Health. 1994; 84(2):290–293.

### No. 57
### DIAGNOSING AND TREATING INFANTS AND TODDLERS IN PUBLIC MENTAL HEALTH SETTINGS

Harry H. Wright, M.D., *Department of Neuropsychiatry, University of South Carolina, 3555 Harden Street Extension, Suite 104, Columbia, SC 29203;* Rosetta H. Penny, M.S.W., Kristin M. Wieduwilt, M.S.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the issues in assessment diagnosis and treatment for infants, toddlers, and their families referred to mental health settings.

### SUMMARY:

Even before their third birthday, children can suffer from overwhelming anxiety, disruptive behavior, and other mental health problems. Fortunately, there has been increasing interest by researchers, clinicians, and policy makers in the social-emotional well-being of infants, toddlers, and their families, and assessmcnt and treatment is now available in a few settings. Each year more residency programs are providing residents training in the assessment and treatment of children under 6 and their families. Other providers of care are recognizing the need for intervention in this age group.

While DSM-IV does not provide adequate coverage for making psychiatric diagnosis in the 0–5 age group, clinicians are seeing more children in the age group and must make diagnosis for statistical and reimbursement purposes. Only recently has there been limited data available on the range of DSM-IV disorders scen in this population. In this report, we provide data (demographic and clinical) on children 0–3 years old seen in two settings for mental health intervention (community mental health; N = 1,284 and infant mental health specialty clinic; N = 150).

The demographics (average age, gender ratio, ethnicity) of the two groups were similar, but the distribution of the DSM-IV diagnoses was different. Most (80%) of the young children had only one diagnosis. Relational problems, adjustment disorder, and pervasive developmental disorders were commonly diagnosed in both settings. Communication problems, anxiety disorders and feedings disorders were diagnosed significantly less often in the community mental health setting. We provide a rank order list of DSM-IV diagnoses made in the community mental health and specialty infant mental health settings and comment on differences and thc adequacy of the DSM-IV use in each setting.

The most common services provided in both settings include assessment, psychiatric medical assessment, intensive in-home family therapy, psychosocial rehabilitation, and caregiver group. Treatment services were not available for close to one-fifth of the population seen in the community mental health setting.

We provide examples of treatment approaches for young children with anxiety and disruptive behavior disorders. There is a widening gap between the need for mental health services for young children and families and available well-trained clinicians to provide the care.

### REFERENCES:

1. Keren M, et al: Diagnoses and interactive patterns of infants referred to a community based infant mental health clinic. J Amer Acad Child Adolesc Psychiatry 2001; 40:27–35.
2. Thomas J, Guskin K: Disruptive behavior in young children: what does it mean? J Amer Acad Child Adolesc Psychiatry 2001; 40:44–51.

### No. 58
### PSYCHIATRIC NOMENCLATURE

Roger Peele, M.D., *Department of Mental Health, Montgomery County, 8002 Lions Crest Way, Gaithersburg, MD 20879-5637*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to state the basis of changes in psychiatric nomenclature over the past half century.

## SUMMARY:

The names science selects for important entities are often not "scientific," e.g., physicists' selection of "einsteinium" for one of the elements, chemists' selection of "Van Der Waals" for a form of electronic coupling, and physicians' selection of "West Nile Virus" for a disease. Scientific fields have considerable discretion as to the names they choose. On the 50th anniversary of DSM-I (1952), a review of psychiatric nomenclature finds considerable willingness to make changes:

DSM-I changed 94% of the names from its predecessor.
DSM-II changed 89% of the names from DSM-I.
DSM-III changed 86% of the names from DSM-II.
DSM-IIIR changed 28% of the names from DSM-III.
DSM-IV changed 48% of the names from DSM-IIIR.

The vast changes in the names have resulted from felt needs to 1) adopt conceptual changes, 2) move to less theoretical labels, 3) increase accuracy, 4) reduce confusion, 5) increase patient acceptance, 6) reflect common usage, 7) change organization of the classification, and 8) be in compliance with the ICDs.

Over the past 50 years, psychiatric nomenclature per se has lacked consistent principles. The agenda for DSM-V should include establishing the rules by which the names of psychiatric disorders are determined, such as finding names that best summarize a condition, create the least confusion, and facilitate the greatest acceptance for both the practitioner and the patient.

## REFERENCES:

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994.
2. Rounsaville BF, Alarcon R, Andrews G, et al: Basic nomenclature issues for DSM-V, in Kupfer DJ, First MB, Regier DA [editors], A Research Agenda for DSM-V. Washington, DC, American Psychiatric Association, 2002, pages 1–29.

# SCIENTIFIC AND CLINICAL REPORT SESSION 20—BIOLOGICAL PSYCHIATRY AND NEUROSCIENCE

## No. 59
## TAK-375 IS A HIGHLY SELECTIVE AGONIST AT THE ML-1 RECEPTOR

Keisuke Hirai, Ph.D., *Takeda Chemical Industries, 2-17-85 Jusohonmachi Yodogawa-ku, Osaka 532-8686, Japan;* Kelli Nishiyama, Koki Kato, Ph.D., Shuii Hinuma, Ph.D., Osamu Uchikawa, Ph.D., Shigenori Ohkawa, Ph.D., Masaomi Miyamoto, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the receptor binding specificity of TAK-375.

## SUMMARY:

*Objective:* Clinical trials to assess the efficacy and safety of TAK-375 for treatment of insomnia and circadian rhythm sleep disorders (CRSDs) are ongoing. The purpose of this study was to examine the specificity and potency of TAK-375 and its major metabolites for ML-1 and ML-2 receptors.

*Methods:* Receptor binding and adenylate cyclase activity were assayed to determine the affinity and activity of TAK-375 and its metabolites for ML-1 and ML-2 receptors.

*Results:* TAK-375 exhibited approximately 15-fold higher affinity than melatonin for the ML-1 receptor from chick forebrain ($K_i$ = 25.4 pM). For the ML-2 receptor from hamster brain ($K_i$ = 2.6 μM), TAK-375 had about 100-fold lower affinity than melatonin. In Chinese hamster ovary cells expressing the human ML-1a receptor, TAK-375 inhibited forskolin-stimulated cAMP production with an $IC_{50}$ that indicated a 4-fold higher potency in comparison to melatonin. The major metabolite of TAK-375, M-II, was also highly selective for ML-1 over ML-2; for ML-1 the affinity of M-II was more than 10-fold lower than that of TAK-375.

*Conclusion:* TAK-375 and its major metabolite are highly selective ML-1 agonists, showing greater affinity, selectivity, and potency than melatonin. This pharmacological profile suggests strong advantages of TAK-375 over existing agents for the treatment of insomnia and CRSDs.

Funding provided by Takeda Chemical Industries, Ltd.

## REFERENCES:

1. Dubocovich ML: Melatonin receptors: are there multiple subtypes? Trends Pharmacol Sci 1995; 16:50–56.
2. Reppert SM, Weaver DR, Godson C: Melatonin receptors step into the light: cloning and classification of subtypes. Trends Pharmacol Sci 1996; 17:100–102.

## No. 60
## SAFETY, PHARMACOKINETICS, AND PHARMACODYNAMICS OF TAK-375 IN HEALTHY ADULTS

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## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the clinical pharmacology of the selective ML-1 melatonin receptor agonist, TAK-375.

## SUMMARY:

*Objective:* TAK-375 is a highly selective ML-1 receptor agonist currently being studied for the treatment of insomnia and circadian rhythm sleep disorders (CRSDs). The purpose of this study was to examine the safety, pharmacokinetics, and pharmacodynamics of a single oral dose of TAK-375 in healthy adult volunteers.

*Methods:* Sixty subjects were randomly assigned in a double-blind fashion to receive a single dose of placebo or TAK-375 at one of five dose levels (4, 8, 16, 32, or 64 mg). Safety, pharmacokinetic, and pharmacodynamic parameters were assessed.

*Results:* TAK-375 was rapidly absorbed ($T_{max}$ < 1 hour) at all dose levels. AUC and $C_{max}$ for TAK-375 exhibited reasonably good dose proportionality. Mean elimination half-lives were dose independent and ranged from 0.834 to 1.903 hours. TAK-375 was extensively metabolized. Half-lives of metabolites appeared comparable across dosing groups. Urinary excretion of unchanged drug was minimal. There was no evidence of significant cognitive impairment as measured by the Digit Symbol Substitution Test, and visual analog scale scores of alertness remained relatively constant. The drug was well tolerated, with a low frequency of drug-related adverse events.

*Conclusions:* The safety, pharmacokinetic, and pharmacodynamic properties of TAK-375 support further study of the drug for treatment of insomnia and CRSDs.

Funding provided by Takeda Pharmaceuticals North America, Inc.

REFERENCES:

1. Wagner J, Wagner ML, Hening WA: Beyond benzodiazepines: alternative pharmacologic agents for the treatment of insomnia. Ann Pharmacother 1998; 32:680–691.
2. Brzezinski A: Melatonin in humans. N Engl J Med 1997; 1336: 186–195.

### No. 61
### SELECTIVITY OF THE ML-1 AGONIST TAK-375: LACK OF BINDING TO NON-ML-1 TARGETS

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#### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the selectivity of TAK-375 for ML-1 melatonin receptors over other binding sites.

#### SUMMARY:

*Objective:* TAK-375 is highly selective for ML-1 receptors compared with ML-2 receptors. In this study, we examined the binding of TAK-375 and its major metabolite M-II to other potential binding sites, including receptors for neurotransmitters, peptides, and cytokines, as well as ion channels and various enzymes.

*Methods:* Conventional receptor binding assays were performed to study displacement of radiolabeled ligands by melatonin, TAK-375, or M-II. Enzyme activities were also measured by standard procedures.

*Results:* TAK-375 showed no evidence of binding to any of a large number of potential binding sites. Of particular interest was the lack of binding to any GABA receptors or opiate receptors. Although melatonin showed weak affinity for $D_1$ and 5-$HT_{1A}$ receptors, TAK-375 showed no evidence of such binding. M-II showed no affinity for any sites with the exception of weak affinity for 5-$HT_{2B}$ receptors ($IC_{50}$ = 1.75 μM). Neither TAK-375 nor M-II affected the activity of any of a large number of enzymes tested.

*Conclusion:* TAK-375 is highly selective for ML-1 receptors, showing no affinity for any of a large number of other receptors, including GABA and opiate receptors. Its major metabolite, M-II, showed only weak affinity for one non-ML-1 receptor.

Funding provided by Takeda Chemical Industries, Ltd.

REFERENCES:

1. Wagner J, Wagner ML, Hening WA: Beyond benzodiazepines: alternative pharmacologic agents for the treatment of insomnia. Ann Pharmacother 1998; 32:680–691.
2. Brzezinski A: Melatonin in humans. N Engl J Med 1997; 336:186–195.

## SCIENTIFIC AND CLINICAL REPORT SESSION 21—PEDIATRIC ADHD

### No. 62
### AN OPEN-LABEL TRIAL OF ADDERALL XR: QUALITY-OF-LIFE ASSESSMENTS

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#### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe differences in quality of life, satisfaction, and preference between Adderall XR and other stimulant medication regimens for the treatment of ADHD in the community practice setting.

#### SUMMARY:

*Objective:* This study was conducted to evaluate the tolerability of Adderall XR in the treatment of pediatric attention deficit/hyperactivity disorder (ADHD) in the community practice setting.

*Method:* A prospective, open-label, seven-week study was conducted at 386 sites. A total of 2,956 children (mean age = 9.5 years) with a DSM-IV diagnosis of ADHD who were currently taking stable doses of immediate-release Adderall or any methylphenidate formulation were enrolled. Tolerability was assessed by the Pediatric Quality of Life Inventory (PedsQL) and by satisfaction and preference questionnaires.

*Results:* There was a statistically significant improvement from baseline in the mean PedsQL Total Score at week seven (baseline = 74.5, week seven = 81.0; mean change = +6.4 [N=2,490, SD=12.6], $p < .0001$). Peds QL physical and psychosocial health summary scores both showed significant improvement ($p < .0001$), compared with baseline values, with a mean change of +4.3 and +7.6, respectively. After seven weeks of therapy with Adderall XR, satisfaction and preference results reveal significant improvement over baseline treatment regimens.

*Conclusion:* Children with ADHD that was well controlled with stimulant therapy, showed significant improvement in quality of life and satisfaction with medication after switching to treatment with Adderall XR. The medication was well tolerated. Adderall XR appears to be a safe and efficacious once-daily treatment for pediatric ADHD.

Funding provided by Shire Pharmaceutical Development Inc.

REFERENCES:

1. Biederman J, Lopez F, Boellner S, et al: A randomized, double-blind, placebo-controlled, parallel-group study of SLI381 (Adderall XR) in children with attention-deficit/hyperactivity disorder. Pediatrics 2002; 110:258–266.
2. Varni JW, Seld M, Knight TS, et al: The Peds QL 4.0 Generic Core Scales: sensitivity, responsiveness, and impact on clinical decision-making. J Behav Med 2002; 25:175–193.

### No. 63
### LONG-TERM SAFETY AND EFFICACY OF ADDERALL XR IN CHILDREN WITH ADHD

Mark C. Chandler, M.D., *NC Neuropsychiatry, 1829 E. Franklin Street, #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 multicenter, open-label extension study was conducted to assess the long-term (24-month) safety and efficacy of Adderall XR therapy.

*Method:* 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 ten-item Global Index Scale—Parent version (CGIS-P).

*Results:* At 24 months data showed 560 subjects in the intent-to-treat population. Efficacy was maintained over two years: quarterly CGIS-P total scores (mean ± SD) were 11.6 ± 8.1 at baseline and 8.8 ± 5.3, 8.5 ± 5.9, 8.4 ± 6.0, 8.0 ± 5.6, 8.0 ± 5.6, 8.2 ± 5.6, 7.7 ± 5.4, and 7.6 ± 5.5 for quarters one to eight, respectively. The most commonly reported adverse events were headache (11.0%), infection (6.9%), anorexia (6.5%), insomnia (4.9%), and abdominal pain (4.8%). Most adverse events were mild or moderate in intensity. Analyses of quality-of-life assessments performed between 12 and 24 months will also be presented along with detailed 24-month ECG, physical, and laboratory data.

*Conclusion:* Persistent therapeutic effects of Adderall XR during two years of therapy were demonstrated, and daily doses from 10 to 30 mg were well tolerated.

Funding provided by Shire Pharmaceutical Development Inc.

## REFERENCES:

1. Biederman J, Lopez FA, Boellner SW, et al: A randomized, double-blind, placebo-controlled, parallel-group study of SLI381 (Adderall XR) in children with attention-deficit/hyperactivity disorder. Pediatrics 2002; 110:258–266.
2. 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, Oct 26, 2000.

## No. 64
## AN OPEN-LABEL, COMMUNITY-ASSESSMENT TRIAL OF ADDERALL XR IN PEDIATRIC ADHD

Paul J. Ambrosini, M.D., *Department of Psychiatry, MCP Hahnemann University, 3200 Henry Avenue, Philadelphia, PA 19129;* Frank A. Lopez, M.D., Mark C. Chandler, M.D., Simon J. Tulloch, M.D., M. Alex Michaels, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the efficacy and safety of Adderall XR in the treatment of ADHD in the community practice setting.

## SUMMARY:

*Objective:* This study was conducted to evaluate the tolerability and effectiveness of Adderall XR in the treatment of pediatric attention-deficit/hyperactivity disorder (ADHD) in the community practice setting.

*Method:* A prospective, open-label, seven-week study was conducted at 385 sites. A total of 2,968 children (mean age = 9.5 years) with a DSM-IV diagnosis of ADHD who were currently taking stable doses of immediate-release Adderall or any methylphenidate formulation were enrolled. Efficacy was assessed by the Conners Global Index Scale-Parent version (CGIS-P) 12 hours after a single morning dose and by the Clinical Global Impression (CGI) Scale.

*Results:* There was statistically significant improvement from baseline in the mean CGIS-P score at week seven (baseline = 11.7, week seven = 7.3; mean change = −4.4 [N = 2,497, SD = 8.5]; $p < .0001$). CGI-improvement scores revealed that 80.1% of subjects were much improved or very much improved; only 8.9% were minimally worse, much worse, or very much worse. The most frequently reported treatment-emergent adverse events for Adderall XR that were considered drug-related or possibly related were insomnia (5.7% of subjects reporting), anorexia (4.7%), headache (4.4%), and nervousness (3.6%).

*Conclusion:* Children with ADHD that was well controlled with stimulant therapy, showed significant improvement in symptoms after switching to treatment with Adderall XR. Adderall XR appears to be a safe and efficacious once-daily treatment for pediatric ADHD.

Funding provided by Shire Pharmaceutical Development Inc.

## REFERENCES:

1. Biederman J, Lopez FA, Boellner SW, et al: A randomized, double-blind, placebo-controlled, parallel-group study of SLI381 (Adderall XR) in children with attention-deficit/hyperactivity disorder. Pediatrics 2002; 110:258–266.
2. McCracken J, Biederman J, Greenhill L, et al: Analog classroom assignment 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, Oct 26, 2000.

# SCIENTIFIC AND CLINICAL REPORT SESSION 22—GERIATRIC PSYCHIATRY

## No. 65
## NIMH ATYPICAL ANTIPSYCHOTIC EFFECTIVENESS TRIAL IN ALZHEIMER'S CATIE-AD

M. Saleem Ismail, M.D., *Department of Psychiatry, University of Rochester, 435 East Henrietta Road, Rochester, NY 14620;* Ge A. Donker, M.D., Karen S. Dagerman, M.S., Sonia Davis, D.P.H., Pierre N. Tariot, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the nature of effectiveness trials and the design of a landmark dementia trial and recognize variation in clinical and research practice in the treatment of dementia with psychosis and/or agitation.

## SUMMARY:

The NIMH-sponsored Clinical Antipsychotic Trial of Intervention Effectiveness–Alzheimer's Disease (CATIE-AD) is a multicenter effectiveness trial assessing multiple outcomes over nine months in 450 outpatients with AD who might benefit from atypical antipsychotics. The sequential "hybrid" design combines elements of efficacy trials with effectiveness trials to assess the comparative outcomes of risperidone, olanzapine, and quetiapine, and, at a second level, the likelihood of response to a subsequent antipsychotic or to citalopram in patients who did not respond to initial treatment. Its design takes advantage of the uncertainty principle and the concept of clinical equipoise in assessing the nonsuperiority of the intervention algorithms. In this presentation we will first describe the protocol, barriers to recruitment, intersite variability, and characteristics of the first 111 patients randomly assigned to treatment groups. The age range is 51–103 years (mean = 78); 58% are female, 58% married, 37% widowed, 76% living at home, and 21% minorities. Mean MMSE is 14. About 25% are severely, two-thirds are moderately, and the rest are mildly demented. BPRS factor scores show that 57% of patients had at least mild or moderate hostility/suspiciousness, and 50% had at least mildly to moderately severe psychosis. Our presentation highlights some of the variations in clinical practice and clinical research encountered in this trial, such as relatively brief periods of medication exposure before switching therapies.

## REFERENCES:

1. Schneider LS, Tariot PN, Lyketsos CG, et al: National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE): Alzheimer's disease trial methodology. Am J Geriatr Psychiatry 2001; 9:346–360.
2. Alexopoulos GS, Silver JM, Kahn DA, et al: The Expert Consensus Guidelines Series: Treatment of Agitation in Older Persons with Dementia [Special Report]. Post Grad Med 1998; 1/3:1–88.

## No. 66
## META-ANALYSIS OF RISPERIDONE FOR DEMENTIA: THE PRICE PAID FOR EFFICACY

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### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand how meta-analysis can better describe risperidone outcomes and issues of effectiveness in patients with dementia.

### SUMMARY:

*Objective:* Antipsychotics constitute about 30% of long-term-care prescriptions. Atypical antipsychotics, mainly risperidone, have replaced conventionals for agitated and psychotic dementia patients, an unapproved indication. We conducted an independent systematic review of risperidone in people with dementia to quantify efficacy evidence and adverse events and to estimate effectiveness.

*Methods:* Established methods were used for searching and abstracting previous studies, including unpublished presentations. Randomized, placebo-controlled, double-blind clinical trials of risperidone were selected. Intent-to-treat analyses were used; effect sizes were calculated by standard techniques.

*Results/conclusions:* Three trials were included. The 1 mg/day fixed-dose group from one was combined with the adjustable-dose groups (mean 1.1 mg/day) from the others to include a total of 981 nursing home patients. Patients had agitation or aggression; about 70% had AD and 22% had vascular dementia. Trials were 12 weeks. Risperidone had clear incremental effect over placebo for BEHAVE-AD scale change and for 30% improvement (standardized mean difference = 0.27, 95% CI = 0.13 to 0.40, rate difference = 0.07, 95% CI = 0.01 to 0.16). These modest effect sizes were mitigated significantly by noncompletion in both groups and accumulated adverse events due to risperidone. The single 2 mg/day fixed-dose comparison markedly increased adverse events, to the extent of minimizing overall effectiveness, such that it might represent an undesirable dose.

### REFERENCES:

1. Schneider LS, Pollock VE, Lyness SA: A meta-analysis of controlled trials of neuroleptic treatment in dementia. J Am Geriatr Soc 1990; 38:553–563.
2. Schneider LS, Tariot PN, Lyketsos CG, et al: National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE): Alzheimer's disease trial methodology. Am J Geriatr Psychiatry 2001; 9:346–360.

## No. 67
## SWITCHING ELDERLY CHRONIC SCHIZOPHRENIA PATIENTS TO OLANZAPINE: A PROSPECTIVE STUDY

Yoram Barak, M.D., *Department of Psychogeriatrics, Abarbanel Hospital, 15 KKL Street, Bat Yam 59100, Israel;* Eyal Z. Shamir, M.D., Ronit Weizman, M.D., Dov Aizenberg

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to evaluate the need for switching treatment of elderly, chronic schizophrenia patients to atypical antipsychotic agents.

### SUMMARY:

*Objective:* The purpose of this study was to examine whether elderly patients suffering from chronic schizophrenia or schizoaffective disorder would benefit if switched to olanzapine from other neuroleptic treatment.

*Methods:* Twenty-one hospitalized patients with a diagnosis of chronic schizophrenia or schizoaffective disorder who were being treated with neuroleptic medication were switched to olanzapine. The Positive and Negative Syndrome Scale (PANSS), Geriatric Depression Scale (GDS), and Clinical Global Impression-severity (CGI) scale were completed while patients were taking their previous medication regimen and again six months after the last patient had started taking olanzapine. Patients were evaluated by a blinded rater. The mean duration of treatment was 289 days (SD = 139, minimum = 29, maximum = 552). Three patients discontinued study participation. Mean end dose of olanzapine was 13 mg (SD = 5.7). Paired samples t tests were used to test change for PANSS positive, negative and total scales, CGI, GDS, and body weight.

*Results:* The PANSS (positive, $p = .002$; negative, $p = .003$; general, $p = .003$; and total, $p = .000$) and CGI ($p = .000$), but not the GDS ($p = .67$), demonstrated statistically significant improvement. There was no significant change in body weight ($p = .61$).

*Conclusions:* Patients with chronic schizophrenia in this study showed improvement after being switched to olanzapine. Clinically meaningful change was observed mainly in positive symptoms.

Supported by a restricted educational grant from Eli Lilly, Israel.

### REFERENCES:

1. Massand PS, Berry SL: Switching antipsychotic therapies. Ann Pharmacother 2000; 34:200–207.
2. Nemeroff CB: Dosing the antipsychotic medication olanzapine. J Clin Psychiatry 1997; 58(suppl 10): 45–49.

# SCIENTIFIC AND CLINICAL REPORT SESSION 23—THE PROMISE OF SCIENCE: THE POWER OF HEALING

## No. 68
## SERUM LIPID FRACTIONS IN CLOZAPINE-TREATED PATIENTS OVER A TWO-YEAR PERIOD

Charles F. Caley, Pharm.D, *Department of Burlingame, Institute of Living, 400 Washington Street, Hartford, CT 06106;* Stephen B. Woolley, M.P.H., John W. Goethe, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss issues related to lipid abnormalities in patients treated with clozapine.

### SUMMARY:

*Objective:* Clozapine may be associated with hypertriglyceridemia, yet total cholesterol concentrations typically change very little. No information exists regarding the potential effects clozapine may have on LDL or HDL cholesterol.

*Method:* Medical and computer records between 1999 and 2001 (three time points) were reviewed retrospectively for 91 clozapine-treated outpatients. Patient demographics, psychiatric/medical diagnoses, pharmacotherapy, weight, total/LDL/HDL cholesterol, serum triglyceride, and serum glucose data were collected.

*Results:* Patients treated with clozapine averaged 37 years old at $t_1$. During the study period, more than half of the sample had serum lipid values within normal limits. Yet, at any single time point, 36%–44% had a total cholesterol value > 200 mg/dL, 18%–26% had LDL > 130 mg/dL, 48%–58% had HDL < 40 mg/dL, and 40%–49% had triglyceride > 200 mg/dL. There was a significant association between gender and HDL concentration at each time point. No other single demographic or clinical feature distinguished patients with versus without lipid abnormalities.

*Conclusion:* As clozapine treatment progresses in a patient's care, many may not have serum lipid abnormalities. Yet a significant minority may have important deviations in one or more lipid fractions. These results support annual lipid profile monitoring for clozapine-treated patients.

## REFERENCES:

1. Gaulin BD, Markowitz JS, Caley CF, et al: Clozapine associated elevations in serum triglycerides. Am J Psychiatry 1999; 156: 1270–1272.
2. Ghaeli P, Dufresne RL: Serum triglyceride levels in patients treated with clozapine. Am J Health-Syst Pharm 1996; 53: 2079–2081.

## No. 69
## THE INFLUENCE OF GROUP PSYCHOEDUCATION ON QUALITY OF LIFE IN SCHIZOPHRENIA PATIENTS AND THEIR RELATIVES

Lucie Motlova, M.D., *3rd Medical School, Charles University, 67 Pine Lane, Los Altos, CA 94022;* Eva Dragomirecka, Ph.D., Filip Spaniel, M.D., Pavla Selepova, Richard Zalesky, M.D., Eva Goppoldova

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the importance of family psychoeducation as a part of complex therapy of schizophrenia.

## SUMMARY:

*Objective:* To investigate the influence of family psychoeducational programs on quality of life, to compare quality of life in patients and their relatives, and to compare two types of family psychoeducational programs.

*Method:* In a randomized, three-month follow-up study in the clinical department of Prague Psychiatric Center, 33 outpatients with schizophrenia and 61 relatives participated either in an eight-week parallel group program, one hour per week, or in an intensive eight-hour, one-day, nonparallel group program. The intervention focused on delivery of information about schizophrenia and on teaching effective strategies for avoiding family behaviors that predict high relapse rates. The S-QUA-LA questionnaire (Subjective Quality of Life Analysis), a self-administered questionnaire covering health status, everyday activities, social interactions, and inner reality was completed.

*Results:* The relatives had higher QOL scores (''importance'' multiplied by ''satisfaction'') in health and family domains than the patients with schizophrenia. The patients were significantly more satisfied with the physical autonomy, mental well-being, and family domains after the program. There were no significant differences between the two programs.

*Conclusions:* Family psychoeducational programs contribute to improvement in schizophrenic patients' quality of life.

Supported by grant CNS LN00B122MSMT CR from the Ministry of Education and Youth, Czech Republic, and the NIH Fogarty Program on Finance and Mental Health Services Training in the Czech Republic, School of Public Health, University of California, Berkeley (D43 TW05810-01).

## REFERENCES:

1. Zannotti M, Pringuey D: A method for quality assessment in psychiatry: the S-QUA-LA (Subjective QUAlity of Life Analysis). Quality of Life News Letter 1992; 4:6.
2. Dixon L, Adams C, Lucksted A: Update on family psychoeducation for schizophrenia. Schizophr Bull 2000; 26:5–20.

## No. 70
## HIV-RELATED STIGMA: DISCLOSURE, DEPRESSION, AND SOCIAL SUPPORT

Rachel Power, Ph.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2327, Stanford, CA 94305;* Cheryl Koopman, Ph.D., Dennis M. Israelski, M.D., Ron Duran, Ph.D., David Spiegel, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate knowledge of positive serostatus disclosure patterns among clinic patients and understand the role of psychosocial factors, such as depression and social support, in impeding or facilitating HIV status disclosure.

## SUMMARY:

*Objective:* This study describes disclosure patterns, such as decisions to reveal or withhold serostatus and experiences of regret after disclosure, among HIV-infected clinic patients. Associations of depression and social support with the disclosure variables were examined.

*Methods:* HIV-positive participants were 93 men and 63 women recruited from health clinics in Northern California. The sample was 49% Caucasian, 33% African American, 8% Latino, and 10% other or mixed ethnicity. Structured interview assessments of HIV status disclosure, demographics, depressive symptoms, and social support satisfaction were conducted.

*Results:* Overall, 40% of participants indicated indecision about disclosure, 28% desired to tell certain people they had not yet told, 31% planned never to tell certain people, and 21% regretted having told someone. Participants who experienced regret after disclosure reported significantly greater depressive symptoms ($p < .01$). Furthermore, participants reporting greater social support satisfaction disclosed to significantly more people ($p < .001$).

*Conclusions:* Results suggest that feeling stigmatized after disclosure may be linked to greater depression. Also, these findings indicate that positive social support may ease some of the difficulties associated with disclosure. Counseling interventions that facilitate positive disclosure outcomes while minimizing stigma and discrimination are recommended.

Funding provided by NIMH grant MH-54930 and a San Mateo Medical Center postdoctoral training grant.

## REFERENCES:

1. Niccolai LM, Dorst D, Myers L, et al: Disclosure of HIV status to sexual partners: predictors and temporal patterns. Sex Transm Dis 1999; 26:281–285.
2. Serovich JM, Brucker PS, Kimberly JA: Barriers to social support for persons living with HIV/AIDS. AIDS Care 2000; 12:651–662.

# SCIENTIFIC AND CLINICAL REPORT SESSION 24—TOPICS IN SUICIDE AND VIOLENCE

## No. 71
## IMPULSIVITY, SUICIDE, AND PREFRONTAL HYPOMETABOLISM IN BORDERLINE PERSONALITY

Paul H. Soloff, M.D., *Department of Psychiatry, University of Pittsburgh/WPIC, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Carolyn Meltzer, M.D., Carl Becker, B.A., Phil J. Greer, M.A., Thomas M. Kelly, Ph.D., Doreen Constantine, M.Ed.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the role of impulsivity and its neurobiology in the behavioral and affective dysregulation of patients with BPD.

## SUMMARY:

*Objective:* Impulsivity is a heritable trait of temperament and a clinical risk factor for suicidal behavior across diagnostic categories. Among violent criminal offenders, murderers, and aggressive psychiatric patients, impulsivity has been associated with hypoperfusion and decreased glucose uptake in areas of the prefrontal, frontal, and temporal cortexes. Impulsivity is also a core clinical characteristic of BPD, a disorder defined, in part, by both impulsive-aggressive and suicidal behaviors. We examined impulsive, nondepressed BPD subjects with histories of suicidal behavior or self-injury to look for abnormalities in cortical glucose metabolism in areas associated with regulation of mood and impulse.

*Method:* Structured interviews, including the SCID, IPDE, DIB, and suicide and aggression histories were used to select 13 nondepressed female BPD subjects with histories of suicidal behavior or self-injury and nine healthy female comparison subjects for [$F^{18}$] FDG PET neuroimaging studies. Impulsivity and impulsive-aggression were assessed by using the Barratt Impulsiveness Scale and the Brown Goodwin LHA; depressed mood by using the Ham-D-24. PET data were analyzed by using SPM-99, with Ham-D-24 scores as covariates.

*Results:* Significant reductions in FDG uptake were found in BPD subjects relative to comparison subjects in medial orbital frontal cortex bilaterally (BA 9, 10, 11). There were no significant areas of increased uptake in BPD subjects relative to comparison subjects.

*Conclusion:* Behavioral and affective dysregulation in BPD, including the diathesis to impulsive-aggression, suicidal behavior, and self-injury, may be due in part to the neurobiology of impulsivity in the PFC.

Supported by NIMH grant MH-48463 and NIH CRC grant MO1RR00056.

## REFERENCES:

1. Mann JJ, Waternaux C, Haas GL, et al: Toward a clinical model of suicidal behavior in psychiatric patients. Am J Psychiatry 1999; 156:181–189.
2. Soloff PH, Meltzer CC, Greer PJ, et al: A fenfluramine-activated FDG-PET study of borderline personality disorder. Biol Psychiatry 2000; 47:540–547.

## No. 72
## SUICIDE RATES OVER THE DECADE ACROSS CIVILIAN AND MILITARY POPULATIONS

Karen M. Eaton, M.S., *Department of Psychiatry, Walter Reed, 503 Robert Grant Avenue, Silver Spring, MD 20910-7500;* Charles W. Hoge, M.D., Stephen C. Messer, Ph.D., Abigail L. Garvey-Wilson, M.D., Sandra E. Lesikar, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that suicide rates in the U.S. military are significantly lower than in the civilian population and the importance of making systematic demographic adjustments to suicide rates to more accurately examine differences in suicide rates between service branches.

## SUMMARY:

*Objective:* Population-based studies of suicide among young employed adults are rare. This study utilized data from the active-duty U.S. military population to examine patterns and correlates of suicide in a young working group. The purpose of this study was to compare the suicide rate among military personnel with that in the U.S. general population, as well as across service branches, by using systematic demographic rate adjustment.

*Method:* Suicide rates were computed for military personnel (ages 17–64) for 1990–2000 by using the Defense Medical Surveillance System. Military rates were compared to U.S. civilian population rates by using the 2000 census as the standard population for direct rate adjustments by age, gender, and race.

*Results:* The crude rates between military service branches ranged from 10.47 to 13.38 (per 100,000). After adjustment, rates decreased, ranging from 6.33 to 9.07. The adjusted suicide rate for the total military population (8.13, 95% CI = 7.78 to 8.48) was significantly lower than the civilian population rate (12.31, 95% CI = 12.15 to 12.47). Suicide rates after adjustment were comparable across the service branches.

*Conclusions:* This population-based study examined suicide rates among young workers, an understudied segment of the population. Adjusted U.S. military rates were comparable across service branches and overall were lower than civilian rates.

## REFERENCES:

1. Cassinatis EG, Rothberg JM: Suicide in the United States military, in Suicide: Biopsychosocial Approaches. Edited by Botsis AJ, Soldatos CR, Stefanis CN. Amsterdam, Elsevier Science, 1997, pp 23–32.
2. Helmkamp JC: Suicides in the military: 1980–1992. Mil Med 1995; 160:45–50.

## No. 73
## CLOZAPINE REDUCES VIOLENT BEHAVIOR IN HETEROGENEOUS DIAGNOSTIC GROUPS

John E. Kraus, Jr., M.D., *Department of Psychiatry, Dorothea Dix Hospital, 3601 Mail Service Center, Raleigh, NC 27699-3601;* Brian B. Sheitman, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize characteristics of persistently violent patients and recognize the role for clozapine in the treatment of persistently violent patients.

## SUMMARY:

*Objective:* Violent behavior is a significant problem in the psychiatric hospital setting. Persistently violent patients often require seclusion and/or restraints and typically receive high doses of medication and polypharmacy. Clozapine has been found to be effective in reducing aggression in patients with psychosis. Thus, we examined the effects of clozapine in a heterogeneous group of persistently violent patients.

*Method:* Consecutive hospital incident reports over five months (N = 419) were reviewed to identify perpertrators of multiple episodes of violent behavior. Data on the type of violent behavior, hospital location, and diagnoses of the perpetrator were collected. A chart review of the effect of clozapine in persistently violent patients was performed. Changes in the number of violent episodes and the need for seclusion and restraint were assessed for a three-month period before and after use of clozapine.

*Results:* Less than 2% of all patients treated during this time period were responsible for 56% of all violent episodes. The rates of violence differed significantly among the hospital units, with the highest rates in the female acute and long-term units and the deaf unit. More than half of the persistently violent patients had a primary diagnosis of a neurological or personality disorder. Clozapine treatment resulted in marked decreases both in violent episodes and in the use of seclusion and restraint.

*Conclusions:* Our data support earlier studies demonstrating that a small number of patients are responsible for the majority of violent episodes in a hospital setting and that high rates of neurological deficits and personality disorder are diagnosed in this group. These data suggest a role for clozapine in the treatment of persistently violent patients irrespective of DSM-IV diagnosis.


## REFERENCES:

1. Owen C, Tarantello C, Jones M, et al: Repetively violent patients in psychiatric units. Psychiatr Serv 1998; 49:1458–1461.
2. Chengappa KNR, Vasile J, Levine J, et al: Clozapine: its impact on aggressive behavior among patients in a state psychiatric hospital. Schizophr Res 2002; 53:1–6.


# SCIENTIFIC AND CLINICAL REPORT SESSION 25—ISSUES IN PSYCHIATRY

## No. 74
## CHILDREN EXCLUDED FROM PRIMARY SCHOOL: RANDOMIZED, CONTROLLED TRIAL OF A TEAM INTERVENTION

Christos Panayiotopoulos, Ph.D., *Department of Psychiatry & Behavioral Sci., University of Manchester, Oxford Road, M13 9PI, Manchester, United Kingdom;* Michael J. Kerfoot, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be familiar with the psychosocial features of school exclusion at individual, family, and institutional levels and should be knowledgable about the different components of multidisciplinary team intervention, its advantages and limitations, and its short-term and long-term outcome potential.

## SUMMARY:

*Objective:* To establish whether a new intensive multidisciplinary team intervention for pupils excluded from primary school because of disruptive/antisocial behavior reduced the number of excluded days and emotional and behavioral difficulties.

*Method:* One hundred twenty-four pupils, aged 4–12 years old, excluded from school for a fixed or permanent period, were randomly allocated to standard care (N = 62) or standard care plus the intervention (N = 62). The intervention included a range of treatments such as parent management training, CBT, brief family intervention, play therapy, and support and advice to the schools. The standard care received either no visits or a variety of services offered locally. Both groups were assessed at recruitment, and then at three and six months. Primary outcomes were the number of excluded days pupils received within the trial and secondary outcomes examined broader aspects of the child's behavior at home and school and parental stress.

*Results:* There were no significant differences in the primary outcomes between the two groups at either of the outcome assessments. Parents in the intervention group were more satisfied with the treatment ($p < .000$, mean difference = 2.66, 9.5%CI = 1.6 to 3.6). The intervention group, without the noncompliance cases did significantly better ($p < .014$, mean difference = −7.15, 95%CI = −12.8 to −1.4).

*Conclusions:* The intervention reduced the number of excluded days and emotional symptoms for pupils engaged in the intervention, although children excluded from primary schools have longstanding problems that need a long-term, rather than a short-term, intervention.

Funding provided by the Department of Health (U.K.).


## REFERENCES:

1. Angold A, Messer SC, Stangl D, et al: Perceived parental burden and service use for child and adolescent psychiatric disorders. Am J Public Health 1998; 88:75–80.
2. Gowers SG, Harrington RC, Whilton A, et al: Brief Scale for Measuring the Outcomes of emotional and behavioral disorders in children: Health of the nation Outcome Scales for Children and Adolescents (HoNOSCA). Br J of Psychiatry 1999; 174:413–416.


## No. 75
## MALPRACTICE LIABILITY AND MANAGED CARE: IS A RESOLUTION IN SIGHT?

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 a more effective defense should a 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 that denied or limited treatment. Several lines of approach to liability in physician/insurer/patient relationships have been considered by the courts, often following principles applicable to hospital situations. Federal ERISA law preempting state laws in managed care further complicated the legal situation and increased physician risk. Public anger over perceived injustices have led many states to legislate allocation of responsibility for malpractice, and modification of ERISA by Congress is pending. Federal courts have begun to review ERISA provisions and to decide precedent-setting cases. This paper summarizes applicable law and reviews the most recent changes in this rapidly evolving field.


## REFERENCES:

1. Lowenkopf EL, Rychik A: Malpractice liability and managed care. Directions in Psychiatry 2000; 20:45–54.
2. Mariner M: Liability for managed care decisions: the Employment Retirement Income Security Act (ERISA) and the uneven playing field. Am J Public Health 1996; 86:863–869.


## No. 76
## THE POWER OF HUMOR IN PSYCHOTHERAPY

William F. Fry, Jr., M.D., *Department of Psychiatry, Stanford University Emeritus, 156 Grove Street, Nevada City, CA 95959-2602*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to assist therapists in making effective use of humor in their professional work and in avoiding detrimental effects of the power of humor.

## SUMMARY:

It is my observation, from the combined perspective of 50 years of clinical psychiatric practice and 50 years of scientific study of humor, that viewpoints regarding the roles of humor in psychotherapy have undergone significant revision during the past 25 years. During the enigmatic year 1971, two articles were published in the *American Journal of Psychiatry* regarding the use of humor in psychotherapy.

One, published in January, was titled "The Destructive Potential of Humor in Psychotherapy" (Lawrence Kubie). The other, published in November, was titled "The Place of Humor in Psychotherapy" (Warren Poland). Books and articles published since 1971 have mainly presented the position that humor is valuable in developing rapport and insight during psychotherapy. Utilizing humor in psychotherapy has become recommended because of its effectiveness in attaining objectives in these two vital areas. Also, clarification of objectives and therapeutic advice is assisted by using humor judiciously. With regard to this factor of prudence in using humor during psychotherapy, Kubie's admonition about the difference between laughing *with* the patient and laughing *at* the patient remains of great importance.

## REFERENCES:

1. Fry WF, Salaneh W, eds. Advances in Humor and Psychotherapy. Sarasota, FL, Professional Resources Press, 1993.
2. Buxman K, LeMoine A, eds. Nursing Perspectives on Humor. Staten Island, NY, Power Publications, 1995.

# SCIENTIFIC AND CLINICAL REPORT SESSION 26—PSYCHOPHARMACOLOGY OF HEADACHE AND ANXIETY DISORDERS

## No. 77
## CLINICAL EXPERIMENTS WITH SERTRALINE IN PANIC DISORDER

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 recognize (1) the differential effects between imipramine and sertraline treatment completers, (2) the differential outcome between sertraline as first treatment versus next-step switch strategy in panic disorder.

## SUMMARY:

*Objective:* Two questions relating to the management of panic disorder with antidepressants were explored: (1) Are there different patterns of improvement and of change in side effects between sertraline and imipramine treatment completers? (2) Is the efficacy of sertraline different as a switch treatment strategy in imipramine failures than as first treatment?

*Method:* Sixty-two patients with panic disorder with agoraphobia were treated: 51 patients with imipramine (141 ± 40 mg/d), 11 patients with sertraline initially (primary group) (70 ± 25 mg/d), and 11 patients switched from imipramine to sertraline (transfer group) (68 ± 25 mg/d). Similar procedures were used in these 24-week trials, with major outcome assessed at baseline and weeks 8, 16, and 24, and side effects assessed more frequently. There were no concurrent behavioral interventions. Written consent was obtained. Treatment was free.

*Results:* Repeated measures ANOVA revealed greater early improvement with imipramine than sertraline but no enduring differences between treatments beyond week 8. The side effects burden was significantly greater during imipramine treatment but clinically insignificant at the end of the treatment, except for a 10-bpm increase in heart rate. Change in sexual dysfunction and weight did not differ between the two treatments. Hierarchical linear modeling revealed that the sertraline primary group increased end-state functioning (range: 0–7) faster than the sertraline switch-treatment group by 0.098 units per week ($p < .01$).

*Conclusion:* Newer antidepressants that have dual serotonergic and noradrenergic action and that are better tolerated than traditional tricyclics may be optimal treatments for panic disorder. The decrease in efficacy of sertraline as next-step treatment is concordant with clinical intuition but contrary to findings in depression.

Supported in part by NIMH grant MH-42730 and an unrestricted grant from Pfizer.

## REFERENCES:

1. Mavissakalian MR: Switching from imipramine to sertraline in panic disorder. Paper presented at the annual meeting of the American Psychiatric Association, Philadelphia, May 18–23, 2002.
2. Thase ME, Rush AJ, Howland RH, et al: Double-blind switch study of imipramine or sertraline treatment of antidepressant-resistant chronic depression. Arch Gen Psychiatry 2002; 59: 233–239.

## No. 78
## DOUBLE-BLIND ORAL MORPHINE IN TREATMENT-RESISTANT OCD

Lorrin M. Koran, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, OCD Clinic #2363, Stanford, CA 94305-5721;* Kim D. Bullock, M.D., Bettina E. Franz, M.D., Nona Gamel, M.S.W., Michael A. Elliott, M.A.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss safety and effectiveness of intermittent oral morphine in treatment-resistant OCD and potential mechanisms of action.

## SUMMARY:

*Objective:* Between 20% and 40% of OCD patients do not benefit from serotonin reuptake inhibitors (SRIs). Open-label trials in such patients have reported response to oral morphine and tramadol. This study tested the hypothesis that once-weekly oral morphine is beneficial.

*Method:* We recruited subjects who had had OCD for ≥ three years, ≥ two failed adequate SRI trials, and Y-BOCS scores ≥ 21. Current medications were continued. In a randomized, crossover, double-blind design, subjects received two-week blocks of morphine sulfate, lorazepam, and placebo. Week two dose was increased, decreased, or maintained, depending on response and side effects.

*Results:* The 18 subjects had failed three to six adequate SRI trials. The median screening Y-BOCS score was 27.5. The median Y-BOCS score decrease after patients' highest morphine dose was 13%. Four subjects' scores decreased > 40%, and two > 25%. The median Y-BOCS score decrease after the highest lorazepam dose was 6%; two scores decreased ≥ 25%. After placebo, no Y-BOCS score decreased ≥ 25%. A Friedman two-way ANOVA was significant ($p = .01$); Wilcoxon matched-pairs signed-ranks test was significant for morphine versus placebo ($p = .005$) but not for lorazepam versus placebo. Several morphine responders maintained response without exhibiting tolerance, euphoria, or drug seeking.

*Conclusions:* Once-weekly oral morphine appears safe and substantially ameliorates OCD symptoms in some patients. Further research is indicated.

## REFERENCES:

1. Warneke L: A possible new treatment approach to obsessive-compulsive disorder. Canad J Psychiatry 1997; 42:667–668.
2. Jolas T, Nestler EJ, Aghajanian GK: Chronic morphine increases GABA tone on serotonergic neurons of the dorsal raphe nucleus: association with an up-regulation of the cyclic AMP pathway. Neurosci 2000; 95:433–443.

No. 79
## TREATMENT OF TENSION HEADACHE WITH MIRTAZAPINE

Isin B. Kulaksizoglu, M.D., *Atakoy 11 Kisim Zambak #D14, Istanbul, Turkey;* Sibel Gakir, M.D., Mustafa Ertas

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that mirtazapine may be efficacious in the treatment of tension-type headache comorbid with depression.

### SUMMARY:

*Objective:* Mirtazapine is a novel antidepressant, different from all other currently available antidepressants. It enhances noradrenergic and serotonergic neurotransmission via blockade of $\alpha$-adrenoceptors. The effect of mirtazapine on tension headache in depressed patients was examined.

*Methods:* We recruited 26 outpatients of both sexes, older than 18 years with DSM-IV major depressive disorder (HAM-D-17 $\geq$ 14) and tension-type headache. The Hamilton Depression Rating Scale (HAM-D-17) and the Clinical Global Impression Scale (CGI) were used to assess efficacy in the baseline, first, fourth, and sixth weeks. Mirtazapine was used in flexible dosing between 15 and 45 mg/day. Tolerability was assessed by registering treatment-emergent adverse events. Headache was assessed with WASS.

*Results:* Twenty-three patients were women, and 21 were married. Mean age was 38 years. Significant reduction overall in the CGI-S was seen as early as week one (baseline to fourth week: 21.8 $\pm$ 5.13 to 10.34 $\pm$ 8.28 [$p < .001$]; baseline to sixth week: 21.8 $\pm$ 5.13 to 7.23 $\pm$ 7.35 [$p = .003$]). Significant reduction overall in the HAM-D-17 total scores was seen as early as week one (baseline to first week: 4.72 $\pm$ 0.06 to 3.65 $\pm$ 0.06 [$p < .001$]; baseline to sixth week: 2.50 $\pm$ 0.04 to 1.62 $\pm$ 0.04 [$p = .165$]). Significant reduction in headache was found (baseline to sixth week: 5.84 $\pm$ 1.98 to 2.61 $\pm$ 2.08 [$p < .001$]). Only one patient could not complete the treatment period because of untolerated adverse effects. The two most frequently reported adverse events were sedation and weight gain/increased appetite.

*Conclusion:* Mirtazapine is an effective and well-tolerated treatment for tension-type headache comorbid with depression. The involvement of serotonin and noradrenaline in headaches would support treatment with antidepressants that work on either of these neurotransmitters. Mirtazapine has both noradrenergic and serotonergic activity. By acting as a 5-HT$^3$ antagonist, it relieves headache. Additional research is needed.

### REFERENCES:

1. DeBoer T: The pharmacologic pofile of mirtazapine. J Clin Psychiatry 1996; 57(suppl 4):19–25.
2. Brannon GE: Use of mirtazapine as prophylactic treatment for migraine headache. Psychosomatics 2000; 41:153–154.

# SCIENTIFIC AND CLINICAL REPORT SESSION 27—INTERNATIONAL PSYCHIATRY

No. 80
## EXCESS MORTALITY IN SCHIZOPHRENIA IN STOCKHOLM COUNTY, SWEDEN

Massimo di Giannantonio, M.D., *Department of Psychiatry, University of Ehieti, Via Dei Vestini #5, Ehieti 66100, Italy;* Nestor Correia, Lena Brandt, B.S.C., Anders Ekbom, M.D., Par Sparen, Ph.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to differentiate schizophrenia patients with increased suicide risk from patients with increased risk for cardiovascular death.

### SUMMARY:

*Objective:* The aim of the study was to assess mortality outcome in schizophrenia, as well as time trends for schizophrenia mortality, in Stockholm County, with a population of 1.8 million.

*Method:* All patients with schizophrenia between 1973 and 1995 in Stockholm County (3,929 men and 3,855 women) were followed up in the cause-of-death register from their first hospital diagnosis of schizophrenia. Standardized mortality ratios (SMRs) in five-year age and calendar-time classes, as well as the number of excess deaths and time trends for SMRs, were calculated.

*Results:* SMRs for all causes of death were 2.8 for men and 2.4 for women. For cardiovascular deaths, SMRs were 2.3 and 2.1, respectively. SMRs for suicide were 15.7 and 19.7. Most excess deaths were due to natural causes of death. Suicide was most increased in young patients and in the first years after the first diagnosis. SMRs for all causes of death were increased 1.7-fold in men and 1.3-fold in women, with cardiovascular death increased 4.7-fold and 2.7-fold, respectively.

*Conclusion:* For schizophrenia patients followed up from their first diagnosis, mortality ratios were higher than in cross-sectional mortality studies. Rising mortality trends indicate that schizophrenia patients have not shared in the improvements in health that benefit the general population.

Funding provided by the Stockholm County Council.

### REFERENCES:

1. Ösby U, Correia N, Brandt L, et al: Mortality and causes of death in schizophrenia in Stockholm County, Sweden. Schizophr Res 2000; 45:21–28.
2. Ösby U, Correia N, Brandt L, et al: Time trends in schizophrenia mortality in Stockholm County, Sweden: cohort study. BMJ 2000; 321:483–484.

No. 81
## SEX DIFFERENCES IN HEALTH SERVICE USE AND FUNCTIONING ASSOCIATED WITH DEPRESSIVE SYMPTOMS: FINDINGS FROM THE UTRECHT HEALTH PROJECT

Mirjam I. Geerlings, Ph.D., *Julius Center, University Medical Center Utrecht, P.O. Box 85500, Room D01 335, Utrecht 3508GA, Netherlands;* Huib Burger, Ph.D., Johan M. Havenaar, M.D., Mattijs E. Numans, M.D., Diederick E. Grobbee, Ph.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that the consequences of depression may be more severe in men, although women more often have depression.

### SUMMARY:

*Objective:* To examine sex differences in health service use and functional limitations associated with depressive symptoms as measured with the SCL-90 depression subscale.

*Method:* A population-based cohort study was conducted in a geographically defined suburban residential area near Utrecht, the Netherlands (the Utrecht Health Project). Participants were 930 women and 757 men, 18 years or older, with mean age of 40 years (response rate = 74%). Service use was estimated from contacts with general practitioners within the last two months, visits to a medical specialist within the last two months, and use of prescribed medication within the last three months. Limitations in role, social, and physical functioning were defined as any health-related interference

in work activities; in social activities; and in sports or walking, climbing stairs, etc., respectively.

*Results:* Women had a higher median depression score than men (19 versus 17; $p < .001$). Women reported more frequent service use and more limitations in role, social, and physical functioning. Adjusted for age, employment status, and number of somatic illnesses, higher depression scores were associated with visits to a medical specialist in men (odds ratio = 1.04, 95% CI = 1.00 to 10.7), but not in women. In men, higher depression scores were more strongly associated with limitations in role (OR = 1.22, 95% CI = 1.17 to 1.28), social (OR = 1.18, 95% CI = 1.11 to 1.24), and physical functioning (OR = 1.08, 95% CI = 1.03 to 1.13) than in women (OR = 1.14, 95% CI = 1.11 to 1.17; OR = 1.10, 95% CI = 1.07 to 1.14; and OR = 1.04, 95% CI = 1.01 to 1.07, respectively). No sex differences were observed in GP contact or medication use.

*Conclusion:* Depressive symptoms, health service use, and functional limitations are more common in women. However, if depressive symptoms are present, the consequences may be more severe in men.

Funding provided by the Dutch Ministry of Health, Dutch Medical Research Council.

## REFERENCES:

1. Wells KB, et al: The functioning and well-being of depressed patients: results from the Medical Outcomes Study. JAMA 1989; 262:914–919.
2. Kessler RC, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Arch Gen Psychiatry 1994; 51:8–19.

## No. 82
## BINGE EATING DISORDER IN FIJI, A SMALL-SCALE, INDIGENOUS SOCIETY

Anne E. Becker, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-725, Boston, MA 02114;* Rebecca A. Burwell, M.Phil., Kesaia Navara, Stephen E. Gilman, Sc.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) describe the prevalence and correlates of binge-eating among Fijian women and (2) understand the effects of social transition and acculturation on binge-eating symptoms in another cultural context.

## SUMMARY:

*Objective:* Little is known about the prevalence of binge-eating cross-culturally. Moreover, there have been no published studies exploring binge-eating disorder in small-scale, indigenous societies. The current study investigated the prevalence and correlates of binge-eating in a community sample of Fijian women.

*Method:* Fifty ethnic Fijian women completed a self-report measure on dieting and attitudes toward body shape and the QEWP-R; height and weight were also measured. The patterns of dieting, high BMI, and attitudes toward eating and body image were compared among women with and without a history of binge-eating.

*Results:* Ten percent of the respondents reported at least weekly binge-eating during the past six months, and 4% endorsed symptoms consistent with binge-eating disorder. Binge-eating in this sample was significantly associated with a reported history of BMI > 35, history of dieting, and higher concern with body shape. Binge-eating was not associated with several markers of acculturation in this sample, although it was associated with some nontraditional Fijian attitudes toward the body.

*Conclusions:* Binge-eating appears to occur in a social context with traditions concerning weight and diet widely disparate from Western populations; however, correlates of binge-eating in this sample suggest acculturated attitudes toward weight and body shape play a contributory role.

## REFERENCES:

1. Becker AE, Burwell RA, Gilman SE, et al: Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls. Br J Psychiatry 2002; 180:509–514.
2. Fairburn CG, Doll HA, Welch SL, et al: Risk factors for binge eating disorder: a community-based, case control study. Arch Gen Psychiatry 1998; 55:425–432.

# SCIENTIFIC AND CLINICAL REPORT SESSION 28—CROSS-CULTURAL AND MINORITY ISSUES

## No. 83
## PREDICTORS OF FIRST DEPRESSIVE EPISODE IN BLACK AND WHITE WOMEN IN MIDLIFE

Joyce T. Bromberger, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, WPIC, Pittsburgh, PA 15213;* Howard M. Kravitz, D.O., Hsiao-Lan Wei, M.S., Karen A. Matthews, Ph.D., Charlotte Brown, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants will have increased their understanding of risk factors for a first lifetime depressive episode during midlife in women.

## SUMMARY:

*Objective:* To examine predictors of first lifetime episode of depression in a cohort of midlife women participating in the Study of Women's Health Across the Nation (SWAN).

*Methods:* The Structured Clinical Interview for DSM-IV (SCID-IV) was conducted at baseline and annually with 443 African American and white women, age 42–52 years. Among the 196 women without a history of major depression or depression not otherwise specified (DNOS) and at least three follow-up assessments, we compared baseline demographic, psychosocial, and health characteristics of those with and without onset of DSM-IV major depressive episode (MDE) or DNOS during four years of follow-up using chi-square and t tests.

*Results:* Forty-six (23%) women met criteria during follow-up for either MDE or DNOS; 22 had MDE. Rates of episodes were higher among African Americans than whites (30% versus 19%, $p = .08$). Baseline predictors of episodes included higher BMI ($p = .02$), a very upsetting chronic problem ($p = .005$), CES-D $\geq 16$ ($p < .004$), more body pain ($p = .03$), poor role functioning due to physical or emotional problems (ps = .002 and $p = .04$, respectively), poor social functioning ($p = .01$), more frequent mood symptoms ($p = .002$), higher trait anxiety ($p = .004$), greater cynicism ($p = .09$), and higher somatic sensitivity ($p = .02$).

*Conclusions:* Data suggest that African American women are at greater risk than white women for an incident depressive episode during midlife. In addition to subsyndromal mood symptoms, predictors of an episode included at least one chronic stressor, poor role functioning, personality traits such as anxiety and cynicism, and somatic sensitivity. This study contributes to the limited literature on risk factors for incident depression, particularly among minority women.

Funding provided by the National Institute on Aging and NIMH.

REFERENCES:

1. Bruce ML, Hoff RA: Social and physical health risk factors for first-onset major depressive disorder in a community sample. Soc Psychiatry Psychiatr Epidemiol 1994; 29:165–171.
2. Kessler RC, McGonagle KA, Nelson CB, et al: Sex and depression in the National Comorbidity Survey, II: cohort effects. J Affective Disorders 1994; 30:15–26.

## No. 84
## WHEN THE POETRY NO LONGER RHYMES: SOMALIS IN THE AMERICAN PSYCHIATRIC CLINIC

Deborah L. Scuglik, M.D., *2423 Meadow Hills Drive SW, Rochester, MN 55902;* Mark D. Williams, M.D., Kathleen Logan, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) understand the unique needs and acculturation patterns of immigrant Somalis, (2) increase awareness of the impact Somali culture can have on psychiatric care, and (3) acquire awareness of possible countertransference issues and how these may influence psychiatric care.

### SUMMARY:

*Objective:* To determine the cultural characteristics and psychiatric needs of immigrant Somalis and identify cultural differences between American caregivers and Somali patients and the resultant dynamics/barriers to care.

*Methods:* Demographic data from the Minnesota Departments of Human Services and Children, Families, and Learning for the past ten years were reviewed. Health professionals and psychiatrists in a tertiary care center were surveyed. Employers, counselors, teachers, community health caregivers, and Somali participants in three communities were individually interviewed regarding their perceptions of medical/psychiatric needs, cultural characteristics, barriers to care, and suggested solutions.

*Results:* Primary obstacles to care included language difficulties, caregivers' cultural misperceptions, noncompliance, alternative time concept, and limited resources. Psychiatric problems are rarely acknowledged by Somali individuals or their families and are traditionally treated with "healers," exorcism, or family support. This stressed population has experienced deterioration of traditional family systems, resulting in increased psychiatric needs unresponsive to traditional approaches. Emergence of a triad of PTSD, depression, and anxiety, labeled "puffis" by the Somalis, may be a new culture-bound syndrome.

*Conclusions:* This high-risk, growing population with unique psychiatric needs presents a challenge to psychiatric caregivers. Recommendations include using the family system with "bargaining" to improve compliance, establishing community education addressing acculturation issues, and reviewing cultural etiquette for interviewing.

### REFERENCES:

1. Okpaku SO: Clinical Methods in Transcultural Psychiatry. Washington, DC, American Psychiatric Press, 1993.
2. Guarnaccia PJ: Research on culture-bound syndromes: new directions. Am J Psychiatry, 1999; 156:1322–1327.

## No. 85
## EFFECTIVENESS AND TOLERABILITY OF NEWER ANTIDEPRESSANTS AMONG DEPRESSED CHINESE-AMERICAN PATIENTS

Albert Yeung, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Standiford Street, Suite 401, Boston, MA 02114;* Nicoletta Clementi-Craven, M.D., David Mischoulon, M.D., Jonathan E. Alpert, M.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D., Jessica L. Murakami, B.A.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the effectiveness and adverse events of newer antidepressants in the treatment of depressed Chinese Americans and predictors of treatment nonresponse.

### SUMMARY:

*Objective:* To investigate the effectiveness and tolerability of newer antidepressants for treating depressed Chinese Americans.

*Method:* Subjects were Chinese Americans treated at the South Cove Community Health Center in Boston for DSM-IV major depressive disorder. The treating psychiatrist selected one of the newer antidepressants and adjusted its dose for each patient based on clinical judgment. Subjects were followed for 12 weeks. The psychiatrist rated subjects with the 17-item HAM-D, monitored medication compliance, and recorded adverse events using the Somatic Symptoms Scale. Response was defined as 50% or greater reduction of baseline HAM-D total score at the end of treatment, and remission as HAM-D total score $\leq 7$.

*Results:* Forty-five depressed Chinese Americans were enrolled in the study (67% were female, mean age = 55 $\pm$ 16 years) and were treated with newer antidepressants, including fluoxetine (N = 8), paroxetine (N = 12), sertraline (N = 5), citalopram (N = 6), mirtzapine (N = 13), and venlafaxine (N = 1). After 12 weeks, the response and remission rates were 58% and 29%, respectively. Nonresponders had a higher rate of noncompliance with treatment ($p = .08$). The most common adverse events were dry mouth (56%), daytime sleepiness (38%), nausea (36%), and fatigue (29%).

*Conclusion:* Newer antidepressants are effective and well tolerated by depressed Chinese Americans. Lack of compliance may contribute to nonresponse to treatment.

### REFERENCES:

1. Ruiz P (ed): Ethnicity and Psychopharmacology (Review of Psychiatry Series, Vol 19, No 4; Oldham JO, Riba MB, series eds.) Washington, DC, American Psychiatric Press, 2000.
2. Lin KM, Poland RE, Nakasaki G (eds): Psychopharmacology and Psychobiology of Ethnicity. Washington, DC, American Psychiatric Press, 1993.

# SCIENTIFIC AND CLINICAL REPORT SESSION 29—SECONDARY OUTCOMES IN ADHD

## No. 86
## CONSISTENCY OF ADHD PARENT/TEACHER SYMPTOM REPORTS: RESULTS OF OROS MPH STUDIES

Stephen V. Faraone, Ph.D., *Department of Pediatric Psychopharmacology, Harvard Medical School, 4F South Main Street, #301 West Bridgewater, MA 02379*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the need for both teacher and parent reports in assessing the degree of ADHD symptoms before and during treatment.

## SUMMARY:

*Objective:* To determine consistency of ADHD symptom reporting between parents and teachers.

*Methods:* Data from two studies were analyzed: a 28-day efficacy study in ADHD children (6–12 years, N = 206) randomly assigned to receive placebo, IR methylphenidate t.i.d., or once-daily methylphenidate (OROS MPH); and a one-year, open-label study in ADHD children (6–13 years, N = 407) receiving once-daily methylphenidate. Efficacy measures included parent/caregiver and schoolteacher ratings using IOWA Conners I/O (inattention/overactivity) and O/D (oppositionality/defiance) scales.

*Results:* Diagnostic efficiency of parent reports of positive change in I/O and O/D scores was a positive predictor of teacher assessment (one-year study): where parents reported a positive change in ADHD symptoms, there was a high likelihood (88%) that teachers would also report a positive change. Negative predictive power was low (38%): parents reporting no positive change agreed with teachers less than half the time. Both studies showed modest parent/teacher agreement for absolute Conners ratings (I/O and O/D). Both parent and teacher ratings suggested that once-daily methylphenidate was superior to placebo.

*Conclusion:* For researchers, these data suggest that parent and teacher ratings lead to similar conclusions from clinical trials of long-acting medications for ADHD. Thus, the cost/benefit ratio for obtaining teacher reports should be considered when designing such trials. For clinicians, it is useful that a report of positive change by the parent is highly likely to predict a similar teacher report.


Supported by McNeil Consumer & Speciality Pharmaceuticals.

## REFERENCES:


1. Gabbard GO: Treatment of Psychiatric Disorders. Washington DC, American Psychiatric Press, 2001.
2. Biederman J, Faraone SV, Milberger S, et al: Diagnosis of attention deficit hyperactivity disorder from parent reports predicts diagnosis based on teacher reports. J Am Acad Child Adolesc Psychiatry 1993; 32:315–317.


## No. 87
## PATIENT AND PARENT SATISFACTION WITH ONCE-DAILY OROS MPH FORMULATION FOR ADHD

Mark A. Stein, Ph.D., *Child National Medical Center, 111 Michigan Avenue N.W., Washington, DC 20010-2970*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate that once-daily methylphenidate (OROS MPH) may be an effective and well-tolerated treatment for adolescents and adults with ADHD in a community setting.


## SUMMARY:

*Objective:* To evaluate the effectiveness of once-daily methylphenidate (OROS MPH) for the treatment of ADHD in adolescents and adults in a community setting.

*Methods:* Subjects were 264 adolescents (13–17 years) and 136 adults (≥18 years) enrolled in this open-label, nonrandomized, nine-month study. Global assessments of treatment (GAT) effectiveness were completed at three, six, and nine months by parents/caregivers (for patients <18 years), adult patients (≥18 years), and investigators. A satisfaction questionnaire was completed at three months by parents/caregivers (patients <18 years). Safety was also assessed.

*Results:* Both parent/caregiver and investigator GAT ratings improved from baseline to nine months. Parent/caregiver or patient ratings of good/excellent at nine months were 90.7% (adolescents) and 89.3% (adults); investigator ratings of good/excellent at nine months were 90.8% (adolescents) and 90.5% (adults). A total of 87.3% of the adolescent's parent/caregivers were satisfied, very satisfied, or extremely satisfied with once-daily methylphenidate. More than 75% of parents/caregivers preferred once-daily methylphenidate to the previous medication; reasons included increased convenience, longer duration of effect, and improved consistency and smoothness of effect. Once-daily methylphenidate was well tolerated.

*Conclusions:* Once-daily methylphenidate is an effective treatment for ADHD in adolescents and adults in community settings.


Supported by McNeil Consumer & Speciality Pharmaceuticals.

## REFERENCES:


1. Pelham WE, Gnagy EM, Burrows-Maclean I, 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 W, et al: Randomized, controlled trial of OROS® methylphenidate once a day in children with attention-deficit hyperactivity disorder. Pediatrics 2001; 108:883–892.


## No. 88
## DRIVING PERFORMANCE AMONG ADOLESCENTS WITH ADHD: MEDICATION EFFECTS

Daniel J. Cox, *Department of Psychiatric Medicine, University of Virginia, Box 800-223, Charlottesville, VA 22908;* Larry Merkel

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate that adolescent males treated with once-daily methylphenidate (OROS MPH) show less variability in driving performance, compared with those treated with three-times-a-day methylphenidate.


## SUMMARY:

*Objectives:* To compare the effects of IR methylphenidate t.i.d. with once-daily methylphenidate (OROS MPH) on driving performance throughout the day among ADHD-diagnosed adolescent male drivers and to evaluate whether a tangible benefit in driving performance is associated with the delivery profile of once-daily methylphenidate.

*Methods:* Participants were six male ADHD adolescents who routinely drive. Design was a repeated measure (2 p.m., 5 p.m., 8 p.m., 11 p.m.) crossover, comparing simulated driving performance.

*Results:* An Impaired Driving Score (IDS) was generated, based on z-scores for each participant's performance. IDS was compared using two (medications) × four (2, 5, 8, 11 pm) ANOVAs. IDS worsened throughout the day under the IR methylphenidate t.i.d. condition, but remained stable under once-daily methylphenidate. Overall, methylphenidate participants taking once-daily methylphenidate performed significantly better and with less variability ($p = .004$). Treatment comparisons at specific time intervals revealed significantly better performance for once-daily methylphenidate at 8 pm ($p = .01$).

*Conclusion:* Participants demonstrated significantly less variability in driving performance and performed significantly better throughout the day when receiving once-daily methylphenidate, compared to those receiving IR methylphenidate t.i.d. Driving performance was significantly improved at 8 p.m. in particular. The improved performance for adolescents treated with once-daily methylphenidate may relate to its smooth, ascending delivery profile.


Supported by McNeil Consumer & Speciality Pharmaceuticals.

## REFERENCES:


1. Nada-Raja S, Langley JD, McGee R, et al: Inattentive and hyperactive behaviors and driving offences in adolescence. J Am Acad Child Adolesc Psychiatry 1997; 36:515–522.

2. Cox DJ, Merkel RL, Dovatchev B, et al: Effect of stimulant medication on driving performance of young adults with attention-deficit hyperactivity disorder: a preliminary double-blind placebo controlled trial. J Nerv Ment Dis 2000; 188:230–234.

# SCIENTIFIC AND CLINICAL REPORT SESSION 30—ETHICAL ISSUES IN THE TREATMENT OF PSYCHOSIS

## No. 89
## FACTORS ASSOCIATED WITH DETERMINING COMPETENCE TO CONSENT IN ACUTE PSYCHOSES

Nicholas A. Keks, M.D., *Department of Psychiatry, MHRI, Locked Bag 11, Parkville, Victoria 3052, Australia;* Viviennne Howe, Kellie M. Foister, Kym Jenkins, M.D., David L. Copolov, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that competency to give informed consent for treatment cannot be determined by diagnosis alone and identify the symptoms that may compromise competency.

### SUMMARY:

*Objective:* To evaluate differences in the capacity of patients with acute psychoses to give informed consent depending on diagnosis and presence of specific symptoms and subsyndromes.

*Method:* A total of 109 acute inpatients (54 males, mean age = 37.2 years, SD = 12.3) with a DSM-IV diagnosis of schizophrenia (N = 64), schizoaffective disorder (N = 25), or bipolar affective disorder (N = 20) participated. Patients were interviewed by using the Positive and Negative Syndrome Scale (PANSS) and the MacArthur Competency Assessment Tool-Treatment (MacCAT-T).

*Results:* On a criterion score of 50% correct overall on the MacCAT-T, 89.1% of the schizophrenia, 84% of the schizoaffective, and 95% of the bipolar affective disorder patients exceeded the threshold, with no significant differences between diagnostic categories. PANSS results distinguished those with significant formal thought disorder (FTD) (N = 45) and those without (N = 64). The FTD group performed consistently worse than those without FTD on the MacCAT-T. No significant effects were evident for other specific symptoms, including hallucinations, mania, and depression, with a marginal result evident for delusional severity.

*Conclusions:* On a diagnostic-group basis, most acutely psychotic inpatients retained competence for informed consent according to our criteria. Specific symptoms were significantly more accurate than diagnosis in predicting performance on tests of competency.

### REFERENCES:

1. Grisso T, Appelbaum PS: Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals. New York, Oxford University Press, 1998.
2. Research Involving Persons with Mental Disorders That May Affect Decision-Making Capacity. Rockville, Md, National Biocthics Advisory Commission, 1998.

## No. 90
## ETHICAL CHALLENGES OF MANAGING PREGNANT PATIENTS WHO HAVE SCHIZOPHRENIA

John H. Coverdale, M.D., *Baylor College of Medicine, One Baylor Plaza, Houston, TX 77005;* Laurence B. McCullough, Ph.D., Frank A. Chervenak, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe an ethical framework to guide decision making about the management of pregnancy of patients with schizophrenia.

### SUMMARY:

*Objective:* Because there is a dearth of literature, an ethical framework to guide decision making about the management of pregnancy with patients with schizophrenia was needed.

*Method:* We reviewed pertinent literature on schizophrenia and pregnancy, including information on maternal and fetal risks and outcomes, and related this information to ethical concepts.

*Results:* We developed an ethical framework with five components: the concept of chronically and variably impaired autonomy, assisted decision making, surrogate decision making, strategies for dealing with the physician's feelings in response to these patients, and the concept of the fetus as a patient. We apply this ethical framework to clinical challenges of decision making during pregnancy with this patient population.

*Conclusions:* The ethics strategies of assisted and surrogate decision making can be used to prevent ethical conflicts in decision making about the management of pregnancy of patients with schizophrenia. These preventive ethics strategies should contribute significantly to reducing the vulnerability of these patients and therefore to enhancing their autonomy in the physician-patient relationship.

### REFERENCES:

1. Coverdale JH, Chervenak FA, McCullough LB, et al: Ethically justified clinically comprehensive guidelines for the management of the depressed pregnant patient. Am J Obstet Gynecol 1996; 171:169–173.
2. McCullough LB, Chervenak FA: Ethics in Obstetrics and Gynecology. New York, Oxford University Press, 1994.

## No. 91
## SCHIZOPHRENIA AND SUICIDE IN THE MANAGED CARE ERA

Bentson H. McFarland, M.D., *Department of Psychiatry, Oregon Health Science University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239;* Lara Davis, B.S., Jo Mahler, M.A.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to discuss relationships among schizophrenia, suicide, and managed care.

### SUMMARY:

*Objective:* The implementation of managed care has raised concerns about access to services for people with schizophrenia. One feared consequence is that suicide attempts may have increased. Medicaid clients with schizophrenia may be especially vulnerable to changes in service delivery. This project examined time trends in general hospital admissions after attempted suicide for people with schizophrenia.

*Methods:* Data were obtained from the Agency for Healthcare Research and Quality's Health Care Utilization Project National Inpatient Sample for the years 1988 through 1999. Information about implementation of Medicaid managed care was obtained from the Substance Abuse and Mental Health Services Administration's Managed Care Tracking System.

*Results:* There were 798,766 admissions of people with a schizophrenia diagnosis, of whom some 16,847 were noted to have attempted suicide. Nationwide, there was no statistically significant increase over time in the fraction of schizophrenia admissions associated with suicide. While time trends varied substantially from state

to state, there was no apparent relationship between attempted suicide admissions and Medicaid managed care implementation.

*Conclusions:* The rise of managed care during the past decades was not associated with a change in rates of suicide-related general hospital admissions for people with schizophrenia.

Funding provided in part by the Stanley Foundation.

REFERENCES:

1. Currier GW: Psychiatric bed reductions and mortality among persons with mental disorders. Psychiatr Serv 2000; 51:851.
2. McFarland BH: Overview of Medicaid managed behavioral health care. New Dir Ment Health Serv 2000; 85:23–32.

## SCIENTIFIC AND CLINICAL REPORT SESSION 31—ALCOHOL AND DRUG-RELATED DISORDERS

### No. 92
### IMPULSIVITY, SENSATION SEEKING, AND COPING STYLES AMONG SUBSTANCE ABUSERS

Kevin P. Hill, M.D., *Department of Psychiatry, Harvard Longwood, 330 Brookline Avenue, Boston, MA 02215;* Ashwin A. Patkar, M.D., Charles C. Thornton, Ph.D., Edward Gottheil, M.D., Anup M. Desai, M.D., Heather W. Murray, B.A., Michael J. Vergare, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize impulsivity and sensation-seeking as clinically important behavioral measures among substance abusers seeking treatment.

SUMMARY:

*Objective:* We investigated whether pretreatment measures of impulsivity and sensation-seeking were associated with psychopathology and coping styles in substance-abusing patients entering outpatient treatment.

*Methods:* Assessments of impulsivity and sensation-seeking were obtained for 142 substance abusers entering outpatient treatment by using the Zuckerman Sensation Seeking Questionnaire (ZSSQ). These were correlated with standardized measurements of psychopathology, coping styles, and addiction severity.

*Results:* Scores on the impulsive-sensation seeking dimension of the ZSSQ showed a significantly positive correlation with several psychopathological measures such as suicidal ideation, number of suicide attempts, psychotic symptoms, learned helplessness, and scores on the Beck Depression Inventory and Neuroticism-Anxiety scale. Scores on the impulsivity-sensation seeking dimension were also positively correlated with poor coping styles, in particular denial and mental disengagement, and high scores on four of the seven Addiction Severity Index subscales (r ranged from .27 to .17; $p < .001$ to $p < .05$).

*Conclusion:* Impulsivity-sensation seeking traits appear to be associated with higher psychopathology and poor coping styles among substance abusers entering treatment. Assessments of these traits may lead to early identification and possibly more targeted treatments for patients who pose a challenge to traditional substance abuse programs.

Funding provided by NIDA grants RO1DA08527 and K08-DA00340.

REFERENCES:

1. Moeller FG, Steinberg JL, Petty F, et al: Serotonin and impulsive/aggressive behavior in cocaine dependent subjects. Prog Neuro-Psychopharm Biol Psychiatry 1994; 18:1027–1035.
2. Allen TJ, Moeller FG, Rhoades HM, et al: Subjects with a history of drug dependence are more aggressive than subjects with no drug use history, Drug Alcohol Depend 1997; 46:95–103.

### No. 93
### SUBSTANCE ABUSE DISORDERS AND HISTORY OF CHILDHOOD SEXUAL ABUSE IN A POPULATION OF U.S. VETERANS

Jehangir B. Bastani, M.D., *VAMC, 650 East Indian School Road, Phoenix, AZ 85012;* Martin Mellstrom, Ph.D., Vicki A. Alberts, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) recognize the incidence of childhood sexual abuse and (2) understand the significance of sexual history in substance abusers of both genders.

SUMMARY:

*Objective:* Substance abuse problems are often chronic and recurrent despite treatment with well-studied modalities. This is likely a result of heterogeneous patient populations who may have different background and prognostic factors. Initial research suggested that patients with a history of childhood sexual abuse are more likely to suffer from substance abuse disorders than patients without such history. Little research has been done examining these issues in the population of U.S. veterans, who are known to have an elevated risk of substance abuse disorders compared to the general population.

*Method:* From October 2001 to July 2002, one of us (J.B.) completed an initial psychiatric evaluation for each veteran coming to treatment for substance abuse disorders at our center. They were specifically asked about a history of childhood sexual abuse.

*Results:* Of 273 patients interviewed, 51 reported a history of childhood sexual abuse. The male-to-female veteran ratio was 7.5 to 1. Details as to duration of abuse, demographics, psychiatric illnesses, age of onset, type of substance abuse, and other associated findings are presented.

*Conclusions:* This study documented an increased frequency of childhood sexual abuse among U.S. veterans seeking treatment for substance abuse. The authors present further data for male and female veterans. The findings have important implications for their integration into treatment and prognosis. This aspect of history taking is fundamental to treatment planning.

REFERENCES:

1. Simpson TL, Miller R: Concomitance between childhood sexual and physical abuse and substance use problems. Clin Psychol Rev 2002; 22:27–77.
2. Bulik O, Prescott C, Kendler K: Features of childhood sexual abuse and the development of psychiatric and substance use disorder. Br J Psychiatry 2001; 179:444–449.

### No. 94
### ATTACHMENTS FOR IN-TREATMENT ALCOHOLICS AND TEENS PREDICTED TO BE ADDICTS

Marc A. Lindberg, Ph.D., *Department of Psychology, Marshall University, 1600 Hal Greer Boulevard, Huntington, WV 25755-2672;* Stuart Thomas, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand and diagnose specific attachment, family, and related personality characteristics associated with alcoholism, and to use a psychometrically superior diagnostic.

SUMMARY:

*Objective:* Because attachment and relationship issues have been shown experimentally and clinically to be implicated in the onset of alcoholism, the attachment relationships and personality characteristics of alcoholics in treatment centers (study 1) and young people who are predicted to become alcoholics (study 2) were examined. The Attachment and Clinical Issues Questionnaire (ACIQ), a new 29-scale instrument with average alphas of .79, fake scales, and extensive validity testing, was used to measure attachment and family and emotional dynamics.

*Method:* Study 1 compared 27 patients in residential treatment centers with 118 subjects selected from a larger study and matched on age, socioeconomic status, and sex, with a mean age of 37.44 years. Study 2 was performed with 350 high school and college students. "Potential alcoholism" was measured by the sum of the MASTM and MASTD and CUGE scores.

*Results:* In study 1, a stepwise discriminant function analysis found that the shame, anxiety, and preoccupied mother and partner scales served as the best discriminators between the two groups ($p < .000$). Further tests revealed that the groups also significantly differed on 15 of the 29 scales in predictable fashions. In study 2, the measure of potential alcoholism was correlated with the scales of the ACIQ. Twelve of the 15 significant results from study 1 were replicated with the "potential alcoholics."

*Conclusion:* The results converged on the findings that alcoholics in treatment and "potential alcoholics" both suffer from the same kinds of attachment, emotional regulation, and family dynamics issues.

Funding provided by Marshall University.

REFERENCES:

1. Fonagy P, Leigh T, Steele M, et al: The relation of attachment status, psychiatric classification, and response to psychotherapy. J Consult Clin Psychol 1996; 64:22–31.
2. Higley JD, Suomi SJ, Linnoila M: A nonhuman primate model of type II excessive alcohol consumption? 1. low cerebrospinal fluid 5-hydroxyindoleacetic acid concentrations and diminished social competence correlate with excessive alcohol consumption. Alcohol Clin Exp Res 1996; 20:629–642.

# SCIENTIFIC AND CLINICAL REPORT SESSION 32—AIDS AND HIV-RELATED DISORDERS

## No. 95
## PSYCHIATRIC EFFECTS ASSOCIATED WITH EFAVIRENZ: A RETROSPECTIVE STUDY

Talia Puzantian, Pharm.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M8, San Francisco, CA 94110;* Jeannie Lee, Pharm.D., Regina J. Lee, Pharm.D., Janice Wong, Pharm.D., Li Liu, M.D., Dan H. Karasic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the risk of neuropsychiatric effects of efavirenz therapy.

SUMMARY:

*Objective:* Efavirenz use may be limited by neuropsychiatric side effects. Emerging data suggest the incidence of such effects may be higher than reported, particularly in patients with psychiatric or substance use histories. The study objective was to determine (1) the incidence of neuropsychiatric effects associated with efavirenz at a large urban academic center and (2) whether history of substance use or psychiatric illness predisposes patients to psychiatric effects of efavirenz.

*Methods:* A retrospective electronic chart review of HIV patients who discontinued efavirenz or nelfinavir was conducted. Evaluation of demographics, disease state, duration of therapy, reasons for discontinuation, adverse effects, psychiatric and substance use history, psychiatric referral, and initiation of psychiatric medications was performed.

*Results:* Overall, 36% of efavirenz patients discontinued medication due to any side effect, compared with 14.4% of nelfinavir patients. Patients who discontinued efavirenz experienced significantly more neuropsychiatric effects than those who discontinued nelfinavir. The incidence of more serious psychiatric effects in patients who discontinued efavirenz was 22.2%. Eleven efavirenz patients, compared with two nelfinavir patients, were referred to psychiatry for depression, anxiety, or aggressive behavior thought to be caused or exacerbated by study medications.

*Conclusion:* Clinicians should be aware of the neuropsychiatric effects of efavirenz, particularly in "real-world" settings, as they may be more common and severe than current reports indicate.

Supported by a grant from the UCSF-Gladstone Institute of Virology and Immunology NIH Center for AIDS Research (P30 MH-59037).

REFERENCES:

1. Peyriere H, Mauboussin JM, Rouanet I, et al: Management of sudden psychiatric disorders related to efavirenz. AIDS 2001; 15:1323–1328.
2. Puzantian T: Central nervous system adverse effects with efavirenz: case report and review. Pharmacotherapy 2002; 22:930–933.

## No. 96
## PTSD AND ACUTE STRESS REACTIONS TO RECENT LIFE EVENTS AMONG HIV-POSITIVE PERSONS

Cheryl Koopman, Ph.D., *Department of Psychiatry, Stanford University, MC 5718, Stanford, CA 94305-5718;* Cheryl Gore-Felton, Ph.D., Negar Azimi, B.A., Kristian O'Shea, Rachel Power, Ph.D., Dennis M. Israelski, M.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that acute stress reactivity may lead to adverse health for HIV-positive persons and understand that HIV-positive persons with PTSD may need help with ongoing life stressors.

SUMMARY:

*Objective:* This study examined acute stress reactions to recent life events in relation to posttraumatic stress disorder (PTSD) symptoms among HIV-positive men and women.

*Method:* Participants included 64 HIV-seropositive persons (33 men and 31 women). They were assessed at baseline on medical status, demographic characteristics, and PTSD symptoms and then randomly assigned to receive either group therapy plus education or education alone. Three months later they were assessed for acute stress reactions to recent life events.

*Results:* Nearly a third (31.3%) of the participants reported levels of acute stress reactions to recent life events that met all symptom criteria for the diagnosis of acute stress disorder. However, only 9.4% of the respondents described an event that was threatening to the life or physical integrity of themselves or others. Acute stress reactions to recent life events were significantly and positively related to experiencing PTSD symptoms prior to traumatic life events. Acute stress did not differ significantly by gender, AIDS status, or whether participants had received group therapy.

*Conclusion:* A subset of individuals with HIV/AIDS who experience high levels of acute stress reactivity to life events considered nontraumatic are likely to have PTSD in response to previous traumatic life events.

Funding provided by the NIMH Office of AIDS Research.

## REFERENCES:

1. Lutgendorf SK, Antoni MH, Ironson G, et al: Cognitive-behavioral stress management decreases dysphoric mood and herpes simplex virus-type 2 antibody titers in symptomatic HIV-seropositive gay men. J Consult Clin Psychol 1997; 65:31–43.
2. Goodkin K, Fuchs I, Feaster D, et al: Life stressors and coping style are associated with immune measures in HIV-1 infection. Int J Psychiatry Med 1992; 22:155–172.

## No. 97
## USE OF MARIJUANA TO MANAGE DISTRESS SYMPTOMS AMONG HIV-INFECTED PERSONS

Diane Prentiss, M.A., *Research Unit, San Mateo Medical Center, 222 West 39th Avenue, San Mateo, CA 94403;* Rachel Power, Ph.D., Gladys Balmas, M.P.H., Dennis M. Israelski, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) demonstrate knowledge in regard to the prevalence of mental health issues among HIV-infected persons, (2) demonstrate knowledge in regard to the prevalence of smoked marijuana among HIV-infected clinic patients for the purpose of relieving symptoms of anxiety and/or depression, and (3) demonstrate a greater understanding of the need for on-site mental health screening and psychiatric treatment in HIV health clinics.

## SUMMARY:

*Objectives:* This study assessed the prevalence of marijuana use to relieve psychiatric symptoms among a diverse HIV-infected clinic population.

*Methods:* HIV-infected patients were targeted for recruitment through consecutive and snowball sampling at three community health settings in Northern California. The mean age of participants (N = 252) was 43 years, and 26% were female. African Americans constituted 34% of the study population, whites 32%, and Latinos 27%. Structured interview assessments and medical chart data extraction were conducted.

*Results:* Fifty-three percent of participants had received a prior psychiatric diagnosis, and 32% reported recent psychiatric treatment. The use of smoked cannabis in the last four weeks was reported by 23%. Among patients reporting marijuana use, 60% identified relief from anxiety and/or depression as the primary health benefit. Being Caucasian was significantly associated with recent marijuana use (odds ratio = 3.40, 95% CI = 1.85 to 6.25), and heavy users of alcohol were more than two-and-a-half times more likely than other subjects to have also smoked marijuana (OR = 2.66, 95% CI = 1.22 to 5.79).

*Conclusions:* The results indicate significant use of marijuana to manage depression and anxiety in this ethnically diverse, low-income population. Routine screening for mental health issues and on-site psychiatric services in HIV clinic settings are recommended.

Funding provided by the San Mateo County Health Center Foundation.

## REFERENCES:

1. Ogborne AC, Smart RG, Weber T, et al: Who is using cannabis as a medicine and why: an exploratory study. J Psychoactive Drugs 2000; 32:435–443.
2. Troisi A, Pasini A, Saracco M, et al: Psychiatric symptoms in male cannabis users not using other illicit drugs. Addiction 1998; 93:487–492.

# SCIENTIFIC AND CLINICAL REPORT SESSION 33—ADJUNCTIVE TREATMENTS IN SCHIZOPHRENIA

## No. 98
## MODAFINIL FOR FATIGUE DUE TO ANTIPSYCHOTIC MEDICATIONS USED FOR TREATING SCHIZOPHRENIA

**WITHDRAWN**

## No. 99
## RIVASTIGMINE AND GALANTAMINE TREATMENT FOR SCHIZOPHRENIC COGNITIVE IMPAIRMENT

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

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize neurocoginitive deficits in schizophrenia, describe their management with rivastigmine and galantamine, and appreciate its impact on quality of life, social functioning, and functional recovery.

## SUMMARY:

*Objective:* Neurocognitive impairment is an intrinsic feature of schizophrenia. Despite beneficial effects of atypical antipsychotics on cognition, these improvements will not return most schizophrenic patients to normative standards of cognitive functioning. Changes in cholinergic function in schizophrenia provide the rationale for testing the effectiveness of cholinesterase inhibitors in treating cognitive impairment.

*Method:* A six-month double-blind, placebo-controlled trial of rivastigmine (1.5 mg b.i.d.) and galantamine (3 mg b.i.d.) as adjunctive treatment in stable schizophrenic patients with cognitive impairment receiving clozapine, risperidone, or olanzapine was conducted. Subjects were 39 patients, 16 males and 23 females, aged 20–58 years (mean = 38.03), with a duration of illness of six to 30 years, (mean = 15.84) and two to 11 years of taking clozapine (mean 5.38), two to five years of taking olanzapine (mean = 3.19), or two to seven years of taking risperidone (mean = 4.73). They were rated on the PANSS, quality-of-life measures, and a battery of cognitive tests.

*Results:* Thirty-two patients completed the trial, 11 taking galantamine, 11 taking rivastigmine, and ten taking placebo. Five patients withdrew their consent, and two discontinued medication due to side effects. All patients taking galantamine and rivastigmine and one patient taking placebo showed improvement in PANSS score, cognition, and quality of life. Five patients started working, and two enrolled in educational upgrading. Four patients stopped smoking.

*Conclusion:* The results suggest the usefulness of rivastigmine and galantamine in enhancing cognitive performance and in improving social and work function in schizophrenic patients.

## REFERENCES:

1. Rosler M, Anand R, Cicin Sain A, et al: Efficacy and safety of rivastigmine in patients with Alzheimer's disease: international randomised controlled trial. Br Med J 1999; 318:633–638.
2. Raskind MA, Peskind ER, Wessel T, et al: Galantamine in ADs a 6-month randomized, placebo-controlled trial with 6-month extension. Neurology 2000; 54:2261–2268.

## No. 100
## MODAFINIL AS ADJUNCT TREATMENT IN SCHIZOPHRENIA: AN OPEN-LABEL STUDY

Murray H. Rosenthal, D.O., *BMR HealthQuest, 3625 Ruffin Road #100, San Diego, CA 92123-1841;* Sharon Bryant, Ph.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the potential of using modafinil as adjunct treatment for patients with schizophrenia

### SUMMARY:

*Objectives:* Patients with schizophrenia experience cognitive impairments associated with hypofunctioning of the frontal cortex. Management of cognitive dysfunction in these patients is a clinical challenge and may affect patients' medication compliance. Modafinil is a novel wake-promoting agent that works through the sleep/wake centers of the brain to activate the cortex. Modafinil has been shown to improve cognitive performance in healthy volunteers. This study assessed modafinil as adjunctive therapy in patients with schizophrenia or schizoaffective disorder.

*Methods:* In this four-week, open-label, single-center pilot study, 11 patients received modafinil (days one to 14, 100 mg/day; days 15–28, 100 or 200 mg/day) in addition to current antipsychotic therapy. Patients were evaluated for global functioning and overall clinical condition by the investigator and a psychiatrist who was blind to study group assignment. Levels of fatigue and changes in cognitive functioning were assessed. Adverse events were monitored.

*Results:* Nine patients completed the study. Modafinil significantly improved patients' global functioning, overall clinical condition, and fatigue (all $p < .05$ for change from baseline). Modafinil did not adversely affect the Positive and Negative Syndrome Scale score. Treatment emergent adverse events of all causes included dry mouth ($N = 2$) and hallucinations ($N = 2$). One patient discontinued due to hallucinations that were considered possibly related to inadequate antipsychotic therapy.

*Conclusion:* Modafinil improved global functioning and overall clinical condition in patients with schizophrenia. Additional controlled studies are warranted.

Funding provided by Cephalon, Inc.

### REFERENCES:

1. Stahl SM: Awakening to the psychopharmacology of sleep and arousal: novel neurotransmitters and wake-promoting drugs. J Clin Psychiatry 2002; 63:467–468.
2. Turner DC, Robbins TW, Dowson J, et al: Modafinil: a novel cognitive enhancer. Presented at the British Association of Psychopharmacology annual meeting, Harrogate, UK, July 2002.

# SCIENTIFIC AND CLINICAL REPORT SESSION 34—WOMEN'S HEALTH

## No. 101
## SERTRALINE PREVENTS POSTPARTUM DEPRESSION

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### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to treat postpartum-onset major depression preventively in women who have had previous episodes.

### SUMMARY:

*Objective:* Women who have suffered episodes of major depression (MD) constitute a high-risk group for additional episodes after childbirth. We conducted a double-blind, randomized trial to test the efficacy of setraline in preventing recurrent depression in the postpartum period.

*Methods:* Women who had at least one past episode of MD were recruited during pregnancy. Subjects were nondepressed during the index pregnancy. They were assigned randomly to receive sertraline or placebo for immediate postpartum treatment. The mothers were assessed for 20 sequential weeks with the Hamilton Rating Scale for Depression and the Structured Clinical Interview for DSM-IV to monitor for recurrence of MD.

*Results:* A significant difference in the rate of recurrence in women treated with sertraline compared to placebo was observed. Of 12 subjects who took sertraline preventively, one (0.083, 95% CI = 0.00 to 0.34) suffered a recurrence. Of eight subjects who took placebo, four (0.50, 95% CI = 0.16 to 0.84) suffered recurrences (Fisher's exact $p = .04$).

*Conclusions:* Sertraline conferred preventive efficacy for postpartum depression beyond that of placebo.

Funding provided by NIMH.

### REFERENCES:

1. Wisner KL, Perel JM, Peindl KS, et al: Prevention of recurrent postpartum depression: a randomized clinical trial. J Clin Psych 2001; 62:82–86.
2. Kendell RE, Chalmers JC, Platz C: Epidemiology of puerperal psychoses. Br J Psychiatry 1987; 150:662–673.

## No. 102
## DEPRESSED WOMEN HAVE ELEVATED COAGULATION FACTORS IN MIDLIFE

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### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the increased risk of hypercoagulability in midlife women with depression compared to those without depression, regardless of current psychotropic medication use.

### SUMMARY:

*Objective:* Depression is a risk factor for cardiovascular disease (CVD) in adults and may be related to hypercoagulability, which is also a risk factor for CVD. One proposed mechanism is a detrimental effect of depression on hemostatic parameters.

*Methods:* We measured levels of fibrinogen, factor VIIc, plasminogen activator inhibitor antigen-1, and tissue plasminogen activator antigen in 3,167 women, age 42–52 years, enrolled in the Study of Women's Health Across the Nation (SWAN). Depression status was determined during the same visit by using the Center for Epidemiological Studies-Depression Scale (CES-D).

*Results:* The prevalence of depression (CES-D $\geq$ 16) was 24.3%. Depression was associated with higher levels of all coagulation factors. After controlling for other variables, including smoking, ethnicity, prevalent disease, and the use of medications (including psychotropics), associations were maintained for fibrinogen (mean $\pm$ SD = 304.1 $\pm$ 72.2 mg/dl versus 290.6 $\pm$ 66.8 mg/dl, $p = .0001$)

and factor VIIc (125.2 ± 53.1 ng/dl versus 118.8 ± 35.5 ng/dl, p = .0014).

*Conclusions:* Depression is associated with higher levels of coagulation factors, especially fibrinogen and factor VIIc. These findings are consistent with the hypothesis that a balance between hemostatic and fibrinolytic activity may contribute to the complex relation of depression with CVD.

## REFERENCES:

1. Musselman DL, Tomer A, Manatunga AK, et al: Exaggerated platelet reactivity in major depression. Am J Psychiatry 1996; 153:1313–1313.
2. Frasure-Smith N, Lesperance F, Talajic M: Depression following myocardial infarction: impact on 6-month survival. JAMA 1993; 270:1819–1825.

## No. 103
## HRT WITH ANDROGENS AS A STRATEGY TO TREAT POSTMENOPAUSAL DEPRESSION

Rodrigo Dias, M.D., *Department of Neuropsychiatry, UNESP, CP 540-FAC Medicina De Botucatu, Botucatu, SP 18618-970, Brazil;* Florence Kerr-Correa, M.D., Luzia A. Trinca, Ph.D., Ricardo A. Moreno, M.D., Anagloria Pontes, M.D., Hans W. Halbe, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate the influence of steroids hormones on the treatment response of postmenopausal depression.

## SUMMARY:

*Objective:* To evaluate effects of HRT with and without androgens on menopausal depressive women.

*Methods:* Thirty-two menopausal, depressive (DSM-IV) women, mean age = 53.6 years, were treated with venlafaxine (mean = 83.04 mg), randomly assigned to four HRT groups in a double-blind design, and followed for 24 weeks. Group one (N=8) received estrogen (0.625 mg), medroxyprogesterone acetate (2.5 mg), and methyltestosterone (2.5 mg). Group two (N=8) received esrogen (0.625 mg) and medroxyprogesterone acetate (2.5 mg). Group three (N=8) received methyltestosterone (2.5 mg). Group four (N=8) received none of the three HRT treatments.

Outcomes measured by the Montgomery-Asberg Depression Rating Scale were analyzed by repeated measures technique (MI and mixed procedures of SAS), after using multiple imputation for missing responses due to dropout.

*Results:* At baseline, the mean MADRS score was 32.72. Nineteen (79.17%) women showed remission: eight (100%) from group one, five (71.43%) from group two, three (75%) from group 3, and three (60%) from group four. Reduction was not related to venlafaxine doses (r = .09, p = .16). No statistical difference in outcome among the groups was observed at the end of the study (p > .10). However, HRT with androgen helped to better reduce the MADRS score during treatment.

*Conclusion:* Preliminary results suggest better patient outcome with HRT plus androgens, but findings must be carefully analyzed.

Supported by grant 99/12769-8 from Fundacão Amparo à Pesquisa do Estado de São Paulo.

## REFERENCES:

1. Eriksson E, Sundblad C, Larden M, et al: Behavioural effects of androgens in women, in Mood Disorders in Women. Steiner M, Yonkers K, Eriksson E, eds. London, Martin Dunitz, 2000, pp 223–246.
2. Soares CN, Almeida OP, Joffe L, et al: Efficacy of estradiol for the treatment of depressive disorders in perimenopausal women. Arch Gen Psychiatry 2001; 58:529–534.

# SCIENTIFIC AND CLINICAL REPORT SESSION 35—BIPOLAR DISORDERS

## No. 104
## BIPOLAR DISORDER TREATMENT: CRITICAL SYNTHESIS OF GUIDELINES AND ALGORITHMS

Heinz C. Grunze, M.D., *Department of Psychiatry, University of Munich, Nussbaumstr 7, Munich 80336, Germany*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) critically assess a number of different consensus guidelines and treatment algorithms for acute bipolar mania and (2) reconcile the recommendations with recent trial data and effectively apply them to the clinical management of acute mania.

## SUMMARY:

The flow of data from clinical studies in acute mania and other phases of bipolar illness necessitates the ongoing generation and revision of existing treatment guidelines. Recent findings have also prompted the development of operationalized treatment algorithms in bipolar disorder. Several approaches have been taken to develop treatment guidelines, such as opinion-based expert surveys, consensus panel literature interpretations, and systematic literature reviews that provide a rationale for choosing or avoiding specific options in given situations. This report will critique these approaches, then synthesize and augment their recommendations using the latest clinical data. How these recommendations reflect and relate to current clinical practice will also be addressed. A frequent criticism of guidelines is that they are routinely used, but seldom adhered to in practice, particularly in treatment of complex psychiatric diseases such as bipolar disorder. First-line treatment recommendations for acute mania include monotherapy with lithium or divalproex and the addition of an atypical antipsychotic for more severe or psychotic cases. Atypical antipsychotic adjunct therapy is also a second-line option for less severe mania that has responded poorly to mood stabilizer alone. The anticipated outcome of clinical trials of newer agents for the treatment of acute mania will be an invaluable component in shaping future guidelines and algorithms for the treatment of bipolar disorder. The role of other factors, such as patient preference and the context of treatment, will also be discussed.

## REFERENCES:

1. Suppes T, Dennehy EB, Swann AC, et al: Report on the Texas Consensus Panel of Medication Treatment of Bipolar Disorder 2000. J Clin Psychiatry 2002; 63:288–299.
2. Grunze H, Kasper S, Goodwin G, et al: The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders, Part II: Treatment of Mania. World J Biol Psychiatry (in press).

## No. 105
## RAPID CYCLING BIPOLAR DISORDER: FOCUS ON TREATMENT

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney-NY Presbyterian Hospital, 525 East 68th Street, Box 140, New York, NY 10021;* S. Nassir Ghaemi, M.D., Martin Harrow, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) differentiate the features of bipolar disorder patients with a rapid cycling course and (2) be better equipped to meet the challenges of treating and studying rapid cycling.

SUMMARY:

Rapid cycling is a course specifier defined as ≥ four affective episodes/year that occurs in about one-fifth of bipolar disorder patients. This phenomenon appears more frequently in younger individuals, women, and bipolar II disorder patients. Risk factors associated with cycle acceleration may include prior antidepressant treatment and substance use disorders. A recent history of rapid cycling correlates with poor treatment outcomes with most standard agents, particularly lithium monotherapy. Bipolar patients with rapid cycling can be expected to cycle out of a current episode (or into one) sooner than non-rapid-cycling patients and may differ in demographic or other characteristics from other bipolar disorder patients. For these reasons they are often excluded from studies seeking to measure treatment effects. This report presents data from an ongoing, open-label study of 40 rapid-cycling bipolar I disorder patients treated with the atypical antipsychotic quetiapine and followed for up to one year. Significant and sustained improvement from baseline was observed for both manic and depressive symptoms. Longer-term and larger-scale controlled studies examining treatment-emergent effects associated with monotherapy and combination treatments will also be discussed.

REFERENCES:

1. Calabrese JR, Shelton MD, Bowden CL, et al: Bipolar rapid cycling: focus on depression as its hallmark. J Clin Psychiatry 2001; 62(suppl):34–41.
2. Ghaemi SN: New treatments for bipolar disorder: the role of atypical neuroleptic agents. J Clin Psychiatry 2000; 61:33–42.

## No. 106
## MOOD STABILIZERS: STANDARD, NEW, AND PUTATIVE

Eduard Vieta, M.D., *Department of Psychiatry, Hospital Clinic, Villarroel 170, Barcelona 08036, Spain;* Anabel Martinez-Aran, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) critically assess mood stabilization as a concept and (2) relate this information to bipolar psychopathology and use it to augment clinical decision making in the management of acute mania.

SUMMARY:

Mood stabilization, although poorly defined, is often used to describe the treatment objectives for major forms of psychopathology, such as borderline personality disorder and bipolar disorder. The term is not officially recognized by international regulatory authorities, and there are several definitions in the literature that compete for consensus status. Interventions effective in one phase of bipolar disorder that do not have a negative effect in other phases (e.g., by causing switching or cycle acceleration) meet liberal criteria. More stringent criteria require bimodal efficacy in both the manic and the depressive phases. A third framework recognizes that single compounds are unlikely be equally effective in each phase of the illness and that mood stabilization is a matter of degree rather than an absolute property. Thus, mood-stabilizing therapy should have efficacy in at least two of the following domains: acute mania, acute depression, or prophylaxis. Newer agents, such as certain atypical antipsychotics, have been shown to have efficacy in acute mania while not precipitating the emergence of depressive symptoms. How such evidence relates to clinical practice and concepts of mood stabilization will be discussed.

REFERENCES:

1. Ghaemi SN: On defining "mood stabilizer." Bipolar Disord 2001; 3:154–158.
2. Ketter TA, Calabrese JR: Stabilization of mood from below versus above baseline in bipolar disorder: a new nomenclature. J Clin Psychiatry 2002; 63:146–151.

# SCIENTIFIC AND CLINICAL REPORT SESSION 36—VIOLENCE, TRAUMA, AND VICTIMIZATION

## No. 107
## TREATMENT OUTCOME FOR SEXUALLY ABUSED CHILDREN AT ONE-YEAR FOLLOW-UP

Judith A. Cohen, M.D., *Department of Psychiatry, Allegheny General Hospital, 4 Allegheny Center, 8th Floor, Room 864, Pittsburgh, PA 15212;* Anthony P. Mannarino, Ph.D., Kraig Knudsen, M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify two types of treatment commonly provided to sexually abused children, recognize key components of each treatment model, and identify three areas of functioning that improved more with CBT than NST in sexually abused children.

SUMMARY:

*Objective:* Few randomized, controlled treatment trials (RCT) have been conducted with traumatized children; fewer still have included follow-up assessments of children's longer-term functioning. This RCT evaluated functioning during one year after treatment in sexually abused children.

*Method:* Eighty-one symptomatic sexually abused children age 8–14 years were evaluated at an outpatient child psychiatry program that specializes in treating traumatized children and randomly assigned to trauma-focused cognitive behavior therapy (CBT) or nondirective supportive therapy (NST) provided individually to the child and nonoffending parent for 12 sessions. Assessment instruments included the Trauma Symptom Checklist for Children, the Children's Depression Inventory, the State-Trait Anxiety Inventory for Children, the Child Sexual Behavior Inventory, and the Child Behavior Checklist.

*Results:* At one year follow-up, differences between the two treatment groups were more marked than at posttreatment, with the children who received CBT experiencing significantly greater improvement in posttraumatic stress disorder symptoms, depression, and anxiety than those who received NST.

*Conclusions:* This study provides further evidence that CBT interventions produce significant and lasting improvements in traumatized children and that the benefits of this type of treatment may increase over time.

Funding provided by the National Center for Child Abuse and Neglect.

REFERENCES:

1. Cohen JA, Mannarino AP: Interventions for sexually abused children: initial treatment findings. Child Maltreatment 1998; 3:17–26.
2. Cohen JA, Mannarino AP: Predictors of treatment outcome in sexually abused children. Child Abuse and Neglect 2000; 24:983–994.

## No. 108
## PSYCHOLOGICAL SYMPTOMS SIX YEARS AFTER A PLANE CRASH

Christoffel J. Yzermans, Ph.D., *Nivel, Post Office Box 1568, Utrecht 3500BN, Netherlands;* Ge A. Donker, M.D., Hiske E. Becker, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that six years after a major event (plane crash) psychological symptoms and problems persist in the persons involved, even in persons not directly exposed to the event.

## SUMMARY:

*Objective:* To determine the rate, predictors, and functional outcomes of psychiatric morbidity and (partial) PTSD in residents and rescue workers six years after being involved in an air disaster in Amsterdam.

*Method:* Two questionnaires were sent to those who agreed to participate: the Symptom Checklist-90-Revised, used to assess psychiatric morbidity, and the Rotterdam Symptom Checklist (RSCL), used to measure functional impairment, activity level, and perception of well-being.

*Results:* Two-thirds of the residents were identified as having psychiatric morbidity, and 17% as having (partial) PTSD. Several unexplained physical symptoms were reported. Predictors of psychiatric morbidity and (partial) PTSD were: being born outside the Netherlands, having witnessed the crash, being confronted with the death of a relative, and physical injuries due to the disaster. Subjects with (partial) PTSD showed poorer scores on the RSCL, especially on measures of physical health and perceived well-being.

*Discussion:* Six years after a plane crash, residents and rescue workers had an increased prevalence of psychiatric morbidity and (partial) PTSD. Male residents born abroad and those with the highest exposure were most at risk. These data support the hypothesis that subjects with significant trauma earlier in life and those who lack social support may be most at risk for long-term psychological consequences of a major event.

Funding provided by the Netherlands Ministry of Health.

## REFERENCES:

1. Donker GA, Yzermans CJ: Comparison between self-reported symptoms and general practice records. Br J Gen Pract (in press).
2. Carlier IVE, Gersons BPR: Stress reactions in disaster victims following the Bijlmermeer plane crash. J Traum Stress 1997; 10:329–335.

### No. 109
### SAN FRANCISCO THIRD GRADERS AFTER 9/11: THREE WINDOWS TO HEALING

Lenore C. Terr, M.D., *Department of Psychiatry, University of California at San Francisco, 450 Sutter Street, Room 2534, San Francisco, CA 94108-4204*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to (1) Understand how abreaction, context, and correction work toward children's healing after a distant trauma (9/11) and (2) recognize how children's art reflects these three qualities.

## SUMMARY:

*Objective:* No previous studies have examined whether children's art after a disaster shows emotional expression (abreaction), thinking with perspective (context), and/or new plans of action for the self and/or community (correction). This study considers how nine-year-olds at a safe distance from the World Trade Center and Pentagon drew and expressed themselves in late September 2001, late January 2002, and late May 2002.

*Methods:* On three days in 2001–2002, all nine-year-olds attending a co-ed private school were asked by their teachers to "draw what you have been going through since 9/11" and to write one sentence about it. At the end of the year, they took their art home. No personal data were collected. The author examined and rated each piece of art for abreaction, context, and correction. Additional ratings were made for denial, other pathological defenses, and fantasy formation. Individuals were assessed by using longitudinal statistical analysis.

*Results/conclusions:* Children's trauma-based art showed longitudinal consistency of symbols. Abreaction was most intense early and tended to fade later. Corrections were affected by what the government did, making children feel safer as the year progressed. But contexts lagged behind. Children remained puzzled about why the events occurred. Although they felt more connected after 9/11 to their American and world brethren, they looked to their homes and families for explanations and perspectives.

## REFERENCES:

1. Terr L, Bloch DA, Michel BA, et al: Children's symptoms in the wake of *Challenger:* a field study of distant traumatic effects and an outline of related conditions. Am J Psychiatry 1999; 156:1536–1544.
2. Terr L: Too Scared to Cry. New York, Harper & Row, 1990.

# SCIENTIFIC AND CLINICAL REPORT SESSION 37—ISSUES IN THE TREATMENT OF DEPRESSION AND SEXUAL DYSFUNCTIONS

### No. 110
### MAINTAINING COMPLIANCE AND REMISSION IN MDD WITH SILDENAFIL PRESCRIPTION FOR SSRI-SD

H. George Nurnberg, M.D., *Health Science Center, University of New Mexico, 2600 Marble Avenue, NE, Albuquerque, NM 87131;* Paula L. Hensley, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the necessity of treating side effects for maintaining antidepressant compliance.

## SUMMARY:

*Objective:* Maintaining compliance with recommended antidepressant treatment is a common and longstanding concern in medical practice. Although 70%–90% of major depression (MDD) patients respond to the first or second antidepressant prescribed, 50% discontinue before 90 days and only 10%–15% complete the guideline recommended four to six months of continuation treatment. Serotonergic antidepressant associated sexual dysfunction (SRI-AASD), which occurs in 25%–75% of patients, is a principal independent factor leading to treatment failure. This study examined whether effective sildenafil treatment of this pernicious side effect supported continuation/maintenance antidepressant management for continued MDD remission and improved treatment outcomes.

*Method:* Ninety men with MDD in remission and SRI-AASD, who were taking stable-dose antidepressants, were randomly assigned to receive sildenafil (50–100 mg adjustable) or placebo for six weeks. With the blind maintained, responders in the randomized controlled trial discontinued sildenafil for three weeks run-in, and upon determining persisting SD, received eight weeks additional open-label sildenafil. Double-blind partial/nonresponders (CGI > 2) repeated the initial six weeks of open-label sildenafil and eight weeks of extension for responders. Outcome measures included the International Index of Erectile Function, the UNM Sexual Function Inventory, the Clinical Global Impression-Sexual Function (CGI-SF) scale, and the Hamilton depression scale.

*Results:* Sildenafil treatment resulted in significant improvement of sexual dysfunction in the double-blind, placebo-controlled, and

single-blind open phases (effect-size = 1.07; 95% CI = 0.77 to 1.37); 73 of 77 (95%) subjects completing all 24 study weeks (87%) improved significantly (CGI-SF < 2) with no MDD relapses/recurrences (HAM-D ≤ 7).

*Conclusion:* Sildenafil effectively and persistently reversed SRI-AASD, supporting effective SRI-antidepressant dose adherence and MDD remission. Adverse effect management improves disease management outcomes.

Supported by Pfizer Inc.

## REFERENCES:

1. Numberg HG, Gelenberg A, Hargreave TB, et al: Efficacy of sildenafil citrate for the treatment of erectile dysfunction in men taking serotonin reuptake inhibitors. Am J Psychiatry 2001; 158:1926–1928.
2. Numberg HG, Hensley PL, Lauriello J: Sildenafil in the treatment of sexual dysfunction induced by selective serotonin reuptake inhibitors: an overview. CNS Drugs 2000; 13:321–335.

## No. 111
## EFFICACY AND SAFETY OF SILDENAFIL CITRATE IN MEN WITH SEROTONERGIC-ANTIDEPRESSANT-ASSOCIATED ERECTILE DYSFUNCTION: RESULTS OF A PROSPECTIVE, MULTICENTER, RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114;* H. George Nurnberg, M.D., Stuart N. Seidman, M.D., Willis Holloway, Jr., M.D., Mildred Farmer, M.D., Susan Nicholas, Vera Stecher, Ph.D.

## EDUCATIONAL OBJECTIVE:

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

## SUMMARY:

*Objective:* To evaluate the efficacy and tolerability of sildenafil citrate in men with serotonergic antidepressant associated erectile dysfunction (ED) and to assess treatment satisfaction.

*Method:* Men (≥18 years old) with major depressive disorder (MDD) in remission (HAM-D ≤10) who had been taking a serotonergic antidepressant for eight weeks or more at a stable dose for at least four weeks and who experienced antidepressant-associated ED were randomly assigned to receive sildenafil (50 mg p.r.n., flexible to 25 mg or 100 mg) or matching placebo for six weeks of double-blind treatment. Outcomes measured were questions three (Q3; frequency of penetration) and four (Q4; frequency of maintained erections after penetration) of the International Index of Erectile Function (IIEF) and the Erectile Dysfunction Inventory of Treatment Satisfaction (EDITS).

*Results:* At week six or endpoint, sildenafil patients (N = 68) had significantly higher mean scores on IIEF Q3 (3.9 ± 0.2) and Q4 (3.7 ± 0.2), compared with placebo patients (N = 65; 3.1 ± 0.2 and 2.8 ± 0.2, respectively; $p < .003$). The mean EDITS index score in the sildenafil group (68.4 of 100) was significantly higher than that in the placebo group (44.6; $p < .0001$). The most frequently reported adverse events (all causes) included headache (9% sildenafil versus 9% placebo), dyspepsia (9% versus 1%), facial flushing (9% versus 0%), rhinitis (4% versus 1%), and abnormal vision (3% versus 0%). Four sildenafil and seven placebo patients discontinued double-blind treatment; none were related to the study drug.

*Conclusions:* Sildenafil was effective and well tolerated in treating ED associated with serotonergic antidepressant therapy for MDD.

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, Seidman SN, Gelenberg AJ, et al: Depression, antidepressant therapies, and erectile dysfunction: clinical trials of sildenafil in treated and untreated patients with depression. Urology 2002; 60(2 suppl 2):58–66.

## No. 112
## PRETREATMENT CHARACTERISTICS OF PLACEBO RESPONSE IN MAJOR DEPRESSION

Andrew F. Leuchter, M.D., *Department of Psychiatry, Neuropsychiatric Institute-UCLA, 760 Westwood Plaza, Room 37-426, Los Angeles, CA 90024-8300;* Ph.D. Melinda Morgan, Ph.D., Ian A. Cook, M.D., Michelle Abrams, R.N., Jennifer Dunkin, Ph.D., Elise Witte, Ph.D., Scott D. Greenwald, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand previous research on predictors of placebo response in depression and new findings integrating neurophysiologic, cognitive, and symptom measures to predict response.

## SUMMARY:

*Objective:* To identify the neurophysiologic, symptomatic, and cognitive characteristics of subjects who are likely to respond to placebo in clinical trials for MDD.

*Method:* Fifty-one subjects with MDD were treated in clinical trials with either fluoxetine (N = 24) or venlafaxine (N = 27). All subjects underwent pretreatment assessment with quantitative electroencephalographic (QEEG) cordance, as well as symptom ratings and neuropsychological testing. After a one-week single-blind, placebo lead-in, subjects were randomly assigned to double-blind placebo-controlled treatment with one medication. At the end of eight weeks, the blind was broken and treatment response assessed. Response was defined by a final Hamilton Depression Rating Scale score of ≤ 10.

*Results:* Fifty-two percent (13/25) of the medication-treated subjects and 38% (10/26) of the placebo-treated subjects, responded to treatment. Placebo responders had lower frontocentral cordance, compared with all other subjects ($p < .006$) and medication responders in particular ($p < .004$). Placebo responders also had faster cognitive processing time as assessed by neuropsychological testing and a lower rate of reporting of late insomnia ($p < .033$). Logistic regression using these pretreatment measures accurately identified 97.6% of eventual placebo responders.

*Conclusion:* These findings suggest that pretreatment assessment of prospective subjects for clinical trials may be useful for identifying subjects who are likely to show robust response to placebo.

Funding provided by NIMH, Eli Lilly and Company, and Wyeth-Ayerst Laboratories.

## REFERENCES:

1. Leuchter AF, Cook IA, Morgan M, et al: Changes in brain function of depressed subjects during treatment with placebo. Am J Psychiatry 2002; 159:122–129.
2. Mayberg H, Silva JA, Brannan SK, et al: The functional neuroanatomy of the placebo effect. Am J Psychiatry 2002; 159: 728–737.

## SCIENTIFIC AND CLINICAL REPORT SESSION 38—COGNITIVE BEHAVIORAL THERAPY

### No. 113
### A COGNITIVE-BEHAVIORAL TREATMENT FOR HYPOCHONDRIASIS

**WITHDRAWN**

### No. 114
### THE EFFECTIVE DELIVERY OF COGNITIVE-BEHAVIORAL THERAPY FOR PANIC DISORDER: AN INTERNATIONAL MULTICENTER TRIAL

Justin A. Kenardy, Ph.D., *Department of Psychology, University of Queensland, Brisbane, QQ 4072, Australia;* Michael G. Dow, Ph.D., Craig G. Taylor, M.D., Derek W. Johnston, Ph.D., Michelle G. Newman, Ph.D.

#### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to determine the impact of computer-assisted CBT on panic disorder.

#### SUMMARY:

*Objectives:* Cognitive behavior therapy (CBT) is the psychological treatment of choice for panic disorder (PD), but given limited access to CBT, it must be delivered with maximal cost-effectiveness. Previous research has found that a brief computer-augmented CBT was as effective as extended therapist-delivered CBT. The aim of this study was to replicate and extend these findings.

*Method:* In order to test this finding, 163 patients with PD across two sites in Scotland and Australia were randomly allocated to 12 sessions of therapist-delivered CBT (CBT12), six sessions of therapy either therapist-delivered (CBT6) or with computer augmentation (CBT6-CA), or a wait list comparison condition. In total, 140 patients completed treatment. Outcome was assessed by using an empirically derived composite measure incorporating standard measures of panic, anxiety and avoidance, reliable change, and health-related disability.

*Results:* All the treatments were more effective than the wait list. On completer and intention-to-treat analyses, CBT12 was more effective than CBT6 but not different from CBT6-CA. The active treatments did not differ statistically at six-month follow-up. No site differences were found.

*Conclusion:* The use of computers as an innovative adjunctive therapy tool was supported and merits further investigation.

#### REFERENCE:

1. Newman MG, Kenardy J, Herman S, et al: Comparison of cognitive-behavioral treatment of panic disorder with computer-assisted brief cognitive-behavioral treatment. J Consult Clin Psychol 1997; 65:173–178.

### No. 115
### EFFICACY OF SELF-ADMINISTERED COGNITIVE BEHAVIOR THERAPY AND SERTRALINE IN PANIC DISORDER

Jacques Bradwejn, M.D., *Department of Psychiatry, University of Ottawa, 1145 Carling Avenue, Ottawa, ON K17 7K4, Canada;* Diana Koszycki, Ph.D., Zindel V. Segal, Ph.D.

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that self-administered cognitive behavior therapy, in combination with pharmacotherapy, is an effective treatment for panic disorder.

#### SUMMARY:

*Objective:* Evidence suggests that a combination of CBT and pharmacotherapy can optimize treatment response in patients with panic disorder (PD). While pharmacological interventions can be easily delivered by family physicians, accessibility to trained CBT therapists is often limited, particularly in outer urban and rural areas, preventing a combined approach from being implemented. This multisite study evaluated the acute and long-term effects of self-administered CBT (SCBT) and sertraline (maximal dose = 200 mg/d), alone or in combination, in 251 patients with PD with or without agoraphobia. Results of the acute phase are presented.

*Method:* Patients were randomly assigned to 12 weeks of treatment with sertraline (N = 63), placebo pill (N = 62), sertraline plus SCBT (N = 65), or placebo plus SCBT (N = 61). Efficacy measures included patient self-monitoring of panic attacks and anticipatory anxiety, the Mobility Inventory for Agoraphobia (MI), the Body Sensations and Agoraphobic Cognitions Questionnaires (BSQ, ACQ), the Sheehan Disability Scale (SDS), and the Clinical Global Improvement (CGI) scale. Efficacy analysis was conducted on an intent-to-treat sample.

*Results:* The four treatments were equivalent in reducing the frequency and intensity of panic attacks. Sertraline plus SCBT was significantly better than placebo ($p < .05$) in decreasing the intensity of anticipatory anxiety and reducing scores on the MI, BSQ, ACQ, SDS, and CGI-severity of illness scale.

*Conclusions:* Self-administered CBT, in combination with sertraline, is an effective acute treatment for PD and improves core PD symptoms, including anticipatory anxiety, avoidance, and catastrophic cognitions.

Funded by the Medical Research Council of Canada (POP-15247) and Pfizer Canada.

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2. Londborg PD, et al: Sertraline in the treatment of panic disorder: a multi-site, placebo-controlled, fixed dose investigation. Br J Psychiatry 1998; 173:54–60.

## SCIENTIFIC AND CLINICAL REPORT SESSION 39—OUTCOMES IN DEPRESSION

### No. 116
### PROBLEM-SOLVING ABILITY AND COMORBID PERSONALITY DISORDERS IN DEPRESSED OUTPATIENTS

Rebecca Harley, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Megan E. Hughes, B.A., Heidi D. Montoya, B.A., George I. Papakostas, M.D., Albert Yeung, M.D., Paolo Cassano, M.D., Amy H. Farabaugh, Ph.D., Maurizio Fava, M.D.

#### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the relationships between personality disorder comorbidity and problem-solving ability among patients suffering from major depressive disorder.

## SUMMARY:

*Objective:* There is good evidence that poor problem-solving ability is associated with major depressive disorder (MDD), but very little is known about the possible contributions of specific personality traits to this relationship. We assessed the relationship between problem-solving ability and personality disorder comorbidity among outpatients with MDD.

*Methods:* Drug-free outpatients (155 women and 136 men; mean age = 39.9 years) with a diagnosis of MDD according to the SCID-P were also administered the clinician-rated SCID-II to assess possible personality disorder comorbidity. In addition, these subjects were administered the Problem Solving Inventory (PSI), a 35-item self-rating questionnaire assessing problem-solving behavior and attitudes, with higher scores indicating more dysfunctional behavior/attitudes.

*Results:* Significantly ($p < .05$) higher PSI scores were associated with specific comorbid personality disorders diagnoses (avoidant, dependent, self-defeating, passive aggressive, narcissistic, and borderline). These relationships remained statistically significant even after adjustment for age and/or gender (whenever such adjustments were indicated), with the greatest degree of significance ($p < .0001$) concerning the relationship between PSI scores and both avoidant and borderline personality disorders.

*Conclusion:* Outpatients with MDD with specific patterns of personality disorder comorbidity appear to report poorer problem-solving ability than depressed patients without such comorbidity. Further studies exploring the nature of this relationship are warranted.


## REFERENCE:


1. Cannon B, Mulroy R, Otto MW, et al: Dysfunctional attitudes and poor problem solving skills predict hopelessness in major depression. J Affect Disord 1999; 55:45–49.


## No. 117
## A COMPARISON OF WEIGHT CHANGES ASSOCIATED WITH DIFFERENT AUGMENTATION STRATEGIES


Christina M. Dording, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Megan E. Hughes, B.A., Pamela A. Roffi, B.S., Roy H. Perlis, M.D., Jonathan E. Alpert, M.D., Dan V. Iosifescu, M.D., Maurizio Fava, M.D.


## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the effects on weight of various augmentation strategies in depressed patients.


## SUMMARY:

*Objective:* Although augmentation strategies are commonly used in the management of depressed SSRI nonresponders, very little is known about the effects on weight of such strategies. We assessed whether fluoxetine augmentation with low-dose lithium or low-dose desipramine would differ, in terms of weight changes, from raising the dose of fluoxetine alone.

*Methods:* Weight measures before and after the augmentation period were available for 91 outpatients with major depressive disorder (45 men and 46 women; mean age = 40.9 ± 10.7 years) who were either partial or nonresponders to eight weeks of treatment with 20 mg/day of fluoxetine, and who had been randomly assigned to four weeks of double-blind treatment with high-dose fluoxetine (40–60 mg/day), fluoxetine plus lithium (300–600 mg/day), or fluoxetine plus desipramine (25–50 mg/day).

*Results:* There was no significant difference in the mean change in weight from the beginning of the double-blind phase to endpoint across the three treatment groups [high-dose fluoxetine (N = 29): 0.97 lbs. (weight loss); fluoxetine plus desipramine (N = 31): 0.37 lbs. (weight loss); fluoxetine plus lithium (N = 31): 0.48 lbs. (weight gain)], before and after adjusting for age and gender. However, after adjusting for age and gender, there was a statistically significant ($p < .05$) difference in the mean percent change in weight from the beginning of the double-blind phase to endpoint across the three treatment groups [high-dose fluoxetine: 0.8% (weight loss); fluoxetine plus desipramine: 0.1% (weight loss); fluoxetine plus lithium: 0.3% (weight gain)].

*Conclusion:* This four-week double-blind study suggests that, while a dose increase in fluoxetine may be associated with a small weight loss, augmentation with desipramine is relatively weight neutral and augmentation with lithium may be associated with weight gain.


## REFERENCES:


1. Saches GS, Guille C: Weight gain associated with use of psychotropic medications. J Clin Psychiatry 1999; 60(suppl 21): 16–19.
2. Fava M, et al: Fluoxetine versus sertraline and paroxetine in major depressive disorder: changes in weight with long-term treatment. J Clin Psychiatry 2000; 61:863–867.


## No. 118
## DEPRESSION DISEASE MANAGEMENT IMPROVES DEPRESSION AND QOL


Ron Aubert, Ph.D., *DMA, Medco Health Solutions, 100 Parsons Pond Drive, Franklin Lakes, NJ 07417;* Fang Xia, Ph.D., Cindy Woo, M.P.H., George Fulop, M.D.


## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the benefits of a depression disease management program to improve quality of life and symptoms of depression in a PBM-based intervention.


## SUMMARY:

*Objective:* To evaluate the impact of educational calls and mailings on quality of life (QOL), symptom burden, and productivity among members with new or recurrent depression enrolled in a PBM-based disease management program.

*Method:* A pre-post evaluation was completed that included members identified from pharmacy claims data and invited to participate in a depression health management program. Program participants received up to two calls and three educational mailings focused on the importance of and barriers to medication compliance, productivity, and satisfaction with the program (N = 494). Quality of life was measured by using the SF-12, symptom burden was measured by using the SCL-20, and productivity was estimated by using questions taken from the Midlife Development in the United States Survey.

*Results:* At the four-month follow-up, compared to baseline, depression disease management program participants had significantly better SF-12 quality-of-life mental (37.2% versus 48.2%, $p < .0001$) and physical functioning scores (43.3% versus 44.4%, $p = .012$) and fewer lost productivity days (3.9 versus 1.7, $p < .0001$). In addition, more than 44% of participants reported a 50% or greater reduction in depression symptoms.

*Conclusion:* A 50% decrease in depressive symptoms and a return to population-normal range of mental health quality of life were noted after initiating a PBM-based depression disease management program. The clinical improvement observed was consistent with previous interventions described in depression disease management programs conducted at managed care organizations and academic centers.

REFERENCES:

1. American Psychiatric Association, Work Group on Major Depressive Disorders: Practice Guideline for the Treatment of Patients with Major Depressive Disorder (revision). Am J Psychiatry 2000; 157(4 (suppl):1–45.
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# SCIENTIFIC AND CLINICAL REPORT SESSION 40—SLEEP DISORDERS

## No. 119
## MODAFINIL IMPROVES COGNITION IN NARCOLEPSY PATIENTS WITH EXCESSIVE SLEEPINESS

Jonathan R. L. Schwartz, M.D., *Integris Sleep Center, 4200 South Douglas Avenue, Suite 313, Oklahoma City, OK 73109;* Michael T. Nelson, Rod J. Hughes, Ph.D., Chris A. Veit, M.S.W., Kenneth C. Cobb, Elliott R. Schwartz, D.O.

### EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to understand how modafinil improves wakefulness and executive function in patients with excessive sleepiness associated with narcolepsy.

### SUMMARY:

*Objective:* Patients with excessive sleepiness associated with narcolepsy experience cognitive impairment. The novel wake-promoting agent modafinil works selectively through the sleep/wake centers of the brain to activate the frontal cortex. Modafinil has been shown to improve wakefulness in patients with narcolepsy and cognitive performance in models of sleep loss. We evaluated the effects of modafinil on wakefulness and executive function in narcolepsy patients.

*Methods:* Twenty-four narcoleptic patients with residual late-afternoon/evening sleepiness despite a satisfactory daytime response to modafinil participated in this randomized, double-blind study. Following a one-week placebo washout period, patients received treatment for three weeks with either modafinil 400 mg once daily (400 mg at 7 a.m. and placebo at noon) or 600 mg as a split dose (400 mg at 7 a.m. and 200 mg at noon). Wakefulness was assessed by using the Maintenance of Wakefulness Test, and executive function was assessed by using the Wisconsin Card Sort Test (WCST).

*Results:* Both doses of modafinil significantly improved patients' ability to sustain wakefulness at week three compared with baseline ($p < .01$). Although both doses of modafinil reduced the total number of errors on the WCST at week three versus baseline, this improvement reached statistical significance only for the 600 mg split dose ($p < .01$). Modafinil was well tolerated at both doses.

*Conclusion:* Modafinil improves wakefulness and executive function in patients with excessive sleepiness associated with narcolepsy.

Funded by Cephalon, Inc.

### REFERENCES:

1. Scammell TE, Estabrooke IV, McCarthy MT, et al: Hypothalamic arousal regions are activated during modafinil-induced wakefulness. J Neurosci 2000; 20:8620–8628.
2. Turner DC, Robbins TW, Dowson J, et al: Modafinil: a novel cognitive enhancer. J Psychopharmacol 2002; 16(suppl):A27.

## No. 120
## MODAFINIL AS ADJUNCTIVE THERAPY IMPROVES QUALITY OF LIFE IN SLEEP APNEA

Milton K. Erman, M.D., *Department of Psychiatry, University of California at San Diego, 9834 Genesee Avenue, Suite 328, La Jolla, CA 92037-1223*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the effect of sleep apnea on quality of life and understand the appropriate use of adjuntive therapeutic options.

### SUMMARY:

*Objective:* Patients with obstructive sleep apnea (OSA) experience sleepiness and impaired quality of life (QOL). Nasal continuous positive airway pressure (nCPAP) treats respiratory abnormalities and improves QOL. Despite regular nCPAP use, some patients experience residual sleepiness and reduced QOL. Modafinil, a novel wake-promoting agent, improved QOL in a short-term study in OSA patients with residual sleepiness despite regular nCPAP use. We report the effects of chronic treatment with modafinil on QOL in this population.

*Methods:* Patients with OSA and residual sleepiness despite regular nCPAP use entered a 12-week, randomized, double-blind, placebo-controlled, parallel-group study. Patients received placebo or modafinil titrated to 200 mg or 400 mg once daily. Functional status and QOL were assessed by using the 30-item Functional Outcomes of Sleep Questionnaire (FOSQ) and the 36-item Short Form Health Survey (SF-36).

*Results:* OSA patients who used nCPAP ($N = 309$) were randomly assigned to treatment groups; data for 268 regular nCPAP users are reported here. Modafinil significantly improved QOL at week 12 compared with baseline ($p < .05$). At week 12, modafinil significantly improved FOSQ total score and domain scores for vigilance, general productivity, activity level, and intimacy. Significant results were also found for SF-36 domain scores for vitality, general health, and physical composite index. Modafinil was well tolerated. The most common adverse events were headache, nausea, and anxiety.

*Conclusion:* Modafinil significantly improved measures of QOL, including vitality and productivity, when used as an adjunct to regular nCPAP therapy.

Funded by Cephalon, Inc.

### REFERENCES:

1. Beusterien KM, Rogers AE, Walsleben JA, et al: Health-related quality of life effects of modafinil for treatment of narcolepsy. Sleep 1999; 22:757–765.
2. Feldman N, Walsleben JA: Effect of modafinil on nighttime sleep and quality of life in patients with sleep apnea and residual daytime sleepiness despite effective NCPAP therapy [abstract]. Chest 2000; 118(suppl 14):146S.

## No. 121
## MODAFINIL IMPROVES QUALITY OF LIFE AS ADJUNCT TREATMENT OF OBSTRUCTIVE SLEEP APNEA

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 demonstrate improvement in functional quality of life with modafinil administered as adjunct therapy with nasal continuous positive airway pressure in patients with obstructive sleep apnea who experience residual daytime sleepiness.

## SUMMARY:

*Objective:* Excessive sleepiness is a primary symptom of obstructive sleep apnea (OSA) and impairs quality of life. Nasal continuous positive airway pressure (nCPAP) is the gold standard for treating nighttime respiratory abnormalities and improves QOL. Despite regular use of nCPAP, some patients experience residual excessive sleepiness and reduced QOL. Modafinil, a novel wake-promoting agent, improves health-related QOL in patients with excessive sleepiness associated with narcolepsy. This randomized, double-blind, placebo-controlled, parallel-group study investigated the effect of modafinil on functional quality of life in OSA patients with residual daytime sleepiness despite regular nCPAP use.

*Methods:* Patients received modafinil (200 mg/day, week one, titrated to 400 mg/day, weeks two to four) or matching placebo as an adjunct to nCPAP once daily for four weeks. Quality of life was assessed by using the Functional Outcomes of Sleep Questionnaire (FOSQ), administered at baseline, week one, and week four.

*Results:* A total of 157 patients were enrolled. Treatment with nCPAP plus modafinil significantly improved sleep-related functional status, compared with nCPAP plus placebo. Treatment with nCPAP plus modafinil significantly improved FOSQ total scores (weeks one and four) and the FOSQ vigilance (weeks one and four) and activity level (week one subcales versus placebo ($p < .05$).

*Conclusions:* Adjunctive treatment with modafinil may improve functional quality of life in patients with residual daytime sleepiness despite regular use of nCPAP.


Funded by Cephalon, Inc.

## REFERENCES:


1. Pack AI, Black JE, Schwartz JRL, et al: Modafinil as adjunct therapy for daytime sleepiness in obstructive sleep apnea. Am J Respir Crit Care Med 2001; 164:1675–1681.
2. Beusterien KM, Rogers AE, Walsleben JA, et al: Health-related quality of life effects of modafinil for treatment of narcolepsy. Sleep 1999; 22:757–765.

# SYMPOSIUM 1—BORDERLINE PATIENTS AT THE BORDER OF TREATABILITY

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to (1) improve understanding of the borderline patient's ambivalence about living and the ways in which suicidal risk can be assessed and managed, (2) recognize factors that are associated with high treatment utilization without good outcome in patients with severe BPD, (3) understand different variants of the erotic transference in borderline patients and be better prepared to deal with this situation clinically, (4) recognize patient characteristics associated with poor treatment response, and (5) diagnose with greater accuracy and devise more effective treatment strategies in working with highly challenging borderline patients whose antisocial features may include credit-card theft, stalking, or malicious acts.

## No. 1A
## MANAGING THE REAL RISK OF SUICIDE IN BORDERLINE PATIENTS

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*

SUMMARY:

Suicide is a real danger in patients with borderline personality disorder. The 9% risk is more than 400 times that found in the general population. This fact reflects these patients' belief that life without a caretaking other is not worth living.

This presentation will describe issues in assessing immediate and long-term suicide risk. It will then describe strategies for managing those borderline patients where real risk is found. Even when risk of suicide is real, responses that try to enlist the patient's volition to live should be attempted. The use of interpretations, however accurate, about the meanings associated with being saved (i.e., being lovable, being adopted, etc.) should be used judiciously. The countertransference feelings and the liability issues that arise in managing these risks will be discussed.

## No. 1B
## TREATMENT UTILIZATION BY PATIENTS WITH SEVERE BPD

Donna S. Bender, Ph.D., *NYS Psychiatric Institute, 1051 Riverside Drive, Box 129, New York, NY 10032;* Andrew E. Skodol II, M.D.

SUMMARY:

Borderline personality disorder (BPD) is associated with serious self-destructive tendencies, such as self-mutilation and suicidal behavior, as well as significant impairment in many areas of functioning. Patients with BPD struggle with affective instability, identity disturbance, and marked interpersonal discord. At its worst, BPD can be refractory to treatment, in spite of extensive use of various modalities.

The purpose of this presentation is to explore elements affecting treatment utilization and outcome by patients with BPD, particularly in more difficult cases. To frame the issue, data from a multi-site longitudinal study will be presented, which demonstrates patients with BPD use significantly more mental health treatments in greater amounts than patients with major depression and no personality disorder. For many severe cases of BPD, it will also be shown that heavy use of treatment resources does not lead to improvement in functioning. Examples of contributing factors that will be explored are extensive comorbidity, both Axis I and Axis II; lack of adequate or appropriate social supports; and noncompliance or negative alliance with therapists. Specific case examples will be presented to illustrate the complex interplay of various features that make BPD a potentially tragic disorder and one of the greatest challenges faced by mental health professionals.

## No. 1C
## EROTICIZED TRANSFERENCES IN THERAPY WITH BORDERLINE PATIENTS

Frank E. Yeomans, M.D., *Department of Psychiatry, Weill Cornell, 135 Central Park West, Suite 1-N, New York, NY 10023*

SUMMARY:

Therapists are often intimidated/challenged in their efforts to treat borderline patients. The initial challenge is often that of meeting, containing, and addressing levels of aggression that are involved in the negative transference. However, as difficult as that stage of therapy may be, the most difficult challenges with these patients may occur later on in cases where the transference takes on an overtly erotic tone. In these cases, therapists are faced with the need to understand a particularly intense and complex transference-countertransference matrix. This talk will address some of the vicissitudes of this situation. Two clinical examples will be discussed illustrating a crucial distinction between the eroticized transference that is in the service of aggression and a more simple, straightforward variant of the eroticized transference.

## No. 1D
## THE ALMOST-UNTREATABLE NARCISSISTIC PATIENT

Otto F. Kernberg, M.D., *Department of Psychiatry, New York Hospital/Cornell, 21 Bloomingdale Road, White Plains, NY 10605-1504*

SUMMARY:

This presentation will summarize the prognostic indications for the psychodynamic psychotherapy of patients with narcissistic personality disorder. They include severity of antisocial features, degree of aggressive behaviors toward others and self, remaining capacity of object relations, capacity to work commensurate with education and cultural background, and drug and alcohol abuse.

The technical preconditions for assuming a reliable therapeutic working relationship will be explored. The exploration and resolution of dominant transference issues underlying the strong tendency of these patients to devalue the treatment, and dropping out, will be explored.

Clinical case material will illuminate all these issues, with particular relevence to the experiences of the psychotherapy project of the Cornell University Medical Center, Westchester Division.

## No. 1E
## AN EMPIRICAL APPROACH TO THE BORDER OF TREATABILITY IN BPD PATIENTS

John F. Clarkin, Ph.D., *21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

The research literature indicates a number of ways that patients with borderline personality disorder (BPD) present impediments and lack of response to treatment. First of all, the treatment dropout

rate in this patient group is more extensive than other diagnostic categories, ranging from 30% to 70% in various studies. Secondly, although mean scores indicate treatment effectiveness in some studies, focus on mean scores alone can distract from variability in patient response. Finally, therapists have difficulty dealing with these patients, and prominent research groups have instituted group consultation for the therapists to overcome this obstacle to treatment.

An ongoing randomized clinical trial comparing three types of outpatient psychotherapy (supportive, cognitive-behavioral, and psychodynamic) of one-year duration for BPD patients presents an opportunity to empirically define the border of treatability. The border of treatability has been operationalized as those patients who prematurely (within the first four months) drop out of treatment or attend less that half of the scheduled sessions, and those patients who remain or become more symptomatic within the first four months of a planned one-year treatment.

Preliminary analyses indicate that patient factors related to untreatability as operationalized above are baseline aggression, identity diffusion, and temperamental aspects of poor effortful control. These results will be discussed in reference to the clinical descriptions of untreatability.

## No. 1F
## BORDERLINE PATIENTS WITH ANTISOCIAL FEATURES: SPECIAL TREATMENT ISSUES

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, # 114, New York, NY 10024-6027*

### SUMMARY:

Among borderline patients whose severe psychopathology places them also at the "border" of treatability are those with a strong admixture of antisocial features. Those who are fully comorbid—satisfying DSM criteria for both borderline and antisocial personality disorders (i.e., BPD × ASPD) may not even present themselves to treating facilities, and come into contact with treating institutions only through the intervention of the law.

Those with less prominent antisocial traits may present with a variety of clinical pictures that may include obsessive love, with physical stalking and harassing phone calls, nonviolent paraphilic tendencies (telephone schatologia, frotteurism, etc), or credit card fraud and other acts of theft. The latter are often confined to stealing from family members, whose reluctance to involve the law "protects" the offending member from brushes with the authorities. The spreading of malicious rumors as an act of revenge for a past hurt constitutes another variety.

Though presenting inordinate difficulties to their therapists, many of these patients can be helped significantly. What will usually be required is a combined approach, emphasizing drastic, innovative limit-setting techniques tailored to the patient, along with intensive therapy. Depending upon the cognitive style of the patient, this may be of a cognitive type, or of a psychodynamic type. The main goal of the therapy is to address the underlying motive forces, including feelings of deprivation, extreme dependency (especially in stalking cases), or bitterness compounded with vengefulness.

It is of prognostic importance to assess the degree of psychopathic tendencies via the Hare Psychopathy Checklist-Revised [PCL-R]: scores in the high range (>29) bespeak a gloomy outlook, whereas borderline patients with low scores (5–15) may prove rewardingly amenable to treatment. Clinical examples of the main subtypes will be given.

### REFERENCES:

1. Gunderson JG: Borderline personality disorder: a clinical guide. APPI, Washington, DC, 2001.
2. Bender DS, Dolan RT, Skodol AE, Sanislow CA, Dyck IR, McGlashan TH, Shea MT, Zanarini MT, Oldham JM, Gunderson JG: Treatment utilization by patients with personality disorders. Am J Psychiatry 2001; 158:295–302.
3. Kernberg OF: Love in the analytic setting, in Love Relations: Normality and Pathology. New Haven, Yale University Press, pp. 113–126, 1995.
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5. Clarkin JF, Foelsch PA, Levy KN, et al: The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. Journal of Personality Disorders 2001; 15(6), 487–495.
6. Stone, MH: Gradations of antisociality and responsivity to psychosocial therapies, in Psychotherapy of Personality Disorders. Review of Psychiatry. Edited by Gunderson & Gabbard, vol. 19. Washington DC, Amer Psychiat Press, pp 95–130, 1999.

# SYMPOSIUM 2—MINERAL/VITAMIN MODIFICATION OF MENTAL DISORDERS AND BRAIN FUNCTION

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize that subclinical micronutrient intake occurs in subsections of the population and disrupts mood and cognition, (2) recognize the importance of micronutrient intake as a causal factor in antisocial behavior, (3) recognize the potential role of micronutrient treatment of mood and behavior problems, and (4) recognize potential difficulties posed by micronutrient research and treatment, especially concerning toxicity, drug interactions, and lack of government regulation.

## No. 2A
## NUTRIENTS ALTER IQ AND MOOD IN HEALTHY VOLUNTEERS: A PLAUSIBLE HYPOTHESIS?

David Benton, Ph.D., *Department of Psychology, University of Swansea, Singleton Park, Swansea Wales SA2 8PP, United Kingdom*

### SUMMARY:

Double-blind, placebo-controlled studies that considered the impact of micronutrients on the intelligence of normal children will be reviewed. A Medline search produced 13 studies of multi-mineral/vitamin supplementation. Of these, 10 reported a positive response, all with nonverbal rather than verbal measures of IQ (improvement in the range of 3–9 points). Not all children responded; rather there is a minority, those with diets low in micronutrients, who benefited. The size of this minority varied and may reflect socioeconomic variables. Selenium supplementation in five double-blind trials was associated with improved mood and anxiety in normal healthy volunteers, as measured with the Profile of Mood States. The mechanism of selenium action is not known, but it does not appear to involve glutathione peroxidase, as there is evidence that levels of selenium above those needed to maximize the activity of this selenoprotein improve mood. Living in an area with low soil selenium may speculatively be a critical variable. There are four well-controlled studies reporting that vitamin B1 supplementation improved mood, which was associated with increased erythrocyte transketolase activity, the standard measure of B1 status. Many of these findings still require large-scale replications, but the hypothesis that micronutrient status influences psychological functioning of some people is plausible. Dietary intake of micronutrients of psychiatric patients deserves attention.

## No. 2B
## INFLUENCE OF MICRONUTRIENTS ON ANTISOCIAL BEHAVIOR OF YOUNG-ADULT PRISONERS

C. Bernard Gesch, C.Q.S.W., *Lab of Physiology, University of Oxford, Parks Road, Oxford OX1 3PT, United Kingdom;* Sean M. Hammond, Ph.D., Sarah E. Hampson, Ph.D., Anita Eves, Ph.D., Martin J. Crowder, Ph.D.

### SUMMARY:

There is evidence that offenders consume diets lacking in essential nutrients and that this may adversely affect their behavior.

*Objective:* To test empirically if physiologically adequate intakes of vitamins, minerals, and essential fatty acids cause a reduction in antisocial behavior.

*Methods:* Experimental, double-blind, placebo-controlled, randomized trial of nutritional supplements on 231 young adult prisoners, comparing disciplinary offenses before and during supplementation.

*Results:* Compared with placebos, those receiving the active capsules committed an average of 26.3% (8.3%–44.3%, 95% CI) fewer offenses ($p = 0.03$, two tailed). Compared with baseline, the effect on those taking active supplements for a minimum of two weeks ($n = 172$) was an average 35.1% (16.3%–53.9%, 95% CI) reduction of offenses ($P < 0.001$, two tailed), whereas placebos remained within standard error.

*Conclusions:* Antisocial behavior in prisons, including violence, is significantly reduced by ensuring prisoners receive physiologically adequate intakes of vitamins, minerals, and essential fatty acids, with similar implications for those eating poor diets in the community. Since physiological intakes of these nutrients are essential, this study provides important evidence that poor nutrition may be a cause of antisocial behavior.

## No. 2C
## NUTRIENT TREATMENT OF ADULT BIPOLAR DISORDER AND CHILDHOOD MOOD LABILITY

Bonnie J. Kaplan, Ph.D., *Department of Pediatrics, University of Calgary, 1820 Richmond Road, SW, Calgary Alberta T2T 5C7, Canada*

### SUMMARY:

A multi-ingredient nutritional supplement (containing no lithium) was evaluated in open-label trials for its impact on bipolar disorder, mood lability, and explosive rage in both adults and children. Assessment of adults at entry and post-treatment used the Hamilton-Depression Scale (Ham-D), Brief Psychiatric Rating Scale (BPRS), and Young Mania Rating Scale (YMRS). In 11 adults (aged 19–46) with bipolar disorder who were followed for a mean of 44 weeks, paired t-tests showed treatment benefit on all measures (Ham-D $p < .01$, BPRS $p < .05$, YMRS $p < .01$), and the need for psychiatric medications decreased ($p < .01$). Assessment of children included the YMRS, Child Behavior Checklist (CBCL), and Youth Outcome Questionnaire (YOQ). In nine children (aged 8–15) followed for an average of 14 weeks, lower scores were obtained for all seven of the CBCL scales that had been elevated ($p < .05$ to $p < .01$); the YOQ and YMRS also showed significant improvement ($p < .001$ and $p < .05$, respectively). Effect sizes for all variables in both adults and children were large (>.8). Two additional children will be presented who were studied with ABAB reversal designs. Side effects (nausea, soft stools) were occasional, mild, and transitory. In addition to lithium, other micronutrients should be examined for potential mood-stabilizing properties. Randomized, placebo-controlled trials in adult bipolar disorder have been funded.

## No. 2D
## CLINICAL QUESTIONS AND CONCERNS RAISED BY MICRONUTRIENT TREATMENTS

Charles W. Popper, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-1048*

### SUMMARY:

In this symposium, evidence is presented that broad-based mixtures of minerals and vitamins might have mood-stabilizing, anti-aggressive, cognition-enhancing, and other therapeutic CNS properties. Clinically and statistically significant symptom reductions were noted within weeks and sustained over months of observation, using both standard (e.g., Recommended Daily Allowance) and high-dose strategies. While further studies of nutrient-behavior interactions are justified, such treatments raise various concerns. Despite widespread public use, controlled toxicity studies on micronutrient combinations are not available, suggesting the need for rigorous FDA regulation of nutrient products. Possible mechanisms of actions of minerals and vitamins on CNS function can be considered speculatively, pending confirmation of the clinical findings. Preliminary observations of interactions between micronutrients and psychiatric medications, generally in the direction of potentiating psychotropic drug effects and withdrawal effects, require clinicians' vigilance. The ethics of scientific research using complex combinations of ingredients, and issues related to IND approval by the FDA, will be reviewed. The problems of media sensationalism and excessive skepticism regarding nutrient treatment have raised interesting challenges to the dispassionate conduct of research. The commercial implications of these findings will be discussed, in view of the possibility that micronutrient treatments might someday offer inexpensive alternatives to pharmaceutical treatments.

### REFERENCES:

1. Benton D: Micro-nutrient supplementation and the intelligence of children. Neurosci Biobehav Rev 2002; 25:297–309.
2. Gesch CB, Hammond SM, Hampson SE, Eves A, Crowder MJ: Influence of supplementary vitamins, minerals, and essential fatty acids on the antisocial behaviour of young adult prisoners: randomized, placebo-controlled trial. Br J Psychiatry 2002; 181:22–28.
3. Kaplan BJ, Simpson JSA, Ferre RC, Gorman CP, McMullen DM, Crawford SG: Effective mood stabilization with a chelated mineral supplement: an open-label trial in bipolar disorder. J Clin Psychiatry. 2001; 62:936–944.
4. Popper CW: Do vitamins or minerals (apart from lithium) have mood-stabilizing effects? J Clin Psychiatry 2001; 62:933–935.

# SYMPOSIUM 3—BPD: NEUROSCIENCE TO TREATMENT AND BACK

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize that borderline patients in both clinical and research settings can be screened for the presence of BPD with a high degree of both sensitivity and specificity, (2) be aware of latest advances of neurobiologic research in BPD and their implications for treatment and should be able to treat these disorders more effectively, (3) recognize the pathophysiological significance of emotional dysregulation to BPD, (4) be able to discuss the results of recent pharmacologic treatments for BPD and current methods for assessing outcome, and (5) be familiar with the data supporting DBT as an intervention for BPD.

## No. 3A
## THE MCLEAN SCREENING INSTRUMENT FOR BPD

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

### SUMMARY:

*Objective:* Borderline personality disorder (BPD) is a common psychiatric disorder that is often overlooked in treatment settings. This report describes the validation of a new self-report screening measure for DSM-IV BPD—the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD).

*Method:* A total of 200 subjects with treatment histories whose ages ranged from 18 to 59 filled out the MSI-BPD. Each subject was then interviewed, blind to MSI-BPD results, with the BPD module of the Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV).

*Results:* Of these 200 subjects, 139 (69.5%) met DSM-IV criteria for BPD as assessed by the BPD module of the DIPD-IV and the remaining 61 subjects (30.5%) did not. Using logistic regression analyses, an MSI-BPD cutoff of 7 or more of the measure's 10 items was judged to be the best cutoff score. This was so because it yielded both good sensitivity (.81) (percentage of correctly identified cases) and specificity (.85) (percentage of correctly identified non-cases) for the diagnosis of DSM-IV BPD. Even better diagnostic efficiency was found for the 55 subjects below the age of 25 (sensitivity = .91 and specificity = .92).

*Conclusions:* The MSI-BPD may be a useful screening instrument for the presence of DSM-IV borderline personality disorder.

Supported by a grant from Eli Lilly and Company.

## No. 3B
## BIOLOGY OF BPD: TOWARD A RATIONAL PHARMACO/PSYCHOTHERAPY

Larry J. Siever, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place. Box 1230, New York, NY 10029;* Antonia S. New, M.D., Harold W. Koenigsberg, M.D., Marianne Goodman, M.D., Monte S. Buchsbaum, M.D., Anissa Abi-Dargham, M.D., Marc Laruelle, M.D.

### SUMMARY:

Studies of the neurobiology of BPD suggest that the susceptibility to BPD is encoded in dimensions of vulnerability including affective instability and impulsive/aggression. Other related pathology may include a cognitive and dissociative dimension. Studies using neuroimaging, genetics, cognitive and affective neuroscience, and psychophysiology suggest that reduced activity in prefrontal cortical control areas such as orbital frontal and ventromedial prefrontal cortex are less effective in preventing the emergence of aggression, in part, apparently because of reduced serotonergic facilitation. Serotonin transporter number may be reduced, while postsynaptic 5-$HT_2$ receptor number may be compensatorily increased, with net reduced responsiveness, so that serotonin is less effective at facilitating prefrontal suppression. Subcortical structures such as amygdala and hyperthalamus may be overactive in response to incoming affectively charged stimuli, underlying the affective lability characteristic of these patients. Altered dopamine and enkaphalin activity may also play a role in borderline psychopathology. A better knowledge of the neurobiology of these disorders may help us to find pharmacologic interventions that may target these neurobiologic vulnerability dimensions such as SSRIs to restore inhibitory control, mood anticonvulsants to stabilize affective instability, and atypical neuroleptic medications to restore altered serotonergic/dopamininergic inbalances. Psychosocial interventions may help to shift the maladaptive coping strategies acquired in the context of intense, shifting affects as well as impulsive acting out patterns by cognitive-behavioral or psychodynamic methods.

## No. 3C
## NEURAL SUBSTRATES OF EMOTIONAL DYSREGULATION IN BPD

Nelson H. Donegan, Ph.D., *Department of Psychiatry, Yale University, P O 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 develop a better understanding of the neuropathophysiology responsible for emotional dysregulation in patients with borderline personality disorder (BPD) by using emotional perturbation procedures coupled with fMRI.

*Method:* The Ekman and Friesen picture series of facial expressions (fearful, sad, happy, and neutral expressions) and a fixation point were presented in a block design during an fMRI imaging session. Subjects had no task other than to concentrate on the faces.

*Results:* Using region of interest analyses and comparing blocks of a particular facial expression to blocks with the fixation point for both groups, planned contrasts revealed that borderline patients (N = 15) showed significantly more left amygdala activation to fearful ($p < .001$), sad ($p < .05$), and neutral ($p < .05$) faces compared with normal controls (N = 10), but did not differ significantly in amygdala activation to happy faces ($p = .2$). Subgroups of BPD patients with active PTSD (N = 7) or MDD (N = 7) showed comparable levels of left amygdala activation to BPD patients without PTSD (N = 7) or MDD (N = 7), respectively ($p > .3$ in both cases). Comparing the 11 BPD patients who were medicated to the four who were not revealed that patients with medication showed lower levels of left amygdala activation than patients without medication, but their level of activation was still significantly higher than normal. These results suggest that neither medication, MDD, nor PTSD status were likely causes of the difference in left amygdala reactivity between the NC and BPD groups.

*Conclusion:* Pictures of human emotional expressions elicit robust differences in amygdala activation levels in borderline patients compared with normal control subjects, and can be used as probes to study the neuropathophysiological bases of borderline personality disorder.

## No. 3D
## PHARMACOTHERAPY FOR BPD: NEW OPPORTUNITIES

S. Charles Schulz, M.D., *Department of Psychiatry, University of Minnesota Medical School, 2450 Riverside Avenue, Minneapolis, MN 55106;* K. Adityanjee

### SUMMARY:

In the last decade, a number of psychotropic medications have been introduced for the treatment of Axis I disorders that show significant efficacy with fewer side effects. Such agents from the class of atypical antipsychotics, new antidepressants including the SSRIs, and mood stabilizing anticonvulsants with extended action, have all been tried for borderline personality disorder in studies of varying designs. With the publication of treatment guidelines for BPD by the APA comes the need for further evidence-based pharmacologic treatment. The purpose of this presentation is to describe and compare the results of studies with atypical antipsychotic medica-

tions, antidepressants, and mood stabilizers. Special attention will be drawn to the assessment of dimensions within borderline personality disorder, as well as an exploration of outcome measures such as neuropsychological testing. Since the last annual meeting, a number of new studies have been completed that contribute to our understanding of medication treatment for this severe disorder.

In conclusion, this presentation connects with the preceding presentations describing the field's greater understanding of the neuroscience of BPD and provides a bridge to further work in psychosocial approaches.

### No. 3E
### DIALECTICAL BEHAVIOR THERAPY FOR PATIENTS MEETING CRITERIA FOR BPD

Marsha M. Linehan, Ph.D., *Department of Psychology, University of Washington, NI-25 P.O. Box 351525, Seattle, WA 98195*

SUMMARY:

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment developed by Marsha Linehan and her associates at the University of Washington aimed specifically at treating the suicidal patient meeting criteria for borderline personality disorder. As a whole, DBT focuses on synthesizing interventions focused on acceptance with those focused on change, a reciprocal with an irreverent communication style, and an emphasis on teaching the patient to manage both personal and professional provider networks with intervening in the environment when necessary. Validation of the patient is combined with change strategies such as (1) behavioral analyses, (2) application of behavioral strategies of contingency management, exposure procedures (cue exposure, response prevention), cognitive modification, behavioral skills training, (3) in vivo crisis intervention, (4) structuring the environment so that it does not reinforce dysfunctional acts, and (5) providing support for the therapist treating the borderline patient. Over a series of clinical trials, DBT has been shown effective in reducing the incidence of suicide attempts, deliberate but non-suicidal self-injurious behavior, treatment drop-out, inpatient hospitalization, substance abuse, depression and anger, as well as improving general and social adjustment. Most recent applications and outcome data will be presented and discussed.

REFERENCES:

1. Hyler SE, Skodol AE, Kellman HD, Oldham JM, Rosnick L: Validity of the Personality Diagnostic Questionnaire—Revised: comparison with two semistructured interviews. Am J Psychiatry 1990; 147:1043–1048.
2. Siever LJ: Biology of borderline personality disorder. TEN 2001; 3(11):41–47.
3. Linehan MM: Understanding Borderline Personality Disorder. NY, Guilford Press, 1995.
4. Schulz SC, Camlin KL: Treatment of borderline personality disorder: potential of the new antipsychotic medications. J Prac Psychiatry and Behav Hlth 1999; 5:247–255.

## SYMPOSIUM 4—PATHOLOGICAL BODY SCULPTING IN THE ATHLETE
## International Society for Sport Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the possibility of EDs in male athletes and be aware of vulnerable sports, and (2) understand childhood and family traits, body image disorders, and other attributes that may be risk factors for the use of anabolic-androgenic steroids in young men.

### No. 4A
### LITTLE GIRLS IN PRETTY BOXES: THE MAKING AND BREAKING OF ELITE GYMNASTS AND FIGURE-SKATERS

Joan Ryan, *P.O. Box 8, Ross, CA 94957*

SUMMARY:

How young girls abuse themselves, with the urging of coaches, parents, to have abnormally thin and small bodies in order to excel at their sport. This leads to health problems such as anorexia, bulimia, low bone density, depression, higher risks of injury and premature ends to their careers.

### No. 4B
### EATING DISORDERS IN THE MALE ATHLETE

Antonia L. Baum, M.D., *Department of Psychiatry, George Washington University, 5522 Warwick Place, Chevy Chase, MD 20815*

SUMMARY:

Eating disorders do occur in male athletes. They are less prominent than in female athletes, and therefore in danger of being missed. The high-risk sports fall into the same categories as with females: aesthetic sports, sports in which low body fat is advantageous such as cross country running and marathoning, and sports in which there is a need to "make weight," including wrestling and horse racing.

The phenomenology of these kinds of cases will be discussed, as well as some discussion of treatment issues.

### No. 4C
### RISK FACTORS FOR ANABOLIC-ADROGENIC STEROID ABUSE: A CASE CONTROL STUDY

Harrison G. Pope, Jr., M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Gen Kanayama, M.D., Geoffrey Cohane, B.A., James I. Hudson, M.D.

SUMMARY:

*Background:* Anabolic-androgenic steroid (AAS) use represents a major public health problem in the United States, but the risk factors for this form of drug use are little studied.

*Methods:* We evaluated 48 men who had used AAS for at least two months and 45 who had never used AAS, using a verbal interview and a battery of questionnaires covering possible demographic, familial, and psychosocial risk factors for AAS use. All subjects in both groups were experienced weightlifters; thus, differences between groups were likely to be associated specifically with AAS use, rather than with weightlifting in general.

*Results:* AAS users reported significantly poorer relationships with their fathers and greater childhood conduct disorder than non-users. At the time that they first started lifting weights, AAS users were significantly less confident than non-users about their body appearance. AAS users displayed much higher rates of other illicit substance use, abuse, or dependence than non-users, with use of other illicit substances almost always preceding first use of AAS.

*Conclusions:* In comparison to non-AAS-using weightlifters, AAS users appear to display a premorbid pattern of increased antisocial traits and decreased "male body esteem."

REFERENCES:

1. Pope HG Jr, Brower KJ: Anabolic-Androgenic Steroid Abuse. in Sadock BJ, Sadock VA, eds. Comp Textbook of Psychiatry/VII. Phil, PA: 2000; 1085–95.
2. Ryan J: Little Girls in Pretty Boxes. Warner Books, NY, 1995.
3. Baum A: Young Females in the Athletic Arena. Child and Adolescent Clinics VA, Vol. 7, 1998.

# SYMPOSIUM 5—COMPULSIVE BUYERS: TREATING THE CASUALTIES OF CONSUMERISM

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand compulsive buying and its features, (2) recognize that negative affect is a common trigger for compulsive buying episodes. They should also learn why. (3) use appropriate pharmacotherapies for compulsive buying, (4) identify several psychotherapy techniques that are useful in treating compulsive shopping, and (5) understand the treatment response and one-year course of compulsive buying disorder after a three-month controlled trial of citalopram.

## No. 5A
## PHENOMENOLOGY AND EPIDEMIOLOGY OF COMPULSIVE BUYING

Donald W. Black, M.D., *Psychiatry Research MEB, Univ of Iowa College of Med, Iowa City, IA 52242*


### SUMMARY:

Compulsive buying is defined as a clinical disorder characterized by maladaptive preoccupation with buying, shopping, or buying or shopping impulses or behavior accompanied by evidence of impairment and is not due to mania or hypomania. The disorder has been estimated to affect from 2% to 8% of the general adult population in the U.S.; 80% to 90% of those affected are female. Onset occurs in the late teens or early twenties and the disorder is generally chronic. Psychiatric comorbidity is frequent, particularly mood, anxiety, substance use, eating, and personality disorders.

The disorder is usually chronic. Shopping tends to be frequent and not confined to holidays or birthdays. Patients report irresistible urges to buy and have generally tried unsuccessfully to control them. Shopping episodes generally lead to positive affects, though are often followed by feelings of guilt or remorse. Most compulsive buyers prefer to shop alone and buy for themselves. Small items—clothing, shoes, jewelry, and make-up are the most common purchased by women who tend to buy in quantity. Greater severity of the buying disorder is associated with lower income, spending a lower percentage of income on sale items, and having a greater likelihood of Axis I or Axis II comorbidity.


## No. 5B
## EXAMINATION AND EXPLANATION OF THE TRIGGERS FOR COMPULSIVE BUYING DISORDERS

Ronald J. Faber, Ph.D., *Journalism, University of Minnesota, 111 Murphy Hall, Minneapolis, MN 55455*


### SUMMARY:

Some compulsive buyers appear to feel compelled to go shopping every day. They report experiencing anxiety on days they don't go shopping. For others, however, compulsive buying binges are more episodic. This leads to the question: what triggers these episodes of compulsive buying?

Our research indicates that compulsive buying is frequently triggered by negative affective states. This can be seen across a number of different research techniques. One study shows that compulsive buyers frequently respond to sentence completion fragments with mentions of negative moods. In a second study, compulsive buyers were more likely to report negative moods prior to buying than a comparison group. Finally, factor analysis of the cues said to worsen compulsive buying show that one of the two factors represents negative mood states. Taken together, these studies suggest that episodes of compulsive buying are triggered by negative affect. This is discussed in relation to two possible theories. One is that compulsive buying serves as a way of manipulating mood state. The second possibility is that negative affect may deplete self-regulatory resources.


## No. 5C
## PHARMACOTHERAPY FOR COMPULSIVE BUYING

Kim D. Bullock, M.D., *1609 Sanchez Avenue, Burlingame, CA 94010;* Helen W. Chuong, M.S., Lorrin M. Koran, M.D.


### SUMMARY:

No standard treatment exists for the DSM-IV Impulse Control Disorders Not Elsewhere Classified, including compulsive buying disorder. This presentation reviews the suggested pharmacotherapies and their theoretical bases. McElroy et al. (1991) reported benefit from antidepressant therapy in three cases of compulsive buying disorder with comorbid depression and anxiety, and later, in a retrospective chart review of 20 patients, from antidepressants often combined with mood stabilizers. Lejoyeux (1995) reported two patients in whom treatment for comorbid mood disorder led to remission of compulsive buying behavior. Black (1997) reported fluvoxamine effective in patients without comorbid major depression, suggesting improvement was independent of treating mood symptoms. Two double-blind, placebo-controlled trials (Ninan et al, 2000; Black et al., 2000) found fluvoxamine no better than placebo, but both utilized shopping logs, which may have been therapeutic. Kim (1998) reported improvement from naloxone, an opioid antagonist, in a case series. An open-label and a double-blind cross-over trial of citalopram (Koran et al 2002a,b) both report positive results. Detailed results and potential mechanisms will be discussed.


## No. 5D
## GROUP PSYCHOTHERAPY FOR COMPULSIVE SHOPPING: PILOT DATA

Heidi Hartston, Ph.D., *Department of Psychiatry, Stanford University, 401 Quarry Road/MC5721, Stanford, CA 94305;* Lorrin M. Koran, M.D.


### SUMMARY:

Shopping has become more than just the process of attaining needed products. For some, shopping is a relaxing hobby or a pleasant afternoon pastime. However, for others, it can become a maladaptive, destructive problem. Clinically significant "compulsive shopping behavior" can be associated with shame, guilt, embarrassment, helplessness, inefficacy and loss of control, and difficulty affording basic needs, as well as debt, bankruptcy, and marital discord. For compulsive shoppers who could not try, or preferred not to try psychopharmacological treatment, we developed and tested a group psychotherapy treatment protocol.

This presentation will begin with an overview of reported treatments and resources, then summarize data from three 12-week group therapy trials for compulsive shopping. The groups emphasized cognitive-behavioral interventions (CBT), dialectical-behavioral (DBT), and emotionally focused work. All groups demonstrated statistically significant improvements in shopping behavior, (decreased frequency of impulsive expenditures, less money spent, reduced functional interference due to shopping urges). All participants reported an increased sense of control over shopping urges. Participants utilizing DBT interventions also reported a greater reduction in intensity of shopping urges. Compulsive shopping behavior, group psycho-

therapy techniques, results, and obstacles encountered during treatment will be discussed.

### No. 5E
### A ONE-YEAR NATURALISTIC FOLLOW-UP OF PATIENTS WITH COMPULSIVE BUYING DISORDER

Elias Aboujaoude, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Ste 2301A, Stanford, CA 94305-5546;* Lorrin M. Koran, M.D., Kim D. Bullock, M.D., Helen W. Chuong, M.S.

SUMMARY:

We conducted the first long-term naturalistic follow up of patients with compulsive buying disorder, a DSM-IV impulse control disorder not otherwise specified. We followed patients from a 12-week, open-label trial of citalopram, 20 mg/day to 60 mg/day (Koran et al. 2002). In that trial, 17 (71%) of 24 subjects meeting suggested diagnostic criteria (McElroy et al., 1994) were responders (CGI-I "much" or "very much improved" and Y-BOCS-Shopping Version score decreased ≥50%). Follow-up telephone interviews occurred three, six, nine, and 12 months after study end. "Remission" meant no longer meeting diagnostic criteria. Of 17 responders at study end, 81%, 71%, and 73% were in remission at three, six, nine and 12 months. Two-week compulsive buying expenditures decreased from $826 at study end to $351 at month 12; median debt decreased from $14,000 to $1,600. No clear association existed between taking medication and remission status: Fisher's Exact Test, p = 0.55, 0.08, 0.58 and 0.60 at months 3, 6, 9, and 12. The majority of patients whose compulsive buying disorder responded to citalopram were in remission at each follow-up, though the status of individual patients varied. Half or more of the six citalopram non-responders were still ill at each follow up.

REFERENCES:

1. Black DW: Compulsive buying disorder—definition, assessment, epidemiology, and clinical management. CNS Drugs 2001; 15:17–27.
2. Faber RJ, Christenson GA: In the mood to buy: differences in the mood states experienced by compulsive and other consumers. Psychology and Marketing 1996; 13 (8): 803–819.
3. Koran LM, Bullock KD, Hartston HJ, Elliott MA, D'Andrea V: Citalopram treatment of compulsive shopping: an open-label study. J Clin Psychiatry 2002; 63 (8): 704–8.
4. Compulsive buying disorder: definition, assessment, epidemiology, and clinical management. CNS Drugs 2001; 15(1):17–27.
5. Koran LM, Bullock KD, Harston HJ, et al: Citalopram treatment of compulsive shopping: an open-label study. J Clin Psychiatry 2002; 63:704–708.
6. McElroy SL, Keck PE Jr, Pope HG Jr, et al: Compulsive buying: a report of 20 cases. J Clin Psychiatry 1994; 55:242–248.

## SYMPOSIUM 6—QUALITY OF CARE FOR CHILDREN AND ADOLESCENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize what quality of care indicators are composed of, (2) have awareness of variation in adherence by treatment setting, (3) have increased awareness of current practices in relation to quality of care recommendations, and factors associated with provision of quality care in treatment of attention-deficit/hyperactivity disorder (ADHD) and psychotic disorders in routine psychiatric practice, (4) understand practice guidelines and quality indicators for the treatment of children and adolescents with major depressive disorder and the extent to which psychiatrists in routine practice settings provide treatment consistent with guideline recommendations; recognize current limitations in use of guidelines in quality assessment. To inform clinicians and researchers on the effect of multiple informants when studying quality of care.

### No. 6A
### ESTIMATING QUALITY OF ADHD TREATMENT IN PRIMARY CARE AND MENTAL HEALTH SETTINGS

Regina Bussing, M.D., *Division of Child Psychiatry, University of Florida, 1600 SW Archer Road Box 100234, Gainesville, FL 32610-0234;* Cynthia W. Garraw, Ph.D., Bonnie T. Zima, M.D.

SUMMARY:

*Objective:* This study provides preliminary estimates of the quality of ADHD treatment by primary care and specially mental health providers.

*Method:* Using a school-district-wide sample of 266 children at high risk for ADHD and parents, psychopathology, service use, and care processes were assessed. Case-mix and treatment patterns were compared by provider type for youth who had received outpatient mental health services in the past year. Adherence to four quality-of-care indicators addressing ADHD education, school contact, medication management, and psychosocial treatment, based on the AACAP practice parameters, was examined.

*Results:* Pediatricians were the sole source of past year mental health services for 44% of the children. Of the remaining youth, a mental health specialist provided treatment either alone or in combination with a primary care provider. Children receiving care by a specialty mental health provider had greater comorbidity and higher caregiver strain. Adherence was highest for ADHD education (76%), followed by medication management (66%), psychosocial interventions (52%), and school involvement (34%). Provision of psychosocial interventions and school contact were greater among children receiving ADHD care in the specialty mental health care sector.

*Conclusion:* Future studies are needed to develop quality-of-care indicators that are applicable to assessing care across sectors.

### No. 6B
### QUALITY OF CARE FOR CHILDREN IN ROUTINE PSYCHIATRIC PRACTICE

Farifteh F. Duffy, Ph.D., APIRE, *American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Joyce C. West, Ph.D., William E. Narrow, M.D., Donald S. Rae, M.A., Maritza Rubio-Stipec, Sc.D.

SUMMARY:

*Objectives:* (1) To assess rates of conformance with quality indicators developed by the APA Task Force on Quality Indicators for Children for psychopharmacologic treatment of attention-deficit/hyperactivity disorder (ADHD) and psychotic disorders; and (2) to examine health plan, setting, and psychiatrist factors associated with the provision of quality care.

*Methods:* Using cross-sectional data from the 1997 and 1999 APIRE Practice Research Network, Study of Psychiatric Patients and Treatments, a total of 180 child and adolescent patients with ADHD and 79 patients with psychotic disorders were identified.

*Results:* Study findings suggest an overall conformance rate of 71% for the provision of stimulants for ADHD and 39% conformance rate for the provision of atypical antipsychotic medication for psychotic disorders. Factors such as patients' health plan, treatment setting, and psychiatrists' training were associated with the provision of quality care; however, patients' clinical characteristics may account for some of the observed differences in care across treatment

settings, highlighting potential reasons for deviation from recommended quality indicators.

*Conclusion:* According to standards set by APA's task force, a large proportion of patients, particularly those with psychotic disorders, received treatment that did not conform with the recommended quality indicators. Although several factors were associated with quality care, longitudinal research is needed to better understand clinical rationale for deviation from recommended quality of care.

## No. 6C
## QUALITY OF CARE FOR CHILDREN AND ADOLESCENTS WITH MDD

William E. Narrow, M.D., *APIRE, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Farifteh F. Duffy, Ph.D., Joyce C. West, Ph.D., Donald S. Rae, M.A., Maritza Rubio-Stipec, Sc.D.

### SUMMARY:

*Objectives:* To assess rates of conformance with guidelines for the psychiatric treatment of children and adolescents with major depressive disorder (MDD) and examine factors associated with guideline conformance.

*Methods:* Using cross-sectional data from the 1997 and 1999 APIRE Practice Research Network Study of Psychiatric Patients and Treatments, 67 child and adolescent patients with MDD were identified. Quality indicators were developed by the APA Task Force on Quality Indicators for Children.

*Results:* Psychotherapy was provided to 61% of the sample. Although cognitive-behavioral therapy is recommended, the type of psychotherapy given could not be assessed in this study. The rates of antidepressant medication treatment were 77% in 1997 and 86% in 1999. Only 53% and 58%, respectively, received a selective serotonin reuptake inhibitor as recommended. The data suggest that board certification and subspecialty status of the psychiatrist, clinical and demographic status of the patient, treatment setting, and managed care involvement play a role in conformance to guideline recommendations. However, relatively small sample sizes preclude definitive conclusions.

*Conclusions:* Psychiatrists provide psychopharmacologic treatment to this population more frequently than psychotherapy. Reasons for non-conformance with evidence-based practice guidelines need further exploration, but appear to be multifactorial. Larger outcome studies of routine treatments for children and adolescents are needed.

## No. 6D
## THE USE OF MULTIPLE INFORMANTS IN QUALITY OF CARE: ARE THEY INTERCHANGEABLE?

Maritza Rubio-Stipec, Sc.D., *APIRE, 1400 K Street NW, Washington, DC 20005;* Garrett Fitzmaurice, Sc.D., Glorisa Canino, Ph.D.

### SUMMARY:

The study of mental health service use in children requires the collection of multiple informant data. Presence of a diagnosis and impairment serves as an indicator of need for services. The standard instruments for classifying a child within a diagnosis require multiple informants, usually the parent and the child and at times the teacher. The type of treatment received introduces a new informant, usually the provider; compliance with treatment is reported by parent and children. Finally, the assessment of quality of care implies measured outcomes that can change over time. The latter are usually obtained from the parent, the child, and the provider. The field is in great need of novel approaches for aggregating the information obtained from multiple sources to enhance our understanding of how treatment affects the course of a disorder.

In this paper, we make use of two random samples of youth 11–17 from the island of Puerto Rico to study the effect of the informant in measuring changes in outcome after a period of one year. We contrast parent and youth reports and two disorders, ADHD and depressive disorders. Analyses are made in one sample and replicated in the other.

### REFERENCES:

1. American Psychiatric Association: Quality Indicators: Defining and Measuring Quality in Psychiatric Care for Adults and Children. American Psychiatric Press, Washington, DC., 2002.
2. Jensen PS, Rubio-Stipec M, Canino G, Bird HR, Dulcan MK, Schwab-Stone ME, Lahey BB: Parent and child contributions to diagnosis of mental disorder: are both informants always necessary? J Am Acad Child Adolesc Psychiatry 1999; 38(12):1569–79.

# SYMPOSIUM 7—PRACTICING PSYCHIATRY IN 2003

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to explicate the basics of patient advocacy in the public and private sectors. After this presentation, the participant should be better able to recognize and withstand temptations and pressures toward a reductionistic model of psychiatric care and to practice Psychiatry in a way that is ethical and personally rewarding.

## No. 7A
## THE FUTURE OF PSYCHIATRY

Brian Crowley, M.D., *Suite 215, 5225 Connecticut Avenue, NW, Washington, DC 20015-1845;* John C. Urbaitis, M.D.

### SUMMARY:

John Urbaitis and Brian Crowley find continuing satisfaction in diversified professional activities. We have a sense of creative activism in the face of destructive forces threatening our specialty such as for-profit managed care.

Both of us:

1. See a wide variety of patients in many settings: hospital, office, emergency room. John does partial hospital, C&L, and even house calls.

In his office practice, Brian calls his primary service "Psychotherapy with or without SSRIs," and enjoys work with young verbal patients who wish to understand their lives and make changes in relationships—not just get symptom relief from a pill. He rarely engages in "split treatment" and feels psychiatrists need to resist the pressure to become chemists only.

2. Both teach. This is a major commitment for John. Also, he has been the mental health service for his hospital's house staff for 25 years.

3. Both are active in professional organizations, including APA and their DBs.

4. Brian enjoys some public-sector service in the Department of Defense's Deployment Health Clinical Center, as well as clinical research on trauma and PTSD with the outstanding USUHS team headed by Bob Ursano.

5. Brian relishes private forensic practice, which is exciting and pays well without theft from managed care.

6. Both Brian and John work for reforming the health care delivery system, which we all notice has most serious defects.

Brian calls attention to the ideas for consumer-driven reform in Regina Herzlinger's work.

This solid mix of patient care, teaching, and professional advocacy provides these two psychiatrists a rewarding career as well as a good living.

## No. 7B
## THE ABC'S OF PRIVATE PRACTICE

Garry M. Vickar, M.D., *11125 Dunn Road Suite 213, St. Louis, MO 63136;*

### SUMMARY:

Drawing from 27 years of private practice, this presentation is a basic set of principles, the ABCs, that apply. Around these simple, but not simplistic, concepts are ideas that, much like the popular book, Everything I Needed to Know I Learned in Kindergarten, are still concepts that are valuable for physicians trying to practice in the private sector. A variety of tips and clinical hints will be incorporated around these concepts of (A) = availability, accessability, affability, (B) = believability, (C) = confidence, collegiality, competence.

In today's environment residents coming out of training know more about brain chemistry than they do about interpersonal skills. Tragically, many resident training programs pay only lip service to psychotherapy, much like 30 years ago many programs paid very little attention to brain chemistry. In the marketplace today new physicians have to choose whether they go out on their own, join a group, make deals with managed care and promise to deliver care cheaply. These are some of the concepts and ideas to be addressed in this, a repeat of a program presented last year with colleagues from throughout the country, all in private practice, all offering their perspective on how to still make a living.

## No. 7C
## PRIVATE AND PUBLIC PSYCHIATRIC PATIENT ADVOCACY

Lee H. Beecher, M.D., *Creekside Professional Building, 6600 Excelsior Boulevard, Suite 121, Saint Louis Park, MN 55426;* Roger Peele, M.D.

### SUMMARY:

Loss of control of the arrangements for medical care in the private sector has occurred by limiting practitioner networks, micromanaging care, setting low fees, and shifting costs to patients. In the public sector, government, under pressure to reduce costs by shifting risks to the private sector through privatization in Medicaid and Medicare, behavioral carveouts, and civil commitment, is often the only route to hospitalization in the public sector. Further, the loss of control in the private sector pushes patients toward the public. In turn, the increased barriers to access in the public sector leave the psychiatrically ill headed for the streets or the criminal justice system.

Public policies to reverse these devastating trends require exact explication of responsibilities of all the agents involved: (1) the federal government, (2) the state government, (3) the county/city/local government, (4) the employer, and (5) in some situations, the patients themselves. A key requirement of an adequate public policy is to equalize the status of the people with psychiatrically ill with people with other illnesses.

Because the psychiatrically ill need services beyond treatment, such as sheltered educational opportunities, sheltered work situations, housing support, transportation support, and so forth, the responsible agent for these needs also must be explicated. Stigma, conceptual problems, and the "need" to reduce spending in the private and public sector have worked against a positive public policy for the psychiatrically ill.

## No. 7D
## THE PRACTICE OF COMPLETE PSYCHIATRY

Ronald D. Abramson, M.D., *25 Main Street, Suite 7, Wayland, MA 01778;* Robert L. Pyles, M.D.

### SUMMARY:

Psychiatry is the only specialty of medicine whose main areas of concern are understanding and treating disorders located in the objective biological brain as well as the subjective psychological mind. The greatest satisfactions in psychiatric practice derive from the opportunity to have a deep understanding of patients through both domains and, thereby, to make a real difference in patients' lives.

Modern scientific advances have greatly augmented the available armamentarium of biological and concrete behavioral therapies but, together with economic factors, have fostered concrete reductionism. Psychiatrists often find themselves as only one element of the total array of mental health treatments and stand in danger of loosing the familiar connection with patients that constitutes the greatest professional satisfaction.

This presentation will present experiences from successful psychiatric practices that document principles of ethical and professionally satisfying practice. In part, these are:

1. Maintain a psychoanalytic as well as a biological point of view avoiding concrete reductionism.
2. See a broad range of patients and spend sufficient time to understand the patients' own point of view, and thus, learn best how to be a significant positive influence in their lives.
3. Participate in social and political activities that advance the cause of psychiatry and psychiatric patients.

### REFERENCES:

1. Campion EW: A symptom of discontent. NEJM 2001; 344:223–225.
2. Herzlinger R: Market Driven Health Care. Perseus Books, 1997.
3. Surgeon General Reports on the Mentally Ill.
4. Stone AA: The Decline and Fall of Psychoanalysis—And What It Means to Physicians. T*E*N 2001; 3(2): 48–52.

# SYMPOSIUM 8—CHALLENGES IN CROSS-CULTURAL PSYCHIATRY: FOCUS ON DEPRESSION AND ETHNOPSYCHOPHARMACOLOGY

### EDUCATIONAL OBJECTIVES:

To understand how depressed Chinese Americans perceive their illness and how it affects their help-seeking behavior. To recognize the cross-cultural differences in the manifestation of depression in the Indian population, and learn about strategies to facilitate treatment and enhance compliance in this population. To allow the clinician to effectively diagnose and treat depression in Hispanic patients, and appreciate the impact of cultural factors on the presentation of psychiatric symptoms. To understand the principles of ethnopsychopharmacology and the impact of race, sex, and culture on medication metabolism, interactions, and compliance in the treatment of depressive disorders.

## No. 8A
## IMPACT OF CULTURAL BELIEFS ON THE TREATMENT OF DEPRESSED CHINESE-AMERICANS

Albert Yeung, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Standord Street, Suite 401, Boston, MA 02114*

SUMMARY:

In European and North American cultures, depression is a well-accepted psychiatric syndrome characterized by specific affective, cognitive-behavioral, and somatic symptoms. In many non-European cultures, including Nigerians, Chinese, Canadian Eskimos, Japanese, and Southeast Asians, equivalent concepts of depressive disorders are not found (Marsella et al., 1985). Studies exploring illness beliefs of depression among depressed Chinese Americans with a low degree of acculturation have shown that many of them were unaware of, or were unfamiliar with the concept of major depression. The discrepancy of illness beliefs between less acculturated Chinese Americans and their physicians has led to under-recognition and undertreatment of depression among Chinese Americans. Possible solutions to improve treatment of depressed Chinese Americans will be discussed.

## No. 8B
## DIAGNOSIS AND TREATMENT OF DEPRESSIVE DISORDERS IN THE ASIAN-INDIAN POPULATION

Shamsah B, Sonawalla, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Asian Americans from the Indian subcontinent are a growing ethnic group in the U.S., representing about 8% of the population. This subgroup of individuals have their own set of cultural norms, family traditions, and religious belief systems, with diversity within subgroups. All these factors may influence manifestation of depression and impact treatment outcome. Depressive disorders are underdiagnosed and undertreated in this population, and mental illness is frequently viewed as an embarrassment or stigma. Young women often face unique pressures in the system; research suggests that suicide rates among young (<30y) female immigrants from the Indian subcontinent are higher than in their male counterparts and young women in the countries to which they immigrate. Herbal remedies and alternative treatments are widely used. Family involvement is important in all stages of care, including interactions with the treating physician and compliance with treatment. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements, and adverse event profiles for antidepressant medications in this population. Understanding the complex cultural belief systems may allow clinicians to assess some of the cultural factors in treatment and potentially increase treatment acceptability and compliance, particularly with antidepressant medications. Suggested modifications for managing depression in the Indian population will be discussed. Findings from cross-cultural studies comparing depression in college students in India and the U.S. will be discussed.

## No. 8C
## MANAGEMENT OF DEPRESSION IN THE HISPANIC POPULATION

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

SUMMARY:

Increasing numbers of psychiatrists work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the Hispanic-American population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culture-bound syndromes (such as ataque de nervios, and susto) on assessment; and review different approaches to treatment, including the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

## No. 8D
## PRINCIPLES OF ETHNOPSYCHOPARMACOLOGY

David C. Henderson, M.D., *Department of Psychiatry, Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

Understanding basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions, and medication compliance. Ethnopsychopharmacology examines biological and non-biological differences across race, ethnicity, sex, and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter- and intra-group differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and are affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. Depression is one of the most common medical/psychiatric disorders and occurs across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic, and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. This paper will review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders.

REFERENCES:

1. Kleinman A: Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry. University of California Press, Ltd. London, England, 1980.
2. Patel SP, Gaw AC: Suicide among immigrants from the Indian subcontinent: a review. Psychiatric Services 1996; 47(5):517–21.
3. Ruiz P: Assessing, diagnosing, and treating culturally diverse individuals: a Hispanic perspective. Psychiatric Quarterly 1995; 66: 329–341.
4. Mischoulon D: Management of major depression in Hispanic patients. Directions in Psychiatry 2000; 20:275–285.
5. Ruiz P (ed): Ethnicity and Psychopharmacology. Washington, DC, American Psychiatric Press, 2001.

# SYMPOSIUM 9—CORE COMPETENCES: HOW THEY FIT INTO CERTIFICATION AND RECERTIFICATION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to specify the implications of core competencies for residency training and specialty certification and recertification (maintenance of certification).

## No. 9A
## HISTORY OF THE CORE COMPETENCY MOVEMENT

Thomas A.M. Kramer, M.D., *3034 Palm Lane, Northbrook, IL 60062*

SUMMARY:

An overview of the history of the competency movement will be provided to demonstrate that core competencies are not a new idea. Advantages of using the core competencies to guide training and assessment will be presented. Another aspect of this movement is the broadening of the definition of competence to include patient-physician communication skills, professionalism, and systems-based knowledge, in addition to medical knowledge. Implications of the movement for maintenance of certification (recertification) will be addressed.

## No. 9B
## ABPN WORKS ON CORE COMPETENCIES

Daniel K. Winstead, M.D., *Department of Psychiatry & Neurology, Tulane University Medical Center, 1440 Canal Street, "TB48", Ste 1000, New Orleans, LA 70112*

SUMMARY:

The work that the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology have done to develop core competencies for psychiatry will be reviewed. The impact that these initiatives have had on residency training programs and the ABPN's certification processes will be discussed.

## No. 9C
## THE RELATIONSHIP BETWEEN CORE COMPETENCIES AND MAINTENANCE OF CERTIFICATION

James H. Scully, Jr., M.D., Medical Director, *American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*

SUMMARY:

The implications of core competencies for maintenance of certification (recertification) will be presented. The American Board of Medical Specialties has identified the following four components to be assessed: professional standing, commitment to lifelong learning and involvement in a periodic self-assessment process, cognitive expertise, and evaluation of performance in practice. The ABPN's plans for recertification, as well as those of other specialty boards, will be reviewed.

REFERENCES:

1. Carraccio C: Shifting paradigms: from Flexner to competencies. Acad Med 2002; 77:361–367.
2. Epstein RM, Hundert EM: Defining and assessing professional competence. JAMA 2002; 287:226–235.
3. Scheiber SC, Kramer TAM, Adamowski SE: Core Competencies for Psychiatric Practitioners. Washington, DC, American Psychiatric Press, 2003.
4. American Board of Medical Specialties: 2002 Annual Report and Reference Handbook. Evanston, IL, American Board of Medical Specialties, 2002.

# SYMPOSIUM 10—PSYCHIATRY AND THE PHARMACEUTICAL INDUSTRY: WHERE IS THE BOUNDARY?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the pervasive influence of pharmaceutical marketing on psychiatric practice, delineate the ethical issues arising from these relationships, and site objective sources of information, (2) demonstrate exposure of trainees to drug company marketing, and the extent to which trainees recognize the influence of this exposure, and list strategies for improving trainee sophistication in responding to drug detailer and academic presentations, (3) have a basic understanding of the pricing and third-party reimbursement system for medications, especially how these affect public sector practice; and be able to make more informed choices about medication prescribing, and (4) understand ways that speakers can provide ethical, objective educational experiences in industry-sponsored educational activities.

## No. 10A
## PHARMACEUTICAL PROMOTION: EFFECTS ON THE PRACTICE OF PSYCHIATRY

Amy C. Brodkey, M.D., *Department of Psychiatry, University of Pennsylvania, 4641 Roosevelt Boulevard, Philadelphia, PA 19124–2399*

SUMMARY:

The pharmaceutical industry is the most profitable business in the United States, with domestic sales of well over $100 billion for U.S. brand-name drug companies alone. Marketing costs currently exceed 30% of revenues, far surpassing outlays for both research and development and drug 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. 10B
## 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. 10C
## THE PHARMACEUTICAL INDUSTRY AND PUBLIC PSYCHIATRY PRACTICE

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 15 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 cases, the newer drugs offer the promise of greater efficacy and fewer side effects. These newer drugs are also significantly more expensive than the drugs they have replaced. Almost all of them are on patent. With increased medication options, there is a greater need for information about how to choose them, how to prescribe them, and how they may interact.

These facts raise questions for practitioners in the public sector. How do we choose drugs when the costs are being paid by public funds? How are the costs of drugs reimbursed? When do we prescribe a generic drug? What use do we make of educational and other materials offered by the pharmaceutical industry? Upon what sources of information can we rely? How do we relate to industry representatives and make use of samples and patient assistance programs? How do we relate to pharmacies? I will discuss these questions using national data and local case examples.

## No. 10D
## INDUSTRY-SPONSORED 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.

### REFERENCES:

1. Wazana A: Physicians and the pharmaceutical industry: is a gift ever just a gift? JAMA 2000; 283:373–80.
2. Steinman MA, et al: Of principles and pens: attitudes and practices of medicine housestaff toward pharmaceutical industry promotions. Am J Med 2001; 110:551–557.
3. Griffith D: Reasons for not seeing drug representatives. BMJ 1999; 319:69–70.
4. Bowman MA, Pearle DL: Changes in drug prescribing patterns related to commercial company funding to continuing medical education. J Contin Educ Health Prof 1988; 8(1):13–20.

# SYMPOSIUM 11—EVALUATING CLINICAL COMPETENCE: CURRENT OPTIONS, FUTURE DIRECTIONS

### EDUCATIONAL OBJECTIVES:

Participants will (1) gain insights into the underlying processes of thinking that are fundamental to core competencies required for optimal performance. In addition, insights into training modalities that would enable better decision making will be provided, (2) define competence, identify five methods of measuring competence from the ACGME toolbox, to construct a portfolio of competence measures.

## No. 11A
## ENCOMPASSING ASSESSMENT OF COMPETENCY

Siegfried Streufert, Ph.D., *Department of Psychiatry, Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210;* Usha G. Satish, Ph.D.

### SUMMARY:

Many practitioners and researchers view "competence" as engaging in correct actions in response to specific challenges. Competency would mean selecting the "right" rather than "wrong" response. Prior to the renaissance such a view would have been universally meaningful. With the advent of modern science at the time of Copernicus, Gallilei, Newton, and others, competency often could require more, e.g., the sequential deconstruction (reductionism) and reconstruction of physical and conceptual systems. Cognitive (e.g., Streufert, 1997) and science wide (e.g., Kauffman, 1995) complexity theory have expanded the concept of competency even further, requiring, where needed, effective dealing with challenges despite the presence of VUCAD (volatility, uncertainty, complexity, ambiguity, and delayed feedback), i.e., effective functioning at the "edge of chaos" (Gleick, 1987). No matter whether we are dealing with restoring the cognitive competency of patients, or whether we desire to improve the competency of health care personnel, a focus upon specific (often isolated) "correct" responses to task and social challenges continues to be useful where task requirements are indeed "simple." In contrast, an assessment of competency focusing on "correct" responding is often out of place in today's VUCAD world. Whenever task and/or social settings require, we need assessment methodologies that parallel real-world challenges.

## No. 11B
## EVALUATING COMPETENCE IN PSYCHOTHERAPY

John Manring,, M.D., *SUNY, Department of Psychiatry, 750 East Adams Street, Syracuse, NY 13210;* Bernard D. Beitman, M.D., Mantosh J. Dewan, M.D.

### SUMMARY:

*Background:* The Residency Review Committee for Psychiatry has recently charged psychiatry training programs with developing methods to demonstrate competence of trainees in five areas of psychotherapy. Each program must decide what specific skills are essential for competence in each of the five listed psychotherapies. This requires determining whether those skills that are necessary are also sufficient for effective psychotherapy, and whether additional specific skills are required for each one.

*Method:* Two lists of general skills for psychotherapy are compared, one from the perspective of specific "schools" of psychotherapy and one from a more eclectic "integrative" approach. The issue of measuring competence is addressed by placing ratings of "competent" midway on a continuum from "novice" to "expert." Thirteen methods for measuring competence from the ACGME "tool-box" are described and reviewed with respect to applicability to psychotherapy. Examples of toolbox implementation are described based on a functioning psychotherapy evaluation program at the University of Missouri.

*Results and Conclusions:* The authors found both theoretical as well as practical problems in measuring competence in psychotherapy. We propose that global rather than highly specific assessment methods may be more practical in these early stages of development, and we offer specific suggestions for assessment components that can currently be implemented.

## No. 11C
## TOWARD IMPROVED EVALUATIONS: TRAINING COMPETENCY

Usha G. Satish, Ph.D., *Department of Psychiatry, Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210;* Siegfried Streufert, Ph.D., Mantosh J. Dewan, M.D., John Manring, M.D., Sarah Vander Voort, B.S.

### SUMMARY:

*Background:* A unique assessment technique, the Strategic Management Simulation (SMS), was employed to assess core competencies in psychiatric residents in the realm of problem solving capacities. The SMS is used world wide to assess and train skills required for integrative decision making including flexibility, critical thinking, initiative, use of strategy and breadth of approach.

*Method:* Resident performance on the SMS, standard tests such as PRITE and Columbia psychotherapy exams were obtained. In addition, attending faculty members who were familiar with the residents' work evaluated each resident on a rating scale.

*Results:* Several simulation measures correlated as highly as or higher with faculty ratings than PRITE and Columbia Psychotherapy values. In contrast to performance measurement on the two standard tests, however, simulation performance values (which tend to be highly stable over time) can be obtained at any time (e.g., immediately after entry into a residency program) and reflect specific different components of resident problem-solving.

*Conclusion:* The data indicate that the simulation technique is able to accurately assess multiple aspects of performance by psychiatric residents in a relatively brief period. Obtained information about the resident's (or resident candidate's) performance can be used for focused feedback and training to enhance subsequent resident performance.

### REFERENCES:

1. Streufert S: Complexity: an integration of theories. Journal of Applied Social Psychology 1997; 27(23), 2068–2095.
2. ACGME Outcome Project: Toolbox of Assessment Methods, Version 1.1, September, 2000.
3. Satish U, Streufert S, Marshall R, Smith S, et al: Strategic management simulations is a novel way to measure resident competencies. The American Journal of Surgery 2001; 181:557–561.

# SYMPOSIUM 12—OCD SPECTRUM ILLNESSES: WHAT DOES IT MEAN? DOES IT HELP OUR TREATMENT?

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will become acquainted with the similarities and differences among obsessive compulsive disorder, body dysmorphic disorder and hypochondriasis. All three disorders are within the obsessive compulsive spectrum. (1) appreciate the potential usefulness of neuropsychological tasks in delineating endophenotypes; (2) understand the possible implications of these findings for the pathophysiology of OCD; (3) recognize children with complex symptomatology and to identify various diagnostic interfaces that may pose similar difficulties treatment, and; (4) understand the relationship between OCD and grooming disorders and appreciate their potential genetic basis.

## No. 12A
## BDD AND HYPOCHONDRIASIS: ARE THEY PART OF THE OCD SPECTRUM?

Fugen Neziroglu, Ph.D., *Bio-Behavioral Institute, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021;* Dean McKay, Ph.D., Jose A. Yaryura-Tobias, M.D.

### SUMMARY:

Disorders that share the same phenomenology of obsessions and compulsions are considered to be part of the obsessive compulsive spectrum disorders. However, it is questionable whether sharing of these two symptoms is sufficient to place these disorders under the same category. Body dysmorphic disorder (BDD) has received a lot of attention recently and to a lesser degree hypochondriasis (HC). Twenty-three patients with BDD, 26 patients with HC and OCD, and 16 patients with HC alone were compared with 22 patients with obsessive compulsive disorder (OCD) on a number of variables. Results indicated that BDD patients are similar to OCD patients for measures of obsessionality, compulsivity, and depression as well as anxiety. However, OCD patients had higher levels of physical anxiety whereas BDD patients had high levels of overvalued ideas. Interestingly, HC patients also had higher levels of overvalued ideas as compared with OCD patients in addition to higher levels of panic and agoraphobic cognition. Although their levels of obsessionality were similar, they differed in terms of compulsivity. There seems to be evidence that BDD and HC fit within the OC spectrum disorders. Implications for treatment within this framework will be discussed.

## No. 12B
## ADHD AND OCD: COGNITIVE CHARACTERISTICS

Paul D. Arnold, M.D., *Neurogenetics, Cenre for Addiction and Mental Health, 250 College Street 3rd Floor, Toronto, ON M5T 1R8, Canada;* Russell Schachar, M.D., Shirley Chen, M.D., Abel Ickowicz, M.D.

SUMMARY:

*Objective:* The objective is to determine whether children with attention deficit hyperactivity disorder (ADHD) with or without obsessive-compulsive behavior (OCB) exhibit similar clinical and cognitive characteristics.

*Method:* Consecutively referred children diagnosed with ADHD in a child psychiatry clinic with or without OCB are compared with one another and with a group of normal controls on a variety of clinical and cognitive measures, including a measure of cognitive inhibition.

*Results:* In our sample of ADHD children, 11.2% have clinically significant OCB. According to parents, children with OCB are significantly more perfectionistic ($p < 01$), significantly more impaired overall ($p < 05$), and exhibit a strong trend toward increased oppositional behavior ($p = .059$). According to teachers, children without OCB exhibit more problems with cognition/inattention ($p < 05$). There are no significant differences between the two clinical groups with respect to measures of intellectual, academic, and language functioning, or in a measure of executive functioning.

*Conclusions:* These findings suggest that children with ADHD with and without OCB are similar with respect to executive functioning though exhibiting some important clinical differences. Further research using additional cognitive measures in larger numbers of children, including children with pure OCD, is needed.

## No. 12C
## COMPLEX PSYCHOPATHOLOGY AND DESCRIPTIVE SYMPTOMATOLOGY IN CHILDREN

Jose A. Yaryura-Tobias, M.D., *Bio-Behavioral Psychiatry, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021-5309;* Dena Rabinowitz, Ph.D., Fugen Neziroglu, Ph.D.

SUMMARY:

Children with symptoms from multiple diagnostic categories who have been unresponsive to traditional treatments pose a unique challenge to clinicians. In this study, we sought to identify clinical and biological markers that may help distinguish these children during assessment. Data were collected on seven children with a multiplicity of symptoms who had histories of psychopharmacological and psychotherapeutic interventions with limited or lack of improvement. On average, these children exhibited symptoms from at least four different diagnostic categories and met full DSM-IV criteria for between one to five diagnoses. The most prevalent diagnoses were attention deficit hyperactivity disorder, obsessive-compulsive disorder, oppositional defiant disorder, and pervasive developmental disorder. This group of children also exhibited a high incidence of sensory hyperarousal (86%), sudden anger outburst and tantrums (86%), hyper-sexuality (71%), and regressive and grooming behaviors including sniffing, grunting, skin picking, and hoarding (71%). Many of these children also had indications of a history of bacterial or viral infection that may have had effects on the neurological system (86%) or may have resulted in anatomical abnormality of the brain (29%). Children with this cluster of symptoms may have complex diagnostic pictures that may pose specific challenges for the treating clinician.

## No. 12D
## A PRELIMINARY INVESTIGATION OF THE GENETIC BASIS OF GROOMING DISORDERS

Margaret A. Richter, M.D., *Anxiety Clinic, Center for Addiction and Mental Health, 250 College Street, Room 1148, Toronto, ON M5T 1R8, Canada;* Paul D. Arnold, M.D., Emanuela Mundo, M.D., Sam Fariba, B.S.C., James L. Kennedy, M.D.

SUMMARY:

*Objective:* OCD is commonly regarded as the core of a "spectrum" of related disorders, based on similarities in phenomenology, epidemiology, neurobiology, and response to serotonergic medication. Grooming disorders such as trichotillomania and compulsive skin picking have been suggested for inclusion in this group, but genetic risk factors have yet to be directly investigated in these putative spectrum disorders.

*Method:* Individuals meeting criteria for trichotillomania and/or clinically significant compulsive skin picking were ascertained in a well-characterized sample of 198 OCD probands and first-degree relatives. In total, 23 eligible comorbid families were tested using the Family-Based Association Test (FBAT). Two candidate genes we have previously identified as associated with increased risk of OCD were investigated: the 5HT1Dβ receptor and the NMDA receptor 2B subunit (GRIN2B) genes.

*Results:* Results were non-significant in the families with comorbid grooming disorders ($z = 0.94$, $p = 0.35$ for 5HT1Dβ, $z = 1.41$, $p = 0.16$ for GRIN2B) in contrast with the OCD-only families.

*Discussion:* These results do not support a specific role for the 5HT1Dβ or GRIN2B genes in trichotillomania or compulsive skin-picking. Further testing in larger samples with primary grooming disorders is warranted. This work was supported in part by the Ontario Mental Health Foundation and the Canadian Institutes of Health Research.

REFERENCES:

1. Yaryura-Toblas JA, Neziroglu F: Obsessive Compulsive Disorders Spectrum: Pathogenesis Diagnosis and Treatment. Washington DC, American Psychiatric Press, 1997.
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# SYMPOSIUM 13—EVOLUTION OF THE SOCIAL BRAIN: IMPLICATIONS FOR MEDICAL EDUCATION AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to show how medical students encountering a stressful year gained benefit from minimal but structured faculty boosting signals, understand the relationship between emotional expression and reduced distress among cancer patients, and how such expression elicits social support and reduces stress. Understand (1) the paradoxical relationship between personal identity and therapeutic change, (2) the sociodynamics of psychological realities, and (3) how to respect pathogenic aspects of selfhood while reframing them toward a therapeutic outcome. Should understand basic research findings on the evolution of incest avoidance and familial affiliation and how cultural practices may disrupt behavioral and psychological adaptations. Recognize and understand some fundamental ways that evolution organized the growth of the human brain in social attachments that are adaptations, specifically those between parent and child.

## No. 13A
## STRESSED STUDENTS BENEFIT FROM FOCUSED SOCIAL BOOSTING SIGNALS

Russell Gardner, M.D., *Department of Psychiatry, Medical College of Wisconsin, 4610 University Avenue #1070, Madison, WI 53705-3323*

SUMMARY:

Human evolution resulted in an increased neocortical-whole brain ratio that correlates with group size, implying that human interactions increased in complexity and nuance. Research on 40 medical students over 36 weeks of their first year illustrates the operation of boosting signals. Their student cohort experienced unusual stress. Two matched groups provided weekly questionnaires (for which they were paid) that assessed drinking behavior, stress-reward levels, and inner-outer locus of control. In additional to the questionnaires, one group wrote weekly short essays responded to quickly and positively by faculty while the other filled out forms only. The first 12 weeks did not differ significantly in drinking behavior but the latter 24 weeks diverged increasingly widely with an ANOVA main effect of $p < .05$, the essay group drinking less and the non-essay group more. Both groups showed increasing stress levels, and the non-essay group showed this to correlate with progressively increased inner locus of control ($r = 0.8$ in the final 12 weeks), while the essay group seemed to relax and let themselves register a greater outer locus of control not correlated with stress. Review of essay content showed that faculty approval mattered. The experiment documented a human capacity to gain benefit from allies.

## No. 13B
## FEELING AND HEALING: EMOTIONAL AND SOCIAL EXPRESSION AMONG CANCER PATIENTS

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford, CA 94305-5718;* Janine Giese-Davis, Ph.D., Cheryl Koopman, Ph.D., Lisa D. Butler, Ph.D., Catherine Classen, Ph.D., Matthew J. Cordova, Ph.D.

SUMMARY:

As advances in medical treatment extend life with cancer, converting it in many cases from a terminal to a chronic illness, problems in coping with the disease and its treatment become more important. The strong emotions associated with illness can either be obstacles to or facilitate social support. We have recently reported confirmation of earlier findings of significant reductions in distress among metastatic breast cancer patients randomized to a year of supportive-expressive group psychotherapy. Here we report that decreases in suppression of emotion mediate these decreases in distress. Ninety-six of 125 women provided follow-up data. Women in the treatment group showed a significant decrease in mean Courtauld Emotional Control Scale (CECS) scores (measuring emotional suppression) over 12 months when compared with the women in the control condition. Using ANOVA, we observed a significant relationship between decrease in suppression on the CECS and decrease in PTSD symptoms on the Impact of Event Scale (IES) [$t(3,93) = 4.0$, $p < .0001$]. We also found that increasing emotional self-efficacy on the Stanford Self-Efficacy for Serious Illness Scale (SSESI) was associated with decreasing IES scores [$t(3,61) = 4.08$, $p < .0001$]. These findings confirm earlier observations that suppression of emotion is associated with higher distress among cancer patients, despite their tendency to under-report their distress. Thus, emotional expression in a supportive group environment enhances the management of disease-related emotion, reduces distress, and enhances social support. Data on the relationship between loss of social support and loss of normal diurnal cortisol rhythms will also be presented that have implications for effects of stress and support on survival time.

## No. 13C
## THE SOCIODYNAMICS OF PERSONAL IDENTITY AND THERAPEUTIC CHANGE

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health Sciences University, V3MHC Portland VA, P.O Box 1035, Portland, OR 97207;*

SUMMARY:

Patients often resist therapeutic change in defense of their perceived personal identity, saving face, even when the change is otherwise feasible and desired congruently. Optimum change then occurs, paradoxically, when patients instead strive to become more who they already are. This relationship between personal identity and therapeutic change remains elusive within science and clinical practice. It can be understood through a sociodynamic perspective. Like other psychological realities, personal identity is strongly experienced yet partly deceptive—defended heavily, while concurrently shaping and being shaped by hypnotic-like entanglements with significant others. The resulting tension between defense and reframability carries therapeutic implications. Aversive affect often lessens when defensive avoidance is redirected toward supported approach. Therapists can modify pathogenic psychosocial vicious circles by shifting from complementary roles toward accessing patients' intrinsic coping skills. Resistance softens when respected as an assertion of identity. Patients then can be challenged to define and refine this identity, as formal treatment—effective, efficient and relatively safe with otherwise refractory personality syndromes. Therapeutic change correlates highly with patients' self-therapeutic activity. All of these processes are optimized by strong therapeutic role boundaries, respect for autonomy, and skilled use of reframing.

## No. 13D
## NATURE DISRUPTED: DARWIN AND THE BORDERLINE PERSONALITY

Mark T. Erickson, M.D., *Institute Medicine, Alaska Psychiatric, 2900 Providence Drive, Anchorage, AK 99508*

SUMMARY:

Recent findings from ethology, anthropology, and attachment studies cast new light on our understanding of the evolution of the social brain and psychoanalytic theory. My focus will be on the origins, and pathological disruption, of the boundaries between sexual and familial affiliation. Ethological studies show that incest is rare in nature, precisely the opposite of what had long been assumed, and that an adaptation for incest avoidance exists in nearly all species. Anthropological research indicates that a homologous incest avoidance adaptation exists in humans and depends on close association during a sensitive phase of approximately the first three years of life. Attachment studies suggest that the quality of early affiliation further modulates the development of stable unconscious boundaries between sexual and familial forms of affiliation. Cultural practices, non-existent in evolutionary history, may unwittingly disrupt normal developmental conditions for our species, giving rise to boundary confusion and behaviors, including child sexual abuse, which have not been observed in other primate species. This integrated perspective points to a novel understanding of psychopathological sequelae of childhood abuse, including the borderline personality. The implications for treatment and psychiatric education will be discussed.

## No. 13E
## THE EVOLVED SOCIAL BRAIN AND CHILD DEVELOPMENT

John R. Evaldson, M.D., *200 West DeVargas Street, Suite #3, Santa Fe, NM 87501-2679*

### SUMMARY:

A comparison of human social behavior with other Great Apes helps us understand our adaptations. Our human brain grew to its large size in the contexts of living in larger and more complex social groups, and the use of language. Only the tolerance of and care giving to the dependent infant has allowed this increased brain size. Attachment describes this process of care-fostered development. Well functioning adaptations likely represent frutiful adaptations.

The process of attachment occurs via all sensory-motor systems during normal nurturing activities like feeding and proximity maintaining for safety. The neuro-hormonal basis of the internal attachment experience is beginning to be understood. The concept of affect regulation organizes our understanding of how parent and child recognize and modulate each other, such as comforting during fear or pain. Later in development parents teach recognition of internal states, and how to use such awareness for problem solving while dampening less adaptive action-prone behaviors.

Attachment implies separation, and the relationship prepares for pro-social experiences with non-related others. Examples include how to cope with strangers, making alliances with others, how to assess risk, and how and when to compete and strive for status.

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# SYMPOSIUM 14—ABORTION: SCIENTIFIC DATA TO INFORM CLINICAL CARE

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) demonstrate a clear understanding of the relevance of pregnancy and abortion in the United States, so as to further clarify these roles in the lives of female patients, (2) understand current methods of first and second trimester abortion and have an understanding of the abortion experience for women in the U.S., (3) appropriately identify, assess, and elicit cultural issues that impact treatment of women from S. Asian cultures, and be able to assist patients in making healthy treatment choices, (4) demonstrate a working knowledge of the general laws that surround abortion care, and have the means to direct patients to appropriate legal resources, and (5) use psychiatric abortion data in clinical care.

## No. 14A
## AN OVERVIEW OF ABORTION IN THE U.S.

Stanley Henshaw, Ph.D., *Alan Guttmacher Institute, 120 Wall Street, New York, NY 10005;* Annie Keating

### SUMMARY:

This slide presentation presents the facts on abortion in the United States, developed by the Alan Guttmacher Institute and Physicians for Reproductive Choice and Health (PRCH). It provides the most important and comprehensive statistics on the incidence of unintended pregnancy and abortion. Topics include unintended pregnancy and abortion; who has abortions, why and when in pregnancy; safety of abortion; provision of and access to abortion services; and a comparative international perspective.

Almost half of all pregnancies in the United States are unintended, and almost half of these unintended pregnancies end in abortion. Since so many women go through the emotional and psychological decision-making process and experience of unintended pregnancy and abortion, it is useful for psychiatrists to understand the facts around these issues and how they may relate to mental health care. Abortion is often stigmatized and marginalized from mainstream medicine, despite the fact that it's one of the most common and safest medical procedures in the U.S. This PRCH/AGI slide presentation offers a factual presentation on unintended pregnancy and abortion, dispelling myths while providing a sociological context/framework to understand the issues.

## No. 14B
## SURGICAL AND MEDICAL ABORTION IN THE 21ST CENTURY: UPDATE FOR PSYCHIATRISTS

Karen Meckstroth, M.D., *OB/GYN, University of California San Francisco, 1001 Potrero Avenue, San Francisco, CA 94110*

### SUMMARY:

By age 45, about 40% of U.S. women have had at least one abortion. Although only 10% of abortions are performed in the second trimester of pregnancy, nearly half of these women say they experienced difficulty making arrangements for the abortion. The small number of physicians and facilities that perform second-trimester terminations offer either dilation and evacuation (D&E) or induction of labor, usually not both. Intact D&E, the so-called "partial birth abortion" is rarely used, usually in cases where women desire to see and grieve with an intact fetus. Nearly all providers perform first trimester abortion by suction, either with an electronic machine or handheld suction (manual vacuum aspirator). Women who desire an early pregnancy termination have the option of medical abortion. Women value that medical abortion avoids the experience of surgery and anesthesia, offers privacy, and provides a feeling of control over the abortion process. About 95% of women who undergo medical abortion with mifepristone and misoprostol say they would recommend the procedure to a friend or choose it again. The abortion experience varies depending on the setting. Seventy percent of abortions occur in abortion clinics where the primary service is abortion. Most of these clinics experience anti-choice harassment.

## No. 14C
## FEMALE FETICIDE: A CROSS-CULTURAL PERSPECTIVE

Geetha Jayaram, M.D., *Department of Psychiatry, Johns Hopkins University School of Medicine, 600 North Wolf Street, M-101, Baltimore, MD 21287*

SUMMARY:

From 1978 to 1982, 78,000 female fetuses were destroyed in India using amniocentesis for gender detection. "Sex detection" clinics use amniocentesis, chorionic- villus- sampling, and ultrasound to curtail birth of female children. Female births have declined; female infant-mortality is higher. Twenty-two percent of maternal mortality is from abortions. In reviewing the literature on female feticide from 1990–2002, we noted the impact of cultural norms on status of women; complex interactions between advanced technology and societal expectations in India. Legal changes/actions are initiated by the American/Indian Medical Associations to address practice guidelines and ethics.

The Indian Medical Association has issued a statement of widespread concern about the lack of practitioner ethics, negative consequences to women and their families, and adverse demographic outcomes. The Indian Government in 1994 passed regulations on diagnostic procedures.

The World Medical Association in April 2000 denounced the practice of female feticide, and use of selective sex determination for nonmedical purposes. The International Medical Graduate Council of the American Medical Association helped develop a policy statement in 2001.

The presentation will include the need for urgent psychiatric intervention/care, family planning, gender-specific roles, demographic impact, post-partum depression, and treatment similarities among cultures with case studies.

## No. 14D
## ABORTION AND THE LAW

Jennifer Dalven, J.D., *Repro Freedom, ACLU, 125 Broad Street, New York, NY 10004*

SUMMARY:

This presentation will provide an overview of the legalities of abortion, as laws on abortion can and do vary from state to state. Psychiatrists will be given a general sense of what the current laws are, as well as answers to common legal questions that surround the abortion procedure, including minors' rights to abortion, confidentiality, informed consent, and equal access to reproductive health care. A basic summary of the history of abortion law in the United States will be provided. Participants will be given the appropriate resources to assist their patients and will demonstrate a working knowledge of the legal complexities and pitfalls that women and their physicians face. There will be time for discussion on the ethical implications of abortion, as well as the ramifications of such a political issue for the medical and legal professions.

## No. 14E
## ABORTION AND PSYCHIATRY: CARING FOR WOMEN AND FAMILIES

Nada L. Stotland, M.D., *Department of Psychiatry, Rush Medical College, 5511 South Kenwood Avenue, Chicago, IL 60637*

SUMMARY:

Psychiatrists encounter many women patients who have had abortions in the past, or who become pregnant and make abortion decisions during treatment. The psychological experience and psychiatric outcome of induced abortion depend on several factors, including the circumstances under which the pregnancy is conceived, the resources a woman brings to potential mothering, her religious and philosophical attitudes toward abortion, the accessibility and quality of abortion services, and her pre-existing state of mental health. Methodological rigor requires both that these data be available to the researcher and accounted for in the data analysis, and that the psychiatric outcome of abortion be compared with the outcome of continued pregnancy, labor, and delivery. Women cannot be randomly assigned; they must self-select for each group. Despite these methodological challenges, there are some useful data about abortion outcomes. Most women experience self-limited guilt, sadness, and/or relief. The incidence of serious psychiatric illness after abortion is significantly lower than the incidence after childbirth. Outcomes are optimized when a woman is allowed to make an autonomous choice consonant with her own values and circumstances and to be supported regardless of the choice she makes. Psychiatric expertise can help patients make and work through these important decisions.

REFERENCES:

1. Koonin LM, et al: Abortion surveillance-United States, 1997. CDC Surveillance Summaries, MMWR 2000; 49 (no. SS-11): 1–43.
2. Henshaw SK: Abortion incidence and services in the United States, 1995–1996. Fam Plann Perspect; 1998; 30(6).
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4. Alan Guttmacher Institute. "State Policies in Brief" (fact sheets, updated monthly)
5. Stotland NL: Abortion: Facts and Feelings. American Psychiatric Press Inc., Washington, D.C., 1998.

# SYMPOSIUM 15—SPIRITUALITY AND WORLD VIEW IN CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES:

At the concluson of this symposium, the participant should (1) appreciate the concept of world view as defined by Freud, (2) recognize historical antecedents in psychiatry, which have led to an increased interest in the patient's world view, (3) understand the importance of the clinician's world view in his or her patient management, (4) the participant will demonstrate increased awareness of the importance of spirituality and religion in patients' lives as well as increased competence in the assessment of world view and faith issues.

## No. 15A
## THE WELTANSCHAUUNG OF SIGMUND FREUD: CLINICAL IMPLICATIONS

Armand M. Nicholi, Jr., M.D., *Harvard Medical School, 209 Musterfield Road, Concord, MA 01742-1648*

SUMMARY:

The key to the success of the doctor-patient relationship rests heavily on the doctor's understanding of the patient's world view. All patients, whether they realize it or not, possess a world view. Their world view organizes their inner life and influences their image of themselves, their purpose, their values, their motivation, their relationships, and how they confront illness and death. The patient's world view reveals more about the patient than any other part of the personal history.

Sigmund Freud spent the last 30 years of his life writing extensively about his "Scientific Weltanschauung" or world view. He spelled out in detail his philosophy concerning the basic "problems of existence" and waged an ongoing attack against what he referred to as the "Religious Weltanschauung." Freud's world view, proffered along with his clinical and theoretical contributions, continues to influence, not only the practice of psychiatry, but many other disciplines as well. Scholars in the history of science argue that a scientist's world view influences not only what the scientist investigates but how he perceives what he investigates. To understand the

scientist's contributions, therefore, one must have some understanding of his world view and the presuppositions that view implies.

This paper explores Freud's specific world view and discusses whether it preceded or resulted from his clinical observations. The presenter will draw upon the philosophical and autobiographical writings of Freud as well as on personal interviews with Freud's daughter Anna.

## No. 15B
## THE CLINICAL ASSESSMENT OF THE PATIENT'S WORLD VIEW

Irving S. Wiesner, M.D., *Swarthmore Medical Center, Yale Avenue and Chester Road Suite 102, Swarthmore, PA 19081*

### SUMMARY:

Obtaining information relating to the religious or ideological orientation and beliefs of patients can be accomplished by approaching this facet of human experience with the same curiosity, suspended judgment, and sensitivity applied to the overall clinical psychiatric evaluation.

It is important to first consider the clinical presentation, which includes the referral pattern, the specific clinical setting, patient characteristics, and patient attitudes toward spirituality and religion.

Initial questioning about the role of spirituality and religion in the patient's life will be outlined. Nonverbal and emotional responses to these questions can yield extremely valuable information. Questions of an existential nature will further elicit the degree to which faith functions in the patient's life and how their presenting problems and potential solutions are influenced by their beliefs.

Investigating the presence of God concepts, prayer and ritual practices, and religious/spiritual community affiliations will demonstrate that this approach is another "royal road to the unconscious." Questions directed toward specific issues such as guilt, forgiveness, suffering, sexuality, and death can uncover much useful clinical material that can be utilized in diagnostic formulations as well as therapeutic interventions.

## No. 15C
## DIAGNOSIS AND FORMULATION: INTEGRATING SPIRITUAL AND RELIGIOUS PERSPECTIVES

Mark E. Servis, M.D., *Department of Psychiatry, UC Davis Medical Center, 2230 Stockton Boulevard, Sacramento, CA 95817;* Allan M. Josephson, M.D.

### SUMMARY:

A fundamental task of the clinical psychiatrist is the development of a biopsychosocial formulation. This framework identifies factors that predispose an individual to a mental disorder and the factors that precipitate and perpetuate the disorder. This presentation will give an overview of an interactive risk model of psychopathology and the role of religious and spiritual factors in such a model.

This presentation will describe and give clinical case examples of religious and spiritual problems that (1) exacerbate or contribute to mental disorder, (2) result from mental disorder, (3) exist independently from mental disorder, and (4) occur in the absence of mental disorder. The role of DSM-IV nosology will be discussed and a brief review of the role of religious and spiritual factors in depression, anxiety disorders, and substance abuse. In addition to factors that place an individual at risk for disorder, a comprehensive formulation must consider which factors protect an individual from disorder. The session will include a review of the protective functions of ritual, belief, and community.

Any formulation must prepare for treatment intervention. The presentation will conclude with a discussion of treatment foci of the four cases presented and highlight areas where clergy, spiritual leaders, and clinicians can use concepts understood by both (e.g., basic trust) to facilitate referrals.

## No. 15D
## THERAPEUTIC IMPLICATIONS OF WORLD VIEW

John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115*

### SUMMARY:

Mental health professionals increasingly agree that they should appreciate the diversity of their patients' cultural and religious beliefs (Koenig 1988; Richards and Bergin 2000). But when and how should they take these into account in formulating a treatment plan? Should a therapist's own world view matter?

Philosophies of life are apt to influence the therapeutic approach to problems that have an existential dimension, such as identity, hope, meaning/purpose, morality, and relationship to authority. This presentation will consider several examples.

Clinicians generally take one of four of the following general approaches to problems involving world view: dealing only with their psychological aspects, acknowledging larger issues and referring the patient to outside resources, working within the patient's system of belief, and addressing the issues using a shared world view (Peteet 1994).

Deciding how to deal with world view issues in treatment presents both clinical and ethical challenges. These include identifying the patient's greatest need, maintaining appropriate boundaries, dealing with transference and countertransference responses, and achieving adequately informed consent.

## No. 15E
## CLINICAL PERSPECTIVES ON SPECIFIC WORLD VIEWS

John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115;* Allan M. Josephson, M.D., Abba E. Borowich, M.D., S. Atezaz Saeed, M.D., Mark E. Servis, M.D., Samuel B. Thielman, M.D.

### SUMMARY:

The earlier presentations have focused on general principles of assessment, formulation, and treatment intervention that apply to most spiritual traditions. A major challenge for clinicians is understanding the details of specific traditions, which include issues of culture, belief, and practice. Beliefs often shape the behavior of adherents by providing support in health and complicating recovery in pathology. After the clinician understands specific details, he/she must use judgment in determining whether the beliefs and practices of the individual are relevant in clinical management. At times this is difficult and finding an "interpreter" for the spiritual tradition may be necessary.

To that end, this concluding segment of the symposium will present case material from the perspective of individual faiths. The co-chairs of the symposium (AJ and JP) will lead a discussion based on case vignettes presented by panel participants (AB, MS, SS, ST). Audience participation is welcomed and will be coordinated by co-chairs. Judaism, Islam, Christianity, Hindu, Buddhist, and Secularist/Atheist perspectives will be reviewed.

Panelists will consider the following in presenting their cases: beliefs that may support psychopathology; spiritual factors that may protect an individual from psychopathology; managing the therapeutic relationship when the clinician shares, or does not share, the spiritual perspective of the patient.

REFERENCES:

1. Nicholi A. Jr: The Question of God: C.S. Lewis and Sigmund Freud Debate God, Love, Sex and the Meaning of Life. The Free Press, Simon & Schuster, 2002.
2. Wiesner IS: The clinical exploration of the patient's world view. Directions in Psychiatry 1996; 16:12.
3. Josephson A: Diagnosis and formulation: integrating spiritual and religious perspectives, in Handbook on Religion and Spirituality in Clinical Practice. Edited by Josephson A, Peteet J. APP, Inc., in Press.
4. Peteet J: Therapeutic implications of world view, in Handbook on Religion and Spirituality in Clinical Practice, APP Inc, in press.
5. Thielman S: Worldview and psychotherapy in global perspective, in Handbook on Religion and Spirituality in Clinical Practice. Edited by Josephson A, Peteet J. APPJ Press.

## SYMPOSIUM 16—COGNITIVE THERAPY IN NOVEL CLINICAL SITUATIONS: RATIONALE, ISSUES, AND CONTROVERSIES

### EDUCATIONAL OBJECTIVES:

At the end of this course, the participant should be able to (1) critically evaluate the basic assumptions of CT and their recent applications to disorders other than depression and anxiety; (2) formulate case conceptualizations using CT principles in ADD, Cancer and Schizophrenia; and (3) make a balanced personal evaluation on whether CT is useful in these conditions.

### No. 16A
### DEVELOPING COGNITIVE THERAPY FOR ADULTS WITH ADHD: WHY BOTHER?

Stephen P. McDermott, M.D., *Cognitive Therapy Institute, 25 Walnut Street, Suite 200, Wellesley, MA 02481*

SUMMARY:

Medications are considered the first-line treatment for adults with attention-deficit/hyperactivity disorder (ADHD). Authors have suggested that psychotherapy is often unproductive in adults with ADHD. Some recommend the use of "coaching" (often by nonprofessionals) instead of psychotherapy as a useful adjunct to medications.

Dr. McDermott will look at efforts underway at centers across the country to apply cognitive therapy to patients with this challenging disorder. He will examine the question of whether cognitive therapy can serve as an adjunct for, or alternative to, medications in the treatment of ADHD in adults.

### No. 16B
### COGNITIVE-BEHAVIOR THERAPY FOR INDIVIDUALS WITH SCHIZOPHRENIA

Jan L. Scott, M.D., *University Dept. of Psychological Medicine, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G120XH.*

SUMMARY:

The early descriptions of cognitive-behavior therapy largely focused on its use in non-psychotic emotional disorders. However, even Beck himself, in a 1957 case study, identified that similar approaches could prove beneficial to individuals with psychotic symptoms. It was not until the 1980s that case studies and small open trials began to be published in the literature. These demonstrated that cognitive-behavior therapy could help particularly with medication refractory psychotic symptoms. Over the last two decades a number of randomized, controlled trials have explored the additional benefits of using cognitive-behavior therapy in conjunction with antipsychotic medication. This paper will give an overview of the approach to formulation in schizophrenia and describe how delusional beliefs can be understood in terms of their meaning to the individual and also the cognitive processes (e.g. arbitrary inference, maximization/minimization) that can play a role in maintaining such beliefs. The paper will highlight effective interventions, the limitations of this approach and briefly review the findings of the key randomized trials published to date.

### No. 16C
### PSYCHIATRIC ASPECTS IN ONCOLOGY: END-OF-LIFE DECISIONS

Anton C. Trinidad, M.D., *Department of Psychiatry, Washington Hospital Center, 110 Irving Street, NW, Washington, DC 20010*

SUMMARY:

Cognitive therapy interventions in terminal cancer often deviate from standard cognitive therapy. While depression and anxiety are common symptoms, the therapist grapples with issues that are existential. In this part of the symposium, Dr. Trinidad discusses these therapeutic aspects by discussing a case, that of a woman who has metastatic breast cancer who survived the dire prognosis of her oncologists for two years, living in a form of suspended existence. The therapeutic sessions may be considered hybrid—cognitive, existential and supportive. It is hoped that this part of the symposium would spark a productive discussion of whether this form of therapy connotes "therapeutic drift" or "therapeutic flexibility" in cognitive therapy.

REFERENCES:

1. McDermott SP: Cognitive Therapy of Adults With Attention Deficit/Hyperactivity Disorder. Attention Deficit Disorders and Co-morbidity in Children, Adolescents and Adults. Washington DC, American Psychiatric Press, Inc., 2000.
2. Birchwood M, Fowler D, Jackson C: Early Interventions in Psychosis: A Guide To Concepts, Evidence and Interventions. London, Oxford University Press.
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4. Moorey S: Cognitive Behaviour Therapy for People with Cancer, New Edition. London, Oxford University Press, 2002

## SYMPOSIUM 17—EATING DISORDERS 2003: FROM LABORATORY TO PRACTICE

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize the major problems impeding outpatient therapy for anorexia nervosa, (2) discuss the utility of feeding laboratory studies in evaluating eating behavior and the effects of medications in eating disorder patients, (3) describe common mistakes, uncommon but medically serious errors, and medical situations resulting in malpractice suits encountered in caring for patients with eating disorders, and discuss implications for avoiding these problems in clinical practice.

## No. 17A
## UPDATE: GENETICS OF ANOREXIA AND BULIMIA NERVOSA

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 3600 Forbes Avenue, Suite 600 Iroquis, Pittsburgh, PA 15260;* Wade H. Berrettini, M.D., Bernie Devlin, Ph.D., Andrew Bergen, Ph.D., Cynthia M. Bulik, Ph.D., Dorothy E. Grice, M.D., The Price Foundation Group

### SUMMARY:

Anorexia nervosa (AN) and bulimia nervosa (BN) are transmitted in families and twin studies suggest that there is a substantial genetic contribution. The Price Foundation international collaboration has completed the first genome-wide search for potential susceptibility genes in AN in 192 kindreds with at least one affected relative pair (ARP) with AN or a spectrum eating disorder (ED). Although evidence for linkage in the entire sample was negligible, an analysis using the most narrow affection status model comprised of relatives with only restricting type AN generated a peak multipoint non-parametric linkage score of 3.45 ($p < .0037$) on Chromosome 1. In a further analysis, two variables, drive-for-thinness and obsessionality, incorporated as covariates into the linkage analysis, resulted in several regions of suggestive linkage, one close to genome-wide significance on another region of Chromosome 1 (LOD = 3.46; $p < .00003$). In a second study of 308 kindreds with BN or a spectrum ED, we found significant linkage on another chromosome. These initial findings suggest genetic heterogeneity in EDs and the potential value of genomic analyses conducted on large clinically homogeneous samples.

A growing number of case control studies have examined the potential association of various candidate genes with AN and BN. Evidence linking AN and BN to monoamine function have led researchers to target serotonin, dopamine, and noradrenergic genes with some promising findings related to receptors or transporters. The primary role of feeding, energy expenditure, or gender in the pathology of AN and BN has led researchers to examine genes related to these processes. Findings have been published that suggest possible associations between AN candidate genes such as the estrogen receptor β gene and the gene for agouti-related protein. In summary, although consistent evidence for association of a candidate gene with either AN or BN has not accrued to date, small sample sizes constrain these efforts. Additional research is necessary to clarify conflicting findings and replicate initial results.

## No. 17B
## REALITIES AND CONSTERNATIONS OF OUTPATIENT TREATMENT FOR ANOREXIA NERVOSA

Katherine A. Halmi, M.D., *Westchester Division, New York Presbyterian Hospital, 21 Bloomingdale Road, White Plains, NY 10605-1504;* W. Stewart Agras, M.D., Scott J. Crow, M.D., James E. Mitchell, M.D., G. Terrence Wilson, Ph.D.

### SUMMARY:

*Objective:* To evaluate over a year the course of anorexia nervosa (AN) patients who received cognitive-behavioral therapy (CBT), after a recent weight gain.

*Methods:* One hundred and twenty-two AN patients were randomly assigned within each of three centers (Weill-Cornell Medical Center, University of Minnesota, Stanford University) to CBT, CBT and fluoxetine, or fluoxetine. All treatments received medical management.

*Results:* The dropout/withdrawal rate was high as follows: fluoxetine 30 (73%), CBT 24 (57%), and CBT and fluoxetine 23 (59%). Although there was no significant difference between the groups, those receiving fluoxetine alone dropped out earlier compared with the CBT group. Also, there was fewer acceptance (staying in treatment for at least five weeks) for medication compared with the CBT groups. The percent ideal body weight for those who completed treatment (45) was 97% compared with those who dropped out (54) with 88% and those who were withdrawn (19) with 84%.

*Conclusion:* This study indirectly confirms the salient psychological feature of AN is the resistance and lack of motivation for treatment. Medication (fluoxetine) is accepted better when given with psychotherapy.

## No. 17C
## FEEDING LABORATORY STUDIES IN PATIENTS WITH EATING DISORDERS

James E. Mitchell, M.D., *Neuropsychiatric Research Institute, 700 First Avenue, South, P O Box 1415, Fargo, ND 58103;* Blake A. Gosnell, Ph.D., James L. Roerig, Ph.D., Martina deZwaan, M.D., Stephen A. Wonderlich, Ph.D., Melissa A. Burgard, Beth N. Wambach

### SUMMARY:

Several research groups have developed human feeding laboratories as a way of studying eating behavior in patients with eating disorders. Various paradigms have been employed including the use of standardized buffets, nutritional supplements, and the provision of specific binge foods. The results of these studies suggest that patients with eating disorders will replicate abnormal eating behavior in feeding laboratory studies, and that patients with bulimia nervosa and binge eating disorder consume large amounts of food during eating binges. Our group has demonstrated that the number of foods presented and the amounts of food presented in a human feeding laboratory markedly influence the amount of food ingested during eating binges. In the current study we evaluated the effects of the weight loss agent sibutramine on eating behavior and hunger/satiety in an outpatient sample of patients with binge eating disorder. The results indicate a statistically significantly reduction in the number of calories consumed during binge eating behavior after one and four weeks of treatment, in a placebo-controlled, double-blind, crossover study. These results indicate that a feeding laboratory setting can be successfully employed to study the pharmacological effects of drugs on eating behavior.

## No. 17D
## ARE EATING DISORDERS AND SUBSTANCE USE DISORDERS RELATED?

David B. Herzog, M.D., *Department of Psychiatry, Massachusetts General Hospital, 725 ACC-EDU 15 Parkman Street, Boston, MA 02114;* David J. Dorer, Ph.D., Debra L. Franko, Ph.D., Pamela K. Keel, Ph.D., Valerie Charat, B.A., Erica C. Hutchins, B.A., Rebecca Renn, B.A.

### SUMMARY:

Substance use disorders (SUDs) are frequently comorbid with eating disorders (EDs), yet little is known about the impact of SUDs on ED course and outcome, or about the nature of the association of SUDs and EDs. We have conducted a secondary analysis on data from our longitudinal study of anorexia and bulimia nervosa. The 246 subjects, followed for a median of nine years, were classified at intake as follows: BN (N = 110), binge/purge AN (N = 85), restricting AN (N = 51). During follow-up, 10 new onsets of drug use disorder (DUD) and 24 new onsets of alcoholism (ALC) occurred, bringing lifetime histories of DUD from 13% to 17% (N = 41) and ALC from 17% to 27% (N = 66). To date, 11 women have died (10 AN, 1 BN). Controlling for age and duration of ED episode at intake

in AN, presence of a SUD during the course of the study was significantly associated with increased hazard of death (DUD: LRT = 4.96, df = I, p = .026; ALC: LRT = 11.0, df = 1, p = .0009). We will report on predictors of SUD onset and describe the influence of SUDs on ED recovery, relapse, and symptomatology. We will also test whether bulimic symptomatology in ED women precedes and increases the risk of developing ALC, contributing to knowledge about the nature of the relationship between SUDs and EDs.

### No. 17E
### COMMON AND UNCOMMON MISTAKES IN MANAGING EATING DISORDERS

Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326;* Arnold E. Andersen, M.D., E.L. Danies, J.D.

SUMMARY:

Referral centers that treat and consult on large numbers of patients with eating disorders inevitably encounter patients whose prior care appears to have been problematic. Honest self-appraisal also reveals the fact that over the years they themselves have treated patients whose management at their hands, at least in retrospect, appears to have been questionable. However, the retro-spectoscope is admittedly much easier to employ than the pro-spectoscope. The ambiguous, unpredictable, chaotic, and multidimensional nature of many clinical problems and treatment situations renders after-the-fact critiquing of care hazardous at best. Nevertheless, a careful review of common mistakes and of uncommon serious errors may reveal systematic sources of error and inform education, practice, and supervision. Based on their own considerable clinical experiences, a survey of others, and a review of the medical and medico-legal literature, the authors offer a typology of medical errors in the treatment of eating disorders patients based on omissions, commissions, intensities, and timing. These misjudgments concerning psychological and psychosocial treatments, medical treatments, administrative decisions, and professional boundaries provide the basis for suggestions contributing to guidelines for better care.

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1. Grice DE, Halmi KA, Fichter MM, Strober M, Woodside DB, Treasure JT, et al: Evidence for a susceptibility gene for anorexia nervosa on chromosome 1. Am J Hum Genet 2002; 70:787–92.
2. Vitousek KB: Cognitive-behavioral therapy for anorexia nervosa, in Eating Disorders and Obesity. Edited by Faiburn CC, Brownell K.D. New York, Guilford Press, 2002, pp 308–313.
3. Gosnell BA, Mitchell JE, Lancaster K, Burgard MA, Wonderlich SA, Crosby RD: Food presentation and energy intake in a feeding laboratory study of subjects with binge eating disorder. Int J Eat Disord 2001 31:441–446.
4. Wolfe WL, Maisto SA: The relationship between eating disorders and substance use: moving beyond co-prevalence research. Clinical Psychology Review 2000; 20:617–631.
5. Andersen AE (ed): Eating Disorders. Psychiatric Clinics of North American, 2001.

## SYMPOSIUM 18—ADVANCES IN THE TREATMENT OF CHILDHOOD TRAUMATIC GRIEF

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize symptoms of traumatic grief in preschoolers and identify assessment and treatment approaches, and (1) discriminate between trauma and loss reminders, and identify the primary correlates of each, (2) identify post-war contextual factors that significantly predict grief reactions among war-exposed Bosnian adolescents, and (3) describe primary group-based therapeutic techniques used to treat traumatic bereavement in adolescents.

### No. 18A
### ASSESSING AND TREATING PRESCHOOL TRAUMATIC GRIEF AFTER DOMESTIC VIOLENCE

Alicia F. Lieberman, Ph.D., *Department of Psychiatry, University of California at San Francisco, 1001 Potrero Avenue Suite 2100, San Francisco, CA 94110*

SUMMARY:

This presentation will describe the assessment and treatment of preschoolers who witnessed domestic violence (DV) and whose fathers left the home, subjecting the child to the dual traumatic stresses of exposure to violence and loss of an attachment figure. The sample is ethnically diverse; mothers' socioeconomic status ranges from poverty to upper middle class. The assessment and treatment approaches are based on the premise that preschoolers' psychological functioning and resilience to trauma are related to the level of maternal functioning and the quality of the child-mother relationship.

Relationship based assessment and treatment strategies will be described, including findings regarding DV-exposed preschoolers' symptomatology in comparison to a group of preschoolers matched for age, gender, ethnicity, and maternal education who did not witness domestic violence. Child-parent psychotherapy as a treatment approach simultaneously targeting maternal and child traumatic responses and supporting developmental progress will be described and illustrated with clinical vignettes. Statistical findings will illustrate the mutual influences between maternal and child functioning both before and after treatment.

### No. 18B
### ASSESSMENT AND GROUP-BASED TREATMENT OF TRAUMATICALLY BEREAVED ADOLESCENTS

Christopher M. Layne, Ph.D., *Department of Psychology, Brigham Young University, 2841 TLRB Byu, Provo, UT 84602;* William S. Saltzman, Ph.D., Berina Arslanagic, M.D., Rob Davies, B.A., Robert S. Pynoos, M.D., Gary Burlingame, Ph.D.

SUMMARY:

This presentation will focus on the dual tasks of assessing and treating traumatic bereavement reactions in adolescents exposed to large-scale disasters, with special emphasis given to war-exposed Bosnian youths. Presentation foci will include (1) distinguishing, both conceptually and empirically, between trauma and loss reminders; (2) identifying clinically relevant correlates of trauma and loss reminders; (3) describing the development and preliminary validation of the Expanded Grief Inventory (EGI), an instrument designed to measure complicated grief reactions in adolescents and adults; and (4) describing a group-based treatment protocol for traumatically bereaved Bosnian adolescents as implemented during the 2000–2001 school year. Preliminary results indicate that trauma and loss reminders are related, but empirically distinct, constructs that correlate differentially with posttraumatic stress, depression, and grief reactions. In addition, as theorized, a factor analysis of the EGI provides support for a traumatic intrusion and avoidance factor, an existentially complicated grief factor, and a positive connection factor. Last, an effectiveness evaluation of trauma/grief-focused group therapy indicates that participation is associated with reductions in symptoms of distress, and increases in pro-social academic and peer-related behavior.

## No. 18C
## INTERVENTION FOR CHILD SURVIVORS OF SUICIDE

Cynthia R. Pfeffer, M.D., *Department of Psychiatry, Comell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Children who are bereaved by the suicide of a parent, sibling, or other close relative suffer acute symptoms of grief, anxiety, and depression. Depending upon whether they directly observed the suicide or were present at the scene of death or were given explicit details of the death, such children experience varied intensities of trauma. In addition, such children may experience isolation related to their need to keep the cause of death secret or stigma. This presentation will discuss the clinical characteristics of children who suffered the recent suicide of a loved one. It will describe a bereavement group intervention administered to such children. The efficacy of this intervention will be described. Specifically, the intervention, offered to prepubertal children, age 6 to 12 years, significantly reduced children's symptoms of depression and anxiety. It enhanced their social adjustment during their course of bereavement. Implications of this research for intervening with children who are bereaved by the suicide of a close relative will be discussed.

## No. 18D
## TERRORISM AND THE TREATMENT OF CHILDHOOD TRAUMATIC GRIEF: LESSONS LEARNED FROM 9/11

Robin F. Goodman, Ph.D., *New York University Child Study Center, 577 First Avenue, New York, NY 10016*

SUMMARY:

A clinical and research program for bereaved children in the New York metropolitan area was developed and implemented following the September 11th attack on the World Trade Center. Although able to draw on previous research and experience, the unique aspects of the trauma and New York City impacted the decisions that were made. The presentation outlines the relevant components of the program, the contextual environment in which it was created, the needs of the different constituent groups being served, at the individual, community, and organizational level, and offers suggestions for facilitating future program development.

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2. Layne CM, Pynoos RS, Saltzman WR, et al: Trauma/grief focused group psychotherapy: school-based postwar interventions with traumatized Bosnian adolescents. Group Dynamics: Theory, Research and Practice 2002; 5:277–290.
3. Pfeffer CR, Jiang H, Kakuna T, Hwang J, Metsch M: Group intervention for children bereaved by the suicide of a relative. Journal of the American Academy of Child and Adolescent Psychiatry 2002; 41:505–513.
4. Goodman, RF, Brown, EJ, Courntey, M: Helping children affected by trauma and death. Harvard Mental Health Letter 2002; 18:4–5.

# SYMPOSIUM 19—NOVEL CLINICAL PERSPECTIVES ON THE PATHOPHYSIOLOGY AND TREATMENT OF PTSD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand how learned helplessness can be an animal model of PTSD, (2) recognize role of GABA in neurobiology of PTSD, and be able to (3) treat PTSD with anticonvulsants, (4) describe open-labeled possible effectiveness of the anticonvulsant topiramate on civilian chronic posttraumatic stress disorder and consider the potential mechanisms of action of topiramate that may contribute to its behavioral activity.

## No. 19A
## ANIMAL MODELS OF PTSD: CAN BASIC SCIENCE INFORM THE CLINIC?

Frederick Petty, M.D., *Department of Psychiatry, Creighton University, 3528 Doge Street, Omaha, NE 68131*

SUMMARY:

Posttraumatic stress disorder is, on the surface, the most plausible human mental illness for which an animal model could be developed, since it is caused by a stress. There is a rich animal literature on the harmful effects of stress, dating back over 50 years. However, a concern of some researchers is that behavioral effects of stress seem not to persist in many of these paradigms. We here present a theoretical construct, by which acute inescapable stress causes neurochemical and behavioral changes that persist for days, and most logically model acute stress reactions. On the other hand, by reminding the animal of trauma cues, or by re-exposure to stress, a long-term behavioral susceptibility to stress-induced depression is noted to persist. Data will be presented from the learned helplessness animal model, which is an established animal model of depression, but which also models aspects of PTSD. The importance of the GABA and serotonin systems in this model are highlighted. Also, predictions from the model that can be tested in the clinic will be discussed.

## No. 19B
## GAMMA-AMINOBYTYRIC ACID NEUROHORMONAL MODULATION IN PTSD AND TREATMENT WITH ANTICONVULSANTS

Lori L. Davis, M.D., *Department of Research, VA Medical Center 116, 3701 Loop Road East (151), Tuscaloosa, AL 35404*

SUMMARY:

The research attempting to unravel the complex biological matrix underlying PTSD has primarily focused on the hypothalamic-pituitary-adrenal (HPA) axis, limbic system, and catecholamines. Recently, the focus of research in the pathophysiology of PTSD has broadened to include other neurotransmitters, such as γ-aminobutyric acid (GABA) and glutamate. Evidence to support our hypothesis of GABA dysregulation in PTSD will be described in detail and results of open and controlled trials of GABAergic agents and anticonvulsants, such as divalproex, in the treatment of PTSD will be presented. Specifically, our research shows significant reduction in PTSD symptomatology in an open-labeled, eight-week trial of divalproex. Other investigators have shown positive results with lamotrigine and topiramate. Trials of benzodiazepines have yielded mixed results. The relationship between substance use disorders and PTSD in regard to shared neurohormonal pathways that might explain their comorbidity will be reviewed. Findings from studies using anticonvulsants in the treatment of substance use disorders will be reviewed. We conclude that the use of anticonvulsants in the treatment of PTSD is promising and that more research is needed to further define the efficacy of anticonvulsants in the treatment of PTSD.

## No. 19C
## TOPIRAMATE THERAPY FOR PTSD

Jeffrey L. Berlant, M.D., *Department of Psychiatry, University of Washington, 4477 Emerald, # A-300, Boise, ID 83706-2044*

SUMMARY:

Open-label findings of a favorable effect of topiramate on symptoms of chronic posttraumatic stress disorder (PTSD) in civilians will be presented. Detailed data will be presented describing response of reexperiencing symptoms of intrusive memories and nightmares reliving the trauma, self-report data from the validated instrument the PCL-C (Posttraumatic Stress Disorder Checklist—Civilian Version), time to reported partial and full responses, and dosage at time of onset of partial and full response.

Topiramate has multiple neural mechanisms of activity, including modulation of sodium and calcium channels, GABA receptors, non-NMDA receptors for glutamate, carbonic anhydrase, and protein phosphorylation. Broadening consideration of all of these mechanisms may open up new understanding of the neurophysiopathology of PTSD and suggest new targets for the future development of new agents.

REFERENCES:

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3. Berlant JL, Van Kammen D: Open-label topiramate as primary or adjunctive therapy in chronic civilian posttraumatic stress disorder: a preliminary report. Jr Clin Psych 2002; 63:15–20.
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## SYMPOSIUM 20—INTEGRATING INTERPERSONAL NEUROBIOLOGY IN PSYCHIATRIC TRAINING AND PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) demonstrate an understanding of an interdisciplinary approach to the mind, brain, and human relationships that can be used to help clinical work in patient assessment and education; use these basic ideas and practical applications of neuroscience in the clinical setting to foster patient understanding and patient-physician collaboration, and (2) demonstrate an understanding of an interdisciplinary approach to teaching psychiatric residents that is based on research-based findings from a range of fields that explore the interconnections among mind, brain, and human relationships; apply these basic ideas of interdisciplinary thinking to educational settings.

### No. 20A
### INTEGRATING NEUROSCIENCE INTO CLINICAL PRACTICE

Marilyn B. Benoit, M.D., *Department of Psychiatry, Howard University, 3033 New Mexico Ave, NW #201, Washington, DC 20016*

SUMMARY:

Knowledge is empowering, and can improve one's sense of control of one's illness. Self-management of one's chronic illness, e.g., diabetes, hypertension, heart disease, has been shown to improve with increased knowledge and skills. This presentation will describe how psychiatrists can use the new information from neuroscience and behavioral genetics to educate patients about their psychiatric disorders. Case examples will demonstrate how complex scientific material can be communicated to patients by using drawings, pictures, a model of the brain, and using lay language. The above demystify the brain, science, and the interaction between our genetic endowments and our psychosocial environments. This integrative/educative approach clinically engages patients, fosters increased curiosity about their illnesses, and invites greater participation in understanding and managing their psychiatric disorders. As neuroscience and behavioral genetics continue to unravel the biological substrates and processes involved in psychiatric disorders, and as we pursue the transactional-ecological model of development that has put the nurture vs. nature controversy to rest, psychiatrists can look forward to a stimulating career of lifelong learning. This will in turn further enhance our role as clinicians as we engage our patients as students, rather than victims of their illness.

### No. 20B
### INTEGRATING BRAIN, MIND, AND ENVIRONMENT IN PSYCHIATRIC EDUCATION

Eugene V. Beresin, M.D., *Massachuetts General Hospital, 55 Fruit Street, Bulfinch 449, Boston, MA 02114*

SUMMARY:

It is essential for psychiatric residents to have a sound education in the integration of research and theoretical material with their clinical practice. Such integration is vital in all aspects of their work—from evaluations in their outpatient clinics, to consulting experiences in consultation-liaison, courts, schools, and in community health centers. An integrated method of conceptualizing symptoms and syndromes facilitates effective interviewing and data collection, formulation of cases, development of comprehensive treatment plans, alliance formation, and thoughtful communication with allied health professionals and other colleagues. Training programs can ensure that an integrated approach, involving the domains of mind, brain, and environment/relationships, is the core philosophy behind psychiatric residency education. Specific techniques can be used in a number of settings, such as videotape interviews, multidisciplinary conferences, and use of faculty with alternative perspectives in teaching this complex model. The presenter will discuss ways of providing integrated training using case examples and model curricula to demonstrate alternative ways of meeting this goal.

### No. 20C
### THE NEUROSCIENCE OF PSYCHOTHERAPY

Louis Cozolino, Ph.D., *Department of Psychology, Pepperdine University, 360 North Bedford Drive, Suite 312, Beverly Hills, CA 90210*

SUMMARY:

The objective of this presentation is to offer participants ways of applying neuroscientific principles to the theory and practice of psychotherapy. The case will be made that the underlying principles governing the neural architecture of the human brain have shaped the theory and practice of psychotherapy. The presentation will include a theoretical portion, case discussion, and ongoing questions and answers to achieve the objectives of the presentation. As a result of this presentation, participants will have an increased understanding of how psychotherapy has been shaped by underlying principles of neurology and neuroscience. Various forms of psychotherapy, such as psychodynamic, cognitive behavioral, and family systems, will be reviewed to uncover common elements correlated with success. This framework suggests that the chasm between psychotherapy and the biological sciences will be bridged in the years to come as we learn more about how the brain grows and learns.

## No. 20D
## INTERPERSONAL NEUROBIOLOGY IN THE PALM OF YOUR HAND

Daniel J. Siegel, M.D., *UCLA, 11980 San Vicente Boulevard, Suite 809, Los Angeles, CA 90049*

### SUMMARY:

This presentation will offer an overview of interpersonal neurobiology as a convergent approach to understanding the mind, the brain, and interpersonal relationships. A "hands-on" example of this conceptual approach can be explored using a model of the brain as symbolized within the fist that illustrates the structure-function relationships of the social brain. This model is useful in revealing the central role of the process of neural integration as carried out via the prefrontal regions as they link input from neocortex, limbic structures, and brainstem areas. Recent neuroscience studies have revealed that the orbitofrontal aspect of the prefrontal cortex plays a crucial role in the mediation of several mental processes important to psychiatry and in mental well-being: Autonomic and emotion regulation, attuned communication, executive functions, social cognition, autobiographical memory, and morality each depend upon prefrontal function. Attachment relationships have been shown to facilitate the development of these same mental processes. Exploring the convergent findings from a wide range of scientific disciplines can further our understanding of the mind and help guide future studies that may explore neural integration and deepen our understanding of the mechanisms of attachment and of effective psychotherapy.

## No. 20E
## LIVING WITHOUT EMPATHY: THE MIRROR NEURONS

Nancy S. Wolf, M.D., *1242 Angelo Drive, Beverly Hills, CA 90210-2706*

### SUMMARY:

This presentation will examine the possibility that a particular category of neurons, specifically the mirror neuron, contributes to the development of, as well as the potential treatment of, empathy-related disorders such as autism and narcissism. The research of Rizzolatti, Gallese, Iacoboni and others is examined and applied conceptually to psychopathology and treatment with the presentation of clinical examples. The mirror neuron system appears to be involved in a developmental sequence hypothesized by Kohut (1984), Stern (1985), and others to begin in infancy. This trajectory starts with the onset of "amodal perception" (Stern, 1985), going then to affect resonance, joint attention, and ultimately to symbolization of language. Current work has further illuminated the role of the mirror neurons in defects of imitation and mindblindness and has led to a new view of treatment that will be elaborated. The mirror neuron system represents a general mechanism of brain functioning that underlies empathy. Disruptions in this system may have profound consequences that are displayed in psychopathology of which autism and narcissism are two examples.

### REFERENCES:

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5. Wolf N, Gales M, Shane E, Shane M: The developmental trajectory from amodal perception to empathy and communication: The role of mirror neurons in this process. Psychoanalytic Inquiry 2001; 21:94–112.

# SYMPOSIUM 21—UPDATE ON TREATMENT OF STIMULANT ABUSE

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) demonstrate improved knowledge and skill on core addiction psychosocial treatments, (2) describe an optimal behavioral treatment plan, and determinants of optimal treatment setting for patient with moderately severe cocaine dependence, (3) treat stimulant abuse with medications and recognize their limitations, (4) appreciate psychiatric comorbidity of stimulant abuse, (5) recognize characteristics that predict substance-induced disorders, (6) entertain treatment strategies based upon responsivity to comorbid disorders; (7) understand the epidemiology, pharmacology, and pathophysiology of methamphetamine abuse; (8) recognize the signs and symptoms of methamphetamine abuse; and (9) be familiar with treatment approaches for methamphetamine abuse.

## 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;* Jeffrey A. Berman, M.D., Jon Krejci, M.D., David A. Smelson, Psy.D., Trish Dooley, M.A., Jill Williams, M.D.

### SUMMARY:

Psychosocial interventions continue to be the cornerstone of cocaine addiction treatment. This presentation will review core recovery-oriented psychosocial treatments, 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, and recovery status. Psychosocial treatment models from the Recovery community will be presented and participants will learn about resources and training materials on psychosocial treatment.

## 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;* G. Shimi Kang, M.D., Estee Sharon, Psy.D., Sandrine Picard, 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 counscling (all delivered with group drug counseling), vs. group drug counseling alone. Unexpectedly, individual + group drug counseling produced the best outcome, regardless of psychiatric comorbidity. Self-help participation was a key outcome influence. Level of care matching has also been studied in three studies of the Patient Placement Criteria published by the American Society of Addiction Medicine (ASAM PPC). These trials used a comprehensive, reliable computerized implementation of the ASAM PPC. Two studies naturalistically compared matching-mismatching, one in a VA and another in a public New York City sample. Another study used a random control, multisite, match-mismatch design in eastern Massachusetts. Multidimensional results indicate that matching patients to level of care based on their clinical and psychosocial characteristics (including attitude towards 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 SUBSTANCE ABUSE

David A. Gorelick, M.D., *Department of Clinical Pharmacology, NIH NIDA IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224-0180*

SUMMARY:

Numerous pharmacological treatments for stimulant abuse have been evaluated, but none has been consistently effective in controlled clinical trials. Some medications showing promise in clinical trials, but not FDA approved for this indication, include the selective MAO inhibitor selegiline, anticonvulsants such as phenytoin and vigabatrine, and disulfiram (perhaps by increasing brain dopamine activity). Some promising new approaches undergoing preclinical or phase I clinical evaluation include compounds (e.g., GBR 12909) that bind to the presynaptic dopamine transporter, a major site of action for cocaine; antibodies that bind cocaine peripherally, thus preventing it from entering the brain (cocaine vaccine); and enhancement of cocaine metabolism with the naturally occuring enzyme butryrylcholinesterase. A particularly difficult group of patients to treat are those abusing other drugs in addition to stimulants, e.g., "speedballers." Buprenorphine, a partial mu-opiate agonist, has shown some promise in the treatment of such patients.

## No. 21D
## PSYCHIATRIC COMORBIDITY IN STIMULANT ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Saint Luke's-Roosevelt Hospital Center, 1090 Amsterdam Avenue, 16th Floor, Suite G, New York, NY 10025*

SUMMARY:

Epidemiologic and treatment-survey data consistently indicate that psychiatric comorbidity is very common among stimulant abusers and alters the course and recommended treatment of the substance use disorder. This presentation will focus upon treatment issues of 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: UPDATE 2003

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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# SYMPOSIUM 22—INTERFERON-INDUCED NEUROPSYCHIATRIC SIDE EFFECTS: NEW DATA AND TREATMENTS

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) be sensitized to the risks of IFN-induced depression and what we know about it, (2) be able to identify biological and clinical risk factors for the development of depressive symptoms during IFN alpha therapy and describe relevant pharmacologic strategies for their management, (3) be able to describe behavioral symptoms that develop during IFN alpha therapy and link these to altered activity in specific brain regions as identified by in vivo functional neuroimaging, (4) be able to identify a role for specific NSAIDs in the treatment of depressive-like behavior induced by interferon or endotoxins.

## No. 22A
## INTERFERON-INDUCED DEPRESSION: A CRITICAL ANALYSIS

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### SUMMARY:

Interferon (IFN) has significant antiviral, anticancer, and immunomodulatory properties being used widely to treat hepatitis B and C, malignant melanoma, multiple sclerosis, etc. Of particular interest, IFN is the only FDA-approved treatment for chronic hepatitis C, which affects four to five million Americans. Although IFN is a promising and important treatment for several disorders, its side-effect profile compromises its overall usefulness.

IFN induces a variety of neuropsychiatric and neurotoxic side effects, including depression, anxiety, insomnia, lethargy, confusion, and psychosis. The incidence of developing a depressive disorder during IFN treatment ranges from 0% to 70%, with rates of 30% to 45% cited in more carefully controlled studies. The development of psychiatric symptoms occurs as early as a few days, several weeks, or a number of months after beginning treatment.

The high incidence of IFN-induced depression, coupled with a number of case reports describing suicide attempts and completed suicide in patients being treated with IFN, has contributed to physicians denying IFN to depression-prone patients.

This presentation will review the existing prevalence studies of IFN-induced depression evaluating whether its prevalence and onset—early vs late-depends on the illness being treated, IFN characteristics (dose, frequency, duration, and type of IFN), or patient's psychiatric status.


## No. 22B
## PREDICTION AND PREVENTION OF INTERFERON ALPHA-INDUCED DEPRESSIVE SYMPTOMS

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### SUMMARY:

Interferon-alpha (IFN) treatment is hampered by a high rate of neuropsychiatric disturbance. Thirty percent to 50% of patients undergoing IFN treatment meet criteria for major depression. Depressive symptoms are a primary reason for treatment discontinuation and/or IFN dose reduction, both of which are associated with poor outcome. Antidepressant pre-treatment protects against depression-related IFN-alpha discontinuation. However, not all patients develop depression on IFN-alpha. Therefore, identification of high-risk patients for antidepressant pretreatment is warranted. Because corticotropin releasing hormone (CRH) is known to be activated by IFN-alpha and has been implicated in the pathophysiology of depression, we evaluated HPA axis responses to the first injection of INF-alpha as a predictor of subsequent depression. Increased production of ACTH and cortisol strongly predicted the development of major depression following eight weeks of IFN-alpha treatment. ACTH/cortisol responses to the initial IFN-alpha injection also correlated with mood and anxiety symptoms at eight weeks, but not with fatigue and other neurovegetative symptoms. Interestingly, antidepressant pre-treatment amcliorated depressed mood and anxiety, but not neurovegetative symptoms. Takcn together, these results suggest that immune activation during IFN-alpha therapy may predispose to the following two distinct depressive syndromes: an antidepressant-responsive mood/anxiety syndrome mediated, at least in part, by CRH, and an antidepressant unresponsive neurovegetative syndrome mediated by other pathways.


## No. 22C
## INTERFERON ALPHA-INDUCED FRONTO-STRIATAL DYSFUNCTION: FROM SYMPTOMS TO NEURAL CORRELATES

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### SUMMARY:

Depressive syndromes with affective flattening and psychomotor retardation frequently develop in medically ill patients undergoing interferon (IFN)-alpha therapy for cancers or viral diseases. At the behavioral level, these symptoms are suggestive of fronto-striatal alterations. In order to further assess fronto-striatal activity during IFN-alpha therapy, we conducted brain imaging studies using both functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) in patients receiving IFN-alpha for the treatment of chronic hepatitis C (HCV) or malignant melanoma. Nineteen HCV patients underwent fMRI scans either before or after 12 weeks of IFN-alpha therapy during a task known to enhance striatal activity. In addition, a group of eight patients with malignant melanoma underwent PET scans using fluorine-18 labeled-fluorodeoxyglucose [$^{18}$F]-FDG in rest condition before and after four weeks of high-dose IFN-alpha therapy. Results indicate that IFN-alpha in HCV patients is associated with reduced evoked activity in the striatum and prefrontal cortical areas. These results are consistent with PET findings showing, during IFN-alpha administration, an enhancement of glucose metabolism in the globus pallidus, an area which normally receives inhibitory projections from the striatum. These findings support the hypothesis of fronto-striatal alterations during IFN-alpha therapy and suggest the involvement of basal ganglia circuitry in the development of IFN-alpha-induced depression.


## No. 22D
## ANIMAL MODELS OF INTERFERON-INDUCED DEPRESSION: A ROLE FOR NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

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SUMMARY:

Interferon (IFN)-α and endotoxins (e.g., lipopolysaccharide (LPS)) induce depressive-like symptoms in animals, and result in increased levels of cytokines, stress hormones, and reduced serotonin levels in brain. These widespread alterations mimic many components exhibited by depressed human patients. Recent evidence suggests that depression may be a dysfunction of inflammatory mediators in brain, accompanied by altered stress axis activation, and that nonsteroidal anti-inflammatory drugs (NSAIDs) may be useful in the treatment of this disorder. In one experiment, we demonstrated that IFN-α increased serotonin turnover (including decreased tissue levels of serotonin) specifically within the prefrontal cortex of Wistar rats, yet this effect was completely prevented in rats pretreated with the NSAID diclofenac sodium. In a separate study, we investigated depressive-like behavior induced by LPS. A primary characteristic of depression is anhedonia, which is defined as a loss of interest in pleasurable stimuli. In an animal model of depression, anhedonia is represented by decreased interest in reward-focused behavior. Male, Wistar rats were trained to press a lever for food or sweetened milk reward. After a stable baseline was achieved, animals were exposed to a chronic regimen of either saline or diclofenac. Rats were subsequently challenged with either saline or diclofenac prior to an injection of LPS. Saline+LPS rats exhibited a significant reduction in responding, while this effect was prevented in diclofenac+LPS rats. The data demonstrate that specific NSAIDs may prevent neurochemical alterations induced by IFN-α or may be useful for the treatment of depressive-like behavior elicited by an endotoxin.

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2. Musselman DL, Lawson DH, Gumnick JF, Manatunga AK, Penna S, Goodkin RS, Greiner K, Nemeroff CB, Miller AH: Paroxetine for the prevention of depression induced by high-dose interferon alfa. N Engl J Med 2001; 344(13):961–6.
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4. Dunn AJ, Swiergiel AH: The reductions in sweetened milk intake induced by interleukin-1 and endotoxin are not prevented by chronic antidepressant treatment. Neuroimmunomodulation 2001; 9:163–169.

## SYMPOSIUM 23—ROADS TO HEALING IN MENTAL HEALTH IN THE AMERICAS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant (1) will learn of alternatives to current healing procedures. This talk will signal the opportunities and difficulties of diagnostic manuals when it comes to transcultural psychiatry, (2) will understand the present situation of psycho-education and psychopharmacology, and (3) those attending will understand the gap between science and most mental health patients and the bridges to close the distance.

### No. 23A
### FOLKLORIC ROOTS OF LATIN-AMERICAN PSYCHIATRY: THE CONCEPT OF ILLNESS AND HEALING

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Casilla 1716 127C EQ, Quito, Ecuador*, Roberto E. Chaskel, M.D.

SUMMARY:

Forms of shamanism, witchcraft, and curanderism are considered by many as justified empirical techniques of psychotherapy. But they are guided by unique theoretical constructs. These constructs have to do with the perception of illness and meaning of pathology. As culture is the result, amongst others, of learning processes between the individual and the environment, mental illness finds a road into the culture and gives the experience of illness a cultural perception, which defines the healing process.

### No. 23B
### DIAGNOSTIC ISSUES IN LATIN-AMERICAN PATIENTS: ARE WE ON THE RIGHT ROAD?

Miguel R. Jorge, M.D., *Department of Psychiatry, Brazilian Association of Psychiatry, R. Botucatu 740, Sao Paulo 04023-900, Brazil;* Monchablow Alberto

SUMMARY:

In the United States all Latin American cultures are represented along with European, Asian, and African cultures. The diagnostic manuals are meant to cover all expressions of mental illness, but they have failed on many occasions to cover the individual's approach to his own illness. America is a wonderful melting pot where cultural, anthropologic, and quality of life issues come to the surface when we attempt to use guides such as ICD-10 and DSM-IV. This presentation will concentrate on both the flaws and the strengths of these manuals in order to provide the clinician with additional tools in his endeavor.

### No. 23C
### THE PROMISE OF PSYCHOEDUCATION AND PSYCHOPHARMACOLOGY IN THE LIVES OF LATIN-AMERICAN PATIENTS

Ruben J. Hernandez-Serrano, M.D., *Department of Psychiatry, U.H. Caracas, P.O. Box 17302, Caracas, Venezuela;* Antonio Pacheco, M.D.

SUMMARY:

Although 50 years have passed since they came to life in the Americas, psychoeducation and psychopharmacology are still in a state of rawness, probably due to the fact that psychoeducational techniques were brought attached to psychopharmacology into a non-European society, which generated a fault in it's application. The culture of medication and mental illness is an issue by itself. This presentation covers the issue of medication and illness in light of ethnopharmacology and education within Latin American cultures.

### No. 23D
### PSYCHOTHERAPY: THE APPLICATION OF A TRANSCULTURAL HEALING TECHNIQUE

Amelia E. Musacchio, M.D., *Mental Health, University of Buenos Aires, Santa Fe 3802, 7th Floor, Buenos Aires 1425, Argentina;* Rodolfo D. Fahrer, M.D.

SUMMARY:

Frequently communication between a doctor and his patient is stalled. Based on psychotherapeutic techniques that respect the patient's background, this hurdle can be overcome. Cultural deliverance can enhance the quality of life and keep the individual attached to the healing process. It entails flexibility on the part of the psychotherapist, but foremost it respects the authenticity of the individual. These two elements can, amongst other strategies, make for a successful intervention.

### No. 23E
### THE PROMISE OF SCIENCE AND ITS DELIVERY IN THE AMERICAS

Andres Meerlein, M.D., *Society Psychiatry, Carlos Silva 1292-22 Providence, Santiago De Chile, Chile;* Nestor F. Marchant, M.D.

SUMMARY:

The existence and quality of human resources destined to psychiatric research have developed the field into a privileged area in the field of medicine. Most of the energy goes into the biological area of interest. Financial resources south of the Rio Grande are limited. Therefore, developing countries produce little scientific literature in mental health. Thanks to the internet most mental health workers now have access to up-to-date scientific literature. Still, many other resources such as imaging are only available to 1% of the population. The purpose of this paper is to underline how the population in the Americas has profited from research and what remains to be done for our field to be a fairer one.

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## SYMPOSIUM 24—SEXUAL AND GENDER IDENTITY DISORDERS: QUESTIONS FOR DSM-V

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize basic criticisms of the diagnosis and treatment of gender identity disorder in children and adolescents, (2) understand issues of validity, stigma, and controversy in the current GID diagnostic category for adults, (3) understand and appreciate the inconsistencies inherent in the current DSM formulation of the Paraphilias and its factual discrepancies.

### No. 24A
### GENDER IDENTITY DISORDER IN CHILDREN AND ADOLESCENTS: A CRITICAL REVIEW

Darryl B. Hill, Ph.D., *Department of Psychiatry, Concordia University, 7141 Sherbrooke Street, W, Montreal H4B 3P4, Canada;* Chris Rozanski, B.A., Jessica Carfaginni, B.A., Brian Willoughby

SUMMARY:

While debates continue as to whether or not a diagnosis of gender identity disorder (GID) is wanted or needed by today's adult transsexual, there is even more concern both in academic and lay literature regarding GID diagnosis in children and adolescents. This paper critically evaluates the diagnosis, assessment, and treatment of GID in children and adolescents in light of published controversies, recent evidence, and arguments in social science discourse. In the years since GID's inclusion in the DSM-III, the heat has been rising on these debates, and the case against GID in children and adolescents is strong. This analysis urges a serious reconsideration of GID for children and adolescents. In the very least, since this is a highly contentious diagnosis, with little established reliability and validity, and extremely problematic assessment and treatment approaches, researchers and clinicians need to establish that GID is validly diagnosed with non-biased assessments and treated effectively in accordance with current standards. Overall, there is growing malaise about continuing to pathologize children and youth for extreme gender variance.

### No. 24B
### DISORDERING GENDER IDENTITY: ISSUES OF DIAGNOSTIC REFORM

Katherine Wilson, Ph.D., *Director of Outreach, Gender Identity Center of Colorado, 1455 Ammons Street, #100, Lakewood, CO 80215;* Arlene I. Lev, C.S.W.

SUMMARY:

More than 20 years after the American Psychiatric Association created the diagnostic category "gender identity disorder" in the Diagnostic and Statistical Manual of Mental Disorders, the GID diagnosis continues to raise questions of validity and social stigma amid growing controversy. In recent revisions of the DSM, the GID category has grown increasingly broad, ambiguous, and incongruent with treatment goals intended to mitigate the distress of gender dysphoria. Clinically significant dysphoria, distress, and dysfunction are conflated with the social consequences of stigma and internalized shame. The consequential myth of "disordered" gender identity denies the social legitimacy of all gender variant individuals in their experienced gender identities. At the same time, failure to distinguish gender distress from gender difference in the DSM compromises therapeutic relationships and undermines the access and medical necessity of sex reassignment procedures for transsexuals who suffer gender dysphoria.

### No. 24C
### DSM-IV-TR AND THE PARAPHILIAS: AN ARGUMENT FOR REMOVAL

Charles A. Moser, M.D., *45 Castro Street, #125, San Francisco, CA 94114-1032;* Peggy J. Kleinplatz, Ph.D.

SUMMARY:

The DSM-IV-TR (2000) sets its own standards for inclusion of diagnoses and for changes in its text. The paraphilia section is analyzed from the perspective of how well the DSM meets those standards. The concept of paraphilias as psychopathology was analyzed and assessed critically to determine if it meets the definition of a mental disorder presented in the DSM; it does not. The paraphilia diagnostic category was critiqued for logic, consistency, clarity, and whether it constitutes a distinct mental disorder. The DSM presents "facts" to substantiate various points made in the text. The veracity of these "facts" was scrutinized. Little evidence was found in their support. Problems with the tradition of equating particular sexual interests with psychopathology were highlighted. It was concluded that the paraphilia section is so severely flawed that its removal from the DSM is advocated.

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3. Moser C, Kleinplatz J: DSM-IV-TR and the paraphilias: An argument for removal. Journal of Psychology and Human Sexuality, in press.

# SYMPOSIUM 25—CONFRONTING CRISES IN EDUCATION, MENTAL HEALTH, AND JUVENILE JUSTICE

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the size, depth, and power of the decline in the nation's juvenile mental health and personal development as represented in expanding incarceration statistics for California's children, (2) understand the relationship of the Fresno model interventions to the process and outcome measurements while learning what methodologies work best with children, (3) be able to describe early intervention programs aimed at young children to prevent potential future educational, criminal, and career problems. Providers and child advocates will recognize on the legal means to secure appropriate health, education, and social services for disordered youth.

## No. 25A
## NOTICING NATIONAL PROBLEMS THROUGH STUDY OF CALIFORNIA JUVENILE INCARCERATION DATA

Lawrence K. Richards, M.D., *Department of Psychiatry, 5266 North Valentine, #102, Fresno, CA 93711;* Allison Ganter


### SUMMARY:

Family disruption, divorce, remarriage, re-divorce, lack of parenting, anger, anxiety, depression, suicidal ideation, loss of or failure to develop self-control, disruptive behavior, drug abuse, and a general decline in mental health and personal development and a readiness to sit down and be studius represent the state of affairs for more and more U.S. children. The number of youths appearing at psychiatric emergency services (PES) is increasing, and the number of children entering the juvenile justice system is such that juvenile halls regularly run a census above the rated capacity and soon fill up after camps are developed as alternatives between home detention and commitment.

Because of this the CA Board of Corrections was formed to set and oversee standards for county juvenile facilities and adult jails; in 1995 the BOC began setting minimum standards for juvenile halls (JH) and related camps. In 1999 the BOC began to keep expanded data on these facilities and the children through its Juvenile Detention Profile Survey, (JDPS) collecting quarterly and monthly data.

Three, six, and ten+ years of CA BOC and prior CA Youth Authority (CYA) data are used to expand the above descriptions. The rates of admissions, i.e. bookings, the related crimes or status offenses of truancy or incorrigability, the disposition status, some mental health observations, and the amount of suicidal watches are reviewed. Multiple slides are shown including data on gender, age distribution, types of incarceration, and the relationships between board-rated capacity, (BRC) and average daily population (ADP), and average length of stay (ALS) are discussed. The increasing need for mental health services is presented. In 1999, 2000, and 2001 the statewide average percent of juveniles receiving MH services while in camps and JH's increased from 13%, to 14.5%, to 17%, respectively. Of these, 77%, 66%, and 70% for those years received psychotropic medications. Comments about the above information, degrees of therapy, polypharmacy, followup, and placement problems are made and audience discussion is sought.


## No. 25B
## THE FRESNO-CONTROLLED PREVENTION STUDY FOR CHILDREN

Philip F. Kader, B.A., *Fresno County Probation Department, 2048 North Fine Street, Fresno, CA 93727;* Merle Canfield, Ph.D., Lawrence K. Richards, M.D.


### SUMMARY:

In May, 2002 the U.S. Secret Service and the Department of Education published the "Threat Assessment in Schools" report. One of the most strongly worded conclusions of the document is "connections through human relationships are a central component of a culture of safety and respect." The Fresno study was developed by the county probation department to provide that "connection" while being in a controlled prevention study. In California the leading cause of death for youth 15 to 19 is homicide. Youth between the ages of 12 and 17 are nearly three times as likely as adults to be victims of serious violent crimes, such as murder, rape, and robbery. The greatest chance for both youth crime and victimization is during the after-school hours. The Fresno County Probation Department developed a commitment to crime prevention with the Youth Challenge Community Program, which was begun in 1999. The program provides school site services to youth at greatest risk for involvement in the justice system. It searches for the best chance to reach children ages 10 to 14 through collaborative, family strength-based, wrap-around methodologies. Contracted nonprofit community-based organizations provide specified services that draw from their particular expertise. Using a true experimental design, data are collected about children, families, and community. Process and outcome measurements are made. The data collection includes, but is not limited to, school grades, attendance, behavior, as well as criminality, drug use, mental health referrals, and out-of-control behavior. The presentation will detail the above and show how to do it while reviewing the data.


## No. 25C
## THE FRESNO-CONTROLLED STUDY: DATA ANALYSIS, CONCLUSIONS, AND PREDICTIONS

Merle Canfield, Ph.D., *Alliant International University, 5130 East Clinton Way, Fresno, CA 93727;* Adrianna Shoji, M.A., Kader Philip, Lawrence K. Richards, M.D.


### SUMMARY:

The purpose of this study was to evaluate the effectiveness of an intervention with at-risk youth. Recommendations by school officials are made to the probation officer, who conducts a structured interview. Students determined at risk are randomly assigned to either the treatment or control group. An issue that was confronted and dealt with was that highly motivated probation officers would like all students to be in treatment and if they found a particular student in trouble they would be even more motivated to foil the random assignment. Four hundred and ninety-nine at-risk students between the ages of 12 and 14 participated. Potentially, 276 data elements could be obtained on each subject if they reach all four follow-up periods. Data elements include demographics, legal, academic, and therapeutic involvement. The data described here represent the first two follow-up periods. Many complex relationships among treatment and outcome were assessed using structural equation modeling. By May 2003 most students will have reached all four follow-up periods and be included in the analysis.


## No. 25D
## PREVENTING INCARCERATION: EARLY PREVENTION FOR PRESCHOOLERS

Karen T. Carey, Ph.D., *Department of Psychology, 5310 North Campus Drive, Fresno, CA 93740;* David Barnett, Ph.D.

SUMMARY:

Early intervention has been demonstrated to be effective in preventing life-long problems for children considered to be at risk. Many programs have been implemented across the country and three of these will be described. Social skills for young children have been the primary method used to improve long-term outcomes for these children. In one study in Fresno, Calif., 129 three- to five-year-old children received social skills training for 12 to 24 weeks. Pre and posttest data were collected using the Early Screening Project (Walker, Severson, & Feil, 1995). Results indicated significant gains in social functioning for 113 of the 129 children. In two other longitudinal studies in Cincinnati, Ohio, and St. Paul, Minn. of social skills training with 224 young children, 167 of children who received early intervention in either Head Start programs or private preschool centers were doing well in terms of educational and behavioral outcomes at ages 8 and 10. These children will continue to be followed in their adolescent years. Overall results of these programs thus far indicate significant positive gains for these children. Pre and posttest tools, social skills curricula, and behavioral observations of these children will be discussed.

## No. 25E
## SHORT- AND LONG-TERM EFFECTS OF RISPERIDONE ON CONDUCT PROBLEMS IN CHILDREN

Michael G. Aman, Ph.D., *The Nisonger Center, Ohio State University, 1581 Dodd Drive, Room 175, Columbus, OH 43210-1296;* Robert L. Findling, M.D.

SUMMARY:

Whereas psychotropic agents have frequently been prescribed for managing conduct problems in children, there are few short- or long-term studies of these medications. This paper describes five trials of risperidone in children with subaverage IQs and serious conduct problems. Two six-week trials assessed risperidone using double-blind, placebo-controlled designs. Both trials showed marked reductions in the primary outcome measure (Conduct Problem subscale on the Nisonger Child Behavior Rating Form [NCBRF; $P < .001$]), improvement on the Clinical Global Impressions change score, and improvement on several subscales related to acting-out behaviors. Somnolence, headaches, and increased appetite were among the most common adverse events. These children were followed for an additional 48 weeks in two open-label trials. Risperidone caused marked reductions ($P < .001$) on the NCBRF Conduct Problem subscale in children previously assigned to placebo and sustained improvement in children originally assigned to risperidone. A fifth study examined the effects of open-label risperidone in 500 children with severe conduct problems. Again, ratings on the Conduct Problem subscale showed marked reductions. Implications for the care of children with disruptive disorders are discussed.

## No. 25F
## COURTS AS CASE MANAGERS: AN END TO TRANS-INSTITUTIONALIZATION?

Patrick H. Gardner, J.D., *National Center for Youth Law, 495-14th Street, 15th Floor, Oakland, CA 94612*

SUMMARY:

A defining feature of public children's mental health care in the U.S. is its disaggregated and unplanned character. In every state, five or more agencies are involved in providing care to disordered children. Agencies include mental health, health, developmental disability, drug and alcohol, public schools, juvenile justice, and child welfare. Each has its own mission, culture, procedures, eligibility rules, and funding streams. Which government entity assumes responsibility for a disturbed child's care is often a matter of happenstance, and often agencies ping-pong children back and forth. Shuttling children among agencies has been termed "transinstitutionalization."

The proliferation of mental health programs and funding sources engenders deep frustration on the part of parents and child advocates. Understanding one agency's eligibility and procedural rules, and funding options is a full-time job. Coordinating among programs requires even greater effort. It also makes holding government accountable to at-risk kids more difficult because obtaining services from one agency may require enforcing a duty owed by another.

Under California law, when an abused or neglected child is adjudged dependent, the juvenile court is empowered to make reasonable orders for the care, supervision, custody, conduct, maintenance, and support of the child, including medical support. Additionally, to facilitate coordination and cooperation, California law provides that a court may join in the juvenile court proceedings any agency or private service provider that the court determines has failed to meet a legal obligation to provide services to the child. Together these provisions create an extraordinary opportunity to bridge bureaucratic boundaries and secure mandated services for at-risk youth. Other states also have provisions that enable courts to overcome barriers to providing adequate mental health care.

This presentation will review the nature of the problem of disordered youth that shuttle between agencies. It will outline laws and procedures in several states that allow case managers to surmount barriers to care that result from transinstitutionalization.

The presentation is intended for providers, case managers, policymakers, and advocates seeking to improve access to adequate mental health care for at-risk youth.

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# SYMPOSIUM 26—PSYCHIATRY AND THE POWER OF ADVOCACY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the need for patient advocacy from the perspective of a psychiatrist who is recovering from schizoaffective disorder, (2) understand the "to do's" of advocating to policy makers, (3) demonstrate understanding of how to advocate for open access to atypical antipsychotics, (4) discuss the advocacy issues, challenges, and solutions for psychiatric patients in correctional settings, and (5) describe how psychiatrists can join and collaborate with a professional advocacy organization.

## No. 26A
## INSPIRING PSYCHIATRISTS TO EMPOWER THEIR PATIENTS

Elizabeth A. Baxter, M.D., *Park Center East, 948 Woodland Street, Nashville, TN 37206*

SUMMARY:

In order to advocate for patients effectively, clinicians need to understand more about their patients' illnesses than what is traditionally taught in educational curriculums. Dr. Beth Baxter, a practicing psychiatrist in a mental health center in Nashville, has a unique perspective on the patient's experience because she herself has had schizoaffective disorder since medical school. Currently, she advocates, writes, teaches, and treats patients who are in some ways very much like her. She helped to develop the "Bridges Program," run by the Tennessee Mental Health Consumers Association. Bridges is a psychoeducational program developed to educate mental health care consumers about mental illnesses and to help them cope with their emotions and circumstances. Her presentation will emphasize principles that she has personally discovered through the course of her own recovery, e.g., that people with mental illness don't have to recover completely in order to get on with life, that they must set personal goals and try to meet those goals, and that they need to find someone who believes in them and their recovery.

## No. 26B
## UNDERSTANDING THE PROCESS OF ADVOCATING TO POLICY MAKERS

Patrice A. Harris, M.D., *2801 Buford Highway Suite 501, Atlanta, GA 30329*

SUMMARY:

Psychiatrists are trained to advocate for their patients from a "therapeutic" perspective, not a political one. Said another way, psychiatrists are not prepared to participate in the advocacy movement that is well under way in the United States. Dr. Patrice Harris has traveled nationally to teach and empower psychiatrists and other mental health professionals how to advocate to policy makers. Her presentation will help the psychiatrist understand the "to do's" of advocacy and to feel more comfortable translating familiar values to unfamiliar audiences. To advocate effectively, the psychiatrist must understand that s/he is working outside of their familiar domain. The audience consists of policy makers, e.g., governors or state legislators (people who usually work at "regular" jobs in addition to their elected duties), regulators like commissioners of mental health, state Medicaid directors, drug utilization review boards, etc. The psychiatrist's presentation must not be too "clinical" or "scientific," yet it must be credible and pertinent to local concerns. It must be persuasive but professional, honest, and knowledgeable, and also succinct. Dr. Harris will also present her perspective on the APA's advocacy initiatives.

## No. 26C
## A MODEL PRESENTATION: ACCESS TO MEDICATIONS

Andrew J. McLean, M.D., *Southeast Human Service Center, 2624 9th Avenue SW, Fargo, ND 58103*

SUMMARY:

Rising costs in health care, declining tax revenues, and a slowing economy are leading payers to find ways to reduce costs. When cost reduction strategies are aimed at restricting patient access to certain clinical services, there should be a healthy tension among the stakeholders in the system. The advocacy approach in which the psychiatrist or other mental health professional aligns with an advocacy organization, e.g., the National Mental Health Association or the National Alliance for the Mentally, offers a legitimate strategy to resolve the tension surrounding decisions to restrict treatment. Advocacy efforts have focused on assertive community treatment, housing, rehabilitation, and medication access to name a few. Medication access has been a highly controversial theme most recently. This presentation will model how to advocate in front of non-clinician payers for open access to antipsychotic medications. Using clear and accurate evidence, the presenter will take 15 minutes to make the case that any form of restriction of access to antipsychotic agents is not fiscally or clinically sound, and therefore, not in the best interests of the patient.

## No. 26D
## IS ADVOCACY REQUIRED IN CORRECTIONAL SYSTEMS?

Charles A. Buscema, M.D., *Central New York Psychiatric center, PO Box 300 River Road, Marcy, NY 13403*

SUMMARY:

The criminal-justice system presents special considerations from the advocate's perspective. While the 8th Amendment to the U.S. Constitution guarantees incarcerated persons the right to medical care, it is apparent that they may not be receiving the same quality care that is available for mentally ill persons in the community. Stigma affects the ability to decriminalize behaviors that are usually attributed to mental illness, and political support for this population is more difficult to rally. Within correctional systems, advocacy efforts focus on developing special treatment programming for the mentally ill as an alternative to the common practice of putting them in solitary. Organizations such as NAMI, the Prison Advocacy Network, and the Patient Empowerment Project have been vocal for psychosocial groups and other rehabilitative options. Medication access within these systems may differ from non-correctional mental health programs in the same community, and consequently, may not be fiscally or clinically rational over the long-term. Solutions to these concerns have included treatment malls, medication algorithms, and the development of "peer advocacy" programs. Outside of the system, there is considerable attention to "diversion programs" in which police officers, prosecutors, and judges are educated to recognize mental illness and refer the prisoner appropriately.

## No. 26E
## FORGING ALLIANCES OUTSIDE OF THE POINT OF CARE

David Nelson, M.P.P., *Healthcare Ref., National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314*

SUMMARY:

The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With a network of more than 340 affiliates nationwide, NMHA works "to improve the mental health of all Americans through advocacy, education, research and service." The NMHA is an example of an advocacy organization that welcomes alliances with psychiatrists and other mental health professionals to promote best practices for patients. While parity, access to medications, and Medicaid are among the top issues confronting affiliate, NMHA's health care reform efforts support an ever-growing field of concerns, including employment, involuntary outpatient commitment, justice issues, *Olmstead* planning, and school-based mental health services. Mr. David Nelson, vice president of Healthcare Reform, oversees policy development, grassroots training, and advo-

cacy related to state legislation and appropriations, Medicaid programs, State Children's Health Insurance Program, and Medicare. He will describe NMHA's involvement with advocacy initiatives, and he will delineate concrete ways that psychiatrists can join these and other key advocacy efforts in their states and communities.


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# SYMPOSIUM 27—APPLYING DECISION SCIENCE AND GAME THEORY TO CLINICAL PSYCHIATRY

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants (1) will gain an understanding of the uses and limits of using formal mathematical models such as game theory to enhance our understanding of normal decision making and clinically significant decision pathology, (2) will be able to identify the mode in which patients arrive at decisions. (3) will be able to identify the neural substrates of decision making, and how these neurological structures determine different decision modes, (4) will be able to identify the different functional roles that distinct monoamine neurotransmitter systems play in decision-making processes involving risk, and (5) will understand how different ethnicities may differ in their valuation of mental health states as expressed by the utilities, costs, and tradeoffs involved in symptom reduction.

## No. 27A
## TOWARD A MATHEMATICAL PSYCHIATRY: THE USE AND LIMITATIONS OF FORMAL DECISION MODELS

Lawrence V. Amsel, M.D., *Child Psychiatry, Columbia University, 245 W. 107th Street, New York, NY 10026*


## SUMMARY:

Two recent Nobel Prizes in economics—one to the psychologist Daniel Kahneman for bringing psychology to economics, the other to John Nash for bringing economic modeling to the understanding of behavior—illustrate the emerging importance of Behavioral Decision Science (BDS) to our understanding of human social behavior. Two interdependent research programs, both of which are proving valuable to clinical psychiatry, characterize BDS. One involves formal, mathematical modeling of decision behavior (as illustrated by Nash's work on game theory), and the other involves empirical research based on laboratory studies of subjects performing a variety decision tasks (as illustrated by Kahneman's work on decision anomalies). In this presentation, we will give an overview of BDS, from Bernoulli's development of mathematical models of gambling, through von Neumann/Morgernstern's axiomatization of choice theory, to Kahneman and Tversky's prospect theory. While these models have had an enormous impact on the social sciences, they have seen little application in psychiatry, until recently. Perhaps this is because in the post-Freudian era psychiatry has made great progress by specifically eschewing theoretical models. The DSM, for example, is self-assertively atheoretic. As a specific example of the clinical utility of a formal theoretical model in psychiatry, we present a game theoretic model of suicidal behavior with Nash equilibrium solutions. Despite a simple set of assumptions, the model predicts complex aspects of the clinical phenomenology of suicidal behavior such as the role of hopelessness, future-discounting, attempt lethality, and safety contracting. We will conclude with a discussion of the limitations of such modeling.


## No. 27B
## DECISION MODES AND PSYCHIATRY THERAPY: THE IMPORTANCE OF KNOWING HOW PATIENTS DECIDE

Elke V. Weber, Ph.D., *Department of Psychology, Columbia University, 402B Schermerhorn Hall, New York, NY 10027*


## SUMMARY:

Behavioral decision research has identified qualitatively different ways in which people make decisions, i.e., decision modes. Decision modes differ in the primary psychological processes and decision representations they utilize. Calculation-based decisions are made by evaluating and combining the pros and cons of action alternatives to arrive at the best or a satisfactory choice. Recognition- and rule-based decisions are made by classifying a choice situation as one for which a rule for best action already exists. Action rules often serve a self-control function (e.g., never eat after 7 pm) or are associated with social or professional roles (e.g., as a medical doctor, always stop to help accident victims). Affect-based decisions are made as the result of a fast, holistic, affective evaluation of choice alternatives that results in an approach or avoidance reaction (e.g., impulse purchases or phobic avoidance behaviors). Most decisions involve multiple modes, but I will show that chronic disposition as well as situation-specific variables favor the dominant use of particular decision modes. Psychiatric therapies make implicit assumptions about choice processes that underlie maladaptive behavior. More explicit awareness of the full range of patient decision modes should allow for more focused and effective therapeutic intervention.


## No. 27C
## THE NEUROCOGNITIVE MECHANISMS OF DECISION MAKING

Antoine Bechara, M.D., *Department of Neurology, University of Iowa, 200 Hawkins Drive, Iowa City, IA 52242*


## SUMMARY:

*Background:* Addiction may be related to two processes. One involves abnormal activity in the extended amygdala system, thereby resulting in exaggerated processing of the incentive values of drugs. Another relates to abnormal activity in the prefrontal cortex mechanisms necessary for controlling and inhibiting the drug seeking action. We applied strategies used in the studies of patients with focal lesions in the ventromedial prefrontal cortex (VM) to explore possible defects in prefrontal mechanisms of behavioral control in substance dependent individuals (SDI).

*Methods:* We used a decision-making instrument, the "gambling task" (GT), and we studied groups of SDI, normal controls, and VM patients.

*Results:* In SDI, we revealed three subpopulations: one was without impairments that can be detected by any measure of the GT

paradigm. Another subpopulation was similar to VM patients in that they were insensitive to the future, both positive and negative. A third subpopulation was hypersensitive to reward, so that the presence or the prospect of receiving reward dominated their behavior.

*Conclusions:* The use of neurocognitive criteria to subtype addictive disorders represents a significant paradigm shift with significant implications for guiding diagnosis and treatment. The approach could lead to more accurate subtyping of addictive disorders, and perhaps serve as a guide for more specific, and potentially more successful, behavioral and pharmacological interventions.

Supported by NIDA, DA 1779 and DA12487.

## No. 27D
## THE NEUROMODULATION OF EMOTIONAL CUES IN HUMAN CHOICE

Robert D. Rogers, M.D., *Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, United Kingdom*

### SUMMARY:

While accumulating evidence suggests that effective real-life decision making depends upon the functioning of the orbitofrontal cortex, much less is known about the role of monoamine neurotransmitter systems. In this talk, I describe some recent experiments examining the effects of pharmacological manipulations on the decision making of healthy human volunteers. Volunteers made a series of choices between two simultaneously presented gambles, differing in the magnitude of expected gains (i.e., reward), the magnitude of expected losses (i.e., punishment), and the probabilities with which these outcomes were delivered. We found that manipulations of serotonin function—i.e., rapid dietary tryptophan depletion or treatment with the SSRI, citalopram—affected volunteers' capacity to discriminate between the magnitudes of expected gains associated with each gamble. However, there was little sign of any effect on the discrimination between magnitudes of expected losses or between different probabilities of outcomes. By contrast, manipulations of noradrenergic function—i.e., treatment with the beta blocker, propranolol, or the SNRI, reboxetine—had larger effects on the discrimination between magnitudes of expected losses. These results suggest that the serotonergic and noradrenergic systems have complementary roles in mediating the processing of affective cues in the context of risky decision making. The implications for neuropsychiatric disorders are discussed.

## No. 27E
## ETHNIC DIFFERENCES IN ESTIMATING UTILITIES OF SYMPTOM REDUCTION IN PSYCHOSIS

Leslie L. Lenert, M.D., *Department of Medicine, UCSD, 9500 Gilman Drive 9111-North, San Diego, CA 92093*

### SUMMARY:

If ethnic groups perceive and value mental illnesses and mental health outcomes differently, then allocation of health resources based on the preferences of the majority could result in ineffective and inefficient health care delivery systems. To study this issue, we created streamed-video materials portraying health states with different combinations of schizophrenia symptoms, and linked them to a web-based survey that measured visual analog scale and standard gamble (SG) ratings. We sent announcements to randomly selected members of a large Internet survey panel, deliberately over-sampling minority ethnic groups. We used repeated measures ANOVA, simultaneously examining ratings of mild, moderate, severe, and extreme states to look for associations between demographic factors and preferences. Minority groups rated the severe and extreme states 0.06 to 0.08 higher than CAUC, resulting in differences of 30% or more in the gain in utility with complete remission of certain syndromes. Moreover, while controlling severe symptoms at the cost of inducing an adverse drug effect was a favorable trade-off for 64% of the CAUC, this was true for only 42% of AA, and 49% of LAT ($p < 0.001$). The results suggest potentially important differences in perceptions of quality of life in schizophrenia in persons of different ethnicity.

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# SYMPOSIUM 28—SCHIZOPHRENIA: CURRENT GUIDELINES, PRACTICES, AND EFFECTIVENESS RESEARCH

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) introduce clinicians to current evidence- and expert consensus-based practice guidelines for the treatment of schizophrenia; to increase knowledge and understanding of current psychosocial and psychopharmacologic treatment recommendations for schizophrenia, (2) understand major gaps in research to inform clinical decisions in the treatment of patients with schizophrenia. Learn about major national research studies comparing the effectiveness and tolerability of different antipsychotic treatments for patients with schizophrenia, (3) understand the key influences on clinical decision-making and the effectiveness of clinical decisions related to the medication management of patients with schizophrenia; learn about the largest national study of psychopharmacologic treatment of schizophrenia in routine psychiatric practice, and (4) understand treatment practices for patients with schizophrenia and the extent to which psychiatrists in routine practice settings provide treatment consistent with evidence-based practice guideline treatment recommendations for adults with schizophrenia.

## No. 28A
## OVERVIEW OF BEST PRACTICES: CURRENT TREATMENT GUIDELINES AND PROTOCOLS FOR SCHIZOPHRENIA

Anthony F. Lehman, M.D., *Department of Psychiatry, University of Maryland at Baltimore, 701 West Pratt Street, Suite 388, Baltimore, MD*

SUMMARY:

This presentation will provide an overview of the new key clinical treatment recommendations from the Schizophrenia Patient Outcomes Research Team (PORT), which are planned for completion in January 2003. The new PORT recommendations will be compared and contrasted with other major national practice guidelines and treatment protocols for schizophrenia, including the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Schizophrenia (1997), the Expert Consensus Guideline for the Treatment of Schizophrenia (1999), and the schizophrenia treatment protocol from the Texas Medication Algorithm Project (TMAP) (1999). Key recommendations pertaining to psychiatric management, psychopharmacologic treatments, psychosocial interventions, and electroconvulsive therapy will be reviewed as well as clinical and environmental features influencing treatment. Recommendations pertaining to the acute, continuation and maintenance phases of treatment maintenance will also be addressed. Although the primary focus of the presentation will be to review current "best practices" in the form of key evidence and expert consensus treatment recommendations from these guidelines and protocols, the session will also provide a brief overview of the rationale for developing guidelines and different approaches and methods used to develop the guidelines.

## No. 28B
## RESEARCH GAPS AND CURRENT RESEARCH INITIATIVES TO IMPROVE THE TREATMENT OF SCHIZOPHRENIA

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, Univ. of North Carolina School of Medicine, Room 7025, Neurosciences Hospital, CB7160, Chapel Hill, NC 27599*

SUMMARY:

This presentation will provide an overview of the major gaps in research to inform clinical decisions related to the psychosocial and psychopharmacologic treatment of patients with schizophrenia. It will describe current major research initiatives to address the gaps in the current science base. Two large-scale, NIMH-funded clinical effectiveness studies will be described. The first study, Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE), is a double-blind, randomized treatment study that compares the effectiveness of atypical and conventional antipsychotic medications in 1,800 patients over a 24-month period. Specific aims of the CATIE study include determining the long-term effectiveness and tolerability of the newer atypical antipsychotics relative to each other and to a conventional antipsychotic; and determining the long-term effectiveness of alternative atypical antipsychotics among patients who either discontinue their initial atypical antipsychotic due to intolerance or fail their initial atypical antipsychotic treatment due to lack of efficacy. The second study, Treatment of Early Onset Schizophrenia Spectrum Disorders, is also a double-blind, randomized treatment study examining the long-term effectiveness and safety of three different antipsychotic medications (olanzapine, risperidone, and molindone) in the treatment of early-onset schizophrenia and related disorders among children and adolescents 8 to 19 years of age.

## No. 28C
## FACTORS AFFECTING THE EFFECTIVENESS OF CLINICAL DECISIONS IN TREATING SCHIZOPHRENIA

Mark Olfson, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Box 24, New York, NY 10032;* Joyce C. West, Ph.D., Joshua E. Wilk, Ph.D., Steve Marcus, Ph.D.

SUMMARY:

This presentation will provide an overview of major influences and factors that appear to affect the clinical decision-making process in the medication management of patients with schizophrenia. It will describe a current NIMH-funded research initiative examining clinical decision making in the treatment of schizophrenia, the influences on the process, and its relationship to clinical effectiveness. This study, the largest national study of psychopharmacologic treatment of schizophrenia in routine psychiatric practice, will be described along with preliminary results from initial qualitative research and pilot studies. The study tests a multidimensional model of medication management decision making incorporating the effects of patient, psychiatrist, treatment environment, and other influences on treatment decisions. Preliminary findings will be presented characterizing clinical issues and factors affecting three major treatment decisions including: (1) the management of first treatment episodes, (2) the management of persistent positive psychotic symptoms, and (3) the management of medication non-adherence. Examples of some of the influences on practice that will be explored include clinical considerations (patients' symptoms, side effects, level of functioning); psychiatrists' general treatment orientation, clinical experience with psychopharmacologic treatments for schizophrenia; patient and family preferences; practice characteristics and health plan/health insurance factors and constraints; and interactions with peer psychiatrists and the pharmaceutical industry.

## No. 28D
## THE TREATMENT OF SCHIZOPHRENIA IN ROUTINE PSYCHIATRIC PRACTICE

Joyce C. West, Ph.D., *APIRE, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209;* Joshua E. Wilk, Ph.D., Mark Olfson, M.D., Steve Marcus, Ph.D., Donald S. Rae, M.A., William E. Narrow, M.D., Darrel A. Regier, M.D.

SUMMARY:

*Objectives:* (1) Characterize treatment patterns for adult psychiatric patients with schizophrenia; (2) assess conformance with evidence-based practice guideline recommendations.

*Methods:* Nationally representative data from the 1999 APIRE Practice Research Network Study of Psychiatric Patients and Treatments were used to examine treatment for 284 systematically selected patients with schizophrenia and schizophrenia spectrum disorders.

*Results:* Most patients were clinically complex: 68% had a comorbid Axis I, II, or III disorder, and 32% had a comorbid substance disorder; 80% received two or more medications and 56% three or more; 94% of patients received an antipsychotic (68% atypical), 43% benzodiazepine/antianxiety, 38% antidepressants; 36% had medication side effects and 39% had treatment compliance problems; and 48% received psychotherapy and 63% received some form of psychosocial treatment. Although guideline conformance rates were higher for psychopharmacologic than psychosocial recommendations, rates varied considerably. For example, 95% of the patients with comorbid depression received an antidepressant; however, only 20% of the patients with treatment compliance problems received a depot antipsychotic.

*Conclusions:* Most patients received multiple psychopharmacologic treatments. A significant proportion did not receive guideline-consistent treatment. Longitudinal research that includes an assessment of treatment effectiveness is needed to determine if there is an empirically based clinical rationale for deviating from established treatment guidelines.

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# TUESDAY, MAY 20, 2003

## SYMPOSIUM 29—INTEGRATED TREATMENT: PSYCHOPHARMACOLOGY AND PSYCHOTHERAPY

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) educate the practitioner about development and integrated treatment, (2) conduct an integrated treatment of borderline patients using combined medication and psychotherapy, (3) demonstrate how psychopharmacology and psychotherapy facilitate recovery in anorexia and bulimia; and to understand complexity and chronicity of eating disorders when untreated, (4) understand comorbidity of psychiatric and medical illness and will understand the basis principles and results of psychotherapeutic and psychopharmacologic treatments for depressive and anxiety disorders in person's with medical illness, (5) understand the needs of juveniles with bipolar disorder across different domains and methods of addressing these needs through integrated treatment.

### No. 29A
### INTEGRATED TREATMENT: FROM ADOLESCENCE TO YOUNG ADULTHOOD

Hans Steiner, M.D., *Division of Child Psychiatry, Stanford University, 401 Quarry Road, Room 1136, Stanford, CA 94301*

SUMMARY:

*Background:* Empirical support for the integration of treatment is building. Reviewing the evidence, about ten studies in anxious, depressed, eating disordered, medically ill, disruptive/personality disordered, and psychotic patients support the superior efficacy of combined medication and psychotherapy, if the appropriate outcomes are examined. A theoretical model for the integration of treatment is proposed, based on the developmental concepts of context, complexity, and continuity.

*Method:* We will apply this model in a special case cohort (N = 14; 5 men; mean age 29 years; range 23–45), referred to the presenter for failed treatment in the community. We followed them prospectively for an average of 15 years (from teen years to young adulthood). All of them suffered comorbid conditions; the most common ones were anxiety and depression. We report the use of hospitalization, family therapy, antidepressants, mood stabilizers, antianxiety agents, and individual dynamic treatment, cognitive-behavioral techniques in combination or sequentially.

*Results:* All patients significantly improved on symptom outcomes and personality functioning as combined treatment became effective. No single modality was superior. As developmental demands changed, treatment had to be adapted.

*Conclusion:* Results in this clinical cohort support the flexible application of multiple interventions to achieve optimal outcomes.

### No. 29B
### INTEGRATED TREATMENT OF BPD

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

SUMMARY:

The APA Practice Guidelines Work Group reviewed the literature on the treatment of borderline personality disorder and brought to bear many years of clinical experience in designing the final recommendations. We concluded that the optimal treatment involves a combination of psychotherapy and pharmacotherapy. Two types of psychotherapy have demonstrated efficacy in randomized controlled trials, dialectical behavior therapy and psychodynamic psychotherapy. Medication that focuses on specific target symptoms of borderline personality disorder, the underlying biological temperament of the condition, and the comorbid Axis I disorders, generally facilitates the psychotherapist's capacity to reach the patient with psychological interventions. Specific psychopharmacologic agents will be discussed. Also, the psychotherapeutic issues that frequently emerge in the course of pharmacotherapy will be outlined with advice about various strategies to deal with them.

### No. 29C
### INTEGRATED TREATMENT OF EATING DISORDERS

Kathryn J. Zerbe, M.D., *Center for Women's Health, Oregon Health Sciences University, 3181 SW Sam Jackson Park Road, Mail Code OPO2, Portland, OR 97201-3098*

SUMMARY:

In this presentation, studies published during the 1990s through the first years of the new century will be reviewed to help the clinician understand the importance of integrating pharmacotherapy and psychotherapy in the treatment of anorexia nervosa, bulimia nervosa, and binge eating disorder. Emphasis will be placed on the short-term nature of most studies and the significant number of patients who have been found, according to such studies, to have better functioning after intervention. Differences in clinical population according to race, gender, age, and longevity of illness will also be emphasized. Clinicians will learn that current treatment of most eating disorders is facilitated by integrating multiple modalities (e.g. medication, nutrition, and psychotherapy).

### No. 29D
### PSYCHIATRIC AND MEDICAL ILLNESS

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

SUMMARY:

Psychiatric and medical illness interact in many ways. The medically ill have higher rates of depression, anxiety, traumatic stress, and other psychiatric syndromes, and these psychiatric illnesses can in turn reduce adherence, complicate the course of medical illness, and even worsen prognosis. Yet this comorbid psychiatric illness is

frequently overlooked, since its symptoms are easily misattributed to medical illness and its treatment. As more people are living to cope with chronic or progressive disease, the diagnosis and treatment of comorbid psychiatric disorders become increasingly important. The concept of illness as a stressor, with effects on stress response systems that can affect disease, will be presented. Several decades of research with cancer patients will be reviewed demonstrating that psychotherapeutic intervention results in reduced anxiety, depression, and traumatic stress symptoms. In our current randomized controlled trial of supportive/expressive group psychotherapy with 125 metastatic breast cancer patients, evidence will be presented that the intervention results in significant reductions in PTSD symptoms, emotional suppression, and pain. Cochrane database evidence regarding the efficacy of antidepressant medication with the medically ill will also be presented. Principles of good coping with medical illness and means of integrating psychiatric with other medical care will be summarized.

## No. 29E
## INTEGRATED TREATMENT OF JUVENILE BIPOLAR DISORDER

Kiki D. Chang, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305;* Jaqueline Martin, Ph.D., Maureen Hawkins, Ph.D.

### SUMMARY:

While it is increasingly clear that children and adolescents with bipolar disorder require careful medication management, psychotherapeutic and psychosocial interventions are also needed to ensure good outcome. Children and adolescents with bipolar disorder have specific educational and psychosocial needs that are often unmet by pharmacotherapy alone. Therefore, skillful integration of treatment modalities may be needed in this population.

We will review the unique educational, psychosocial, and pharmacologic needs of children and adolescents with bipolar disorder. We will next report on recent studies using family and group therapies to treat children with bipolar disorder and discuss educational strategies for this population. Finally, we will present how current pharmacologic treatment can be integrated with these other treatment modalities and concerns, presenting data from a psychoeducational support group intervention in adolescents with bipolar disorder.

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# SYMPOSIUM 30—RECENT DEVELOPMENTS IN GAY AND LESBIAN MENTAL HEALTH: A GLOBAL PERSPECTIVE
## APA Committee on Gay, Lesbian, and Bisexual Issues

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) demonstrate a better understanding of homosexuality in China, both historically and currently, (2) have knowledge about Norwegian psychiatry and its views on homosexuality, (3) understand the historical context of treatment of homosexuality, (4) understand recent efforts to organize lesbian and gay psychiatrists internationally through the World Psychiatric Association, Association of Gay and Lesbian Psychiatrists, and the APA.

## No. 30A
## FROM LONG YONG AND DUI SHI TO TONGZHI: HOMOSEXUALITY IN CHINA

Jin Wu, M.A., *CDC, Chinese American Services LG, 2153 W. Cullom Avenue, Chicago, IL 60618*

### SUMMARY:

Homosexuality was recognized and tolerated in ancient China. After being invaded by the Western powers, "progressive" Chinese intellectuals at the turn of the 20th century blamed the "backward" traditions. They looked to Westernization to rescue the nation, when homosexuality was pathologized in the West. A pathological view of homosexuality was adopted by the Chinese along with Western technology. However, only after 1949 was homosexual behavior seriously punished in China and served as grounds for persecution between the 1950s and 1970s. In the 1980s, the Chinese government's "open door" policy made it possible for the Chinese gay and lesbian (tongzhi) community to develop, its bumpy journey reflected the fluctuation of the political situation in China in recent decades. Despite the official pathologizing position of Chinese psychiatry—until recently—in the late 1980s, gay-friendly scholars and health professionals began to sympathetically research tongzhi communities in China and to advocate for sexual minorities. In 2001, the latest edition of the Chinese Classification of Mental Disorders (CCMD-3) removed the diagnosis of homosexuality but added a diagnosis resembling ego-dystonic homosexuality. Nevertheless, the tongzhi community in China has not yet achieved full civil rights.

## No. 30B
## LOOK TO NORWAY? GAY ISSUES AND MENTAL HEALTH ACROSS THE ATLANTIC OCEAN

Reidar Kjaer, M.D., *PO Box 7090 Homansbyen, Oslo 0306, Norway*

### SUMMARY:

*Issue:* This paper addresses the origin of the current theoretical framework for Norwegian psychiatry's understanding of homosexuality. In Norway today, the prevailing attitude is an essentialistic, non-psychopathological understanding of homosexuality based on the generally vague psychosocial and biological understanding of mental health problems and illnesses. This paper points to the influence in Norway of German academic *psychiatry,* and the impact of both pre- and post- World War II psychoanalytic theories. The gay movement's influence on the pro-gay legislation and position statements in psychiatry are emphasized.

*Method:* Review of literature.

*Implications:* Since the radical 1970s, little research has been done in this field of Norwegian psychiatry. This has led to a situation where firm knowledge is scarce and there is a demand for establishing a special competence center. This vacuum has allowed psychoanalysts to fall behind on their theoretical updates and for religious groups to import the reparative therapy movement. Both groups have been challenged. The Norwegian Psychoanalytic Association seems now to have started a process for updating their views on homosexuality. The discrepancy between the progay legislation and the lack of development in Norwegian psychiatry is suggested as a possible field of research.

## No. 30C
## VOICES FROM THE PAST: TREATMENTS OF HOMOSEXUALITY IN THE UNITED KINGDOM SINCE 1950

Michael B. King, M.D., *Department of Psychiatry, RF & Uc Medical School, Rowland Hill Street, London NW32PF, United Kingdom;* Annie Bartlett, M.D., Glen Smith, Ph.D.

### SUMMARY:

The birth of sexology in Europe in the 19th century gave rise to the conceptualization of a person on the basis of his or her sexual desire and behavior. Men and women who were attracted to their own sex became homosexuals and what had been a social and cultural stereotype became a medical diagnosis and by implication subject to treatment.

*Objective:* to understand why people sought to change their sexuality, how they experienced treatment, and how it affected their lives. We also sought to understand how the attitudes of professionals had evolved with time.

*Method:* Thirty men and women who had received treatments and 30 professionals participated in detailed, face-to-face interviews that were analyzed qualitatively.

*Results:* Most "patients" had experienced emotional turmoil about their sexuality that eventually led to treatments to change it. Their experience of treatments that included behavior modification, psychoanalysis, and hormonal manipulation, was almost universally negative. The professionals were ambivalent about the treatments both then and now.

*Conclusions:* The historical context of these treatments are crucial to our understanding of the social bias inherent in psychiatry and psychology and how treatments can be diverted from relief of suffering to meeting unspoken political ends.

*Funding:* Wellcome Trust.

## No. 30D
## EMERGENCE OF LESBIAN AND GAY ISSUES IN INTERNATIONAL PSYCHIATRY

Gene A. Nakajima, M.D., *CSP 1700 Jackson Street, San Francisco, CA 94109*

### SUMMARY:

*Issue:* Since the 1990s, lesbian, gay, and bisexual (LGB) psychiatrists have begun to organize internationally. In particular, members of the Association of Gay and Lesbian Psychiatrists (AGLP), working collaboratively with the American Psychiatric Association (APA), have expanded their advocacy of LGB affirmative psychiatry outside of North America.

*Method:* Review of literature.

*Implication:* AGLP and APA have participated in efforts to depathologize homosexuality in Japan and China. AGLP has sponsored meetings of international psychiatrists annually at APA conventions. Some progress has been made in increasing the awareness of LGB issues within the World Psychiatric Association (WPA). Several symposia have been presented at WPA-sponsored meetings. The WPA leadership has rejected the creation of a special interest section for LGB issues. The APA sponsored a resolution to the WPA endorsing ICD-10's position that homosexuality is not a mental disorder. The WPA assembly has not passed it yet. A future goal is the elimination of stigmatizing diagnoses like egodystonic sexual orientation, sexual maturation disorder, and sexual relationship disorder from the ICD-10. Deletion of these diagnoses will make ICD-10 more compatible with DSM-IV.

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2. Kjaer R: Look to Norway? Gay issues and mental health across the Atlantic Ocean. Journal of Gay and Lesbian Psychotherapy, in press.
3. King MB, Bartlett A: British psychiatry and homosexuality. British Journal of Psychiatry 1999; 174:108–113.
4. Nakajima GA: The emergence of an international lesbian, gay, and bisexual psychiatric movement. J Gay Lesbian Psychotherapy, in press.

# SYMPOSIUM 31—NEW RESEARCH IN GAY, LESBIAN, AND BISEXUAL MENTAL HEALTH MORBIDITY

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize patterns of mental health morbidity risk in non-clinical populations of lesbians, gay men, and bisexual adults, (2) understand the relationship between sexual orientation and mental health in a cohort of Dutch adults, (3) recognize stress processes related to minority status and identify their impact on mental health, (4) describe the evidence suggesting excess risk of depressive distress among lesbians, (5) understand findings of increased rates of depressive disorders and suicidality in a cohort of gay and bisexual men.

## No. 31A
## ESTIMATES OF MENTAL HEALTH MORBIDITY AMONG LESBIAN, GAY, AND BISEXUAL ADULTS

Susan D. Cochran, Ph.D., *Department of Epidemiology, UCLA School of Public Health, 650 Charles Young Drive, Los Angeles, CA 90095-1772*

### SUMMARY:

In recent years, several large-scale, population-based surveys assessing the mental health of Americans included assessments indicative of sexual orientation (genders of sexual partners, sexual orientation identity). We use pooled estimates derived from five surveys (3rd NHANES, 1996 NHSDA, NCS, MIDUS. 1998–2000 CWHS) to compare prevalences of affective, anxiety, and substance use disorders and rates of treatment seeking between respondents classified as probably heterosexual versus those likely to be lesbian, gay, or bisexual. Across studies, the majority of homosexually classified respondents, based on reporting any same-gender sexual partners or a lesbian, gay, or bisexual identity, did not meet screening criteria for the psychiatric disorders measured. However, results suggest higher prevalences of major depression and panic attacks among homosexually classified men as compared with heterosexually classified men and higher rates of alcohol and drug use disorders among homosexually classified women as opposed to heterosexually classi-

fied women. Further, homosexually classified respondents were more likely than heterosexually classified respondents to seek mental health services. While the reasons for this excess morbidity risk are unknown, findings suggest that patterns of mental health morbidity and treatment use among lesbians and gay men may differ in important ways from those seen in heterosexual men and women.

## No. 31B
## SEXUAL ORIENTATION AND HEALTH: NEW FINDINGS FROM A DUTCH GENERAL-POPULATION SURVEY

Theodorus G.M. Sandfort, Ph.D., *HIV Center, NYS Psychiatric Institute, 1051 Riverside Drive, Unit 15, New York, NY 10032;* Vicki M. Mays, Ph.D., Heather Corliss, M.P.H. Ine Vanwesenbeeck, Ph.D., Floor Bakker

SUMMARY:

Research into sexual orientation and health has been constrained by methodological and ideological factors. Recently, studies have been published that allow for a better understanding or sexual orientation-related health differences. Some of the major improvements are better assessment and representative sampling. This presentation will add to this new database, findings from the Dutch National Survey of General Practice (Nivel, 2001), based on face-to-face interviews with a representative sample of the Dutch population. The over 9,600 men and women (18 years and older) participating in the study were asked to indicate their sexual preference on a five-point scale. Of the 4,293 men surveyed, 3.0% said to feel (predominantly or exclusively) attractive to other men; 0.6% said to feel equally attracted to both men and women. Of the 5,316 women surveyed, 2.5% said to feel (predominantly or exclusively) attracted to other women; 1.7% said to feel equally attracted to both women and men. Data will be presented about the relationship of sexual orientation with mental health status and mental health care behavior. The relative large group of homosexual men and women, representative for the Dutch population, allows us to explore health-related differences within those subpopulations as well.

## No. 31C
## MINORITY STRESS AND MENTAL HEALTH IN LESBIANS, GAY MEN, AND BISEXUALS

Ilan H. Meyer, Ph.D., *Sociomedical, Columbia University, 722 W. 168th Street, New York, NY 10032*

SUMMARY:

Lesbians, gay men, and bisexuals (LGB) are subjected to minority stress—related to sexual prejudice, homophobia and heterosexism—that can lead to adverse mental and somatic health. Public health interventions and gay affirmative psychotherapies often attempt to alleviate the negative impact of minority stress. But psychological research has provided little toward understanding such stress. This presentation will report on a study of 156 white, Latino, and African-American LGB individuals. The study used an in-depth structured interview with semi-structured probing of stress-related experience in the year prior to the interview. The paper will present a conceptual model that would describe how distal social conditions such as sexual prejudice are experienced as stressful on the individual level and present new data on minority stress processes, including the experience of prejudice and discrimination. In particular, it will examine how multiple stigmatized identities, related to gender, race/ethnicity, and sexual orientation, interact. The results will then test hypotheses based on the conceptual model of minority stress that propose that excess in stress would lead to excess in mental health problems, in particular depressive symptoms and substance use. Implications to public health and individual psychotherapeutic interventions will be discussed.

## No. 31D
## DEPRESSIVE DISTRESS IN A COMMUNITY SAMPLE OF WOMEN: THE ROLE OF SEXUAL ORIENTATION

Alicia K. Matthews, Ph.D., *Department of Psychiatry, University of Chicago, 5841 S. Maryland Avenue, MC 3077, Chicago, IL 60637;* Towda L. Hughes, Ph.D., Timothy Johnson, Ph.D., Lisa A. Razzano, Ph.D., Roberta Cassidy, Ph.D.

SUMMARY:

*Objective:* Aims were to compare factors known or hypothesized to influence depressive symptomatology in a community sample of lesbian and heterosexual women and to explore the extent that these factors account for the following four indicators of depressive distress: history of therapy for a mental health problem, treatment for depression, suicidal ideation, and suicide attempts. Data were collected in a multisite survey of lesbian's physical and mental health. Bivariate and multivariate analyses were conducted to describe group differences and relationships between study variables. Data from 550 lesbians and 279 heterosexual women are presented. Lesbians reported higher rates of therapy (78% vs. 56%), suicidal ideation (51% vs. 38%), and suicide attempts (22% vs. 13%). Findings confirm earlier reports suggesting that traumatic life events such as physical and sexual abuse, individual traits and coping styles, and the number and severity of life stressors are risk factors for depressive distress. However, findings of higher rates of suicidal behavior and of several risk factors for depressive distress among lesbians suggests that risk for depression may differ for lesbians and heterosexual women. As such, sexual orientation may represent an important but poorly understood risk factor for depressive distress, as well as suicidal ideation and behavior.

## No. 31E
## SEXUAL MINORITY STATUS AND ITS ASSOCIATION WITH SUICIDALITY AND DEPRESSION

Jay P. Paul, Ph.D., *UCSF-CAPS, 74 New Montgomery Street, Ste 502, San Francisco, CA 94105;* Joseph A. Catania, Ph.D., Thomas C. Mills, M.D., Ron D. Stall, Ph.D., Lance Pollack, Ph.D.

SUMMARY:

*Objectives:* We examined lifetime prevalence of suicide attempts, current depressive disorder, and psychosocial correlates in a large population-based sample of men who have sex with men (MSM).

*Methods:* Between November 1996 and February 1998, using random-digit dial methods and stratified sampling, we obtained a household-based probability sample of MSM in four U.S. major cities (n = 2881). Telephone interviews measured a variety of health concerns, including suicidal ideation and attempts, and depressive mood. (Center for Epidemiologic Studies-Depression scale; cut-point of 22).

*Results:* 21% had made a suicide plan, and 12% had ever attempted suicide. Almost half of those 12% made multiple attempts. Most made their first attempt before age 25. Although the reported prevalence of attempts was unchanged across birth cohorts, the mean age at initial attempts has declined. The prevalence of current depression in MSM was 17.2%, significantly higher than in adult U.S. men in general.

*Conclusions:* MSM are at elevated risk for suicide, with such risk clustered earlier in life. Some risk factors were specific to developing a gay/bisexual identity in a hostile environment. Similarly, depression

was both associated with conventional predictors (e.g., substance use, childhood sexual abuse) and gay-specific factors (e.g., recent anti-gay victimization). This highlights the problematic effects of societal discrimination, stigmatization, and harassment.


## REFERENCES:

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2. Sandfort Th GM, Graaf Rde, Bijl RV, Schnabel P: Same-sex behavior and psychiatric disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). Archives of General Psychiatry 2001; 58:85–91.
3. Meyer IH: Minority stress and mental health in gay men. Journal of Health and Social Behavior 1995; 36:38–56.
4. Bradford J, Ryan C, Rothblum E: National lesbian health care survey: implications for mental health care. Journal of Consulting and Clinical Psychology 1994; 62:228–242.
5. Paul JP, Catania J, Pollack L, Moskowitz J, Canchola J, Mills T, Binson D, Stall R: Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents. Am J Public Health 2002; 92(8):1338–1345.


# SYMPOSIUM 32—AN UPDATE ON PARKINSON'S DISEASE AND ITS PSYCHIATRIC COMPLICATIONS

## EDUCATIONAL OBJECTIVES:

At the end of the session, the participant will be familiar with (1) recent trends in the neurological management of PD, current thinking about the genetics of PD, (2) the diagnosis of depression in patients with PD, treatments for depression in patients with PD, (3) the diagnosis of psychosis in the context of PD, the treatment options for psychosis in patients with PD, (4) diagnosis of cognitive impairment in patients with PD, diagnosis of dementia in patients with PD, (5) the diagnosis of anxiety, fatigue and sleep problems in patients with PD, and clinical management of anxiety, fatigue and sleep problems in patients with PD.

## No. 32A
## PARKINSON'S DISEASE: UPDATE ON TREATMENT, ETIOLOGY, AND PATHOGENESIS

Margery Mark, M.D., *Department of Neurology, RWJ Medical School, 97 Patterson Street, Suite 210, New Brunswick, NJ 08901*


## SUMMARY:

In the last ten years, enormous strides have been made in understanding and treating Parkinson's disease (PD). PD is now recognized as more than just a disorder of the nigrostriatal dopamine system, with significant involvement of cognition, behavior, and mood. For bradykinesia, rigidity, and tremor, however, levodopa remains the most efficacious treatment, but recent trends have turned to initial therapy with direct-acting dopamine agonists in younger patients; further, some studies suggest a possible neuroprotective effect of agonists. Peripheral inhibition of catechol-*O*-methyltransferase (COMT inhibitors) allowing prolongation of levodopa action, is another therapeutic alternative added in the last decade. An old drug, amantadine, has found new life in reducing dyskinesias, possibly through its mechanism as an NMDA-receptor antagonist. New drugs in clinical trials aim at improving both parkinsonism and dyskinesia (adenosine $A_{2a}$ antagonists) as well as potentially slowing disease progression (mixed kinase inhibitors). Ultimately, knowing why the cells degenerate will allow targeted drug therapy and interrupt the process. Progress in understanding the disease process itself has been made possible by the identification of genes causing PD (mutations in alpha-synuclein, parkin, and ubiquitin carboxy-terminal hydrolase L1) and the implications for synuclein aggregation and impairment of the ubiquitin/proteasome pathway in cell death.


## No. 32B
## DEPRESSION IN PARKINSON'S DISEASE

Jeffrey L. Cummings, M.D., *Department of Neurology, UCLA/Reed Neurosciences Center, 710 Westwood Plaza, Los Angeles, CA 90095*


## SUMMARY:

Depression is a common finding in patients with Parkinson's disease (PD). Depressive symptoms are present in 40% of patients and approximately 10% meet criteria for a major depressive episode. Depression may precede the onset of motoric abnormalities in PD, occur in concert with the onset of extrapyramidal symptoms, or evolve later in the course of the disease. Depression is more common in patients with evidence of cognitive impairment and in those with psychotic phenomena. Motor abnormalities account for a small amount of the variance of depression severity and the occurrence of depression cannot be attributed solely to physical and cognitive disability. Selective D3-dopamine receptor agonists may decrease the emergence of depression in PD or reduce the severity of depressive symptoms present when the agent is introduced. Selective serotonin reuptake inhibitors are most commonly used for the treatment of depression in PD; patients should be monitored for exacerbation of rigidity and bradykinesia. Tricyclic antidepressants and monoamine oxidase inhibitor are therapeutic alternatives. Electroconvulsive therapy improves both motor symptoms and depression in PD. Motoric symptoms improve earlier in the clinical course and relapse within several weeks. Deep brain stimulation has exacerbated on precipitated depression in some patients with PD treated with this therapeutic modality. Depression in PD provides insight into the central nervous system mediation of mood disturbances.


## No. 32C
## PSYCHOSIS IN PARKINSON'S DISEASE

Laura Marsh, M.D., *Department of Psychiatry, Johns Hopkins, 600 North Wolfe Street, Phipps 300C, Baltimore, MD 21287*


## SUMMARY:

Parkinson's disease (PD) is frequently complicated by psychosis. The psychotic phenomena range from benign visual hallucinations to states of extreme agitation with delusions and hallucinations. Because of complex relationships between motor, cognitive, and psychiatric phenomena and the treatments for each of these aspects of PD, PD-related psychosis is one of the most challenging conditions confronting the geriatric psychiatrist. This presentation will review the role of dopaminergic medications and other risk factors for the development of psychosis. The assessment, differential diagnosis, and comorbidities of psychosis in PD will be overviewed and basic pharmacologic guidelines will be discussed. Newer treatments such as the use of cholinesterase inhibitors will also be discussed. The relationship of Parkinson's disease to lewy body disease will be addressed, with an emphasis on special issues in pharmacologic management. Following this presentation the participant will be familiar with the diagnosis and pharmacologic strategies involved in the management of psychosis in Parkinson's disease.

## No. 32D
## COGNITIVE IMPAIRMENT, DEMENTIA, AND PARKINSON'S DISEASE

Constantine Lyketsos, M.D., *Johns Hopkins University School of Medicine, 600 North Wolfe Street, Osler 320-JHH, Baltimore, MD 21287*

### SUMMARY:

Cognitive impairment affects the great majority of patients with Parkinson's disease (PD) over the course of their illness. While there is some controversy, most of this impairment takes on the phenomenological form of a "sub-cortical" disturbance, as described by the four Ds: dysmnesia, delay, dysexecutive, depletion. A subset of patients with cognitive impairment, about 35% of all patients with PD, meet DSM criteria for dementia. Dementia complicates the clinical picture and further burdens patients and their caregivers. This presentation will briefly review data on the prevalence, incidence, risk factors, and etiopathogensis of cognitive impairment of lesser severity than dementia, and of dementia in PD. A discussion of the differential diagnosis and clinical management of cognitive impairment in PD patients will follow this. It will conclude with initial efficacy and safety findings of a pilot randomized, controlled trial of donepezil for dementia by DSM-IV criteria in patients with PD carried out at Johns Hopkins.

## No. 32E
## ANXIETY, FATIGUE, AND SLEEP IN PATIENTS WITH PARKINSON'S DISEASE

Matthew A. Menza, M.D., *Department of Psychiatry, RWJ Medical School, 675 Hoes Lane, Room D207A, Piscataway, NJ 08854*

### SUMMARY:

Sleep difficulties, anxiety, and fatigue are all common nonmotor problems in patients with Parkinson's disease (PD). While these symptoms are common in geriatric patients, they are particularly problematic for patients with PD. This talk will review the prevalence, etiology, and treatment of these symptoms. Sleep problems include insomnia, parasomnias, REM behavior disorder, excessive daytime sleepiness, and sleep attacks. Anxiety may involve a variety of diagnostic entities as well as subsyndromal anxiety. Fatigue is frequently significant and is described by patients as the second most troubling aspect of this illness. Etiology frequently involves an overlap of symptoms related to age, symptoms related to medications, symptoms that are core to the pathophysiology of PD, and symptoms related to psychiatric illnesses. Keys to recognition of these symptoms will be reviewed and there will be a discussion of treatment approaches. Treatment may involve behavioral approaches, a variety of medications, and in some cases, surgical approaches. Participants should learn to recognize these symptoms and disorders as well as recognize their importance. In addition, participants should become familiar with a variety of treatment approaches.

### REFERENCES:

1. Ahlskog JE: Parkinson's disease: medical and surgical treatment. Neurol Clin 2001; 19:579–590.
2. Aarsland D, Larsen JP, Lim NH, Janvin C, Karleen K, Tandberg E, Cummings JL: Range of neuropsychiatric disturbances in patients with Parkinson's disease. J Neurol Neurosurg Psychiatry 1999; 67:492–496.
3. Henderson MJ, Millers JD: Psychosis in Parkinson's disease: between a rock and a hard place. Int Review of Psychiatry 2000; 12:319–334.
4. Korczyn AD: Dementia in Parkinson's disease. J Neurol 2001; 248 Suppl 3:III1–4.
5. Larsen JP, Tandberg E: Sleep disorders in patients with parkinson's disease. CNS Drugs 2001; 15(4):267–75.

# SYMPOSIUM 33—COPING WITH CATASTROPHE

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize and treat common problems associated with the dying process and better recognize some characteristic internal obstacles to maintaining a useful therapeutic stance, (2) better understand the impact of serious illness on the training psychiatrist and the benefits of processing the experience, (3) recognize the role of psychodynamic and cultural insight in promoting compliance with pharmacologic treatment.

## No. 33A
## PSYCHOTHERAPY OF THE DYING PATIENT

John W. Barnhill, M.D., *Department of Psychiatry, New York Presbyterian-PWC, 525 East 68th Street, Box 181, New York, NY 10021*

### SUMMARY:

Terminal illness may cause a constellation of symptoms, including depression, anxiety, fatigue, pain, and delirium. In addition, the news of a terminal illness tends to induce a characteristic response that fits well with Erickson's final dilemma of life, integrity versus disgust and despair. Likely regression and a constricted time frame offer a poignant and important opportunity for psychotherapy. Helpful psychiatric intervention requires a balance between treating psychiatric symptoms, performing a version of psychotherapy that fits the circumstances, and remaining present for the patient during his final phase of life. This balance is difficult to maintain.

In this talk, Dr. Barnhill will discuss the use of the psychodynamic life narrative with a focus on developmental issues applicable to the end of life. He will discuss the use of medications in the terminally ill, particularly medications not frequently used outside of this population, and he will discuss the countertransference issues that may lead to under- or overreliance on medications. The talk will be structured around applicable cases drawn from his own work with the terminally ill.

## No. 33B
## ILLNESS IN THE TRAINING PSYCHIATRIST

Gregory C. Dillon, M.D., *105 Lexington Avenue #11-D, New York, NY 10016*

### SUMMARY:

The literature on illness in the psychiatrist has traditionally been limited. It has been hypothesized that this is due to a variety of defenses evoked when the psychiatrist's ego integrity is threatened. A recent debate has arisen around the technical question of disclosure by the ailing psychiatrist. The classical analytic stance of abstinence has been challenged by a stance geared toward thoughtful disclosure and therapeutic alliance. Within this debate, the training psychiatrist holds a unique place, as he is confronted with historical and technical weight of the classical stance, yet not yet committed to that approach by experience or trust. The training psychiatrist may maintain a certain flexibility in managing the issues of transference, countertransference, and technical decision making faced by the ill practitioner.

The author, a psychiatric resident, reviews the literature in an effort to examine his response to and management of his own illness,

testicular cancer. He conceptualizes the above debate through the lens of various phases of his diagnosis, surgery, chemotherapy, and recovery. Finally, he reflects on cases within his practice at the time of his illness, concluding that thoughtful and supported processing is more essential than a firm stance on the debate above.

### No. 33C
### TREATING FIREFIGHTERS IN THE AFTERMATH OF 9/11

Kevin V. Kelly, M.D., *85 E End Ave Apt 1G, New York, NY 10028-8026*

SUMMARY:

The members of the Fire Department of New York City (FDNY) suffered extreme trauma on September 11th and in subsequent months. The author has served during that time as consulting psychiatrist to the FDNY's Counseling Service Unit (CSU). This paper describes some of the clinical lessons gleaned from that experience.

The structure of the CSU, and changes in its operation since 9/11, are described. The uniquely traumatic experiences of surviving FDNY members are emphasized, including not only the sudden deaths of 343 members, but also body-recovery duty lasting many months.

The prevalence of PTSD in the survivors is expectably high, and some of its typical features are described. Most members treated with benzodiazepines and antidepressants have responded well; up-to-date outcome results will be reported. However, the firefighters' culture offers powerful resistance to the acceptance of any kind of help, and especially to medication. Thus, the primary clinical challenge has been to use psychodynamic and cultural insights in a way that promote the therapeutic alliance and ultimately compliance with medication. Countertransference considerations are also discussed, especially the absence of an ironic detachment, which had previously characterized the author's clinical work.

REFERENCES:

1. Mayer EL: Some implications for psychoanalytic technique drawn from analysis of a dying patient. Psychoanalytic Quarterly 1994; 63:1–19.
2. Fajardo B: Life-threatening illness in the analyst. Journal of the American Psychoanalytic Association 2001; 49(2):569–86.
3. Halberstam D: Firehouse. New York, Hyperion, 2002.

## SYMPOSIUM 34—STRATEGIES TO OVERCOME RESISTANCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand role of resistance in clinical psychiatry, and will learn to apply dynamic principles in working through resistance, (2) understand several ways that cognitive therapists conceptualize resistance, and learn techniques within the context of the cognitive model to help patients to change more effectively, (3) describe and examine the "resistance" phenomenon in the course of family and child therapy, (4) describe intervention strategy to deal with the resistance in the course of family and child therapy, (5) have a comprehensive understanding of treatment-resistant depression (TRD) be able to evaluate the relationship between medical disorders and TRD; and select and use antidepressant medications in TRD.

### No. 34A
### RESISTANCE AND PSYCHODYNAMICS

R. Rao Goginenl, M.D., *DCBHC, Deveraux Foundation, 410 Bairdd Road, Merion, PA 19066*

SUMMARY:

Freud's discovery of analyzing resistance was the beginning of modern psychoanalysis. Ralph Greenson, in The Technique and Practice of Psychoanalysis, elaborated resistance as conscious, preconscious, or unconscious, and may be expressed by means of emotions, attitudes, ideas, impulses, thoughts, fantasies, or actions defending the status quo of the patient. Wilhelm Reich in 1928 elaborates on the defenses in character disorders. As the scope of psychoanalysis broadened, Bion, Reich, Fairbarn, Kouht, Kernberg, Mahler, Wumser, Klein, and others enabled a great deal to the understanding of the psychodynamics of character disorders, impulse control disorders, masochistic disorders, narcissistic disorders, borderline disorders. The object relations theories, self-psychological theories, attachment theories, separation and individuation theories, as well as the new understanding of the cognitive sciences are enabling us to understand more about personality, memory, and consciousness, etc. To work through resistance, the psychodynamic psychiatrist developed new strategies to work with resistance. The short-term psychodynamic therapy developed by Davanloo, Mann, and Sifntos are examples.

### No. 34B
### OVERCOMING RESISTANCE: TECHNIQUES FROM COGNITIVE THERAPY

Donna M. Sudak, M.D., *Department of Psychiatry, Drexel College of Medicine, 3200 Henry Avenue, Philadelphia, PA 19129*

SUMMARY:

Many times change in therapy is elusive—despite the best efforts of therapists and patients. Factors that contribute to this problem can include comorbidity, patient acuity, forces within the patient's social network, and the current insurance climate that often allows for brief interventions when longer-term treatment would be indicated. Nevertheless, resistance occurs independent of these factors, and cognitive interventions can address it effectively. Validating the patient, a need for psychological change rather than problem solving or new skills, schema change, and need to change views of the self or of change itself are important mediators of resistance. Risk tolerance may need to be improved. In addition, the delayed consequences of change and fear of loss of control can alter the patient's motivation and capacity to do things differently. Techniques to work with these forms of resistance from the cognitive perspective will be presented. Finally, resistance will be explored from the perspective that an incomplete understanding of the patient, or countertransference can be a cause, and cognitive therapy techniques for effective exploration and management of these sources of resistance presented.

### No. 34C
### RESISTANCE BY FAMILIES AND CHILDREN IN PSYCHOTHERAPY

G. Pirooz Sholevar, M.D., *Robert Wood Johnson Medical School, 222 Righters Mill Road, Narberth, PA 19072-1315*

SUMMARY:

The phenomenon of resistance allows the family and its members to participate actively in the psychotherapy process. The "resistance" was once considered an obstacle placed by the family in the course of achieving the therapeutic goals with the intention of derailing the total process. More recently, resistance has come to be viewed

as attempts by the family to make the therapist aware of their unique qualities and accommodate the treatment plan optimally to their needs. Therefore, the phenomenon of "resistance" by the family has come to be viewed as a positive process by which the family can sensitize the therapist to the unique qualities of the family, participate in setting the therapeutic goals reflective of the family's lifelong aspirations, and determine the speed of the therapeutic progress. The success of this process is exhibited by a strong commitment of the family and its members to the therapeutic goals and whole-hearted participation in the therapeutic process.

This paper will examine the relationship between the resistance by the family in terms of its relationship to "shared family conflicts and defenses" as well as their proactive efforts to make the treatment process most responsive to and respectful of their unique requirements. Furthermore, it will explore the relationship between the "resistance" and the ongoing realignments in the power hierarchy and the family roles. The strategic and technical consideration of the above model will allow the therapist to recognize the relationship between the conscious and unconscious resistance of the family units, which can manifest itself through the action of one or more family members. It will allow the therapist to gain the full-hearted and active participation of the family to set therapeutic goals and endorse therapeutic interventions.

## No. 34D
## DIAGNOSTIC AND TREATMENT ALGORITHMS FOR REFRACTORY DEPRESSION

Jay D. Amsterdam, M.D., *Department of Psychiatry, University of Pennsylvania School of Medicine, 3535 Market Street, Philadelphia, PA*

### SUMMARY:

As many as 30% to 40% of depressed patients fail to respond to conventional antidepressant therapy, and 15% may develop a chronic, unremitting depression. A variety of pharmacological, biochemical, and clinical factors may contribute to this situation. However, even after controlling for these variables, a substantial number of patients remain refractory to treatment.

This presentation will describe algorithms for systematically evaluating and treating refractory depression. Topics will include differential diagnosis (e.g., recognizing phenotypic variants of bipolar disorder); iagtrogenic (drug-induced) mood-disorders; medical illnesses presenting as refractory depression (e.g. endocrinopathies); biochemical, genetic, and clinical variables affecting antidepressant drug response; and the rational selection of antidepressants for specific depressive subtypes. An introductory overview of treatment algorithms for refractory depression will be discussed. The necessity of using a "systematic" approach for diagnosis and treatment will be emphasized.

### REFERENCES:

1. Leahy RL: Overcoming Resistance in Cognitive Therapy. New York: Gullford Press, 2000.
2. Sholevar GP: Resistance in child & adolescent psychoanalysis and psychotherapy. In 1993, M.H. Etezady (Ed.), Treatment of Neurotic Child, Northvale, N.J., Jason Aronson, Inc., pp 169–188
3. Amsterdam JD, et al (eds): Treatment-Resistant Mood Disorders: New York, Cambridge University Press, 2001; pp 1–517.

# SYMPOSIUM 35—DEVELOPING CULTURALLY COMPETENT SERVICES FOR MINORITY POPULATIONS
## APA Assembly Committee of Representatives of Minority/ Underrepresented Groups

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the barriers in the psychiatric care of Hispanic Americans and be able to appropriately address and resolve them, (2) understand the barriers to state of the art mental health services, and (3) appreciate the role of culture in developing appropriate services, (4) become familiar with the latest approaches for delivering services to this population.

## No. 35A
## PSYCHIATRIC CARE OF HISPANIC AMERICANS: PROBLEMS AND SOLUTIONS

Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030*

### SUMMARY:

In accordance with the U.S. Census of the year 2000, Hispanic Americans currently constitute the largest ethnic minority group in the U.S. with 35.3 million or 12.5% of the U.S. population. The population growth of the Hispanic-American population during the period 1990–2000 was 58%, in comparison with 50% for Asian Americans, 17% for Native Americans, 16% for African Americans, and only 3% for the Caucasian population. In 1999, Hispanic Americans also had the distinct characteristic of being 33.4% uninsured, in comparison with 21.2% for African Americans, 20.8% for Asian Americans, and only 14.2% for Caucasians. Likewise, the 1999 U.S. median family income for Hispanic Americans was $30,735, in comparison with $44,366 for Caucasians and $51,205 for Asian Americans. For African Americans it was $27,910. These socioeconomic disparities are also reflected in the current health care/mental health care system of this country. In this respect, the care of Hispanic Americans, and also African Americans, leaves much to be desired. In this presentation, we will address the challenges and barriers to the appropriate care of Hispanic Americans, and will also offer potential solutions to these barriers and problems.

## No. 35B
## DEVELOPING SERVICES FOR AFRICAN AMERICANS

William B. Lawson, M.D., *Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, NW, Washington, DC 20061*

### SUMMARY:

The minority supplement to the Surgeon General's Report on Mental Health reaffirmed that African Americans often receive inadequate mental health services. Misdiagnosis is common, inpatient care is overemphasized, follow-up care is often nonexistent. Antipsychotics are overused and at excessive doses, while antidepressants are underused. Ethnic considerations in pharmacological response further complicate these issues. Income and other socioeconomic issues are certainly factors, but cultural factors, racial attitudes, and perception of the mental health system are also factors. More needs to be done to develop a responsive, caring system that addresses the service barriers associated with cultural diversity.

## No. 35C
## DEVELOPING CULTURALLY COMPETENT MENTAL HEALTH SERVICES FOR ASIAN AMERICANS

Evelyn Lee, Ph.D., *Department of Psychiatry, UCSF, 3626 Balboa Street, San Francisco, CA 94121*

### SUMMARY:

The objectives of this presentation are to (1) identify the unique cultural characteristics and mental health needs of API community; (2) address cultural, linguistic, socioeconomic, and geographic barriers to mental health care access and utilization; and (3) provide recommendations for the development of policies and programs to better address the mental health needs of API communities. The report is organized into the following six sections: (1) overview of Asian and Pacific Islander populations, (2) mental health problems and needs of this group, (3) cultural characteristics of Asian Americans in the U.S., (4) concerns about current mental health services systems, (5) moving toward cultural competence, and (6) recommendations for culturally competent services. The report includes samples of culturally competent clinical assessment and treatment strategies, and offers descriptions of some exemplary programs currently serving the API community.

## No. 35D
## NEW APPROACHES FOR DEVELOPING MENTAL HEALTH SERVICES FOR NATIVE AMERICANS

R. Dale Walker, M.D., *Department of Psychiatry, OR Health Sciences University M/S UHN-80, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098*

### SUMMARY:

The Native American, Alaska Native, and Native Hawaiian Populations ethnic groups have enjoyed minimal development of culturally competent mental health services. The Native American population, which represents over 1% of the U.S. population, has grown by over 250% in the past 40 years, suffers from both educational and economic disadvantages, and is overrepresented in prison and homeless populations. Representing over 560 recognized tribes speaking over 200 languages, this group presents many multicultural as well as huge geographic barriers. Native Americans have high rates of alcohol and substance related disorders as well as suicide. While the Indian Health Services has developed some service programs on reservations, only 20% of the Native American population has access to these services.

This presentation will review the specific needs of these populations and also present some new approaches for service delivery, including an integrated school-based treatment program in Oregon serving Native-American youth with alcohol or drug abuse problems, their families, and their communities. The project emphasizes early identification and culturally relevant treatments that foster linkages among the several tribal, local, state, and federal agencies working with American-Indian youth. Using Native counselors, the program offers American Indian Motivational Enhancement Therapy to youth found to have substance abuse problems. A care coordination team assists Native youth with substance abuse problems and their families in navigating the complex array of agencies serving this population. Care coordinators integrate tribal and state juvenile justice programs into the care system as well as linking back to treatment on the reservation. This project will generate evidence-based practices that work on the reservation in Oregon, which may be expanded to other sites.

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2. Snowden LR, Cheung FK: Use of inpatient mental health services by members of ethnic minority groups. Am Psychol 1990; 45:347–355.
3. Lee E (Ed): Working With Asian Americans, A Guide for Clinicians. The Gullford Press, New York, New York, 1997.
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# SYMPOSIUM 36—THE ETHNICITY FACTOR IN PSYCHIATRIC RESEARCH: IDENTITY AND METHODOLOGY ISSUES
## American Society of Hispanic Psychiatry

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify the many variables that interact with the ethnicity factor in the configuration of an individual's identity, (2) define subgroups included under the Hispanic population and apply distinctions in clinical practice and research interpretions, (3) recognize critical issues for selecting, evaluating, diagnosing, and interpreting outcomes of studies including diverse ethnic groups, (4) understand the extent and limitations of the use of race, ethnicity, and culture as categories in contemporary psychiatric research, including as compared with other demographic variables, and assess the specific design and analytical strategies in which they are employed, (5) recognize the importance of the cultural background and needs of people who are research subjects, (6) become familiar with training techniques to enhance the researcher's cultural sensitivity.

## No. 36A
## CULTURAL VARIABLES AND CONTROVERSIES: THE IDENTITY ISSUE

Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Medicine, 2660 Peach Tree Road, NW, Apt. 29B, Atlanta, GA 35305*

### SUMMARY:

Culture, defined as a set of meanings, behavioral norms, and values utilized by members of a particular society as they construct their unique view of the world has, in the concept of ethnicity, a crucially important epistemological instrument. Cultural reference points include variables such as language, religious beliefs, morals, traditions and even dietary habits, technological processes, or financial philosophy. As a whole, they contribute to create everyone's sense of identity and belongingness. Each cultural variable, however, is a matter of debate and controversy and, as a result, the very notion of individual identity cannot be consistently defined. This presentation will analyze these debates and their implications for psychiatric research, particularly in the clinical, epidemiological, and public health arenas. Research approaches in these different settings must be sufficiently flexible to elicit descriptions and/or narratives of cultural variables that would assist effectively in the understanding and appropppriate labeling of specific behaviors.

## No. 36B
## CULTURAL ISSUES AMONG HISPANICS: A PORTRAIT OF HETEROGENEITY

Andres Heerlein, M.D., *Department of Psychiatry, Society of Psychiatry, Carlos Silva 1292-22 Providence, Santiago, Chile*

SUMMARY:

In recent years, several medical studies have tried to compare epidemiological, clinical, or treatment-related factors between different populations in the American continent, assuming the existence of well defined ethnic groups. Most of the Spanish-speaking immigrants living in the U.S. have been identified for these purposes as "Hispanics" even though they show a wide and diverse spectrum of inclusion criteria in each study. Many authors have assumed that this "Hispanic" population may constitute a homogeneous ethnic group, and that it could also be considered identical to the population from Latin America. These assumptions seem to show a lack of objective support and scientific rigor. Many epidemiological studies have shown considerable differences among the so-called "U.S.-Hispanic population" even in parameters considered "hard" such as adult and child mortality, educational level, violence, fertility levels, activity, etc., suggesting a wide intra-group cultural diversity. These distinctions are even more significant when comparing cultural features among Latin American subpopulations. In psychiatric research, a clear definition of homogeneous groups and the consideration of inter-group cultural differences (i.e., Spanish-speaking Americans and Latin Americans) is extremely relevant for methodological and clinico-therapeutic reasons. A recognition of potential biases when using the same methods and instruments in different contexts is needed. Some suggestions are presented to improve this important aspect of ethnicity research.

## No. 36C
## METHODLOGICAL ISSUES IN ETHNICITY RESEARCH

Javier I. Escobar, M.D., *675 Hoes Lane, Piscataway, NJ 08854*

SUMMARY:

In the U.S. at least, the last few years have seen an increased preoccupation with the overall issue of "health disparities." The Surgeon General's Report on Mental Health, Culture, Race and Ethnicity, outlined major issues impacting U.S. minority groups, including their serious underrepresentation in clinical studies.

A parallel report from the National Advisory Mental Health Council emphasized the need to train more minority researchers. Both of these initiatives are starting to have a beneficial impact and the net result may be a substantial increase in new research applications focusing on select ethnic groups as well as the inclusion of higher numbers of minority subjects in clinical research studies. Unfortunately, methodologies have not been adequately revised or developed in order to fit the new initiatives and results of many of these studies may be questioned.

This presentation will first review the literature on ethnic research from the perspectives of patient selection, assessment, diagnosis, instrumental measures, and outcomes. Issues such as selection of heterogeneous, non-representative samples, diagnostic bias, instrument translation and adaptation, and differential response to same instruments by various groups will be highlighted.

In the ensuing discussion, some specific recommendations will be made for doing ethnic research in the 21st century.

## No. 36D
## THE INCLUSION OF RACE AND ETHNICITY IN CURRENT PSYCHIATRIC LITERATURE

Roberto Lewis-Fernandez, M.D., *New York State Psychiatric Institute, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Maria A. Oquendo, M.D., Naelys Diaz, M.S.W., Dana Wachtel, M.S.W., Renato D. Alarcon, M.D.

SUMMARY:

The use of race and ethnicity categories in psychiatric research has risen steadily over the last decades. This is duc in part to growing awareness of the association of minority status with disparities in psychiatric disorder prevalence and outcome, specialty care access, and misdiagnosis. Federal agencies, such as the NIMH and the Surgeon General's Office, either require or actively encourage psychiatric research along racial and ethnic categories in order to identify and correct the source of these disparities. At the same time, the use of race and ethnicity as analytical variables has come under criticism in public health, epidemiology, and anthropology. Critique of these categories centers on their vague and inconsistent definitions, their lack of relationship to biological markers, their potential confounding of illness determinants such as poverty or racism, and their ability to obscure intra-racial (or -ethnic) sociocultural heterogeneity. The contemporary status of race, ethnicity, and cultural categories in psychiatric research has received little empirical attention. We will present data on the use of these categories in seven mainstream psychiatric journals during 2000–2001 as compared with other demographic variables, such as gender or SES. A critique of specific design and analytical strategies involving these categories will also be presented.

## No. 36E
## TRAINING CULTURALLY COMPETENT RESEARCHERS

Miguel R. Jorge, M.D., *Department of Psychiatry, Brazilian Association of Psychiatry, R. Botucatu 740, Sao Paulo 04023-900, Brazil*

SUMMARY:

Not much attention has been given to cultural issues when carrying out clinical work and when conducting different kinds of psychiatric research. The way people from different cultural backgrounds express their normal feelings or psychopathological experiences, or react to treatment interventions are quite diverse across different countries or different ethnic groups inside the same country. On the basis of the Brazilian experience, cultural sensitivity and clinical attention to these issues in research protocols are discussed. This situation demands specific training of researchers in the recognition and handling of cultural variables. Similarly, the adaptation of research instruments to local realities, and the adequate training of field workers involved in conducting interviews and translating subjects' behavior into forms, scales, or different ratings are necessary steps. Mental health clinical and research training should achieve a balance between universality and cultural awareness. Training activities (some of which will be discussed in the presentation) need to take into account the how, where, with whom, and what kind of research the trainee will conduct. International cooperative efforts in the training of culturally competent researchers is a pervasive and challenging issue.

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1. Group for the Advancement of Psychiatry Report No. 145, Commite on Cultural Psychiatry. Cultural Assessment in Clinical Psychiatry. Washington DC, American Psychiatric Publishing, Inc., 2002.

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3. Randolph ET, Escobar JI, Paz D, Forsythe AB: Ethnicity and reporting of schizophrenic symptoms. Nerv Ment Dis 1985; 73:332–340.
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# SYMPOSIUM 37—WHAT THE GENERAL PSYCHIATRIST NEEDS TO KNOW ABOUT ADDICTION PSYCHIATRY

## APA Council on Addiction Psychiatry and American Academy of Addiction Psychiatry

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe the basic biologic mechanisms involved in the rewarding effects of drugs, and understand neurophysiologic changes that occur in the addictive state, (2) have fundamental knowledge about the modern treatment of addiction including specific medications and specific forms psychotherapies, (3) demonstrate improved skills in assessing and treating the dually diagnosed, (4) recognize newly emerging drug abuse in a consultative setting, (5) identify the different "designer or club drugs" of addiction, recognize the different psychiatric syndromes and life-threatening situations associated with the use of MDMA or "ecstasy", GHB, ketamine, and flunitrazepam.

### No. 37A
### NEUROSCIENCE OF ADDICTIONS

Bryon H. Adinoff, M.D., *Department of Psychiatry, University of Texas Southwestern, VAMC 116A 4500 South Lancaster Road, Dallas, TX*

SUMMARY:

Neurophysiologic processes underlie the uncontrolled, compulsive behaviors defining the addicted state. Thus, "hard-wired" changes in the brain are considered critical for the transition from casual to addictive drug use. Although each substance has its own specific mechanism of action, basic similarities are shared between most substances of abuse. The dopamine-rich medial forebrain bundle is involved with the initial rewarding effects of drugs, with progressive changes in this system occuring as drug use persists. Chronic drug use resulting in addiction produces neuromodulatory changes in various limbic regions, including the orbital frontal cortex, the amgydala, and the dorsolateral prefrontal cortex. NMDA, dopamine, GABA, endorphins / enkephalins, CRH, serotonin, and acetylcholine, among others, have all been implicated in the addictive process. Molecular mechanisms have recently been described that may best explain the neural plasticity underlying these neurobiologic changes. Neuroimaging studies have allowed the exploration of both regional brain and neurotransmitter alterations in humans during active drug use, drug craving, and in response to pharmacologic probes. These studies have also revealed striking differences in the brains of male and female addicts. A more sophisticated understanding of these neurophysiologic alterations will better guide medication development for addiction treatment.

### No. 37B
### TREATMENT OF ADDICTIONS

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

SUMMARY:

Basic principles underlying the modern treatment of addiction will be discussed. Generally, this involves a combination of careful psychiatric evaluation and a combination of psychotherapy and medication over the long term. Specific treatments and specific medications for dependence on alcohol, cocaine, heroin, nicotine, and marijuana will be discussed.

### No. 37C
### DUAL DIAGNOSIS

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854;* Sylvia Atdjian, M.D., Jon Krejcl, M.D., Jeffrey A. Berman, M.D.

SUMMARY:

Co-occurring mental illness and addiction has been labeled "dual diagnosis" and is a common clinical problem facing the general psychiatrist. Dual diagnosis includes a wide range of types of cases with different combinations of mental illness and addiction, for example, schizophrenia and cocaine addiction or depression and alcohol dependence. The types of dual-diagnosis cases varies by the clinical mental health or addiction treatment setting, and patients vary according to motivational level in their willingness to address specific disorders. This presentation will focus on important clinical assessment issues, treatment planning, and medication and psychosocial treatment interventions. There will be a focus on dual recovery therapy that integrates and modifies traditional mental health and addiction psychosocial treatments into a blended approach. The core psychosocial addiction treatments of motivational enhancement therapy (MET), relapse prevention, and 12-Step are integrated but modified for the unique clinical needs of different clinical subtypes. Many dually diagnosed patients in the mental health setting have low motivation, so the presentation will include a focus on this problem.

### No. 37D
### CONSULTATION PSYCHIATRISTS: FRONTLINE OBSERVERS OF NEW TRENDS IN ADDICTION

Joel E. Dimsdale, M.D., *UCSD, 9500 Gilman Drive 0804, La Jolla, CA 92093-0804*

SUMMARY:

Consultation psychiatrists are frequently the "canaries in the mines" when it comes to detecting newly emerging drugs of abuse.

With new drugs of abuse knowledge is at a premium. Users typically do not know the purity of the drugs they are consuming. As a result, one is sometimes unsure precisely what compound accounts for the psychopathology. In addition, users are frequently falsely reassured that such drugs are "safe" and "non-addicting" in comparison with older drugs abused by the previous generation. Even if the user is willing to disclose the drug use, the street name of such drugs (e.g., "skittles") is hardly illuminating to the psychiatrist. For non-disclosing users, it is a mistake to rely on toxicology screens to reveal the diagnosis because some drugs are quite difficult to detect through routine toxicology, "stealth" drugs, as it were.

Other drugs' addictive potential is realized only after careful post-marketing surveillance.

This presentation will discuss some of the newly emerging drugs of abuse encountered by a busy consultation psychiatry unit in an academic medical center. Patients may be encountered throughout the hospital in the emergency room, medical/surgical units, or psychiatry units.

## No. 37E
## CURRENT ISSUES IN ADDICTION MEDICINE: CLUB DRUGS

Alvaro Camacho, M.D., *9500 Gilman Drive, La Jolla, CA 92093*

### SUMMARY:

*Objective:* To inform general psychiatrists and health care professionals about the mechanism of action, side effects, and psychiatric symptoms associated with the use of MDMA, GHB, ketamine, and flunitrazepam.

*Methods:* Comprehensive review of the current available literature describing the effects and use of club drugs by different populations; i.e., young adults and gay men.

*Results:* According to the Drug Abuse Warning Network (DAWN), the use MDMA and GHB continues to rise. The abuse of MDMA is growing faster than any other drug. Additionally, DAWN reported a dramatic increase in the GHB- and MDMA-related encounters in the emergency departments across the country.

The abuse of GHB has also risen among health care professionals.

MDMA is related to the amphetamines and to mescaline. Its mechanism of action resembles both the stimulants and the hallucinogens. GHB is a central nervous system depressant. It is a naturally occuring fatty acid derivative of the neurotransmitter gamma-aminobutyric acid. GHB at lower doses produces feelings of euphoria, relaxation, and increased libido. Ketamine is a derivative of PCP, which is a dissociative anesthetic. It produces dramatic feelings of dissociation, a sense of "floating over one's body," auditory hallucinations, and lack of coordination.

Flunitrazepam is a long acting benzodiazepine, commonly prescribed in other countries. It produces sedation and anterograde amnesia.

The overall management of acute intoxication with any club drug includes close monitoring of vital signs, assisted ventilation in case of respiratory depression, use of antipsychotics or sedatives to control perceptual disturbances or severe agitation, and reduced environmental stimuli.

*Conclusion:* The abuse of club drugs, particularly by young people in social settings, should put health care professionals on guard to recognize and manage serious reactions.

### REFERENCES:

1. Koob GF, Le Moal M: Drug addiction, dysregulation of reward, and allostasis. Neuropsychopharmacology 2001; 24(2):97–129.
2. O'Brien CP: A range of research-based pharmacotherapies for addiction. Science 1997; 278:66–70.
3. Ries R: Assessment and Treatment of patients with co-existing mental illness and alcohol and other drug abuse DHHS Publ. #99-3307, 1994.
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5. Smith KM, Larive LL, Romanelli F: Club drugs: methylenedioxymethamphetamine; flunitrazepam, ketamine hydrochloride, and gamma-hydroxybutyrate. Am J Health-Syst Pharm 2002; 59:1067–76.

# SYMPOSIUM 38—EARLY TRAUMA: STRATEGIES FOR INTERVENTION AND TREATMENT

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize assessment and treatment protocols for traumatized infants and young children, (2) learn about the range of therapeutic techniques applicable to the treatment of traumatized preschool children and their families, taking into account the rapid developmental changes that are occurring in the first four years of life, (3) provide information about the psychological effects of violence exposure on young children.

## No. 38A
## THE EARLY TRAUMA TREATMENT NETWORK: ASSESSING AND TREATING TRAUMA IN YOUNG CHILDREN

Alicia F. Lieberman, Ph.D., *Department of Psychiatry, University of California at San Francisco, 1001 Potrero Avenue Suite 2100, San Francisco, CA 94110*

### SUMMARY:

This presentation will describe a four-site collaborative, the Early Trauma Treatment Network (ETTN), funded by SAMHSA's National Child Traumatic Stress Network to collect and evaluate assessment and treatment information involving infants, toddlers, and preschoolers exposed to traumatic stress as the result of abuse, exposure to domestic violence, foster care placement, and bereavement. The collaborative is a response to the dearth of systematic information about the impact of trauma in the first five years of life on different developmental domains and the ontogenesis of psychopathology. The four sites consist of child trauma programs located at the University of California San Francisco, Louisiana State University Medical Center, Boston Medical Center, and Tulane University. The programs are developing a common assessment protocol and implementing a manualized child-parent psychotherapy approach to treatment in order to compare early childhood symptomatology and response to treatment in populations of children and families with different ethnic and cultural profiles, living in different geographical locations, and exposed to different types of trauma. Emerging commonalities and differences among the different sites and their implications for understanding the impact of early trauma on young children's mental health will be discussed.

## No. 38B
## TREATMENT OF PTSD IN INFANTS AND YOUNG CHILDREN

Theodore J. Gaensbauer, M.D., *3955 E Exposition Ave #402-D, Denver, CO 80209-5033*

### SUMMARY:

This presentation will focus on the types of early trauma likely to be seen in an office-based setting, such as those caused by medical treatments, dog bites, and auto accidents, as opposed to the kinds of violent trauma often seen in community-based settings. This difference in setting has significant implications for therapeutic intervention.

A brief discussion of recent research on early memory will provide a rationale for the importance of trauma-specific intervention strategies, even in the preverbal period, over and above generalized nurturing.

Discussion of treatment will be organized around the following goals: (1) establishing a sense of safety; (2) reducing the intensity of the overwhelming affects generated by the trauma; (3) developing a coherent narrative; (4) achieving a sense of mastery; (5) addressing secondary effects, including developmental distortions and behavioral disturbances; and (6) providing support and guidance to the patient's family. Using clinical examples, therapeutic approaches to accomplishing these goals will be illustrated, including individual work with the child using desensitization techniques and structured play situations, and work with the parents in order that they may help the child both in the office setting and in the home environment. Issues of medication will be briefly discussed.

### No. 38C
### PREVENTION AND INTERVENTION FOR YOUNG CHILDREN EXPOSED TO VIOLENCE

Joy D. Osofsky, Ph.D., *Department of Psychiatry, LSU Health Science Center, 1542 Tulane Avenue, New Orleans, LA 70112*

SUMMARY:

Very young children are traumatized by community and domestic violence exposure as victims and witnesses. Information on the effects of violence exposure on young children will be presented, including developmental implications, resultant behaviors, and the most extreme reaction, posttraumatic stress disorder. Parental and caregiver traumatization will also be discussed with emphasis in cases of domestic violence related to the impact on young children. Prevention and early intervention is very important both to reduce exposure to violence and to reach children shortly after exposure. Therefore, the role of the mental health professional as an interventionist with first responders, such as law enforcement, will be discussed as a way to reach traumatized children earlier. Young children in the child welfare system will also be considered because one in five children coming into foster care for the first time is a maltreated baby less than one year old. They are also at high risk for exposure to domestic violence. A model for mental health professionals to develop collaborations with judges and lawyers who work in juvenile court will be presented. The conclusion will describe ways to provide education and relevant information to police and the court on how to help traumatized young children.

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3. Osofsky JD: Children in a Violent Society. New York, Guilford Publishers, 1997.

## SYMPOSIUM 39—EARLY INTERVENTION IN PSYCHOSIS: WHERE SCIENCE MEETS COMMUNITY PSYCHIATRY
## American Association of Community Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be able to (1) understand the importance of early prevention in psychotic disorders, (2) recognize the early pre-onset symptoms of schizophrenia and the likely risk/benefit ratio of early intervention, (3) recognize the prodrome of psychosis and understand the basic elements of a community-based prevention program, (4) have acquired knowledge regarding evaluation of early intervention in psychosis and methods of early case detection, (5) demonstrate knowledge of the difference between early psychosis intervention based on the Early Psychosis Prevention and Intervention Center guidelines and the current public mental health system, and practical steps for implementing these types of changes within a managed care framework.

### No. 39A
### EARLY DETECTION AND MANAGEMENT OF PSYCHIATRIC DISORDER IN YOUNG PEOPLE IN MELBOURNE, AUSTRALIA

Patrick D. McGorry, M.D., *Department of Psychiatry, University of Melbourne, 35 Popular Road, Parkville Victoria 3052, Australia;* Alison R. Yung, M.D., Lisa R. Phillips, B.S.C., Annemarie Wright, B.A., Andrew Chanen, Jane Edwards, Ph.D., Meredith Harris, M.A., Lisa Henry, M.A., Susy Hrrigan, M.A., Philippe Conus, M.D., Martin Lambert, M.D.

SUMMARY:

Over the past decade a model of care providing early detection and optimal care for young people with early psychosis has been developed in Melbourne. The model has expanded from a focus on early psychosis to a full range of diagnostic groups under a youth health umbrella. The latest research will be presented from a mental health literacy campaign (Compass), from the prepsychotic service (PACE), from EPPIC, and from other programs within the umbrella of what is now known as ORYGEN Youth Health. Clinical research is being conducted in eating disorders, borderline personality disorders, mood disorders, and substance use disorders, and a range of neurobiological research is also in progress.

The level of knowledge of mental disorders within the local population and the impact of a mental health literacy campaign will be presented. Progress in intervening in the prepsychotic phase of first-episode psychosis will be reported. A randomized study of two forms of psychological intervention in early borderline personality disorder will be described and the latest outcome data from the EPPIC program will be covered. The findings will underpin a discussion of models of care for young people with emergent psychiatric disorder and provide momentum for further reform.

### No. 39B
### INTERVENTION IN THE SCHIZOPHRENIC PRODROME: THE PREVENTION THROUGH RISK IDENTIFICATION, MANAGEMENT, AND EDUCATION INITIATIVE

Thomas H. McGlashan, M.D., *Department of Psychiatry, Yale University, 301 Cedar Street, P O Box 208098, New Haven, CT 06520-8098;* Tandy J. Miller, Ph.D., Robert B. Zipursky, M.D., Scott W. Woods, M.D., Diana O. Perkins, M.D., Keith A. Hawkins, Ph.D., Jean M. Addington, Ph.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. These trials are testing whether pre-onset treatment can reduce prodromal symptoms, delay or prevent onset and/or improve course and prognosis. The development of reliable and valid assessments of this clinical state plus the emergence of atypical antipsychotic drugs with fewer side effects have rendered such trials feasible. The PRIME initiative (Prevention Through Risk Identification, Management, and Education) is a four-site North American, double-blind, placebo-controlled clinical trial of olanzapine in the treatment of prodromal patients (N = 60) at risk

for schizophrenia. Data describing the sample and why it is called prodromal will be presented, including baseline clinical profiles and unblinded drug-placebo differences in the treatment of "prodromal" symptoms. The implications of the data generated so far in the PRIME and other prodromal treatment studies will be discussed.

## No. 39C
## PORTLAND IDENTIFICATION AND EARLY REFERRAL: FIRST-YEAR OUTCOMES IN A COMMUNITY-WIDE PSYCHOSIS PREVENTION PROGRAM

William R. McFarlane, M.D., *Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102;* William L. Cook, Ph.D., Donna Downing, O.T.R.

SUMMARY:

Portland Identification and Early Referral (PIER) has established a comprehensive population-based system of early detection of prodromal psychosis for Greater Portland, Maine, the first in the U.S. The goal of the program is to reduce the incidence of active psychosis and schizophrenia in and around Portland, Maine (population 260,000), leading to a substantial improvement in the local prognosis for psychotic disorders. The principle strategy is to intervene early, prior to onset, in the course of the onset of psychotic disorders, arresting the development of psychotic symptoms and functional disability. PIER has educated the community at large and trained all health, education, and other professionals in frequent contact with the at-risk population. The treatment is a specialized combination of psychoeducational multifamily group and assertive community treatment. Referrals are occurring at the ECA incidence rates for schizophrenia (1/10,000, 27 cases per year). In the first year of operation, PIER has led to low rates of conversion to psychosis (<6% per year) among prodromal young persons and high rates of engagement (>90% of eligible cases) and retention in treatment (> 85% at three months). Other domains of outcome to be reported include cognitive dysfunction and functional disability. Methods for developing the community-wide early detection system and public education will be described.

## No. 39D
## A COMPREHENSIVE APPROACH TO EARLY INTERVENTION IN PSYCHOSIS: THE PREVENTION AND EARLY INTERVENTION PROGRAM FOR PSYCHOSIS PROJECT (PEPP)

Ashok K. Malla, M.D., *Department of Psychiatry, University of Western Ontario, 375 South Street LHSC WMCH Building, London Ontario N6A 4G5, Canada;* Ross M.G. Norman, Ph.D., Rahud Manchanda, M.D., Terry S. McLean, M.Ed., Derek J. Scholten, M.S.C., Laurel Townsend, Ph.D.

SUMMARY:

Prevention and Early Intervention Program for Psychosis (*www.PEPP.ca*) is a clinical research program in London, Ontario, Canada (population 360,000), designed to evaluate the effect of early intervention on one- and two-year multidimensional outcome using a historical control quasi-experimental design. The program consists of a standardized assessment and evaluation protocol, a phase-specific comprehensive medical and psychosocial treatment protocol, and a two-phase case detection program (phase 1—systemic changes and phase 2—an assertive community case recognition initiative). The content of the treatment has been maintained unchanged over the two phases of case detection. Here we will present data on one- and two-year outcomes: remission rates, quality of life and cognition, examine the effect of DUP and other predictors on dimensions of outcome, and report on the effect of the two phases of case detection on treated incidence and DUP. Our results show 74% and 82% remission rates at one and two years, respectively; significant improvement on cognitive measures and quality of life; an independent relationship between DUP and remission, level of symptoms, and quality of life (social relations); and a complex pattern of change in treated incidence and DUP following each phase of the case detection initiative.

## No. 39E
## THE TIPS PROJECT: CLINICAL AND ORGANIZATIONAL PREREQUISITES FOR EARLY INTERVENTION IN PSYCHOSIS

Jan O. Johannessen, M.D., *Rogaland Psychiatric Hospital, Armauer Hansensvei 20, P.O. Box 1163, Stavanger 4004, Norway*

SUMMARY:

The TIPS project is a Scandinavian multi center early intervention study, aimed at reducing duration of untreated psychosis (DUP) in the experimental sector (Rogaland), and comparing the long-term outcome between the experimental (short-dup) sector, and the comparison sectors (Ojlo, Copenhagen) (long-dup).

The strategies to reduce dup within a catchment area of 400,000 inhabitants will be described.

## No. 39F
## IMPLEMENTING EARLY PSYCHOSIS INTERVENTION IN THE PUBLIC MENTAL HEALTH SYSTEM

Robert M. Wolf, M.D., *Mid-Valley Behavioral Care Network, 1660 Oak Street, SE Suite 203, Salem, OR 97301;* Tamara Sale, M.A.

SUMMARY:

Mid-Valley Behavioral Care Network (MVBCN) is a managed care entity responsible for mental health care for five Oregon counties and over 63,000 Oregon Health Plan members. Since March of 2001, MVBCN has systematically integrated best practice guidelines developed at the Early Psychosis Prevention and Intervention Center in Melbourne, Australia. A regional specialty team, including employees of ten agencies, provides community education, flexible outreach, assessment, medication prescribing emphasizing low doses, psychoeducation about psychosis, cognitive behavioral therapy, family support and education, and groups and individualized planning to support developmental progress and goals. Since the inception of the program, over 60% of participants have returned to work or school, use of involuntary commitment has decreased dramatically, and a wider array of community members are recognizing psychosis and calling for help. Through an approach that emphasizes well-informed individual choice, the majority of people engaged in the program are able to successfully manage their symptoms. MVBCN's experience provides useful lessons for other communities considering how to provide effective, sustainable services for people in the early stages of psychosis.

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# SYMPOSIUM 40— DEHYDROEPIANDROSTERONE: NEUROSTEROID MECHANISMS, EPIDEMIOLOGY, AND APPLICATIONS IN PSYCHIATRY

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) appreciate the role of adrenal hormone in psychiatric disorders, (2) acquire a comprehensive view of current scientific thought regarding DHEA's behavioral effects in humans and its potential as a pharmacologic treatment in psychiatry, (3) recognize patients potentially eligible for DHEA treatment, and to treat them, using the guidelines identified as salient in this research project.

## No. 40A
## DEHYDROEPIANDROSTERONES: NEUROSTEROID MODULATOR OF BRAIN EXCITABILITY, MOOD, COGNITION, AND DRUG DEPENDENCE

Maria Majewska, M.D., DTRD, *NIDA/NIH, 6001 Executive Boulevard Room 4123 MSC 9551, Bethesda, MD 20892-9551*

## SUMMARY:

DHEA(S), a weak adrenal androgen, is a substrate for several other steroids. In the CNS, DHEAS acts as an excitatory neurosteroid, which antagonizes GABA-A receptors, potentiates NMDA receptors, and stimulates release of NE, DA, 5HT, and Ach. In humans adrenal secretion of DHEAS is high at birth, decreases to almost zero in early childhood, increases at adrenarche, peaks in early adulthood, and then steadily declines with aging. Because DHEAS regulates the function of several neurotransmitter systems, it affects sleep, arousal, mood, learning, memory, personality, aggression, and sexual functions, among others. Reduced plasma levels of DHEAS were found in major depression, anxiety disorders, ADHD, delinquency, or refractory cocaine dependence, and correlated with propensity for cardiovascular diseases and cognitive impairments in men. Studies with DHEA treatment of aging populations were inconsistent—some reported improvement of memory, sleep, mood, and sex drive, while others did not. Treatment with DHEA of adrenal deficient patients improved mood, cognition, and sexual and immune functions, but treatment of cocaine addicts was not beneficial and increased cocaine use. The influence of DHEA(S) on psyche is still enigmatic.

## No. 40B
## DEHYDROEPIANDROSTERONE TREATMENT OF ALZHEIMER'S DISEASE AND MAJOR DEPRESSION

Victor I. Reus, M.D., *Langley Porter NPI, University of Psychiatry, 401 Pamassus Avenue, San Francisco, CA 94122-2720;* Owen M. Wolkowitz, M.D.

## SUMMARY:

Dehydroepiandrosterone (DHEA) and its sulfated metabolite (DHEA-S) are the most abundant adrenal and gonadal steroids in humans, yet their physiologic importance remains controversial. The finding that decreents in DHEA(S) levels parallel the aging process and may correlate with cognitive and functional decline has raised speculation that pharmacologic replacement may be associated with improvement in functional status in normal elderly individuals and possibly ameliorate impairments in cognitive status in Alzheimer's disease. We report here the results of a multi-site randomized trial of DHEA (50 mg po. BID; N = 28) or placebo (N = 30) given for six months. DHEA was well tolerated, but was not associated with significant improvement on primary measures of efficacy, although transient improvement was observed at month three. We also review our continuing usage of DHEA(S) as an adjunctive treatment in major depression and its potential physiologic role as an "anti-stress" hormone, counteracting the adverse effects of sustained elevation in glucocorticoid level. DHEA(S) treatment was associated with a marked improvement in depression ratings, in comparison to adjunctive placebo in a six-week, double-blind trial. Methodologic issues in the interpretation of this study, as well as others recently published, will be addressed in addition to risk and safety concerns.

## No. 40C
## DEHYDROEPIANDROSTERONE EFFECTS ON MOOD IN HIV AND DEPRESSED PATIENTS

Judith G. Rabkin, Ph.D., *New York Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Martin McElhiney, Ph.D., Richard Rabkin, M.D., Judy Chiu, B.A., Stephen J. Ferrando, M.D.

## SUMMARY:

*Objective:* To determine whether dehydroepiandrosterone (DHEA) is safe and effective in alleviating mild but persistent depression and low energy in HIV+ adults.

*Method:* An eight-week, double-blind, placebo-controlled trial of DHEA is under way for depressed HIV+ patients. Eligibility criteria included a DSM-IV diagnosis of minor depression or dysthymia and HAM-D = 12–24. Primary outcome measures were CGI scores of 1 or 2 and 50+% decline of HAM-D scores.

*Results:* To date, 71 patients entered and 64 completed the trial; 68% were nonwhite, 83% were gay, and 6% were women. Mean baseline HAM-D was 15.5; mean baseline BDI was 22.65% had an AIDS diagnosis.

Among completers, response was 59% for DHEA patients and 33% for placebo patients ($p = .04$). Intention to treat analysis: DHEA response rate was 51%, and placebo response rate was 31% ($p = .09$). Of those who reported low energy at study baseline, 59% of DHEA patients and 39% of placebo patients reported significant improvement ($p = .09$). Side effects were uncommon and mild.

*Conclusion:* To date, DHEA appears promising for HIV + men and women with mild but persistent depression, although the sample to date is small. Effects on energy level were suggestive. DHEA did not increase testosterone levels among men, or cause decline in immune parameters.

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# SYMPOSIUM 41—SCIENCE AND PSYCHIATRIC PARTICIPATION IN DISASTER

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the central role of psychiatry and mental health services in terrorism preparedness and the tendency of American society to marginalize those services to its detriment, (2) outline the core strategic and tactical elements of a disaster mental health plan using the "Chart and Matrix Disaster Plan System", (3) summarize the current literature on the topic of psychological debriefing, (4) identify the best practices common to most mental health disaster response interventions, and (5) initiate research efforts to evaluate the effectiveness of disaster response interventions, (6) recognize the common countertransference reactions of therapeutic healers following terrorist events, compare and contrast individual vs. community approaches to disaster response, and conceptualize a model of therapeutic healing that begins "at ground zero" and ends with long term treatment.

## No. 41A
## PSYCHIATRY AND SOMATIC MEDICINE IN DISASTER RESPONSE: CARVED OUT AGAIN?

Michael J. Kaminsky, M.D., *Johns Hopkins School of Medicine, 600 North Wolfe Street, Meyer 4-181, Baltimore, MD 21287*

SUMMARY:

Terrorism is a psychological weapon whose political purpose is to use traumatic experiences to promote distrust in government and to foster anxiety symptoms in a population. Terrorism causes many times more mental health victims as physical victims. The long-term functioning of society is more damaged by psychological injury than loss of property or even loss of life.

Unfortunately, psychiatry has a long history of being carved out. The development of state mental hospitals distant from general hospitals and the managed care industry are two examples. Over terrorism it is happening again—witness the marginal role of mental health in most disaster plans and the lack of even its mention in a recent version of the Homeland Security Act. The focus is solely on somatic health issues.

As with the historical examples above, the consequences for the American public of psychiatry being carved-out are financial starvation of psychiatric services and clinical and public health neglect.

The psychological effects of trauma for individuals and society are the psychiatric public health problem of the 21st century. Mental disorders arising from terroristic trauma are democratic; all citizens are potential victims.

Now is the moment for the nation to move mental health to the center of disaster preparedness. It is good sense—and good policy.

Obstacles exist. Controversies over the nature of PTSD, its treatment, psychological interventions, and even what is normal undermine psychiatry's inclusion. Indeed, because of these issues, there are crucial opportunities to fill gaps in our knowledge, while clinically serving the American people. Psychiatry, allied mental health providers, and the nation must seize what the times demand.

## No. 41B
## WHAT YOU NEED TO KNOW TO GET YOURSELF AND YOUR ORGANIZATION READY TO RESPOND TO DISASTERS

George Everly, Jr., Ph.D., *ICISF, 702 Severnside Avenue, Severna Park, MD 21146*

SUMMARY:

Interest in disaster mental health increased dramatically within the United States in 1992 with the advent of the American Red Cross Disaster Mental Health Network. Emphasis at that time was placed upon tactical response training. With the Oklahoma City bombing and the attacks on the Pentagon and World Trade Center, the need for greater emphasis upon strategic planning was made evident.

Based upon more than a decade responding to disasters in the United States, Eastern Europe, Kuwait, and the Orient, the author has designed a framework for creating a disaster mental health response plan. This chart and matrix system may be used by organizations as well as entire communities to prepare for disasters. The model may also be used by departments of psychiatry to plan a psychiatric response for hospitals, universities, and communities at large.

## No. 41C
## CURRENT SCIENCE ABOUT BEST PRACTICES IN DISASTER PSYCHIATRY AND A PROPOSED RESEARCH AGENDA

Michael C. Heitt, Psy.D., *FASAP, Johns Hopkins University, 550 North Broadway #507, Baltimore, MD 21205*

SUMMARY:

With its roots dating back to military practices during the two World Wars, psychological debriefing (PD) has evolved into many forms and techniques. Over the years PD has become fundamental to many contemporary mental health disaster response protocols. The field of disaster psychiatry initially welcomed PD with open arms; however, more recently such interventions have received considerable criticism. Anecdotal claims of efficacy have been challenged with demands for randomized controlled trials and evidence that PD may cause harm. Taking these polarized opinions into consideration, we have developed our own "best practices" and incorporated them into the Johns Hopkins Institutions' disaster response plans. While these practices are supported by a sizable literature and the wisdom of leading authorities in the field, there is little empirical evidence backing them. Because of this, we introduced a research/evaluation component into our disaster planning efforts. We intend to evaluate the effectiveness of our response plan by measuring each planning phase, and we are planning to evaluate our proposed best practices in the event of a major disaster. We are also proposing randomized controlled trials with the goal of isolating the core element(s) of change common to effective disaster response interventions.

## No. 41D
## POST-DISASTER SCIENCE OF THERAPEUTIC HEALING

Everett R. Siegel, M.D., *Department of Psychiatry, Johns Hopkins SOM, 600 North Wolfe Street Meyer 4-181, Baltimore, MD 21287;* Michael C. Heitt, Psy.D.

SUMMARY:

By definition, the goal of terrorism is to create psychological terror. Ultimately, its aim is to create chaos, sow distrust in our institutions, and dehumanize its victims. As psychiatrists, our goal is to respond to the needs of individuals affected by terrorism. By demonstrating organized, humane, and empathic responses to these individuals, not only can we counter some of the psychological destruction of terrorism, but we also provide a mirror of and model for our society's response to terrorism. There are, however, obstacles to our responding effectively to disasters and terrorism. These roadblocks range from counter-transference reactions encountered by

therapists on the scene and eloquently described by psychoanalysts in New York in the wake of 9/11, to the necessity of working simultaneously with both individually oriented models to community-based approaches of treatment. Another challenge to effective psychiatric treatment of victims is the necessity of understanding the individual, biological, and social aspects of disasters and terrorism, and the appropriate clinical approaches during the various stages following such an event.

This talk will present some of the counter-transference responses to terrorism, and provide a model of working with disaster or terror victims through various stages following a terrorist attack or other major disaster.

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## SYMPOSIUM 42—RECOVERY FROM SCHIZOPHRENIA: A CHALLENGE FOR THE 21ST CENTURY

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the rationale for developing an operational definition of recovery from schizophrenia and to become familiar with the empirical support for this definition, (2) know how many patients with first episode schizophrenia are able to achieve sustained symptom improvement, sustained improvement in functioning, and full recovery in both symptoms and functioning, (3) recognize the potential for vocational recovery of some individuals with a schizophrenia spectrum disorder, (4) recognize the phases and tasks of recovery, (5) describe the extent and timing of recovery in various symptom and functional dimensions during the first year of continuous treatment for a schizophrenia spectrum disorder.

### No. 42A
### OPERATIONAL CRITERIA AND FACTORS RELATED TO RECOVERY FROM SCHIZOPHRENIA

Robert P. Liberman, M.D., *Department of Psychiatry, UCLA School of Medicine, 528 Lake Sherwood Drive, Thousand Oaks, CA 91361;* Alex J. Kopelowicz, M.D., Joseph Ventura, Ph.D.

### SUMMARY:

To facilitate future research, an operational definition of recovery from schizophrenia, is proposed that includes symptom remission and return to a high level of functional performance for at least two consecutive years.

*Method:* To validate these criteria, focus groups comprising clients, family members, practitioners, and researchers were conducted and a pilot study of 28 recovered individuals was performed to identify the self-attributions, clinical characteristics, and neurocognitive correlates or recovery from schizophrenia.

*Results:* The focus groups endorsed most of the criteria as being relevant to the construct of recovery, although there were differences between research investigators and others. The pilot study demonstrated significant differences between normal controls, recovered subjects, and non-recovered individuals with schizophrenia on several of the key measures suggesting that quality of sustained treatment, near-normal neurocognition, and absence of the deficit syndrome were key factors associated with recovery.

*Conclusions:* The results of the pilot study generated several hypotheses for future testing and provided validation for the proposed operational definition of recovery from schizophrenia.

### No. 42B
### RECOVERY IN FIRST-EPISODE SCHIZOPHRENIA

Delbert G. Robinson, M.D., *Research Department, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-0038;* Margaret Woemer, Ph.D., Marjorie McMeniman, Ph.D.

### SUMMARY:

*Objective:* Response criteria in schizophrenia studies are usually based upon change in a limited number of areas. This study examined recovery, an outcome criterion requiring sustained improvement in both symptoms and functioning.

*Methods:* Patients with first-episode schizophrenia or schizoaffective disorder were assessed at baseline and then treated according to a medication algorithm. Recovery criteria required remission of positive and negative symptoms and sustained social functioning (fulfillment of age-appropriate role expectations, performance of daily living tasks without supervision, and engagement in social interactions) for a two-year period.

*Results:* By five years after study entry, the cumulative percentage of subjects who had remission of positive and negative symptoms for two years was 47% (95% confidence interval [CI], 36%, 58%). Improvement in functioning at the level specified by the recovery criteria was achieved by 25% (95%CI, 16%, 35%) of subjects. Only 14% (95%CI, 6%, 21%) of subjects met full recovery criteria based upon improvement in symptoms and functioning.

*Conclusions:* Patients with first-episode schizophrenia can achieve sustained symptomatic and functional recovery. Developing treatments to increase the rate of recovery should be an important goal for the field.

### No. 42C
### SCHIZOPHRENIA AND CAPACITY FOR VOCATIONAL RECOVERY

Zlatka L. Russinova, Ph.D., *Center for Psychiatric Rehabilitation, Boston University, 940 Commonwealth Avenue, West, Boston, MA 02215;* Nancy J. Wewiorkski

### SUMMARY:

This paper presents evidence about the potential of adults with schizophrenia spectrum disorders to achieve vocational recovery, defined as the capacity to sustain at least six months of continuous competitive employment per year while working at least ten hours per week. Written survey data were collected from a national, purposive, non-probability sample of 109 individuals who self-reported a diagnosis of a schizophrenia spectrum disorder and met the established criteria for vocational recovery. Eighty-two participants (75%) had continuous employment throughout the two years prior to entering the study while the rest sustained employment for at least 12 months during the same time period. Respondents worked from 10 to 64 hours per week in jobs ranging from unskilled labor to professional and managerial positions. In multivariate analyses, current work hours per week were correlated with prior work history and current receipt of SSI/SSDI; occupational status was associated with educational level and employment setting; and current hourly earn-

ings were correlated with current receipt of SSI/SSDI. Study findings suggest that vocational recovery is possible for this population and that there may be attributes of vocational recovery that are susceptible to clinical and rehabilitative interventions.

## No. 42D
## THE PROCESS OF RECOVERY FROM SCHIZOPHRENIA

LeRoy Spaniol, Ph.D., *CPR, Boston University, 940 Commonwealth Avenue, West, Boston, MA 02215;* Nancy Wewiorski, Ph.D., Cheryl Gagne, M.S., William Anthony, Ph.D.

### SUMMARY:

*Objective:* To facilitate future research on recovery from schizophrenia, the recovery process was empirically examined in 12 individuals over a five-year period.

*Methods:* Twelve individuals with a SCID diagnosis of schizophrenia or schizoaffective disorder were selected from a recently concluded five-year experimental study of psychiatric vocational rehabilitation interventions. Each individual was followed for five years. Every four to six months each person participated in a focused, audiotaped interview about his or her current life experiences. Three researchers reviewed interview summaries and interview notes for themes that emerged from these life experiences.

*Results:* The qualitative analysis characterized the process of recovery as having phases, dimensions, indicators, and barriers to recovery.

*Conclusions:* This empirically derived description of the complex process of recovery, from the perspective of people who are experiencing it, can be used to generate research hypotheses for future studies that further our understanding and promotion of recovery from schizophrenia.

## No. 42E
## MULTIPLE DIMENSIONS OF RECOVERY IN EARLY PSYCHOSIS

David Whitehorn, Ph.D., *Department of Psychiatry, Dalhouse University, 5909 Veterans Memorial Lane, Halifax, NS B3H 2E2, Canada;* Jocelyn Brown, Heather Milliken, M.D., Julie Richard, B.A., Lili Kopala, M.D., Qing Rui, M.D.

### SUMMARY:

*Introduction:* We have applied an operational model to describe recovery in five symptom dimensions and two functional dimensions during the critical first year of treatment for a schizophrenia spectrum disorder.

*Methods:* A total of 103 patients, previously untreated with antipsychotic medications, were assessed at baseline, six, and 12 months of continuous treatment with atypical agents in an early psychosis program. Positive and Negative Syndrome Scale (PANSS), Global Assessment of Function Scale (GAF), and Social and Occupational Functional Assessment Scale (SOFA) were used. Five symptom factors/dimensions (positive, negative, disorganized/cognitive, excitement, anxiety/depression) were derived from the PANSS. Symptom remission was defined as no relevant PANSS item greater than "mild." Functional recovery was defined for daily living (GAF > 30) and reintegration (SOFA > 60).

*Results:* At one year 42% of patients achieved remission in all five symptom dimensions. 95% remitted in the excitement dimension and 67% in each of the other four symptom dimensions. 95% achieved functional recovery for daily living; 50% achieved functional reintegration. Symptom and daily living improvements were nearly complete by six months.

*Conclusion:* An operational model can describe differences in the extent and timing of recovery in several different symptom and functional dimensions and delineate clinically relevant patient subgroups.

### REFERENCES:

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# SYMPOSIUM 43—THE INVISIBLE PLAGUE: SEVERE MENTAL ILLNESS

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize that there are reports of schizophrenia (a chronic, non "organic", psychotic illness) since antiquity; that it was not rare, but not as common as today; supporting the notion of schizophrenia as a syndrome with multiple causes, (2) appreciate that social management of the mentally ill in 17th century England evolved from community tolerance of the mentally ill to an increasing tendency to bring such individuals to the attention of local governmental authorities followed by their incarceration in houses of confinement, (3) review the data on the practice of psychiatry in Egypt during the 19th century and question the changes that were instituted, and their possible effect on the increase in the number of psychiatric patients, (4) consider the implications for psychiatric services of a rising incidence of psychoses and realize the need for more research on this question, (5) know the causes of criminalization of persons with severe mental illness.

## No. 43A
## EVIDENCE FOR THE EXISTENCE OF SCHIZOPHRENIA BEFORE 1750 AND WHAT THAT MAY MEAN

Nigel M. Bark, M.D., *Department of Schizophrenia, Bronx Psychiatric Center, 1500 Waters Place, Ward 19, Bronx, NY 10461*

### SUMMARY:

This paper will demonstrate that cases, or constellations of symptoms, that could be schizophrenia have been reported since antiquity, briefly from ancient Babylon and in the Bible, and in detail in the Ayurvedic, sixth century BCE Compendium of Caraka. Mania and melancholia in classical and medieval literature were clearly distinguished from the "organic" delirium and phrenitis, and their symptoms encompass those of schizophrenia. Henry VI of England and his grandfather, Charles VI of France from the 14th and 15th centuries are examples of schizophrenia and schizoaffective disorder, respectively.

In Elizabethan times in England it was common for charlatans to pretend to be licensed beggars discharged from the Bethlem Hospital, suggesting they were not rare. Shakespeare describes Edgar in King Lear in the guise of Poor Mad Tom with history and symptoms of schizophrenia. Jewish, ancient Irish, and early English laws support the idea of chronic mental illness. But the only data to derive rates from are in the notes of Richard Napier in the early 1600s and the highest possible are at most a fifth of present day rates.

*Conclusion:* Schizophrenia always existed, suggesting multiple causes, but at much lower rates than today.

## No. 43B
## MANAGEMENT OF THE MAD IN 17TH-CENTURY ENGLAND: THE RISE OF CONFINEMENT

Richard Neugebauer, Ph.D., *Brain Disorder #53, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

### SUMMARY:

*Background:* Some historians attribute the first widespread use of physical confinement for the insane to 17th century Europeans. Their accounts rely on printed statutes establishing houses of correction; the impact of these statutes on actual social practice has not been investigated.

*Methods:* We examined this question using 17th century English manuscript records from the Lancashire Quarter Sessions—county administrative and law-enforcement meetings. For the periods 1626–35, 1648–60, and 1666–74 we tested whether there was an increase (1) in the number of mentally ill persons referred to the Sessions and (2) in the proportion who thereafter ordered confined.

*Results:* The number of referred cases increased 4.5 fold, from 0.62 cases per year (1626–35) to three cases (1666–74), an increase that held after controlling for changes in population size and overall volume of Sessions business. The proportion ordered confined rose from 0% in 1626–35, to 9% in 1648–60, to 62% in 1666–1674.

*Conclusions:* These findings offer the first quantitative, archival-based estimates of the magnitude of the change in social and governmental handling of the insane in the 17th century. If Lancashire records are representative, then this period does mark a profound shift from tolerance to banishment in the European response to mental illness.

## No. 43C
## POLITICAL INFLUENCE ON PSYCHIATRY: MALEVOLENT OR BENEVOLENT?

Nasser F. Loza, M.B., *Department of Psychiatry, The Behman Hospital, 32 El Marsad Street - Helwan, Cairo 11421, Egypt;* Waleed A.R. Fawzi, M.S.C.

### SUMMARY:

History has repeatedly shown the relationship between changes within services of psychiatric care provided and the patterns of psychiatric illness observed in a community. Yet provision of services was not always driven by the needs of our patients. Other factors, including political economic and academic developments, have often played a role.

Nineteenth century Egypt was a clear example of rapidly occurring changes. Although never formally occupied, the British invaded Egypt in 1882 and remained there till 1952 (Egypt was a British protectorate from 1914 to 1922 only). Yet as early as the 1860s psychiatry had become one of the important justifications for British presence in the country. It was vital that the benefits of western participation in managing Egypt's internal affairs would be perceived in the social and medical fields and not only as a political and economic intervention. These intrusions resulted in changes from a traditional form of community-based faith healers to a western model of asylum care in closed institutions.

## No. 43D
## THE INCREASING INCIDENCE OF PSYCHOSES FROM 1750 TO THE PRESENT

E. Fuller Torrey, M.D., *Stanley Medical Res. Ins., 5430 Grosvenor Lane, Suite 200, Bethesda, MD 20814-2142*

### SUMMARY:

It is widely assumed that the major psychoses, schizophrenia and bipolar disorder, have changed little in incidence for hundreds of years. However, historical data from the United States, England, and Ireland suggest that psychoses have increased approximately five-fold, as a rate per population, over the past 200 years. Data supporting this include past prevalence and incidence studies, official inquiries, asylum building and overcrowding, and concerns expressed by the media and in literature. If the incidence of psychoses is increasing, it has important implications for psychiatric services. It would partially explain the increasing numbers of seriously mentally ill individuals among the homeless, in jails, and on SSI and SSDI, and also the failure of managed care companies to accurately estimate service needs. It would also explain the studies from Denmark and England reporting significant recent increases in first admissions for psychoses.

## No. 43E
## CRIMINALIZATION OF PERSONS WITH MENTAL ILLNESS IN THE 20TH AND 21ST CENTURIES

H. Richard Lamb, M.D., *Department of Psychiatry, Univ. of Southern CA, School of Medicine, 1937 Hospital Place, Los Angeles, CA*

### SUMMARY:

In 1939 Penrose advanced the thesis that a relatively stable number of persons are confined in any industrial society. He found an inverse relationship between prison and mental hospital populations. Penrose theorized that if one of these forms of confinement is reduced, the other will increase. Thus, where prison populations are extensive, mental hospital populations will be small, and vice versa.

Deinstitutionalization would appear to support this theory. While the number of state hospital beds has decreased from 339 to less than 20 per 100,000 population, the number of mentally ill persons in jails and prisons has soared. The factors most commonly cited on causes of mentally ill persons' being placed in the criminal justice system are the unavailability of long-term hospitalization in state hospitals for persons with long-term, severe mental illness; more formal and rigid criteria for civil commitment; the lack of adequate support systems for mentally ill persons in the community; the difficulty mentally ill persons coming from the criminal justice system have gaining access to mental health treatment in the community; and a belief by law enforcement personnel that they can deal with deviant behavior more quickly and efficiently within the criminal justice system than in the mental health system.

Ways of resolving the problems of criminalization will be discussed.

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# SYMPOSIUM 44—THE EVIL STANDARD: MILESTONES AND CHALLENGES

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant (1) will gain appreciation for the range of reservations curtailing the role of behavioral scientists in defining depravity, and the legal, psychiatric, and societal consequences of that avoidance, (2) will gain understanding for the mcthodology and reliability studies employed to define a legal standard for deprived crimes, (3) recognize the applicability of the Depravity Scale to offenders who exemplify the extremes of personality aberration, and whose crimes justify the most stringent isolation from the community, (4) will gain insight into the reliability and validity of the Depravity Scale items, (5) will gain understanding for the methodology employed to develop a dcpravity standard for use in civil settings, and the range of matters to which it will likely contribute.

## No. 44A
## UNDEFINED EVIL: THE LEGAL, PSYCHIATRIC, AND SOCIETAL CONSEQUENCES OF AVOIDANCE

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

### SUMMARY:

The current climate of forensics, increasingly appreciated for its contribution to the evidence that impacts on justice, inspires science to help courts confront the problems judges and juries grapple with daily. Occasionally, demands are made of psychiatry that we feel ill equipped to address. In recent years, these have included risk assessment and the mandated treatment of scx offenders, among others.

With more intense scrutiny of the intents, actions, and attitudes of offenders and of their crimes, we see clear indications that all crimes contain elements that render them truly exceptional. Numerous reasons have been offered, however, for the reluctance with which psychiatry approaches evil. These are revicwed, along with the problems inherent in these imagined obstacles. Unease in confronting evil has kept depravity cloaked but very present, even as the past century witnessed enormous progress in exploring and distinguishing all facets of human behavior, even beyond diagnosis.

While statutes in many states contain aggravating factors for criminal and civil sentencing such as heinous, atrocious, and cruel; wanton, vile, or outrageous, these terms have heretofore been arbitrarily defined—in part because of the neglect of the behavioral sciences.

Psychiatry's absence in defining standards of these behaviors is all the more problematic given our science's willingness to distinguish what is normal and what is psychopathology.

Clinical and forensic psychiatrists and psychologists, as well as social workers and nurses who attend, will learn of the legal, psychiatric, and societal consequences of avoiding the study of evil.

## No. 44B
## RESEARCHING THE DEPRAVITY STANDARD: RELIABILITY IN DEFINING A DISTINCTIVE CRIME

James Seward, Ph.D., *Department of Psychiatry, The Forensic Panel, 3401 N. 81st Street, Scottsdale, AZ 85251*

### SUMMARY:

Public outrage for the notorious inspires a quest for accountability to those whose actions may distinguish their crimes as heinous, atrocious, or vile. Our legacy of cases of unequal justice, however, mandates that terms and the definitions for them be consistent, non-denominational, and non-explorable.

In an effort to bring fairness and rigor to these designations and to this realm, the author has carefully undertaken development of the Crime Depravity Scale. This device assesses the history and evidence reflecting the defendant's actions before, during, and after the criminal offense, paralleling the deconstruction of cases performed in forensic psychiatric assessment.

In order to facilitate a consensus morality, the Depravity Scale Research Project has employed methodology designed to incorporate a full range of opinion and to develop consensus. The Depravity Scale research, in part studying a self-selected population numbering over 3,000, has examined the impact that numerous psychosocial variables has on peoples' attitudes about what is depravity.

The research has identified, with statistical reliability, specific intents, actions, and attitudes that investigating examiners can assist jurors and judges making determinations of depravity. Participant forensic psychiatrists, psychologists, and social workers that conduct assessments, particularly at the pre-sentencing phase, learn of the process of research of this elusive entity, the data gathered to date, and the statistical analysis of these very important research findings.

## No. 44C
## THE DEPRAVITY SCALE IN RELATION TO THE HISTORIES OF 430 CONVICTED KILLERS

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, # 114, New York, NY 10024-6027*

### SUMMARY:

The concept of depravity, as set forth in Welner's Depravity Scale, has two main areas of relevance in psychiatry. First, in the domain of forensics, depravity draws a circle around those persons who commit crimes involving such elements as torture, dismemberment, extreme humiliation, maximal infliction of pain—designated by the public via terms like atrocious, heinous, etc. There is a need within the judicial system to standardize the categorization of such offenders when they are brought to trial, since the community needs the protection afforded by their prolonged or permanent isolation. Secondly, depravity represents the extreme manifestation of personality aberration, composed of the traits of sadistic, psychopathic, malignant narcissistic, or antisocial by proxy—none of which is dealt with adequately in DSM. The "extreme" in DSM is antisocial personality (ASPD), yet some depraved offenders do not meet ASPD criteria, and few persons with ASPD commit depraved actions. Here, a study of 430 biographies of murderers was made, with attention to which offenders showed exceptional loading on the Depravity Scale. The sample is primarily male, 2/3 of whom were also serial killers. The scale items were examined against this sample to determine a number of validity indicators and correlates. The study demonstrated that the Depravity Scale can distinguish exceptional crimes, even among a sample of convicted murderers. These findings underscore the feasibility of distinguishing actions as "evil" (as defined via the scheming to injure severely or to torture others) in the criminal setting, in an objective manner, that will have important implications vis-à-vis sentencing.

### No. 44D
### THE CIVIL EMPLOYMENT DEPRAVITY SCALE: PRELIMINARY ITEMS AND RESEARCH

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

SUMMARY:

While use of the word "evil" invariably attaches to crime, increased appreciation for psychopathy and other personality disorder constructs enhance our appreciation for the remarkably depraved actions of those who are not charged with crimes. As behavioral scientists, we are professionally sensitive to psychological cruelty and the traumas of everyday life.

In civil cases, verdicts that deem actions "outrageous," in employment, personal injury, and malpractice cases, may escalate damages. But can evil in everyday life be standardized for use in civil cases where damages are sought?

Confronting the need to more consistently and clearly identify depravity as it manifests in the community, the author has carefully undertaken development of the Civil-Employment Depravity Scale. The instrument follows the example of the Crime Depravity Scale to distinguish events qualitatively based on intent, actions, and attitudes, independent of the background of the offender and other collateral issues that may bias juries.

Participants will learn of the methodology employed in arriving at specific criteria now being validated for use in civil courts when claimants raise charges of "outrageous" actions. The evidence-based instrument, when validated, will enhance the disposition of claims of hostile work environments and exceptional abuse or neglect, and cases of disputed termination.

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1. Lifton R: The Nazi Doctors, Basic Books, 1986.
2. Menninger K: Whatever Became of Sin? Hawthorn New York 1973.
3. Sione MH: Serial sexual homicide: Biological, psychological and sociological aspects. J Personality Dis 2001; 15: 1–18.
4. Baumeister R: Evil: Inside Human Violence and Cruelty. WH Freeman, NY, 1999.

## SYMPOSIUM 45—BEREAVEMENT AFTER VIOLENT DEATH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize, diagnose, and manage the response to violent bereavement, (2) identify specific developmental reactions of children and adolescents after a violent death, be familiar with specific issues to consider for assessment and apply specific interventions, (3) understand the programmatic essentials for developing clinical services for families after violent death in an outpatient clinic, (4) identify pre- and post-screening instruments used to guide treatment, and (5) recognize intervention strategies that have been shown to reduce distress in a three-year pilot study.

### No. 45A
### THE EFFECTS OF VIOLENT DEATH ON BEREAVEMENT

Beverley Raphael, M.D., *Centre for Mental Health, NSW Health Department, 73 Miller Street, Locked Mail Bag 961, North Sydney NSW 2 2060, Australia*

SUMMARY:

This paper examines the nature of traumatic stressors associated with bereavements that result from violence. It discusses the traumatic stress and bereavement-related phenomenology that occurs in such circumstances and the potential impact on the course and outcome.

Potential interventions that may mitigate traumatic stress effects are reviewed. Identifying and addressing bereavement-related needs is also a key component of response. Potential for preventive intervention is discussed, and treatment interventions relevant to the complex bereavement, PTSD, and mental health outcomes that may follow are also discussed, as are the longer-term adaptations and management. Both clinical and research issues are considered.

### No. 45B
### COMMUNITY-BASED INTERVENTIONS WITH CHILD AND ADOLESCENT SURVIVORS OF HOMICIDE VICTIMS

Alison A. Salloum, M.S.W., *Children's Bureau, 210 Baronne Street Suite 722, New Orleans, LA 70112*

SUMMARY:

In the United States, most homicides occur in urban areas. Many children, adolescents, and their families in urban communities are faced with the aftermath of having a loved one die due to violence while continuing to live amidst violence and impoverished environments. This section of the symposium will highlight a community-based model program that works with low-income urban children and adolescents who have had someone close die due to violence. The effects of grief and trauma on children and adolescents will be explored and specific assessment and treatment approaches will be presented.

### No. 45C
### SURVIVORS OF VIOLENT LOSS PROGRAM

Stephen R. Shuchter, M.D., *Department of Psychiatry, UCSD School of Medicine, 140 Arbor Drive, San Diego, CA 92103;* Connie A. Saindon, M.A.

### No. 45D
### TERRORISM FACTORS THAT EXACERBATE THE EXPERIENCE OF VICTIMS

Kathryn M. Turman, *Victim Assistant, FBI, 935 Pennsylvania Avenue NW #10151, Washington, DC 20535*

SUMMARY:

The handover of two Libyan intelligence agents in 1999 to stand trial in a special court for the 1988 bombing of Pan Am Flight 103 presented unusual challenges for both the families of the victims and the officials charged with helping them understand and participate in the criminal justice process. More than 700 family members were identified and contacted, and approximately two-thirds took advantage of some form of assistance prior to and during the trial. These family members included young adults and adolescents who were children at the time of the bombing. Working in conjunction with Scottish criminal justice agencies, the Office for Victims of Crime in the U.S. Department of Justice designed a support program that encompassed a wide range of services designed to facilitate victim participation and to mitigate the emotional distress associated with the trial. In the process of helping the families, much was learned about their experience and the impact of losing a loved one in a

violent terrorist act that can inform efforts to assist victims in ongoing and future terrorism cases.

### No. 45E
### THE LONG-TERM PSYCHOLOGICAL EFFECTS OF THE WORLD TRADE CENTER DISASTER: COMMUNITY STRATEGIES FOR SUPPORT

Vilma Torres, M.S.W., *Homicide Program, Safe Horizon, 210 Joralemon Street, Room 608, Brooklyn, NY 11201*

REFERENCES:

1. Raphael B, Martimek M: Assessing traumatic bereavement and posttraumatic stress disorder, in Assessing Psychological Trauma and PTSD. Edited by Wilson J, Keane TM. The Guilford Press, New York, 1997.
2. Salloum A, Avery L, McClain RP: Group psychotherapy for adolescent survivors of homicide victims: a pilot study. Journal of the American Academy of Child and Adolescent Psychiatry 2001; 40:1261–1267.
3. Responding to Terrorism Victims: Oklahoma City and Beyond. Office for Victims of Crime, U.S. Department of Justice, 2000.

## SYMPOSIUM 46—DIVERSE APPROACHES TO ALZHEIMER'S SCREENING

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with the clinical utility of the CANS-MCI.

### No. 46A
### MINI-COG

Soo Borson, M.D., *Department of Psychiatry, University of Washington School of Medicine, 1959 N.E. Pacific Street, Box 356560, Seattle, WA 98195;* James M. Scanlan, Ph.D.

SUMMARY:

The Mini-Cog is a three-minute instrument developed for rapid dementia screening of aging populations, including older adults in primary care settings. Its development was based on the following theoretical and practical considerations: a screening tool should capture critical cognitive deficits present in demented individuals; be brief and easily accepted by patients and relatively insensitive to level of education; require little translation or interpretation to administer to the growing non-English speaking older population of the United States; and easily learned by non-professionals. In both community and epidemiological samples the Mini-Cog has performed as well as or better than the MMSE and longer batteries in identifying demented individuals, and is now being tested prospectively in primary care trials.

### No. 46B
### MEMORY IMPAIRMENT SCREEN

Herman Buschke, M.D., *Deparment of Neurology, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, NY 10461*

SUMMARY:

The Memory Impairment Screen (MIS) is an efficient, validated, rapid, and easily administered screen for Alzheimer's disease (AD), which has good sensitivity, specificity, and positive predictive value. Because simple three-word free recall tests frequently used in clinical practice have low specificity, the MIS was developed to provide a more specific and sensitive memory impairment screen. The MIS integrates controlled learning and cued recall to optimize encoding specificity, maximize retrieval, and improve discrimination. Controlled learning is used to learn four items from different categories by identifying each item when its category cue is presented. Memory is tested by free recall and cued recall after a two-minute delay. If any items are not retrieved by free recall, the category cues for those items are provided to elicit cued recall of those items. Using the same cues for learning and cued recall induces "encoding specificity" that optimizes cued recall and increases specificity because nondemented subjects benefit more from encoding specificity.

### No. 46C
### BRIEF ALZHEIMER'S SCREEN

Marta S. Mendiondo, Ph.D., *University of Kentucky, 101 Sanders-Brown Center on Aging, Lexington, KY 40536-0230;* John W. Ashford, Jr., M.D., Frederick A. Schmitt, Ph.D., Richard J. Kryscio, Ph.D.

SUMMARY:

To develop a Brief Alzheimer Screen (BAS), characteristics of the Mini-Mental State Exam (MMSE) items and category fluency were analyzed using a derivation and validation sequence. Data from CERAD (Consortium to Establish a Registry for Alzheimer's Disease), consisting of 406 normal individuals and 342 patients with mild AD (MMSE > 19), were used. Logistic regression was performed on the derivation subgroups. The resulting model for discriminating between these groups included items in the following order: recall (R, 3 points), animals (# in 30 secs, A), date (D, 1 pt), spell (WORLD backwards, S, 5 pts), (all $p < 0.0001$). Logistic regression analysis for identifying AD or control group membership using these most significant variables produced the following equation ($r^2 = 0.77$):

$BAS = 3 \times R + 2/3 \times A + 5 \times D + 2 \times S$

In the validation subgroup for scores of 22 and below, sensitivity was over 98% with specificity of 87% or less. For a score of 27 or greater, the sensitivity was 90% or less and specificity was over 99%. These data support the BAS as adequately powerful for use in screening for patients over 60 years of age for cognitive impairment that could represent early AD.

### No. 46D
### THE COMPUTER-ADMINISTERED NEUROPSYCHOLOGICAL SCREENING FOR MILD COGNITIVE IMPAIRMENT: SELF-ADMINISTERED SCREENING FOR MILD COGNITIVE IMPAIRMENT

Jane B. Tornatore, Ph.D., *Screen, Inc., 3511 46th Avenue, NE, Seattle, WA 98105;* Emory Hill, Ph.D., Jo A. Laboff, B.S.

SUMMARY:

*Objective:* Instruments for MCI measurement provide useful screening information to determine the need for full diagnostic evaluations of dementia. Screening is improved by testing multiple cognitive domains. The Computer Administered Neuropsychological Screen for Mild Cognitive Impairment (CANS-MCI), a fully automated, reliable, valid instrument that measures multiple cognitive abilities, is presented.

*Methods:* A total of 290 elderly community-dwelling volunteers enrolled in a three-year longitudinal NIA-funded study. Analyses included correlations, *t*-tests, factor analyses, ROC curve analyses, and logistic regressions.

*Results:* The usability, reliability and validity of the CANS-MCI were confirmed. Factor analysis supported a three-factor model (Ver-

bal/Spatial Retrieval, Executive Functioning, and Memory) indicating that the tests measure the intended cognitive dimensions. The factor loadings were all significant and ranged from 54 to 96. For sensitivity percentages ranging between 70% to 80% specificity scores ranged from 39%–82%. Logistic regression analyses indicated that a model incorporating 2 CANS-MCI tests correctly classified 86% of the cases.

*Conclusions:* The CANS-MCI is an easily administered, robust screening tool measuring all cognitive dimensions that predict whether professional testing for cognitive impairment is warranted. Analyses to date indicate respectable levels of reliability and validity, a clear representation of the three-primary factors predictive of Alzheimer's, and the ability to distinguish between MCI and normal functioning.

## No. 46E
## BOWLES-LANGLEY TECHNOLOGY/ASHFORD MEMORY TEST ONLINE VERSION

John W. Ashford, Jr., M.D., *Dept of Psych, University of Kentucky, 101 Sanders-Brown Center on Aging, Lexington, KY 40536-0230;* Jon Livingston, Henry Bowles, Ted Langley, Ph.D., Paul Costa

### SUMMARY:

We have developed a brief (one-minute), easy-to-take, computer-based test to distinguish normal individuals from patients with memory difficulties of the type most specific to Alzheimer's disease. This test is based on short-term memory, perception of complex objects, recognition, and recognition reaction-time. The test requires recall of the pictures for recognition later in the series.

Indications from administration of the test to patients presenting for assessment in a memory disorders clinic and controls are that the test clearly discriminates normals from patients with mild cognitive impairment and both of these from mild dementia patients. Most normals make fewer than 10% errors and have a recognition reaction time less than one second. Patients with mild cognitive impairment generally make 10% to 25% errors and have recognition reaction times of 1 to 1.3 seconds. Mild dementia patients make 25% to 40% errors and have recognition reaction times of 1.2 to 1.6 seconds, and patients with moderate dementia score about chance (around 50% errors) with recognition reaction times over 1.6 seconds.

The test can be administered online and is flexible so that scoring can be monitored and the test continually improved to provide more precise and reliable characterization of patients' levels of impairment.

## No. 46F
## STATISTICAL ISSUES IN EVALUATING ALZHEIMER'S SCREENING TESTS

Helena C. Kraemer, Ph.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, PBS-C305, Stanford, CA 94305-5717*

### SUMMARY:

What difference does it make that a test is to be used for screening, rather than for discrimination or definitive diagnosis? What difference does it make that a test is to be used in a general medical practice rather than in a specialty clinic? Such considerations must affect the statistical evaluation of tests, but are frequently ignored. Here we will consider how the fallibility of the "gold standard," the low prevalence in the population, the fixed cost of the test, the cost of false positives, the cost of false negatives, and the benefit of true positives can be considered in the statistical evaluation of such screening tests.

### REFERENCES:

1. Scanian J, Borson S: The Mini-Cog: receiver operating characteristics with expert and naive raters. Int J Geriatr Psychiatry 2001; 16(2):216–22.
2. Kuslansky G, Buschke H, Katz M. Silwinski M. Lipton RB: Screening for Alzheimer's disease: the memory impairment screen versus the conventional three-word memory test. J Am Geriatr Soc 2002; 60(6):1086–91.
3. Mendiondo MS, Ashford JW, Krysclo RJ, Schmitt FA: Modelling mini mental state examination changes in Alzheimer's disease. Stat Med 2000; 19(11–12):1607–16.
4. Chen P, Ratcliff G, Belle SH, Cauley JA, DeKosky ST, Ganguli M: Cognitive tests that best discriminate between presymptomatic AD and those who remain nondemented. Neurology 2000; 55:1847–53.
5. Kraemer HC, Moritz DJ, Yesavage J: Adjusting Mini-Mental State Examination Scores for age and educational level to screen for dementia: correcting bias or reducing validity? Int Psychogeriatr 1998; 10(1):43–51.

# SYMPOSIUM 47—PERSONAL IDENTITY AND BIPOLAR DISORDER

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) discuss impediments to the creation of a narrative life story in patients with bipolar disorder, and identify some of the underlying contributing cognitive problems, (2) recognize some implications (theoretical, ethical, and clinical) of the application of parfitian theories of personal identity to the changing phases of bipolar disorder, (3) appreciate the role self-trust plays in constructing a narrative self and will learn ways in which clinicians can facilitate appropriate self-trust, (4) understand some of the ways in which value judgments come into the diagnosis and management of bipolar disorder.

## No. 47A
## CREATING NARRATIVE FROM DISJUNCTION: THE CLINICAL PICTURE

Deborah Spitz, M.D., *4 Bathurst Road, Norwich NR2 2PP, England*

### SUMMARY:

Bipolar patients experience states of widely different affects and widely different cognitions. Many patients do not remember, when euthymic, what they said, did, thought, and believed in prior manic or depressed states. The consequent difficulty in developing a stable sense of self is particularly problematic for patients with rapid cycling disorders and for patients whose illness presents in adolescence, a time when identity starts to solidify. This presentation will offer clinical material, drawn from psychotherapy with bipolar patients, to illustrate some of the problems posed by a disjunctive experience of self. It will examine data from the field of psychology that address cognitive carry-over from one affective state to another. The presenter will discuss difficulties the patient faces in creating a continuous and enduring identity, and will explore diagnostic and ethical difficulties the clinician experiences in defining historical material and helping to create a narrative.

## No. 47B
## BIPOLAR DISORDER AND PARFITIAN SUCCESSIVE SELVES

Jennifer Radden, Ph.D., *Department of Philosophy, University of Massachusetts, Morrissey Boulevard, Boston, MA 02125*

### SUMMARY:

Numerical identity provided by a transcendental self or subject was traditionally attributed to all persons. Theories such as Parfit's challenge this, arguing that one or several of the relatively enduring, empirically observable sources of continuity ground our judgment that the same self or person is perpetuated through time. Continuity admits of degree, providing a way not only to assign varying degrees of survival between earlier and later self phases, and thus between normal and pathological experiences and lives, but to employ a survival threshold such that the same body might house several selves successively.

On a theory of personal identity such as Parfit's, the states and traits associated with the different phases of bipolar disorder result in transformations radical enough to warrant the title of successive and even recurrent selves. The criteria for successive selves are applied to the manic and depressive "selves" of the bipolar patient. Personal identity implicates categories such as autonomy and responsibility, so some ethical and clinical as well as theoretical consequences of adopting Parfitian theory are also examined here.

## No. 47C
## NARRATIVE SELVES, RELATIONS OF TRUST, AND BIPOLAR DISORDER

Nancy Potter, Ph.D., *Department of Philosophy, University of Louisville, Louisville, KY 40292*

### SUMMARY:

For some people with bipolar disorder, excessive self-trust in the manic phase conflicts with trusting themselves over time, and radical shifts in mood and activity can undermine one's trustworthiness. Difficulties in trust interface with the ability to construct a narrative. Ideally, the narrative self provides an unfolding rationale for the shape that one's life takes; we measure the success of our narratives, in part, by how well we are able to explain our beliefs, desires, and actions to ourselves and others. Many people with bipolar disorder become caught in a double bind where neither self-trust nor narrative can appropriately develop. Clinicians play a crucial role in extricating patients from this double bind. One aim of therapy may be to develop appropriate self-trust and enhance patient trustworthiness through construction of a narrative where the patient is able to make sense of her changes to herself and others. Because explanations of change from one mood or set of desires to another need to be deep enough to facilitate trust relations, the criteria for a narrative self must not be overly demanding of unity and similarity. This aim requires that the clinician be trustworthy in regard to the specific vulnerabilities of patients with bipolar disorder.

## No. 47D
## VALUES AND THE NATURE OF BIPOLAR DISORDER

Kenneth Fulford, *Department of Philosophy and Psychiatry, Warwick University, Oxford University, Coventry CV4 7AL, United Kingdom*

### SUMMARY:

In bipolar disorder the values and beliefs of a patient may vary widely between their manic, depressed, and euthymic states. The issues that these variations raise for personal identity will be illustrated with the case history of a man, Mr. M, with a diagnosis of mild mania, who periodically refused medication (with lithium), and whose values were radically different in his medicated and unmedicated states. In Mr. M's case there is no unequivocal answer to the question "Who is the real Mr. M?" The wider practical implications of Mr. M's case, for the diagnosis and management of bipolar disorder will be outlined, focusing in particular on some of the ways in which value judgments, as well as careful assessment of the facts, bear on clinical decision making in psychiatry and medicine.

### REFERENCES:

1. Power MJ, et al: The organization of self concept in bipolar disorder: an empirical study and replication. Cognitive Therapy and Research 2002; 26:553–561.
2. Parfit D: Reasons and Persons. Oxford University Press, 1984.
3. Gillett G: The Mind and Its Discontents: An Essay in Discursive Psychiatry. Oxford, Oxford University Press, 1999.
4. Moore A, Hope T, Fulford KWM: Mild mania and well-being. Philosophy Psychiatry, & Psychology 1994; 1(3):165–177.

# SYMPOSIUM 48—THE SPECTRUM OF SEXUAL VIOLENCE: CLINICAL AND CULTURAL IMPACT

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the importance of intervening with adolescents who have histories of sexual abuse and risk behaviors, (2) better comprehend appropriate evaluation of sexual molestation against boys in the church, (3) will be able to distinguish internet channels used to distribute images of sexual violence, (4) recognize the vast differences in health behaviors, attitudes and norms between female adolescents with and without dating violence histories, and (5) be able to identify screening items for dating violence. They will also gain knowledge of the frequency of dating violence among adolescents and the reported screening practices of AACAP members.

## No. 48A
## CHILDHOOD SEXUAL ABUSE AND LATER ADOLESCENT RISK BEHAVIOR

Larry K. Brown, M.D., *Dept of Child Psychiatry, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903;* Celia M. Lescano, Ph.D., Kelsey M. Latimer, B.A.

### SUMMARY:

*Objective:* To describe the relationship between child sexual abuse (CSA) and adolescent risk behavior and provide rationale for intervening with these at-risk teens.

*Method:* Relevant literature and components of a skills-based intervention in adolescents with psychiatric disorders. An ongoing project assessed 264 adolescents regarding sexual abuse and currents sexual behaviors.

*Results:* Logistic analyses adjusting for gender and impulsivity found that a history of sexual abuse was strongly associated with inconsistent condom use (O.R. = 3.1, p = .01). A history of CSA places adolescents at particular risk for engaging in risky sexual and drug-use behaviors. Targeting affect management and cognitive restructuring in adolescents with a history CSA is important in sexual risk reduction. Current research demonstrates specific strategies that target affect and cognition about sexual behavior in order to reduce risk.

*Conclusion:* Targeting specific sequelae of CSA may help to reduce risk behaviors in adolescents.

## No. 48B
## PERSPECTIVES ON SEXUAL MOLESTATION OF BOYS BY ROMAN CATHOLIC PRIESTS

Lynn E. Ponton, M.D., *206 Edgewood Avenue, San Francisco, CA 94117-3715*

SUMMARY:

*Objective:* Both physical and sexual abuse are underreported by adolescent boys. Our culture does not look kindly upon "victims," whether male or female, but boys who have been victimized may be even more prone to feelings of intense shame. This silence is intensified when the abuser is a religious leader such as a priest. Boys remaining silent are only part of the story. Many parents fail to believe their sons when they do tell. The silence is intensified by the Roman Catholic Church, which has denied that sexual abuse by Catholic priests is taking place. When "episodes" with priests are discovered, the men are shifted to other parishes. Inadequate treatment efforts have been recommended. Priests are not the only perpetrators. Boys have been abused by ministers, rabbis, and other trusted religious leaders.

*Objectives:* This presentation will address this complex area of sexuality and power identifying clearer definitions, assessment, treatment, and prevention and underscore the role of the child and adolescent psychiatrist.

*Method:* Case vignettes illustrate this area.

*Conclusion:* Psychiatrists need to understand the possible roles of the child psychiatrist in this complex area and recognize the impact on the children, families, and communities that we work with.

## No. 48C
## SEXUAL VIOLENCE ON THE INTERNET

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

The Internet is becoming ubiquitous. It is being regarded as a necessity for all children and adolescents, both for their current and future educational experiences. Sexual violence is also ubiquitous on the Internet. There are over 30,000 sexual sites demonstrating pornography on the Internet, and among them are a substantial number demonstrating sexual violence toward women. The distribution channels have now expanded to include video, Web cam streaming, and increasingly, online chat rooms in which women are portrayed as being either participating in gang sex or gang rape. This far exceeds any previous distribution routes regarding either the quantity or the mass of the pornography that has been distributed. It is of concern because of the nature of the pornography that is being distributed, balanced toward misogynistic violence.

This presentation will review the significance of the Internet, the scope of sexual material on the Internet, and the prevalence of the sexual violence within the context. Its potential impact on children and adolescents will be reviewed.

## No. 48D
## DATING VIOLENCE AND AFRICAN-AMERICAN ADOLESCENT FEMALES' SEXUAL HEALTH

Ralph DiClemente, Ph.D., *Department of Pediatrics & Psychiatry, Emory University, 1518 Clifton Road, Atlanta, GA 30322;* Gina M. Wingood, Sc.D.

SUMMARY:

*Objective:* This study examines the association between dating violence and the sexual health, behaviors, norms, and attitudes of African-American female adolescents.

*Methods:* Sexually active African-American females between the ages of 14 and 18 were given a self-administered survey and structured personal interview regarding dating violence and sexual behaviors and attitudes. Adolescents with a history of dating violence were then compared with those without with respect to specified outcomes.

*Results:* A total of 522 single, African-American females, 14–18 years, participated in this study. A history of dating violence was reported by 18.4% (N = 96). In logistic analysis, a history of dating violence was associated with poorer sexual health indices, increase in STDs (O.R. = 2.8, $p < .01$), non-monogamous partners, pregnancy and risky attitudes, and a decrease in condom use (O.R. = 0.5, $p < .01$). Dating violence history was also associated with increase in fear of communication regarding pregnancy prevention and consequences of negotiating condom use.

*Conclusions:* Identification of a history of dating violence provides an opportunity for appropriate referral for counseling and education, including pregnancy, HIV, and STD prevention. Helping adolescents deal with dating violence could be an essential element in reducing their risk of pregnancy, STDs, and HIV.

## No. 48E
## ADOLECENT DATING VIOLENCE: SCREENING PRACTICES OF CHILD AND ADOLESCENT PSYCHIATRISTS

Kristie Puster, Ph.D., *Department of Child Psychiatry, UNC-Asheville, Asheville, NC 28802;* Celia M. Lescano, Ph.D., Kelsey M. Latimer, B.A.

SUMMARY:

*Objective:* This project explores the screening practices for adolescent dating violence among psychiatrists in the American Academy of Child and Adolescent Psychiatry (AACAP).

*Methods:* AACAP members with active e-mail addresses were invited to complete an Internet questionnaire regarding screening practices for dating violence and risk behaviors.

*Results:* Two-hundred sixty eight (9.3%) of the 2,889 AACAP members contacted have completed the survey to date, although data collection is still ongoing. Only 20% of clinicians reported screening for dating violence "more than 90%" of the time, compared with 75% who screened for suicidal ideation and 60% who screened for sexual abuse "more than 90% of the time." Practitioners who had ever identified dating violence in a patient ($\chi^2 = 20.21$, $p = 0.001$) and those who had identified dating violence in a patient within the last year ($\chi^2 = 12.94$, $p = 0.024$) were more likely to screen for dating violence than those who had not. Of behaviors associated with dating violence, clinicians were most likely to ask about "forced sex."

*Conclusions:* Despite the prevalence of dating violence, it is screened far less often than other problem behaviors or adverse experiences. The experience of identifying dating violence was associated with more active screening practices, emphasizing the need for consistent screening.

REFERENCES:

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# SYMPOSIUM 49—ADVANCES IN UNDERSTANDING AND TREATING CHRONIC

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should (1) demonstrate understanding of the basic principles of cognitive behavioral analysis system of psychotherapy for chronic depression, (2) recognize the importance of psychosocial outcomes in the treatment of chronic depression and understand methods for their assessment, (3) recognize that patients with chronic depression are not necessarily treatment resistant and require and benefit from long-term pharmacotherapy and/or psychotherapy, (4) recognize the relative efficacy of two psychotherapies and medication for chronic depression.

## No. 49A
## CLASSIFICATION AND NATURAL HISTORY OF CHRONIC DEPRESSION

Daniel N. Klein, Ph.D., *Department of Psychology, SUNY Stony Brook, Psychology B Building, Stony Brook, NY 11794-2500*

SUMMARY:

I will examine the similarities and differences between chronic major depression, double depression, and dysthymia, and between chronic and non-chronic depressions drawing on data from two multisite clinical trials (each N > 600) and a family and follow-up study (N = 142 patients). The first part of the talk will focus on comparing the groups on symptoms, previous course, comorbidity, family history, and treatment response. I will argue that the similarities between the forms of chronic depression outweigh the differences, but that chronic depressions differ from non-chronic major depression in a number of important respects. I will also argue that while the current distinctions between the various forms of chronic depression have limited validity, the distinction between early- and late-onset chronic depression has important correlates.

The second part of the talk will focus on the naturalistic course of dysthymia and double depression. I will present preliminary findings from a seven and a half-year prospective follow-up study, including data on recovery and recurrences of dysthymia, predictors of outcome, and comparisons between dysthymia, double depression, and non-chronic major depression on levels of depressive symptoms and psychosocial functioning over time. I will conclude by discussing implications for treatment and clinical trials.

## No. 49B
## COGNITIVE-BEHAVIORAL ANALYSIS SYSTEM OF PSYCHOTHERAPY

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

SUMMARY:

Cognitive Behavioral Analysis System of Psychotherapy (CBASP) has been shown to be an effective treatment for chronic depression, particularly in combination with antidepressant medication. CBASP's basic premise is that what distinguishes the chronically depressed patient is failure to understand relationships among one's thoughts and behaviors and the outcomes one produces. Its core procedure, "situational analysis" (SA), is designed to facilitate understanding of such relationships and increase interpersonal effectiveness. This presentation will provide an overview of the SA procedure, including focus on the following aspects of a discrete interpersonal encounter: (1) what took place, (2) patient interpretations, (3) verbal/nonverbal behaviors, (4) the actual outcome, and (5) the desired outcome. We will review self-monitoring procedures and in-session prompts used to examine how each thought and behavior contributed, or did not contribute, to achieving the identified desired outcome. In addition, we will discuss how, when there is a discrepancy between actual and desired outcomes, the patient is asked to formulate changes in thinking and behaviors appropriate to achieving a realistic and attainable desired outcome. We will also cover SA's generalization phase where depression maintaining patterns are identified & the patient & therapist discuss how what has been learned can be applied to other situations.

## No. 49C
## TREATING CHRONIC DEPRESSION: PSYCHOSOCIAL OUTCOMES

James H. Kocsis, M.D., *Department of Psychiatry, Cornell University Medical School, 525 East 68th Street, 13th Floor, New York, NY 10021-0012*

SUMMARY:

Chronic forms of depression are associated with significant functional and psychosocial impairment. Treatment of chronic depression with antidepressant medications and/or psychotherapy may lead to rapid and persistent improvement of psychosocial functioning in addition to improvement of depressive symptoms. Thus it is important to assess and target psychosocial impairment measures as a part of the treatment program for chronically depressed patients.

This presentation will review chronic depressive treatment studies that have reported psychosocial outcomes and discuss the implications of the results. Both pharmacotherapy and psychotherapy have yielded rapid and dramatic psychosocial improvement in a subgroup of the patients treated. Combined treatment produced an even more significant effect on psychocial measures. In one recent study of long-term treatment (Kocsis et al, 2002), substantial worsening in psychosocial function measures occurred in patients taking placebo compared with sertraline during 18 months of maintenance. In the subsample of patients who reviewed in remissions throughout maintenance, most of the observed improvement in psychosocial functioning occurred during the acute phase of treatment.

Long-term treatment of chronic depression can result in sustained psychosocial benefits across a broad range of family, marital, and work-related indexes. It is important to assess and optimize psychosocial improvement during chronic depression treatment.

## No. 49D
## CONTINUATION, MAINTENANCE, AND CROSSOVER RESULTS OF CLINICAL TRIALS

Alan J. Gelenberg, M.D., *Department of Psychiatry, University of Arizona Health Science Center, 1501 North Campbell/PO Box 245002, Tucson, AZ 85724-5002*

SUMMARY:

Two recently completed long-term trials of patients with several forms of chronic depression now have been completed. The data are consistent with previous trials by Kocsis et al. and others. In general, patients with different subtypes of chronic depression respond similarly to antidepressant pharmacotherapy or a specific form of psychotherapy (CBASP), with response rates of approximately 50%. One study showed a significantly improved short-term benefit in patients

who received both an antidepressant and CBASP. Patients with chronic depression who do not respond to an initial treatment often respond to a second alternative. Continuation therapy for several months is important, and many patients secure further benefit over the additional timeframe. Maintenance therapy also is beneficial, although the rate of recurrence of patients switched to placebo is not as great as observed in patients with multiple prior episodes of recurrent major depressive disorder.

### No. 49E
### INTERPERSONAL PSYCHOTHERAPY FOR CHRONIC DEPRESSION

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical College, 525 E. 68th Street, Room 1322, New York, NY 10021*

SUMMARY:

Interpersonal psychotherapy (IPT) is a time-limited treatment that has repeatedly demonstrated efficacy in several trials for acute major depression. It has also shown benefits as a prophylactic treatment for recurrent episodic major depression. This presentation will report results from several related NIMH-funded trials testing an adaptation of IPT as a treatment for dysthymic disorder (IPT-D) and chronic major depression: IPT was adapted to meet the particular problems of this chronically ill, chronically hopeless population.

A randomized, controlled comparison (N = 86) of IPT-D, sertraline, supportive psychotherapy (SP), and IPT-D plus sertraline found improvement across cells, with no statistically significant difference between cells. In post hoc analyses, however, pharmacotherapy with or without IPT appeared superior to either psychotherapy alone. Two other trials compared IPT-D to SP for patients with "double" depression (major depression superimposed on dysthymic disorder) and for chronic depression with comorbid alcohol abuse; in the latter study both groups were also encouraged to attend Alcoholics Anonymous meetings. These trials also indicated improvement over time without differences between treatment cells. The implications of these intriguing if underpowered studies will be discussed.

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## SYMPOSIUM 50—BOUNDARY CROSSINGS: CREATIVE THERAPY OR SLIPPERY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) demonstrate a knowledge of the differences between boundary crossings and violations and how to evaluate the risks/benefits of an anticipated boundary crossing, (2) analyze boundary crossing decisions from a risk-benefit perspective; understand the limitations of the concept of the "slippery slope," (3) understand the possible use of non-sexual touch in psychotherapy and recognize the appropriate method of incorporating it into treatment, (4) analyze boundary crossing decisions from a risk management perspective; understand appropriate consultation and its documentation.

### No. 50A
### BOUNDARY VIOLATIONS VERSUS BOUNDARY CROSSINGS

Gail E. Robinson, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada*

SUMMARY:

Boundary violations involve behavior or language that serve only the therapist's interests while causing physical or psychological harm to the patient. Sexual activity of any type is always a boundary violation. Boundary crossings involve behavior or language that deviates from the normal "rules" of therapy. Such crossings may involve changes in the length or venue of sessions, use of language, non-sexual touching, or self-disclosure. Before crossing any boundaries, therapists must consider a number of questions: Why am I thinking of this behavior with this patient at this time? How well do I know the patient? How sure am I about the effect on the patient? Am I doing this for the patient's or my benefit? Therapists need to know how to evaluate their actions and differentiate between behavior that is never acceptable versus that which is sometimes acceptable and, if so, under what circumstances.

### No. 50B
### CREATIVE MOMENTS AND CHALLENGING EVENTS IN THERAPY: BENDING RULES TO HELP

Gary R. Schoener, Psy.D., *Walk-in Counseling Center, 2421 Chicago Avenue, South, Minneapolis, MN 55404*

SUMMARY:

The concern about sexual misconduct by professionals led to an ever broadening concern about boundary violations and the concept of the "slippery slope"—the notion that one boundary violation leads to another and then another. The difference between boundary crossings became blurred with boundary violations and the concept of "dual relationships" seemed a murky warning that any "gray area" might be a minefield.

However, if there is anything that characterizes psychotherapy, it is unique situations and unique challenges. Small towns, college campuses, and membership in a minority group can easily lead to many overlapping relationships and encounters with clients. This presentation will examine a number of areas in which a boundary crossing might be therapeutically indicated and might represent a creative approach to a unique problem.

Issues to be discussed will be attendance at social events such as weddings, funerals, and graduations. Therapist self-disclosure, long acknowledged as a major risk, will be discussed in terms of situations in which the client may benefit from self-disclosure. The concept of respectful equidistance important in relational approaches to therapy will be discussed with regard to therapist neutrality and gratification. The presentation will pose the question as to whether a creative therapist can at times operate "outside the box" and yet provide effective and safe therapy.

The presenter will examine therapist self-examination as well as the role of colleagues who provide consultation in terms of decision-

making in cases where the therapist is considering breaking his or her own rules. The position taken will be similar to that of Kroll (2001) that the concept of the "slippery slope" is itself somewhat slippery.

## No. 50C
## IS PHYSICAL TOUCH STILL A TABOO IN PSYCHODYNAMIC PSYCHOTHERAPY?

Howard E. Book, M.D., *2900 Yonge Street, Suite 101, Toronto, ON M4N 3N8, Canada*

### SUMMARY:

This paper explores possible indications, during psychodynamic psychotherapy, for physical contact with patients. It begins by first historically overviewing how such prohibitions against such contact came into being; and more recently, how current theoretical approaches may support such contact. This presentation then outlines how both perspectives address touching as a boundary crossing and outlines crucial differences between boundary crossings and boundary violations.

The main focus of this paper is in its hypothesis that there is a certain group of patients who, during specific clinical situations, may benefit from physical contact. In particular, it suggests that this group of patients have personality disorders more a reflection of deficits, rather than conflicts in early parent-child interactions. It also outlines how these patients, during specific clinical situations characterized by intransigent, overwhelming, and fragmenting affects, may be unable to modulate these feelings despite the therapist's maintaining vital self-object transferences and offering other supportive psychological activities, but may respond to physical contact by feeling soothed and becoming able to contain and regulate these affects.

This paper also stresses the importance of the therapist asking permission prior to initiating physical contact, exploring the meaning such contact has for the patient, as well as scanning for shifts in transference, therapeutic alliance, or behavior that might signal that eroticization of the relationship has occurred and requires psychotherapeutic attention.

## No. 50D
## PROFESSIONAL BOUNDARIES: NAVIGATING GRAY AREAS AND AVOIDING LEGAL TROUBLE

Linda M. Jorgenson, J.D., *Spero and Jorgenson, 24 Thorndike Street, Cambridge, MA 02141*

### SUMMARY:

The 1980s and 1990s were marked by many licensure board actions and civil suits in which boundary violations were alleged. In many the focus was sexual contact with patients. However, that is a small piece of the picture. The realities of clinical practice bring about situations in which there are gray areas as regards the maintenance of professional boundaries. It is possible to cross boundaries with a therapeutic intent and not be said to have "violated" boundaries.

This presentation will examine what rules and standards exist that lead to difficulty with licensing and regulatory bodies, and which can also be the subject of civil suits. The presenter, an attorney, has represented clients in civil suits but has also advised psychiatrists and other professionals and contributed to the psychiatric literature on boundaries.

She will examine the role of consultation and supervision in examining proposed boundaries crossing as well as documentation that will provide for both a good clinical record and risk-management style protection. She will also discuss risk assessment that a reasonable and prudent psychiatrist should undertake before departing from his or her normal standard of practice. She will also discuss the concept of the standard of care and ways in which a practitioner can be aware of these standards. This will include a discussion as to what variability there is between standards for various therapeutic approaches—supportive therapy, psychodynamic therapy, cognitive-behavioral approaches, and medication management.

Social contacts with current and former clients, holding and other forms of touch, giving and receiving gifts; self-disclosure, and other issues will be examined from a legal risk management perspective. This involves a balancing of clinical thinking and an awareness of various pitfalls in taking risks with certain clients.

### REFERENCES:

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2. Kroll J.: Boundary violations: a culture-bound syndrome. J Am Acad Psychiatry & Law 2001; 29:274–283.
3. Hunter M. Struve J: The Ethical Use of Touch in Psychotherapy. Satget, Newbury Park, Calif, 1997.
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# SYMPOSIUM 51—WOMEN PSYCHIATRISTS USING SCIENCE TO HEAL

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) demonstrate knowledge regarding gender differences in dealing with emotional problems in competitive athletes, and recognize risk factors for psychological problems in competitive athletes, (2) understand both the similarities in trauma themes and differences in leadership style of women concentration camp survivors, (3) demonstrate the resources and skills needed to pursue multicultural genetics research and pursue a research career as women in academic medicine, (4) be able to recognize contributions made by women in culturally appropriate care delivery, (5) have an increased sensitivity to and awareness of cultural influences on mental health service delivery and gender effects on addiction treatment, (6) recognize the potential role of neurosteroids in the pathophysiology and pharmacological treatment of psychiatric disorders, (7) discuss the many cultural factors that can be used to either facilitate or hinder medical education across boundaries of language and sociocultural identity.

## No. 51A
## PSYCHOLOGICAL ISSUES AND WOMEN ATHLETES: IN A LEAGUE OF THEIR OWN

Altha J. Stewart, M.D., *Wayne State University, 200 Riverfront Drive # 28-B, Detroit, MI 48226*

### SUMMARY:

In the 30 years since the passage of Title IX, women athletes remain "on the sidelines" compared with their male counterparts. Women athletes face the same issues as other women in the same age range in general society in the areas of career and relationships. They also experience certain problems unique to their status as athletes. Depending on their athletic skill and ability, they may have limited experience in setting goals outside the athletic arena. Too often the principal focus on their continued achievement means that the emotional and psychological needs of athletes do not get the attention they require. Those who do seek help must also deal with the societal and social stigma surrounding seeking treatment for

emotional problems that may have an impact on their image, status, and performance. Further complicating the matter is the fact that there are few controlled studies on emotional issues in either female or male athletes to guide treatment interventions.

The presentation will include a review of psychiatric literature available on women in sports, as well as a discussion of diagnosis and treatment of some of the psychiatric problems that may present in athletes and the unique issues facing the clinician evaluating athletes.

## No. 51B
## CATHOLIC AND JEWISH WOMEN SURVIVORS OF THE NAZI CAMPS: INSIGHTS

Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 323 East Chestnut Street, Louisville, KY 40202*

SUMMARY:

Data and insights gained ethnographic research based on a 13-page, semi-structured interview given to Catholic and Jewish women who were Nazi camp survivors will be presented. These interviews were conducted in Poland in 1989, in Israel in 1991, and in the U.S. The Catholic women who were captured working in the Polish Underground often were put in camps because of their religion. Often they were graduate students. The Jewish women were put in camps because of their religion. Survivors also had different experiences: Polish Catholic women were often returned to families, Jewish women were often sole survivors. Courage in the camps by all, including caring for and protecting each other and the use of song were unique. Examples will be offered. Common psychological themes will be discussed. Women survivors' compelling leadership styles will be contrasted and reviewed. Finally, practical applications—lessons learned that can be transferred to clinical work with trauma survivors—will be discussed.

## No. 51C
## PURSING GENETICS STUDIES IN HOMOGENOUS PORTUGUESE POPULATIONS

Michelle T. Pato, M.D., *Department of Psychiatry, SUNY Upstate Medical University, 750 East Adams Street IHP, Syracuse, NY 13210;* Emanuela Mundo, M.D., Carlos N. Pato, M.D.

SUMMARY:

Our work has focused on the genetics of schizophrenia and bipolar disorder in a homogenous sample living in Portuguese-speaking populations in mainland Portugal, the Azores Islands, and Madeira. In doing this work, it has been critical to establish rapport in a culturally sensitive way with the treating clinicians, patients, and family members in the communities we have studied.

Preliminary findings in these samples, following over 10 years of work, have borne out our original assumptions about the power of studying such a homogenous sample. The prevalence of .28% for schizophrenia on the main Azorean island of Sao Miguel is less than the 1% usually reported; however the incidence of familiar illness has been much higher, approximately 65% rather than 15%. As expected in this sample, more families might share the some genetic form of a disorder. Our preliminary findings also reveal that while the general sample showed an earlier age of onset among males ($23.7 \pm 8.1$ sd in males vs $27.5 \pm 9.5$ sd) ($t = 2.861$, $p = 0.005$ in females) with schizophrenia when only familial cases were considered, there was both and earlier age of onset and no difference due to gender (($24.4 \pm 8.3$ sd in familial vs $27.7 \pm 9.8$ sd nonfamilial cases) ($t = -2.315$, $p = 0.02$).

Pursuing a career path almost exclusively in research, has been challenging but it has allowed for the opportunity to forge new role definition both as a psychiatrist and as a woman in academic medicine.

## No. 51D
## OUTREACH TO THE INDIGENT MENTALLY ILL IN RURAL INDIA

Geetha Jayaram, M.D., *Department of Psychiatry, Johns Hopkins University School of Medicine, 600 North Wolf Street, M-101, Baltimore, MD 21287*

SUMMARY:

Schizophrenia and epilepsy are the most prevalent of mental illnesses in the rural population in Anekal Taluk, a rural area in Karnataka, India. Poor mentally ill villagers, estimated at 17% of patients at primary health care centers, are unassessed and untreated. The World Bank in 93 reported that Disability Adjusted Life Year Loss from neuropsychiatric disorders exceeds that from all infectious diseases.

A woeful lack of resources and infrastructure greatly differentiates the plight of villagers compared with their Western counterparts. In Anekal Taluk, among a population of 54, 820 persons, at least 2,500 remain untreated.

Using creative means, we collected funds through a collaboration of the Maryland Psychiatric Society and the Rotary Club of Columbia by holding seminars on women's disorders. Grant funds generated will enable phased treatment delivery; women's groups will be utilized to identify/help monitor patients. Further phases are expected to provide ongoing treatment.

Using culturally sensitive means, women's groups will be trained in identifying patients, providing much needed support, integration into primary health care, and manpower.

We expect to identify approximately 488 patients in two years. Funds will continue to be generated to sustain care.

## No. 51E
## INNOVATIVE MODELS FOR MENTAL HEALTH SERVICES TO WOMEN IN HAWAII

Leslie H. Gise, M.D., *John A. Burns School of Medicine, 233 Naalae Road, Kula Maui, HI 96790-9462*

SUMMARY:

This presentation highlights community mental health services in Hawaii. Studies have found that mental health services are not reaching minorities and addiction treatment is not geared toward women. Two innovative programs that are sensitive to the culture and needs of women with severe mental illness will be discussed. A clinical case will illustrate key points. First, clinical research from the Maui Community Mental Health Center on an outpatient group therapy intervention to severely mentally ill persons will be presented. This intervention model is associated with less psychiatric hospitalization, improved medication adherence and as well as increased sensitivity to cultural and gender issues. An innovative community program treatment model for women with addictive disorders will also be discussed. The Malama Family Recovery Center provides addiction treatment and psychiatric consultation to pregnant and parenting women with an emphasis on Hawaiian culture. Most participants are part-Hawaiian, single mothers, lacking a high school education and often addicted to crystal methamphetamine, "batu" or "ice".

A clinical case presentation will illustrate the challenge of reaching out to underserved women with severe and persistent mental illness. A multimodal intervention plan will highlight mental health services

that integrate the culture of the patient, e.g., crisis planning, a Hawaiian healing, and group treatment.

Providing innovative group treatment models for women and integrating these mental health services within the cultural context will be highlighted.

## No. 51F
## FROM BENCH TO BEDSIDE: NEUROSTEROIDS AND GENDER DIFFERENCES IN PSYCHIATRY

Christine E. Marx, M.D., *Department of Psychiatry, Duke University, 508 Fulton Street 116A, Durham, NC 27705*

### SUMMARY:

The term "neurosteroid" refers to steroids formed *de novo* in the brain or from peripheral steroid precursors that cross the blood-brain barrier readily. Many neurosteroids are also neuroactive, and exhibit rapid actions on neuronal excitability. Neurosteroids such as allopregnanolone bind with very high affinity to inhibitory $GABA_a$ receptors and potentiate GABA neurotransmission with 20-fold higher potency than benzodiazepines. The physiologic functions of these potent endogenous molecules in the human brain remain to be elucidated, but increasing evidence suggests that neurosteroids may play a role in the pathophysiology and pharmacologic treatment of psychiatric disorders. Since many neurosteroids are differentially regulated in females compared with males, they are also potential modulators of gender differences observed in depression, schizophrenia, and anxiety disorders.

Neurosteroids have been linked to the reduction of depressive symptoms following treatment with SSRIs, and these molecules are also altered following the administration of certain atypical antipsychotics in rodents. It is possible that neurosteroid induction may contribute to the efficacy of these compounds and to the gender differences in treatment response observed in certain psychiatric disorders such as schizophrenia. Neurosteroids are also neuroprotective in a number of different experimental models. Finally, many neurosteroids increase with stress and demonstrate pronounced effects on the hypothalamic-pituitary-adrenal axis. This presentation will focus on the most recent findings in the neurosteroid field, and the potential relevance of these unique molecules to the gender differences observed in a number of psychiatric disorders.

An innovative collaborative research training model of partnering with scientists from Germany will also be discussed.

## No. 51G
## HIV AND MENTAL ILLNESS EDUCATION INITIATIVE IN SUB-SAHARAN AFRICA

Mary Kay Smith, M.D., *Department of Psychiatry, Medical College of Ohio, 3120 Glendale Avenue, RHC 0079, Toledo, OH 43614-5808*

### SUMMARY:

In an attempt to teach individuals in Sub-Saharan Africa about HIV infection/AIDS and mental illness, it is necessary to understand their sociocultural identities and the cultural factors that impact definitions of health and disease. These factors, along with the roles that religious and supernatural beliefs play in the lives of these individuals, will be discussed in the context of helping or hindering a paradigm shift. The ability to change the conceptual framework of health and illness via communication within a common belief system (in this case, Christianity) will be examined, as will ongoing efforts to provide education about HIV infection/AIDS and mental illness across multiple nations, languages and cultural belief systems. The importance of finding a "common ground" across cultures in translating Western scientific knowledge into healing will be reviewed, along with the effect of gender in that process.

### REFERENCES:

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7. Patel V, et al: Depression in developing countries: lessons from Zimbabwe. BMJ 2001; 322:482–484.

# SYMPOSIUM 52—DARWINIAN EVOLUTION AND PSYCHOPATHOLOGY

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) have enriched understanding of the evolutionary epidemiology of mood adaptation and disease, (2) understand evolutionary developmental factors in adaptation and disease, (3) understand darwinian concepts relevant to clinical diagnostic and treatment, (4) have enriched understanding of psychopathology via evolutionary science.

## No. 52A
## EVOLUTIONARY EPIDEMIOLOGY AND THE NEUROPSYCHIATRY OF MANIA AND 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, 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. Old adaptations can be operationally released often in pathological circumstances as when functional tensions arise between R-complex and upper cortical operations to induce pathophenotypes such as mania depression and thought disorder. Retentions were modified in the course of integration with newer 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. The Hawk-Dove ESS examples deeply canalized, successive, and genetically polymorphic triune neuromentalities entirely compatible with both the basic and clinical science genome to mania-depression (Price, 1998).

## No. 52B
## EVOLUTIONARY DEVELOPMENTAL PSYCHOPATHOLOGY

Ian Pitchford, Ph.D., *Department of Psychiatry, Sheffield University, Center for Psychotherapeutics, Sheffield S3 7RE, United Kingdom*

### SUMMARY:

The idea of domain-specificity has increasingly emerged as part of evolutionary psychology over the last 10 to 15 years. It is little appreciated how, for nearly two centuries, this notion has been central to neuroscience and neurology—its origins lay in a paper read by Marc Dax in Montpellier in 1836 detailing "a series of clinical cases demonstrating that disorders of speech were constantly associated with lesions of the left hemisphere." In order to have any reasonable chance of predicting the consequences of a lesion, the first question any neurologist must answer is "which brain structures are involved?" Some modules, such as the thalamo-amygdala circuits involved in fear conditioning, play such a key role survival that they have been conserved for tens of millions of years. According to a paper I came across recently, in turns of volume the centromedial nucleus of the amygdala is the only brain structure in primates to correlate with life-span (Allman, 1993). In general terms it is legitimate to claim that neuroscience validates the concept of domain-specific functions that has become a tenet of evolutionary psychology.

## No. 52C
## CLINICAL EQUIVALENTS IN PHENOTYPIC EXPRESSION: IMPLICATIONS FOR RESEARCH AND CARE

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

### SUMMARY:

This paper reviews current landmarks in evolutionary phenomenological nosology.

Patients with major psychopathology frequently meet criteria for other psychiatric and substance abuse diagnoses via what is typically referred to as comorbidity. For example, impulse dyscontrol, eating disorders, obsessive-compulsion, and severe anxiety syndromes appear to be phenotypic equivalent expressions of bipolar disorder in some patients. In contrast, other diagnoses appear to represent truly distinct disorders though possibly more prevalent among patients with other primary diagnoses due to shared risk factors. Future studies examining the course of co-occurring syndromes are warranted, particularly those derived from explicitly evolutionary hypotheses.

## No. 52D
## EVOLUTIONARY PSYCHIATRY: THE END OF THE BEGINNING

Hagop S. Akiskal, M.D., *Department of Psychiatry, University of California at San Diego, 3350 La Jolla Village Drive, San Diego, CA 92161*

### SUMMARY:

That psychopathology 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 diverse psychopathology. The forgoing evolutionary perspectives bring together both Freudian and biological psychiatry, I submit that understanding the evolutionary aspects of psychopathology contributes to a richer understanding of human behavior in its boundaries with disease, its adaptive roles, and those therapeutic potentials that therein lie.

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# SYMPOSIUM 53—COMORBID CONDITIONS IN SCHIZOPHRENIA: NEW TREATMENT TARGET OR NEW ILLNESS MODEL?

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) emphasize the psychopathological and clinical need to recognize comorbid conditions in schizophrenia, and the guidelines to adequate the treatments in these cases. The model of schizophrenic illness will also be discussed, (2) consider co-occurring syndromes presenting in the course of schizophrenia from a variety of perspectives, including both potential treatment implications and the possibility that interacting diatheses could be important in the pathophysiological understanding of the disorder in some cases, (3) recognize and assess social anxiety disorder in schizophrenia and will be aware about the impact of this comorbid condition on social adjustment and quality of life of schizophrenics, (4) recognize the impulsive-aggressive symptom domain in schizophrenia, and choose appropriate treatment regimens.

## No. 53A
## CLINICAL CORRELATES AND CHRONOLOGY OF ANXIETY COMORBIDITY IN PSYCHOTIC DISORDERS

Giovanni B. Cassano, M.D., *Department of Psychiatry, University of Pisa, VIA Roma 67, Pisa 56100, Italy;* Liliana Dell'Osso, M.D., Marco Saettoni, Alessandra Papasogli, M.D., Concettina Mastrocinque, M.D., Serena Vignoli, Stefano Pini, M.D.

### SUMMARY:

*Background:* The aim of this study was to explore frequency, chronology, and clinical correlates of Axis I anxiety comorbidity in a cohort of patients with schizophrenia, schizoaffective disorder, bipolar I disorder, and major depression with psychotic features.

*Method:* Two hundred seventy four consecutively hospitalized patients with current psychotic symptoms were recruited for this study. Index episode psychotic diagnosis and psychiatric comorbidity were assessed using the SCID-P. Psychopathology was assessed by the SCID-P, BPRS, SANS, SCL-90, and the Scale to Assess Unawareness of Mental Disorder (SUMD).

*Results:* The total lifetime prevalence of anxiety comorbidity in the entire cohort was 48.8% (n = 135) (47.5% in schizophrenia, 46.9% in schizoaffective disorder, 45.2% in bipolar disorder, and 73.3% in major depression). Overall, the frequency of panic disorder, OCD, and social phobia was respectively 29.2%, 17.9%, and 14.2%. Patient self-reported psychopathology was significantly more severe in patients with comorbid anxiety disorders than in those without. Mean age at onset of anxiety disorders was 21 ± 11.0 years. Mean age at onset of psychotic disorder was 24.9 ± 8.6 years. In 54/

133 (40.6%) patients with comorbid anxiety disorders, the onset of anxiety disorder preceded the onset of psychosis by more than two years and in 46 (34.6%) by more than five years. Linear regression showed that age at onset of psychosis was significantly correlated with social phobia comorbidity (negative) and illness duration (negative).

*Conclusions:* Axis I anxiety comorbidity is a relevant phenomenon in patients with psychotic disorders. In a substantial proportion of patients, the onset of anxiety disorder precedes by several years the onset of psychosis. The nature of chronological relationship between these conditions remains to be elucidate.

## No. 53B
## ILLNESS MODEL?

Samuel G. Siris, M.D., *Long Island Jewish Medical Center, 75-59 263rd Street, Glen Oaks, NY 11004;* Paul C. Bermanzohn, M.D.

### SUMMARY:

Schizophrenia is recognized to be a heterogeneous disorder. This is quite apparent in both its phenomenology and its outcomes. Perhaps it is true in terms of at least some aspects of its pathophysiology as well.

This presentation will begin with a consideration of the well-known stress-diathesis model of vulnerability to psychosis in schizophrenia. This model postulates a continuous spectrum of vulnerability to psychosis in the population, and that persons go on to become psychotic when they experience biopsychosocial stressors in excess of their psychosis vulnerability threshold. This presentation will then explore the possibility that, in certain cases, another co-occurring psychiatric diathesis could act as the stressor in this model. Depression and mania are the co-occurring syndromes that have historically been most often considered concerning this possibility. Obsessive-compulsive disorder and panic disorder are other likely candidates, and there may be others as well such as posttraumatic stress disorder or social phobia. This is an illness model which could account for a variety of course-related features often seen in schizophrenia. It also generates testable hypotheses for validation of pathophysiological and nosological issues, and suggests important and potentially testable implications for treatments.

## No. 53C
## ASSESSMENT AND CHARACTERIZATION OF SOCIAL ANXIETY IN SCHIZOPHRENIA

Stefano Pallanti, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York, NY 10029;* Leonardo Quercioli, M.D., Eric Hollander, M.D.

### SUMMARY:

*Objective:* Social anxiety disorder (SAD) is a frequent, often unrecognized comorbid condition among schizophrenics, correlated to a more severe level of disability. We attempted to precisely define assessment, impact, clinical correlates, and consequences of comorbid SAD in schizophrenia.

*Method:* Eighty schizophrenic patients (DSM-IV) and 27 patients with SAD as primary diagnosis (DSM-IV) have been consecutively enrolled. Assessment included Liebowitz scale for SAD, SANS, SAPS, Social adjustment scale, SF-36 quality of life scale.

*Results:* SAD was diagnosed in 29 (36.2%) of schizophrenics. Liebowitz scale demonstrated no difference in items score profile between schizophrenics with SAD and social anxious subjects. Schizophrenics with SAD had a higher rate of suicide attempts and lethality in their history, more past substance/alcohol abuse disorder, lower social adjustment and lower quality of life, similar SANS and SAPS scores, and were more in current treatment with clozapine or olanzapine than risperidone and quetiapine, compared to schizophrenics without SAD.

*Discussion:* SAD is a high prevalence, disabling, condition in schizophrenia, not related to clinical psychotic symptomatology. Certain atypical antipsychotics seem more related to the presence of SAD in schizophrenics. The search for operational guidelines and adequate next-step treatments for SAD in schizophrenia will be needed.

## No. 53D
## IMPULSIVITY AND AGGRESSION IN SCHIZOPHRENIA: NEW TREATMENT TARGET

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., Nicolo Baldini-Rossi, M.D.

### SUMMARY:

Patients with schizophrenia represent a substantial challenge to clinicians for various reasons, including psychotic symptoms, cognitive impairment, comorbid conditions, and noncompliance. A primary reason that patients with schizophrenia are instituzionalized for long periods of time is due to concomitant impulsive-aggressive symptoms that are often underrecognized and inadequately treated.

This presentation describes the impulsive-aggressive symptom domain in schizophrenia, underlying mechanisms that contribute to these symptoms, and describes a broad range of therapeutic strategies for managing such symptoms. Medication approaches include atypical antipsychotics, anticonvulsants, lithium, SSRIs, opiate antagonists, beta-blockers, and hormonal modulators. Impact on functionality and quality of life are also described.

### REFERENCES:

1. Pini S, Dell'Osso L, et al: Axis I comorbidity in bipolar disorder with psychotic features. Br J Psychiatry 1999; 175:467–71.
2. Siris SG: Depression in schizophrenia: perspective in the era of "Atypical" antipsychotic agents. Am J Psychiatry 2000; 157(9):1379–89.
3. Pallanti S, Quercioli L, Rossi A, Pazzagli A: The emergence of social phobia during clozapine treatment and its response to fluoxetine augmentation. J Clin Psychiatry 1999; 60(12):819–23.
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# SYMPOSIUM 54—ADHD: LONGER-TERM TREATMENT FOR A CHRONIC DISORDER

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the longer term effects of methylphenidale (MPH) on vital signs in youth with ADHD, understand the most common reasons for discontinuation of MPH in chronic treatment/ current study, understand the longer-term effectiveness of OROS MPH, (2) be familiar to new findings on the medium-term stimulant treatment of adults with ADHD.

## No. 54A
## ADHD TREATMENT WITH A ONCE-DAILY FORMULATION OF METHYLPHENIDATE: A TWO-YEAR STUDY

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

SUMMARY:

*Background:* There is a paucity of studies evaluating the longer-term outcome of stimulant medications in the treatment of ADHD. This study assessed the effectiveness and safety of a once a day preparation of methylphenidate (OROS MPH; Concerta), in children with ADHD.

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

*Results:* Fifty-eight percent of youth completed the open-study protocol. There were modest increases in dosing of OROS MPH throughout the study. Ratings showed that treatment efficacy was maintained throughout the study period. Treatment was relatively well tolerated with a similar profile to that seen in shorter-term studies of MPH. There was a lack of clinically meaningful changes in growth, vital signs, or laboratory studies (CBC, liver function tests).

*Conclusions:* Chronic treatment with a once a day preparation of MPH (Concerta) appears to be well tolerated and efficacy was maintained for up to 24 months in this large sample of children with ADHD.

## No. 54B
## PRELIMINARY RESULTS OF A SIX-MONTH TRIAL OF METHYLPHENIDATE IN ADULTS WITH ADHD

Thomas J. Spencer, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, Boston, MA 02114*

SUMMARY:

*Objective:* The mid-term response of adults with ADHD to methylphenidate (MPH) is unknown.

*Methods:* This was a six-month controlled study of MPH in adults with ADHD. Responders (N = 47) to an acute trial were continued into Phase II and assessed every four weeks for six months under double-blind conditions. Patients who did not lose response in Phase II entered a double blind discontinuation, Phase III. In Phase III, half of the MPH subjects had their medication discontinued blindly over a four-week period and half remained on their dose of MPH.

*Results:* Survival analyses revealed that the adjusted rates of response was 96% of subjects maintained on MPH over six months. Patient satisfaction was improved over six months in multiple domains. After six months of treatment, patients randomized to placebo rapidly lost response in a double-blind discontinuation trial. Vital signs did not reveal any untoward effects of six months of MPH treatment.

*Conclusions:* MPH was effective and well tolerated in the medium-term treatment of adults with ADHD. After six months of treatment the response was still medication specific.

## No. 54C
## LONGER-TERM EFFECTIVENESS OF VARIOUS TREATMENTS FOR ADHD: RESULTS FROM THE MULTIMODAL TREATMENT STUDY OF ADHD

Laurence L. Greenhill, M.D., *Department of Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, Box 78, New York, NY 10032*

SUMMARY:

*Background:* While previous studies have demonstrated short-term efficacy of behavioral treatments and pharmacotherapy for the treatment of ADHD, a lack of data on longer-term studies exists comparing these two treatments alone or in combination. The multimodal treatment study of ADHD (MTA) is the largest randomized, prospective, multisite study of longer-term treatment outcome of youth with ADHD.

*Methods:* A total of 579 children with ADHD were randomized to receive 14 months of medication management, intensive behavioral treatment, the two combined, or standard community care. Multiple comprehensive assessments were completed throughout the study.

*Results:* At follow-up, all four groups showed sizable reductions in symptoms over time: for most ADHD symptoms children in the combined or medication management groups showed greater improvement than those given behavioral treatment or community care. Differences in outcome were evident in specific comorbid groups of youth. Important differences in normalization of functioning were also found between the four treatment groups.

*Conclusion:* These longer-term data indicate that the current treatments for ADHD are effective in the longer term management of ADHD youth. Specific treatment strategies may result in different longer-term outcome of children with ADHD.

## No. 54D
## A TEN-YEAR FOLLOW-UP OF ADHD SUBJECTS

Joseph Biederman, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 55 Fruit Street, WACC 725, Boston, MA 02114*

SUMMARY:

*Background:* Previous longitudinal data showed that ADHD children and adolescents are at increased risk for comorbid psychiatric disorders as well as impairments in cognitive, social, family, and school functioning. However, limited data are available on ADHD children followed prospectively into their 20s.

*Methods:* A sample of 140 ADHD boys and 120 control boys were followed over 10 years and assessed with structured diagnostic interviews and blind raters. In addition, subjects were evaluated for cognitive, achievement, social, school, and family functioning.

*Results:* Persistence of ADHD varied with the definition used with the fewest subjects attaining functional remission in adulthood. Analyses of follow-up findings revealed significant differences between ADHD and control subjects in rates of behavioral, mood, and anxiety disorders with these disorders increasing markedly over the 10-year period. Young ADHD adults also had significantly more impaired cognitive, familial, school, and psychosocial functioning than controls. ADHD subjects were significantly more likely than controls to have discipline problems in school, difficulties with legal authorities, and a trend toward more auto accidents with lower satisfaction in their daily lives.

*Conclusions:* These data support the notion that ADHD is a chronic condition and that ADHD subjects are at high risk for developing a wide range of impairments throughout adolescence and early adulthood.

## No. 54E
## DOES THE TREATMENT OF ADHD WITH STIMULANT MEDICATION CONTRIBUTE TO ILLICIT DRUG USE AND ABUSE IN ADULTHOOD? RESULTS FROM A FIFTEEN-YEAR PROSPECTIVE STUDY

Russell A. Barkley, Ph.D., *Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

*Objective:* To examine the extent to which stimulant treatment of hyperactivity during childhood and high school contributed to risk for substance use, dependence, and abuse by young adulthood.

*Methods:* A sample of 147 hyperactive children was followed approximately 15 years into young adulthood (mean age 21 years). At adolescence and young adulthood, probands were interviewed about their use of alcohol and various illegal substances. Information was also collected at those follow-ups on the duration of stimulant medication treatment.

*Results:* Duration of stimulant treatment was not significantly associated with frequency of any form of drug use by young adulthood. Stimulant treated children had no greater risk of trying drugs by adolescence. Nor did they have any greater frequency of drug use by young adulthood. Stimulant treatment in high school also did not influence drug use in adulthood. Stimulant treatment in either childhood or high school was not associated with any greater risk for any drug dependence or abuse disorders by adulthood. Treatment with stimulants did not increase the risk of ever having tried most illegal substances by adulthood except for cocaine. Subsequent analyses showed that this elevated risk was largely mediated by severity of conduct disorder by young adulthood and not by stimulant treatment in childhood.

*Conclusion:* The present study finds no evidence that treatment of hyperactive/ADHD children with stimulants leads to an increased risk for substance experimentation, use, dependence, or abuse.

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.
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## SYMPOSIUM 55—HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 3

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) learn factors important to setting up a new office that will enhance professionalism; (2) develop the skills to avoid the biggest risks for failure in private practice; (3) learn how to structure your professional life so that you will be happy, successful, and ethical, (4) have a list of office features and be able to determine their importance for their setting and goals; (5) know how to assess the merits of a particular office location; (6) be able to assess the relative contributions of office appearance and location on patients' perception and comfort.

### No. 55A
### PERSONAL FACTORS LEADING TO A SUCCESSFUL PRIVATE PRACTICE

William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618*

SUMMARY:

Dr. Callahan will discuss the biggest risks for failure and individual issues that must be accounted for if you are to be successful. Ways to avoid being pulled into unethical behavior are addressed. Having an attorney review your office contracts and avoiding getting taken advantage of in the business and professional world will be detailed. Broad issues for professional success will be covered, including recognizing your own professional value, developing a business plan, and keeping your financial expectations realistic.

### No. 55B
### OFFICE LOCATION AND DESIGN FOR EFFICIENCY AND SUCCESS

Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*

SUMMARY:

Dr. Young will discuss the details of office location and design. He will provide a checklist of features often not thought about that you will want to consider. Factors that are and are not important in where you locate, and tips on how to make that decision are discussed. References to differences based on rural versus urban will also be addressed. The impact on the office on the success of the practice, as well as how well (or not) it represents you will be presented.

### No. 55C
### STREAMLINING OVERHEAD AND MANAGING YOUR BUSINESS IN PRIVATE PRACTICE

Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*

SUMMARY:

Dr. Young will discuss streamlining all aspects of your practice to limit overhead while maximizing earnings and quality. Tips about minimizing personal and office expenses will be offered. Setting fees, billing, scheduling appointments, missed appointments, and other areas are covered.

Dr. Young will also outline necessary insurance, retirement, and banking systems, as well as taxes and areas of potential difficulty for psychiatrists starting a new practice. Finally, the roles of technician, manager, and entrepreneur that are essential to success in a small business will be discussed as they apply to psychiatric practice.

### No. 55D
### MARKETING YOUR UNIQUE PRIVATE PRACTICE

William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618*

SUMMARY:

Dr. Callahan will highlight how to get the right patients through the door. Concepts of branding so that you are distinguishable from the rest of your peers are examined. Marketing also requires persistent visibility and developing name recognition within a region, and then within segments of that region that you are best equipped to serve.

Dr. Callahan has developed an extensive list of different ideas and ways to do this, which you can tailor to your own area and

strengths. The focus in the start-up phase of practice is on methods that will cost you time, but not money, since time is usually more available than money in this phase.


## 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 Healtcare Systems and Financing, 1998.


# SYMPOSIUM 56—ETHICAL ISSUES IN THE U.S. AND FRANCE: VIVE LA DIFFERENCE

## EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to (1) identify some of the cultural issues that underline principle of medical ethics, (2) appreciate the considerable impact that culture may have on the development of ethics principles and on ethics-based psychiatric practice, (3) understand the forthcoming changes in medical and nurse practice due to patients' new rights in France to access their individual medical records, (4) learn the official ethical or legislative position on patients' reading their own medical/psychiatric records, (5) recognize the major ethical issues concerning the psychiatric treatment for women of child bearing age, (6) consider issues in consulting on reproductive choices.

## No. 56A
## FROM ONE CULTURE TO ANOTHER

Charles De Brito, M.D., *Hopital B. Ourano, Avenue 8 Mai 1965, Etampes 91452, France*


### SUMMARY:

The evolution of psychiatric practice in Europe and particularly in France suffers a cultural change that may be dangerous to its own structures.

The progressive acceptance of new legal principles based on an Anglo Saxon approach into the Latin world raises serious questions about ethics in medical practice.

The protective and paternalistic traditional French clinician is progressively replaced by a specialist who provides answers to the consumer in a new legal context that is often misunderstood.

A humanistic culture, established under old principles of medical ethics, is faced with a radical change of the approach toward the individual and his rights in relation with those who take care of his health.

In France, the new legal approach of patients' rights, introduces new rules to the therapeutic relationship. This new framework is not well understood yet by the majority of the medical community and the greatest part of the population. The new dispositive suddenly announced and written down in a new act of law, like the possibility for a patient to consult his own medical file, disturbs the old uses and the traditional mode of practice, creating a great disorder.


## No. 56B
## IMPACT OF CULTURE ON ETHICS

Ezra E.H. Griffith, M.D., *Department of Psychiatry, Yale University School of Medicine, 25 Park Street, Room 626, New Haven, CT 06519-1109*


### SUMMARY:

The interplay of culture and ethics continues to evoke substantial interest because the ethics-based practice of psychiatrists is strongly influenced by culture-based thinking.

It is my contention that recent dynamic forces in the United States have created a cultural context that has led either to the reframing of generic ethics principles or to a reconceptualization of the principles' application. I will further posit that ignoring these new dynamic sociopolitical forces leads to considerable tension and casts professionals from our discipline in a bad light, making them appear selfish and self-serving.

In this presentation, I shall consider the following two examples of the sociopolitical forces' exerting considerable pressure in the cultural context of the United States: the consumer movement as characterized by the National Alliance for the Mentally Ill (NAMI); and the broad movement on behalf of racial and gender equality. I shall then show how these movements have influenced American ethics-based psychiatric practice in domains such as mandatory outpatient treatment, the use of restraint and seclusion, and the patient's participation in research. A brief commentary will be made about the evolutionary impact of these movements in France and elsewhere.


## No. 56C
## ABOUT PATIENTS' INFORMATION IN FRANCE: IS ELECTRONIC MEDICAL RECORD PART OF THE SOLUTION?

Denis H. Chino, M.D., *Valdemame, Hopital Paulguiraud, 54 Avenue De La Republique, Villejuif 94806, France;* Veronique A. Olivier, M.D., Xavier Moine, Agnes Lemoux, Nariechrist Velut-Chino, M.D., Mordka Szpirko, M.D., Isabelle Teillet, M.D.


### SUMMARY:

New rights about patients' health information have been provided this year in France. In this new law and its decree, the medical record is to be made available to the patient and will contain all kinds of information and supports. But we shouldn't forget the medical record's goal is to help the practitioner make good decisions. We will expose and discuss why and how we need to develop in psychiatry a new (but not so new) way to consider the patient's case and all the information that both patients and practitioners need to have access to. We have to go further on these points than the question raised by the new law, what should the practitioner leave in the medical record? And for the patient, what should they think and know about me? To answer, we have to focus on this point: medicine, especially psychiatry, is impossible without the patient's confidence and we need to seek it by all means.

In this submission, we will show by audiovisual how it is possible to include in the EMR (electronic medical record) the health information a practitioner needs and how a medical record would become a new instrument of patient's alliance.


## No. 56D
## PATIENTS READING THEIR OWN RECORDS: SURVEY OF THE U.S. AND COMMENT

Thomas G. Gutheil, M.D., *Department of Psychiatry, UMHC, 6 Wellman Street, Brookline, MA 02446-2831*

SUMMARY:

The results of a survey of U.S. states will be presented, describing the pattern of statutes and regulations governing a patient's rights to read his/her own medical and/or psychiatric records. Clinical aspects of this request will briefly be reviewed.

## No. 56E
## PSYCHIATRIC TREATMENT FOR WOMEN OF CHILD-BEARING AGE: ETHICAL ASPECTS

Christine Germain, M.D., *Department of Psychiatrie, Hal Corentin Celton, 38 Rue Ernest Renan, Issy-Les Moulineau 92130, France;* Francois C. Petitjean, M.D.

SUMMARY:

The respect of physical integrity is one of the most important principles on which medical ethics is based. The 16th article of the Civil Code and the second article of the medical Deontological Code are, in France, the reminders of these principles.

All techniques relative to procreation, whether helping or prohibiting it, rest on this intangible principle. The gynecologists and obstetricians are confronted every day with those questions. The psychiatrists are also concerned for their patients of child bearing age, whose capacities of consent may be affected.

Faced with questions of procreation or contraception for women with mental illness, the doctor has to consider the ethical principles, the inalienable notions of consent and respect of physical integrity, to determine his action. In addition, the question of medical prescriptions for women who wish to procreate raises specifical problems linked with the possible repercussion of the medication on the foetus.

Basing ourselves on deontological principles and legal texts that presently exist in France, we will identify the basic issues concerning psychotropic prescriptions and contraception for women with mental illness. This presentation will provide guidelines to help psychiatrists and mental health teams in their daily practice.

## No. 56F
## WHAT IS A PSYCHIATRIST DOING HERE?

Kathleen M. Mogul, M.D., *Department of Psychiatry, Tufts Medical School, 218 Franklin Street, Newton, MA 02158-2330*

SUMMARY:

Psychiatric evaluative consultations are commonly required before women are considered for various assisted reproductive technologies. The presentation will consider the appropriate clinical and ethical role for the psychiatrist, including should it be as elective consultant or as gatekeeper? Can the psychiatrist's role before other actions, such as adoption or abortion, serve as a comparison guide? Are women and men subjected to similar consultation requirements?

I will discuss these issues and also consider some informal feedback from women who have had personal experience with such evaluations. The intent is to stimulate thoughtful discussion rather than to present solutions.

REFERENCES:

1. Dupont M, Calinaud C, et al: Recommandations pour la communication du dossier médical Les guides de l'AP-HP-2001.
2. Griffith EEH: Ethics in forensic psychiatry: a cultural response to Stone and Appelbaum. J Am Acad Psychiatry Law 1998; 26L171-184.
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4. Gutheil TG, Hilliard JT: Don't write me down: Legal, clinical, and risk management aspects of patients' requests that therapists not keep notes or records. Am J Psychother 2001; 55:157–165.
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6. Stotland NL, Stewart DE: Psychological Aspects of Women's Health Care: Interface Between Psychiatry and Obstetrics and Gynecology, 2nd Edition, APPI, Washington, D.C. 2001.

# SYMPOSIUM 57—PSYCHIATRISTS WITH PSYCHIATRIC DISORDERS: THE FEAR OF STIGMA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe the prevalence of psychiatric treatment in a defined sample of psychiatric residents in Manhattan and recognize that residents may have inherent biases about the use of psychiatric medication in themselves, (2) help psychiatrists recognize their own prejudice against the mentally ill, (3) describe the specific ways in which training directors may enhance residents' acceptance of and access to personal psychiatric treatment, (4) recognize personal bias about mental illness and use of psychotropic medication.

## No. 57A
## PSYCHIATRIC RESIDENTS IN MANHATTAN: A SURVEY OF PERSONAL PSYCHIATRIC TREATMENT

Sylvia P. Emmerich, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, #86, New York, NY 10032*

SUMMARY:

*Background:* Psychiatric residents are often encouraged to undertake personal psychotherapy to resolve issues that emerge during training that interfere with their work with patients. There are no systematic studies of the prevalence of psychiatric treatment among residents, and no information exists regarding residents' perceptions about different types of psychiatric treatment. This survey assessed the prevalence of psychiatric treatment among residents as well as personal attitudes regarding different types of treatments.

*Method:* This study was approved by the IRB at the NYS Psychiatric Institute. A survey instrument was developed and sent to 288 residents in Manhattan, representing all PGY-2 through PGY-4 residents at the 11 psychiatric training programs in Manhattan. The surveys did not ask demographic information, aside from program year, in order to minimize confidentiality concerns among residents.

*Results:* The return rate was 48%. 57% of respondents were in some form of psychiatric treatment; 32% of those in treatment were taking one or more psychiatric medications. The lifetime rate of psychiatric treatment among respondents was 71%, with a 24% lifetime use of one or more psychiatric medications. Questions about readiness to communicate treatment revealed a fear of stigmatization in revealing use of psychiatric medication. This was present even in residents with no history of medication use.

*Conclusion:* While the study sample is limited and the response rate prevents overgeneralization, this is the first systematic study of treatment among psychiatric residents. The results suggest that residents in Manhattan may have significant concerns about stigmatization related to the use of medication as well as internalized biases about the use of medication in themselves. The discussion will focus on further research and how this research may aid in shaping psychiatry training.

No. 57B
### STIGMA AGAINST THE MENTALLY ILL AND ITS EFFECTS ON TREATMENT

Paul J. Fink, M.D., *Department of Psychiatry, Temple University, 191 Presidential Boulevard, Suite C132, Bala Cynwyd, PA 19004-1216*

SUMMARY:

Psychiatrists and other mental health workers have prejudice against mentally ill patients equal to those of others in the community. The stigma against the mentally ill is a barrier to getting treatment and a barrier to staying in treatment. There is a sense that an impairment of the mind is much more serious and negative than physical impairment. When the psychiatrist or other mental health professional feels, consciously or unconsciously, very negative about a mentally ill person, their ability to address the needs of that person or address their own needs is impaired and undermined.

This presentation will focus on the following mechanisms of prejudice: (1) how it works; (2) why it exerts an influence on people; (3) why highly educated people, such as psychiatrists, are vulnerable to negative feelings about the mentally ill; (4) why psychotropic medications are viewed as harmful and why the proper utilization of such medications is undermined by both patients and physicians.

No. 57C
### THE ROLE OF THE TRAINING DIRECTOR IN RESIDENT MENTAL HEALTH: STRATEGIES FOR ENCOURAGING TREATMENT AND REDUCING STIGMA

Elizabeth Auchincloss, M.D., *Department of Psychiatry, NY Hospital/Cornell-Payne Whitney, 525 E 68th Street, New York, NY 10021*

SUMMARY:

Psychiatric symptoms occur in psychiatric residents at the same frequency as in the population at large. The training director plays an important role in promoting the mental health and functioning of individual residents when needed. S/he also must create an environment that combats the prejudice residents feel regarding their own illness.

The training director is in a unique position in evaluating residents' performance and functioning within a training program by virtue of having access to multiple sources of information about a resident. Aside from general clinical proficiency, there are a variety of factors that may influence residents' performance, including life stressors, Axis I psychiatric conditions, and/or counterproductive character traits. Training directors have a responsibility both to residents as well as to patient care to engage residents when problems arise, and facilitate treatment when appropriate.

This presentation will discuss the multiple ways a training director may foster open and accepting attitudes toward personal psychiatric symptoms. These include presentations aimed at acknowledging the presence of a wide range of possible psychiatric symptoms among residents, with an emphasis on the prevalence and ubiquitous nature of some psychiatric symptoms to help foster acceptance of personal psychiatric difficulties. Formal discussions exploring the impact of subtle prejudice or bias may not only help residents acknowledge symptoms within themselves, but can highlight the impact of attitudes on the care of patients. Ways the training director can create a reliable referral network, and insure mechanisms for confidentiality, will be discussed.

No. 57D
### A PSYCHIATRIST'S PERSONAL ENCOUNTER WITH STIGMA

Francine Cournos, M.D., *Department of Psychiatry, NYS Psychiatric Institute-Columbia University, 5355 Henry Hudson Drive, # 9F, New York, NY 10471-2839*

SUMMARY:

In 1999 my memoir, City of One, was published. The book describes the details of my journey through an episode of major depression, and my use of antidepressant medication. Following these revelations, I braced for the worst: my colleagues would shun me, my patients would quit, and referrals would disappear. When none of this happened, I concluded that my fears were largely based on my own conviction that mental illness is shameful, and taking psychotropic medication even more so.

This presentation will examine the impact of our psychiatrists' stigma on our work with patients. I will focus on our willingness to accept mental health treatment not just prescribe it; how secrecy operates to maintain our negative attitudes; the various ways having an experience of mental illness may help or hinder our work with patients; and the important distinction between publicly revealing personal information and doing so while conducting psychotherapy.

I will also argue that the dichotomy between mental and physical illness is false. Serious mental illness is a disease of the whole body (consider, for example, disturbances in appetite, sleep, energy level, heart rate). Abandoning this false dichotomy would reduce the stigma and contribute to better treatment of mental disorders.

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## SYMPOSIUM 58—ADDICTIONS: CUTTING-EDGE TREATMENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand current treatment approaches for cocaine dependence including psychosocial treatments, as well as recent research findings in the area of medication development for cocaine dependence, (2) understand how the more potent heroin available to today's street addict poses a threat to many patient populations and will understand the full array of treatment options available, (3) recognize which patients are appropriate for office-based treatment and how to induct and maintain them, (4) have a greater understanding of the newest developments regarding marijuana, club drugs, and pharmacological strategies which are being, or may be employed to treat marijuana dependence, (5) understand how the complexities inherent in dual diagnosis conditions and effective treatment strategies to deal with this difficult to treat population.

No. 58A
### TREATMENT OF COCAINE DEPENDENCE

Adam M. Bisaga, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 120, NYSPI, New York, NY 10032*

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult and few successful controlled trials. A combination of pharmacological and behavioral interventions will likely

be required for these patients to achieve and maintain abstinence. Antidepressants, with desipramine most studied, have yielded inconsistent results. Medications that affect dopaminergic neurotransmission, including dopamine receptor agonists, dopamine transporter inhibitors, dopamine receptor blockers, and stimulants have also not been consistently successful. Other dopaminergic medications including selegiline and disulfiram are more promising. A current area of interest is the use of excitatory and inhibitory amino acids as well as blockers that will prevent cocaine from entering the brain as in the active immunization approach. Future research will include medication that may prevent relapse in abstinent patients. Despite the absence of effective medication there are several psychotherapeutic and behavioral treatment approaches. Relapse prevention, a cognitive-behavioral intervention, and therapies that incorporate the disease model approach, have been used successfully in pharmacotherapy trials. A community reinforcement plus voucher approach, which incorporates positive incentives for abstinence, 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 a model of comprehensive cocaine dependence treatment will be presented.

## No. 58B
## TREATMENTS FOR 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 its 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. The use of these medications in various settings will be discussed.

## No. 58C
## OFFICE-BASED TREATMENT OF OPIOID ADDICTION

Laura F. McNicholas, M.D., *Department of Psychiatry, University of Pennsylvania, 3900 Woodland Avenue, Philadelphia, PA 19104*

SUMMARY:

There are an estimated one million heroin addicts in the United States of whom less than 200,000 are in treatment at any one time. Faced with that reality, Congress passed legislation that will enable physicians in their offices to prescribe opioid agonists for the treatment of narcotic addiction. This has the potential to "mainstream" addiction treatment and increase the number in treatment. This presentation will cover the office-based prescribing of both agonists, especially the partial agonist buprenorphine, which has certain advantages over existing medications, and antagonists such as naltrexone. Issues such as selection of patients, induction, maintenance, concomitant therapy, safety factors, and termination will be covered.

## No. 58D
## UPDATE ON MARIJUANA AND CLUB DRUGS: CURRENT AND POTENTIAL TREATMENTS

David M. McDowell, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 120, New York, NY 10032*

SUMMARY:

Marijuana is the most commonly used illicit substance in the United States. In addition, the use of "club drugs," in particular MDMA, ketamine, and GHB, are increasing. Contrary to public perception, "club drugs" cause real and substantial morbidity and mortality along with heavy and chronic use of marijuana carries with it substantial morbidity as well as the risk of dependence and withdrawal. These issues have far reaching implications for substance abuse treatment and psychiatric treatment in the future. Pharmacological interventions for marijuana dependence have included mood stabilizers and medication focused on withdrawal symptoms. Treatment strategies for these conditions have focused on prevention measures and psychosocial interventions. These conditions are not as well studied as other substance abuse conditions. In recent years a great deal of work has been completed concerning the basic mechanisms of actions, pharmacology, and neurophysiology of marijuana and its endogenous ligand, anandamide. Given the increasing knowledge about marijuana, new and potential treatments are being studied and even more can be theorized. Especially promising are various pharmacological interventions for marijuana as well as for co-morbid 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. 58E
## TREATMENT OF COMORBID CONDITIONS

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, State Psychiatric Inst., 1051 Riverside Drive, Unit 66, New York, NY 10032;* Suzette M. Evans, Herbert D. Kleber, M.D.

SUMMARY:

Evidence for a link between psychiatric and substance use disorders is strong and converging. Epidemiologic studies have demonstrated that substance abuse is over-represented among individuals with psychiatric conditions. Similarly, numerous prevalence studies among substance abusers seeking treatment have found that the majority of patients have at least one comorbid psychiatric disorder. These psychiatric disorders may include major depression, posttraumatic stress disorder, generalized anxiety and panic disorder, attention-deficit hyperactivity disorder, and schizophrenia/schizoaffective 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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# SYMPOSIUM 59—INTERNET: TECHNICAL, CLINICAL, AND SOCIETAL
## American Association for Social Psychiatry and American Association for Technology in Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe addiction and the Web, both as a treatment adjunct for substance abuse and as a potential addiction itself, (2) self-help resources on the Web, (3) recognize and treat overuse of the Web, (4) discuss sexual activity on the Web, its attractions, modus operandi, and effects; (5) recognize different ways people use Web sex vis-a-vis their relations with real people; (6) treat common conditions arising from Web sex appetites, describe (7) understand how like-minded people find each other on the Web, (8) understand how relationships on the Web develop into pseudocommunities, (9) understand how pseudocommunities recruit and retain members, (10) understand results of pseudocommunity memberships, (11) some of the advantages and disadvantages of online groups in psychiatric rehabilitation, (12) describe and discuss the world of the internet as it portrays and sometimes promotes eating disorder related attitudes, the experiences of patients seeking information and help on the internet, the quality of sources, and guidelines for professionals to help patients contend with what they encounter.

## No. 59A
## ADDICTIONS AND THE INTERNET

Richard N. Rosenthal, M.D., *Department of Psychiatry, Saint Luke's-Roosevelt Hospital Center, 1090 Amsterdam Avenue, 16th Floor, Suite G, New York, NY 10025*

SUMMARY:

The term "addiction" is associated with Web use both as causing new problems and as helping with substance abuse addiction. Proposals for a syndrome of Internet addiction share the notion of too much time being spent on the Internet and some sort of resulting impairment, usually in interpersonal relationships. Physiological effects include disrupted Circadian rhythms from nocturnal activities and physical problems related to prolonged sitting, keyboard use, etc. Internet overuse fits general concepts of addiction and dependency, although its status as a DSM-V psychiatric diagnosis is debatable.

Several studies cite benefits of using the Internet and associated electronic communication as adjuncts to therapy. There is an abundance of factual data on addiction, including photos of organs damaged by substances. Self-help, support, and therapy groups meet using the Web, increasingly with video feeds that show faces in color with good image resolution. During group sessions it is possible for a therapist to go into exchanges with a particular patient that are not shared with the group. Groups can be polled during discussions. Attendance at Web-based sessions has been reported as higher than in conventional face-to-face groups. Patient satisfaction is high, but some patients do not do well using the Internet.

## No. 59B
## SEX AND THE INTERNET

Zebulon C. Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, 19 East 93rd Street, New York, NY 10128*

SUMMARY:

People look for many sorts of sexual gratification on the Internet. Sex sells on the Internet better than anything else. Available products include but aren't limited to (1) sexually suggestive and explicit pictures, stories, and videos that can be seen over the Web or bought for home use; (2) sex products as props for human use or to enhance one's own equipment (penis, breast and other enlargers, etc.); (3) ways of contacting others (both real and synthetic people) to engage in e-mail, phone sex, or face-to-face meetings. These products cater to every imaginable fantasy: heterosexual, homosexual, animal sex, fetishes, sadomasochism, etc. Sexual proclivities are easily fed into search engines. Many sites offer free come-ons to develop interest, charge paying members, do market research, etc. The Web is continuously available, so anyone who is tempted can get as involved as s/he likes. Addiction to sex on the Web can substitute for real relationships, as demonstrated by a case report of a man who became increasingly involved with the Web rather than his family, meeting women in chat groups for conversations leading to mutual masturbatory orgasms. One bout lasted three days without sleep or break except for fast food and liquids.

## No. 59C
## PSEUDOCOMMUNITIES ON THE INTERNET

Steven E. Hyler, M.D., *Department of Psychiatry, Columbia University, 21 Springdale Road, Scarsdale, NY 10583*

SUMMARY:

People find each other on the Web, acting on various needs and desires. This paper discusses interest groups apart from addictions and sex. Many of these reflect political ideologies or attitudes toward life and how to live that in the past have led to people coming together to develop utopian communities that made their mark on American history. Internet "pseudocommunities" have developed in ways that somewhat parallel historical utopian communities, although the participants do not necessarily meet and usually remain part of their communities in real life. A pseudocommunity may develop from the decision of just two people to recruit and retain new members. While such groups have many positive aspects, this paper is concerned with those that turn pathological, usually substituting for relationships that would otherwise be carried on with those around the member in real life. Sometimes such communities develop plans of action to call attention to themselves in the real world. Examples of such actions include hate crimes, anti-abortion activities, etc. While many pseudocommunities are political, points of coalescence may include any idea or set of beliefs. One of the most famous involved the Columbine killers, whose life with each other on the Internet led to their taking real lives.

## No. 59D
## INTERNET SUPPORT: SELF-HELP GROUPS

Robert C. Hsiung, M.D., *Department of Psychiatry, 507 Fullerton Parkway, Suite 3, Chicago, IL 60614*

### SUMMARY:

Groups are a mainstay of psychiatric rehabilitation. The Internet now makes online groups a potential resource for patients. Online groups can be classified as autonomous self-help groups or support groups led by mental health professionals. Online self-help groups hosted by mental health professionals are hypothesized to combine the best (or at least some helpful elements) of both worlds. Psycho-Babble (http://www.dr-bob.org/babble/), a set of groups of this type hosted by the presenter, serves as an example. Between October 2001 and July 2002, 1,500 posting names were registered and used. In the single month of July 2002, 7,522 messages were posted and 1,171,333 Web pages were served. Usage statistics and anecdotal evidence support the effectiveness of these groups. The asynchronous online (message board) format is highly usable and makes this type of group accessible and safe. The members of the group focus on providing the support, and the mental health professional focuses on maintaining the milieu. Drawbacks include the potential for "multiple identities" and the technical difficulty of effectively preventing determined individuals from gaining at least temporary entry into the group. This hybrid type of group combines the support and empowerment of self-help and a milieu maintained by a mental health professional.

## No. 59E
## EATING DISORDERS MEET THE INTERNET: WHAT PATIENTS AND CLINICIANS ENCOUNTER

Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*

### SUMMARY:

The Internet has become a powerful influencing media in the world of young women, the most vulnerable population for developing eating disorders. The percentage of young women surfing the net is very high, and available data show that a large percentage of teenagers search for information related to health, mental health and nutrition. Adolescents are swayed by what they read on the web. Popular sites concerning weight, body image, self-image, beauty and eating attitudes vary from helpful to harmful with regard to the accuracy of their content and the extent to which they convey healthy vs. perverse messages. This presentation will review what is know about the world of the Internet as it portrays and sometimes promotes eating disorder related attitudes, the experiences of patients and families seeking information and help on the Internet, and the quality of sites and sources they are likely to find. This presentation will be based on information obtained from the personal experiences of eating disorder patients who have gone on-line for information, and from professionally conducted searches. Guidelines are offered to help professionals assist patients and families contend with what they are likely to encounter.

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# WEDNESDAY, MAY 21, 2003

# SYMPOSIUM 60—WORLD PSYCHIATRIC ASSOCIATION'S INTERNATIONAL PSYCHIATRY GUIDELINES FOR DIAGNOSTIC ASSESSMENT

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should (1) recognize the importance of structuring the interview process and the effective use of extended sources of information, (2) evaluate psychological functioning and psychopathology in a standardized fashion that is both relevant to the process of differential diagnosis and sensitive to age, gender, cultural, and person-specific considerations, (3) be familiar with this innovative diagnostic model that covers illness and positive aspects of health in a standardized manner as well as a personalized and contextualized formulation of problems, assets, and expectations, (4) use effectively a comprehensive diagnostic formulation to prepare a well rounded treatment plan, and (5) understand the way a clinical history and patient personal information will be placed in a comprehensive diagnostic assessment.

## No. 60A
## INTERVIEWING AND EXTENDED SOURCES OF INFORMATION

Carlos E. Berganza, M.D., *Department of Psychiatry, San Carlos University Hospital, Ave Reforma 13-70, Zona 9, # 11B, Guatemala City 01009, Guatemala*

### SUMMARY:

The process of psychopathological evaluation includes interviewing the patient and available relatives and associates, reviewing documents containing information on the subject's clinical history, organizing the information obtained into appropriate formats, and formulating a diagnostic summary. The interview is a dynamic process, involving a clinician and patient, which should lead to mutual understanding. The clinician should adopt an attentive, interested, listening attitude, convey respect for the person's wishes and dignity, and facilitate the engagement of the patient and the flow of the interview. The assessment process must be systematized in order to control for sources of unreliability in psychiatric diagnosis, e.g., information variance and interpretation variance. The main objective is to provide the clinician with reliable information that may be used in proper planning and case management. Within this context, information gathered through "extended sources" such as parents, spouse, police, teachers, other relatives, other professionals, the family history, or written reports from previous evaluations, complement the data obtained via the verbal expression of the concerned patient or through the mental status examination. This is of great value in the diagnostic process for the purpose of planning, treatment, or disposition. In this presentation, important guidelines about the successful interview, the information that may be obtained directly from the patient, and through "extended sources of information" critical for the comprehensive assessment of the psychiatric patient are presented, and the potential problems involved, are discussed.

## No. 60B
## EVALUATION OF SYMPTOMS AND MENTAL STATUS

Andrew E. Skodol II, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Psychopathology is the study of the nature and causes of mental disorders. Because definitive etiologies for most mental disorders have not been identified, psychopathology is focused on the myriad manifestations of psychiatric illness. These can be grouped into the following five broad domains of human functioning: (1) consciousness, concentration, orientation, memory, and intellect; (2) speech, thinking, perception, and self-experience; (3) emotions; (4) physical manifestations; and (5) behavior.

A comprehensive evaluation documents symptoms elicited or observed during the interview, as well as those present in the past. The clinical significance of symptoms is determined by a consideration of their severity and their meaning in a patient's life. The exploration and probing of symptoms should be guided by hypotheses about their diagnostic significance. Variations in the presentation of psychopathology according to a patient's age, gender, and sociocultural background should be considered in the conduct of the examination and in the interpretation of collected information. The observational findings of the mental status exam should be summarized according to standard domains and diagnoses made according to accepted diagnostic criteria or disorder definitions.

Each of these principles will be illustrated with clinical case illustrations in this presentation.

## No. 60C
## STANDARDIZED AND IDIOGRAPHIC DIAGNOSTIC FORMULATION

Juan E. Mezzich, M.D., *Department of Psychiatric Epidemiology, Mount Sinai School of Medicine, Fifth Avenue & 100th Street, Box 1093, New York, NY 10029-6574*

SUMMARY:

The diagnostic process involves more than identifying a disorder or distinguishing one disorder from another. It should lead to a thorough, contextualized and interactive understanding of a clinical condition and of the wholeness of the person who presents for evaluation and care. This comprehensive concept of diagnosis is implemented through the articulation of two diagnostic levels. The first is a standardized multiaxial diagnostic formulation, which describes the patient's illness and clinical condition through standardized typologies and scales. The second is an idiographic diagnostic formulation, which complements the standardized formulation with a personalized and flexible statement.

A multiaxial diagnostic formulation provides a contextualized and standardized description of the clinical condition through a number of highly informative, therapeutically significant and systematically assessed axes or domains. A tetraaxial formulation, built on the triaxial presentation of ICD-10 is recommended below. The first three axes correspond to ICD-10 and also broadly correspond to the five axes of DSM-IV.

Axis I: Clinical Disorders (general mental, personality and development disorders as well as general medical conditions).

Axis II: Disabilities (in personal care, occupational functioning, functioning with family, and broader social functioning).

Axis III: Contextual Factors (interpersonal and other psychosocial and environmental problems).

Axis IV: Quality of Life (primarily reflecting patient's self-perceptions)

The preparation of the idiographic formulation starts with the recognition of the perspectives of the clinician, the patient, and, whenever appropriate, the family on what is unique, important, and meaningful about the patient. The formulation presents an articulation and integration of these perspectives, which could be discrepant from each other, and call for an interactive resolution and joint understanding of the case at hand. Integration of clinician and patient perspectives, essential for a therapeutic alliance, should be based on empathetic rapport, reflecting mutual respect and interest, and human feeling between clinician and patient. The clinician and patient (with the collaboration of the family as needed) should attempt to reach a joint understanding, to the maximum extent possible, of (1) clinical problems and their contextualization, (2) patient's positive factors, and (3) expectations about restoration and promotion of health.

## No. 60D
## LINKING DIAGNOSIS TO TREATMENT

Ahmed Okasha, M.D., *Institute of Psychiatry, Ain Shams University, 3 Shawarby Street, Cairo, Egypt*

SUMMARY:

A comprehensive idiographic diagnosis will guide us to a better management and subsequently a favorable outcome. Clinicians should not treat a psychiatric disorder, but a psychiatric patient, i.e., one does not treat a depressive disorder, but a depressed patient. Treatment of psychiatric disorders should be tailored according to sociocultural, economic, and individual needs and not follow a ready-made blueprint, i.e., an ideographic formulation of management plan should be drawn for every patient individually. A coexistent axis II diagnosis may have an important impact on the treatment response and prognosis. Although clinicians may follow a certain algorithm for the management, sometimes the clinicians have to follow their own clinical intuition and judgment. Early detection of a disorder and early initiation of treatment have a positive impact on the response and outcome of the patient. Clinicians should work to maximize therapeutic effect while minimizing side effects and have an armamentarium of alternative management strategies, especially when patients have a high level of disability to cope with.

## No. 60E
## A CASE FORMULATION ACCORDING TO THE INTERNATIONAL GUIDELINES FOR DIAGNOSTIC ASSESSMENT

Miguel R. Jorge, M.D., *Department of Psychiatry, Brazilian Association of Psychiatry, R. Botucatu 740, Sao Paulo 04023-900, Brazil*

SUMMARY:

The WPA International Guidelines for Diagnostic Assessment is a tool aimed to improve the psychiatrist's clinical skills in conducting a diagnostic evaluation and formulation as well as setting a treatment plan for a particular patient. Some structured sections guide the clinician through progressive phases in order to achieve effective clinical care. A case formulation will be presented to illustrate how the IGDA should be used.

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# SYMPOSIUM 61—DIMENSIONALITY IN PSYCHIATRIC DISORDERS

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will (1) have a better understanding of the different outlooks concerning the presence of key psychopathological symptoms in major psychiatric disorders, (2) be able to identify the major dimensions of the depressive disorders and to elaborate on their roles in predicting and evaluating the effects of antidepressants, (3) be able to assess patients with mood disorders utilizing information regarding fundamental behavioral dimensions of treatment of bipolar disorder, to increase accuracy of diagnosis, and (4) recognize dimensions underlying the personality disorders and appreciate their significance for diagnosis, etiology, and treatment.

## No. 61A
## A DIAGNOSTIC VERSUS A DIMENSIONAL VIEW OF DELUSIONS: A 20-YEAR FOLLOW-UP

Martin Harrow, Ph.D., *Department of Psychiatry, University of Illinois, 1601 West Taylor Street, M/C 912, Chicago, IL 60612;* Ellen S. Herbener, Ph.D., Kalman J. Kaplan, Ph.D., Joseph F. Goldberg, M.D., Eileen M. Martin, Ph.D.

## SUMMARY:

*Objective:* A dimensional view of major symptoms sees patients from different diagnostic groups as vulnerable to various psychopathological dimensions, such as delusions, or depression, in a trait-like fashion, even years later. This view places less emphasis on diagnosis.

*Method:* To study the issue of diagnosis versus dimensions of psychopathology, 216 patients (including 73 schizophrenic and schizoaffective patients) from the Chicago Followup Study were assessed prospectively at acute hospitalization and then followed up six times over the next 20 years. Employing standardized evaluations, patients were assessed at each follow up for delusions, negative symptoms, affective syndromes, psychosocial functioning, rehospitalization, medications, and global functioning.

*Results:* (1) Not surprisingly, over 75% of the schizophrenics showed delusional activity at one or more of the six follow ups. (2) However, over 60% of the initially psychotic affective disorders also showed delusional activity at one or more follow ups. (3) Delusional activity in the psychotic depressives was not just a function of the severity of their depression, but rather was influenced by a trait-like vulnerability to delusions. (4) However, the delusional activity of the schizophrenics at follow up was more severe and more sustained than that of the initially psychotic affective disorders.

*Conclusions:* The results indicate that both diagnosis and dimensions of psychopathology are important. The data support a model that views individual patients' vulnerability to delusions as a separate trait-like dimension that cuts across diagnosis, but is more frequent, severe, and sustained in some diagnostic groups such as schizophrenia.

## No. 61B
## DIMENSIONS OF DEPRESSION AND DIFFERENTIAL SENSITIVITY TO ANTIDEPRESSANTS

Martin M. Katz, Ph.D., *Department of Psychiatry, University of Texas HSCSA, 6305 Walhonding Road, Bethesda, MD 20816;* Alan Frazer, Ph.D., Charles L. Bowden, M.D.

## SUMMARY:

Intensive behavioral examination of severely depressed patients indicates that conflicting CNS affective states underlie the structure of the disorder. Three independent dimensions are derived: "depressed mood-motor retardation," a "negative arousal state" reflected by anxiety, agitation and somatization, and "hostility-interpersonal sensitivity." In severe cases simultaneous presence of high levels of the depressed mood-motoric and the arousal anxiety dimensions intensify patient suffering. Focus on the first two weeks of treatment show the TCAs to initially reduce anxiety, hostility, and distressed appearance, reflecting change in all three dimensions. Also in that study drug-induced reduction in the CSF concentration of the NE metabolite was associated with change in motor retardation, while CSF concentration of the 5-HIAA was associated with anxiety. Recently completed placebo-controlled studies with amine-selective drugs showed them to induce different early behavioral changes preceding recovery in treatment-responsive patients. Desipramine acted rapidly, reducing motor retardation and depressed mood during the first two weeks. Paroxetine was slower but characterized by early actions on anxiety and the "depressed state." Thus, new results from dimensional analyses of early behavioral actions of the AD subtypes contribute to enhanced understanding of the structure of the depression, basic mechanisms of AD action, and to prediction of treatment response.

## No. 61C
## BEHAVIORAL DIMENSIONS OF BIPOLAR DISORDER

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

## SUMMARY:

Emphasis on identification of primary behavioral dimensions in bipolar disorders may yield more accurate early diagnosis and improve likelihood of successful treatments for bipolar disorders. Clinical features prominent in bipolar depressed compared with unipolar depressed patients include psychomotor retardation, hypersomnia, weight gain, extraversion, novelty seeking, and impulsivity.

Psychiatrists' diagnoses utilizing DSM-IV criteria under recognized bipolar II spectrum conditions by more than 50%. Recent analyses of an extensive behavioral assessment of a group of 162 bipolar I, manic patients identified six principal behavioral factors. These were impulsivity, hyperactivity, depression/anxiety, psychomotor slowing, hostility, and delusions. These factors formed the following four symptomatic clusters: classic mania, depressive mania, psychotic mania, and irritable mania. Divalproex and lithium were equivalently efficacious, and superior to placebo on impulsivity and hyperactivity. Neither drug benefited depression/anxiety, psychomotor slowing or delusions. Divalproex was superior to placebo and lithium in patients with the irritable manic subtype. These and other evidence of consistent behavioral dimensions of bipolar disorder have important implications for diagnosis, treatment, and genetic studies of bipolar disorder.

### No. 61D
### DIMENSIONS OF PERSONALITY DISORDER

Larry J. Siever, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place. Box 1230, New York, NY 10029*

SUMMARY:

Personality disorders as we recognize them clinically are grounded in dimensional temperamental substrates that provide the neurobiologic susceptibilities and foundation to the personality disorders. While numerous dimensional schema for personality disorder have been proposed, including those from a psychometric trait based approach such as the five-factor model, and genetic behavioral approaches such as Cloninger's model. There is convergence among investigators that these dimensional models, which, while differing in some specifics, may be mapped into each other, provide a better explanatory model for personality disorders than categorical approaches. A heuristic framework in which to understand the personality disorders utilizing dimensions of cognitive disorganization, affective instability, impulse dyscontrol, and anxiety will be discussed with illustration of the implications of such a heuristic model for studies of neurobiology, psychosocial antecedents, treatment response, and outcome.

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## SYMPOSIUM 62—WORKPLACE ISSUES IN PSYCHOTHERAPY
## APA Committee on Psychotherapy by Psychiatrists and APA Committee on APA/Business

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) be alert to workplace issues in a patient's life and address them appropriately in a way that may advance the effectiveness of psychotherapy as well as enhance the patient's function as a worker, (2) evaluate mental function in the context of work and compensation structures; be able to evaluate and manage the internal and external risks in work withdrawal, (3) recognize and intervene in workplace power struggles, and (4) understand the application of psychotherapeutic principles to vocational rehabilitation on the public psychiatric setting.

### No. 62A
### WORKPLACE ISSUES ARE VITAL IN PSYCHOTHERAPY

Norman A. Clemens, M.D., *Department of Psychiatry, Case Western Reserve University, 1611 South Green Road, Suite 301, Cleveland, OH 44121-4128*

SUMMARY:

Work plays a vital role in people's lives, yet risks being ignored in psychotherapy. Being out of work is an emergency in someone's life. Self-esteem is closely related to feelings about one's competence and ability to complete tasks, please the boss, achieve status, or advance an emotionally invested cause or project. Transferences to supervisors or coworkers may be powerful. Workplace conflicts or competition may evoke aggressive impulses that activate maladaptive defense mechanisms. Relationships may become sexualized or deteriorate into sadistic harassment. Over-conscientiousness or anxiety about performance may lead to obsessive overwork. Loss of status, major reorganization, or threatened change may cause depression and/or anxiety. Intercurrent mental illness or personal life stresses may lead to distractibility, absenteeism, or "presenteeism."

Challenges calling for clinical judgment and adaptability include whether to give problem-solving advice or explore internal causes and conflicts; whether to communicate with third parties, especially supervisors, about perceived external pressures and possible remedies; dealing with actual dangerous or damaging situations; decisions about return to work. Clinicians must be mindful that the employer's role with the patient is to deal forthrightly with behavior and job performance, not to create a therapeutic environment on the job.

### No. 62B
### DISABILITY AND PSYCHOTHERAPY

Marcia A. Scott, M.D., *19 Sibley Court, Cambridge, MA 02138*

SUMMARY:

Disability is commonly thought of as monetary benefits an employee receives while sick and out of work. But being sick and out of work don't necessarily qualify a covered employee for disability benefits (what are more properly called "wage replacement" benefits). In fact, employees with psychiatric illnesses usually work except during significant exacerbations.

Withdrawal from work, applying for benefits, and not working are life changing events and fruitful material in psychiatric treatment. The psychiatrist or psychopharmacologist can't escape playing a conscious or unconscious role in the events and consequences that follow, even in high functioning patients. Lack of a shared understanding of the terms and consequence of work withdrawal and disability status can place the patient and the therapy at risk.

This talk will cover the basic knowledge needed to establish a realistic working relationship around issues of work withdrawal. Topics include the meaning of work complaints and job issues in treatment, assessment of mental function related to work, contractual and documentation requirements for benefit eligibility, benefit limitations, the impact of work and benefit structures on illness and treatment, the ying and yang of work withdrawal, and resources to prevent regression and maintain employability.

### No. 62C
### A PSYCHODYNAMIC MODEL FOR SEXUAL AND OTHER FORMS OF WORKPLACE HARASSMENT AND VIOLENCE

Stuart W. Twemlow, M.D., *1417 Bigelow Commons, Enfield, CT 06082-3349*

SUMMARY:

Beginning with a brief literature review, this paper outlines a dialectical model for sexual and other forms of workplace harassment in which the role-dependent models of bully, victim, and bystander are seen to complexly interact and facilitate each other. An organization that has a bully always has the other two roles represented according to the model. It is suggested that for a workplace to

function harmoniously all three roles must be addressed, and the power struggle resolved. The theory is illustrated with a series of case studies drawn from a forensic psychiatry practice. These include some more unusual forms of harassment such as the harassment of a Mexican-American woman by an African-American woman, the harassment of a middle-aged conservative man by two young women, the harassment of a man by several male employees, together with traditional patterns of an older male employer harassing a younger female employee. Psychoanalytic processes that explain the pathological patterns are illustrated with material drawn from a psychoanalysis of a harassed woman. The paper concludes with some brief suggestions for a plan for workplace intervention.

### No. 62D
### PSYCHOTHERAPY AND VOCATIONAL REHABILITATION IN COMMUNITY PSYCHIATRY

Linda G. Gochfeld, M.D., *Department of Psychiatry, UMDNJ-RW Johnson Medical School, 40 Witherspoon Street, Princeton, NJ 08542*

SUMMARY:

Treatment of patients who are disabled by serious mental illness must be informed by psychotherapeutic principles and techniques. The individual is understood within a cultural, social and economic reality context. The major task is to develop a consistent, trusting relationship, for support during gradual improvement of functioning. The paradigm, "first validation, then skills training," is common to effective models of psychotherapy and rehabilitation.

The choice of goals and interventions requires respectful investigation of the patient's reality situation, history, wishes and fears. Desire to work and past work history are important determinants of success. Fear of losing benefits is a real impediment, and must be addressed. Past work failures and successes are discussed and reframed in solution-oriented ways. Management of residual symptoms (e.g. anxiety, drug cravings) in the work situation is an ongoing topic. Social skills training can be offered in group or individual settings. Family meetings provide support for role functioning.

Specific vocational skills assessment/training, prevocational or sheltered work may be useful. Studies indicate that the most effective model is supported employment, with job placement as soon as feasible, then on-site outreach and support by the counselor.

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## SYMPOSIUM 63—THE NATURE AND TREATMENT OF BDD FROM CLINICIANS' AND PATIENTS' PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, (1) attendees will gain knowledge of the presentation and common features of body dysmorphic disorder, (2) participants should have a better understanding of the available cognitive treatment techniques for BDD, (3) attendees will become familiar with behavioral treatment of body dysmorphic disorder, (4) attendees will gain knowledge about the role of plastic surgery in body dysmorphic disorder, and (5) attendees will learn biological theories and psychopharmacological strategies in the treatment of body dysmorphic disorder.

### No. 63A
### AN OVERVIEW OF THE PHENOMENOLOGY AND DIAGNOSTIC ISSUES IN BDD

James Claiborn, Ph.D., *Manchester Council, 51 Goppstown Road, Manchester, NH 03104*

SUMMARY:

Body dysmorphic disorder is a common but significantly underrecognized disorder that can produce severe interference with functioning and is associated with high rates of comorbidity with depression and is often associated with suicide. This section of the symposium will provide an overview of the disorder, review the diagnostic criteria, provide information about epidemiology of the disorder, and discuss its most common presentations. Methods of assessments and treatment will be identified. An explanation for why the disorder is so frequently undiagnosed and the consequences of this will be discussed.

### No. 63B
### NEW COGNITIVE INTERVENTIONS FOR BDD

Sabine Wilhelm, Ph.D., *Department of Psychiatry, MGH/Harvard, 13th Street, Charlestown, MA 02129*

SUMMARY:

Individuals with body dysmorphic disorder are excessively preoccupied with imagined or slight defects in appearance. Many patients describe that they spend more than an hour per day thinking about their defect(s) and that these thoughts are very painful. Recent research has begun to clarify underlying beliefs and attitudes in BDD. For example, patients often endorse beliefs such as "If my appearance is defective, I am worthless" or "If I am unattractive, I am unlovable." Other cognitive variables such as perfectionism and negative interpretation biases also appear to play an important role in the development and maintenance of BDD. These maladaptive beliefs and strategies lead to shame and anxiety in social situations.

Despite increasing evidence of the important role that cognitive errors and information processing biases appear to play in the etiology and maintenance of BDD, many clinicians are not familiar with cognitive interventions for this disorder. In the last few years, numerous new cognitive techniques have been developed for BDD. This presentation will familiarize attendees with the latest advances in the research on cognitions and information processing in BDD and empirically tested cognitive interventions.

### No. 63C
### BEHAVIORAL TREATMENT OF BDD

Fugen Neziroglu, Ph.D., *Bio-Behavioral Institute, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021*

SUMMARY:

Since the inclusion of body dysmorphic disorder (BDD) in the DSM, there have been several studies looking at the treatment efficacy of behavior therapy. Conceptualizing BDD as part of the obsessive compulsive spectrum disorders, we began to use similar behavioral approaches as that for obsessive compulsive disorder (OCD). Both BDD and OCD manifest symptoms of obsessions and compulsions/avoidance behaviors such as preoccupation with one's appearance and mirror checking. Research in OCD has demonstrated that

exposure and response prevention, a specific form of behavior therapy, is effective in targeting obsessions and compulsions. A review of the behavioral literature will be provided, including our own studies with case illustrations to demonstrate how behavior therapy is utilized for BDD.

### No. 63D
### ADDICTION TO PLASTIC SURGERIES IN PEOPLE WITH BDD

Eda E. Gorbis, Ph.D., *Department of Psychiatry, UCLA School of Medicine, 921 Westwood Blvd, Suite 224, Los Angeles, CA 90024*

SUMMARY:

Some people with body dysmorphic disorder (BDD) use plastic surgery as an answer to their never-ending dissatisfaction with their physical appearance. One of the manifestations of BDD is seeking professional medical help, in particular, going to plastic surgeons. The major concern is that plastic surgeons and general practitioners do not recognize BDD. People with BDD perceive dramatic problems in their appearance. They get repeated unnecessary plastic surgeries to correct the problem with their appearance. However, even after getting the surgery, which is supposed to fix the problem, they do not stay satisfied for a long time. People with BDD either find something else wrong with the "problem area" that they had a plastic surgery for or their concern/preoccupation moves to another area of the body. The current literature indicates that approximately 6% of individuals seeking cosmetic surgery actually have BDD. Most patients become worse after surgery and their depression increases. An overall view of cosmetic surgery in BDD and specifically treatment of one patient with 17 plastic surgeries will be presented.

### No. 63E
### BIOLOGICAL TREATMENT FOR BDD

Jose A. Yaryura-Tobias, *M.D., Bio-Behavioral Psychiatry, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021-5309*

SUMMARY:

The central theme of body dysmorphic disorder (BDD) is profound dissatisfaction with one's body shape and/or size. Biologically speaking, the history of BDD is fairly recent, posing more questions than answers. There are the following two concepts central to the pathology of BDD: (1) the patient's perceptual experience of his/her own body based on cues of corporal attractiveness, rejection, and acceptance, and (2) the question of whether perceptual distortions are the result of a delusional process or an obsessional overvalued ideational. Taking these factors into consideration as determinants of treatment options will aid in properly preparing one to begin the appropriate pharmacotherapy. Biological treatments for BDD include chemical agents, electroconvulsive therapy, and neurosurgery. From this array of options, we must select what we consider to be the most suitable treatment options for each individual patient. Currently available pharmacotherapy options will be discussed.

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## SYMPOSIUM 64—CLINICAL MANAGEMENT OF SCHIZOPHRENIA WITH COMORBID CONDITIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the different potential clinical origins of a depression-like syndrome in patients with schizophrenia, appreciate their significance and implications, and formulate appropriate intervention strategies, (2) be familiar with the current state of knowledge regarding management of schizophrenia with comorbid anxiety disorders, (3) understand how different components of a biopsychosocial treatment approach meet the clinical needs of patients with comorbid schizophrenia and PTSD, (4) review the options in managing acute episodes of agitation, and (5) review the options in managing patients beyond the acute episode.

### No. 64A
### CLINICAL MANAGEMENT OF DEPRESSION IN SCHIZOPHRENIA

Samuel G. Siris, M.D., *Long Island Jewish Medical Center, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

This presentation approaches the clinical 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 effects of 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, MAOI and other 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. 64B
### 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;* Miklos F. Losonczy, M.D.

SUMMARY:

Anxiety disorder is one of the most prevalent psychiatric conditions. While anxiety symptoms such as obsessive-compulsive disorder (OCD) and panic attack in schizophrenia have long been recognized, its underlying clinical and neurobiological implications remain poorly understood. Earlier diagnostic conventions precluded simultaneously diagnosing schizophrenia and anxiety disorders. Consequently, the anxiety disorders, including obsessive-compulsive disorder (OCD) and panic disorder (PD) in schizophrenia, were believed to occur only rarely and carry no significant clinical implications. Recent research, however, have shown greater prevalence rates and worse clinical course with poor outcome in this subgroup of schizophrenia with comorbid anxiety disorders. Furthermore, recent biological research has also demonstrated unique neurobiological basis in these anxiety disorders (i.e. OCD, panic disorder) and use of the specific adjunctive pharmacological interventions have shown positive outcome. However, the clinical management of schizophrenia with comorbid anxiety disorders continues to challenge practicing clinicians.

While further studies are needed, evidence suggest that the schizophrenia patients with comorbid anxiety disorders require specific, in-depth clinical evaluations, and an individualized treatment approach for the optimal outcome. This symposium will examine the existing clinical, epidemiological, and neurobiological evidence, and suggest a novel approaches for their clinical management.

## No. 64C
## SCHIZOPHRENIA AND PTSD

Lewis A. Opler, M.D., *Department of Psychiatry, New York University School of Medicine, 765 Gramattan Avenue, Mt. Vemon, NY 10552;* Mary Jane Alexander, Kristina H. Muenzenmaier, M.D., Anne-Marie Shelley, Ph.D.

SUMMARY:

Childhood physical and sexual abuse is found in 34% to 54% of patients with severe mental illness. Typically, these patients exhibit symptoms of both schizophrenia and complex PTSD, raising dilemmas of assessment, diagnostic classification, and clinical treatment. A biopsychosocial model that employs the most effective psychopharmacological, cognitive-behavioral, and supportive interventions, while minimizing coercive approaches like restraint, seclusion, and forced medication, is currently being developed and tested. Our program utilizes a range of antipsychotic, antidepressant, and anti-anxiety medications to target psychosis, flashbacks, nightmares, numbing, and hyperarousal. In regard to psychosocial strategies, the early disruption of trust and object constancy by intimate victimization has led us to encourage the establishment of long-term, stable therapeutic relationships, despite the rapid patient turnover presently prevalent for most persons with SMI. Finally, cognitive-behavioral group therapy techniques have been developed for these patients with 80% reporting that cognitive-behavioral interventions are "very helpful." We are expanding the availability of PTSD groups at our facility and are conducting efficacy studies, as well as developing manuals of techniques used (coping sheets, thought correction, stress management, re-scripting of nightmares).

## No. 64D
## PERSISTENT AGGRESSIVE BEHAVIOR IN SCHIZOPHRENIA: UPDATE 2003

Leslie L. Citrome, M.D., *Clinical Research/CREF, Nathan Kline Institute for Psych. Research, 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. 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.

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# SYMPOSIUM 65—NEW RESEARCH AND NOVEL THERAPEUTIC STRATEGIES FOR OCD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) review pharmacologic therapies for refractory OCD, (2) learn the results of a RCT of IV clomipramine, (3) understand the uses of neurosurgery in the treatment of patients with OCD that have failed pharmacologic and behavioral treatment, (4) recognize the key components of EX/RP and learn how efficacious this treatment can be, (5) be familiar with cognitive theories of OCD, and (6) learn specific meditation techniques for treating OCD, anxiety disorders, managing fear, anger, and be familiar with clinical results that indicate this protocol efficacy for new, treatment refractory OCD patients, and as adjuncts to medication/BT.

## No. 65A
## PHARMACOLOGIC STRATEGIES FOR REFRACTORY OCD

Brian A. Fallon, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Suzanne Feinstein, Ph.D., Franklin R. Schneier, M.D., Raphael Campeas, M.D., Carlos Blanco-Jerez, M.D., Michael R. Liebowitz, M.D.

SUMMARY:

For patients with SRI-refractory OCD, IV clomipramine (CMI) has been considered an effective option. After reviewing current strategies, we will present the results of our controlled study of IV CMI, assessing efficacy and speed of response.

*Methods:* Forty-six patients with a history of poor response to oral CMI and at least one SSRI received two weeks of either (1) IV CMI and oral placebo, or (2) IV placebo and oral CMI. This was followed by eight weeks of oral CMI. Patients were prospectively categorized regarding the type of obsession (e.g., aggressive vs symmetry) and the motivation (e.g., just right vs prevent harm). Blood levels for CMI were assessed.

*Results:* At week 4, 30% of patients in each treatment arm had a CGI rating of at least much improved. At week 10, 29% in the oral CMI arm were responders vs 17% in the IV CMI arm. ANCOVAs at week 10 failed to show significant difference between the groups on the YBOCS. Although 23% of patients benefitted, the results clearly demonstrate that IV CMI compared with oral CMI was neither more effective nor more rapid in action.

*Discussion:* Historical and biological factors associated with response will be addressed, along with the implications for future research.

## No. 65B
## NEUROSURGICAL APPROACHES TO TREATMENT-INTRACTABLE OCD

Steven A. Rasmussen, M.D., *Department of Psychiatry, Brown University, 345 Blackstone Boulevard, Providence, RI 02906-7010;* Benjamin D. Greenberg, M.D., George Noren, M.D., Richard Marslano, R.N., Jane L. Eisen, M.D.

SUMMARY:

An initial group of 15 patients with intractable OCD received bilateral single lesions in the anterior limb of the internal capsule. YBOCS scores were unchanged at eight months, suggesting that the single-lesion procedure was ineffective. Thirteen of these 15 patients had a second bilateral lesion placed just ventral to the initial lesion in the coronal plane. Five of these 13 patients were very much improved (greater than 35% improvement on the YBOCS) one year after the second procedure. Global Assessment of Functioning (GAF) scores also improved from 32 at baseline to 40 at one year, to 52 at four years (n=11/13). No adverse effects on personality or cognition were found.

Twenty-five additional patients with intractable OCD have received two shots bilaterally during a single procedures, with 18 followed for at least two years. Twelve of these patients were much improved (at least a 25% reduction on the YBOCS) at six months. Sixty-five percent of patients were much improved in one year. Using the more conservative criterion of "very much improved" (35% reduction on the YBOCS), the response rate was 37.5% of patients at six months, and 46% at one year. Improvement in level of functioning as assessed by the GAF was similar to the Single Stage Repeated group. Gamma capsulotomy is an effective and safe treatment for patients with disabling OCD who have failed pharmacologic and behavioral treatment.

## No. 65C
## THE ROLE OF COGNITIVE-BEHAVIORAL THERAPY IN THE TREATMENT OF OCD

H. Blair Simpson, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive Unit 69, New York, NY 10032;* Michael R. Liebowitz, M.D.

SUMMARY:

Two treatments proven to be effective for patients with obsessive compulsive disorder (OCD) are pharmacotherapy with serotonin reuptake inhibitors (SRIs) and cognitive behavioral therapy consisting of exposure and response (ritual) prevention (EX/RP). This presentation will describe the different components of EX/RP and how to implement them in clinical practice for maximal effect. In addition, the evidence for EX/RP's efficacy in OCD will be reviewed. This evidence will include (1) results from a large, recently completed, randomized clinical trial (RCT) that compared the effects of SRI pharmacotherapy (specifically clomipramine) and EX/RP in OCD patients and found that all active treatments were superior to pill placebo but that EX/RP was superior to CMI in some analyses; and (2) preliminary findings from an ongoing RCT that is examining the efficacy of augmenting SRI pharmacotherapy with EX/RP in OCD patients. At the end of this presentation, mental health providers will learn the key components of EX/RP and understand how efficacious EX/RP treatment can be for OCD.

## No. 65D
## EFFECTS OF COGNITIVE THERAPY FOR OCD

Gail Steketee, Ph.D., *Social Work, Boston University, 264 Bay State Road, Boston, MA 02215;* Sabine Wilhelm, Ph.D.

SUMMARY:

Recent cognitive theories of OCD posit that unpleasant intrusive thoughts and images provoke negative interpretations and associated strong emotional reactions. This is followed by efforts to avoid, suppress, or undo the thoughts, thereby strengthening their emotional valence and consequent rituals to reduce discomfort. Cognitive therapy (CT) derived from this model follows a Beckian method that employs Socratic questioning and a variety of techniques to evaluate the interpretations and associated beliefs that underpin the OCD symptoms. Outcomes of these treatments across several international controlled trials will be presented, including specific effects of CT on OCD symptoms, mood state, and problematic beliefs. In particular, we will present findings from our own recent trial of CT that addresses cognitive domains of responsibility and overestimation of threat, perfectionism and intolerance of uncertainty, and overimportance and control of thoughts. Our research examines whether CT alters these types of beliefs and whether change in beliefs predicts change in OCD symptoms. Findings indicate that YBOCS scores dropped substantially to well below the clinical cutoff and that depressed mood and negative interpretations and beliefs also reduced substantially. Cognitive predictors of outcome will be examined and discussed with regard to mechanisms of action in cognitive therapy.

## No. 65E
## KUNDALINI YOGA MEDITATION FOR THE TREATMENT OF OCD

David Shannahoff-Khalsa, B.S., *INLS, University of CA at San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0402*

SUMMARY:

A review of an RCT and detailed meditation protocol employed in comparison for treating OCD patients will be presented. Group 1 (11 adults) employed Kundalini Yoga (KY), a protocol consisting of 11 components (techniques to induce a meditative state, energize, reduce anxiety, one specific for OCD, manage fear and anger), and Group 2 (10 adults) employed the Relaxation Response and Mindfulness Meditation. Baseline and three-month interval testing was employed for the Yale-Brown Obsessive Compulsive Scale (Y-BOCS); Symptoms Checklist-90-Revised Obsessive Compulsive (SCL-90-R OC) and Global Severity Index (SCL-90-R GSI) Scales;

Profile of Mood States (POMS); Perceived Stress Scale (PSS); and Purpose-in-Life (PIL). At three months, Group 1 demonstrated greater improvements on the Y-BOCS, SCL-90-R OC and GSI Scales, POMS, and greater but non-significant improvements on the PSS and PIL scales. An intent-to-treat analysis (Y-BOCS) showed that only Group 1 improved. Within-group statistics only showed Group 1 significantly improved, and Group 2 showed no efficacy on any scale. Groups were merged for an additional year using KY techniques. At 15 months, mean group improvements were 71%, 62%, 66%, 74%, 39%, and 23%, respectively. In conclusion, KY techniques show promise with OCD patients whether new to therapy or treatment refractory to medication and/or behavior therapy.

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## SYMPOSIUM 66—E-THERAPY, TELEPSYCHIATRY, AND VIRTUAL ENVIRONMENTS: THE EVOLUTION OF CYBERPSYCHIATRY

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant (1) should become aware of the pros and cons of e-therapy as a therapeutic modality, (2) will be more proactive, less fearful, and more able to pursue technological advances so that psychiatry can survive and thrive in the 21st century, (3) will be familiarized with some novel techniques used to study and measure aspects of human consciousness, with special attention to use of a driving simulator, (5) understand the rationale for VR applications for neuropsychological assessment rehabilitation, (6) understand the specific advantages available with VR for these applications, and (7) learn about results from current VR neuropsychological research.

### No. 66A
### FRONTIERS IN PSYCHIATRIC COMPUTEROLOGY

James E. Swain, M.D., *Department of Psychiatry, Yale Child Study Center, 230 South Frontage Road, New Haven, CT 06520-7900*

### SUMMARY:

The sophisticated ability of computers to organize information and assist with human communication lends itself to many uses in psychiatry. Many fascinating practical and ethical issues have been raised. The uses of computers as aids in psychiatric treatment range from data management to providing new means of communicating, to assisting with diagnosis and treatment. Debates regarding such uses range from justifiable concerns over possible misuse to open enthusiasm for the growing multitude of uses. Given the inevitable ongoing technical abilities of computers and increasing availability to clinicians as well as the general public, it is important that psychiatrists participate in this debate.

Case vignettes will be used to highlight a discussion of the frontiers of computer use in clinical and research psychiatry, including topics such as the Internet and psychiatry, virtual psychiatry, and applications of computers to child and adolescent psychiatry.

### No. 66B
### OVERCOMING IMPEDIMENTS TO TECHNOLOGICAL ADVANCES IN PSYCHIATRY

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*

### SUMMARY:

Technological advances stand to benefit all areas of medicine, including psychiatry. Nevertheless, despite vast changes that have occurred within almost all areas of medicine, psychiatry lags behind all other areas of medicine. What are the critical barriers that are preventing psychiatrists from implementing information technologies?

This symposium will explore training, personal, professional, and organizational barriers that are preventing psychiatry from fully exploring and utilizing the technological advances that are moving the rest of medicine and the world forward. What are the consequences of these barriers and the lack of the utilization of these technologies? How will it affect psychiatry in the 21st century? What will be the downside? Is there an "imagined" upside? Is the lack of implementation of the technology of any value to psychiatry and our patients? What do we imagine? What is real?

### No. 66C
### MEASURING CONSCIOUSNESS: VIRTUAL ENVIRONMENTS IN THE ASSESSMENT OF HUMAN PERFORMANCE

Henry J. Moller, M.D., *Department of Psychiatry, University of Toronto, 399 Bathurst Street, Toronto Western, Toronto, ON M5T 258, Canada*

### SUMMARY:

The rationale for virtual environments (VEs) designed to study human consciousness is fairly logical. By analogy, much like an aircraft simulator serves to test and train piloting ability under a variety of systematic and controlled conditions, computer-generated environments can be developed that create scenarios that may be similarly used to assess and rehabilitate human cognitive and functional processes. This work has the potential to improve our capacity to understand, measure, and treat the impairments typically found in clinical populations with CNS dysfunction as well as advance the scientific study of normal cognitive and functional/behavioral processes. Older techniques borrowed from the fields of electrophysiology and biofeedback have proven helpful in overcoming the potential human-machine interface barrier in these applications.

A variety of state-of-the-art paradigms taking advantage of these relatively novel technologies will be highlighted, as well as ongoing research to assess impairments in consciousness using a computerized driving simulator. Psychiatric and public health implications of this research will be discussed.

### No. 66D
### VIRTUAL ENVIRONMENT FOR THE ASSESSMENT OF ATTENTION AND MEMORY PROCESSES

Albert A. Rizzo, Ph.D., *Department of Gerontology, University of Southern California, 3715 McClintock Avenue, MC0191, Los Angeles, CA*

SUMMARY:

Virtual reality (VR) technology applications for the study, assessment, and rehabilitation of individuals with neuropsychiatric conditions are increasingly available for the 21st century mental health clinician and researcher. What makes VR application development in this area so distinctively important is that it represents more than a simple linear extension of existing computer technology for human use. VR offers the potential to deliver systematic human testing and training simulation environments that allow for the precise control of complex, dynamic 3D stimulus presentations, within which sophisticated behavioral recording is possible. When combining these assets within the context of functionally relevant, ecologically valid VR environments, a fundamental advancement emerges in how human cognition and functional behavior can be assessed and rehabilitated.

This presentation will focus on the development and initial results of ongoing clinical trials using two Head Mounted Display (HMD)-delivered VR scenarios: The Virtual Classroom and The Virtual Office. These scenarios are currently being used to assess attention performance in children with attention deficit hyperactivity disorder and in the assessment of memory in adults a variety of neurocognitive deficits.

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## SYMPOSIUM 67—REPLENISHING OURSELVES: SUPPLY OF PSYCHIATRISTS FOR THE PRESENT AND THE FUTURE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should (1) recognize major trends in the distribution of psychiatrists in the U.S., (2) understand how to estimate psychiatric workforce requirements employing a "needs-based" approach and to use that method to clarify important diagnosis and treatment, access to care, and scope of practice issues.

### No. 67A
### CURRENT STATUS OF THE PSYCHIATRY WORKFORCE IN THE U.S.

90089; Darrel A. Regier, M.D., *Office of Research, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Joshua E. Wilk, Ph.D., Joyce C. West, Ph.D., Farifteh F. Duffy, Ph.D.

SUMMARY:

Using data from the American Psychiatric Institute for Research and Education (APIRE) and the American Medical Association (AMA), the current workforce in psychiatry will be described, including demographic characteristics and professional activities. There are an estimated 40,867 clinically active psychiatrists in the U.S., reflecting a 4% increase since 1996. Approximately 73% of APA members are male and 75% are Caucasian. Members of Asian descent are overrepresented in APA as compared with the general U.S. population, while Hispanics, African Americans, and American Indians are underrepresented. There are approximately 14 clinically active psychiatrists practicing in the U.S. per 100,000 individuals; however, rates vary significantly across geographic regions. While psychiatrists today work, on average, the same number of hours as a decade ago, they're seeing more patients and spending less time with patients. Additionally, psychiatrists report spending a higher proportion of their time in administrative activities and a lower proportion of their time in direct patient care than 10 years ago. The number of psychiatrists who report private practice as their primary work setting has decreased over the last decade, with less than half of their patient care time in either individual or group practice. Possible explanations for these findings will be discussed.

### No. 67B
### IMPLICATIONS OF A NEEDS-BASED APPROACH TO PSYCHIATRIC WORKFORCE

Larry R. Faulkner, M.D., *Office of the Dean, University of SC School of Medicine, Columbia, SC 29208*

SUMMARY:

The author reviews a needs-based approach to estimating psychiatric workforce requirements that entails the following five determinations: (1) number of people with mental health problems, (2) number of people needing mental health treatment, (3) number of people needing psychiatric treatment, (4) amount of psychiatric time required to meet patient needs, (5) amount of time psychiatrists have available to provide direct patient care. Questions, issues, and strategies raised by the needs-based approach are outlined. The author suggests that only a carefully orchestrated, coordinated effort among national psychiatric organizations will ensure that the future psychiatric workforce is adequate to meet the needs of the mentally ill.

### No. 67C
### CHILD AND ADOLESCENT PSYCHIATRY WORKFORCE: A CRITICAL SHORTAGE AND NATIONAL CHALLENGE

Wun-Jung Kim, M.D., *Medical College of Ohio, Kobacker Center Child Division, 3130 Glendale Avenye, Toledo, OH 43614-5810*

SUMMARY:

Despite the decades-long projection of an increasing utilization of child and adolescent psychiatry services and an under-supply of child and adolescent psychiatrists, the actual growth and supply of child and adolescent psychiatrists has been very slow. Inadequate support in academic institutions, decreasing GME funding, decreasing clinical revenues in the managed care environment, and devalued image of the profession have made academic child and adolescent psychiatry programs struggle for recruitment of both residents and faculty, although child and adolescent psychiatry has made impressive progress in its scientific knowledge base through research, especially in neuroscience and developmental science. While millions of young people suffer from severe mental illnesses, there are only about 6,300 child and adolescent psychiatrists practicing in the U.S. There is also a severe maldistribution of child and adolescent psychia-

trists, especially in rural and poor urban areas having significantly reduced access. By any method of workforce analysis, it is evident that there will continue to be a shortage of child and adolescent psychiatrists well into the future. Medical/psychiatric educators have a mission to encourage medical students and general psychiatry residents to enter into child and adolescent psychiatry, to provide crucial mental health care, and health care/policy advocacy for our country's youngest and most vulnerable citizens.

## No. 67D
## SCHOOL BY SCHOOL TRENDS IN MEDICAL STUDENT CAREER CHOICE OF PSYCHIATRY, 1999–2001

Frederick S. Sierles, M.D., *Department of Psychiatry, Finch University, 3333 Green Bay Road, North Chicago, IL 60064;* Stephen H. Dinwiddle, M.D., Delia Patroi, M.D., Nutan Atre-Vaidya, M.D., Michael J. Schrift, D.O.

### SUMMARY:

There is a paucity of recent papers about factors affecting school-by-school differences in medical student career choice of psychiatry. The proportion of seniors matching into psychiatry (PMP) at each school results from a complex interplay between (1) national and regional trends (extrinsic factors), and (2) characteristics of each medical school, including its psychiatry department's educational programs (intrinsic factor). Our goal was to ascertain factors influencing PMP at individual schools from 1999–01.

The dependent variable was the average PMP from each U.S. school in 1998–99. 1999–00, and 2000–01. (PMP for individual schools will not be listed.) Independent variables included the school's geographic region, tuition, type of funding, local managed care penetration, proportion of the department's residents who were IMGs, admissions preference for applicants with rural or disadvantaged backgrounds or primary care interests, the student body ethnic makeup, and having a psychiatrist dean.

PMP was obtained for every U.S. school. Data about each independent variable were obtained for >98% of schools. Compared with 1991–92 findings, school-by-school PMP changed significantly, as did the relationship between PMP and several extrinsic variables.

While national, extrinsic factors influence school-by-school PMP, the quality of each department's medical student education programs also contributes notably.

## No. 67E
## DEPARTMENTS OF PSYCHIATRY WITH HIGH RECRUITMENT INTO PSYCHIATRY FROM 1999–2001: IMPLICATION FOR MEDICAL STUDENT EDUCATION

Darlene Shaw, Ph.D., *Charleston, SC 29401;* Frederick S. Sierles, M.D., Joshua T. Thornhill IV, M.D., Kathleen A. Clegg, M.D., Lowell D. Tong, M.D.

### SUMMARY:

Between 1998–2002, progressively more U.S. graduates have matched into psychiatry. But these percentages are below those between 1940–1977, when 5% to 10% of U.S. graduates chose psychiatry, and 1988–89, when slightly more than 5% of graduates chose psychiatry. Still between 1999–2001, nine schools averaged 6.8% or more (range of averages 6.8% to 10.8%) of their graduates choosing psychiatry. Presuming that over and above national and regional trends (extrinsic factors) that affect recruitment, there is an association between the quality of a psychiatry department's educational programs (intrinsic factors) and the number of the school's graduates choosing psychiatry, we asked directors of medical student education at four of the nine highest-recruiting schools to summarize their programs and to speculate about the reasons for their high recruitment. The schools are the University of South Carolina, the Medical University of South Carolina, Case Western Reserve, and University of California, San Francisco. The author summarizes (1) key features of the programs at each of these schools, and (2) her and her co-authors' speculations about why these schools recruit well. Regardless of whether these speculations are accurate, aspects of each program could be used at other schools for educational—not necessarily recruitment—purposes.

## No. 67F
## AN ANALYSIS OF RECENT TRENDS IN PROGRAM SIZE, PROGRAM TYPE, AND DEMOGRAPHICS IN PSYCHIATRIC RESIDENCY TRAINING AND ITS WORKFORCE

Nyapati R. Rao, M.D., *Department of Psychiatry, SUNY Downstate Medical Center, 450 Clarkson Avenue Box 1203, Brooklyn, NY 11203*

### SUMMARY:

The current study was conducted to examine the trends in the supply, distribution, and demographics of psychiatry residents in the decade of the 1990s, especially whether the predicted downsizing of psychiatric residency training programs had actually occurred and how it affected training programs of different sizes and locations. Additionally, the status of international medical graduates (IMGs) vis-a-vis United States medical graduates (USMGs) in the GME workforce was compared. Data for this study were obtained from the American Medical Association's Annual Survey of GME Programs as well as data from the APA's Psychiatry Resident Census. This study found significant declines in the total number of residents per program over the years. Between 1992–99, the total number of residents in general psychiatry training programs dropped by 8.4% and the total number of general psychiatry residency programs dropped by 6%. The percentage of USMGs fell from a high of 76% in 1989–92 to 58% in 2001, while the percentage of IMGs rose from 29% in 1972–73 to 43% in 2001. Larger programs suffered greater losses in residents than smaller programs. Medical school programs fared better than non-medical school-based programs. Finally, the psychiatric resident workforce has become smaller, more diverse, more heavily represented by females, and older than ever before. Possible explanations for these findings and their policy implications are discussed.

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# SYMPOSIUM 68—PTSD: A LATIN-AMERICAN NIGHTMARE

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize and understand the concept of severe stressor or trauma, (2) recognize the different criteria needed to make the diagnosis of PTSD, (3) be familiar with the epidemiology of PTSD, (4) identify the neuroanatomical changes of patients with PTSD, and (5) be familiar with the different biological changes in patients with PTSD.

## No. 68A
## TRAUMA AND PTSD: SOME NEW CONCEPTS

Jose M. Canive, M.D., *Department of Psychiatry, VA Medical Center, 2100 Ridgecrest Drive SE, Albuquerque, NM 87108*


### SUMMARY:

PTSD is probably one of the few disorders recognized more by the cause than by the symptoms to the point that one of the requirements for the diagnosis is to meet the stressor criterion. In DSM-IV the criteria specify that "the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others." This definition would include rape, other assaults, kidnapping, terrorist attacks, being taken hostage, torture, severe accidents, war, human-nature-made disasters, and witnessing assaults or persons being killed by unnatural ways.

The second category necessary to make the diagnosis is the one dealing with re-experiencing the symptoms as intrusive recollections, distressing dreams, acting or feeling as if the traumatic event were occurring, or experiencing psychological distress at exposure to cues that symbolize the traumatic event.

The third category has to do with the avoidance symptoms and the last one with issues of increased arousal such as difficulty falling sleep, irritability, anger, problems concentrating, hypervigilance, and exaggerated startle response.

Due to this wide variety of symptoms, it is important to make a proper differential diagnosis not only to plan for a proper treatment but to determine the multiple comorbidities common to this disorder.


## No. 68B
## NEUROBIOLOGICAL FINDINGS ON PTSD

Gerardo Villareal, M.D., *Psychiatry, VA Medical Center, 1501 San Pedro Drive SE, Albuquerque, NM 87108*


### SUMMARY:

The neurobiology of PTSD has been studied extensively during the last two to three decades. Patients with chronic PTSD have been found to have increased circulating levels of norepinephrine and increased reactivity of the alfa-2 adrenergic receptors plus increased levels of thyroid hormone. Neuroanatomical studies have identified anomalies in the amygdala and hippocampus with demonstration of increased reactivity of the amygdala and anterior paralimbic region by studies with PET and fMRI.

Other interesting findings have been lower cortisol levels with increased levels of corticotropin-releasing factor in CSF.

These findings are different from what happens in normal persons or patients with depressive disorders and help to explain many of the different symptoms developed by patients who suffer this terrible disorder.


## No. 68C
## RESILIENCE: A NEW CONCEPT

Dora Cardona, M.D., *Universidad Tecnologica CMTY Med., Multifamiliar La Villa Bloque Z, Pereira, SA, Colombia*


### SUMMARY:

At least two studies, after the September 11 terrorist attack, have shown that the incidence of PTSD is higher in Hispanic groups than other groups.

These findings are different than the findings of studies done in Texas and California, where the incidence of mental disorders in Mexicans born in Mexico and Mexicans born in the U.S. is less. We will be reporting data from a study conducted in Colombia after the earthquake that occurred in the area called the "Coffee Axis of Colombia" a couple of years ago. In this study, we found that the development of PTSD after the disaster was relatively small compared with other similar circumstances in other parts of the world.

Due to these findings, we decided to study the psychological phenomenon of resilience and we will present data of 2,000 interviews done with persons living in the area of the earthquake. Based on this study, we will discuss the different factors that influence resilience and how this knowledge can be applied to prevent the development of PTSD after disasters. We will incorporate elements of the other presentations and will develop an algorithm to be utilized in prevention efforts during disasters.


## No. 68D
## TRAUMA AND DEBRIEFING IN THE COLOMBIAN ARMY

Daniel Toledo, M.D., *Departmento de Psiquiatria, Militar Hospital, Bogota, Colombia*


### SUMMARY:

War is considered one of the most severe traumas and the incidence of PTSD in war veterans is very high.

Colombia is under the influence of a not-declared civil war with almost daily confrontations between the gerrillas and the Colombian army. This situation has exposed thousands of soldiers and civilians to the horrors of war with the subsequent development of PTSD among many of them.

We will be presenting data on the incidence of PTSD in the Colombian army and will discuss the methods utilized to prevent the development of the disorder and a description of the health services structured to provide these preventive measures and the identification and treatment of soldiers suffering acute stress reactions and PTSD.


## No. 68E
## PTSD AND PET: THE MALVINAS TRAUMA

Roxana Galeno, M.D., *O. Andrade 290, Mendoza 5500, Argentina*


### SUMMARY:

The imaging studies done in patients suffering a posttraumatic stress disorder have shown a reduction in the volume of the right hippocampus (5% to 10%). Also an increased incidence of cavum septi pellucidum in patients with PTSD compared with healthy volunteers.

In other studies, it was found that veterans with PTSD, but not healthy combat veterans, had increases in regional cerebral blood flow in the ventral anterior cingulated gyrus and right amygdala.

We will discuss the PET findings in 15 veterans of the Malvina's war (1982) with PTSD compared with six veterans without PTSD in a study conducted by the Instituto Neurociencias and the Escuela de Medicina Nuclear Mendoza, Argentina.

## No. 68F
## COMPREHENSIVE MANAGEMENT OF THE PATIENT WITH PTSD

Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Medicine, 2660 Peach Tree Road, NW, Apt. 29B, Atlanta, GA 35305*

### SUMMARY:

The treatment of the patient suffering a posttraumatic stress disorder fits the concept of management more than the concept of treatment due to the multiple signs and symptoms of the illness.

The therapeutic modalities utilized are multiple and many of them complimentary of each other. Among them we can utilize psychoeducation, cognitive therapy, psychodynamic psychotherapy, and pharmacotherapy.

Among these therapies the ones that are more utilized are the cognitive-behavioral ones, which include techniques such as exposition, systematic desensitization, cognitive processing, stress inoculation, biofeedback, and relaxation training.

One technique that incorporates several of these techniques is called virtual therapy, which has been developed for the treatment of PTSD veterans in the Atlanta VA Hospital. Patients are exposed to different visual images created by computer graphics, which are introduced gradually and systematically under continuous control. The visual images are transmitted utilizing a visor close to the patient's eyes. At the same time the patient and the therapist have control of the different sounds connected with the visual imagery.

## No. 68G
## PSYCHOPHARMACOLOGY AND PTSD

Luis F. Ramirez, M.D., *Quality Outcomes, 7531 Old Quarry Lane, Brecksville, OH 44141-1541*

### SUMMARY:

Practically all psychotropic medications have been utilized in the pharmacological management of the patient suffering a posttraumatic stress disorder.

The objectives of the psychopharmacological treatment are improvement of the symptoms, increase the capacity of adaptation to stress, decrease the risk of comorbidity, decrease disability, and improve the quality of life. Despite these objectives, many believe that the treatment with medications is secondary to the psychological treatments and only indicated to treat the biological alterations suffered by the patient.

The treatment with medications can be divided in two types, acute and chronic.

The acute treatment is focused in helping to reduce the fear and the neuronal imprinting with the objective of reducing the sensitization, the consolidation of memories, and in general the reduction of symptoms such as depression and anxiety.

Currently, the following are considered first-line medications: SSRIs, nefazodone, and venlafaxine. These medications have demonstrated to be useful in the reduction of intrusive symptoms, numbing, avoidance, and hyperarousal.

Other medications such as anticonvulsants and mood stabilizers are alternatives for patients with irritability, explosiveness, or re-experiencing symptoms that have not responded to other medications.

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# SYMPOSIUM 69—MANAGING SUICIDALITY IN BPD

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand empirical data on the prevalence and occurrence of completed suicide in borderline personality disorder, (2) recognize risk factors for suicidal behavior in BPD, (3) describe the psychological differences between acute and chronic suicidal states and the Gunderson approach to chronic suicidal ideation, (4) recognize and be able to manage medicolegal problems related to suicide litigation with borderline patients, and (5) understand data on the relationship between DBT and suicidality.

## No. 69A
## LONG-TERM OUTCOME AND SUICIDE IN BPD

Joel F. Paris, M.D., *Department of Psychiatry, Sir Mortimer B Davis Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, PQ H3T 1E4, Canada*

### SUMMARY:

*Objective:* To review findings on suicide completion drawn from long-term outcome studies of borderline personality disorder (BPD).

*Methods:* A literature review (MEDLINE and PSYCLIT) was conducted on all follow-up studies of BPD since 1980.

*Results:* About 10% of borderline patients eventually commit suicide. There are few strong predictors of completion. The age at which completions occur is relatively late; in the longest follow-up study, it was age 37. The maximal level of suicidal threats occurs much earlier than completed suicides.

*Conclusions:* Borderline patients are at risk for suicide, but there is no evidence that completions can be prevented.

## No. 69B
## SUICIDE PREDICTION IN BPD

Donald W. Black, M.D., *Psychiatry Research MEB, Univ of Iowa College of Med, Iowa City, IA 52242*

### SUMMARY:

Suicidal behavior is perhaps the most vexing symptom associated with borderline personality disorder (BPD) and is nearly universal. It is estimated that 75% of persons with BPD attempt suicide; and approximately 10% will complete suicide. Persons with BPD carry out a mean of 3.4 attempts. Because psychiatrists must provide for patient safety to help prevent tragic outcomes, suicide prediction, and prevention is an important part of the clinical management of persons with BPD.

While suicide prediction is fraught with difficulty, as studies of psychiatric inpatient populations have shown, the task is more so in persons with BPD. Clinicians must avoid the mistake of thinking that a pattern of repeated attempts indicates little desire to die. Research has provided clues to those at greatest risk for suicide attempts, including the presence of accompanying major depressive disorder (MDD) or a substance use disorder, individually or together. Comorbidity with MDD serves to increase both the number and seriousness of the suicide attempts. Hopelessness and aggression independently increase the risk of suicidal behavior.

In summary, BPD is frequently complicated by suicidal behavior. Clinicians have an important role in preventing patient suicides by understanding its risk factors.

### No. 69C
### CHRONIC SUICIDALITY AND BPD

Randy A. Sansone, M.D., *Sycamore Primary Care, 2115 Leiter Road, Miamisburg, OH 45342*

SUMMARY:

Chronic self-destructive behavior is characteristic of individuals with borderline personality disorder (BPD). These behaviors function in a variety of intrapsychic and interpersonal ways, including the regulation of strong affective states, organization of oneself during a fleeting quasi-psychotic episode, punishment of a perceived bad self, maintenance of a negative identity, displacement of anger from others toward self, and elicitation of caring responses from others. These complex psychological functions appear to be chronic adaptations, which is in stark contrast to the psychological themes observed in acute suicidal states, which are momentary and fleeting. Therefore, it seems clinically appropriate to categorize suicidal ideation in these terms (i.e., acute vs. chronic).

In terms of therapeutic management, this dichotomy is meaningful. For example, in acute suicidal states, the clinician assesses risk factors, takes a directive approach to disposition, and temporarily assumes responsibility for the patient for a greater long-term benefit. In chronic suicidal states, the behavior functions as a disturbed way of relating to others and if approaches to acute suicidal ideation are utilized, they may actually reinforce unhealthy interpersonal dynamics and divert intervention from critically important therapeutic issues. Various approaches to chronic suicidal ideation will be reviewed and contrasted with acute approaches.

### No. 69D
### LIABILITY ISSUES IN LITIGATION AFTER SUICIDE

Thomas G. Gutheil, M.D., *Department of Psychiatry, UMHC, 6 Wellman Street, Brookline, MA 02446-2831*

SUMMARY:

Patients with borderline personality disorder both threaten and attempt suicide as well as, unfortunately, succeeding. This segment of the panel will address the risk-management aspects of post-suicide litigation, suicide assessment and prevention, post-suicide intervention and outreach, and aspects of malpractice litigation relevant to this situation.

*Results:* Risk-management strategies can decrease the probability of post-suicide litigation.

### No. 69E
### THE APPLICATION OF DIALECTICAL BEHAVIOR THERAPY TO CHRONIC SUICIDALITY IN BPD

Marsha M. Linehan, Ph.D., *Department of Psychology, University of Washington, NI-25 P.O. Box 351525, Seattle, WA 98195*

SUMMARY:

Dialectical behavior therapy (DBT) is a method for managing emotional dysregulation in borderline patients. It has now been shown to be effective in reducing suicidal behavior by a number of clinical trials, most recently in studies from outside the Seattle area. The approach involves identifying emotional triggers for suicidality and helping patients to problem solve and develop alternative behavior to regulate dyphoric affects.

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## SYMPOSIUM 70—TERRORISM, WAR, AND REFUGEES: PSYCHIATRIC EFFECTS AND PREVENTION?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand an epidemiological approach to assessing children's psychological reactions after a terrorist attack, and describe the prevalence of these reactions, (2) understand the similarities and differences in the responses of Kenyans and Americans to terrorist bombing, and the lessons each can learn from the other.

### No. 70A
### NEW YORK CITY CHILDRENS' REACTIONS TO TERRORISM AFTER 9/11

Christina Hoven, D.P.H., *Department of Child Psychiatry, Columbia-NYS PI, 1051 Riverside Drive, Unit 43, New York, NY 10032;* Cristiane Duarte, Ph.D., Ping Wu, Ph.D., Donald Mandell, Cecilie Birner, Julia Mooney, B.A.

SUMMARY:

*Objective:* To evaluate the impact of terrorism on children's mental health and expectations about their future.

*Method:* A cross-sectional study assessed a representative sample of New York City public school students, grades 4 through 12, six months post 9/11. A questionnaire was designed to gather information on demographics, different types of exposures to 9/11 events, health problems, discrimination, service need and utilization, and student's perspectives about the future. The questionnaire also included the DISC Predictive Scales, a screening measure used here to assess eight probable psychiatric disorders.

*Results:* A higher than expected number of students throughout NYC screened positive for a broad range of psychiatric disorders. Factors such as gender, grade level, and having a family member exposed to the attacks were associated with mental health problems. We will present findings from ongoing analyses of how children's concerns about issues related to terrorism (reoccurrence of the WTC attacks, bioterrorism, economic consequences, and discrimination)

are associated with psychopathology and influence their expectations about the future.

*Conclusions:* The World Trade Center attacks had a large impact on NYC public school students' mental health. We predict that expectations about the future will vary according to the level of children's concerns about future outcomes of terrorism.

## No. 70B
## TERRORISM IN NAIROBI AND NEW YORK: THE LESSONS LEARNED

Frank G. Njenga, M.D., *PO Box 73749, Nairobi 00200, Kenya*

SUMMARY:

On August 7, 1998, the American Embassy in Nairobi was blown up by a terrorist bomb. A total of 253 people died and 5,000 were injured. Following the September 11, 2001, attack at the World Trade Center in New York, many questions have been asked about the lessons learned from the African experience and the extent to which the lessons were applied following September 11. This presentation describes the Kenyan and U.S. response to the bombing and concludes that Kenyan and American people have many lessons to learn from each other as they go through the process of nursing the psychological wounds inflicted by a common enemy, thousands of miles apart. Vicarious traumatization of Kenyan people following TV exposure to events of September 11 is briefly discussed as is the massive potential for opportunities for joint research on transcultural issues in response to trauma and factors that promote or delay recovery.

## No. 70C
## VIOLENCE AGAINST CIVILIANS: A HISTORICAL PERSPECTIVE

Nasser F. Loza, M.B., *Department of Psychiatry, The Behman Hospital, 32 El Marsad Street—Helwan, Cairo 11421, Egypt;* Waleed A.R. Fawzi, M.S.C.

SUMMARY:

Throughout history human civilizations have resorted to violence to defend or promote political and/or ideological beliefs. Somehow history is written by the victorious. This presentation aims at reviewing the major acts of violence against civilians in human history looking at motivational factors, fanaticism, outcome, and final judgment of history.

From early civilizations, Pharaonic and Greco-Roman wars against civilians and religious wars of the assassins and the crusaders, examples of violence against civilians will be analyzed in comparison to the less violent battles of the early Islamic era.

Psychological aspects of violence including unconscious reinforcement concepts of anomy and altruism will be discussed vs positive rewards of economic and social benefits related to violence.

Finally, a review of the recent literature on the topic will examine difficulties of conducting objective research in the area of violence against civilians.

## No. 70D
## MENTAL HEALTH SEQUALAE OF THE LEBANON WARS

Elie G. Karam, M.D., *Department of Psychiatry, St Georges Hospital, Achrafleh, PO Box 166378, Beirut 1100-2807, Lebanon;* Aimee N. Karam, Ph.D., John A. Fayyad, M.D., Caroline E. Cordahi, DEA, Zeina W. Mneimneh, M.P.H., Nadine Melhem, Ph.D.

SUMMARY:

Our group (I.D.R.A.C: Institute for Development Research and Applied Care) has been investigating the effects of the Lebanon Wars on the mental health of children, adolescents, and adults in Lebanon for the past two decades. We have done so using international instruments (CIDI, DIS.) and instruments we created (WEQ). Several findings have come out of our research. War traumata are additive. People do not get "used" to them; comorbidity is the name of the game: PTSD and depression more often co-exist than not. Preventive, group-based, large-scale treatment for war-related mental health disorders, has proven to be neither efficient nor effective (We tested it on a large number of adolescents and children N=2,500 and followed up prospectively). Fre-war and non-war variables (family psychiatric history, personal psychiatric history, other psychosocial stressors) interact and at times and in specific populations (children) override war events. Measurement of war events remains an important issue in research and our experience is that the evaluation of the witnessing factor, subjective perception, and objective evaluation of war events are all independent and yet interactive factors that have to be taken into account very seriously in research on war.

## No. 70E
## TRANSGENERATIONAL TRANSMISSION OF AGGRESSION

Sam Tyano, M.D., *Telaviv University Medical School, PO Box 102, Petah Tikvah 49101, Israel*

SUMMARY:

Plenty has been written lately on the influence of acts of terror on the public in general and on children in particular. Most researchers who conduct research in different countries, describe the same symptoms in the majority of the population, with specific characterizations for children and for adolescents. The diagnosis is usually not difficult, yet the tratment unfortunately is complex and there is no agreement among researchers on the timing of intervention or even if there is room for an intervention.

On one hand at least there is consensus, and that is that prevention is the most efficient tool in the clinic of personal and social violence. One form of prevention is educating for tolerance and civil rights. Due to the vital role that media plays today in the development of knowledge and affect in children and adolescents, we shall discuss the means we see as important in prevention through education and the processes of transgenerational transmission of violence.

If we indeed accept the importance of these processes, prevention is more efficient than treatment.

We shall describe the influence of terror on children and the tools we believe should be used for prevention.

## No. 70F
## NOT TRAUMATIZED BUT DEMORALIZED: MENTAL HEALTH NEEDS OF ASYLUM SEEKERS IN BRITIAN

Patrick J. Bracken, M.D., *Health Studies, University of Bradford, Horton Park Centre, Bradford BD7 3EG, United Kingdom*

SUMMARY:

Western European countries, including the United Kingdom, have witnessed the arrival of an increased number of asylum seekers over the past 10 years. There are many reasons for this increase. Mental health problems often figure highly. The presenter of this paper will argue that the discourse of posttraumatic stress disorder (PTSD) is inadequate as a way of framing and understanding these mental health problems. He argues that many difficulties arise from the

practical problems of life in exile and makes the case that we should be thinking more about demoralization and less about trauma.


## REFERENCES:

1. Hoven CW, Duarte CS, Lucas CP, Mandeli DJ, Wu P, Rosen C: Effects of the World Trade Center Attack on NYC Public School Students Initial Report to the New York City Board of Education. Applied Research and Consulting, LLC & Columbia University Mailman School of Public Health and New York State Psychiatric Institute: New York, 2002.
2. Nyamal & Njenga: Mental Health Response to a Major Disaster: The Nairobi Experience. WPA Congress. Hamburg, August, 1999.
3. Skodol AE (Ed.): Psychopathology and Violent Crime. American Psychiatric Association, Washington DC, 1998.
4. Karam EG, Melhem N, Karam AN, Yabroudi P, Zbouni V, Mansour C: War and Mental Health: Children and the Grapes of Wrath. The Updated report. Beirut, Lebanon, UNICEP, 1997.
5. Salmon K, Bryant RA: Posttraumatic stress disorder in children. The Influence of developmental factors. Clin Psychol Rev 2002; 22(2):163–88. Review PMID: 11806018 (PubMed-indexed for MEDLINE)


# SYMPOSIUM 71—NEUROPSYCHIATRIC ASPECTS OF HIV/AIDS: AN OVERVIEW, PART 1

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) delineate the challenges that psychiatrists must be aware of when treating HIV patients, (2) identify new trends in viral detection and clinical measurements, (3) describe updated HIV treatment guidelines, options, and controversial unanswered questions, (4) understand risk factors and clinical manifestations in HIV/AIDS, (5) understand differential diagnosis in HIV/AIDS, (6) understand the treatment of the neuropsychiatric complications in HIV/AIDS, (7) list the general and specific psychopharmacological treatment approaches, (8) review clinical cases that illustrate common characteristics, diagnostic approaches, and management issues, and (9) to discuss cultural contexts and assumptions with which each case is analyzed.

## No. 71A
## HIV TREATMENT UPDATE

Paul Volberding, M.D., *4150 Clement St., VAMC 111, San Francisco, CA 94121*


### SUMMARY:

There are an increasing number of antiretroviral agents being used to treat HIV-infected patients. To successfully diagnose and treat patients with HIV/AIDS, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations. Treating HIV-infected persons, however, is becoming increasingly complex. Antiretroviral regimens have major side effects and pose significant adherence problems. This session will provide the most up-to-date epidemiological information, guidelines for antiretroviral therapy, and drug-drug interaction information. The session will include a lecture and question and answer period providing participants the opportunity to discuss individual clinical concerns.


## No. 71B
## 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:

Enormous mental health challenges face a patient with HIV/AIDS. Studies estimate that as many as 75% of all AIDS patients will show symptomatic central nervous system consequences. Despite advances in antiretroviral therapy, the neurological manifestations of HIV infection are a major source of morbidity and mortality. It is vital for psychiatrists to be involved in the diagnosis and treatment of HIV/AIDS patients. HIV infection of the central nervous system can lead to a range of neuropsychiatric symptoms including minor cognitive-motor disorder, HIV-associated dementia, delirium, and psychosis. This session will cover the complications of the central and peripheral nervous systems and address psychopharmacologic interventions. The session will include a lecture and a question and answer period to provide participants with the opportunity to discuss clinical problems.


## No. 71C
## CASE DISCUSSION AND CLINICAL PANEL

Warren M. Liang, M.D., *Department of Psychiatry, University of Cincinnati, PO Box 670559, Cincinnati, OH 45267*


### SUMMARY:

The case discussion provides an opportunity for psychiatrists to become active participants in the symposia. This session will introduce case examples of how to evaluate and treat a patient with HIV/AIDS. The case discussion will reinforce knowledge gained from the HIV treatment update and CNS manifestations, including basic medical facts, neuropsychiatric aspects of HIV/AIDS, and diagnosis and treatment information. Throughout this session, participants will have access to expertise provided by a clinical panel.



### REFERENCES:

1. Panel on Clinical Practices for Treatment of HIV Infection: Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents. Department of Health and Human Services/ Henry J. Kaiser Foundation, 2002.
2. Tyler L: Through a glass, darkly: cerebrospinal fluid viral load measurements and the pathogenesis of human immunodeficiency virus infection of the central nervous system. Arch Neurol 2002; 59:909–912.
3. Cournos F, Forstein M (eds.): What Mental Health Practitioners Need to Know About HIV and AIDS. Jossey-Bass 87, Fall 2000.


# SYMPOSIUM 72—UNMET NEEDS IN BIPOLAR DISORDER: REDEFINING THE SPECTRUM AND ITS BOUNDARIES

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) be able to recognize the global clinical picture of bipolar spectrum, with a special emphasis on atypical, early onset, or comorbid forms, and improve the choice of early treatment.

## No. 72A
## OCD-BIPOLAR COMORBIDITY REDEFINED: PLACE OF CYCLOTHYMIA

Elie G. Hantouche, M.D., *Department of Psychiatry/Mood Center, Pitie-Salpetriere Hospital, 43 Bd Hopital, Paris 75013, France*

SUMMARY:

Clinical research has largely focused on comorbidity of unipolar depression and obsessive compulsive disorder (OCD). However in practice, resistant, complex, or severe OCD patients not infrequently may suffer from a typical or hidden soft bipolar disorder. In a collaborative study with the French Association of OCD, we systematically explored the rate of major depression and bipolar comorbidity (mania, hypomania, cyclothymia) by using fully structured self-rated questionnaires for major depression, hypomania, and mania (DSM-IV criteria) and self-rated scales (Angst's checklist of Hypomania and Cyclothymic Temperament Scale). Data are available in a total sample of 628 patients suffering from OCD. According to DSM-IV definitions of (hypo)mania, 11% of the sample was classified as bipolar (3% BP-I and 8% BP-II). When dimensionally rated, 30% obtained a cut-off score ≥ 10 on the Hypomania checklist and 50% were classified as cyclothymic. In contrast to non-cyclothymics, the cyclothymic OCD patients were characterized by higher global severity and frequency of some OCD symptomatology (aggressive, impulsive, religious and sexual obsessions, compulsions of control, hoarding, repetition); more episodic course; greater rates of major depressive episodes (89% vs 64%) with higher intensity and recurrence of depression associated with higher rates of suicide attempts (20% vs 12%) and psychiatric admissions (46% vs 35%); and finally, a less favorable response to anti-OCD treatments and elevated rate of mood switching with aggressive behavior (49%). Our data extend previous research on "OCD-bipolar comorbidity" (Chen & Dilsaver, 1995; Perugi et al, 1997) as a highly prevalent and largely under-recognized entity, and probably as a distinct form of OCD.

## No. 72B
## THE ATYPICAL DEPRESSION: BIPOLAR II BORDERLINE CONNECTION

Giulio Perugi, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa 56100, Italy;* Hagop S. Akiskac, M.D.

SUMMARY:

The constructs of atypical depression, bipolar II, and borderline personality overlap. The extent of overlap between atypical depression and bipolar II varied from 36% to 72%, whether the latter was defined narrowly (spontaneous hypomania ≥ 4 days) or broadly (e.g., cyclothymia-based). Atypical depressives who met the DSM-IV criteria for borderline personality, compared with those who did not, were significantly higher in lifetime comorbidity for body dysmorphic disorder, bulimia nervosa, as well as narcissistic, dependent and avoidant personality disorders, and cyclothymia. Atypical depressives with borderline personality also scored higher on reactivity of mood, interpersonal sensitivity, functional impairment, avoidance of relationships, and other rejection avoidance. Cyclothymic temperament seems to account for much of the relationship between atypical depression and BPD. We attempt to provide an empirically-based answer to the difficulty of separating the shifting affective symptomatology of these patients from their long-term temperamental and characterologic attributes. Trait mood lability and interpersonal sensitivity 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-borderline patients display during their 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.

## No. 72C
## EARLY RECOGNITION OF SOFT-SPECTRUM BIPOLAR DISORDER IN CHILDREN

Eric A. Youngstrom, Ph.D., *Department of Psychology, Case Western Reserve, 10900 Euclid Avenue, Cleveland, OH 44106-7123*

SUMMARY:

Although Kraepelin identified pre-adult cases of bipolar disorder, diagnosis of bipolar disorder in children has been rare until recently. Identification is hampered by uncertainty about prevalence, and there is considerable debate among researchers and clinicians about the extent to which the presentation of bipolar disorders changes developmentally. This paper reviews how development influences the presentation of manic and depressive symptoms. Differential diagnosis in youths involves separating mania from other disruptive behavior disorders as well as unipolar depression. This paper reviews risk factors, early symptoms, symptoms that differeniate bipolar from other juvenile disorders, measurement of mood cycling in children, and rating scales (parent, clinician, and self-report) that have accrued evidence of validity based on a cohort of 612 outpatients aged 5–17, including more than 160 with bipolar I and another 150 with other bipolar spectrum diagnoses. Diagnostic efficiency statistics indicate that although several measures statistically separate groups (ps<.0005), parent report on the GBI appears most clinically useful. Participants will learn what tools are available to aid in screening for juvenile bipolar disorder, as well as helping rule in or rule out the diagnosis, and monitoring change in symptom severity in response to treatment.

## No. 72D
## EATING DISORDERS AND BIPOLARITY: CLINICAL AND TREATMENT ISSUES

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

SUMMARY:

Eating disorders and bipolar spectrum disorder are common health problems that overlap to a significant degree. However, little is known about the nature of this overlap, as well as the assessment and treatment of an eating disorder with comorbid bipolar spectrum disorder. In this presentation, available community, clinical, and family history studies showing that anorexia nervosa, bulimia nervosa, and binge eating disorder may be related to bipolar spectrum disorder will be reviewed. Available research on effective treatments for bipolar spectrum disorder that have been studied in eating disorders will be summarized, as will effective treatments for eating disorders that have been studied in bipolar spectrum disorder. Preliminary guidelines for the treatment of an eating disorder with comorbid bipolar spectrum disorder will then be suggested.

## No. 72E
## CONTRASTING EARLY TREATMENT OF BIPOLAR DISORDER WITH THE 2002 APA GUIDELINES

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

SUMMARY:

The objective for this presentation will be to contrast the mental health care received by patients with bipolar disorder (BD) early in the course of their illness with the 2002 APA guidelines. To examine current health care provided to patients with BD, 3,059 subjects meeting criteria for BD using the Mood Disorders Questionnaire (MDQ) were surveyed for medical consulting/treatment patterns. Of 2,450 MDQ positive subjects who returned the survey, only 18.2% had been correctly detected; 41% had been misdiagnosed, and 41% had not been diagnosed. Psychiatrists correctly detected the illness 48% of the time, primary care practitioners (PCP) 23%, and other mental health professionals 23%. In contrast to the APA guidelines, psychiatrists used antidepressants without mood stabilizers/antipsychotics in 32% of correctly diagnosed patients and PCPs in 43%. PCPs used antidepressants with mood stabilizers/antipsychotic agents in 65% of misdiagnosed patients. Herbal preparations and other alternative therapies were used alone in 12% of correctly detected patients, 19% of those misdiagnosed, and 21% of those not diagnosed. The highest rates of accurate diagnoses are made by psychiatrists, but even psychiatrists misdiagnosed patients 52% of the time. Mood stabilizers are under utilized as treatments for BD and antidepressants without mood stabilizers are over utilized.

REFERENCES:

1. Hantouche EG, Angst J, Demonfaucon C: Cyclothymic OCD: a distinct form? J Affect Disord, in press.
2. Perugi G, Akiskal HS: Are bipolar II, atypical depression, and borderline personality overlapping manifestations of a common cyclothymic-sensitive diathesis? J Clin Psychiatry, in press.
3. Youngstrom EA, Findling RL, Danielson CK, Calabrese JR: Discrimitive validity of parent report of hypomanic and depressive symptoms on the General Behavior Inventory. Psychological Assessment 2001; 13:267–276.
4. Krüger S, Shugar G, Cooke RG: Comorbidity of binge eating disorder and the partial binge eating syndrome with bipolar disorder. Intl J Eating Disord 1996; 19:45–52.
5. Calabrese JR, Hirschfeld RMA, Weissman MM, Reed M, Davies MA, Frye MA, Keck PE, Lewis L, McElroy SL, McNulty JP, Wagner KD: The impact of bipolar I and bipolar II disorders on patients in the United States. Submitted to the Journal of Clinical Psychiatry.

## SYMPOSIUM 73—GLUTAMATE: AN EXCITING NEUROTRANSMITTER

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) appreciate potential roles of neuroimaging in characterizing the integrity and regulation of brain glutamate systems, (2) understand the neurobiology of anxiety disorders as well as potential targets for newer, more specific drugs to treat these disorders, (3) have a basic knowledge of the glutamate field and it's potential promise as a new area of psychopharmacology. (4) understand the pharmacological activity of the mGlu receptors in both animal and human models of the anxiety, and be able to understand the potential role of newer agents in the treatment of these disorders.

### No. 73A
### NEUROIMAGING OF HUMAN GLUTAMATERGIC SYSTEMS

Robert M.A. Hirschfeld, M.D., *Department of Clinical Neuroscience, VA Connecticut Healthcare, 950 Campbell Avenue, West Haven, CT 06516;* John H. Krystal, M.D., Graeme Mason, Ph.D., Aysenil Belger, Ph.D.

SUMMARY:

Glutamatergic systems provide the primary form of excitatory neurotransmission for the human cerebral cortex and limbic system. Over the past 10 years, disturbances in glutamatergic systems have been implicated in the symptoms and cognitive deficits associated with nearly every neuropsychiatric disorder. This presentation will briefly introduce neuroimaging modalities for evaluating the structural integrity and functional regulation of human glutamatergic systems. Highlighting illustrative applications to schizophrenia research, this presentation will review magnetic resonance techniques including diffusion tensor imaging (DTI), 1H- and 13C-magnetic resonance spectroscopy (MRS), and so-called "pharmaco-functional magnetic resonance imaging (pharmaco-fMRI)." It will also briefly illustrate new ligands that may make positron emission tomography (PET) or single photon emission computerized tomography (SPECT) imaging of glutamate receptors possible in humans. These emerging techniques are broadening the scope and significance of clinical research on human glutamatergic systems.

### No. 73B
### THE ROLE OF GLUTAMATE IN PSYCHIATRIC DISORDERS

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:

The neurobiological basis of anxiety has important implications for new pharmacological mechanisms of action to treat anxiety disorders. Several theories of a neurobiological basis exist. For example, investigations into the molecular genetics of anxiety disorders, and the effects of the environment on brain function, reveal important findings pertinent to the discovery of novel effective treatments. Understanding the roles of norepinephrine, sertonin, CRH, substance P, and other systems in the cause of anxiety also supports theories of a neurobiological basis. L-Glutamate (glutamate) is ubiquitous in the central nervous system (CNS) and plays a major role as an excitatory neurotransmitter in most CNS processes. The mGluR2 receptors are expressed (mGluR2 mRNA) primarily in the brain's limbic structures. These areas (in particular the amygdaloid nuclei) are thought to play an important role in the somatic expression of fear via the brainstem/spinal cord and to be an important site of action of anxiolytic drugs. The complex nature of glutamate transmission modulation and differential expression of mGlus in various neuroanatomical regions may provide specific therapeutic opportunities, expecially in the treatment of anxiety disorders, as well as in schizophrenia.

### No. 73C
### GLUTAMATE IN PRECLINICAL MODELS OF ANXIETY

Darryle Schoepp, Ph.D., *Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*

SUMMARY:

Although glutamate is the primary excitatory neurotransmitter in the mammalian central nervous system, few drug candidates that directly target glutamatergic neuronal transmission have been investigated clinically. Such agents (eg. NMDA receptor antagonists for cerebral ischemia) have generally failed due to side-effect issues and/or lack of efficacy. Nevertheless, the cloning of multiple families of glutamate receptors and transporters has recently provided a vari-

ety of new targets. Thus, modulation of glutamatergic excitatory amino acid transmission still represents a novel approach to treat a variety of neuropsychiatric disorders. Metabotropic glutamate (mGlu) receptors are a heterogeneous family of G-protein coupled receptors (mGlul-8), which function to modulate glutamatergic functions via pre-synaptic, post-synaptic, and/or glial mechanisms. The compound LY354740 is the first highly selective and systematically active agonist for group II mGlu receptors (mGlu2/3). LY354740 has been shown to preferentially suppress glutamatergic excitations in limbic brain synapses (e.g. amygdala) involved in expression of fear/anxiety. Administration of LY354740 is anxiolytic in certain benzodiazepine-sensitive models at doses that did not produce the CNS side-effects that are associated with benzodiazepines. On this basis, LY354740 represents mGlu2/3 agonists such as a new class of pharmacological agents (mGlu2/3 agonists), which are currently being investigated in humans to treat anxiety.

## No. 73D
## THE EXPERIENCE WITH A GLUTAMATE AGONIST IN GAD

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

### SUMMARY:

Metabotropic receptors are highly heterogeneous and can modulate either presynaptic release of glutamate or postsynaptic sensitivity of the cell to glutamate excitation. LY334740 is a novel structural analogue of glutamate that shows specificity at the mGluR2 receptor. Oral or parenteral administration of LY354740 has shown anxiolytic activity, the fear-potentiated startle (FPS) model in rats (Schoepp et al., CNS Drug Rev. 5: 1–12, 1999). In a human model of FPS, Grillon et al (NCDEU 2002) replicated these effects with single doses of LY354740 (20 mg and 200 mg) vs. placebo in healthy volunteer subjects in whom they demonstrated a lack of baseline effects, a reduction in fear-potentiated startle to a "threat of shock" stimulus, and a smaller increase in anxiety compared with baseline during the fear-potentiated startle experiment measured by the Spielberger state anxiety. In another animal anxiety model, systemic administration of LY354740 was shown to prevent lactate-induced panic-like responses in panic-prone rats (Shekar and Keim, Neuropharmacol, 39: 1139–1146, 2000). In a human anxiety provocation model LY354740 400 mg daily also reduced panic anxiety following four weeks' therapy in DSM-IV-diagnosed panic patients during a single-breath 35% CO2 re-challenge (Levine et al, Neuropharmacology, in press). Results from a multicenter GAD study will also be discussed.

### REFERENCES:

1. Magistretti PJ, Pellerin L, Rothman DL, Shuiman RG: Energy on demand. Science 1999;283(5401):496–7.
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3. Schoepp DD: Unveiling the functions of presynaptic metabotropic glutamate receptors in the central nervous system. The Journal of Pharma Exper Ther 2001; 299:1:12–20.
4. Gorman JM, Kent JM, Coplan JD: Current and emerging therapeutic of anxiety and stress disorders, in KL Davis, D Charney, JT Coyle, C Nemeroff (Eds.): Neuropsychopharmacology: The Fifth Generation of Progress. Philadelphia, Lippincott Williams and Wilkins 2002; pp. 976–980.

# SYMPOSIUM 74—COGNITIVE DYSFUNCTION IN BIPOLAR DISORDER

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the presence of clinically relevant cognitive dysfunctions in a significant proportion of bipolar disorder.

## No. 74A
## NEUROPSYCHOLOGICAL FUNCTIONING IN BIPOLAR DISORDER

Eduard Vieta, M.D., *Department of Psychiatry, Hospital Clinic, Villarroel 170, Barcelona 08036, Spain;* Anabel Martinez-Aran, Ph.D.

### SUMMARY:

Although cognitive dysfunctions in psychosis have been classically associated with schizophrenia, there is clinical evidence that some bipolar patients show cognitive disturbances either during acute phases or in remission periods in bipolar disorder.

*Methods:* The main computerized database has been screened crossing the terms "cognitive deficits," "neuropsychology," "intellectual impairment," "mania," "depression," and "bipolar disorder."

*Results:* Changes in the fluency of thought and speech, learning and memory impairment, and disturbance in associational patterns and attentional processes are as fundamental to depression and mania as are changes in mood and behavior. Moreover, a significant number of bipolar patients show enduring cognitive deficits during remission from affective symptoms. However, there are several methodological pitfalls in most studies such as unclear remission criteria, diagnostic heterogeneity, small sample sizes, absence of longitudinal assessment, practice effect, and poor control of the influence of subthreshold symptoms and pharmacological treatment.

*Conclusions:* Most studies point at the presence of diffuse cognitive dysfunction during the acute phases of bipolar illness. Most of these deficits seem to remit during periods of euthymia, but others may persist in approximately one third of bipolar patients.

## No. 74B
## PSYCHOMOTOR AND ATTENTIONAL IMPAIRMENT IN BIPOLAR DISORDER

Katherine E. Burdick, Ph.D., *Department of Psychiatry, Yale University, 169 Ocean Drive West, Stanford, CT 06902*

### SUMMARY:

Recent evidence suggests that many patients with bipolar disorder show persistent low-grade forms of psychopathology between full affective episodes, indicating incomplete remission. Neuropsychological deficits have been reported in euthymic bipolar patients and may be an important factor in understanding the high incidence of chronic psychosocial difficulties, despite apparent clinical recovery. Among the defining features of bipolar disorder are psychomotor and cognitive impairment. Psychomotor and attention functions can be linked to the integrity of the prefrontal cortex, which has been a consistent structural abnormality in neuroimaging studies in bipolar patients. Elucidating the nature and extent of deficits in these areas may carry important treatment implications. Overlapping neuroanatomical and neurochemical properties of psychomotor and attention deficits suggest that dopamine plays an important role in the development and treatment of depression in bipolar disorder. Data will be reviewed on neuropsychological, neuroanatomical, and neuroendo-

crine correlates of bipolar disorder related to dopaminergic functioning. Original data will be presented in a sample of patients with bipolar depression demonstrating specific deficits in executive attention, with relative sparing of more automatic attentional functions, lending support to data indicating dopaminergic dysfunction in bipolar depression. The relationship between depressive severity, psychomotor functioning, and attention impairment will be discussed.

## No. 74C
## WORKING MEMORY IN BIPOLAR DISORDER: NEUROCOGNITIVE AND FUNCTIONAL IMAGING FINDINGS

Caleb M. Adler, M.D., *Department of Psychiatry, 231 Albert Sabin Way, Cincinnati, OH 45267-0559;* Stephen M. Strakowski, M.D.

### SUMMARY:

*Objective:* Working memory is an aspect of short-term memory in which representations are briefly stored and made available for use. In this study we examined working memory performance over a parametric series of working memory tasks. We then utilized fMRI to examine areas of brain activation associated with performance of a working memory task in bipolar patients to compare working memory-related activation with that of healthy controls and correlate that activation with previous affective episodes.

*Methods:* Bipolar patients and healthy controls performed computer-generated "zero-back" (attention); and "one-," "two-," and "three-back" (working memory) tasks. The subjects performed "zero-" and "two-back" tasks during fMRI in a boxcar design; "zero-back" task served as the contrast condition for the "two-back" task.

*Results:* Bipolar patients demonstrated decreasing working memory performance, compared with healthy controls, over increasingly difficult tasks. Patients concomitantly demonstrated changes in working memory related activation, compared with controls. Performance inversely correlated with number of depressive episodes, and specific activation changes were associated with affective history.

*Conclusions:* These data are consistent with previous observations of cognitive impairment with bipolar disorder and suggest brain regions that may be involved. These findings further suggest that neuropathology in these regions may be related to occurrence of affective episodes.

## No. 74D
## DIFFERENTIATING BIPOLAR DISORDER AND ADHD: COMORBIDITY VERSUS SINGLE DIAGNOSIS

Joseph Biederman, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 55 Fruit Street, WACC 725, Boston, MA 02114;* Janet Wozniak, M.D., Eric Mick, Sc.D., Stephen V. Faraone, Ph.D.

### SUMMARY:

*Objective:* To determine whether attention deficit hyperactivity disorder (ADHD) with comorbid bipolar disorder (BPD) could be distinguished from other cases of ADHD using the cognitive, psychiatric, and psychosocial functioning of ADHD children with and without comorbid BPD.

*Method:* A sample of 260 children (140 ADHD and 120 controls) were evaluated at baseline and four-year follow-up using DSM III-R structured diagnostic interviews and blind raters to assess psychiatric diagnoses. Subjects were also evaluated for academic, cognitive, family, school, and social functioning.

*Results:* At baseline, 11% of ADHD children were diagnosed with BPD and an additional 12% were diagnosed at follow-up. These rates were significantly higher than those of controls at either assessment. The most common presentation of BPD at both baseline and follow-up was irritable, and mixed with rapid cycles. The children with comorbid ADHD and BPD had significantly higher rates of additional psychopathology, psychiatric hospitalization, and severely impaired psychosocial functioning than other ADHD children. ADHD children with comborbid BPD had a very severe symptomatic picture of ADHD and prototypical correlates of ADHD. Comorbidity between the two disorders was not due to symptom overlap.

*Conclusions:* These results suggest that children with ADHD are at an increased risk for developing BPD with its associated severe dysfunction, incapacitation, and morbidity.

## No. 74E
## COGNITIVE SIDE EFFECTS OF MOOD STABILIZERS

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney-NY Presbyterian Hospital, 525 East 68th Street, Box 140, New York, NY 10021;* Katherine E. Burdick, Ph.D.

### SUMMARY:

Cognitive dysfunction has frequently been cited in conjunction with both illness phenomenology and iatrogenic treatment effects in bipolar disorder. While lithium, conventional neuroleptics, and some anticonvulsants have historically been linked with impaired memory and attention, a number of newer anticonvulsants as well as atypical antipsychotics have been shown to carry substantially less risk in these areas. Some agents that could increase prefrontal dopamine release or show pre-cholinergic effects may also confer some advantage for either reducing adverse cognitive effects of else promoting cognitive enhancement. This presentation will review data from open and controlled trials of mood stabilizers and atypical antipsychotics most commonly used in bipolar disorder. Cognitive impairment appears more prevalent among certain agents (notably topiramate) than others, although factors such as combination therapy, dose-dependency, and underlying affective or other psychiatric symptoms may contribute importantly to overall clinical presentations.

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# SYMPOSIUM 75—ROLES FOR PSYCHIATRY IN END-OF-LIFE CARE

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should demonstrate improvements in the following skills related to treatment of terminally ill patients: diagnostic acumen for depression and com-

plicated grief; an understanding of meaning-based psychotherapeutic treatment of terminally ill patients; effective end-of-life communication training for physicians.

## No. 75A
## DEPRESSION AT THE END OF LIFE: IS THAT ALL THERE IS?

Michael A. Weitzner, M.D., *H Lee Moffitt Cancer Center, 12902 Magnolia Drive-MOD 3, Tampa, FL 33612-9416*

SUMMARY:

Although it is well recognized that patients at the end of life have increased depressive symptomatology, true clinical depression is under-recognized and not as aggressively treated as it should be. In fact, it is often stated by clinicians, "of course they are depressed...they are dying." Research in inpatient palliative care settings suggests that the incidence of clinical depression may be as high as 25%. In outpatient hospice settings, that incidence may be closer to 40%. However, is clinical depression all that there is? Little work has focused on the contributions of social-cognitive factors to the development of depressive symptomatology and clinical depression in persons at the end of life. Such social cognitive factors include social isolation, loneliness, boredom, social disengagement, and diminished mental stimulation. These factors have implications for the types of psychosocial treatments that these patients may need but have not been offered. The focus of this presentation will be to present data on the contributions of these social-cognitive factors to the development of depression in patients at the end of life and the role that psychiatrists need to play in the psychosocial care of the dying.

## No. 75B
## MEANING-CENTERED GROUP PSYCHOTHERAPY IN ADVANCED CANCER PATIENTS

William Breitbart, M.D., *Department of Psychiatry, Memorial Sloan Kettering Hospital, 1242 Second Avenue, Box 421, New York, NY 10021–6007;* Christopher Gibson, Ph.D., Hayley Pessin, Ph.D., Mindy Greenstein, Ph.D., Barry D. Rosenfeld, Ph.D., Alexis Tomarken, M.S.W., Michael Kramer

SUMMARY:

As the disciplines of supportive care and palliative medicine mature in the United States, it is becoming more apparent that concepts of adequate palliative care must be expanded on their focus beyond pain and physical symptom control to include psychiatric, psychosocial, existential, and spiritual domains of care. We have developed and manualized an eight-week "Meaning-Centered Group Psychotherapy," based on the principles of Viktor Frankl's logotherapy, designed to help patients with advanced cancer sustain or enhance sense of meaning, peace, and purpose despite the limitations of cancer illness and impending death. With funding from NYH/NCCAM, we are conducting a randomized, controlled clinical trial of this new and unique psychotherapy intervention for advanced cancer patients aimed at enhancing psychological and spiritual well-being and quality of life. We are comparing the efficacy of Meaning-Centered Group Psychotherapy with a standard supportive group psychotherapy. A total of 118 cancer patients will be randomized to receive one of these two interventions. Each intervention is eight weeks in duration, comprised of eight weeks of one-and-a-half hour group sessions. Subjects are assessed at baseline, end of intervention, and at three month follow-up. The presentation will describe the concepts of meaning in relationship to advanced cancer, and will describe the intervention. Preliminary data will be presented.

## No. 75C
## COMPLICATED GRIEF: CONCEPTUAL ISSUES, EPIDEMIOLOGY, AND EVIDENCE-BASED

Holly G. Prigerson, Ph.D., *Department of Psychiatry, Yale University, 34 Park Street, Room 522, New Haven, CT 06519*

SUMMARY:

This presentation begins with an overview of studies demonstrating the need to conceptualize, diagnose, and treat complicated grief (CG) as a distinct psychiatric disorder. Analyses revealing how CG symptoms cluster together and distinguish themselves from those of depression and anxiety will be presented, as will results of Receiver Operating Characteristic curve and Item Response Theory analyses indicating the performance of proposed CG consensus criteria. Additionally, the prevalence of CG and comorbidity with MDD and PTSD in several independent, culturally diverse samples, including terminally ill patients and caregivers, will be discussed. Clinicians will be informed of significant risk factors to identify those patients likely to be particularly vulnerable to CG (eg, attachment styles; type of interpersonal relations with the terminally ill patient; kinship relationships; experiences of childhood loss, abuse, and neglect; cause and quality of death). Results of analyses of protective factors (preparedness for the death, social support, religiousness, health behaviors) will suggest potential mechanisms for improving adjustment to an impending or recent loss of an intimate.

## No. 75D
## EMOTIONAL BARRIERS TO END-OF-LIFE COMMUNICATION: AN INNOVATIVE TRAINING FOR PHYSICIANS

Joseph S. Weiner, M.D., *Department of Psychiatry, LIJ Medical Center, 400 Lakeville Road Room 101, New Hyde Park, NY 11040;* Debra L. Roter, Ph.D., Steven A. Cole, M.D.

SUMMARY:

Health care providers have intense emotional experiences provoked by death. Clinicians are poorly trained to manage these emotions, commonly leading to avoidance behaviors around terminally ill patients. Compounding this are cognitive misconceptions that providers have about end-of-life care. These misconceptions further elicit uncomfortable emotions, exacerbating clinician avoidance.

This presentation will describe common physician-centered emotional and cognitive barriers to communication with seriously ill patients. It also describes an innovative communication-training program at Long Island Jewish Medical Center designed to increase physician skill and comfort during advance care planning discussions. This program is based on cognitive-behavioral and adult learning theories.

With funding from the Project on Death in America, we are conducting two randomized, controlled studies of the effects of this training program on physicians' skills and attitudes regarding advance care planning discussions. One study is with third-year medical students, the other is with medicine interns. In each study, we are comparing the efficacy of an eight-hour training program in Advance Care Planning Communication (ACPC) with general medical communication training. Trainees will be assessed at baseline, immediately after training and several months later to assess retention of skills. This presentation will describe preliminary data from these two studies.

## No. 75E
## OREGON'S DEATH WITH DIGNITY ACT: WHO CHOOSES PHYSICIAN-ASSISTED SUICIDE?

Linda K. Ganzini, M.D., *Department of Psychiatry, Portland VAMC (P3MHDC), 3710 SW United States Veterans Hospital Road, Portland, OR 97207–1034;* Elizabeth E. Goy, Ph.D.

SUMMARY:

The Death with Dignity Act, which legalized physician-assisted suicide (PAS) for terminally-ill patients, was enacted in Oregon in 1997. I will present results from a series of studies, including surveys of and interviews with Oregon physicians and hospice professionals who cared for requesting patients, and terminally-ill patients. Although hospice referral was the most successful intervention associated with requesting patients changing their mind about PAS, 78% of PAS deaths are in hospice patients. Desire to control the circumstances of death and maintain independence, readiness to die, and assessing quality of life as poor were the most important reasons for these requests. The least important reasons included poor social support and concerns about being a financial drain. Among patients who received lethal prescriptions, hospice professionals rated depression as among the least important reasons patients requested PAS. Among ALS patients, however, hopelessness was a strong predictor of persistent interest in PAS. Patients were concerned about burdening their families; however, hospice nurses reported that the families, compared with other hospice families, were less likely to be burdened by care, including the cost of care, and more likely to find positive meaning in caregiving.

REFERENCES:

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2. Greenstein M, Breitbart W: Cancer and the experience of meaning: a group psychotherapy program for people with cancer. Am J Psychother 2000;54:486–500.
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## SYMPOSIUM 76—NEW AND PRACTICAL WAYS TO EFFECTIVELY TREAT BORDERLINE PATIENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to treat borderline patients more effectively and with less burden.

### No. 76A
### A PSYCHOEDUCATION PROGRAM FOR BORDERLINE PATIENTS

Mary C. Zanarini, Ed.D., *Department of Psychiatry, McLean-Harvard Hospital, 115 Mill Street, Belmont, MA 02478;* John G. Gunderson, M.D.

SUMMARY:

Clinical experience suggests that most borderline patients are not told of their diagnosis. They are either given no diagnostic information or their comorbid Axis I disorders are described as their primary problem. Of those who are told that they may have borderline personality disorder (BPD), most are not provided with up-to-date information concerning the disorder.

In this report, we describe a new psychoeducation program for borderline patients. This program has two phases. The first phase involves a careful diagnostic assessment of all Axis I and II disorders using a battery of widely used semistructured interviews. The results of this diagnostic evaluation are then discussed with the patient. Those who meet criteria for BPD are invited to enter the second phase of the program. This phase consists of four group sessions of an hour in length. During these group sessions, a set curriculum concerning the phenomenology, etiology, treatment, and course of BPD is presented. This curriculum can be taught equally well by nonprofessionals with relevant clinical experience and mental health professionals.

Preliminary data (N=35) detailing the acceptability of this program to patients, their families, and the clinicians treating them will be presented. Preliminary data concerning the clinical utility of this program will also be presented.

### No. 76B
### EFFECTIVENESS OF INPATIENT DIALECTICAL BEHAVIORAL THERAPY FOR BPD: A CONTROLLED TRIAL

Martin Bohus, M.D., *Department of Psychiatry, Albert Ludwig University, Hauptstr. 5, Freiburg D-79104, Germany*

SUMMARY:

Dialectical Behavioral Therapy (DBT) was initially developed and evaluated as an outpatient treatment program for chronically suicidal individuals with borderline personality disorder. This study aims to evaluate a three-month DBT inpatient treatment program. Clinical outcome, including changes on measures of psychopathology and frequency of self-mutilating acts, within four months was assessed for 50 female borderline patients. Thirty-one patients had participated in a three-month inpatient DBT program; 19 patients had been placed on a waiting list and received treatment as usual. Post testing was conducted four months after the initial assessment (four weeks after discharge for the DBT group). Pre-post comparison revealed significant changes for the DBT group on ten of 11 psychopathological variables and significant reductions in self-injurious behavior. The waiting list group did not show any significant changes at the four-month point. Group versus time comparison gave evidence that the DBT group improved significantly more than participants on the waiting list on seven of the nine variables analyzed, including dissociation, depression, anxiety, interpersonal functioning, social adjustment, and global psychopathology. The data suggest that three months of inpatient DBT treatment is significantly superior to unspecific treatment. Within a relatively short time frame, improvement was found across a broad range of psychopathological features.

### No. 76C
### AN ATTACHMENT-THEORY-BASED, MENTALIZATION-FOCUSED PSYCHOTHERAPY FOR BPD: THEORY AND PRACTICE

Peter Fonagy, Ph.D., *Psychoanalysis Unit, University College of London, Gower Street, London WC1E 6BT, United Kingdom*

SUMMARY:

'Classical' interpretive insight-oriented psychoanalytic psychotherapy is of limited applicability when it comes to treating severely dysfunctional individuals with BPD in public health care settings. Based on a developmental theory of their dysfunctions, we have developed and demonstrated the efficacy of a structured long-term psychotherapeutic intervention that is ideally delivered in the context of a partial hospital treatment (Bateman & Fonagy, 2001). The theory holds that a severely neglected or biologically vulnerable child has

reduced awareness of internal states and copes with thoughts/feelings through action. The intervention consists of group and individual therapy aimed at presenting a view of the internal world of the patient that is stable, coherent, can be clearly perceived, and may be adopted as the reflective part of the self (the self-image of the patients' mind. The goal of the treatment is the enhancement of awareness of thinking about thoughts and feelings, i.e. mentalization (Fonagy et al., 2002). The key features of the program are (1) high level of structure that is consistent and reliable. (2) individualized care plan, (3) intensive therapeutic input over an 18-month period, (4) a theoretically coherent yet flexible approach, (5) a focus on (attachment) relationships. The paper will describe the key techniques used to enhance the processes of mentalization.

## No. 76D
## SPLIT TREATMENTS: FROM PROBLEM TO ASSET

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*

### SUMMARY:

One consequence of managed care has been that the usual outpatient treatment for borderline patients now involves a separation of psychotherapy and psychopharmacology. This has invited splits, wherein the treaters assume contradictory and polarized attributions of goodness or badness. This paper develops the thesis, using clinical vignettes, that because borderline patients often cannot sustain ambivalent feelings towards others, the opportunity to split off their hostile/negative feelings without leaving treatment requires having two (or more) treaters—as long as those treaters recognize and don't collude with the splitting process. The notoriously high rates of dropouts (roughly 40%–60%) and noncompliance (roughly 50%) that are traditionally associated with treating borderline patients reflect practices in which clinicians' well-meaning efforts lack adequate "holding" by others. The value of split treatments can be established by combining either psychotherapy or psychopharmacology with family, group, or other modalities.

## No. 76E
## BOUNDARIES, LIABILITY, AND COUNTERTRANSFERENCE IN THE TREATMENT OF BPD

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

### SUMMARY:

The maintenance of reasonable professional boundaries is often highly problematic in the treatment of patients with borderline personality disorder. Ordinary professional boundaries associated with the practice of psychiatry may be experienced by patients with BPD as cruelly depriving. Clinicians may assume that they must modify the boundaries in sometimes extraordinary ways to fend off aggression. However, the patient can never be blamed for the psychiatrist's violations of professional boundaries. The psychiatrist or other clinician must accept a certain degree of anger, contempt, and hatred as part of the treatment of patients with borderline psychopathology. Case illustrations will be used to show how attempts to disavow the "bad object" role may contribute to a pattern of escalating boundary disturbances that are ultimately destructive to the treatment.

### REFERENCES:

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2. Bohus M, Haaf B, Stiglmayr CE, Pohl U, Boehme R, Linehan MM: Evaluation of inpatient dialectical-behavioral therapy for borderline personality disorder-a prospective study. Behav Res Ther 2000; 38:875–887.
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4. Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). Affect Regulation, Mentalization and the Development of the Self. New York: Other Press.
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# SYMPOSIUM 77—THE DUAL-DIAGNOSIS CHALLENGE: ASSESSMENT AND TREATMENT

### EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to understand the diagnostic and prognostic issues in differentiating between substance-induced psychotic disorder and primary psychotic disorder in dual diagnosis.

## No. 77A
## USING THE PSYCHIATRIC RESEARCH INTERVIEW FOR SUBSTANCE AND MENTAL DISORDERS TO DIAGNOSE PSYCHOTIC DISORDERS IN SUBSTANCE USERS

Deborah S. Hasin, Ph.D., *Department of Epi/Psychiatry, Columbia University, 1051 Riverside Drive, Box 123, New York, NY 10032*

### SUMMARY:

Differentiating primary from substance-induced disorders in individuals who drink heavily or use drugs is a challenge for researchers and treatment providers. The Psychiatric Research Interview for Substance and Mental Disorders (PRISM) is designed to make systematic diagnoses in substance users. A test-retest study of the DSM-III-R version of the PRISM showed kappas of 63, 76, and 79 for current, past, and lifetime psychotic symptoms, respectively. The PRISM, now updated for the DSM-IV distinction between primary and substance-induced psychotic disorders, offers several unique features. First, a general history of substance use is obtained prior to the psychotic section, providing an informed context for probing symptoms and periods of psychosis. Second, substance use relevant to psychotic symptoms is evaluated according to specific guidelines, to increase the consistency in ratings. Third, a primary active phase or other psychotic period is sought (e.g., a period occurring during abstinence or minimal use), reducing the potential need to "recycle" through questions on psychosis if some or all periods occur during heavy substance use. Fourth, psychotic periods that meet all criteria for primary disorders except for occurrence during periods of heavy substance use are ascertained in addition to primary disorders. We present PRISM diagnostic data obtained at baseline for 400 subjects enrolled in a longitudinal study of early phase psychosis and substance use comorbidity.

Findings are presented on the concordance of PRISM research diagnoses with routine DSM diagnoses made by clinical staff in the emergency service and inpatient settings.

The use of PRISM principles and procedures to improve diagnostic reliability is discussed.

## No. 77B
## APPLICATION OF THE LEAD STANDARD IN DUAL-DIAGNOSIS PATIENTS

Michael B. First, M.D., *Department of Biometrics, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 60, New York, NY 10032-2603*

### SUMMARY:

The determination of whether psychotic symptoms are primary or secondary to the substance use is often quite challenging. This presentation will first describe a best-estimate diagnostic procedure used in a longitudinal study of 400 patients with early phase psychosis and substance use comorbidity. It was based on the LEAD standard, proposed by Spitzer in lieu of a diagnostic gold standard, which recommends the use of longitudinal data, applied by expert diagnosticians, using all data available. For these patients, assessment data obtained at baseline, six months, and 12 months was utilized, consisting of narrative summaries of PRISM interviews, PANSS scores, urine toxicology results, substance use and psychotic symptom timelines, and available chart material. Diagnostic expertise was insured by the use of trained clinicians who were required to fill out a diagnostic decision tree for each evaluation. Patients were then assigned to one of four categories that indicated the causal relationship between the substance use and psychosis (i.e., exclusively substance-induced, exclusively primary psychotic, mixed cases with primary psychotic at index with prior or consequent substanced-induced psychosis, and indeterminate situations). The presentation concludes with a summary of the diagnostic evaluations obtained in the sample of 400 patients.

## No. 77C
## DIFFERENTIATING PRIMARY VERSUS DRUG-INDUCED PERSISTING PSYCHOSIS: BIOLOGICAL MARKERS

Nashaat N. Boutros, M.D., *Department of Psychiatry, West Haven VAMC-Yale University, 950 Campbell Avenue, Suite 116A, West Haven, CT 06516*

### SUMMARY:

While evidence has accumulated that chronic drug use may result in autonomous psychotic disorders, it continues to be impossible to differentiate such a syndrome from idiopathic schizophrenia based on clinical symptomatology or history alone. The use of extensive and standardized clinical instruments is likely to markedly improve our ability to differentiate among patients who would be more likely to have one or the other of these disorders. Clinical scales, none the less, remain an extension of the clinical syndrome and may suffer from similar limitations. The use of biological markers to help differentiate these syndromes may be a necessary, albeit difficult to accomplish step. Evoked potential measurement is a noninvasive method that allows the examination of many of the cognitive processes known to be abnormal in schizophrenia. Starting with the brain-stem evoked responses, through the mid-latency, and ending with Event-Related Potentials (ERPs), available evidence that the two syndromes may have different signatures will be reviewed. Our preliminary conclusion is that, while suggestive evidence of significant and potentially diagnostically useful differences exist, this area of research remains in its infancy. Larger and more longitudinal follow-up studies are necessary.

## No. 77D
## COURSE OF SUBSTANCE ABUSE AMONG COMORBID PSYCHOTIC PATIENTS: TWO-YEAR FOLLOW-UP IN FIRST ADMISSION PATIENTS

Mark J. Sedler, M.D., *Department of Psychiatry, State University of New York, Putnam Hall South Campus/HSC T10-020, Stony Brook, NY 11749;* Evelyn J. Bromet, Ph.D., Joseph E. Schwartz, Ph.D.

### SUMMARY:

This study is based on a large sample of new-onset psychosis in the Suffolk County Psychosis Project. A prior analysis of comorbidity using the SCID severity rating found that 17.4% of males and 6.2% of females had moderate or severe substance abuse at the time of admission compared with 41.5% of males and 68.2% of females with no lifetime diagnosis of substance abuse. In general, nearly all those with moderate to severe substance abuse began abuse or dependence several years prior to the onset of psychosis.

The present analysis examines the longitudinal course of substance use in this group at two years follow up. Preliminary assessment indicates a marked decline in substance abuse but persistence of psychosis in the follow-up ratings.

## No. 77E
## PEER SUPPORT FOR THE TREATMENT RESISTANT: WILL IT HELP?

Carol L.M. Caton, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 56, New York, NY 10032;* Sam Tsemberis, Ph.D., Robert E. Drake, M.D., Mindy J. Fullilove, M.D., Carlos E. Almeida, Jr., M.D., Henry L. McCurtis, M.D., Frederic I. Kass, M.D.

### SUMMARY:

Despite mounting evidence that early treatment of psychotic disorders is associated with a better outcome, patients with early-phase psychosis and concurrent substance use are notoriously difficult to engage in treatment. Our own longitudinal data show that fewer than one-third of patients with this comorbidity attend any mental health outpatient treatment in the six-month period following an initial crisis episode. Fewer than one in five have attended a substance abuse treatment program in this interim. Lack of involvement in treatment is associated with continued substance use and increased risk of a more difficult illness course.

To address this problem, we are developing a peer support intervention. Our model involves the close collaboration of consumer and traditional mental health workers, similar to those previously developed for community case management programs. Key assumptions guiding its development are that outreach is critical to the information of a relationship and that shared experience regarding illness background and ethnocultural identity is helpful in overcoming communications barriers. In this symposium presentation, we discuss the rationale and precedent for the peer-support approach, review the steps in intervention development including the hiring and training of peer workers, and present preliminary evidence of its value in improving engagement in treatment.

### REFERENCES:

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2. Spitzer RL: Psychiatric diagnosis: are clinicians still necessary? Compr Psychiatry 1983; 24:399–411.

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4. Rabinowitz J, Bromet EJ, Carlson G, Schwartz JE: Prevalence and severity of substance use disorders and onset of psychosis in first-admission psychotic patients. Psychological Medicine 1998; 28:1411–1419.
5. Dixon L, Backman A, Lehman A: Consumers as staff in assertive community treatment programs. Administration and Policy in Mental Health 1997; 25:199–208.

## SYMPOSIUM 78—IS THIS AN ACT OR AN ACT? APPROACHES TO ASSERTIVE COMMUNITY TREATMENT

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand the unique needs of a forensic MICA population living in the community, and ways in which an ACT team approach can help them reintegrate into society, (2) describe use of and modification in the ACT model with homeless persons with severe mental illness, (3) will have a greater understanding of how to provide consumer-driven services and treatment.

### No. 78A
### ADAPTING THE ASSERTIVE COMMUNITY TREATMENT MODEL TO WORK WITH FORENSIC MICA POPULATION IN SUPPORTED APARTMENTS

Michelle Des Roches, M.S.W., *PSTP, Project Renewal, 200 Varick Street, New York, NY 10014*

SUMMARY:

Project Renewal's Parole Support and Treatment Program has developed a treatment team which, though based on an ACT team model, includes certain variations that show how the traditional model can be modified to optimally serve a specific population. Designed to meet the needs of a MICA population as they re-enter the community from prison, our team must help consumers overcome specific obstacles and limitations imposed by the criminal justice system. Parole conditions often include mandatory participation in our program and treatment compliance. We have also been given the opportunity to provide temporary housing for program participants in shared, scatter-site apartments for the duration of their parole. This allows staff to create a community among the residents through therapeutic and recreational groups, but it also sets time limits in terms of how long the team is allowed to work with an individual. The expectation is that by the time consumers complete parole, they will be ready to transition to new housing and to community service providers for ongoing MICA treatment. This presentation focuses on how our adaptations of the traditional ACT model make it an effective transitional treatment modality with forensic MICA clients trying to re-establish their lives in the community.

### No. 78B
### ASSERTIVE COMMUNITY TREATMENT WITH HOMELESS INDIVIDUALS

Ann L. Hackman, M.D., *Programs Assertive Community Treatment, University of Maryland Medical Center, 630 West Fayette Street, 4 East, Baltimore, MD 21201*

SUMMARY:

In 1993, at the University of Maryland, Lehman and Dixon completed a three-year research demonstration project in which a randomized, controlled study evaluated the effectiveness of Assertive Community Treatment (ACT) with homeless people with severe mental illness in Baltimore City. Their work found the model to be effective in decreasing hospital days, increasing time in housing, and improving quality of life measures. This presentation describes the subsequent experience of this ACT team during the past decade in providing services to more than 500 individuals. Of persons served almost two thirds have schizophrenia spectrum diagnoses and more than 85% are dually diagnosed. The presentation includes discussion of phases of treatment for homeless individuals and modifications in the model with this population including the mini-team concept, employment of a consumer advocate, and family outreach coordinator on the team, provision of dual-diagnosis treatment and transitioning of patients to less intensive services. The presentation further addresses issues around providing services including housing in the face of increasing economic restrictions and growing pressures of managed care.

### No. 78C
### PATHWAYS TO HOUSING: FROM STREETS TO HOMES: HOUSING PEOPLE WITH DUAL DIAGNOSIS DIRECTLY FROM THE STREETS

Sam Tsemberis, Ph.D., *Pathways To Housing, 155 West 23rd Street, 12th Floor, New York, NY 10011*

SUMMARY:

This presentation describes Pathways to Housing, an innovative and effective program that fuses Assertive Community Treatment teams with supported housing to significantly reduce homelessness for people with dual diagnoses. Program services are based on the principles of psychiatric rehabilitation, including a radical acceptance of consumers' preferences and a harm reduction approach to substance abuse services. The program offers individuals with long periods of homelessness and dual diagnoses immediate access to permanent independent housing without requiring sobriety or participation in psychiatric treatment as a prerequisite for housing. Assertive Community Treatment teams provide clinical and support services for tenants. The teams operate in a manner consistent with most ACT fidelity dimensions except when they diverge from the program's consumer-driven philosophy. Results of a program evaluation study will be presented where 225 individuals were randomly assigned to Pathways to Housing or services as usual and followed for a period of two years. Discussion will focus on policy and program planning issues pertaining to the use supported housing as a supplement to ACT teams serving this population.

### No. 78D
### ASSERTIVE COMMUNITY TREATMENT IN NEW YORK: A PLATFORM FOR IMPLEMENTING EVIDENCE-BASED PRACTICES

Linda Rosenberg, M.S.W., *New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12229*

SUMMARY:

The New York State Office of Mental Health has developed a model for ACT that will be used to guide a major statewide expansion of this proven psychosocial treatment. The model includes several components, including Medicaid reimbursement, statewide uniform standards for ACT teams, and OMH licensing of all ACT providers. Additionally, the model will use ACT as a platform to implement other proven evidence-based practices, including supported employ-

ment, training for recipients in wellness self-management, family education, integrated treatment for co-occuring substance use disorders, and guidelines-based psychopharmacology. This will be accomplished through required participation by ACT providers in a skills development program, which will include training in ACT core processes, specific training in the other evidence-based practices, and ongoing consultation and clinical supervision by program experts. Finally, the model includes comprehensive outcomes assessment. ACT team members will complete a standardized assessment for each service recipient at enrollment, six-month intervals, and discharge. The rich data set collected will be used for performance management at the program level, and for statewide benchmarking and quality improvement activities.

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3. Tsemberis S, Eisenberg R: Pathways to housing: supported housing for street dwelling individuals with psychiatric disabilities. Psychiatric Services 51:(4) 487–493.
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## SYMPOSIUM 79—THE ESSENCE OF LEARNING PSYCHIATRY: CLINICAL SUPERVISION

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the historical influences on the development of clinical supervision, (2) be aware of the different theoretical models and of the relevance of principles of adult learning, (3) demonstrate an understanding of the evidence base for the efficacy/effectiveness of supervision in clinical psychiatry training, (4) recognize the potential problem encountered by trainees and supervisors in a range of settings.

### No. 79A
### MODELS OF CLINICAL SUPERVISION

Peter Burnett, B.M., *Western Mental Health Service, Locked Bag 10 Parkville, Melbourne 3052, Australia;* Alexandra M. Cockram, M.Ed., Pete M. Ellis, B.M., David Burke, Brian Kelly, B.M.

### SUMMARY:

Clinical supervision is an essential component of training in psychiatry as in all of medicine, but is surprisingly little studied in the literature. Its early origins, in the form of an apprenticeship model of training, can be traced to the time of Hippocrates. More explicit development of the concept came in the field of social work in the 19th century, and in psychotherapy. From these disciplines came awareness of the different processes embedded within the construct of supervision, such as educative, supportive, managerial, mentoring, and clinical care. Educationalists have demonstrated the different style of learning in adults, which is of considerable importance in supervision and psychiatric training generally. These issues are important for understanding the process of supervision and for making it more effective and relevant, leading to improved learning for residents. The issue is approached by reviewing the literature.

### No. 79B
### EVIDENCE FOR THE EFFICACY: EFFECTIVENESS OF SUPERVISION IN CLINICAL PRACTICE

Alexandra M. Cockram, M.Ed., *Illawarra Mental Health Service, PO Box 52, Shell Harbour Square, Wollongong NSW 2529, Australia;* Pete M. Ellis, B.M., Brian Kelly, B.M., David Burke, Peter Burnett, B.M.

### SUMMARY:

The evidence for the effectiveness of supervision in postgraduate education is limited. The expected outcome of supervision is also complex: improved clinical practice, mentorship, support, education and training. This presentation will review the current literature related to supervision in postgraduate medical education with a particular focus on psychiatry. It will also consider the methodology of existing research in both the current practice and the difficulties. This review will generate future research priorities in this area.

### No. 79C
### SUPERVISION IN PSYCHIATRY TRAINING: CURRENT STATUS AND LIMITATIONS

Brian Kelly, B.M., *Department of Psychiatry, University of Queensland, Princess Alexandra Hospital, Woolloongabba, QLD 4113, Australia*

### SUMMARY:

Clinical supervision has a central role in psychiatry training, yet considerable obstacles are faced in implementing supervision requirements across the diversity of training settings and stages of training. Such obstacles include the variability in standards and quality of supervision and the limited formal support offered to supervisors. The range of tasks to address in supervision can be broad, reflecting the wide-ranging roles undertaken by psychiatrists within mental health services. These roles encompass addressing clinical, administrative, and research skills of a psychiatrist, alongside ethical frameworks and professional conduct underpinning these skills. Current structures for provision of supervision are limited in their capacity to promote these goals. Trainees report high prevalence of adverse experiences throughout their training, and these may include adverse supervision experiences. Mechanisms to monitor, review, and evaluate supervision have been limited. Other challenges are encountered in the substantial changes to mental health services that have occurred in recent years, and the effect on the role of the psychiatrist in some services, and the support for their role as supervisors.

The current role of supervision in psychiatric training and limitations encountered necessitates substantial revision of the structures used to promote the key role of supervision in psychiatric training.

### No. 79D
### THE DEVELOPMENT OF A MODEL FOR TRAINING AND ACCREDITING SUPERVISORS

David Burke, *Department of Psychiatry, St. George Hospital, Gray Street, Kogarah 2217, Australia;* Alexandra M. Cockram, M.Ed., Pete M. Ellis, B.M., Brian Kelly, B.M., Peter Burnett, B.M.

### SUMMARY:

Supervision is regarded as a cornerstone of psychiatry training. Traditionally, it has been based on the apprenticeship model of medical training, and in psychiatry it has been informed by some of the principles of psychodynamics. More recently supervision in

psychiatry has borrowed from the areas of adult education, management, and problem-based learning. Recently the Royal Australian and New Zealand College of Psychiatrists (RANZCP) developed a set of guidelines for the training and accrediting of supervisors. The principle aims, the selection criteria, the content of the training, the performance criteria and the ongoing accreditation of supervisors will be described—with an emphasis on the content of the supervisor training. This session is for psychiatrists involved in supervising trainee psychiatrists, and for trainees being supervised, and is designed to increase their understanding of the nature and practice of supervision in psychiatry.

### REFERENCES:

1. Clarke D: Supervision in the training of a psychiatrist. Aust NZ J Psychiatry 1993; 27:306–310.
2. Kilminster SM, Jolly BC: Effective supervision in clinical practice settings: a literature review. Medical Education 2000;34:827–840.
3. Burke D, Kelly B, Cockram A: Guidelines for RANZCP-accredited supervisors who experience problems in supervision. Australasian Psychiatry 2000;B(2):110–113.
4. Burke D, Burnett P, Evans M: Guidelines for RANZCP-accredited trainees who experience problems in supervision. Australian Psychiatry 2000; 8:15–7.

## SYMPOSIUM 80—META-ANALYSES OF THE EFFICACY OF SECOND VERSUS FIRST-GENERATION ANTIPSYCHOTICS

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand current approaches to summarizing data from randomized trials, including systematic reviews, meta-analysis, and methods of investigating heterogeneity between studies, be familiar with the use of the results of systematic reviews in clinical decision-making, (2) recognize current evidence regarding the efficacy of second-generation antipsychotics, (3) recognize the high potential of meta-analytic techniques to inform clinical practice, (4) view meta-analysis in a clinical framework.

### No. 80A
### SYSTEMATIC REVIEWS OF RANDOMIZED TRIALS: THE EXAMPLE OF THE ATYPICAL ANTIPSYCHOTICS

John R. Geddes, M.R.C., *Department of Psychiatry, University of Oxford, Wameford, Oxford OX3 7JX, United Kingdom*

### SUMMARY:

Over the last two decades there have been significant advances in the methodology of summarizing the data from randomized, controlled trials (RCTs). It is recognized that the appropriate pooling of the unbiased estimates from multiple RCTs can yield improved power and precision in the estimation of treatment effects, as well as identifying deficiencies in the trials. The results of systematic reviews and meta-analyses are sometimes controversial, often because they demonstrate smaller (or even negative) treatment effects than those achieved by conventional narrative review. Meta-regression is a recent technique that investigates the association between a study-level characteristic (patient subgroup, dose of drug etc) and the treatment effect. Although meta-regression is a useful technique, it is has limited statistical power and, as it loses the protection of the randomization, is susceptible to bias by confounding. As an example, a systematic review of 52 randomized trials including 12,649 patients, compared the atypical antipsychotics with conventional drugs. There was substantial heterogeneity between the trials for both symptom reduction and dropout. Meta-regression suggested that the heterogeneity was explained by the dose of conventional drug used in the trials. The comprehensive analysis of an unbiased sample of RCTs can maximize the clinical usefulness of the results.

### No. 80B
### THE EFFECTS OF OLANZAPINE ON THE FIVE DIMENSIONS OF SCHIZOPHRENIA DERIVED BY FACTOR ANALYSIS

John M. Davis, M.D., *Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612;* Nancy Chen, M.S.

### SUMMARY:

We present meta-analysis of 142 controlled studies (124 second-generation antipsychotic [SGA] versus first-generation antipsychotic (FGA) studies; 18 studies between SGAs). We also conducted meta-regressions to explore the effect of comparator dose on our data. We found amisulpride, clozapine, olanzapine, and risperidone to be significantly more efficacious than FGAs, while other SGAs were not. We were unable to replicate Geddes et al's finding regarding the effect of dose of comparator when SGAs were examined separately.

In another meta-analysis, we examined olanzapine efficacy using raw data from Eli Lilly & Company of all registrational, double-blind random assignment studies of olanzapine compared with placebo or haloperidol. We also performed analyses of raw data from two large randomized, double-blind clinical trials comparing risperidone with haloperidol, one conducted in the United States and the other in Canada. Olanzapine produced statistically significant symptom improvement on the PANSS (or BPRS) total score and five factors (negative symptoms, positive symptoms, disorganized thoughts, hostility/impulsivity, and anxiety/depression). Our meta-analyses on the raw data of the registrational studies of olanzapine and risperidone found both SGAs slightly superior to FGAs on positive symptoms, but moderately superior on negative symptoms, cognitive symptoms (thought disorder), mood, and impulse control/excitement.

### No. 80C
### EXAMPLES OF HOW META-ANALYSES CAN INFORM CLINICAL PRACTICE

Stefan Leucht, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11041;* Thomas Barnes, M.D., John M. Kane, M.D., Rolf Engel, Ph.D., Werner Kissling, M.D., Johannes Haman, M.D., Kristian Wahlbeck, M.D.

### SUMMARY:

In order to demonstrate the high potential of meta-analytic techniques, the highlights of three recent meta-analyses involving the second-generation antipsychotics (SGA) will be presented. In the first meta-analysis, we compared two mechanisms of action that may make an antipsychotic atypical. The most popular explanation for atypicality is the combined blockade of central dopamine and serotonine receptors. All SGA that are currently marketed in the U.S. share this property. In the meta-analysis it was, however, shown that amisulpride, a pure dopamine receptor antagonist with selective action on the mesolimbic system, leads to the same atypical clinical affects as the other drugs.

In the second meta-analysis, we analyzed the potential of the SGA to reduce relapse rates. Combining the data from 10 studies with 2,061 patients, a modest but statistically significant reduction of the relapse risk by the new drugs was shown.

The third meta-analysis involved all comparisons between SGA and low potency conventional drugs. The main result was that as long as the low-potency conventional antipsychotics were used at

mean doses lower than 600mg chlorpromazine equivalent per day, no superiority of the new drugs in EPS could be found. The clinical implications of these findings will be discussed.

## No. 80D
## A META-ANALYSIS OF THE EFFICACY OF SECOND-GENERATION ANTIPSYCHOTICS

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford, CA 94305-5490;* John M. Davis, M.D., Nancy Chen, M.S.

### SUMMARY:

One of the most important clinical decisions is which antipsychotic to prescribe. Consensus panels differ markedly. Some algorithms that recommend second-generation antipsychotics (SGA) as first-line treatment are based on side-effect advantages, but are equivocal on efficacy differences. Others have issued equivocating guidelines, recommending all antipsychotics and leaving the clinician without an effective guide. Geddes and others question whether SGAs are more efficacious than first-generation antipsychotics (FGAs). We reviewed 18 studies of comparisons between SGAs. Meta-analyses of olanzapine vs. clozapine and risperidone vs. clozapine comparisons showed no significant differences. No efficacy difference was detected among amisulpride, risperidone, and olanzapine. Single studies of clozapine-zotepine, olanzapine-amisulpride, olanzapine-ziprasidone, remoxipride-clozapine, and risperidone-aripiprazole comparisons all displayed no important differences.

We will present the clinical questions and each speaker will present his data. We will review the SGAs in a clinical context and place the results of this evidence-based analysis of efficacy in a clinical context with consideration of side-effect differences as well. We have analyzed the raw data from much of the international randomized trials of risperidone versus olanzapine and will present results from this analysis.

### REFERENCES:

1. Geddes JR, Freemantle N, Harrison P, Bebbington PE: Atypical antipsychotics in the treatment of schizophrenia—systematic overview and meta-regression analysis. British Medical Journal 2000; 321:1371–1376.
2. Davis JM, Chen N: The effects of olanzapine on the 5 dimensions of schizophrenia derived by factor analysis: combined results of the North American and international trials. Journal of Clinical Psychiatry 2001;62(10):757–771.
3. Stefan Leucht, Gabi Pitschel-Walz, Rolf Engel, Werner Kissling: Amisulpride an unusual atypical antipsychotic. A meta-analysis of randomized controlled trials. Am J Psychiatry 2002; 159:180–190.
4. Davis JM, Chen, N, and Glick JD: A meta-analysis of the efficacy of second-generation antipsychotics. Manuscript under review.

# SYMPOSIUM 81—THE PSYCHOLOGICAL IMPACT OF 9/11: RESULTS FROM FIVE MAJOR STUDIES

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe psychological effects of the Sept. 11 attacks and the role that television coverage may have played in those effects, (2) recognize the prevalence of terrorism-related persistent stress following 9/11, (3) recognize the relationship between persistent stress and terrorsin-related behaviors, (4) discuss the prevalence, correlates, and progress of post-traumatic stress disorder after a disaster, and (5) describe the relationships between psychological resiliency and the psychosocial variables of social support, coping styles, and emotional expression in coping with traumatic experience.

## No. 81A
## FINDINGS FROM THE NATIONAL STUDY OF AMERICANS' REACTIONS TO 9/11

William E. Schlenger, Ph.D., *RTI, PO Box 12194, Res Tri Park, NC 27709-2194;* Juesta M. Caddell, Ph.D., Lori Ebert, Ph.D., John A. Fairbank, Ph.D., Richard A. Kulka, Ph.D.

### SUMMARY:

This presentation will describe the results of a national survey of (direct and indirect) exposures to the Sept. 11 terrorist attacks and of psychological symptoms in the second month after the attacks. A national probability sample that included oversamples of the New York and Washington, D.C., metropolitan areas was surveyed. Outcomes assessed included PTSD symptoms and symptoms of general psychological distress. Findings indicate that during the second month after the attacks, general psychological distress levels—across the nation and in the attack sites—were within normal limits. The prevalence of PTSD, however, was elevated in New York (11.2%), but not in Washington (2.7%) or the rest of the country (4.0%). Findings also indicate that PTSD symptom levels were related to direct exposure to the attacks and to the number of hours of TV coverage watched on Sept. 11 and the following few days. Although the findings from this study are not definitive on this point, the investigators interpret the pattern of findings as consistent with the hypothesis that TV watching was best understood as a coping mechanism for people who were already distressed, rather than as an exposure.

## No. 81B
## A NATIONAL LONGITUDINAL STUDY OF PSYCHOLOGICAL CONSEQUENCES OF 9/11

Bradley D. Stein, M.D., *RAND, 1700 Main Street, Santa Monica, CA 90407;* Marc N. Elliott, Ph.D., Lisa H. Jaycox, Ph.D., Rebecca L. Collins, Ph.D., Sandra H. Berry, M.A., Mark A. Schuster, M.D.

### SUMMARY:

*Background:* The September 11 terrorist attacks had an immediate psychological impact across the U.S. Little is known about how psychological effects and behavioral reactions evolve following indirect exposure to terrorism.

*Methods:* On September 14–16, we conducted a national random-digit-dialing telephone survey of 560 adults. From November 9–28, 395 were re-surveyed about their terrorism-related stress and behaviors.

*Results:* Sixteen percent of adults had persistent stress, reporting, substantial stress symptoms in both September and November; 18% of parents reported persistent stress in their children. Adults with persistent stress reported accomplishing less at work, avoiding public gathering places, and using alcohol or drugs because of worries about terrorism. The majority coped by talking with family and friends; however, many reported sometimes feeling unable to share their terrorism-related thoughts and feelings with others because it made others uncomfortable. Few reported receiving counseling or information about stress from medical or mental health professionals.

*Conclusion:* One in six adults reported persistent terrorism-related stress; many more reported terrorism-related behavioral responses. They turned to family and friends for support, but at times many felt uncomfortable doing so. Clinicians and policymakers should consider how the health-care system might more effectively respond

to individuals needing information and counseling following terrorist events.

## No. 81C
## PTSD IN NEW YORK CITY AFTER 9/11

Sandro Galea, M.D., *CUES, New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029;* Heidi S. Resnick, Ph.D., Dean Kilpatrick, Ph.D., Jennifer Ahem, M.P.H., Joel Gold, M.D., Jennifer Stuber, Ph.D., David Vlahov, Ph.D.

### SUMMARY:

*Background:* We assessed the prevalence of posttraumatic stress disorder (PTSD) in residents of New York City (NYC) one, four, and six months after the September 11 attacks.

*Methods:* In each survey we used random-digit-dialing to contact a representative sample of adults in progressively larger portions of the NYC metropolitan area. Participants were interviewed about exposure to the events of September 11 and PTSD symptoms.

*Results:* We interviewed 1,008, 2,001, and 2,752 adults in the three surveys, respectively. In Manhattan south of 110th street, the past month prevalence of PTSD related to the September 11 attacks was 7.5% (95% CI=5.7–9.3) one month after, 1.7% (95% CI=0.4–3.0) four months after, and 0.6% (95% CI=0.3–0.9) six months after September 11. In the same area, the prevalence of sub-threshold PTSD related to the attacks was 17.4% (95% CI=14.8–20.0), 6.0% (95% CI=2.2–5.8), and 4.7% (2.5–6.9) one, four, and six months after September 11, respectively. Contrary to expectations, prevalences of PTSD and sub-threshold PTSD were higher in NYC than in Manhattan when both were measured in surveys 2 and 3.

*Conclusions:* There was a substantial burden of acute PTSD in NYC after the September 11 attacks and a higher prevalence of subsyndromal symptoms. The progression of PTSD symptoms in the general NYC population after a large human-made disaster has implications for public mental health preparedness.

## No. 81D
## PRIOR TRAGEDY MATTERS: CROSS COMMUNITY RESPONSES TO 9/11

E. Alison Holman, Ph.D., *Department of Psychology and Social Behavior, UC Irvine, School of Social Ecology, Room 3340 SE II, Irvine, CA 92697–7085;* Roxane Silver, Ph.D., Daniel McIntosh, Ph.D., Michael Poulin, B.A., Virginia Gilrivas, M.A.

### SUMMARY:

Prior trauma may be a risk factor for psychological difficulties following the September 11, 2001 terrorist attacks (cf. Turner & Lloyd, 1995). Two and six months after 9/11, we surveyed probability samples of adults residing in communities previously exposed to large-scale interpersonal violence (i.e., Columbine High School shooting in Littleton, CO), terrorism (i.e., Murrah Federal Building bombing in Oklahoma City), or natural disaster (i.e., Hurricane Andrew in Miami). Rates of September 11th-related posttraumatic stress symptoms in each community were compared with a random sample of New York City residents and to a national probability sample. Adjusting for demographics, pre-9/11 mental and physical health, prior stressful experiences, and 9/11-related experiences, residents of Littleton, CO, and the surrounding metropolitan community reported rates of September 11th-related posttraumatic stress symptoms one-half of those seen nationally, while Miami residents reported symptomatology comparable to that obtained in NYC. Oklahoma City residents did not differ significantly from the national sample. The psychological effects of a national trauma cannot simply be predicted by exposure to prior community trauma. Instead, the type of trauma experienced and the community response following it may help explain subsequent resilience or vulnerability.

## No. 81E
## PSYCHOSOCIAL PREDICTORS OF RESILIENCY IN COPING WITH THE TRAGEDY OF 9/11

Lisa D. Butler, Ph.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, #2320, Stanford, CA 94305-5544;* Jay Azarow, Ph.D., Juliette C. Desjardins, M.D., Cheryl Koopman, Ph.D., Sue DiMiceli, B.A., David Spiegel, M.D.

### SUMMARY:

*Objective:* In the present study we examine psychosocial predictors of psychological resiliency following the events of 9/11/01, including demographic variables, emotional expression, social support, and coping styles.

*Method:* Data were collected as part of an Internet-based study of how over 7,000 Americans and others were coping with the stress of the terrorist attacks. Longitudinal data were collected from about 2,000 participants assessed in the first 12 weeks after the attacks and then again at a six-month follow-up.

*Results:* Preliminary analyses of baseline data (N = 2,175) indicate that male gender ($p < .01$), less education, more emotional expression, a larger support network, higher satisfaction with emotional support received (all $p < .0001$), and positive reframing, active coping, and acceptance ($p < .01$ to $p < .05$), were all associated with lower levels of distress (overall adj. R square = .39, $p < .0001$). Longitudinal analyses will examine the relationship of these baseline variables to psychological and social well-being and distress at follow-up.

*Conclusions:* This study indicates specific components of resiliency in response to highly stressful events such as 9/11/01. These data provide an empirical framework for mental health interventions designed to increase resiliency and reduce distress in response to traumatic events.

### REFERENCES:

1. Galea S, Ahern J, Resnick H, et al: Psychological sequellae of the September 11 attacks in New York City. New England Journal of Medicine 2002;346:982.
2. Schuster MA, Stein BD, Jaycox LH, Collins, RL, Marshall GN, Elliott MN, Zhou AJ, Kanouse DE, Morrison JL, Berry SH: A national survey of stress reactions after the September 11, 2001, terrorist attacks. N Engl J Med 2001;345(20):1507–1512.
3. Galea S, Ahern J, Resnick H, Kilpatrick D, Bucuvalas M, Gold J, Vlahov D: Psychological sequelae of the September 11th attacks in Manhattan, New York City. New England Journal of Medicine 2002;346:982–987.
4. Norris, FH, Byrne CM, Diaz E: 50,000 disaster victims speak: An empirical review of the empirical literature. 1981–2002. The National Center for PTSD and The Center for Mental Health Services, 2001.
5. Butler LD, Seagraves DA, Desjardins JC, Azarow J, Hastings TA, Garlan RW, DiMicell S, Winzelberg A, Spiegel D: How to launch a national Internet-based panel study fast—Lessons from studying how Americans are coping with the September 11, 2001, tragedy. CNS Spectrums 2002; 7(8).

# SYMPOSIUM 82—GAY AND LESBIAN PARENTING

### EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should (1) understand the current research on G&L families, the lack of negative

outcomes for the children in these families, the limitations of the "deficit model," and the benefit to further research examining the difference in G&L families, (2) more effectively work with G&L families by identifying the barriers to securing the best legal protection for their children and aid the judicial system in supporting the best interests of the children, (3) work with male couples who are or are considering being parents through the understanding of the individual and societal forces that inform their parenting, (4) demonstrate understanding of the issues involved with G&L parents adopting internationally, adopting older children, and being in the foster system, and (5) work with a variety of constellations of G&L families with the understanding of the common psychosocial issues contained in the different constellations.

## No. 82A
## CHILDREN OF GAY AND LESBIAN PARENTS: CONFRONTING MYTHS AND STEREOTYPES

Ellen Haller, M.D., *Department of Psychiatry, UCSF, Box F-0984/ 401 Pamassus Avenue, San Francisco, CA 94142*

SUMMARY:

*Objective:* Gay and lesbian (G & L) parents and their children are a diverse group not unlike families headed by heterosexual parents. It is difficult to estimate the exact number of G & L headed families since many G & L parents continue to conceal their sexual orientation due to fears of discrimination, including that they would lose custody and/or visitation rights. There has been much speculation about the emotional development and consequences for children raised by G & L parents. Much of the research to date samples the children of divorced lesbian mothers, as compared with single divorced heterosexual mothers.

The three main areas of concern regarding the development of children raised by G & L parents include gender development, emotional development, and social development. Data will be presented from the results of the latest empirical studies addressing these areas of concern.

*Conclusion:* The empirical research thus far supports no negative evidence regarding the development of children raised in G & L families. While there are some differences, they should not be conceptualized in a "deficit mode." Implications for further research to understand these differences and how they can inform us on issues such as gender role are important to consider.

## No. 82B
## LEGAL ISSUES FOR GAY AND LESBIAN FAMILIES: PROTECTING THE CHILDREN

Charles Spiegel, J.D., *LGBT Comcenter, Our Family, 1800 Market Street, Suite 402, San Francisco, CA 94102*

SUMMARY:

*Objective:* As any parent would, G&L parents want to protect their children to their best ability. Society, however, does not always offer them the legal protection that is available to heterosexual families. A legal parental relationship is the only method to ensure that the child has all of the rights contained in a parent-child bond, such as custody, visitation, medical care, inheritance, and other financial benefits. Non-biologic G&L parents can achieve this through joint or second-parent adoption, but there are many areas in our country that do not allow this. Without these protections, children can lose access to a parent they have known all their lives.

*Conclusion:* It is useful for psychiatrists to know the social and legal pressures on G&L families. Some parents have difficulty securing the best protection for their children for many reasons, such as the anxiety attendant in confronting a discriminatory legal system, internalized homophobia, or financial pressures. Psychiatrists can support these families for the benefit of the parents and the children.

## No. 82C
## GAY CAUCASIAN COUPLES ADOPTING BIRACIAL CHILDREN AT BIRTH

Brian N. Kleis, M.D., *The Childrens Health Council, 650 Clark Way, Palo Alto, CA 94304*

SUMMARY:

*Objective:* Raising a family requires social supports to ensure the emotional and social well-being of children. There are the following three principle difficulties faced by a gay male couple in adopting children of a different race: (1) limitations of social training and support in the traditional roles of nurturing an infant and young child, (2) the current limitations of straight and gay culture in terms of its support for gay parenting, and (3) continued racism and its impact on families. Although none of these factors alone is unique, together they pose challenges and opportunities to learn about parenting, sexism, homophobia, and capacities to address them within a family setting. Overcoming or managing these difficulties potentially provides a model for social and moral development that can be a compass for larger group and social processes.

*Conclusion:* For the benefit to their children, gay males have to consciously work to understand all the influences that guide their decisions to be parents and how to manage individual and societal forces that impact their family. When done in a conscientious manner, and the community they reside in can manage their concerns about this family, the children should have no barriers to fully developing their potential. They also get a closer understanding of many difficult social issues including racism, homophobia, and sexism.

## No. 82D
## NEW AVENUES FOR GAY AND LESBIAN PARENTS: FOSTERING AND INTERNATIONAL ADOPTIONS

Margery S. Sved, M.D., *Adult Psychiatry, Dorothy Dix Hospital, South Boylan Avenue, Raleigh, NC 27603-2176*

SUMMARY:

*Objective:* Working in the mental health field, one is more aware of the number of children worldwide longing for a home. Many brave souls take in children with current challenges or past tragedies without any professional training. As the opportunity for G&L adults to become parents are increasing, in some places they can become foster parents. International adoptions, although fraught with their own complexities, are a viable alternative as well. In both instances, cross-cultural issues are notable and must be addressed for the benefit of the children and family. Homophobia can also emerge and must be handled in a calm, direct manner to not allow it to interfere with caring for children in need. Despite the challenges, the many rewards inherent in raising children make this rewarding.

*Conclusion:* There are many children that are awaiting loving homes that can manage their needs either on a short or long-term basis. Mental health professionals are in a good position to support these children and the parents who want to take them in, especially with the difficulties posed by the foster care system. Gay and lesbian families appear willing to do their part in helping these children by the number willing to be involved with foster care, international adoption, or adoption of older children.

## No. 82E
## GAY ADOPTION, STEPPARENTS, AND LESBIAN MOMS: A NEW AMERICAN FAMILY

S. Zev Nathan, M.D., *1335 State Street, Santa Barbara, CA 93101*

SUMMARY:

*Objective:* Creating families with children where there are no pre-existing models is a challenge faced by gay men and lesbians. Families can be created via adoption, donor insemination, co-parent adoptions, and step parenting. These families must learn how to establish role definitions and relationships for adults in the children's lives for whom there are no specific English words. As children live primarily in the mainstream culture of extended family, neighborhood, and school, they have the awkward task of explaining this different family structure to peers and adults in the outside world—and must deal with how the culture views them. All of these issues, which evolve as children mature and develop, may become particularly challenging as youth go through normal psychosexual development.

*Conclusion:* Child and adolescent psychiatrists should become aware of the wide range of family structures that are in the gay and lesbian community. They should also be cognizant of common psychosocial issues among children and adults in gay and lesbian households. As the percentage of gay and lesbian households with children is increasing, it is likely that children of such families will start to appear in our practices.

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4. Brooks D, Goldberg S: Gay and lesbian adoptive and foster care placement can they meet the needs of waiting children? Soc Work 2001; 48(2):147–57.
5. Benkoff L: Reinventing the Family: The emerging story of Gay and Lesbian Families. Crown Publishers, NY, NY., 1994.

# THURSDAY, MAY 22, 2003

# SYMPOSIUM 83—THE EFFECT OF PERSONALITY DISORDERS ON THE TREATMENT OF AXIS I DISORDERS
## Association for Research in Personality Disorders

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) have a better understanding of how the DSM cluster C (anxious cluster) personality disorders affect the outcome of treatment of Axis I disorders, (2) understand how different combinations of personality disorders can affect outcome of treatment of an Axis I disorder, (3) have a better understanding of how schema-based therapy can be used with borderline personality disorder, (4) better understand how Dialectic Behavior Therapy can aid in the treatment of female borderline substance abusers, and (5) better understand how emotional dysregulation can affect the treatment of an Axis I disorder.

## No. 83A
## THE ANXIOUS PERSONALITY DISORDER CLUSTER AND OUTCOME OF TREATMENT OF AXIS I DISORDERS

James H. Reich, M.D., *Department of Psychiatry, Stanford Medical School, 2255 North Point Street, Unit 102, San Francisco, CA 94123*

SUMMARY:

The literature on the effect of the presence of a personality disorder on the outcome of an Axis I disorder is relatively straightforward. The presence of a personality disorder causes a worse outcome. However, different personality disorders are quite different, raising the question if this outcome is the same for all three DSM personality disorder clusters. There are reviews in this area with conflicting conclusions. This report made a careful examination of the literature in this area. This review of the literature indicates that the anxious cluster personality disorders do correlate with poorer outcome for treatment to an Axis I disorder. However, there is an anomaly as certain anxious cluster personality traits respond to certain treatments for Axis I disorders, creating a paradoxical effect in certain circumstances. These findings will be discussed in detail.

## No. 83B
## THE EFFECT OF AXIS II DIAGNOSIS AND TREATMENT OF AXIS I DISORDERS

Cesare Maffei, M.D., *Department of Psychiatry, Vita Salute San Raffaele University, Via Prinetti 29, 20127, Milano, Italy;* Francesca Blondini, Ph.D.

SUMMARY:

A number of clinical observations and empirical researches suggest that the presence of personality disorders has some effect, in general negative, on treatment and outcome of psychiatric disorders. In this research we studied a sample of 127 consecutively admitted outpatients with Axis I (mainly anxiety and affective disorders) and Axis II diagnoses (mainly Cluster B and C disorders). All the patients were diagnosed with standardized procedures and were treated with medications and individual psychotherapy by psychiatrists and clinical psychologists working in our department. We studied concluded, interrupted, and running treatments using simple and objective parameters, such as length of treatments, interruptions, hospitalizations etc., in order to identify "bad" and possibly "good" matchings of Axis I and Axis II disorders. Preliminary results seem to show that, independently from the nature of Axis I disorder, it is possible to divide all the subjects into the following four Axis II groups, from "bad" to "good": (1) borderline antisocial; (2) borderline, with other Axis II diagnoses, except antisocial; (3) Cluster B, not borderline; (4) Cluster C. These data seem to confirm that impulsiveness and aggressiveness related to personality disorders play a negative role in treatment of patients with Axis I disorders.

## No. 83C
## INTERVENTIONS FOR AXIS II PATIENTS WITH COMORBID AXIS I DISORDERS

David P. Bernstein, Ph.D., *Department of Psychology, Bronx VAMC/ Fordham University, 130 Kingsbridge Road, Dealy Hall, 3rd Floor, Bronx, NY 10568*

SUMMARY:

*Objective:* In this presentation, I will discuss psychotherapeutic interventions to ameliorate Axis I symptoms in patients with severe personality disorders, using Jeffrey Young's schema-Focused Cognitive Therapy as a theoretical framework.

*Methods:* I will present case studies of two patients with borderline personality disorder and comorbid major depression. Both patients were treated for over two years using Schema-Focused Cognitive Therapy, an integrative therapy for personality disorders that combines cognitive, behavioral, psychodynamic, and experiential techniques.

*Results:* Standard cognitive therapy methods (e.g., thought records) had failed to ameliorate mood and anxiety symptoms in either borderline patient. Schema Therapy, with its emphasis on the therapeutic relationship and empathic confrontation of maladaptive behaviors, in addition to cognitive restructuring, produced substantial improvement in mood and anxiety symptoms in one patient, but less successful outcome in the other. Reasons for these differential outcomes (e.g., greater devaluation of the therapist by the latter patient) will be discussed.

*Conclusions:* Schema Therapy techniques can help to reduce Axis I symptoms in patients with severe personality disorders who have failed standard cognitive therapy, but such patients present many challenges.

## No. 83D
## PERSONALITY DISORDERS PREDICT COMPLETION OF SUBSTANCE ABUSE TREATMENT

Per Vaglum, M.D., *Department of Behavioral Sciences, University of Oslo, Sognsvannsvelen 9, P.O. Box 1111 Blindern, Oslo N-0317, Norway*

### SUMMARY:

The dropout rate in all kinds of substance abuse treatment is still high. We need knowledge from prospective studies from different representative treatment modalities about how personality disorders (PD), together with other background characteristics, influence treatment completion.

A total of 307 drug abusers (33% women, mean age at intake: 31 years (14–54, SD: 8.1)) entering consecutively 13 different inpatient treatment programs were followed prospectively for three years. These programs were selected as representative for all types of inpatient treatment modalities in Norway. EuroASI interview, SCL-25, and the self-report inventory MCMI-II were used, the last one to assess the prevalence of DSM-III-R personality disorders (PD). The total dropout rate was 60%. A logistic regression analysis showed that controlled for gender, age, drug preferred, years of injections, number of previous institutional treatments, and present type of treatment modality, those with a high number of PDs significantly less often completed the treatment (OR = 0.4). Thus, PDs were very important for involving substance abusers in treatment, and competence of establishing a therapeutic relationship with abusers with PDs as well as offering them psychotherapy, is highly needed in the substance abuse field.

## No. 83E
## DIALECTIC BEHAVIOR THERAPY IN BORDERLINE SUBSTANCE ABUSERS

Wim Van Den Brink, M.D., *Department of Psychiatry, Amsterdam University, Tafelbergweg 25, 1105 BC Amsterdam, Netherlands;* Edle Raundal, Ph.D.

### SUMMARY:

In many areas of psychiatry there is evidence of personality affecting the outcome of treatment of an Axis I disorder. In the area of substance abuse there have been both positive and negative findings. Many of these studies have methodologic flaws. It has even been considered that the substance abuse obscures the measurement of personality to the point where it is hard to make a firm diagnosis. This presentation attempts to address the issue with a rigorous treatment design. Female substance abusers in the Netherlands who had borderline personality disorder were identified by standardized methods. They were then randomized to different treatment conditions, one of which was Dialectic Behavior Therapy. The use of Dialectic Behavior Therapy showed promise in a combined treatment approach to this group. Strengths and weaknesses of the approach will be discussed.

## No. 83F
## EMOTIONAL DYSREGULATION AND TREATMENT OF AXIS I DISORDERS

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 10560 Blundell Road, Richmond, BC V64 161, Canada*

### SUMMARY:

Often, when considering how personality affects the outcome of treatment of an Axis I disorder, a DSM diagnosis or cluster is used. However, there are dimensional aspects of personality that also are quite relevant to this issue. Previous work by this author using twin studies and dimensional analysis revealed the presence of a higher-order personality dimension named emotional dysregulation. This is a dimension that resembles, but is different from, neuroticism. This presentation will discuss how this cluster of traits might affect the treatment of an Axis I disorder. Among the useful approaches, at times, may be to understand the nature of the personality dysfunction and to work within it rather than attempt treatment of the personality aspect of the clinical case.

### REFERENCES:

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2. Reich JH, Green AI: Effect of personality disorders on outcome of treatment. Journal of Nervous and Mental Disease 1991; 179:74–83.
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4. Vaglum P: Antisocial personality disorder and narcotic addiction, in Psychopathy. Antisocial, Criminal and Violent Behavior. Edited by Millon T, et al. Guilford, N.Y., 1998.
5. Robins C: Dialectical behavior therapy for borderline personality disorder, Psychiatric Annals, 2002;10.
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# SYMPOSIUM 84—THE DIFFICULT-TO-TREAT PSYCHIATRIC PATIENT

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to plan the treatment of the dissociative identity disorder patient and decide how to select interventions and strategies according to an orderly paradigm.

## No. 84A
## THE DIFFICULT-TO-TREAT EATING-DISORDERED PATIENT

Katherine A. Halmi, M.D., *Westchester Division, New York Presbyterian Hospital, 21 Bloomingdale Road, White Plains, NY 10605-1504;* Wendy A. Harris, M.D., Claire Wiseman, Ph.D.

### SUMMARY:

The eating disorders have the reputation of being impossible to treat among the general public and medical and psychiatric communities.

Those with anorexia nervosa have a passionate refusal to change their behavior and a profound denial of the seriousness of their illness. Those with bulimia nervosa often have a secondary positive effect from binge eating, which may alleviate anxiety and boredom. In both of these disorders about three-fourths of the patients will have a chronic relapsing course that may go on for years. There is no treatment that can guarantee a cure for either of these disorders.

Problems with the treatment of eating-disorder patients fall into two broad categories, experience of the treatment team and type of therapy.

For the treatment-refractory eating-disorder patients, more imaginative and creative combinations of cognitive-behavioral therapy, pharmacotherapy, and family counseling must be used. This presentation will give specific examples of refractory-treatment patients and the treatment approaches used to facilitate their recovery.

## No. 84B
## WORKING WITH THE DIFFICULT-TO-TREAT DID PATIENT

Richard P. Kluft, M.D., *Department of Psychiatry, Temple University, 111 Presidential Blvd Suite 238, Bala Cynwyd, PA 19004*

### SUMMARY:

The treatment of dissociative identity disorder (DID) and allied forms of dissociative disorder not otherwise specified (DDNOS) often proves difficult and prolonged. These conditions rarely respond to brief interventions and their core features are not resolved by psychopharmacology, even though medications are generally helpful in addressing particular target symptoms and/or comorbid conditions. Long-term psychotherapy is an essential treatment modality. The psychotherapy follows the phase-oriented model of trauma treatment. It proceeds from a phase oriented toward establishing safety and strengthening the patient, through a phase of dealing with traumatic experiences and grieving their impact, to a phase of reconnection, involving many forms of integration. Those patients who are unable to process their traumatic experiences (irrespective of the historical accuracy of the memories presented to the psychiatrist) will require an ongoing supportive treatment that prioritizes safety and function above the resolution of the DID/DDNOS itself. Stalemates and difficulties in the treatment are the rule rather than the exception with this group of patients. Illustrative concerns associated with impeding or stalemating the treatment will be reviewed, and approaches to their resolution will be offered. An algorithm for decision making in the conduct of such psychotherapies will be discussed.

## No. 84C
## THE DIFFICULT-TO-TREAT PTSD PATIENT

Randall D. Marshall, M.D., *Department of Anxiety Disorders, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Elizabeth A. Hembree, Ph.D., Lee A. Fitzgibbons, Ph.D., Edna B. Foa, Ph.D.

### SUMMARY:

Knowledge regarding effective treatment of posttraumatic stress disorder (PTSD) has advanced considerably in recent years. Empirically based expectations of treatment course and outcome alert us early when a patient is not responding. However, the existing body of literature informs us little about the characteristics of PTSD sufferers who are difficult to treat or respond poorly to interventions of proven effectiveness. In this presentation, we combine clinical wisdom and experience with what the literature does offer and make recommendations for working with difficult-to-treat PTSD patients.

Most of the controlled studies of PTSD treatment have been conducted with cognitive-behavioral and pharmacological interventions. We briefly review the treatment literature for both biological and cognitive-behavioral therapies, present a summary of our knowledge of non-responders, discuss treatment strategies for the difficult-to-treat PTSD patient, with special emphasis on strategies that may be implemented with psychosocial treatment, and present a case vignette that serves to illustrate such a person.

### REFERENCES:

1. Halmi KA: Eating disorders: anorexia nervosa, bulimia nervosa and obesity, in American Psychiatric Press Textbook of Psychiatry, third edition. Edited by Hales, KE, Tudopsky, SC, Talbott J. Washington, D.C., Am Psychia Press Inc, 1999, pp. 983–1002.
2. Kluft RP: The difficult-to-treat patient with dissociative disorder, in The Difficult-to-Treat Psychiatric Patient. Edited by Dewan MJ, Pies RW. Washington, DC, American Psychiatric Press, 2002, pp 209–242.
3. Foa EB, Rothbaum BO: Treating the Trauma of Rape. New York, Guilford Publications, Inc, 1997.

# SYMPOSIUM 85—QUALITY MEASUREMENT IN A CANADIAN INNER-CITY ACADEMIC ENVIRONMENT

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify innovative strategies to evaluate programs and service delivery models across mental health delivery systems. (2) Identify innovative strategies to evaluate programs and service delivery models for vulnerable and marginalized populations, (3) identify strategies to promote effective evaluation within and across mental health programs. (4) Critique common clinical and systems barriers to integrating research in community-based mental health services for vulnerable populations, and identify some innovative strategies for promoting evaluation infrastructures in these clinical settings. (5) Understand essential elements of ACT and intensive case management in relation to how they can facilitate optimal everyday functioning for clients with SPMI. (6) Understand some of the issues involved in using outcome data for planning mental health systems in the inner city.

## No. 85A
## QUALITY MEASUREMENT IN MENTAL HEALTH CARE

Ian C. Dawe, M.D., *Department of Mental Health, St Michael's Hospital, 2012 30 Bond Street, Toronto, ON M5B 1W8, Canada*

### SUMMARY:

In today's challenging health care environment, providers of mental health care are facing greater pressures to deliver more and more services of higher quality to a variety of challenging populations. Consumers, as well as funders of health care, continue to expect the

delivery of high-quality care without dramatic increases to the tax or insurance base that funds that care. Increasingly, as key drivers of resource expenditures, health care providers are expected to be accountable for the quality of the care they deliver. Yet the precise meaning of quality in the mental health care context remains ill-defined and its application, controversial.

This portion of the symposium will examine some relevant definitions of health care quality, explore some reasons for previous resistance to quality initiatives, scrutinize newer quality concepts, and end with a call for a greater degree of provider input in the quality process. It will set the stage for the presentations that follow by providing a context by which participants can understand the fundamental constructs of quality measurement and apply them to clinical practice situations so as to develop and implement interventions that actually improve the quality of patient care.

## No. 85B
## EVALUATION OF A MOBILE CRISIS SERVICE IN THE INNER CITY

Nancy E. Read, M.S.C., *Department of Mental Health, St. Michaels Hospital, 30 Bond Street Room 17026 CC, Toronto, ON M5B 1W8, Canada;* Joanne C. Walsh, B.S.C.N., Sean B. Rourke, Ph.D., Ian C. Dawe, M.D.

### SUMMARY:

Mobile crisis services are considered to be an integral part of an effective emergency mental health system to decrease hospital admissions, divert individuals from the forensic system, and increase use of community-based treatments, although systematic evaluations of their effectiveness are lacking. This presentation will describe the development and evaluation of a two-year mobile crisis intervention team (MCIT) pilot project carried out in a Canadian inner-city setting. The MCIT is composed of a crisis nurse and a non-uniformed police officer who have responded to over 500 emergency (911) calls for emotionally disturbed persons over the past two years. Delineation of the unique challenges in developing and implementing this MCIT program with vulnerable and marginalized populations will be discussed. Outcomes from the clinical research database will also provide an overview of the sociodemographic characteristics of this sample, access issues to treatment, and differential support needs of high-risk clients within the inner city.

## No. 85C
## PROMOTING SYSTEMS EVALUATION OF INNER-CITY COMMUNITY MENTAL HEALTH PROGRAMS

Margaret Gehrs, R.N., *Department of Mental Health, St. Michael's Hospital, 17075-30 Bond Street, Toronto, ON M5B 1W8, Canada;* John H. Langley, M.D.

### SUMMARY:

Systems evaluation relies on the ability to effectively integrate research in and across practice settings such that clinical outcomes can be evaluated and compared. All too often researchers encounter barriers and resistance from clinical staff in carrying out research in clinical settings. These difficulties can be amplified in inner-city mental health settings where research subjects consist of vulnerable homeless individuals with serious mental illness. This presentation will describe a multi-site research project, including a randomized controlled trial at a large Canadian inner-city teaching hospital. The study compares assertive community treatment and intensive case management for homeless individuals with serious mental illness and co-occurring substance use problems. The presenters will describe the processes used to create an infrastructure promoting a research culture within these clinical settings, including implementing standardized evaluation measures, supporting psychiatrists and other clinical staff to participate in the evaluation process, and maintaining ethical standards in studying vulnerable populations. Implications of the outcome data for system design of inner-city mental health programs will be discussed.

## No. 85D
## REDUCTION IN MENTAL HEALTH SERVICES USE IN SEVERE AND PERSISTANT MENTAL ILLNESS CLIENTS WITH ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE CASE MANAGEMENT

Donald A. Wasylenki, M.D., *Department of Mental Health, St. Michaels Hospital, 30 Bond Street, Toronto, ON M5b 1W8, Canada;* Sean B. Rourke, Ph.D., Paul S. Links, M.D.

### SUMMARY:

The purpose of this study is to compare the impact of assertive community treatment (ACT) and intensive case management (ICM) on everyday functioning in patients with severe and persistent mental illness (SPMI) in an inner-city setting (southeast Toronto).

*Methods:* Eighty patients with SPMI were randomly assigned to receive ACT (n=40) or ICM (n=40) treatment for 18 months. Primary and secondary outcome measures included number of crisis episodes, emergency room (ER) visits, and hospitalizations across 18 months, as well as changes at nine and 18 months in overall functioning (Multonomah Community Ability Scale; MCAS) and psychiatric symptomatology (Brief Psychiatric Rating Scale). ACT and ICM were matched at baseline on all measures. For the present analyses, complete data were available for approximately 90% and 70% of cases at nine- and 18-month evaluations, respectively.

*Results:* (1) ER visits and hospitalizations were reduced in both ACT and ICM at nine months; (2) total frequency of crisis episodes are significantly reduced in the second nine months of intervention; (3) MCAS scores improved similarly (i.e., about 20%) in both interventions at nine months; (4) psychiatric symptoms are reduced about 10% in both interventions.

*Conclusions:* ACT and ICM interventions are effective for SPMI in the inner city.

## No. 85E
## USING OUTCOME DATA TO PLAN MENTAL HEALTH SYSTEMS IN THE INNER-CITY

Lorne A. Tugg, M.D., *Department of Psychiatry, St. Michael's Hospital, 30 Bond Street, Toronto, ON M5P 2J6, Canada*

### SUMMARY:

This presentation will focus on the different issues involved in making use of outcome data in planning a community psychiatry program in a Canadian inner-city academic hospital.

The data presented earlier in the symposium, from the randomized controlled trial of assertive community treatment, will be used to demonstrate the value and limitations of outcome-data-driven program planning as applied in the inner-city context.

### REFERENCES:

1. IsHak WW, Burt T, Sederer L: Outcome Measurement in Psychiatry: A Critical Review. Washington: APPI, 2002.
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3. Meisler N, Blankertz L, Santos AB, McKay C: Impact of assertive community treatment on homeless persons with co-occurring severe psychiatric and substance use disorders. Comm Mental Health J 1997; 33:113–122.

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5. Rosenblatt A, Attkisson CC: Assessing outcomes for sufferers of severe mental disorder: a conceptual framework and review. Evaluation and Program Planning 1993; 16:347–363.

# SYMPOSIUM 86—THE VETERANS ADMINISTRATION EXPERIENCE: TREATING COMORBID HEPATITIS C AND SUBSTANCE USE DISORDERS/ PSYCHIATRIC ILLNESS

## EDUCATION OBJECTIVES:

At the conclusion of this symposium, the participant should demonstrate awareness of (1) overall HCV tested seroprevalence rates in the veteran population, (2) time trends in testing patterns, (3) rates of psychiatric and substance use disorders comorbidities, (4) assess and manage substance use disorders in the context of patients receiving treatment for Hep C, including interferon treatment, (5) evaluate and manage depression in patients with hepatitis C and those treated with interferon therapies, (6) demonstrate understanding of high rates of PTSD comorbitity among HCV+ veterans and recognize potential treatment issues.

## No. 86A
## PATTERNS IN HEPATITIS C: PREVALENCE AND COMORBIDITIES IN NORTHWEST VETERANS

Kevin L. Sloan, M.D., *Department of Psychiatry, VA Puget Sound HCS, 1660 S. Columbian Way, 116-DDTP, Seattle, WA 92108;* Kristy A. Straits-Troster, Ph.D., Jason A. Dominitz, M.D., Daniel R. Kivlahan, Ph.D.

SUMMARY:

*Background:* Hepatitis C virus (HCV) infection, a leading cause of chronic hepatitis, cirrhosis, and end-stage liver disease, is estimated to be present in 1.8% of the U.S. general population, but rates reported in veterans range from 1.7% to 35%.

*Objectives:* We reviewed computerized medical records of all veterans tested for HCV at eight VA medical centers to (1) report HCV-testing results and time trends, (2) identify diagnostic and laboratory markers for positive HCV serology, and (3) ascertain rates of comorbid psychiatric and substance use disorders among seropositive individuals.

*Results:* Of the 37,938 veterans tested, 8,230 (21.7%) had evidences of current or prior HCV infection. The number of patients tested annually increased from 2,335 to 18,191, while the proportion with first-time positive HCV antibody test results decreased from 35% to 10%. HCV-infected veterans were significantly more likely to have positive hepatitis B serology (odds ration [OR] 5.19), persistently elevated alanine transaminase levels (OR 5.10), and diagnoses of drug-use disorders (OR 2.98). Furthermore, of the 6,073 HCV-positive individuals seen during 2000, 4,480 (74%) had a history of drug or alcohol diagnoses, 3,911 (64%) had a history of major psychiatric diagnoses, and 3,271 (54%) had both.

## No. 86B
## ASSESSMENT AND MANAGEMENT OF SUBSTANCE USE DISORDERS IN HEPATITIS C PATIENTS

Mark L. Willenbring, M.D., *Department of Psychiatry, VA Medical Center, 1 Veterans Drive, Minneapolis, MN 55417;* Eric W. Dieperink, M.D., Samuel Ho, M.D.

SUMMARY:

*Objective:* Provide an overview of current knowledge regarding screening and management of substance use disorders (SUD) in patients with hepatitis C (HCV) infection.

*Method:* Literature review and clinical experience at the Chronic Hepatitis Clinic at the Minneapolis VAMC. A retrospective chart review of 206 consecutive patients will be presented. Data collected related to degree of liver fibrosis, HCV risk factors, psychiatric and SUD diagnoses, and treatment outcome.

*Results:* Although SUD is common among HCV patients (over 80% in this study), surprisingly little is known about their effect on treatment compliance or outcomes. Lifetime alcohol consumption has been reported to reduce treatment response, but in this study, SUDs didn't affect outcome. Although there are consensus standards regarding exclusion criteria, there is currently no empirical basis for them. Patients with SUD appear to be excluded at rates that are not justified by any data.

*Conclusions:* High rates of exclusion of SUD patients in the absence of empirical justification suggest that many are being excluded inappropriately. This may occur because of discomfort on the part of HCV treatment providers. Application of known screening and management techniques for SUD could reduce inappropriate exclusions and improve overall treatment outcomes.

## No. 86C
## EVALUATION AND MANAGEMENT OF DEPRESSION IN PATIENTS WITH HEPATITIS C

Eric W. Dieperink, M.D., *Department of Psychiatry, Veterans Affairs, 1 Veterans Drive, Minneapolis, MN 55417;* Mark L. Willenbring, M.D., Peter Hauser, M.D., Samuel Ho, M.D.

SUMMARY:

*Objective:* Provide an overview of current knowledge regarding evaluation and management of depressive symptoms in patients with hepatitis C virus (HCV) infection, prior to and during treatment with interferon (IFN).

*Method:* Literature review and clinical experience at the chronic hepatitis C clinic at the Minneapolis VAMC. A study of neuropsychiatric symptoms associated with IFN treatment of HCV will be presented. Demographic and prospective data collected include psychiatric and substance use histories, seven measures of neuropsychiatric symptoms, and IFN treatment outcome.

*Results:* Of the 31 patients not in psychiatric care at baseline, major depressive disorder (MDD) symptoms occured in 23% of patients, although 48% required treatment for neuropsychiatric symptoms. Antidepressant treatment prevented worsening of symptoms. Patients with existing psychiatric disorders were more symptomatic at baseline and worsened; however, all but one patient completed a full course of IFN therapy. A family history of mood disorder and a history of more than two psychiatric diagnoses predicted the need for psychiatric treatment.

*Conclusions:* Depression and other psychiatric problems are common in patients with hepatitis C. Patients with psychiatric disorders can successfully complete a course of IFN therapy when treated collaboratively by psychiatrists and hepatologists.

## No. 86D
## PTSD AND HEPATITIS C COMORBIDITY AND IMPLICATIONS FOR INTERFERON-BASED TREATMENTS

Kristy A. Straits-Troster, Ph.D., *Substance Abuse, VA Puget Sound, 1160 S. Columbian Way, 116ATC, Seattle, WA 98108;* Miles E. McFall, Ph.D., Kevin L. Sloan, M.D., Jason A. Dominitz, M.D.

SUMMARY:

Rates of substance use disorders among Vietnam veterans with PTSD have been reported to be as high as 75%. Because substance use, particularly IVDU, is an important risk factor for hepatitis C virus (HCV) infection, it follows that persons infected with HCV may be affected by comorbid PTSD. The extent and impact of PTSD comorbidity among HCV+ veterans is unknown. We sought to determine the prevalence of PTSD among VHA Northwest Network veterans tested for HCV and to compare HCV+ veterans with and without PTSD regarding treatment access and service utilization. Data were extracted from electronic medical records. Between 10/1996 and 8/2000, 25,080 veterans were tested for HCV infection. The veterans with positive HCV antibody results (5,406/25,080, 21.6%) included many with PTSD diagnoses (1,576/5,406, 29%). HCV+/PTSD+ veterans had high rates of comorbid diagnoses of drug use disorders (81%), alcohol use disorders (70%), psychotic disorders (22%), and 39% were homeless. HCV+ patients with no recent psychiatric or substance abuse history were more likely to receive interferon-based treatment (6.9%) than those with PTSD (3.9%) or other psychiatric or substance-use diagnoses (2.3%). Results suggest that a large subset of HCV+ veterans also have PTSD and complex psychosocial problems that may impact HCV treatment and adherence.

REFERENCES:

1. El-Serag HB, Kunik M, Richardson P, Rabeneck L: Psychiatric disorders among veterans with hepatitis C infection. Gastroenterology 2002; 123(2):476–82.
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4. Cheung R, Ahmed A: Treating chronic hepatitis C patients with psychiatric disorders: an uphill battle. American Journal of Gastroenterology 2001; 96(1):3–4.

## SYMPOSIUM 87—CHILDREN AT RISK FOR MENTAL ILLNESS IN LATIN AMERICA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the significance of suicidal ideation in the diagnosis of depression in children, (2) recognize the significance and identify the presence of hallucinations and delusions in the diagnosis of psychosis in children, (3) recognize the impact of ADHD in children and understand the potential role of both psychopharmacological and psychotherapeutic approaches to treatment in children with ADHD, (4) recognize the impact of TS in children; to understand the potential role of risperidone treatment in TS and to determine the effectiveness of atypical antipsychotic medication in children with TS, and (5) recognize the significance of somatic complaints in the diagnosis of anxiety and depression in children.

### No. 87A
### CORRELATES OF SERIOUS SUICIDAL IDEATION AMONG CENTRAL-AMERICAN YOUTHS

Lenn Murrelle, Ph.D., *Preventive Medicine, Virginia Community University, Richmond, VA 23298;* Leo Russo, Ph.D., Enrique Warner, M.P.H., Luis Sandi, M.D., Alfredo Moreno, M.D.

SUMMARY:

*Objective:* Early identification of children at high risk for suicide attempts is an important preventive strategy. One such high-risk group includes youths with serious current suicidal thoughts (ideation), who are known to have a greater likelihood of prior and future suicide attempts. While researchers have identified key factors associated with suicidal ideation among children in the United States, little is known about which youths are at enhanced risk in Latin America.

*Methods:* As part of a large, epidemiologic study of risk and protective factors for healthy adaptation among Central American adolescents, confidential, self-report survey was administered to nearly 20,000 randomly selected students in Panama, Costa Rica, and Guatemala. Along with a question regarding frequent suicidal thoughts in the past three months, data were collected on factors known from the research literature in the United States to correlate with suicidal ideation.

*Results:* Among these were age, sex, family cohesion, neighborhood violence exposure, substance use and abuse, family drug involvement, adult emotional support, positive interactions with teachers, school commitment, negative family interactions, depressive symptoms, conduct problems/aggressivity, family punishment practices, parental and personal religiosity, and family structure. Stepwise, hierarchical logistic regression analysis was used to confirm prior findings in non-Latin American samples and to identify the key risk and protective factors by sex, age, and country subgroups.

*Conclusions:* Preventive implications of the results are presented.

### No. 87B
### PHENOMENOLOGY AND TREATMENT OF PSYCHOSIS IN CHILDREN

Rosa E. Ulloa, M.D., *Clinical Research, Institute of Mexican Psychiatry, Calzada Mexico Xochmilco 101, Mexico City 14370, Mexico*

SUMMARY:

*Objective:* To examine the demographic, clinical characteristics, and treatment of Mexican children and adolescents diagnosed with schizophrenia.

*Methods:* A group of 195 patients were assessed with the Schedule of Affective Disorders and Schizophrenia for School-age Children Present-Episode version, and classified as definite, probable, or non-psychotic. Clinical and demographic characteristics of the groups were compared, and symptoms of psychosis were analyzed using factor analysis.

*Results:* These patients received a mean of 2.5 (+/–0.86) drugs for their treatment, the most frequently used antipsychotic in this population was haloperidol (41%). Adjunctive medication included anticholinergics (62.1%), benzodiazepines (14.9%), anticonvulsants (17.9%), and antidepressants (10.3%).

*Conclusions:* Psychotic patients had a higher frequency of comorbid disorders and suicidal ideation.

### No. 87C
### DIAGNOSIS AND TREATMENT OF CHILDREN WITH ADHD: A CHILEAN EXPERIENCE

Arturo Grau, M.D., *Universidad de Chile, Hospital Calvo MacKenna, Santiago de Chile, Chile*

SUMMARY:

*Objective:* Few studies have examined the prevalence of children with attention-deficit/hyperactivity disorder (ADHD) in Chile who are receiving both psychotherapy and pharmacotherapy. This study reports on ADHD in a Chilean community sample.

*Methods:* We screened 13,677 children (7–17 y.o) in 19 schools in the Comuna La Florida, Santiago-Chile, with the Center for Epidemiological Studies Depression Scale (CES-D). The top decile of CES-D scorers and a random sample of the remainder were interviewed using the Schedule for Affective Disorders and Schizophrenia for School-aged Children (K-SADS).

*Results:* The weighted prevalence of ADHD in this sample is 5% (more in males than females). Significant associations ($p < .05$) are found for diagnosis and treatment (psychotherapies and pharmacotherapies). Medication use ($p < 0.1$) is negatively associated with ADHD.

*Conclusion:* ADHD is a significant problem in children. They utilized both psychotherapies and pharmacotherapies. Parents' decisions to use of any particularly therapeutic approach warranting further study.

## No. 87D
## A STUDY OF RISPERIDONE IN THE TREATMENT OF CHILDREN WITH TOURETTE'S SYNDROME

Carolina Remedi, M.D., *Department of Neuropsychopharmacology, Argentine College, Cardoba-Argentina, Argentina;* Carlos Soria, M.D., Nestor Edelstein, M.D.

### SUMMARY:

*Objective:* To evaluate the effectiveness and tolerability of risperidone in children and adolescents with Tourette's syndrome.

*Method:* Twenty-one patients, 15 males and six females, aged 7 to 16 years, were assigned to risperidone for 12 weeks. Risperidone was initiated at a dose of 0.5 mg/day and flexibly titrated to a maximum of 6mg/day. Additional drugs clonidine 0.3/0.5mg/day (also active for management of tics) and sertraline 150mg/day were administered for the treatment of comorbidity (5 ADHD; 2 OCD and 2 MDD).

*Results:* Risperidone was significantly more effective in reducing by 80% the Global Severity and Total Tic scores on the Yale Global Tic Severity Scale. Risperidone also significantly reduced tic frequencies as evaluated by the Clinical Global Impression Subscales. The mean (+/–SD) daily dose of risperidone during the 12 weeks of the trial was 2.2 +/– 4.6 mg. Mild transient somnolence was the most common adverse event. No clinically significant effects were observed on weight and appetite and/ or specific ratings of extrapyramidal symptoms or akathisia.

*Conclusions:* In this limited sample, risperidone (0.5–6mg/day) appears to be effective and well tolerated in the treatment of Tourette's Syndrome. Risperidone may be associated with a lower risk of extrapyramidal side effects in children. However, additional studies are necessary to evaluate more fully its safety and efficacy in children with tic disorders.

## No. 87E
## ANXIETY, DEPRESSION, AND SOMATIC COMPLAINTS IN TRAUMATIZED CHILDREN

Ruby Castilla-Puentes, M.D., *Department of Epidemiology, University of Pittsburgh, Swan Study 3811 O'Hara Street, Pittsburgh, PA 15213;* Miguel Habeych, M.D., Ivan Gomez, M.D., Sandra Castilla-Puentes, M.D., Wilma Castilla-Puentes, M.D., Maria C. Caballero, R.N., Gilmarosa De Contreras, M.S.W.

### SUMMARY:

*Objective:* To identify the most common physical complaints in a sample of children and adolescents living in a rural area of Colombia, SA. Whether somatic symptoms are more likely to be associated with the witness of traumatic events, high levels of anxiety, or high levels of depression was also explored.

*Methods:* A total of 300 school-aged children/adolescents from a stratified, random sample of schools in a rural area in Belon, Boyaeá, Colombia, were ascertained. 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 sociodemographics information and an inventory of traumatic events and somatization symptoms.

*Results:* The most common somatic complaint was in the gastrointestinal category. In simple regression analyses, anxiety level as measured with the SCARED Scale significantly predicted the presence of somatic symptoms. Although the correlation between depression from the CDI score and somatic symptoms approached significance ($r = .11$, $p = .061$), the correlation between anxiety levels from the SCARED score and somatic symptoms was significant ($r = .36$, $p = .001$).

*Conclusions:* Information that somatic complaints are commonly an expression of underlying anxiety may facilitate the treatment and thereby help avoid unnecessary medical workups and sequelae from traumatized children.

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# SYMPOSIUM 88—POLYPHARMACY: EVIDENCE BASIS VERSUS CLINICAL EXPERIENCE

### EDUCATIONAL OBJECTIVES:

At the end of this presentation, the attendee will be able to (1) describe the Massachusetts Division of Medical Assistance's identification of costly and potentially ineffective psychiatric polypharmacy prescribing practices and its attempts to influence prescribers to examine and change these practices, (2) appreciate the influence of the placebo effect on the response to polypharmacy and understand the mechanisms that mediate this effect, (3) describe the prevalence of antidepressant co-prescribing in one population, list the mechanisms proposed to justify this practice, and understand the strengths and limitations of the evidence for effectiveness of antidepressant co-prescribing, (4) be familiar with the clinical evidence supporting combination treatment, (5) and recognize and treat the most common underlying causes of insomnia in psychiatric patients.

## No. 88A
## POLYPHARMACY: EXTENT OF THE PROBLEM AND THE MASSACHUSETTS RESPONSE

Annette Hanson, M.D., *Division of Med Asst Office Clinic, 600 Washington Street, 5th Floor, Boston, MA 02111*

SUMMARY:

In Massachusetts, pharmacy expenses constitute the most rapidly increasing segment of the Medicaid budget. Medications used primarily in treating psychiatric disorders comprise 47% of the pharmacy budget, which reached $950 million in FY 2002. In the face of decreasing state revenues, the Massachusetts Medicaid agency (Division of Medical Assistance [DMA]) undertook an examination of how the limited health care resources are used. Nonpsychiatric drug costs were addressed by designating preferred agents within each therapeutic class that could be prescribed without prior authorization. The approach taken with psychiatric drugs, by contrast, relied on the development of a DMA task force that focused on the prevalence, reasons for, and expense associated with several poorly justified polypharmacy practices: co-prescribing of atypical antipsychotics, co-prescribing of SSRIs, and the co-prescribing of five or more psychiatric drugs (often from multiple prescribers). The DMA has limited capacity to manage pharmacy usage because of federal mandates that limit co-payments, development of formularies, or other methods used by commercial insurers. It is therefore attempting to impact prescribing practices through education of its providers by letters, consultation opportunities, and CME courses. Prior authorization may ultimately also be considered necessary for certain medications or specific uses of particular medications.

## No. 88B
## THE PLACEBO EFFECT IN THE ASSESSMENT OF POLYPHARMACY

Walter A. Brown, M.D., *Department of Psychiatry, Brown University, 108 Driftwood Drive, Tiverton, RI 02878*

SUMMARY:

Doctors and their patients routinely ascribe healing powers to treatments that are essentially inert. It isn't that these treatments don't provide benefit; most of them do. The catch is, the treatment in itself is of no particular value. The benefit comes from the treatment situation, the placebo effect.

A placebo-controlled, double-blind clinical trial is the best, albeit not a foolproof, way to determine the efficacy of a putative treatment. Few drug combinations have been subjected to this sort of scrutiny. In the absence of such evidence, several features of the condition and the response to treatment provide clues as to the likelihood that an observed benefit of treatment rests on the placebo effect. When highly placebo responsive conditions (e.g., depression, panic disorder, insomnia) improve with treatment one must be cautious in attributing the improvement to the treatment itself. Further, less severe and less chronic variants of an illness tend to be most placebo responsive. Finally, when disparate treatments provide equivalent benefit, one must consider the possibility that some common feature of these treatments is the active ingredient. In such instances the treatment situation, or placebo effect, must be considered.

## No. 88C
## CO-PRESCRIBING ANTIDEPRESSANTS: DUAL OR DUELING TREATMENT?

James M. Ellison, M.D., *Department of Geriatrics, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Many clinicians consider the co-prescribing of antidepressants an effective intervention in appropriately chosen clinical situations. Heterocyclic agents are co-prescribed with serotonergic antidepressants or with MAO inhibitors, agents such as bupropion and mirtazapine have been co-prescribed with antidepressants from other classes, serotonergic agents from different classes have been combined, and even two selective serotonin reuptake inhibitors have been co-prescribed. Clinical reasons for these practices include efforts to increase the degree of symptom alleviation, expand the spectrum of symptoms addressed, or improve the management of side effects. Theoretical justifications for co-prescribing antidepressants include both pharmacodynamic and pharmacokinetic mechanisms. The evidence basis for this practice is limited, but some data support the hypothesis of synergistic effects with specific combinations of antidepressants. Data regarding actual combinations prescribed and their prevalence among the Massachusetts Medicaid-insured population will be reviewed in an attempt to understand how clinicians combine antidepressants in non-academic practice settings. Do the actual combinations reflect the theoretical justifications for co-prescribing? Do the rates of co-prescribing reflect the number of treatment-resistant patients? Principles of evidence-based prescribing suggest the need for further education of clinicians as well as further investigation of the pros and cons of co-prescribing antidepressants.

## No. 88D
## COMBINATION TREATMENT IN SCHIZOPHRENIA

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

SUMMARY:

Combinations of antipsychotic medications are commonly prescribed for treatment-resistant or intolerant schizophrenia patients, although very few data are available to validate or guide this practice. Only one adequately controlled trial has been reported, a 10-week, placebo controlled trial of the selective D2 antagonist, sulpiride, added to an optimal dose of clozapine in 28 schizophrenia patients. Results from this clinical trial and from open trials of combination therapy will be reviewed, with an emphasis upon methodological concerns, evidence for efficacy, and potential adverse effects. An approach to combination treatment will be suggested, along with a rationale based upon receptor affinity profiles of these agents. The lack of evidence for combination therapy in schizophrenia and the need for well-controlled trials will be emphasized.

## No. 88E
## TREATMENT OF INSOMNIA IN THE PSYCHIATRIC PATIENT

John W. Winkelman, M.D., *Department of Sleep Medicine, Brigham and Women's, 1400 Center Street, Suite 109, Newton Center, MA 02459*

SUMMARY:

Most individuals with psychiatric illness have problems falling or staying asleep, or describe non-restorative sleep. Unfortunately, many physicians do not assess their patients for underlying causes of insomnia, but rather, treat the symptom alone with sedating medications. This paper will address insomnia as a symptom, describing many of its most common causes in the psychiatric patient. Furthermore, the importance of treating insomnia will be stressed, given the data that untreated insomnia may predict the future appearance of anxiety, mood, and substance use disorders.

Insomnia can be a presenting or a residual symptom of psychiatric illness, a medication side-effect, and/or an independent effect of a medical or sleep disorder. The high frequency of insomnia in patients with schizophrenia, bipolar disorder, PTSD, substance abuse, and depressive disorders will be reviewed. The relative rates of insomnia associated with psychiatric medications will also be discussed. The role of concurrent medical illness in the pathogenesis of insomnia, particularly in the elderly, will be stressed. Finally, the presenting

symptoms and treatments of sleep apnea, restless leg syndrome, poor sleep hygiene, and the sleep-phase disorders will be reviewed.

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# SYMPOSIUM 89—TRUTH AND EXPECTATIONS IN PSYCHOPHARMACOLOGY

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) learn about the various sources of psychopharmacology information and the use of this information by trainees and early-career psychiatrists; understand how training and early-career psychiatrists approach psychopharmacology and polypharmacy decisions and dilemmas; recognize the complex factors that impinge on psychopharmacology practice of early-career psychiatrists, (2) understand issues of confidentiality that apply to participation in clinical trials, (3) understand the very complex interaction among new research, new and old products, and psychiatric practice, (4) understand how much the investigator, the patient and the IRB should know about clinical trials, (5) know what key factors influence individual decisions regarding research participants.

## No. 89A
## PSYCHOTHERAPY AND INFORMED CONSENT

Harold I. Eist, M.D., *10436 Snow Point Drive, Bethesda, MD 20814*

## SUMMARY:


The early-career psychiatrist encounters many challenges in psychopharmacology decisions that involve skillful management of multiple medications. This presentation will address three critical questions facing trainee and early-career psychiatrists: What are the sources of information employed by these physicians? How do early-career psychiatrists approach complicated psychopharmacology problems? What are the complicating factors that influence their decision-making?

During residency, information is gathered from the didactic curriculum, journal clubs, inpatient/outpatient supervision, meetings and conferences, literature searches and reading, industry detailing, research experience, and peer discussion. Immediately after training, early-career doctors can utilize continued peer and expert supervision, literature reviews, continuing medical education events, industry sources, conferences, and increasing clinical experience. The central issue is the relative proportion that each of these potential sources contributes to both knowledge and practice, and this will be further discussed.

The second question will be addressed by a discussion of the decision-making frameworks employed by early-career psychiatrists in the challenging context of an increasing array of medicines as well as complex pharmacodynamics and pharmacokinetics.

Finally, several factors that increase the complexity of practice and influence the use of polypharmacy will be discussed, including treatment-resistance, psychiatric comorbidity and diagnostic clarity, managed care and formularies, restricted encounter numbers and visit times, split treatments, off-label uses, and patient beliefs and preferences, to name a few.


## No. 89A
## PSYCHOTHERAPY AND INFORMED CONSENT

Harold I. Eist, M.D., *10436 Snow Point Drive, Bethesda, MD 20814*

## SUMMARY:


Currently mental illnesses constitute 12% of the global burden of disease, yet the mental health budgets of the majority of countries in the world constitute less than 1% of their total health expenditure. Health plans and most governments worldwide discriminate against the mentally ill.

Due to scientific advances and slowly diminishing stigma relating to increased knowledge and public educaton, more people are and will be seeking out psychiatric treatments and psychotherapy. This is critically important because it is estimated that by the year 2020 mental illnesses will constitute more than 15% of the global burden of illness.

This treatment cannot successfully proceed without confidentiality and privacy protections (Jaffe vs Redmond). Part of the informed consent process is carefully explaining privacy protections to potential patients. Without these protections and understandings and assurances regarding them, patients will fear committing to the treatment they require. This failure will be detrimental to the patient, the patient's loved ones, and the community.


## No. 89B
## NEW AND OLD PRODUCTS IN PSYCHIATRIC PRACTICE

Rodrigo A. Munoz, M.D., *University of California at San Diego, 3130 5th Avenue, San Diego, CA 92103*

## SUMMARY:


Psychiatrists may choose today from a record number of pharmaceutical compounds effective in treating the most common disorders in our practices. Words with emotional meaning ("new generation," "atypical," "old," "obsolete") have entered the debate as to why each agent is used. The case for new compounds is clear for those effective in psychosis: if we manage to eliminate extrapyramidal side effects, tardive dyskinesia, and neuroleptic malignant syndrome from our practices, we will be able to serve more patients, and will be able to explore the outer limits of antipsychotic therapy.

Antidepressant compounds, their indications and contraindications, their therapeutic profile, and their side effects seem to evolve in front of our eyes. There are still patients profiling from therapies proposed four decades ago, while some complain about unexpected problems with new compounds.

The time may have come for the psychiatric clinician to enter coalitions with researchers and teachers in looking for a better understanding of effectiveness, therapeutic limitations, and best practices.

## No. 89C
## TRUTH AND EXPECTATIONS IN THE CHANGING GLOBAL MARKET PLACE

Debra R. Lappin, J.D., *3130 Fifth Avenue, San Diego, CA 92103*

SUMMARY:

The world of clinical trials is changing rapidly. The role of the participant is changing from that of a passive subject, to an autonomous participant, to a true partner in the research enterprise. This shift creates new and evolving notions of what is the "truth" about a particular study and when, how, and to whom this truth must be conveyed.

Financial relationships among the investigator, the institution, the IRB, and the sponsor are increasingly complex and demanding review, elimination or management, and new methods of appropriate disclosure. Guidelines for proper disclosure of these relationships by the institution and the investigator remained ill-defined and illusive.

In this session, many troublesome questions will be illuminated and examined through a case study. These will include:

Who within the institution is and should be charged with examining conflicts of interest?

What is the role of the IRB in addressing conflicts?

What constitutes meaningful disclosure to the participant about financial conflicts of interest held by the investigator or the institution?

What very real pressures does the sponsor exert during the trial? And, how should these be managed? As one example, how and when are negative results disclosed, and what pressures exist to prevent this disclosure?

When and how will the participant learn the results of the trial?

## No. 89D
## THERAPEUTIC OPTIONS IN PERIODS OF AMBIGUITY

Rosemary Quigley, J.D., *Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030*

SUMMARY:

Various entities influence what patients and research participants know about their therapeutic options. My comments will focus on two prongs of influence—the patient populations themselves and the advocacy organizations that are charged to serve them. First, patients who participate in research are disadvantaged at times because of some lack of access to information that should be included in informed consent. As one example, participants may not learn about adverse events that have gone on in the trial or during related trials. This sort of information is uniquely personal to the research participants and to the degree that they would have wanted to know upon enrollment, they may have an interest in this information being disseminated to future enrollees. Second, advocacy groups can influence the best course of action for patients. While most of these recommendations may be in the interest of the patients, it is not uncommon for advocacy organizations themselves to develop alliances with pharmaceutical companies and other entities that could influence relationships between advocates and patients. Such influences are little discussed in debates on informed consent and clinical research and are especially critical to improving care for psychiatric patients.

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1. Kingsbury SJ, Yi D, Simpson GM: Psychopharmacology: rational and irrational polypharmacy. Psychiatric Services 2001; 52(8):1033–1036.
2. The World Health Report 2001 Mental Health: New Understanding, New Hope.

# SYMPOSIUM 90—MODEL PSYCHIATRY RESIDENCY PROGRAMS ON RELIGION AND SPIRITUALITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) teach residents methods for engaging therapeutically different forms of spiritual expression in their patients' lives, (2) enrich residency training program curricula in psychiatry and spirituality through enhanced seminars, case conferences and clinical rotations, (3) understand how psychiatry residency training can incorporate discussion of religion and spirituality, (4) familiarize participants with the innovative program the UW psychiatry residents participate in to learn about spirituality and culture in psychiatry, (5) and recognize challenges involved in teaching residents about spirituality and psychiatry, and the way that one course has evolved over time.

## No. 90A
## TEACHING SPIRITUALITY AT GEORGE WASHINGTON UNIVERSITY

James L. Griffith, M.D., *Department of Psychiatry, George Washington University Medical Center, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037*

SUMMARY:

The George Washington University psychiatry curriculum emphasizes treatment within the family, community, and cultural contexts of patients' lives. Teaching on spirituality is incorporated within seminars on cross-cultural psychiatry, psychotherapy training, and consultation-liaison psychiatry, together with a specific PGY-III seminar on "Conducting Psychotherapy with Spiritually, Religiously, or Ideologically-Committed Patients." This curriculum teaches residents: (1) to recognize, appreciate, and inquire about spiritual dimensions of their patients' lives, whether or not psychiatrist and patient hold similar beliefs or practices; (2) practical knowledge about the major spiritual and religious traditions; (3) skills and attitudes that help patients to educate the psychiatrist about their unique spiritualities; (4) specific skills for engaging in psychotherapy a patient's spirituality expressed as narratives, beliefs, practices, rituals, communities, and intrapersonal dialogues with God or spiritual beings; (5) skills for conducting psychiatric treatment collaboratively with the practices of a particular spiritual tradition when that adherence to that tradition is core for the patient's identity; (6) skills for ascertaining when certain religious beliefs or spiritual practices produce destructive consequences and methods for addressing those issues in treatment; (7) utilization of patients' spiritual resources in promoting resilience to long-term effects of chronic medical and psychiatric disorders.

## No. 90B
## UNIVERSITY OF CALIFORNIA AT DAVIS'S ENHANCED CURRICULUM IN SPIRITUALITY AND PSYCHIATRY

Mark E. Servis, M.D., *Department of Psychiatry, UC Davis Medical Center, 2230 Stockton Boulevard, Sacramento, CA 95817*

SUMMARY:

The UC Davis residency training program had offered a limited curriculum in psychiatry and religion consisting of a brief series of seminars in the PGY-4 year. In response to resident feedback that this teaching was too limited, too late, and too narrow in scope, the residency training program developed a comprehensive, four-year

curriculum in psychiatry and spirituality. The new enhanced program offers seminars, clinical conferences, and rotations tailored to the clinical experiences of residents. Faculty from psychiatry, internal medicine, and pastoral services provide the teaching and supervision. Highlights of the curriculum from each year of training include the following:

*PGY-1 Year:* Seminars introducing the topic of spirituality and religion in psychiatry, and an interdisciplinary case conference with chaplains.

*PGY-2 Year:* Seminars on religion and religious beliefs of the culturally diverse community of California during rotations within the Sacramento County community mental health system.

*PGY-3 Year:* Seminar of spiritual and religious issues in psychotherapy during the year-long outpatient year.

*PGY-4 Year:* Seminars on transpersonal psychiatry, the neuroscience of religious experience, and cults and new religious movements. An elective one-month rotation in the UC Davis hospice program.

Didactic offerings are closely coordinated to the resident's clinical experience throughout the four years.

## No. 90C
## TULANE UNIVERSITY'S CURRICULUM ON SPIRITUALITY AND MENTAL HEALTH

Janet E. Johnson, M.D., *Department of Psychiatry, Tulane University Medical Center, 1440 Canal Street, TB53, New Orleans, LA 70112;* Donald P. Owens, Jr., Ph.D., Patrick T. O'Neill, M.D.

### SUMMARY:

The Religion and Spirituality and Mental Health curriculum at Tulane University Health Sciences Center includes universal issues and topics in religion and spirituality and mental health, as well as components that are fairly unique to the Southern United States, and New Orleans in particular. The objective of this curriculum is to provide psychiatric residents with an overview of religious and spiritual beliefs and practices, to provide residents with an appreciation of how these beliefs and practices affect their patients' lives, and to provide residents with knowledge and experience in addressing religious and spiritual issues in their clinical work. The curriculum consists of lectures and seminars, clinical experiences, resident case presentations, movie nights, and several elective options. Lecturers and supervisors include department of psychiatry faculty, the medical school's chaplain, and community religious and spiritual leaders. Lectures and seminars include eight sessions for PGY-1, six sessions for PGY-2, eight sessions for PGY-3, and three sessions for PGY-4. Additionally, the department's grand rounds will feature topics on spirituality and psychiatry at least twice an academic year. Clinical experiences include PGY-2 residents on the C/L service who will present cases with spiritual implications and PGY-3 residents on a full-time outpatient rotation who will present psychotherapy cases with spiritual implications. Residents will be expected to include a spiritual history when conducting observed patient interviews throughout their training. Spiritual and religious issues will be discussed as part of psychotherapy supervision.

## No. 90D
## THE UNIVERSITY OF WASHINGTON'S CURRICULUM ON SPIRITUALITY AND CULTURE IN PSYCHIATRY

Lorin D. Gardiner, M.D., *Department of Psychiatry, University of Washington, 325 9th Avenue/Box 359896, Seattle, WA 98103*

### SUMMARY:

The University of Washington's Religion/Spirituality and Culture in Clinical Practice curriculum for the general psychiatry residents is exciting and innovative. Seattle is a multicultural city where many different forms of religious and spiritual beliefs are practiced. Residents learn about clinical relevance of these beliefs and practices in the assessment and management of patient's mental health problems. Having people from various communities in Seattle involved in the teaching helps residents better understand the diversity of their patients and stimulates interest in those communities.

There are 22 didactic sessions spread across the four years of residency. These focus on assessment, research, collaborating with clergy, culturally based healers, spirituality through the life cycle, and spirituality/culture in clinical practice. There is a panel discussion with clergy and spiritual leaders from the major world religions and one with therapists from these religions. Residents rotating on the consult service have spiritual care staff rounding with them. There are opportunities for residents to rotate in the international clinic, which serves refugee and immigrant populations. Regular case conferences are held with a focus on spiritual/cultural issues and field trips are organized to various Buddhist temples, a downtown shelter, and an AA meeting.

## No. 90E
## RELIGION, MENTAL HEALTH, AND CULTURE: THE HARVARD LONGWOOD COURSE FIVE YEARS LATER

John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115;* Mary K. McCarthy, M.D.

### SUMMARY:

Nine years ago the Harvard Longwood Psychiatry Residency Training Program introduced in an integration seminar for PG-4 residents a session on dealing with religious and spiritual issues in psychotherapy. Continued interest in the transference, countertransference, and boundary issues involved led to two, then four, then six sessions. As a result of receiving a Templeton Curriculum Award in 1998, these sessions became a full semester course, "Religion, Mental Health and Culture," that included more invited guest speakers; relevant material (such as taking a religious history) was also offered earlier in the curriculum. Several changes made since in the course reflect the faculty's attempt to deal creatively with the following challenges: the heterogeneity and individual character of each class; the need for balance between presentations by guest speakers and discussion of residents' own concerns; and the difficulty of being practical but not narrowly focused. Residents continue to appreciate most a focus on helping patients to deal with the religious, spiritual, and moral struggles that they bring to treatment. Sessions that help them articulate what they themselves bring to these encounters have been among the most successful. Other recent expressions of interest in this area by residents and faculty include a resident-run spirituality interest group and a psychiatry grand rounds where a case was presented and discussed by three experts.

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3. Larson D, Lu F, Swyers, J: Model Curriculum for Psychiatry Residency Training Programs on Religion and Spirituality in Clinical Practice (revised), Rockville, MD, National Institute for Healthcare Research, 1997.
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# SYMPOSIUM 91—CONCEPTUALIZATION OF JEONG AND ITS APPLICATION TO THE HEALING PROCESS

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand a Korean ethos or emotion called Jeong in light of Bowby's attachment theory, (2) understand the similarities and differences between jeong and amae and their clinical implications, (3) understand the significance of restoring the connectedness of the past and present in the healing process via Korean rituals, (4) understand the concept of woori (we-ness) bonded by jeong and its implication to the dynamics of hwabyung and borderline personality disorder, (5) and be able to understand and use the concept of jeong and haan as a therapeutic tool in working with Korean/Asian patients.

## No. 91A
## ATTACHMENT AND JEONG: ARE THEY CONNECTED?

David S. Rue, M.D., *Department of Psychiatry, Cleveland Clinic Desk P57, 9500 Euclid Ave, Cleveland, OH 44195–0001*

SUMMARY:

John Bowlby, M.D., an English psychoanalyst, reported his observations on mother-infant interactions in his trilogy, Attachment and Loss. In the first of his three volumes, Attachment, published in 1969, Bowlby described the variations in mother-child interactions and infant behavior. Some mothers were highly attentive, interactive, and responsive to their infants, while other mothers seemed angry, depressed, and non-responsive. He described the developmental differences of infants with responsive and non-responsive mothers. His pioneering work on attachment provided the foundation in our current understanding of maternal-infant attachment and infant development. In Korea, jeong is the word for an ethos or emotion that instantly draws people together. For Koreans, the origin of all jeong-related emotions is mo jeong, mother's love for her infant. mo jeong is the fountainhead for all other derivative Jeong, such as woo jeong (friendship), ae jeong (romantic feelings) or In Jeong (humanitarian spirit). Like Bowby's children, Korean children are believed to exhibit different attachment behaviors, depending on the quality of mo-jeong they receive from their mothers, namely the quality of attachment. In this paper, the root dynamics of mo jeong, its impact on the subsequent psychosocial development of Korean children and adults, and Koreans' peculiar penchant for jeong as well as their struggles with it are discussed, in light of Bowlby's attachment theory and Erik Erikson's psychosocial development theory.

## No. 91B
## A COMPARATIVE ANALYSIS OF JEONG OF KOREA AND AMAE OF JAPAN

Byung Kun Min, M.D., *Department of Psychiatry, Keyo Hospital, 280-1 Wangk-Dong Uwangsi, Kyung-Gi-Do, Korea*

SUMMARY:

The psychodynamic understanding of jeong and amae has been introduced to the Western schools of psychiatry. Both have contributed to the concept of dependency and attachment in terms of their inter-individual bridge making. They are similar, originating from mother-infant relationship and growing into interdependency.

They also are dissimilar to each other. Jeong influences both horizontal and vertical relationship and constitutes components of "We-ness," while amae seems more closely related to a vertical relationship in its development. This paper will contrast the dependency and attachment between jeong and amae and will discuss the differences and similarities of the norms, psychopathologies of two cultures, as well as their clinical implications.

## No. 91C
## RESTORING OF JEONG THROUGH THE USE OF HEALING RITUALS IN BEREAVEMENT PERIODS

Soo Kyung Chang, M.D., *Wiltem Clinic, 3255 Wilshire Boulevard, Los Angeles, CA 90010;* Christopher K. Chung, M.D.

SUMMARY:

Jeong is a concept with both intrapsychic and interpersonal components. In the interpersonal realm, it describes feelings of closeness and connectedness toward others. When this flowing of jeong toward another person is blocked or terminated, due to the death of another person, it leaves a large wound/scar, termed haan. The Korean healing ritual of Chin or Ki Gut, which brings the past to the here and now, allows temporal connectedness to be restored and offers a time and place to complete any unfinished business.

Healing for a grieving person occurs only after completion of unfinished business, which involves an actual display of jeong (connectedness) manifested by considerate and helpful actions, as well as by restoring connections with the dead by affirming the existence of jeong. When jeong is displayed during times of difficulty and pain, this consideration (a part of jeong) is felt more deeply and acts as a catalyst to develop trust through the sharing of pain and suffering. Participants in the healing ceremony also display consideration and help to communicate jeong to grieving persons, in turn increasing trust and jeong.

## No. 91D
## FROM WE-NESS PERSPECTIVES: DYNAMICS OF BPD AND HWABYUNG

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

SUMMARY:

Woori may be difficult to translate into English. It is a concept that has sprung from a collectivistic culture mediated by jeong. The approximate translation of woori is "we-ness," yet it is not just the plural form of "I" or "me." Woori is actually a more singular entity, formed by multiple "I"(s) glued together by jeong. Understanding this phenomenon of we-ness will clarify important issues of cognitive patterns in Koreans/Asians, their norms, and their pathologies.

This paper will contrast the dynamics of hwabyung (a Korean culture-bound syndrome) and borderline personality disorders in Western culture. The betrayal of an expected connectedness in a jeong-based culture may play a significant causative role in hwabyung, literally anger syndrome. A similar dynamic may apply to borderline personality disorders in an individualistic culture, where jeong is not established. In both settings, vulnerable patients pathologically seek connectedness. Restoring jeong and connectedness is important in the treatment of hwabyung. Perhaps establishing a jeong-type bond can aid in the healing process of borderline personality disorders, as well.

For these populations, contextual significance rather than the content of symptoms may become the critical point of psychotherapy.

## No. 91E
## PSYCHOTHERAPEUTIC APPLICATIONS OF JEONG AND HAAN

Luke Kim, M.D., *1301 Brown Dr, Davis, CA 95616-0801*

SUMMARY:

Many immigrant Korean/Asian patients are uncomfortable and not familiar with getting help for personal or family-related problems from a mental health professional, who is essentially a stranger or outsider of the circle. They may not trust a stranger. Moreover, many have feelings of shame, stigma, and embarassment in seeking mental health help. This may be overcome by understanding and applying the concept of jeong in the doctor-patient relationship; it will further promote therapeutic engagement. Clinical examples will be presented, including risks of transference and countertransference, as well as boundary issues.

Haan represents the opposite of jeong. It is a grudge, a form of grievance with suppressed feelings of resentment, anger, and desires for revenge. Haan feelings are often manifested by symptoms of depression, anxiety, and somatization in the form of hwabyung. Many Korean patients, especially elderly women, respond readily to the questions: Do you have haan in your life? Can you tell me about your haan? These can be very helpful and therapeutic questions to open with when discussing depression and somatization with the elderly. Examples will be illustrated.

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# SYMPOSIUM 92—BOUNDARIES EDUCATION: AN EXPERT UPDATE ON DIVERSE APPROACHES AND SETTINGS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize key elements in designing and implementing an educational program on boundary issues in the treatment relationship, with special emphasis on management of sexual feelings and prevention of sexual misconduct, (2) describe at least two exercises that can be used to train professional boundaries; list at least three popular films that can be used in training; list at least two training videotapes, (3) identify helpful processes in a model of supervision that aims to assist trainees with the management of their intense feeling states and in the construction of optimally therapeutic boundaries, (4) design and implement boundaries training for physicians that integrates clinical, ethical, legal, and public health considerations.

## No. 92A
## EFFECTIVE BOUNDARIES EDUCATION

Gregg E. Gorton, M.D., *Department of Psychiatry, Jefferson Medical, 1201 Chestnut Street, Suite 1400C, Philadelphia, PA 19107;* Steven E. Samuel, Ph.D., Gail Zivin, Ph.D.

SUMMARY:

For more than 10 years, we have provided a 10–12 hour 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 curriculum. The current paper will draw upon what we have learned about how to design, implement, and teach these topics. We have found that in order to be most effective such education must integrate a didactic, information-imparting approach with an experiential, emotionally meaningful approach. The teaching must also be highly sensitive to trainees' needs as well as to their different cultural and gender backgrounds. Faculty must be able to put trainees at ease through use of humor and appropriately engaged role-modeling, yet must also be able to heighten anxiety as necessary to manage trainees' avoidance of emotionally challenging issues. Use of team teaching and mixed gender faculty is critical, as is use of a variety of teaching tools, such as faculty case presentations, videotaped vignettes and documentaries, boundary exercises, debates on controversial topics such as criminalization of MD-patient sex, victims' accounts, and appropriate readings. Ultimately, the classroom must become a safe professional venue within which to reflect upon and grapple with a host of sensitive issues, including the range of normative feelings of attraction toward patients; the appropriate containment, understanding, and therapeutic management of erotic transference and countertransference; and, the pros/cons of self-disclosure. Whether or not education can ultimately prevent boundary violations, effective boundaries education can potentially enhance trainees' capability as therapists with all patients so that their power to heal can be most optimized.

## No. 92B
## TOOLS FOR PREVENTIVE AND REMEDIAL BOUNDARIES TRAINING

Gary R. Schoener, Psy.D., *Walk-In Counseling Center, 2421 Chicago Avenue, South, Minneapolis, MN 55404*

SUMMARY:

Training on professional boundaries and their maintenance, in psychiatry and in medicine in general, has been developing during the past two decades. Organizations outside of the field, but which impact on it, such as the JCAHO are now publishing advisories about professional boundaries. At the same time the development of "boundaries retraining" for impaired professionals has been evolving. Last but not least, clinics, hospitals, and other employers are expected to do a better job of orienting and training both paraprofessionals and professionals on the maintenance of appropriate professional boundaries.

Facing these challenges, the psychiatrist, in the role of a teacher, consultant, or even administrator needs to be aware of the most up-to-date methods and techniques of providing this training. Individual practitioners themselves will also find this useful in that in the face of legal actions against their peers they may seek to engage in self-study. Using understanding from review of licensure complaints and civil suits against practitioners for "boundary violations," as well as the dynamics of boundaries crossing, the presentation will outline some strategic areas that the prudent psychiatrist will be concerned with in his or her role as a clinician, teacher, supervisor, or employer of other professionals.

This presentation will demonstrate training exercises as well as examine existing training tapes from psychiatry, nursing, medicine, psychology, and other fields. It will also examine the use of some popular movies and TV program segments for training. Many of these items are inexpensive to obtain and provide for a lively training experience. Training on the maintenance of boundaries and the ethical/legal challenges in practice can in fact be quite lively and interest-

ing. The presenter consults and trains internationally on preventive and remedial boundaries training in a variety of health care fields.

### No. 92C
### SUPERVISION OF INTENSE AFFECTIVE REACTIONS TO PATIENTS AND CONSTRUCTION OF OPTIMAL BOUNDARIES

Nancy A. Bridges, L.C.S.W., *Department of Psychiatry, Cambridge Hospital, 135 School Street, Belmont, MA 02478*

SUMMARY:

Clinicians frequently encounter intense and even startling feelings within themselves during therapeutic interactions with patients. Managing and formulating intense feeling states is central to the psychodynamic and interpersonal management of boundaries. Absence of supervisory attention to these issues leaves clinicians exposed to the risk of engaging in destructive behavioral enactments or developing practice styles that abandon the patient and stifle the psychotherapeutic process. This paper proposes a model of individual supervision that focuses on trainees' dynamic relational understanding and management of intense feelings, as well as on the construction of clinically useful and ethically sound treatment boundaries. Consideration is given to how the supervisor sets the frame, formulates learning goals, and introduces and manages the emergence of personal feelings. Helpful processes include attending to trainees' safety and comfort, assuming an educational rather than a therapeutic stance, fostering skill development and acquisition, and providing students with a cognitive framework for understanding affect. Shame and self-consciousness may be diminished through the supervisor's willingness to assume a self-revelatory stance that includes both sharing personal treatment mistakes and making her own self-monitoring process transparent. Ethical supervision is embedded in a clearly articulated supervisor-student relationship that monitors for any misuse of power or boundary crossings and yet is capable of deeply personal discourse with the supervisee.

### No. 92D
### TEACHING BOUNDARIES TO PHYSICIANS OF ALL KINDS

Wemer Tschan, M.D., *Psychiatrist FMH, Nevensteiner Strasse 7, Basel 4053, Switzerland*

SUMMARY:

All medical professionals are confronted with boundary issues in their daily practice. Whether radiologist, gynecologist, ENT specialist, internist, general practitioner, surgeon or psychiatrist—all must scrupulously maintain professional boundaries with their patients. As increasing reports about physician sexual misconduct have emerged over the last several years, it has become more clear in parts of Europe that the practice of medicine involves significant risk of personal or even sexual relationships developing with patients. In Basel, Switzerland, the State Medical Association implemented a pilot program of postgraduate boundaries education for physicians. This paper will describe the multidisciplinary curriculum utilized in this program. It includes medical ethics, legal issues, trauma to victims, risks to physicians, and techniques for preventing boundary problems. Teaching personnel include judges, forensic experts, state health authorities, and members of a consumer support network, as well as an expert psychiatrist (the presenter). Thus, the concept of professional boundaries is addressed from a variety of perspectives in order to portray the complexity of boundaries phenomena and also in order to have maximal impact on physician-learners participating in the training. Program evaluation data thus far clearly show both interest in and need for more education of this kind. They also reveal the need for further discussion of all kinds of boundary issues, not just those involving physician-patient sex.

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2. Schoener GR: Preventive and remedial boundaries training for helping professionals and clergy: successful approaches and useful tools. J of Sex Education and Therapy 1999; 24:209–217.
3. Bridges N: Teaching psychiatric residents to respond to sexual and loving feelings: the supervisory challenge. Psychotherapy Practice and Research 1998; 7:217–226.
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## SYMPOSIUM 93—SCHIZOPHRENIA WITH COMORBIDITY: DIAGNOSES OR DIMENSIONS?

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be (1) familiar with the current state of clinical and research evidence of comorbid conditions in schizophrenia, (2) understand advantages of dimensional approaches to the classification of psychiatric disorders, (3) and understand how using symptom dimensions can guide treatment planning and improve outcomes.

### No. 93A
### CLINICAL AND RESEARCH EVIDENCE FOR COMORBIDITY IN SCHIZOPHRENIA

Michael Y. Hwang, M.D., *Department of Psychiatry, East Orange VA Medical Center, 385 Tremont Avenue, East Orange, NJ 07018-1095*

SUMMARY:

Schizophrenia has been long regarded as a heterogeneous disorder with diverse clinical phenomena. Recent study has demonstrated distinct but varying neurobiological abnormalities in schizophrenic illness. While the existence of comorbid psychiatric conditions such as depression, obsessive-compulsive (OC) and panic symptoms, and impulsive-aggressive behavior has been well recognized, it is poorly studied and understood. Recent clinical and epidemiological study has shown a significantly greater prevalence rate of comorbid psychiatric disorders and a subgroup of these patients show greater neuropsychiatric impairments with poor outcome. In addition, treatment studies have shown positive symptom response to the specific pharmacotherapy in schizophrenia with comorbid symptoms. While these clinical and research findings need further verification, current evidence suggests in-depth symptom assessment and specific treatment intervention offer the optimal treatment response and outcome.

In this symposium presentation, we will examine the current epidemiological, clinical, and research evidence in schizophrenia with comorbid disorders and discuss the diagnostic and treatment issues.

### No. 93B
### TOWARD A DIMENSIONAL APPROACH TO PSYCHIATRIC NOSOLOGY

Robert F. Krueger, Ph.D., *Department of Psychology, University of Minnesota, 75 East River Road, Minneapolis, MN 55455*

SUMMARY:

Classification of psychiatric disorders typically involves a categorical approach. In this approach, categories of psychiatric disorder are defined by specific numbers and types of symptoms. Nevertheless, the following two fundamental problems stem from the categorical approach: comorbidity and within-category heterogeneity. Comorbidity refers to a specific patient meeting criteria for two or more categorical disorders, and is commonly observed in patients presenting for treatment. Within-category heterogeneity refers to the tendency for patients who meet criteria for a specific categorical disorder to differ in important respects, such as prognosis, course, and pattern of comorbid psychopathology. Both comorbidity and within-category heterogeneity complicate efforts to associate specific categorical diagnoses with specific effective treatments. Nevertheless, both of these interrelated problems—comorbidity and within-category hetcrogeneity—can be overcome by switching to a dimensional approach to psychiatric classification. In a dimensional approach, comorbidity is dealt with by rating the patient on multiple, homogenous symptom dimensions simultaneously. Within-category heterogeneity is dealt with by employing psychometric techniques to refine and homogenize these symptom dimensions. I will outline our efforts to work toward a dimensional approach to the "externalizing" (substance use and antisocial behavior) disorders, and will discuss how our approach can be extended to other domains, especially schizophrenia.

## No. 93C
## USING SYMPTOM DIMENSIONS TO GUIDE TREATMENT

Lewis A. Opler, M.D., *Department of Psychiatry, New York University School of Medicine, 765 Gramattan Avenue, Mt. Vernon, NY 10552;* Anne-Marie Shelley, Ph.D., Joseph Battaglia, M.D., Jeffrey Lucey, M.D.

SUMMARY:

Viewing schizophrenia as a multidimensional disorder can lead to improved outcomes. Using the Positive and Negative Syndrome Scale (PANSS) allows rigorous assessment of the following five symptom dimensions: positive, negative, activation, dysphoric mood, and autistic preoccupation. Using PANSS dimensional scores to guide our psychosocial as well as pharmacological interventions, we designed a treatment program to match the five symptom dimensions of schizophrenia using group therapy employing cognitive-behavioral interventions and psychoeducation. We found that patients attending "syndrome-specific" groups, in addition to standard medication and routine clinical care, showed an additional 22% decrease in total symptom severity, accounted for by statistically significant differences between groups on all five PANSS factors. Our program has now been described in manuals, allowing its implementation in similar treatment settings.

## No. 93D
## DIAGNOSTIC MODELS AND SUBJECTIVITY

John S. Strauss, M.D., *Department of Psychiatry, Yale Medical School, 50 Burton Street, New Haven, CT 06515*

SUMMARY:

The struggle between dimensional and typological views of mental illness is often closely linked to the role, the background, and the preferences of the person who is evaluating the patient. What is more appealing to that person, the neat simplicity of categories or the complex continua of intersecting dimensions? But what is truly important is the reality. What is really out there?

As Shakespeare and others have noted, appearance and reality are not always one and the same. The struggle between the dimensional and typological models of classifying mental illness may need to be resolved ultimately by realizing that both models tend to use a narrow range of methods to observe and measure. That range permits only so-called "objective" measures. But, for a human science, what is seen and classified from outside depending as it does on traditional methods borrowed from non-human science ignores the majority of data potentially available from patients. In this report, I will describe what greater attention to a range of subjective phenomena might contribute to breaking the gordian knot of categorical and dimensional struggles to understanding mental illness.

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1. Hwang MY, Bermanzohn PC (Editors): Clinical Management of Schizophrenia with Comorbid Conditions. Clinical Monograph Series, APPI, Washington, D.C. 2001.
2. Krueger RF, Piasecki TM: Toward a dimensional and psychometrically informed approach to conceptualizing psychopathology. Behaviour Research and Therapy 2002; 40:485–499.
3. Shelley AM, Battaglia J, Lucey J, Ellis A, Opler LA: Symptom specific group therapy for inpatients with schizophrenia. Einstein Quart J Biol Med 2001; 18:21–28.
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# SYMPOSIUM 94—DELIRIUM SUBTYPES: DIAGNOSIS AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) appreciate underdiagnosis of delirium after TBI, the lack of clarity of terms like posttraumatic amnesia, and neuropathogenesis of TBI delirium, (2) describe the morbidity related to an episode of delirium, (3) and recognize the possible benefit of donepezil in preventing or treating delirium.

## No. 94A
## DELIRIUM AFTER POST-TRAUMATIC BRAIN INJURY

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

SUMMARY:

Delirium is an acute confusional state with many possible etiologies. Its phenomenology and neuropathogenesis may be related to a final common pathway of cholinergic deficiency with dopaminergic excess. TBI is associated with cholinergic hypofunction. Psychiatrists are becoming more involved with TBI patients; but physiatrists do not use DSM-IV terms for cognitive and behavioral consequences of TBI; instead they use "post-traumatic amnesia" and "post-traumatic agitation." Neither is equivalent exactly to delirium. Frontotemporal mechanical injury is most common in TBI but symptoms can also result from edema, seizure, hypoxia, embolism, increased ICP, hemorrhage, and drugs that contribute to even broader neuroanatomical effects. TBI rating scales include Glasgow Coma Scale, Galveston Orientation and Amnesia Test, Ranchos Los Amigos Cognitive Scale—none of which captures the full range of delirium symptoms—rather level of consciousness and/or a few components of cognitive function. A University of Mississippi research team prospectively compared delirium ratings with traditional TBI scales in 82 moderate to severe TBI rehabilitation inpatients immediately following the injury to better understand the incidence and overlap

between delirium, agitation and "post-traumatic amnesia." Results show a high occurrence of prolonged delirium, likely related to CNS structural damage.

## No. 94B
## THE DELIRIUM EXPERIENCE

William Breibart, M.D., *Department of Psychiatry, Memorial Sloan Kettering Hospital, 1242 Second Avenue, Box 421, New York, NY 10021-6007*

### SUMMARY:

We conducted a systematic examination of the experience of delirium in a sample of 154 hospitalized patients with cancer. Patients all met DSM-IV criteria for delirium and were rated with the Memorial Delirium Assessment Scale as a measure of delirium severity, phenomenology, and resolution. Of the 154 patients assessed, 101 had complete resolution of their delirium and were administered the Delirium Experience Questionnaire (DEQ) a face-valid measure that assesses delirium recall and distress related to the delirium episode. Spouse/caregivers and primary nurses were also administered the DEQ to assess distress related to caring for a delirium severity (OR = 11.3), and the presence of perceptual disturbances (OR = 6.9) were significant predictors of delirium recall. Mean delirium-related distress levels (on a 0–4 numerical rating scale of the DEQ) were 3.2 for patients who recalled delirium, 3.75 for spouses/caregivers, and 3.09 for nurses. Logistic-regression analysis demonstrated that the presence of delusions (OR = 7.9) was the most significant predictor of patient distress. Patients with "hypoactive" delirium were just as distressed as patients with "hyperactive" delirium. Karnofsky Performance Status (OR = 9.1) was the most significant predictor of spouse/caregiver distress. Delirium severity (OR = 5.2) and the presence of perceptual disturbances (OR = 3.6) were the most significant predictors of nurse distress. In conclusion, a majority of patients with delirium recall their delirium as highly distressing. Delirium is also a highly distressing experience for spouses/caregivers and nurses who are caring for delirious patients. Prompt recognition and treatment of delirium is critically important to reduce suffering and distress.

## No. 94C
## MOTORIC SUBTYPES OF DELIRIUM: THE LIMERICK DELIRIUM STUDY

David J. Meagher, M.D., *Department of Psychiatry, Regional Hospital, Dooradoyle, Limerick, Ireland;* Maria Moran, M.B., Sinead Donnelly, M.D., Bangaru Raju, M.D., Christopher Gibson, Ph.D., Annie Tremblay, M.D.

### SUMMARY:

Delirium is a common neuropsychiatric disorder. Evidence suggests that delirium can be usefully divided into clinically distinct motoric subtypes that may differ in etiology treatment responsiveness, and course. A number of separate criteria for defining motoric subtypes have been suggested but further phenomenological investigation is required to clarify the boundaries and significance of motorically defined subtypes in delirium. The study involved the assessment of delirium symptoms (DRS-98), cognitive performance (CTD) and motoric symptoms (Motoric symptom checklist) in a cohort of patients developing DSM-IV delirium in a palliative care setting. A preliminary analysis (n=30) indicated patterns of neuropsychological profile with prominent disturbances of attention. The more complete study will allow more detailed assessment of the relationship between neuropsychological profile and other symptoms of delirium as well as the comparison of motoric subtype frequency according to the three principal existing subtyping schema (Lipowski, 1990; Liptzin and Levkoff 1992; O'Keefe and Lavan, 1999) to identify core features of hyperactive, hypoactive, and mixed motoric subtypes.

## No. 94D
## CHOLINESTERASE INHIBITORS IN THE INTERVENTION AND TREATMENT OF DELIRIUM

Benjamin Liptzin, M.D., *Department of Psychiatry, Baystate Medical Center, 759 Chestnut Street, Springfield, MA 01199*

### SUMMARY:

It is well known that the cholinergic system is involved in memory and consciousness. Anticholinergic drugs are known to cause delirium. In addition, physical illness may be associated with a rise in serum anticholinergic activity. With the advent of cholinesterase inhibitors, it is worth asking whether these agents can be used to prevent or treat delirium. In order to study this question, elderly patients undergoing elective joint replacement procedures were asked to participate in a double-blind, placebo-controlled study of donepezil starting two weeks before their surgery at 5 mg every morning. Patients were assessed at baseline prior to the surgery and then for two weeks after the surgery, including their hospital stay and rehab period. Each patient was interviewed by a trained reviewer using the Delirium Symptom Interview. In addition, the patient's chart was reviewed and nursing staff were interviewed about the patient's symptoms. Data suggest that donepezil reduced the incidence and duration of delirium in this population. The incidence of delirium in this relatively young and healthy population was lower than previously reported. Suggestions for further research will be described.

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4. Rogers MP, et al: Delirium after elective orthopedic surgery: risk factors and natural history. Int J Psychiatry Med 1989; 19:109–121.

# SYMPOSIUM 95—A TERRORIST'S COMPETENCY TO STAND TRIAL: ASSESSING AMNESIA

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify the varying types of amnesia, (2) possess a fact-based approach for assessing amnesia within the criminal justice system, particularly amongst individuals awaiting trial/adjudication, (3) appreciate how the law regards amnesia and an individual's competency to defend himself, (4) appreciate how attorneys defend and prosecute cases when defendants present with amnesia, (5) identify the clinical areas relevant to the assessment of trial competency in an individual charged with a crime who claims trauma-induced amnesia, (6) and this presentation is intended to enhance the understanding of issues involved in assessing competence to stand trial.

## No. 95A
## A HISTORICAL APPROACH TO ASSESSING RECOLLECTION OF AN ALLEGED TERRORIST

Stuart B. Kleinman, M.D., *Department of Psychiatry, Columbia University, 315 Central Park West, Ste 9N, New York, NY 10025*

SUMMARY:

Psychologically based amnesia, i.e. dissociative amnesia, dissociative fugue, is typically triggered by a severe traumatic event, for example, combat, violent assault, or less typically, by an intense, internal psychological conflict, for example, regarding aggressive impulses. Differentiation of genuine from malingered amnesia can be difficult.

Assessment of amnesia, once potential organic etiologies have been excluded, requires knowledge of how dissociative amnesia normatively presents, and of what clinical findings indicate or strongly suggest intentional exaggeration/fabrication.

Generalized amnesia begins from the time of a precipitating trauma or conflict and encompasses all of an individual's prior life experiences. Localized amnesia involves lack of recall for events immediately surrounding a trauma/threatening conflict. Continuous amnesia involves an ongoing inability to recall events, and is quite unusual.

The forensic evaluee in this case reported being 20 years younger than he actually was, inconsistently displayed continuous amnesia, recalled information from the period for which he was purportedly amnestic—a phenomenon that can occur with genuine amnesia, did not remember information he expectedly would be able to despite being amnestic, and used tenses inconsistently. The import of these findings to this case in particular and amnesia in general will be discussed.

## No. 95B
## PROSECUTING AND DEFENDING AN AMNESIC INDIVIDUAL ACCUSED OF PARTICIPATING IN TERRORISM

Andrew A. Rubin, J.D., *One North Broadway, Ste 1502, White Plains, NY 10601*

SUMMARY:

I am an attorney specializing in criminal defense and have been invited to participate in a discussion regarding the effect of amnesia on a defendant's competency to proceed to trial. The law regarding competency, or fitness to proceed, both federally and in the State of New York defines incompetency, essentially, as a lack of an understanding of the proceedings or ability to assist in one's own defense, resulting from a mental disease or defect.

Amnesiacs, because of their inability to recall the events concerning the charges against them, would seem to fit into the category of being unable to assist their attorney in their defense. The prevailing law, however, is otherwise.

I have been both a prosecutor for over 14 years and a defense attorney for almost 15 years, and will be prepared to discuss both sides of this competency issue. From the defendant's side, how can an individual assist in his defense if he is unable to relate the facts to his attorney? From the prosecution side, an inability to recall, in an otherwise competent person, does not render a person incompetent because he is fully able to evaluate the evidence presented and communicate with his attorney regarding the evidence and issues raised at trial. I will also be prepared to discuss the strategy regarding the questioning of expert witnesses with respect to this competency issue.

## No. 95C
## COMPETENCY IN A DEFENDANT WHO CLAIMS AMNESIA

Eric D. Goldsmith, M.D., *420 Madison Avenue, Suite 504, New York, NY 10017*

SUMMARY:

In a high profile federal trial of several men charged with conspiracy to kill U.S. citizens related to the U.S. African embassy bombings, one of the defendants claimed he was traumatized by correctional officers, developed a retrograde amnesia, and as a result was incompetent to stand trial. This examiner was appointed by the judge to conduct an evaluation that needed to be completed in a timely manner so as not to disrupt the ongoing trial. Multiple documents and videotapes from the jail were reviewed, both prosecution and defense attorneys were consulted, and the defendant was interviewed on two separate occasions for a total of seven hours. Although the defendant appeared to be exposed to a traumatic stressor, it did not result in retrograde amnesia. This examiner concluded that the defendant's presentation was inconsistent with what would be expected for the true amnesia and he malingered his condition.

## No. 95D
## ASSESSING COMPETENCE TO STAND TRIAL IN AN ALLEGED TERRORIST: THE ROLE OF PSYCHOLOGICAL TESTING

Barry D. Rosenfeld, Ph.D., *Department of Psychology, Fordham University, 441 East Fordham Road, Bronx, NY 10458*

SUMMARY:

This presentation focuses on a wide array of issues involved in the psychological assessment of an individual alleged to have engaged in terrorist activities. The presentation will begin with an overview of testing and assessment issues, including cultural and language barriers to the use of psychological tests, the assessment of malingering and distortion, and the use of traditional psychological tests to address specific psycho-legal issues such as competence to stand trial. Following this overview of the assessment issues, the potential impact of extended incarceration in general, and solitary confinement in particular, on psychological functioning will be discussed. The existence of a "solitary confinement syndrome" and related issues such as Ganser's syndrome and other theoretically relevant clinical issues will be discussed, as well as the utility of psychological tests to assess these issues. Finally, this presentation will focus on the application of these issues to a particular case involving an alleged terrorist referred for evaluation of competence to stand trial. In particular, issues such as current and past psychological functioning, real and perceived language barriers, and issues of malingering and deception are discussed.

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2. Wilson v. United States, U.S., 391 F2d 460 (D.C. Circuit 1968)
3. Kopelman MD: Crime and amnesia: a review. Behavioral Sciences and the Law 1987; 3:323–342.
4. Rosenfeld B, Sands S, Van Gorp W: Have we forgotten the base rate problem? Methodological issues in the detection of distortion. Archives of Clinical Neuropsychology 2000; 15:349–359.

# SYMPOSIUM 96—NEW EVIDENCE ON EXPOSURE AND PRESENT-FOCUSED TREATMENTS FOR COMPLEX PTSD

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe the relative benefits of a trauma-focused group therapy compared with a present focused group therapy, (2) recognize symptoms of complex PTSD, (3) become familiar with several useful intervention techniques, (4) summarize the evidence for a present-centered approach, recognize the strengths and weakness of the BIT model of treatment, and critically evaluate the place for a non-exposure based treatment of PTSD, and (5) describe the results of a randomized trial of trauma treatment with substance abuse.

## No. 96A
## TRAUMA-FOCUSED VERSUS PRESENT-FOCUSED GROUP THERAPY FOR SURVIVORS OF CHILDHOOD SEXUAL ABUSE

Catherine Classen, Ph.D., *Department of Psychiatry, Stanford University School of Medicine, 401 Quarry Road, Room 2334, Stanford, CA 94305-5544;* Cheryl Koopman, Ph.D., David Spiegel, M.D.

## SUMMARY:

*Objective:* The sequelae of childhood sexual abuse includes a large array of long-term effects such as PTSD, depression, affect dysregulation, sexual revictimization, addictive behaviors, and interpersonal problems. The best method of treating this vast array of problems is a pressing concern. This presentation provides a preliminary report of a controlled, randomized group therapy intervention trial for women with histories of childhood sexual abuse and who are at risk for HIV infection.

*Method:* Women are judged at risk if they meet at least one of the following three criteria: (1) were sexually revictimized within the last year, (2) engaged in unsafe sex within the last year, or (3) met criteria for substance abuse or dependence within the last year. One hundred and seventy-two women were recruited into this study comparing trauma-focused group therapy against present-focused group therapy and a wait-list condition. Participants were provided six months of group therapy and followed for 12 months. Six-month follow-up data on approximately 120 participants and 12-month follow-up data on approximately 72 participants will be presented.

*Results:* Outcome data will include sexual revictimization, sexual behaviors, substance use, PTSD and other trauma symptomatology, interpersonal problems, and post-traumatic growth.

*Conclusions:* Treatment implications will be discussed.

## No. 96B
## EMOTIONAL REGULATION AND INTERPERSONAL SKILL AS A PREREQUISITE TO EMOTIONAL PROCESSING OF TRAUMATIC MEMORIES

Marylene Cloitre, Ph.D., *Department of Psychiatry, New York Hospital, 425 East 61st Street, 4th Floor, New York, NY 10021*

## SUMMARY:

A phase-based treatment for woman with chronic PTSD related to childhood abuse was tested in a randomized controlled trial. Phase 1 focused on skills training in affect and interpersonal regulation (STAIR), while Phase 2 implemented a modified version of prolonged exposure. Phase 1 is a preparatory/stabilization phase intended to address problems in functioning commonly found in this population such as self-injurious behaviors and to prepare the client for the emotionally intensive Phase 2 work. Compared with a Minimal Attention Waitlist (n = 22), women in the STAIR/modified PE treatment (n = 24) showed improvement in three targeted symptom domains: emotion regulation, interpersonal functioning, and PTSD symptoms. In addition, Phase 1 improvement in negative mood regulation and the development of a positive therapeutic alliance were significant predictors of PTSD symptom reduction during Phase 2 exposure. Data from a second, dismantling study will be presented, which address the following questions: (1) whether PTSD symptoms, symptom exacerbation and dropout rates are more greatly reduced in the two phase treatment (STAIR/PE) or whether the simpler exposure (PE) alone treatment does just as well in reducing PTSD and maintaining clients treatment, and (2) whether a no-exposure emotion-focused treatment (STAIR alone) can resolve PTSD as well as the two exposure based treatments.

## No. 96C
## DEVELOPMENT AND INITIAL EVALUATION OF BRIEF INTEGRATIVE THERAPY FOR PTSD IN FEMALE CHILDHOOD SEXUAL ABUSE SURVIVORS

Annmarie McDonagh-Coyle, M.D., *Department of Psychiatry, Dartmouth Medical, PO Box 205, Lebanon, NH 03766;* Julian Ford, Ph.D., Christine Demment, Ph.D.

## SUMMARY:

*Objective:* Building on efficacy results from a recent randomized clinical trial of a present-centered therapy in a sample of childhood sexual abuse (CSA) survivors with PTSD, we modified the treatment to increase potency.

*Method:* Modifications include consistently focusing on current interpersonal targets for problem solving in and out of session; adding emphasis on understanding the ways in which trauma's shadow affects current problem-solving attempts, and increasing education about the role of affects as sources of information and motivation to be used during problem-solving attempts. Fifteen to 20 women participated in this Brief Integrative Therapy.

*Results:* Data comparing pre-treatment to post-treatment PTSD severity, depression, anxiety, social functioning, and life satisfaction will be presented.

*Conclusions:* We will highlight the strengths and limitations of the therapy.

## No. 96D
## OUTCOME OF TRAUMA TREATMENT WITH COMORBID SUBSTANCE ABUSE

Julian Ford, Ph.D., *Department of Psychiatry, University of Connecticut Health, 263 Farmington Avenue, MC 6228, Farmington, CT 06030;* Linda Frisman, Ph.D.

## SUMMARY:

This presentation describes the development of, and a randomized controlled trial evaluating, a manualized treatment protocol for trauma survivors with chronic complex PTSD and co-occurring addictive disorders conducted in three public sector addiction treatment agencies serving ethno-culturally diverse, low socioeconomic status women and men, Trauma Adaptive Recovery Group Education and Therapy (TARGET). TARGET teaches a sequential process for regaining a participant-observer stance in relation to reactivated trauma memories in current stressful experiences that is designed to enable clients to become aware of and consciously utilize existing skills for processing affectively charged information. The pedagogic model is summarized by the acronym, FREEDOM - focusing, recognizing triggers, emotion recognition, evaluating one thought at a time, defin-

ing one goal at a time, observing previously unrecognized effective behaviors that are options for achieving goals, and making a contribution. Compared with addiction treatment as usual (TAU) at a six-month follow up, TARGET was associated with statistically and clinically significant reductions in the severity of trauma-related and psychiatric symptoms, attrition, and substance use relapse, and enhanced psychosocial functioning.


### REFERENCES:

1. Herman JL: Trauma and Recovery. Harper Collins Publishers, 1992.
2. Cloitre M, Koehen KC, Cohen LR, Han H: Skills training in affective and interpersonal regulation followed by exposure: a phase-based treatment for PTSD related to childhood abuse. Journal of Consulting and Clinical Psychology, 2002, in press.
3. Foa EB, Dancu CV, Hembree EA, Jaycox LH, Meadows EA, Street GP: A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. JCCP 1999; 67:194–200.
4. Foa E, Keane T, Friedman M (eds.): Effective Treatments for PTSD: Practice Guidelines From the International Society for Traumatic Stress Studies. New York, Guilford Press.


## SYMPOSIUM 97—THE NEUROPSYCHIATRIC ASPECTS OF HIV/AIDS: EVALUATION AND TREATMENT, PART 2

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be (1) review how CNS involvement may present as common patient complaints; (2) review various etiologies; (3) identify strategies for evaluating mental status, (4) identify general and specific drug-drug principles and interaction; (5) acknowledge drug prescribing guidelines and patient discussion points, (6) and describe the epidemiology of mood disorders in HIV/AIDS, (7) describe the symptoms attributed to mood disorders in HIV/AIDS, (8) define the components of diagnostic evaluation and pharmacologic treatment of mood disorders within the context of HIV/AIDS.

### No. 97A
### EVALUATING THE NEUROPSYCHIATRIC PATIENT

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:

Worldwide, 30 million people are infected with HIV disease. In the United States, where antiretroviral medications are more readily available, infection rates continue to rise most quickly in women of childbearing age, young people of color, and more recently among the elderly. Neurological illnesses are the initial manifestation of AIDS in 7% to 20% of patients. However, the frequency of neurologic complications increases over the course of the illness. Assessment and management of the neuropsychiatric conditions of HIV are vital for patients. Mental health providers need to possess the knowledge to successfully evaluate for cognitive, affective, and behavioral dysfunction. The lecture will be followed by a question and answer period.


### No. 97B
### SIX THINGS YOU NEED TO KNOW: DRUG-DRUG INTERACTIONS

Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*


### SUMMARY:

More HIV-infected patients are living longer due to antiretroviral medications. Drug interactions are common in HIV treatment. However, when other drugs and substances, such as prescription, over-the-counter, illegal, and food and herbal substances, are also taken, serious complications can occur. The presenter will offer the essential, need-to-know information about drug-drug interactions, including when combination therapy should be initiated, recommended drug doses, and patient adherence.


### No. 97C
### MANAGING DEPRESSION AND ANXIETY: ASSESSMENT AND TREATMENT

Warren M. Liang, M.D., *Department of Psychiatry, University of Cincinnati, PO Box 670559, Cincinnati, OH 45267*


### SUMMARY:

Mood disorders in HIV are common. Depression appears to be the most common psychiatric disorder found among HIV-infected patients. In fact, cross-sectional and prospective studies in both HIV+ and at-risk HIV populations estimate lifetime prevalence of depression disorders to range from 22.1% to 61.0%. It may be difficult to diagnose depression and anxiety in HIV-infected patients. This session will provide diagnostic evaluation and pharmacologic treatment knowledge for psychiatrists working with HIV/AIDS patients.



### REFERENCES:

1. Castellon SA, Hinkin CH, Myers HF: Neuropsychiatric disturbance is associated with executive dysfunction in HIV-1 infection. Journal of the International Neuropsychological Society 2000; 6:336–347.
2. Morbidity and Mortality Weekly Report. Report of the NIH Panel to Define Principles of Therapy of HIV Infection. Centers for Disease Control and Prevention. 1998; 47:RR-5.
3. Klesmer J, Badescu R. Pharmacologic treatment of mood disorders in acquired immune deficiency syndrome (AIDS). Curr Psychiatry Rep. 2002; 4(3):222–7.


## SYMPOSIUM 98—NEW RESEARCH IN THE BIOLOGY AND TREATMENT OF BULIMIA NERVOSA

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) characterize the relationship of eating patterns to alterations in satiety perceptions in individuals with current or past episodes of bulimia nervosa, (2) recognize factors which may contribute to a disturbance in satiety among patients with bulimia nervosa, (3) learn about new findings in serotonin receptor activity in relationship to symptoms in bulimia nervosa, (4) understand the role and efficacy of medication to treat patients with bulimia nervosa, especially antidepressant drugs and promising newer classes of pharmacotherapeutic agents, (5) and discuss new technologies which are available for disseminating treatment for eating disorder patients, including telemedicine and the use of hand-held computers.

No. 98A
## IMPAIRED SATIETY IN BULIMIA NERVOSA: STATE VERSUS TRAIT

David C. Jimerson, M.D., *Department of Psychiatry, Beth Israel Hospital, 330 Brookline Avenue, Boston, MA 02215-5491;* Barbara E. Wolfe, Ph.D., Erand D. Metzger, M.D.

SUMMARY:

*Objective:* Recent studies suggest that neurobiological alterations may contribute to impaired perceptions of satiety in bulimia nervosa (BN), and that impaired satiety may in turn play a role in the excess food consumption characteristic of binge episodes. This study assessed whether impaired satiety reflects a stable trait characteristic that persists in individuals who have recovered from bulimia nervosa (RBN).

*Methods:* Female subjects in the RBN, BN, and healthy control groups were matched for age and BMI and were medication free. Analog scale ratings were obtained before and after a single-item test meal on the placebo day of neuro-endocrine studies conducted on a clinical research unit.

*Results:* Test-meal food intake was significantly elevated for the BN group, while food intake for the RBN group was similar to the controls. Ratings of hunger, fullness, and satiety were not significantly different for the three study groups. Controls, but not the BN or RBN groups, showed the expected significant correlations between meal size and changes in ratings of hunger, fullness, and satiety.

*Conclusions:* These preliminary results extend previous studies showing impaired satiety in BN, and suggest that abnormalities in perceived hunger and satiety may persist following remission of bulimic episodes.

No. 98B
## DISTURBANCES IN SATIETY IN BULIMIA NERVOSA

B. Timothy Walsh, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit #98, New York, NY 10032-2603;* Michael J. Devlin, M.D., Ellen Zimmerli, Ph.D., Harry Kissileff, Ph.D., Janet L. Guss, M.A., Robyn Sysko, B.A.

SUMMARY:

There is consistent but circumstantial evidence that patients with bulimia nervosa (BN) have a disturbance in the development of satiety. Laboratory studies have found that the binge meals of patients with BN are comprised of many more calories than even large meals of controls. Yet, it appears that patients with BN develop full satiety only after the consumption of such binge meals: Normally, physiological activity of the stomach and small intestine contributes to the development of satiety during a meal. In the last 10 years, consistent data have emerged from several laboratories suggesting that the functioning of the stomach and small intestine are not normal in BN. This presentation will review ongoing studies of cholecystokinin (CCK) release, gastric emptying, and gastric relaxation following food consumption in patients with bulimia and in normal controls. These studies indicate that patients with bulimia nervosa exhibit diminished CCK release, delayed gastric emptying, and impaired gastric relaxation. It is likely that, because of such abnormalities, peripheral biological signals that promote the development of normal post-prandial satiety are impaired in BN. Such disturbances may contribute to patients' difficulties recovering from this illness, and may provide opportunities for novel treatment interventions.

No. 98C
## ALTERATIONS OF 5HT 1A AND 2A RECEPTORS PERSIST AFTER RECOVERY FROM BULIMIA NERVOSA

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 3600 Forbes Aveue, Suite 600 Iroquis, Pittsburgh, PA 15260;* Guido K.W. Frank, M.D., Carolyn Meltzer, M.D., Julie Price, Ph.D., Wayne C. Drevets, M.D., Chester Mathis, Ph.D.

SUMMARY:

Several lines of evidence suggest that disturbances of the serotonin (5HT) system may contribute to the pathophysiology of bulimia nervosa (BN). To determine whether disturbances of $5HT_{1A}$ and $5HT_{2A}$ receptors were independent of malnutrition, women were studied who were long-term recovered from BN (>1 year normal weight, regular menstrual cycles) compared with control women (CW).

We have replicated our initial finding that $5HT_{2A}$ receptor activity, using [$^{18}$F]altanserin and PET; is reduced in recovered BN women in the orbital frontal cortex. Theoretically, such a disturbance may contribute to altered impulse control. Preliminary data, using PET with [carbonyl-$^{11}$C]WAY100635, suggest that recovered BN women have a significant increase of $5HT_{1A}$ receptor activity in post-synaptic cortical and limbic regions and pre-synaptic raphe regions. Considerable data implicate $5HT_{1A}$ receptor activity in the modulation of anxiety, a symptom that commonly occurs premorbidly in BN and persists after recovery.

This PET technology holds the promise of understanding the complexity of neuronal systems in human behavior. 5-$HT_{1A}$ and 5-$HT_{2A}$ receptors have inverse relationships and interactions with other systems, such as glutamate and GABA, which may serve to modulate noradrenergic or cortex pyramidal systems. In summary, these PET-radioligand studies confirm that altered 5HT neuronal pathway activity persists after recovery from BN. These psychobiological alterations might contribute to traits, such as increased anxiety or extremes of impulse control, or disturbed eating behavior, that, in turn, may contribute to a vulnerability to the development of BN.

No. 98D
## PHARMACOTHERAPY OF BULIMIA NERVOSA: A REVIEW OF ESTABLISHED MEDICATIONS AND PROMISING NEW AGENTS

Allan S. Kaplan, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, EN8-231, Toronto, ON M5G 2C4, Canada*

SUMMARY:

*Objective:* To critically review the published evidence for the effectiveness of pharmacotherapy in the treatment of BN.

*Methods:* Through an extensive literature review, recent and previous published studies utilizing medication to treat BN were identified and reviewed.

*Results:* There are over 25 published placebo-controlled trials evaluating the effectiveness of antidepressant pharmacotherapy in the treatment of BN. These studies report a mean reduction in binge frequency of 70% and mean remission rates of approximately 30%. They find no difference in efficacy between different classes of antidepressant drugs. There is a disturbingly high rate of relapse, between 30% to 45%, in patients maintained on antidepressant drugs for up to six months. A number of other classes of drugs, including anticonvulsants, mood stabilizers, appetite suppressants, and opiate antagonists, have been utilized in the treatment of BN without demonstration of consistent efficacy. However, odansitron and topiramate have shown promise in preliminary studies in the treatment of BN.

*Conclusion:* There is data to support the adjunctive use of antidepressants in the treatment of BN. There is inadequate data to support the use of other types of medication in the treatment of BN, although topiramate and odansitron are promising new drugs that ment further investigation.

## No. 98E
## NEW MODELS FOR DISSEMINATING PSYCHOTHERAPY FOR EATING DISORDERS

James E. Mitchell, M.D., *Neuropsychiatric Research Institute, 700 First Avenue, South, P O Box 1415, Fargo, ND 58103;* Stephen A. Wonderlich, Ph.D., James L. Roerig, Ph.D., Martina de Zwaan, M.D., Ross D. Crosby, Ph.D.

### SUMMARY:

Over the last few decades a number of effective forms of psychotherapy for patients with eating disorders have been developed and empirically tested. This literature supports the fact that for bulimia nervosa there is a consensus as to what is the treatment of choice, CBT. However, other literature shows quite clearly that effective treatments such as CBT are not being widely utilized and that most practicing psychotherapists have not been adequately trained in their usage. Because of this, investigators have been looking at alternative models of treatment delivery. These include telemedicine-based psychotherapy, the use of stepped-care approaches (wherein subjects are treated by self-help or assisted self-help and/or medication management and then referred for tertiary care if they fail to respond to these less intensive interventions), phone therapy, Internet-based interventions, and the use of hand-held computers as therapy tools or adjuncts. This paper will review the current literature in this area and offer practical recommendations regarding the use of such approaches. Resources available in these areas that might be of use to practicing clinicians will be reviewed.

### REFERENCES:

1. Wolfe BE, Metzger ED, Levine JM, Finkeistein DM, Cooper TB, Jimerson DC: Serotonin function following remission from bulimia nervosa. Neuropsychopharmacology 2000; 22:257–263.
2. Walsh BT, Devlin MJ: Eating disorders: progress and problems. Science 1998; 280:1387–90.
3. Kaye WH, Frank GK, Meltzer CC, Price JC, McConaha CW, Crossan PJ, Klump KL, Rhodes L: Altered serotonin 2A receptor activity in women who have recovered from bulimia nervosa. American Journal of Psychiatry 2001; 158(7):1152–1155.
4. Eisikovits O, Dierberger A, Westen D: A multidimensional, meta-analysis of pharmacotherapy for bulimia nervosa: summarizing the range of outcomes in controlled clinical trials. Harvard Review of Psychiatry 2002; 10(4):193–211.
5. Mitchell JE, Wonderlich S, Bakke B, Erickson R: Administering cognitive behavioral therapy bulimia nervosa via telemedicine in rural settings. Int J Eat Disord 2001; 30:454–457.

# SYMPOSIUM 99—TERRORISM AND POLITICAL VIOLENCE IN THE 21ST CENTURY: NEW FORMS AND RESPONSES

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify prominent characteristics of the violent true believer, (2) understand the conflicts and psychodynamics and be better able to recognize the emotions and behaviors that alert one to the conditions and risks of a murder-suicide occurring, therefore to attempt to prevent one or both tragic component, (3) differentiate the psychological motivations and constraints for terrorists to use weapons of mass destruction, (4) demonstrate increased understanding of terror as a socio-psychologic construct via literary perspectives, (5) and demonstrate understanding of reconciliation following war and terrorism and the opportunities and obstacles, linked to psychosocial consequences.

## No. 99A
## THE VIOLENT TRUE BELIEVER: HOMICIDAL AND SUICIDAL STATES OF MIND

J. Reid Meloy, Ph.D., *964 5th Avenue, Suite 409, San Diego, CA 92101*

### SUMMARY:

Dr. Meloy will present the results of an advisory paper written for the Counter-intelligence Division of the FBI as a forensic psychological consultant. The paper proposes a schematic for understanding the "violent true believer": an individual who is committed, or appears to be committed, to an ideology or belief system that advances the killing of the self and others as a legitimate means to further a particular goal. This presentation will focus on the following three areas: (1) a brief overview of the research on homicide-suicide and its relevance to violent true beliefs; (2) elaboration of prominent characteristics of the violent true believer, including envy, dependency, omnipotence, depression, entitlement, grandiosity, psychopathy, predation, paranoia, and a sense of a foreshortened future; and (3) profiling characteristics of such individuals, including both long-term and short-term behavioral indices.

## No. 99B
## THE PSYCHOLOGY OF MURDER-SUICIDE: RELATION TO SUICIDAL TERRORISM

Melvyn M. Nizny, M.D., *3001 Highland Avenue, Cincinnati, OH 45219-2315*

### SUMMARY:

The complex of murder-suicide, i.e., the self-inflicted death of an individual who commits murder is explored in its psychodynamic and historical contexts. The disaster of 9/11/01 has highlighted that which has been occurring in our everyday lives on a daily basis, i.e., is already well known to us. Apparent random violent acts can be viewed within a container of known processes and conflicts expressed by such themes as helplessness, jealousy, loss, depression, meaninglessness, attachment, separation, love, and hate. "Types" of murder-suicide and precipitating factors leading to it will be defined. The author will explore the evolution and etymologic roots of common terms that relate to death, and the ways civilizations have attempted to contain its occurrence and/or promoted its necessity such as for survival. Exploring the pairing of murder and suicide will instruct and increase awareness for all of us to work toward vigilance that is the route to prevention of tragedy.

This session is important to all clinicians, especially those who treat patients with suicidal ideation and/or are violence prone and those involved in educational or correctional settings where behavior such as bullying can generate the precursors to a later murder-suicide.

## No. 99C
## DIFFERENTIATING THE MOTIVATIONS AND CONSTRAINTS FOR WEAPONS OF MASS DESTRUCTION TERRORISM

Jerrold M. Post, M.D., *Department of Political Psychiatry, George Washington University, 2013 G Street, N.W., Suite 202A, Washington, DC 20052*

SUMMARY:

There is a heightened concern in the United States over the specter of a catastrophic domestic chemical or biological terrorist attack. Billions are being invested in training first responders for what is acknowledged to be a high consequence–low probability event. But while substantial investment is being devoted to protecting our vulnerable society from such a devastating act, there is very little attention being devoted to who might do it, and why, and, as important, who might not do it, and why not.

This paper differentiates the motivations and constraints for the different types of terrorists. For almost all terrorists who are trying to influence the West to support their cause, mass casualty chemical/biological/radiological/nuclear (CBRN) terrorism would be highly counter-productive, although some discriminate tactical attacks that do not affect their own constituents could be considered. The major exception is religious fundamentalist terrorists, who seek not to influence the West but to expel the secular modernizing West and have revenge against the West. These groups, which follow the dictates of destructive charismatic religious leaders, are not constrained by their audience on earth, for their radical clerics have indicated their acts have sacred significance; they are "Killing in the Name of God."

## No. 99D
## TERROR AND WAR: LITERARY PERSPECTIVES

Tvrtko Kulenovic, Ph.D., *Department of Philosophy, University of Sarajevo, Bosnia Herzegorina, U.S.S.R.*

SUMMARY:

The last ten years of wars in the Balkans and the attacks in the United States are two recent examples of acts of war creating terror in civilian populations. In European art before the 20th century, war was not represented as terror, psychic horror, but as an external event, or even as "heroic landscape." War was an opportunity to "earn," to plunder, to rape, to bring "maturity" to young men, and also a ritualistic valve for liberating destructive forces present in human nature. But then, why this change of paradigm, this psychological deterioration in the 20th century? Development of war technologies is certainly one reason. But there are also other factors, including in previous times war was made by professional warriors or by peasant masses who lived in the state of permanent war. With the French Revolution, and after that in the Kingdom of Prussia, general military service was introduced, including people with extreme sensitivity, poets and poetic souls who have found in themselves no response whatsoever to the demands of war. The result was a clash between a man and his environment, the feeling of terror and PTSD presented as the consequence, and of course, representation of these mental states in art and literature. This presentation will view the matter of war as terror from a literary perspective, including Freud, Nikola Rusovic, Pat Barker, and literature from wartime in Bosnia-Herzegovina.

## No. 99E
## PATHS AND OBSTACLES TO RECONCILIATION IN KOSOVO

Stevan M. Weine, M.D., *Department of Psychiatry, University of Illinois at Chicago, 2216 Lincoln Wood Drive, Evanstan, IL 60201;* Ferid Agami, M.D.

SUMMARY:

Although the international community has declared that reconciliation is a precondition for statehood in Kosovo, it is not well understood how reconciliation fits within the "Kosovar reality." A central concern is how to guide the Kosovar people and government down a path of reconciliation that is based upon genuine understandings of local conditions, including both challenges and opportunities. This will require specific attention to the complex interactions of the socially destabilizing experiences of traumatization, loss, and rapid globalization, and to the stabilizing structures of the Kosovar family, Kosovar national identity, and religion. Kosovar history provides important examples of precedents for reconciliation that must be examined alongside historical examples from other countries of reconciliation following political violence. The challenge that must be embraced by Kosovar and international professionals and intellectuals is to deploy interdisciplinary scholarship and dialogue in order to elaborate a rhetorical remapping of reconciliation for Kosovo. The American and Kosovar co-authors draw upon actual engagement and field research to examine these matters with a specific concern for the possible roles of leaders, public intellectuals, and psychiatric professionals.

REFERENCES:

1. Hoffer E: The True Believer. 1951. Reprint, New York, Harper & Row, 1966.
2. Schlesinger LB: The catathymic crisis, 1912-present: a review and clinical study. Aggression and Violent Behavior 1996; 1(4):307–316.
3. Post J: Psychological and motivational factors in terrorist decision making: implications for CBW terrorism, in Toxic Terror. Edited by Tucker J. M.I.T. Press, 2000.
4. Barter, P: Regeneration, 1991.
5. Weine S: When History is a Nightmare: Lives & Memories of Ethnic Cleansing in Bosnian-Herzegorina, Rutgers University Press, 1999.

# SYMPOSIUM 100—BIPOLAR SPECTRUM OR BORDERLINE PERSONALITY? A RELEVANT DISTINCTION?

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize bipolar II behind characterlogical masks, (2) recognize that a significant proportion of patients currently labeled borderline personality disorder develop their condition as an outgrowth of strong genetic/constitutional vulnerability to affective (esp. bipolar) illness; their co-occurrence influences the type and course of treatment, (3) familiarize participants with new information about the phenomenologic and genetic correlates of the affective, cognitive and behavioral symptoms found across the bipolar-borderline spectrum, (4) attendees will be familiar with issues regarding the differential safety, efficacy, and utility of drug therapies used commonly for both bipolar and borderline personality disorders, (5) and to inform participants about the nosologic/pathologic basis for disease classification relevant to future editions of the DSM, as illustrated by Axis I-Axis II boundary overlaps exemplified by the bipolar spectrum and borderline psychopathology.

## No. 100A
## BORDERLINE PERSONALITY OR BIPOLAR II?

Hagop S. Akiskal, M.D., *Department of Psychiatry, University of California at San Diego, 3350 La Jolla Village Drive, San Diego, CA 92161*

SUMMARY:

There is a great deal of confusion in both official diagnostic systems and clinical approaches to diagnosis of bipolar II and borderline personality disorders. A great part of the problem is due to the

overlap of diagnostic criteria. It is generally believed that mood lability and excited periods of short duration (less than four days) are more pathognomonic for borderline personality. However, prospective data indicate that mood lability is the most specific predictor of bipolar II outcome. Another confounding variable is atypicality in the depressive picture, which is common to both disorders, yet rejection sensitivity and resultant hostile outbursts are deemed more "typical" for borderline personality. New research conducted by the author with Italian collaboration indicates that atypical depression, borderline personality, and bipolar II disorder represent overlapping manifestations of a common diathesis of a cyclothymic-sensitive nature. Suicidal crises are also common in all three conditions. The notion that bipolar II is episodic and borderline personality chronic is not borne out by clinical and research experience. Given the foregoing considerations and given that pharmacological treatment for all three conditions overlap, in my opinion a differential diagnosis is not meaningful in most instances.

## No. 100B
## BORDERLINE, BIPOLAR, AND BEYOND: AFFECTIVE ILLNESS AS PRECURSOR TO BORDERLINE PERSONALITY

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, #114, New York, NY 10024-6027*

SUMMARY:

For the last quarter century there has been a continuous controversy regarding the relationship between borderline personality disorder [BPD] and affective illness. Some have championed the hypothesis that there is a significant subset of BPD patients for whom an underlying predisposition to some form of affective illness is a crucial etiological factor. Others have downplayed any such connection, asserting that depressive conditions are common among many personality disorders, not just BPD. Still others have claimed that BPD is just the reverse side of a coin whose main face is PTSD—set most often in motion by incest or other early traumata.

While most now agree that nature and nurture *both* are relevant in BPD, an "informative" case that allows us to tease apart these influences is one where nurture is basically benign: here, it becomes impossible to ignore the impact of genetic and/or intrauterine factors. It turns out that a significant proportion of BPD patients are concomitantly bipolar (esp. bipolar II or III [i.e., antidepressant-induced], or, if followed long enough, ultimately become bipolar. The situation is sample-dependent; some clinicians encounter only trauma-engendered cases; others see numerous BPD patients with family pedigrees dotted with unipolar and bipolar relatives. I have treated BPD patients from comfortable circumstances and nurturing, non-traumatizing families. Some showed bipolar-II illness first and then BPD. In others, the BPD manifested itself in adolescence, with bipolarity showing in the 20s. The pharmacotherapy of such patients can be enormously complex and is never sufficient by itself to restore good function, since years-long psychotherapy is also necessary. Several vignettes will be presented in support of these observations.

## No. 100C
## DIMENSIONAL VERSUS CATEGORICAL PSYCHOPATHOLOGY: GENETIC CORRELATES

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney-NY Presbyterian Hospital, 525 East 68th Street, Box 140, New York, NY 10021*

SUMMARY:

Recent clinical and basic/genetic studies have begun to examine dimensional rather than categorical aspects of psychopathology. Constructs such as impulsivity, aggression, sensation-seeking, and mood lability may represent bona fide phenotypes, combinations of which may create mosaic forms of illness that span a range of clinical presentations. In this sense, phenotypic heterogeneity may blur distinctions between Axis I and Axis II forms of illness. This presentation will examine dimensions of psychopathology that span heterogeneous clinical presentations currently identified as falling either within the realm of bipolar spectrum or Cluster B personality disorders. Evidence from family pedigree data will be reviewed as well as candidate gene polymorphism studies (e.g., serotonergic and dopaminergic) relative to behavioral phenotypes. Comorbid features such as substance misuse will further be considered as epigenetic phenomena either secondary to a primary illness or as concomitant features of a broader complex clinical syndrome.

## No. 100D
## DIFFERENTIAL PHARMACOTHERAPY OF BIPOLAR SPECTRUM AND BPD

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Hospital, 49 Fayette Street, #1, Cambridge, MA 02138*

SUMMARY:

Substantial overlap has been observed between bipolar spectrum disorders and borderline personality disorder, both with regard to clinical phenomonology as well as treatment. While medication response to some medical conditions may help serve to externally validate the presence of a specific diagnosis (e.g., as in the case of bacterial vs. viral infections), the same view seldom applies to severe psychopathology, where target symptoms rarely are pathognomonic of any one disease state. Thus, empiric trials of mood stabilizers, antidepressants, anxiolytics, and antipsychotic medications are frequently undertaken in patients who manifest illness signs that overlap across multiple diagnostic entities. Data will be reviewed from controlled trials on the safety, utility, and efficacy of major psychotropic medication classes for conditions and target symptoms relevant to both bipolar and borderline personality disorder. Although antidepressants are frequently used in both instances, the risks for mood destabilization and worsening clinical course remain an understudied focus of research in cyclical mood disorders to the extent that anticycling drugs may yield neuroprotective and other benefits both short and long term, their role may be especially important for clinical conditions that involve affective instability and periodic, recurrent psychopathology.

## No. 100E
## NOSOLOGY AND DSM-V: LESSONS FROM THE BIPOLAR-BORDERLINE CONTROVERSY

Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 4-113, Baltimore, MD 21287-7413*

SUMMARY:

Many hope that DSM-V will propose a systematic classification of mental disorders and so move our discipline beyond DSM-IV, that is to advance us from a diagnostic nomenclature built around clinical descriptions toward a taxonomy of disorders according to their pathological natures. Such a systematic classification would promote hypothesis-driven research and provide a more coherent foundation from which to defend and explain psychiatric thought and practice. The considerations involved in such an advance will be illustrated here in the discussions of bipolar II and borderline personality disorders—their conceptual distinctions and overlapping clinical presentations—all though, with the aim of refining concepts

and validating explanations for the benefit of classificatory thought and clinical practice.


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# SYMPOSIUM 101—NEW INTRAVENOUS TREATMENTS: A NEW TOOL TO OVERCOME DIFFICULTIES AND RESISTANCE

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand and discuss the role of intravenous treatment for resistant depression and OCD, identify pharmacokinetic predictors of treatment response, (2) should be familiar about intravenous citalopram procedure, and will be informed on the compared advantages, effectiveness, and safety of i.v. citalopram compared with i.v. clomipramine, (3) learn that intravenous antidepressant treatment has a fast onset and is efficacious, (4) discuss the utility of intravenous clomipramine in refractory OCD, (5) and should be familiar with intravenous clomipramine safety and efficacy in treatment resistant youth.

## No. 101A
## INTRAVENOUS ANTIDEPRESSANTS: A PHARMACOKINETIC PERSPECTIVE ON RESPONSE AND RESISTANCE IN MAJOR DEPRESSION AND OCD

Emanuela Mundo, M.D., *Department of Psychiatry, University of Milan, Ospedaleluigisacco Viagbgrassi 74, Milan 20145, Italy;* Silvio R. Bareggi, M.D., Carlo A. Altamura, M.D.


SUMMARY:

Intravenous (i.v.) antidepressants appear to shorten the latency of the clinical response and to be effective in resistant cases of major depression (MD) and obsessive-compulsive disorder (OCD). The aims of presentation are (1) to review the literature on the i.v. use of antidepressants in MD and OCD, (2) to identify pharmacokinetic correlates of treatment outcome, and (3) to address the value of plasma levels as early predictors of response or resistance. Pulse loading i.v. clomipramine or citalopram in MD and/or OCD significantly improve clinical response in some patients. Pharmacokinetic variables appear to account for this variability. A recent study showed that the acute response to i.v. clomipramine and the long-term oral treatment response are gender related. These differences correlate with plasma concentrations of clomipramine and its metabolites. The steady-state levels in MD or OCD patients responder to i.v. citalopram were shown as related to clinical response. Consequently, plasma level determination may be a useful tool for early detection of responders or refractory patients. Further studies in progress will address the genetic variability underlying pharmacokinetic variability and heterogeneity of clinical response to SRIs. The clinical relevance of early detection of responders and non-responders based on pharmacokinetic and pharmacogenetic characteristics will be discussed.


## No. 101B
## INTRAVENOUS CITALOPRAM AND CLOMIPRAMINE IN MAJOR DEPRESSION: A DOUBLE-BLIND STUDY

Stefano Pallanti, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York, NY 10029;* Leonardo Quercioli, M.D.


SUMMARY:

Objective of the present study is to evaluate the effectiveness, safety, and tolerability of citalopram (CIT) compared with clomipramine (CMI), both gradually dosed, slow-drop, intravenously administered, in patients with major depressive episode. Forty subjects (20 in each arm) were randomly assigned to CIT or CMI two-week intravenous infusions protocol followed by a six-week equal-dosage oral follow-up. Rating scales used were MADRS, Ham-A, and DOTES.

Twelve of 17 subjects who concluded the infusional protocol on CMI (70.6%) and 15/19 (78.9%) on CIT had significant improvement (MADRS score reduction >= 25%). CIT group showed an earlier and greater reduction of anxiety symptoms as measured by Ham-A compared to the CMI group from day-3 ($p<.05$), day-7 ($p<.02$), day-10 ($p<.02$), and at day-14 ($p<.05$). More undesired side effects and a higher rate of dropout cases in the infusion period were found in CMI group. No differences were found in MADRS and Ham-A scales at the end of the six-week follow-up between the two groups. This group of subjects, in a prospective one-year follow-up showed lower relapse rate compared with a matched group treated with oral CMI or CIT from the beginning.

Intravenous CIT appear as effective as CMI in depressed patients, with an earlier reduction of associated anxiety symptoms and lower rate of side effects.


## No. 101C
## INTRAVENOUS ANTIDEPRESSANT THERAPY WITH MIRTAZAPINE AND CITALOPRAM

Siegfried Kasper, M.D., *Department of General Psychiatry, University of Vienna, Wahringer Gurtel 18-20, Vienna A-1090, Austria;* Anastasios Konstantinidis, M.D., Diethar Winkler, M.D., Juerren Stastny, M.D., Christian Barnas, M.D., Eva Hilger-Assem, M.D., Franz Mueller-Spahn, M.D.


SUMMARY:

Several antidepressants are available as intravenous formulation, clomipramine, dibenzepine, doxepine, viloxazine, citalopram and recently mirtazapine. This method of administration is mainly used in Europe. There are relatively few studies and the additional benefits conferred by parental vs. oral administration are still debated. We recently conducted an open-label study with 15mg mirtazapine intravenously in 27 inpatients with moderate to severe major depression and found, compared with baseline, a significant decrease of HAMD total score ($p<0.001$); the side effects were mild and transient. Based on the preliminary observation, it seemed that there is faster onset of action of depressive mood as well as anxiety when intravenous mirtazapine is used compared with the oral route of administration. This preliminary study shows that intravenous mirtazapine is an effective, safe, and well-tolerated treatment for depression. In a

review (Kasper, Müller-Spahn, 2002) we summarized four available open studies and three placebo-controlled studies evaluating the antidepressant efficacy of citalopram intravenously (20–60mg). The results from both open and double-blind clinical studies suggest this to be an effective and well-tolerated treatment for depression.

Further placebo-controlled studies are needed to evaluate the efficacy of intravenous antidepressant treatment modalities; however, the results presented indicate that it is a valuable addition to the antidepressant armamentarium.

## No. 101D
## PULSE-LOADED INTRAVENOUS CLOMIPRAMINE FOR REFRACTORY OCD

Lorrin M. Koran, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, OCD Clinic #2363, Stanford, CA 94305-5721*

### SUMMARY:

From 20% to 40% of OCD patients fail to respond adequately after two or more oral trials of serotonin reuptake inhibitors (SRIs). In a double-blind pilot study of intravenous versus oral pulse-loaded clomipramine (CMI) for such patients, intravenous CMI was clearly superior. The current study is enrolling patients who have failed at least two adequate SRIs and have Yale-Brown Obsessive Compulsive Scale (Y-BOCS) scores of at least 21. In a double-blind, double-dummy design, they receive 150 mg of oral or intravenous CMI on day 1 and 200 mg on day 2, and start 12 weeks of open-label oral CMI (200 mg) on day 6. Of the first 14 patients, one (7%) was a responder (Y-BOCS decrease of at least 25%) at day 6, three (21%) after on week of oral CMI, and seven (50%) by the end of week 4. One lost the response after week 4. One responder had previously failed an adequate oral CMI trial. The blind will be broken after 35 patients. If all or most of the seven responders received intravenous pulse-loaded CMI, this treatment may be highly effective in refractory OCD. More data and potential mechanisms of action will be discussed.

## No. 101E
## INTRAVENOUS CLOMIPRAMINE IN ADOLESCENTS WITH TREATMENT-RESISTANT OCD AND DEPRESSION

Floyd R. Sallee, M.D., *Department of Psychiatry, Cincinnati Children's Hospital Medical Center, 3333 Burnett Avenue, Cincinnati, OH*

### SUMMARY:

Twelve of 17 subjects who concluded the infusional protocol on CMI (70.6%) and 15 of 19 (78.9%) on CIT had significant improvement (MADRS score reduction >= 25%). CIT group showed an earlier onset and obsessive-compulsive disorder (OCD) carries significant morbidity, and major depressive disorder (MDD), considerable mortality risk, in adolescent patients. Standard treatments with serotonin reuptake inhibitors (SRI) is complicated by a high therapeutic failure rate (20% to 30% are resistant), as well as subtherapeutic or partial response in a significant proportion of patients. Our laboratory has examined the time to response and treatment outcome of resistant adolescent subjects, defined as failing two or more SRI treatments of adequate dose and duration. MDD adolescents (n=16) of which eight were given a single dose (200mg clomipramine (CMI)), while OCD adolescents (n=6) of which two were given two doses (150 mg followed by 200 mg CMI) over a 48-hour period by rapid intravenous infusion. In groups that received IV CMI, treatment response was significantly better in IV CMI-treated (MDD 7/8; OCD 2/2) when compared with saline or oral-CMI treated (MDD 3/6; OCD 1/4) adolescents. The IV CMI group continued improvement when oral therapy with any SRI was re-established. Intravenous CMI requires further safety and efficacy evaluation in adolescents with SRI treatment-resistant disorders.

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# SYMPOSIUM 102—INTERESTS AND VULNERABILITIES OF HEALTH CARE

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand (1) clinicians' acquiescence to threats against their interests; (2) vulnerabilities; (3) adverse effects on patient care and society; (4) the role of physician beneficence with societal nonreciprocity, and (5) the value of a contractual model in re-establishing optimum health care parameters, (6) how psychiatry is rendered particularly vulnerable to outside threats by its relative lack of within-group coherence, and (7) possible strategies for psychiatry to strengthen its collective self-assertion, (8) recognize medicolegal aspects of duties to others than patients, (9) understand the manner in which managed care has drastically changed psychiatric practice, (10) recognize the dilemmas experienced psychiatric educators face in a managed care environment; and (11) recognize the need to develop strategies for improving psychiatric education.

## No. 102A
## BENEFICENCE AND NONRECIPROCITY IN CONTEMPORARY HEALTH CARE

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health Sciences University, V3MHC Portland VA, P.O. Box 1035, Portland, OR 97207*

### SUMMARY:

Clinicians are anomalous in their collective failure to openly define and defend their own interests. These include ability to provide optimum patient care, personal rewards, salutary work milieu, and safety from culpability for matters beyond their control. Instead, they passively acquiesce to incremental assault against these interests. To do otherwise would be uncomfortable, poorly received, and in some settings taboo. One contributory factor is an incongruity between physicians' tradition of beneficence and current political-economic realities. Clinicians' image of selfless beneficence, de-emphasizing personal interests, benefited all parties when others reciprocated in kind both by ratifying clinicians' idealized image and by respecting their de-emphasized interests. Today, society treats clinicians as any self-interested group, but holds them to their self-idealization. By tacitly accepting this imbalance, clinicians assume a losing position in the societal interplay, undermining their tangible and intangible resource base, which also harms their patients and society. Within

this changed milieu, beneficence and optimum health care are most likely to re-optimize through a contractual model, with everyone's interests and differential responsibilities openly stated, respected, and balanced. I will discuss how such a model can be applied toward optimizing efficacy, efficiency, consent, and safety in the clinical management of psychiatric patients.

### No. 102B
### PSYCHIATRY'S INTERNAL DISSENSION

Michael T. McGuire, M.D., *Department of Psychiatry, University of California at Los Angeles, PO Box 1646, Cottonwood, CA 96022*

SUMMARY:

A common observation of groups of individuals (and non-human primates) is that after they have reached a certain number they split off and take on individual identities, purposes, ways of communicating, and competitively engage groups from which they split. Psychiatry has been particularly susceptible to internal splits for the following three reasons: (1) its multiple views of causality, (2) its multiple forms of treatment, and (3) its inefficient self-monitoring of causal hypotheses and intervention effectiveness. The net effect is that psychiatry is composed of multiple small groups, each advocating its own variation on causality of mental illness and preferred treatment. Such groups compete to survive economically, to acquire supporting funds and influence, and to extend the impact of their particular views. Psychiatry's failure to effectively define and defend its interests to outside parties is due largely to the following two facts: (1) group energies have focused primarily on internal competition and economic survival, and (2) there is no consensus on its causal views or intervention choices.

### No. 102C
### DUTIES TO OTHERS: MEDICOLEGAL ASPECTS

Thomas G. Gutheil, M.D., *Department of Psychiatry, UMHC, 6 Wellman Street, Brookline, MA 02446-2831*

SUMMARY:

In a discussion of clinicians' interests, a strong counter force is clinicians' duties to others. The earliest form of this duty, to one's own patients, goes back to Hippocrates. A new theme emerging from case law over the last several decades is duty to third parties beyond our patients. The Tarasoff case was the first important decision, in California, which imposed a duty to warn and/or protect third parties who are endangered by patients' actions. Since then the driving cases and "false memory" cases have followed a similar course, with psychiatrists being held liable for their patients' harms to third parties. All contribute to clinicians' vulnerability to retribution for matters beyond their immediate control. These issues and their medicolegal aspects have important clinical and risk management implications for practicing clinicians, which will here be reviewed.

### No. 102D
### MANAGED CARE AND THE DILEMMAS OF PSYCHIATRIC EDUCATION

Seymour L. Halleck, M.D., *Department of Psychiatry, University of North Carolina, 500 Laurel Hill Road, Chapel Hill, NC 27514*

SUMMARY:

One of the most extraordinary events in the most recent history of psychiatry is the drastic change in the manner in which treatment is provided to psychiatric patients. In addition to the greater emphasis on pharmacotherapy, there has been an increasing acceptance of the idea that even moderately intensive, concurrent psychotherapy is either unnecessary or can be provided by someone, other than the treating physician, who is likely to have limited training and skills. This trend reflects in part expansion of scientific knowledge. But, it is also fueled by the dictates of managed care.

Many psychiatrists who have been practicing for more than 10 years fear that what is now viewed as acceptable care is actually substandard care. Experienced psychiatrists who also teach face especially serious problems. Should they teach practices that they believe are optimum for patients, knowing that most of their students will be unable to implement them? Should they risk demoralizing students by communicating to them the pessimistic messages that they will be under continuing pressure to provide what the teacher believes to be inferior care? Should they warn of the growing malpractice risks involved in practicing under the restraints of managed care? Is it ethical to teach acceptance of what the educator believes is substandard care?

This presentation discusses why and how psychiatric educators have failed to respond to these issues in a thoughtful and assertive manner.

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## SYMPOSIUM 103—COMORBIDITY WITH SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with evidence on the relationship between depression and substance dependence and its treatment implications and understand the influence ADHD and its treatment have on the developmental course of substance abuse in ADHD individuals.

### No. 103A
### SUBSTANCE ABUSE AND DEPRESSION

Edward V. Nunes, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Depression is arguably the most prevalent psychiatric syndrome to co-occur in substance-dependent patients in whom it has often been associated with poor prognosis. Since the toxic effects of substance use or withdrawal can produce symptoms of depression, there has been controversy regarding the significance of depression among substance abusers. This talk will outline a contemporary guideline for diagnosis and treatment with attention to how to separate symptoms representing toxic effects of substances from true depressive disorders warranting specific clinical interventions. Evidence on the predictive validity of the DSM-IV categories of primary and substance-induced depression will be reviewed as will studies on the treatment of depression in various substance-dependent populations, both pharmacotherapy and psychotherapy.

## No. 103B
## SUBSTANCE ABUSE AND PTSD

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Charleston, SC 29425;* Susan Sonne, Ph.D., Therese Killcen, Ph.D., Aimee McRae, Ph.D.

SUMMARY:

While PTSD and cocaine dependence commonly co-occur, questions have been raised concerning differences between individuals who had PTSD before cocaine use and individuals who had the trauma and PTSD occur in the context of cocaine dependence. In order to investigate this topic, 37 individuals with comorbid PTSD and cocaine dependence entering a pharmacologic treatment trial were divided into two groups: one in which the trauma and PTSD occurred before the onset of cocaine dependence (primary PTSD) and one in which the PTSD occurred after cocaine dependence was established (primary cocaine). In the primary PTSD group, the trauma was generally childhood abuse. In the primary cocaine group, the trauma was generally associated with the procurement and use of cocaine. In the primary PTSD group, there were significantly more females ($p \leq 0.05$), more other Axis diagnoses ($p \leq 0.05$), more Cluster B and Axis II diagnoses ($p \leq 0.05$), and more benzodiazepine and opiate use. There was significantly more cocaine use in the month before study entry in the primary cocaine group. There were no significant differences in PTSD symptoms or severity, alcohol use, or other demographic variables between groups. In conclusion, regardless of the relative order of onset of PTSD and cocaine dependence, individuals with these comorbid conditions are similar in many ways. Gender differences in order of onset should be considered.

## No. 103C
## SUBSTANCE ABUSE AND ADD

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

SUMMARY:

The co-occurrence of ADHD and substance use disorders (SUD, including drug and alcohol abuse and dependence) has been increasingly reported in clinical and research settings and is known to be associated with substantial impairment. Studies in ADHD children growing up as well as those in adults with ADHD have shown an increased risk for SUD in those with persistent ADHD. Moreover, those with the highest risk for, and earliest onset of, SUD were found in those with co-occurring conduct or bipolar disorders. ADHD adults with SUD had a different course in the development of their SUD as well as a longer duration of SUD compared to their non-ADHD peers.

Recent work had demonstrated that the pharmacotherapy of ADHD significantly reduces the risk for SUD. The pharmacotherapeutics of adolescents and adults with ADHD and SUD remains unclear. In this talk, a systematic data-oriented presentation of this important overlap will be presented. Appropriate intervention strategies, including both psychotherapy and pharmacotherapy of individuals with ADHD and SUD, will be presented.

## No. 103D
## SUBSTANCE ABUSE AND SOCIAL PHOBIA

Hugh Myrick, M.D., *Department of Psychiatry, Medical University of South Carolina, 109 Bee Street, Charleston, SC 29425*

SUMMARY:

Social phobia is defined as a marked and persistent fear of situations in which an individual is exposed to unfamiliar people or to the scrutiny of others. Typically, this fear leads to avoidance of feared situations and results in impairment in academic, occupational, and social functioning. The National Comorbidity Survey (NCS) conducted by Kessler and colleagues (1994) found a 13.3% lifetime prevalence and 7.9% 12-month prevalence of social phobia in the general population. There have been high rates of comorbidity with other psychiatric disorders in social phobia and in particular with substance abuse. From a self-medication standpoint, it seems clinically reasonable that social phobics would be prone to the abuse of alcohol and illicit drugs. Once the diagnosis of comorbid social phobia and substance abuse has been made, treatment needs to address both conditions. As social phobia may interfere with an individual's ability to engage effectively in treatment, early recognition is paramount to improve chances of recovery. The presentation will address the recognition and treatment considerations in the individual with comorbid social phobia and substance dependence.

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# SYMPOSIUM 104—LOVE FROM PATHOLOGY TO NORMALITY: FRENCH AND AMERICAN STYLE, PART 2

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to (1) identify the major clinical features of erotomania, in its classical description as well as its modern aspects, (2) appreciate normal and pathological love in medical marriages, (3) recognize the meaning ascribed to love according to the pathological condition of patients, and to understand how love can challenge clinical practice, (4) and recognize the role that love plays cross-culturally in human behavior, and understand different meanings of love, including its painful aspects, in clinical practice.

## No. 104A
## BROKEN HEARTS, HEAVY HEARTS: NARRATIVE, DISTRESS, AND COMPLIANCE AFTER AN INFARCT

Danielle Groleau, Ph.D., *Department of Psychiatry, McGill-Jewish Hospital, 4333 Cote Sainte Catherine, Montreal, QC H3T 1E4, Canada;* Evelyne Hudon, M.D., Laurence J. Kimayer, M.D., Francois Lesperance, M.D., Zeev Rosberger, Ph.D.

SUMMARY:

Compliance with treatment after a myocardial infarct (MI) implies a change in many behaviors linked to exercise, medication, diet, and smoking. Approximately 50% of post-infarct patients are noncompliant with this regimen, thus reducing their chances of survival dramatically. No studies have yet examined the role played by cultural determinants of compliance after an MI. This paper presents preliminary results from an ethnographic study of cultural determinants of compliance among French Canadians immediately following their first MI. An interpretative-critical approach was used to analyze narratives of 60 patients recruited in four Montreal hospitals. Although most patients could identify the risk factors for an MI, they attributed other types of meaning and reasoned differently about their "heart attack" and related compliance issues. Presented results focus on the role played by the cultural metaphor of the heart as the organ recipient of love, stress, and distress and how this metaphor translates into narratives of a broken heart as well as a popular theory of cardiac health. We conclude by discussing how the pervasive concepts of "compliance" and "risk factors," although widely accepted in public health and evidence-based medicine, are limited constructs to communicate with patients about their health behavior.

## No. 104B
## FROM EROTOMANIA TO STALKING

Francois C. Petitjean, M.D., *Department of Psychiatry, C. Hospital Sainte Anne, Cabanis Nunber 1st, Paris 75014, France;* Natacha Fouilhoux, M.D., Agop Kaveojan, M.D.

SUMMARY:

Stalking and erotomania are two different concepts that may, however, overlap. Erotomania, defined as the illusion that another person is in love with the individual, is included in DSM-IV as a subtype of delusional disorder. It was described by the French psychiatrist G. de Clerambault in 1942, but is seldom observed nowadays in it's typical form.

Stalking is a type of behavior that is punished by law.

Authors describe the case of a 34-year-old male, admitted to hospital involuntarily for behavioral disorders consisting of threatening letters sent to a young woman he had met seven years earlier; his behavior included surveillance and stalking. Basing their study on this clinical case, the authors take a fresh look at erotomania; they compare this case with the classical descriptions of de Clerambault and J. Lacan and explore the possibility that clinical features may have changed under the influence of the evolution in society.

## No. 104C
## THE LOVE LIFE OF MELANCHOLICS

Peter D. Kramer, M.D., *Yale Medical School, 236 Hope Street, Providence, RI 02906-2212*

SUMMARY:

Although depression and its variants are among the most common of mental illnesses, there have been few attempts to integrate observations regarding the intimate social effects of mood disorder. Through reference to clinical encounters, this presentation will outline an approach to questions concerning the relationship between melancholy and love. In particular, it will ask how depression and minor depression affect choice in romantic liaisons and how they affect the conduct and termination of those relationships. A key issue is the social valuation of melancholy, i.e., when is depression a handicap, and when is it a boon? The presentation is part of a larger inquiry into the cultural meaning of melancholy.

Though it will refer to published literature, this presentation will be speculative—an invitation to research not yet performed.

## No. 104D
## THE MEDICAL MARRIAGE

Michael Myers, M.D., *2150 W. Broadway, #405, Vancouver, BC V6K 4L9, Canada*

SUMMARY:

Mythology abounds about the health of intimate relationships of physicians, whether they be marriages, same-sex relationships, unmarried co-habiting, or separate living relationships. There are no recent empirical data on physicians' intimate relationships. The divorce rate of physicians is no higher than other groups of professionals, and virtually nothing statistically is known about the viability of lesbian and gay male physician relationships. Through the lens of love, from pathology to normality, I will examine four subtypes of medical marriages: (1) physicians living in a second, third, or more marriage; (2) gay male and lesbian physician intimate relationships; (3) physicians and their spouses or partners who live with diagnoses on Axis I, II, and/or III; (4) physicians in intermarriages whether they be racial, ethnic, and/or faith. Themes include developmental stages in the identity formation of physicians, the technological and managerial culture of medical practice today and its clash with the humanity of the physician, the physician's success or failure at mature love, the "wounded healer" physician, and the "love-sick" physician who crosses boundaries with patients. Physicians who seem most happy in love have been able to successfully integrate the responsibilities of their work and intimate relationships.

## No. 104E
## THE CLINICAL MEANING OF LOVE

Richard Rechtman, M.D., *Department of Psychiatrie, Inst Marcel Riviere, Le Mesnil St. Deni 78321, France;* Eric J. Marcel, M.D.

SUMMARY:

Except in specific delusions, like the classical French erotomania, it seems that love has not received much psychiatric attention. In DSM-IV, for example, there is just a brief quotation on a subtype of delusional disorder, the erotomanic type where pathological love is the feature. But even there, the point is not love itself but the delusional idea of being loved by someone else, generally of higher status. While usually considered as a stress factor in various disorders such as anxiety and depression, only Axis IV allows to code love in "other condition that may be a focus of clinical attention" (p 675). Furthermore, love is not explicitly quoted in this section and may just be included in "Relational Problems," V61.1 "Partner Relation Problem." This lack of diagnosis demonstrates that from a nosological point of view love is neither pathological nor normal, it just belongs to human condition. But, behind this diagnostic discretion, love can nevertheless challenge clinical practice. From a clinical and and anthropological point of view, the author will discuss the way clinicians ascribe different meanings to love according to the pathological condition of their patients.

## No. 104F
## TRANSCULTURAL ASPECTS OF LOVE

James K. Boehnlein, M.D., *Dept of Psychiatry (OP-02), Oregon Health Sciences Univ, 3181 SW Sam Jackson Park Rd, Portland, OR 97201-3011*

SUMMARY:

Cultural meanings always shape the human experience. Love and the suffering sometimes associated with it 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. In some cultures, romantic love may be an impediment to a stable, successful, and socially satisfactory marriage because it may negatively impact other familial bonds and loyalties. Falling in love often requires denial and idealization, but also can be a test of ego strength and integration. Ideally, it can be a very special form of attachment and a combination of various types of bonds that human beings can form, regardless of culture or ethnicity.

From a transcultural and anthropological view, the author will discuss different meanings of love, including painful aspects, as they appear in clinical practice. This topic integrates with other presentations in this symposium and will complement the general discussion.

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## Component Workshop 1
## RESTRAINTS: STRATEGIES TO REDUCE AND OPTIMIZE PATIENT SAFETY
## APA Committee on Standards and Survey Procedures

*Chairperson:* Charles E. Riordan, M.D., *Hospital of St. Raphael, 1450 Chapel Street, New Haven, CT 06511-4405*
*Participants:* Kathleen McCann, D.N.S.c, Steven I. Altchuler, M.D., Dennis J. Milke, M.D. Marlin R.A. Mattson, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to utilize a variety of clinical strategies to optimize patient safety for those situations in which this is an appropriate treatment.

### SUMMARY:

The presenters will focus on a variety of clinical practices designed to reduce the use of restraints as well as practices for the safe applications of this intervention. Discussion will include the role of restraints for behavioral purposes on medical and surgical floors, and psychopharmacological strategies that are designed to diminish the use of restraints. Over the past year the American Psychiatric Association along with the National Association of Psychiatric Health Systems, and the American Psychiatric Nurses Association have developed a joint project to share ideas on strategies, protocols, and best practices to deal with alternative interventions to the use of restraints. Experiences from this database will be shared with participants. Attendees will be encouraged to share ideas that have been useful in either reducing the use of restraints or optimizing patient safety for those for whom restraints are necessary.

### REFERENCES:

1. Currier GW, Farley-Toombs C: Use of restraint before and after implementation of the new HCFA rules. Psychiatric Services 2002; 53:138–140.
2. Johnson M, Hauser P: The practices of expert psychiatric nurses: accompanying the patient to a calmer personal space. Issues in Mental Health Nursing 2001; 22:651–668.

## Component Workshop 2
## EARLY INTERVENTION FOLLOWING MASS VIOLENCE: DESIGNING AN EFFECTIVE APPROACH
## APA Committee on Psychiatric Dimensions of Disaster

*Chairperson:* John S. Kennedy, M.D., *Behavioral Health, Bethesda Naval Hospital, 8901 Wisconsin Avenue, Bethesda, MD 20889*
*Participants:* Joseph C. Napoli, M.D., Matthew J. Friedman, M.D., Beverley Raphael, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to describe the different types of interventions currently in use following mass violence and summarize the considerations to be considered in selecting from among them.

### SUMMARY:

The technique of psychological debriefing for individuals affected by traumatic incidents was born in military settings then imported into the civilian sector—first for groups of professional helpers (EMT's, fire fighters, disaster workers, police), then for a wide variety of individuals directly or indirectly affected by trauma and loss. Recent studies have called into question the premise that single-session debriefings prevent the development of psychological symptoms in the wake of traumatic incidents. Yet the recent terrorist attacks have prompted the use of these techniques as never before. The workshop panel have broad experience in clinical and field settings and extensive familiarity with the "debriefing controversy" from both practical and academic perspectives. In this workshop they will provide a digest of recent publications on this topic, including the 2002 NIMH Report, "Mental Health and Mass Violcnce," and note the many opportunities for future research in this area. Finally, they will provide practical suggestions for the prudent use of early intervention techniques. Audience members will be encouraged to pose questions to the panel and provide illustrative examples from their own recent experiences.

### REFERENCES:

1. Van Emmerik AAP, Kamphuis JH, Hulsbosch AM, Emmelkamp PMG: Single session debriefing after psychological trauma: a meta-analysis. Lancet 2002; 360:766–71.
2. Everly GS, Boyle SH, Lating JM: The effectiveness of psychological debriefing with vicarious trauma: a meta-analysis. Stress Medicine 1999; 15:229–233.

## Component Workshop 3
## PATIENT SAFETY IN PSYCHIATRY: MINIMIZING THE USE OF RESTRAINT AND SECLUSION
## APA Council on Quality

*Co-Chairpersons:* Alfred Herzog, M.D., *Hartford Hospital, 80 Seymour Street, Hartford, CT 06102-5037*, Miles F. Shore, M.D., *Harvard University, 76 John F. Kennedy Street, Cambridge, MA 02138*
*Participants:* Steven J. Karp, D.O.

### EDUCATIONAL OBJECTIVE:

At the close of this session, the attendee should be able to identify major recommendations of a national patient safety campaign in psychiatry and major elements of a strategy to minimize the use of restraint and seclusion.

### SUMMARY:

In response to a national groundswell to improve patient safety and reduce adverse medical events in all of medicine, the APA Task Force on Patient Safety has delivered major recommendations for psychiatry's concerted attention. Three primary goals are receiving intensive focus: minimized use of restraint and seclusion, reduction of adverse medication events, and reduction of the number of suicides in inpatient/residential settings. This workshop will highlight the major recommendations of APA's patient safety campaign and then examine the elements of a systemwide program that has minimized the use of restraint and seclusion. The presenter addressing seclusion and restraint will discuss organizational change strategies; medications; staff training in risk assessment, crisis prevention, and intervention; patient-debriefing methods; data collection and analysis; and recovery-based treatment models. Attendees may participate through a question and answer period following the description of APA goals, plans, and services concerning patient safety and following the description of approaches that are effective in reducing the use of restraint and seclusion. This workshop is geared to physicians practicing in hospital or residential settings; however, elements of the presentation may be helpful to professionals who practice in outpatient settings as well.

### REFERENCES:

1. Report of Task Force on Patient Safety. American Psychiatric Association, Approved by Board of Trustees 2002.
2. Busch AB, Shore M: Seclusion and restraint: a review of recent literature. Harvard Review of Psychiatry, 2000; Vol. 8:No. 5

Component Workshop 4
## AMBULATORY DETOXIFICATION FROM OPIOIDS: DOING IT WELL AND GETTING PAID TOO
**APA Committee on Treatment Services for Patients with Addictive Disorders**

*Co-Chairpersons:* George F. Kolodner, M.D., *Georgetown University School of Medicine, 6th Floor Kober-Cogan, 3800 Reservoir Road, Washington, DC 20007-2197*, Samuel M. Silverman, M.D., *643 Prospect Avenue, West Hartford, CT 06105-4202*
*Participants:* Thomas R. Kosten, M.D., Jonathan D. Book, M.D., Brealyn M. Sellers, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to accomplish detoxification from opioids safely and effectively on an outpatient basis as well as know alternative methods of contracting and billing for this service.

### SUMMARY:

Last year the APA Committee on Treatment Services for Patients with Addictive Disorders began a series of workshops on ambulatory detoxification in order to provide a forum for discussion and learning by clinicians who wanted to know more about how to deliver these services outside of traditional inpatient settings. Focusing initially on alcohol, the series moves on this year to opioids. Addiction to prescription narcotics and heroin has become a growing clinical problem because of the increased availability and potency of these substances. Several pharmacological alternatives exist for detoxification, each with its own set of advantages and disadvantages. Presenters will describe specific medication protocols and billing alternatives. The use of the APA listserve for ambulatory detoxification—"detoxdoc"—will be described. The audience will have the opportunity to question the presenters about the details of their protocols, as well as to describe additional clinical approaches that they have found to be efficacious.

### REFERENCES:

1. Rounsaville BJ, Kosten TR: Treatment for opioid dependence: quality and access. JAMA 2000; 283 (10).
2. O'Connor PG, et al: Three methods of opioid detoxification in a primary care setting. Annals of Internal Medicine 1997; 127:526–530.

Component Workshop 5
## PRACTICE SETTINGS FOR EARLY CAREER PSYCHIATRISTS: A PRIMER
**APA Assembly Committee of Early Career Psychiatrists**

*Chairperson:* Jeffrey A. Naser, M.D., *Main Line Clinical, 121 North Wayne Avenue #300, Wayne, PA 19087*
*Participants:* Angelique D. Goodhue, M.D., John R. Chamberlain, M.D., Adam R. Chester, D.O.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to discuss the various career options and practice settings available to early career psychiatrists.

### SUMMARY:

The field of psychiatry provides a wide array of career options, from academic/research positions to private practice settings, from crisis management to administrative roles. The task of choosing how one practices, as well as the practice setting, can be a daunting experience. This is even more true just out of training or early in one's career. This workshop will present a panel of early career psychiatrists who will discuss their career choices, as well as the factors they considered in making these choices. Presentations will focus on the strengths and weaknesses of each setting. In addition, personal issues such as life-style, personality, interests, personal strengths and weaknesses, and life goals will be considered. Presentations will include discussions on various practice settings, including private practice, community psychiatry, academics, and hospital-based practices. In addition, career options considered will include general psychiatry, child and adolescent psychiatry, forensic psychiatry, consultation-liaison psychiatry, and administrative roles within psychiatry. A panel discussion with a question-and-answer period will conclude the workshop.

### REFERENCES:

1. Cavanaugh JL Jr: Career decisions in the early postresidency years. American Journal of Psychiatry 1975; 132:277–80.
2. Coons RH Jr: A survey of psychiatric group practice administrators: what does the future hold. Journal of Mental Health Administration 1986; 13:38–44.

Component Workshop 6
## THE RESEARCH BASE FOR NEW DIAGNOSTIC CRITERIA FOR DEPRESSION
**APA Committee on Psychiatric Diagnosis and Assessment**

*Co-Chairpersons:* Darrel A. Regier, M.D., *Office of Research, American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA. 22209*, Norman Sartorius, M.D., *Department of Psychiatry, Hopitaus University De Geneve, 2 Chemin de Petit-Bel-Air, 1225 Chenebourg, Geneva, Switzerland*
*Participants:* J. John Mann, M.D., David Shaffer, M.D., Dennis S. Charney, M.D., Wayne C. Drevets, M.D., T. Bedirhan Ustun, M.D., David J. Kupfer, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate knowledge of key areas in neuroscience, clinical science, and public health research as they relate to the development of new diagnostic criteria for mood disorders in DSM-V.

### SUMMARY:

Following the development of ICD-10 and DSM-IV, a rapidly expanding body of scientific research has evolved in neuroscience, clinical science, and in public health research and practice. Prior to initiating future revisions of either of these two major diagnostic systems, a collaborative international research effort is expected, which may potentially provide a new basis for the classification of some mental disorders. Using depression as a model, the potential will be explored for complementing the current phenomenological (descriptive symptom) criteria with a classification based on environmental and neurobiological etiologies, pathophysiology, and functional anatomical localization. The contributions of research from the multiple scientific fields will be reviewed, and the implications of being able to integrate such findings into a common set of diagnostic criteria will be discussed.

### REFERENCES:

1. Regier DS, Narrow WE, First MB, Marshall T: The APA classification of mental disorders: future perspectives. Psychopathology. 2002; 35:166–70.
2. National Institute of Mental Health: Breaking Ground, Breaking Through: The Strategic Plan for Mood Disorders Research of the National Institute of Mental Health. National Institute of Mental Health, Bethesda, MD, 2002.

Component Workshop 7
## MOOD DISORDERS IN PHYSICIANS, AN UPDATE: HOW TO IDENTIFY, DIAGNOSE, AND PROVIDE TREATMENT
**APA Corresponding Committee on Physician Health, Illness, and Impairment**

*Chairperson:* John A. Fromson, M.D., *Mass Medical Society, 860 Winter Street, Waltham, MA 02451*
*Participants:* Penelope P. Ziegler, M.D., Patti Tighe, M.D., Michael F. Myers, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize manifestations of mood disorders in physicians; outline specific factors that are barriers to resident physicians seeking psychiatric care; describe barriers and recommend methods to overcome resistance.

### SUMMARY:

Depression, bipolar disorder, and other affective disorders are frequently underdiagnosed or misdiagnosed in physicians. A depression may present as a marital conflict; a hypomanic or mixed episode may cause a physician to be labeled "disruptive"; the alcoholic physician entering rehab may have started drinking to medicate an undiagnosed bipolar disorder. This presentation will also explore physicians' reluctance to seek treatment for depression and other mood disorders. Dr. Penelope Ziegler will discuss the variable presentations of mood disorders in physicians. Identification and treatment presents specific challenges in the resident population. Dr. Patti Tighe will present information on the particular challenges residents face due to circumstances specific to the training years. Dr. Michael Myers will discuss the suicidal physician: assessment for suicidality and increased risk; issues around hospitalization, both voluntary and involuntary; dimensions of ambulatory treatment; and the aftermath of death by suicide for the physician's family, medical colleagues and friends, patients, and the treating psychiatrist. Dr. John Fromson will talk about treatment issues including the reluctance physicians have to being treated by other physicians. During the discussion, the audience will participate by asking questions, offering comments, and sharing relevant stories.

### REFERENCES:

1. Bauman KA: Physician suicide. Arch Fam Med 1995; 4:672–673.
2. Brewin CR, Firth-Cozens J: Dependency and self-criticism as predictors of depression in young doctors. J Occup Health Psychol 1997; 2:242–246.

Component Workshop 8
## MEDICARE UPDATE 2003
**APA Medicare Advisory Corresponding 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.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand changes that have occurred in the Medicare program over the past year and how theses changes will affect the practice of psychiatry.

### SUMMARY:

The panel and audience will interact in a discussion of the changes that have taken place in the Medicare program over the past year. Of particular interest will be how the advent of the Progressive Corrective Action system has changed, or is supposed to change, the way claims are reviewed. Changes in the Medicare appeals process as of October 2002 will also be discussed. The panel will present the latest information and then respond to attendees' specific questions about complying with Medicare regulations, interactions with Medicare carriers and fiscal intermediaries, and how to navigate the Medicare system with as much ease as possible. This workshop is intended for individuals who are responsible for the treatment of Medicare beneficiaries.

The workshop is a presentation of the APA's Medicare Advisory Committee.

### REFERENCES:

1. Schmidt C: CPT Handbook for Psychiatrists, 2nd edition.
2. American Medical Assn: CPT 2003.

Component Workshop 9
## USING RADIO TO COMBAT STIGMA AND IMPROVE THE IMAGE OF PSYCHIATRY
**APA Alliance**

*Co-Chairpersons:* Harvey L. Ruben, M.D., *Department of Psychiatry, Yale School of Medicine, 77 Knollwood Drive, New Haven, CT 06515-2413,* Jo Ellen Fasanello, *APA Alliance, 4955 Cliffside Drive, Clarence, NY 14031*
*Participants:* Michael Blumenfield, M.D., Frederick K. Goodwin, M.D., Linda S. Austin, M.D., Harry A. Croft, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to be trained to use these radio to fight stigma and improve psychiatry's image.

### SUMMARY:

This workshop will be presented by five seasoned psychiatric broadcasters who have a wealth of experience on the radio and in the media in general. These psychiatrists will present their approach to using radio both to combat stigma and to improve the image of our profession. Specific techniques will be discussed for dealing with local radio in small and large markets, and national radio of both the commercial and public broadcast variety. Tools for giving information in ways that are understandable and appealing to the audience will be described. Examples of using radio in these various formats to achieve the goals of fighting stigma and improving the image of psychiatry will also be presented. Workshop participants will be asked to give examples of their own media experiences, and these will be discussed and critiqued by the panelists. At the end of this workshop, participants will understand how radio is used to achieve these goals. They will also understand what they must do if they are interested in becoming involved in radio, and how and where they can obtain training in order to do this.

### REFERENCES:

1. Group for the Advancement of Psychiatry: Speaking Out for Psychiatry: A Handbook for Involvement with the Mass Media. Report No. 124, October, 1987.
2. Ruben HL: Interacting with the media after trauma in the community, in Responding to Disaster: A Guide for Mental Health Professionals, edited by Austin L: APPI, Washington, DC, 1992, pp. 125–136.

## TUESDAY, MAY 20, 2003

### Component Workshop 10
### PRACTICAL TIPS ON HOW TO BE A SUCCESSFUL AUTHOR
### American Psychiatric Publishing Inc. Editorial Board

*Chairperson:* Robert E. Hales, M.D., *Department of Psychiatry, University of California Davis, 2230 Stockton Boulevard, Sacramento, CA 95817*
*Participants:* Glen O. Gabbard, M.D., John M. Oldham, M.D., Alan F. Schatzberg, M.D., Donna E. Stewart, M.D.

#### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to list five practical strategies, which should increase the chances of being a successful author.

#### SUMMARY:

The workshop is designed for psychiatrists who are interested in becoming an author or editor. The participants are all members of the American Psychiatric Publishing Editorial Board and are accomplished authors and editors with extensive publishing experience. Dr. Hales will provide an overview of how book proposals and manuscripts are reviewed at APPI and provide specific guidelines to potential authors on the necessary steps to follow. Dr. Gabbard will discuss how authors may wish to develop overall themes or topics for their books and how to get feedback from more experienced authors. Dr. Oldham will provide suggestions on how to evaluate other books that have been published and how to develop a unique or novel focus. Dr. Schatzberg will outline strategies for editors managing the publication process of large texts. Dr. Stewart will summarize how authors may assist marketing in promoting their work, and what they may do individually to increase awareness among colleagues, trainees, and other potential readers about their work. Audience participation will be encouraged through question-and-answer sessions after each presentation and by asking attendees to provide personal anecdotes.

#### REFERENCES:

1. Kay J, Silberman EK, Pessar L: Handbook of Psychiatric Education and Faculty Development. Washington, DC, American Psychiatric Publishing, 1999.
2. Borus JF, Sledge WH: Psychiatric education, in American Psychiatric Press Textbook of Psychiatry, Third Edition, edited by Hales RE, Yudofsky SC, Talbott JA. Washington, DC, American Psychiatric Publishing, 1999.

### Component Workshop 11
### HOW TO PROVIDE GERIATRIC PSYCHIATRY DURING RESIDENCY
### APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly

*Chairperson:* Colleen J. Northcott, M.D., *Department of Psychiatric Mood Disorders, University British Columbia, 2255 Wesbrook Mall, Vancouver, BC V6T 2A1, Canada*
*Participants:* Barbara J. Justice, M.D., Iqbal Ahmed, M.D., Josepha A. Cheong, M.D.

#### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to design an effective geriatric psychiatry experience for general psychiatry residency.

#### SUMMARY:

This workshop will provide a practical, interactive, "how-to" approach to meeting the new ACGME requirement of "30 days of clinical experience in geriatric psychiatry" during general residency (as of January 2001). This workshop is designed particularly for general psychiatry programs that do not have geriatric psychiatry fellowships or dedicated geriatric psychiatry services (such as inpatient units). We will look at the challenges of providing clinical experience and supervisory expertise in geriatric psychiatry. Residents' perceptions and experience of geriatric training will be discussed. We encourage participants to bring to the session their experiences or concerns in providing geriatric psychiatry training. The presenters, representing expertise from APA, AAGP, and AADPRT, will offer models for providing geriatric psychiatry experience in both form and content. We expect to generate additional ideas from the participants for meeting the new requirement and enhancing general psychiatry training.

#### REFERENCES:

1. Kennedy GJ, Goldstein MZ, Northcott CJ, et al: Evolution of the geriatric curriculum in general residency training: recommendations for the coming decade. Academic Psychiatry 1999; 23:187–97.
2. Rubin EH: Current advances in Alzheimer's disease: a medical model paradigm for psychiatric education. Psychiatric Clinics of North America 1997; 20:77–89.

### Component Workshop 12
### PSYCHIATRIC MANAGEMENT OF HIV, HEPATITIS C, AND SUBSTANCE ABUSE
### APA Committee on AIDS

*Chairperson:* Milton L. Wainberg, M.D., *Department of Psychiatry, New York Psychiatric Institute-Columbia University, 404 Riverside Drive, Unit 5B, New York, NY 10025*
*Participant:* Steve L. Batki, M.D., Karl Goodkin, M.D.

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify guidelines for making multiple diagnoses; understand HIV and hepatitis C virus co-infection; recognize issues and complications regarding patient substance abuse; and identify pharmacologic treatment options for the multiply diagnosed patient.

#### SUMMARY:

This workshop will open with three short presentations. The first presentation, an overview of the multiply diagnosed patient, will offer guidelines for the differential diagnosis of the HIV-infected patient and will outline treatment strategies for the multiply diagnosed patient. The presentation on HIV/AIDS and hepatitis C will provide psychiatrists with tools for evaluating and treating the patient who has co-occurring HIV/AIDS and hepatitis C infection. The final presentation, on HIV and substance abuse, will offer psychiatrists strategies for helping patients with co-occurring HIV/AIDS and substance abuse. The workshop will close with a question-and-answer period, providing participants with the opportunity to discuss individual clinical problems.

#### REFERENCES:

1. Bing EG, Burnam MA, et al: Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. Arch Gen Psychiatry 2001; 58:721–8.
2. Prakash O, Mason A, Luftig RB, Bautista AP: Hepatitis C virus (HCV) and human immunodeficiency virus type 1 (HIV-1) infections in alcoholics. Front Biosci. 2002; July 1:7.

Component Workshop 13
## IMGS: CHALLENGES AND SOLUTIONS
**APA Committee on International Medical Graduates**

*Co-Chairpersons:* Josie L. Olympia, M.D., *Buffalo Psychiatric Center, 400 Forest Avenue, Buffalo, NY 14213,* Godehard Oepen, M.D., *Department of Psychiatry, University of Alabama, 223 Trace Ridge Road, Birmingham, AL 35244-3926*
*Participants:* Moitri N. Datta, M.D., Elizabeth J. Santos, M.D., Rolando R. Velasquez, L.L.B.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify challenges that IMGs face and through interaction with others, develop some solutions; learn updated information on obtaining a J-visa, J-1 visa waiver, and current immigration rules.

### SUMMARY:

IMGs have been an integral part of the U.S. physician population for many years. Numbering approximately 166,000 in July 2002, they comprise about 25% of the U.S. physician population. A foreign medical education for citizens as well as noncitizen graduates offers numerous challenges when they want to practice in this country. Foremost are accreditation obstacles, with more stringent requirements for certification from the ECFMG. For foreign-born IMGs, there are problems in obtaining a visa, obtaining a residency, differences in training, language, and acculturation difficulties. This workshop will bring together both early career and senior IMGs who will discuss problems they face and share their experiences. An immigration lawyer, who is one of the presenters, will give updated information on immigration rules and answer questions on J-1 visa and J-1 visa waivers.

### REFERENCES:

1. Greene J: Is it time for the U.S. to start training more physicians? AM News 2001; 44 (16).
2. Antoline D: The risks and benefits of a medical education abroad; Academic Psychiatrist 2002; July–August.

Component Workshop 14
## NEW APA ETHICS PROCEDURES: IMPLICATIONS FOR THE PROFESSION, PART 1
**APA Ethics Appeal Board**

*Co-Chairpersons:* Richard D. Milone, M.D., *120 Forest Avenue, Rye, NY 10580,* Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030*
*Participants:* JoAnn Macbeth, J.D., Alfred Herzog, M.D., Alan A. Stone, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participation should be able to recognize the new APA ethics procedures and understand their implications for APA members and APA district branches.

### SUMMARY:

This year, the APA ethics procedures for investigating complaints of alleged unethical conduct were reviewed as a result of the APA president's initiative, with the concurrence of the Board of Trustees. Thus, an APA task force, the APA Ethics Committee, and the APA Ethics Appeals Board have extensively modified all existing APA procedures and guidelines to conform with the new changes instituted in this regard. (Another task force is currently rewriting/revising the Annotations to the Principles of Medical Ethics...) In view of this, it is imperative that APA members be informed and educated in this regard. Thus, this workshop has been organized for the purpose of presenting to the APA membership the new approaches. The changes have many implications for the APA district branches since it is at that level that triage of ethics complaints will take place. The intention of this workshop is to stimulate and activate participation between the attendees and the presenters. Attention will be given to providing educational guidance for APA district branch officers and staff. The new educational approach to resolving some ethical complaints will be extensively addressed.

### REFERENCES:

1. American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. APPI Press, Washington DC, 2001.
2. DuBois JM, Burkemper J: Ethics education in US medical schools: a study of syllabi. Academic Medicine 2002; 77:432–437.

Component Workshop 15
## CAREER CHOICES IN PSYCHIATRY: EXPLORING FELLOWSHIP TRAINING
**APA Assembly Committee of Area Member-in-Training Representatives**

*Chairperson:* Caroline E. Fisher, M.D., *University of Mass Medical School, 55 Lake Avenue North, Worcester, MA 01655*
*Participants:* Mathieu Bermingham, M.D., John R. Chamberlain, M.D., Maria I. Fernandez, M.D., Joshua A. Israel, M.D., John C. Furman, M.D.

### EDUCATIONAL OBJECTIVE:

This workshop examines the decision to undertake fellowship training. At the conclusions of this workshop, the participants will be able to identify advantages and disadvantages of the practice of consult-liaison, child, geriatric, forensic and public psychiatry, and to understand their own decision-making process.

### SUMMARY:

The practice possibilities in psychiatry are diverse and becoming more so. Psychiatrists, too, vary in their interests, lifestyle goals, and working style, so it's no surprise that the decision of whether to undertake fellowship training is one of the more complex decisions psychiatrists face. This workshop is to help psychiatric residents and established psychiatrists who are considering fellowship training determine whether subspecialty training will meet their needs and further their career goals. Five early career psychiatrists, practicing in child, geriatric, forensic, and consult-liaison psychiatry will discuss their own decision-making process and how they chose their specialty. They will also describe what their daily work is like and what drew them to their current work settings. Finally, they will offer their insight on what was useful to them when making this decision and what they wish they had done differently. After a brief introduction, speakers will take part in a panel discussion of audience questions. There will be ample opportunity to discuss issues related to career choices, subspeciality training, practice opportunities, and professional lifestyles.

### 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 16
## IT DOESN'T HAPPEN TO US: INSIDER'S VIEW OF TRAUMA IN MINORITY COMMUNITIES
**APA/Center for Mental Health Services and APA/ AstraZeneca Minority Fellows**

*Chairperson:* Napoleon B. Higgins, Jr., M.D., *Department of Psychiatry, UTMB Galveston, 301 University Boulevard, Route 0193, Galveston, TX 77555-0193*
*Participants:* Lacresha L. Hall, M.D., Aruna S. Rao, M.D., Jean-Marie Alves-Bradford, M.D., Eric R. Williams, M.D.

### EDUCATIONAL OBJECTIVE:

To recognize unique perceptions and expressions of trauma in African-American, Latino, Asian, and refugee communities in the United States, to learn culturally sensitive alternatives to traditional methods of communication and education, and to enhance outreach efforts to improve care for the minority patient.

### SUMMARY:

The purpose of this talk is to present a novel minority perspective on issues regarding trauma. We will specifically focus on the views of African-American, Latino, Asian, and refugee communities in the United States. Currently, psychiatry is focusing on cross-cultural differences and disparities in treatment, assessment, and diagnosis in minority groups. What makes this talk unique is that it will concentrate on how minority communities view trauma, communicate symptoms, and resist acceptance of mental illness. This talk will discuss obstacles in seeking treatment, such as cultural and language barriers, as well as difficulties in therapeutic alliance between the patient and physician. We will also identify distortions of how mental illness and mental health professionals are viewed by the minority community. Many cultures deny that mental illness occurs in their population and often believe that it is a "White American majority" problem that does not affect them. By the end of the talk, the participant will know how to identify cultural barriers to treatment and facilitate exchange between mental health professionals and the minority community. With this seminar we hope to advance intervention, education, and advocacy for minority populations.

### REFERENCES:

1. Weine S: From war zone to contact zone: culture and refugee mental health services *JAMA*. 2001; 285:1214.
2. Holman E, Silver RC, Waitzkin H: Traumatic life events in primary care patients: a study in an ethnically diverse sample. Archives of Family Medicine 2000; 9:802–810.

## Component Workshop 17
## RACISM: DIAGNOSTIC AND TREATMENT CONSIDERATIONS
**APA Committee of Black Psychiatrists**

*Chairperson:* Michelle O. Clark, M.D. *5248 Village Green, Los Angeles, CA 90016*
*Participants:* Carl C. Bell, M.D., George L. Mallory, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant will have had an opportunity to hear a review of the literature on this subject and to dialogue with experts in the area.

### SUMMARY:

Our component, the Committee of Black Psychiatrists, committed to a continuing discussion of this subject with participants at two previous annual meeting programs (2000 and 2001). We review history and psychiatric opinion on the subject of racism and discuss issues including considerations for evaluation, diagnosis, and treatment of syndromes or situations in which race and racism are at issue.

### REFERENCES:

1. Kupfer DJ, First MB, Regier DA, editors: A Research Agenda for DSM-V, Washington, DC, APPI, 2002.
2. U.S. Department of Health and Human Services: Culture, Race and Ethnicity—a Supplement to Mental Health: A Report of the Surgeon General, Rockville, Md. 2001.

## Component Workshop 18
## ENCOUNTERING THE SPIRITUAL IN PSYCHIATRIC (PSYCHOTHERAPY) PRACTICE
**APA Northern California Psychiatric Society**

*Chairperson:* Kalpana I. Nathan, M.D., *Menlo Park Division Bldg 321, VA Palo Alto Health Care System, 795 Willow Road, Menlo Park, CA 94025*
*Participants:* Randall Weingarten, M.D., Bruce Linenberg, Ph.D., Steven Fisdel, M.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to conceptualize integration of spiritual practices in psychotherapeutic techniques, both in a hospital setting and in private practice, appreciate the essence and phenomena in various religions that create meaning in psychotherapy, explore ways of integrating psychological perspectives of religions in the practice of psychiatry.

### SUMMARY:

This workshop will focus on the interface of religion, spirituality, and psychiatry. The panel will briefly present the psychological perspectives of various religions, including Christianity, Judaism, Hinduism, Islam, and Buddhism, and how this gets translated into psychotherapeutic techniques in creating balance and meaning in an individual's life. The psychotherapeutic approaches, rhetoric (art of persuasion) and hermeneutics (study of meanings) in the context of the power of healing will be explored. The key concepts of forgiveness, acceptance, authenticity, insight, and compassion will be explored, and how we can translate these into our psychiatric practice and bring about effective changes in the lives of those we treat will be elaborated. The dialectical model of change and acceptance and the underlying spiritual principles will be explored. The panel will briefly present the incorporation of spiritual practices such as meditation, prayer, and mindfulness in a day program in a hospital setting such as the Veteran Affairs hospital, as well as in individual psychotherapy, and encourage audience participation in exploring innovative approaches to integrative practice in psychiatry. Participants can present complex clinical situations from their practice for discussion.

### REFERENCES:

1. Koenig HG, Hover M, Bearon LB, Travis JL: Religious perspectives of doctors, nurses, patients and families: Some interesting differences. Journal of Pastoral Care 1991:45: 254–267.
2. Frank & Frank: Persuasion and Healing: A Comparative Study of Psychotherapy, third edition. Johns Hopkins University Press, Baltimore, 1991.

Component Workshop 19
## SEXUAL HARASSMENT: VICTIMS FACE CONFIDENTIALITY ISSUES IN PSYCHIATRIC CARE
**APA Committee on Women**

*Co-Chairpersons:* Rita R. Newman, M.D., *Department of Psychiatry, St. Barnabas Medical Center, 1046 South Orange Avenue, Short Hills, NJ 07078-3131*, Annette J. Hollander, M.D., *247 Sunset Avenue, Englewood, NJ 07631-4414*
*Participants:* Maria T. Lymberis, M.D., David W. Garland, Esq., Francine Weiss, Esq.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the position of the psychiatrist performing consultations and treatment of victims of sexual harassment and the need to explain the issues of confidentiality to the patient so he/she will better understand the legal procedures and possible disclosures in a court of justice.

### SUMMARY:

Attorneys working on both sides, for plaintiff and defendant, in the arena of work discrimination will review what would be most helpful to them as they prepare cases for mediation, settlement, or suit in a court of law. Psychiatrists of the N.J.P.A. Committee on Women have been studying sexual harassment in the workplace for more than 10 years. We have focused on confidentiality as it affects the individual's privacy and willingness to share information with the psychiatrist, knowing that the information and personal history could be accessible to the opposing attorney and the court. Many hesitate to seek psychiatric consultation for sexual harassment, afraid disclosures would cause further humiliation and embarrassment.

From a plaintiff's viewpoint, the more money the plaintiff is seeking, the more disclosure of personal life will be required. Early discussion between plaintiff and psychiatrist becomes necessary so the plaintiff is aware of what disclosure is required in the attempt to receive a large monetary damage award or settlement. At issue is the inherent conflict between the plaintiff's right to privacy and the defendant's right to a fair trial in this post-1994 Amendment to Rule 412 of the Federal Rules of Evidence Period. This workshop will illustrate how the plaintiff's prior psychiatric treatment records and sexual history became crucial.

### REFERENCES:

1. Simon R: The credible forensic psychiatric evaluation in sexual harassment litigation. Psychiatric Annals 1996; 26:3.
2. McDonald R: Forensic aspects of sexual harassment. Psychiatric Clinics of North America 1999; 22:129–45.

Component Workshop 20
## PATIENT SAFETY IN PSYCHIATRY: REDUCING INPATIENT SUICIDE
**APA Committee on Quality Indicators**

*Co-Chairpersons:* Miles F. Shore, M.D., *Harvard University, 76 John F. Kennedy Street, Cambridge, MA 02138*, Alfred Herzog, M.D., *Hartford Hospital, 80 Seymour Street, Hartford, CT 06102-5037*
*Participant:* Paul Quinnett, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the close of this session, the attendee should be able to identify major recommendations of a national patient safety campaign in psychiatry and major elements of a suicide prevention strategy.

### SUMMARY:

In response to a national groundswell to improve patient safety and reduce adverse medical events in all of medicine, the APA Task Force on Patient Safety has delivered major recommendations for psychiatry's concerted attention. Three primary goals are receiving intensive focus: minimized use of restraints and seclusion, reduction of adverse medication events, and reduction of the number of suicides in inpatient/residential settings. This workshop will highlight the major recommendations of APA's patient safety campaign and then examine strategies to reduce inpatient suicides. The presenter will review assessment, reassessment, risk detection, identification of statistically known vulnerabilities, monitoring plans, communication among caregivers, work with the patient's family or support system, and documentation. Attendees may participate through a question-and-answer period following the description of APA goals, plans, and services concerning patient safety and following the description of elements of suicide-prevention plans. This workshop is geared to physicians practicing in hospital or residential settings; however, elements of the presentation may be helpful to professionals who practice in outpatient settings as well.

### REFERENCES:

1. Report of Task Force on Patient Safety: American Psychiatric Association, Approved by Board of Trustees 2002.
2. Reducing Suicide: A National Imperative, National Academy of Sciences, National Academy Press, Washington, D.C., 2002.
3. Preventing Patient Suicides, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, 2000.

Component Workshop 21
## NEW APA ETHICS PROCEDURES: IMPLICATIONS FOR THE PROFESSION, PART 2
**APA Ethics Committee and APA Ethics Appeal Board**

*Chairperson:* Wade C. Myers, M.D., *Department of Psychiatry, University of Florida, P.O. Box 100234/JHMHC, Gainesville, FL 32603*
*Participants:* William Arroyo, M.D., Harriet C. Stern, M.D., Donald G. Langsley, M.D., Spencer Eth, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the new APA ethics procedures and their implications for members and district branches.

### SUMMARY:

This workshop is the second of a two-part workshop on new APA ethics procedures sponsored jointly by the APA Ethics Appeals Board (Part 1) and the APA Ethics Committee (Part 2). The area of profession ethics in psychiatry has been a rapidly evolving area of late. This workshop, in coordination with Part 1 presenters, will continue the presentation of the status of new, recent, and proposed ethics procedural changes including the "educational option," a statute of limitations for ethics complaints, conclusion of a case without a finding, and stipulated agreements. Following brief presentations, panel members representing the APA Ethics Committee, district branches, and the Task Force on Ethics Regulation and Enforcement will facilitate audience discussion of these area. Attendees' discussions of how these new and proposed changes affect or might affect their district branch's ethics process will be a particularly valuable learning opportunity for those in attendance. Additionally, current and past chairs of the APA Ethics Committee and district branch ethics committees will be encouraged to attend, as will district branch executive directors, further enriching the learning environment.

REFERENCES:

1. American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, APA Press, Washington, DC, 2001.
2. American Psychiatric Association Ethics Committee: Discussion of the Procedures for Handling Complaints of Unethical Conduct, APA, Washington DC, 2001.

## Component Workshop 22
## AIDSISM, AGEISM, RACISM: PSYCHIATRIST'S ROLE IN THE GERIATRIC AIDS EPIDEMIC
## APA New York County District Branch's AIDS Committee

*Co-Chairpersons:* Kenneth B. Ashley, M.D., *Department of Psychiatry, Beth Israel Hospital, 85 East 10th Street, #1F, New York, NY 10003-5407*, Mary Ann Cohen, M.D., *Mt Sinai Medical Center, 220 West 93rd Street #14A, New York, NY 10025-7413*
*Participants:* Kristina L. Jones, M.D., John A.R. Grimaldi, Jr., M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the association of mental illness and HIV risk in the older adult psychiatric population, to recognize risky behaviors, and to educate patients, families and other clinicians to prevent the transmission of geriatric AIDS.

### SUMMARY:

The rate of HIV infection was found to be triple in persons with schizophrenia and quadruple in persons with affective disorder compared with those without serious mental illness. The prevalence of geriatric AIDS is now estimated to be 15% of the total cumulative AIDS population in the United States. Most older AIDS patients are African American or Latino. The hidden nature of the geriatric AIDS epidemic may be a result of AIDSism, ageism, and racism, as well as the high prevalence of serious mental illness.

Persons with geriatric AIDS present late and have rapid progression, multiple medical and psychiatric illnesses, and higher mortality rates. Most older people do not consider themselves at risk for AIDS. Their physicians may not consider them to be at risk either and may feel uncomfortable taking sexual or drug histories or older patients.

Psychiatrists have long-term, nonjudgmental, trusting relationships with patients. They routinely take sexual and drug histories and encourage behavior change. They can also recognize and address cognitive impairment or other psychiatric disorders that can lead to risky behaviors. The panel will discuss the role of the psychiatrist in the education of patients, families, and other clinicians to help prevent transmission of geriatric AIDS and in the identification and treatment of those who are infected will HIV. Audience members will be encouraged to compare these observations with their experiences treating older patients and HIV-infected patients.

### REFERENCES:

1. Funnye AS, Abbasi JA, Biamby G: Acquired immunodeficiency syndrome in older African Americans. J Natl Med Assoc 2002; 94:209–214.
2. Blank MB, Mandell DS, Aiken L, Hadley TR: Co-occurrence of HIV and serious mental illness among Medicaid recipients. Psychiatric Services 2002; 53:868–873.

## WEDNESDAY, MAY 21, 2003

## Component Workshop 23
## WOMEN'S LEADERSHIP 101
## APA Committee on Women

*Co-Chairpersons:* Caroline E. Fisher, M.D., *University of Mass Medical School, 55 Lake Avenue North, Worcester, MA 01655*, Jodi E. Star, M.D., Department of Psychiatry, *University of Florida, 5648 South West, 104th Terrace, Gainesville, FL 32608*
*Participants:* Leslie H. Gise, M.D., Donna M. Norris, M.D., Marcia K. Goin, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify several factors that influence career advancement for women psychiatrists and learn strategies to advance their own career, promote themselves within their field, and assume leadership positions.

### SUMMARY:

The glass ceiling is not only a problem for corporate women, it is a reality in medicine as well. Despite the fact that women currently comprise 42% of medical school graduates, women physicians continue to be underrepresented in positions of authority and leadership and to earn less than their male counterparts. Many women physicians, especially early in their careers, may lack the tools, background, and experience necessary to advance in their career path. In this workshop, a member-in-training, an early career psychiatrist, and three established women leaders give their perspective on ways to overcome the unique challenges that women face in their quest for access to positions of leadership. Using personal and professional experiences, presenters will elucidate "what counts" to progress and succeed in a career in psychiatry. Topics include how to seek out and get good mentoring, how to obtain leadership experience in each stage of your career, how to network, how to get training in skills you may not have learned in medical school (like public speaking, managing people, and managing projects), how to develop your qualifications for leadership positions, and how to find leadership positions and put yourself in them. There will also be time to discuss your own questions and concerns and strategize with the presenters about specific situations.

### 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. 1999 Socio-economic Monitoring System Survey, AMA Center for Health Policy Research. Chicago IL, 1999.

## Component Workshop 24
## GREAT EXPECTATIONS: INTEGRATING MIND AND BRAIN IN RESIDENT TRAINING
## APA/GlaxoSmithKline Fellows

*Co-Chairpersons:* Jodi J. Gold, M.D., *New York Presbyterian (Cornell), 1320 York Avenue #31Z, New York, NY 10021*, Rebecca Brendel, M.D., *McLean/Mass General Hospital, 115 Mill Street, Belmont, MA 02478*
*Participants:* Abigail B. Schlesinger, John W. Grace, Alec O. Oskin

## EDUCATIONAL OBJECTIVES:

The participants will appreciate the stated training objectives of residency training programs as they pertain to being a well integrated psychiatrist i.e., combining biological and psychological modalities competently, the perceived desire, competency and reality of practicing as an integrated psychiatrist in the 21st century, and how multiple factors such as didactics, role models, geography, managed care, and economics impact resident perceptions.

## SUMMARY:

Psychiatry continues to become more diverse and complex, with increasing emphasis placed on incorporating the biopsychosocial model in the assessment and treatment of mental illness. One trend in psychiatric training is for programs to develop core competencies in biological and psychological modalities. The implication is that well-rounded trainees will practice psychiatry that fully integrates the sciences of mind and brain. If the goal is to create a fully integrated psychiatrist then it should be evident in training objectives and resident perspectives.

We will examine expectations of residents in developing the ability to practice psychiatry. We will survey residents at approximately 16 residency programs in the United States and Canada. The survey will collect data on residents' perceptions regarding desire, ability and feasibility to practice psychiatry in a way that fully integrates biological and psychological approaches. The survey will attempt to identify the factors that influence these perceptions.

The workshop will be directed at trainees, residency directors, and those who are interested and involved in training psychiatrists. At the workshop, we will briefly present the history of the integrated residency training program and review a cross-section of residency training missions in 2003. We will compare stated residency missions with resident survey responses, and examine factors that affect resident perspectives. There will be a discussion of the perceived incentives and obstacles to training and practicing as an integrated psychiatrist.

## REFERENCES:

1. Gabbard GO, Gunderson JG, Fonagy P: The place of psychoanalytic treatments within psychiatry. Arch Gen Psychiatry 2002; 59:505–10.
2. Kandel ER: Biology and the future of psychoanalysis: a new intellectual framework for psychiatry revisited. Am J Psychiatry 1999; 156:505–24.
3. Luhrmann TM: Of Two Minds: The Growing Disorder in American Psychiatry. Alfred Knopf, New York, 2000.

## Component Workshop 25
## PATIENT SAFETY IN PSYCHIATRY: REDUCING ADVERSE MEDICATION EVENTS
## APA Task Force on Patient Safety

*Co-Chairpersons:* Alfred Herzog, M.D., *Hartford Hospital, 80 Seymour Street, Hartford, CT 06102-5037,* Miles F. Shore, M.D., *Harvard University, 76 John F. Kennedy Street, Cambridge, MA 02138*
*Participant:* John W. Goethe, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the elements of a patient safety/quality improvement system that support clinical decision making, help prevent prescribing errors, and collect data for purposes of improving patient care within a psychiatric unit, hospital or office.

## SUMMARY:

In response to a national groundswell to improve patient safety and reduce adverse medical events in all of medicine, the APA Task Force on Patient Safety has delivered major recommendations for psychiatry's concerted efforts. Three primary goals are receiving intense attention: minimized use of restraints and seclusion, reduction of the number of suicides in inpatient/residential settings, and reduction of adverse medication events. This workshop will highlight the major recommendations of the APA's patient safety campaign and opportunities to reduce adverse medication events. The current trend emphasizes automation, handheld devices that can reduce errors related to prescription writing and drug interactions, or installation of computerized physician order entry (CPOE) systems by large hospitals. The financial investment required for CPOEs is not yet available to many psychiatric facilities. The workshop gives primary focus to a description of a more affordable PC-based program that simultaneously offers clinical decision support for individual physicians and streamlined data entry and practice evaluation for a hospital and its quality assurance teams. Attendees may participate through a question-and-answer period following the description of APA goals, plans, and services concerning patient safety and following the description of the combined clinical decision support/practice evaluation system. This workshop is geared to physicians practicing in hospital, residential, or outpatient settings.

## REFERENCES:

1. Report of Task Force on Patient Safety, American Psychiatric Association. Approved by Board of Trustees 2002.
2. Bates DW: Frequency, consequences and prevention of adverse drug events, Journal of Quality Clinical Practice 1999; 19:13–17.
3. Bates DW, Leape LL et al: Effect of computerized physician order entry and a team intervention on prevention of serious medical errors. JAMA 1998; 280:1311–1316.
4. Goethe JW, Schwartz HI, Szarek BL, Physician compliance with practice guidelines. Connecticut Medicine 1997; 61(9):553–558.

## Component Workshop 26
## WHAT IS THE ETHICAL STANCE? ISSUES RELATED TO WORLD PSYCHIATRY AND COURTS
## APA Council on Psychiatry and Law and APA Committee on Judicial Action

*Chairperson:* Jeffrey L. Metzner, M.D., *Department of Psychiatry, University of Colorado, 3300 East First Avenue, Suite 590, Denver, CO 80206-5808*
*Participants:* Alan A. Stone, M.D., Renee L. Binder, M.D., Richard Bonnie, L.L.B.

## EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to discuss the ethical and legal issues related to APA's support of various documents and a legal case.

## SUMMARY:

The APA Council on Psychiatry and Law and the Committee on Judicial Action are often asked to review the legal and ethical implications for APA's involvement in a variety of issues. This component workshop will discuss three of these issues: the Declaration of Madrid, the WHO Manual on Mental Health Legislation, and a legal case. The WPA's Declaration of Madrid was endorsed by APA, with many substantial qualifications. For example, the Madrid standards endorsed the right to refuse treatment unless refusal endangered the life of the patient or others. If this legal standard were applied in the U.S. patients would be allowed to deteriorate. The Madrid Declaration will be cited in future litigation to the detriment of psychiatric patients. The World Health Organization has distributed a draft of a Manual on Mental Health Model Legislation for all the countries of the world. This document supports massive legal due-process rights and review, but does not address the scarcity of psychiatrists and mental health professionals and vast poverty of many

countries. The Committee on Judicial Action reviewed a request from a state psychiatric association to support an amicus brief in a case involving the alleged firing of a physician for refusing to breach professional medical ethics. The case has implications for employment in managed care organizations.

## REFERENCES:

1. WHO: Draft Manual on Mental Health Legislation.
2. WPA: The Madrid Declaration on Ethical Standards for Psychiatric Practice.

## Component Workshop 27
## TEACHING COMPETENCE IN PSYCHOTHERAPY TO RESIDENTS: ARE FACULTY COMPETENT?
## APA Committee on Psychotherapy by Psychiatrists

*Chairperson:* Lisa A. Mellman, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*
*Participants:* Jerald Kay, M.D., David A. Goldberg, M.D., Joanna E. Steinglass, M.D., Jennifer K. Coffman, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) recognize the ACGME regulations requiring residents to be competent in five types of psychotherapy 2) define competence in faculty 3) describe methods of assessing faculty competence 4) recognize problems faculty have developing competence 5) describe models of faculty development.

## SUMMARY:

The Accreditation Council of Graduate Medical Education (ACGME) requirements that psychiatry residencies demonstrate their residents are competent in five specified psychotherapies places a substantial responsibility on faculty to teach for competence. Residency training programs have begun defining psychotherapy competencies and determining methods for assessing them in their residents. Yet residents and others voice concern about whether faculty are competent to teach these five psychotherapies, placing the lens of scrutiny on teachers and supervisors. Although residency training programs are required to evaluate the performance of faculty, many do not systematically review supervision, and most have not assessed faculty for their ability to teach for competence in psychotherapy.

In this workshop presenters will 1) briefly review the new regulations requiring residencies to teach residents competency in five specified psychotherapies, 2) define competence in faculty, 3) describe methods for assessing the performance of faculty, 4) present the findings of a survey of residents evaluating the competence of their teachers and supervisors, 5) discuss common problems faculty have in developing competence, and 6) present models for faculty development in teaching psychotherapy.

## REFERENCES:

1. Jacobs D, David P, Meyer DJ: The Supervisory Encounter: A Guide for Teachers of Psychodynamic Psychotherapy and Psychoanalysis. Yale Univ Press, 1995.
2. Beresin E, Mellman L: Competencies in psychiatry: the new outcomes-based approach to medical training and education. Harvard Rev Psych 2002; 10:185–91.

## Component Workshop 28
## GLOBAL TRAUMA: EXPERIENCE AND IMPLICATIONS FOR DSM-V
## APA Council on Global Psychiatry

*Co-Chairpersons:* Arthur M. Kleinman, M.D., *Harvard University, 330 William James Hall, 33 Kirkland St, Cambridge, MA 02138-2044*, Harold I. Eist, M.D., *10436 Snow Point Drive, Bethesda, MD 20814*
*Participants:* Robert J. Ursano, M.D., Lars Weisaeth, M.D., Arieh Y. Shalev, M.D., Elie G. Karam, M.D., Raphael Beverley, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants should recognize the multiple stress-related effects of trauma and identify populations must vulnerable to such disorders. In addition participants should recognize the impact this information will have on the revisions the DSM will be undergoing in the future.

## SUMMARY:

This workshop will highlight the work of international research investigators in the field of trauma and its mental health consequences. Among the study populations to be presented are those exposed to chronic wartime stress and terrorism, hostage situations, and torture. The multiple clinical manifestations of stress-related mental disorders will be discussed, including onset, course, and long-term outcomes. Aspects of risk and resilience that place individuals at higher or lower risk for stress-related disorders will be presented. Finally, implications of this work for revisions of the DSM and ICD diagnostic classifications will be discussed.

## REFERENCES:

1. Norwood AE, Ursano RJ, Fullerton CS: Disaster psychiatry: principles and practice. Psychiatr Q. 2000; 71:207–26.
2. Ursano RJ, McCaughey, Fullerton CS, ed.: Individual and Community Responses to Trauma and Disaster. The Structure of Human Chaos., Cambridge, MA, Cambridge University Press, 1995.

## Component Workshop 29
## TRAUMA AND HOMELESSNESS: PSYCHIATRIC ASPECTS OF A SOCIOECONOMIC PROBLEM
## APA Northern California Psychiatric Society

*Co-Chairpersons:* Adam P. Nelson, M.D., *Psychiatric Foundation, 1030 Sir Francis Drake, Suite 120-3, Kentfield, CA 94904*, Byron J. Wittlin, M.D., *VA Out-Patient Clinic, 205 13th Street, San Francisco, CA 94103*
*Participants:* Mary K. Connor, Jean A. Marsters, M.D., Robert A. Rosenheck, M.D.

## EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participant will be able to: recognize the diagnosis of post-traumatic stress disorder and other stress-related disorders as underdiagnosed entities among homeless persons, describe the relationship between stress-related disorders and other comorbid conditions, including mental illness and substance abuse, in homelessness, identify clinical, social, and political issues and treatment implications of psychiatric disorders in a homeless population.

## SUMMARY:

Psychiatrists have a new place to practice, and it isn't a hospital, clinic, or a private office. It's the streets, the shelters, the single-room occupancy hotels, the temporary encampments, or wherever one finds those who are homeless. In the United States, homelessness is on the rise, both in prevalence and visibility. Until now, the problem has been regarded as one of poverty and substance abuse,

and accepted approaches to solving the problem have reflected this thinking. Recently, new data are starting to shift our thinking about etiologies of homelessness. Not surprisingly, several studies have shown a correlation between homelessness and exposure to trauma, leading to much higher than average incidence of comorbid mental disorders, including PTSD, mood disorders, anxiety disorders, psychotic disorders, personality disorders, and substance abuse. However, more recently, studies, including ours, have identified psychological and neuropsychiatric relationships between exposure to premorbid trauma, typically severe, repetitive, and either violent or sexual, and eventually becoming homeless and permanently disabled. In this workshop we will review recent statistics on homelessness and examine risk factors, relationship to trauma, and implications for treatment approaches and public health policies.

## REFERENCES:

1. Goodman L, Saxe L, Harvey M: Homelessness as psychological Trauma Broadening Perspectives. Am Psychol 1991; 46:1219–25.
2. Rosenheck R, Fontana A: A model of homelessness among male veterans of the Vietnam War generation. Am J Psychiatry 1994; 151:421–7.

## Component Workshop 30
## UNITED WE STAND: DEVELOPING PARTNERSHIPS FOR PATIENT ADVOCACY
### APA Committee on Public Affairs and APA Committee on Government Relations

*Chairperson:* Mary H. Davis, M.D., *Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232-5070*
*Participants:* Jeffrey Akaka, M.D., John Bush, Judith F. Kashtan, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize models of successful coalition building and be able to develop strategies to apply in their community; identify allied groups and their resources with respect to advocacy; and develop an action plan for public policy and member participation specific to their state association.

## SUMMARY:

This session is designed for any professional interested in patient advocacy and coalition building. It would be especially useful for district branch public affairs representatives, legislative representatives, DB presidents, president-elects, early career psychiatrists, as well as members in training interested in community advocacy. Successful advocacy programs and projects will be reviewed. Resource materials will be provided to participants. Perspectives from patient advocacy groups will be provided on issues that unite and divide. Participants will have the opportunity to describe needs in their community, with discussion on strategies to approach and resolve problems.

## REFERENCES:

1. Cutler J: The Legislative Representative Handbook: A Guide to Grassroots Advocacy
2. Rodman R: Dance of Legislation

## Component Workshop 31
## CPT CODING AND DOCUMENTATION UPDATE
### APA Committee on RBRVS, Codes, and Reimbursements

*Co-Chairpersons:* Chester W. Schmidt, Jr., M.D., *Department of Psychiatry, 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.

## EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participants will: 1) be knowledgeable about current Medicare coding changes, 2) updated about Medicare reimbursement concerns, 3) have their questions about coding and reimbursement answered.

## SUMMARY:

The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding, and current issues associated with documentation guidelines. This years workshop will focus on 1) child/geriatic coding problems, 2) development of a model local medical reimbursement policy, 3) a review of current Medicare reimbursement issues and concerns, and 4) documentation guidelines for evaluation and management codes. Time will be reserved for questions and comments by the participants and problems faced by the participants in their own practices.

## REFERENCES:

1. American Medical Association: CPT 2002. Chicago, Illinois.
2. Schmidt CW: CPT Handbook for Psychiatrists, 2nd edition, Washington, D.C., American Psychiatric Press, 1999.

## Component Workshop 32
## RETIREMENT ISSUES FOR PSYCHIATRISTS AND THEIR SPOUSES
### APA Lifers and APA Task Force on Senior Psychiatrists

*Chairperson:* Hugh C. Hendrie, M.D., *Indiana University Center for Aging Research, Regenstrief Institute, 1050 Wishard Boulevard - RG6, Indianapolis, IN 46202*
*Participants:* Irvin M. Cohen, M.D., Mary Austrom, Ph.D., Captane P. Thomson, M.D.

## EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participants will understand the challenges opportunities and benefits associated with retirement; recognize the predictors of life satisfaction for retirees; appreciate the different perspectives and expectations of retirement between physicians and spouses.

## SUMMARY:

This workshop is designed for retired psychiatrists, those contemplating retirement, and their spouses. The faculty will present topics relating to three main themes; the experiences, the challenges, and the predictors of life satisfaction of retired physicians; the corresponding and in many respects quite different responses from the spouses of retired physicians; and the opportunities available to senior psychiatrists considering a career change. The presentations are based on the results of three large surveys of retired physicians and their spouses involving more than 2,000 physicians and more than 1,000 spouses. These included a national survey of orthopedic surgeons, a survey of Texas physicians, and a survey of a multi-specialty group of Indiana University alumni. These collectively

represent the largest existing database of the opinions of retired physicians and their spouses. This highly interactive workshop will include three presentations addressing the main themes. Audience participation is encouraged throughout these presentations. It is hoped that this workshop will act as a springboard for the proposed APA survey on senior psychiatrists and their spouses sponsored by the APA Lifers and the APA Task Force on Seniors Psychiatrists, which will be launched at this meeting. Questionnaires for this survey will be distributed at the workshop.

## REFERENCES:

1. Ritter MA, Austrom MG, Zhou H, Hendrie HC: Retirement from orthopaedic surgery. Journal of Bone and Joint Surgery 1999; 81A:414–418.
2. Lees E, Liss SE, Cohen IM, et al: Emotional impact of retirement on physicians. Texas Medicine 2001; 97:66–71.

## Component Workshop 33
## STATE OF THE STATES FOR STATE HOSPITAL PSYCHIATRISTS
## APA Caucus of State Hospital Psychiatrists

*Co-Chairpersons:* Beatrice M. Kovasznay, M.D., *Department of Forensic Affairs, New York Office of Mental Health, 44 Holland Avenue, First Floor, Albany, NY 12229*, Yadollah M. Jabbarpour, M.D., *Office of the Chief of Staff, Catawba Hospital, PO Box 200, Catawba, VA 24070*
*Participants:* Thomas W. Hester, M.D., Perry B. Bach, M.D., Anita Everett, M.D., Wayne F. Brown, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the issues facing state hospital psychiatry in a time of many changes and learn successful strategies for addressing these issues.

## SUMMARY:

The role of state hospitals in the spectrum of mental health services has changed dramatically across the country in recent years. Along with these changes, the role of state hospital psychiatrists has also changed. We have had to adapt to a changing mission, a changing patient population, and increasing accountability to nonclinical administrators and politicians. We have increased interface with the private sector in the form of managed care and contract-based care, and we have increased interface with the criminal justice system.

In this workshop we will discuss how specific states have handled these changes. There will be specific examples from four states, Virginia, Hawaii, Colorado, and Utah. A panel discussion will follow, with a focus on strategies for dealing with change. Audience participation is encouraged.

## REFERENCES:

1. Fisher WH, Barreira PJ, Geller JL, et al: Long-stay patients in state psychiatric hospitals and the end of the 20th century. Psychiatric Services 2001; 52:1051–1056.
2. Mowbray CT, Grazier KL, Holter M: Managed behavioral health care in the public sector: will it become the third shame of the states? Psychiatric Services 2002; 53:157–170.

## Component Workshop 34
## DEPRESSIVE DISORDERS AND HISPANICS: A DEVELOPMENTAL PERSPECTIVE
## APA Committee of Hispanic Psychiatrists

*Co-Chairpersons:* Ana E. Campo, M.D., *University of Miami, 4330 Surrey Drive, Coconut Grove, FL 33133*, Oscar E. Perez, M.D., *1400 North El Paso Street, Building A, El Paso, TX 79902*
*Participants:* Daniel Castellanos, M.D., Sayonara Baez, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the epidemiological, clinical characteristics of depressive disorders in Hispanic youth, adults and the elderly, identify the social and cultural factors that are associated to depressive disorders in Hispanic children and adolescents, adults and the elderly.

## SUMMARY:

Hispanics are the largest minority in the United States. Mental health issues among Hispanics have been traditionally overlooked and understudied. Depression is one of the most common clinical conditions among all ethnic groups. This workshop will address the state of our knowledge regarding depressive disorders among Hispanic children and adolescents, adults, and the elderly. Current research regarding the epidemiology of depressive disorders among Hispanics across the life cycle will be reviewed. Clinical characteristics specific to the Hispanic population will also be explored. Pertinent sociocultural factors, assessment techniques, and skills unique to working with this population will be addressed. The impact of cultural beliefs on psychiatric treatment, expression of symptomatology, and accessing care will be addressed in the discussion. The interchange with the participants will be enhanced by presentation of case material for each age group. Implications for clinical practice will be emphasized.

## REFERENCES:

1. U.S. Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.
2. Hough RL, Landsverk JA, Karno M, et al: Utilization of mental health services by Los Angeles Mexican Americans and non-Hispanic whites. Archives of General Psychiatry 1987; 44:702–709.

## Component Workshop 35
## WHY PSYCHIATRY? SAYS MOM
## APA Committee of Asian-American Psychiatrists

*Co-Chairpersons:* John S. Luo, M.D., *Department of Psychiatry, University of California Davis Health Systems, 2230 Stockton Boulevard, Sacramento, CA 95817*, Surinder S. Nand, M.D., *Psychiatric Services, VA Chicago Health Care Systems, 820 S Damen, Chicago, IL 60612*
*Participants:* Mona H. Gill, M.D., Sue Lee, M.D., Mary Ann Barnovitz

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the individual, family, cultural, and community factors that influence the choice of psychiatry as a specialty among Asian Americans. This workshop will propose solutions to overcome these barriers.

SUMMARY:

Asian Americans and Pacific Islanders are a large proportion of medical students in the United States. Less than 4% of medical students select psychiatry as their career choice, and an even smaller percentage of these students are Asian Americans. There are a number of factors that contribute to the trend among Asian Americans. These include individual perceptions and experiences with mental health as well as family influences and pressures regarding career choice. In addition, cultural and community factors also play a significant role.

Participants in this workshop will hear reflections from a panel consisting of a medical student, resident physician, and practicing psychiatrist on the individual, familial, cultural, and community factors that contribute to the barriers in choosing psychiatry as a profession. Discussion will address the barriers and provide solutions to changing this trend, which impacts the ability of the profession to provide culturally competent care.

REFERENCES:

1. Gurel L: Some characteristics of psychiatric residency training programs. Am J Psychiatry 1975; 132:363–72.
2. Lee EK, Kaltreider N, Crouch J: Pilot study of current factors influencing the choice of psychiatry as a specialty. Am J Psychiatry 1995; 152:1066–9.

## Component Workshop 36
## CLINICAL ISSUES OF ETHNIC DIVERSITY IN LONG-TERM CARE FACILITIES
## APA Committee on Ethnic Minority Elderly

*Co-Chairpersons:* Ronald Brenner, M.D., *St. John's Episcopal Hospital, 327 Beach 19th Street, Far Rockaway, NY 11691-4423*, Josepha A. Cheong, M.D., *Department of Psychiatry, University of Florida Health Science Center, PO Box 100256, Gainesville, FL 32610-0256*
*Participants:* Iqbal Ahmed, M.D., Warachal E. Faison, M.D., Mia J. Robinson, Ella Brodsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and address the various issues pertinent to the care of ethnically diverse patient populations in the long-term-care facility settings. Specific issues addressed are language, diet, clothing, religion, and recreation.

SUMMARY:

The need to develop sensitivity to cultural and ethnic factors that affect the health care of the elderly is essential. More than 30 different cultures and origins are represented in long-term-care settings nationally. The ethnic minority elders include migrants and immigrants who have moved here from abroad and are often subject to difficulties because of limited English-speaking skills. Ethnic minority elderly share many of the same needs as those in the dominant culture; however, many have different and additional needs. Researchers have found that cultural needs are expressed in the "desire to have meals with the familiar taste, to listen to music with familiar cadences, to have access to and contact with the religious world that has long sustained and comforted them, and to be able to enjoy books, magazines, and films that speak of things familiar and reassuring" (Pensabrene and Wilkinson). Cultural care for the elderly in nursing homes is essential for health, well-being, growth, and survival. This workshop focuses on issues particular to the care of ethnic minority elderly in the long-term setting by reviewing a pilot survey to better understand the issues and propose potential solutions.

REFERENCES:

1. Mintzer JE, et al: Daughters caregiving for Hispanic and non-Hispanic Alzheimer patients: does ethnicity make a difference? Comm Mental Health J. 1992; 28:4.
2. Barney KF: From Ellis Island to assisted living: meeting the needs of older adults from diverse cultures. Am J Occupational Therapy 1991; 45:586–593.

## Component Workshop 37
## IMPLICATIONS OF FINANCING OF HEALTH CARE FOR PSYCHIATRIC EDUCATION AND PRACTICE
## APA Council on Healthcare Systems and Financing

*Chairperson:* Barry F. Chaitin, M.D., *Department of Psychiatry, University of California - Irvine, 101 The City Drive, Orange, CA 92868-3298*
*Participants:* Nyapati R. Rao, M.D., Bruce J. Schwartz, M.D., Frederick J. Stoddard, Jr., M.D., Allison M. Wehr, M.D., Rebecca Brendel, M.D., Joyce A. Tinsley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the financing of residency education and current residency requirements; be aware of the potential effects changes in health care financing have on training; the potential disconnect between training and future practice.

SUMMARY:

The workshop will outline the status of the financing of residency training requirements and explore the potential effects of changes in health care financing on these underpinnings of residency training. It will also look at the experience of current residents working in a health care system under considerable stress. The workshop will also try to identify future health care systems trends, their impact on residency training, and future roles of psychiatrists.

REFERENCES:

1. Hoge MA, Jacobs SC, Belitsky R: Psychiatric residency training, managed care, and contemporary clinical practice. Psychiatric Services 2000; 51:1001–5.
2. Panzarino PJ Jr.: Psychiatric training and practice under managed care. Adm Policy Ment Health 2000; 28:51–9.

## Component Workshop 38
## INTERSEX CONDITIONS: CONTROVERSIES AND NEW APPROACHES TO TREATMENT
## APA Committee on Gay, Lesbian, and Bisexual Issues

*Chairperson:* Richard O. Hire, M.D., *344 West 23rd Street, Apartment 1B, New York, NY 10011-2215*
*Participants:* Jack Drescher, M.D., Benjamin H. McCommon, Jr., M.D., Vernon A. Rosario, M.D.

EDUCATIONAL OBJECTIVES:

The participant will be able to identify intersex conditions and the common issues that arise for the affected individuals. The participant will understand the traditional approach to management of this condition as well as understand new approaches.

SUMMARY:

Intersex conditions occur when external genitalia, internal sex organs, and chromosomal sex are not in concordance due to a variety of medical situations. The historical approach to treatment focused on early surgical intervention and unambiguous gender assignment. Recent research along with the accounts of adult intersex individuals

have challenged this historical approach. The historical approach and recent scientific evidence challenging this approach will be presented. New models of treatment that emphasize family and patient participation in decision making will be discussed. These new models highlight an important role for mental health professionals in the management of intersex conditions. Finally, key issues that arise in the treatment of an intersex person will be discussed using a clinical case presentation.

The workshop is for clinicians who treat patients with intersex conditions or their family members, who educate clinicians, and other interested clinicians. Audience members will be encouraged to share their expertise in treating intersex individuals and to ask questions about this condition and its treatment.

REFERENCES:

1. Diamond M, Sigmundson HK: Sex reassignment at birth: long-term review and clinical implications. Arch Pediatr Adolesc Med 1997;151:298–304.
2. Schober JM: Long-term outcomes and changing attitudes to intersexuality. BJJ International 1999; 83(suppl 3):S39–S50.

## THURSDAY, MAY 22, 2003

### Component Workshop 39
### NEVER-TAUGHT DILEMMAS: WHEN WORK AND DISABILITY ISSUES IMPACT PATIENT CARE
### APA Corresponding Committee on Psychiatry in the Workplace

*Co-Chairpersons:* Steven E. Pflanz, M.D., *FE Warren AFB USAF, 68A Fort Warren Avenue, Cheyenne, WY 82001,* Marcia A. Scott, M.D., *19 Sibley Court, Cambridge, MA 02138*
*Participants:* Daniel B. Borenstein, M.D., Jacquelyn B. Chang, M.D., Harry Prosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the critical issues involved in fitness for duty and disability evaluations and develop the skills necessary to conduct these evaluations.

SUMMARY:

The challenges of fitness for duty and disability are vital issues for today's workplace that are often not covered in psychiatric training. Work, work-related benefits (disability, workers' compensation) and work regulations (ADA, FMLA, employment contracts) impact the course of psychiatric illness and treatment and the patient's life decisions. These are inescapable issues (both conscious and unconscious) in the relationship and discourse between patient and psychiatrist, whether treatment consists of psychotherapy or psychopharmacology. Psychiatrists are also referred cases for the evaluation of worker fitness for duty, eligibility for benefits or job protection under the ADA or FMLA. Attendees will understand how employment regulations and benefit contracts affect treatment and patient decisions. They will be better able to evaluate work issues and work function in the setting of psychiatric illness, make disability and return-to-work recommendations, anticipate the impact of work and work withdrawal on treatment and recovery, anticipate the consequences of disability recommendations on the individual's future, and deal with issues of documentation and privacy when they treat patients. They will be more equipped to make work recommendations to patients, employers, and policy makers. The formal presentations will brief and focused so that the majority of the workshop can be dedicated to a discussion of the challenges and pitfalls of fitness for duty and disability evaluations.

REFERENCES:

1. Scott M, Harnett CA: Psychiatrists in the workplace. Psych Annals 1995; 25:224–228.
2. Pflanz SE: Psychiatric illness and the workplace: perspectives for occupational medicine in the military. Milit Med 1999; 164:401–406.

### Component Workshop 40
### SUMMARY OF THE SURGEON GENERAL'S MEETING ON HEALTH OF THE MENTALLY RETARDED
### 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:* Carl B. Feinstein, M.D., Paula J. Lockhart, M.D., Stephen B. Corbin, D.D.S., Timothy Shriver, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the diagnostic criteria for mental retardation (MR), conditions for which MR is part of the diagnosis, and know health disparities in the mentally retarded.

SUMMARY:

Mental retardation (MR) is a condition in which the individual suffers from functional limitations as a result of an intelligence quotient (IQ) of less than 70. This affects hundreds of thousands in this country. Despite these numbers, these individuals receive a disproportionately small amount of the resources allocated to health care. Among other disparities, mentally retarded persons suffer from dental problems, abuse, and obesity at far higher rates than the general population. In 2002, the U.S. Surgeon General generated a report outlining the health disparities of the mentally retarded and recommendations for closing these gaps. In this workshop, Dr. Feinstein will describe the diagnostic criteria for MR and discuss a number of conditions that cause it. Dr. Lockhart will present the disparities mentally retarded individuals face in obtaining mental health care, and Dr. Corbin will describe those for medical and dental care. Dr. Shriver will conclude by presenting the role of psychiatrists and other medical and mental health professionals in providing services to and advocating for the mentally retarded. Each discussant will use 15 minutes. As chairperson of this workshop, Dr. Dryden-Edwards will introduce each presenter and facilitate discussion.

REFERENCES:

1. Closing the Gap: A National Blueprint to Improve the Health of Persons With Mental Retardation, Report of the Surgeon General's Conference on Health and Human Services, 2002.
2. Feinstein C, Reiss A: Psychiatric disorders in mentally retarded children and adolescents, In F. Volkmar (Ed) Child and Adolescent Psychiatric Clinics of North America, October 1996.

### Component Workshop 41
### THE ADMINISTRATIVE PSYCHIATRY CREDENTIAL
### APA Committee on Psychiatric Administration and Management

*Chairperson:* Stuart B. Silver, M.D., *4966 Reedy Brook Lane, Columbia, MD 21044-1514*
*Participants:* Paul Rodenhauser, M.D., S. Atezaz Saeed, M.D., Veena Garyali, M.D., Beth Ann Brooks, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, the participant should be able to discuss the value and process of obtaining the APA certificate in

administrative psychiatry and understand approaches to preparation for the examination process.

## SUMMARY:

The APA Committee on Psychiatric Administration and Management will describe the purpose and process of APA certification, as well as the knowledge candidates are expected to possess in four main areas of mental health system management: administrative theory and human resources, law and ethics, budget and fiscal management, and psychiatric care management. This session is for psychiatrists who are applying, or considering application, for APA Certification in Psychiatric Administration and Management. The administrative psychiatry examination is given yearly in conjunction with the APA Annual Meeting.

## REFERENCES:

1. Information Bulletin for Applicants: 20th Edition; Committee on Psychiatric Administration and Management, APA, Washington, DC.
2. Rodenhauser P: Mental Health Care Administration: A Guide for Practitioners, Ann Arbor, U of Michigan Press, 2000.

Component Workshop 42

### PRACTICING REWARDING PSYCHIATRY IN JAILS AND PRISONS: A PRACTICUM
### APA Caucus of Psychiatrists Working in Correctional Settings

*Chairperson:* Henry C. Weinstein, M.D., *Department of Psychiatry, New York University, 1111 Park Avenue, New York, NY 10128*
*Participants:* Kathryn A. Burns, M.D., Kenneth G. Gilbert, M.D., Annette L. Hanson, M.D., John S. Zil, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the participants should appreciate and understand the basic, practical, issues of practicing psychiatry in jails and prisons.

## SUMMARY:

The 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. Treatment of Offenders with Mental Disorders, edited by Wettstein R. Guilford, New York, 1998.

Component Workshop 43

### BIRACIAL OR BICULTURAL AMERICANS: ISSUES AND INSIGHTS FOR THERAPY
### APA Caucus of Asian-American Psychiatrists and APA Northern California Psychiatric Society's Committee on Asian-American Issues

*Chairperson:* Jacquelyn B. Chang, M.D., *UCSF, 341 Spruce Street, Suite C, San Francisco, CA 94118*
*Participants:* Brett J. Sevilla, M.D., Naomi K. Lam, M.D., Annette Albright, M.D., Masaru J. Fisher, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the psychiatric literature on biracial or bicultural individuals, recognize the challenges of growing up biracial or bicultural, and identify therapeutic issues in treating biracial or bicultural individuals.

## SUMMARY:

Biracial or bicultural individuals are a growing population in the United States. In the 2000 census, 6.8 million people (2.4 percent of the U.S. population) identified as belonging to two or more races. Of these individuals, 93% are biracial and 42% are children. Over time, psychiatry will have increasing contact with this group as more children are born to interracial couples, and more individuals identify themselves as biracial or bicultural.

This workshop will review some of the existing psychiatric literature on biracial or bicultural individuals. Panelists are psychiatrists of biracial or bicultural background who will speak on their personal and professional experiences to provide insight into the biracial or bicultural individual. The audience will hear from a child psychiatrist of Irish/Filipino descent, a general adult psychiatrist of Japanese/Chinese descent, and two members-in-training of African-American/Vietnamese descent and Jewish/Japanese descent. Together their thoughts will form the foundation for an interactive discussion with the audience.

This workshop is jointly sponsored by the APA Caucus of Asian American Psychiatrists and the Northern California Psychiatric Society Committee on Asian American Issues in recognition of the growing biracial or bicultural population stemming from interracial marriages. Individuals from all backgrounds will benefit from attending this workshop.

## REFERENCES:

1. Root MPP: The Multiracial Experience. Thousand Oaks, CA, Sage Publications, 1996.
2. O'Hearn CC: Half and Half: Writers on Growing Up Biracial and Bicultural. New York, Pantheon Books, 1998.

Component Workshop 44

### TRANSITION INTO THE POSTRESIDENCY PERIOD
### APA New York County District Branch

*Co-Chairpersons:* Dinu P. Gangure, M.D., *St. Luke's Hospital, 515 West 59th Street, New York, NY 10019*
Scott R. Masters, M.D., St. Lukes-Roosevelt, *1090 Amsterdam Avenue, New York, NY 10025*
*Participants:* Evaristo O. Akerele, M.D., Marianne Guschwan, M.D., Carl Shusterman, Esq.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to identify the pros and cons of various career paths in the postresidency period. These paths include fellowship training, academia with the subcomponents (education, research, administration), private practice, practice as employee, and work in psychiatrically underserved areas.

SUMMARY:

Transition into the postresidency period is a topic of great interest to trainees. Guidance and leadership offered to residents during this process is an essential component of education and training. The panel will address the various types of additional training available after residency, including but not limited to psychiatric fellowships. Then, the multiple aspects of an academic career will be discussed focusing on the following subcomponents: education, research, and administration. Private practice versus practice as an employee in the first five years after the residency will be addressed, with pros and cons of the transition to each of them discussed. Finally, aspects of working in psychiatrically underserved areas will be shared, including loan-forgiveness programs and J waivers. The workshop presenters will encourage dialogue with the participants. Each of the four speakers will be allotted 15 minutes for their presentation. The workshop will conclude with a 30-minute question-and-answer period.

REFERENCES:

1. Kupfer DJ, Hyman SE, Schatzberg AF, et al: Recruiting and retaining future generations of physician scientists in mental health. Arch Gen Psychiatry. 2002; 59:657–60.
2. Cutler J: Choosing a career in psychiatry. Am J Psychiatry. 1996; 153:1372–3.

Component Workshop 45

## COMBINED RESIDENCY TRAINING: NOW WHAT ARE YOU DOING?

**APA Central California Psychiatric Society**

*Chairperson:* Shannon T. Suo-Chan, M.D., *University of California - Davis, 2230 Stockton Boulevard, Sacramento, CA 95817*
*Participants:* Susan Padrino-Iler, M.D., Quinton E. Moss, M.D., Jodi E. Star, M.D., 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. According to the AMA's Fellowship and Residency Interactive Electronic Database (FRIEDA), there are currently 51 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 the strengths of combined psychiatric residencies, barriers to integrated curricula, and future directions of these programs and residents who complete combined training in the 21st century. Training programs represented will be family practice/psychiatry, internal medicine/psychiatry, neurology/psychiatry, and pediatrics/psychiatry/child psychiatry.

REFERENCES:

1. Risley R: Combining family practice and psychiatry resident training. Psych Times, August 2001.
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 training programs. Fam Med 1999; 9:606.

Component Workshop 46

## UPDATE ON PRACTICE GUIDELINES: PTSD/ ACUTE STRESS DISORDER

**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:* Laura J. Fochtmann, M.D., Robert J. Ursano, M.D., Carl C. Bell, M.D. Spencer Eth, 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 PTSD/Acute Stress Disorder Guideline.

SUMMARY:

Since its inception in 1991, the APA practice guidelines project has published 12 guidelines. In developing each practice guideline, the use of an evidence-based process has resulted in documents that are both scientifically sound and clinically useful to practicing psychiatrists. In this workshop, panelists will review the outline and content of a new practice guideline that is under development: the Practice Guideline for the Treatment of Patients with PTSD/Acute Stress Disorder. Persons attending the session are invited to comment on the broad array of issues relating to this guideline including the specific content of the guideline, implications for the field, and strategies for evaluating and disseminating the practice guidelines.

REFERENCES:

1. Foa E, Keane T, Friedman M: Effective Treatment for PTSD. Guilford Press, 2000.
2. American Academy of Child and Adolescent Psychiatry. Summary of the practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. J Am Acad Child Adolesc Psychiatry 1998; 37:997–1001.

Component Workshop 47

## DADDY AND PAPA: A PSYCHOSOCIAL PROFILE OF GAY PARENTING

**APA Committee on Gay, Lesbian, and Bisexual Issues**

*Chairperson:* Jack Drescher, M.D., *420 West 23rd Street, #7D, New York, NY 10011–2174*
*Participants:* Daniel W. Hicks, M.D., Diana C. Miller, M.D., Susan A. Turner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the psychological motivations of gay men and women who seek to raise children, recognize the complex psychosocial responses that gay-parented families evoke, and recognize how gay- and lesbian-parented families both challenge and affirm current developmental and psychological theories.

SUMMARY:

"Daddy & Papa" is a documentary film that explores the lives of gay men raising children and profiles the psychological, cultural, and political implications of gay fatherhood. This film captures one of the most dramatic social changes of the last decade: a marked increase in parenting of children conceived or adopted by gay couples or by single gay men and lesbian women. Numerous studies consistently demonstrate that children raised by gay or lesbian parents exhibit emotional, cognitive, social, and sexual functioning equal to that of children raised by heterosexual parents. Research also indicates that optimal development for children is based not on parental

sexual orientation, but on stable attachments to committed and nurturing adults. The growing "gayby boom" has challenged many cultural notions, as well as psychological theories, regarding what constitutes normal child development, the nature of parental identifications, and how gender roles are learned. After viewing segments of the film, and through interactive discussion with the APA's Committee on Gay, Lesbian and Bisexual Issues, this workshop aims to increase clinicians' awareness of and sensitivity to the complex psychological and psychosocial issues surrounding gay- and lesbian-parented families.

### REFERENCES:

1. Gay and Lesbian Parenting, edited by Glazer DF, Drescher J. New York, The Haworth Press, 2001.
2. Green J: The Velveteen Father: An Unexpected Journey to Parenthood. New York, Villard, 1999.

## MONDAY, MAY 19, 2003

### Issue Workshop 1
### TEACHING COGNITIVE-BEHAVIOR THERAPY: EFFECTIVE TRAINING IN UNEXPECTED SETTINGS

*Chairperson:* Donna M. Sudak, M.D., *Department of Psychiatry, Drexel College of Medicine, 3200 Henry Avenue, Philadelphia, PA 19129*
*Participants:* Judith S. Beck, Ph.D., Jesse H. Wright, M.D., Robert M. Goisman, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) understand the core knowledge base needed for residents to effectively employ CBT, (2) review means of evaluating residents' performance, (3) identify patient populations outside the general psychiatry outpatient clinic that would provide residents with opportunities for supervised practice, and (4) review supervision techniques that maximize efficiency.

### SUMMARY:

ACGME requirements for residency training in psychiatry require residents to achieve competency in cognitive behavioral therapy. CBT has a rich literature regarding therapist training and evaluation of therapist competency, and this knowledge base can help training directors to teach trainees efficiently and effectively. Despite this, programs often face significant demands on resources and frequently have difficulty finding sufficient supervised patient experiences in the resident outpatient clinic. This workshop will focus on teaching participants models for training residents in CBT in other settings, including inpatient units, medication management clinics, bipolar disorder specialty clinics, and personality disorder specialty clinics. The audience will review key features of a didactic program, discuss the rating scales available to evaluate resident performance, and see how these methods of training can be employed in different settings and with more severely ill patients. Methods of supervision and teaching (i.e., group, telephone, computer-based) that can be used to increase efficiency will be presented. We anticipate considerable discussion about the barriers to setting up new models of patient care in traditional inpatient and outpatient settings, and we plan to problem solve with the audience, discussing how other programs have been able to educate residents effectively. The audience will receive information about resources to enhance the training of residents, faculty, and staff.

### REFERENCES:

1. Wright JH, Thase ME, Beck AT, et al (eds): Cognitive Therapy With Inpatients. New York, Guilford Press, 1993.
2. Basco MR, Rush AJ: Cognitive-Behavioral Therapy for Bipolar Disorder. New York, Guilford Press, 1996.

### Issue Workshop 2
### UNDERSTANDING TRANSGENDERED YOUTH: TREATMENT AND SERVICE STRATEGIES

*Co-Chairpersons:* Richard R. Pleak, M.D., *Department of Child Psychiatry, Schneider Children's Hospital, Suite 135, New Hyde Park, NY 11040,* Sarah E. Herbert, M.D., *Emory University, 1365-B Clifton Avenue, NE, #6100, Atlanta, GA 30322*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand who transgendered youth are, to appreciate the stresses and other issues that affect TG youth, and to identity options in the treatment and provision of services to TG youth.

### SUMMARY:

Transgendered teenagers are a poorly understood and very understudied population. These adolescents face unique developmental and social issues that affect medical and psychiatric assessment, treatment, and service delivery. The presenters have considerable experience working with transgendered (TG) youths. In this workshop, the nature of transgenderism and gender identity will be discussed, and developmental issues will be highlighted. Dr. Herbert will review TG identity formation, sexual behaviors, and high-risk behaviors in TG teens. Dr. Pleak will address practical considerations for assessment, diagnosis, and treatment in various settings, including an exploration of the psychiatrist's role in hormonal and surgical treatments. Case vignettes will be provided, and the audience will be encouraged to discuss their own cases and particular difficulties and successes in treatment that have been encountered. A more thorough understanding of transgendered adolescents can lead to more effective strategies for treatment and service delivery.

### REFERENCES:

1. Pleak RR, Anderson DA: Observation, interview, and mental status assessment (OIM): homosexual, in Handbook of Child and Adolescent Psychiatry, Vol 5. Edited by Noshpitz JD. New York, John Wiley & Sons, 1998, pp 563–574.
2. Cohen-Kettenis PT, van Goozen SH: Sex reassignment of adolescent transsexuals: a follow-up study. J Am Acad Child Adol Psychiatry 1997; 36:263–271.

### Issue Workshop 3
### MORAL ASPECTS OF CLINICAL PRACTICE: A FUNCTIONAL APPROACH

*Chairperson:* John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize moral challenges inherent in clinical work and the usefulness of a paradigm based on moral functioning for approaching them.

### SUMMARY:

Psychiatrists often grapple with their role in patients' moral lives. How much should a therapist intervene with an individual who is harming herself or others, for example, by engaging in unsafe sex with random partners, driving drunk, or neglecting children? How can therapists help patients who are struggling with whether it is right for them to divorce, if and how to forgive a childhood abuser,

or how much to sacrifice for an aging parent? How should therapists deal with the person who is convinced that he deserves to suffer or that the state owes him a living?

Clinicians have increasingly recognized the need to look beyond the ethics of autonomy and neutrality for answers to these questions. They articulate other therapeutic ideals and have begun to examine the clinical relevance of ethical reasoning, forgiveness, and evil. This workshop considers how moral functioning may provide a framework for understanding the clinician's role as a moral agent. After briefly reviewing the development of the individual's ability to perform basic moral tasks, participants will use case material to explore approaches to clinical challenges involving caring, ethical dilemmas (e.g., concerning confidentiality and dual relationships), unfair pain, guilt/shame, and the phenomena of moral growth and transformation. The goal of the session is to clarify the skills necessary for the career-long process of practicing in an optimally integrated way.

## REFERENCES:

1. Peteet JR: Moral Dimensions of Mental Health Practice. Washington, DC, American Psychiatric Press (in press).
2. Doherty WJ: Soul Searching: Why Psychotherapy Must Promote Moral Responsibility. New York, Basic Books, 1995.

## Issue Workshop 4
## MULTICULTURALITY SQUARED: TRAINING MULTICULTURAL RESIDENTS TO TREAT MULTICULTURAL PATIENTS

*Co-Chairpersons:* Susan Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504,* Harvey Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504*
*Participants:* Henry L. McCurtis, M.D., David W. Preven, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants should be better able to recognize and incorporate the multicultural needs of both their trainees and their patients.

## SUMMARY:

The need for psychiatric residents to be trained to understand and be sensitive to the multicultural background and needs of their patients has been an established part of residency training programs for a very long time. Many of today's training programs have themselves taken on an extremely multicultural appearance, with growing diversity and residents from nations around the world. This presents training programs and directors with a unique challenge: how to satisfy these needs while maintaining the basic principles and integrity of the practice of psychiatry and psychotherapy. This workshop will present some methods used in several training programs to adapt to this realignment. Participants will be asked, both as trainees and trainers, to share their experiences of how such diverse needs are being met and how better to meet them in the future.

## REFERENCES:

1. Fiscella K, Frankel R: Overcoming cultural barriers: international medical graduates in the United States. JAMA 2000; 283:1751.
2. Collins JL, Mathura CB, Risher DL: Training psychiatric staff to treat a multicultural patient population. Hosp Com Psychiatry 1984; 35:372–376.

## Issue Workshop 5
## SANTERIA AS A RELIGION IN MENTAL HEALTH PATIENTS

*Chairperson:* Jose M. Soto, M.D., *Department of Psychiatry, School of Medicine, 671 Hoes Lane, Piscataway, NJ 08855*
*Participants:* Liliam Perez, M.D., Virginia Contreras, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants should be able to understand the significance of Santeria as a religion and integrate this knowledge to enhance and strengthen the therapeutic alliance.

## SUMMARY:

Santeria is one of the New World religions. The main followers of this belief are of Caribbean and Latin American descent, but other cultures are also exploring this religion. In Santeria's belief system, Olardumare is the source of ashe, the spiritual energy which makes up the universe. He relates with the world and mankind through emissaries, called Orishas.

Coming from Africa to the New World, Orishas were hidden behind a facade of Catholicism; therefore, saints represented the Orishas. This is why the religion came to be known as Santeria. The estimated number of followers in the United States ranges from 22,000 to over 5 million. New York, Miami, and Los Angeles are Santeria strongholds that also practice Catholicism or a combination of both.

This workshop will educate participants about the practice of Santeria. A review of the literature will be provided to show how these beliefs affect psychiatric illness. The results of a cross-sectional study, done at an inner-city hospital, of Santeria beliefs and practices will be presented. At the end of the presentation, the workshop will be highly interactive; presenters will share their own experiences of working with these patients and will engage the audience in sharing their experiences.

## REFERENCES:

1. Moreno M: The Altar of My Soul: The Living Traditions of Santeria. New York, One World, 2000.
2. Garcia J: The Osha: Secrets of Yoruba-Lacumari-Santeria Religion in the United States and Americas. New York, Athelia-Henrietta Press, 2000.

## Issue Workshop 6
## RISK-MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE

*Chairperson:* Alan I. Levenson, M.D., *75 North Calle Resplendor, Tucson, AZ 85716-4937*
*Participants:* Ellen R. Fischbein, M.D., Martin G. Tracy, J.D., Jacqueline M. Melonas, J.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the major psychiatric professional liability risks that lead to malpractice lawsuits, discuss emerging practice trends that increase malpractice risk, and use risk management strategies to decrease major professional liability, including liability related to suicide, supervision, cybermedicine, HIPAA, etc.

## SUMMARY:

Malpractice suits pose a significant problem for psychiatrists, regardless of whether they work in private practice, academic, or institutional settings. At least 8% of practicing psychiatrists are sued each year. It is important that psychiatrists understand the sources of malpractice lawsuits and become aware of malpractice risks in terms of their own work as clinicians, teachers, and administrators.

The workshop will present data from the APA-endorsed Psychiatrists' Professional Liability Insurance Program identifying common sources of malpractice actions against psychiatrists. The nature of malpractice lawsuits will be described, and data on the causes and outcomes of such lawsuits will be presented. Special emphasis will be placed on malpractice as it relates to the process of supervision and working with nonpsychiatrists and on the risk associated with new forms of telecommunication and cybermedicine. Information regarding malpractice insurance policies and questions that must be addressed when purchasing a policy will be provided. 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. Psychiatry Ann 1999; 29:241–245, 327–332.
2. Hickson GB, Federspiel CF, Pichert JW, et al: Patient complaints and malpractice risk. JAMA 2002; 287:2951–2957.

## Issue Workshop 7
## MEDITATION: THEORY, THERAPY, RESEARCH, AND PRACTICE

*Chairperson:* Roger N. Walsh, M.D., *Department of Psychiatry, University of California Medical School, Irvine, CA 92697-1675*
*Participants:* Charles Tart, Ph.D., Shauna Shapiro, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the end of this workshop, participants should be familiar with the psychological and biological effects of meditation, able to assess its clinical applications, diagnose complications, and initiate a personal meditation practice if they wish.

## SUMMARY:

In the late 1970s an APA task force called for investigation of the effects and therapeutic potentials of meditation. Twenty-five years later, that call has been answered. Several hundred studies make meditation the second most researched therapy, behind only cognitive behavioral therapies. A wide array of psychological, physiological, biochemical, spiritual, and therapeutic effects have been detected. Psychological effects include evidence for enhanced perceptual sensitivity, accuracy, and empathy. Meditators show improved personality measures of, for example happiness, self-control, self-acceptance, self-actualization, and maturity. Likewise, performance measures suggest evidence of, for example, increased learning ability, academic performance, WAIS scores, and creativity. Demonstrated psychotherapeutic applications include treatment of substance abuse, hostility, mild to moderate depression, and stress-related disorders. Psychosomatic applications include treatment of hypertension, hypercholesterolemia, and coronary artery disease. Healthy normal subjects evidence enhanced subjective well-being, self-actualization, and spirituality. Complications, though infrequent, do occur, and psychiatrists are likely to see more of them. This workshop will provide an overview of meditation theory, summarize and evaluate research findings and clinical implications, offer introductory meditation techniques for those wishing to begin a personal practice, and allow participants to discuss personal and professional applications with the panelists, who are both meditation teachers and researchers.

## REFERENCES:

1. Shapiro S, Walsh R: An analysis of recent meditation research suggestions for future directions. J Human Psychol (in press).
2. Tart C: Mind Science: Meditation Training for Practical People. Novato, CA, Wisdom Editions, 2001.

## Issue Workshop 8
## INSTITUTE OF MEDICINE STUDY: INCORPORATING RESEARCH INTO RESIDENCY TRAINING

*Chairperson:* Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*
*Participants:* Michael T. Abrams, M.P.H., James J. Hudziak, M.D., Michelle B. Riba, M.D.

## EDUCATIONAL OBJECTIVE:

By the conclusion of the workshop, participants will be able to describe concerns stimulating the Institute of Medicine study on incorporating research into residency training, detail the work of the IOM Committee on psychiatric training, and discuss the implications of the report as they pertain to Federal agencies, professional regulatory bodies, and individual departments and programs.

## SUMMARY:

Policy makers are concerned that shrinking numbers of general and child/adolescent psychiatrists entering and sustaining careers as patient-oriented researchers may create a public health problem for the nation. They fear that questions of major importance regarding practical psychiatric treatments may go unanswered due to insufficient psychiatric researcher workforce. As one response to these concerns, the National Institute of Mental Health (NIMH) commissioned the Institute of Medicine (IOM) to conduct a study concerning incorporation of research into psychiatric residency training. An IOM committee composed of psychiatrists, nonpsychiatrist academic physicians, a neuroscientist, and a health economist heard expert testimony from various salient stakeholder perspectives, reviewed available pertinent literature, deliberated, and prepared a report with specific recommendations regarding psychiatric training, scheduled to be published just before the American Psychiatric Association annual meeting in May 2003. This workshop will describe the committee's work to date, including public and secondary source information that the committee has coalesced and reviewed. Recommendations from the report will be discussed if the report has been formally released; alternatively, the progress of the committee will be reviewed. The final report is directed to diverse elements in the field, including the NIMH, psychiatric education regulatory bodies, and individual departments and training programs.

## REFERENCES:

1. Kupfer DJ, Hyman SE, Schatzberg AF, et al: Recruiting and retaining future generations of physician scientists in mental health. Arch Gen Psychiatry 2002; 69:657–660.
2. Nathan DG: Careers in translational clinical research: historical perspectives, future challenges. JAMA 2002; 287:2424–2427.

## Issue Workshop 9
## EXPANDING TELEPSYCHIATRY BEYOND PATIENT CARE: OPPORTUNITIES AND CHALLENGES

*Co-Chairpersons:* R. Andrew Harper III, M.D., *Department of Psychiatry, UT-Medical Houston, 6431 Fannin, JJL304, Houston, TX 77030,* Anu A. Matorin, M.D., *UT-Medical School Houston, 1300 Moursund, Houston, TX 77030*
*Participants:* Jacqueline C. McGregor, M.D., Christopher R. Thomas, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants will be able to discuss the application of telepsychiatry to areas other than direct patient care and the challenges involved in these programs.

SUMMARY:

Telepsychiatry is an expanding mode of delivery for psychiatric treatment. Technology for videoconferencing has been improving rapidly, and the availability of this connectivity is increasing. These factors combine to create opportunities for psychiatrists beyond the provision of patient care. This workshop will focus on several programs that take advantage of these opportunities and expand telepsychiatry to provide additional services beyond direct care. Areas discussed will include using telepsychiatry to provide education for physicians, consultation to social service agencies, consultation and education for schools, and parenting classes for families. Presenters will describe the programs in which they have participated and explain the strategies involved in establishing telepsychiatry services. Challenges and limitations, such as barriers to starting up a program, strategies for establishing liaisons with community institutions, program sustainability, and funding, will also be reviewed. Participants will be able to confer with panelists about using this technology and have the opportunity to ask specific questions regarding telepsychiatry. Participants will be encouraged to discuss additional uses for this communication modality. This workshop is intended for those with established telepsychiatry programs seeking to expand services, as well as for participants currently planning a program or hoping to establish one in the future.

REFERENCES:

1. Baer L, Elford DR, Cukor P: Telepsychiatry at forty: what have we learned? Harv Rev Psychiatry 1997; 5:7–17.
2. Baigent MF, Lloyd CJ, Kavanagh SJ, et al: Telepsychiatry: 'tele' yes, but what about the 'psychiatry'? J Telemed Telecare 1997; 3(suppl 1):3–5.

## Issue Workshop 10
## NONSEXUAL BOUNDARY VIOLATIONS

*Chairperson:* Malkah T. Notman, M.D., *Department of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02445*
*Participants:* Elissa P. Benedek, M.D., Carl P. Malmquist, M.D., Linda M. Jorgenson, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should 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 embarrasment. The psychiatrist as a parent with children in the same school as patients' children, or 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. Forensic psychiatrists will describe situations where boundary crossings have occurred and their resolution. Clinical implications will be considered. An attorney will discuss the need for the professional 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 11
## PSYCHOLOGICAL MANAGEMENT OF PSYCHOSIS

*Chairperson:* Eric R. Marcus, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*
*Participants:* Lewis A. Opler, M.D., Ian E. Alger, M.D., Clarice J. Kestenbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will be better able to diagnose psychotic symptoms, form therapeutic alliances with psychotic patients, help patients accept medication, work with families, and diagnose psychosis in children and adolescents.

SUMMARY:

The purpose of this workshop is to discuss and demonstrate the psychological management of psychotic symptoms so that those who treat psychosis will be better able to talk to psychotic patients, understand their experience, and help them emerge from psychotic suffering. The workshop is for psychiatrists who work with psychotic patients. First, the psychological structure of delusions and hallucinations will be described. The use of this information to diagnose psychosis and psychotic illness, to increase self-observation, and to strengthen the therapeutic alliance will be demonstrated. Second, the role of psychological management in pharmacological treatment will be discussed. Without an understanding of the meaning of medication to the patient, the rate of noncompliance and relapse is high. Third, family work with psychotic patients will be discussed. Building therapeutic alliances with such families requires an understanding of the effect of psychotic illness on family functioning. Work with families lowers relapse rates. Fourth, work with psychotic children and adolescents will be discussed. An understanding of cognitive and emotional development is crucial if psychotic illness is to be properly diagnosed and treated in children and adolescents.

REFERENCES:

1. Marcus ER: Psychosis and Near Psychosis. Madison, Conn, International Universities Press (in press).
2. Opler LA, Ramirez PM, Mougios VM: Outcome measurement in serious mental illness, in Outcome Measurement in Psychiatry: A Critical Review. Edited by Ishak WW, Burt T, Sederer LI. Washington, DC, American Psychiatric Publishing, 2002, pp 139–154.

## Issue Workshop 12
## 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 OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize a second mode of transference, introjective identification, and understand and use the unique interventions for this inner working-through process. The participant should also 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, and often result 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 increased power of healing in 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, 1990, pp 475–490.
2. Lipsius SH: Working through in psychoanalytic psychotherapy: an alternative and complementary path. J Am Acad Psychoanal 2001; 29:585–600.

### Issue Workshop 13
### DEPRESSION AND THE PHYSICIAN: WHEN BEING A "GOOD" DOCTOR IS NOT ENOUGH

*Chairperson:* Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada*
*Participants:* Daniel P. Chapman, Ph.D., Donna M. Norris, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) appreciate the complexity of depression in physicians and (2) acquire skills in treating physicians more effectively.

## SUMMARY:

It is well-known that mood disorders are not uncommon in physicians, but good empirical data on incidence and prevalence, phenomenology, and prevention (primary, secondary, and tertiary) are lacking. However, based on what is known about depression in doctors, psychiatrists can begin to improve their diagnostic, therapeutic, and advocacy skills. In 15-minute presentations, Dr. Chapman will review the limited epidemiological data on psychiatric disorders in physicians, including the prevalence of depression, gender differences, and the comorbidity of psychiatric disorders with substance abuse and dependence in this population. Dr. Norris will discuss the phenomenology of depression in physicians, its often elusive and unrecognized nature, the tendency toward "self-diagnosis and self-treatment," and the effects of disclosure on medical licensure. Dr. Myers will examine mood disorders and loss (both cause and effect), depression and the doctor's marriage and family, suicide, and advocacy imperatives when psychiatrists treat symptomatic physicians. During the 45-minute discussion period, the audience will participate by posing questions, providing commentary, and presenting disguised vignettes from their own practices if they choose.

## REFERENCES:

1. Gautam M: Depression and anxiety, in The Handbook of Physician Health. Edited by Goldman LS, Myers M, Dickstein LJ. Chicago, American Medical Association, 2000.
2. Myers MF: Physicians Living With Depression (videotape). Washington, DC, American Psychiatric Press, 1996.

### Issue Workshop 14
### INNOVATIVE TREATMENT IN BULIMIA NERVOSA

*Co-Chairpersons:* Waguih W. Ishak, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Drive, Los Angeles, CA 90048*, McLeod F. Gwynette, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive, Los Angeles, CA 90048*
*Participants:* Edi Cooke, Psy.D., Michelle McParland, R.D., Marlene Clark, R.D., Antonia N. Ludwig, M.F.T.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the manifestations of and available treatments for bulimia nervosa and demonstrate familiarity with current developments in the biological treatment of bulimia nervosa.

## SUMMARY:

Bulimia nervosa has been increasing in prevalence in Western nations during recent decades. Despite the development of multiple treatment modalities, both biological and psychosocial, bulimia nervosa remains difficult to treat in acute and chronic settings. The purpose of this workshop is to educate psychiatric health care providers about the manifestations and treatment of bulimia nervosa. This workshop will utilize video footage of actual bulimia nervosa patients to allow participants to identify DSM-IV diagnostic criteria interactively. Once participants have gained a thorough understanding of the diagnosis of bulimia nervosa patients, the workshop will focus on state-of-the-art psychotherapeutic interventions and advanced nutritional counseling techniques applicable to bulimia nervosa patients. The workshop will then cover current biological treatment interventions including the presenters' "gold standard" of treatment for bulimia nervosa. Finally, the workshop will conclude with an interactive discussion of innovative biological treatment interventions for bulimia nervosa patients, as well as of the latest data derived from an ongoing pharmacological study being conducted by the workshop's presenters.

## REFERENCES:

1. Dalle Grave R, Ricca V, Todesco T: The stepped-care approach in anorexia nervosa and bulimia nervosa: progress and problems. Eat Weight Disord 2001; 6:81–89.
2. Bacaltchuk J, Hay P: Antidepressants versus placebo for people with bulimia nervosa. Cochrane Database Syst Rev 2001; 4:CD003391.

### Issue Workshop 15
### MANAGEMENT OF DISINHABITION IN DEMENTIA

*Co-Chairpersons:* Theron C. Bowers, Jr., M.D., VAMC Houston, 6126 Dumfries, Houston, TX 77096, Sheila M. Loboprabhu, M.D., *Department of Psychiatry, VA Medical Center, 2002 Holcombe Boulevard, 116 Gero, Houston, TX 77030*
*Participants:* Claudia Orengo, M.D., John H. Coverdale, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, the participant should have an understanding of the clinical, ethical, and social issues involved in the management of sexually inappropriate behavior in the nursing home setting.

## SUMMARY:

Sexual acting out behaviors such as compulsive masturbation, genital exposure, attempts to fondle, and attempts at coitus in inappropriate circumstances are disruptive and distressing behaviors in a nursing home setting. Such behaviors may expose the patient, nursing home, and treating doctors to liabilities. These behaviors are a common cause for nursing home placement difficulties. This workshop will discuss psychopharmacological, psychological, ethical, and social issues involved in the management of sexually inappropriate behavior in the nursing home setting. Case vignettes will be used to illustrate specific examples of such behavior. The presenters will discuss a multidisciplinary approach, which encompasses a review of psychotropic agents, hormonal therapies, behavioral and environmental management, and liaison with the nursing staff and family. This session is intended for psychiatrists, psychologist, nurses, and social workers who work with the elderly or in a nursing home setting. Audience participation is welcomed. Participants will be asked to present specific clinical examples or problems for discussion.

## REFERENCES:

1. Cooper AJ: Medroxyprogesterone acetate (MPA) treatment of sexual acting out in men suffering from dementia. J Clin Psychiatry 1987; 48:368–370.
2. Shelton PS, Brooks VG: Estrogen for dementia-related aggression in elderly men. Ann Pharmacotherapy 1999; 33:808–811.

## Issue Workshop 16
## PREPARING PSYCHIATRISTS FOR MASS-CASUALTY EVENTS

*Chairperson:* Kenneth S. Thompson, M.D., *IPHP, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*
*Participants:* Anthony T. Ng, M.D., David A. Pollack, M.D., Stephen M. Goldfinger, M.D., Audrey R. Newell, M.D. Gina Perez, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant will understand the core issues involved in being prepared for a mass-casualty event and will know how to get further training in this area.

## SUMMARY:

The events of September 11, 2001 and the anthrax attack demonstrated once again that, at any given moment, community psychiatrists may be called upon to respond to a mass-casualty event. The anticipation of more terror has combined with a growing awareness of the importance of psychiatric aspects of disasters to highlight the need for psychiatric involvement in disaster/terrorism planning and response. The critical role played by government and public services in this arena dictates the involvement of community psychiatrists working in public service.

Unfortunately, community psychiatrists have not been prepared for either role: to respond to disaster or to help in preparing for it. Simply put, community psychiatrists have not been trained for these roles. To rectify this situation, the Center for Mental Health Services of the Substance Abuse and Mental Health Service Administration has partnered with the American Association of Community Psychiatrists to create a workgroup to map out a curriculum of what psychiatrists need to know. The workgroup is also charged with determining how to disseminate this knowledge to the field. This workshop is for psychiatrists who want to be prepared in the event of mass trauma or terror in their community. Panelists from the work group will describe the process and the products of the effort so far.

## REFERENCES:

1. Ursano RJ, Fullerton CS, Norwood AE: Psychiatric dimensions of disaster: patient care, community consultation, and preventive medicine. Harv Rev Psychiatry 1995; 3:196–209.
2. Gold J, Vlahov D: Psychological sequelae of the September 11 terrorist attacks in New York City. N Engl J Med 2002; 346:982–987.

## Issue Workshop 17
## IMPLEMENTING WEB-BASED PSYCHOPHARMACOLOGY ALGORITHMS: PROBLEMS AND SOLUTIONS

*Co-Chairpersons:* David N. Osser, M.D., *Department of Psychiatry, Brockton VA Medical Center, 940 Belmont Street, Brockton, MA 02401,* Peter D. Anderson, Pharm.D., *Taunton State Hospital, 60 Hodges Avenue Extension, Taunton, MA 02780*
*Participants:* Alejandro Y. Mendoza, M.D., William L. Grapentine, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants should understand how to utilize evidence-based psychopharmacology algorithms in a busy public hospital (without new funding) and how to improve patient outcomes in the process.

## SUMMARY:

Although psychopharmacology algorithms are proliferating in the literature, the practical issues that come up in trying to "implement" them in the clinical setting have received much less attention. The Psychopharmacology Algorithm Project at the Harvard Medical School's South Shore Psychiatry Department since 1996 has had a web site that offers a novel way of communicating the clinical recommendations in its evidence-based algorithms for schizophrenia, depression, and anxiety disorders. The information is designed to be accessible rapidly so that it can be considered before the treatment decision is made. The address is *www.mhc.com/Algorithms.*

To test the feasibility of using this web site, two field trials have occurred at Taunton State Hospital under the auspices of a performance improvement team, using a variety of outcome measures. In this workshop, clinicians who participated in these trials will describe the usefulness of the algorithms for patient care and the barriers that were identified and had to be overcome to optimally use these decision support tools. Two attending psychiatrists working on an adult and an adolescent continuing care unit will describe their experiences. The project coordinator, a clinical pharmacist, will also offer observations. The audience will be invited to interact with the speakers on the theme of using algorithms in the real world.

## REFERENCES:

1. Rush AJ, Crismon ML, Toprac MG, et al: Implementing guidelines and systems of care: experiences with the Texas Medication Algorithm Project (TMAP). J Pract Psychiatry Behav Health 1999; 5:75–86.
2. Osser DN, Patterson RD: Enhancing clinical decision-making. Psychiatr Times 2002; 20(5):24–26.

## Issue Workshop 18
## TELEPSYCHIATRY WITH DEVELOPMENTALLY DISABLED: TEACHING, TRAINING, AND TREATING

*Chairperson:* Roxanne F. Szeftel, M.D., *740 26th Street, Santa Monica, CA 90402-3150*
*Participants:* Syed S. A. Naqvi, M.D., Arom J. Evans, M.D., Henrik Zakari, M.D., Marina Bussel, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) recognize the basic components necessary to provide successful telepsychiatry clinics and (2) recognize the best ways to evaluate mental illness in specialty populations such as the developmentally disabled by using telepsychiatry.

### SUMMARY:

This session is intended for physicians who wish to learn more about setting up and running telepsychiatry clinics and who are interested in developmental disabilities or child psychiatry training experiences. The presenters started the first telepsychiatry clinic in California for patients of all ages with mental illness, as well as autism, mental retardation, and other developmental disorders. The presenters describe their experience over the past 5 years in running this subspecialty telepsychiatry service. They describe the hub and telesite clinic set-up and the things that have made these clinics successful, such as the clinic model of consultation to local doctors rather than direct treatment of the patients. Aspects of child psychiatry training in this program include genetics components and on-site side-by-side supervision of the residents by attending psychiatrist. In addition, training has also focused on teaching residents to better understand, communicate with, and evaluate nonverbal and mentally retarded patients; making accurate mental illness diagnoses in mentally retarded population; providing genetics training about behavioral phenotypes of common mental retardation syndromes and genetic disorders; using telepsychiatry clinics to provide subspecialty care and training; and using a clinic model of consultation and collaboration to promote more effective outcomes at remote sites.

### REFERENCES:

1. Elford R, et al: A randomized, controlled trial of child psychiatric assessments conducted using videoconferencing. J Telemed Telecare 2000; 6:73–82.
2. Hilty D, et al: Telepsychiatric consultation for ADHD in a primary care setting. J Am Acad Child Adol Psychiatry 2000; 39:15.

## Issue Workshop 19
## ETHNIC BIODIVERSITY IN SUBSTANCE ABUSE AND MENTAL HEALTH DISORDERS

*Chairperson:* Jeffrey N. Wilkins, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive, Room E130, Los Angeles, CA 90048*
*Participants:* Katherine G. Mellott, M.D., Jack Kuo, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be familiar with ethnic differences in the pharmacokinetics and pharmacodynamics of antidepressants, neuroleptics, and anxiolytics and should understand the implications of genetic polymorphism in the treatment of affective disorders and substance abuse.

### SUMMARY:

The purpose of this workshop will be to familiarize the audience with recent findings regarding genetic polymorphisms and treatment response rates to antidepressants, anxiolytics, and neuroleptics, particularly response rates to the selective serotonin re-uptake inhibitors and their relation to ethnic differences in the activity of the hepatic enzyme CYP2D6 and the serotonin transporter protein. Significant differences in activity of these enzymes and transporter proteins have been demonstrated in the African American, Hispanic, and Asian populations, compared to Caucasians. The significance of these findings for current clinical practice and the psychopharmacological treatment of affective disorders will be discussed. Possible implications of these findings in explaining differences in substance abuse patterns and treatment response rates among ethnic groups will be explored. The relative contribution of biological, societal, and cultural factors in the diagnosis and treatment of mental illness will be examined. Beyond a consideration of ethnicity, there will be further discussion of the largely unexplored potential for gender and sexual orientation differences to affect the diagnosis and treatment of affective disorders and substance abuse. Last, the audience will be invited to suggest further avenues of research in biodiversity and mental illness.

### REFERENCES:

1. Lin KM, Poland RE, Nuccio I, et al: A longitudinal assessment of haloperidol doses and serum concentrations in Asian and Caucasian schizophrenic patients. Am J Psychiatry 1989; 146: 1307–1311.
2. Gelernter J, Cubells JF, Kidd JR, et al: Population studies of polymorphisms of the serotonin transporter gene. Am J Med Genet 1999; 88:61–66.

## Issue Workshop 20
## DISTINGUISHING MENTAL ILLNESS FROM BAD BEHAVIOR IN PRISONERS

*Chairperson:* Lee H. Rome, M.D., *Department of Psychiatry, University of Michigan, 567 Liberty Pointe Drive, Ann Arbor, MI 48103*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should have an increased understanding of relevant variables and diagnostic approaches involved in effective identification of major mental disorders in behaviorally disordered prisoners.

### SUMMARY:

Prisons contain a highly skewed and heterogeneous population of behaviorally disordered people. The problematic behavior of prisoners includes classic presentations of full DSM-criteria major mental disorders, impulsive undersocialized conduct, affectively labile behavior, misconduct due to cognitive impairment, maladjustment secondary to existential/situational crisis, transference-related conditioned behavior (e.g., projective identification, PTSD), malingering, and predatory/narcissistic antisocial behavior. The mix of underlying etiologies constitutes both a fascinating clinical mine and humbling minefield. Although some clinical presentations are as straightforward as any textbook case seen in community practice, others are puzzling and atypical and pose a challenge to the most experienced clinicians. Such enigmatic presentations, which create the risk of either underdiagnosis or overdiagnosis, will be the focus of this workshop. After a brief introduction and overview of the topic, case vignettes illustrating various clinical and institutional factors relevant to accurate and valid diagnosis will be reviewed and discussed. The workshop attendees are encouraged to actively participate in the discussion and present cases from their correctional practices. Although all case material will be anonymous, due to the nature of the clinical material being considered, attendance at this workshop is open only to APA members (and nonmember clinicians with approval by the workshop chairperson).

## REFERENCES:

1. Wettstein RM: Treatment of Offenders with Mental Disorders. New York, Guilford, 1998.
2. Roth LH: Correctional psychiatry, in Forensic Psychiatry and Psychology. Edited by Curran WJ, McGary AL, Shah SA. Philadelphia, Davis, 1986, pp 429–468.

### Issue Workshop 21
### LESSONS LEARNED FROM SEPTEMBER 11

*Chairperson:* David C. Lindy, M.D., *CMHS, Visiting Nurse Services, 1250 Broadway, 3rd Floor, New York, NY 10001*
*Participants:* Neil Pessin, Ph.D., Anand Pandya, M.D., Craig L. Katz, M.D., Sander Koyfman, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should have a deeper understanding of the administrative and clinical dynamics of responding to the 9/11 disaster.

## SUMMARY:

The huge impact of the September 11 attacks on the World Trade Center has presented an unprecedented challenge to New York City's mental health community. This has occured in two phases. In the first, the acute aftermath of the disaster, the many mental health professionals and institutions who volunteered their services had to learn to deal with the trauma affecting both the victims and themselves. (Many were victims themselves). It was also critical that these efforts took place within the administrative structures that evolved to manage the disaster relief efforts. The second, chronic phase of the 9/11 disaster aftermath is the current period in which delayed sequelae emerge. People suffering from these symptoms are often hard to find, and well-intended administrative efforts to identify and treat them, like the federally funded Project Liberty, need to ensure that the right people are receiving the right services.

The Visiting Nurse Service of New York's Community Mental Health Services (VNS) and Disaster Psychiatry Outreach (DPO) are two organizations that have been very involved in both phases of the 9/11 disaster relief effort. This workshop will informally present "lessons learned" from experiences with this work and include an open forum in which other mental health professionals with 9/11 experience or experience with other disasters can discuss and share their perspectives.

## REFERENCES:

1. Disaster Response and Recovery: A Handbook for Mental Health Professionals. Rockville, Md, CMHS, 1994.
2. Wolf ME, Mosnaim AD: Posttraumatic Stress Disorder: Etiology, Phenomenology, and Treatment. Washington, DC, American Psychiatric Press, 1990.

### Issue Workshop 22
### A PSYCHIATRIST'S VIEW ON ARTISTS AND THE ARTS

*Chairperson:* Frans de Jonghe, Ph.D., *Mentrum, 2e C. Huygenstraat 37, Amsterdam 1054 AG, Holland*
*Participants:* Wilco Tuinebreyer, M.D., Cecile M.T. Gijsbers van Wijk, M.D., Hetty M. Visser, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should have a better understanding and appreciation of the complex relationship between psychiatry and the arts, as well as insight into what art can teach us to improve our understanding of the creative process and hence of our patients and ourselves.

## SUMMARY:

In this workshop four psychiatrists from The Netherlands discuss the complex relationship between psychiatry and the arts as illustrated by the work of a contemporary Dutch painter, the psychiatric history of a female French sculptor, and the literary masterpiece of a Hungarian novelist.

Dr. Tuinebreyer delves into the creative process and the artist's mindset. Considering the work of Ronald Ophuis, a young Dutch painter, he sketches how creativity relates to personality characteristics and psychopathology. Personality characteristics that are indispensable to artists are deemed essential to innovative psychiatrists.

Dr. Gijsbers van Wijk and Dr. Visser present the tragic case history of Camille Claudel: pupil, model, muse, and mistress of Rodin. The psychiatric history of this female French sculptor of the *fin-de-siècle* who spent 30 years of her life in a mental institution, illustrates the conditions in European psychiatry of that era. Was Camille a classic hysteric, the victim of Rodin, or a talented sculptor felled by paranoid schizophrenia?

Professor De Jonghe presents an analysis of the recently rediscovered literary novel *Embers* by the Hungarian writer Sandor Marai. From a psychoanalyst's perspective, he explores the love and hate of the three main characters and uncovers the layers of meaning of the desolate universe they inhabit.

## REFERENCES:

1. Boden MA: Dimensions of Creativity. Cambridge, Massachusetts Institute of Technology, 1994.
2. Ayral-Clause O: Camille Claudel: A Life. New York, Abrams Books, 2002.
3. Marai S: Embers. New York, Knopf. 2001.

### Issue Workshop 23
### RESTORATIVE JUSTICE AND THERAPEUTIC JURISPRUDENCE: AN ENJOYABLE EXCHANGE OF IDEAS

*Co-Chairpersons:* Lawrence K. Richards, M.D., *Department of Psychiatry, 5266 North Valentine, #102, Fresno, CA 93711,* Abraham L. Halpern, M.D., *New York Medical College, 720 The Parkway, Mamaroneck, NY 10543-4299*
*Participants:* Patrick H. Gardner, J.D., Philip F. Kader, B.A., Honorable Peggy Hora, J.D., Pauline H. Tesler, J.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to describe Restorative Justice and Therapeutic Jurisprudence and discuss their similarities and dissimilarities.

## SUMMARY:

Restorative Justice is a way of thinking and responding to conflicts, disputes, or offenses; it focuses on 'making things right' for all people. It is not permissive; it prefers to deal cooperatively, constructively, at the earliest possible time, before matters escalate. It holds disputants and offenders accountable, and it empowers victims and offenders while attempting to repair the breach and reintegrate all into community.

In his Overview of Therapeutic Jurisprudence for the International Network on Therapeutic Jurisprudence, David Wexler wrote that this is a "perspective that regards the law as a social force that produces behaviors and consequences." It focuses on the law's effect on emotional life and on psychological well-being. Therapeutic Jurisprudence is the study of therapeutic and antitherapeutic consequences of the law, meaning the law in action, not simply the law on the books (Wexler et al).

This workshop brings together a political science graduate working for the Fresno County Probation Department, an attorney working for children at the National Center for Youth Law, a sitting judge

who has previously presented at the APA annual meeting in 1993 on women's addiction issues, and a private practice attorney, all under the moderation of a private practice psychiatrist now doing publicly funded child psychiatry. Dr. Abraham Halpern, past president of the American Academy of Psychiatry and Law will serve as co-chair and discussant after the aforementioned have led the attendees in an exchange of ideas.

## REFERENCES:

1. Briathwaite J: Restorative Justice and Therapeutic Jurisprudence. Criminal Law Bulletin 2002; 38:244.
2. Stolle DP, Wexler DB, Winick BJ, eds: Practicing Therapeutic Jurisprudence. Durham, Carolina Academic Press, 2002.

## Issue Workshop 24
## YOUTH VIOLENCE: PRINCIPLES OF PREVENTION

*Co-Chairpersons:* Paul J. Fink, M.D., *Department of Psychiatry, Temple University, 191 Presidential Boulevard, Suite C132, Bala Cynwyd, PA 19004-1216,* Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago, IL 60617-2746*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the nature of youth violence, recognize markers for identifying at-risk children early, and use principles of prevention and examples to understand the directions needed to develop prevention programs.

## SUMMARY:

This workshop will address the current status of prevention efforts in the area of youth violence. The number of incidents nationwide is down, and for several years the number of murders of young people was down on an annual basis. However, there is always the unusual event and the rare explosion plus the constant reality that children and adolescents do act out in a number of ways. There are preventive techniques. Paul Fink will describe the solutions that have been found in Philadelphia. Carl Bell will discuss his extraordinary work in Chicago. The theoretical, practical, and clinical issues will be discussed, and ways of assessing the risk of violence in young people will be discussed through presentation of research findings and practical plans that have been put into place around the United States.

## REFERENCES:

1. Canada G: Fist, Stick, Knife, Gun. Boston, Beacon Press, 1995.
2. Garbarino J: Lost Boys. New York, Free Press, 1999.

## Issue Workshop 25
## LONG-TERM STRUCTURED CARE: A FAMILY PERSPECTIVE

*Co-Chairpersons:* H. Richard Lamb, M.D., *Department of Psychiatry, Univ. of Southern California, School of Medicine, 1937 Hospital Place, Los Angeles, CA 90033-1071,* Carla Jacobs, *National Board of Directors, 17602 17th Street, #102-281, Tustin, CA 92780*
*Participants:* Curtis Flory, M.B.A., E. Fuller Torrey, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the family's perspective on why there is a need for long-term structured care for many persons with severe mental illness.

## SUMMARY:

The success of deinstitutionalization should be measured by more than reduced hospital populations. The many mentally ill persons who end up on the streets and in jails and prisons must be considered. According to Department of Justice estimates, approximately 283,000 severely mentally ill persons were imprisoned in 1998, and it is also estimated that approximately 200,000 severely mentally ill persons are homeless. The impact and cost in terms of tragedy to the families is incalculable. Clearly, more community treatment providing varying degrees of support and structure is needed.

Not enough emphasis has been placed on those who need group settings with professional supervision; independent living is not a realistic goal for many. The amount of structure needed ranges on a continuum from independent living to 24-hour hospital care. It is essential to facilitate access to hospital care for patients who need it, for as long as they need it. It should be emphasized, however, that fewer persons will require hospital care in those communities that offer a complete array of excellent and integrated community-based services.

The economics of providing adequate and appropriate care is an extremely important issue in these times of fiscal shortages. Data will be given to show that such a strategy is cost-effective.

## REFERENCES:

1. Lamb HR, Bachrach LL: Some perspectives on deinstitutionalization. Psychiatr Serv 2001; 52:1039–1045.
2. Lamb HR: The new state mental hospitals in the community. Psychiatr Serv 1997; 48:1307–1310.

## Issue Workshop 26
## IMMINENT RISK OF SUICIDE IN CORRECTIONAL FACILITIES

*Chairperson:* Karl E. Weaver, M.D., *California Men's Colony, PO Box 12826, San Luis Obispo, CA 93406-2826*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize nine particularly high-risk scenarios for completed suicide, appreciate similarities and differences between suicides in corrections and the community, and be aware of the uses and limitations of written risk assessments and differences between epidemiologic and clinical factors in predicting short-term risk.

## SUMMARY:

Nine particularly high-risk scenarios for suicide within corrections will be reviewed. Similarities with and differences from scenarios in the community will be discussed. Audience questions and comments will be included, and the following issues will be addressed: the use of formal risk assessment, short-term versus long-term risks for completed suicide, the difference between epidemiologic data and clinical pictures for prediction, clinician concerns regarding malingering and secondary gain, and effective interventions in correctional settings. A basic knowledge of the literature regarding suicide risk assessment and an interest in suicide prevention in forensic settings are desirable. At the conclusion of the workshop, the participant should be able to identify inmates in correctional facilities who pose a particularly high risk for suicide attempts in the near future and should have a clear understanding of how to evaluate and manage suicide risk in correctional inmates.

## REFERENCES:

1. Hayes LM: Prison Suicide: An Overview and Guide to Prevention. Mansfield, Mass, National Institute of Corrections, 1995.

2. Jacobs DG: Guide to Suicide Assessment and Intervention. San Francisco, Jossey-Bass, 1999.

## Issue Workshop 27
## THE IMPACT OF SUICIDE ON CLINICIANS

*Chairperson:* Eric M. Plakun, M.D., *The Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262*
*Participants:* Jane G. Tillman, Ph.D., Edward R. Shapiro, M.D., Edward K. Rynearson, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant 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 who committed suicide and those who will. Mental health clinicians often have less contact with death 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 and the empathic attunement and emotional availability to patients that is part of mental health clinical work. This workshop offers an initial presentation from a pilot study revealing seven thematic clinician responses to suicide: initial shock; grief and sadness; changed relationships with colleagues; dissociation; grandiosity, shame, and humiliation; crisis of faith in treatment; and an effect on work with other patients. In a second presentation, suicide will be explored as one form of violence that affects clinicians. Exploring therapist responses to suicide and violence offers an opportunity to anticipate and avoid professional isolation and disillusionment and may help professionals provide and receive help during such crises. The workshop will include ample time for interactive discussion with participants about their own experiences with patient suicides.

### REFERENCES:

1. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. J Psychother Pract Res 1994, 3:138–148.
2. Powell J, Geddes J, Deeks J, et al: Suicide in psychiatric hospital inpatients. Br J Psychiatry 2000; 176:272.

## Issue Workshop 28
## EVIDENCE-BASED MEDICINE: AN APPLICATION IN CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY

*Co-Chairpersons:* Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390,* Robert A. Kowatch, M.D., *Department of Psychiatry, University of Cincinnati, 231 Bethesda Avenue, PO Box 670559, Cincinnati, OH 45267-0559*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to demonstrate knowledge of EBM terminology and discuss its application in child and adolescent psychopharmacology.

### SUMMARY:

Evidence-based medicine is increasingly being recognized as what will become the working standard in clinical decision making. In psychiatry, there are few systematic reviews of the literature that use evidence-based medicine (EBM) techniques. The purpose of this workshop is to provide the participants with an overview of the basic principles of EBM and their applications in psychiatry. The workshop will begin with a review of basic principles and terms of EBM. The general EBM guidelines will be reviewed as they apply to other areas of medicine and diseases such as hypertension and diabetes. Subsequently, each chairperson will give a 15-minute review of an area in child and adolescent psychopharmacology in which EBM techniques have been applied. These will include the psychopharmacological treatment of bipolar and depressive illnesses.

Following these presentations, participants will review several recent articles using these technologies. Questions regarding the types of cases that might best fit EBM analytic techniques and how clinicians might utilize these techniques in their own private practices will be discussed. Last, the best sources of reference materials available for EBM in mental health will be discussed.

### REFERENCES:

1. Sackett DL, Straus S, Richardson WS, et al.: Evidence-Based Medicine: How to Practice and Teach Evidence-Based Medicine. 2nd ed. Edinburgh, Churchill Livingston, 2000.
2. Clinical Evidence Mental Health. London, BMJ Publishing Group, 2002.

## Issue Workshop 29
## PSYCHOTHERAPY WITH AFRICAN-AMERICAN PATIENTS: TRAINING PERSPECTIVES

*Co-Chairpersons:* Anu A. Matorin, M.D., *UT-Medical School Houston, 1300 Moursund, Houston, TX 77030,* Irma J. Bland, M.D., *Mental Health-Region 1, Regional Administrator/CEO, 136 South Roman Street, 2nd Floor, New Orleans, LA 70112*
*Participants:* Henry L. McCurtis, M.D., Pedro Ruiz, M.D., Sujit R. Varma, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the unique complexities of learning to do psychotherapy with ethnic minority patients, particularly African American patients, and help develop creative and practical treatment strategies in the context of residency training.

### SUMMARY:

In recent years, the topic of psychotherapy has become very prominent in the United States. Managed care not only has challenged psychiatrists' ability to do psychotherapy, but evidence-based medicine has also placed a series of research-oriented demands on psychotherapists. While this issue is being widely debated, little emphasis has been given to the issue of cross-cultural psychotherapy focusing on the ethnic minority groups who reside in the United States. The presenters focus on the unique issues and challenges faced by psychiatric residents in attempting to treat African American patients with psychotherapy. This workshop will briefly address the case of an African American woman treated with psychotherapy by a PGY-3 resident in the Department of Psychiatry and Behavioral Sciences at the University of Texas at Houston. Special focus will be given to the African American culture within the context of the majority culture. Additionally, the presenters will address the appropriate role of supervision and other training initiatives directed to achieve an optimal learning experience during residency training. Finally, the presenters will promote a productive exchange of ideas with the participants of the workshop.

### REFERENCES:

1. Neighbors HW, Jackson JS, Broman C, et al: Racism and the mental health of African Americans: the role of self and system blame. Ethnicity of Disease 1996, 6:167–175.

2. Carter JH: Frequent mistakes made with black patients in psychotherapy. J Nat Med Assoc 1979; 71:1007–1009.

## Issue Workshop 30
## MIND-BODY CONNECTION IN TRADITIONAL CHINESE MEDICINE

*Co-Chairpersons:* Jing-Duan Yang, M.D., *Department of Psychiatry, Jefferson Medical College, 833 Chestnut East, Suite 210, Philadelphia, PA 19107,* Daniel A. Monti, M.D., *Department of Psychiatry, Jefferson Medical College, 1020 Sansom Street, Suite 1652 Thomp, Philadelphia, PA 19107*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants should be able to understand mind-body interaction in the paradigm of traditional Chinese medicine and have a better appreciation of how TCM modalities work in treating mental and physical ailments.

### SUMMARY:

There is increasing scientific literature regarding the close interactions of body and mind. Traditional Chinese medicine (TCM) has long recognized these interactions and applied them to health maintenance and the treatment of physical and mental disorders. In particular, there is evidence to support that TCM modalities, such as acupuncture, have efficacy in treating some mental and physical ailments, such as pain, addiction, and depression. This workshop explores why these TCM modalities are able to produce such effects—with a particular focus on the TCM paradigm of mind-body interactions. The panelists will present theoretical and clinical materials illustrating these interactions and provide an Eastern perspective on psychosomatic disorders. The audience will be encouraged to participate in discussion and provide viewpoints on the topics presented.

### REFERENCES:

1. Allen JJB: An acupuncture treatment study for unipolar depression. Psychol Sci 1998; 9:397–401.
2. Shang C: Emerging paradigms in mind-body medicine. J Altern Complement Med 2001; 7:83–91.

## Issue Workshop 31
## COGNITIVE THERAPY FOR PERSONALITY DISORDERS

*Chairperson:* Judith S. Beck, Ph.D., *Cognitive Therapy & Research, The Beck Institute, 1 Belmont Avenue, Suite 700, GSB Bldg, Bala Cynwyd, PA 19004*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) conceptualize personality disorder patients according to the cognitive model, (2) recognize therapeutic alliance issues in treatment of personality disorders, (3) and 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 ten 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, development of the therapeutic relationship, treatment planning, and the adjunctive use of medication. Role-playing will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout, and a final segment will instruct interested participants in the steps they can take to learn about this empirically validated approach for a difficult patient population.

### REFERENCES:

1. Beck AT, Freeman A, et al: Cognitive Therapy of Personality Disorders. New York, Guilford, 1990.
2. Beck JS: Cognitive approaches to personality disorders, in American Psychiatric Press Review of Psychiatry, Vol. 1. Edited by Dickstein L, Riba MB, Oldham JM. Washington, DC, American Psychiatric Press, 1997.

## Issue Workshop 32
## DISCUSSING THE CONCEPT OF MENTAL HEALTH COURTS

*Chairperson:* Lawrence K. Richards, M.D., *Department of Psychiatry, 5266 North Valentine, #102, Fresno, CA 93711*
*Participants:* Honorable Harold Shabo, J.D., Honorable Peggy Hora, J.D., Pauline H. Tesler, J.D., Meghan Lang, J.D., Allison Ganter, M.S.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to discuss the concept of mental health courts and understand issues related to their origination, evolution, current standing, and anticipated future.

### SUMMARY:

While the most important and organized type of mental health court may be that for juveniles, there are drug courts per se, and family law and family court are undergoing their own evolution. The concepts of Therapeutic Jurisprudence are influencing this. The mental health court's applicability toward juvenile issues will be discussed. California has two of the better known such courts, one in Los Angeles County and one in Santa Clara. The National Center for Youth Law has recently expanded its work by arranging for the services of a UCLA graduate who will assist those courts in gaining access to and coordination of various agency resources and programs. Many children are in detention for delinquent behaviors stemming primarily from mental illness. Thirty to 75 percent of incarcerated youth nationwide have a diagnosible mental illness, and possibly 20% of those have more serious disorders such as bipolar disorder or major depression. In Los Angeles and Santa Clara, prosecutors, public defenders, and the courts collaborate under close court supervision to divert youth from the dead-end of Juvenile Hall, with treatment emphasized.

Civil child advocates are needed to help youth obtain necessary social services, and it is anticipated links between advocates and juvenile justice partners will facilitate this.

### REFERENCES:

1. Arredondo DE, et al: Juvenile mental health court: rationale and protocols. Juvenile and Family Court Judge 2001; Fall, pp 1–19.
2. Babb B, Moran J: Substance abuse, families, and unified family courts: the creation of a caring justice system. Journal of Health Care Law and Policy 1999; 3:1.

Issue Workshop 33
## LEARNING PSYCHOTHERAPY IN PRIVATE PRACTICE

*Co-Chairpersons:* Bernard D. Beitman, M.D., *Department of Psychiatry, University of Missouri, 3 Hospital Drive, Columbia, MO 65201,* Rodrigo A. Munoz, M.D., *University of California at San Diego, 3130 5th Avenue, San Diego, CA 92103*
*Participants:* Harold I. Eist, M.D., Roger Peele, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to use the ideas presented to evaluate and enhance their skills in psychotherapy.

### SUMMARY:

Psychotherapy is a crucial element in the nation's healthcare system, yet there is no standard introduction to its practice. Each training program finds its own, sometimes idiosyncratic, niche and is not called to the task of demonstrating effectiveness. Those programs that offer structured training in key approaches tend not to present models that integrate the various schools.

Dr. Beltman has extensive experience in training residents in the crucial elements of psychotherapy. His program, started at the University of Missouri-Columbia and at Stanford University, is now used by more than 40 universities in the United States, as well as in Australia, Spain, and Latin America.

Can these psychotherapy training modules based upon common factors while recognizing individual differences be extended to those now in the private practice of psychiatry? This workshop presents the challenges and opportunities offered by the creation of a common ground in the use of psychotherapy in everyday practice. The participants, coming from very different backgrounds, share a major interest in promoting quality, validity, and efficacy in psychotherapy.

### REFERENCES:

1. Beitman BD, Yue D: Learning Psychotherapy. New York, WW Norton, 1999.
2. Sartorias N, De Girolamo G, et al (eds): Treatment of Mental Disorders: A Review of Effectiveness. Washington, DC, American Psychiatric Press, 1993.

Issue Workshop 34
## PATIENT RESPONSIBILITY FOR ADDICTION TO PRESCRIBED SUBSTANCES

*Chairperson:* Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medical School, 96 Larchwood Drive, Cambridge, MA 02138-4639*
*Participants:* Paul K. Robindra, D.P.H., Brian Johnson, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to reliably evaluate patient responsibility for addiction to prescribed and nonprescribed substances in clinical and forensic contexts.

### SUMMARY:

Drug use, abuse, and dependency vary among members of the population based upon drug, set, and setting. Recent work has focused on the question of responsibility for addiction. A related question is whether there is a difference in patient responsibility for addiction to prescribed versus nonprescribed substances.

The question of responsibility for addiction to prescribed substances will be explored across a variety of treatment settings including primary care, traditional psychiatric, and managed health care dominated treatment contexts. The results of an evidence-based review and analysis will be presented, including characteristic differences between those who become dependent upon prescribed medications versus those who become dependant upon nonprescribed substances.

Workshop participants will be facilitated in conducting a review and analysis of their own clinical and forensic case experience involving approaches and methods for evaluating patient responsibility for addiction to prescribed and nonprescribed substances. The workshop is appropriate for all psychiatrists, particularly those with experience in the treatment or forensic evaluation of addictive behaviors.

### REFERENCES:

1. Committee on Addictions of the Group for the Advancement of Psychiatry: Responsibility and choice in addiction. Psychiatr Serv 2002; 53:707–713.
2. Bursztajn HJ, Brodsky A: Captive patients, captive doctors: clinical dilemmas and interventions in caring for patients in managed health care. Gen Hosp Psychiatry 1999; 21:239–248.

## TUESDAY, MAY 20, 2003

Issue Workshop 35
## BRIEF PSYCHODYNAMIC PSYCHOTHERAPY OF PANIC: A LEARNING-STRATEGY APPROACH

*Co-Chairpersons:* Bryan K. Touchet, M.D., *4502 East 41st Street, Tulsa, OK 74135-2512,* Kim A. Coon, L.P.C., *University of Oklahoma, 4502 East 41st Street, Tulsa, OK 74135*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to list several learning strategies that may present in a group of trainees, formulate panic symptoms from a psychodynamic perspective, and understand the theory and techniques utilized in Milrod and colleagues' manual.

### SUMMARY:

Reflecting research gains in the neurosciences and market forces in mental health care, contemporary psychiatry training programs often emphasize biological models and treatments. Counterbalancing these forces is the recent ACGME mandate requiring that psychiatry residents be trained for measurable competency in five psychotherapy models, one of which is psychodynamic psychotherapy. This workshop involves participants in a psychodynamic psychotherapy-teaching model in development at the University of Oklahoma—Tulsa, Department of Psychiatry. The format uses an "engager" learning strategy as defined by ATLAS (Assessing the Learning Strategies of Adults) and teaches competencies through a time-limited, manual-guided treatment of a simulated patient with a specific DSM-IV disorder (panic disorder). The participants in this workshop will discover several learning strategies including their own by using the self-administered ATLAS, will acquire knowledge of the psychodynamic formulation of panic and its treatment through a brief lecture presentation, and will begin developing procedural knowledge of brief psychodynamic psychotherapy of panic through "engaging" group analysis and discussion of videotape simulation of patient-therapist dialogue. This workshop is targeted to academic mental health professionals interested in learning and teaching a model of psychodynamic psychotherapy.

### REFERENCES:

1. Conti GJ, Kolody RC: Guide for Using ATLAS: Assessing the Learning Strategies of Adults. Stillwater, Okla, Oklahoma State University, 1999.

2. Milrod B, Busch F, Cooper A, et al: Manual of Panic-Focused Psychodynamic Psychotherapy. Washington, DC, American Psychiatric Press, 1997.

## Issue Workshop 36
## CONSENT EVALUATIONS: ASSESSING CAPACITY FOR DECISION MAKING AND FOR VOLUNTARISM

*Chairperson:* Laura W. Roberts, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker NE, Albuquerque, NM 87131*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants should be able to characterize the essential components of informed consent and to apply a framework for assessing decisional capacity and voluntarism capacity in consent evaluations.

### SUMMARY:

This workshop offers an introduction to the ethically and legally important practice of informed consent and to the tasks of evaluating decisional capacity and capacity for voluntarism. The workshop leader will present the essential components of informed consent, including the nature of the relationship and decision, the content and process of information-sharing, four elements of decisional capacity, and four elements of voluntarism capacity. Distinctions between informed consent and refusal, between high-risk and low-risk decisions, and between clinical and research consent will be carefully outlined. The material will be presented in a manner that is down-to-earth and memorable. This workshop will make extensive use of videotaped materials from the media and from clinical and research settings to illustrate key teaching points. Specific methods for evaluation and documentation will be illustrated. Resources for further study will be provided to all participants. This basic workshop will be of interest to a diverse audience, including clinicians, residents, researchers, and academic faculty.

### REFERENCES:

1. Roberts LW: Informed consent and the capacity for voluntarism. Am J Psychiatry 2002; 159:705–712.
2. Appelbaum PS, Grisso T: Assessing patients' capacities to consent to treatment. New Eng J Med 1988; 319:1635–1638.

## Issue Workshop 37
## ARTISTIC USE OF THE CREATIVE UNCONSCIOUS IN THE THERAPEUTIC ALLIANCE

*Co-Chairpersons:* Ian E. Alger, M.D., *500 East 77th Street, #132, New York, NY 10162-0021,* Ferruccio A. di Cori, M.D., *University of Rome, via della Piramide Cestia 1, Rome, Italy*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to appreciate the complexity and therapeutic potential of the merging of collaborative artistic expression in a therapeutic context.

### SUMMARY:

This workshop will feature a live spontaneous demonstration by Ferruccio di Cori, M.D., Professor of Psychiatry in the Department of Literature at the University of Rome. Dr. di Cori, well-known for his creative teaching and therapeutic work with psychodrama, has developed a creative, artistic psychotherapy that involves a dual approach in a collaborative interplay between patient and therapist, between painting and poetry. This method has been used especially with patients having difficulties in adapting to academic work or showing signs and symptoms of a depressive syndrome.

During the workshop, the "patient" will spontaneously create a surrealistic watercolor painting, and then Dr. di Cori, in the role of therapist, will write a spontaneous creative literary response to the patient's painting. The two participants will then enter into a dialogue about this mutually creative experience, and the audience will be invited to share their responses and to consider with the artist and Dr. di Cori the therapeutic implications of this innovative creative/therapeutic interaction.

### REFERENCES:

1. McManus IC: Humanity and the medical humanities. Lancet 1995; 346:1143–1145.
2. Horowitz HW: Poetry on rounds: a model for the integration of humanities into residency training. Lancet 1996; 347:447–449.

## Issue Workshop 38
## PSYCHIATRY TRAINING FOR PRIMARY CARE PHYSICIANS: WHAT, HOW MUCH, AND HOW?

*Chairperson:* Hoyle Leigh, M.D., *Department of Psychiatry, University of California, 2615 East Clinton Street, Room 2A24, Fresno, CA 93703-2223*
*Participants:* Deborah C. Stewart, M.D., Tana A. Grady-Weliky, M.D., Don R. Lipsitt, M.D., Seth M. Powsner, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify specific areas of need for psychiatric training in primary care and render an opinion about minimal psychiatric competence for primary care.

### SUMMARY:

A majority of primary care training directors are dissatisfied with the current status of psychiatry training in their programs. The moderator of this workshop will briefly present preliminary findings of a current survey addressing this issue. The following questions will be posed: What mental health skills and knowledge are appropriate to which primary care programs? What is the proper role of primary care physicians in diagnosing and treating various psychiatric conditions, such as somatoform disorders and psychiatric emergencies? How much of the training should be done in medical school as opposed to residency? Are there special psychiatric training needs for pediatrics? Are joint psychiatry–primary care programs useful? Dr. Grady-Weliky will discuss her extensive experience in medical education and a joint psychiatry–primary care training program. Dr. Stewart will draw from her experience as a pediatrician as well as an associate dean for medical students. Dr. Lipsitt will report on a focus group survey on psychiatric curricula for primary care physicians. Dr. Powsner will discuss the interface between primary care and emergency psychiatry. Presentations will be limited to 60 minutes, with 30 minutes for discussion with the audience. The discussion is expected to stimulate psychiatric educators to develop a set of minimal competencies in mental health for primary care training programs and to generate ideas that will lead to the development of more effective and efficient curricular models.

### REFERENCES:

1. Hodges B, Inch C, Silver I: Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950–2000: a review. Am J Psychiatry 2001; 158:1579–1586.
2. Horowitz L, Kassam-Adams N, Bergstein J: Mental health aspects of emergency medical services for children: summary of a consen-

sus conference. Academic Emergency Medicine 2001; 8:1187–1196.

## Issue Workshop 39
## DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINE PATIENTS

*Co-Chairpersons:* Eric M. Plakun, M.D., *The Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262,* Edward R. Shapiro, M.D., *Admissions, Austen Riggs Center, 25 Main Street, PO Box 962, Stockbridge, MA 01262-0962*

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to enumerate principles in the dynamic psychotherapy of self-destructive patients with borderline personality disorder, implement newly acquired skills in establishing and maintaining a therapeutic alliance with such patients, and be familiar with the countertransference problems inherent in work with these patients.

### SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable challenge for the 21st-century psychiatrist. Although much has been written about metapsychological issues in psychodynamic psychotherapy, little has been written to help clinicians establish a viable therapeutic relationship with these patients. This workshop begins with a presentation of eight principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The principles are (1) differentiation of lethal from nonlethal self-destructive behavior, (2) inclusion of lethal self-destructive behavior in the initial therapeutic contract, (3) metabolism of the countertransference, (4) engagement of affect, (5) nonpunitive interpretation of the patient's aggression, (6) assignment of responsibility for the preservation of the treatment of the patient, (7) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (8) provision of an opportunity for reparation. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

### REFERENCES:

1. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. J Psychother Pract Res 1994; 3:138–148.
2. Plakun EM: Making the alliance and taking the transference in work with suicidal borderline patients. J Psychother Pract Res 2001; 10:269–276.

## Issue Workshop 40
## THE DEVELOPMENT, IMPLEMENTATION, AND OPERATION OF DIVERSE TELEPSYCHIATRY PROGRAMS

*Chairperson:* Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*
*Participants:* Donald M. Hilty, M.D., Beverly N. Jones, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be familiar with factors concerning the development and implementation of telepsychiatry programs involving three different populations: children and adolescents at a community mental health facility, adults using a consultation-liaison model, and a geriatric population in nursing homes.

### SUMMARY:

Telepsychiatry is increasingly being discussed as a viable alternative therapeutic modality for the delivery of care to a broad range of clinical populations in many diverse settings. For those beginning to consider telepsychiatry for their practice, few resources are available to provide guidance from the consideration of a project to its development, implementation, and operation. The three presenters have been involved with successful, ongoing telepsychiatry projects involving different-aged populations in diverse settings, e.g., children and adolescents at a community mental health facility, adults using a CL model, and a geriatric population in nursing homes.

Fifteen-minute presentations will be given by each participant about the critical issues that were involved with starting and maintaining the telepsychiatry program. The audience members can then ask questions about their own telepsychiatry efforts, how to best pursue these efforts in different arenas, and how to obtain funding, deal with contract and legal issues, and ultimately sustain their programs. Active participation will be emphasized for all members of the audience to help them develop more active, strategic plans for how they can pursue their own telepsychiatric programs.

### REFERENCES:

1. Hilty DM, Luo JS, Morache C, et al: Telepsychiatry: what is it and what are its advantages and disadvantages? CNS Drugs 2002; 16:527–548.
2. Loane M, Wootton R: A review of guidelines and standards for telemedicine. J Telemed Telecare 2002; 8:63–71.

## Issue Workshop 41
## CHALLENGING BEHAVIOR, MENTAL ILLNESS, AND DEVELOPMENTAL DISABILITIES

*Co-Chairpersons:* Earl L. Loschen, M.D., *1516 Denison Drive, Springfield, IL 62794-9642,* Robert J. Pary, M.D., *SIU School of Medicine, PO Box 19642, Springfield, IL 62794-9642*
*Participant:* Josefina M. Baluga, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify behaviors and symptoms in persons with developmental disabilities that may indicate an underlying mental illness, propose diagnostic processes, and outline how this diagnostic understanding can affect the treatment of challenging behaviors.

### SUMMARY:

About 40% to 50% of persons with developmental disabilities may experience mental illness. Although developmental disabilities are relatively rare in the community, there are millions of persons with these diagnoses. The presentation of mental illness in this population is often not straightforward. In many instances the patient presents with a variety of challenging behaviors such as aggression or self-injurious behavior. Patients with depression are often noted to be self-injurious, and others with bipolar disorder can be seen as aggressive. These symptoms are not specific and therefore pose serious diagnostic challenges to the psychiatrist. This workshop will explore the diagnostic dilemmas posed by this population of patients using case examples and audience participation in identifying potential diagnostic issues and discussion of relevant clinical issues. The use of alternative data gathering techniques will be discussed as one of many methods to enhance the diagnostic process. A series of case examples will be presented with opportunity for the audience to provide postulated diagnostic impressions as well as discussion of the issues presented by the case. This session is for psychiatrists

who may see persons with developmental disabilities in their practice and who are challenged to provide recommendations for treatment.


## REFERENCES:

1. Lowry MA, Charlot LR: Depression and associated aggression and self-injury. NADD Newsletter 1996; 13(5):1–5.
2. Fletcher R, Menolascino F: Mental Retardation and Mental Illness. New York, Lexington Books, 1989.


## Issue Workshop 42
## TREATMENT OF SCHIZOPHRENIA: ANTIPSYCHOTIC POLYPHARMACY VERSUS MONOTHERAPY


*Chairperson:* Andre Tapp, M.D., *28932 11th Place South, Federal Way, WA 98003-3706*
*Participants:* Donald C. Goff, M.D., William G. Honer, M.D., Alexander L. Miller, M.D., Robert A. Rosenheck, M.D.


## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to consider whether the practice of using combination antipsychotic therapy is justified and evaluate the need for using higher doses of atypical antipsychotics rather than combination therapy in some patients.

## SUMMARY:


Antipsychotic polypharmacy, once ananthema among clinicians, is finding a comeback in modern practice. Antipsychotic polypharmacy, usually by combining a conventional antipsychotic with one of the newer atypical agents, is relatively common in today's practice, yet the evidence to support this practice is slim and relies mostly on case reports and retrospective studies. The presenters will discuss different aspects of the antipsychotic polypharmacy issue. Dr. Tapp will present a survey of prescribers using combination therapy and will discuss the reasons clinicians are using the combination. He will also present a retrospective study of antipsychotic polypharmacy to show the effect of this practice on this sample of patients. Dr. Miller will present a psychopharmacological paradigm using the Texas State system and the experience of its application with a focus on the use of antipsychotic polypharmacy. Dr. Goff will review the literature and present his own research on the use of antipsychotic polypharmacy. Dr. Rosenheck will present data on the use of combination antipsychotic therapy within Veterans Affairs health care settings and the outcome data related to this practice. Dr. Honer will review the purported mechanism of action as it relates to combination antipsychotic use. After the presentation, the panel will lead an open forum to discuss the optimal treatment for patients with persistent symptoms of schizophrenia. Members of the audience will be encouraged to participate in this discussion.



## REFERENCES:

1. Goff DC, Freudenreich O, Evins AE: Augmentation strategies in the treatment of schizophrenia. CNS Spectrums 2001; 6:904–911.
2. Leslie DL, Rosenheck RA: Use of pharmacy data to assess quality of pharmacotherapy for schizophrenia in a national health care system: individual and facility predictors. Med Care 2001; 39:907–909.


## Issue Workshop 43
## RELEVANT DATA FOR THE PRACTICING PSYCHIATRIST: COMORBIDITIES/COMBINED TREATMENT


*Chairperson:* Daniel A. Deutschman, M.D., *Department of Psychiatry, Case Western Reserve University, 18051 Jefferson Park Road, Middleburg Heights, OH 44130*
*Participants:* Terence L. Witham, M.D., John S. Lloyd, Ph.D., Robert J. Ronis, M.D., Rebecca S. Bierman, D.O. Stephen M. Goldfinger, M.D.


## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand (1) the safety, tolerability, and efficacy of combined pharmacotherapy approaches for comorbid, high-risk, treatment-resistant patients and (2) the utility of well-designed electronic medical records for naturalistic study data collection.

## SUMMARY:


The literature on medication treatment for depression, mood instability, and psychosis is largely based on prospective, "double-blind" studies of patients who meet rigorous inclusion/exclusion criteria. Unfortunately, fewer than 15% of patients seen in psychiatric practice meet these criteria. The generalizability of the data gathered in this manner is in question. Additionally, many patients respond incompletely to monotherapy. Limited literature is available to guide psychiatrists in the combined-agent treatment for these patients.

Naturalistic studies using Electronic Medical Records (EMR) in real-world situations can allow tracking of comorbid, high-risk patients who require treatment with multiple agents. This workshop will review the data gathered on an "open-label" series of 7,500 comorbid patients receiving combination pharmacotherapy who were seen in more than 40,000 interviews. The EMR allows retrospective cross-referencing of all elements in the dataset. Age range was 5 to 96 years. The population was > 90% white. Less than 10% were chronically mentally ill. The discussants have wide experience supervising residents, VAH, and CMHC psychiatrists in the treatment of complex patients. They will critique the EMR, the data collection methods, the complexity of the patient comorbidities, and the results of the combined therapies.



## REFERENCES:

1. Lam RW, et al: Combined antidepressants for treatment-resistant depression: a review. J Clin Psychiatry 2002; 63:685–693.
2. Zimmerman M, Mattia JI, Posternak MA: Are subjects in pharmacological treatment trials of depression representative of patients in routine clinical practice? Am J Psychiatry 2002; 159:469–474.


## Issue Workshop 44
## THE BENZODIAZEPINE CONTROVERSY


*Co-Chairpersons:* Christopher K. Chung, M.D., *Department of Psychiatry, Harbor UCLA Medical Center, 1000 West Carson Street, Torrance, CA 90509,* Dean M. De Crisce, M.D., *Harbor-UCLA Medical Center, 1000 West Carson Street, Box 498, Torrance, CA 90509*
*Participants:* Stephen B. Seager, M.D., Ricardo P. Mendoza, M.D., John W. Tsuang, M.D.


## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant will be able to appreciate the controversy surrounding the use and misuse of benzodiazepines and their utility in treating various psychiatric disorders and will also be more aware of the growing politics restricting their use in some locations.

## SUMMARY:


A recent decision was made by the Los Angeles County Department of Mental Health to remove most benzodiazepines from the county formulary, affecting the treatment of thousands of patients. Benzodiazepines are minor tranquilizers that are used to treat panic disorder, anxiety disorders, insomnia, medication side effects, catatonia, alcohol withdrawal, and other psychiatric conditions. Although they have a dependency liability, they are effective and are considered the "gold standard" in treating some selected patients. This recent move is similar to changes made in other locales, such as the decision

to include benzodiazepines in the triplicate program of the city of New York in the 1980s.

This workshop will engage pharmacotherapists, through active discussion, in the philosophy of benzodiazepine use and will consider the controversies, from differing standpoints, surrounding long-term treatment, conservative management, and their use in the treatment of the substance abusing patient. This recent restrictive decision offers the opportunity to examine the dilemna between clinical decision making and political decision making regarding choice of treatment. Active discussion between the participants and presenters will be encouraged in order to facilitate the open examination of ideas and clinical experiences.

## REFERENCES:

1. Schwartz HI, Blank K: Regulation of benzodiazepine prescribing practices: clinical implications. Gen Hosp Psychiatry 1991; 13:219–224.
2. Moller HJ: Effectiveness and safety of benzodiazepines. J Clin Psychopharmacol 1999;19(6 Suppl 2):2S–11S.

## Issue Workshop 45
## SURGEON GENERAL'S REPORT ON CULTURE, RACE, AND ETHNICITY: CLINICAL IMPLICATIONS

*Chairperson:* Theresa M. Miskimen, M.D., *Department of Psychiatry, UMDNJ-RWJ University Hospital, 11 Graham Place, Englishtown, NJ 07726*
*Participants:* Nang Du, M.D., James W. Thompson, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, 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's General 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 of seeking and receiving good quality mental health treatment need to be understood and addressed not only by researchers but also by clinicians who will ultimately confer services. The panelists will 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 the 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 specifically 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, US 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, et al: Filters on the pathway to mental health care: II. sociodemographic factors. Psychol Med 1995; 25:1149–1160.

## Issue Workshop 46
## THE PSYCHIATRIC CARE OF SURVIVORS OF TORTURE

*Chairperson:* Asher D. Aladjem, M.D., *Primary Care, Bellevue, NYU, 550 First Avenue, New York, NY 10016*
*Participants:* Kimberly A. Busi, M.D., Sophia Banu, M.D., Hawthorne Smith, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the end of the workshop, the participant should be able to identify the unique mental health care needs of patients who are survivors of torture and other human rights abuses, to understand the elements of a collaborative treatment model, to appreciate the unique issues faced in education and supervision of trainees in this area, and to be aware of a new psychiatric fellowship focused on this patient population.

## SUMMARY:

Psychiatrists and psychologists from the Bellevue/NYU Program for Survivors of Torture will lead an issues workshop to expose participants to the unique mental health needs of patients who are survivors of torture and other human rights abuses.

Developed in response to the high prevalence of patients who were survivors of severe human rights abuses in the clinics at Bellevue Hospital, the Bellevue/NYU Program for Survivors of Torture is the first comprehensive treatment center for survivors of torture in the New York City area. Clinicians will describe the program and outline how the services address unique needs of this underserved patient population. A collaborative treatment model will be presented. In addition, the educational and research activities of program clinicians will be discussed, including the first fellowship in the psychiatric care of survivors of torture and other human rights abuses, inaugurated by the program in 2001. Finally, clinical material about the psychiatric care of Tibetan refugees will be presented as a clinical example in a specific cultural group.

The four panelists will give brief, informal presentations lasting no more than 15 minutes each. In the remainder of the workshop, presenters will answer questions and solicit audience participation by raising specific issues for discussion.

## REFERENCES:

1. Keller AS, Saul JM, Eisenman DP: Caring for survivors of torture in an urban, municipal hospital. J Ambul Care Manage 1998; 21(2):20–29.
2. Eisenman D, Keller As, Kim, G: Survivors of torture in a general medical setting: how often have patients been tortured, and how often is it missed? West J Med 2000; 172:301–304.

## Issue Workshop 47
## DEVELOPMENT OF THE SCHOOL-BASED ADOLESCENT DEPRESSION AWARENESS PROGRAM

*Co-Chairpersons:* Karen L. Swartz, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 3-181, Baltimore, MD 21287-7381,* Todd S. Cox, M.D., *Georgetown University Hospital, 3800 Reservoir Road, 616 Kober, Washington, DC 20007-2197*
*Participants:* Elizabeth A. Kastelic, M.D., Sallie Mink, R.N.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify the steps in developing a curriculum to educate the community about mental health issues, distinguish an educational program from a screening or clinical program, and understand the methods used to assess education program effectiveness.

## SUMMARY:

This presentation will describe the development of the Adolescent Depression Awareness Program (ADAP), a standardized curriculum to educate high school students, teachers, and parents about teenage depression. In contrast to other school-based programs, ADAP has a curriculum focused on education about depression as a treatable medical illness. The process for assessing such a curriculum includes comparison of alternative methods. The students were exposed to either the full curriculum (three hours of in-class instruction) or a limited curriculum (one-hour presentation). To objectively assess the program's effectiveness, pretests and posttests were administered to students in both groups. Data from the past year, based on test data from 1,679 students in the full curriculum and 466 students in the limited curriculum, will be presented. The workshop will discuss three areas: a review of other school-based programs and development of the ADAP curriculum; content of the curriculum, including use of the video *Day for Night: Recognizing Teenage Depression;* and methods for assessing the curriculum's effectiveness with a discussion of results. Audience participation will involve a discussion following each section. Discussion topics will include other educational programs, the key elements for education about depression, and methods to assess any community education program.

## REFERENCES:

1. Shaffer D, Vieland V, Garland A, et al: Adolescent suicide attempters: response to suicide-prevention programs. JAMA 1990; 264:3151–3155.
2. Shaffer D, Garland A, Vieland V, et al: The impact of curriculum-based suicide prevention programs for teenagers. J Am Acad Child Adolesc Psychiatry 1991; 30:588–596.

## Issue Workshop 48
## DEVELOPMENTS IN COGNITIVE THERAPY FOR SCHIZOPHRENIA

*Chairperson:* David G. Kingdon, M.D., *1st Floor Department of Psychiatry, University of Southampton, Brintons Terrace, Southampton SO14 OYG, England*
*Participant:* Douglas Turkington, M.B.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to critically appraise the evidence for the effectiveness of CBT for schizophrenia and understand the approach being used in general psychiatric settings to manage positive and negative symptoms.

## SUMMARY:

Evidence for the effectiveness of cognitive therapy in schizophrenia is growing: there are now 14 randomized clinical trials and a number of meta-analyses. This evidence will be critically reviewed with the audience, and indications for treatment will be discussed. The strongest evidence is for treatment of persistent positive symptoms, but three studies have also shown results for negative symptoms.

The techniques being used will be briefly described and their application to routine clinical practice demonstrated by using videotape and role-play. These techniques are based on a psychiatric formulation, which elicits vulnerabilities and strengths and examines possible precipitating events and circumstances in understanding current symptoms. They are then used for focused work, e.g., for compliance management and work on hallucinations, delusions, thought disorder, and negative symptoms. Structured reasoning can assist in reattribution of "voices," development of coping strategies, and empowerment in managing critical content. Patients with delusions may benefit from understanding perpetuating factors, e.g., low self-esteem and isolation, and a systematic reorienting toward dealing with these issues. Negative symptoms seem to have benefited from attention to pacing, timing, and, paradoxically, reduction in perceived pressure. The audience will be strongly encouraged to contribute their own patient scenarios for discussion.

## REFERENCES:

1. Kingdon DG, Turkington D: A Casebook Guide to Cognitive Behaviour Therapy: Practice, Training and Implementation. Chichester, Wiley, 2002.
2. Gould RA, Mueser KT, et al: Cognitive therapy for psychosis in schizophrenia: an effect size analysis. Schizophr Res 2001; 48:335–342.

## Issue Workshop 49
## PSYCHIATRIC ILLNESS AND THE WORKPLACE

*Chairperson:* Steven E. Pflanz, M.D., *FE Warren AFB USAF, 68A Fort Warren Avenue, Cheyenne, WY 82001*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the relationship between work stress and mental health and the role of the psychiatrist in minimizing the effect 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 other mental health professionals are often faced with patients suffering from emotional distress that is attributed to job stress. Fifteen percent 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. The workshop will examine the common sources of job stress and the mechanisms by which work stress can lead to psychiatric illness. Last, the workshop will explore how the mental health professional can forge a partnership with patients and employers to reduce work stress and ameliorate or eliminate psychiatric illness in working patient populations.

## REFERENCES:

1. Pflanz SE: Occupational stress and psychiatric illness in the military: investigation of the relationship between occupational stress and mental illness amongst 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 50
## PSYCHIATRIC PERSPECTIVES ON THE EXECUTION PROCESS: A CONTINUING CONUNDRUM

*Chairperson:* Howard J. Osofsky, M.D., *Department of Psychiatry, Louisiana State University HSC, 1542 Tulane Avenue, New Orleans, LA 70112-2865*
*Participants:* Rahn K. Bailey, M.D., Alfred M. Freedman, M.D., Abraham L. Halpern, M.D., Donna M. Mancuso, M.D., Michael J. Osofsky, Ira D. Glick, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the policies of the APA and the AMA related to physician participation in capital punishment as well as the ethical and psychological concerns of psychiatrists and others working within the execution process.

### SUMMARY:

For the past two decades a debate has persisted regarding what roles are ethically appropriate for psychiatrists in relation to executions. Should psychiatrists evaluate inmates for competency to be executed, prescribe medications to restore competency, or participate in a professional role at executions? Dr. Mancuso will review APA and AMA guidelines and their rationale. Drs. Halpern and Freedman will update their earlier positions about roles for psychiatrists, and Dr. Bailey will address other perspectives. Inmates on Death Row may suffer from severe mental illness, and record review sometimes indicates inadequate pretrial psychiatric evaluations. How should this problem be addressed? Death Row inmates can develop severe mental illness. How can their current condition and suffering be addressed without violating ethical principles? How can legal efforts help with this process? Mr. Osofsky will present findings from his applied mental health study in which he interviewed 200 correctional officers in three states who work with executions and inmates on Death Row. Although diffusing responsibility by stressing their roles as correctional officers, they present an interesting variety of concerns about the inmates, the victims, involved families, and their work. Hearing these officers' views will encourage the audience to confront complex feelings about executions and the roles that the psychiatric profession may play in furthering understanding of these issues.

### REFERENCES:

1. Freedman M, Halpern L: The psychiatrist's dilemma: a conflict of roles in legal executions. Aust N Z J Psychiatry 1999; 33:629–635.
2. American Medical Association Council on Ethical and Judicial Affairs: Physician participation in capital punishment: evaluation of prisoner competence to be executed: treatment to restore competence to be executed. CEJA Report, Section 6A-95, 1995.

## Issue Workshop 51
## FROM NEUROPATHOLOGY TO TREATMENT: EMERGING TREATMENT STRATEGIES FOR ALZHEIMER'S DISEASE

*Chairperson:* Jacobo E. Mintzer, M.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425*
*Participants:* Gary L. Wenk, Ph.D., David Snowdon, Ph.D., Rachelle S. Doody, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) detail the neuropathologic changes that occur in Alzheimer's disease, (2) explain the impact of these changes on cognition and functioning and the pharmacologic rationale for emerging treatment approaches, (3) evaluate evolving clinical trial data of both cholinergic and noncholinergic agents, and (4) discuss the efficacy and safety of combination treatment regimens for moderate-to-severe Alzheimer's disease.

### SUMMARY:

The pathologic processes that give rise to the impairments associated with Alzheimer's disease (AD) are complex and involve disturbances in numerous neurochemical pathways. Past research and treatment have focused primarily on augmenting cholinergic neurotransmission. More recent evidence suggests that changes in glutamatergic activity play an important pathophysiologic role in AD. Promising data suggest that agents that antagonize the excitotoxic effects of glutamate may provide neuroprotection and enhanced cognition in AD. One such agent, memantine, is a moderate-affinity, uncompetitive *N*-methyl-D-aspartate (NMDA) receptor antagonist that has shown positive results in clinical trials for the treatment of AD. These data, as well as evolving clinical trial data with acetylcholinesterase inhibitors, will be reviewed. Whether a combination of these two therapeutic approaches is more beneficial at slowing the progression of AD will also be explored through the evaluation of recent data from a large, double-blind combination therapy study in patients with moderate to severe AD. An interactive panel discussion between the faculty and the audience will follow.

### REFERENCES:

1. Reisberg B, Möbius HJ, Stöffler A, et al: Long-term treatment with the NMDA antagonist memantine: results of a 24-week, open-label extension study in moderately severe to severe Alzheimer's disease (abstract # 2039.) Presented at the 8th International Conference on Alzheimer's Disease, July 20–25, 2002, Stockholm, Sweden.
2. Wenk GL, Hauss-Wegrzyniak B, Willard LB: Pathological and biochemical studies of chronic neuroinflammation may lead to therapies for Alzheimer's disease, in Research and Perspectives in Neurosciences: Neuro-Immune Neurodegenerative and Psychatric Disorders and Neural Injury. Edited by Patterson P, Kordon C, Christen Y. Heidelberg, Germany, Springer-Verlag, 2000 pp 73–77.

## Issue Workshop 52
## THE EMERGING ROLE OF PSYCHIATRY IN A BIOTERRORISM RESPONSE

*Chairperson:* Anthony T. Ng, M.D., *311 President Street., #2, Brooklyn, NY 11231*
*Participants:* Robert DeMartino, M.D., Kenneth S. Thompson, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, the audience will have a greater understanding of the role of psychiatrists in disaster preparedness and response to acts of biochemical terrorism.

### SUMMARY:

The mental health risks of biochemical terrorism have been of significant concern since the devastating attack on the World Trade Center on September 11th, 2001, followed by the anthrax attacks on the United States. While mental health consequences have been described in the aftermath of a biochemical terrorism incident, such as anxiety, depression, and symptoms of PTSD, the role of psychiatrist in disaster preparedness for biochemical terrorism response and

the acute response phase has been more theoretical. The discussants in this workshop will first provide an overview of the mental health concerns associated with biochemical terrorism as well as the overall role of psychiatrist in biochemical terrorism response. The mental health response from the institutional perspective will be illustrated by a description of the biochemical terrorism program at the University of Pittsburgh Medical Center Health System Bioterrorism Preparedness Group. Last, a description of an actual response by Disaster Psychiatry Outreach to the anthrax attacks at NBC and ABC in New York City will be discussed. The audience for the workshop will be mental health professionals who will likely be called upon in a biochemical terrorist incident. They can be psychiatrists or any mental health professionals who may interact closely with psychiatrists. The audience will supplement the discussants' presentation through interactive dialogue during the presentation as well as a more formal question-and-answer session at the end of the presentation. The audience will also be encouraged to relate any previous experience they may have had in mental health preparedness and response to acts of biochemical terrorism.

## REFERENCES:

1. Norwood AE, Holloway HC, Ursano RJ: Psychological effects of biological warfare. Milit Med 2001; 166:27–28.
2. North CS, Pfefferbaum B: Research on the mental health effects of terrorism. JAMA 2002; 288:633–636.

## Issue Workshop 53
## HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 1

*Co-Chairpersons:* William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*
*Participants:* Jacqueline M. Melonas, J.D., Martin G. Tracy, J.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should (1) know ten key tips for avoiding lawsuits and malpractice, (2) know the three most frequent reasons why psychiatrists are successfully sued, and (3) be aware of different types of malpractice insurance.

## SUMMARY:

This is part one in a three part comprehensive course that provides information needed to launch a successful private practice. It is composed of two workshops and one symposium, all on one day, offered for the last five years and directed by faculty who have succeeded in using this information. Even if the participant is not in private practice, this course will offer useful information that will help the participant launch his/her career. The material is constantly updated with up-to-the-minute solutions from the faculty's thriving practices.

Part one focuses on risk management, avoidance of malpractice suits, ways to maximize quality, and high-risk issues that must be addressed in private practice. Drs. Callahan and Young are joined by experts in the field Jackie Melonas, 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 will cover coding for maximum billing, marketing, office location and design, streamlining the practice, and business/financial principles.

## REFERENCES:

1. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996.
2. Practice Management for Early Career Psychiatrists. Washington, DC, APA Office of Healthcare Systems and Financing, 1998.

## Issue Workshop 54
## SPIRITUAL AND RELIGIOUS ASSESSMENT IN CLINICAL PRACTICE

*Co-Chairpersons:* Francis G. Lu, M.D., *Department of Psychiatry-7M8, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110,* Christina M. Puchalski, M.D., *George Washington University, 2300 K Street, NW, Room 336, Washington, DC 20037*
*Participant:* James L. Griffith, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, the participant should be able to understand the importance of incorporating history taking and assessment of religious/spiritual issues in clinical work and understand the practical methods of utilizing the assessment in treatment planning.

## SUMMARY:

According to the APA practice guidelines for the psychiatric evaluation of adults and the DSM-IV outline for cultural formulation, cultural issues, including religion/spirituality, should be incorporated in history taking, assessment, and treatment planning. Yet clinicians may be unfamiliar with methods of religion/spirituality assessments. This workshop will review cases that demonstrate methods of interviewing, assessment, and treatment planning. Participants will be invited to critique and comment on these cases and use them as a stimulus for discussion of their own clinical work. Specific issues to be discussed will include the importance of respectful rapport, the use of the DSM-IV outline for cultural formulation, the DSM-IV diagnosis of religious or spiritual problems, and the use of religious/spiritual consultations and interventions, such as with chaplains.

## REFERENCES:

1. Koenig H (ed): Handbook of Religion and Mental Health. San Diego, Academic Press, 1998.
2. Koenig H: Spirituality in Patient Care: Why, How, When, What. Philadelphia, Templeton Press, 2002.

## Issue Workshop 55
## CAREER DEVELOPMENT AND RISK MANAGEMENT

*Co-Chairpersons:* Joseph M. Schwartz, M.D., *Department of Psychiatry, Johns Hopkins, 600 North Wolfe Street, Meyer 121, Baltimore, MD 21287,* George A. Fouras, M.D., *30 Corwin Street, # 2, San Francisco, CA 94114-2356*
*Participants:* Martin G. Tracy, J.D., Jacqueline M. Melonas, J.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the major psychiatric professional liability risks that lead to malpractice lawsuits, discuss emerging practice trends that increase malpractice risk, and use risk management strategies to decrease major professional liability, including liability related to suicide, supervision, cybermedicine, HIPAA, etc.

## SUMMARY:

Malpractice suits pose a significant problem for psychiatrists, regardless of whether they work in private practice, academic, or institutional settings. At least 8% of practicing psychiatrists are sued each year. It is important that 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 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, including sources of risk management information for the prevention of professional liability lawsuits, will be presented.

## REFERENCES:

1. 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 1998; 5:40–111.
2. Hickson G, et al: Patient complaints and malpractice risk. JAMA 2002; 287:2951–2957.

## Issue Workshop 56
## THERAPEUTIC ISSUES IN SELF-INJURIOUS BEHAVIOR

*Co-Chairpersons:* Jose A. Yaryura-Tobias, M.D., *Bio-Behavioral Psychiatry, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021-5309,* Fugen Neziroglu, Ph.D., *Bio-Behavioral Institute, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize various treatment approaches to self-injurious behavior and to recognize different types of self-injurious behavior in different populations.

## SUMMARY:

Self-injurious behavior, used as a broad term, describes three different types of behaviors: intentional infliction of bodily injuries to oneself without intent to die, with intent to die, and parasuicide (behaviors that resemble suicidal acts regardless of intention). Treatment strategy comprises three armamentarium tools: pharmacological, cognitive behavioral, and neurosurgical. In the workshop all three treatment approaches will be presented. Attendees will learn what approach to use depending on the type of self-injurious behavior presented in clinical practice. They will also learn how to engage the patient in therapy and to increase the patient's motivation by means of specific interviewing strategies. Neurosurgical findings will be briefly presented. Factors influencing treatment outcome, such as abuse history, personality, and special triggers, will be discussed. The role of anger, dissociation, and lack of pain, as well as biological and psychological factors explaining these symptoms will be presented. Most important, attendees will have an opportunity to present their cases and, through role playing, assessment and treatment strategies will be illustrated.

## REFERENCES:

1. Yaryura-Tobias JA, Mancebo MC, Neziroglu F: Clinical and theoretical issues in self-injurious behavior. Revista Brasileira de Psiquiatria 1991; 21:178–183.
2. Yaryura-Tobias JA, Neziroglu F, Kaplan S: Self-mutilation, anorexia, and dysmenorrhea in obsessive compulsive disorder. Int J Eat Disord 1995; 17:33–38.

## Issue Workshop 57
## TECHNOLOGY SERVES THE PATIENT: ALGORITHMS, MONITORING, AND DECISION SUPPORT

*Chairperson:* Daniel A. Deutschman, M.D., *Department of Psychiatry, Case Western Reserve University, 18051 Jefferson Park Road, Middleburg Heights, OH 44130*
*Participants:* Naakesh A. Dewan, M.D., Joshua E. Freedman, M.D., Seth M. Powsner, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the quality improvement benefits to patients and psychiatrists of three technologic innovations: (1) web-based medication treatment algorithms, (2) telephone symptom monitoring systems for case finding and risk assessment, and (3) electronic medical records for decision support with treatment-resistant patients.

## SUMMARY:

Psychiatrists, public health planners and HMOs face complex challenges in providing care for individual patients and populations. This workshop will demonstrate and critique three systems developed by using technology to assist psychiatrists in delivering better care: 1) evidence-based algorithms for physician treatment decisions, 2) telephone symptom monitoring and risk assessment, and 3) data retrieval for decision support with treatment-resistant patients.

The Center for Quality Innovations and Research (CQIR) is a web-based decision-support system designed to facilitate quality improvement efforts by guiding psychiatrists in applying the latest evidence-based algorithms to treatment-resistant patients.

An innovative telephone symptom monitoring system (TSMS) allows patients in HMOs to dial in and be screened for depression. The system facilitates case finding, case monitoring, and risk assessment in large populations.

An electronic medical record (Behavior2003) allows all relevant data about treatment-resistant patients (symptom response, medication doses, side effects, and laboratory test values) to be retrieved in an ordered array to facilitate informed treatment decisions.

The discussant is a psychiatrist clinician with a computer technology background. He will discuss and critique the three systems and the benefits to care delivery provided by them. Ample time will be devoted to questions and answers.

## REFERENCES:

1. Gilbert DA, et al: Texas Medication Algorithm Project: definitions, rationale, and methods to develop medication algorithms. J Clin Psychiatry 1998; 59:345–351.
2. Tang PC, LaRosa MP, Gorden SM: Use of computer-based records, completeness of documentation, and appropriateness of documented clinical decisions. J Am Med Inform Assoc 1999; 6:245–251.

## Issue Workshop 58
## WOMEN IN ACADEMIC PSYCHIATRY: OPPORTUNITIES, OBSTACLES, AND STRATEGIES

*Co-Chairpersons:* Carolyn B. Robinowitz, M.D., *7204 Helmsdale Road, Bethesda, MD 20817-4624,* Carol C. Nadelson, M.D., *Director's Office of Women's Careers, Brigham and Womens Hospital, 75 Francis Street, PBB5-503, Boston, MA 02115*
*Participants:* Lynn C. Epstein, M.D., Joan A. Lang, M.D., Donna E. Stewart, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify issues affecting women in academic psychiatry, emphasizing factors that impede and promote their careers, as well as strategies for success.

## SUMMARY:

Although the number of women psychiatrists has increased over the past decades, women continue to be underrepresented in academia and academic leadership. Women psychiatrists collect at the junior faculty level and clinical ranks, advancing more slowly than their male peer cohort, with very few women becoming chairs or deans. Women psychiatrists are less likely than their male counterparts to choose research or academic careers, especially if they are married and have children, while women's attrition from academia is higher. Women psychiatrists do less research, are less likely to have had formal research training, receive fewer NIH research grants or other grant support, and are less apt to be principal investigators or first authors. Women publish fewer original or review articles (except for a few superstars, where male and female productivity is equal). Almost all women in academia note the lack of active mentors as well as role models. This workshop for women and others interested in academic productivity will address issues influencing women's academic careers. Presenters include department chairs, deans, and leaders in organized psychiatry; they will analyze these factors, describe some personal experiences, and, through interaction with participants, develop strategies for success in the academic environment.

## REFERENCES:

1. Association of American Medical Colleges: Increasing Women's Leadership in Academic Medicine: Report of the AAMC Project Implementation Committee. Washington, DC, AAMC, 2002.
2. Bickel J, Clark V, Marshall LR: Women in US Academic Medicine Statistics, 2000–2001. Washington, DC, Association of American Medical Colleges, 2001.

### Issue Workshop 59
### THE ART OF THE UNCONSCIOUS: SHAKESPEARE, POETRY, FILM, AND PSYCHIATRY

*Chairperson:* Steven E. Pflanz, M.D., *FE Warren AFB USAF, 68A Fort Warren Avenue, Cheyenne, WY 82001*
*Participant:* Charles R. Joy, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand that the various forms of art are windows into the human unconscious and examine both literature and the performing arts for the connection between art and the unconscious for both 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 the presenters' writings as well as from favorite poets. The coup de grace will be a short performance of a classic scene from Shakespeare by the two facilitators. Throughout the workshop, the presenters 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. Pharos 1999; 1:8.
2. Pflanz SE: Winter's ill wind. West Virginia Medical Journal 2000; 96:573.

### Issue Workshop 60
### ASIAN INDIANS IN INTERFAITH MARRIAGES: CHALLENGES, CONFLICTS, AND COMPROMISES
*Indo-American Psychiatric Association*

*Chairperson:* Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, Southern Illinois University, Choate Mental Health Center, Anna, IL 62906*
*Participants:* Surinder S. Nand, M.D., Bala Sarma, M.D., Mina S. Bobdey, M.R.C., Iqbal Ahmed, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, the participant should be aware of important challenges and conflicts faced by Asian Indians in interfaith marriages and the compromises made to make marriages functional.

## SUMMARY:

Of the 10 million Asian Americans (4.2% of the general U.S. population), Asian Indians comprise about 1.7 million, the third largest minority group after Chinese and Filipinos. Aside from India, with over a billion people, significant number of Asian Indians live in Australia, Canada, Fiji, Guyana, Mauritius, South Africa, Surinam, Trinidad, United Kingdom, and United States. Major faiths of Indians include Hinduism, Islam, Sikhism, Christianity, and Jainism. Interfaith marriage refers to married couples whose religious affiliations are different. Asian Indian intermarriages are becoming common in India and more so outside India. Potential areas of difficulties in interfaith marriages include prejudices and stereotypes, celebration of festivals, value systems, food habits, gender issues, identity, child rearing practices, and adjusting to extended family members. Following the introduction of the subject matter by the chair, interfaith married faculty of different faiths will share from their personal experience about facing challenges, resolving conflicts, and reaching compromises. Audience participation will be strongly encouraged.

## REFERENCES:

1. Mental Health: Culture, Race and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. Rockville, Md, Department of Health and Human Services, 2001.
2. Intermarriages are on the rise. India Abroad, July 30, 1999.

### Issue Workshop 61
### THE ROLE OF THE SOUL: THE IMPACT OF SPIRITUAL BELIEF SYSTEMS OF HEALING

*Chairperson:* Walter R. Byrd, Jr., M.D., *WVU Medical School, 930 Chestnut Ridge Road, Morgantown, WV 26505*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to appreciate and understand the potentially valuable contribution

that healthy and balanced spirituality from many traditions can have on both the practitioner and the patient within the healing process.

SUMMARY:

The workshop chairperson is residency training director of a psychiatric residency program in the eastern United States. The Faith Factor Religious Survey (FFRS) was initially compiled for use by psychiatric residents in assisting them toward a better understanding of the relative significance of religious and spiritual belief systems in their own personal and professional practices. Insights arising from the frank and active discussions among faculty and residents in response to the questionaire have clearly fostered an improved level of appreciation for the place that spiritual and religious beliefs hold in the constellation of factors making up the patient's clinical history and affecting the doctor-patient relationship. The workshop format will involve each attendee completing the 33-item FFRS, followed by a lively discussion facilitated by the workshop leader exploring responses to the survey and the role that religious/spiritual issues may play in the healing process within a psychiatric setting. Insights from the basic tenets of Judeo-Christian practice, the Four Noble Truths of Budda, the Five Pillars of Islam, and the ancient Greeks will be incorporated.

REFERENCES:

1. Boehnlein J: Psychiatry and Religion: the Convergence of Mind and Spirit. Washington, DC, American Psychiatric Press, 2000.
2. Shafranske E: Religious involvement and professional practices of psychiatrists and other mental health professionals. Psychiatr Ann 2000; 30:525–532.

## Issue Workshop 62
## POST-GENOCIDE PSYCHOLOGICAL TRAUMA IN FILM: UNDER THE DOMIN TREE

*Co-Chairpersons:* Maurice Preter, M.D., *Department of Psychiatry, University of Mississippi Medical Center, 6295 Old Canton Road, 9A, Jackson, MS 39211,* Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medical School, 96 Larchwood Drive, Cambridge, MA 02138-4639*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to use a contemporary film to highlight and discuss postgenocide child and adolescent psychological trauma and to have a better understanding of the cultural-historical context of the Shoah and its aftermath, as well as of the effect of massive traumatization on children and families in general.

SUMMARY:

Dr. Harold Bursztajn and Dr. Maurice Preter continue their exploration of postgenocide psychological trauma and its cinematographic representation by showing and discussing this award-winning 1994 Israeli movie that is based on the highly acclaimed autobiography of Gila Almagor, one of Israel's leading actresses. Set in the young Jewish state shortly after the end of the Shoah, *Under the Domim Tree* chronicles life in a rural boarding school for adolescent orphan survivors brought to Israel after the end of the massacre of the European Jews. During the day, the children attempt to maintain the image of ordinary teenagers, only to face their horrific memories and inner turmoil after nightfall.

*Under the Domim Tree* will be used to illustrate in a postgenocide context themes familiar to psychiatrists working with children and adults traumatized by massive and catastrophic loss: the struggle to maintain a resemblance of familiarity in the face of utter destruction; the fantasies of the sudden return of those lost that alternate with the longing for closure; the breakdown of relatedness, with suicide as its most extreme consequence. The search for continuity when the intrapsychic and the interpersonal fabric of meaning and memory is ripped asunder on both an individual and collective basis will be explored.

REFERENCES:

1. Almagor G, Schenker H (translators): Under the Domim Tree. New York, Simon & Schuster, 1995.
2. Bowlby J: Loss: Sadness and Depression, Vol 3. Cambridge, Mass, Perseus Books, 1982.

## Issue Workshop 63
## HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 2

*Co-Chairpersons:* William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*
*Participants:* Tracy R. Gordy, M.D., Chester W. Schmidt, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to (1) understand the use of codes for insurance to accurately reflect work with patients, (2) understand documentation requirements consistent with the codes, and (3) know where to go to get updated information on coding.

SUMMARY:

This is part two in a three-part comprehensive course that provides participants with information needed to launch a successful private practice. It is composed of two workshops and one symposium, all on one day. Offered for the last five years, the workshop is directed by faculty who have succeeded by using this information. Even for participants who are not in private practice, this course will offer useful information to assist the participant in launching his/her career. The workshop material is constantly updated with up-to-the-minute solutions from the faculty's practices. Part two focuses on the complexities of using the insurance industry's procedure codes to accurately reflect work with patients. Even in a fee-for-service, cash-based practice, many patients will require "superbills" for insurance so they can be reimbursed. There are documentation requirements for each code, and not understanding them and following them can leave the practitioner at risk of prosecution 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. Washington, DC, APA Office of Healthcare Systems and Financing, 1998.
2. Logsdon L: Establishing A Psychiatric Private Practice. Washington, DC, American Psychiatric Press, 1985.

# WEDNESDAY, MAY 21, 2003

## Issue Workshop 64
## CULTURE, RACE, ETHNICITY, AND PSYCHOPHARMACOLOGY: RECENT RESEARCH ADVANCES

*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 90502*
*Participants:* Edmond H.T. Pi, M.D., Ricardo P. Mendoza, M.D., William B. Lawson, M.D., Tarek A. Okasha, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the role of pharmacogenetics, pharmacokinetics, and pharmacodynamics in the psychopharmacological treatment of ethnic minorities in the United States.

## SUMMARY:

The United States has undoubtedly become a pluralistic society. This current multiethnic and multiracial environment has permeated all aspects of American society, including psychiatric care. During the last decade, major efforts have been dedicated to the study of the effects of pharmacogenetics, pharmacokinetics, pharmacodynamics, and environmental factors (diet, culture, etc.) upon psychopharmacological treatment among ethnic, racial, and cultural groups in this country. The outcome of current research efforts will be presented and highlighted in this workshop. The approach to the audience will be interactive. Each presenter will address a given topic for only five minutes to stimulate thinking on this issue, followed by a 60 minutes of open discussion with the attendees. The presenters' five-minute presentations will focus on: 1) Dr. Ruiz: relevance of the topic, 2) Dr. Lin: definition and role of pharmacogenetics, pharmacokinetics, pharmacodynamics, and environmental factors, 3) Dr. Pi: highlights of research outcomes for Asian Americans, 4) Dr. Mendoza: highlights of research outcomes for Hispanic Americans, 5) Dr. Lawson: highlights of research outcomes for African Americans, and 6) Dr. Okasha: perspectives from non-U.S. cultures. It is hoped that this workshop will stimulate further research efforts in this key topic for the field of psychiatry in the United States and abroad.

## REFERENCES:

1. Ruiz P (ed): Ethnicity and Psychopharmacology. Washington, DC, American Psychiatric Press, 2000.
2. Link KM, Cheung F: Mental health issues for Asian Americans. Psychiatr Serv 1999; 50:774–780.

Issue Workshop 65

# REVISION OF THE APA ETHICS ANNOTATIONS: FOSTERING DIALOGUE

*Co-Chairpersons:* Laura W. Roberts, M.D., Scott Y. Kim. M.D.
*Participants*: S. Nassir Ghaemi, M.D., Richard D. Milone, M.D., Michael R. Arambule, M.D., Jennifer Radden, Ph.D.

## EDUCATIONAL OBJECTIVE:

To review the existing ethics annotations document of the APA; to generate discussion of the strengths and limitations of current code with annotations; to describe the revised document, as it is envisioned, and to get feedback from workshop participants on key ethical issues facing the profession.

## SUMMARY:

The task force is responsible for revising the APA ethics principles and annotations will host this workshop in an effort to foster dialogue and to allow for a full and open process of reflection. Issues related to limitations in the existing document will be outlined. The proposed structure and conceptual basis for the revised document will be presented. Codes of ethics from other professional organizations will be reviewed for their relevance and value. The workshop leaders will invite comments, concerns, and guidance from the workshop participants. Experiences of colleagues in evaluating and monitoring the professional conduct of colleagues will be elicited, and examples of controversial issues will be raised for discussion.

Issue Workshop 66

# THE DISRUPTIVE PHYSICIAN 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 OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify barriers to effective leadership in hospital settings, understand effective interventions to prevent escalation of behavioral disruption in a hospital system, 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 professional 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 apparent. This workshop will delineate disruptive behaviors and explore how different types of hospital cultures 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 settings 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. Physician Executive, March–April 1999.
2. Sotile WM, Sotile MO: How to shape positive relationships in medical practices and hospitals. Physician Executive, July–August, 1999, Sept–Oct, 1999.

Issue Workshop 67

# THE UNWRITTEN RULES FOR SUCCESS AS A COMMUNITY PSYCHIATRIST

*Co-Chairpersons:* Stephen M. Goldfinger, M.D., *Department of Psychiatry, SUNY Health Sciences, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203,* Charles W. Huffine, Jr., M.D., *University of Washington, 3123 Fairview Avenue East, Seattle, WA 98102-3051*
*Participants:* Stuart A. Anfang, M.D., Kenneth S. Thompson, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify principles and methods that will enable them to shape their careers in public practice settings, including rural and urban community practice, child and geriatric practice, and practice focused on seriously mentally ill adults.

## SUMMARY:

For residents and early-career psychiatrists interested in community psychiatry, negotiating a job in a publicly funded clinic or finding a role in a community-based treatment setting can be daunting. Psychiatrists may be offered jobs that involve only a narrow scope of duties, often limited to diagnosis and medication management. Four psychiatrists who have found excellent careers in community

practice will share their principles and methods for forging a successful community practice. Each presenter is at a different stage in his career trajectory. Each has a very different type of practice, ranging from urban to rural, working with children and adolescents to adults and older adults, and each comes from a different region of the country with different rules and circumstances. The purpose of sharing these experiences is to define the unwritten rules of community practice, those essential items that one does not learn in medical school or residency that enable one to create a gratifying community practice experience.

## REFERENCES:

1. Ranz J, Stueve A: The role of the psychiatrist as a program medical director. Psychiatr Serv 1998; 49:1203–1207.
2. Boyce P, Tobin M: Defining the roles of the consultant psychiatrist in a public mental health service. Aust N Z J Psychiatry 1998; 32:603–611.

## Issue Workshop 68
## THE MONTGOMERY COUNTY EMERGENCY SERVICE DIVERSION MODEL: A COMPREHENSIVE CONTINUUM OF FORENSIC INTERVENTIONS

*Chairperson:* Rocio Nell, M.D., *Montgomery County Emergency Service, Inc., 50 Beech Drive, Norristown, PA 19403-5421*
*Participant:* Donald S. Kline, Ph.D.

## SUMMARY:

Nationally, up to 16% of those in local jails have a diagnosable mental illness. In many states, mentally ill prisoners far outnumber patients in state mental health facilities. About 20% to 40% of individuals with severe mental illness are arrested during their adult lives, principally for minor nonviolent offenses related to their illness. Psychiatrists in emergency and community settings and crisis psychiatric facilities can act to minimize the suicide risk, exacerbation of symptoms, and stigmatization added by involvement of those with severe mental illness in the criminal justice system.

Montgomery County Emergency Service, Inc. (MCES) is a nonprofit psychiatric hospital that has, for almost 30 years, pioneered strategies for diverting appropriate mentally ill individuals from the criminal justice system, minimizing the imprisonment of offenders with severe mental illness, and increasing their access to treatment. The contributions of MCES have been nationally recognized, documented by research, and widely replicated. Their effectiveness is demonstrated by police acceptance and by the presence of few severely mentally ill inmates in the local prison. The MCES model is based on strong psychiatric involvement, comprehensive crisis intervention, and an orientation to the needs of the criminal justice system. This presentation outlines the innovative MCES model for practitioners interested in enhancing diversion services in their communities.

## REFERENCES:

1. A model prison diversion program: the Criminal Justice–Community Outreach Department of the Montgomery County Emergency Service, Norristown, Pennsylvania. Psychiatr Serv 2000; 51: 1440–1442.
2. Drain J, Solomon P: Describing and evaluating jail diversion services for persons with serious mental illness. Psychiatr Serv 1999; 50:56–61.

## Issue Workshop 69
## 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*
*Participants:* Robert Hsuing, M.D., Cheryl King, M.S., Jaskaran Singh, M.D., Jesse H. Wright, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants should be able to (1) understand the power and value of electronic medical records (EMR), (2) recognize features of EMR that contribute to enhanced function, and (3) understand how to select, customize, and implement an EMR system.

## SUMMARY:

Health care is under assault. Medical knowledge is growing exponentially. While demanding more comprehensive data to meet NCQA requirements, managed care payers steadily decrease reimbursements. Medicare's rigid data criteria tied to reimbursements threaten medical doctors with fraud and abuse charges. Electronic medical records (EMR) may hold the answer since they readily provide comprehensive data, quality-of-care enhancement, and increased productivity.

Four 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, Harvard University, 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) electronic scheduling, 5) billing, 6) multisite capacity, and 7) seamless inpatient and outpatient data integration. The data systems will be demonstrated. Costs, implementation issues, patient and physician satisfaction, and future developments will be discussed. The discussant 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 Am Med Inform 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 Am Med Inform Assoc 1999; 6:245–251.

## Issue Workshop 70
## INDIVIDUAL PSYCHOTHERAPY WITH MEN SUFFERING FROM FATHER LOSS

*Chairperson:* Lawrence L. Kennedy, M.D., *1601 Boswell, Topeka, KS 66604*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) understand the effect of father loss on male patients, (2) understand the value of individual psychotherapy with a male therapist for these patients, and (3) appreciate counter-transference issues in working with such patients in individual therapy.

SUMMARY:

It has been noted by a number of authors that the loss of a father by a man during early childhood has a powerful life-long effect on personality development and relationships. Many of these men suffer from "father hunger" and often have difficulty in dealing with male authority figures in their lives, as well as struggle with their own sons or in their own experiences in male authority roles. Many of these men experience particular difficulty in mid-life.

Depression and substance abuse are common symptoms for this middle-aged population. These patients do well in individual psychotherapy, usually twice a week, with a male therapist over a period of one to two years. Strong transferences develop with the therapist, and it is important that the therapist becomes a "father substitute" for the patient as this transference emerges. The therapist must be aware of the complexities of father/son relationships in order to be helpful to the patient. The therapy offers a special opportunity for these men to "re-work" relationship issues with their fathers and sons and can have a powerful effect on these patients. A number of case examples that typify common psychodynamic issues having to do with absent fathers will be presented.

REFERENCES:

1. Herzag JM: Father Hunger: Explorations With Adults and Children. Hillsdale, NJ, Analytic Press, 2001.
2. Etchegoyen A, Trowell J: The Importance Of Fathers: A Psychoanalytic Re-Evaluation. New York, Brunner-Routledge, 2002.

## Issue Workshop 71
## MATCHMAKER, MATCHMAKER MAKE ME A MATCH

*Chairperson:* Lawrence Bryskin, M.D., Albert *Einstein College School of Medicine, 157 East 80th Street, New York, NY 10021-0438*
*Participants:* Abba E. Borowich, M.D., Esther Jungreis, Maurice Stein, Rabbi Zvi Schachtel, B.A., Rena Hirsch, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be knowledgeable about *shadchanim* matchmakers, the body of knowledge they utilize, and how it compares to issues such as fear, dependency, narcissism, poor self-image, and parental involvement, the obstacles we see as preventing marriage.

SUMMARY:

Of various interpersonal relationships requiring treatment, marriage stands out as most common and significant. Problems range from aversion to or fear of commitment to marital failure.

Success in utilizing the professional body of knowledge has been found wanting. From time immemorial, for the Jewish people, especially within the more traditionally observant community a group of people has devoted itself to matching couples. Although not formally trained, they carry the wisdom of the culture, their own psychological sophistication, and personal experience. How do they function? What are their goals? How do they measure success? What problems do they have? These and other questions will be addressed in the workshop. Case presentations will be offered. Discussion will include audience participation.

For ages the religious community has seen it as a responsibility to bring young men and women together for marriage. Now this service has also emerged in the secular society as evidenced by numerous advertisements in the media, including web sites. This topic should be of interest to everyone working with patients having difficulty "finding a mate."

REFERENCES:

1. Greenberg D, Witzen E: Santity and Sanctity. New Haven, Conn, Yale University Press, 2001.
2. Kranzler G: Williamsburg: A Jewish Community in Transition. New York, Philipp Feldheim, 1961.

## Issue Workshop 72
## THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

*Chairperson:* Steven E. Pflanz, M.D., *FE Warren AFB USAF, 68A Fort Warren Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to critically examine contemporary films with mental health content and understand how the images portrayed in these films influence the public perception of psychiatry and mental illness.

SUMMARY:

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Perhaps unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments, and the profession of psychiatry. In particular, the far-reaching appeal of films with success at the box office gives them a unique opportunity to shape the attitudes of everyday Americans. Oftentimes, mental health professionals pay more attention to films that achieve critical acclaim for their artistic merits. The value of these films is undeniable. However, to understand the forces shaping the public perception of 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 over the past five years, including such films as *A Beautiful Mind, K-Pax, Don't Say a Word, The Sixth Sense, 28 Days, and Mumford.* Each of these films achieved a certain degree of both critical acclaim and box office success and was seen by millions of Americans. To generate discussion, short film clips from these movies will be viewed. The majority of the session will be devoted to audience discussion of these and other films and of how contemporary film influences the image of psychiatry in America.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd ed. Washington, DC, American Psychiatric Press, 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Films in Psychotherapy. New York, John Wiley & Sons, 1998.

## Issue Workshop 73
## WHEN PSYCHIATRISTS HAVE A MENTAL ILLNESS: THE STORIES OF THEIR LOVED ONES
*National Alliance for the Mentally Ill*

*Co-Chairpersons:* Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 323 East Chestnut Street, Louisville, KY 40202*
*Participants:* Jane Baxter, Marian Fireman, M.D., Raymond M. Reyes, M.D., Suzanne E. Vogel-Scibilia, M.D., Andrew Vogel-Scibilia

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to appreciate the challenges for family members of psychiatrists who have suffered a mental illness.

SUMMARY:

At four previous annual meetings of the American Psychiatric Association, several psychiatrists have given personal testimonials about receiving a diagnosis and being treated for a psychiatric illness. Themes have included overcoming stigma, challenges in training, recognizing and accepting the illness in oneself, dimensions of treatment, unique issues when one is a minority psychiatrist, implications for medical licensure, struggles with disability insurers, and advanced directives at work. What about their families? Do they feel stigmatized? How have their lives been affected? What can they teach us? In this interactive workshop, co-chairs Dr. Michael Myers and Dr. Leah Dickstein will make introductory comments. The participants will then hear from the family members of the following psychiatrists: Dr. Suzanne Vogel-Scibilia, Dr. Beth Baxter, Dr. Marian Fireman, and Dr. Raymond Reyes. At least 30 minutes of the workshop time will be reserved for discussion. Attendees are encouraged to ask questions, comment, and suggest further directions for this collaborative workshop.

REFERENCES:

1. Baxter EA: The turn of the tide. Psychiatr Serv 1998; 49:1297–1298.
2. Casey N: Unholy Ghost: Writers on Depression. New York, Morrow, 2001.

## Issue Workshop 74
## CUTTING-EDGE ISSUES IN CROSS-CULTURAL PSYCHIATRY

*Chairperson:* Albert C. Gaw, M.D., *San Francisco Mental Health Rehabilitation Facility, 887 Potreto Avenue, San Francisco, CA 94110*
*Participants:* Desmond S. Fung, M.D., Alice C. Tso, M.D., Phuong-Thuy Le, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify emerging issues in cross-cultural psychiatric care for Asian/Pacific and Asian American patients.

SUMMARY:

Clinicians practicing in various cultural settings are often confronted with novel and challenging clinical issues that require innovative approaches and treatment interventions. This presentation will highlight such cutting-edge cultural issues culled from the experiences of three psychiatrists treating Asian patients in different cultural settings: Hong Kong, San Francisco, and Silicon Valley in California.

Dr. Desmond Fung will comment on the effect of socioeconomic downturn on mental health and patterns of suicidal behavior among Hong Kong Chinese. Dr. Alice Tso will discuss psychiatric treatment of Asian immigrants in San Francisco. Her presentation will also highlight cultural issues in psychotherapy for Asians. Dr. Phuong-thuy Le will present her experience in using media such as radio talk shows, television, and newspapers to destigmatize mental illnesses in Vietnamese Americans communities across the country.

REFERENCES:

1. Gaw AC: Concise Guide to Cross-Cultural Psychiatry. Washington, DC, American Psychiatric Publishing, 2000.
2. Gaw AC: Culture, Ethnicity, and Mental Illness. Washington, DC, American Psychiatric Press, 1993.

## Issue Workshop 75
## THE PSYCHIATRIST'S NIGHTMARE: A MALPRACTICE LAWSUIT

*Chairperson:* David W. Preven, M.D., *Albert Einstein Med, 1825 Eastchester Road, Room 256, Bronx, NY 10461-2373*
*Participants:* Susan Stabinsky, M.D., Jacqueline M. Melonas, J.D., Harvey Stabinsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the risks in their clinical practice for a malpractice lawsuit.

SUMMARY:

In recent years, the risk for litigation against psychiatrists has increased remarkably. As the pharmacological armament has increased, so has the risk for malpractice. The three most common causes for a lawsuit currently are 1) incorrect treatment, 2) misdiagnosis, and 3) suicide. Not only are lawsuits costly in time and perhaps money, they are remarkably draining on the psychiatrist's emotional life. This workshop will review strategies for avoiding litigation and, if it occurs, for surviving emotionally and financially. Specific issues to be addressed include the use of drugs off-label and in higher doses than the FDA guidelines. Other risks that will be discussed include medical backup and coverage, rules for reducing risk when consulting, and steps to take if a suicide occurs.

The panel includes insurance experts from two different companies, a psychiatrist also trained as a lawyer, and the director of a large municipal psychiatric department who has also served as president of a district branch. The chair will provide case examples as will the participants. There will be ample time for the audience to share not only their experiences but the approaches they or their lawyers have taken to manage this personal professional crisis.

REFERENCES:

1. Resnick PJ, ed: Forensic psychiatry. Psychiatric Clinics of North America, March, 1999.
2. Charles S, Kennedy E: Defendant: A Psychiatrist on Trial for Medical Malpractice. New York, Vintage, 1986.

## Issue Workshop 76
## COUNSELING COMMITTED COUPLES: RETHINKING THERAPEUTIC NEUTRALITY

*Chairperson:* Scott D. Haltzman, M.D., *Brown University, NRICMHC Box 1700, Woonsocket, RI 02895*
*Participants:* Jack Drescher, M.D., Janice R. Levine, Ph.D., Doriana F. Morar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the unique qualities of marriage/committed relationships and explore the role of the psychiatrist in counseling individuals. The participant will gain insights into the benefits and limits of therapeutic neutrality in the context of cultural, ethnic, and sexuality based biases.

SUMMARY:

Epidemiological evidence supports the health advantages of marriage. Married individuals are generally better off financially, they live longer, and they are less likely to experience psychiatric or substance abuse morbidity. The children of married couples fare better socially, economically, and emotionally. Gay men who remain

in monogamous relationships are better protected against sexually transmitted disease. In fact, 90% of individuals describe desiring marriage or long-term committed relationships. Yet, despite the potential benefits of a committed relationship, 50% of marriages will end in divorce, and approximately 80% of married individuals will consider divorce at some time. Traditional psychotherapeutic approaches caution against giving advice in support of committed relationships.

Dr. Haltzman has published and spoken nationally on the health advantages of marriage. Dr. Drescher has written and presented at the APA on psychoanalysis and will address the ambiguity surrounding long-term relationships in the gay/lesbian/bisexual/bigender community. Dr. Levine, author of *Why Do Fools Fall in Love?*, will examine the evolved values that direct actions of therapists and patients. Dr. Morar practiced in post-Communist Romania; she will address cultural aspects of marriage. The intended audience is individual or couples' therapists or public policy advocates. They will have an opportunity to share clinical vignettes and opinions.

## REFERENCES:

1. Kramer P: Should You Leave? A Psychiatrist Explores Intimacy and Autonomy and the Nature of Advice. New York, Scribner, 1997.
2. Waite L, Gallagher M: A Case for Marriage: Why Married People Are Happier, Healthier, and Better Off Financially. New York, Doubleday, 2000.

## Issue Workshop 77
## INTERGENERATIONAL TRANSMISSION OF TRAUMA AND PREVENTION OF LONG-TERM CONSEQUENCES OF TRAUMATIC STRESS

*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., Charles W. Portney, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) understand the concept of intergenerational transmission of trauma and (2) understand different modalities in which intergenerational transmission of trauma affects behavior, clinical presentation, and decision making both on a microcultural and international level.

## SUMMARY:

Increasing interest in the medical consequences of traumatic stress in general, and victimization in particular, has pointed to the priority of preventing the psychiatric consequences of trauma. Unlike other areas of preventive medicine, prevention of trauma-related psychopathology has to involve a broad spectrum of action, including psychoeducation of the public and health care providers and education of local, national, and international officials. This workshop is part of an ongoing effort to educate psychiatrists about intergenerational transmission of trauma. Current research suggests that man-related/manmade trauma is more likely to result in trauma-related psychopathology. Factors of prevention to be examined this year include: 1) examination of intergenerational transmission of trauma (familial factors); 2) violence prevention in society; and 3) the effect of politicians on cultivating primitive defenses. The author is co-chairman of the Special Interest Group on Intergenerational Transmission of Trauma and Resiliency at the International Society of Trauma Stress Studies. This year additional emphasis will be placed on possible long-term consequences of psychological trauma related to the attack of September 11, 2001. Clinical examples drawn from different populations (victims of childhood trauma, Holocaust families, violent offenders) will be discussed, with audience participation.

## REFERENCE:

1. Novac A: Special consideration in the treatment of traumatized patients. Psychiatr Times 2002, 18:92–93.

## Issue Workshop 78
## INDIVIDUAL PSYCHOTHERAPY FOR MARITAL PROBLEMS

*Co-Chairpersons:* Michael C. Hughes, M.D., *Hughes Family Psychiatric Center, 2801 Ponce de Leon Boulevard, Suite 430, Coral Grables, FL 33134,* Eva C. Ritvo, M.D., *Department of Psychiatry, University of Miami, 3026 North Bay Road, Miami Beach, FL 33140-3813*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize a differential approach to various kinds of marital therapy and to understand theory and methodology for the individual treatment for one person of the marital dyad as well as parallel individual treatment for each marital partner by separate therapists, collaboratively.

## SUMMARY:

Marital problems are ubiquitous. Perhaps half of those seeking treatment have marital problems as a primary concern. Nevertheless, marital therapy—the treatment of the marital relationship—is infrequently learned or practiced by psychiatrists and is generally thought of unidimentionally as the treatment of the marital couple conjointly, by a social worker or lesser-trained counselor. This presentation discusses individual therapeutic approaches to marital therapy and considers differential selection between conjoint, individual, and group modalities.

Individual therapy for the treatment of the marital relationship is described in two formats: treatment of one member of the marital dyad while the other is not in treatment (one person marital therapy), and treating each member of the couple by separate therapists who meet collaboratively to foster the treatment process (collaborative marital therapy). Theoretical and methodological approaches to marital issues are discussed and applied to case illustrations. Intrapsychic and interpersonal themes, highlighted through the dyadic and transferential relationship of individual psychotherapy, are utilized within the framework of the marital process. The utility of individual therapy is emphasized for such themes as intimacy and separateness, repetitive problematic interactional patterns, and issues of power and conflict. Advantages and limitations of this form of therapy are contrasted with those of other marital therapies. Audience participation and contributions are emphasized.

## REFERENCES:

1. Ritvo E, Glick I: Concise Guide to Marriage and Family Therapy. Washington, DC, American Psychiatric Press, 2002.
2. Lewis JW: Marriage as a Search for Healing. New York, Brunner/Mazel, 1997.

## Issue Workshop 79
## HEPATITIS C INFECTION: THE NEXT PSYCHIATRIC EPIDEMIC

*Chairperson:* Andrew F. Angelino, M.D., *Department of Psychiatry, Johns Hopkins University, 4940 Eastern Avenue, A4C-461A, Baltimore, MD 21224*
*Participant:* Glenn J. Treisman, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to demonstrate understanding of the state of the art of hepatitis C

diagnosis and treatment and recognize and treat psychiatric comorbidities of hepatitis C infection and of its treatment.

## SUMMARY:

Hepatitis C infection has an estimated prevalence of 4 million cases in the United States. Psychiatric patients are vulnerable to acquiring hepatitis C infection. The treatment for hepatitis C, interferon alpha, leads to new or worsening of psychiatric symptoms in many patients. This workshop will present current medical information about hepatitis C virus, its epidemology and transmission, natural history of the infection, and the treatment algorithm. The presenters will then discuss the comorbidities of psychiatric disorders and substance use disorders as barriers to effective treatment and present the results of a national consensus meeting on management of psychiatric complications in hepatitis C/interferon treatment. At the end of the presentation, participants will discuss the psychiatric management of several patients infected with hepatitis C and recommendations regarding the timing and nature of interferon therapy.

## REFERENCES:

1. National Institutes of Health Consensus Development Conference Statement: Management of Hepatitis C: 2002. Bethesda, Md, NIH, Sept 12, 2002.
2. Rosenberg S, Goodman L, Osher F, et al: Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. Am J Public Health 2001; 91:31–37.

## Issue Workshop 80
## FAMILY THERAPY TRAINING FOR PSYCHIATRY RESIDENTS

*Chairperson:* Steven J. Wolin, M.D., *George Washington University, 5410 Connecticut Avenue NW, # 113, Washington, DC 20015-2819*
*Participants:* Ellen M. Berman, M.D., John S. Rolland, M.D., John Sargent, M.D., Peter J. Steinglass, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to describe the details of three formats for teaching family therapy to psychiatry residents—didactic courses, demonstration interviewing, and clinical supervision; understand the strengths and problems associated with each; and assess the potential value for their own use.

## SUMMARY:

Most adult and child psychiatrists practice some forms of couple and family assessment and treatment. As a result, a minimum of couple and family therapy training is required of all psychiatry residents. While all training programs offer some experience in learning how to evaluate and treat couples and families, there has been little description and discussion of the types of family therapy training offered in residency training, or their perceived efficacy. The Academy of Family/Systems Psychiatrists is committed to enhancing family therapy within psychiatry, including high-quality family therapy training for adult and child psychiatry residents. In this workshop, five members of the caucus, themselves directors of family therapy courses or programs for residents, will describe the format and content of their programs, as well as their personal assessment of the experiences for residents. During the first hour, our panelists will review the didactic courses, demonstration interview techniques, and clinical supervision methods within their programs, as well as the integration of family therapy with other psychiatric treatment modalities. Panelists will then respond to each other's presentations. For the last 30 minutes, the panelists will interact with other workshop participants. The caucus anticipates an ongoing discussion to improve young psychiatrists' family therapy skills.

## REFERENCES:

1. Gurman AS, Fraenkel P: The history of couple therapy: a millenial review. Family Process 2002; 41:199–260.
2. Liddle HA, Breunlin DC, Schwartz RC (eds): Handbook of Family Therapy Training and Supervision. New York, Guilford Press, 1988.

## Issue Workshop 81
## FAMILY THERAPY FOR ANOREXIA NERVOSA

*Chairperson:* James D. Lock, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 1120, Palo Alto, CA 94305*
*Participant:* Daniel Le Grange, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, participants should be able to appreciate the basic techniques involved in an evidence-based family therapy for anorexia nervosa.

## SUMMARY:

The objective of this workshop is to illustrate how parents and families can be effective and essential participants in the treatment of anorexia nervosa. The presenters will review the key controlled studies related to treatment of anorexia nervosa, then follow this with a review of the main components of the Maudsley family therapy approach for anorexia nervosa. Following this, participants will be involved in role-playing of key therapuetic interventions and strategies used in this approach. In particular, the process of scientific evidence that supports this treatment will be reviewed. Techniques to be demonstrated include therapeutic engagement with the entire family, separation of the patient from the illness, circular questioning, and a family meal. In addition, case vignettes will be used to illustrate progression through the three stages of treatment. This includes a demonstration of the parents' intense involvement at the outset of treatment to address the patient's weight loss and need to focus on the eating disorder initially, as well as how the therapist moves to these other issues after weight restoration and normal eating is mostly restored. A period of questions and answers will follow the presentations and role-plays to allow participants to examine the approach for themselves.

## REFERENCES:

1. Lock J, Le Grange D: Treatment Manual for Anorexia Nervosa: A Family Based Approach. New York, Guilford, 2001.
2. Eisler I, Dare C, Hodes M, et al: Family therapy for adolescent anorexia nervosa: the results of a controlled comparison of two family interventions. J Child Psychol Psychiatry 2000; 41:727–736.

## Issue Workshop 82
## HELPING THE HEALERS: PROVIDING IMPAIRMENT EDUCATION TO PHYSICIANS

*Chairperson:* Karen E. Broquet, M.D., *Southern Illinois University School of Med., PO Box 19636, Springfield, IL 62794-9636*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) understand the risk of depression, substance abuse, impairment or suicide in physicians, especially during the training years, and (2) provide effective education to resident and practicing physicians regarding physician impairment.

SUMMARY:

Physicians are at high risk for depression and substance abuse, especially during training. In one series of impaired physicians, 92% had a psychiatric or substance use disorder. The suicide rate for male physicians is equal to the general population, with 10% occurring during training. The suicide rate for female physicians is three to four times that of the general population, with 29% occurring during training. In addition to providing treatment to individual physicians, psychiatrists are often called upon to provide leadership and education regarding impairment in the medical community. This workshop will help participants do this more effectively.

The workshop will review current information on depression and impairment in physicians. An example of how impairment education is delivered in an academic institution is described, with a brief discussion of how it can be adapted to a nonacademic setting. The majority of the workshop will be group discussion. Participants will be asked to share their ideas and experiences.

This workshop is for anyone with an interest in physician mental health and wellness.

REFERENCES:

1. Hawton K, Sakarovitch A, Simkin S, et al: Suicide in doctors: a study of risk according to gender, seniority, and specialty in medical practitioners in England and Wales, 1979–1995. J Epidemiol Community Health 2001, 55:296–300.
2. Collier VU, et al: Stress in medical residency: status quo after a decade of reform? Ann Intern Med 2002; 136:384–396.

## Issue Workshop 83
## DO I NEED AN MBA TO TRANSFORM MY CAREER?

*Chairperson:* Arthur L. Lazarus, M.D., *Pfizer Inc., 6830 Windham Parkway, Prospect, KY 40059*

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

The workshop leader will discuss a typical executive MBA curriculum, the MBA "life cycle," and the resources needed to complete such a program. Workshop participants will have a chance to learn about marketplace opportunities for physician executives and how to sidestep career traps. The careers of physicians who recently graduated from executive MBA programs will be profiled. There will be ample time to ask questions and discuss personal experiences to help plan for a career in medical management or psychiatric administration.

REFERENCES:

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

## Issue Workshop 84
## THE BEGINNINGS STAGES OF COUPLES' THERAPY: VIDEO CASE STUDIES

*Chairperson:* Ian E. Alger, M.D., *500 East 77th Street, #132, New York, NY 10162-0021*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify the critical issues in couples therapy, particularly as they emerge in the initial assessment during early therapy sessions, and develop an increased awareness of his or her style as a couples' therapist.

SUMMARY:

Participants will have the opportunity to view videotaped couples' sessions and to role-play clinical examples of couples' treatment with the leader. The focus of the workshop will be on identifying issues of engagement, problem identification, change facilitation, and closure with couples during the first and second therapeutic meetings. Workshop participants will have the opportunity to compare their own clinical experiences related to working with couples and in dealing with contemporary couples' problems such as separation and divorce, issues in second marriages, sexuality and intimacy, and conflicts that arise in a dual-career situation.

REFERENCES:

1. Alger I: Marital therapy with dual-career couples. Psychiatr Ann 1991; 21:8.
2. Gurman AS, Jacobson NS: Clinical Handbook of Couple Therapy. New York, Guilford Press, 2002.

## Issue Workshop 85
## HEALING THE HURT CHILD: TREATING FETAL ALCOHOL SYNDROME SPECTRUM DISORDER CHILDREN

*Chairperson:* Peter D. Ganime, M.D., *Department of Psychiatry, UMDNJ-Meridian, c/o Ganime 335 Garrison Way, Conshohocken, PA 19428*
*Participants:* Denise Aloisio, M.D., Grace Hickey, Psy.D., Joanne Dunnigan, M.S.W., Jennifer Smith, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to better understand the special treatment needs of FAS spectrum disorder young children and their caregivers and better appreciate the importance of multidisciplinary treatment.

SUMMARY:

Children who have been exposed to drugs and alcohol in utero often have complex behavioral treatment needs across multiple life domaines. This is why multidisciplinary team treatment is frequently necessary. This workshop brings together a developmental pediatrician, a child psychiatrist, a child and family therapist, a psychologist, and the administrator of a behavioral health treatment program to discuss the challenges presented by these young children and the needs of their caregivers.

The effects of prenatal exposure to drugs and alcohol upon early development will be addressed, and current controversies about psychopharmacological treatment of very young children will be discussed. Education of parents, preschool teachers, and other caregivers will be described, and ways of assessing treatment responses and

outcome will be presented. The effect of these children on child serving systems such as health care and education will be reviewed, and participants will be encouraged to join in on a discussion about how the needs of these young children may be best met.

## REFERENCES:

1. England MJ, Coles RF: Preparing for communities of care for child and family mental health for the twenty-first century. Child Adoles Psychiatr Clin N Am 1998; 7:469–481.
2. Walker A, Rosenberger M, Balaban-Gil K: Neurodevelopmental and neurobehavioral sequelae of selected substances of abuse and psychiatric medications in utero. Child Adoles Psychiatr Clin N Am 1999; 8:845–867.

## Issue Workshop 86
## GOING PUBLIC OVER PATIENT PRIVACY

*Chairperson:* Rodrigo A. Munoz, M.D., *University of California at San Diego, 3130 5th Avenue, San Diego, CA 92103*
*Participants:* Pamela J. Wright-Etter, M.D., Kevin M. Etter, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the participant should be able to (1) understand the difference between confidentiality and privacy as it pertains to medical records, (2) be familiar with the APA's guidelines on construction of release of information and ethical obligations regarding same, and (3) be knowledgeable about the case law as it pertains to this topic.

## SUMMARY:

In March of 1999, Dr. Kevin Etter and Dr. Pamela Wright-Etter were asked to release entire psychiatric records of several of their patients to BCBSNC. The battle for privacy cost them their private practice. In November of 2001 they were given the Profiles of Courage Award by the APA in recognition of their efforts to protect patient privacy. The presenters will discuss the conundrum of privacy in an era of increasing intrusions into the physician-patient relationship by managed care, citing specific ethical and legal references they relied upon when making their decision. This workshop will provide participants a chance to hear the "full story" of the Etters' experience. Ample opportunity will be provided for audience participants to interact with one another and share their own experiences about requests for records by managed care under the guise of a "routine audit."

## REFERENCES:

1. The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Washington, DC, American Psychiatric Association, 2001.
2. Jaffe V. Redmond US, 64 USLW 4490 (1996).

## Issue Workshop 87
## CHILDREN OF PSYCHIATRISTS: INSIGHTS AND RECOMMENDATIONS FROM THOSE WHO KNOW

*Co-Chairpersons:* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 323 East Chestnut Street, Louisville, KY 40202,* Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0704, Ann Arbor, MI 48109-0704*
*Participants:* Cory Butterfield, David Robinowitz, M.D., Barbara Kamholz, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should gain insight into the nature of good parenting.

## SUMMARY:

This is the eighth children of psychiatrists workshop. Each year current and future parents of all ages attend to learn from children of all ages what good parenting is. In its many variations, good parenting is based on the vision of raising physically and mentally healthy, happy, and humane children and future adult. Past speakers have offered useful personal anecdotes and unique words of advice in attendees, primarily psychiatrists, at all levels of training and practice.

For 2003 in particular, parents are even more concerned about effective communication with their children as a consequence of 9/11.

## REFERENCE:

1. Freud A: The Ego and the Mechanisms of Defense (1937), Vol 2. The writings of Anna Freud. New York, International Universities Press, 1979.

## Issue Workshop 88
## INTERNATIONAL PSYCHIATRIC/ PSYCHOPHARMACOLOGICAL ORGANIZATIONS' COLLABORATION

*Supported by Collegium Internationale Neuro-psychopharmacologicum, European College of Neuropsychopharmacology, World Federation of Societies of Biological Psychiatry, and World Psychiatric Association*

*Chairperson:* Marcia K. Goin, M.D., *Department of Psychiatry, University of Southern California, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90017-4085*
*Participants:* Paul S. Appelbaum, M.D., Herbert Y. Meltzer, M.D., Yves LeCrubier, M.D., Ahmed Okasha, M.D., Carlos R. Hojaij, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify and discuss commonalities and differences in the ways different international psychiatric and psychopharmalogical organizations approach the common problems of stigma, mental health parity, and training of physician mental health workers.

## SUMMARY:

Worldwide, there has been a great increase recently in the social and political activities of international psychiatric organizations. This has resulted in duplication of effort, a waste of funds, and uncertainty among governmental agencies as to which of several voices should be listened to. There is a great amount of agreement by the organizations on many issues. This workshop will outline for the first time the activities and the beginning collaboration among the American Psychiatric Association, the Collegium Internationale Neuro-Psychopharmacologicum, the European College of Neuropsychopharmacology, the World Federation of Societies of Biological Psychiatry, and the World Psychiatric Association. These organizations have many commonalities as well as very distinct and different identities. To improve their effectiveness in dealing with common goals and international issues, these organizations have joined together to develop a unified approach to work on specific worldwide issues in their area. The initial issues will be 1) the stigma attached to a psychiatric as opposed to a physical diagnosis and illness, 2) improving the quality of life and the delivery of psychiatric and mental health services to underserved populations, 3) affecting national policies regarding the care and treatment of individuals with psychiatric disorders, and 4) improving the delivery of psychopharmacological treatment through the use of algorithms and professional education. The consolidation of effort is expected to increase the effectiveness

of programs, reduce duplication, and decrease the cost per delivered unit of effort.


## REFERENCES:

1. Okasha A: The Declaration of Madrid and its implementation. World Psychiatry 2002; 1:125.
2. Pincus H, Tanielian L, Marcus SC, et al: Prescribing trends in psychotropic medications. JAMA 1998; 279:526.


## THURSDAY, MAY 22, 2003

### Issue Workshop 89
### TEACHING PSYCHIATRIC ETHICS ENGAGINGLY, EFFECTIVELY
*Association for Academic Psychiatry*

*Chairperson:* Laura W. Roberts, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker NE, Albuquerque, NM 87131*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to characterize recommended core curricular content and skills in psychiatric ethics education and to employ key teaching and assessment techniques, including ethics and professionalism competence assessment.

## SUMMARY:

This workshop is a hands-on introduction to the teaching of psychiatric ethics in a manner that is engaging and imparts demonstrable skills. The field of psychiatric ethics and its essential content and skills will be defined. Core curricular content in psychiatric ethics training will be presented, based on scholarship and up-to-date educational guidelines for ethics and professionalism in medical education. Developmentally attuned goals and objectives for ethics training and for ethics competence assessment will be outlined. The course leader will demonstrate and/or illustrate a number of ethics teaching and assessment techniques that are engaging, impart valuable knowledge and skills, and have been well received by diverse audiences. Specific methods for assessing ethics skills and evaluating clinical ethical competence with empirical validation findings will be presented. The need to separate moralism from ethical knowledge and skill, the importance of professionalism and respect in the training environment, and the role of faculty professional development will be explored. Tactics for "inventing" curricular time and resources for ethics education will be discussed. Key resources for ethics education will be provided to all participants. This workshop is intended for teachers, supervisors, and training program leaders and is offered in affiliation with the Association for Academic Psychiatry.


## REFERENCES:

1. American Medical Association Council on Ethical and Judicial Affairs: Code of Medical Ethics: Current Opinions with Annotations, 2002–2003 ed. Chicago, AMA Press, 2002.
2. LW Roberts, A Dyer: Concise Guide for Psychiatric Ethics. Washington, DC, American Psychiatric Press, (in press).


### Issue Workshop 90
### NEUROBIOLOGY OF LEARNING: MOVING FROM THE IVORY TOWER INTO THE CLASSROOM

*Chairperson:* Janet E. Osterman, M.D., *21 Ocean View Drive, Hingham, MA 02043-1224*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to describe the neurobiology of learning and the role of long-term potentiation, discuss the application of these concepts to enhance effectiveness in teaching, and develop methods to enhance teaching effectiveness.

## SUMMARY:

The goal of teaching is to help the student learn and retain new knowledge, concepts, and skills. Learning is a complex neurobiological process that involves neuronal change 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, and 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 and develop the concept that there are variations in learning that mandate a multimodal teaching method to maximize effectiveness. This workshop will review the types of memories involved in learning and the processes involved in encoding of semantic, episodic, and procedural memories. 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 leaning and memory encoding to enhance teaching skills and for improved curriculum development will be discussed. The workshop will conclude with a question and answer session.


## REFERENCES:

1. Turnball J: Bench to beside in medical education. Academic Med 1999; 74:664–666.
2. Cahill L, McGaugh JL, Weinberger NM: The neurobiology of learning and memory: some reminders to remember. Trends in Neurosci 2001; 24:578–581.


### Issue Workshop 91
### THE USES AND ABUSES OF PSYCHIATRIC INDEPENDENT MEDICAL EXAMINATIONS: AN ETHICAL DILEMMA?

*Chairperson:* Landy F. Sparr, M.D., *Department of Psychiatry, Oregon Health Sciences University, PO Box 1034/PVAMC P-7-MHDC, Portland, OR 97006*
*Participant:* Michael D. Freeman, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize that reasonableness of treatment of injured patients is a complex issue and that financial incentives may undermine and compromise Independent Medical Examinations (IMEs).

## SUMMARY:

The Independent Medical Examination (IME) is an ethical lightning rod. The stated purpose of the IME is to review the appropriateness of a specific treatment for a particular condition in a patient, usually for an insurer with a fiduciary responsibility to pay for treatment that is reasonable and necessary. While the reimbursement rate for the IME is predetermined, insurers are most likely to request IMEs from providers whose reports favor them. There are generally no peer review or licensing board disciplinary consequences for providers who are influenced by financial self-interest. Thus, the system invites abuse. Attorneys for plaintiffs have called IME providers "hired guns" or "whores." In *Foltz v. State Farm*, it was alleged that the insurer sent medical claims to an outside reviewer knowing he would recommend reducing or denying them. The case was settled after five years of pretrial motions. It has been alleged that insurers usually settle lawsuits out of court to avoid written judicial opinions. This is an issue of interest to psychiatrists who are often asked to evaluate post-injury emotional damages and/or pre-existent illness. There is little discussion of the IME in the medical and psychiatric

literature. The purpose of this workshop is to provide a forum for discussion with ample opportunity for audience participation.

## REFERENCES:

1. Tsushima WT, Foote R, Merrill TS, et al: How independent are independent psychological examinations: a workers' compensation dilemma. Prof Psychol Res Pract 1996; 27:626–628.
2. Rossie GV, Gretzinger RD: Toward making IMEs independent. Pain Res Manage 2001; 6:9–10.

## Issue Workshop 92
## BEYOND THE CHALK BOARD: USING COMPUTERS TO ENHANCE PSYCHIATRIC EDUCATION

*Chairperson:* Sudha Prathikanti, M.D., *Department of Psychiatry, University of California at San Francisco, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110*
*Participant:* Lee A. Rawitscher, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize successful methods for integrating computer technologies such as online courses and interactive DVD modules into psychiatric curricula. The participants will also recognize the vital roles that traditional classroom discussions and clinical supervision continue to play in education of medical students and residents.

## SUMMARY:

For psychiatric educators, it has been both exciting and challenging to explore how the Internet and electronic media might be used to enhance the psychiatric curricula of medical students and residents. Over the past decade, a plethora of computer-based innovations have been introduced within medical education, including online courses, videoconferencing on laptops, full-text electronic libraries, and interactive software programs for teaching basic science as well as diagnosis and treatment. Yet, many educators in psychiatry are uncertain how to integrate these innovations into more traditional learning environments such as the classroom, bedside rounds, or clinical supervision. This workshop will focus on how psychiatric instructors at the University of California, San Francisco, are successfully blending computer-based teaching and evaluation tools in two settings: 1) the core psychiatry clerkship for medical students and 2) a behavioral medicine module for primary care medicine residents. The presenters will examine some of the pitfalls and shortcomings of the new technologies as well as the ways in which they can enhance the educational process. Participants will be engaged in a vigorous dialogue on the factors essential to a successful integration of computer-based technologies within traditional learning environments.

## REFERENCES:

1. Cartwright JC, Menkens R: Student perspectives on transitioning to new technologies for distance learning. Comput Inform Nurs 2002; 20:143–149.
2. Blashki G, McCall L, Piterman L, et al: A Graduate Certificate and Master in General Practice Psychiatry by distance education. Aust Fam Physician 2002; 31:394–397.

## Issue Workshop 93
## SPECIFIC PSYCHOTHERAPEUTIC TECHNIQUES FOR ADOLESCENTS

*Chairperson:* Eva M. Szigethy, M.D., *Department of Psychiatry, Boston Children's Hospital, 300 Longwood Avenue, Boston, MA 02115-5724*
*Participants:* Barbara L. Milrod, M.D., Lena Verdeli, Ph.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able (1) to recognize how key developmental and clinical issues during adolescence can be addressed in psychotherapy, regardless of the modality used, and (2) to understand how specific psychotherapy modalities (cognitive behavior, interpersonal, and psychodynamic) approach developmental issues in adolescents with mood and anxiety disorders.

## SUMMARY:

Adolescence is a time of significant flux involving psychosocial transitions and maturation of affect regulation and cognitive function. It is also a time of heightened risk and dysfunction. With the growing national shortage of specialty-trained child psychiatrists, more adolescents are being treated by adult-trained mental health providers. This workshop is designed to help general psychiatrists provide psychotherapy to adolescents from a developmental perspective. First, the presenters will provide a broad overview of key psychosocial, emotional, and cognitive changes during adolescence and how this knowledge can be incorporated into psychotherapy sessions across modalities. Second, the presenters will focus on three psychotherapy modalities (cognitive behavior, interpersonal, and psychodynamic) and how each specifically addresses developmental considerations during adolescence both during case formulation and treatment. Dr. Szigethy will discuss how cognitive behavior therapy can be used to prevent and treat depression. Dr. Milrod will discuss how psychodynamic therapy can be used to treat panic disorder. Dr. Verdeli will discuss how interpersonal psychotherapy can be used for subsyndromal bipolar disorder to prevent functional impairment. Each speaker will present general didactic material, illustrate the principles of the technique using a clinical case presentation, and invite audience participation in discussion.

## REFERENCES:

1. Weisz JR, Hawley KM: Developmental factors in the treatment of adolescents. J Consult Clin Psychol 2002; 70:21–43.
2. Milrod B, Busch F, Leon AC, et al: A pilot open trial of brief psychodynamic psychotherapy for panic disorder. J Psychother Pract Res 2001; 10:239–245.

## Issue Workshop 94
## PSYCHIATRIC TREATMENT AND PERSONAL GROWTH: WHAT ABOUT US?

*Co-Chairpersons:* Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 323 East Chestnut Street, Louisville, KY 40202*
*Participants:* Francine Cournos, M.D., Carl C. Bell, M.D., Margery S. Sved, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) appreciate the importance of self-care in enhancing professional satisfaction and (2) experience less stigma about oneself and colleagues.

## SUMMARY:

Reflection is central to our professional development. In this interactive workshop, five seasoned psychiatrists will share ten-minute stories. Dr. Michael Myers will review the noxious effects of stigma in the lives of psychiatrists, not only shame about illness or its treatment but also embarrassment about a range of self-disclosures to colleagues and trainees. Dr. Leah Dickstein will discuss three decades of personal growth: sitting in with analysts in England, reading psychiatric literature and selected biographies, and learning from patients and teaching residents. Dr. Francine Cournos, acknowledging that she violated the taboo against public disclosure in her recent memoir, will discuss the influence that her own experience

with antidepressants, psychotherapy, and psychoanalysis has played in her conviction about the power of our treatments. Dr. Carl Bell will present his young professional conflicts around leadership as his reason for being analyzed and will focus on the strength model of treatment, i.e., the cultivation of humor, creativity, empathy, and spiritual development. Dr. Margery Sved, will discuss how a history of depression and being denied disability insurance influenced the decisions she made a significant mid-life career change. During the 40-minute discussion period, the audience will participate by posing questions, providing commentary, and sharing their own stories if they choose.

## REFERENCES:

1. Cournos F: City of One: A Memoir. New York, WW Norton, 1999.
2. Myers MF: Cracks in the mirror: when a psychiatrist treats physicians and their families, in A Perilous Calling: The Hazards of Psychotherapy Practice. Edited by Sussman MB. New York, John Wiley 1995, pp 163–174.

## Issue Workshop 95
## A PROGRAM TO ENHANCE CULTURAL COMPETENCY IN RESIDENCY TRAINING

*Chairperson:* Hinda F. Dubin, M.D., *Institute of Psychiatry, University of Maryland, 701 West Pratt Street, Baltimore, MD 21201–1023*
*Participants:* Lisa D. Green-Paden, M.D., Theodora G. Balis, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) recognize the basic components of an effective cultural diversity training program, (2) list basic relevant data about specific cultures, and (3) treat patients of various cultures more effectively.

## SUMMARY:

It is essential that residents are trained to be aware of cultural differences in the patients they treat and that they are sensitive to how these differences affect patients' needs and perceptions. This workshop will preview a highly successful course design to address these needs and will present specific cultural data relevant to several populations encountered by psychiatrists. These include the African American community, the Orthodox Jewish populace, and immigrant populations. Other cultures will be briefly highlighted as well. Strategies to treat members of these groups will be used as illustrations of knowledge and techniques that can be globalized to work with other populations.

Participants will then engage in interactive case discussions of specific culturally laden treatments and will have opportunities to join in role plays of patient encounters in which culture is a significant component. This course is intended for educators, residents, and psychiatrists who wish to increase their cultural sensitivity and knowledge. Of note, the presenters are both psychiatrists and members of the specific group about which they will provide training.

## REFERENCES:

1. Burt VK, Rudolph M: Treating an orthodox Jewish woman with obsessive-compulsive disorder: maintaining reproductive and psychologic stability in the context of normative religious rituals. Am J Psychiatry 2000; 157:620–624.
2. Sue DW, Sue D: Counseling the Culturally Different: Theory and Practice. New York, Wiley, 1999.

## Issue Workshop 96
## CLINICAL MANAGEMENT OF DIFFICULT SCHIZOPHRENIA

*Co-Chairpersons:* Michael Y. Hwang, M.D., *Department of Psychiatry, East Orange VA Medical Center, 385 Tremont Avenue, East Orange, NY 07018-1095,* Miklos F. Losonczy, M.D., *Department of Mental Health, VA NJ Health Care System, 151 Knollcroft Road, Lyons, NJ 07939*
*Participants:* Samuel G. Siris, M.D., Faiq A. Hameedi, M.D., Naveed Iqbal, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the participant will be familiar with the current state of knowledge regarding some common and challenging clinical conditions in schizophrenia.

## SUMMARY:

Schizophrenic spectrum disorder encompasses diverse clinical phenomena, and recent research has demonstrated varying neurobiological abnormalities. This clinical and biological diversity in schizophrenic illness continues to challenge practicing clinicians in terms of assessment and treatment. Current clinical and epidemiological evidence suggests that schizophrenic patients with coexisting psychiatric and medical conditions, including depression, anxiety disorders, and impulsive-aggressive behaviors, may account for a considerable part of schizophrenic heterogeneity. Furthermore, a comorbid medical condition such as medication-induced metabolic dysfunctions has increasingly confounded care. Recent clinical and research evidence suggests in-depth clinical assessment and specific pharmacological treatment with psychosocial intervention result in the optimal outcome.

The workshop will review recent research findings and include discussion of the clinical management of several clinical conditions. Dr. Siris will review the various comorbid depressive phenomena in schizophrenia and discuss their management. Dr. Hwang will discuss the diagnostic and treatment issues of obsessive-compulsive phenomena in schizophrenia. Dr. Hameedi will present management of medical comorbidity in schizophrenia. Dr. Iqbal will review and discuss the clinical and neurobiological considerations of high-risk suicidal schizophrenia. Finally, Dr. Losonczy will review systematic approaches in the management of schizophrenia and present a currently emerging treatment algorithm. At end of the presentation, participants will be encouraged to share their experiences.

## REFERENCES:

1. Hwang MY, Bermanzohn PC (eds): Management of Schizophrenics with Comorbid Conditions. Clinical Monograph Series. Washington, DC, American Psychiatric Press, 2001.
2. Hwang MY (ed): Assessment and treatment schizophrenia with comorbid disorders. Psychiatr Ann 2000, 30(1).

## Issue Workshop 97
## CD-ROMS FOR DUMMIES: A STEP-BY-STEP GUIDE FOR DEVELOPING EDUCATIONAL CDS

*Chairperson:* Kristi S. Williams, M.D., *Department of Psychiatry, Medical College of Ohio, 3120 Glendale Avenue, Toledo, OH 43614*
*Participants:* Marijo B. Tamburrino, M.D., Cindy J. Stengle, B.B.A.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the basic steps for developing an educational CD for

patients, generate potential topics and content for their own CD, and receive collegial feedback on their potential topics.

## SUMMARY:

The purpose of this workshop is to demonstrate to health care professionals the basic steps for developing their own patient education CD-ROMs. Discussion by group leaders will address the fundamentals of obtaining funding, collaborating with a producer, and choosing subject material and graphics. Tips on editing, legal issues, and dressing for the videotaping will also be covered, along with ideas on how to get the final product disseminated. Small group exercises will be woven throughout the didactic material, providing participants the opportunity to brainstorm subtopic themes, practice editing, practice using a simulated teleprompter, and experience an interactive segment of the authors' CD-ROM. In the final small group exercise, participants will be invited to assimilate all that they have learned by choosing a topic and drafting an outline for a CD-ROM that they might wish to create in the future. Ample opportunity will be given for volunteers to share their ideas with the group leaders and other participants to receive meaningful feedback. It is important for health care professionals to be aware of how to develop a CD-ROM as our society begins to utilize computers more frequently as an efficient means of disseminating important information to patients and their families.

## REFERENCES:

1. Agre P, Dougherty J, Pirone J: Creating a CD-ROM program for cancer-related patient education. Oncol Nurs Forum 2002; 29:573–580.
2. Kolasa KM, Jobe AC, Miller MG: Using computer technology for nutrition education and cancer prevention. Acad Med 1996; 71:525–526.

## Issue Workshop 98
## MAKING THE MEDIA WORK FOR YOU

*Chairperson:* Nada L. Stotland, M.D., *Department of Psychiatry, Rush Medical College, 5511 South Kenwood Avenue, Chicago, IL 60637*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to conduct a successful media interview. Participants will work, hands-on, with different case scenarios for interviews and will come away with the skills they need to teach the public about psychiatry and to demonstrate what accessible, honest, caring, and knowledgeable professionals psychiatrists are.

## SUMMARY:

As experts in mental health, psychiatrists are often sought after by the media. However, most psychiatrists are not formally trained in how to speak to members of the press, and they may feel intimidated, worry that they will look funny on camera, or worry that they will be tripped up by a trick or hostile question. In this special session targeted towards members in training and early-career psychiatrists, participants will learn how to communicate with the media and the public. This will be a highly interactive workshop, with attendees participating in videotaped mock interviews. This workshop will cover the specifics of conducting an interview and will offer tips on such topics as managing stress and positioning in front of the camera. Different interviewing scenarios will be discussed. This workshop will help build young psychiatrists' communication skills and will enable them to better draw upon their extensive medical knowledge and convey information to the public through the media with accuracy, confidence, empathy, and care.

## REFERENCES:

1. Stotland NL: Psychiatry, the law, and public affairs. J Am Acad Psychiatry Law 1998; 26:281–287.
2. Sabbagh LB: Managing the media interview. Compr Ther 1998; 24:33–35.

## Issue Workshop 99
## THE EMPATHIC HEALER: ARTIST OR SCIENTIST?

*Chairperson:* Michael J. Bennett, M.D., *11 Dunbarton Road, Belmont, MA 02478-2458*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants 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 biological as well as psychological nature of this basic human capacity.

## 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. By basing interventions on diagnosis alone, medical psychotherapists increasingly presume to treat diseases rather than the persons who suffer from them. Pressured by the practice climate and misled by the false dichotomy between mind and brain, many practitioners have abandoned their traditional role as healers.

This workshop 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 100
## TREATING ADDICTION: MEETING NEW NEEDS IN A NEW WORLD

*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 OBJECTIVE:

At the conclusion of this session, the participant should be able to describe new directions being taken in addiction treatment, including psychotherapy and psychopharmacologic approaches.

SUMMARY:

This will be the 36th year of a dialogue with addiction experts begun by John Ewing at the APA annual meeting. Every year a wide-ranging discussion pertaining to issues in addiction treatment and its relationship to psychiatry is begun with brief presentations by a panel of experts. The theme, Treating Addictions: New Needs in a New World, is related to The Promise of Science, the Power of Healing. Patients are growing more diverse in cultural background, choices of drugs, and ways they are administered. The world is also changing, with Internet availability of drugs; terrorism leading to increased anxiety, PTSD, depression, and substance abuse; and new methods of treatment, including new pharmacotherapies and psychotherapies tailored to treating addictions and comorbidity. This workshop will help the participant learn more about new treatment strategies and how to integrate them with practice. The panelists will speak for no more than five minutes each, then open up the floor to a wide range of discussion with the audience, with no one speaking for more than two minutes. The workshop provides an opportunity for young as well as experienced therapists to have their questions answered by master clinicians and teachers.

REFERENCES:

1. Mack AH, Franklin JE Jr, Frances RJ: Concise Guide to Treatment of Alcoholism & Addiction, 2nd ed. Washington, DC, American Psychiatric Publishing, 2001.
2. Frances RJ, Miller SI, eds: Clinical Textbook of Addictive Disorders, 2nd ed. New York, Guilford, 1998.

## Issue Workshop 101
## PSYCHODYNAMICS IN TREATMENT-REFRACTORY DEPRESSION

*Co-Chairpersons:* Eric M. Plakun, M.D., *The Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262,* Edward R. Shapiro, M.D., *Admissions, Austen Riggs Center, 25 Main Street, PO Box 962, Stockbridge, MA 01262-0962*
*Participant:* David L. Mintz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to enumerate psychodynamic principles for work with treatment-refractory depression, and should have an enhanced understanding of and ability to use a psychodynamic approach to improve outcomes in 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 medication alone. Treatment with these patients often becomes chronic crisis management. Training programs have only recently begun to reemphasize mastery of psychodynamic concepts that may be useful in integrating a treatment approach for these patients. This workshop offers an approach derived from a longitudinal study of treatment-refractory patients in extended treatment at the Austen Riggs Center. Ten psychodynamic principles extracted from study of successfully treated patients are presented. These include, among others, listening beneath symptoms for repeating themes, putting unavailable affects into words, attending to transference-countertransference paradigms contributing to treatment refractoriness, and attending to the meaning of medications. This psychodynamic approach is used to guide interpretation in psychotherapy but also to guide adjunctive family work, integrate the psychopharmacologic approach, and maximize medication compliance. Ample opportunity will be offered for workshop participants to discuss their own cases as well as material offered by the presenters.

REFERENCES:

1. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure and clinical application. Am J Psychiatry 1987; 144:543–550.
2. McLaughlin J: Clinical and theoretical aspects of enactment. J Am Psychoanalytic Assoc 1991; 39:595–614.

## Issue Workshop 102
## 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 OBJECTIVE:

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 problem-solving model and a humanistic expression- and relation-enhancing model.

SUMMARY:

Four dimensions, or "bridges," to help integrate family therapy and pharmacotherapy will be outlined from the presenter's new book *Bridges for Healing.* 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. This workshop is intended for practitioners with some interpersonal therapy and pharmacotherapy experience.

REFERENCES:

1. Resnikoff R: Bridges for Healing: Integrating Family Therapy and Psychopharmacology. Philadelphia, Brunner-Routledge, 2001.
2. Resnikoff R, Lapidus D: Psychopharmacology in conjunction with family therapy. J Family Psychother 1998; 9:1–18.

## Issue Workshop 103
## MAKING TELEPSYCHIATRY WORK FOR YOU

*Co-Chairpersons:* Debra A. Katz, M.D., *Department of Psychiatry, University of Kentucky, 3470 Blazer Parkway, Lexington, KY 40509,* Rob Sprang, M.B.A., *Kentucky Telecare K117 KY Clinic, 740 South Limestone Street, Lexington, KY 40536*
*Participants:* Timothy S. Allen, M.D., Shari G. Sistrunk, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will understand (1) types and costs of videoconferencing technology, (2) applications of telepsychiatry in educational, administrative, and clinical settings, and (3) how to develop an affordable telepsychiatry system that meets participants' needs.

SUMMARY:

Telemedicine systems, some costing as little at $2500, can be used to bridge distances between teachers and students, patients and healers, and co-workers who work at distant sites. The University of Kentucky Department of Psychiatry has actively used telemedicine since 1995 to provide: (1) clinical services to rural patients, incarcerated children and adults, and patients in their homes, (2) school-based consultation to underserved children, (3) administrative meetings between distant sites, (4) court testimony without travel, and (5) resident teaching by lecturers from across the country to enhance training.

This workshop will provide practical information about how to set up a telemedicine system that works for participants' individual needs, how to make the best use of available financial resources, specific applications of telepsychiatry (including school-based consultation, evaluation and treatment of juvenile justice and prison populations, and resident education by distant teachers), and medico-legal issues.

Participants will explore potential applications of telepsychiatry with the leaders of this workshop, who include a residency training director, a forensic psychiatrist, a child psychiatrist in private practice, and the director of the University of Kentucky telemedicine program. This workshop will show videotapes of telepsychiatry in action and provide resources to help participants develop their own telepsychiatry solutions.

REFERENCES:

1. Baer L, Elford R, Cukor P: Telepsychiatry at forty: what have we learned? Harvard Rev Psychiatry 1997; 5:7–17.
2. Doze S, Simpson J, Halley D, et al: Evaluation of a telepsychiatry pilot project. J Telemed Telecare 1999; 5:38–46.

## Issue Workshop 104
## DYSMORPHOLOGIES: RECOGNITION AND TREATMENT

*Co-Chairpersons:* Syed S. A. Naqvi, M.D., *Department of Psychiatry, Cedars-Sinai Hospital, 5209 Thalians, 8730 Alden Drive, Los Angeles, CA 90048,* Jeremy E. Revell, M.D., *Cedars-Sinai Hospital, 8730 Alden Drive, Los Angeles, CA 90048*
*Participant:* Robb Saito, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant will be able to recognize the major genetic causes of dysmorphologic disorders that lead to psychiatric comorbidities. The participant will also be educated on the current state-of-the-art treatment modalities for each disorder.

SUMMARY:

This workshop addresses the various genetic and syndromal dysmorphologic disorders. Often subtle and overlooked by clinicians, the dysmorphologic disorders can have a significant neuropsychiatric effect on patients. This workshop explores the various dysmorphologies, phenotypes, and genotypes, as well as state-of-the-art treatment and detection modalities. Topics of discussion will include Prader-Willi syndrome, fragile X syndrome, Down's syndrome, Turner's syndrome, Angelman syndrome, Williams syndrome, velo-cardio-facial syndrome, Rett's syndrome, and fetal alcohol syndrome. The workshop will have an open lecture format and include presentation of video clips and photographs. State-of-the-art biopsychosocial treatment for the various disorders will be discussed.

REFERENCES:

1. Mann MR, Bartolomei MS: Towards a molecular understanding of Prader-Willi and Angelman syndromes. Hum Mol Genet 1999; 8:1867–1873.
2. Bottani A, Robinson WP, DeLozier-Blanchet CD, et al: Angelman syndrome due to paternal uniparental disomy of chromosome 15: a milder phenotype? [see comments]. Am J Med Genet 1994; 51:35–40.

## Issue Workshop 105
## PSYCHIATRIC DISABILITY: THE ROLE OF PSYCHIATRIC ASSESSMENT

*Chairperson:* Edward A. Volkman, M.D., *Temple University, 3401 North Broad Street, Philadelphia, PA 19140-5103*
*Participant:* Janice Volkman, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should know the meaning of "meeting a listing," be able to enumerate psychiatric disorders that meet that criterion, and include drug use without disqualifying the claimant. The participant should know how to present "impairment" in a form that satisfies the administrative law judge and the criteria set employed by vocational experts.

SUMMARY:

After brief introductory presentations by an administrative law judge (ALJ) and a psychiatrist, the audience will be asked to discuss each of three case summaries that will be distributed at the workshop. At the end of the formal presentations and case discussions, there will be a period (20 minutes) of summary discussion.

The ALJ presentation is intended to familiarize the audience with disability law, its terms of art, the criteria set used by judges to determine disability, the role of the vocational expert in determining the limitation parameters of the various psychiatric diagnoses, and the various roles the psychiatrist may play in the process. The psychiatrist will go over the various diagnoses that "meet a listing" in terms of which symptoms will be most relevant to the ALJ's determination of disability. The cases will be bowdlerized versions (to protect claimant confidentiality) of actual cases heard in the Office of Hearings and Appeals. They will be specifically chosen to illuminate the role the psychiatric assessment played in the ultimate determination of entitlement to disability. The assessments will be constructed to demonstrate the most and least efficacious ways of presenting clinical findings.

REFERENCES:

1. Wylonis L: Psychiatric disability, employment, and the Americans With Disabilities Act. Psychiatric Clinics of North America 1999; 22:147–158.
2. Leo RJ: Social Security disability and the mentally ill: changes in the adjudication process and treating source information requirements. Psychiatric Annals 2002; 32:284–292.

## Issue Workshop 106
## THE MEANING OF THE PACIFIC RIM FOR WORLD AND AMERICAN PSYCHIATRY
*Pacific Rim College of Psychiatrists*

*Co-Chairpersons:* Francis G. Lu, M.D., *Department of Psychiatry-7M8, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110,* Bruce Singh, M.D., *University of Melbourne, Royal Melbourne Hosp, 7th Floor C Connibere Boulevard, Victoria 3050, Australia*
*Participants:* Ching-Piao Chien, M.D., Robert O. Pasnau, M.D., Milton H. Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the meaning and importance of the Pacific Rim for world and American psychiatry.

SUMMARY:

The Pacific Rim, stretching from Australia through the United States to South America, encompasses many diverse cultures with different diagnostic systems, training methods, and systems of care and research. Yet American psychiatrists often are not well informed about this region, from which many immigrant Americans come. Since 1980, the Pacific Rim College of Psychiatrists has provided a forum for psychiatrists from this region. This workshop will bring together four previous recipients of the APA Kun-Po Soo Award (Drs. Lu, Chien, Pasnau, and Miller) who are Fellows of the Pacific Rim College of Psychiatrists to discuss the importance and meaning of the Pacific Rim for world and American psychiatry. Dr. Singh, President of the Pacific Rim College of Psychiatrists, will share his perspectives.

REFERENCES:

1. Lee E (ed): Working With Asian-Americans. New York, Guilford, 1997.
2. Tseng W-S: Handbook of Cultural Psychiatry. New York, Academic Press, 2001.

## Issue Workshop 107
## AN UPDATE ON MANAGEMENT OF SUICIDE ATTEMPTS: A REVIEW FOR CLINICIANS

*Co-Chairpersons:* Jose de Leon, M.D., *Department of Psychiatry, University of Kentucky, 627 West 4th Street, MHRC 627, Lexington, KY 40508-1207,* Maria A. Oquendo, M.D., *Department of Neuroscience, New York State Psychiatric Institute, 1051 Riverside Drive, Box 42, New York, NY 10032*
*Participants:* Jeronimo Saiz-Ruiz, M.D., Enrique Baca-Garcia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should have a basic understanding of the current state of clinical guidelines 1) to assess suicide attempts in the emergency room and 2) to treat suicidal patients (or those with high risk).

SUMMARY:

Although recommendations for the assessment and treatment of suicide attempts are described in the literature, there is limited information regarding how suicidal attempters or patients with high risk for suicide attempts are managed in the clinic. The limited available information suggests that clinicians do not always follow the guidelines provided by suicide experts. A brief synthesis of published guidelines describing the assessment of suicide attempts will be provided. The demographic and clinical variables associated with hospitalization after a suicide attempt will be reviewed. A dialogue will then be established so that the audience can discuss their own experiences with the assessment and treatment of suicidal attempters and patients with high suicidal risk. Then ideas will be exchanged with the participants regarding the practicality of using current expert guidelines for the assessment and treatment of suicide in the complex world of clinical practice. The need for improvements to bring patient management closer to current recommendations and to make expert guidelines more closely reflect the complexities of the clinical environment will be emphasized.

REFERENCES:

1. Oquendo MA, Kamali M, Ellis SP, et al: Adequacy of antidepressant treatment after discharge and the occurrence of suicidal acts in major depression: a prospective study. Am J Psychiatry 2002; 159:1746–1751.
2. Baca-Garcia E, Diaz-Sastre C, Garcia Resa E, et al: Variables predicting hospitalization after a suicide attempt (submitted).

## Issue Workshop 108
## ADHERENCE TO HIV MEDICATIONS IN THE PSYCHIATRICALLY ILL: NEW FINDINGS

*Chairperson:* Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco, CA 94110*
*Participants:* David Bangsberg, M.D., Joshua Bamberger, M.D., James L. Sorensen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the effects of psychiatric illnesses on adherence to HIV medications and the effect of interventions to improve adherence.

SUMMARY:

Adherence to highly active antiretroviral therapy (HAART) has been associated with dramatic reductions in AIDS-related illnesses and mortality. The benefits of HAART have been more limited with urban poor, mentally ill, and substance-using populations. Psychiatric illness and, in particular, symptoms of depression are associated with nonadherence to HAART, treatment interruption, missed medical appointments, and increased risk of HIV disease progression and mortality. The presenters direct research and public health programs that study the effects of psychiatric illness on HAART adherence and that intervene to attempt to improve adherence in HIV-positive mentally ill persons. The effects of HAART nonadherence on health, the psychiatric contributors to nonadherence, and programs to improve adherence in psychiatrically ill will be discussed. Audience participation will be encouraged, with substantial time for discussion.

REFERENCES:

1. Perry S, Karasic D: Depression, adherence to HAART, and survival. Focus: A Guide to AIDS Research and Counseling 2002; 17(9):5–6.
2. Perry S, Bangsberg DR, Charlebois ED, et al: Depressive symptoms predict mortality and HAART adherence (abstract). XIV International AIDS Conference, Barcelona, July 7–12, 2002.

## Issue Workshop 109
## INPATIENT VIOLENCE: LESSONS FROM THE INNER-CITY PSYCHIATRY HOSPITAL

*Chairperson:* Jeffrey M. Levine, M.D., *Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*
*Participants:* Ali Khadivi, Ramon C. Patel, M.D., Merrill R. Rotter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the clinical, legal, and administrative issues involved in treatment of violent psychiatric inpatients.

SUMMARY:

The number of psychiatrically ill inpatients who have had history of violence is rising. Involvement with the criminal justice system, substance abuse, and poverty have been cited as contributing factors to the reported concomitant increase in inpatient violence. The purpose of this workshop is to explore the clinical and administrative issues that are involved in treating violent psychiatrically ill inpatients. Four clinicians who work in inner-city acute and state hospital facilities will critically discuss challenges and treatment strategies in managing violent inpatients.

The workshop will start with a brief review of research on inpatient violence. Then, using case examples, the presenters will discuss the clinical and administrative challenges in approaching inpatient violence. Emphasis will be placed on how to maintain the therapeutic alliance, to protect the rights and the safety of the patient, and at the same time to ensure the safety of other patients and staff. In addition, the effect of exposure to the criminal justice system on psychiatric patients and its implications for management of violence in the civil hospital will be discussed. The workshop will be highly interactive. The audience will be invited from the start to share their experiences in treating violent psychiatric inpatients.

## REFERENCES:

1. Nijman HL, Campo JM, Ravell DP, et al: A tentative model of aggression on inpatient psychiatric wards. Psychiatr Serv 1999; 50:832–834.
2. Volavka J, Mohammad Y, Vitrai J, et al: Characteristic of state hospital patients arrested for offenses committed during hospitalization. Psychiatr Serv 1995; 46:796–800.

## Issue Workshop 110
## PSYCHIATRIC CARE OF MUSLIM PATIENTS: A U.S. PERSPECTIVE

*Co-Chairpersons:* Arif M. Shoaib, M.D., *UTMSI, 1300 Moursund, #180, Houston, TX 77030,* Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030*
*Participants:* Syed A. Husain, M.D., Ayesha Mian, M.D., Mohammad F. Danish, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the unique cultural characteristics of the Muslim population that resides in the United States and to provide appropriate psychiatric care to the Muslim patients in the United States.

## SUMMARY:

Since the end of World War II, large waves of immigrants have entered the United States. The rate of growth of ethnic miniority groups in this country rose astronomically in the last 20–30 years. Among these immigrants and ethnic groups, Muslims constitute a significant number. The presenters will discuss the unique characteristics of the Muslim population of the United States. The presenters will focus on aspects that are relevant to the psychiatric care of these patients, including the role of religion, child rearing practices, the understanding of the etiology of psychiatric illness, and the cultural manifestations of psychiatric symptoms. Special attention will be given to Muslim women's mental health issues and the understanding of suicide according to the Muslim faith. Brief presentations will be followed by extensive audience participation as the focus of the learning process. It is hoped this interaction will lead to a better understanding of how best to provide psychiatric care to Muslim patients in the United States.

## REFERENCES:

1. Chaleby S, Racy J: Psychotherapy With the Arab Patient. New York, Shawn McLaughlin, 1999.
2. Kelly W Jr, Aridi A, Bakhtiar L: Muslims in the United States: an exploratory study of the universal and mental health values. Counseling & Values 1996; 40:206–218.

## Issue Workshop 111
## THE POWER OF HEALING: SPIRITUALITY GROUP WORK WITH PSYCHIATRY STAFF

*Chairperson:* C. Paul Yang, M.D., *Department of Psychiatry, UC San Francisco, 1001 Potrero Avenue, Unit 7C, San Francisco, CA 94110*
*Participants:* Hendry Ton, M.D., Heather M. Hall, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to acquire tools for cultivation of empathy, compassion, and love, and enhance their ability to integrate spirituality into patient care.

## SUMMARY:

Research suggests that spirituality is positively associated with health. In recent years, more patients and clinicians are exploring how spirituality may enhance psychological growth and facilitate the healing of illness.

This workshop will be both didactic and experiential. In the didactic part, the presenters will share their experience in conducting spirituality groups for psychiatry staff at the UCSF-San Francisco General Hospital over the past two years. The goal of these groups was to facilitate the cultivation and integration of love, empathy, and compassion into patient care. Group members read and discussed relevant subjects as well as shared their experiences and insight gained from daily practice of spirituality. In the experiential portion of the workshop, the presenters and participants will create a clinician spirituality group in a supportive context. Participants will share their experience with integrating spirituality into their clinical practice. They will also learn about and be guided through a session of mindfulness meditation.

This workshop is designed for clinicians who are interested in incorporating spirituality into patient care. Through sharing and discussion, the participants will learn ways to cultivate and apply empathy and compassion in the clinical setting. The workshop will be nondenominational, and no special religious or spiritual background is required for participating.

## REFERENCES:

1. Miller WR: Integrating Spirituality into Treatment. Washington DC, American Psychological Association, 1999.
2. Walsh R: Essential Spirituality: The Seven Central Practices to Awaken Heart and Mind. New York, Wiley, 1999.

## Issue Workshop 112
## HARM REDUCTION: A CRITICAL REVIEW

*Co-Chairpersons:* Jeffrey N. Wilkins, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive, Room E130, Los Angeles, CA 90048,* Jack Kuo, M.D., *131 North Croft Avenue Apt. #302, Los Angeles, CA 90048-3443*
*Participants:* Glenn Backef, Maria Chavez

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) use evidence-based harm reduction strategies in the treatment of substance abuse and (2) demonstrate knowledge of the socioeconomic and political dimensions of harm reduction.

## SUMMARY:

The harm reduction movement emerged in response to the growing threat posed by the HIV epidemic over the past two decades. During

that time harm reduction has implemented a number of controversial strategies such as needle exchange programs, methadone maintenance, drug education that emphasizes safety over total abstinence, and syringe injection rooms in an effort to reduce the negative consequences of drug use. Continued support for such strategies will depend on evidence demonstrating efficacy.

This workshop will critically examine current harm reduction strategies as well as the socioeconomic, political, racial, and legal dimensions of the harm reduction movement with the objective of outlining pragmatic, evidence-based approaches to substance abuse. Participants will engage in an interactive dialogue about substance abuse with an expert panel providing diverse perspectives ranging from public health policy to scientific research to political activism. The workshop is intended for any members interested in creative yet effective approaches to the challenging issues posed by the field of addictions psychiatry.

## REFERENCES:

1. Evidence-Based Findings on the Efficacy of Syringe Exchange Programs: An Analysis From the Assistant Secretary for Health and Surgeon General of the Scientific Research Completed Since April 1998. Washington, DC, Department of Health and Human Services, 2000.
2. Joseph H, Stancliff S, Langrod J: Methadone maintenance treatment (MMT): a review of historical and clinical issues. Mount Sinai J Med 2000; 67:347–364.

## Issue Workshop 113
## PARENTING WITH THE BRAIN IN MIND: ATTACHMENT AND SELF-UNDERSTANDING

*Chairperson:* Daniel J. Siegel, M.D., *UCLA, 11980 San Vicente Boulevard, Suite 809, Los Angeles, CA 90049*
*Participant:* Mary Hartzell, M.Ed.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate an understanding of parenting that synthesizes findings from attachment research and neurobiology, recognize how a parent's narrative coherence can influence the child's security of attachment, and appreciate the benefits of an interdisciplinary approach to teaching parents about the brain that promotes self-knowledge and their children's security of attachment.

## SUMMARY:

This presentation will offer a practical guide that enables professionals to assist parents in raising children by translating recent advances in a range of scientific fields that inform our understanding of the importance of nurturing relationships. The targeted audience, psychiatrists and other mental health professionals who work with parents and families, will be actively involved in an interactive discussion that will cover such areas as attachment, memory, the development of self-regulation, emotions and their communication, states of mind, and integrative processes in the brain. The presenters will describe practical strategies incorporating approaches to child-rearing that can be enhanced by understanding the brain and how it shapes and is shaped by interpersonal relationships. By understanding the nature of the emotional and social brain, parents can attain a useful perspective on the importance of relationships in the unfolding of their child's and their own developing mind. The deepening of parents' self-understanding is associated with an enhanced security of attachment of their children. This presentation will offer an opportunity for mental health professionals to learn about this integrated developmental approach to teaching parents that can enhance children's security of attachment.

## REFERENCES:

1. Siegel DJ: The Developing Mind: Toward a Neurobiology of Interpersonal Experience. New York, Guilford, 1999.
2. Siegel DJ: Toward an interpersonal neurobiology of the developing mind: attachment relationships, "mindsight," and neural integration. Infant Mental Health J 2001; 22:67–94.

## Issue Workshop 114
## SERVICE INTEGRATION AND CONTINUITY IN CALIFORNIA: PROGRAMS FROM HARBOR-UCLA

*Chairperson:* Mary E. Read, M.D., *Dept of Psychiatry, UCLA, 1000 West Carson Street, Box 497, Torrance, CA 90509*
*Participants:* Michael W. Smith, M.D., Paul G. Arns, Ph.D., Leslie Groenewold, R.N.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to describe how the integration of multidisciplinary care for patients with severe chronic mental illness can increase both the quality of care for the patients and the efficiency of the larger system of care.

## SUMMARY:

New treatments and psychiatric service options for high-utilization patients with severe mental illnesses are more critical as funding sources and systems of care change. The Harbor-UCLA Department of Psychiatry's AMI/ABLE Integrated Services Program and Sunnyside Psychiatric Step-down Unit are innovative public/private partnerships developed to provide high-quality psychiatric care to this population while decreasing costs. The AMI/ABLE program representatives and medical directors will describe how full integration of psychiatric, general medical, psychosocial, and case management interventions, along with assigning a single team of providers to maintain direct responsibility across all levels of care (inpatient, outpatient, 24-hour emergency response), has resulted in treatment cost reductions of approximately 75% as well as improved community functioning for the program's high-risk patients. The Sunnyside program representatives and medical directors will describe how the clinical needs for psychiatric patient care, family psychoeducation, psychosocial rehabilitation groups, and general medical care are coordinated with the administrative challenges of benefits establishment, legal issues, and placement to achieve the larger system goals of decreasing length of stay and "administrative" status on the acute inpatient units. The audience will be encouraged to discuss how these and other innovations might be adapted to their own treatment systems.

## REFERENCES:

1. Smith TE, Hull JW, Hedayat-Harris A, et al: Development of a vertically integrated program of services for persons with schizophrenia. Psychiatr Serv 1999; 50:931–935.
2. Longo DA, Marsh-Williams K, Tate F: Psychosocial rehabilitation in a public psychiatric hospital. Psychiatr Q 2002; 73:205–215.

## Issue Workshop 115
## BRIDGING THE GAP BETWEEN MENTAL HEALTH AND PRIMARY CARE FOR ASIAN AMERICANS

*Co-Chairpersons:* Francis G. Lu, M.D., *Department of Psychiatry-7M8, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110,* Henry Chung, M.D., *Pfizer, 235 East 42nd Street, New York, NY 10017*
*Participants:* Sue S. Chan, M.D., Teddy Chen, M.D., Albert Yeung, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) list at least four barriers to access to care among Asian Ameri-

cans and (2) describe model programs that use the primary care system as a vehicle for the delivery of mental health services to patients.

## SUMMARY:

According to the 2001 report of the Surgeon General, *Mental Health: Culture, Race and Ethnicity* Asian Americans, compared to all other racial and ethnic groups, have the lowest utilization of mental health services and experience the greatest delay in receiving appropriate care, which results in poorer outcomes. Their reluctance to seek help can be attributed to many causes: the severe stigma of seeking services for mental illness, the lack of cultural and linguistic competence of some mental health systems, and the relative lack of bilingual and bicultural mental health professionals. As for all the racial and ethnic groups, the Surgeon General recommended greater integration of mental health services and primary care to help close these disparities. This workshop will begin with a psychiatrist's presentation of the case of a Chinese patient that illustrates common barriers assessing and managing mental health issues in primary care. A primary care physician will join the discussion with the audience to help elucidate the clinical and systems barriers. Brief presentations of model programs that have effectively overcome these barriers at the Charles B. Wang Community Health Center in New York City and at Massachusetts General Hospital in Boston will be presented. Audience discussion will focus on how to further develop such services in their own settings.

## REFERENCES:

1. Chung H, Kramer E, Lipkin M (eds): Behavioral Health Care of Asian-Americans (special Issue). Western J Med 2002; 176:217–279.
2. Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, Md, US Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001

## Issue Workshop 116
## COMPUTER-ASSISTED PSYCHOTHERAPY IN CLINICAL PRACTICE

*Chairperson:* Jesse H. Wright, M.D., *Department of Psychiatry, University of Louisville, Norton Psychiatric Center, P.O. Box 35070, Louisville, KY 40232*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) explain the rationale and indications for computer-assisted psychotherapy, (2) identify pros and cons of different formats for computer-assisted psychotherapy, and (3) describe methods of integrating computer-assisted psychotherapy into clinical practice.

## SUMMARY:

This workshop is intended for clinicians who may be interested in using computer tools for psychotherapy as an adjunct to clinical practice. The presentation also may be helpful for those who wish to use computer-assisted therapy software for training or research applications. After a brief explanation of the rationale for computer-assisted therapy (CAT), the pros and cons of major forms of CAT (e.g., text-based programs, multimedia, DVD-ROM, virtual reality, and palm-top computers) will be detailed. The use of CAT in clinical practice will be demonstrated with a multimedia program for cognitive therapy.

Workshop participants will discuss the different types of CAT with a focus on: (1) indications for using computer tools in therapy, (2) ethics of using therapeutic software, (3) integration of computer and human components of therapy, (4) methods of using computer tools in clinical practice, and (5) economic and managed care considerations. The presentation will include short didactic segments, distribution of handouts that explain key features of different types of software, a "hands-on" demonstration of a DVD-ROM multimedia program, and discussion of issues in the implementation of CAT.

## REFERENCES:

1. Wright JH, Wright A: Computer-assisted psychotherapy. J Psychother Prac Res 1997; 6:315–329.
2. Wright JH, et al: Development and initial testing of a multimedia program for computer-assisted cognitive therapy. Am J Psychother 2002; 56:76–86.

## Issue Workshop 117
## RACIAL, ETHNIC, AND CULTURAL BIAS IN PSYCHOTHERAPY

*Chairperson:* Edmundo J. Ruiz, M.D., *1103 North Seymour Avenue, Laredo, TX 78040-5381*
*Participant:* Homero R. Sanchez, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be aware of the crucial importance of knowing how to deal with patients with different ethnic and cultural values.

## SUMMARY:

This workshop considers the existing biases of therapists and patients toward each other. It will describe the need for self-evaluations in both therapists and patients to become aware of the impact that their biases have on a positive and trusting patient-therapist relationship, especially when the patient and therapist are from different ethnic and cultural backgrounds. It is a known fact that the more culturally different the patient and therapist are, the more difficult it will be for both to understand each other. Their perception of each other will be influenced by their own positive or negative transference and counter-transference, as well as by generational or historical events transmitted or learned and not necessarily through personal experience (pseudotransference).

Listening to free-floating feelings at the beginning of the session will facilitate a state of ease in the patient, while at the same time, the therapist is doing a self-evaluation. After this working through and listening to positive and negative elements, conscious and unconscious, during the initial sessions, all are usually able to talk more freely about the "here and now" and later are better able to appreciate the specific needs of the individual, group, or family.

## REFERENCES:

1. Wade P, Bernstein BL: Culture sensitivity training and counselors' race: effects on black female clients' perceptions and attrition. J Counseling Psychol 1991; 39:9–15.
2. American Psychological Association: Guidelines for psychological practice with ethnic, linguistic, and culturally diverse populations. Amer Psychologist 1993; 48:445–483.

## Issue Workshop 118
## ESSENTIAL SKILLS 101: WRITING MANUSCRIPTS FOR PUBLICATION

*Chairperson:* Laura W. Roberts, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker NE, Albuquerque, NM 87131*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to construct the framework for a manuscript, characterize the series of steps involved in getting a paper written and published, and adopt more effective strategies for developing successful papers for peer-review journals.

SUMMARY:

This workshop is a hands-on introduction to the essential skill of writing manuscripts for publication in peer-reviewed academic medical journals. The course leader will present the frameworks of empirical and conceptual manuscripts and of specialized format papers, such as annotated bibliographies, review papers, and brief reports. Participants will be introduced to the process of getting a paper published, including manuscript preparation, submission, editorial review, peer-review, revision and resubmission, editorial decision making, and publication production. This process will be discussed step-by-step, with insights from the perspective of writers, reviewers, and editors. Strategies for assessing one's strengths and motivations as a writer, for choosing the "right" target journal for a paper, for selecting the "right" presentation, for responding to reviewers' concerns, and for working with editors will be addressed. Tips for effective collaboration with co-authors will be discussed. This workshop will utilize several learning formats (e.g., formal presentations, interactive exercises, and Q & A), and it will have a tone of warmth and collegiality. It is aimed at enhancing the skills of early- and middle-career academic psychiatrists but will be valuable for more senior faculty who serve as mentors, reviewers, and guest editors. Up-to-date resource materials will be provided to all participants.

REFERENCES:

1. International Committee of Medical Journal Editors: Uniform requirements for manuscripts submitted to biomedical journals. JAMA 1997; 277:927–934.
2. AE Kazdin: Preparing and Evaluating Research Reports, in Methodological Issues and Strategies in Clinical Research, 2nd ed. Washington, DC, American Psychological Association, 1998.

# ADVANCES IN PSYCHOTHERAPY

## ADVANCES IN PSYCHOTHERAPY: AN UPDATE ON PSYCHIATRIC TREATMENTS FOR PSYCHIATRIC DISORDERS

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the role that the various psychotherapeutic approaches play in the treatment of major psychiatric disorders.

### SUMMARY:

This symposium will bring psychiatrists and other mental health professionals up to date on the current thinking about the role that psychotherapeutic approaches play in the general treatment of psychiatric disorders. Dr. Gabbard will present an overview of how psychotherapy affects the brain, and how we conceptualize the role that medication and psychotherapy play, respectively, in psychiatric treatment. Dr. Rothbaum will update the audience on the most recent empirical data, suggesting which psychotherapeutic treatments are most likely to help patients with posttraumatic stress disorder. Dr. Thase will present an overview of the efficacy data on interpersonal and cognitive behavior therapies. He will stress the need to tailor the treatment to the patient and will also discuss when to incorporate pharmacotherapy. Dr. Nadelson will comment on the importance of gender issues in all psychotherapeutic treatments and illustrate particular populations where gender considerations are paramount. Dr. Gunderson will close the symposium by providing a perspective on how the psychotherapeutic strategies of personality disorders have changed over the last decade or so. The symposium will end with a 30-minute question-and-answer session.

### REFERENCES:

1. Gabbard, GO (editor). Treatments of Psychiatric Disorders: Third Edition. Washington, D.C., American Psychiatric Publishing, 2001.

## ADVANCES IN PSYCHOTHERAPY: GENDER ISSUES IN PSYCHOTHERAPY

Carol C. Nadelson, M.D., *Director's Office of Women's Careers, Brigham and Women's Hospital, 75 Francis Street, PBB5-503, Boston, MA 02115*

### SUMMARY:

As in all areas of health care, gender is an important variable in the treatment of a variety of psychiatric symptoms and disorders. Gender affects and is affected by psychosocial factors as well as physiological or metabolic differences between men and women. Gender can influence the patient's choice of caregiver, the 'fit' between caregiver and patient and the sequence and content of the clinical material presented. It also affects the diagnosis, length of treatment, and even the outcome of treatment, from psychosocial and biological perspectives.

This talk will focus on the relationship between gender and treatment and consider psychosocial and biological variables. It will examine biological influences, developmental and life experiences, gender differences in personality styles, and the effects of stereotypes and values.

## ADVANCES IN PSYCHOTHERAPY: TREATMENT OF PERSONALITY DISORDERS

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA, 02478-9106*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to review the developments and current status of knowledge about treatment for personality disorders.

### SUMMARY:

This presentation will summarize the changes in treatment of personality disorders (PDs) since the inception of the TPD series. Notable changes are:

(1) the shift from treatments dominated by the psychoanalytic paradigm to treatments that are multimodal and include psychopharmacology and cognitive behavioral approaches, and

(2) the shift from reliance on expert clinical authority to empirically based evidence.

The presentation will then summarize the current knowledge about treatment for each of the three chapters. Cluster A treatments rely more on psychopharmacology and have the most gloomy prognosis. Cluster B treatments have had the most treatment research, involve multimodal strategies, and are associated with a wide range of outcomes. Treatments for Cluster C rely most on individual psychotherapy and, though not well researched, are associated with the best outcomes.

### REFERENCE:

1. Gunderson JG, Gabbard GO, (Eds); Personality Disorders in Treatments of Psychiatric Disorders, Third Edition, Volume 2 (G. Gabbard, Ed), American Psychiatric Publishing, Wash, DC, 2001, pp 2223–2370.

## ADVANCES IN PSYCHOTHERAPY: MIND AND BRAIN IN PSYCHIATRIC TREATMENT

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate knowledge of the mind-brain interface as it applies in the pathogenesis and treatment of psychiatric disorders.

### SUMMARY:

The mind-brain interface may be the cutting edge of psychiatry at the moment. However, the philosophical dimensions of the mind and brain are complicated and essentially unsolved by many attempts by philosophers and scientists. From a practical standpoint, the implication of both mind and brain must be incorporated by the biopsychosocial psychiatrist in both diagnostic understanding and treatment planning. Most major psychiatric disorders are caused by complex interactions between environment and gene expression. In addition, the treatment itself must take into account altering the brain in terms of neurotransmitter functions, while also attending to internal object relations, subjective concerns that are idiosyncratic and fueled by conflict, and unconscious fantasies. We no longer view "biologically based" problems as requiring medication and "psychologically based" problems as requiring psychotherapy. We now know that psychotherapy has a powerful impact upon the brain. Psychotherapy studies are providing one important bridge between mind and brain.

### REFERENCE:

1. Gabbard GO: A neurobiologically informed perspective on psychotherapy. British Journal of Psychiatry 2000; 177:117–122.

## ADVANCES IN PSYCHOTHERAPY: TREATMENT OF PTSD

Barbara O. Rothbaum, Ph.D., *Department of Psychiatry, Emory Clinic, Emory University School of Medicine, 1365 Clifton Road, N.E., Atlanta, GA 30322*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be familiar with various treatment options for PTSD and data as to their efficacy.

### SUMMARY:

The pharmacotherapy and psychotherapy literature for posttraumatic stress disorder (PTSD) will be succinctly reviewed and discussed. Currently, two medications have an FDA approval for PTSD, both SSRIs. The data on the SSRIs for PTSD are the strongest of all pharmacologic interventions and will be the focus of discussion. Data from the large multisite trials of sertraline and paroxetine will be reviewed, along with data from smaller trials of other medications. The psychotherapy discussion will focus on cognitive behavioral treatments (CBT) of PTSD. As exposure therapy has received more empirical support than any other intervention for PTSD, prolonged imaginal exposure will be highlighted. Exposure therapy involves assisting patients in recalling their traumas in their imaginations and recounting them repeatedly in a therapeutic manner until discomfort decreases. 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. Lastly, early interventions for individuals who have recently suffered a traumatic event will be discussed. It is concluded that the SSRIs and CBT therapies are very effective for chronic PTSD, but clinicians should use caution in intervening immediately following traumatic exposure.

### REFERENCE:

1. Foa EB, Friedman M, Keane T: Effective Treatments for Posttraumatic Stress Disorder: Practice Guidelines from the International Society for Traumatic Stress Studies. Guilford Press, 2000.

## ADVANCES IN PSYCHOTHERAPY: PSYCHOEDUCATIONAL PSYCHOTHERAPIES FOR DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, University of Pittsburgh-WPIC, Bellt843, Pittsburgh, PA 15260*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to consider important specific and common (nonspecific) elements to psychotherapy of depression.

### SUMMARY:

Depressive disorders are heterogeneous conditions that respond unpredictably to diverse interventions. For decades, psychiatrists have accepted psychotherapy as the treatment of first choice for all but the most severe forms of depression. Despite such recognition, however, there has been an undercurrent of discontent with the quality of the data that justify a "psychotherapy-first" approach. In this era of evidence based medicine and cost containment, psychotherapy is beginning to be undervalued. This talk will focus on the evidence that psychotherapy is an effective treatment of major depressive disorder and dysthymia, including studies of differential responses to psychotherapy and pharmacotherapy. There is some evidence of poorer psychotherapy response among depressed patients manifesting signs of central nervous system hyperarousal. It is concluded that combined treatment is indicated (i.e., cost offsetting) for patients with more chronic, severe-recurrent, or treatment resistant forms of depression. It will be suggested that treatments should be chosen for a given patient on the basis of preference, availability, and the estimated likelihood of response. This approach is predicated on prospective monitoring of outcome and timely, sequential implementation of alternate strategies.

### REFERENCE:

1. Thase ME. Depression-focused psychotherapies. in: Treatment of Psychiatric Disorders. Edited by Gabbard GO. Washington, D.C., American Psychiatric Press, Inc., Third Edition, Volume 2, 2001, pp 1181–1227.

# ADVANCES IN RESEARCH

## LATEST DEVELOPMENTS IN THE GENETICS OF MOOD DISORDERS

*Chairperson*: Herbert Pardes, M.D.
*Co-Chairperson*: Geetha Jayaram, M.D.
*Participants*: Constantine Lyketsos, M.D., J. Raymond DePaulo, Jr., M.D., John M. Kane, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session participants will be able to discuss methological issues in studying efficacy and effectiveness of antipsychotic drugs, understand the evidence for a genetic etiology in bipolar and unipolar disorders. They will also review recent evidence regarding neuropsychiatric disorders in Alzheimer's disease.

### SUMMARY:

Although great strides have been made in the development and marketing of new antipsychotic medications, it has been difficult for clinicians to draw conclusions regarding the relative merits of so-called atypical medications in general, and specific drugs in particular. Dr. Kane's review will discuss the design and methodologic issues in studying the efficacy and effectiveness of these drugs. He will focus on particulars of management of treatment refractory patients, sharing new meta-analytic data.

Dr. Lyketsos' review will include current knowledge about the prevalence, classification, impact, etiology and treatment of neuropsychiatric disorders related to Alzheimer's disease. Specifically, he will focus on affective disturbances and psychotic disturbances seen in such patients, demonstrating their substantial frequency and the impact that these conditions have for patients and their caregivers. Future research will be reviewed.

Family, twin, and adoption studies provide strong evidence for a genetic etiology in mood disorders. Dr. DePaulo will present epidemiological evidence, the interplay of pathogenesis and environmental factors associated with these illnesses, future directions in developing diagnostic tests and predicting treatment response. He will focus on familial and genomic studies in bipolar families and some findings in unipolar disorder. Clinical strategies for increasing the power of linkage and association studies will be reviewed.

### REFERENCES:

1. Leucht S, Barnes TRE, Kissling W, Engel RR, Correll C, Kane JM. Relapse prevention in schizophrenia with new generation Antipsychotics: A systematic review and explorative meta-analysis of randomized controlled trials. American Journal of Psychiatry, in press.
2. Lyketsos CG, Rabins PV, Breitner JCS. An evidence-based proposal for the classification of neuropsychiatric disturbance in Alzheimer's disease. International Journal of Geriatric Psychiatry 2001; 16(11): 1037–1042.
3. Badner JA, Gerxhon ES. Meta-analysis of whole-genome linkage scans of bipolar disorder and schizophrenia. Mol Psychiatry. 2002; 7(4): 405–411.

# CONTINUOUS CLINICAL CASE CONFERENCE

## 1. TREATMENT OF THE VIP PATIENT: TWO PATIENTS, TWO THERAPISTS: PART I AND II

Efram Bleiberg, M.D., *Director, Professionals in Crisis Program, The Menninger Foundation, 5800 Southwest 6th Avenue, Topeka, KS 66601,* Richard L. Munich, M.D.,

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with the special factors influencing the treatment of patients with extraordinary political, financial, professional, or athletic status. The problems of patient entitlement and therapist countertransference will be highlighted.

### SUMMARY:

On day one of the program, Dr. Bleiberg will present a case with discussion initiated by Dr. Munich. The emphasis will be on case management and problems of treatment resistance and facilitation of an attenuated reflective functioning.

On day two, Dr. Munich will present the psychotherapy of a patient involved in the field. The emphasis will be on questions of professional identity, relationship issues, and countertransference. Dr. Bleiberg will lead the discussion of this case.

Over the course of the two days, we will review the process of mentalization and the special sensitivity of many of these patients to social and emotional cues as well as the conditions under which this hypersensitivity fuels issues of shame and narcissistic vulnerability. These issues, in turn, lead to an inability to use treatment, as the treatment relationship becomes a source of vulnerability. The discussion will serve to illustrate a systematic approach to build a treatment alliance and the patient's vulnerabilities while mobilizing the patient's strengths.

### REFERENCES:

1. Munich RL: The VIP as Patient: Syndrome, Dynamic and Treatment, in A. Tasman, R.E. Hales, A.J. Frances (Eds.), American Psychiatric Press Review of Psychiatry, Vol. 8, Chapter 29. Washington D.C.: American Psychiatric Press, Inc., 1989, pp. 580–593.
2. Fonagy P, Target M: Playing With Reality: I. Theory of Mind and the Normal Development of Psychic Reality. International Journal of Psychoanalysis 1996; 77:217–233.
3. Fonagy P, Steele M, Steele H, Moran G, Higgitt A: The Capacity for Understanding Mental States: The Reflective Self in Parent and Child and Its Significance for Security of Attachment. Infant Mental Health Journal 1991; 12(3):201–218.

## 2. A CASE OF MURDER AND DISSOCIATIVE IDENTITY DISORDER: REAL OR MALINGERED MENTAL ILLNESS: PART I & II

*Moderator:* Britta Ostermeyer, M.D., *11100 Euclid Avenue, 2nd Floor, Cleveland, OH 44106*
*Presenters:* Thomas G. Cobb, M.D., *Department of Forensic Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, Ohio 44106*, Renee M. Sorrentino, M.D., Richard P. Kluft, M.D., and Phillip J. Resnick, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this two-day presentation, the participant will be more familiar with how to identify and evaluate patients with dissociative identity disorder (DID). The participant will also learn strategies to detect malingered mental illness in general and in patients with DID.

### SUMMARY:

The diagnosis of DID remains a challenging one for most mental health professionals. DID is difficult to distinguish from malingering and many therapists remain unclear whether their patients suffer from true DID.

We will present a case of a homosexual man with two identities, one of which killed his lover. Videotaped sessions of the patient's two identities discussing the murder will be shown. The participant will learn skills in how to identify malingered mental illness and how to distinguish it from genuine psychiatric disease and DID. The role of DID as a defense for criminal responsibility will be discussed as well. An interactive dialogue with attendees will be highly encouraged.

### REFERENCES:

1. Kluft RP: The simulation and dissimulation of multiple personality disorder. American Journal of Clinical Hypnosis 1987; 30: 104–118.
2. Kluft RP: Current Issues in Dissociative Identity Disorder. Journal of Practical Psychiatry and Behavioral Health 1999; 5: 3–19.
3. Resnick PJ. The Detection of Malingered Psychosis. Psychiatric Clinics of North America 1999; 22: 159–172.

# CLINICAL CASE CONFERENCES

## 1. DIAGNOSTIC AND TREATMENT ISSUES IN THE CARE OF AN ADOLESCENT WITH COMORBID BIPOLAR DISORDER AND ADHD

Earlene E. Strayhorn, M.D., *1022 S. Oak Park Avenue, Oak Park, IL 60304-1925,* Bente Clausen, M.S.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with the recognition and identification of the separate and comorbic spectrum of bipolar disorder and attention deficit/hyperactivity disorder (ADHD) in an adolescent and make appropriate recommendations regarding psychopharmacologic treatment.

### SUMMARY:

Differentiating and adequately treating comorbid adolescent bipolar disorder and ADHD is increasing and proving to be an ongoing diagnostic and treatment challenge in the child and adolescent psychiatric community. Identifying the clinical spectrum of both these conditions separately and as comorbid diagnoses will be examined through a clinical presentation of a 14-year-old female currently being treated at a community-based mental health center. The initial psychiatric diagnostic wvaluation and treatment of this challenging patient will be reviewed and discussed, highlighting the adolescent developmental and familial issues, psychosocial therapies, and pharmacological treatments implemented over several years. Pertinent child and adolescent research literature will be available. Practical suggestions utilizing child and adolescent psychiatrically trained professionals and educational and community resources will be suggested. Participants will be encouraged to discuss their patient cases.

### REFERENCES:

1. Carlson G: Juvenile mania versus ADHD. Journal of the American Academy of Child and Adolescent Psychiatry 1999; 38: 353–354.
2. Farone S, et al: Is comorbidity with ADHD a marker for juvenile-onset mania? Journal of the American Academy of Child and Adolescent Psychiatry 1997; 36: 1046–1055.

## 2. DYSKINESIAS IN A SOMATICALLY PREOCCUPIED PATIENT AFTER TREATMENT WITH ATYPICAL ANTIPSYCHOTICS

Curley L. Bonds, M.D., *University of California Los Angeles Neuropsych Institute, 760 Westwood Plaza B8-233, Los Angeles, CA 90024,* Joseph M. Pierre, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have an increased understanding of the potential for atypical antipsychotic medications to induce extrapyramidal symptoms (EPS) and other movement disorders. Clinicians will be taught strategies to differentiate between drug-induced movements, conversion tremors, and benign or essential tremors.

### SUMMARY:

Atypical antipsychotic medications are known to have reduced liability for inducing movement disorders compared with conventional neuroleptics. In this case, a patient with treatment-emergent movements following exposure to antipsychotic medications will be presented. The evaluation of this patient's symptoms presented a particular challenge because of preexisting psychosomatic, genetic and environmental factors. The intersection of obsessive-compulsive symptoms and psychotic symptoms will be reviewed in the context of this case. Reports suggesting that atypical antipsychotics may have obsessogenic as well as antiobsessional effects will be discussed. Dr. Bonds will discuss the role of psychotherapy and psychopharmacology. Dr. Pierre will review simple office-based techniques that can be applied to evaluate the presence of abnormal movements in all patients treated with antipsychotic medication.

### REFERENCES:

1. Caroff SN, Mann SC, Campbell EC, et al: Movement disorders associated with atypical antipsychotic drugs. J Clin Psychiatry 2002; 63 Supplement 4:12–9.
2. Wirshing WC: Movement disorders associated with neuroleptic treatment. J Clin Psychiatry 2001; 62 Supplement 21:15–8.

## 3. TREATING THE CHRONICALLY MEDICALLY ILL ADOLESCENT: A CASE STUDY

Gia M. Crecelius, M.D., *11701 Montana Avenue, #402, Los Angeles, CA 90049-4735,* Margaret Stuber, M.D.

### EDUCATIONAL OBJECTIVES:

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### SUMMARY:

We will review the course of therapy of a young adult living with a life threatening illness since infancy. We will discuss the effect chronic illness throughout childhood and adolescence had on the emergence of developmental delays, learning disorders, mood and anxiety disorders, and substance abuse. We will also cover how chronic illness affected the formation of age appropriate relationships and the attainment of developmental goals.

### REFERENCES:

1. Chochinov HM: Psychiatry and Terminal Illness. Can J Psychiatry 2000;45(2):143–150.
2. Whitt JK, Hunter RS, Dykstra W, Lauria MM, Stabler B, Taylor CA: Pediatric liaison psychiatry: a forum for separation and loss Int J Psychiatry Med 1981–1982; 11(1) 59–68.

## 4. DEALING WITH DIAGNOSTIC AMBIGUITY: WHEN SOMATIC MEMORY AND ANXIETY SYMPTOMS CONFUSE

Jayne M. Stevenson, M.D., *35 Paloma Avenue, Pacifica, CA 94044,* Joel Yager, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will learn to understand how to approach diagnosis and treatment of a patient with multiple vague somatic and psychological complaints; understand the concepts of somatization, symptoms associated with chronic fatigue syndrome and the cognitive dysfunction that may be caused by anxiety.

### SUMMARY:

This clinical conference examines the clinical decision-making processes required and diagnostic difficulties presented when patients report various vague somatic and psychological symptoms that don't easily aggregate in straightforward DSM-IV or medical diagnoses.

We present the case of Mr A, a 59-year-old divorced white male, a highly accomplished computer scientist, who presented to the university mental health clinic with concerns about "blackouts and memory problems." Presenting complaints also included fatigue, aches and pains in different parts of his body. He came to the clinic on advice of a friend who suggested that he seek treatment for his anxiety problems. He believed he was anxious secondary to his memory problems. Later he wondered if he might have chronic fatigue syndrome.

In this case, the somatic complaints and memory difficulties can have many causes. Their workup and treatment may become complicated by difficulties imposed by separation of psychiatric and medical care.

We present the patients history in a "case based" format, inviting the audience to stop along the way and wrestle with the clinical questions we pose at each decision point.

### REFERENCES:

1. Wessely S: The epidemiology of chronic fatigue syndrome. Epidemiologic Reviews, 17(1):139–51, 1995.
2. Barsky AJ, Borus JF: Functional Somatic Syndromes. Annals of Internal Medicine, 1999; 130(11):910–21.

# FOCUS LIVE

## 1. BIPOLAR DISORDER

*Chair:* Deborah Hales, M.D.
*Co-chair:* Mark H. Rapaport, M.D.
James W. Jefferson, M.D., *Clinical Professor of Psychiatry, University of Wisconsin Medical School, Madison, Wisconsin; Distinguished Senior Scientist, Madison Institute of Medicine®, Inc. President, Healthcare Technology Systems, Inc.*

### EDUCATIONAL OBJECTIVES:

Participants will engage in a self-assessment activity designed to aid them in identifying areas where more study could be undertaken to enhance clinical management of patients with bipolar disorder.

As a result of participation in this interactive workshop, participants will have the opportunity to review many aspects of current clinical knowledge and increase their understanding of treatment of bipolar disorder.

### SUMMARY:

In FOCUS Live! sessions, expert clinicians, who served as the guest editors of the first issues of Focus will lead lively multiple choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison with other clinicians in the audience. Questions will cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

There is growing evidence that bipolar disorder and bipolar spectrum disorders are both prevalent and pernicious. The riddles of bipolar disorder are far from solved, but considerable progress has been made in the last decade across a broad front. This workshop will present current clinical treatment information about bipolar disorder using an interactive question and answer audience response system. This new format allows each participant to take a self-assessment "exam" with answers and discussion led by our expert faculty.

### REFERENCES:


1. Jefferson JW: Bipolar disorders: A brief guide to diagnosis and treatment. FOCUS: The Journal of Lifelong Learning in Psychiatry 2003;1:7–14.
2. Rapaport MR, Hales DJ: Relapse prevention and bipolar disorder: a focus on bipolar depression. FOCUS: The Journal of Lifelong Learning in Psychiatry 2003;1:15–31.


## 2. SUBSTANCE ABUSE

*Chair:* Deborah Hales, M.D.
*Co-chair:* Mark H. Rapaport, M.D.
Kathleen T. Brady, M.D., PhD., *Co-Director of the NIDA Postdoctoral Substance Abuse Research Training Program, Director, Addiction Psychiatry Fellowship Program, The Center for Drug and Alcohol Programs, CDAP, Medical University of South Carolina (MUSC) Institute of Psychiatry (IOP).*

### EDUCATIONAL OBJECTIVES:

Participants will engage in a self-assessment activity designed to help them identify areas where they might benefit from more study. This self-assessment is specifically designed to improve clinical management of patients with substance abuse disorders.

As a result of participation in this interactive workshop, participants will have the opportunity to review many aspects of current clinical knowledge and increase their understanding of treatment of substance abuse disorders.

### SUMMARY:

In FOCUS Live! sessions, expert clinicians, who served as the guest editors of the first issues of Focus will lead lively multiple choice questions-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience. Questions will cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

Substance use and abuse is a ubiquitous problem in our society. The magnitude of the problem is illustrated by findings of the National Household Survey, which shows that in 2000 an estimated 14.5 million Americans were dependent on either illicit drugs or alcohol. In addition to recognition and diagnosis of substance abuse disorders, it is increasingly important to be efficient and effective in treatment delivery. There are a wide variety of evidence-based psychotherapies and pharmacotherapies that domonstrate efficacy and effectiveness for the treatment of substance abuse disorders. New developments in behavioral therapies include expanded uses of contingency management. New developments in pharmacotherapies include new opioid agonist therapy. This session will provide current treatment information and this session format allows each participant to take a self-assessment "exam" with answers and discussion led by expert faculty on questions of substance abuse treatment.

### REFERENCES:


1. Gold PB, Brady KT: Clinical Synthesis of Evidence-Based Treatments for Substance Use Disorders: FOCUS: The Journal of Lifelong Learning in Psychiatry 2003;2, in press.
2. Mack AH, Frances RJ: Substance Related Disorders: Update: FOCUS: The Journal of Lifelong Learning in Psychiatry 2003;2, in press.

# FORUMS

## 1. WORKING WITH ORGANIZED MEDICINE: THE AMA AND STATE MEDICAL SOCIETIES

*Chairperson:* Kenneth M. Certa, M.D.
*Participants:* Carolyn B. Robinowitz, M.D., John S. McIntyre, M.D., Gwen Lehman, and Rodrigo A. Muñoz

### EDUCATIONAL OBJECTIVE:

At the conclusion of the forum, participants will be familiar with the organizational structure of the AMA and state medical societies; identify mechanisms for participation in medical society affairs; recognize opportunities and possible barriers for collaborative efforts

### SUMMARY:

As recent events have shown, a close working relationship with other organizations within the federation of medicine is necessary to ensure success in our common agenda. It is important for psychiatrists to understand how state medical societies and the American Medical Association set policy. This forum will describe the organizational structure of these groups, outline ways psychiatrists can become involved in influencing policy and lobbying activity, and discuss some effective strategies for collaborative effort.

### REFERENCES:


1. Landerws SH, Sehgal AR: How do physicians lobby their members of Congress? Arch Int Med 200; 160: 3248–3251.
2. Crosby M: Political Lobbying for Child and Adolescent Psychiatry. Child Adoles Psychiatr Clin N Am 2002; 11(1) 145–58.


## 2. THE PLACEBO EFFECT: SCIENCE, BELIEF, AND CLINICAL PRACTICE

*Chairperson:* Philip R. Muskin, M.D.
*Co-Chairperson:* Andrew F. Leuchter, M.D.
*Participants:* Howard Fields, M.D. and David Spiegel, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of the forum, participants will understand biological correlates of the placebo response; review the mind-body interaction as demonstrated by the placebo response; review types of positive and negative placebo response

### SUMMARY:

This forum will focus on the placebo effect. Placebo, deriving from the Latin, "I will please," plays a powerful role in medical research and in the everyday practice of medicine. It is a poorly understood phenomenon, and thus stirs up tremendous controversy. While some reviewers contend there is no such thing as a placebo effect, the FDA requires that all new mediations be compared with, and show superior efficacy to placebo.

The speakers will address placebo from a variety of perspectives including the science that demonstrates the effect of placebo, myths about what placebo does or does not do, and how the belief in a healing entity might alter the believer's physiology. Audience participation will be encouraged during the presentation.

### REFERENCES:


1. Leuchter AF et al: Changes in brain function of depressed subjects during treatment with Placebo. American Journal of Psychiatry 2002; 159:122–129.
2. Shapiro AK, Shapiro E: The Powerful Placebo: From Ancient Priest to Modern Physician. Baltimore, Johns Hopkins University Press, 1997.


## 3. MUSIC AND THE MIND: GEORGE GERSHWIN

*Chairperson:* Richard Kogan, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should have an awareness of the impact of psychiatric illness on the creative process and should understand some fundamental concepts about creativity and genius.

### SUMMARY:

George Gershwin (1898–1937) is unquestionably one of the greatest and most beloved composers in American history. Among the more remarkable aspects of his creative genius were his ability to extract music out of what others would consider to be mere noise (listening to the honking of Parisian taxi horns inspired him to write "An American in Paris") and his ability to fuse the seemingly distinct classical, jazz, and Broadway show tune traditions.

Psychiatrist and award-winning concert pianist Dr. Richard Kogan (first prize-Chopin Competition) will perform "Rhapsody in Blue" and other musical examples to illustrate the connections between Gershwin's psyche and his musical output. Particular attention will be focused on those aspects of his story relevant to mental health professionals:

- his childhood Conduct Disorder which was dramatically altered by his exposure to music
- his chronic hyperactivity and his unrestrained narcissism
- his depressive episode that was treated by a psychoanalyst who missed the clues that Gershwin was suffering from the brain tumor that would eventually kill him.

Dr. Kogan will demonstrate the creative impact of this depression, as Gershwin shifted from composing jaunty love songs like "I Got Rhythm" to writing his most anguished score in "Porgy and Bess".

### REFERENCES:


1. Jablonski E, Gershwin.
2. Peyser, Joan, "The Memory of All That"


## 4. NEUROBIOLOGY OF PARENT-CHILD RELATIONSHIPS: APPLICATIONS TO PSYCOTHERAPY

*Chairperson:* Bernard D. Beitman, M.D.
*Co-Chairperson:* Eva M. Szigethy, M.D.
*Participants:* Robert J. Waldinger, M.D., David Reiss, M.D., and Jill M. Hooley, Ph.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to summarize evidence on neurobiological correlates of parent-child relationships such as genetic predisposition, autonomic functioning, and emotional regulation and their relationship to future development of psychopathology in adult relationships; to discuss innovative ways these findings can inform the psychotherapeutic process.

### SUMMARY:

Empirical evidence suggests strong associations between parent-child relationships and later psychopathology in adolescence and adulthood. There is a growing interest in the neurobiological correlates of family social interactions, such as criticism, abuse, and parenting style, and the interplay between these biological and behavioral factors in influencing adult social relationships. This forum will review links between these variables and offer ways in which this information can both inform and possibly mediate behavioral change in therapy. Dr. Waldinger will present observational data on how childhood sexual abuse may be linked with difficulties regulating emotional arousal and with altered autonomic functioning in

intimate adult relationships. Dr. Reiss will review data on how genetic and family relationship factors differentially influence the development of psychopathology during adolescence and adulthood. He will explore the salience of periods of genetic activity and genetic quiescence for understanding the links between family relationships and behavioral development. Dr. Hooley will present brain imaging data examining the differential processing of maternal criticism and praise in healthy adults versus adults with a history of depression. Her work shows how psychosocial challenge paradigms can be used to inform neuroimaging studies in depression. Such understanding about the neurobiological correlates of early family interactions has important implications for determining factors that may mediate therapeutic change during the therapy process.

### REFERENCES:

1. Orr SP, Lasko NB, Metzger LJ, Berry NJ, Ahern CE, Pitman RK: Psychophysiologic assessment of women with posttraumatic stress disorder resulting from childhood sexual abuse. J Consulting & Clinical Psychology 1998; 66: 906–913.
2. Reiss, D, Pedersen NL, Cederblad M, Lichtenstein P, Hansson K, Neiderhiser JM, Elthammar O. Genetic probes of three theories of maternal adjustment: I. Recent evidence and a model. Family Process 2001; 40: 247–259.
3. Butzlaff RL, Hooley JM: Expressed emotion and psychiatric relapse: A meta-analysis. Archives of General Psychiatry 1998; 55:547–552.

## 5. TERRORISM AND PSYCHOSOCIAL PREPAREDNESS

*Chairperson:* Howard J. Osofsky, M.D.
*Participants:* Harold S. Koplewicz, M.D., Joy D. Osofsky, Ph.D., Betty Pfefferbaum, M.D., and Robert J. Ursano, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand coping mechanisms that are helpful for children and families in the face of terrorist attacks, identify and evaluate short and long-term mental health sequellae, and provide therapeutic interventions on an individual and community level.

### SUMMARY:

In the face of terrorist threats, our tendency is to focus on tangible deficits, for example, stockpiling vaccines, while giving scant attention to the fact that terrorist attacks are primarily intended to produce panic and psychological damage. It is crucial that we prepare ahead by providing communities with psychological tools to increase resilience, developing proactive, community-level behavioral and public health strategies that decrease helplessness and increase effective response. Dr. Joy Osofsky, drawing on experience with community and domestic violence, will address the mental health sequellae of children and families' exposure to such violence. She will discuss effective prevention and intervention strategies and applicability to terrorism. Dr. Robert Ursano will discuss our knowledge of the psychological impact of terrorism and effective approaches to expectable short and long term problems. He will review specific concerns of military personnel and their families. Dr. Betty Pfefferbaum will describe her extensive studies follow the terrorist attack in Oklahoma City. She will focus specifically on early and long term sequellae for children and families and factors that enhance community resilience. Dr. Harold Koplewicz will review components of the NYC 9/11 experience and useful strategies that he and others have developed to help parents and teachers. Finally, we will summarize what we have learned that can help proactively and in response, including system approaches for preparedness.

### REFERENCES:

1. Osofky JD, Osofsky HJ: Traumatized Young Children and Families: Understanding the Impact and Ways to Help Them Heal. Journal of Infant, Child and Adolescent Psychiatry, Submitted, 2002.
2. Norwood AE, Holloway HC, Ursano RJ: Psychological Effects of Biological Warfare Military Medicine. 2001; 166 (12 suppl) 27–8.
3. North, CS, Pfefferbaum B: Research on the Mental Health Effects of Terrorism, Journal of the American Medical Association. 2002; 288(5): 633–6.

## 6. PROZAC ON THE COUCH: PRESCRIBING GENDER IN THE ERA OF WONDERDRUGS

*Chairperson:* Jonathan M. Metzl, M.D.
*Participants:* Joel T. Braslow, M.D., Ph.D. and David M. McDowell, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this forum, participants will be able to understand the ways in which medications function symbolically as well as chemically; consider the relevance of gender and culture to the history of psychotropic medications; reflect on one's own, culturally based assumptions about psychotropic medications.

### SUMMARY:

This forum will explore the gender history of psychotropic medications, in conjunction with the release of a new book, Prozac on the Couch. Participants will learn about the cultural half-lives of Miltown, Valium, and Prozac, the three best-selling psychotropic wonder drugs of the latter half of the twentieth century. The forum will trace the notion of "pills for everyday worries" through psychiatric and medical journals, popular magazine articles, pharmaceutical advertisements, and published first-person accounts of mental illness, from 1950 to 2003, in order to explore the development of brand-named psychotropic medications both as forms of treatment and also as symbols of cultural inquietude, made to listen and talk back in response to the perception of social change. In the process, the forum will look closely at the mother's little helpers, valleys of dolls, Prozac nations, and other gender-inflected stereotypes of psychopharmaceuticals in American culture. In exploring the popular and medical discourses through which psychotropic drugs are researched, marketed, employed, and dispensed into the American imagination, the forum will ultimately show how gender roles shape many of the ways in which "emotional" problems are understood and identified at different points in time.

### REFERENCES:

1. Metzl JM. Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs. Durham, Duke, 2003.
2. Zita JN: Body Talk. New York, Columbia, 1998.

## 7. INTIMATE PARTNER VIOLENCE AND ABUSE: IDENTIFICATION AND INTERVENTION WITHIN A BEHAVIORAL HEALTH STUDY

*Chairperson:* Penny K. Randall, M.D.
*Participants:* Carole L. Warshaw, M.D., Patricia Salber, M.D., Robin A. Dea, M.D., and Bridgid McCaw, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to learn about the prevalence of Intimate Partner Violence and Abuse (IPVA) within common behavioral health populations; to articulate the impact of Intimate Partner Violence and Abuse (IPVA) as a

comorbidity in a behavioral health population; to increase skills in detection of IPVA in behavioral health populations; to review best practices related to intervention in IPVA

## SUMMARY:

Intimate Partner Violence and Abuse (IPVA) is a significant public health issue affecting women. Numerous medical organizations have recommended that routine screening of women be conducted to assist in the prevention, identification, and care for victims of violence. This forum reviews the prevalence of IPVA and its impact as a comorbity in behavioral health populations. Signs of IPVA easily can be obscured by the symptoms of a co-existing behavioral health disorder, such as depression, substance use disorder, or even posttraumatic stress disorder. In this forum, we will review expert consensus opinion regarding screening in a behavioral health population. Moreover, participants will be trained on the impact of IPVA and the dynamics involved in perpetuation of the abuse. Finally, participants will learn about the range of interventions that can be taken to increase the safety of victims.

## REFERENCES:

1. Berman B, Brismar B: Suicide attempts by battered wives. Acta Psychiatr Scand 1991; 83, No. 5, 380–4.
2. Brown, Schuckit: Alcoholism and affective disorder: clinical course of depressive symptoms. Am J Psychiatry 1995; 152(1):45–52
3. Brown TG, Werk A, Caplan T, Shields N, Seraganian P: The incidence and characteristics of violent men in substance abuse treatment. Addict Behav 1998; 23(5):573–86.
4. Chermack ST, Blow FC. (2002): violence among individuals in substance abuse treatment: the role of alcohol and cocaine consumption. Drug Alcohol Depend, Mar 1;66(1):29–37.
5. Dienemann J, Boyle E, Baker D, Resnick W, Wiederhorn N, Campbell J: Intimate partner abuse among women diagnosed with depression. Issues Ment Health Nurs 2000. 2002; 21(5):499–513
6. Gleason WJ: Mental disorders in battered women: an empirical study. Violence and Victims, 1993; (8)1:53–68.

## 8. ABPN UPDATE: REQUIREMENTS FOR ABPN EXAMINATION

*Chairperson:* Stephen C. Scheiber, M.D.
*Participants:* Naleen N. Andrade, M.D., Glenn C. Davis, M.D., Michael H. Ebert, M.D., Larry R. Faulkner, M.D., David A. Mrazek, M.D., Burton V. Reifler, M.D., James H. Scully, Jr., M.D., and Elizabeth B. Weller, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to assist resident members, young career psychiatrist members, and other members in learning the policies and procedures of the ABPN for certification, recertification and subspecialization.

## SUMMARY:

An overview of the policies and procedures of the American Board of Psychiatry and Neurology will be presented followed by an active dialogue about the necessary conditions for admission to the certification examination, the examination process and the current status of recertification and subspecialization. Material will focus on the resident members and young career psychiatrists.

Resident and young career psychiatrists will be encouraged to attend and ask questions about certification, recertification, and subspecialization in addition to the specifics of the Part I and Part II written and oral examinations for certification. Participants will be urged to discuss child and adolescent psychiatry, addiction psychiatry, forensic psychiatry, geriatric psychiatry, clinical neurophysiology, and pain management.

## REFERENCES:

1. Shore J, Scheiber SC: Certification, Recertification and Lifetime Learning. APPI Press, Washington, D.C. 1994
2. American Board of Medical Specialties: Recertification for Medical Specialists, ABMS, Evanston, IL 1987.

## 9. MEANINGFUL ACTIVITIES AND STRUCTURE MATTER: HOW A PREVOCATIONAL PROGRAM HELPS SEVERELY MENTALLY ILL CLIENTS

*Chairperson:* Amelia Truman
*Participants:* Israel Katz, M.D.

## EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to identify the successful components of a hospital-based prevocational program and define the resources needed to replicate this program.

## SUMMARY:

Clients who are severely mentally ill have faced multiple and lengthy hospitalizations that have hindered their social development as well as their ability to work. While many have tried to hold jobs they have been unsuccessful at sustained employment because of their impairments.

The objective of the prevocational program is to engage clients from outpatient program in activities that foster productive use of their time, encourage them to develop meaningful work experiences, and explore work as an expression of personal creativity and effectiveness. Meaningful activities, as an alternative to "hanging out", builds self-esteem, develops socialization skills, provides structure, and improves the quality of life.

These clients take more time to learn the basic fundamentals of successful employment. Their histories of hospital recidivism and lengthy institutional placements, along with neurobiological factors and delayed social development weigh heavily on their ability to learn. While some clients may be able to move on to competitive employment, others may need to stay in a structured environment. The prevocational program provides containment for clients as they learn new skills in spite of their psychiatric symptomatology.

## REFERENCES:

1. Anthony W A, Rogers F S, Cohen M, Davies R R: Relationship between psychiatric symptomatology, work skills, and future vocational performance. Psychiatric Services 1995; 46(4):353–358.
2. Bell M D, Lysaker P H: Psychiatric symptoms and work performance among persons with severe mental illness. Psychiatric Services 1995; 46(5): 508–510.
3. Eklund M, Hansson L, Bejerholm U: Relationships between satisfaction with occupational factor and health-related variables in schizophrenia outpatients. Social Psychiatry and Psychiatric Epidemiology 2001; 36:79–85.

## 10. APA AND THE PHARMACEUTICAL INDUSTRY: CONTROVERSIES AND APPROACHES

*Chairperson:* Stephen M. Goldfinger, M.D.
*Participants:* Charles R. Goldman, M.D., Geetha Jayaram, M.D., David M. McDowell, and Daniel K. Winstead, 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—SCHIZOPHRENIA TREATMENT IN THE COMMUNITY: THE ROLE OF LONG-ACTING ANTIPSYCHOTICS
## Supported by Janssen Pharmaceutica

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should able to appreciate the role of medication adherence on long-term course of illness, understand issues which guide selection of drug and mode of administration in individual cases, consider data on effectiveness of first and second generation long-acting antipsychotic medications, and discuss methods and approaches to increase patient and clinician acceptance of long-acting formulations of antipsychotics.

### No. 1A
### KEY ISSUES IN LONG-TERM PHARMACOTHERAPY OF SCHIZOPHRENIA

William T. Carpenter, Jr., M.D., *PO Box 21247, Baltimore, MD 21228*

### SUMMARY:

Antipsychotic medication is a key element in long-term treatment. Critical issues include selection of drug and dose, mode of administration, integration with psychosocial treatment and rehabilitation, rapid response during exacerbation, the problem of insight, and the challenge for patient collaboration. Poor medication adherence is perhaps the most common and preventable of the major factors adversely affecting the course of illness. Reasons for poor adherence in chronic illnesses will be noted, and issues special to schizophrenia will be explored. Data on adherence and methods of remediation will be presented.

The role of depot preparations will be discussed. Data on effectiveness, optimal dosing, and patterns of use in the U.S. will be presented. Guidelines for deciding respective advantages of oral and depot preparations in individual cases will be described.

Oral preparations of new-generation drugs may be associated with better adherence and reduced relapse/rehospitalization rates. Data on this issue will be presented, and reasons for increased effectiveness will be discussed. In this context, the role for long-acting preparations of second-generation antipsychotic drugs will be presented.

### No. 1B
### THE LATEST ADVANCE IN LONG-ACTING ANTIPSYCHOTIC THERAPY

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

### SUMMARY:

Conventional long-acting antipsychotics, although meeting a distinct need in the spectrum of available treatments, retain the safety disadvantages of the conventional orals. In addition, conventional depots are oil based, and are therefore associated with viscosity-related injection site pain and cumulative local tissue damage. The first available long-acting atypical antipsychotic will be an aqueous-based formulation of risperidone, which in two pivotal trials was associated with low patient ratings of injection site pain. Biweekly injections provide relatively little fluctuation in plasma levels compared with oral treatment. Data from a 12-week double-blind, randomized trial in patients with schizophrenia show improvements in PANSS Total, and subscale scores that were superior to placebo. A second flexible-dosing pivotal trial evaluated clinically stable patients over 50 weeks of open-label treatment. Patients in all dose groups showed significant sustained improvements from baseline in PANSS Total and subscale scores. The highest dose tested, 75 mg, offered no greater efficacy than the 25 mg or 50 mg doses in either trial. All three doses were well tolerated; the 25 mg dose had an adverse event profile similar to placebo. Patient satisfaction ratings were favorable. Data from additional new studies on methods for transitioning from prior treatments will also be presented.

### No. 1C
### TRANSLATING FROM CLINICAL TRIALS TO COMMUNITY CARE FOR PATIENTS WITH SCHIZOPHRENIA

Jacqueline M. Feldman, M.D., *908 20th Street South, 4-CCB, Birmingham, AL 35294*

### SUMMARY:

Interpreting data from clinical trials is often challenging for those who work directly with patients in the real world. Frontline mental health care providers are asked to accept results that assume extraordinary treatment criteria: patients who have no medical illness, patients who are adherent, patients who are sober, and patients who lead simple, uncomplicated lives. Data are offered with the presumption that staff can quickly assimilate changes in prescribing, distribution, and administration of rigorous protocols. New medications hit the market adorned with promise (New! Improved! Better! Faster! Safer!) that may or may not be fulfilled upon extensive use in the community.

Physician willingness to try novel medications is predicated on a variety of issues, but is anchored in their search for better treatment modalities for their patients. Use of medication that can improve symptoms, minimize side effects, enhance functioning *as defined by the patient,* and ameliorate the life-disrupting effect of the illness is the ultimate goal for every provider, consumer, and family member; each medication is measured by how it meets, exceeds, or stumbles in meeting these expectations. The impact of these parameters will be discussed related to the utilization of long-acting antipsychotic medication in patients with schizophrenia.

### No. 1D
### OVERCOMING OBSTACLES TO PATIENT ACCEPTANCE OF LONG-ACTING ANTIPSYCHOTICS

David C. Henderson, M.D., *25 Staniford Street, Boston, MA 02114*

### SUMMARY:

Clinician and patient acceptance of conventional depot injectable antipsychotics has been limited in the U.S. by several factors, including side effects (especially EPS/TD), limited efficacy similar to their oral counterparts, stigma and pain associated with injections, and a link with mental illness severity and chronic noncompliance. Clinician perceptions of patient acceptance of injections together with negative assessments of the older depot neuroleptics also have biased antipsychotic prescribing toward daily oral atypical formulations. However, results of several controlled studies demonstrated that, once they tried them, patients preferred depot antipsychotics to oral counterparts of the same drugs and were satisfied or very satisfied with their depot medication. Clinical practice in countries such as Australia heavily favors long-acting depot preparations. A new long-acting injectable formulation of risperidone promises to combine the improved efficacy and safety of the atypicals with the continuous therapy and improved compliance offered by depot conventionals. With some barriers removed, better acceptance of this drug delivery method may be possible. This presentation will discuss approaches to increase the acceptance of long-acting injectable antipsychotics by both clinicians and patients, and address the role that clinician

perceptions and attitudes play in influencing patient acceptance of these medications.

## REFERENCES:

1. Kane JM: Schizophrenia. N Engl J Med 1996;334(1):34–41.
2. Kane J, et al: Efficacy and safety of Risperdal Consta TM, a long-acting injection risperidone formulation. Abstract presented at ACNP. December 9–13, 2001, Waikoloa, Hawaii.
3. Blac Klar P, Cutler D (eds): Chapter 13, in Ethics in Community Mental Health Care: Commonplace Concerns. Kluwer Academic/ Plenum Publishers.
4. Walburn J, et al: Systematic review of patient and nurse attitudes to depot antipsychotic medications. Br J Psychiatry 2001;179:300–307.

# INDUSTRY-SUPPORTED SYMPOSIUM 2— BIPOLAR DISORDER: STRATEGIES FOR STABILIZING PATIENTS OVER THE LONG TERM
## Supported by GlaxoSmithKline

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to contrast outcomes of treating bipolar depression with antidepressants, evaluate new data on use of antidepressants in BPD, assess psychosocial factors and develop an early warning plan to avoid destabilization.

## No. 2A
## NEW RESULTS FROM THE STANLEY BIPOLAR TREATMENT NETWORK

Robert M. Post, M.D., NIMH, *900 Rockville Pike, Building 10, Room 3V-21, Bethesda, MD 20892*

## SUMMARY:

The appropriate treatment and management of bipolar depression has become a critical area of research in the psychiatric community as appreciation increased regarding its long-term impact, persistent nature, complexity of treatment, and direct (via suicide) and indirect (via medical comorbidity) mortality risks. Recent guidelines provide relatively limited direction addressing long-term treatment issues of depressive symptoms, including whether to continue antidepressant medications, and use of experimental agents.

To address these issues and advance our knowledge of the long-term treatment and management of bipolar disorder patients, the Stanley Bipolar Treatment Network was founded in 1995. This network, comprised of three U.S. and two European sites at academic institutions followed more than 1,000 bipolar patients on a monthly basis during its seven-ycar history.

Recognizing the difficulties treating and the consequences of undertreating depression, one area of focus for the network was the long-term outcome and best treatment approaches for bipolar depression. Results on the impact on illness course by discontinuing versus continuing antidepressant treatment following decrease of symptoms will be presented. In addition, data from the recently completed double-blind study of omega-3 versus placebo add-on for depressive symptoms, and from the double-blind study of add-on bupropion, sertraline, or venlafaxine will also be presented.

## No. 2B
## UPDATE ON ANTICONVULSANTS FOR BIPOLAR DISORDERS

Charles L. Bowden, M.D., *7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

## SUMMARY:

Antiepilcptic drugs have assumed a first-line role for many components of treatment of bipolar disorder, and adjunctive roles for additional psychiatric clinical needs. Divalproex for mania and lamotrigine for depression, both acutely and prophylactically, are primary treatment choices in bipolar disorder, on the basis of large-scale, well-designed studies.

During prophylactic use lamotrigine also provides some protection against manic aspects of bipolar disorder, and divalproex provides some protection against depressive aspects. Carbamazepine also benefits manic states, with evidence of benefit strongest for atypical manic states. Other antiepileptic drugs have had substantial use in bipolar disorder; however, evidence indicates either lack of efficacy, or studies have been insufficient to reach a conclusion. For example, studies of gabapentin do not support antimanic effects, although adjunctive benefits on anxiety spectrum symptoms can be inferred from studies.

New evidence indicates that antiepileptic drugs can be beneficially combined with good tolerability. Antiepileptic drugs and lithium act principally inside the neuron to modulate neuronal function, mechanisms fundamentally different from antidepressant and antipsychotic drugs, which act on primary neurotransmitter systems. A primary point in understanding so-called anticonvulsants is that each is distinct in mechanism, in profile of benefits, and in adverse-effect profile.

## No. 2C
## PRACTICAL STRATEGIES TO AVOID MEDICATION-INDUCED MOOD DESTABILIZATION IN BIPOLAR PATIENTS

Carlos M. Zarate, Jr., M.D., *361 Plantation Street, Worcester, MA 01605;* Holly A. Swartz, M.D.; David J. Kupfer, M.D.

## SUMMARY:

The goals of mood stabilization are not only to treat and prevent manias and depressions, but also to minimize or eliminate drugs that can induce mood episodes or cycle accclerations. Some psychotropics, such as divalproex, achieve and sustain euthymia predominantly via their antimanic action (i.e., from above baseline mood). Other agents, such as lamotrigine, may do so through antidepressant properties (i.e., from below mood baselines). Still others may induce manias (such as most standard antidepressants) or depressions (as seen with conventional antipsychotics), causing uncertainty about their long-term safety and impact on the course of bipolar illness.

This presentation will review current information about clinical and pharmacologic factors related to mood destabilization in the treatment of bipolar disorder. Strategies will be discussed to help aid clinicians avoid medication-induced mood destabilization, including the following: (1) profiling bipolar patients most vulnerable to antidepressant-induced manias, focusing on the impact of rapid cycling, multiple antidepressant trials, and substance-abuse comorbidity; (2) comparing the long-term antidepressant benefits of lithium or anticonvulsants; (3) examining the role of conventional and atypical antipsychotics relative to the treatment vs. precipitation of mood episodes; and (4) the use of mood charting to identify prodromal signs of mood destabilization during long-term pharmacologic management.

## No. 2D
## PSYCHOSOCIAL STRATEGIES TO PROMOTE STABILIZATION AND ENHANCE COPING IN PATIENTS WITH BIPOLAR DISORDER

David J. Miklowitz, Ph.D., *Muenzinger Building Room D244, Boulder, CO 80309*

### SUMMARY:

The poor long-term outcomes observed in bipolar disorder, even among those patients who adhere relatively consistently to their pharmacotherapy regimen, encouraged several groups of investigators to consider the psychosocial factors that might lead to destabilization in this patient population.

One view, originating in research on schizophrenia, was that family environments characterized by high expressed emotion (e.g., hostility, criticism, over-involvement) could lead to symptomatic decompensation through this specific form of overstimulation. Another view, originating from research on unipolar disorders and circadian rhythms, was that disruption in social routines and social interactions could precipitate episodes through circadian dysregulation thought to be fundamental to episode onset. Specific treatments were developed to address each of these psychosocial pathways to destabilization and each has demonstrated positive effects on long-term mood stability.

This presentation will focus on elements common to these two psychosocial interventions that can be implemented by any clinician working with patients suffering from bipolar disorder. These elements include education of patients and significant others about the illness, promotion of regular sleep-wake cycles, avoidance of interpersonal and intellectual overstimulation, daily monitoring of mood symptoms, identification of early warning signs of new episodes, and development of a plan for management of early warning signs.

### REFERENCES:

1. Calabrese JR, Bowden CL, Sachs GS, Ascher JA, Monaghan E, Rudd GD, for the Lamictal 602 Study Group: A double-blind placebo-controlled study of lamotrigine monotherapy in outpatients with bipolar I depression. Lamictal 602 Study Group. J Clin Psychiatry 1999;60(2):79–88.
2. CL Bowden, JR Calabrese, SL McElroy, L Gyulai, Awasf, F Petty, HG Pope, Jr., JC-Y Chou, PE Keck, Jr., LJ Rhodes, AC Swann, RMA Hirschfeld, PJ Wozniak: A randomized, placebo-controlled, 12-month trial of divalproex and lithium in treatment of outpatients with bipolar I disorder. Archives of General Psychiatry 2000;57:481–489.
3. Ketter TA, Calabrese JR: Stabilization of mood from below versus above baseline in bipolar disorder: a new nomenclature. J Clin Psychiatry 2002;63:146–151.
4. Frank E, Swartz HA, Kupfer DJ: Interpersonal and social rhythm therapy: managing the chaos of bipolar disorder (Biol Psychiatry 2000;48:593–604.

# INDUSTRY-SUPPORTED SYMPOSIUM 3—ANXIETY DISORDERS: SOURCES, SIGNS, AND SOLUTIONS
## Supported by Forest Laboratories, Inc.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to review the incidence, impact, symptomatology, cause, and treatment of anxiety disorders, with an emphasis on new therapies.

## No. 3A
## EXAMINING ANXIETY'S UNDERPINNINGS

Christine Heim, Ph.D., *1256 Briarcliff Road, Room 427, Atlanta, GA 30322*

### SUMMARY:

According to epidemiological studies, children who have been exposed to early childhood trauma may have an increased risk for the development of anxiety disorders. Early life stress, and the alteration of neural circuitry by stress hormones may account for this. The etiology of anxiety disorders may include increased activity of the hypothalamic pituitary axis, as well as the alteration of neurotransmitter systems as a basis for neurobiological changes. Genetic proclivity for anxiety disorders also needs to be considered. In addition, childhood anxiety disorders, such as separation anxiety or childhood social anxiety disorder, may predict future recurrence of anxiety disorders in adults. This talk will focus on current research into the childhood origins of adult anxiety disorders, including strategies for preventing or minimizing the detrimental effects of early childhood stress. The pharmacological and psychotherapeutic treatment of childhood anxiety will also be reviewed.

## No. 3B
## ANXIOUS BODY, ANXIOUS SELF, ANXIOUS PSYCHIATRISTS

Mack Lipkin, M.D., *550 First Avenue, New York, NY 10016*

### SUMMARY:

Most anxiety disorders have associated somatic complaints. Diagnosis and treatment of anxiety disorders forces psychiatrists to encounter patients' often intense somatic concerns, which evoke anxiety in the psychiatrist as well. "Do I reassure this person with chest pain or call an ambulance?" This presentation will begin with review of the somatic presentations and manifestations of common anxiety disorders and related psychosomatic syndromes (such as chronic fatigue, fibromyalgia) with significant anxiety components. For example, approximately 75% of people with chronic fatigue syndrome have been estimated to also have anxiety disorders, suggesting that anxiety disorders to a large degree underlie this syndrome. Panic patients account for 40% of ER chest pain. Other common symptoms include shortness of breath, autonomic nervous symptom-related muscular tension, tremulousness, and tremor; GI symptoms and signs, and more. An approach to evaluation and treatment of patients' somatic complaints with guidance on how psychiatrists can differentiate anxiety-derived symptoms, when to refer and when to reassure, and how to work with the patient's primary care physician, will be presented.

## No. 3C
## FACING UP TO SOCIAL ANXIETY DISORDER

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

### SUMMARY:

Social anxiety disorder (SAD) is an often debilitating condition that is frequently misdiagnosed and misunderstood. Several recent studies have investigated the potential neurobiological and genetic basis for this condition, which has been estimated to affect approximately 7% of the American population. Twin studies indicate that SAD is moderately heritable, and further suggest that genetic influences may impact both the cognitive dimensions central to this anxiety disorder, as well as specific anxiety-related personality traits. Fear circuitry involved in SAD includes the amygdala, hippocampus, and limbic and cortical regions associated with these structures.

Neuroimaging data suggest that both cognitive-behavioral and antidepressant treatment decrease cerebral blood flow to these brain regions, and that these changes are accompanied by a decline in SAD symptoms. This lecture will provide an overview of the genetic and neurobiological underpinnings to SAD, and will discuss the implications of these findings both toward understanding this disorder as well as to providing better treatments.

## No. 3D
## GENERALIZED ANXIETY DISORDER: BENEATH THE SURFACE

Jonathan R. T. Davidson, M.D., *Trent Drive, Room 4082B, Box 3812, Durham, NC 27710*

### SUMMARY:

Generalized anxiety disorder (GAD) has many long-term costs and complications. These may include lost time at work, cost of medication and care, lost productivity, and lost quality of life. GAD has additionally been associated with an increased incidence of substance abuse and depression. The neurobiological basis for GAD has been hypothesized to involve serotonergic, noradrenergic, and neuroendocrine systems, as well as disruptions in the autonomic nervous system. Because GAD is the most common anxiety disorder in primary care, a recent consensus statement has been issued relating to its appropriate psychotherapeutic and pharmacological treatment. Benzodiazepines, other medications that act on the GABAergic system, and antidepressants are among the current treatments available for treating this disorder. The impact of GAD and its potential basis will be discussed, in addition to possible individual and combined treatments for GAD.

## No. 3E
## THE NEUROBIOLOGY OF PANIC DISORDER AND OCD

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

### SUMMARY:

Panic disorder (PD) and obsessive-compulsive disorder (OCD) are subclasses of anxiety disorders, both commonly treated with SSRIs. The neurobiological basis for panic disorder (PD) is also theorized to be due to a disturbance in neurotransmitters, possibly a dysregulation of norepinephrine and/or gamma aminobutyric acid (GABA). Other biological theories include the involvement of cholecystokinin, and abnormalities in respiratory and brainstem function. Cognitive-behavioral therapies may be effective for treating either of these disorders, as well as SSRIs, dual reuptake inhibitors, and benzodiazapines. In terms of the possible biological basis for OCD, both the response of many OCD patients to SSRI treatment, as well as correlation between improvement in OCD symptoms and changes in serotonergic markers, suggest that disturbances in serotonin may underlie this disorder. However, additional evidence suggests a role of dopamine, or that both neurotransmitter systems may be involved. Neuroanatomical imaging studies have focused on the activity of cortical inputs to the basal ganglia and the role that this circuitry may play in OCD. The possible neurobiological components of these disorders will be discussed, which will provide a context for understanding appropriate pharmacological treatments that may serve to modulate the neurochemistry of the anatomical systems involved.

### REFERENCES:

1. Heim C, Nemeroff C: Neurobiology of early life stress: clinical studies. Semin Clin Neuropsychiatry 2002;7:147–159.
2. Lipkin M Jr: Psychiatry and primary care: two cultures divided by a common cause. New Dir Ment Health Serv 1999;7–15.
3. Stein M, Gorman J: Unmasking social anxiety disorder. J Psychiatry Neurosci 2001;26:185–189.
4. Davidson J: Pharmacotherapy of generalized anxiety disorder. J Clin Psychiatry 2001;62:46–50.
5. Stahl S: Selective actions on sleep or anxiety by exploiting GABA-A/benzodiazepine receptor subtypes. J Clin Psychiatry 2002;63:179–180.

# INDUSTRY-SUPPORTED SYMPOSIUM 4—NEW STRATEGIES FOR MANAGING BIPOLAR DISORDER
## Supported by Janssen Pharmaceutica

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to implement new strategies for the management of acutely ill bipolar patients, implement new strategies for maintenance of bipolar disorder.

## No. 4A
## CLINICAL MANAGEMENT OF BIPOLAR PATIENTS: A DIFFICULT TASK

Dwight L. Evans, M.D., *305 Blockley Hall, 423 Guardian Drive, Philadelphia, PA 19104*

### SUMMARY:

Bipolar disorder presents very different clinical management challenges at different points in time. Stabilization of mania and/or mixed episodes usually requires inpatient treatment with several medications. Depressive episodes more often can be managed on an outpatient basis and often require both pharmacologic and psychotherapeutic interventions. Maintenance treatment usually requires involvement by everyone concerned. In light of lack of insight in patients with bipolar illness, ensuring adherence to treatment throughout the illness phases can be very difficult. Successful strategies involve a collaboration between the patient, family members, and the physician, plus continuity of care and utilization of medications that have relatively benign side-effect profiles. This presentation will review data on adherence to treatment in bipolar patients and recommend useful strategies to improve adherence.

## No. 4B
## RATIONAL POLYPHARMACY IN THE TREATMENT OF PATIENTS WITH BIPOLAR DISORDER

S. Nassir Ghaemi, M.D., *49 Fayette St., #1, Cambridge, MA 02138*

### SUMMARY:

Treatment of patients with bipolar disorder often requires combination therapy as only a relatively small fraction of patients remit with monotherapy. This is partly due to the phasic nature of bipolar disorder, which sometimes requires different pharmacological approaches for depressive and manic phases, as well as for maintenance therapy. Currently used medication combinations for the treatment of bipolar disorder include multiple mood stabilizers, combinations of mood stabilizers and antidepressants, and, more recently, mood stabilizers with atypical antipsychotics. Some anticonvulsants (lamotrigine and gabapentin) may also have beneficial effects in the treatment of bipolar disorder. However, despite widespread use of such combinations, a limited number of controlled studies are available to provide a rationale for their use and evaluate potential for syner-

gies. A thorough understanding of the mechanisms of action of agents from different classes and the neurophysiologic underpinnings of bipolar disorder will help greatly in the development and testing of rational drug combinations for the treatment of this disorder. This rational approach may increase the value of combination therapy in clinical practice in terms of improvements in both efficacy and safety.

### No. 4C
### EMERGING TREATMENT FOR BIPOLAR DISORDER: A NEW ROLE FOR ATYPICAL ANTIPSYCHOTICS

S. Nassir Ghaemi, M.D., *49 Fayette Street, #1, Cambridge, MA 02138*

SUMMARY:

I will first define a mood stabilizer as a medication with efficacy in two phases of bipolar disorder, (mania, depression, or prophylaxis). Current evidence for efficacy with atypical antipsychotic agents is most convincing for acute mania. New controlled evidence in acute depression and prophylaxis of bipolar disorder will also be presented, but I will conclude that the current evidence best supports the use of atypical antipsychotic agents as adjunctive mood-stabilizing agents, not as monotherapy. Used in long-term polypharmacy, therefore, attention needs to be given to long-term issues, particularly medication noncompliance, weight gain, tardive dyskinesia, and diabetes risks.

### No. 4D
### COMPLEXITIES IN THE TREATMENT OF JUVENILE BIPOLAR DISORDER

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

SUMMARY:

Accurate diagnosis of bipolar disorder in children and adolescents is essential; however, establishing this diagnosis in children poses a significant clinical challenge. Young children often show marked mood lability and mixed states that differ from the presentation of bipolar disorder in adolescents and adults. Given some overlap in the symptoms of bipolar disorder in children and attention deficit hyperactivity disorder, it is important for the clinician to distinguish between these two disorders. Although bipolar disorder in children and adolescents has serious consequences on emotional, social, and academic functioning, there are very little controlled data about effective treatments for this disorder. Mood stabilizers, such as lithium and divalproex, are frequently used to treat this disorder and there is currently increasing interest in the use of atypical antipsychotics and newer anticonvulsants. In addition to assessing efficacy of these agents, safety issues regarding their use in children and adolescents need to be examined. This presentation will focus on clinical features of bipolar disorder in children, differential diagnosis between bipolar disorder and attention deficit hyperactivity disorder, and new research findings for treatment of bipolar disorder in children and adolescents.

REFERENCES:

1. Practice Guideline for the Treatment of Patients with Bipolar Disorder (revision). Am J Psychiatry 2002;159(4 Suppl):1–50.
2. Ghaemi SN: New treatments for bipolar disorder: the role of atypical neuroleptic agents. J Clin Psychiatry 2000;61 Suppl 14:33–42.
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## INDUSTRY-SUPPORTED SYMPOSIUM 5—GENETICS AND PSYCHIATRY: REAL GENES, REAL PROGRESS
## Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand how genes and environment interact to modify behavior and complicate phenotype identification; review the evolving concept of phenotype.

### No. 5A
### GENETIC ENGINEERING IN ANIMALS: NEW INSIGHTS ABOUT ANXIETY AND ANTIDEPRESSANTS

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

SUMMARY:

Though anxiety is thought of as a uniquely human experience, anxious behaviors can be modeled in animals and molecular mechanisms that are critical for the expression of such behaviors can be identified. Pharmacological studies of anxiety have suggested an important role of 5-HT1a receptor function, but treatment effects cannot differentiate primary mechanisms from secondary compensations. Genetic engineering of candidate genes and cell phenotypes can help illuminate basic mechanisms and identify new therapeutic targets. Mice genetically engineered to lack 5-HT1a receptors early in life grow up to manifest abnormal anxiety related behaviors and fail to show normal responses to certain antianxiety/antidepressant treatments, even if these receptors are later expressed normally, suggesting early developmental imprinting of anxiety-related molecular pathways. 5-HT1a stimulation also has been implicated in neurogenesis in adult hippocampal dentate gyrus, and these genetically altered animals do not respond to SSRIs with the expected increase in neurogenesis. Irradiation of the mouse hippocampus also impairs the neurogenesis response to SSRIs, suggesting that the molecular pathways involved in this cellular response to antidepressant therapy are novel targets for treatment of mood and anxiety disorders.

### No. 5B
### RECENT ADVANCES IN STATISTICAL AND GENE-FINDING METHODS IN PSYCHIATRIC GENETICS

Richard Straub, M.D., NTH, *Building 10, Room 4N-311 MSC 1395, Bethesda, MD 20892-1395*

SUMMARY:

Among the many exciting areas of development in psychiatric genetics, this presentation will examine two: statistical genetic models applied to twin data and methods of gene localization via linkage and fine-mapping techniques. Four areas in statistical genetics will be covered: (1) multivariate models that examine the degree of sharing of genetic and environmental risk factors for common psychiatric disorders, (2) genotype-environment interaction where genetic risk factors modulate the sensitivity of the organism to the pathogenic effects of environmental adversity, (3) genotype-environment correlation where genetic factors influence the risk for exposure to adver-

sity, and (4) complex developmental models incorporating genetic and key environmental risk factors. The methods, strengths, and limitations of linkage analysis and fine mapping by association will then be reviewed and the results of genome scan linkage analyses for schizophrenia examined. Two new developments will be highlighted. Meta-analyses of the multiple available genome scans have allowed us to examine, in a statistically rigorous way, the vexing problem of replication or non-replication of putative susceptibility regions. Fine-mapping work using the latest molecular and statistical tools, is now being carried out in several labs trying to localize and directly identify the pathogenic alleles that predispose to schizophrenia.

## No. 5C
## GENE AND PROTEIN EXPRESSION IN BRAIN: IT DEPENDS ON INHERITANCE

Joel E. Kleinman, M.D., *10 Center Drive, Building 10, Rm. 45237A, Bethesda, MD 20892-1379*

### SUMMARY:

The advent of molecular biology and the completion of the human genome project have led to a renaissance in postmortem human brain studies, especially with regard to schizophrenia. On one hand, gene and protein expression can be studied at the cellular level. On the other hand, array technology allows for the simultaneous study of thousands of genes from the same sample. This talk will apply these techniques stratified by candidate genotypes to a neuronal circuit crucial to elucidating the neuropathology of schizophrenia: the prefrontal cortex(PFC)-hippocampal formation-midbrain circuit with particular focus on glutamate pyramidal neurons and midbrain dopamine(DA) neurons. In the case of the former, abnormalities in pyramidal neurons in schizophrenia will be related to a gene, BDNF. Moreover, a poymorphism in BDNF has been shown to effect the protein expression of that gene in PFC. In a second example of the effects of genes on this circuitry, a polymorphism for the gene for COMT, which leads to decreases in PFC DA, leads to dramatic changes in midbrain mRNA expression for tyrosine hydroxlase, the rate-limiting enzyme in DA synthesis. It would appear then that the COMT polymorphism, which is associated with some of the cognitive deficits of schizophrenia, may also lead to increased DA production that is thought to subserve the psychotic symptoms. Lastly, in an effort to identify further targets associated with these genes, array technology is being used to examine the effects of polymorphisms for both BDNF and COMT on thousands of other PFC genes.

## No. 5D
## RETHINKING THE CONCEPT OF PHENOTYPE IN PSYCHIATRY

Robert Freedman, M.D., *4200 East 9th Avenue, C-268-7, Denver, CO 80262*

### SUMMARY:

The traditional assumption of psychiatric genetics is that genes will help explain psychiatric phenomenology, particularly diagnosis. However, DSM-IV was not designed with human gene function in mind and genes do not encode for psychopathology. Genes encode simple molecules in cells that alter cell function and brain information processing. Thus, it has become appreciated that identifying biological traits associated with mental illness that reflect abnormal information processing in brain may offer better targets for understanding gene effects related to susceptibility. In schizophrenia, studies of genetically at-risk relatives of schizophrenic individuals have identified several such traits, including abnormalities of executive cognition linked to frontal lobe function, abnormal eye movements, abnormal electrophysiologic measures, and abnormal functional imaging phenotypes. The proof of concept that these traits are closer to the biologic effects in brain of susceptibility genes for schizophrenia has emerged from studies of the alpha-seven nicotinic receptor gene and the so-called P50 evoked potential. Similar proof of concept has been observed for the COMT gene and abnormal information processing in prefrontal cortex. These observations suggest new ways of thinking about how genes increase risk for mental illness, and about how psychiatric diagnosis may ultimately be revised.

## No. 5E
## IN VIVO APPROACHES TO IDENTIFYING GENETIC MECHANISMS OF SUSCEPTIBILITY

Daniel R. Weinberger, M.D., *10 Center Drive, Building 10, Room 4S-235, Bethesda, MD 20892-1379*

### SUMMARY:

The era of human gene discovery is rapidly unfolding, but one of the future challenges will be understanding the implications of genetic variation on brain function and how this increases susceptibility for mental illness. In vivo functional brain assays, such as those performed with neurocognitive tests and with neuroimaging, offer unique information that may be useful as target phenotypes for understanding the functional implications of genetic variation and mechanisms of susceptibility. This lecture will illustrate the power of this approach to understand the functional implications of relevant candidate genes in psychiatry. A series of studies will be described, including prefrontal, hippocampal, and amygdala information processing, as phenotypic targets for analysis of the effects of functional polymorphisms in candidate genes related to the biology of these processes. Examples include the following: (1) a functional variation in the gene for COMT predicts the efficiency of prefrontal information processing during working memory and in the prefrontal response to amphetamine during working memory; (2) a functional polymorphism in the gene for BDNF affects the activity of the hippocampus during working memory; (3) a functional polymorphism in the gene for the serotonin transporter effects the activity of the amygdala during the processing of emotional stimuli; (4) a functional polymorphism in the DAT affects information processing in putamen.

### REFERENCES:

1. Gross C, Zhuang X, Stark K, et al: Serotonin 1A receptor acts during development to establish normal anxiety-like behaviour in the adult. Nature 2002;416:396–400.
2. Kendler KS (2001). Twin studies of psychiatric illness: an update. Archives of General Psychiatry 58:1005–1014.
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5. Hariri A, Weinberger DR: Imaging genomics. Brit Med Bulletin, 2002, in press.

# INDUSTRY-SUPPORTED SYMPOSIUM 6—BEYOND BENZODIAZEPINES: NEW MOLECULES FOR THE TREATMENT OF ANXIETY
## Supported by Pfizer Inc.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the frequency of childhood anxiety disorders and what is known about long-term treatment outcomes; assess the economic, educational, marital, social, and health care burden associated

with anxiety disorders; recognize the burden of illness of generalized anxiety disorder (GAD), and compare and contrast the advantages and disadvantages of existing and potential new treatments for GAD; identify new molecular targets for potential antianxiety medications by reviewing current strategies.

## No. 6A
## CHILDHOOD ANXIETY DISORDERS: DOES TREATMENT AFFECT LONG-TERM OUTCOME?

Moira A. Rynn, M.D., *3535 Market Street, Suite 670, Philadelphia, PA 19104-3309;* Sarosh Khalid-Khan, M.D.

### SUMMARY:

Anxiety disorders, especially overanxious disorder/generalized anxiety disorder (GAD) and social phobia are among the most common diagnoses reported in childhood and adolescent epidemiological studies. In addition to impaired functioning, children with anxiety disorders often suffer from somatic symptoms leading to increased pediatrician visits and medical costs.

One of the few prospective studies (Last, Hansen, Franco, 1997) assessing anxious children's adjustment to early adulthood suggests that anxious children, especially with comorbid depression, were less likely than controls to be living independently, working, or in school. It is hoped that early treatment intervention will alter the course of these disorders for later adult development. Two published clinical trials on the treatment of childhood GAD document the efficacy of individual cognitive-behavioral treatment with two- to five-year follow-up assessment, showing that treatment gains were maintained (Kendall et al. 1994; 1997).

This session will review limited data available on long-term treatment outcomes for psychosocial and pharmacotherapy for childhood anxiety disorders, including results of a three-year follow up of an acute GAD treatment study (Rynn et al, 2000).

## No. 6B
## THE BURDEN OF ANXIETY DISORDERS

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

### SUMMARY:

Anxiety disorders afflict 24.9% of the general U.S. population and carry a heavy economic, educational, occupational, marital, social, and health care burden. The annual cost to the U.S. economy is estimated at more than $42 billion in direct nonpsychiatric medical treatment costs, (54%), psychiatric treatment costs (31%), indirect workplaces costs (10%), mortality costs (3%), and prescription pharmaceutical costs (2%).

Patients with anxiety disorders have an increased risk of hypertension, heart disease, depression, substance abuse, and dependence. They are more likely to rely on disability and welfare programs, take medication, and overutilize the health care system (e.g., frequent medical visits and diagnostic evaluations, laboratory tests, and hospitalizations). They are also less likely to graduate from college, less likely to marry, and more likely to suffer from sexual dysfunction and marital discord.

Furthermore, all five major anxiety disorders are associated with an increased risk of suicide. The odds risk of a suicide attempt is 6 for posttraumatic stress disorder (PTSD), 5.6 each for panic disorder, and generalized anxiety disorder (GAD), 2.1 for social anxiety disorder, and 3.2 for all anxiety disorders combined.

## No. 6C
## TREATMENT FOR GENERALIZED ANXIETY DISORDER: CURRENT AND NEAR TERM

Stuart A. Montgomery, M.D., *P.O. Box 8751/19 Street Leonard's Road, London, England W13 8PN*

### SUMMARY:

The concept of generalized anxiety disorder (GAD) has evolved from the much briefer duration of anxiety neurosis recognized in DSM-II to a chronic well-defined disorder associated with high levels of disability, as described in DSM-IV.

Until recently, benzodiazepines have been widely used in treating GAD despite a lack of evidence of long-term efficacy. Recent placebo-controlled studies of lorazepam, 6 mg daily, have shown efficacy but the tolerance, memory disturbance, and possible dependence continue to compromise treatment. SSRIs, such as paroxetine and sertraline, and SNRIs, such as venlafaxine, are also effective but demonstrate a slow onset of action and the usual gastrointestinal side effects of serotonergic compounds.

Newer compounds with novel mechanisms of action, such as pregabalin, now have substantial evidence of efficacy with five positive placebo-controlled studies in the short term and one positive placebo-controlled relapse prevention study in the long term. The advantage of pregabalin is seen in terms of the early onset of effect and good tolerability without the disadvantages associated with benzodiazepines or the SSRIs.

## No. 6D
## FUTURE DIRECTIONS: NEW MOLECULAR TARGETS FOR THE TREATMENT OF ANXIETY

Jack M. Gorman, M.D., *1051 Riverside Drive Unit 32, New York, NY 10032*

### SUMMARY:

Current treatments for anxiety and anxiety disorders are remarkably successful, with most patients achieving a reduction in symptoms and experiencing only mild to moderate adverse events. Shortcomings of current pharmacological treatment for anxiety, however, such as latency to response and failure to establish remission, indicate an existing need for better anxiolytic treatment.

One major strategy is to use insights from molecular and preclinical research to find new molecules for the treatment of anxiety. While benzodiazepines are effective and widely used, they produce unwanted sedation and dependency. Molecular studies have shown that binding benzodiazepines to $GABA_A$ receptors containing the $alpha_1$ subunit mediates the sedative properties of benzodiazepines. Molecules, therefore, have been designed to produce antianxiety effects without causing sedation. Another approach is administering drugs that are only partial benzodiazepine agonists, like pagoclone. Such drugs may have antianxiety effects without causing physical dependency. Other strategies for enhancing GABA effects are being developed, including the use of the selective GABA reuptake inhibitor tiagabine and the GABA enhancer pregabalin. Other strategies include corticotropin-releasing factor (CRF) antagonists, substance P antagonists, and drugs inhibiting glutamate neurotransmission.

### REFERENCES:

1. Kendall PC, Southam-Gerow MA: Long-term follow-up of a cognitive-behavioral therapy for anxiety—disordered youth. J Consult Clin Psychol 1996;64:724–730.
2. Greenberg PE, Sisitsky T, Kessler RC, et al: The economic burden of anxiety disorders in the 1990s. J Clin Psychiatry 1999;60:426–435.

3. ECNP Consensus Meeting. Reference Guidelines for the Investigation of GAD. Guidelines for investigating efficacy in GAD. Eur Neuropsychopharmacol 2002;12:81–87.
4. Gorman JM, Kent JM, Sullivan GM, Coplan JD: Neuroanatomical hypothesis of panic disorder, revised. Am J Psychiatry 2000;157:493–505.

# INDUSTRY-SUPPORTED SYMPOSIUM 7—ENHANCING OUTCOMES BY ADDRESSING CRITICAL CHALLENGES IN THE TREATMENT OF SCHIZOPHRENIA

**Supported by Eli Lilly and Company**

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the challenges of schizophrenia to improve treatment selection and improve patient outcomes.

## No. 7A
## SCHIZOPHRENIA: NEW UNDERSTANDINGS OF THE EARLY STAGE OF ILLNESS

Diana O. Perkins, M.D., *101 Manning Drive, Campus Box 7160, Chapel Hill, NC 27599-7160*

### SUMMARY:

Emerging evidence suggests that the early stages of schizophrenia are a critical window, where optimal intervention strategies may improve long-term prognosis. Expectations are that with optimal clinical management, most first-episode patients should have remission of positive symptoms. Duration of untreated illness is consistently associated with clinical and functional outcomes, suggesting that the earlier antipsychotic treatment is initiated in the course of illness, the more likely that there is positive symptom recovery from a first episode. New data further suggest that atypical antipsychotics may offer enhanced efficacy in first-episode patients compared with typical antipsychotics. In addition, new, more aggressive psychosocial and psychotherapeutic strategies may improve likelihood of treatment adherence and impact long-term functional outcomes. In this presentation optimal treatment strategies of patients in their first episode of psychosis will be presented. The evidence that early identification and intervention may impact prognosis will be reviewed, and the potential impact of early identification programs on duration of untreated psychosis discussed. Data will be presented from recent neuroimaging studies that suggest that clinical deterioration is associated with changes in brain structures, with implications that there may be a potentially preventable neuroprogressive feature in some individuals with schizophrenia. In addition, data from first-episode clinical trials will be discussed, emphasizing the evidence that atypical antipsychotics may offer hope of improved clinical outcomes.

## No. 7B
## IMPROVING COGNITION FOR QUALITY OUTCOMES

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

### SUMMARY:

Neurocognition is severely impaired in schizophrenia. The relevance of this neurocognitive impairment is clear, as deficits on tests of attention, memory, motor functions, and executive functions are more strongly correlated with outcome then is any other aspect of the illness. Patients in the first episode of psychotic illness also demonstrate severe impairments, which may be particularly important as neurocognitive skills may determine success in the areas of occupational and social functioning. Typical antipsychotic medications, such as haloperidol, have little impact on neurocognitive deficits in chronic patients; however, few data are available on low-dose strategies in first-episode patients. Recent studies suggest that novel antipsychotics such as clozapine, risperidone, quatiapino, and olanzapine enhance neurocognitive function in patients with chronic schizophrenic. Olanzapine has been found to be superior to low-dose haloperidol in improving cognition in patients with first-episode psychosis. Since cognitive deficits are so strongly associated with important clinical factors such as therapeutic alliance, adherence and long-term social outcomes, it is likely that these treatment-related improvements in neurocognitive function will lead to improved therapeutic relationships and eventually, improvements in important aspects of the quality of everyday life. The clinical significance of recent neurobiological findings of reduced progressive ventricular enlargement with atypical antipsychotics will also be discussed.

## No. 7C
## TREATMENT CHALLENGES FOR THE PATIENT WITH ACUTE AGITATION

Leslie L. Citrome, M.D., *140 Old Orangeburg Road, Building 37, Orangeburg, NY 10962-2210*

### SUMMARY:

Acute agitation is a frequent reason for presentation to an emergency room, and if unchecked, leads to subsequent admission to a psychiatric inpatient unit. Agitation places other patients, mental health workers, and family members or other caregivers at risk for harm.

The management of agitation in patients with schizophrenia requires two simultaneous approaches. First, there is a need to manage acute episodes of agitation. Second, there is a need to decrease the frequency and intensity of these episodes. New pharmacological approaches promise to quickly calm the agitated patient, and treat the underlying disease process that may be the root cause for the disturbed behavior.

This presentation will first review the definitions of agitation, aggression, violence, and hostility, as all four terms are commonly used in the psychiatric literature. Next, the epidemiology of aggressive behavior and schizophrenia will be reviewed, followed by an extensive discussion of the pharmacological treatment strategies for acute episodes of agitated behavior. This includes newer formulations of novel antipsychotics such as liquids and rapidly disintegrating tablets, as well as intramuscular preparations. The results of pivotal systematic and well-designed clinical trials are discussed within the context of actual clinical practice.

## No. 7D
## METABOLIC ISSUES WITH ANTIPSYCHOTIC THERAPY

John B. Buse, M.D., *5039 Old Clinic, Building CB# 7110, Chapel Hill, NC 27599-7110*

### SUMMARY:

While there have been advances in the treatment of schizophrenia, some of the older metabolic issues persist. Hyperglycemia, diabetes, weight gain, and sexual dysfunction have been reported both in patients with untreated schizophrenia and in patients treated with medication, leaving it difficult to identify which condition came first, the disease state or the medication adverse effect.

There are risk factors for diabetes that predict diabetes risk in the general population: age, family history, overweight, race/ethnicity,

hypertension, dyslipidemia, history of gestational diabetes, previous abnormal glucose levels, or evidence of insulin resistance (acanthosis nigricans or polycystic ovarian syndrome). These risk factors predict hyperglycemia during therapy with antipsychotic agents.

This presentation will discuss the metabolic issues of hyperglycemia, weight gain, and hyperprolactinemia and their effect on the overall management of the patient.

Recommendations will be provided to review specific efficacy and safety parameters in selecting an antipsychotic. Thus, decisions regarding antipsychotic therapy should be made on the basis of the psychiatric diagnosis and predicted efficacy of a given agent in an individual and not based on concerns regarding metabolic issues.

### No. 7E
### MAINTENANCE STRATEGIES: BALANCING EFFICACY AND SAFETY TO PREVENT RELAPSE

Thomas F. Liffick, M.D., *415 Mulberry St, Evansville, IN 47713-1230*

SUMMARY:

The promise of scientific advancement has provided our patients with renewed opportunities for a return to a higher level of function. The ability to remain healthy is a significant factor if people with severe and persistent psychiatric illness are to take advantage of those opportunities. Optimizing efficacy, safety, and tolerability in the long term will help achieve higher goals such as avoidance of relapse, return to productivity, and improved quality of life, all of which contribute to the healing process. Available data on relapse rates in schizophrenia will be reviewed as will results of studies looking at functional measurements of improvement. Information about long-term side effects will be presented. Finally, the improved tolerability of these medications will be reviewed because of its relationship to compliance and outcome.

REFERENCES:

1. Lieberman JA, Perkins D, Belger A, Chakos M, Jarskog F, Boteva K, Gilmore J: The early stages of schizophrenia: speculations on pathogenesis, pathophysiology, and therapeutic approaches. Biol Psychiatry, 2001.
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## INDUSTRY-SUPPORTED SYMPOSIUM 8—OPTIMIZING EFFICACY AND TOLERABILITY OF ANTIDEPRESSANT THERAPY: DOES SELECTIVITY OF ACTION MATTER?
## Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with the different choices for the treatment of depression, as well as their pros and cons.

### No. 8A
### THE ALPHABET SOUP OF ANTIDEPRESSANT PHARMACOLOGY: FROM TCA'S AND MAOI'S TO SSRI'S, SNRI'S, AND BEYOND

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

SUMMARY:

The precise role that monoamine system deficiencies play in the etiology of depression remains unclear; however, all antidepressant agents in current use act to increase levels of serotonin (5-HT), norepinephrine (NE), and/or dopamine (DA) in the brain. The distinct mechanisms by which various agents elevate monoamine levels contribute both to therapeutic activity and side-effect profiles.

Classical tricyclic antidepressants (TCAs) potently but non-selectively inhibit reuptake of NE, whereas monoamine oxidase inhibitors (MAOIs) interfere with the metabolism of biogenic amines. Efforts to develop agents with fewer side effects and reduced toxicity in overdose led to the introduction of the selective serotonin reuptake inhibitors (SSRIs), which show far greater affinity for the 5-HT transporter compared with transporters for NE and DA.

Three other classes of drugs enhance serotonergic neurotransmission; however, these classes have the following additional effects: SNRIs inhibit reuptake of both 5-HT and NE, nefazodone weakly inhibits 5-HT and NE reuptake and potently antagonizes the 5-HT2 receptor, and mirtazapine antagonizes central alpha2-autoreceptors and 5-HT2 and 5-HT3 receptors. Two agents with no direct effects on serotonergic neurotransmission are bupropion, a selective inhibitor of NE and DA reuptake, and reboxetine (which is not marketed in the U.S.), a selective inhibitor of NE uptake.

This presentation will provide an overview of the basic psychopharmacology of the various classes of currently available antidepressant drugs.

### No. 8B
### SSRI'S AND BEYOND: SPECTRUM OF EFFICACY OF NEWER ANTIDEPRESSANTS

Justine M. Kent, M.D., *1051 Riverside Drive, Unit 41, New York, NY 10032*

SUMMARY:

Among the goals of new drug development is improvement of the "therapeutic ratio" (i.e., maintenance or enhancement of efficacy combined with diminishment or elimination of unwanted side effects) relative to older classes of agents. In the case of antidepressants, the selective serotonin reuptake inhibitors (SSRIs) have achieved spectacular commercial success, largely because their increased pharmacologic specificity translated into greater safety and tolerability compared with tricyclic antidepressants (TCAs), monoamine oxidase inhibitors, and even some of the newer dual- or mixed-mechanism drugs.

The SSRIs have been shown to have equivalent or greater efficacy than non-selective agents for the treatment of depression and are as or more effective than other classes of antidepressants in treating a broad range of psychiatric disorders, including generalized anxiety, panic, posttraumatic stress, and obsessive-compulsive disorders, bulimia, and dysthymia. This presentation will review the clinical evidence supporting the usefulness of SSRIs and other, newer antidepressants, for the treatment of depression and anxiety disorders, as well as the neuroanatomical pathways that may underlie these agents' broad spectrum of effect.

## No. 8C
## EFFICACY OF NEWER ANTIDEPRESSANTS

Michael E. Thase, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593*

### SUMMARY:

Major depression is a common and disabling—yet highly treatable—disorder. Currently available antidepressants are generally viewed as comparably effective, with intent-to-treat response rates (defined as at least a 50% improvement in symptoms) of approximately 50% to 60%. The selective serotonin reuptake inhibitors (SSRIs) are now the most widely prescribed antidepressants, in large part because of their improved safety and tolerability compared with older antidepressants. Nevertheless, there are some data to suggest that the SSRIs may be somewhat less effective than agents with both serotonergic and noradrenergic effects. Additionally, patients who fail to respond to an SSRI may benefit from augmentation or switch strategies that combine pharmacologic mechanisms.

The ultimate goal of the treatment of depression, however, extends beyond reduction of symptoms, to the achievement of full remission from depression. While well-controlled, prospective studies of sufficient power are lacking, results from pooled analyses of completed data sets and meta-analyses suggest that higher rates of remission may be achieved with venlafaxine compared with at least some SSRIs. Some data also suggest an earlier onset of benefit with mirtazapine. The strength and limitations of these findings, their potential clinical import, and directions for future research will be discussed.

## No. 8D
## GENERALLY WELL TOLERATED: COMPARATIVE ADVERSE-EVENT PROFILES OF NEWER ANTIDEPRESSANTS

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

### SUMMARY:

The new generation of antidepressants have the great advantage of more tolerable adverse events as compared with the older generation. This does not mean that no adverse events exist, and the newer generation also carries with it its own set of unique problems. While the optimal method to compare adverse event profiles is with head-to-head studies, sometimes these are not available. Instead, a reasonable method is to compare the differences in adverse events for these newer antidepressants with placebo in pivotal clinical trials. This presentation will contrast and compare the ratio of side effects of the newer antidepressants compared with placebo and discuss possible mechanisms of action that may explain the scientific basis for these side effects.

### REFERENCES:

1. Delgado PM, Moreno FM: Role of norepinephrine in depression. J Clin Psychiatry 2000;61(suppl 1):5–12.
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4. Peretti S, Judge R, Hindmarch I: Safety and tolerability considerations: tricyclic antidepressants vs. selective serotonin reuptake inhibitors. Acta Psychiatr Scand Suppl 2000;403:17–25.

# INDUSTRY-SUPPORTED SYMPOSIUM 9—DIAGNOSIS AND TREATMENT: MOOD STABILIZERS ACROSS THE PSYCHIATRIC SPECTRUM
## Supported by Abbott Laboratories

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to review the clinical treatment targets for mood stabilizers, and discuss the evidence in each of these conditions/diagnoses for clinical efficacy.

## No. 9A
## A SYSTEMATIC APPROACH TO THE TREATMENT OF IMPULSIVITY

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

### SUMMARY:

Initiation of behavior requires a balance between generation of behavior and matching it to context. Initial screening occurs outside of consciousness over less than half a second, and involves a filter including the prefrontal cortex, amygdala, and other brain regions. Impulsivity occurs when this process fails, potentially leading to destructive acts, including violence and suicide. No behavior is innately impulsive; it can be either impulsive or planned. The distinguishing mark of impulsivity is lack of reflection or regard for consequences. Impulsivity can occur through at least two interrelated mechanisms: a defective filter, or an otherwise normal filter overloaded by overstimulation or generation of excessive "spontaneous" behavior. Laboratory and personality measures demonstrate both state- and trait-related increases in impulsivity in bipolar disorder, which may correspond, in part, to disturbances in the generation or filtering of behavior. Behavioral sensitization may increase susceptibility to impulsivity, contributing to the apparent overlaps among bipolar disorder, substance abuse, and stress-related disorders, in which data demonstrate that impulsivity is a measurable common factor. Pharmacologic and behavioral management of impulsivity have synergistic roles and depend on the interaction between trait-related deficits in the behavioral filter and more state-related problems of overstimulation, hypermotivation, or substance abuse.

## No. 9B
## THE ROLE OF MOOD STABILIZERS IN THE MANAGEMENT OF AGITATION IN DEMENTIA

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

### SUMMARY:

Agitation is one of the most common neuropsychiatric disturbances associated with Alzheimer's disease and related dementias. Management of this symptom cluster is extremely challenging for physicians, but vital to improving patient and caregiver well-being. Effective treatment may be hindered by a number of issues, including symptom heterogeneity, assessment problems, and a relative lack of specific pharmacologic treatments. Antipsychotic medications have traditionally been prescribed in this population, but modest efficacy and unfavorable side effects gave rise to a search for other alternatives. The use of anticonvulsants for agitation in dementia was originally advocated on the basis of extrapolation from reports of reduced agitation, agitation, irritability, and impulsivity across a spectrum of other neuropsychiatric disorders. These experiences led to clinical trials investigating the efficacy and tolerability of carbamazepine

and divalproex sodium as treatment for agitated nursing home residents with dementia. This session will review pertinent mood stabilizer clinical trials data and place these findings within the context of practical management of agitated patients with dementia. Additionally, there will be a brief exploration of intriguing information suggesting that mood stabilizers such as lithium and valproate possess neuroprotective properties that may be relevant to Alzheimer's disease treatment.

## No. 9C
## EFFICACY OF TREATMENT WITH MOOD STABILIZERS IN ACUTE SCHIZOPHRENIA

Carol A. Tamminga, M.D., *Maple and Locust Street, Box 21247, Baltimore, MD 21228*

### SUMMARY:

The use of mood stabilizers in persons with schizophrenia, especially those residing in hospital, has been used by clinicians with variable intensity for many years. Anticonvulsants have long been used in schizophrenia, like barbiturates and phenytoin and newer anticonvulsant/mood stabilizers have been applied when available. As the pathophysiology of schizophrenia has converged, speculation on the potential mechanisms of mood stabilizers' clinical actions has emerged. In functional brain imaging studies of persons with active schizophrenia, several CNS regions seem to be consistently affected, including the limbic system including the hippocampus and anterior cingulate—regions also vulnerable in epilepsy and targeted by anticonvulsants. Whether mood stabilizers modulate glutamatergic transmission in these areas or alter GABAergic inhibition is not yet determined, but their limbic action is highly probable. Thus, the clinical data of the efficacy of divalproex sodium in augmenting the antipsychotic action of two newer antipsychotic drugs (risperidone and olanzapine), have come in a context of plausible mechanisms. We speculate that mood stabilizers modify (perhaps stabilize) neuronal activity in limbic brain areas, augmenting the antidopaminergic (and antipsychotic) action of traditional and new antipsychotics in the basal ganglia. An argument could be made for calling this a reduction of "neuronal impulsivity" in the schizophrenia limbic system.

## No. 9D
## COMORBIDITIES AND TREATMENT ISSUES IN SUBSTANCE USE DISORDERS

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

### SUMMARY:

There is a complex relationship between substance use disorders and many psychiatric disorders including bipolar disorder, PTSD, and personality disorders. We can link these disorders on several lines of evidence. First, there is phenomenologic evidence in that we see common symptoms such impulsivity and irritability in these disorders. Second, there is neurobiological evidence in that there is dysfunction in neurotransmitter systems such as glutamate and GABA that perpetuate these disorders. Kindling or neuronal sensitization may also be involved. And last, there is pharmacologic evidence to think these disorders in that they all seem to respond to mood stabilizers. Mood stabilizers may play a role in not only decreasing the overt symptoms of these disorders, but they may also provide neuroprotective effects over the neuronal damage associated with these disorders. In addition, the role of mood stabilizers in reducing relapse by decreasing protracted withdrawal symptoms, treating comorbid psychiatric conditions, and decreasing symptoms such as impulsivity and aggressivity that are common to substance use will be discussed.

## No. 9E
## AFFECTIVE INSTABILITY AND IMPULSIVE AGGRESSION IN CLUSTER B AND DEVELOPMENTAL DISORDERS

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

### SUMMARY:

The affective instability and impulsive-aggression symptom domain cut across various psychiatric disorders, including borderline personality disorders and autism. These symptoms, which influence the course of illness and response to treatment, cause substantial impairment in the life of patients with BPD and autistic disorder. Symptoms include mood instability, self-injury, and aggression, and may be associated with EEG abnormalities in both conditions. Orbitofrontal—limbic circuitry modulated by specific neurotransmitter systems, such as 5HT and GABA, may modulate the expression of both impulsive aggressive behaviors and affective instability. Targeted treatments to modulate key neurotransmitter systems decrease limbic excitability and increase orbitofrontal activity may reduce symptoms of affective instability and impulsive aggression, and result in substantial improvement in functional ability and more situationally appropriate interactions.

### REFERENCES:

1. Moeller FG, Barratt ES, Dougherty DM, Schmitz JM, Swann AC: Psychiatric aspects of impulsivity. American Journal of Psychiatry 2001;158:1783–1793.
2. Tariot PN, Ryan JM, Porsteinsson AP, Schneider LS: Pharmacologic treatment for behavioral symptoms of Alzheimer's disease. Clinics in Geriatric Medicine 2001;17(2):359–376.
3. Wassef AA, Dott SG, Harris A, Brown A, O'Boyle M, Meyer WJ 3rd, Rose RM: Randomized, placebo-controlled pilot study of divalproex sodium in the treatment of acute exacerbations of chronic schizophrenia. J Clin Psychopharmacol 2000;20:357–361.
4. Brady KT, Myrick H, McElroy S: The relationship between SUD, impulse control disorders, and pathologic aggression. Am J Addictions 1998;(7):221–230.
5. Hollander E, Evers M: New developments in impulsivity. Lancet 2001;358:949–950.

# INDUSTRY-SUPPORTED SYMPOSIUM 10—MOODS CYCLES, AND MOTHERHOOD
# Supported by GlaxoSmithKline

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose and treat mood anxiety disorders related to pregnancy, postpartum, the menstrual phase, and menopause.

## No. 10A
## DEPRESSION IN PREGNANCY AND LACTATION: MAKING INFORMED DECISIONS TO PROTECT THE MOTHER AND INFANT

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

### SUMMARY:

The treatment of psychiatric illness during pregnancy and lactation represents a complex clinical situation. The increased incidence of mood and anxiety disorders during the childbearing years under-

scores the high probability that the clinician will encounter such situations. In the absence of scientifically derived treatment guidelines, it is important to appreciate the limitations of the available data and establish a reasonable methodology for comparing treatment options. Pivotal to a comprehensive risk/benefit assessment is the ability to compare equally efficacious medications to minimize fetal and neonatal exposure. Clinical and preclinical antidepressant exposure data including placental passage and breast milk excretion will be discussed during this presentation. In addition, guidelines for proper interpretation of available data so that they become clinically relevant to psychiatric practice will be provided.

## No. 10B
## MOTHERS, BABIES, AND CHILDREN: MENTAL HEALTH IN THE POSTPARTUM AND BEYOND

Shaila Misri, M.D., *1081 Burrard Street, 2B-250, Vancouver, BC Canada V6Z 1Y6*

### SUMMARY:

Women of childbearing age are at high risk for major depression. Ten percent of women in the postpartum period experience a serious depression necessitating psychiatric intervention. A variety of treatment options is currently available. In this paper, new data on the use of SSRIs and cognitive-behavior therapy as a treatment modality for postpartum depression will be reported. In addition, a review of new research in the area of adverse effects of maternal mental health in babies will be presented with specific emphasis on long-term follow up of the children. A five-year prospective data of a cohort consisting of mother-infant dyads at birth and at age 3 and 5 will be presented; results will focus on the cognitive and emotional development of children exposed to three different SSRIs (paroxetine, sertraline, and fluoxetine) throughout pregnancy and at four months postpartum. This new research will help clinicians make the right decisions regarding treatment issues related to women during childbearing stages.

## No. 10C
## PHARMACOLOGICAL TREATMENT OF PREMENSTRUAL DYSPHORIA: WHAT IS SUFFICIENT?

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

### SUMMARY:

Recent advances in the diagnosis of severe premenstrual dysphoria support a unique syndrome, premenstrual dysphoric disorder (PMDD), that occurs during the luteal phase of the menstrual cycle and is associated with substantial functional impairment. Approximately 3% to 4% of women suffer from isolated symptoms during the luteal phase of the cycle and a larger proportion of women probably experience premenstrual worsening of ongoing emotional symptoms. Among the antidepressant agents, PMDD treatment response is uniquely linked to agents that block the serotonin transporter. Recent data find that some women with PMDD respond to treatment when it is administered intermittently during the luteal phase of the menstrual cycle. However, the necessary duration of luteal phase treatment may vary from one patient group to another and from one agent to agent. Intermittent administration of an antidepressant agent is a fairly unique approach to treatment of a psychiatric syndrome, especially considering the widely held view that antidepressant agents must be administered for three to four weeks before therapeutic benefit is evidenced. In this presentation, new data on the intermittent use of serotonin reuptake inhibitors for PMDD will be presented, and theories regarding the mechanisms underlying this response will be discussed.

## No. 10D
## IS IT JUST ME OR IS IT HOT IN HERE? WHAT EVERY PSYCHIATRIST SHOULD KNOW ABOUT

C. Neill Epperson, M.D., *100 York Street, Suite 2H, New Haven, CT 06511*

### SUMMARY:

While an increasing number of menopause-aged women are questioning whether their new-onset or ongoing psychiatric issues are "hormonal," most general psychiatrists feel ill-equipped to respond to their clients' queries. Hormones, and in particular estrogen, are no longer in the sole domain of the gynecologist but have steadily seeped into the psychiatrist's consciousness as a possible trigger for mood and cognitive changes as well as a potential pharmacologic tool. Although it is questionable whether the menopause confers an increased risk for major depression, many peri- and postmenopausal women experience interfering mood and cognitive and physical symptoms associated with irregular and/or decreased production of estrogen. Within the past two years, two double-blind, placebo-controlled studies have confirmed that estradiol is an effective treatment for major or minor depression in perimenopausal women. Thus, the overarching goal of this session will be to provide psychiatrists with a basic understanding of (1) the menopause transition, (2) the neurobiological effect of estradiol, (3) when and how to appropriately institute estrogen as a pharmacologic agent, and (4) how to use traditional psychotropic medications such as selective serotonin reuptake inhibitors to manage menopause-related symptoms in women for whom estrogen replacement is contraindicated.

### REFERENCES:

1. Newport DJ, Wilcox MM, Stowe ZN: Antidepressants during pregnancy and lactation: defining exposure and treatment issues. Sem Perinatol 2001;25:177–190.
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# INDUSTRY-SUPPORTED SYMPOSIUM 11—ENHANCING SKILL TREATING COMORBID DEPRESSION AND NEUROLOGICAL ILLNESS
## Supported by Organon Inc.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the neurobiology of depression in patients with medical and neurologic illnesses; be able to choose the best antidepressant for patients with comorbid medical and neurological illnesses.

## No. 11A
## DEPRESSION IN NEUROLOGICAL DISORDERS

Gary J. Tucker, M.D., *1959 Pacific Street, Box 356560, Seattle, WA 98195*

SUMMARY:

It is the intent of this paper to examine the prevalence of affective disorders in neurological disorders. We will demonstrate that the incidence of affective disorder is greater in neurological conditions than other medical disorders, e.g., cardiac, GI, etc. (with the highest prevalence being in those neurological disorders that affect the basal ganglia and frontal lobes). The greater prevalence of affective disorder in the neurological disorders of the basal ganglia and frontal lobes is not surprising as these same anatomic sites and their neurotransmitter systems have been strongly implicated in the etiology of primary affective disorders. We will also discuss the similarities and differences in phenomenology of depression in neurological disorders as well as the similarities and differences in the treatment of affective disorders in these neurological disorders, particularly disorders of the basal ganglia such as Parkinson's disease.

## No. 11B
## DEPRESSION IN DEMENTING DISORDERS

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

SUMMARY:

Depression occurs in approximately 40% of patients with Alzheimer's disease (AD), 40% of patients with Parkinson's disease and dementia, 35% to 50% of those with vascular dementia (VaD), and 50% to 60% of patients with dementia with Lewy bodies (DLB). Depression is common in both dementia and in minimum cognitive impairment (MCI) syndromes that precede diagnosable dementia. Depression in MCI and in early-stage dementia must be distinguished from late-onset depression and the cognitive impairment that may accompany mood disorders. Depression must also be distinguished from apathy, a syndrome common in dementia that has overlapping figures but occurs independently of depression. Depression exaggerates disability in dementia and often worsens cognition. Neurobiological correlates of depression in dementia vary across disease states. Low CSF 5-hydroxyindoleacetic acid and diminished orbitofrontal and caudate metabolism occur in depression associated with PD. In AD, depression correlates with frontal hypometabolism. Depression in VaD is most common when the ischemic injury involves the deep white matter or there are multiple lacunes in the basal ganglia. Dysfunction of a related set of frontal-subcortical structures appears to be a common underlying feature of depression in dementia. Some studies have shown responses to either serotonergic agents or mixed serotonergic/noradrenergic agents.

## No. 11C
## DEPRESSION FOLLOWING TRAUMATIC BRAIN INJURY

David B. Arciniegas, M.D., *4200 East Ninth Avenue, Denver, CO 80262*

SUMMARY:

Major depressive episodes develop in 30% to 70% of patients during the first year following a traumatic brain injury (TBI) and negatively affect recovery from TBI. The evaluation of depression following TBI requires consideration of pre-injury variables, the nature of the injury, and the medical, neurological, and psychosocial sequelae of the injury. Pre-injury variables, including poor premorbid psychosocial adjustment, substance abuse, and poor family support are associated with the development of depression following TBI. Depression following brain injury appears to be most closely associated with left-hemisphere lesions, and anterolateral frontal contusions involving serotonergic and noradrenergic afferents, and injuries that disrupt left frontal-subcortical circuits. Clinicians must be aware of the manner in which common comorbid post-injury conditions such as headache, dizziness, sleep disturbance, pain, and cognitive impairments may initiate, maintain, and/or exacerbate depression following TBI. These signs and symptoms of these conditions often confound accurate diagnosis of depression, and often require concurrent treatment in order to effect relief from depression. Comorbid psychiatric problems, as well as factors fostering symptom elaboration or producing secondary gains, require identification and appropriate treatment. With these issues in mind, optimal pharmacotherapies for depression following TBI will be discussed based on the clinical studies performed in this population.

## No. 11D
## TREATMENT OF DEPRESSION IN PATIENTS WITH LIFE-THREATENING AND TERMINAL ILLNESS

Norman Sussman, M.D., *150 East 58th Street, 27th Floor, New York, NY 10155*

SUMMARY:

It is understandable that patients with diagnoses of terminal illnesses or HIV experience high levels of depression, anxiety, and stress. The presence of heightened rates of anxiety and depression makes it important to assess and treat these symptoms and disorders in these patients. There is some evidence interventions can significantly improve the quality of life of patients with terminal and life-threatening illnesses. Because patients in this population often experience pain and insomnia along with mood disturbances, treatments that provide symptomatic relief as well as treatment of the underlying psychiatric disorder are preferred. For example, antidepressants that improve multiple symptoms minimize the number of medications required. Impact of an antidepressant on drug interactions is also an important consideration in drug selection, given the multiple medications people are given with these illnesses.

## No. 11E
## TARGETING ANTIDEPRESSANT THERAPY TO MEDICAL COMORBIDITY

Steven L. Dubovsky, M.D., *4200 East Ninth Avenue Box C260, Denver, CO 80262*

SUMMARY:

Psychiatrists are uniquely qualified to use knowledge of the complex actions and interactions of antidepressant treatments to prescribe therapies that can benefit medical illnesses and their treatment and to minimize the use of medications that will aggravate the medical disorder. In this presentation, I will discuss properties of commonly used medications that make them more or less useful for depressed patients with medical disorders not addressed in other presentations in the symposium. In addition to providing clinical "pearls" about antidepressant choices for patients with cardiovascular disease, stroke, migraine headaches, traumatic brain injury, and diabetes mellitus, new information will be presented about the use of ECT and rTMS. The presentation will conclude with a systematic rationale for evaluating beneficial and adverse effects and potential drug interactions in any medical setting using knowledge of receptor, neurotransmitter, second messenger, and actions of antidepressants on processes that influence activity of other drugs including P-glycoprotein and organic acid transporters in addition to CYP 450 enzymes.

REFERENCES:

1. Lauterbach E: Psychiatric Management in Neurological Disease. APPI Press, Washington DC, 2000.
2. Cummings JL, Trimble MR: Concise guide to neuropsychiatry and behavioral neurology, 2nd ed. Am Psychiatric Assn, Washington, D.C., 2002.
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5. Goodnick PJ, Hernandez M: Treatment of depression in comorbid medical illness. Expert Opinion in Pharmacotherapy 2000;1:1367–1384.

## INDUSTRY-SUPPORTED SYMPOSIUM 12—AN INTEGRATED APPROACH TO THE MANAGEMENT OF BIPOLAR DISORDER: AN ALLIANCE OF SCIENCE AND MEDICINE
## Supported by Eli Lilly and Company

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the most current research data regarding the efficacy of treatment management for all aspects of bipolar disorder.

### No. 12A
### THE ROLE OF GENETICS IN BIPOLAR DISEASE

Wade H. Berrettini, M.D., *415 Curie Boulevard, Room 111, Philadelphia, PA 19104*

SUMMARY:

This paper reviews the history of molecular genetic linkage and linkage disequilibrium (LD) or association studies of bipolar disorder (BPD). The topic is introduced with a brief discussion of various genetic concepts, including linkage and linkage disequilibrium. It is emphasized that criteria for declaring linkage must include independent confirmation by multiple groups of investigators. Given that the inherited susceptibility for BPD is most likely explained by multiple genes of small effect, simulations indicate that *universal* confirmation of valid linkages cannot be expected due to sampling variation and genetic heterogeneity. With this background, several valid linkages of BPD to genomic regions are reviewed, including some which may be shared with schizophrenia. These results suggest that nosology must be changed to reflect the genetic origins of the multiple disorders that are collectively described by the term, BPD.

### No. 12B
### THE IMPORTANCE OF MOOD STABILIZATION IN THE TREATMENT OF MANIA

John Cookson, M.B., *85B Forest Road London, London, England E83BT*

SUMMARY:

Lithium, valproate, and carbamazepine are sometimes considered cornerstones of treatment of acute mania and are frequently continued after resolution of the episode for prophylaxis. However, the response rate with these agents as monotherapy is low. Antipsychotic agents are commonly used during mania. In 2002, the APA published guidelines on the treatment of mania, advise the combined use of an antipsychotic with valproate or lithium. Conventional antipsychotics are associated with EPSEs that may be more common in patients with mania than with schizophrenia. This favors the use of atypical antipsychotics in bipolar disorder. Several agents from this class (olanzapine, risperidone, ziprasidone, and aripiprazole) have been shown to be effective in acute mania. There is concern that the use of conventional antipsychotics in mania is followed by the development of depression. The pharmacological profile of certain atypical antipsychotics such as olanzapine and risperidone suggests that these drugs may have antidepressant actions. The use of olanzapine in mania is less likely than haloperidol to be followed by depression, and further treatment for one year can prevent affective recurrences. For bipolar depression, mood stabilization is also important in order to reduce the risk of mania developing when depression improves.

### No. 12C
### BIPOLAR DEPRESSION AND SUBSTANCE ABUSE: WHICH IS THE DRIVING FORCE?

Joseph F. Goldberg, M.D., *525 East 68th Street, Box 140, New York, NY 10021*

SUMMARY:

Depression and substance abuse comorbidity together represent two of the most virulent yet understudied aspects of bipolar illness. Dually diagnosed bipolar patients often have greater morbidity, heightened suicide risk, poorer treatment responses, and more extensive functional impairment than those with bipolar disorder alone. Advances in both basic science and neuropharmacology have begun to shed new light on the clinical and pathophysiologic mechanisms relevant for understanding and treating dual diagnosis bipolar patients.

This presentation will discuss common genetic and neurobiologic aspects of bipolar depression and substance abuse, alongside shared processes relevant to behavioral sensitization, mood dysregulation, craving, impulsivity, and sensation seeking. New data regarding current pharmacologic strategies will be reviewed, including the relative utility of anticonvulsants, atypical antipsychotics, antidepressants, and opioid antagonists. The presentation will conclude with a discussion of the combined pharmacologic and psychosocial strategies that may help to attenuate depressive symptoms and substance abuse as well as optimize mood stabilization.

### No. 12D
### A DISEASE MANAGEMENT STRATEGY FOR BIPOLAR DISORDER

Ellen Frank, Ph.D., *O'Hara Street, Pittsburgh, PA 15213-2593;* David J. Kupfer, M.D.; Holly A. Swartz, M.D.; Andrea Fagiolini, M.D.

SUMMARY:

Manic-depressive illness or bipolar I disorder is, in almost all cases, a chronic life-long condition. As such, it calls for the same kind of chronic disease management strategies that have proven successful in the management of other chronic medical conditions including asthma, diabetes, and hypertension. A less intensive, but similar approach may be indicated for patients with bipolar II disorder.

We have found that the treatment team approach is ideal for implementing a disease management strategy such as the one described below; however, the physician in solo practice or working in a setting where physician extenders are not available can certainly implement such a program alone. In our approach, members of the

treatment team work together to implement the nine essential elements of the disease management strategy. These elements are (1) education about bipolar disorder, (2) education about the medications used to treat bipolar disorder, (3) education about basic sleep hygiene, (4) careful review of the therapeutic effects of the patients' medication regimen, (5) careful review of any side effects the patient is experiencing, (6) medical and behavioral management of side effects, (7) identification of patient-specific early warning signs of impending episodes, (8) development of an early warning signs management plan, including 24-hour access to one clinician or the other or a knowledgeable member of their practice group, and (9) nonspecific support.

This presentation will focus on a detailed description of the nine elements of our bipolar disorder disease management program and present data on its efficacy in reducing both manic and depressive relapse in the context of a long-term clinical trial.

## No. 12E
## OPTIMIZING TREATMENT TO PREVENT RELAPSE

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

### SUMMARY:

Until recently, the efficacy of pharmacological agents in preventing relapse of mood episodes in bipolar disorder had been poorly studied. Lithium was the most well studied agent in randomized, controlled trials and most lithium studies were over two decades old. Moreover, several methodological problems thwarted attempts to examine the efficacy of newer putative mood stabilizers. Now the results of a number of new randomized, controlled clinical trials of lithium, divalproex, olanzapine, and lamotrigine provide important data regarding the efficacy of these agents in preventing relapse into manic and depressive episodes. These data also suggest, for the first time, that many patients have significantly lower relapse rates with combination therapy compared with mood-stabilizer monotherapy. Furthermore, recent studies suggest that mood stabilizers decrease the risk of manic and hypomanic switching by as much as 50% and that antidepressant discontinuation is associated with a significant risk of depressive relapse for many patients. The implications of the results of these randomized, controlled and naturalistic studies for clinical patients will be emphasized.

Combination therapy may increase the risk for medication side effects, which have been associated with poor treatment adherence, and, ultimately, an increased risk of relapse. Minimizing side effects and maximizing treatment adherence are important goals of long-term treatment.

### REFERENCES:

1. Berrettini WH: Molecular linkage studies of bipolar disorders. Bipolar Disorders 2001;3:276–283.
2. Narendran R, et al: Olanzapine therapy in treatment-resistant psychotic mood disorders: a long-term follow-up study. J Clin Psychiatry 2001; Jul;62(7):509–16.
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4. Swartz HA, Frank E, Kupfer DJ: Interpersonal and social rhythm therapy, in Mood Disorders: A Handbook of Science and Practice. Edited by Mick Power. John Wiley & Sons, Ltd., in press.
5. Keck PE, Jr, Manji HK: Current and emerging treatments for acute mania and long-term prophylaxis of bipolar disorder, in Neuropsychopharmacology: The Fifth Generation of Progress. Edited by Davis K et al. Lippincott Williams & Wilkins, NY, 2002, pp1109–1115.

# INDUSTRY-SUPPORTED SYMPOSIUM 13—REMISSION IN PSYCHIATRIC DISORDERS: DEFINITIONS, ISSUES, AND TREATMENTS
## Supported by Wyeth Pharmaceuticals

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to employ alternative definitions of remision, be familiar with recent data on differential effectiveness, and understand the need for longer trials.

## No. 13A
## PSYCHOSOCIAL FUNCTIONING IN DEPRESSION

Ivan W. Miller, Ph.D., *593 Eddy Street, Providence, RI 02903*

### SUMMARY:

This presentation will review the data concerning psychosocial functioning in depression. Current studies indicate that depressed patients manifest significant impairment in psychosocial functioning; that these impairments improve with treatment; but for many patients, even after clinical improvement, psychosocial functioning does not return to normal levels.

Following this review, inclusion of psychosocial measures in definitions of treatment response in depression will be discussed. Data from a NIMH-funded outcome trial of severely depressed patients will be used to illustrate the potential advantages of integrating symptomatic and psychosocial measures in assessing outcome in depression.

## No. 13B
## REMISSION IN MAJOR DEPRESSION: A FREQUENTLY ILLUSIVE GOAL

Alan F. Schatzberg, M.D., *401 Quarry Road, Stanford, CA 94305-5717*

### SUMMARY:

This talk reviews recent studies on achieving remission in major depression. A number of issues/questions are discussed: How was remission defined in a specific study? Was the definition post-hoc? Did trials utilize achieving remission as a targeted endpoint? Was duration of trial sufficiently long? Was dosage adequate? We then discuss pharmacological effects of specific antidepressants and review recent comparative studies on SSRIs vs. new-agent drugs with multiple pharmacological effects (e.g. dual-uptake inhibotors) with a critical eye as to whether these newer agents are more likely to result in achieving remission in patients with major depression. We present a strategy for designing studies to explore relative efficacy vis-a-vis remission. Clinical implications for future drug selection are discussed.

## No. 13C
## RESPONSE AND REMISSION IN GAD

Alan J. Gelenberg, M.D., *1501 North Campbell/PO Box 245002, Tucson, AZ 85724-5002*

### SUMMARY:

Characterized by chronic and uncontrollable worry, generalized anxiety disorder (GAD) is the most prevalent anxiety disorder. Its current, one-year, and lifetime prevalences are 1.5% to 3%, 3.3% to 5%, and 4% to 7%, respectively. The rate of lifetime comorbidity

is 90%, with other anxiety disorders and major depression extremely common. Symptoms was and wane, but full remission is uncommon (38% at five years), and relapses are common. Comorbidity worsens prognosis. GAD, which by current definition starts relatively late in life, requires long-term treatment. Modern antidepressants are superior to placebo for short- and long-term treatment. At least one antidepressant has shown long-term efficacy and rates of both response and remission that exceed placebo. Modern antidepressants are generally more tolerable than benzodiazepines, and also treat the frequently comorbid depression. Superior efficacy (i.e., remission as opposed to response) improves function, productivity, and quality of life.

## No. 13D
## REMISSION IN BIPOLAR DISORDER ACROSS THE LIFE SPAN

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

### SUMMARY:

Bipolar disorder (BD) is a chronic, relapsing illness, characterized by individuals often spending 20% of their life in manic or depressive episodes. Thus, after achieving remission, preventing relapse is crucial in treating BD in all age groups. One year after recovery, the rate of relapse in pediatric bipolar disorder has been estimated at 38%. For adults, the rate may be 48% after one year for pure mania and 72% after four years for any mood episode. Episodes of mixed states may last longer and reoccur sooner than those of pure depression or mania. Recent data are beginning to suggest the need for continuous treatment with mood stabilizers through euthymic periods and the use of adjunctive medications such as antidepressants or antipsychotics to maintain remission. Even after achieving remission, patients in euthymic states may have underlying cognitive or emotional deficits that place them at higher risk for future mood episodes. Therefore, psychotherapeutic and psychosocial interventions may be necessary to support pharmacologic efforts in maintaining remission.

We will review the known data regarding the natural course of bipolar disorder beginning in childhood and extending through the later adult years. Studies of maintenance treatment and relapse prevention in bipolar disorder in children, adolescents, and adults will be presented. Finally, we will summarize methods of achieving and maintaining remission in bipolar disorder across the life span.

## No. 13E
## RESPONSE AND REMISSION IN DEPRESSION: THE ACNP CONSENSUS REPORT

John A. Rush, M.D., *University of Texas, Department of Psychiatry, 5323 Harry Hines Boulvard, Dallas TX 75390-9086*

### SUMMARY:

The American College of Neuropsychopharmacology (ACNP) commissioned a Consensus Report on the topics of response, remission, and recovery as applied to major depressive disorder. This presentation will summarize these recommendations and their implications for conducting intervention trials and for clinical practice. This group considered the following issues:

1. Should day-to-day function be part of the definition of response, remission or recovery?
2. Is there a minimal period of time needed to declare response, remission or recovery?
3. What is meant by "minimal or no symptoms" to define remission?
4. How long should remission be present in order to declare recovery?
5. What level of symptoms results in loss of remission or recovery?

Answers to these questions were arrived at by examining the modest literature available and by consensus. The implications of these answers for the design and analysis of efficacy and effectiveness trials and for clinical practice will be discussed. Specific investigations to determine the validity of these questions will be presented.

### REFERENCES:

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3. Angst J, Sellaro R: Historical perspectives and natural history of bipolar disorder. Biol Psychiatry 2000;48(6):445–457.
4. Frank E, Prien R, Jarrett RB, et al. Conceptualization and rationale for consensus definitions of response, remission, recovery, relapse and recurrence in major depressive disorder. Arch Gen Psychiatry 1991;48:851–855.

# INDUSTRY-SUPPORTED SYMPOSIUM 14—BARRIERS TO OPTIMAL OUTCOME IN ANXIETY AND DEPRESSION
## Supported by GlaxoSmithKline

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be better able to develop and maintain therapeutic alliances, appreciate the effect of medication nonadherence on therapeutic outcome in the treatment of mood and anxiety disorders, understand the technology underlying controlled-release drug formulations, understand the need for and application of evidence-based medicine in the practice of psychiatry.

## No. 14A
## FROM MEDICATION NONCOMPLIANCE TO MEDICATION INTEREST: THE ART OF DISCUSSING MEDICATIONS WITH PATIENTS

Shawn C. Shea, M.D., *1502 Route 123 North, Stoddard, NH 03464*

### SUMMARY:

The foundation of successful treatment is medication adherence, and the cornerstone of this foundation is the quality of the patient-physician alliance. In this symposium, the delicate art of introducing medications, sharing concerns about side effects, and creatively resolving tensions about continuing medications is viewed as the arena from which the therapeutic relationship is ultimately forged.

The speaker will address the many factors that can transform a potentially oppositional relationship into a viable collaboration. The complex methods by which patients weigh the pros and cons of taking medications is examined in depth. How patients find answers to the following three questions is explored: (1) Does this drug make me feel better? (2) Is it worth it to me to take this drug? and (3) What does it say about me that I have to take this drug?

From an understanding of how patient's "wrestle with" and, ultimately, answer these questions, concrete examples of specific interviewing techniques for decreasing medication resistance are described. These flexible interviewing techniques are designed to decrease our patient's concerns about their medications while empowering them to realistically weigh their pros and cons—helping to transform medication nonadherence into medication interest.

## No. 14B
## CONTROLLED-RELEASE ANTIDEPRESSANT FORMULATIONS: ADVANTAGES AND LIMITATIONS

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

SUMMARY:

In recent years, new methods of drug delivery, including sustained or timed-release formulations of established psychotropic agents have been developed. These formulations were designed to blunt the variability in peak and trough concentrations associated with traditional, immediate-release technology and thereby to improve compliance and minimize treatment attrition. Despite the increased use of sustained-release formulations, few practitioners are familiar with the technologies used and many have questions about their impact on clinical practice.

The various technologies used in sustained-release formulations of antidepressants and anxiolytics will be described and compared. The benefits and limitations of these new drug delivery systems will be addressed. Attention will be given to such practical questions as to how and whether to switch from immediate-release formulations to sustained-release formulations, to the mg to mg equivalency of immediate- and sustained-release formulations, and whether the switch to a sustained-release formulation is associated with an alteration in drug half life, duration of therapeutic action, withdrawal, drug interactions, or use in hepatic or renal disease, or among the young and elderly. In addition, the clinical trial efficacy and safety data on the available controlled-release anxiolytics and antidepressants will be reviewed and critiqued.

## No. 14C
## AN EVIDENCE-BASED APPROACH TO CLINICAL TRIALS IN ANXIETY AND DEPRESSION

Flavio Kapczinski, Ph.D., *Rua Costa 30501, Porto Alegre, RS Brazil 900110-270*

SUMMARY:

Evidence-based medicine (EBM) is gaining acceptance in general medicine as a useful method of integrating the findings of randomized, controlled studies into clinical practice. EBM converts clinicians' need for information into answerable questions, identifies the best evidence needed to answer the questions, and critically appraises the information obtained. Information about patient care and outcomes is needed by general clinicians on average five times per inpatient stay and three times per out-patient clinic visit. There is no reason to believe that such needs should be different within the current standards of psychiatric care. The value of the information provided by EBM is clear when large data sets, such as those provided by clinical trials on anxiety and depressive disorders, are considered. This presentation will overview the principles of EBM and will demonstrate the application of EBM in assessing available data on SSRI and SNRI treatment of generalized anxiety disorder. A systematic review and meta-analysis was conducted using the Cochrane Collaboration format. SSRIs and SNRIs were compared, as a group, and individually, to placebo. Both SSRIs and SNRIs proved to be superior to placebo and presented a similar acceptability profile. No direct comparisons are available between SSRIs and SNRIs, which does not allow for a direct comparison of effect size between groups.

## No. 14D
## CASE-BASED APPROACH TO OPTIMAL OUTCOME IN DEPRESSION AND ANXIETY

Lori Calabrese, M.D., *1330 Sullivan Avenue, South Windsor, CT 06074*

SUMMARY:

There are several barriers that prevent patients from optimal outcome, and inhibit the degree to which they can return to their "best selves." This presentation will build on the first three in the symposium by discussing clinical pearls that can help psychiatrists in practice cultivate patient adherence and symptomatic remission despite diagnostic muddies, comorbid conditions, and multiple side effects. We will present case studies of two patients with complicated clinical presentations and discuss how to evaluate clinical symptoms, clarify the diagnoses for each, choose first-line treatments and dosing strategies, and manage the side effects that emerged during treatment.

REFERENCES:

1. Tasman A, Riba M, Silk K: The Doctor-Patient Relationship in Pharmacotherapy. The Guilford Press, New York, 2000.
2. Gumnick JF, Nemeroff CB: Problems with currently available antidepressants. J Clin Psychiatry 2000;61:5–15.
3. Sackett DL, Strauss SE, Richardson WS, Rosenberg W, Haynes RB: Evidence-Based Medicine—How to practice and teach EBM. Churchill Livingstone: New York, 2000.

# INDUSTRY-SUPPORTED SYMPOSIUM 15—NEW CHALLENGES IN THE MANAGEMENT OF DEPRESSION
## Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should demonstrate increased knowledge about managing depression across the spectrum of age ranges and treatment settings, including indentifying and managing depression in children; establishing collaborative relationships with primary care physicians; achieve rapid onset of antidepressant response and remission in adults; and improve quality of life in depressed elderly patients.

## No. 15A
## SOLVING THE CONUNDRUM OF CHILDHOOD DEPRESSION

Karen D. Wagner, M.D., *301 University Boulevard, Galveston, TX 77550-0188*

SUMMARY:

Depression in children and adolescents is a serious clinical disorder that adversely affects children's social, emotional, and academic functioning. Depression in youth poses a number of significant diagnostic and treatment challenges for clinicians. In young children, an episode of depression may be a harbinger of bipolar disorder. Depression in teenagers who exhibit irritable mood may be missed by clinicians, since it may be attributed to a developmental phase rather than a disorder. Children who are depressed often have depressed parents, which may complicate the child's clinical course and treatment response. Recently, selective serotonin reuptake inhibitors have been shown to be effective in treating childhood depression; however, there is limited information for clinicians about other antidepressants and combination treatments. Preventing depression in children at high risk for depression is another area of clinical need. This presentation will focus on clinical challenges related to diagnostic issues, clinical course, parental depression, treatment, and prevention strategies for depression in children and adolescents.

## No. 15B
## ACHIEVING RAPID-ONSET OF ACTION AND REMISSION IN DEPRESSED ADULTS

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

SUMMARY:

The delay in onset of action of antidepressants is a frequent patient complaint and a significant deterrent to patient compliance. Emerging data suggest that clinically and statistically significant reduction of symptoms of depression may be achieved with several of the newer generation antidepressants. This may help to address some of the concerns with regard to onset of action. Another significant problem in the acute treatment of depression is achieving remission rather than simply a response to treatment. A rationale for achieving remission will be presented as well as new data on remission rates of the antidepressants. Hopefully this will enable the clinician to improve compliance and treatment of patients suffering from depression.

## No. 15C
## TICKLING THE BRAIN: ADVANCES IN ANTIDEPRESSANT BRAIN STIMULATION TECHNIQUES

Mark S. George, M.D., *67 President Street, Room 502 North, Charleston, SC 29425-0720*

SUMMARY:

Functional brain imaging studies have revealed how the brain regulates mood, and have shed light on what may be going wrong in depression. Developing in tandem with these brain imaging advances are a host of new ways of stimulating brain circuits-tickling the brain. All of these techniques have either been proven to treat depression, or theoretically might help alleviate depressive symptoms. For example, electroconvulsive therapy (ECT) remains the most effective treatment for resistant depression. New studies are refining the way it is delivered, and are helping to understand how it works. Recently scientists have discovered how to cause an ECT-like seizure with powerful magnets-a technique called magnetic seizure therapy (MST). There is also now a large literature on stimulating the prefrontal cortex to treat depression, and not causing a seizure, using transcranial magnetic stimulation (TMS). Finally, there are two more-invasive stimulation techniques called vagus nerve stimulation (VNS) and deep brain stimulation (DBS). These treaments are daily helping to treat epilepsy and Parkinson's Disease, respectively, and have shown potential as antidepressant treatments. This talk summarizes the latest developments stressing both the promise, and the limitations, of these new technologies. Brain electrical stimulation techniques will likely play an ever-expanding role in psychiatric therapeutics, both as stand-alone treatments but more likely in combination with medications.

## No. 15D
## ENHANCING COLLABORATION BETWEEN THE PRIMARY CARE PHYSICIAN AND THE PSYCHIATRIST

Larry Culpepper, M.D., *Dowling 5S, 1 Boston Medical Center Place, Boston, MA 02118*

SUMMARY:

Many patients are referred to psychiatrists for the treatment of depression after being initially diagnosed in primary care. Frequently this involves patients with hard-to-treat, resistant, or atypical depression. Patients who require non-pharmacological treatments are also often referred. An understanding of the conventional treatment of depression in primary care by the psychiatrist may assist in the further treatment of the depressed patient. For example, primary care physicians may be less likely to treat off label, and are additionally unlikely to try antidepressant drug combinations or to use supplemental drug therapies. The primary care physician may also be more likely to discontinue drug therapy early, due to a lack of understanding of delays in antidepressant response. This could lead to the erroneous conclusion that a specific medication was ineffective in that patient. This talk will discuss how primary care physicians treat depressed patients, including how they determine when to refer to a psychiatrist. Strategies for developing an interactive relationship between psychiatrist and primary care physician, which allow for optimal treatment of the depressive illness, will also be reviewed.

## No. 15E
## MAINTAINING QUALITY OF LIFE IN THE ELDERLY

Steven P. Roose, M.D., *722 West 168th Street, New York, NY 10032*

SUMMARY:

When treating depression in the elderly, many factors must be considered, including the frequent coexistence of dementia, bereavement, and medical illness. Concomitant medical illness can greatly exacerbate depression, and can itself be exacerbated by depressive illness. Medical comorbidity can also cause complications due to the coadministration of several medications. In the depressed elderly, as in other populations, response to MAOIs and tricyclics has been observed; however, these medications have been known to cause many side effects and drug interactions. Newer treatments may provide a better choice for this population, particularly those with a low potential for interaction with P450 enzymes and receptors associated with side effects. Medications may have different efficacy in elderly patients compared with the younger populations in which clinical trials are most commonly conducted. In addition, the necessary duration of antidepressant therapy in the elderly patient needs to be evaluated and understood. Finally, the problem of sexual dysfunction in the elderly may contribute to the incidence of depression. Because antidepressants are often associated with sexual side effects, the treating clinician needs to anticipate the problem of sexual dysfunction, and understand possibilities for addressing it.

REFERENCES:

1. Wagner KD, Wohlberg C: Efficacy and safety of sertraline for treatment of pediatric major depression disorder. New Research Abstracts, American Psychiatric Association 2002;327:89.
2. Nemeroff CB, Entsuah AR, Kunz NR: Remission Rates During Long-Term of Depression Venlafaxine. APA Annual Meeting 2002.
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# INDUSTRY-SUPPORTED SYMPOSIUM 16—ISSUES IN TREATING MANIA: ACUTE AND CONTINUATION PHASE
## Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will be familiar with treatment options and strategies useful over the first

several months for management of patients with manic or mixed episodes.

## No. 16A
## MANAGING ACUTE MANIA IN THE EMERGENCY ROOM

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

SUMMARY:

Mania accounts for one in seven psychiatric emergencies and is among the most challenging presentations. A number of target symptoms place patients at risk. Manic patients are usually hyperactive, frequently engaging in risky behaviors. They can be intrusively gregarious and sexually provocative. They may feel invulnerable and underestimate the consequences of their behavior. Decreased need for sleep increases their exposure. While sometimes surprisingly agreeable, they can be very irritable and have a history of violence. The aggressiveness of bipolar women, in particular, is often underestimated. Substance abuse aggravates mania and increases the frequency of hospital visits.

Oral treatment is preferred and patients will usually assent to oral medication presented in an assertive fashion. However, bipolar patients often lose insight into their illness in the manic phase.

This presentation will describe an intensivist approach to the management of mania. An episode will be divided into termination of the emergency and induction of acute treatment. Both oral and parenteral strategies will be discussed, considering varying degrees of diagnostic confidence, cooperation, bipolar subtype, and comorbidity.

## No. 16B
## PHARMACOLOGICAL OPTIONS FOR THE TREATMENT OF PEDIATRIC MANIA

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

SUMMARY:

The lifetime prevalence of pediatric bipolar disorders is estimated at 1%. However, children and adolescents with bipolar disorder are difficult to diagnose and treat because they commonly present with rapid cycling or in mixed states and with co-occurring attention-deficit/hyperactivity disorder (ADHD). Currently, manic youth are typically treated with pharmacological agents, such as divalproex and lithium, which have demonstrated efficacy based on studies of manic adults. However, over half of manic children and adolescents fail to respond to initial treatment with mood stabilizer monotherapy. Therefore, alternative pharmacological options are necessary.

Controlled investigations of atypical antipsychotics suggest they are effective for the treatment of adult mania. More recently, we have completed a study that indicates quetiapine in combination with divalproex is more effective for the treatment of adolescent bipolar mania than divalproex alone. Additionally, our results suggest that quetiapine is well tolerated when used in combination with divalproex for the treatment of mania. We will review data from this and open-label investigations of other atypical antipsychotics and new antiepileptic agents in the treatment of pediatric mania. Additionally, we will discuss strategies for the treatment of pediatric mania and comorbid ADHD.

## No. 16C
## APPROACHES TO THE TREATMENT OF MANIA

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

SUMMARY:

The application of new pharmacotherapies for the treatment of mania has prompted a reevaluation of traditional approaches to this aspect of bipolar disorder. Such a reevaluation is apparent in the American Psychiatric Association's recently revised guidelines for the treatment of bipolar disorder. The presenter will discuss the strengths and limitations of data from controlled clinical trials in mania, and the ways in which they can contribute to an evidence-based approach to treatment. In particular, studies of newer anticonvulsants and atypical antipsychotics will be reviewed, and comparative data with older interventions discussed.

## No. 16D
## FAMILY INTERVENTION AND PHARMACOTHERAPY IN THE POST-EPISODE PHASE OF BIPOLAR

David J. Miklowitz, Ph.D., *Muenzinger Building Room D244, Boulder, CO 80309;* Jeffery Richards; Elizabeth George

SUMMARY:

Although drug treatment is the primary means of stabilizing an acutely ill bipolar patient, new evidence suggests adjunctive psychotherapy may help prevent relapse and reduce symptom fluctuations. Family-focused psychoeducational treatment (FFT) is one of several empirically supported methods to increase resiliency during the post-episode period. It consists of 21 outpatient sessions delivered in three modules: psychoeducation about bipolar disorder, communication training, and problem-solving skills training. A randomized trial at the University of Colorado involved 101 adult bipolar I patients who, following an episode of mania or depression, received FFT with medication or a treatment-as-usual intervention (crisis management) with medication. FFT led to longer survival intervals and less severe ongoing symptoms than crisis management. Patients in FFT were also more complaint with medications. A second randomized trial at UCLA (N = 53) found that, over two years, FFT and medications were associated with lower rates of re-hospitalization and symptom relapse than individual therapy and medications. Preliminary results from an open trial at Colorado suggest that family psychoeducation may help stabilize adolescent bipolar patients who are taking mood medications. Discussion will focus on mechanisms of action of family interventions and how to adapt these interventions to community mental health settings.

## No. 16E
## IDENTIFYING SUICIDAL BEHAVIORAL AND AT-RISK PATIENTS

Gary S. Sachs, M.D., *50 Staniford Street, Suite 580, 5th Floor, Boston, MA 02114*

SUMMARY:

Suicide is a complication of a psychiatric disorder that requires additional risk factors because most psychiatric patients never attempt suicide. Major depression and suicide are associated with fewer serotonin transporter (5-HTT) sites. A diffuse reduction of 5-HTT binding in the prefrontal cortex (PFC) of individuals with major depression may reflect a widespread impairment of serotonergic function consistent with the range of psychopathologic features in major depression. Numerous abnormalities have been found in the serotonergic system in suicide attempters and completers. A stress-diathesis model for suicidal behavior has been proposed to assist clinicians in determining which patients are at risk. Once high-risk patients are identified, their suicide risk can be managed through treatments such as prophylactic lithium treatment and other pharmacologic approaches.

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4. Miklowitz DJ, Simoneau TL, George EL, Richards JA, Kalbag A, Sachs-Ericsson N, Suddath R: Family-focused treatment of bipolar disorder: one-year effects of a psychoeducational program in conjunction with pharmacotherapy. Biol Psychiatry 2000;48:582–592.

# INDUSTRY-SUPPORTED SYMPOSIUM 17—TRICKS OF THE TRADE IN THE LONG-TERM TREATMENT OF DEPRESSION
## Supported by Organon Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize and manage factors complicating treatment of depression.

## No. 17A
## CLINICAL MANAGEMENT OF PSYCHIATRIC COMORBIDITIES

R. Bruce Lydiard, M.D., *1 Poston Road, Suite 150, Charleston, SC 29407*

SUMMARY:

Psychiatric comorbidity in patients with depression is more the rule than exception. Approximately 40% of patients with depression suffer from an anxiety disorder, and over two thirds experience significant symptoms of anxiety. These comorbidities affect response to treatment, clinical course, and long-term management. This presentation will review recent data on psychiatric comorbidities in depression, and will offer evidence-based practical strategies for the clinical management of these complications in long-term treatment.

## No. 17B
## SEXUAL DYSFUNCTION IN DEPRESSION

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

SUMMARY:

Side effects to antidepressant medications often limit the dose and duration of treatment, potentially leading to relapse of depressive symptoms. Long-term adverse effects may interfere with quality of life if patients adhere to the prescribed treatment regimen. Sexual dysfunction may be a symptom of depression, or may result from antidepressant therapy. At least 37% of patients treated with newer antidepressants experience significant, global sexual dysfunction, which may represent either a residual symptom of depression or a side effect of the antidepressant. Risk factors for sexual dysfunction with antidepressant use 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, are taking a higher daily dose of the antidepressant, use any concomitant medication, have a comorbid illness known to cause sexual dysfunction, with a prior history of antidepressant-induced sexual dysfunction, or have poor lifelong psychosexual adjustment. Identification of risk factors, and prescription of an antidepressant with few negative effects on sexual functioning may avoid the problem. Strategies to manage sexual dysfunction associated with antidepressant medications include modification of the medication dose, drug holidays, use of antidotes/adjunctive agents, or antidepressant substitution. Addressing the problem of antidepressant-induced sexual dysfunction may enhance medication compliance, with resulting maintenance of remission and improved quality of life.

## No. 17C
## SLEEP CHANGES DURING LONG-TERM TREATMENT WITH ANTIDEPRESSANTS

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

SUMMARY:

Sleep disturbances are common long-term side effects of treatment with antidepressants. For example, in a six-month follow-up of selective serotonin reuptake inhibitor (SSRI) treatment, insomnia and somnolence were reported as early onset, persistent side effects in 9% and 6% of patients, respectively; and as late-onset side effects in 4% and 3% of patients, respectively. In evaluating sleep disturbances during long-term treatment with antidepressants, clinicians should consider the possibility that these may be residual symptoms of depression, prodromal symptoms of relapse, or the result of concomitant substance abuse. Change in dosing schedule can be a valid means of managing both insomnia (by shifting the timing of antidepressant administration to early in the morning) and hypersomnia (by shifting to bedtime dosing) caused by antidepressants. Other sleep hygiene measures (e.g., avoiding daytime napping) can also help manage insomnia. On the other hand, many adjunctive drug treatments have been used to manage insomnia: sedating antidepressants (e.g., mirtazapine, trazodone, nortriptyline), benzodiazepines, zolpidem, zaleplon, or sedating antihistamines. For patients with hypersomnia, augmentation with psychostimulants, modafinil, activating antidepressants (e.g., bupropion, protriptyline), or dopaminergic agents appear to be potentially helpful. Familiarity with the complex interaction among sleep, depression, and antidepressant medications may help clinicians select agents that best suit the needs of individual patients.

## No. 17D
## ANTIDEPRESSANT-INDUCED COGNITIVE CHANGES AND APATHY: ARE THERE ANY ANTIDOTES?

Jerrold F. Rosenbaum, M.D., *15 Parkman Street, ACC 812, Boston, MA 02114*

SUMMARY:

Among the most consistently reported long-term complaints to clinicians by patients on antidepressants, particularly SSRIs, in addition to changes in sexual function, are subtle and diagnostically elusive concerns that mimic but are apparently not depressive symptoms but still affect quality of life. These symptoms include changes in motivation and drive, changes in perceived cognitive performance and attention, and complaints of mental slowing or memory dysfunction. Objective study of these changes, occurring as they tend to over the long term, variably, and in a minority of patients, is rare and even neuropsychological testing is unlikely to identify a specific dysfunction. Nonetheless, the familiarity of these reports to clinicians suggests they merit our attention; moreover, therapeutic strategies

aimed at addressing these symptoms are often dramatically beneficial, underscoring the importance of recognition. Examples of these strategies include the reported salience of noradrenergic and dopaminergic agents in reversing apathy and attentional difficulties and the use of cholinergic agents to address complaints of memory difficulties. The possible neurobiological bases for these symptoms and the array of therapeutic options and strategies to address them will be reviewed in this presentation.

## No. 17E
## PRACTICAL APPROACHES TO ANTIDEPRESSANT-INDUCED WEIGHT GAIN

David L. Ginsberg, M.D., *530 First Avenue, Suite 7D, New York, NY 10016*

### SUMMARY:

Weight gain is a relatively common problem during both acute and long-term treatment with antidepressants. When clinically significant, such weight gain may increase the risk for medical complications such as diabetes, cardiovascular disease, respiratory problems, and some forms of cancer. Moreover, undesired weight gain is an important contributing factor to noncompliance with pharmacotherapy and may add to the burden of preexisting depression. Thus, clinicians should consider this issue in the relative risks and benefits of proposed treatments.

Until recently, assessing the relative risk for weight gain with antidepressants has been limited by the paucity of controlled studies and by numerous methodologic limitations. The comparative effects of antidepressants on weight, both acutely and chronically, will be reviewed. While the mechanisms by which antidepressants result in weight gain are not well understood, they presumably involve increased energy intake, decreased energy expenditure, or a combination. Preliminary evidence suggests that there are differences among antidepressants in how they result in weight gain. Patient-specific factors are also important but even less well studied.

An understanding of the relative propensities of antidepressants to cause weight gain is important for rational drug selection or switching strategies. In addition, adequate consideration of patient risk factors and the mechanisms by which the various drugs cause weight gain can form the basis for strategies to prevent or minimize this adverse effect. In cases where a medication with weight-gaining liability is the most efficacious for a particular patient, adjunctive treatment is appropriate. This would include behavioral interventions like diet and exercise or augmentation with other drugs. These pharmacological approaches for weight loss in patients with antidepressant-associated weight gain will be reviewed in detail with a focus on practical value to clinicians.

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# INDUSTRY-SUPPORTED SYMPOSIUM 18—PHARMACOLOGICAL TREATMENT OF CHRONIC PAIN: COMORBIDITY WITH DEPRESSION AND OTHER PSYCHOTIC DISORDERS
## Supported by Eli Lilly and Company

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to use an understanding of physiology to diagnose and select rational pharmacotherapy of chronic pain.

## No. 18A
## PSYCHIATRIC COMORBIDITY AND OTHER COMORBIDITIES ASSOCIATED WITH CHRONIC PAIN

David Fishbain, M.D., *600 Alton Road, Miami Beach, FL 33139*

### SUMMARY:

Recent psychiatric research has shown that rather than "cause" chronic pain (CP), psychiatric comorbidities are commonly found in association with CP. These comorbidities affect how the chronic pain patient (CPP) copes with CP. This presentation will delineate the psychiatric comorbidities (affective disorders, suicidal behavior, anxiety syndromes, substance-related disorders, somatoform disorders) commonly found in association with CP and their prevalence. In addition, the importance of "other" comorbidities (myofasical pain syndrome, secondary gain, malingering, sleep disorder, headache, anger/grief over job loss, organic diagnosis elusive, violent ideation) to the understanding of the CPP will be presented and discussed.

## No. 18B
## THE NEUROBIOLOGY OF PAIN

Edward C. Covington, Jr., M.D., *9500 Euclid Ave, Cleveland, OH 44195-0001*

### SUMMARY:

New findings concerning the physiology of pain reveal that older concepts falsely imply a fixed stimulus: perception relationship. Pain is more a creation of the CNS than a gauge of stimulation. Some symptoms considered functional reflect spinal cord events. Unexplained pain may reflect remote events, as pain induces progressive CNS changes. The concept of chronic pain as prolonged acute pain is invalid. Effective treatment of acute pain may mitigate chronic pain.

The pain system normally serves a warning function. When suppressed, it permits function despite injury. It may be sensitized, promoting protection of injured parts, and it may be reorganized, in which cells die, new terminals appear, and synapses are modified. This presentation will discuss:

- Pain modulatory mechanisms and implications for therapeutic intervention.
- Hyperalgesia, changes in dorsal horn circuitry, and sensitization.
- Sensitization phenomena that involve peripheral afferents, DH, thalamus, and cortex.
- The role of inflammatory substances in producing neuropathic-like pains.
- Mechanisms of sympathetically maintained pain.
- Functional and structural neurological changes that follow sensory nerve damage or prolonged stimulation.

• Structures for pain facilitation and inhibition and their influence by opioids and tricyclics.
• The role of glia, once considered "glue," in pain perception.

## No. 18C
## ADJUVANTS AS ANALGESICS: MECHANISM-BASED PHARMACOTHERAPY IN PAIN MEDICINE

Rollin Gallagher, M.D., *1800 Lombard Street, 1st Floor, Philadelphia, PA 19146*

### SUMMARY:

Psychotropics are analgesic. Analgesics are psychotropic. The neuropharmacology of pain perception and modulation now blurs this distinction. A decade ago rational pharmacotherapy, based on the WHO ladder of pain severity, included only opioids, acetomenophen, and NSAIDs as analgesics, whereas psychotropics and anticonvulsants were considered "adjuvants." Now all may claim the title "analgesic" based on mechanism of action—on how classes affect the neurophysiology of pain processing and, within each class, on highly individualized receptor affinities and pharmacokinetics. Thus, practical pharmacotherapy of chronic pain and its comorbidities has evolved dramatically. As we define specific mechanisms for pain, we choose our medications and treatments accordingly. Thus, activity at sodium and calcium channels and various receptors such as glutamate, norepinephrine, and serotonin may be targeted mechanisms. Frequently more than one mechanism is involved in pain, so often we prescribe medication from two or more classes—if we treat common psychiatric comorbidities as well, selection becomes more complex. While balancing symptom relief and side effect and toxicity burden, medication may be rationally combined (although combinations of medications have yet to be studied due to the high cost incurred by such complex methodologies) with other pain treatments, to achieve the dual goals of controlling pain and improving physical and psychosocial functioning. Combinations of medications need study if we want to convert from art to evidence-based pain medicine.

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## No. 18D
## PAINFUL PHYSICAL SYMPTOMS AND DEPRESSION: TREATMENT WITH 5HT/NOREPINEPHRINE ANTIDEPRESSANTS

Michael J. Detke, M.D., *Lilly Corporate Center DC 2206, Indianapolis, IN 46285*

### SUMMARY:

Pain is both a common symptom of major depression and a common comorbidity with a complex causal relationship. Tricyclic antidepressants have long been known for their efficacy in chronic, especially neuropathic, pain. Their analgesic effects are likely mediated by dual 5HT and NE reuptake inhibition. SSRIs have been studied in pain disorders as well and found less effective. More recently, novel agents have been developed that re-create the dual 5HT and NE reuptake inhibition of some TCAs without the limitations on safety and tolerability. These include veniafaxine, minacipran, and duloxetine. Data for the effectiveness of antidepressants in the treatment of pain disorders will be reviewed. This will be supplemented with data demonstrating the effectiveness of one of the newer agents, duloxetine, in the treatment of the painful physical symptoms of depression. In addition, there will be some review of the thesis that treatment of both the emotional and physical symptoms of depression may lead to better overall patient outcomes. Finally, new data on the effectiveness of duloxetine in painful disorders will be presented.

## No. 18E
## THE USE OF OPIOID ANALGESICS FOR CHRONIC PAIN: CONTROVERSIES AND CHALLENGES

Steven A. King, M.D., *301 East 17th Street, Room 1029, New York, NY 10003*

### SUMMARY:

Opioid analgesics are a mainstay of the treatment of many types of pain. Though the safety and efficacy of their use for acute pain in postoperative and traumatic pain and for cancer-related pain have long been accepted, the use of these medications for the management of chronic pain remains controversial. The current literature indicates that many patients with chronic pain may benefit from opioids. However, there are patients who do not respond to them and some who develop new problems related to their use. Physicians are not only concerned about the possible negative effects opioids can have on patients but also the potential for being sanctioned by state and federal authorities if they prescribe opioids for patients with chronic pain. Many of these concerns are often related to confusion about the various terms that are employed to describe the use and misuse of these drugs and uncertainty about the frequency with which problems occur when they are prescribed for legitimate medical purposes.

This presentation will review guidelines for the therapeutic use of opioids for patients with chronic pain and the terminology related to these drugs including abuse, addiction, dependence, and pseudoaddiction. Methods for maximizing the benefits of these medications for patients while minimizing the risk of potential legal problems for the physicians who prescribe them will be discussed.

## No. 18F
## ADJUVANT ANALGESICS: EFFICACY EVIDENCE FOR THE TREATMENT OF NEUROPATHIC PAIN

David Fishbain, M.D., *600 Alton Road, Miami Beach, FL 33139*

### SUMMARY:

In recent years research evidence has indicated that neuropathic pain (NP) is commonly found in cancer patients with chronic pain and patients with benign chronic nonmalignant pain. This presentation will describe how a physician can diagnose NP. In addition, this presentation will review the latest evidence for the efficacy of various psychopharmacological agents in the treatment of NP. This will include the following: non-steroidal anti-inflammatories, acetaminophen, antidepressants, anticonvulsants, benzodiazepines (clonazepam), gabanergic agents, local anesthetics, NMDA receptor antagonists, opioids, and topical agents (ASA, clonidine, capsaicin, lidocaine patch). Finally, evidence for superior efficacy of some agents over others for the treatment of NP will be reviewed.

# INDUSTRY-SUPPORTED SYMPOSIUM 19—STRESS, PSYCHOPATHOLOGY, AND THE BRAIN: NOVEL INTERVENTION STRATEGIES
## Supported by Wyeth Pharmaceuticals

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the relationship between stress and psychopathology; the basic mechanisms underlying vulnerability for stress; principles of gene therapy and how they may be used in the future; and understand potential new treatments for depression and anxiety-blockade of cortisol and CRF receptors.

## No. 19A
## OVERVIEW OF THE RELATIONSHIP BETWEEN STRESS, DEPRESSION, AND ANXIETY

Christine Heim, Ph.D., *1256 Briarcliff Road, Room 427, Atlanta, GA 30322*

### SUMMARY:

There is now considerable evidence that one or more genetic liabilities and stressful experiences interact in determining individual vulnerability to depression and anxiety. In particular, a preeminent role of early adverse experiences in the development of depression and anxiety has been documented in case-control, epidemiological, and twin studies. The manifestation of depression and anxiety disorders in adulthood is often mutually related to acute or chronic stress. Alterations of central nervous system circuits integrally involved in the regulation of stress and emotion may represent the underlying biological substrate of an increased vulnerability to develop depression and anxiety in relation to stress. Specifically, increased corticotropin-releasing factor (CRF) neuronal activity is believed to mediate the relationship between stress, depression, and anxiety. Preclinical studies suggest that CRF hyperactivity and sensitization of the stress responses occur as the persisting effects of stress during development. Similar findings are emerging from clinical studies. The concatenation of these findings suggests that genetic disposition coupled with early stress in critical phases of development shape a neurobiologically vulnerable phenotype with a lowered threshold to develop depression and anxiety upon further stress exposure. This pathophysiological model may provide novel approaches to the prevention and treatment of depression and anxiety.

## No. 19B
## THE POTENTIAL FOR GENE THERAPY IN THE TREATMENT OF STRESS AND RELATED DISORDERS

Robert Sapolsky, Ph.D., *Gilbert Lab/MC 5020, Stanford, CA 94305-5020*

### SUMMARY:

Along with all branches of the life sciences, neurobiology has been deeply affected by the genomic revolution. One outcome of this has been the growing possibility of using gene therapy techniques to alter neuronal function. In this symposium, I will review the basics of neuronal gene therapy and give an overview of the realm in which there has been the most progress, namely using these approaches to spare neurons from death in response to necrotic or neurodegenerative diseases. More than two dozen different genes have been used in vector systems to spare neurons from death in models of neurological diseases, and the first clinical trials with humans are now being conducted.

This progress has made it possible to consider using gene transfer techniques to address more subtle issues, namely, altering neuronal function. I will then review recent work from my group harnessing gene therapy approaches to alter the neuronal response to stress. These studies show that it is possible to block the deleterious neuronal effects of some of the hormones of the stress response, and to even convert some of these endangering effects into beneficial ones.

## No. 19C
## THE BIOLOGY OF STRESS AND VULNERABILITY

Michael Meaney, Ph.D., *6875 Lasalle Boulevard, Montreal, Quebec, Canada H4H1R3*

### SUMMARY:

Maternal care during the first week postpartum regulates hippocampal glucocorticoid receptor (GR) gene expression throughout the life of the offspring, an effect that is accompanied by enduring changes in hypothalamic-pituitary-adrenal (HPA) function under conditions of stress. Increased maternal licking/grooming stimulates the release of serotonin (5-HT) at the level of the hippocampus and this effect appears to be obligatory for that on GR expression. Maternal licking/grooming also stimulates increased expression of the transcription factors NGFI-A (aka egr-1, zif268, etc.) in hippocampal neurons and the effect is blocked by 5-HT7 receptor antagonists and is mediated by increased activation of the cAMP pathway. In vitro, 5-HT increases GR expression in hippocampal neurons and the effect is blocked by 5-HT7 receptor antagonists, or by co-administration of antisense oligonucleotides targeting NGFI-A. Maternal licking/grooming also increases the binding of NGFI-A and AP-2 to its consensus sequences on a region of the promoter for the human GR gene. Finally, in collaboration with Moshe Szyf (McGill University), we found hypomethylation of DNA sites associated with the NGFI-A binding region on a promoter for rat hippocampal GR. This same promoter sequence is differentially expressed in hippocampal samples from mother that show high versus low levels of pup licking/grooming. Together, these findings suggest that maternal care produces sustained structural changes in the regulatory region for the rat GR gene leading to long-term changes in gene expression, which then form the basis for sustained individual differences in stress responses.

## No. 19D
## NOVEL PHARMACOLOGICAL STRATEGIES TO TREAT STRESS-RELATED PSYCHOPATHOLOGY AND MEDICAL ILLNESSES

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

### SUMMARY:

It is well documented that stress exposure can lead to the development of psychopathology as well as other medical disorders. Cortisol, the major stress hormone released with activation of the HPA axis, may play a pathophysiological role in diabetes, obesity, hypertension, osteoporosis, depression, and memory dysfunction. The effects of cortisol on brain function are mediated by mineralocorticoid and glucocorticoid receptors. Evidence suggests that overactivity of the HPA axis occurs in depression and this is particularly prominent in psychotically depressed individuals. Data will be presented demonstrating that the use of drugs that antagonize brain glucocorticoid receptors can rapidly decrease psychotic symptoms in these patients. Corticotrophin-releasing factor (CRF) is a neuropeptide in the brain that not only regulates the stress-induced activation of the HPA axis, but also mediates the behavioral and autonomic changes associated with stress. Data from animal studies will be presented that support

a role for CRF receptors in mediating anxiety, depression, irritable bowel syndrome, and cardiovascular disease. In addition, data from early clinical trials will be presented that support a role for the use of CRF antagonists in the treatment of depression. Finally, the possibility of using SSRIs and SNRIs as preventive strategies in individuals who are hyperresponsive to stress will be discussed.

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1. Arborelius L, Owens MJ, Plotsky PM, Nemeroff CB: The role of corticotropin-releasing factor in depression and anxiety disorders. J Endoctinol 1999;160(1):1–12.
2. Sapolsky R, Steinberg G: Gene therapy for acute neurological insults. Neurology 1999;10:1922.
3. Meaney MJ: Maternal care, gene expression and the development of individual differences in stress responses. Annual Reviews of Neuroscience 2002, 1161–1192.
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# INDUSTRY-SUPPORTED SYMPOSIUM 20—DEPRESSION, APATHY, AND FATIGUE IN NEUROPSYCHIATRIC DISORDERS

**Supported by Cephalon Inc.**

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to distinguish between and provide the differential diagnoses and intervention options for, daytime fatigue, apathy, and excess daytime sleepiness in patients with psychiatric disorders.

## No. 20A
## DISORDERS OF MOTIVATION: THE THIRD DOMAIN OF PSYCHOPATHOLOGY

Robert S. Marin, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213*

### SUMMARY:

The aim of this presentation is to describe the conceptual foundation for disorders of motivation and to use apathy to illustrate the heuristic value of motivation for understanding and managing disorders of motivation. Motivation is a third domain of psychopathology, potentially comparable in importance to the more familiar domains of cognition and emotion. Motivation refers to the structure of goal-directed behavior and includes those factors that account for its direction, intensity, initiation, and persistence. Disorders of motivation are subclassified by the presence of increased motivation, decreased motivation, and dysregulation of motivation. Apathy, which means diminished activity due to lack of motivation, is a model disorder of diminished motivation. Apathy has validity as a symptom, a syndrome, and a dimension of behavior. The phenomenology of apathy exemplifies the terminology of disorders of motivation: lack of initiative, impersistence, goallessness, perseveration, lack of drive or energy, and diminished emotional responsiveness to goal-related events (shallow affect). Apathy has a unique differential diagnosis, which includes depression, dementia, demoralization, aprosodia, catatonia, psychomotor retardation, and akinesia. Empirical studies over the last 10 years indicate that apathy can be discriminated from depression and that it has disease-specific correlates and mechanisms, e.g. in stroke, Parkinson's disease, Alzheimer's disease, and AIDS. Experience to date, though limited, indicates many ways in which knowledge of apathy and related disorders of diminished motivation benefits assessment and management.

## No. 20B
## FATIGUE AND DEPRESSION IN CANCER AND AIDS

William Breitbart, M.D., *1242 Second Avenue, Box 421, New York, NY 10021-6007*

### SUMMARY:

The assessment and diagnosis of fatigue in cancer/AIDS can be facilitated by the use of newly developed ICD-10 criteria. Differentiating fatigue from depression can also be challenging. These two issues will be reviewed.

The treatment of cancer-related fatigue is multimodal and multidisciplinary, involving patient and family education, treatment of the causes of fatigue, treatment of fatigue directly, and management of the consequences of fatigue. Treatments aimed at countering fatigue directly and nonspecifically include nonpharmacologic and pharmacologic interventions. The mainstay of pharmacologic interventions aimed at treating cancer-related fatigue directly and nonspecifically are the psychostimulant drugs (e.g., methylphenidate, pemoline). In this presentation, Dr. Breitbart will report on the first double-blind, randomized, placebo-controlled trial of psychostimulants for the treatment of fatigue in an AIDS population, which demonstrates the efficacy and safety of psychostimulants. Recommendations for the use of psychostimulants in treating cancer-related fatigue will be presented.

## No. 20C
## APATHY IN NEUROPSYCHIATRIC DISORDERS

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

### SUMMARY:

Apathy is a common, disabling, under-recognized, and undertreated aspect of neuropsychiatric disorders. Apathy is common in Alzheimer's disease (70%), frontotemporal dementia (90%), dementia with Lewy bodies (70%), and progressive supranuclear palsy (90%). It is less common in Parkinson's disease (40%) and corticobasal degeneration (40%). Apathy has specific identification in standard psychotic nomenclature such as DSM-IV. Apathy occurs in patients with depression but also occurs in the absence of depression and the two do not have the same clinical and neurobiologic correlates. Apathy correlates with cognitive impairment, especially executive dysfunction and decline in activities of daily living. Disturbed function of anterior cingulate cortex and related subcortical structures is the most common associated neurobiologic abnormality. Atypical antipsychotics, activating antidepressants, psychostimulants, dopaminergic agents, and cholinesterase inhibitors may improve apathy.

## No. 20D
## DEPRESSION, FATIGUE, AND EXCESSIVE DAYTIME SLEEPINESS IN SLEEP DISORDERS

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

### SUMMARY:

Somnolence is a common complaint in psychiatric patients. Symptoms of sleepiness or fatigue can masquerade as mood or cognitive complaints, complicating psychiatric diagnosis and treatment. Moreover, many patients with mood disorders have debilitating comorbid symptoms of fatigue or sleepiness that may require ancillary treatment in order for psychiatric remission to occur. This presentation will describe a useful diagnostic approach to complaints of sleepiness, sleeplessness and fatigue, and their relationship to underlying symptoms of depression and the most common primary sleep disorders. An understanding of the primary sleep disorders is important

for the practicing psychiatrist in order to address sleep complaints among the psychiatrically ill. Obstructive sleep apnea syndrome, which is especially common in 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 psychosis or dissociative phenomenon. Fatigue, depressive symptoms, and sleepiness are presenting symptoms in patients with circadian rhythm disorders, as well as primary mood disorders. Restless legs syndrome and nocturnal myoclonus produce sleepiness symptoms that may present as inattention or hyperactivity, leading to significant problems with both diagnosis and treatment. The participant will develop an awareness of these sleep disorders, the overlapping presentation in the depressed patient, and the special considerations for treatment of sleepiness and fatigue in the psychiatric population.

### No. 20E
### APATHY IN SCHIZOPHRENIA

Donald C. Goff, M.D., *25 Stanford Street, Boston, MA 02114*

SUMMARY:

Apathy is a common and often disabling negative symptom in schizophrenia for which a large literature on pathophysiologic models and pharmacologic treatments exists. Fatigue and depression can generally be discriminated from the classic negative symptoms, although psychomotor retardation is a negative symptom that resembles fatigue behaviorally, if not subjectively. The differential diagnosis of apathy and other negative symptoms will be reviewed and etiologic models, including dysregulation of dopaminergic brain reward circuits and of glutamatergic NMDA receptor activity will be explored. Evidence for therapeutic efficacy in schizophrenia patients with atypical antipsychotics, selective serotonin reuptake inhibitors, and glutamatergic agents also will be discussed.

REFERENCES:

1. Marin RS: Apathy—who cares? an introduction to apathy and related disorders of diminished motivation. Psychiatric Annuls 1997;27:18–24.
2. Cella D, Peterman A, Passik S, Jacobsen P, Breitbart W: Progress toward guidelines for the management of fatigue. Oncology (Huntingt). 1998;12(11A):369–77.
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5. Goff DC, Evins AE: Negative symptoms in schizophrenia: neurobiological models and treatment response. Harvard Review of Psychiatry 1998;6:59–77.

## INDUSTRY-SUPPORTED SYMPOSIUM 21—PEPTIDES AND HORMONES AS TARGETS IN ANTIDEPRESSANT TREATMENT
## Supported by Merck U.S. Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand how peptide and hormone systems are involved in mood regulation; have a working knowledge of new antidepressants that involve peptide and hormone receptors as targets.

### No. 21A
### DEVELOPMENT OF A PET TRACER FOR CLINICAL TRIALS OF SUBSTANCE P ANTAGONISTS

Richard Hargreaves, Ph.D., *770 Sumneytown Pike, WP 42-300, West Point, PA 19486*

SUMMARY:

Substance P ($NK_1$ receptor) antagonists (SPAs) are in clinical development for the treatment of chemotherapy-induced nausea and vomiting and depression. A PET radiotracer [$^{18}$F]SPA-RQ (Substance P Antagonist Receptor Quantifier) was developed to study $NK_1$ receptors in living brain. The distribution and pharmacology of central $NK_1$ receptors was studied in preclinical species and postmortem human brain using autoradiography. Biodistribution studies showed that the [$^{18}$F]SPA-RQ signal in brain was blocked by SPAs at levels that correlated well with functional activity in assays of CNS $NK_1$-receptor antagonism. PET studies of [$^{18}$F]SPA-RQ in Rhesus monkeys before and after treatment with potent selective SPAs confirmed the specificity of the signal and the suitability of this radiotracer for studies in humans. The distribution of [$^{18}$F]SPA-RQ in human brain reproduced the signal and pattern seen in monkeys. Binding of the tracer to $NK_1$ receptors in healthy human and depressed subjects was inhibited in a dose-related manner by pretreatment with clinically active SPAs such as MK-0869. This series of studies show that [$^{18}$F]SPA-RQ is a valuable tool for $NK_1$ receptor quantitation in living human brain, as well as for predicting receptor occupancy by SPAs in proof of concept clinical trials.

### No. 21B
### RECENT STUDIES ON SUBSTANCE P ANTAGONISTS

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

SUMMARY:

Substance P is a peptide that binds to neurokinin receptors in brain. Recent data in lower animals suggest that neurokinin-1 (NK-1) receptors in the brain may play a key role in modulation of stress responses. This presentation will initially review data derived from three basic research strategies—knock-out mice, NK-1 antagonist effects on behavior, and effects of cellular incorporation of specific NK-1 saporin toxins. These data indicate that blocking NK-1 receptors reverses behavioral effects of stress and suggest that these findings on NK-1 or substance P antagonists could be effective antidepressants and/or anxiolytics in man.

We then review recent studies on Substance P antagonists in major depression. MK-869 and paroxetine were significantly more effective than was placebo in a study of patients with major depression. Side-effect profile appeared to favor MK-869. The next trial employed four doses of MK-869, one dose fluoxetine, and placebo. There was no difference in efficacy among all six cells. A subsequent NK-1 candidate (Compound A) has recently been compared with placebo in melancholic depressives. Compound A was significantly more effective than placebo, providing further proof of efficacy. The significance of positive, failed, and negative trials in antidepressant drug development is discussed.

### No. 21C
### THE THERAPEUTIC POTENTIAL OF CORTICOTROPHIN-RELEASING FACTOR ANTAGONISTS

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

SUMMARY:

Cortcotropin releasing factor (CRF) is a peptide that is distributed throughout the brain and plays a major role in regulating the hypothalamic-pituitary adrenal axis and stress-related behavior. There are at least four CRF endogenous ligands and two CRF receptors. Numerous preclinical studies administering CRF and CRF antagonists to animals demonstrate that CRF in limbic and brain stem regions play an important role in modulating stress-related endocrine, autonomic, and behavioral responses. Results from our laboratory suggest that CRF R1 and R2 are involved in these responses. Studies in humans with depression demonstrate elevated CRF concentrations in CSF and in post-mortem tissue from suicide victims. Furthermore, a reduction in CRF receptors has been reported in frontal cortex in patients that committed suicide. For the above reasons, there has been intense interest in developing small molecules that antagonize CRF receptors for potential therapeutic use in depression and anxiety disorders. To date, a number of CRF R1 antagonists are undergoing early clinical testing and one open clinical trial with a selective R1 antagonist suggests antidepressant activity. CRF R2 small molecule antagonists have yet to be identified but based on animal data also have therapeutic potential. The relevant proclinical worked will be reviewed and data available from clinical studies will be presented to provide an update of the therapeutic potential of using CRF antagonists for the treatment of psychiatric disorders.

## No. 21D
## ESTROGEN AND MOOD

Elizabeth A. Young, M.D., *205 Zina Pitcher Place, Ann Arbor, MI 48109*

SUMMARY:

Because the incidence of depression is higher in women and this incidence begins to rise at puberty, the role of estrogen on mood and anxiety systems has been of interest. The changes in mood associated with reproductive hormones are often during the time of declining estrogen, such as premenstrual or postpartum. Studies in animals and humans have demonstrated that estradiol decreases cortisol and catecholamine responses to stress. In animals, physiological doses of estrogen decrease anxiety, perhaps by acting on serotonin systems. In basic science studies, estrogen can act like an antidepressant on serotonin systems, particularly on the activity of the serotonin transporter. Recent studies in premenopausal women with major depression suggest that estradiol is significantly lower in the follicular phase in women with major depression. All of these studies suggest that estrogen may be useful as an adjunct for the treatment of major depression. Studies in postmenopausal women found that women on HRT plus sertraline demonstrated greater global improvement of depression than women on sertaline alone. Studies in postpartum depression found that the addition of estrogen improved mood in women taking antidepressants. Studies examining the effectiveness of estradiol in improving mood in women who are SSRI nonresponders are under way.

## No. 21E
## THE ROLE OF ANTIGLUCOCORTICOID AGENTS IN THE TREATMENT OF MAJOR DEPRESSION

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

SUMMARY:

Major depression has long been associated with abnormalities in the hypothalamic pituitary adrenal (HPA) axis. Examples of these HPA abnormalities in depression include high rates of dexamethasone non-suppression on the DST, high basal cortisol levels, elevated urinary-free cortisol, and elevated corticotrophin-releasing factor (CRF) levels. It is therefore intuitive that anti-glucocorticoid agents may have an important role to play in the treatment of depression. In this presentation, the clinical data on anti-glucocorticoid agents in the treatment of depression are reviewed. The benefits and limitations of different classes of anti-glucocorticoid strategies are considered, including cortisol synthesis inhibitors, CRF antagonists, and glucocorticoid receptor antagonists.

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3. Bakshi VP, Kalin NH: Bio Psychiatry Corticotropin-releasing hormone and animal models of anxiety: gene-environment interactions. Bio Psychiatry 2000;15:48(12):1175–98.
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# INDUSTRY-SUPPORTED SYMPOSIUM 22—A COMPREHENSIVE APPROACH TO MANAGING BIPOLAR DISORDER: BENCH TO BEDSIDE AND BEYOND
## Supported by Ortho-McNeil Pharmaceutical

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the usage of laboratory trials and clinical results to deliver treatment to patients with bipolar disorder.

## No. 22A
## NEUROPLASTICITY AND CELLULAR RESILIENCE IN BIPOLAR DISORDER

Husseini K. Manji, M.D., *49 Convent Drive, Room B1EE16, MSC4405, Bethesda, MD 20892;* Gregory J. Moore, Ph.D.; Grazyna Rajkowska, Ph.D.; Guang Chen, Ph.D.

SUMMARY:

Recent studies demonstrating adult human neurogenesis have highlighted the degree of neuroplasticity that can persist into senescence, and generated considerable excitement about developing therapeutic strategies to reverse disease-associated neuronal atrophy and death. Intriguingly, lithium and valproate have recently been demonstrated to robustly increase the expression of a completely unexpected target—the major neuroprotective protein bcl-2. Consistent with these effects, both lithium and valproate exert robust neuroprotective effects in a variety of paradigms. Both agents also robustly activate the ERK MAP kinase cascade, a signaling pathway utilized by many endogenous neurotrophic factors. In recent longitudinal 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 with the recent morphometric studies demonstrating cell loss and atrophy in BD, these results suggest that a reconceptualization about the pathogenesis of BD may be warranted. Bipolar disorders may arise, at least in part, from

impairments of neuroplasticity and cellular resilience, and suggest novel targets for the development of improved therapeutics.

## No. 22B
## THE TREATMENT OF ACUTE MANIA

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

SUMMARY:

The bipolar pharmacopoeia is rapidly expanding. This is particularly noteworthy in the treatment of acute mania. As reflected in the 2002 APA Treatment Guidelines for Bipolar Disorder, the FDA-approved mood stabilizers lithium, divalproex sodium, and olanzapine have clear evidence of anti-manic properties. This presentation will review the controlled literature and clinical guidelines of these antimanic agents. There is as well, great interest in further development of anticonvulsant and atypical antipsychotic agents in the treatment of acute mania. This presentation will review preliminary impressions of newer anticonvulsants (gabapentin, topiramate, carbamazepine, oxcarbazepine, zonisamide, levetiracetam) and atypical antipsychotics (clozapine, risperidone, quetiapine, ziprasidone, aripiprazole) and their potential role in the treatment of acute mania. Evidence-based guidelines will be reviewed to finally conceptualize cutting-edge treatment algorithms for acute mania.

## No. 22C
## TREATMENT OF BIPOLAR DISORDER WITH COMORBID PSYCHIATRIC OR MEDICAL DISORDERS

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

SUMMARY:

Increasing epidemiological data show that bipolar disorder co-occurs with psychiatric and medical disorders at rates that are significantly higher than those in the general population. Such disorders include substance use disorders, anxiety disorders, migraine, and obesity, among others. Research futher suggests that bipolar disorder with comorbidity is characterized by an earlier age of onset, poorer outcome, and unfavorable response to lithium-based treatment. However, little controlled data are available regarding the treatment of bipolar disorder complicated by a concurrent psychiatric or medical disorder. In this presentation, available community, clinical, and family data on the overlap of bipolar disorder with other psychiatric and medical disorders are reviewed. Controlled studies of therapeutic agents for bipolar disorder that have been studied in various comorbid conditions (e.g., valproate in panic disorder, migraine prevention, and substance abuse; carbamazepine in substance withdrawal; topiramate in binge eating disorder, obesity, migraine prevention, and substance abuse (alcohol dependence) will also be summarized. Preliminary suggestions for the management of bipolar disorder with various comorbid psychiatric and medical disorders will then be suggested.

## No. 22D
## MANAGEMENT OF SUICIDE PREVENTION IN BIPOLAR DISORDER PATIENTS

Maria A. Oquendo, M.D., *1051 Riverside Drive, Box 42, New York, NY 10032;* Michael F. Grunebaum, M.D.; David J. Printz, M.D.; Leo Sher, M.D.; J. John Mann, M.D.

SUMMARY:

Patients with bipolar disorder are at high risk for suicide completion compared with other major psychiatric disorders and have a high rate of suicide attempts, the best predictor of future completed suicide. A recent meta-analysis found an 18.9% mean mortality from suicide in bipolar subjects and that 25% to 50% of all bipolar patients report at least one suicide attempt. Pharmacological strategies for the prevention of suicide behavior in bipolar patients will be reviewed. Studies suggest that lithium and serotonin-enhancing antidepressants reduce suicidal behavior in bipolar patients. These studies of suicide prevention will be discussed in the context of the Stress Diathesis Model, to explore whether this model explains the empirical fact that some drugs appear to have antisuicidal properties while others do not. The model explains the differential effect of such medications compared with other antidepressants or mood stabilizers on suicidal behavior by illustrating the impact of these potentially antisuicidal medications on the diathesis. This effect, which is in addition to their ability to contain the underlying psychiatric condition, may be mediated through augmentation of serotonergic function, leading to lower impulsivity and aggression and consequently reducing suicidal behavior. Serotonergic enhancing drugs therefore can potentially reduce suicidal behavior.

## No. 22E
## PSYCHOTHERAPY FOR BIPOLAR DISORDER?

Ellen Frank, Ph.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Holly A. Swartz, M.D.; David J. Kupfer, M.D.

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.

Described psychosocial approaches to bipolar disorder include psychoeducation, group therapy, cognitive-behavioral therapy, couples therapy, family therapy, and interpersonal psychotherapy. Results from randomized controlled trials of family psychoeducational treatment (Miklowitz et al., 2000) suggest that this treatment may be more efficacious in the treatment and prevention of depression relative to mania, while interpersonal and social rhythm therapy (Frank, 2003) may be effective in ameliorating both manic/hypomanic and depressive symptoms.

The small number of well-designed studies and preponderance of case reports limit definitive conclusions about the role of psychotherapy in the treatment of bipolar disorder. However, converging reports suggest that cognitive-behavioral therapy, family therapy, and interpersonal and social rhythm therapy may all be useful approaches in combination with appropriate pharmacotherapy. We propose a novel approach to the treatment of bipolar disorder that includes the use of phase-specific sequenced psychotherapies delivered in variable patterns and linked to fluctuating mood states.

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# INDUSTRY-SUPPORTED SYMPOSIUM 23—A RATIONAL ALGORITHM FOR SELECTING ATYPICALS IN SCHIZOPHRENIA AND BIPOLAR DISORDER: CUSTOMIZING TREATMENT FOR OPTIMAL OUTCOMES

**Supported by AstraZeneca Pharmaceuticals**

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize that no single atypical antipsychotic is tolerated and efficacious in all patients, and that customizing the selection of an atypical to fit the patient's medical risk profile is a rational approach to outcomes.

## No. 23A
## EFFICACY OF ATYPICAL ANTIPSYCHOTICS: HOW DO THEY COMPARE?

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

## SUMMARY:

In contrast to older conventional antipsychotic agents, the newer "atypical" medications exhibit a broader spectrum of efficacy, demonstrating greater efficacy in negative, cognitive, and mood symptom domains. There are limited data on how available first-line atypical agents (risperidone, olanzapine, quetiapine, ziprasidone) compare with each other with regard to overall efficacy and efficacy in specific symptom domains. To address this question comprehensively, two separate analyses were conducted. Firstly, all published short-term, randomized, controlled clinical trials (total = 22) of these agents in schizophrenia and schizoaffective disorder were analyzed and the extent of improvement across these agents was compared. While the amount of improvement with a particular agent across its different studies varied, the average improvement was similar for the agents for all efficacy parameters considered. Secondly, all randomized, controlled clinical trials directly comparing two or more of these agents in patients with schizophrenia or schizoaffective disorder were analyzed; only four such trials (all industry-sponsored) were identified. While there were few small differences, the preponderance of data in each study suggested no differences in efficacy. While data thus far do not support assertions of differential efficacy between risperidone, olanzapine, quetiapine, and ziprasidone, there are clear differences in their side-effect profiles and these are briefly summarized. Appropriate dosing is significantly related to optimizing efficacy.

## No. 23B
## MINIMIZING SPECIFIC MEDICAL PROBLEMS BY CUSTOMIZING ANTIPSYCHOTIC SELECTION

Henry A. Nasrallah, M.D., *1500 East Woodrow Wilson Drive, Jackson, MS 39216*

## SUMMARY:

All four first-line atypical antipsychotics currently available have very similar efficacy but different medical safety profiles. The key to successful antipsychotic therapy is to select the atypical that is best tolerated by a specific patient. To match a patient with the least medically disruptive atypical antipsychotic for that patient, physicians must be aware of the unique medical history and susceptibility profile for each patient. The major adverse effects associated with various atypical antipsychotics include (1) neurological movement disorders (EPS), (2) weight gain and obesity, (3) hyperglycemia/diabetes, (4) hyperlipidemia, (5) sexual dysfunction, (6) cardiovascular disease.

Thus, for psychotic populations at risk for EPS (elderly, females, and certain ethnic groups such as African Americans) the atypical with placebo-level EPS effects should be selected first. For those at risk for obesity (patients with personal and/or family history of obesity), the atypical with the lowest weight gain should be selected first. For patients at risk for diabetes (those with personal or family history of diabetes), the atypical with the lowest hyperglycemic effects is the logical first choice. For patients at high risk for gonadal neuroendocrine disruption (adolescents and females and males in the peak child-bearing years), the atypical with placebo-level prolactin levels at any dose should be used. Finally, for patients at risk for cardiac arrhythmia (patients with chronic heart disease, family history of QTc syndrome, taking multiple medications that prolong the QTc, or with electrolyte imbalance such as hypokalemia or hypocalcemia), the atypical with the lowest QTc effects should be used first.

Thus, a logical algorithm that utilizes each of the four atypicals for the appropriate patient can be implemented in the clinical setting. Clinical examples will be provided.

## No. 23C
## SERIOUS MEDICAL MORBIDITY AND ATYPICALS: DEFINING AND AVOIDING THRESHOLDS OF RISK

Diana O. Perkins, M.D., *101 Manning Drive, Campus Box 7160, Chapel Hill, NC 27599-7160*

## SUMMARY:

Patients with schizophrenia are at increased risk for a variety of medical disorders, including diabetes, heart disease, and osteoporosis. Lifestyle and health habits, including smoking, poor eating habits, and sedentary lifestyle are frequent and important contributors to increased risk. The atypical antipsychotic medications, risperidone, olanzapine, quetiapine, ziprasidone, and clozapine, while offering important advantages over older antipsychotic medications, may increase risk of medical morbidity. Weight gain has emerged as a troublesome and potentially serious side effect of some of the atypical antipsychotics. Alterations in lipid metabolism, especially serum triglyceride levels, are associated with atypical antipsychotic use. Weight gain and lipid abnormalities are associated with health risks, including heart disease, joint disease, diabetes, cancers, and sleep apnea. Weight gain may impact a patient's quality of life and willingness to take antipsychotics. The clinical implications of increased prolactin, particularly at the level typically found with risperidone treatment, are as yet uncertain. High prolactin may directly cause enlargement of breast tissue and lactation, and may directly and indirectly impact sexual function and bone turnover increasing risk of osteoporosis. This presentation will summarize the potential adverse health consequences of atypical antipsychotics. Emphasis will be placed on overall risk assessment in patients with schizophrenia, including evaluation of health habits and lifestyle, and monitoring weight, body mass index, and critical laboratory values. The value of various intervention strategies to reduce risk will be discussed.

## No. 23D
## BIPOLAR DISORDERS AND SCHIZOPHRENIA: SIMILARITIES AND DIFFERENCES IN SUSCEPTIBILITIES TO SIDE EFFECTS

Claudia F. Baldassano, M.D., *3600 Market Street, Philadelphia, PA 19104*

### SUMMARY:

It has long been known that patients with bipolar disorder and schizophrenia differ in some respects as to side-effect risks with antipsychotic treatment. With traditional antipsychotics, there was increased risk of extrapyramidal symptoms (EPS) in bipolar disorder compared with schizophrenia. Further, patients with schizophrenia have a higher spontaneous rate of tardive dyskinesia (untreated with antipsychotics) and diabetes mellitus compared with the general population, unlike patients with bipolar disorder. Recent research with atypical antipsychotics indicates that patients with bipolar disorder remain sensitive to EPS, though less than with traditional antipsychotics. Consequently, the doses of atypical antipsychotics used in bipolar disorder are roughly half those used in schizophrenia. We will present data suggesting that the most common and problematic EPS in patients with bipolar disorder is akathisia, whereas parkinsonism and tardive dyskinesia are less common. We will also review evidence that patients with bipolar disorder are at increased risk of weight gain with atypical antipsychotics, compared with schizophrenia, partially due to the need to combine these agents with mood stabilizers. Risks for emergence of diabetes mellitus, elevated cholesterol levels, and hyperprolactinemia, appear similar in both diagnoses.

## No. 23E
## EFFICACY TO EFFECTIVENESS WHEN TREATING SCHIZOPHRENIA

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

### SUMMARY:

Outcome research in schizophrenia has shown a gap between outcome as found in clinical trials (*efficacy*) and outcome in usual clinical care (*effectiveness*). Unfortunately, most of the time, *effectiveness* outcomes have not been as good as those found in *efficacy* trials.

This presentation will discuss several new approaches in understanding *effectiveness* in antipsychotic therapy for patients with schizophrenia. The ultimate goal is to understand how to get the most from psychosocial and pharmacologic therapies in schizophrenia.

- Review the NIMH—sponsored Comparative Effectiveness of Antipsychotic Medications in Patients with Schizophrenia study, which compares the four atypical antipsychotics with a conventional antipsychotic under treatment conditions approximating "usual" practice, another related study comparing the effectiveness of olanzapine, quetiapine, and risperidone for first-episode patients.
- Review a recent effectiveness study of cognitive-behavior therapy (CBT) modified for patients with schizophrenia (The Insight Programme). This study evaluated whether psychiatric nurses given a brief but intensive course on CBT could effectively deliver brief CBT intervention in "usual" practice conditions in the United Kingdom.

The talk will conclude by discussing the theoretical and practical implications of the efficacy/effectiveness models for pharmacologic and psychosocial treatments of schizophrenia.

### REFERENCES:

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2. Nasrallah HA: A rational, effectiveness-oriented approach for selecting the optimal atypical. J Psychotic Dis 2002;6:7–16.
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5. Weiden P, Olfson M: Cost of relapse in schizophrenia. Schizophr Bull 1995;21:419–428.

# INDUSTRY-SUPPORTED SYMPOSIUM 24—PSYCHIATRY AND MEDICINE: COMMON PATIENTS, DIFFERENT PERSPECTIVES
## Supported by Pfizer Inc.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand why the recognition of depression in patients with cardiovascular disease is important when establishing treatment priorities, recognize medical illnesses and understand how treating the depression can improve a medical patient's overall quality of life, recognize the need for early identification and treatment of anxiety disorders in primary care.

## No. 24A
## THE PATHOPHYSIOLOGY AND PSYCHOPHARMACOLOGY OF COMORBID CARDIOVASCULAR DISEASE AND DEPRESSION

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

### SUMMARY:

Although major depression and depressive symptoms are commonly encountered in medical populations, overwhelming evidence suggests that these disorders are frequently underdiagnosed and undertreated in patients with cardiovascular disease (CVD). Several studies have shown that depression and its associated symptoms are a major risk factor for both the development of CVD and death after index myocardial infarction (MI). Recognition of depression in patients with CVD, therefore, is of utmost importance when establishing treatment priorities. The Sertraline Anti-Depressant Heart Attack Randomized Trial (SADHART) was the first double-blind, placebo-controlled trial to investigate the cardiovascular safety, tolerability, and antidepressant efficacy of sertraline treatment (flexible dosing, 50 to 200 mg) in 369 hospitalized patients with acute MI or unstable angina in the immediate postinfarction period. Results of SADHART, which will be discussed in further detail, showed that sertraline-treated patients had a consistently lower incidence of serious treatment-emergent cardiovascular events as compared with placebo.

Another study, Enhancing Recovery in Coronary Heart Disease (ENRICHD), assessed the effect of psychosocial intervention in post-MI patients with depression. Results of this trial showed that treating depression immediately after MI is important, and that psychosocial interventions may improve medical outcomes after acute MI, especially in men.

The pathophysiological mechanisms underlying the increased risk of MI and stroke in depressed patients have been scrutinized, and two major theories have emerged: the platelet hyperactivity hypothesis and the heart rate variability hypothesis. These pathological alterations in depressed patients will also be discussed.

## No. 24B
## MEDICAL ILLNESS AND DEPRESSION: A DELICATE INTERPLAY BETWEEN BIOLOGY AND BRAIN

Dominique L. Musselman, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Clinical depression commonly co-occurs with general medical illnesses, such as diabetes, stroke, and cancer. Although comorbid depression often goes undetected and untreated, research suggests that the recognition and treatment of comorbid depression may reduce suffering and disability, enhance compliance with medical treatments, and improve quality of life,

Multiple large-scale, community-based studies indicate that depression increases the risk of Type II diabetes, even accounting for usual factors that contribute to these conditions. Moreover, in patients with Type II diabetes, depression is associated with hyperglycemia and an increased risk for diabetic complications, while relief of depression has been associated with improved glycemic control. For patients who have suffered a stroke or who have been diagnosed with cancer, depression is associated with increased morbidity and mortality.

In this presentation, the delicate interplay between medical illness and comorbid depression will be explored. Recent studies examining the benefits of treating depression in the context of medical illness will also be reviewed.

## No. 24C
## MANAGEMENT OF ANXIETY DISORDERS IN PRIMARY CARE: IMPLICATIONS FOR PSYCHIATRISTS

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

SUMMARY:

Patients who seek treatment for psychiatric disorders, such as anxiety disorders, are more likely to do so in the primary care setting; however, relatively little is known about the frequency or nature of treatment in this setting. The Primary Care Anxiety Project (PCAP) is a longitudinal, naturalistic study, which examined the clinical course, psychosocial functioning, treatment, and economic burden of anxiety disorders in 539 primary care patients.

The purpose of this investigation was threefold: (1) to examine the types of treatment received by a cohort of individuals with anxiety disorders presenting in primary care, (2) to investigate the demographic and clinical factors associated with the increased likelihood of receiving treatment for the disorder, and (3) to elucidate the reasons that affected individuals fail to receive or follow through with prescribed treatments.

Results from the PCAP study indicate that a significant proportion of primary care patients with anxiety disorders are not being treated, underscoring the need for increased education of primary care providers and the public about the importance of early identification of anxiety disorders and their efficacious treatment.

## No. 24D
## LONG-TERM TREATMENT OF ANXIETY AND DEPRESSION: WHY, WHEN, HOW?

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

SUMMARY:

As studies have shown, depression is a recurrent and chronic disorder associated with high rates of impairment and comorbidity with other disorders. Similarly, anxiety disorders are chronic and disabling and generally require long-term treatment. While treatment options are available and can greatly improve functioning in patients with chronic depression and anxiety disorders, undertreatment still persists. In some cases, undertreatment is the result of incomplete or incorrect diagnoses, or inadequate treatment duration.

During this presentation, our current understanding of the chronicity of depression and anxiety disorders will be discussed. Treatment goals and expected outcomes in terms of time to recovery, time to recurrence, and quality of life based on data and observations from the NIMH Collaborative Depression Study and the Harvard/Brown Anxiety Disorders Research Program (HARP) study will be reviewed.

In addition, recommendations for long-term treatment based on these data and recently completed long-term, randomized clinical trials will be discussed.

## No. 24E
## THE SUCCESSFUL INTERVENTION: MANAGEMENT OF THE PATIENT WITH MEDICAL COMORBIDITIES

Larry Culpepper, M.D., *Dowling 5S, 1 Boston Medical Center Place, Boston, MA 02118*

SUMMARY:

Studies have convincingly shown that as many as 50% of patients in primary care have medical and psychiatric diagnoses that require dual treatment. It is not surprising, therefore, that the concept of primary care psychiatry has emerged in recent years as one way to address the problem. In one study of 268 physicians with board certification in both internal medicine and psychiatry, 75% identified themselves as psychiatrists working predominantly in psychiatry; 95%, however, reported using both their medical and psychiatric training in their professional work.

In light of the large overlap between medicine and psychiatry, there is an increasing need for physician training in both specialties. In this presentation, two patient case studies will be reviewed from the perspective of both the psychiatrist and the primary care physician. One case will focus on depression in a patient with cardiovascular disease; the other will focus on the treatment of anxiety in a patient with diabetes. The case studies will elucidate the need for increased collaboration between primary care and psychiatry, despite increasing systematic forces that separate the specialties. One model of collaboration based on the evidence of integration in primary care and stepped care will be described.

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# INDUSTRY-SUPPORTED SYMPOSIUM 25—MEDICAL CONSIDERATIONS IN THE MANAGEMENT OF SPECIAL PATIENT POPULATIONS
## Supported by Eli Lilly and Company

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss medical comorbidities commonly seen in special patient populations with mental illness.

## No. 25A
## MEDICAL VULNERABILITY IN SCHIZOPHRENIA

Donald C. Goff, M.D., *25 Stanford Street, Boston, MA 02114*

### SUMMARY:

Mortality rates in schizophrenia are two to four times higher than in the general population, and life expectancy is approximately 10 years shorter. Results from studies of mortality rates among chronically mentally ill patients in Massachusetts will be presented to identify medical diagnoses responsible for high mortality rates. While suicides and accidental deaths contribute to excess mortality, recent studies indicate that cardiovascular and respiratory diseases play important roles as well. Risk factors for cardiovascular and respiratory diseases will be reviewed, emphasizing factors that are particularly elevated in schizophrenia, including cigarette smoking, obesity, and diabetes. Sources of increased medical vulnerability may include genetic predisposition, lifestyle issues, medication effects, and inadequate access to medical care. Each of these factors will also be discussed, with emphasis upon approaches to encourage healthier lifestyles among patients with schizophrenia. Screening for cardiovascular risk factors and other preventable causes of medical morbidity will also be discussed, along with models for improving medical care.

## No. 25B
## MEDICAL CONSIDERATIONS IN BIPOLAR DISORDER

Lauren B. Marangell, M.D., *6655 Travis, Suite 560, Houston, TX 77030*

### SUMMARY:

Psychotropic treatment selection for patients with bipolar disorder includes a review of medication efficacy and medication safety, but should also include a review of the patient's current medical condition. Recent reports have emerged about the safety of antipsychotics and anticonvulsants used to treat bipolar disorder. Side effects, such as tardive dyskinesia and hyperprolactinemia, are considered to be medication induced. In addition, recent literature indicates that obesity is a common problem in the bipolar patient population, leading to its own risks of hyperlipidemia and hyperglycemia. This presentation will focus on the incidence of obesity and the risks associated with obesity in the bipolar patient population. It will conclude with a discussion on the management of medication side effects, such as tardive dyskinesia and hyperprolactinemia.

## No. 25C
## MEDICAL CONCERNS IN PHARMACOTHERAPY FOR THE COMPLICATED PEDIATRIC BIPOLAR PATIENTS

Charles S. Schultz, M.D., *2450 Riverside Avenue, F282/2A West, Minneapolis, MN 55454-1495*

### SUMMARY:

*Background:* Children and adolescents with bipolar disorder frequently present with high levels of comorbidity. Although few clinical trials exist to guide our treatment of these highly complex individuals, initial clinical evidence suggests that a combined pharmacotherapy approach with attention to the medical complications inherent in such a process is necessary in the management of bipolar youth. Side effects such as weight gain, may represent limiting factors in treatment.

*Method:* This presentation summarizes current research regarding the complicated pharmacological treatment of pediatric-onset bipolar disorder and its associated comorbid conditions.

*Results:* Preliminary data suggest that both ADHD and depression can be treated in children and adolescents with pediatric-onset bipolar disorder, but only after the mood symptoms of mania are well stabilized. Complications of side effects such as weight gain and drug-drug interactions must be considered in the combined pharmacotherapy of pediatric patients.

*Conclusion:* Treatment of pediatric-onset bipolar disorder requires a cautious combined pharmacotherapy approach to address issues of comorbidity. Preliminary evidence suggests that symptoms associated with ADHD and depression can be addressed with medications specific for these conditions, but only when these medications are sequenced after mood stabilizers. The risk for manic exacerbation exists as well as other medical side effects.

## No. 25D
## COURSE AND TREATMENT OF BIPOLAR ILLNESS DURING PREGNANCY, POSTPARTUM, AND LACTATION

Lee S. Cohen, M.D., *15 Parkman Street, WACC 815, 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 and treatment strategies for 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 and lactation will be discussed.

## No. 25E
## MEDICAL COMORBIDITY AND BIPOLAR DISORDERS IN OLD AGE: IMPACT ON DIAGNOSIS, TREATMENT, AND OUTCOME

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

### SUMMARY:

The relatively high prevalence of medical and especially neurologic comorbidity associated with bipolar disorders in old age creates challenges in our understanding of the pathogenesis and classification of these disorders. The concept of secondary mania is based on the premise of a clear association between cerebral organic factors and the manifestation of a manic syndrome. However, data from studies in old age suggest that genetic factors are still important even in

this subgroup. The vascular depression hypothesis in geriatric depression has also led to a proposed subtype of late-onset mania associated with cerebrovascular pathology.

Treatment is affected by medical comorbidity in two ways. First, the capacity of elderly people with medical and neurologic comorbidity to tolerate pharmacological treatment is limited. Second, there is evidence that outcome is worse when significant neurologic or medical burden is present. This is true whether measured as morbidity such as rehospitalization rates or persistent symptoms. Furthermore, mortality is especially high in elderly bipolars even when compared with age- and sex-matched unipolar depressives.

Cognitive impairment, neurologic lesions, and medical comorbidity are unique aspects of treating the elderly and require careful study to improve our understanding of the nature and management of these increasingly prevalent disorders.

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# INDUSTRY-SUPPORTED SYMPOSIUM 26—TREATMENT OF COMORBIDITY IN NEUROPSYCHIATRIC DISORDERS IN CHILDREN AND ADOLESCENTS

**Supported by Janssen Pharmaceutica**

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the rationale for combination pharmacotherapy in pediatric psychiatry, describe common comorbidities in pediatric psychiatry, and be able to describe the risks of polypharmacy in pediatric psychiatry.

## No. 26A
## CHILD AND ADOLESCENT PSYCHIATRIC DISORDERS: PEDIATRIC BIPOLAR DISORDERS AS A MODEL

Janet Wozniak, M.D., *55 Fruit Street, Boston, MA 02114*

## SUMMARY:

Overlap in core symptoms and clinical presentation occurs among youth presenting with pervasive development disorder (PDD), disruptive behavior disorders, and mood disorders, complicating both diagnosis and treatment. In various reports of childhood-onset bipolar disorder, high rates of co-occurrence are found with disruptive behavior disorders (e.g., conduct disorder 37%, oppostional defiant disorder 88%, ADHD 98%, PDD 11%) complicating diagnosis and treatment of these children. In a report of children with PDD, similar high rates of comorbidity were noted (conduct disorder 13%, oppositional defiant disorder 55%, ADHD 74%, bipolar disorder 21%). Reports examining the overlap between bipolar disorder and ADHD as well as the overlap between PDD and bipolar disorder suggest that these comorbidities are not due to overlapping symptoms or misdiagnosis of one disorder for the other; rather, the evidence suggests that both disorders co-exist and require their own specific treatments. Children and adolescents with psychiatric symptoms can be difficult to diagnose due to overlapping symptoms and comorbidity. However, accurate diagnosis is key to rational pharmacotherapy.

## No. 26B
## RATIONAL MANAGEMENT OF DISRUPTIVE BEHAVIOR DISORDERS AND COMORBIDITY

Jeffrey Newcorn, M.D., *One Gustave, Box 1230, New York, NY 10029*

## SUMMARY:

Attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD) form the disruptive behavior disorders (DBDs) in DSM-IV-TR. These conditions frequently co-occur, have some shared symptoms (e.g., impulsivity), and may present with similar impairments (e.g., behavioral noncompliance; peer rejection; poor academic function). ADHD and ODD occur comorbidly approximately 40% of the time, in both directions. Virtually all children with CD have ODD. ADHD is less often comorbid with CD than ODD, but rates are still high (15% to 25% of children with ADHD; the majority of children with CD). In addition, ADHD, ODD and CD frequently co-occur with depressive (15% to 25%) and anxiety (25% to 35%) disorders, and there is recent interest in their overlap with bipolar disorders. Children with DBDs and comorbidity represent a more severely affected group, and have increased risk for poor long-term outcome (e.g., antisocial and substance abuse disorders). Hence early identification and treatment is essential. A variety of evidence-based medication and psychosocial interventions are available. Recent findings indicate that multimodal treatment may produce the best overall response. This presentation will review information from recent studies regarding differential diagnosis and treatment of DBDs with comorbidity, focusing on the potential impact of comorbidity and its treatment on long-term outcome.

## No. 26C
## COMBINED PHARMACOTHERAPY IN THE MANAGEMENT OF BIPOLAR DISORDER

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

## SUMMARY:

The pharmacological management of pediatric bipolar disorder presents unique challenges to the treating psychiatrist. The most well established medications for this condition are lithium and divalproex sodium. Recently, atypical antipsychotics have been shown to have substantial promise in the treatment of this challenging patient population. Unfortunately, monotherapy of pediatric bipolarity does not seem to lead to complete remission of symptoms in most patients. Although few placebo-controlled data are available on the issue of combination treatment of young patients with bipolar disorder, there are now several studies of varying methodological rigor to suggest that treatment with more than one mood stabilizer may be a rational strategy in the acute management of these youths.

What substantially complicates the treatment of young patients with bipolar disorder is the observation that high rates of comorbid conditions such as ADHD, anxiety disorders, conduct disorder and substance use disorders are seen in this population. These comorbidities further highlight the fact that combined pharmacotherapeutic interventions are oftentimes considered and implemented for young patients with bipolar disorder. This presentation will review what is known about the use of combination therapy in the treatment of pediatric bipolarity.

## No. 26D
## RECENT ADVANCES IN THE PHARMACOTHERAPY OF PERVASIVE DEVELOPMENTAL DISORDERS

Christopher J. McDougle, M.D., *1111 W. 10th Street, KI 2nd Floor, Indianapolis, IN 46202-4800;* David J. Posey, M.D.

### SUMMARY:

Significant advances have been made in the pharmacotherapy of pervasive developmental disorders (PDDs), including autism. The pharmacological management of PDDs remains largely based on identifying target symptoms that may be drug responsive. Many younger-aged patients present with interfering motor hyperactivity and inattention. To date, results from studies of psychostimulants for these symptoms have shown modest benefit, at best. Larger-scale investigations of these agents are under way. Preliminary studies of alpha-2 agonists have shown some promise for this symptom cluster. Interfering ritualistic behavior is also often a target of drug treatment for these patients. A limited number of controlled studies of serotonin reuptake inhibitors (SRIs) have suggested that this class of drugs may be helpful for these symptoms, particularly in post-pubertal patients. Significant aggression, self-injury, and property destruction can also accompany the PDDs. The use of atypical antipsychotics has proven particularly helpful for these serious behaviors. The NIMH-sponsored Research Units on Pediatric Psychopharmacology (RUPP) Network recently completed a controlled study of an atypical antipsychotic in 101 children and adolescents with autism, which demonstrated substantial benefit for aggressive symptoms. Results from early trials of drugs targeted toward the core social impairment of autism and other PDDs, including agents with prominent effects on the glutamate system, are encouraging.

## No. 26E
## CLINICALLY RELEVANT DRUG-DRUG INTERACTIONS IN PEDIATRIC PSYCHIATRY

Michael D. Reed, Pharm.D., *10900 Euclid Avenue, Cleveland, OH 44106*

### SUMMARY:

Serious consequences due to drug-drug interactions continue to plague contemporary psychopharmacology practice. This importance is heightened when considering the large number of agents (e.g., herbal products) patients self-consume for the remedy of their underlying disorders. The possibility of a drug-drug interaction should be considered anytime a new or unsuspected effect occurs that complicates the clinical management of a patient in the setting where the patient is receiving more than one drug. Thus, a detailed history of exactly what a patient is receiving from all health care providers / counselors or what a health care worker, parent, relative, or councilor is providing to the child either as prescribed or self-medicated must determined. Unfortunately, the incidence of clinically relevant drug-drug interactions in children is unknown. Although the possibility of a clinically relevant event in pediatrics may superficially appear to be remote as children rarely receive chronic polypharmacy. However, the one pediatric population that does often receive chronic pharmacotherapy and possibly in multidrug combinations are children receiving psychoactive drugs prescribed by their child psychiatrist.

### REFERENCES:

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# INDUSTRY-SUPPORTED SYMPOSIUM 27—REDUCING SUICIDALITY IN SCHIZOPHRENIA AND BIPOLAR DISORDER
## Supported by Novartis Pharmaceuticals Corporation

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the patients with bipolar disorder or schizophrenia who are at greater risk for suicidality, assess the level of risk, and apply the most appropriate pharmacologic and psychotherapeutic techniques to deal with current crises and minimize future suicidality.

## No. 27A
## SUICIDALITY AND ITS MANAGEMENT IN SCHIZOPHRENIA AND BIPOLAR DISORDER

Kay R. Jamison, Ph.D., *720 Rutland Avenue/Meyer 4-181, Baltimore, MD 21205*

### SUMMARY:

Suicidality, the spectrum of suicidal behaviors, remains one of the most challenging and costly problems facing psychiatrists. Approximately 10,000 people in the U.S. with schizophrenia or bipolar disorder commit suicide each year, while suicide threats and attempts are responsible for a very high proportion of their emergency room visits and hospitalizations. The stress-diathesis model provides a useful basis for considering the complex causes of sucidality and organizing a multifaceted clinical response. Clinicians must address the feelings of hopelessness, massive anxiety, impaired cognitive abilities, and perceived lack of familial support, along with using medication and increased surveillance, including hospitalization, to shorten the at risk period and to prevent a completed suicide. In an acute crisis, medication or ECT and provision of a safe environment are critical to a successful, rapid resolution of the greatest risk, yet many sucides occur even with hospitalized patients. During this period, a relationship of trust with a clinician can be established, even during a psychotic period, that can be of great value during the further recovery and prevention of recurrences. Long-term treatment also requires pharmacologic interventions along with addressing the core deficits in self-esteem and optimism.

## No. 27B
## A MODEL FOR SUICIDE ASSESSMENT

Douglas G. Jacobs, M.D., *One Washington Street, Suite 304, Wellesley Hills, MA 02481*

### SUMMARY:

Suicide is a multi-factorial event, including many complex and interacting risk factors. Some of those include psychiatric illness, comorbidity, family history, and specific symptoms such as hopelessness and impulsiveness. A model of suicide assessment is proposed for identifying and treating patients with suicidal behavior. The difference between suicide assessment and suicide prediction is emphasized. The suicide assessment model will review the literature and clinical consensus surrounding relevant risk factors. Other important components of a suicide assessment to be discussed include conducting a specific suicide inquiry, highlighting components of suicidal ideation, and the significance and categorization of suicide attempts. Guidelines for determining the level of suicide risk are presented. Lastly, the importance of documentation is explained along with risk management implications.

## No. 27C
## REDUCING SUICIDALITY IN SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER

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

### SUMMARY:

Approximately 50% of patients with schizophrenia have some type of suicidality and about 10% die by suicide. Typical neuroleptic drugs do not appear to reduce the rate of completed suicide. Beginning in 1995, a variety of studies, using various methodologies, suggested that clozapine reduced the suicide attempt and completion rates in patients with schizophrenia by about 75% to 30% compared with other treatments. The advantage of clozapine to reduce suicidality has been confirmed in a controlled clinical trial (InterSePT), which compared clozapine and olanzapine in 980 patients with schizophrenia or schizoaffective disorder at high risk for suicide. This two-year study was randomized, provided equal clinical contact in both groups, full access to ancillary medications, blinded ratings of psychopathology and suicidality, and a blinded expert Suicide Monitoring Board, which determined whether an event met criteria for suicide, suicide attempt, or hospitalization to prevent suicide. The primary outcome measure indicated that the time to a suicide attempt was significantly longer in the clozapine-treated patients. The hazard ratio for the clozapine-treated group was 25% lower than for olanzapine. The clinical significance and biological basis for the ability of clozapine to reduce suicidality in schizophrenia will be discussed.

## No. 27D
## TREATMENT AND SUICIDE RISKS

Ross J. Baldessarini, M.D., *115 Mill Street, MRC 316, Belmont, MA 02478-1048;* John Hennen, Ph.D.; Leonardo Tondo, M.D.

### SUMMARY:

Meta-analysis of research on suicide in bipolar and unipolar manic-depressive patients found strong, consistent evidence for reduction of suicide risk by 85% during long-term lithium treatment. Attempt-risk during treatment was close to general population estimates, but completed suicides still exceeded general population suicide rates, suggesting major but incomplete protection. These results compared well with those of our Sardinian collaborative study, which found 83% fewer suicidal acts among 360 bipolar I and II patients during vs. before long-term lithium treatment. In a subgroup discontinuing electively when stable, suicidal acts increased 20-fold within 12 months of treatment discontinuation, then returned to pretreatment rates. Paralleling morbidity risks, suicidal risk was twice greater after abrupt or rapid discontinuation. In the Sardinian sample, nearly all acts occurred with depression or mixed dysphoric agitation, following multiple, severe depressions, prior attempts, especially early in bipolar illness well before sustained maintenance treatment. The findings indicate major reductions of suicidal risk during long-term lithium treatment of major affective disorder patients, most likely reflecting protection against depression. They also highlight needs for earlier diagnosis and intervention, and encourage further study of mortality risks with other psychiatric disorders and treatments.

### REFERENCES:

1. Jamison KR: Night Falls Fast: Understanding Suicide. Alfred Knopf Press, 1999.
2. Jacobs DC (ed): Harvard Medical School Guide to Suicide Assessment and Intervention. San Francisco, CA, Jossey-Bass; 1998.
3. Caldwell CB, Gottesman II: Schizophrenia a high-risk factor for suicide: clues to risk reduction. Suicide Life Threat Behav 1992;22:479–493.
4. Tondo L, Hennen J, Baldessarini RJ: Reduced suicide risk with long-term lithium treatment in major affective illness: a meta-analysis. Acta Psychiatr Scand 2001;104:163–172.

# INDUSTRY-SUPPORTED SYMPOSIUM 28—IMPAIRMENT OF STRUCTURAL PLASTICITY IN SEVERE MOOD DISORDERS: CAUSAL OR COLLATERAL? PART 1
## Supported by Abbott Laboratories

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss mechanisms involved in neurogenesis, cellular atrophy and cell death; neuroimaging; and the effects of mood stabilizers on specific mollecular and cellular targets.

## No. 28A
## STRESS, GLUCOCORTICOIDS, AND NEURON DAMAGE: CURRENT STATUS

Robert Sapolsky, Ph.D., *Gilbert Lab/MC 5020, Stanford, CA 94305-5020*

### SUMMARY:

Glucocorticoids, the adrenal steroids secreted during stress, play a critical role in helping an organism survive an acute homeostatic crisis. At the same time, it has been clear for decades that an excess of stress or glucocorticoids can be pathogenic. Such deleterious actions include the nervous system, particularly the hippocampus. This talk will review the mechanisms thought to underlie the ability of glucocorticoids to (1) inhibit neurogenesis, (2) cause atrophy of dendritic processes, (3) impair the capacity of neurons to survive coincident insults, (4) kill neurons outright. The talk will also review current thinking as to how these adverse glucocorticoid actions might play a role in the hippocampal atrophy reported in major depression and posttraumatic stress disorder.

No. 28B
## REGULATION OF FUNCTIONAL NEUROGENESIS IN THE ADULT BRAIN

Fred Gage, M.D., *10010 North Torrey Pines Road, La Jolla, CA 92037*

### SUMMARY:

Most neurons in the adult central nervous system are terminally differentiated and are not replaced when they die. Evidence now exists that small populations of neurons are formed in the adult olfactory bulb and hippocampus. In the adult hippocampus, newly born neurons originate from putative stem cells that exist in the subgranular zone of the dentate gyrus. Progeny of these putative stem cells differentiate into neurons in the granular layer within a month of the cells' birth, and this late neurogenesis continues throughout the adult life of all mammals. Stem cells can be harvested from a variety of brain and spinal cord regions, genetically modified, and transplanted back to the brain and spinal cord where they can differentiate into mature glia and neurons depending on the local environment. In addition, environmental stimulation can differentially affect the proliferation, migration, and differentiation of these cells *in vivo*. These environmentally induced changes in the structural organization of the hippocampus result in changes in electrophysiological responses in the hippocampus, as well as in hippocampal related behaviors. We are studying the cellular, molecular, as well as environmental influences that regulate neurogenesis in the adult brain and spinal cord.

No. 28C
## NEUROMORPHOMETRIC AND NEUROPATHOLOGICAL ABNORMALITIES IN MOOD DISORDERS

Wayne C. Drevets, M.D., *15K North Drive, MSC 2670, Bethesda, MD 20892-2670*

### SUMMARY:

Neuroimaging studies of major depressive disorder and bipolar disorder have identified abnormalities of brain function and structure in areas of the prefrontal cortex, mesial temporal cortex, and basal ganglia. Post-mortem studies of these areas demonstrate abnormal reductions of synaptic markers and glial cells, without corresponding loss of neurons, suggesting the volume loss results from a reduction in neuropil. These structural neuroimaging abnormalities persist across episodes, although the timing of their onset remains unclear.

Many of the regions affected by these structural changes show increased glucose metabolism during major depressive episodes. Because the glucose metabolic signal is dominated by glutamatergic transmission, these data suggest that excitatory transmission through the limbic-cortical-striatal-pallidal-thalamic circuits is elevated during depression. The co-occurrence of increased glutamatergic transmission in depressed subjects who are also hypersecreting cortisol further suggests that the grey matter reductions in these areas reflects dendritic atrophy, which can be produced in animal models by interactions between chronically elevated glucocorticoid secretion plus NMDA-glutamate receptor stimulation.

Mood stabilizing and antidepressant medications exert neuroplastic effects that may protect against such processes. Some mood stabilizers, in particular, appear to increase gray matter volume and protect against glial loss in bipolar disorder. These neuroplastic effects may prove integral to the therapeutic effects of such agents, because the structures affected by volumetric loss in mood disorders are known to participate in modulating emotional behavior.

### REFERENCES:

1. Sapolsky R: Stress, glucocorticoids and their adverse neurological effects: Relevance to aging. Experimental Gerontology 1999;34:721.
2. van Praag H, Kempermann G, Gage FH: Neural consequences of environmental enrichment. Nature Review Neuroscience 2000;1:191–198.
3. Drevets WC, Gadde K, Krishnan R: Neuroimaging studies of depression, in The Neurobiological Foundation of Mental Illness: Second Edition. Edited by Charney DS, Nestler EJ, Bunney BJ. Oxford University Press, New York, in press.

# INDUSTRY-SUPPORTED SYMPOSIUM 28—IMPAIRMENT OF STRUCTURAL PLASTICITY IN SEVERE MOOD DISORDERS: CAUSAL OR COLLATERAL? PART 2
## Supported by Abbott Laboratories

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss mechanisms involved in neurogenesis, cellular atrophy, and cell death; neuroimaging; and the effects of mood stabilizers on specific mollecular and cellular targets.

No. 28A
## REDUCED HIPPOCAMPAL VOLUME IN ADULT MAJOR DEPRESSION: THE ROLE OF CHILDHOOD

Meena Vythilingham, M.D., *15K North Drive, Room 111, MSC 2670, Bethesda, MD 20892-2670*

### SUMMARY:

Preclinical and clinical studies suggest that severe stress early in life is associated with persistent changes in the hypothalamic-pituitary-adrenal (HPA) axis and smaller hippocampal volume. Although the relationship between stress and major depressive disorder (MDD) is well established, prior hippocampal morphometric studies in MDD neither reported nor controlled for a history of early childhood trauma. Results from hippocampal morphometric studies in subjects with MDD with and without childhood abuse and healthy controls will be presented to highlight the contribution of trauma to smaller hippocampal volume in MDD, and explain the inconsistencies in magnetic resonance imaging (MRI) findings in MDD.

The theory that repeated hypercortisolemia during recurrent depressive episodes results in hippocampal volume loss and impaired declarative memory was examined in patients with MDD without a history of childhood abuse. Changes in hippocampal volume and declarative memory were measured after successful antidepressant treatment to evaluate if selective serotonin reuptake inhibitors (SSRIs) alter hippocampal structure and function in patients with MDD.

No. 28B
## TARGETING STRUCTURAL PLASTICITY FOR OPTIMAL TREATMENT OF SEVERE MOOD DISORDERS

Husseini K. Manji, M.D., *49 Convent Drive, Room B1EE16, MSC4405, Bethesda, MD 20892*

SUMMARY:

Recent genomic and proteomic studies have revealed unexpected long-term targets for the actions of mood stabilizers. Most notably, lithium and valproate have been shown to robustly activate neurotrophic and neuroprotective signaling cascades normally utilized by *endogenous growth factors.* Thus, both lithium and valproate activate the MAP kinase cascade, upregulate the major neuroprotective protein bcl-2, and have been demonstrated to exert neuroprotective effects in numerous preclinical studies, including in models of stroke and Huntington's disease. Complimentary cross-sectional human neuroimaging and postmortem studies suggest that patients chronically treated with these agents *do not* show prominent atrophy or glial loss. Furthermore, longitudinal high-resolution 3-D MRI and MRS studies have shown that not only does chronic lithium increase N-acetyl-aspartate levels, a marker of neuronal viability, but it actually increases *total gray matter content* in limbic and limbic-related areas in bipolar patients. The effects are regionally selective, and are not observed in healthy volunteers, suggesting a specific reversal of illness related atrophy by lithium. These exciting results have already led to the initiation of clinical trials with lithium and/or valproate as potential long term disease modifying agents in Alzheimer's disease and schizophrenia. The adjunctive use of these "plasticity enhancers" may produce optimal long-term treatment for severe neuropsychiatric disorders.

REFERENCES:

1. Vythilingam et al: Reduced Hippocampal Volume in Adult Major Depression: The Role of Childhood Trauma. Submitted for publication.
2. Manji HK, Drevets WC, Charney DS: The Cellular Neurobiology of Depression. Nature Medicine 2001;7(5):541–547.

## INDUSTRY-SUPPORTED SYMPOSIUM 29—IMPULSIVITY, AGGRESSION, AND SUICIDE: VERSATILITY OF LITHIUM AND MOOD STABALIZERS, PART 1
## Supported by Solvay Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize contributing factors to the development of impulsivity, aggression, and suicide, and adopt effective management strategies to reduce these problem behaviors.

### No. 29A
### TREATING IMPULSIVITY IN IMPULSE CONTROL AND PERSONALITY DISORDERS

Eric Hollander, M.D., *One Gustave Levy Place, Box 1230, New York, NY 10029;* Stefano Pallanti, M.D.; Erica Sood, B.A.; Daphne Simeon

SUMMARY:

Impulsivity, a trait dimension, is the failure to resist an impulse, drive, or temptation that is harmful to oneself or others. Behavioral manifestations include inability to wait for rewards, carelessness, risk taking, sensation seeking, underestimation of harm, and extroversion. Impulsivity is a core symptom of a broad spectrum of psychiatric disorders, including impulse control disorders, personality disorders, neurological disorders, and substance abuse. The neurocircuitry of impulsivity has been greatly elucidated, involving orbitofrontal-limbic circuits modulated by serotonergic, noradrenergic, dopaminergic, and GABA input. Comorbid psychiatric disorders, such as bipolar spectrum and attention-deficit hyperactive disorders, contribute to the expression of impulsivity. Thus, affective instability may be a target for pharmacological modulation of impulsivity.

We describe placebo-controlled pharmacological treatment trials of impulsivity. In bipolar spectrum pathological gamblers, sustained-release lithium was superior to placebo in reducing both affective instability and impulsive gambling. Controlled studies of mood stabilizers on impulsive aggression in impulsive personality disorders are also detailed. Mechanisms of action of lithium and mood stabilizers in impulsivity are presented, and successful treatment algorithm strategies for reducing impulsivity highlighted.

### No. 29B
### PRIMARY AND SECONDARY DISORDERS OF AGGRESSION IN YOUTH: MOOD STABILIZERS, ATYPICALS, AND STIMULANTS

Hans Steiner, M.D., *401 Quarry Road, Room 1136, Stanford, CA 94301*

SUMMARY:

*Background:* Disorders of aggression in youth can be divided into primary (oppositional defiant and conduct disorders) and secondary (disorders where aggression is not part of the syndrome definition, but a common complication, e.g. depression and bulimia). Psychopharmacology is relatively underutilized and understudied in these disorders.

*Methods:* A review of the literature and analyses of new data sets in underage boys and girls will be presented, examining the impact on different forms of aggression and disorders of aggression.

*Results:* Findings are that mood stabilizers, especially lithium carbonate, are most commonly studied and have been shown to be effective against affective impulsive aggression. Atypicals are most commonly prescribed, regardless of diagnosis. Stimulants have good effects on overt aggression and weaker effects on covert aggression. Studies with antidepressants are needed.

*Conclusion:* Our database on the psychopharmacology of aggression in youth is building and becoming more sophisticated. Specific pathways for intervention are emerging.

### No. 29C
### STRATEGIES FOR AUGMENTATION OF PSYCHOPHARMACOLOGICAL INTERVENTIONS IN YOUTH WITH DISORDERS OF AGGRESSION

Kirti Saxena, M.D., *4012 Quarry Road, Palo Alto, CA 94305*

SUMMARY:

Psychopharmacological interventions in youth have found increasing support in empirical and increasingly rigorously designed studies. Most of the extant literature emphasizes placebo controlled comparisons of single agents. There are some studies directly comparing comparable types of medications for the treatment of specific syndromes. However, mostly in children and adolescents, comorbidity is the rule rather than the exception, and the practitioner is usually faced with situations in which monotherapy is not maximally effective. Studies of add-on treatments and augmentation are needed. We are describing available data and background information for psychopharmacological augmentation strategies in youth. This is especially relevant in the treatment of juvenile bipolar disorder, disruptive behavior disorders, depression, and trauma-related psychopathology. The review of literature reveals no rigorously designed empirical studies regarding these interventions. However, we will discuss salient principles for the practitioners who find monotherapy ineffective, called from the existing clinical literature and based on several group's algorithms, as described in clinical manuals. We will

then show the application of these algorithms in our clinical case series. The safety and efficacy of these strategies will be discussed in detail.

REFERENCES:

1. Hollander E, Evers M: New developments in impulsivity. Lancet 2001;358:949–950.
2. Steiner H: The evaluation and management of aggression in juveniles. New Directions in Psychiatry 2002;22(11):355–369.
3. Carroll W, Hughes et al: Journal of American Academy of Child and Adolescent Psychiatry 1999;38:1442–1454.

## INDUSTRY-SUPPORTED SYMPOSIUM 29—IMPULSIVITY, AGGRESSION, AND SUICIDE: VERSATILITY OF LITHIUM AND MOOD DISORDER, PART 2
## Supported by Solvay Pharmaceuticals, Inc.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize contributing factors to the development of impulsivity, aggression, and suicide, and adopt effective management strategies to reduce these problem behaviors.

### No. 29A
### LITHIUM TREATMENT OF PATIENTS WITH SUICIDAL AFFECTIVE DISORDER: RISK FACTORS AND MEDIATORS

Jan A. Fawcett, M.D., *1725 West Harrison Street, Suite #955, Chicago, IL 60612*

SUMMARY:

Evidence has grown suggesting that lithium treatment decreases suicide and suicidal behaviors in patients with recurrent affective disorders. Reviews of 33 retrospective studies and one prospective study have provided evidence that the occurrence of suicide and suicide attempts is significantly less with patients receiving lithium treatment than in those not receiving lithium. A recent analysis did not support the conclusion that lithium has uniquely anti-suicidal properties. One possible issue in attributing an anti-suicidal effect to lithium is the fact that differences in compliance in those patients committing suicide has not been addressed completely by the retrospective analysis employed in the majority of studies. It is debated whether the putative anti-suicidal effect of lithium is related to improved clinical control of affective symptoms or whether lithium has a specific independent effect acting to reduce suicidal behaviors. It has been shown that many patients demonstrate a range of clinical symptoms acutely prior to suicide, including severe psychic anxiety, agitation, panic attacks, and global insomnia, as well as increased impulsiveness. Assessment and timely treatment of these target symptoms may prevent suicide. This presentation will consider the possible mechanisms by which lithium may reduce suicidal behavior and discuss the question of what patients in terms of diagnoses and risk factors for suicide might be appropriate for lithium treatment.

### No. 29B
### EFFECTS OF LITHIUM ON IMPULSIVITY, AGRESSION, AND SUICIDE

Frederick K. Goodwin, M.D., *2150 Pennsylvania Avenue, N.W., 8th Floor, Washington, DC 20037*

SUMMARY:

This presentation will review recent evidence that lithium can dramatically reduce suicide rates among manic depressive patients, an effect that may differentiate lithium from two other putative stabilizers, carbamazepine and divalproex. Since a history of aggressive behavior is a risk factor for completed suicide, data showing reductions in aggressive behavior on lithium will also be reviewed.[1,2]

The first large scale report suggesting an anti-suicide effect with lithium in recurrent affective disorder was a meta-analysis of 28 studies involving over 16,000 patients in which suicide averaged seven to eight times lower among patients on lithium compared with those that were not. Following a randomized two and a half year prospective study showing lithium superior to carbamazepine in preventing suicide in bipolar patients ($p<.02$), we compared the impact of lithium vs. divalproex and carbamazepine on suicides and attempts in two large HMO populations of bipolar patients (n= 28,728) followed for up to seven years. The rates of suicide per 1,000 patient years were 2.6 times higher among patients on either anticonvulsants (avg. 1.43) than on lithium (0.55). A similar pattern was noted for outpatient or inpatient suicide attempts. For the smaller group of patients on the *combination* of lithium and an anticonvulsant (n=3067), the rate of attempts was similar to the anticonvulsant alone groups.

REFERENCES:

1. Tondo L, Hennen J, Baldessarini RJ: Lower suicide risk with long-term lithium treatment in major affective illness: a meta-analysis. Acta Psychiatr Scand 2001.
2. Goodwin F, Hunkler E, Fireman B, Revicki D, Simon G: Comparative impact of lithium divalproex and carbamazepine on suicides and attempts in two large HMO's, submitted.

## INDUSTRY-SUPPORTED SYMPOSIUM 30—BIPOLAR DISORDER IN WOMEN: SPECIAL CONSIDERATIONS AND EVOLVING TREATMENT, PART 1
## Supported by GlaxoSmithKline

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be acquainted with the clinical management issues for bipolar women ranging from efficacy of treatment to the impact of treatment on reproductive endocrine function.

### No. 30A
### BIPOLAR DISORDER IN WOMEN: PHENOMENOLOGY AND RESPONSE TO TREATMENT

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

SUMMARY:

Bipolar disorder is a highly prevalent illness and is equally prevalent in men and women. Nonetheless, several studies have described gender-based differences with respect to clinical presentation of this illness. For example, rapid cycling bipolar disorder (RCBD) has been shown to be more common in women than men; whether response to treatment for RCBD is different in women compared with men has not been adequately described. This presentation will review gender-based differences in phenomenology of bipolar illness as well as available data on response to treatment with respect to major classes of compounds used to treat this illness. Gender-based differences with respect to diagnosis and treatment allows for more

effective treatment planning for patients and can minimize the morbidity associated with incompletely treated psychiatric illness.

### No. 30B
### COURSE AND TREATMENT OF BIPOLAR DISORDER DURING PREGNANCY

Lee S. Cohen, M.D., *15 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

While the postpartum period has typically been considered a period of risk for relapse of bipolar disorder, systematic data regarding the course of bipolar disorder during pregnancy are sparse. The management of bipolar women who plan to conceive or those who are pregnant or puerperal poses significant challenges for clinicians who care for these patients. Recent data suggest that pregnancy is not "protective" against relapse of psychiatric disorder and that for bipolar women specifically, relapse is common after lithium discontinuation.

This presentation reviews the major clinical dilemmas associated with management of 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 for women trying to conceive and during pregnancy will be presented. An algorithm for assessment of risks and benefits using both older and newer psychiatric medications across a variety of classes of compounds including antipsychotics and mood stabilizers will be presented. Given the growing use of anticonvulsants to treat bipolar illness, particular attention will be given on available reproductive safety data regarding these compounds.

REFERENCES:

1. Leibenluft E: Women with bipolar illness: clinical and research issues. Am J Psychiatry 1996;153:163–73.
2. Nonacs R, Viguera AC, Cohen LS: Psychiatric aspects of pregnancy, in Women's Mental Health. Edited by Kornstein SG, Clayton AH. Guilford Publications, New York, 2002.

## INDUSTRY-SUPPORTED SYMPOSIUM 30—BIPOLAR DISORDER IN WOMEN: SPECIAL CONSIDERATIONS AND EVOLVING TREATMENT, PART 2
## Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be acquainted with the clinical management issues for bipolar women ranging from efficacy of treatment to the impact of treatment on reproductive endocrine function.

### No. 30A
### BIPOLAR ILLNESS AND THE POSTPARTUM PERIOD: CLINICAL ISSUES AND CONTROVERSIES

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

SUMMARY:

The postpartum period is a period of risk for emergence of new onset psychiatric disorders, or for substantial worsening of pregravid mood and anxiety disorders. Recent work suggests that many bipolar women are especially vulnerable to relapse during the postpartum period. Estimates of risk for relapse among bipolar women during the postpartum period are between 30% and 50%. Several investigators have evaluated the extent to which postpartum prophylaxis with lithium attenuates such risk. Results of this work point to a significant reduction in rates of relapse in women who receive lithium during the first 48 hours postpartum compared with women who do not receive prophylactic treatment. However, there is no consensus on the best timing of prophylaxis and whether lithium is superior to other mood stabilizers as a prophylactic agent. Other clinical issues to be addressed in this presentation include the incidence of neonatal toxicity with use of mood stabilizers proximate to delivery, neurobehavioral outcome following exposure to mood stabilizers, and breastfeeding with mood stabilizers.

The goal of this presentation is to review data on the epidemiology, course, and treatment of bipolar illness during the postpartum period as well as to highlight controversial clinical issues related to mood stabilizers and neonatal outcome, neurobehavioral outcome, and breastfeeding, which are areas requiring further research.

### No. 30B
### USE OF ANTIEPILEPTICS MEDICATIONS IN WOMEN

Martha J. Morrell, M.D., *710 West 168th Street, New York, NY 10032*

SUMMARY:

Some antiepileptic drugs have negative effects on fertility, gynecological health, contraceptive efficacy, and pregnancy outcome. Cytochrome P450 enzyme inducing AEDs increase sex steroid binding and metabolism and reduce levels of estrogen and of androgens. AEDs, which inhibit cytochrome P450 enzymes, reduce metabolism and increase steroid concentrations. Some deficits are AED-specific, more than 40% of women with epilepsy on valproate have polycystic ovaries and/or hyperandrogenism and these abnormalities reversed when women were changed to lamotrigine.

Children born to mothers with epilepsy taking AEDs have a 4% to 8% risk of a major malformation, in contrast to 2% to 4% in the general population. Defects have been reported after exposure to all of the older AEDs used as monotherapy or in polytherapy, and after exposure to the newer AEDs used in polytherapy. Since older AEDs have anti-folate effects, the American Academy of Neurology recommends that women with epilepsy taking AEDs receive 0.8 to 1 mg/day of folic acid. A recent survey of health care providers documents a low level of knowledge and high degree of uncertainty regarding best practices in caring for women receiving AEDs. As use of AEDs grows, such knowledge is essential.

REFERENCES:

1. Viguera A, Nonacs R, Cohen L, Tondo L, Murray A, Baldessarni R: Risk of recurrence of bipolar disorder in pregnant vs. nonpregnant women after discontinuing lithium maintenance. Am J Psychiatry 2000;157:179–184.
2. Morrell MJ, Sarto GE, Osborne Shafer P, Borda EA, Herzog A, Callanan M: Health issues for women with epilepsy: a descriptive survey to assess knowledge and awareness among healthcare providers. J Women's Health Gender-Based Med 2000;9:959–965.

## INDUSTRY-SUPPORTED SYMPOSIUM 31—MANAGING THE SPECTRUM OF PSYCHOTIC DISORDERS, PART 1
## Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the importance and goals of treatment for first-episode and

acute psychosis, and the pros/cons of currently available antipsychotics for acute-phase pharmacotherapy; identify patient populations that pose particular challenges to treatment for psychosis; and describe psychosocial, pharmacologic, or other interventions that may be appropriate for these patients.

### No. 31A
### CLINICAL CONSIDERATIONS IN THE MANAGEMENT OF FIRST-EPISODE AND ACUTE EXACERBATION OF SCHIZOPHRENIA

Ira D. Glick, M.D., *401 Quarry Road, Suite 2122, Stanford, CA 94305-5490*

SUMMARY:

Treatment goals during the acute phase of schizophrenia are to prevent harm, control disturbed behavior, suppress psychosis, promote a rapid return to the patient's best level of functioning, and formulate both short- and long-term treatment plans to minimize the chances of relapse. Antipsychotic pharmacotherapy is indicated for nearly all acute psychotic episodes. Patients with schizophrenia have higher rates of suicide, as well as higher mortality rates from all causes, compared with the general population. Therefore antipsychotic therapy should begin early in the treatment plan to minimize risk of suicide or other dangerous behaviors. Prompt initiation of effective antipsychotic therapy may also improve patient recovery. Longer durations of untreated psychosis, particularly in first-episode schizophrenia, are associated with poor treatment response and long-term outcome (McGlashan and Johannessen, 1996). The selection of an antipsychotic medication, from among the many available conventional and second-generation agents, is determined after considering the agent's short-term efficacy and safety, patient tolerance of side effects, and the need for short-acting oral, short-acting intramuscular, or long-acting formulations. The current antipsychotic treatment arsenal will be significantly bolstered by the introduction of drugs' that can enhance compliance and post-hospitalization outcomes. A new generation of antipsychotic is currently under development that promises to improve upon many of the shortcomings of currently available therapies. Such a new-generation antipsychotic may have potential for becoming the treatment of choice for first-episode and acute exacerbation of schizophrenia.

### No. 31B
### CHALLENGES IN THE MANAGEMENT OF PSYCHOSIS IN SPECIAL POPULATIONS

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

SUMMARY:

Although currently available antipsychotic medications are generally safe and effective in a majority of individuals with psychotic disorders, special challenges exist in the treatment of some unique patient populations. A significant number of patients do not respond to either first-generation or second-generation antipsychotic agents. Even among those who do respond, incomplete response, loss of medication efficacy, and intolerance of side effects are problems that commonly confront patients and clinicians. In particular, elderly patients and those with complicating neurological or medical comorbidities may find the cardiac, motor, metabolic, and anti-adrenergic/anti-cholinergic side effects of some antipsychotics difficult to tolerate. Long-term compliance is also difficult to achieve in patients with significant cognitive impairment, and those without adequate social and family support networks. It is clear that many shortcomings currently exist in the treatment of psychosis in these special populations. Improvement of therapy for these patients may result from the introduction of newer generation antipsychotic agents with better efficacy and fewer side effects, as well as intensive psychosocial interventions that are specifically tailored to these unique patient groups.

REFERENCES:

1. McGlashan TH, Johannessen JA: Early detection and intervention with schizophrenia: rationale. Schizophr Bull 1996;22:201–222.
2. Glick I, Murray S, Vasudevan P, et al: Treatment with atypical antipsychotics: new indications and new populations. J of Psychiatric Res 2001;35:187–191.

## INDUSTRY-SUPPORTED SYMPOSIUM 31—MANAGING THE SPECTRUM OF PSYCHOTIC DISORDERS, PART 2
## Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the importance and goals of treatment for first-episode and acute psychosis, and the pros/cons of currently available antipsychotics for acute-phase pharmacotherapy; identify patient populations that pose particular challenges to treatment for psychosis; and describe psychosocial, pharmacologic, or other interventions that may be appropriate for these patients.

### No. 31A
### LONG-TERM EFFECTIVENESS OF ANTIPSYCHOTIC THERAPIES: REAL-WORLD CONSIDERATIONS

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

SUMMARY:

Efficacy rates for antipsychotic agents determined in carefully controlled clinical trials do not accurately estimate their long-term effectiveness in the real world. Although the past 40 years have brought real advances in the treatment of psychosis, long-term outcomes for patients with schizophrenia have remained disappointing. Among patients with schizophrenia, quality of life is often poor, fewer than 20% are employed in competitive work at any time, about two thirds suffer parkinsonian symptoms, and the lifetime risk of suicide is approximately 10%. Of successfully treated patients discharged from the hospital, 50% will be rehospitalized within one year; even when patients remain stable, symptoms may frequently persist (Weiden et al, 1996). Problems in the pharmacotherapy for individuals with schizophrenia may include partial effectiveness for psychotic symptoms and poor safety and tolerability that reduce compliance. In addition, although available second-generation antipsychotics improve negative symptoms and cognitive impairments, their effects are limited. Improvements in the long-term outcomes of patients with schizophrenia will occur when more patients receive effective psychosocial treatments combined with pharmacotherapy. This is more likely to occur as symptom control improves for partial responders to antipsychotics, when pharmacological strategies result in greater improvements in negative and cognitive symptoms, and when medications are introduced with improved safety and tolerability profiles. This talk will review new and innovative pharmacological strategies that have the potential for improving long-term outcomes in schizophrenia.

## No. 31B
## EVOLVING ROLE OF NOVEL ANTIPSYCHOTICS FOR THE MANAGEMENT OF ACUTE MANIA

Terence A. Ketter, M.D., *401 Quarry Road, Room 2124, Stanford, CA 94305-5723*

### SUMMARY:

Agents used to treat acute mania include the mood stabilizers lithium, divalproex, and carbamazepine, as well as first- and second-generation antipsychotics. Although mood stabilizers are cornerstones of mania treatment, response rates may be as low as 50%. Thus, the 2002 American Psychiatric Association Bipolar Disorder Treatment Practice Guideline Revision (BPTPG-R) continued to advocate adjunctive antipsychotics and benzodiazepines to manage acute agitation (with intramuscular preparations) or psychosis while awaiting or augmenting the effects of mood stabilizers. BPTPG also recommended antipsychotic plus mood stabilizer combinations for severe mania, and antipsychotic or mood stabilizer monotherapies in less ill patients. First-generation antipsychotics were previously widely used to treat mania, but are limited by poor tolerability. For example, extrapyramidal symptoms appear more common in patients with mania, than in patients with schizophrenia. BPTPG-R now advocates the use of second-rather than first-generation antipsychotics, based on better tolerability. Several second-generation antipsychotics have been effective for treatment of acute manic episodes in randomized trials, and novel agents such as aripiprazole, a partial dopamine receptor agonist and mixed serotonin receptor agonist/antagonist are currently being investigated. These studies should help further clarify the roles of new antipsychotics in the treatment of acute mania in patients with bipolar disorders.

### REFERENCES:

1. Weiden P. Aquila R, Standard J: Atypical antipsychotic drugs and long-term outcome in schizophrenia. J Clin Psychiatry. 1996;57(suppl 11):53–60.
2. Nemeroff CB: An ever-increasing pharmacopoeia for the management of patients with bipolar disorder. J Clin Psychiatry 2000;61(suppl13):19– .

# INDUSTRY-SUPPORTED SYMPOSIUM 32—TREATING DEPRESSION: WHAT MATTERS? PART 1
## Supported by Eli Lilly and Company

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the characteristics and burden of illness of difficult to treat depression and describe the clinical challenges associated with more difficult to treat depressions, including bipolar depression, treatment-resistant depression, and psychotic depression.

## No. 32A
## BRAIN MATTERS

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

### SUMMARY:

Converging evidence suggests that depression is unlikely a disease of a single brain region or neurotransmitter system. Rather, it is best viewed as a multidimensional, systems-level disorder affecting discrete but integrated pathways involving select cortical, subcortical, and limbic sites and their related neurotransmitter and molecular mediators. It is further postulated that depression is not simply the result of dysfunction in one or more components, but also involves failure to maintain homeostatic control in times of increased stress. Treatments for depression can similarly be viewed in this general framework, with different treatments modulating distinct targets resulting in a variety of complementary adaptive effects. To this end, regional abnormalities using functional neuroimaging have been identified in patients with depression, including changes associated with treatment response and failure. Although the relative contribution of individual regions varies as a function of clinical state, involvement of cortical, paralimbic, and subcortical regions is seen across studies. Cortical deficits normalize with treatment; paralimbic and subcortical regions show a more complex state-trait pattern. Formal testing of disease-specific and state-specific functional interactions among regions in this depression "network" will be discussed with an emphasis on markers of treatment resistance and relapse risk.

## No. 32B
## GENDER MATTERS

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

### SUMMARY:

The gender difference in the prevalence of major depressive disorder is one of the most consistent findings in psychiatric epidemiology. The higher rate of depression in women begins in early adolescence and persists through midlife. Gender differences in depression have also been demonstrated in symptom presentation, comorbid disorders, course of illness, and response to various treatments. The inclusion of women in clinical trials and a greater interest in examining the relationship between gender and outcome have contributed to a growing body of knowledge in this area. This talk will review available evidence regarding gender differences in the phenomenology and treatment of depression. The need for a gender-specific approach to evaluation and treatment will be discussed.

## No. 32C
## TREATING DEPRESSION: TIME MATTERS

Beny Lafer, M.D., *R Joaquin Floriano 871 #34, Sao Paulo, Brazil*

### SUMMARY:

The clinical use of antidepressants is marked by a two- to three-week delay in onset of their therapeutic action and up to 50% of patients fail to meet full remission after eight weeks of a single-drug treatment.

After achieving full remission the clinician should decide with the patient and based on several criteria if the treatment should be continued and for how long. Furthermore, a high proportion of patients will present a relapse or recurrence in the long-term follow-up, and maintenance treatment should be administered in the majority of cases.

This presentation will review clinical and prospective studies that focus on predictors of good and poor response for an acute antidepressant trial and the ideal timing for switch and/or optimization of treatment. Prospective maintenance studies that focus on strategies in relation to class of drug used and long-term treatment duration will be reviewed.

Data will be presented in order to emphasize that in the treatment of major depression time matters in several ways: time to achieve acute response, time to make important clinical decisions (switch, optimization, augmentation), and duration of maintenance treatment.

# INDUSTRY-SUPPORTED SYMPOSIUM 32—TREATING DEPRESSION: WHAT MATTERS? PART 2
## Supported by Eli Lilly and Company

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the characteristics and burden of illness of difficult to treat depression and describe the clinical challenges associated with the more difficult to treat depressions including bipolar depression, treatment-resistant depression, and psychotic depression.

## No. 32A
## BIPOLAR MATTERS

Lori L. Altshuler, M.D., *300 Medical Plaza, Suite 1544, Los Angeles, CA 90024;* Mark A. Frye, M.D.

### SUMMARY:

While the literature abounds in randomized, double-blind trials for unipolar depression, very few controlled treatment trials have been performed for bipolar depression.

In this lecture, the classic symptoms of bipolar depression and the limited treatment trials will be reviewed. The concerns to consider when treating bipolar depression, including antidepressant-induced mania, cycling, and treatment resistance will be discussed. New data on augmentation approaches and maintenance strategies will also be reviewed.

### REFERENCES:

1. Mayberg HS, Brannan SK, Mahurin RK, McGinnin S, Silva JA, Tekell JL, Jerabek PA, Martin CC, Fox PT: Regional metabolic effects of fluoxetine in major depression: serial changes & relationship to Clinical Response. Biol Psychiatry 2000;48:830–843.
2. Kornstein SG, Wojcik BA: Depression, in Women's Mental Health: A Comprehensive Textbook. Edited by Kornstein SG, Clayton AH. Guilford Press, 2002, pp. 147–165.
3. Post RM, Altshuler LL, Frye MA, Suppos T, Rush AJ, Keck PE, McElroy SL, Denicoff KD, Leverich GS, Kupka R, Nolen WA: Rate of switch in bipolar patients prospectively treated with second generation antidepressants as augmentation to mood stabilizers. Bipolar Disorders 2001;3:259–265.

## No. 32B
## TREATMENT MATTERS

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

### SUMMARY:

Most head-to-head trials of antidepressants, whether placebo-controlled or not, find that active treatments have similar response rates. Some studies have shown advantages of one antidepressant or another in terms of response rates, while others have shown differences in remission rates. Important issues to consider when interpreting these studies, relevant to clinical practice, are the rate of dose increase, whether the minimally effective or maximally tolerated dose was used, and differences in dropout rates due to either lack of efficacy or intolerable side effects. When newer antidepressants are introduced into the market, while they are shown to have efficacy (better than placebo), the advantages and disadvantages over existing antidepressants are sometimes less clear. Remission, however, seems to be an important outcome that is starting to show differences between antidepressants. This presentation will review the benefits (including remission rates) and risks of SSRIs (fluoxetine, paroxetine, sertraline, citalopram, escitalopram), TCAs, MAOIs, bupropion, mirtazapine, nefazodone, venlafaxine, and duloxetine. Also, optimal treatment tactics will be discussed.

### REFERENCES:

1. Nierenberg AA, McLean NE, Alpert JE, Worthington JJ, Rosenbaum JF, Fava M: Early nonresponse to fluoxetine as a predictor of poor 8-week outcome. Am J Psychiatry 1996;153(11):1508–1509.

# INDUSTRY-SUPPORTED SYMPOSIUM 33—EVIDENCE-BASED TREATMENT OF PSYCHIATRIC DISORDERS, PART 1
## Supported by Wyeth Pharmaceuticals

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the principles of evidence-based mental health.

## No. 33A
## EVIDENCE-BASED MEDICINE: WHAT IS IT?

K. Ranga R. Krishnan, M.D., *Box 3950 DUMC, Durham, NC 27710*

### SUMMARY:

Evidence-based medicine is not cookbook medicine. It is also not a cost cutting venture. It is the integration of best evidence with the best clinical knowledge to enhance the treatment of patients. In evidence-based medicine, the first step is to ask the right question, the next step is to identify the available evidence, then appraise the evidence and then apply to a given clinical situation. The first step in formulating the questions is to get it to the key question for the given problem, i.e., is treatment X better than treatment Y? The next step is to search for evidence. One of the best sources is the Cochrane reviews. Another ideal resource is the Medline. If the evidence has been appraised before, then it makes it easy. If not one has to quickly appraise the material to make it useful. The appraisal is to first ask if there are systematic reviews, i.e., Cochrane, if not randomized trials, if not open label trials, if not epidemiological work, and finally, case reports or series. As we go down the ladder, the quality of evidence becomes weaker. In this presentation, we will go through the steps in appraising the evidence and then illustrate how to integrate with the clinical treatment decision. We will introduce the concept of Number Needed to Treat and how to use this to evaluate whether one treatment is better than another. We will also discuss how to conduct a systematic review and evaluate metanalyses.

## No. 33B
## EVIDENCE-BASED MEDICINE AND DEPRESSION TREATMENTS

Michael E. Thase, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593*

### SUMMARY:

An evidence-based medicine (EBM) approach is well suited for selection of treatments that are known to be effective for depression. For depressed outpatients, EBM-validated treatments include various classes of antidepressants and several forms of psychotherapy. The combination of psychotherapy and pharmacotherapy is most likely to offer added benefits for patients with more severe and recurrent, chronic, or complicated depressive disorders. Heretofore, there has been little evidence of a true differential therapeutics of depression that could be confirmed with meta-analytic techniques. Recently,

however, it has been recognized that the contributions of various active components of treatment response are typically dwarfed by the so-called nonspecific correlates of response. With this knowledge, larger data sets can be re-examined to look for the smaller-sized effects likely to be attributable to mechanistically different (presumably) treatment effects. Appropriately powered metaanalyses confirm a number of clinically meaningful differences between treatments, including comparisons of TCAs and MAOIs or SSRIs, as well as among SSRIs, venlafaxine, and other newer antidepressants.

## No. 33C
## EVIDENCE-BASED MEDICINE: SCHIZOPHRENIA

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

### SUMMARY:

The evidence base for various treatments for schizophrenia will be reviewed using systematic reviews where possible. The following topics will be reviewed. Assertiveness community training: ACT invariably reduced the cost of hospital care, but did not have a clear-cut advantage over standard care when other costs were taken into account. Case Management: Case management approximately doubled the numbers admitted to psychiatric hospitals. Cognitive Rehabilitation Techniques: Cognitive rehabilitation was as acceptable as placebo and occupational therapy with low attrition in both groups, no effects were demonstrated. Determine the effects of risperidone compared with other atypical antipsychotic drugs for schizophrenia. The equivalence of clozapine and risperidone for treatment-resistant schizophrenia cannot be assumed and there seems to be little to choose between risperidone and olanzapine in terms of efficacy. Zipresidone compared with placebo, typical and other atypical antipsychotic drugs for schizophrenia: Ziprasidone may be an effective antipsychotic with less extrapyramidal effects than haloperidol but has more nausea than other typicals. Olanzapine as compared with placebo, typical and other atypical antipsychotic drugs for schizophrenia: Olanzapine may offer antipsychotic efficacy with fewer extra-pyramidal side effects than typical drugs but more weight gain. Quetiapine: Quetiapine may produce lower incidences of suing medication for extrapyramidal side effects such as parkinsonism, akathisia and dystonia.

### REFERENCES:

1. Tansella M: The scientific evaluation of mental health treatments: an historical perspective. Evidence Based Mental Health 2002;5:4–5.
2. Thase ME: Studying new antidepressants: if there was a light at the end of the tunnel could we see it? Journal of Clinical Psychiatry 2002;63(Suppl 2):24–28.
3. Gorman JM, Kent JM: SSRIs and SNRIs: Broad spectrum of efficacy beyond major depression. J Clinical Psychiatry 1999;60(suppl. 4):33–38.

# INDUSTRY-SUPPORTED SYMPOSIUM 33—EVIDENCE-BASED TREATMENT OF PSYCHIATRIC DISORDERS, PART 2
## Supported by Wyeth Pharmaceuticals

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the principles of evidence-based mental health.

## No. 33A
## EVIDENCE-SUPPORTIVE THERAPIES FOR GAD AND SOCIAL ANXIETY DISORDER

Jack M. Gorman, M.D., *1051 Riverside Drive Unit 32, New York, NY 10032*

### SUMMARY:

As is the case with other anxiety disorders and with depression, rigorously controlled and appropriately analyzed studies support the use of two types of treatment for generalized anxiety disorder (GAD) and social anxiety disorder (SAD): medication and cognitive-behavioral psychotherapy. For GAD, there are numerous studies supporting the efficacy of benzodiazepines and the azapirone buspirone. However, data suggest that antidepressants are more effective. The largest available databases for antidepressant medication in the treatment of GAD involve extended-release venlafaxine and paroxetine. Data also show that applied relaxation therapy and cognitive-behavioral therapy (CBT) are at least as effective as medication, although there are to date no published trials directly comparing medication with psychosocial interventions. For SAD, controlled data exist for the benzodiazepine clonazepam and for the monoamine oxidase inhibitor phenelzine. The most extensive databases involve the selective serotonin reuptake inhibitors paroxetine, sertraline, and fluvoxamine. Group CBT has also been extensively studied and yields effect sizes at least as good as medication. One direct head-to-head comparison between medication (phenelzine) and group, CBT showed that the former worked more quickly than the latter, that both active therapies were better than control treatment and equal to each other in efficacy, and the CBT provided a more durable response than medication.

## No. 33B
## EVIDENCE-BASED ECT AND TRANSCRANIAL MAGNETIC STIMULATION

Sarah H. Lisanby, M.D., *1051 Riverside Drive, NYSPI #126, New York, NY 10027-6902*

### SUMMARY:

Decades worth of research are available to support the high degree of efficacy and safety of electroconvulsive therapy (ECT) in the treatment of major depression and other disorders. In comparison, transcranial magnetic stimulation (TMS) is a relatively new experimental technique. Both ECT and TMS are devices that induce electrical current in the brain, thereby modulating cerebral functioning. Critical questions about appropriate dosage, site of administration, and patient selection pertain to both ECT and TMS. Recently, several studies have directly compared the efficacy of ECT with TMS. In evaluating the evidence for the efficacy of various ECT modalities, large blinded, randomized clinical trials are available. In the case of TMS, the evidence base is much smaller. Nevertheless, a Cochrane review and other meta-analyses of the efficacy of TMS are available, as are a growing number of blinded, randomized clinical trials. The evidence for and against the efficacy of TMS will be reviewed, and the quality of the evidence will be critically evaluated.

### REFERENCES:

1. Konradi C, Heckers S: Antipsychotic drugs and neuroplasticity: insights into the treatment and neurobiology of schizophrenia. Biological Psychiatry 2001;50(10):729–742.
2. Burt T, Lisanby SH, Sackeim HA: Neuropsychiatric applications of transcranial magnetic stimulation: a meta analysis. International Journal of Neuropsychopharmacology 2002;5:73–103.

# INDUSTRY-SUPPORTED SYMPOSIUM 34—MANAGING ANXIETY AND SLEEP: A NEW ERA FOR GAMMA-AMINOBUTYRIC ACID, PART 1
## Supported by Cephalon Inc.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, psychiatrist will learn the physiologic and potential pathophysiologic roles of GABA. Additionally, psychiatrists should understand the differences between the management of neuropsychiatric syndromes versus symptoms, particularly with novel GABAergic medications.

## No. 34A
## NUANCES OF INHIBITION: GAMMA-AMINOBUTYRIC ACID IN THE HUMAN BRAIN

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

### SUMMARY:

Gamma-aminobutyric acid (GABA) is the principal inhibitory neurotransmitter in the brain and acts on three receptor classes: GABA-A, GABA-B and GABA-C. GABA-A and GABA-C receptors are ionotropic receptors with an integral anion channel, whereas GABA-B receptors are metabotropic acting via G-protein coupled mechanisms. Through these differing receptors and anatomical localization, GABA can have global as well as selectively nuanced inhibitory effects. These effects can fundamentally alter the functional activity of critical neurocircuits relevant to psychiatry.

The GABA-A receptor effects have been the principal focus of drug discovery because of their multiple effects including affect regulation, cognition, and the stress response. Agents affecting the GABA-A receptor include agonists such as benzodiazepines, inverse agonists such as beta-carbolines, and antagonists such as flumazenil. Endogenous neurosteroids also have complex and clinically important effects. At least 14 subunits of the mammalian GABA-A receptor have been identified and cloned. Subunits differentially mediate the anxiolytic and sedative effects of benzodiazepines. Through its interactions with various systems such as serotonin and CRF, GABA has complex and multi domain effects. Novel GABAergic agents have different pharmacological and therapeutic effects and will be examined for the practicing clinician. The goal will be to place in perspective the role of GABAergic agents in the symptom and syndromal management of the spectrum of neuropsychiatric disorders seen in psychiatric practice.

## No. 34B
## GAMMA-AMINOBUTYRIC ACID MECHANISMS IN SLEEP DISORDERS

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

### SUMMARY:

Increasingly, GABAergic neurons are being found to play a key role in determining both wakefulness and sleep. A recent animal study showed, somewhat unexpectedly, that injection of the inhibitory neurotransmitter gamma aminobutyric acid (GABA) into the pontine reticular formation induces prolonged periods of wakefulness. Conversely, the application of bicuculline, a GABA-A antagonist, produces long durations of REM sleep. Benzodiazepines historically, and more selective GABA-A agonists over recent years, have demonstrated the consistent effect of reducing sleep latency (presumably by increasing arousal thresholds) and frequently increasing total sleep time. The increase in sleep time has generally been due to an increase in the lighter stages of non-REM sleep. Two large human trials have shown marked close-dependent increases in slow wave sleep and sleep EEG delta power with sodium oxybate, a putative GABA B agonist with reported indirect dopaminergic activity. These studies noted a high correlation between the increased delta power and improvements in objective measures of daytime alertness. Case reports have also suggested that some GABAergic medications can normalize sleep architecture in patients with anxiety disorders. Selective GABA reuptake inhibition with tiagabine has been shown to correlate with significant improvements in slow-wave sleep suggesting a possible role in the treatment of chronic insomnia, a condition with much symptom overlay with other chronic anxiety disorders. Findings of reduced arousal threshold coupled with enhanced sensory evoked responses during sleep in chronic insomniacs lead to the speculation of altered GABA activity during sleep as well as prior to sleep onset in these patients. In contrast to the difficulties initiating and/or making sleep experienced by insomniacs, narcopeptics suffer marked difficulties maintaining wakefulness. The majority of those individuals have complete atrophy of CNS hypocretia containing neurons. These neurons may play a key role in inhibitory feedback to GABA neurons during the light portion of the circadian cycle. These findings again point to the importance of the sleep-wake regulatory role of GABA neuronal systems.

### REFERENCES:

1. Northoff G: GABA-ergic modulation of prefrontal spatio-temporal, activation pattern during emotional processing: a combined fMRI/MEG study with placebo and lorazepam. Journal of Cognitive Neuroscience 2002;14(3):348–70.

# INDUSTRY-SUPPORTED SYMPOSIUM 34—MANAGING ANXIETY AND SLEEP: A NEW ERA FOR GAMMA-AMINOBUTYRIC ACID, PART 2
## Supported by Cephalon Inc.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, psychiatrist will learn the physiologic and potential pathophysiologic roles of GABA. Additionally, psychiatrists should understand the differences between the management of neuropsychiatric syndromes versus symptoms, particularly with novel GABAergic medications.

## No. 34A
## NOVEL GAMMA-AMINOBUTYRIC ACID TREATMENTS IN NEUROPSYCHIATRIC DISORDERS

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

### SUMMARY:

Benzodiazepines (BZs) are used clinically for the treatment of anxiety, insomnia, seizure disorders, and muscle tension. They also have pharmacological amnestic side effects and the potential for withdrawal after continuous use. Though BZs have benefits in the management of syndromes like anxiety disorders (e.g. panic disorder), they are also used for symptom control in multiple psychiatric and general medical disorders. Use for such different purposes do not change the pharmacological effects of BZs and clinicians may fail to monitor effects different from the therapeutic target symptom.

The mechanism of action of BZs is through allosteric modulation of the GABA-A receptor. Novel GABAergic agents, including several anticonvulsants, may have more selective or global effects compared with the BZs. Preliminary studies and case reports suggest

that these novel GABAergic drugs may provide an anxiolytic benefit equivalent to that of the BZs without undesirable sedating and dependence producing effects. These issues will be examined so that the promise of science can be best translated to clinical practice.

### No. 34B
### IN VIVO MEASUREMENTS OF GAMMA-AMINOBUTYRIC ACID IN NEUROPSYCHIATRIC DISORDERS

Linda Chang, M.D., *P.O. Box 5000 Building 490, Upton, NY 11973*

SUMMARY:

Gamma-amino-butyric acid (GABA) is a major inhibitory neurotransmitter in the brain, and is linked to the metabolism of glutamate, glutamine, and the TCA cycle. The anatomical localization and possible roles of GABA in anxiety and mood disorders will be reviewed. In addition, clinical studies measuring GABA *in vivo,* using proton magnetic resonance spectroscopy, in neuropsychiatric disorders will be reviewed and discussed.

## INDUSTRY-SUPPORTED SYMPOSIUM 35—FACING UNMET NEEDS: ATYPICAL ANTIPSYCHOTICS FOR MOOD AND ANXIETY
## Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the benefits as well as limitations of the current therapeutic modalities for the treatment of mood and anxiety disorders; examine the potential role of atypical antipsychotics to improve patient outcomes.

### No. 35A
### MECHANISM OF ACTION OF ATYPICAL ANTIPSYCHOTICS IN MOOD AND ANXIETY DISORDERS

Pierre Blier, M.D., *100 Newell Drive, Suite LA100, Gainesville, FL 32610;* Steven T. Szabo, Ph.D.; Peter Berqvist; Jianming Dong, Ph.D.

SUMMARY:

Atypical antipsychotics exert a variety of neurochemical effects, making them drugs of choice in the treatment of psychotic disorders. These properties, mainly 5-$HT_2$ and D2 receptor antagonism, appear to confer these agents effectiveness when combined with antidepressant drugs. Selective serotonin (5-HT) reuptake inhibitors (SSRIs) enhance 5-HT transmission in brain regions involved in mediating depressive and obsessional compulsive symptoms (OCS) with a delay that is consistent with the differential times they require to exert their therapeutic actions in these disorders. It is postulated that atypical antipsychotics can potentiate the action of SSRIs in OCS by blocking D2 receptors because they do not block effectively 5-HT2 receptors in the orbitofrontal cortex, a brain region intimately involved in OCS. In major depression and PTSD, the beneficial action of these antipsychotics, when added to a SSRI, may result from an enhancement of norepinephrine (NE) transmission. This is based, in part, on their capacity to increase NE neuronal firing on their own. As well, the combination of 5-HT reuptake inhibition and 5-$HT_{2A}$ antagonism enhances NE release. This produces an initial inhibition of the firing of NE neurons, which is then followed by a complete recovery due to the desensitizion of the $\alpha_2$-adrenergic autoreceptors.

### No. 35B
### USE OF ATYPICAL ANTIPSYCHOTICS IN MOOD DISORDERS

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

SUMMARY:

Currently available agents in treatment of mood disorders include antidepressants (TCAs, SSRIs, MAOIs, and other agents) and mood stabilizers (e.g., valproate, lithium, carbamazepine). Emerging data also suggest that some atypical antipsychotic agents (risperidone and olanzapine) possess antidepressant and mood-stabilizing properties, at least in patients with bipolar disorder. Treatment of patients with mood disorders often necessitates combination treatments, because only a relatively small fraction of patients with mood disorders attain remission with monotherapy. In the case of treatment-resistant major depression, current recommendations include switching to another class of antidepressant, combination of two antidepressants with differing mechanisms of action, or augmentation therapy with lithium or thyroid hormone. Adding the atypical antipsychotics olanzapine and risperidone to SSRIs has been found to be helpful in two small studies. In bipolar disorder, combinations of mood stabilizers and antidepressants have been found to be beneficial as well. Several recent studies also indicate an additional benefit of atypical antipsychotics as adjunctive therapies to mood stabilizers for rapid reduction of symptoms in mania. There is also evidence that monotherapy with atypical antipsychotics is as effective as treatment with mood stabilizers in the treatment of mania. Additionally, the improved safety profile of atypical vs typical antipsychotics renders them an attractive choice as adjunct therapy in treatment-resistant mood disorders. This presentation will review the current data on the use of atypical antipsychotics as adjunctive and monotherapy in the treatment of mood disorders.

### No. 35C
### TREATMENT OF ANXIETY DISORDERS: THERAPEUTIC CHALLENGES OF THE FUTURE

Olga Brawman-Mintzer, M.D., *PO Box 250861, Charleston, SC 29425-0001*

SUMMARY:

Anxiety disorders are chronic and debilitating illnesses, affecting at least 25% of the U.S. population. The economic burden associated with anxiety disorders is substantial, reaching approximately $42 billion in 1990 in the U.S. alone. In the last decade significant advances in the treatment of anxiety disorders have been made, particularly with the advent of the selective serotonin reuptake inhibitors (SSRIs) in this patient population. However, despite effective treatments, many patients remain symptomatic and remission rates remain relatively low. Increasingly, psychiatrists are faced with complex, often comorbid patients, who didn't exhibit full response to prior treatments, and the need for additional therapeutic strategies is emerging. This presentation will examine the available therapeutic strategies in the management of anxiety disorders. The limitations of currently utilized treatments in specific patient populations will be addressed.

Further, review of newer treatment options, specifically the potential role of atypical antipsychotics in the management of these patient populations, will be presented. Finally, the risks associated with these new treatments, and their potential impact in this patient population, will be examined.

## No. 35D
## ATYPICAL ANTIPSYCHOTICS IN PTSD: RATIONALE AND ROLE

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

### SUMMARY:

Posttraumatic stress disorder (PTSD) is a prevalent, often chronic, significantly disabling illness. A subset (5% to 10%) of patients with PTSD exhibit psychotic symptoms; these patients tend to be poorly responsive to treatment with selective serotonin reuptake inhibitors (SSRIs) alone but show beneficial effects of adjunctive treatment with atypical antipsychotic agents.

Non-psychotic PTSD is responsive to SSRIs, but response rates in controlled studies rarely exceed 60% and even fewer patients (20% to 30%) experience improvement that could be characterized as remission. Consequently, a role exists for adjunctive treatments that might further improve outcomes. Promising results with atypical antipsychotic agents in PTSD with psychotic symptoms, combined with a theoretical rationale for reducing hyperarousal associated with hyperactivity in stress-responsive neuronal systems, has led to testing of these agents as stand-alone or adjunctive treatments in PTSD without psychosis. Results from double-blind, placebo-controlled research in this area will be presented.

## No. 35E
## WORKING WITH THE PATIENT AS A CO-THERAPIST: STRATEGIES TO ENHANCE TREATMENT

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

### SUMMARY:

Adherence to medication treatment is a central issue for the longer-term management of a wide variety of psychiatric disorders. For example, despite a plan for long-term (if not lifelong) medication use in bipolar disorder, there is reliable evidence that adherence to pharmacotherapy often fails within the first several months of treatment. This presentation provides a practical clinical model for strategies to enhance medication adherence. Adherence difficulties associated with both acute and maintenance phases of treatment will be discussed, along with review of emprically supported strategies to enhance adherence, including the role of motivational interviewing and use of life-history motivational strategies with patients with affective disorders. These strategies will be placed in the context of social/psychological research indicating factors that are likely to influence the patient's opinions about their care and the importance of compliance with treatment. This information will be summarized in the context of practical clinical strategies for improving adherence and outcome in pharmacotherapy.

### REFERENCES:

1. Szabo ST, Blier P: Effects of the selective serotonin reuptake blocker and 5-HT2A receptor antagonist YM992 on the firing activity of locus coeruleus noradrenergic neurons. Journal of Pharmacology and Experimental Therapeutics, 2002 (in press).
2. Nemeroff CB: Augmentation strategies in patients with refractory depression. Depress Anxiety 1996–97;4(4):169–81.
3. McDougle CJ, Epperson N, Pelton GH, Wasylink S, Price LH: A double-blind, placebo-controlled study of risperidone addition in serotonin reuptake-refractory OCD. Arch Gen Psychiatry 2000;57:794–801.
4. Stein MB, Kline NA, Matloff JL: Adjunctive olanzapine for SSRI-resistant combat-related posttraumatic stress disorder: a double-blind, placebo-controlled study. American Journal of Psychiatry, in press.
5. Otto MW, Reilly-Harrington N, Sachs G: Psychoeducational and cognitive-behavioral strategies in the management of bipolar disorder. Journal of Affective Disorders, in press.

# INDUSTRY-SUPPORTED SYMPOSIUM 36—BIPOLAR DISORDER ACROSS THE LIFE CYCLE
## Supported by Abbott Laboratories

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the impact of early diagnosis and comorbidities on a bipolar disorder patient's course of illness, and review pharmacologic treatment strategies for bipolar disorder throughout phases of the illness and life cycle.

## No. 36A
## REPRODUCTIVE HEALTH AND METABOLIC CORRELATES IN WOMEN RECEIVING TREATMENT FOR BIPOLAR DISORDER

Natalie L. Rasgon, M.D., *300 Medical Plaza, Suite 1544, Los Angeles, CA 90095-7057*

### SUMMARY:

Menstrual abnormalities and endocrine dysfunction have been reported at a high rate among women receiving treatment for bipolar disorder (BPD). Medications used to treat BPD (e.g., lithium, divalproex [VPA], and atypical antipsychotics) have been shown to alter endocrine function, possibly influencing serum levels of reproductive hormones, and consequently impacting reproductive function. However, only one study has been published to date, which specifically addresses medication effects on reproductive endocrine function in women with BPD. Several reports have been published, however, that have addressed this topic in women with epilepsy, some suggesting an association between the anticonvulsants used in treatment (namely, VPA) and reproductive abnormalities in women ranging from menstrual dysfunction to polycystic ovary syndrome (PCOS). Yet, controversy still exists as to whether manifestation of menstrual abnormalities and PCOS in women with epilepsy is related to the administration of anticonvulsants or is specifically related to epilepsy. Similarly, no consensus has been reached regarding the association between reproductive endocrine function and anticonvulsant use for the treatment of BPD.

This presentation will review data available from women receiving anticonvulsants for the treatment of BPD. Evidence supporting etiological models of reproductive dysfunction in women with BPD will be considered, and diagnostic and treatment options will be discussed.

## No. 36B
## BIPOLAR DISORDERS IN ADULTHOOD

John M. Zajecka, M.D., *1725 West Harrison Street, Suite 955, Chicago, IL 60612*

### SUMMARY:

Bipolar disorder is more prevalent than many realize. Rates of bipolar disorders range from 2.6% to 7.8% of the adult population. Yet the bipolarity often goes unrecognized as patients generally present in outpatient settings with depressed symptoms. This misdiagnosis can lead to devastating consequences. Practical suggestions for clinicians will be offered for differential diagnosis. The rapid

and safe reduction of manic symptoms is an important initial goal of the pharmacologic treatment of acute mania. For both humanitarian and economic reasons, interest in rapidly reducing symptoms of mania with pharmacologic loading strategies has increased over the past decade. Therapeutic strategies for complex cases will be outlined, and the research basis supporting these approaches will be critiqued.

## No. 36C
## SECONDARY MANIAS AND COMORBID CONDITIONS

James C.Y. Chou, M.D., *Room 20W13A NBA 462 First Avenue, New York, NY 10016*

### SUMMARY:

The DSM-IV does not allow clinicians to diagnose secondary mania as bipolar disorder; however, these patients differ from those who do not develop mania on antidepressants or stimulants. Given the development of antidepressant-exacerbated manic symptoms, there may be some underlying bipolar diathesis. Bipolar patients are at significant risk for substance abuse and dependence, with a prevalence rate of 40% to 60%. Some data suggest the most common psychiatric diagnosis among cocaine abusers other than cocaine dependence is bipolar disorder. The following four theories of comorbid substance abuse and bipolar disorder will be reviewed: a genetic predisposition to both, bipolar disorder causes people to use substances, substance abuse causes people to have bipolar disorder, and people are treating their bipolar disorder with substances. In the general population, migraine is more common in women, but among bipolar patients there is equal gender distribution. Furthermore, the rate of migraine among bipolar patients is very high. Among children and adolescents, most bipolar patients also qualify for an ADHD diagnosis, although the converse is not true. Treatments for ADHD may affect the course of bipolar disorder. Recommendations for treatment will focus on the use of mood stabilizers and atypical antipsychotics in these populations, with emphasis on treating the mood disorder first and the comorbid condition second.

## No. 36D
## COMBINATION TREATMENTS: WHAT TO USE AND WHEN

Joseph R. Calabrese, M.D., *11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*

### SUMMARY:

Bipolar illness is a severe, heterogeneous disorder that presents clinicians with numerous challenges. Combination therapy has become the standard of care in the treatment of bipolar disorder, and particularly in patients with treatment-refractory variants such as those with rapid cycling. The emerging consensus is that if one follows a patient on monotherapy for sufficiently long periods of time, that individual will eventually require treatment with a concomitant agent or agents to maintain full remission. New treatments for all clinical states of bipolar disorder have been developed, which translates to many choices for the clinician. This presentation will discuss these choices of combination treatment strategies for patients with bipolar disorder. Up to one-fourth of bipolar patients may develop rapid-cycling disorder, in which four or more episodes occur within a year. 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, based on the revised APA Guidelines for the Treatment of Patients With Bipolar Disorder, will be reviewed.

## No. 36E
## MANAGEMENT OF SIDE EFFECTS AND TREATING TO WELLNESS

Charles L. Bowden, M.D., *7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

### SUMMARY:

Despite an expanded number of treatments with good evidence of efficacy for one or more aspects of bipolar disorder, many patients either fail to achieve or maintain optimal levels of both symptomatic and functional outcome over long periods. Although a portion of such sub-optimal outcomes is inherent to the disease, most stem from a lack of consistent application of current knowledge and treatments. A fundamental step is to engage the patient to collaborate with the psychiatrist and treatment team. This entails education and often specific counseling. Treatment regimens need to be developed over sufficient time to optimally apply each component, and also combine medications with markedly differing profiles of benefit and tolerability. Some of the steps to achieve this high level of wellness are straightforward: physicians often stop at a dosage of medication that yields modest improvement, when further medication might yield remission. Case illustrations of the approaches suitable to use with current medications will be presented.

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5. Bowden CL, Gonzales CL: Prevention of recurrences in patients with bipolar disorder. Treatment of Recurrent Depression. Review of Psychiatry. Edited by Greden JF, Oldham JM, Riba MB. American Psychiatric Publishing, Inc. Washington DC, 2001, pp 81–101.

# INDUSTRY-SUPPORTED SYMPOSIUM 37—SLOWING DISEASE PROGRESSION AND THE LONG-TERM MANAGEMENT OF DEMENTIA
## Supported by Novartis Pharmaceuticals Corporation

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the audience will be familiar with the neuropathological and neurochemical changes associated with progression of named dementias, the role of ChE enzymes in AD, and the impact of inhibiting such enzymes.

## No. 37A
## MECHANISMS OF DISEASE PROGRESSION IN DEMENTIA

Nigel Greig, Ph.D., *5600 Nathan Shock Drive, Baltimore, MD 21224-6825*

### SUMMARY:

*Objectives:* To provide an overview of the theories put forward to explain the progressive symptomatic pattern of disease progression associated with dementia.

*Summary of Presentation:* Two cholinesterase (ChE) enzymes, butyrylcholinesterase (BuChE) and acetylcholinesterase (AChE), exist in the central nervous system. In the normal brain, AChE expression predominates. However, BuChE activity increases progressively over the course of AD, and AChE expression progressively falls. Recent studies have also suggested that BuChE may have a greater role in normal cholinergic transmission than once thought, and may play a constitutive role in the hydrolysis of acetylcholine (ACh) in the normal brain.

Of the three currently used ChE inhibitors, only the carbamate rivastigmine is able to interact with both AChE and BuChE, thereby facilitating dual inhibition of the two ChE enzymes. Central BuChE inhibition has been correlated with cognitive improvement in AD patients following treatment with rivastigmine. In animals, specific BuChE inhibition improves learning and memory in aged rats and transgenic mice, as well as greatly increasing brain AChE levels without producing toxicity.

Like AChE, evidence also suggests that BuChE may also play a role in AD pathogenesis by promoting abnormal APP processing, which may enhance β-amyloid toxicity, facilitating maturation of neuritic plaques. Selective BuChE inhibitors have been shown to reduce levels of APP and decrease secreted β-amyloid. Therefore, inhibiting BuChE in addition to AChE may provide additional clinical benefits in patients with dementia by augmenting acetylcholine levels and potentially slowing disease progression. It is further possible that the carbamate structure of rivastigmine may provide for beneficial effects on APP processing with resultant disease modifying properties, which are independent of the ChE inhibitor action of the agent.

Dual ChE inhibitors, such as rivastigmine and tacrine, have also been shown to preserve both nicotinic and muscarinic ACh receptors in the brains of patients with AD, which may maintain function and slow the loss of these receptors typically observed in AD.

## No. 37B
## TARGETING CHOLINERGIC THERAPY TO SLOW DISEASE PROGRESSION

Steven G. Potkin, M.D., *Brain Imaging Center, Room 166, Irvine, CA 92697-3960*

### SUMMARY:

*Objectives:* To show that differences between currently available ChE (cholinesterase) inhibitors may be harnessed to provide a more targeted treatment for individuals with different stages of dementia.

*Overview of Presentation:* The potential of ChE inhibitors to provide long-term stabilizing effects on disease progression has been documented in randomized start studies, which can distinguish between symptomatic and disease modifying effects of individual ChE inhibitors. Additionally, targeting patients most likely to benefit from cholinergic therapy or from a specific ChE inhibitor may improve long-term clinical outcomes. PET and fMRI studies assessing cognitive and brain activation patterns in relation to genetic risk of AD (the apolipoprotein E-4) provide a means of detecting pre-clinical AD and raise the question of initiating treatment prior to symptom onset. Patients with more rapidly progressing disease, which is highly predictive of the need for earlier institutionalization, show the greatest response to rivastigmine therapy, most notably in the domains of ADL and cognition, suggesting that they are particularly likely to benefit from treatment with this ChE inhibitor. In addition, the pharmacological differences between ChE inhibitor may impact efficacy during long-term use, at different stages of dementia and on specific symptoms.

*Concluding Statement:* Early treatment, particularly in at-risk patients, and greater understanding of the efficacy and safety profiles of ChE inhibitors may be strategically used to slow the symptoms of the disease and perhaps disease progression itself.

## No. 37C
## BRAIN IMAGING AND CSF CHOLINESTERASE INHIBITION: LONG-TERM DATA

Agneta Nordberg, M.D., *Stockholm, Sweden S-14186*

### SUMMARY:

*Objectives:* To examine how brain imaging techniques can be used to examine disease progression and the therapeutic benefits of long-term cholinesterase (ChE) inhibitor therapy for Alzheimer's disease (AD) and other dementias.

*Overview of Presentation:* Data suggest that therapy should be initiated early to achieve maximum symptomatic benefit and possibly alter disease progression. Progress in the field of functional imaging suggests that these techniques may facilitate both early diagnosis and also the evaluation of treatment efficacy over the course of the disease.

Neuroimaging techniques have shown ChE inhibitors can improve cerebral blood flow in the brain, including areas involved in AD. An increase in glucose metabolism in areas involved in attention and memory processing has also been shown following long-term treatment with rivastigmine. This finding correlated with sustained inhibition of AChE and BuChE in cerebrospinal fluid (CSF) and beneficial effects on cognitive function. In contrast, other ChE inhibitors show a lack of sustained inhibition of AChE in CSF over 12 months of treatment. Dual ChE inhibitors (rivastigmine and tacrine) preserve nicotinic ACh receptors in AD patients, which may maintain function and slow the loss of these receptors.

*Concluding Statement:* Given the various potential disease modifying effects of ChE inhibitors in addition to their symptomatic benefits, early intervention and long-term treatment of AD may achieve maximum benefits.

## No. 37D
## A CRITICAL REVIEW OF THE LONG-TERM DATA WITH CHOLINESTERASE INHIBITORS

P. Murali Doraiswamy, M.D., *3350 Hospital South, Box 3018, Durham, NC 27708*

### SUMMARY:

*Objectives:* To present data that suggest that, with customized, strategically delivered clinical intervention, beneficial symptomatic treatment can be delivered to patients with all levels of symptom severity and with varying levels of disease progression

*Overview of Presentation:* Current clinical strategies in the treatment of AD and other forms of dementia are limited and patients at the later stages of disease progression frequently receive inadequate or ineffective therapy. However, recent trials of cholinesterase (ChE) inhibitors have shown significant benefits in patients with severe AD, justifying the use of these agents along the continuum of disease severity. AD patients exhibit different levels of cholinergic deficit and tolerability to drugs affecting the cholinergic system. Treatment should therefore be tailored to accommodate such needs,

thus maximizing benefits over the course of the disease. Such tailoring includes dose changes during disease progression, changing the ChE inhibitor (switching), and the use of combination therapy.

*Concluding Statement:* The customized tailoring of medication to suit individual patients may prolong the benefits of treatment with ChE inhibitors.

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# INDUSTRY-SUPPORTED SYMPOSIUM 38—OPTIMIZING TREATMENT FOR PATIENTS WITH SCHIZOPHRENIA: TARGETING POSITIVE PATIENT OUTCOMES

**Supported by Pfizer Inc.**

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss antipsychotic medication history and recognize the role of receptor pharmacology in medication efficacy; describe short- and long-term treatment options for persons with psychosis; recognize symptoms of metabolic dysfunction; identify how new medications affect glucose metabolism and are associated with a risk of diabetes.

## No. 38A
## THE SCIENCE OF ANTIPSYCHOTICS: MECHANISTIC INSIGHT

Daniel E. Casey, M.D., *3710 SW, U.S. Veterans Hospital Road, Portland, OR 97201*

## SUMMARY:

With the introduction of the conventional antipsychotics in the 1950s, clinicians began to expect effective treatment of positive symptoms of schizophrenia; however, these drugs do not resolve negative and cognitive symptoms of schizophrenia and are also associated with serious side effects, including EPS and tardive dyskinesia. In 1990, clozapine was introduced to the market, labeled the first new antipsychotic owing to its improved efficacy and side-effect profile. Clozapine proved effective in alleviating many of the positive, negative, and cognitive symptoms of schizophrenia, and treatment with clozapine did not result in almost inevitable EPS or tardive dyskinesia. Over the past decade, a number of different new antipsychotics have been developed.

New antipsychotics have an affinity for multiple dopamine-receptor subtypes as well as serotonin, norepinephrine, and glutamate receptors, allowing for better treatment outcomes. The antagonism of the 5-$HT_{2A}$ receptor may be responsible for improvement in negative symptoms and decrease in EPS. In addition to providing enhanced efficacy, the affinity of the new drugs for multiple receptors introduces new side effects not seen with the conventional agents, including weight gain. Each new antipsychotic has a unique receptor-binding profile that corresponds to its pharmacologic and side-effect profile. Understanding the differences in mechanisms of action of new antipsychotics will allow clinicians to better choose treatment that meets needs of each individual patient.

## No. 38B
## MANAGEMENT OF ACUTE PSYCHOSIS FROM EMERGENCY TO STABILIZATION

Daniel L. Zimbroff, *1317 West Foothill Boulevard, Suite 200, Upland, CA 91786*

## SUMMARY:

In treating and managing acute psychosis in persons with schizophrenia, early intervention may be valuable. The need to quickly control severe symptoms, however, must be balanced with a treatment algorithm that is both safe and efficacious.

The present management of acute psychotic agitation varies among clinicians. Key treatment goals have been to calm the agitated, assaultive, violent, or disruptive patient; minimize the danger to self and others; and achieve a smooth transition from intramuscular to oral maintenance. For many years, intramuscular treatment with benzodiazepines and/or conventional antipsychotics, such as haloperidol, has been the mainstay of treatment for acute psychosis. Unfortunately, the poor tolerability of conventional antipsychotics compromises their usefulness for both short- and long-term treatment. Although new antipsychotics have a more favorable side-effect profile, the transition from an intramuscular formulation has been problematic. Fortunately, the development of intramuscular formulations of olanzapine and ziprasidone offer new treatment options for patients experiencing acute psychotic episodes.

During this presentation, the use of intramuscular agents, standard antipsychotics, and new antipsychotics in the emergency room setting will be reviewed, and the strengths and limitations of each will be discussed.

## No. 38C
## BEYOND CONTROL OF ACUTE EXACERBATION: ENHANCING AFFECTIVE AND COGNITIVE OUTCOMES

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

## SUMMARY:

From the perspective of efficacy, the main advantages of the group of new antipsychotic drugs, which include ziprasidone, clozapine, quetiapine, olanzapine, and risperidone, are their ability to improve cognitive function. Other advantages are more selective, e.g., clozapine in treatment-resistant schizophrenia, while the advantages for positive and negative symptoms in neuroleptic-responsive patients are more modest and sometimes difficult to demonstrate. This advantage for cognitive function is important because of the abundant evidence that cognitive function is a key predictor of work and social function and social skills acquisition. The drug-induced cognitive improvement can synergize with typical rehabilitation programs and more experimental cognitive retraining programs to optimize these areas of improvement. Improved cognition also has implications for better compliance and decreased caretaker burden. This talk will provide new data on the efficacy of this class of drugs relative to each other and to typical neuroleptics. Current theories linking efficacy in cognition to unique effects on cortical dopaminergic and cholinergic function, and improved patterns of connectivity in the brain during

cognitive task performance will be discussed. Finally, pharmacologic strategies to augment the cognitive improvement due to the new antipsychotic drugs will be discussed.

## No. 38D
## FACTORS IN ANTIPSYCHOTIC DRUG SELECTION: TOLERABILITY CONSIDERATIONS

Henry A. Nasrallah, M.D., *1500 East Woodrow Wilson Drive, Jackson, MS 39216*

### SUMMARY:

With the widespread use of atypical antipsychotics over the past several years, adverse metabolic effects have emerged as the most serious medical consequences of pharmacotherapy with at least some of these agents. Initially, weight gain and obesity were observed (especially with clozapine and olanzapine, but subsequently, type 2 diabetes and dyslipidemias became apparent as well. Further, many reports in the literature suggest that sudden and severe (occasionally fatal) diabetic ketoacidosis (DKA) can emerge during treatment with some atypical antipsychotics even in the absence of adiposity. A marked increase of scrum lipids, (especially triglycerides), have also been reported, to varying degrees with different atypicals. This presentation will review the data regarding metabolic dysfunction in patients with psychosis (schizophrenia and bipolar disorders). It will be emphasized that populations with psychosis have a two to threefold higher prevalence of diabetes even before treatment with any antipsychotics, suggesting a possible genetic linkage or comorbidity. This was confirmed with glucose regulation studies in schizophrenia and mania. The induction of type 2 diabetes with atypicals has further increased the prevalence of non-insulin-dependent diabetes from about 6% to 8% to 11% to 15% according to recent studies, and even higher rates of subclinical hyperglycemia. The serious weight gain (e.g. 26–29 lbs after one year of clozapine or olanzapine treatment) is an important risk actor, but sudden DKA has now been reported in patients with minimal weight gain, suggesting alternative mechanisms, such as insulin resistance, as a direct effect of some atypicals. Psychiatrists can reduce the risk of metabolic disorders in schizophrenia and bipolar disorder by avoiding the use of certain atypicals as first line in patients with a personal or family history of diabetes, obesity and hyperlipidemias. Regulatory agencies in some countries have already taken action in this regard.

## No. 38E
## OBESITY, DIABETES, AND METABOLIC SYNDROME: NEW CHALLENGES IN ANTIPSYCHOTIC DRUG THERAPY

Enrique Caballero, M.D., *One Joslin Place, Boston, MA 02215*

### SUMMARY:

Some new antipsychotic agents are one of several types of medications that may potentially impair glucose metabolism. For example, studies have shown that persons treated with clozapine and olanzapine have developed elevated fasting serum insulin levels, which suggests insulin resistance. Insulin resistance may be a result of irregularities in the insulin action sequence. Some new antipsychotics may decrease insulin-sensitive glucose transporters, and glucose transporters mediate the majority of insulin-stimulated transport activity. These agents may lead to these changes through a direct mechanism in muscle or through an increased production of various elements from the adipose tissue, such as free fatty acids, as a result of the well-known increase in weight that some of them may promote. Furthermore, atypical antipsychotics antagonize the 5-$HT_{1A}$ receptors, possibly resulting in the decreased response of pancreatic B-cells to blood sugar levels. The further study of the effects of medications on glucose metabolism and the mechanisms behind these effects is essential to developing better treatment regimens that minimize insulin resistance and avoid such associated health risks as obesity and diabetes.

## No. 38F
## LONG-TERM TREATMENT GOALS: ENHANCING HEALTHY OUTCOMES

Carol A. Tamminga, M.D., *Maple and Locust Street, Box 21247, Baltimore, MD 21228*

### SUMMARY:

The long-term management of schizophrenia with a goal of functional rehabilitation remains an enormous challenge to clinicians despite improvements in drug therapy, psychosocial treatments, and family and community interventions. The goals of long-term therapy are to preserve the gains made during acute treatment, prevent symptom exacerbation, enhance psychosocial functioning, and improve quality of life. Schizophrenia is an illness that disrupts broad areas of mental function, including thought, cognition, affect, and motor performance. The new antipsychotics should aid clinicians in meeting higher treatment goals for persons with schizophrenia. These agents combine high efficacy with improved tolerability, mainly through a low liability for extrapyramidal symptoms, and probably improved cognitive effect. Recent studies have demonstrated efficacy of these new antipsychotics in improving psychopathology and symptoms and preventing relapse during long-term use. These drugs are likely to provide clinicians with an increasingly viable option in the long-term treatment and rehabilitation of schizophrenia.

### REFERENCES:

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# INDUSTRY-SUPPORTED SYMPOSIUM 39—BIOLOGICAL AND PSYCHOLOGICAL ADVANCES IN THE TREATMENT OF SCHIZOPHRENIA: REVISITING AND UPDATING MEYER'S PSYCHOBIOLOGY FOR THE 21ST CENTURY

**Supported by Bristol-Myers Squibb Company**

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to state the goals and potential symptomatic benefits that can be achieved with the use of CBT as an adjunct to antipsychotic medication in the management of patients with schizophrenia; understand the mechanisms of action of currently available and newer antipsychotic medications, and how these mechanisms result in both

efficacy and side-effects profiles; understand how clinical trial data can be used to optimize care and the limitations in adaptation of such information to clinical practice.

## No. 39A
## PSYCHOLOGICAL MECHANISMS OF PSYCHOSIS: IMPLICATIONS FOR PSYCHOTHERAPEUTIC INTERVENTION

Douglas Turkington, M.B., *Queen Victoria Road, New Castle, United Kingdom NE1 4LP*

### SUMMARY:

New psychological models of psychosis onset and maintenance form the basis for psychotherapeutic intervention. These models, techniques, and effects sizes, with the different psychotherapeutic interventions, will be presented, with a focus on cognitive-behavioral therapy (CBT) and the relationship of its effects to Meyer's psychobiology. An overview of the use of CBT in schizophrenia will be given, as well as the results of recent trials. A randomized trial compared the effects of expert-provided CBT (N=46) vs. a control group that received "befriending" (N=44), in treating patients with medication-resistant schizophrenia. A subsequent randomized field study then compared CBT delivered by trained supervised psychiatric nurses vs. "treatment as usual." In both studies, CBT provided greater benefits than control. CBT performed by behavior therapists achieved improved understanding, adherence to therapy, and symptom management in patients with chronic schizophrenia, leading to a good outcome in many patients (NNT=4 for a >50% symptomatic improvement at follow up). Patients who received CBT from psychiatric nurses, showed significantly greater improvement in insight (p=0.001), overall symptomatology (p=0.015), and depression (p=0.003), but not in psychotic symptoms, negative symptoms, or burden of care. There was no significant increase in suicidal ideation. Further assessment six months after the end of therapy revealed that the effect on insight was durable (p=0.021) and that involvement of a caregiver was crucial (p=0.026). In addition, negative symptoms were improved significantly at follow up in the CBT group (p=0.002). In summary, psychological models of psychosis foreseen by Meyer have now been tested in randomized, controlled trials. Cognitive-behavioral therapy (CBT) based on these models has been found to produce substantial and durable effects in schizophrenia.

## No. 39B
## BIOLOGIC MECHANISMS OF PSYCHOSIS: FROM DOPAMINE EXCESS TO DOPAMINE STABILIZATION

Bryan L. Roth, M.D., *10900 Euclid Avenue, Room W438, Cleveland, OH 44106-4936*

### SUMMARY:

According to the dopamine hypothesis of schizophrenia, symptoms of psychosis arise from dopamine dysregulation in the brain. Positive symptoms of psychosis are believed to arise from excess dopaminergic activity in the mesolimbic pathway, while negative and cognitive symptoms are believed to arise from a deficiency in dopaminergic signaling in the mesocortical pathway. First-generation antipsychotic agents such as suppress positive symptoms through their potent antagonism of D2 dopamine receptors in the mesolimbic pathway. However, this mechanism of action may result in the exacerbation of negative symptoms via further suppression of dopamine activity in the mesocortex. Suppression of dopamine activity in the nigrostriatal pathway produces tardive dyskinesia and other extrapyramidal symptoms, while suppression of dopamine in the tuberoinfundibular pathway disinhibits prolactin secretion, leading to hyperprolactinemia, effects on fertility, and sexual side effects. Antimuscarinic, anti alpha-1-adrenergic, and anti-histaminergic properties of these agents produce additional side effects such as cognitive blunting, orthostatic hypotension, and sedation. Second-generation antipsychotics are generally serotonin-dopamine antagonists. Serotonin modulates dopamine levels to different degrees in each of the dopaminergic pathways. By antagonizing both serotonin 2A receptors and D2 receptors simultaneously, it is possible to reduce positive symptoms without exacerbating negative and cognitive symptoms of schizophrenia. Extrapyramidal symptoms (EPS) are greatly reduced, allowing far better patient quality of life with long-term treatment. However clozapine, olanzapine, risperidine, quetiapine, and ziprasidine may produce additional side effects such as increased risk of seizure, dyslipidemias, and significant weight gain, and QTc prolongation. These agents interact with multiple 5HT receptors, multiple dopamine receptors, noradrenergic and 5HT transporters, and muscarinic, histaminic, and alpha 1 and alpha 2 adrenergic receptors. The ideal antipsychotic would possess a mechanism of action that normalizes dopamine activity, and a more favorable side-effect profile than currently available agents possess. Administration of such an agent may help to minimize first-episode psychosis, and to prevent further disease progression.

## No. 39C
## WHAT IS AN ADEQUATE TREATMENT RESPONSE? ESTABLISHING THERAPEUTIC GOALS IN SCHIZOPHRENIA

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

### SUMMARY:

There were two breakthroughs when clinical trials first demonstrated that medications could treat schizophrenia. One breakthrough was obvious—namely, that it was possible to treat schizophrenia with pharmacotherapy. The other breakthrough was in clinical trials methodology. More recently, however, clinical trials methods have not kept up with advances in antipsychotic medications, at least to the extent that they cannot provide the answers that clinicians want to know when a new antipsychotic is introduced. It is difficult to identify appropriate efficacy targets in an illness as complex as schizophrenia. In addition to symptom response, there are many other kinds of important outcomes, such as effects on cognition, mood, anxiety, and freedom from burdensome medical and neurological side effects. Examination of data from clinical trials of recently introduced antipsychotics illustrates the kind of information that can be obtained form standard trial designs. These studies are useful in determining differences in side-effect profiles among the newer antipsychotics. However, one serious limitation of such trials, which use groups of patients, is the lack of information on how to tailor therapy for an individual patient. Therefore, the question of how best to use clinical trial information in clinical practice remains unanswered. Physicians must decide whether and how to switch patients between different antipsychotics, and determine if some patients are willing to tolerate extensive symptoms and side effects that would be unacceptable to less ill patients, in order to maximize long-term efficacy. More than ever, physicians need to understand both the psychosocial and pharmacologic aspects of using newer medications, as well as the unique properties of each of the novel antipsychotics.

## No. 39D
## LONG-TERM TREATMENT OF SCHIZOPHRENIA: MOVING FROM A RELAPSE-PREVENTION MODEL TO A RECOVERY MODEL

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

### SUMMARY:

Schizophrenia is still characterized by high relapse rates and difficulty of reintegration into the community, despite recent advances in disease management. Distinct challenges are encountered at each disease stage. During the early prodromal phase, subtlety of symptoms and the absence of frank psychosis may hinder diagnosis and prevent early psychologic and pharmacologic therapy. Stigma and the lack of social support networks prevent patients from obtaining appropriate care at every stage of the disease. Effective early treatment can help to prevent or delay disease progression and psychotic episodes. A combined psychosocial and pharmacologic treatment approach can ameliorate symptoms of acute psychosis, and long-term therapy can prevent disease progression and promote patient rehabilitation. However, loss of efficacy and noncompliance are major contributors to the high recurrence rates of acute psychosis in patients with schizophrenia (Weiden et al, 1996; Marder, 1998). Several factors influence noncompliance, including drug abuse, homelessness, comorbidities such as depression, lack of supportive social structures, cognitive impairment, and objectionable side effects. Extrapyramidal symptoms and tardive dyskinesia are major side effects of the earlier generation antipsychotics, while metabolic effects such as weight gain, dyslipidemias, and diabetes are major side effects of many second-generation agents. Other side effects that may limit the use of first- or second-generation antipsychotics include somnolence, orthostatic hypertension, prolactin elevation, and ZTc prolongation. Effective management of schizophrenia will depend upon the availability of new-generation highly effective drugs with benign tolerability profiles and the ability to improve cognitive symptoms, early diagnosis and prevention, intensive cognitive-behavioral therapy, and improved psychosocial support structures.

## No. 39E
## DIAGNOSTIC BOUNDARIES BETWEEN BIPOLAR DISORDER AND SCHIZOPHRENIA: IMPLICATIONS FOR PHARMACOLOGICAL INTERVENTION

Stephen M. Strakowski, M.D., *231 Albert Sabin Way, Cincinnati, OH 45267-0559*

### SUMMARY:

According to DSM-IV diagnostic criteria, psychosis is a hallmark of schizophrenia and a defining feature of related diseases. However, psychosis may be present in other psychiatric or neurologic conditions. Acute mania in bipolar disease can resemble schizophrenia. Psychosis may also be associated with depression, cognitive disorders, and Alzheimer's dementia. Antipsychotic medications have demonstrated efficacy in the treatment of patients with schizophrenia. However, the first-generation antipsychotics such as chlorpromazine, haloperidol, and thioridazine were associated with serious extrapyramidal side effects, which limited their use in other diseases. The second-generation agents currently available are more tolerable than older agents, and novel antipsychotics that are in development promise efficacy with even better tolerability profiles. The addition of better drugs to the treatment armamentarium has encouraged physicians to use the newer antipsychotics as primary or adjunctive pharmacotherapy in an expanded set of indications. Clozapine, risperidone, olanzapine, quetiapine, and ziprasidone have all been reported to produce responses in the treatment of acute bipolar mania (McElroy and Keck, 2000). A novel antipsychotic, aripiprazole, has also demonstrated efficacy in acute mania, as well as the ability to reduce cognitive impairment. Antipsychotic, mood stabilizing, and cognitive enhancement properties, together with a benign side-effect profile, make such new-generation antipsychotics an attractive treatment option for manic depressive patients and elderly patients suffering from dementia.

### REFERENCES:

1. Turkington D, Kingdon D, Turner T: Effectiveness of a brief cognitive-behavioural intervention in the treatment of schizophrenia. Br J Psych 2002;180(6):523–527.
2. Stahl SM: Antipsychotic agents, in Essential Pharmacology. Cambridge, Cambridge University Press, 2000, pp 401–458.
3. Collaborative Working Group on Clinical Trial Evaluations: Clinical development of atypical antipsychotics: research design and evaluation. J Clin Psychiatry 1998;59(suppl 12):10–16.
4. Weiden P, Aquila R, Standard J: Atypical antipsychotic drugs and long-term outcome in schizophrenia. J Clin Psychiatry 1996;57(suppl 11):53–60.
5. McElroy SL, Keck PE Jr: Pharmacologic agents for the treatment of acute bipolar mania. Biol Psychiatry 2000;48:539–557.

# INDUSTRY-SUPPORTED SYMPOSIUM 40—REAL-WORLD CHALLENGES IN DEPRESSION AND ANXIETY
## Supported by GlaxoSmithKline

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the consequences of undertreatment of social anxiety disorder, late-life depression with comorbid medical disorders and bipolar depression; learn principles of treatment for social anxiety disorder, late-life depression, comorbid depression, and bipolar depression.

## No. 40A
## LONG-TERM CONSEQUENCES OF SOCIAL ANXIETY DISORDER: BREAKING THE CYCLE

Karen D. Wagner, M.D., *301 University Boulevard, Galveston, TX 77550-0188*

### SUMMARY:

There is recent focus on the occurrence of social anxiety disorder in children and adolescents. Similar to depression, the onset of social anxiety disorder often occurs during the childhood years and is associated with significant morbidity and a chronic course. Prevalence rates may be as high as 10% in children and adolescents. Social anxiety disorder tends to be a chronic disorder that significantly impacts the child's relationship with peers and overall performance. Youngsters who develop social anxiety disorder also have an increased incidence of comorbid simple phobia, agoraphobia, alcohol and drug abuse, and major depression throughout their lifetime. Although treatment of childhood social anxiety disorder is not well studied, both psychosocial and pharmacologic therapies may be useful. The SSRIs are the most thoroughly studied treatment for social anxiety disorder. Further study of treatments is warranted, particularly because there is continuity between social anxiety disorder in youth and in adulthood. This presentation will focus on diagnostic issues, course, and current treatments for major depression and social anxiety disorder in children and adolescents.

## No. 40B
## DEPRESSION AND ANXIETY IN MEDICAL ILLNESS: THE BRAIN-BODY INTERFACE

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

### SUMMARY:

Depression and anxiety are extremely common, but underdiagnosed in the medically ill population. Clinicians struggle with the diagnostic criteria to be used to diagnose depression and anxiety in this population given the confounds of the medical illness. Studies have shown that patients with major depression, hospitalized for medical illness, have a five to 15 times greater likelihood of in-hospital death. The relationship of depression and anxiety in specific medical illnesses including cardiovascular disease, cerebrovascular disease, chronic pain syndromes, irritable bowel syndrome, amongst others, has demonstrated a bi-directional comorbidity of depression and anxiety. The talk will discuss the recent understanding of the relationship of depression and anxiety in specific medically ill populations as well as evidence-based recommendations for the management of this comorbidity with both pharmacotherapies and non-pharmacological treatments. Recent studies, including the SADHART study showing a decrease in mortality in treated versus untreated patients, will also be a focus of this talk. Special considerations with regard to drug-drug interactions in this population will also be discussed.

## No. 40C
## OVERCOMING STIGMA AND OPTIMIZING OUTCOME IN LATE-LIFE DEPRESSION

Lori J. Birdsong, M.D., *325 Ninth Avenue, Box 359797, Seattle, WA 98104-2499*

### SUMMARY:

Late-life depression and depressive symptoms are common but often go unrecognized by clinicians, patients, and families. They are associated with disability, functional decline, diminished quality of life, caregiver burden, increased service utilization, and mortality from comorbid medical conditions or suicide. Depression is not a natural consequence of aging, and stigma prevents many patients from seeking treatment. Furthermore, late-life depression can be difficult to diagnose because of comorbid medical illness, cognitive impairment, complicated social situations, or adverse life events. Pharmacotherapy and psychotherapy have been shown to be effective treatments for late-life depression, and treatment approaches for the elderly depressed patient will be reviewed. Clinicians, patients, and their families also need to be educated about this disorder so that more patients are effectively diagnosed and treated.

## No. 40D
## THE CLINICAL CHALLENGE OF DEPRESSION IN BIPOLAR DISORDER

David L. Dunner, M.D., *4225 Roosevelt Way NE, 306C, Seattle, WA 98105-6099*

### SUMMARY:

Bipolar depression remains one of the most difficult clinical challenges in psychiatry. Patients with bipolar depression are at greatly increased risk of severe episodes, treatment resistance, switch to mania, rapid cycling, and suicide. Bipolar depression may be misdiagnosed as unipolar depression. Although the literature on the treatment of the depressive phase of bipolar disorder consists primarily of anecdotal reports and open-label studies, the number of randomized, controlled trials is increasing. Antidepressants and psychotherapy are effective in the treatment of the bipolar depression. However, the use of antidepressant medication alone in a patient with bipolar disorder is associated with a risk of switch to hypomania or mania. The SSRIs and bupropion are believed to be less likely to cause switching than TCAs. Lithium treatment has been shown to reduce suicidal behavior in bipolar patients, but lithium is only somewhat effective for rapid cyclers. The anticonvulsant lamotrigine is being studied as a treatment for the depressive phase of bipolar disorder and may also be useful in rapid cycling patients. Psychotherapy, especially CBT, may be quite useful, and newer psychotherapies are being studied. Clinical strategies for the treatment and prevention of depression in patients with bipolar disorder will be presented.

### REFERENCES:

1. Schwartz CE, Snidman N, Kagen J: Adolescent social anxiety as an outcome of inhibited temperament in childhood. J Am Acad Child Adolesc Psychiatry 1999;38(8):1008–1014.
2. Von Ammon Cavanaugh S, et al: Medical illness, past depression, and present depression: a predictive triad for inhospital mortality. American Journal of Psychiatry 2001;158:43–48.
3. Lebowitz BD, Pearson JL, Schneider LS, et al: Diagnosis and treatment of depression in late-life. JAMA 1997;278(14):1186–1190.
4. American Psychiatric Association: Practice guideline for the treatment of patients with bipolar disorder. Am J Psychiatry 2002;159(4Suppl):1–50.

# INDUSTRY-SUPPORTED SYMPOSIUM 41—WOMEN AND PSYCHIATRIC DISORDERS: DOES GENDER MATTER FOR TREATMENT?
## Supported by Wyeth Pharmaceuticals

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the extent to which gender may affect the phenomenology and response to treatment across a spectrum of psychiatric disorders.

## No. 41A
## HORMONES AND THE BRAIN

Meir Steiner, M.D., *301 James Street, South, Room 639, Hamilton, ON Canada L8P 3B6*

### SUMMARY:

The differences in prevalence, course, and response to treatment of major mood and anxiety disorders between men and women are believed to be affected by hormonal, reproductive, and genetic factors. These differences are further highlighted by differential exposure/response to environmental influences and by physiological differences. The role and potential relevance of sex hormones to female-specific psychiatric disorders are even more obvious. Levels of estrogen (E) and progesterone (P) vary significantly across the female lifespan. Behaviors such as moodiness, irritability, and relationship conflicts around the time of puberty may in part reflect increased sensitivity of neurotransmitter systems to changes in sex hormone levels. The constant flux of E and P levels continues throughout the reproductive years. PMS/PMDD may be the result of an altered activity (or sensitivity) of certain neurotransmitter systems to hormonal fluctuations in genetically vulnerable women. Pregnancy and delivery also produce dramatic changes in E and P levels, which may help explain the increased vulnerability to perinatal depression, and finally at menopause the loss of modulating effects of E and P may underlie the development of perimenopausal mood disorders.

Differences caused by genetic polymorphism, combined with the flux in the hormonal milieu, may determine how women react to environmental stress and predict the development of mood disorders.

## No. 41B
## SEX, HORMONES, AND DEPRESSION: THE IMPACT OF SEX STEROIDS ON MOOD ACROSS THE REPRODUCTIVE LIFE CYCLE

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

### SUMMARY:

Periods of intense hormonal fluctuations have been associated with heightened prevalence and exacerbation of underlying psychiatric illness, particularly the occurrence of premenstrual dysphoria, puerperal depression, and depressive symptoms during the menopausal transition. It has been speculated that sex steroids such as estrogens, progestogens, testosterone, and dehydroepiandrosterone (DHEA) exert a significant modulation of brain functioning, possibly through interactions with various neurotransmitter systems. It is therefore intuitive that abrupt alterations of these hormones would interfere with mood and behavior. However, accumulating data suggest that hormonal interventions may also promote relief or even remission of depressive symptoms, as already demonstrated in studies on perimenopausal women treated with transdermal estradiol.

This presentation will review the potential role of sex hormones for the treatment of depressive disorders in women. Essentially, there are preliminary but promising data on the use of estrogens as an antidepressant strategy (monotherapy or augmenting agent) for perimenopausal and postmenopausal women. Existing data on the use of testosterone and DHEA will be also critically discussed.

## No. 41C
## TRAUMA AND PTSD IN WOMEN

Shamsah B. Sonawalla, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114*

### SUMMARY:

Exposure to traumatic events is not unusual. According to the National Comorbidity Survey, 61% of men and 51% of women report experiencing at least one traumatic experience in their lifetime. They are associated with increased medical and psychiatric comorbidity, including depression, substance use disorders, and anxiety disorders, in particular, posttraumatic stress disorder (PTSD).

PTSD is a highly prevalent, chronic, and disabling disorder, with a reported prevalence of 8% in the general population, according to studies conducted prior to the September 11 terrorist attacks. PTSD has been found to respond modestly well to psychosocial as well as pharmacological intervention. Gender differences exist in the likelihood of traumatic exposure and the subsequent risk of developing PTSD. Women are more likely to report rape, sexual molestation, and childhood physical abuse. They are approximately twice as likely to develop PTSD following traumatic exposure as men. Women are also reported to have a greater number of reexperiencing symptoms and a longer duration of PTSD than men.

The presentation will discuss exposure to traumatic events and PTSD in women. It will focus on gender differences in clinical presentation, course, and treatment of PTSD. The cultural aspects of PTSD in women will be discussed. In addition, findings from a study assessing the prevalence of PTSD in survivors of an earthquake will be discussed. The presentation will aim for a comprehensive coverage of this increasingly recognized and treated disorder.

## No. 41D
## WOMEN AND ALCOHOL USE DISORDERS

Shelly F. Greenfield, M.D., *115 Mill Street, Belmont, MA 02178*

### SUMMARY:

Although substance abuse and dependence have been increasing among women in the United States, only during the past two decades have researchers started to focus on women and alcohol use disorders. In the past all-male samples were generally used because they were much more easily available; when mixed-gender populations were examined, women were often underrepresented. Recent studies on gender differences in alcohol use disorders have found that compared with men, women become intoxicated after drinking half as much, metabolize alcohol differently, develop cirrhosis of the liver more rapidly, and have a greater risk of dying from alcohol-related accidents. This talk will review the existing literature, focusing on four central questions: (1) Are alcohol use disorders becoming increasingly prevalent in women, thereby closing the gender gap between men and women? (2) Do the physical effects of alcohol differ by gender, and if so, why? (3) Do men and women differ in frequency and type of treatment services sought for alcohol use disorders? (4) What role does gender play in the process of recovery from alcohol dependence?

## No. 41E
## DOES GENDER MATTER TO TREATMENT?

Jerrold F. Rosenbaum, M.D., *15 Parkman Street, ACC 812, Boston, MA 02114*

### SUMMARY:

Recent investigation over the last decade has begun to focus on gender-based differences in risk for psychiatric disturbance and response to treatment. How various factors such as reproductive hormonal environment and past psychiatric and psychosocial history interact and contribute to what is seen clinically in female patients presenting with a wide range of psychiatric disorders remains to be more clearly delineated.

This presentation will focus on (1) gender-specific considerations with respect to (1) risk for psychiatric disorder, (2) phenomenology of mood disturbance, and (3) response to antidepressant treatment. Data will be reviewed that addresses the question of whether differences in response to treatment can be observed in populations of younger and older women treated with various classes of available antidepressants. A model will be presented that may be used to identify those patients for whom gender and other variables do matter with respect to vulnerability to psychiatric disorders and how this can guide the specific treatments received (i.e., hormones versus other antidepressants).

### REFERENCES:

1. Woosley RL, Anthony M, Peck CC: Biological sex analysis in clinical research. J Womens Health Gend Based Med 2000;9:933–4.
2. Soares CN, Almeida OP, Joffe H, Cohen LS: Efficacy of estradiol for the treatment of depressive disorders in perimenopausal women: a randomized, double-blind, placebo-controlled trial. Arch Gen Psychiatry 2001;58:529–534.
3. Yehuda R: Post-traumatic stress disorder. New England Journal of Medicine 2002;346(2):108–14.
4. Greenfield SF: Women and alcohol use disorders. Harvard Review of Psychiatry 2002;10:76–85.
5. Brawman-Mintzer O: Sex differences in psychopharmacology, in SG Kornstein & AH Clayton Women's Mental Health. Edited by Kornstein SG, Clayton AH. New York, NY, Guilford Press, 2002.

## INDUSTRY-SUPPORTED SYMPOSIUM 42—NEUROPSYCHIATRY IN THE AGE OF POLYPHARMACY, PART 1
## Supported by Janssen Pharmaceutica

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to discuss the rationale for combining medications from different or the same chemical classes in treatment of psychiatric disorders based on mechanisms of action and potential efficacy and safety benefits, and identify gaps in the evidence supporting polypharmacologic approaches to the management of several important mental illnesses.

### No. 42A
### AN EVIDENCE-BASED APPROACH TO RATIONAL POLYPHARMACY IN SCHIZOPHRENIA

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

### SUMMARY:

Schizophrenia is one of the most devastating illnesses affecting patients. Only 30% to 50% of patients with schizophrenia have an optimal response to monotherapy with atypical antipsychotics. Clinicians often use augmentation strategies including conventional neuroleptics, benzodiazepines, mood stabilizers, and antidepressants amongst others to optimize response for positive, negative, and cognitive symptoms in schizophrenia. Unfortunately, the evidence supported by randomized, controlled clinical trials lags behind the clinical usage of augmentation strategies in schizophrenia. The talk will discuss the evidence including randomized, controlled trials of antidepressants like mirtazapine and reboxetine, acetyl cholinesterase inhibitors like donepezil, modulators of the AMPA-receptors like ampakine, atypical antipsychotics for the augmentation of clozapine, as well as mood stabilizers like divalproex sodium in this patient population. Recommendations regarding the choice of augmentation strategies and potential pharmacokinetic and pharmacodynamic interactions will also be a subject of this talk.

### No. 42B
### POLYPHARMACY IN THE TREATMENT OF BIPOLAR DISORDER

### SUMMARY:

Only one-third of patients with bipolar disorder respond to a single mood stabilizer. Hence, most patients with bipolar disorder need polypharmacy. The problem is that many patients receive a confused polypharmacy, which is often ineffective.

I will first define polypharmacy as reflecting the use of two or more primary medications for a condition. I will discuss two historical rules derived from past opposition to polypharmacy in medicine which, if followed, provide a basis for rational polypharmacy. The first, Holmes' rule, demands evidence for efficacy before using a medication. The second, Osler's rule, requires treatment to be directed at diagnoses/syndromes, not symptoms.

In the case of bipolar disorder, I will argue that irrational polypharmacy has been due to breaking both of these rules, particularly in the use of antidepressants. I will review some of the evidence regarding potential mood-destabilizing effects of antidepressants. On the other hand, polypharmacy with multiple mood stabilizers has been shown to increase efficacy, and two new classes of agents with potential mood-stabilizing properties, atypical neuroleptics and novel anticonvulsants, greatly increase the clinician's options.

### REFERENCES:

1. Goff DC, Leahy L, Berman I, Posever T, Herz L, Leon AC, Johnson SA, Lynch G: A placebo-controlled pilot study of the ampakine CX516 added to clozapine in schizophrenia. Clin Psychopharmacol 2001;21:484.
2. Ghaemi SN (Ed.): Polypharmacy in Psychiatry. New York, Marcel Dekker, 2002.

## INDUSTRY-SUPPORTED SYMPOSIUM 42—NEUROPSYCHIATRY IN THE AGE OF POLYPHARMACY, PART 2
## Supported by Janssen Pharmaceutica

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be aware of the historical rules, Holmes' rule and Osler's rule, that allow for effective polypharmacy; understand the limitations of polypharmacy in bipolar disorder with antidepressants; and recognize how best to combine mood stabilizers in the polypharmacy of bipolar disorder.

### No. 42A
### POLYPHARMACY IN THE TREATMENT OF MAJOR DEPRESSION

Mark Rapaport, M.D., *8950 Villa La Jolla Drive, Suite 2243, La Jolla, CA 92037*

### SUMMARY:

Twenty years after DeMontigny extrapolated from basic science to clinical practice to introduce lithium augmentation, polypharmacy for the treatment of depression is widespread. Reports of other potential antidepressant augmentations and combinations have been reported every few years: thyroid, tricyclics, buspirone, bupropion, stimulants and dopaminergic agents, mirtazapine, atypical antipsychotics, and newer anticonvulsants. Double-blind, randomized, controlled trials (RCT) of these augmenting agents, however, are few and far between. Like lithium, many of these augmentation trials have a rationale for mechanisms of synergy; others are simply empirical. This presentation will review antidepressant augmentation and combination strategies, their putative mechanisms of action, and evidence for efficacy. Clinician choice of augmentation will be presented with a focus on the gap between evidence supporting strategies and their popularity. The NIMH Sequenced Treatment Alternatives to Relieve Depression (STAR*D) project should provide data for comparing selected strategies within the next few years.

### No. 42B
### COMBINATION THERAPY FOR ALZHEIMER'S DISEASE: WHAT ARE WE WAITING FOR?

P. Murali Doraiswamy, M.D., *3350 Hospital South, Box 3018, Durham, NC 27708*

### SUMMARY:

Cholinesterase inhibitors represent the only approved strategy for treating Alzheimer's disease. Investigational agents in trials include NMDA antagonists, ampakines, anti-amyloid strategies, anti-inflammatory agents, vitamins, chelators, ginkgo, statins, and hormones. There is also increasing data with regard to the efficacy of antidepressants and antipsychotics for treating specific behaviors in dementia. In the absence of a single agent that can halt or reverse AD progression, it is likely that a combination therapy approach will be used to treat these patients. Trials examining combinations of cholinesterase

inhibitor with a variety of agents (glutamate antagonists, sertraline, risperidone, vitamins, and statins) are either completed or planned. I will begin by using an interactive audience response to examine current combination therapy practices among clinicians. This will be followed by a review of the available evidence for rational combination therapies in dementia. Finally, using models from cancer, epilepsy, and hypertension, I will illustrate potential trial designs and regulatory challenges for proving efficacy of combinations. These data will serve to highlight the urgent need for our field to conceptualize and begin to systematically test such approaches to better benefit patients.

### REFERENCES:

1. Amsterdam JD, Hornig M, Nierenberg AA (eds): Treatment Resistant Mood Disorders. Cambridge University Press, Cambridge, UK.
2. Doraiswamy PM, Steffens DS: Combination therapy for early Alzheimer's disease: What are we waiting for? JAGS 1998;46:1322–1324.

## INDUSTRY-SUPPORTED SYMPOSIUM 43—TREATING ADHD ACROSS THE LIFE CYCLE, PART 1
## Supported by Novartis Pharmaceuticals Corporation

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to explain the pathophysiologies of ADHD, especially the neurobiological abnormalities associated with the condition; to explain the symptoms, impairments, manifestations, and comorbidities of ADHD in children, adolescents and adults; to recognize the advantages and disadvantages of available and future pharmacologic therapies for the treatment of ADHD.

### No. 43A
### PATHOPHYSIOLOGY OF ADHD

Stephen V. Faraone, Ph.D., *750 Washington Street, Suite 255, South Easton, MA 02375*

### SUMMARY:

The pathophysiology of ADHD is complicated, with genetic, environmental, and neuropsychologic contributions. The genetic component is substantial: molecular genetics approaches have shown that the genes involved in dopaminergic and noradrenergic pathways may confer an increased susceptibility to ADHD. Possible contributory environmental factors include pregnancy and delivery complications, marital distress, family dysfunction, and low social class. Based upon the pattern of neuropsychological deficits in ADHD children, impairments in executive function have been hypothesized. This pattern is similar to that seen in adults with frontal lobe damage, which suggests that the frontal cortex or regions projecting to it are dysfunctional in at least some ADHD children. Moreover, neuroimaging studies have highlighted the possible role of fronto-subcortical pathways in ADHD. Three subcortical structures (caudate, putamen, and globus pallidus) implicated in these studies are part of the neural circuitry underlying motor control, executive function, inhibition of behavior, and modulation of reward pathways. These frontal-striatal-pallidal-thalamic circuits provide feedback to the cortex for the regulation of behavior. Notably, these pathways are rich in catecholamines, which have been implicated in ADHD by the mechanism of action of stimulants and noradrenergic antidepressants, which treat many ADHD patients effectively.

### No. 43B
### ADHD FROM CHILDHOOD TO ADOLESCENCE: DEVELOPMENTAL ISSUES IN CLINICAL

Russell A. Barkley, Ph.D., *55 Lake Avenue North, Worcester, MA 01655*

### SUMMARY:

ADHD is characterized by symptoms in two main categories, inattention and a combination of hyperactive and impulsive behavior. The disorder is increasingly seen as a developmental failure in the brain circuitry that governs inhibition and self-control, termed "executive function." With development, the nature of normal executive function changes from the more externalized form of childhood to the more internalized form of adolescence. Children with ADHD seem to lack the necessary restraint to make this maturational transition. Inattention, impulsivity, the inability to defer immediate rewards, and other features of ADHD have different impacts on young children than on adolescents. The use of stimulants and antidepressants in children and adolescents is reviewed, as are the most common behavioral approaches. At present, stimulants are the only FDA-approved treatment for ADHD. The benefits of effective treatment for reducing risky behaviors, enhancing family harmony, school performance, and self-esteem are also emphasized in this session.

This presentation will review the results of research concerning the risks and adverse outcomes associated with ADHD in the following domains of functioning: psychiatric, educational, social, emotional, adaptive, occupational, and antisocial/substance use. The results of the presenter's Milwaukee follow-up study of ADHD children into adulthood will be blended with the findings of other longitudinal and cross-sectional studies to present the diversity of adverse outcomes that may be associated with the disorder. In addition, the contribution of comorbid disorders to these outcomes will be discussed, where known.

### REFERENCES:

1. Faraone SV, Doyle AE: The nature and heritability of attention-deficit/hyperactivity disorder. Child and Adolescent Psychiatric Clinics of North America 2001;10, 299–316, viii–ix.
2. Barkley RA: Attention-deficit hyperactivity disorder. Sci Am 1998;279(3):66–71.

## INDUSTRY-SUPPORTED SYMPOSIUM 43—TREATING ADHD ACROSS THE LIFE CYCLE, PART 2
## Supported by Novartis Pharmaceuticals Corporation

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to explain the pathophysiologies of ADHD, especially the neurobiological abnormalities associated with the condition; to explain the symptoms, impairments, manifestations, and comorbidities of ADHD in children, adolescents and adults; to recognize the advantages and disadvantages of available and future pharmacologic therapies for the treatment of ADHD.

### No. 43A
### ADHD IN ADULTS: DEVELOPMENTAL ISSUES IN CLINICAL PRESENTATIONS

Thomas J. Spencer, M.D., *15 Parkman Street, Boston, MA 02114*

### SUMMARY:

ADHD may be present in as many as 6% of adults. The epidemiology, pathophysiology, natural history, and treatment of adult ADHD

are summarized in this presentation. Diagnosing ADHD in adults is complicated by the lack of a diagnostic "gold standard." In order to diagnose ADHD in adulthood, a childhood history consistent with ADHD should be present. Other key diagnostic features in adults include poor concentration, irritability, stress intolerance, inconsistent performance, and poor task completion. Comorbid psychiatric conditions, such as mood, anxiety, and antisocial disorders are common in adults with ADHD and should be included in the differential diagnosis. As with children, adults with ADHD may have a catecholamine imbalance. Agents that affect catecholamines such as stimulants, (methylphenidate, dextroamphetamine, and pemoline) as well as noradrenergic antidepressants, appear to be the most effective agents in this population, with more than half of treated patients reporting symptom relief. At present, no medication is FDA-approved for treating ADHD in adults. The most likely future approaches to the research and treatment of adult ADHD are also discussed during this session.

### No. 43B
### TREATMENT OPTIONS: EVOLVING TREATMENTS FOR A CHANGING DISEASE

Joseph Biederman, M.D., *55 Fruit Street, WACC 725, Boston, MA 02114*

SUMMARY:

Current and future treatment options for patients with ADHD are reviewed. The symptoms of ADHD may be caused by a dysfunctional dopamine system that ultimately manifests itself in a reduced ability to sustain attention, in hyperactivity, and in motor and cognitive impulsivity. A review of the evidence implicating imbalances in brain neurotransmitter systems in ADHD is presented. The stimulants methylphenidate and selected amphetamines are, at present, the only agents approved by the FDA for the pharmacologic treatment of ADHD. Other drugs, including some antidepressants (tricyclics and bupropion) and $\alpha_2$-adrenergic agonists (clonidine), are also prescribed when deemed appropriate by clinicians. Although the precise neurochemical and functional substrates of the symptoms of ADHD are not known, the most likely mechanisms of action of these drugs are briefly reviewed. Differences in drug categories, dosing regimens, stimulant formulations, and side-effect profiles, are summarized. Finally, future trends in the pharmacologic management of ADHD are described.

REFERENCES:

1. Biederman J, Faraone SV, Spencer T, Wilens T, Mick E, Lapey KA: Gender differences in a sample of adults with attention deficit hyperactivity disorder. Psychiatry Res 1994;53:13–29.
2. Solanto MV: Dopamine dysfunction in AD/HD: integrating clinical and basic neuroscience research. Behav Brain Res 2002;130(1–2):65–71.

## INDUSTRY-SUPPORTED SYMPOSIUM 44 INSOMNIA IN TODAY'S SOCIETY: CONSEQUENCES AND TREATMENTS, PART 1
## Supported by Sanofi-Synthelabo, Inc.

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should (1) understand the interrelationship between insomnia and psychiatric disorders, (2) attain knowledge of the available pharmacological treatments, (3) be able to use various cognitive-behavioral treatments for insomnia, and (4) recognize when to refer insomnia patients to a sleep specialist.

### No. 44A
### THE IMPORTANCE OF IDENTIFYING AND TREATING INSOMNIA

David N. Neubauer, M.D., *4940 Eastern Avenue, Suite A4 Center, Baltimore, MD 21224*

SUMMARY:

Clinically significant problems with insomnia affect at least 10% of adults in our society, and the prevalence is much greater among individuals with psychiatric disorders. The consequences of persistent insomnia may be quite varied and result in considerable quality of life deterioration. For all people, chronic insomnia increases the risk for new-onset mood and anxiety disorders. Insomnia may be especially problematic in contributing to morbidity in a broad spectrum of psychiatric patients. This talk will review the primary causes of sleeplessness in the general population and will focus specifically on the relationship of sleep and mental health. The early recognition of sleep disturbance and subsequent treatment efforts can have a major impact in reducing the frequency and severity of psychiatric illness.

### No. 44B
### PHARMACOTHERAPY OF INSOMNIA

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

SUMMARY:

Pharmacotherapy is the mainstay of treatment for insomnia. This presentation will critically evaluate the pharmacopeia of drugs that are currently used, examining evidence for efficacy and limitations of its use.

Benzodiazepines, once the gold standard of insomnia treatment, will be reviewed. Despite considerable evidence for efficacy, potential adverse effects of drug dependence, impairment of psychomotor functioning, ataxia, and sexual dysfunction will be discussed.

Alternatively, a number of other treatments have been utilized that appear to be safer, such as tricyclics antidepressants, antihistamines, and trazadone. Nonetheless, these treatments have not been well studied and frequently have been associated with anticholinergic and cardiovascular side effects. Melatonin, a pineal gland hormone, has also been utilized for insomnia with some controversial findings.

The non-benzodiazepines, as exemplified by zolipdem, are unique hypnotics that are short acting and highly selective with minimal side effects. The presentation will examine a number of different non-benzodiazepines, for example, zolipdem and zaleplon, and also discuss the role for this class of drugs in the treatment of insomnia in depressed patients.

This presentation will also discuss various general problems in the treatment of insomnia, e.g., how long to treat? Does one prescribe nightly use or PRN use? What to do for insomnia in depressed patients?

REFERENCES:

1. Ford DE, Cooper-Patrick L: Sleep disturbances and mood disorders: an epidemiologic perspective. Depress Anxiety 2001;14:3–6.
2. Asnis GM, Chakraburtty A, DuBoff AE, Krystal A, et al: Zolpidem for persistent insomnia in SSRI-treated depressed patients. Journal of Clinical Psychiatry 1999;60, 668–77.

# INDUSTRY-SUPPORTED SYMPOSIUM 44—INSOMNIA IN TODAY'S SOCIETY: CONSEQUENCES AND TREATMENTS, PART 2
## Supported by Sanofi-Synthelabo, Inc.

### EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should (1) understand the interrelationship between insomnia and psychiatric disorders, (2) attain knowledge of the available pharmacological treatments, (3) be able to use various cognitive-behavioral treatments for insomnia, and (4) recognize when to refer insomnia patients to a sleep specialist.

## No. 44A
## COGNITIVE-BEHAVIORAL THERAPY OF INSOMNIA

Shari Kohn, Ph.D., *111 East 210 Street, Bronx, NY 10467*

### SUMMARY:

The efficacy of cognitive-behavioral treatments for insomnia has been well documented. The results of many controlled studies have shown that after an average of five sessions, cognitive-behavioral treatments consistently reduce self-reported sleep complaints, and some have shown long-term benefits. Furthermore, cognitive-behavioral techniques have been shown to facilitate withdrawal of hypnotics in patients with chronic insomnia. Specific cognitive-behavioral treatments for insomnia include, but are not limited to, stimulus control, sleep restriction, cognitive restructuring, paradoxical instructions, self-monitoring, progressive muscle relaxation, and biofeedback. Characteristics common to patients, especially those with insomnia, can undermine these interventions and need to be addressed. These characteristics include noncompliance, poor understanding and recall of instructions (recall can be as low as 13%), previous treatment failures, expectations, performance anxiety, and secondary gain. Specific techniques will be taught to psychiatrists not previously trained in cognitive-behavioral interventions. Furthermore, the importance of promoting psychoeducation to the patient, for example, teaching "good sleep hygiene," will be discussed. In addition, the consideration of cognitive-behavioral techniques in conjunction with hypnotics, particularly for chronic forms of insomnia, will be addressed. Finally, interventions addressing characteristics of patients with insomnia which, if not attended to, may undermine treatment, and modalities of assessment will also be reviewed.

## No. 44B
## WHEN TO REFER A PATIENT WITH INSOMNIA TO A SLEEP SPECIALIST LABORATORY

Michael Thorpy, M.D., *111 East 210th Street, Bronx, NY 10467*

### SUMMARY:

Insomnia is a common symptom in psychiatric disorders. Most psychiatrists are comfortable with treating insomnia in their patients. However, sometimes the question of a specific sleep disorder that requires polysomnographic evaluation is raised, or a patient has severe and intractable insomnia that requires referral to a sleep specialist.

The psychiatrist needs to know when a patient is suitable for referral. Certain sleep disorders, such as obstructive sleep apnea syndrome, periodic limb movement disorder, and nocturnal epilepsy can only be diagnosed by overnight polysomnographic or EEG monitoring. Polsomnography can also be useful in the diagnosis of arousal disorders, such as sleepwalking, sleep terrors, or confusional arousals. REM sleep behavior disorder can be differentiated from nightmares and precipitating causes such as sleep apnea can be determined.

Some symptoms, such as excessive daytime somnolence may raise a question of narcolepsy or idiopathic hypersomnia and investigations that include a Multiple Sleep Latency Test may be indicated. Most often excessive sleepiness is a result of insufficient sleep, but once sleep is extended and the patient still has daytime somnolence should the patient be referred? This question and others will be discussed in this presentation.

### REFERENCES:

1. Lacks P, Morin CM: Recent advances in the assessment and treatment of insomnia. Journal of Consulting and Clinical Psychology 1992;60, 586–594.
2. Nowell PD, Buysse DJ: Treatment of insomnia in patients with mood disorders. Depress Anxiety 2001;14(1):7–18.

# INDUSTRY-SUPPORTED SYMPOSIUM 45—OBESITY IN PSYCHIATRIC PRACTICE: RECOGNITION AND TREATMENT, PART 1
## Supported by Ortho-McNeil Pharmaceutical

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize factors that place patients at risk for obesity and know what treatment options are available.

## No. 45A
## OBESITY UPDATE

Robert Kushner, M.D., *150 E. Huron, Suite 1100, Chicago, IL 60611*

### SUMMARY:

The American people are in the midst of an obesity epidemic. According to the 1999 statistics from CDC, 61% of adults in the U.S. are considered overweight. Its etiology is multifactorial, presumably brought about by an interaction between predisposing genetic and metabolic factors and a rapidly changing environment. The social pressures that expose individuals to high-calorie, high-fat convenience foods, along with technical advances that promote sedentary behavior, have led to involuntary obesity. These social and environmental causes of energy imbalance are considered the major underlying factors for the markedly increased prevalence of obesity over the past several decades.

The greatest concern of the obesity epidemic is the harmful effect on a patient's health. Obesity, diet, and physical inactivity are responsible for approximately 300,000 preventable deaths per year. Obesity is a contributing factor to type 2 diabetes, hypertension, coronary artery disease, obstructive sleep apnea, and some forms of cancer, among others. Metabolic syndrome, which comprises a cluster of abnormalities including abdominal obesity, hypertriglyceridemia, low levels of HDL-cholesterol, hypertension, and impaired glucose tolerance, is seen in approximately 24% of U.S. adults. A targeted approach to patient care is addressed in 1998 NHLBI clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults.

## No. 45B
## PSYCHOTROPIC MEDICATION AND WEIGHT GAIN

David B. Allison, Ph.D., *1665 University Boulevard, RPHB 327, Birmingham, AL 35294-0022*

SUMMARY:

This presentation will review data on the frequency and severity of psychotropic-induced weight gain, focusing on the antipsychotic agents. Although an association between the use of antipsychotic medication and weight gain has long been noted, in recent years, this problem has generated increased concern and attention. In part, this reflects the fact that the newer antipsychotic medications have a reduced frequency of other significant side effects; such as extrapyramidal movements. However, recent data also suggest that a number of the newer antipsychotic medications are associated with greater weight gain compared to older medications. Such weight gain has the potential for adverse clinical consequences. Excessive weight gain is associated with the development of potentially serious medical complications, such as diabetes and hypertension, and may increase patients' reluctance to remain on medication and thereby increase the risk of relapse. The available data indicate that there are significant differences among antipsychotic agents in their propensity to cause weight gain. Although the data are fewer, there is significant evidence suggesting that some mood stabilizers and, less certainly, some antidepressants, are also associated with weight gain. This presentation will present an overview of the problem of weight gain associated with psychotropic medications, including mechanisms, magnitude and time course, and possible interventions.

## No. 45C
## OBESITY AND PSYCHIATRIC DISORDERS

Laurel Mayer, M.D., *1051 Riverside Drive, Unit 98, New York, NY 10032*

SUMMARY:

Obesity is currently a significant public health problem in the United States. While the etiology of obesity is clearly multi-factorial, including genetic and environmental components, psychiatrists should also be aware that psychiatric disorders can contribute to the development of obesity.

This talk will discuss the relationship between psychiatric disorders and obesity. Primarily, the talk will focus on binge eating disorder. Binge eating disorder (BED) is characterized by repeated episodes of binge eating without compensatory behaviors to adjust for the increased intake in calories. Associated with this increased intake, patients are often overweight.

Weight changes associated with depression will also be discussed. Unlike melancholic depression, which often presents with weight loss, atypical depression is associated with increased appetite and significant weight gain. The negative self-evaluation and lack of motivation that accompany depression can confound efforts to minimize the weight gain.

Eating and weight changes associated with other major psychiatric disorders will also be discussed.

REFERENCES:

1. The Practical Guide to the Identification, Evaluation and Treatment of Overweight and Obesity in Adults. NIH Publication Number 00-4084, 2000, www.nhlbi.nih.gov.
2. Allison DB et al: Antipsychotic-induced weight gain. Am J Psychiatry 1989;156:1686–1696.
3. Devlin MJ, Yanovski SZ, Wilson GT: Obesity: what mental health professionals need to know. Am J Psychiatry 2000;157(6):854–66.

# INDUSTRY-SUPPORTED SYMPOSIUM 45—OBESITY IN PSYCHIATRIC PRACTICE: RECOGNITION AND TREATMENT, PART 2
## Supported by Ortho-McNeil Pharmaceutical

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize factors that place patients at risk for obesity and know what treatment options are available.

## No. 45A
## PSYCHOLOGICAL TREATMENT OF OBESITY AND BINGE EATING

Denise E. Wilfley, Ph.D., *667 South Euclid, Campus Box 8134, St. Louis, MO 63110*

SUMMARY:

Obesity is associated with many health problems, such as hypertension, diabetes, and cardiovascular disease, all of which are among the leading causes of death in the United States. Of obese individuals seeking weight loss, as many as 30% suffer from binge eating disorder (BED). Comprehensive psychological treatment for obesity includes cognitive and behavior change strategies designed to decrease caloric consumption, improve nutrition, and increase energy expenditure through physical activity. In addition, techniques geared to modify thoughts and attitudes about weight regulation are also important. There are two currently accepted approaches to treat BED: specialty treatments that target the eating disorder and behavioral weight loss interventions that target obesity. Specialty treatments that target binge eating have consistently documented short- and long-term success with reducing binge eating and associated psychopathology in controlled trials, but specialty treatments only minimally impact weight. Behavioral weight loss interventions produce clinically significant short-term weight loss and reductions in binge eating among obese BED individuals, but the long-term impact on binge eating, weight, and other eating disorder psychopathology remains unclear. This presentation will review the state of the science in psychological treatment research for obesity and BED, with a focus on the implications of this research for clinical practice.

## No. 45B
## PHARMACOTHERAPY OF OBESITY AND BINGE EATING

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

SUMMARY:

Pharmacotherapy is becoming an increasingly important modality in the management of binge eating and obesity. However, only one medication is approved by the Food and Drug Administration (FDA) for the treatment of an eating disorder associated with binge eating (fluoxetine in bulimia nervosa) and only two medications (sibutramine and orlistat) are FDA approved for the long-term treatment of uncomplicated obesity (obesity without psychopathology). In this presentation, medications that have been studied in the treatment of bulimia nervosa, binge eating disorder, and obesity, with and without psychopathology, will be presented. Specific medications reviewed will include serotonin selective reuptake inhibitors (SSRIs) (e.g. fluoxetine), noradrenergic agents (e.g., phentermine and bupropion), serotonin norepinephrine selective reuptake inhibitors (SNRIs) (e.g.,

sibutramine and venlafaxine), antiepileptics associated with weight loss (e.g., topiramate and zonisamide), and lipase inhibitors (e.g., orlistat). Existing guidelines for the use of pharmacotherapy in these disorders will be reviewed, and additional guidelines incorporating new treatment data will be suggested.

REFERENCES:

1. Wilfley DE: Psychological treatment of binge eating disorder, in Eating Disorders and Obesity. Edited by Fairburn, Brownell KD. New York, NY, Guilford Press, 2001, pp 350–353.
2. Malhotra S, McElroy SL: Medical management of obesity associated with psychopathology. J Clin Psychiatry 2002;63(Suppl 4):24–32.

## INDUSTRY-SUPPORTED SYMPOSIUM 46—COMPASSIONATE AND SAFE EMERGENT CARE: BEST PRACTICES IN ANTIPSYCHOTIC USE
## Supported by Janssen Pharmaceutica

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to summarize currently available psychopharmacological treatment options in acute care; evaluate equivalence of various orally and/or intramuscularly applied antipsychotic agents; identify the impact of quality of acute antipsychotic care for the success of long-term treatment.

### No. 46A
### CAN ACUTE CARE BE COMPASSIONATE?

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

SUMMARY:

Behavioral emergencies are common in health care settings and strategies have evolved for managing them. Concentration of dangerous patients in hospitals and the frequency of hospital staff injuries are rising. None the less, there is increasing concern about the use of restraints. Restraints may work, but only in the limited sense of preventing injuries. Meanwhile, most staff injuries occur while restraining patients and patients sometimes die in restraints or develop PTSD. It is troubling that facilities with similar patients have widely divergent rates of restraint, suggesting that institutional culture is more important than clinical factors in determining the use of restraints. Hence, restraints are now described as a security procedure rather than a treatment and may be used only as a last resort. Medications are a form of restraint under some circumstances. Assessment and treatment process rather than the agent distinguishes treatment from restraint. Behavioral emergencies are a temporary departure from the usual physician-patient relationship during which time the physician acts as proxy decision maker. This presentation will use case vignettes and expert consensus guidelines to illustrate the threshold for emergency interventions and alternative strategies for various emergency conditions. Gender, race and ethnicity, consumer preferences, and long-term consequences will be considered.

### No. 46B
### CAN ACUTE CARE BE COMPASSIONATE? PROVIDER/NURSE'S PERSPECTIVE

Grad Green, M.S.N., *322 Hanover Avenue, #311, Oakland, CA 94606-1394*

SUMMARY:

Psychiatric emergency services (PES) provide stabilization and alleviation of symptoms related to crises. As the health care industry shifts its focus, the complex task of advocating and accessing care produces additional stress for both patients and staff in the PES. Decreased inpatient lengths of stay and lack of available, appropriate community-based resources place PES clinicians in positions of rationing care. This experience of powerlessness can produce cynicism, burnout, and loss of compassion by staff. Teamwork, crucial to the efficacy of PES services, is then compromised. This presentation will focus on the efficacy of a crisis case management program based in an urban psychiatric emergency service. The purpose of the case management service is to advocate for community-based services, assist with access, and provide interim transitional care for patients until a linkage occurs. This presentation will focus on the creative uses of resources by staff and the positive side effects of such a program as it influences the work and morale of the PES staff to continue providing care for patients in crisis. This presentation will also explore the use of humor and humanism in creating an environment of collaboration and teamwork incorporating self-care and group cohesion.

### No. 46C
### EVALUATING EQUIVALENCE OF ANTIPSYCHOTICS: ORAL VERSUS IM ADMINISTRATION FOR ACUTE DISORDERS

Glenn W. Currier, M.D., *300 Crittenden Boulevard, Rochester, NY 14542-8409*

SUMMARY:

Pharmacological treatment of behavioral disturbances has a long history in the medical literature. In spite of several changes over the years, in the past few decades clinicians have relied heavily on parenteral high potency neuroleptic drugs such as haloperidol, often in combination with benzodiazepines and anticholinergic agents. The impact of this choice on longer term compliance has not been explored until recently. While atypical antipsychotic drugs have supplanted older agents for care of psychotic spectrum disorders in most instances, their use in the emergency setting has been limited by lack of parenteral forms and lack of adequate efficacy studies. In this presentation, Dr. Currier will review the literature supporting the use of oral or intramuscular typical antipsychotics, benzodiazepines, and atypical antipsychotic drugs. Along with efficacy data from pivotal trials and Phase 4 studies, specific emphasis will be placed on patients' self-reported experiences with these agents. Recommendations for use of specific drugs with specific disease entities and patient subsets will be reviewed. Finally, we will discuss barriers to conducting research in this challenging clinical setting, and will summarize and contextualize the available literature to support rational, safe, and humane clinical care.

### No. 46D
### EVIDENCE-BASED MEDICINE AND THE EVOLVING STANDARD OF CARE: DEVELOPING THE TREATMENT ALLIANCE

Frederick Veser, M.D., *2617 Bohichet Road, Johns Island, SC 29455;* Joseph J. Zealberg, M.D.; Belynda D. Veser, M.D.

SUMMARY:

The expanding pharmacopeia available to effectively treat acute agitation and psychosis may provide both patient and provider with a multitude of choices to better effect treatment. As with any choice, informed decisions are founded in education, which can be facilitated through the development of alliances for both patient and provider.

The patient/provider alliance is able to empower the patient giving them a degree of control through choices. It also presents the provider with an invaluable tool: an informed patient. The benefits of this alliance include not only increases in compliance, but eventually better and more tolerable long-term care. In addition, the continuing education of the provider, through the development of provider/provider alliances across the spectrum of physicians, is able to promote the dissemination of new ideas as well as the issues confronted by each. These dialogues will not only aid in the implementation of novel therapies, including challenging old habits and "gold standards," but also in assessing and prioritizing areas of future research. The benefits of these alliances, however, are not without their own set of issues, particularly within the acute care setting where the fine balance between safety and efficacy is more evident. Recent studies and developments which address this matter will be discussed.

## No. 46E
## TRANSITIONING PATIENTS FOR LONG-TERM SUCCESS

Robert R. Conley, M.D., *Maple and Locust Streets, P.O. Box 21247, Baltimore, MD 21228*

### SUMMARY:

Acutely agitated psychotic individuals are challenging to manage, causing a focus on short-term outcomes. However, schizophrenia is a lifetime disease, and medication noncompliance rates may be as high as 74% within two years. Relapse and rehospitalization rates are also high, driven partly by lack of continuous medication. Long-acting antipsychotics improve compliance, and in long-term studies relapse rates are lower with conventional decanoate than with oral preparations. However, the decanoates are plagued by the same side effects and limited-spectrum efficacy as the oral conventionals. Broader efficacy and greater tolerability have made atypical antipsychotics the current standard of care. While atypical antipsychotics may prolong remission versus oral conventionals when medication is taken, as recently demonstrated for risperidone vs haloperidol, long-term adherence rates may be similarly poor. Weight, metabolic, and cardiac issues with some atypicals complicate the treatment decision. A recent advance, a long-acting form of the atypical antipsychotic risperidone, promises to combine the adherence advantages of decanoates with the efficacy and safety advantages of risperidone. When considering a medication choice for an acutely agitated psychotic patient, consideration of both short- and long-term implications may offer the patient a better chance for a sustained improvement in quality of life.

### REFERENCES:

1. Allen MH, Currier GW, Hughes DH, Reyes-Harde M and Docherty JP: Expert Consensus Guideline Series: Treatment of Behavioral Emergencies Postgraduate Medicine Special Report 2001:1–90. http://www.psychguides.com/gl-treatment_of_behavioral_emergencies.html.
2. Kirk S et al: Changes in health and job attitudes of case managers providing intensive services. Hospital and Community Psychiatry 1993;44(2).
3. Currier GW: Atypical Antipsychotic medications in the psychiatric emergency service. J Clin Psychiatry 2000;61(suppl 14):21–26.
4. Veser FH, Veser BD, Zealberg JJ: Risperidone in the treatment of acute agitation and psychosis. Soc Acad Emerg Med 2002;9:388.
5. Csemansky JG, Mahmoud R, Brenner R: A comparison of risperidone and haloperidol for the prevention of relapse in patients with schizophrenia. N Engl J Med 2002;346(1):16–22.

# INDUSTRY-SUPPORTED SYMPOSIUM 47—JUVENILE BIPOLAR DISORDER: CONTEMPORARY ISSUES IN RESEARCH
## Supported by Novartis Pharmaceuticals Corporation

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the clinical presentation of juvenile BPD and how it relates to the adult form of the disorder, the major comorbid conditions with BPD in youth and treatment strategies, and understand treatment issues in managing mania, depression, and comorbidity in youth with BPD.

## No. 47A
## 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 as to its comorbidity with other psychiatric conditions. In this talk, recent data on psychiatric comorbidity with BPD will be reviewed. One of the most clinically relevant and well replicated findings in the area of 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. 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 appear to represent more than symptom overlap—supported by recent family studies. Substance abuse is an important comorbid condition in BPD and appears to particularly aggregate in youth who manifest the onset of their mania in adolescence. In this session, a review of the major comorbidities with BPD in children and adolescents will be reviewed with an emphasis on the clinical distinction of the BPD and the comorbid condition. Treatment implications of specific comorbid conditions with BPD will be presented.

## No. 47B
## PEDIATRIC MANIA: A DEVELOPMENTAL SUBTYPE OF BIPOLAR DISORDER?

Joseph Biederman, M.D., *55 Fruit Street, WACC 725, Boston, MA 02114;* Eric Mick, Sc.D.; Stephen V. Faraone, Ph.D.; Thomas J. Spencer, M.D.; Timothy E. Wilens, M.D.; Janet Wozniak, M.D.

### SUMMARY:

Despite ongoing controversy, the view that pediatric mania is rare or nonexistent has been increasingly challenged, not only by case reports, but also by systematic research. This research strongly suggests that pediatric mania may not be rare, but that it may be difficult to diagnose. Since children with mania are likely to become adults with bipolar disorder, the recognition and characterization of childhood-onset mania may help identify a meaningful developmental subtype of bipolar disorder worthy of further investigation. The major difficulties that complicate the diagnosis of pediatric mania include the following: (1) its pattern of comorbidity may be unique by adult standards, especially its overlap with attention-deficit/hyperactivity disorder, aggression, and conduct disorder; (2) its overlap with sub-

stance use disorders; (3) its association with trauma and adversity; (4) its response to treatment is atypical by adult standards.

## No. 47C
## THE THERAPEUTIC ROLE OF ATYPICAL ANTIPSYCHOTIC MEDICATIONS IN PEDIATRIC-ONSET BIPOLAR DISORDER

Janet Wozniak, M.D., *55 Fruit Street, Boston, MA 02114*

### SUMMARY:

*Background:* Children with bipolar disorder frequently present with an atypical clinical picture including high levels of comorbidity. Initial clinical evidence suggests that atypical antipsychotic medications may play a unique therapeutic role in the management of bipolar youth.

*Method:* This presentation summarizes current research regarding the presentation and comorbidity associated with pediatric-onset bipolar disorder, focusing on treatment data that document the therapeutic role of atypical antipsychotic medications in rapidly managing the mood instability and aggression present in bipolar youth.

*Results:* In a retrospective chart review study of 28 children with bipolar disorder, we documented an 82% improvement in both manic and aggressive symptoms with risperidone treatment without serious adverse effects. In an open-label trial in 23 bipolar youths, olanzapine treatment was efficacious and well tolerated in the treatment of acute mania. Although quetiapine and ziprasidone have not been investigated in the treatment of pediatric bipolar disorder, their side-effect profiles could make them viable options if proven efficacious.

*Conclusion:* Treatment of pediatric-onset bipolar disorder requires a combined pharmacotherapy approach to address issues of comorbidity. Atypical antipsychotic medications have thus far provided promising results, but there is a need for additional controlled clinical trials.

## No. 47D
## TREATMENT OF PEDIATRIC BIPOLAR DISORDER WITH ANTICONVULSANT MOOD STABILIZERS

Joseph M. Gonzalez-Heydrich, M.D., *300 Longwood Avenue, Boston, MA 02115*

## No. 47E
## GENETICS OF EARLY-ONSET BIPOLAR DISORDER

Stephen V. Faraone, Ph.D., *750 Washington Street, Suite 255, South Easton, MA 02375*

### SUMMARY:

Family, twin, and adoption studies have consistently shown bipolar disorder to be a highly heritable condition. We review the extant genetic literature about early-onset bipolar disorder from two perspectives. We show that many studies show early-onset bipolar disorder to be more highly heritable than later-onset bipolar disorder. We also show that onset in childhood confers a greater risk to relatives than onset in adolescence. In addition, early-onset bipolar disorder is known to show substantial comorbidity with attention deficit hyperactivity disorder and conduct disorder. We review the literature on this topic and show how it supports the idea that early-onset bipolar disorder with these comorbidities may be a developmental subtype of bipolar disorder. In addition, new data are presented on a genome-wide scan of 538 people in 97 families with bipolar disorder. We found that the age at onset of bipolar disorder had significant heritability (40%, p = .004). Three chromosomal regions yielded multipoint LOD scores greater than 2.5: markers DLS1292, GATA31B, and GATA153 on chromosomes 12, 14, and 15, respectively. We also describe the clinical correlates of age at onset of bipolar disorder and discuss how these concur with prior work in the areas.

### REFERENCES:

1. Wilens T, Biederman J, Millstein R, Wozniak J, Hahesy T, Spencer T: Risk for substance use disorders in youth with child and adolescent bipolar disorder. J Am Acad Child Adolesc Psychiatry 1999;38:680–686.
2. Feadda G, Baldessarini R, Suppes T, Tondo L, Becker I, Lipschitz D: Pediatric-onset bipolar disorder: a neglected clinical and public health problem. Harvard Rev Psychiatry 1995;3:171–195.
3. Frazier J, Meyer M, Biederman J, Wozniak J, Wilens T, Spencer T, Kim G, Shapire S: Risperidone treatment for juvenile Bipolar Disorder: a retrospective chart review. Journal of the American Academy of Child and Adolescent Psychiatry 1999;38:960–965.
4. Strober M, Morrell W, Burroughs J, Lampert C, Danforth H, Freeman R: A family study of bipolar I disorder in adolescence. Early onset of symptoms linked to increased familial loading and lithium resistance. Journal of Affective Disorders 1988;15, 255–268.

# INDUSTRY-SUPPORTED SYMPOSIUM 48—CHALLENGES IN DEMENTIA: EVIDENCE-BASED CONSIDERATIONS FROM EARLY DIAGNOSIS TO LONG-TERM MANAGEMENT

**Supported by Eisai Inc., Pfizer Inc.**

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify potential screening tools for the detection and treatment of Alzheimer's disease, recognize the symptoms of mild cognitive impairment and its implications for AD, understand the role of cholinesterase inhibitors in treating AD, discuss strategies and lifestyle choices that may help protect the brain.

## No. 48A
## VALIDATED SCREENING TOOLS FOR DEMENTIA

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

### SUMMARY:

Alzheimer's disease (AD) is the most common cause of dementia for elderly patients. Unfortunately, AD is seldom diagnosed soon after symptomatic onset. Although current treatments may slow progressive cognitive decline, they seldom reverse it. Earlier recognition and detection of dementia would allow available treatments to be employed when they may preserve more functional capacity. Early detection also permits timely patient and family education, development of social support systems, and important financial and legal planning. Effective systems for patient screening are key to early recognition and detection of AD.

Screening approaches to identify cognitive impairment in the elderly have included direct patient evaluation and collateral informant questionnaires. Although both approaches accurately identify unrecognized dementia, large community screening can be time consuming and resource intensive. Interactive voice response systems integrate telecommunications networks with computer-automated processing. Studies have shown that computer-automated telephone screening for early dementia using either informant or direct assessment is feasible and could provide wide-scale, cost-effective screening, education, and referral services to patients and caregivers.

## No. 48B
## REAL WORLD ASSESSMENT AND MANAGEMENT OF MILD COGNITIVE IMPAIRMENT: A CASE STUDY

M. Saleem Ismail, M.D., *435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

Mild cognitive impairment (MCI) is a clinical entity that is increasingly regarded as an important transitional stage of cognitive dysfunction between normal aging and early Alzheimer's disease (AD). Practically speaking, MCI is characterized by significant short-term memory impairment in the absence of frank dementia or impaired function. The clinical criteria for MCI include memory complaint by the patient and/or family member, objective evidence of memory impairment, normal general cognitive functioning, and preserved activities of daily living.

The importance of MCI lies in the fact that these individuals are at significantly increased risk for developing AD. This recognition has led to ongoing clinical trials of various agents aimed at potentially delaying 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 manage 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 AD pathology. Future diagnostic techniques may allow improved identification of those patients with MCI who indeed have evolving AD. Early identification of these at-risk individuals will be particularly important for conducting novel intervention trials.

## No. 48C
## ISSUES AND PRACTICAL LESSONS IN CLINICAL TRIALS IN DEMENTIA

Rachelle S. Doody, M.D., *6550 Fannin, Suite 1801, Houston, TX 77030*

SUMMARY:

The cholinergic hypothesis holds that a loss of cholinergic function in the brains of Alzheimer's disease (AD) patients accounts for some of their symptoms, and that cholinergic augmentation should therefore improve symptoms in AD patients. Although it was assumed that cholinergic cell loss occurred early and progressed in tandem with disease severity, recent data suggest that cholinergic loss may not occur with the same timing in every patient. The cholinesterase inhibitors have been shown to be efficacious in AD in trials designed to detect benefit compared with placebo, and these benefits have been assumed to be reversible and strictly symptomatic. Clinical trials with these agents have taught us the following: these drugs, particularly in high doses, seem to benefit all patients with mild to moderate AD; benefits can be seen in cognition, behavior, and functioning; benefits may consist of temporary improvement over baseline, temporary stabilization, or slowed decline; benefits can be seen in patients with severe AD; the duration of benefits seems to extend in many patients for years; the trials have shown some results previously hypothesized to indicate effects on disease progression (as opposed to strictly symptomatic effects).

## No. 48D
## CHOLINESTERASE INHIBITORS IN VASCULAR DEMENTIA: A NEW TREATMENT MODEL?

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

SUMMARY:

Vascular lesions were the first recognized cause of dementia in the elderly (ie, arteriosclerotic dementia). Vascular dementia (VaD) may be caused by large and small vessel strokes, and subcortical small vessel disease. Vascular lesions may interrupt prefrontal-subcortical circuits causing memory loss, executive dysfunction, apathy, and depression. 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 Alzheimer's disease (AD). The frequent association of stroke and AD complicates the diagnostic process of vascular dementia (VaD).

Cholinesterase inhibitors are the cornerstone of therapy for AD. Recent evidence suggests substantial overlap in the clinical presentation and pathogenesis of AD and VaD. Clinical and pathological observations indicate that patients with VaD may have reduced levels of cholinergic neurons in the central nervous system, and may therefore benefit from treatment with cholinesterase inhibitors. We will examine a study that demonstrated that use of a cholinesterase inhibitor showed improvement in cognition and caregiver-assessed global function in patients with probable or possible VaD.

## No. 48E
## STRATEGIES FOR KEEPING THE BRAIN YOUNG

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

SUMMARY:

Technological developments during the past decade have led to a greater understanding of brain function and genetic risk in Alzheimer's disease (AD), particularly early in the disease course. For assessing dementia or age-related memory complaints, functional imaging—particularly positron emission tomography (PET) scanning because of the biological information it provides—offers the advantage of providing a positive diagnosis of early AD often before clinicians can identify the condition using conventional clinical assessments. Longitudinal clinical and autopsy studies have shown that PET provides greater diagnostic accuracy than standard clinical assessment methods. The characteristic parietal and temporal deficits observed on a PET scan can be recognized years prior to clinical confirmation, particularly when combined with genetic risk measures (apolipoprotein E-4 [APOE-4]). Emerging data indicate clear advantages to early treatment with cholinesterase inhibitors. For people with mild forms of age-related memory loss, the body of evidence also points to lifestyle choices that may protect the brain from future decline. Essentially, what is healthy for the body is healthy for the brain. Although definitive proof of the value of many of these interventions is not yet available, the risks are minimal and are not likely to outweigh the many benefits.

REFERENCES:

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2. Petersen RC, Stevens JC, Ganguli M, Tangalos EG, Cummings JL, DeKosky ST: Practice parameter: early detection of dementia: mild cognitive impairment (an evidence-based review). Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2001;56:1133–1142.
3. Leber P: Slowing the progression of Alzheimer disease: methodologic issues. Alzheimer Disease and Associated Disorders 1997;11(supp 5):S10–S21.
4. Results from a clinical study with donepezil in patients with vascular dementia. Presented at: 2nd International Conference on Vascular Dementia; January 25, 2002; Salzburg, Austria.
5. Small G: The Memory Bible: An Innovative Strategy for Keeping Your Brain Young. New York, NY, Hyperion, 2002.

# INDUSTRY-SUPPORTED SYMPOSIUM 49—COMBINED PHARMACOTHERAPY FOR BIPOLAR DISORDERS
## Supported by GlaxoSmithKline

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify bipolar patients who may benefit from specific combined psychotherapy and manage such patients effectively over the long term.

## No. 49A
## THE RATIONALE FOR COMBINED PHARMACOTHERAPY

Frederick K. Goodwin, M.D., *2150 Pennsylvania Avenue, N.W., 8th Floor, Washington, DC 20037*

### SUMMARY:

This presentation will provide the foundation for the key themes that will be developed by the individual speakers, focusing first on the reasons for the existing preference for monotherapy trials. The two major rationales for combined treatment—targeting of different symptom clusters and synergisms in the mechanisms of action of different drugs—will be illustrated by specific examples: the treatment of breakthrough depressions and the management of comorbid substance abuse and of psychotic features. With regard to potential synergisms, open trials data and clinical experience with enhanced therapeutic-to-side-effect ratios achieved by combining modest doses of two potentially synergistic drugs will be presented.

## No. 49B
## POTENTIAL SYNERGIES IN THE MECHANISMS OF ACTIONS OF MOOD STABILIZERS

L. Trevor Young, M.D., *1200 Main Street, West, Room HSC 4N81, Hamilton, ON Canada L8N 3Z5*

### SUMMARY:

Recent genomic and proteomic studies have revealed unexpected long-term targets for the actions of lithium and valproate (VPA). In general, the genes and proteins can be categorized as (1) those exerting trophic effects and regulating cell survival, (2) those regulating critical cytoskeletal proteins, (3) those regulating cellular signaling. Surprisingly, despite their dramatic structural dissimilarity, lithium and VPA do share a number of important long-term biochemical targets. However, the two drugs utilize different acute biochemical pathways to end up at the same final common target, and therefore often produce additive effects. Furthermore, in many cases, the drugs produce the same "final common functional equivalent" (e.g., enhanced neuroplasticity), but achieve this therapeutically relevant physiological endpoint by affecting different targets to varying degrees (e.g., bcl-2 vs. MAP kinases). Once again, this suggests the possibility of obtaining additive (and potentially synergistic) benefits by the co-administration of both agents. The concerted use of genomic and proteomic strategies to refine the treatment response in heterogeneous groups of bipolar patients into mechanism-based subcategories may ultimately allow for the matching of combinations of particular target-based therapies to subgroups of patients. Such strategies may lead to improved long-term outcomes, by simultaneously targeting pathways that are often involved in the deleterious compensatory adaptations to a primary drug.

## No. 49C
## MOOD-STABILIZER COMBINATIONS: MULTIMODAL THERAPY OR POLYPHARMACY?

Terence A. Ketter, M.D., *401 Quarry Road, Room 2124, Stanford, CA 94305-5723*

### SUMMARY:

The mood stabilizers lithium (LI), carbamazepine (CBZ), and divalproex (DVPX) are commonly combined with one another. However, there are only limited data describing the safety and efficacy of such combinations. Skillfully applied combinations can increase efficacy but not toxicity and may be rightly regarded as multimodal therapy in that they utilize treatments with varying mechanisms of action and enhance clinical outcome. However, on occasion combinations may fall to offer enhanced efficacy or inflict additional adverse effects, and thus may rightly receive the more pejorative label of Polypharmacy. LI actions on intracellular signaling suggest a potential for enhancing actions of diverse agents, based on amplifying signals downstream from the receptors influenced by other drugs. This concept is supported by clinical studies suggesting efficacy of lithium combined with other agents. CBZ and DVPX also impact intracellular signaling, but there are fewer data demonstrating the efficacy of combination therapies using these agents. All three mood stabilizers have the potential for additive increases in adverse effects based on both pharmacodynamic and pharmacokinetic drug interactions. CBZ is of particular concern for the latter, while its recently marketed analog oxcarbazepine appears less problematic. Thorough knowledge of these potential assets (enhanced efficacy) and liabilities (increased adverse effects) is necessary for optimal use of mood stabilizer combinations.

## No. 49D
## ANTIDEPRESSANTS IN COMBINATION THERAPY OF BIPOLAR DISORDERS

S. Nassir Ghaemi, M.D., *49 Fayette Street, #1, Cambridge, MA 02138*

### SUMMARY:

The role of antidepressants in bipolar disorder remains controversial. While these agents are prescribed in ≥50% of patients with bipolar disorder, recent studies indicate that antidepressants may actually destabilize the long-term course of bipolar disorder.

This presentation will review recent controlled studies regarding antidepressant use in bipolar disorder that suggest that the efficacy of antidepressants lies in their limited ability in acute settings to maximize mood stabilizer use, and that prophylactic efficacy with antidepressants in bipolar disorder is absent. Recent data will also be examined that indicate that antidepressant use in bipolar disorder may lead to three possible adverse outcomes; in particular, worsening of rapid cycling, antidepressant drug tolerance, or depressive relapse upon antidepressant withdrawal. Recent studies will be presented that suggest that in these instances, newer antidepressants may not be clearly safer than their older counterparts. This presentation will provide evidence that there is reason to exercise more caution in the use of antidepressants in bipolar disorder than is currently the case, and that their use in combination therapy should be limited. Fortunately, choices are available for bipolar disorder that include properties that both stabilize the mood and provide antidepressant effect, stabilizing "from below."

## No. 49E
## ATYPICAL ANTIPSYCHOTICS COMBINED WITH STANDARD MOOD STABILIZERS FOR BIPOLAR

Joseph F. Goldberg, M.D., *525 East 68th Street, Box 140, New York, NY 10021*

SUMMARY:

Atypical antipsychotic drugs originally emerged in the treatment of bipolar disorder as safer and potentially more effective alternatives to conventional neuroleptics, particularly during acute mania. Since then, their use has expanded to virtually all phases of bipolar illness, both short and long term. As molecules with binding affinities at receptor sites for multiple neurotransmitter systems, some atypical agents may constitute broad-spectrum acting psychotropic compounds. Recent investigators have begun to identify agents such as olanzapine, risperidone, or quetiapine that may produce pharmacodynamic synergy when combined with standard mood stabilizers.

This presentation will review the neuropharmacologic rationale for combining atypical antipsychotic drugs with lithium or anticonvulsant mood stabilizers, alongside data from existing clinical trials regarding the efficacy and safety of mood stabilizer monotherapies versus cotherapies with atypical antipsychotics. Recommendations will be offered for determining when combination therapies with specific agents are indicated, as well as criteria for dosing and duration of combination therapy to sustain remissions, minimize relapse risk, and manage side effects.

REFERENCES:

1. Keck PE Jr., McElroy SL, Strakowski SM, et al: Compliance with maintenance treatment in bipolar disorder. Psychopharmacol Bull 1997;33:87–91.
2. Manji HK, Du J, Chen HK: Pharmacogenomics of Bipolar Disorder in Pharmacogenomics: The Search for Individualized Therapeutics. Edited by Licinio J, Wong Ma-Li. Wiley, 2002, 397–412.
3. 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(1):9–15.
4. Ghaemi SN, Ko JY, Goodwin FK: "Cade's Disease" and beyond misdiagnosis, antidepressant use, and a proposed definition for bipolar spectrum disorder. Can J Psychiatry 2002;47:125–134.
5. Tohen M, Chengappa K, Suppes T, et al: Efficacy of olanzapine in combination with valproate or lithium in the treatment of mania in patients partially nonresponsive to valproate or lithium monotherapy. Arch Gen Psychiatry 2002;59:62–69.

# INDUSTRY-SUPPORTED SYMPOSIUM 50—NOVEL THERAPEUTIC OPTIONS FOR PSYCHOTIC DISORDERS

**Supported by Bristol-Myers Squibb Company**

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the evolution of antipsychotic agents, recognize the clinical implications of differences in the pharmacological profiles of various antipsychotic agents, evaluate comparative outcomes associated with various antipsychotic drugs and discuss the influence of tolerability on the overall effectiveness of antipsychotic therapy, describe real-world challenges to achieving optimal therapeutic outcome, discuss the role of clinical experience in guiding state-of-the-art practice, review recent and ongoing clinical trial results with existing and emerging antipsychotic therapies and their implications for optimizing treatment for patients with psychotic disorders.

## No. 50A
## THE EVOLUTION OF ANTIPSYCHOTIC THERAPY: A MECHANISM-BASED EVALUATION

W. Wolfgang Fleischhacker, M.D., *Anichstrasse 35, Clin. Dept. Bio. Psychiatry, Innsbruck, Austria A-6020*

SUMMARY:

The predominant hypothesis regarding the pathophysiology of schizophrenia is that it is associated with impaired dopamine neurotransmission in the brain. Increased dopaminergic activity in subcortical regions, particularly in the mesolimbic pathway, is associated with positive symptoms of schizophrenia. Negative and cognitive symptoms, on the other hand, seem to result from decreased dopamine activity in prefrontal cortical regions. Development of antipsychotic therapies and our understanding of the pathophysiology of psychoses have progressed hand in hand, from the first trials that established dopamine antagonism as effective treatment for psychotic disorders. The first revolutionary steps were followed by decades of continued efforts to improve both the efficacy and safety of available therapies. Clozapine was the first antipsychotic that proved that psychotic symptoms could be successfully treated without the risk of extrapyramidal symptoms. This marked the beginning of the era of second-generation antipsychotics. We are currently on the threshold of yet another stage of antipsychotic drug development. New pharmacologic approaches involve partial dopamine receptor agonism, resulting in stabilization, rather than complete blockade, of dopamine neuronal pathways. Without sacrificing potent antipsychotic activity, this mechanism allows physiological function of dopamine systems. Other potentially promising routes of investigation include modulation of glutamatergic systems, drugs interacting with membrane phospholipid structures, and neuropeptides as modifiers of classic neurotransmitter systems. In addition, monotherapeutic approaches are being supplemented with add-on strategies (pharmacologic or psychosocial) to enhance efficacy.

## No. 50B
## LIMITATIONS OF EXISTING ANTIPSYCHOTIC THERAPIES

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

SUMMARY:

Although the new atypical agents have revolutionized the treatment of schizophrenia, the need for improved therapies remains. Many patients respond suboptimally to treatment, and full functional recovery is rare. The impact of the introduction of second-generation antipsychotics on functional and social outcome in psychotic disorders will be summarized. In addition, side effects of antipsychotic medications have not been completely eradicated. Extrapyramidal symptoms, the adverse effect most usually associated with patient dissatisfaction with therapy, have been dramatically reduced but are still present to varying degrees during treatment with atypical agents. Hyperprolactinemia and sedation, which can severely affect quality of life, are common with some of the new antipsychotic agents. Perhaps more disturbing are metabolic adverse events that seem to be more common with some of the atypical agents than they were with conventional antipsychotics. Weight gain, dyslipidemia, and glucose intolerance can have serious adverse effects on long-term health. Weight gain also presents a tolerability problem, as it affects satisfaction with therapy and compliance. As antipsychotic therapies evolve, emphasis is therefore being placed on maintaining efficacy while improving the safety and tolerability profiles of new medications.

## No. 50C
## DEVELOPMENTS IN ANTIPSYCHOTIC THERAPY: REAL-WORLD CLINICAL EXPERIENCE

Susan M. Maixner, M.D., *1500 East Medical Center Drive, Ann Arbor, MI 48109-0704*

SUMMARY:

While clinical trials provide essential information regarding the efficacy of antipsychotic therapies, they seldom measure real-world outcomes such as daily functioning and ability to reintegrate into society. These outcomes depend not only on the efficacy of therapy as measured by usually employed rating scales, but also on improvement in cognition, satisfaction with therapy resulting in long-term compliance, and a side-effect profile that does not stigmatize the patient. As the efficacy and safety/tolerability profiles of antipsychotic agents improve, quality-of-life indicators and meaningful employment will increasingly become the new standards for measuring outcome. In addition, clinical management of patients with psychotic disorders needs to consider impact of therapy on overall patient health. For instance, long-term side effects of some medications include metabolic abnormalities, cardiovascular complications, and cognitive impairment. Considering these effects is particularly important when treating younger patients, as the risk of these complications will increase over the long term. When treating elderly patients, on the other hand, it may be more important to avoid orthostatic hypotension, which can cause syncope and increase the likelihood of bone fractures. Finally, practical issues in the everyday clinical setting include determination of optimal dosing regimens and appropriate protocols for switching pharmacologic therapies.

## No. 50D
## EMERGING CLINICAL DEVELOPMENTS IN SCHIZOPHRENIA AND PSYCHOTIC DISORDERS RESEARCH

Jeffrey A. Lieberman, M.D., *Room 7025, Neurosciences Hospital, CB7160, Chapel Hill, NC 27599*

SUMMARY:

The efficacy of atypical antipsychotics for short-term treatment of acute exacerbations of schizophrenia has been well established. Recently, long-term trials have indicated that newer agents have certain advantages over conventional antipsychotics for maintenance of response and prevention of relapse. These trials, however, have differed with respect to the patient populations, trial designs, and prespecified outcome measures, making any generalized comparisons difficult. In order to address the need for direct comparisons of different antipsychotic regimens under conditions deemed relevant to everyday patient management, the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) project has been launched by the National Institute of Mental Health. Other areas of novel ongoing clinical research include trials that enroll patients who have typically been underrepresented or excluded from large clinical trials: first-episode, elderly, pediatric, and treatment-refractory patients. In addition, as the tolerability of novel antipsychotics improves, interest in intervening early in the course of psychotic illness grows, with the hope that intervention during the prodromal phase may prevent progression of psychosis or decrease its duration and severity. Finally, an accumulating body of evidence indicates that new antipsychotic agents are effective as either monotherapy or as adjuvants to mood stabilizers for treatment of patients with bipolar disorder.

REFERENCES:

1. Lieberman JA, Golden R, Stroup S, McEvoy J: Drugs of the psychopharmacological revolution in clinical psychiatry. Psychiatr Serv 2000;51(10):1254–8.
2. Fontaine KR, Heo M, Harrigan EP, Shear CL, Lakshminarayanan M, Casey DE, Allison DB: Estimating the consequences of antipsychotic induced weight gain on health and mortality rate. Psychiatry Res 2001;101(3):277–88.
3. Kapur S, Remington G. Atypical antipsychotics: new directions and new challenges in the treatment of schizophrenia. Annu Rev Med 2001;52:503–517.
4. Lieberman JA, Perkins D, Belger A, Chakos M, Jarskog F, Boteva K, Gilmore J: The early stages of schizophrenia: speculations on pathogenesis, pathophysiology, and therapeutic approaches. Biol Psychiatry 2001;50(11):884–97.

# INDUSTRY-SUPPORTED SYMPOSIUM 51—BIPOLAR DISORDER: CLINICAL AND PUBLIC HEALTH IMPLICATIONS OF MEDICAL AND PSYCHIATRIC COMORBIDITY
## Supported by Ortho-McNeil Pharmaceutical

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the high prevalence of medical and psychiatric comorbidity in bipolar disorder, the impact of comorbid conditions on prognosis and their implications for concurrent treatment.

## No. 51A
## TREATMENT APPROACHES FOR MANAGING ANXIETY DISORDER IN THE BIPOLAR PATIENT

Patricia Suppes, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Bipolar disorder is often accompanied by anxiety disorders, most notably panic disorder and social phobia. Symptoms of anxiety and panic disorder followed by hypomania seem to complicate the course of illness. In addition, panic attacks during mania, as well as bipolar disorder manifesting as episodic obsessive compulsive disorder, have been reported. Those individuals with both an anxiety disorder and bipolar disorder are likely to experience a more severe course than patients without a comorbid anxiety disorder.

Pharmacological treatment of the comorbid anxiety disorder is challenging, as these symptoms are most often treated with antidepressant medications, which can exacerbate mood symptoms and potentially cause switch. Controlled clinical trials of treatments for bipolar disorder traditionally exclude patients with anxiety disorders, providing little insight into potential treatments. Anticonvulsants, typically used as antimanic agents, may be helpful in reducing anxiety. New treatment approaches for patients with comorbid bipolar disorder and anxiety also will be discussed, including non-pharmacological, adjunctive treatments.

## No. 51B
## THE CHALLENGE OF TREATING BIPOLAR DISORDER AND SUBSTANCE ABUSE

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

SUMMARY:

It has long been recognized that bipolar disorder and alcoholism commonly co-occur. The ECA Study reported a 60.7% lifetime prevalence rate for substance abuse or dependence in persons with bipolar I disorder; among substances, alcohol was the most common substance abused. A subscale analysis of the ECA study showed that BPI and BPII populations had the highest lifetime prevalence rate of alcoholism (46.2% and 39.2%, respectively) followed by schizophrenia (33.7%), panic disorder (28.7%), unipolar depression (16.5%), and the general population (13.8%). Thus, by prevalence

data alone, this comorbidity represents an enormous public health problem. Furthermore, this comorbidity has been associated with a greater illness burden as represented by an increased number of past hospitalizations (predominately for mania) and a higher prevalence rate of dysphoric mania, rapid cycling, suicidality, treatment noncompliance, health care utilization, and poor treatment response. This presentation will review treatment strategies that are focused both on mood stabilization and alcohol withdrawal/relapse prevention.

## No. 51C
## NEW TREATMENT OPTIONS FOR EATING DISORDERS AND OBESITY WITH COMORBID BIPOLAR DISORDER

Shishuka Malhotra, M.D., *231 Albert Sabin Way, Cincinnati, OH 45267-0559*

SUMMARY:

Eating disorders, obesity, and bipolar spectrum disorders are common health problems that overlap to a significant degree. However, little is known about the nature of this overlap, as well as the assessment and treatment of an eating disorder and/or obesity with comorbid bipolar disorder. In this presentation, available community, clinical, and family history studies showing that anorexia nervosa, bulimia nervosa, binge eating disorder, and obesity may be related to bipolar disorder will be reviewed. Available research on effective treatments for bipolar disorder that have been studied in eating disorders or obesity will be summarized, as will effective treatments for eating disorders or obesity that have been studied in bipolar disorder. Preliminary guidelines for the treatment of an eating disorder and/or obesity with comorbid bipolar disorder will then be suggested.

## No. 51D
## INFLUENCE OF MEDICAL COMORBIDITIES ON TREATMENT APPROACHES IN BIPOLAR PATIENTS

John L. Beyer, M.D., *Box 3519, Durham, NC 27710*

SUMMARY:

Most studies on treatment of bipolar patients have included primarily patients in good physical health, excluding medical comorbidity. On the other hand, bipolar disorder with medical comorbidity is the norm rather than the exception amongst patients who are seen in most clinical settings. The treatment of bipolar disorder in medically ill patients is challenging. Recognition, compliance, medical comorbidity, side effects, and tolerance of treatment regimens are major clinical problems. The key factors that one has to keep in mind are the interactions between medical disease and treatment and drug-drug interactions. For lithium renal disease is an important disease interaction. For valproate liver disease is an important factor. For lamotrogine dermatological conditions are important. These disease interactions will be discussed. In addition, indirect interaction due to the side effects of the drug on disease processes will be addressed. There are numerous drug interactions of relevance. These will be presented in detail. However, there are limited data on whether medical comorbidity affects treatment response.

## No. 51E
## GENDER AND BIPOLAR DISORDER

Lori L. Altshuler, M.D., *300 Medical Plaza, Suite 1544, Los Angeles, CA 90024;* Mark A. Frye, M.D.

SUMMARY:

While bipolar disorder affects men and women equally, there are some aspects of the illness or its treatment that impact women more than men. Women spend more time than men in the depressed phase and are more apt to experience mixed states and rapid cycling. Bipolar women are also more likely to have significantly higher rates of comorbid substance abuse compared with women in the general population. Data also suggest weight gain and obesity have different prevalence rates in men and women with bipolar disorder. Women with bipolar disorder who want to get pregnant must consider the impact of the use of medications on the developing fetus during pregnancy and the risk of relapse without using medication in pregnancy. The postpartum time is a period of great risk for an episode of illness. Findings on the prevalence of polycystic ovarian disease in women taking anticonvulsants will also be discussed.

REFERENCES:

1. Perugi G, Toni C, Akiskal HS: Anxious-bipolar comorbidity: diagnostic and treatment challenges. The Psychiatric Clinics of North America 1999;22:565–583.
2. Salloum IM, Thase ME: Impact of substance abuse on the course and treatment of bipolar disorder. Bipolar Disord 2000;2:269–280.
3. Malhotra S, McElroy SL: Medical management of obesity associated with psychopathology. J Clin Psychiatry 2002;63(Suppl 4):24–32
4. Strakowski SM, DelBello MP, Adler CM: Comparative efficacy and tolerability of drug treatments for bipolar disorder. CNS Drugs 2001;15(9):701–718.
5. Altshuler LL, Cohen LS, Moline ML, Kahn DA, Carpenter D, Docherty JP: The expert consensus guideline series: treatment of depression in women 2001. Postgrad Med Special Report 2001:1–116.

# INDUSTRY-SUPPORTED SYMPOSIUM 52—STRIVING TO HEAL THE MIND: THE CHALLENGE OF PTSD
## Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to understand the worldwide prevalence of PTSD, the traumas most likely to cause PTSD, the conditional risk of PTSD among emergency room patients with different trauma profiles, and the typical course of PTSD.

## No. 52A
## THE GLOBAL BURDEN OF PTSD: RESULTS FROM THE WORLD HEALTH ORGANIZATION INTERNATIONAL CONSORTIUM ON PSYCHIATRIC EPIDEMIOLOGY

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

SUMMARY:

Data on the cross-national epidemiology of posttraumatic stress disorder are presented from community epidemiological surveys in the WHO International Consortium in Psychiatric Epidemiology (ICPE). The prevalence of trauma exposure is found to vary enormously across the participating ICPE countries. The conditional risk of PTSD, in comparison, is much more consistent across countries. Traumas that involve interpersonal violence are much more likely to lead to PTSD than are traumas that do not involve interpersonal violence. However, trauma type does not predict the persistence of PTSD. History of psychopathology is consistently the most powerful

vulnerability factor for PTSD among people who have been exposed to trauma. History of psychopathology is also a powerful predictor of the course of PTSD. Recovery from PTSD within one year of onset is not uncommon, although a comparatively high proportion of cases become chronic. People with PTSD are much more likely than those with most other mental disorders to seek treatment. Fewer than half of those who are treated for PTSD receive care that meets minimum standards for treatment appropriateness.

## No. 52B
## EXPOSURE TO STRESS AND TRAUMA ACROSS THE LIFE SPAN: NEUROBIOLOGICAL CONSEQUENCES

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

### SUMMARY:

Animal models of neonatal maternal separation in rats, and maternal neglect or adverse rearing conditions during infancy in primates, have demonstrated that exposure to stressful conditions during critical periods of development can induce persistent changes in neuroendocrine function and stress responsivity. The findings from a growing body of preclinical work have generated hypotheses about the pathoetiology of hypothalamus-pituitary-adrenal (HPA) system and corticotropin-releasing-factor (CRF) function abnormalities in humans with mood and anxiety disorders. Recent investigations have begun to translate the animal models into clinical paradigms using neuroendocrine challenge protocols in both patients with posttraumatic stress disorder (PTSD) and major depression (MD), as well as in nonpsychiatric controls who have had significant exposures to stress during early life. The nature and timing of exposure to stress appear to be critical variables in determining an organism's biological trajectory and related behavioral manifestations. While other specific risk factors also contribute to the development of psychopathology, converging evidence now supports the notion that exposure to stressors early in life (childhood or adolescence) is associated with persistent central CRF hypersecretion and a pattern corresponding HPA axis "desensitization" characteristic of depression. Exposure to significant stress or trauma during adulthood may lead to a different, seemingly opposite, direction of HPA axis alteration. Later-life exposure to stress may influence a pattern of heightened HPA neuroendocrine sensitization, and the development of PTSD symptoms.

## No. 52C
## EARLY INTERVENTION FOR PTSD PROPHYLAXIS IN TRAUMA SURVIVORS: EMERGING EVIDENCE

Arieh Y. Shalev, M.D., *PO Box 12000, Jerusalem, Israel 91120*

### SUMMARY:

Posttraumatic stress disorder (PTSD) is triggered by salient and stressful events, following which most affected subjects are continuously symptomatic. Risk factors that follow the traumatic event contribute significantly to the occurrence of the disorder. PTSD, therefore, may be prevented either by early treatment or by reducing the effect of concurrent risk factors. Recent evidence suggests that clinical interventions reduce the incidence of PTSD, when administered to persistently symptomatic, help-seeking survivors. Therapeutic interventions provided to entire cohorts of survivors, however, may have little or even negative effects. Little is known about the effect of non-clinical, health-promoting interventions on the incidence of PTSD. Thus, as currently understood, the prophylaxis of PTSD relies on discerning appropriate candidates for clinical interventions, adjusting treatment to needs, and using targeted interventions. This presentation will discuss the roles and the specific targets of pharmacological, cognitive-behavioral, and supportive early interventions in the prophylaxis of PTSD.

## No. 52D
## HEALING THE MIND: THERAPEUTIC APPROACHES FOR CHRONIC PTSD

Barbara O. Rothbaum, Ph.D., *1365 Clifton Road, NE, Atlanta, GA 30322*

### SUMMARY:

The Expert Consensus Guidelines on PTSD recommended psychotherapy alone or in combination with medication for most cases of PTSD. Published treatment guidelines and the literature on the utility of psychotherapy in the management and treatment of patients with PTSD will be succinctly reviewed and discussed. In particular, the presentation will focus on several areas of psychotherapy such as cognitive-behavioral treatments (CBT), including the various CBT techniques, exposure therapy, stress inoculation training (SIT), cognitive processing therapy (CPT), and cognitive therapy. Exposure therapy has received the most empirical support for its use in chronic PTSD across trauma populations. It involves assisting patients in recalling their traumas in their imaginations and recounting them repeatedly in a therapeutic manner until the discomfort of recollecting the traumatic experience decreases. Indeed, SIT, an anxiety management training package of techniques, cognitive processing therapy developed for rape victims, cognitive therapy, and combination approaches all have some evidence for their efficacy in the management and treatment of PTSD. In addition, data on eye movement desensitization and reprocessing (EMDR), and virtual reality exposure therapy, areas of increasing interest for non-pharmacotherapeutic options for PTSD, will be presented.

## No. 52E
## MEDICINES THAT HEAL THE MIND: PHARMACOLOGICAL APPROACHES FOR PTSD

Jonathan R.T. Davidson, M.D., *Trent Drive, Room 4082B, Box 3812, Durham, NC 27710*

### SUMMARY:

Until the mid 1990s, the medication treatments for PTSD were disappointing. This was reflected in the mediocre effect sizes found in many double-blind, placebo studies in PTSD. The monoamine oxidase inhibitors (MAOIs) and the tricyclic antidepressants (TCAs) are associated with troublesome side effects and poor adherence by patients. In the late 1990s, a series of double-blind, placebo-controlled studies with the SSRIs sertraline, paroxetine, and fluoxetine found that they provided better than expected therapeutic benefit in the core PTSD clusters of numbing, intrusions, and hyper-arousal, in addition to the other anxiety and mood dimensions usually associated with PTSD. PTSD carries the highest suicide risk of any anxiety disorder. Fortunately, the newer antidepressants effective in PTSD are safer in overdose than earlier treatments. Recently, double-blind studies with the SNRI venlafaxine XR show promise in the treatment of this disorder. A number of other medications, including atypical neuroleptics and mood stabilizing anticonvulsants, can be of benefit especially on the intrusions/re-experiencing cluster. This presentation will review current medication strategies for treating PTSD.

### REFERENCES:

1. WHO International Consortium of Psychiatric Epidemiology. Cross-national comparisons of the prevalence and correlates of mental disorders. Bulletin of the World Health Organization 2000;78:13–426.
2. Heim C, Newport DJ, Bonsall R, Miller AH, Nemeroff CB: Altered pituitary-adrenal axis responses to provocative challenge

tests in adult survivors of childhood abuse. Am J Psychiatry 2001;158:575–581.
3. Shalev AY: Acute stress reactions in adults. Biol Psychiatry 2002;51(7):532–543.
4. Rothbaum BO, Meadows EA, Resick P, Foy DW: Cognitive-Behavioral Treatment Position Paper Summary for the ISTSS Treatment Guidelines Committee. Journal of Traumatic Stress 2000;13:558–563.
5. Davidson JR: Recognition and treatment of posttraumatic stress disorder. JAMA 2001;286(5):584–588.

# LECTURES

## LECTURE 1
## APPI/APA'S MANFRED S. GUTTMACHER AWARD LECTURE
## EXPERT TESTIMONY IN THE AGE OF *DAUBERT*

Diane H. Schetky, M.D., *PO Box 220, Rockport, ME 04856,* Elissa P. Benedek, M.D., *Department of Psychiatry, University of Michigan, 2311 East Stadium, Suite 111, Ann Arbor, MI 48104*

SUMMARY:

Drawing on her experience as an expert witness in cases of alleged child sexual abuse over the past 25 years, Dr. Schetky will trace the evolution of permissible expert witness testimony in civil litigation. Most courts have moved from the *Frye* test, which requires that scientific evidence be "generally acceptable as reliable" in the scientific community to *Daubert,* which leaves judges with the onus of becoming gatekeepers over scientific opinion testimony. The net effect has been that of generally more rigorous challenges to expert testimony and the expectation that it be evidence based. This requires the expert witness to be conversant with a wide body of research literature that simply didn't exist in the 1980s, when child and adolescent psychiatrists were first drawn into this arena. Parallel developments in evidentiary standards have occurred in regard to scrutinizing the testimony of child witnesses. These will also be discussed, as expert witnesses may be called upon to rehabilitate or undermine a child's testimony. Yet another development impacting child and adolescent forensic psychiatrists has been the emergence of professional codes of ethics and practice parameters that make specific reference to the practice of forensic child and adolescent psychiatry.

REFERENCE:

1. Schetky DH, Benedek EP (Eds): Principles and Practice of Child and Adolescent Forensic Psychiatry. Washington, DC, American Psychiatric Publishing, 2002.
2. Ceci SJ, Hembrooke H (Eds): Expert Witnesses in Child Abuse Cases. American Psychological Association, 1998.

## LECTURE 2
## APA'S PATIENT ADVOCACY AWARD LECTURE
## LABELING THE DISSENTER AS MAD: FORENSIC PSYCHIATRY IN CHINA AND ITS POLITICAL ABUSES

Robin Munro, M.A., *18 Hillrise Mansions, Warltersville Road, London, N19 3PU, London*

SUMMARY:

For half a century in China, political and religious dissenters have been branded as criminals by the government and sent to prison, often for many years. Unknown until very recently, however, is the fact that a significant proportion of these peaceful dissidents and critics of the Chinese government have also, as used to occur in the Soviet Union, been labelled as "dangerously mentally ill" and sent for involuntary and indefinite psychiatric treatment in police-run mental asylums. Such practices reached a peak during the Cultural Revolution, when as many as 70 percent of the alleged criminally insane in China were officially said to be "political cases." The figure fell to around 10 percent of the criminal psychiatric caseload in the 1980s and to around one percent in the early 1990s—only then reaching approximately the same level as that found at the height of similar abuses in the former Soviet Union. Since the start of the Chinese government's harsh crackdown on the Falun Gong spiritual movement in mid-1999, moreover, more than 300 of the group's practitioners are reported to have been forcibly committed to mental asylums by the police, indicating that a disturbing resurgence in the abuse of psychiatry for purposes of political repression is currently underway in China. How should the international psychiatric community respond to this substantial new ethical and human rights challenge from the world's most populous nation?

REFERENCE:

1. *Dangerous Minds: Political Psychiatry in China Today and its Origins in the Mao Era,* Robin Munro, pub. by Human Rights Watch and Geneva Initiative on Psychiatry, New York: August 2002.

## LECTURE 3
## DISTINGUISHED PSYCHIATRIST LECTURE SERIES
## THE NEUROBIOLOGICAL CONSEQUENCES OF CHILD ABUSE

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University School of Medicine, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Preclinical and clinical studies have revealed that adverse experience such as maternal deprivation early in life is associated with alterations in central nervous system (CNS) neurotransmitter circuits previously shown to be altered in many patients with depression. The diagnostic and treatment implications of these findings will be described.

REFERENCES:

1. Heim C and Nemeroff CB. 2001. The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. Biol Psychiat 49:1023–1039.
2. Heim C, Newport DJ, Heit S, Graham YP, Wilcox M, Bonsall R, Miller AH and Nemeroff CB. 2000. Pituitary-adrenal and autonomic responses to stress in adult women after sexual and physical abuse in childhood. JAMA 284:592–597.

## LECTURE 4
## MAKING HEALTH CARE SAFE

Lucian L. Leape, M.D., *Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115-6092*

SUMMARY:

Stimulated by the shocking 1999 Institute of Medicine (IOM) report, *To Err is Human,* a national patient safety movement has emerged. The IOM's transforming message, that most medical errors are due to faulty systems not faulty people, requires that we re-examine virtually everything we do, for health care is laden with faulty systems.[1] Much of the initial work in improving patient safety has concentrated on implementing safe medication practices, a concern of special relevance to psychiatry.

But making health care safe requires much more than just implementing safer practices; it requires a culture change. Other hazardous industries that have succeeded in achieving high levels of safety, such as the airlines and nuclear power, have done so by creating a culture wherein safety is the number one priority and every individual feels personally responsible for safety.

In this lecture, we will explore both the practical implications and the theoretical underpinnings of the safety movement as they have emerged from the fields of cognitive psychology and human factors engineering, fields that should have special resonance with psychiatrists. Achieving safety is, after all, at its heart a behavioral challenge.

REFERENCE:

1. Leape L. Error in medicine. JAMA 1994; 272:1851–1857.

## LECTURE 5
## DISTINGUISHED PSYCHIATRIST LECTURE SERIES COMMUNITY PSYCHIATRY: 1963–2003

Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago, IL 60617-2746*

SUMMARY:

In 1963, President Kennedy's CMHC Act formalized the community mental health movement by asserting there were five basic services for community mental health: 1) Inpatient hospitalization, 2) Psychiatric Emergency Services, 3) Day Treatment/Psychosocial Rehabilitation, 4) Outpatient Services, 5) Consultation & Education. In 1980, President Carter's Mental Health System's Act outlined seven additional services that were necessary for comprehensive community mental health care: 1) Screening before hospitalization, 2) Post hospitalization follow-up, 3) Services to elderly, 4) Services to children, 5) Alcoholism services, 6) Drug abuse services, 7) Residential services. These services were to actualize the thirteen major principles of community psychiatry are 1) responsibility to a population, 2) Treatment that is close to the patient, 3) Comprehensive services, 4) Multidisciplinary approach, 5) Continuity of care, 6) Consumer participation, 7) Prevention (Tertiary Prevention, Secondary Prevention, and Primary Prevention—Biotechnical and Psychosocial prevention techniques), 8) Mental Health Consultation, 9) Assessment and Evaluation, 10) Avoidance of Unnecessary Hospitalization, 11) Linkage to Health Care, 12) Formal Education/Partnerships with Education, 13) Private Practice. In addition to these principles other principles of a) Case Management, b) Vocational Services, c) Assertive Community Treatment, d) Educational Services, e) Victims Services, f) Research, g) Education/Training, h) Leadership/Management.

REFERENCE:

1. Bell CC. Community Mental Health. Chicago: Community Mental Health Council, Inc., 2001.

## LECTURE 6
## INTERNATIONAL PSYCHIATRIST LECTURE SERIES
## SCHIZOPHRENIA IS MORE THAN A NEURODEVELOPMENTAL DISEASE

Robin M. Murray, M.B., *Department of Psychiatric Medicine, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London, SE5 8AF, England*

SUMMARY:

Schizophrenia results from the cumulative effect of a number of physical and social risk factors. The individual inherits an unfortunate combination of genes, each of which is not uncommon in the general population. The resultant deviant traits may be compounded by pre- and perinatal complications, and consequently many preschizophrenic children show minor developmental delays and cognitive difficulties. These propel the child on a trajectory of increasing oddness and alienation from his peers, and he may begin to have quasi-psychotic ideas about them. However, additional factors in early adult life such as drug abuse (psychostimulants and cannabis) and/or social adversity (e.g. life events, isolation, migration) are generally required to push the individual over a threshold into the expression of frank psychosis. The hallucinations and delusions arise from dopamine sensitization, which causes the abnormal attribution of significance to neutral internal and external stimuli. This view implies that treatment should be directed at more than psychotic symptoms. Attention should also be paid to those factors that contribute to the persistence of the psychosis such as underlying anxiety and depression, drug abuse and social isolation. Combining cognitive-behavioural psychotherapy with atypical antipsychotics results in a much improved outcome.

## LECTURE 7
## APA'S SIMON BOLIVAR AWARD LECTURE THE COMMITMENT OF PSYCHIATRISTS: LESSONS FROM AL-ANDALUS

Juan J. Lopez-Ibor, Jr., M.D., *Department of Psychiatry, San Carlos University Hospital, Nueva Zelanda 44, Madrid, 28035, Spain*

SUMMARY:

Psychiatrists should, and usually are, committed with knowledge and to alleviating the problems of society in which they live. There have been in the history of humanity a few periods of enlightened societies in which tolerance led to increasing knowledge, creativity, and common living in spite of many individual differences. One such period took place in the Iberian Peninsula 1,000 years ago, in the city of Cordoba and ruled by the Caliph Abd-Al-Rahman III and the Omayyad rulers. The translation of ancient Greek philosophy into Arabic and later into Latin and Romance languages had to adapt the knowledge of a pantheistic culture into three monotheistic religions living together in the same land. This was done without violating the original texts in a period of great tolerance and cultural achievements. Physicians played an important role in this process and this is reflected in the way mental diseases were described and mental patients taken care of. For instance, there were 30 hospitals with a ward for mental patients in the area of Cordoba during this period. There are two lessons to be learned: One, how tolerance lead to these achievements and second, how intolerance led to an end to this enlightenment after a couple of centuries.

REFERENCES:

1. López-Ibor Jr JJ: The history of Spanish psychiatry, in Anthology of Spanish Psychiatric Texts. JJ López-Ibor, C. Carbonell, J. Garrabe (Eds.) World Psychiatric Association, 2001.
2. Howells JG: World History of Psychiatry. Brunner/Mazel, New York, 1975.

## LECTURE 8
## WILLIAM C. MENNIGER MEMORIAL LECTURE HORSEMEN OF THE APOCALYPSE: TERROR, NIHILISM, AND SCIENCE

Charles Krauthammer, M.D., *1225 19th Street, NW, Suite 620, Washington, DC 20036-2411*

SUMMARY:

The 1990s were a holiday from history, a post-Cold War sleep of the innocent. September 11 woke us to the reality of the 21st century. The obvious threat is from without: nihilistic ideologies armed with weapons of mass destruction, a gift of modern science. How we deal with this threat will determine the survival of Western civilization. The internal threat is more insidious, but also involves a harnessing of science to profoundly dangerous human impulses, the foremost of which are hubris and willfulness. Human cloning is prototypical of that threat from within.

REFERENCES:

1. Krauthammer C: Crossing Lines: a Secular Argument Against Research Cloning. The New Republic, April 29, 2002.
2. Krauthammer C: Holiday From History. Washington Post, Friday, February 14, 2003; Page A31.

## LECTURE 9
## OUTSIDE LECTURE
## CURRENT PERSPECTIVES ON OUR NATIONAL DRUG CONTROL STRATEGY

Andrea Grubb Barthwell, M.D., *Office of National Drug Control Policy, Executive Office of the President, Washington, DC 20503*

### SUMMARY:

Andrea Grubb Barthwell, MD, FASAM was nominated to serve as Deputy Director of Demand Reduction for the Office of National Drug Control Policy by President George W. Bush in December 2001 and confirmed by the United States Senate on January 28, 2002. Within ONDCP, Dr. Barthwell provides executive leadership of the Office of Demand Reduction and serves as a principal advisor to ONDCP Director John P. Walters on priorities, objectives, and goals pertaining to demand reduction policies within the National Drug Control Strategy.

Reflecting her commitment to merging scientific validity with practice, Dr. Barthwell has combined involvement in governmental policy with community-based work in organizations dealing with the human side of addiction.

Dr. Barthwell will provide an overview of the Bush Administration's drug demand reduction vision and strategies with particular attention to contemporary features such as the President's new treatment initiative announced during the 2003 State of the Union address, ONDCP's Marijuana Initiative, student drug testing, and the impact of these efforts on substance abuse prevalence in the United States.

### REFERENCE:

1. National Drug Control Strategy-2003. *Balanced Strategy Builds on Success, New Drug Treatment Initiative Highlighted.*

## LECTURE 10
## APA'S ADOLF MEYER AWARD LECTURE
## GENES, FAMILY RELATIONSHIPS, AND DSM-V

David Reiss, M.D., *Ross Hall, Room 613, GW University Medical Center, 2300 Eye Street, NW, Washington, DC 20037-2336*

### SUMMARY:

Recent and respected research suggests that many major psychiatric disorders can be considered illnesses of the brain. Research also acknowledges the importance of social stress in the manifestations of illness. This includes severe conflict in parent-child, sibling, and marital relationships. Some view these only as social "context" summoning psychiatric illness or relapse, not as central constituents of the disorder itself. Thus, the principal task of our next DSM is to better define distinctive genetic and neurobiological features of psychiatric syndromes. Problematic social relationships might appear on a subordinate axis as "modifiers or precipitants" of illness.

New and less familiar research suggests a different conceptual position for relationship problems. Data from novel twin and adoption designs—conducted by our research group and by others—suggest that parental, sibling and marital relationships are important behavioral phenotypes. These relationships are influenced by specific genetic factors and these genetic factors are the same as those that influence anxiety, depressive and conduct problems. Findings suggest that these common genetic influences—those that influence both social relationships and psychiatric symptoms—may be central to the pathogenesis of some disorders. If these findings are tested more critically and replicated more broadly, then features of the patient's intimate social relationships may help to define both the pathogenesis and distinctive features of many psychiatric disorders.

### REFERENCE:

1. Reiss, D., and Neiderhiser, J. "The interplay of genetic influences and social processes in developmental theory. Specific mechanisms are coming into view", *Development and Psychopathology,* 12:357–374, 2000

## LECTURE 11
## FRONTIERS OF SCIENCE LECTURE SERIES
## NEUROGENETICS: INSIGHT INTO NEURODEGENERATION AND APPROACHES TO SCHIZOPHRENIA

Christopher A. Ross, *Johns Hopkins School of Medicine, Ross Building, Room 618, 720 Rutland Avenue, Baltimore, MD 21205*

### SUMMARY:

Modern molecular genetic and neurobiologic techniques have led to great advances in our understanding of neurodegenerative diseases, and are beginning to provide insights into psychiatric diseases such as schizophrenia. Many neurodegenerative diseases, including Huntington's disease, Parkinson's disease, and also Alzheimer's disease, are now appreciated to involve protein misfolding and abnormal protein interactions. Huntington's disease is an autosomal dominant genetic disorder caused by a triplet repeat expansion in the HD gene, resulting in a huntingtin protein with an abnormally long polyglutamine stretch and altered conformation. Abnormal interactions with other proteins within the cell then cause neuronal cell death in selective regions of the brain, resulting in motor, cognitive and emotional changes. Neuroimaging studies indicate that individuals with the HD gene mutation begin to have basal ganglia atrophy well before the clinically diagnosable syndrome, suggesting that when treatments are available they should begin in presymptomatic mutation-positive individuals. Parkinson's disease, by contrast, had long been considered to be mostly sporadic, but rare families with genetic forms of the disease are yielding insight into a pathogenic pathway involved in all patients with the disease. Abnormal interactions involving parkin and alpha-synuclein contribute to the formation of the Lewy bodies, the characteristic neuropathology of the disease. The same kinds of techniques that have been so powerful in studying these neurodegenerative diseases are now being applied to schizophrenia. These techniques are beginning to provide cell biological evidence in favor of the hypothesis that schizophrenia involves abnormalities in cerebral cortical development.

### REFERENCES:

1. Ozeki Y, Tomoda T, Kleiderlein J, Kamiya A, Bord L, Fujii K, Okawa M, Yamada N, Hatten ME, Snyder SH, Ross CA, Sawa A. Disrupted-in-Schizophrenia-1 (DISC-1): Mutant truncation prevents binding to NudE-like (NUDEL) and inhibits neurite outgrowth. *Proc. Natl. Acad. Sci. USA.* 2003, Jan 7;100(1): 289–294.
2. Ross CA, Polyglutamine pathogenesis: emergence of unifying mechanisms for Huntington's disease and related disorders. *Neuron* 2002 (35):819–822.

## LECTURE 12
## INTERNATIONAL PSYCHIATRIST LECTURE SERIES
## THE SEARCH FOR GENES OF BIPOLOAR DISORDER: FROM CLASSICAL GENECTICS TO NOVEL MOLECULAR TARGETS

Julien Mendlewicz, M.D., *Department of Psychiatry, Erasme Hospital, 808 Route De Lennik, Brussels, Belgium 1070*

### SUMMARY:

Manic depressive (bipolar) illness is a common and complex disorder characterized by the alternance of depressive and manic episodes, and a rather high mortality rate mainly due to suicide. The bipolar

phenotype is most probably determined by the interaction of susceptibility genes and psychosocial vulnerability factors.

Classical studies on human genetics of bipolar illness will be reviewed. These include adoption, twin and family studies of bipolar patients. Modern methods using molecular genetic strategies as they apply to psychiatric genetics will be discussed.

Several susceptibility genes have been proposed to be related to the bipolar phenotype, among them, candidate genes of interest for the understanding of the pathophysiology of bipolar disorder.

Nosological, therapeutic and ethical implications of molecular genetic approaches in psychiatry will be emphasized.

## REFERENCE:

1. M. Baron. Manic-depression genes and the new millennium: poised for discovery. Molecular Psychiatry, 7 (4), 342–358, 2002

## LECTURE 13
## DISTINGUISHED PSYCHIATRIST LECTURE SERIES PSYCHIATRIC ORGANIZATIONAL LEADERSHIP: REFLECTIONS, PREDICTIONS, AND PROPOSALS

Carolyn B. Robinowitz, M.D., *7204 Helmsdale Road, Bethesda, MD 20817-4624*

## SUMMARY:

It has often been said that if we did not have certain organizations or institutions, we would be forced to invent them. Such a statement holds true for the American Psychiatric Association. As the lead organization for American psychiatry and psychiatrists, the APA has been pivotal in enhancing the state of the science and art of psychiatric care, as well as improving access to care and diminishing the stigma faced by psychiatric patients. Psychiatrists alone can represent themselves or the field adequately; we need a strong and proactive voice to support us and our work. Yet, many psychiatrists reflect the behavior of their sisters and brothers in medicine—no longer joining their membership organization, which continues to work on their behalf even as they discontinue their participation and financial support. Time and financial constraints, family needs, and identification with smaller and more focused work groups have been cited as possible cause, but disenchantment and dissatisfaction with organizations also plays a part.

What is the role and future of organized medicine in general and psychiatry in particular? What are the issues that most affect our field—patients as well as practitioners? How do we grade the work of the APA? Is the psychiatric glass half empty or half full? What can and should an organization do to be most effective? How should we shape or re-invent an organization for and of psychiatrists?

This presentation will reflect on organizational history—accomplishments and disappointments, and address these questions as well as consider future directions for organizational function and leadership.

Managers often disregard the fact that leadership is the most important factor when an organization has to implement serious changes.

Increase Urgency, Build the Guiding Team, Get the Vision Right, Communicate for Buy-In, Empower Action, Create Short-Term Wins, Don't Let Up, and Make Change Stick. Certainly, anyone that has led change can figure this out for change often fail in corporations because the changes do not alter behavior. He identifies the most common mistakes in effecting change, offering eight steps to overcoming obstacles. The eight-step process consists of establishing a sense of urgency by analyzing competition and identifying potential crises; putting together a powerful team to lead change; creating a vision; communicating the new vision, strategies, and expected behavior; removing obstacles to the change and encouraging risk taking; recognizing and rewarding short-term successes; identifying people who can implement change; and ensuring that the changes become part of the institutional culture for long-term transformation and growth. The author acknowledges that substantive change requires leadership, but not the elitist notion of leadership as a divine gift of birth granted to a few. Kotter makes a compelling case that winners will be those who outgrow their rivals. *Mary Whaley.*

## REFERENCES:

1. *Psychiatry in the New Millennium,* Weissman, S. Sabshin, M and Eist, H Eds., Washington DC, American Psychiatric Press, Inc. 1999
2. *Leading Change* Kotter, JP, Cambridge, MA Harvard Business School 1996
3. *The Heart of Change,* Kotter, JP, Cohen, DS, Cambridge, MA, Harvard Business School 2002

## LECTURE 14
## THE HEALER'S ART: UNDERGRADUATE EDUCATION FOR MEANING AND COMMITMENT

Rachel Naomi Remen, M.D., *P.O. Box 1339, San Francisco, CA 94941*

## SUMMARY:

Meaning is a function of the heart. Reclaiming the meaning of our work may require confronting the shadow of Medicine and recovering from the wounds of our training. But just as curriculum wounds, curriculum can also heal. Drawing on her ten-year experience designing and implementing transformational medical curricula, Dr. Remen will clarify the difference between training and education and share the innovative educational strategies and theories of UCSF's award winning course, The Healer's Art. The Healer's Art was featured in US News and World Report's "Best Graduate Schools 2002" and is presently being replicated in medical schools nationwide.

## REFERENCES:

1. Western Journal of Medicine, January 2001 "Recapturing the Soul of Medicine" by Rachel Naomi Remen, M.D. Vol 174, Pages 4–5

## LECTURE 15
## FRONTIERS OF SCIENCE LECTURE SERIES MENTAL ILLNESS, HUMAN RIGHTS, SCIENCE, AND CULTURE: A VIDEOTAPED DOCUMENTATION OF CONDITIONS IN MEXICAN PSYCHIATRIC HOSPITALS

Robert L. Okin, M.D., *1001 Potrero Avenue, San Francisco, CA 94110*

## SUMMARY:

The speaker will discuss attempts to place the needs of people with mental disabilities on the international human rights agenda so they can receive the advocacy and protections similar to other vulnerable populations. As an example of the need for such advocacy, he will describe the conditions of Mexican psychiatric hospitals and present a videotaped documentation of these conditions. Strategies to improve this situation will be described along with the concrete results of these strategies. The speaker will then confront the questions of (1) whether psychiatrists from one nation which neglects its mentally ill citizens, have the responsibility, much less the right, to criticize the conditions experienced by the mentally ill in other nations; and (2) whether governments can mitigate their responsibilities to the mentally ill by claims of national poverty. Finally, he will argue that the treatment of the mentally ill in all nations is an issue at the frontiers of science and culture.

REFERENCE:

1. *Human Rights and Mental Health, Mexico.* Rosenthal, Eric; Okin, Robert L., et al. Mental Disabilities Rights International, Washington, D.C., 2000

## LECTURE 16
## APA'S GEORGE TARJAN AWARD LECTURE HEALTH, CULTURE, AND SOUTH ASIAN INDIANS IN NORTH AMERICA

Prakash N. Desai, M.D., *Department of Psychiatric Services, VA West Side Medical Center, 820 South Damen Avenue, Chicago, IL 60612-3740*

SUMMARY:

Immigrants bring their culture with them and try to hang on to significant facets of their culturally shaped world view and behaviors for several generations. Attitudes about health and help-seeking behaviors are deeply ingrained and are an aspect of their cultural inheritance.

This paper will trace the history of immigration of South Asian Indians to North America beginning in the last decades of the 19th century to the present, followed by a review of religion and healing in India for a better appreciation of their adaptation. The psychological adaptation of Indians has followed traditional patterns of initial culture shock to eventual successful adaptation to the host culture, albeit with its distinctive pattern of immigration and travel back to India. Relative affluence and the professional backgrounds of this immigrant group have also made the adaptation a more distinct process. The paper will further examine their patterns of worship, values that govern the patterns of marital and intergenerational relationships, food habits, rituals, and outcomes of unsuccessful adaptation. Their concern for hierarchies in the social and personal order, emphasis on avoidance of conflict and competition, centrality of connectedness and relatedness, and norms of conduct appropriate to the particulars of each context stand out as distinctive psychosocial characteristics. Finally, the help seeking behaviors in physical and psychological illnesses will be examined.

REFERENCES:

1. Desai P: Health and Medicine in the Hindu Tradition. New York, Crossroads, 1990.
2. Leonard KI: The South Asian Americans. Westport, Connecticut, Greenwood Press, 1997.

## LECTURE 17
## DISTINGUISHED PSYCHIATRIST LECTURE SERIES CAN PSYCHIATRY IMPROVE COMMUNITY WELFARE? NEW RESEARCH AND PRACTICE PARADIGM

Kenneth B. Wells, M.D., *Department of Psychiatry, University of California Los Angeles—NPI, 10920 Wilshire Boulevard, Suite 300, Los Angeles, CA 90024*

SUMMARY:

Mental disorders are leading causes of disability worldwide, but treatment rates for many psychiatric disorders are low in community populations and there are disparities in quality and outcomes of care. Efforts to address unmet need have focused on improving quality of care in practice settings and evaluating the impact of legislative initiatives such as parity bills. These approaches have not led to broad or sustained gains in quality of care or economic welfare for communities. This talk presents a paradigm to extend services research approaches to reducing unmet need to community intervention techniques and societal welfare outcomes, to broaden the goals and reach of interventions to communities. The potential of this approach is illustrated with findings from Healthcare for Communities and Partners in Care. Research that addresses unmet needs of high-risk communities requires new goals, research methods, and styles of engaging populations and subjects. This paradigm requires integrating medical and public health goals and altering medical and research communication styles toward participation and outreach. Further, a community paradigm implies greater public accountability in both research and practice, particularly an obligation to meaningful sharing and to enable use of research findings in communities.

REFERENCE:

1. Wells KB, Sherbourne CD, Schoenbaum M, Duan N, et al: Impact of disseminating quality improvement programs for depression in managed primary care: a randomized, controlled trial.'' JAMA 2000;283(2):212–220.

## LECTURE 18
## DISTINGUISHED PSYCHIATRIST LECTURE SERIES THE MEANING OF COGNITIVE IMPAIRMENT

Marshal F. Folstein, M.D., *Department of Psychiatry, New England Medical Center, 750 Washington Street, Box 1007, Boston, MA 02111*

SUMMARY:

Cognitive impairment means a defective capacity to think. The minimental state examination is one of many measures of cognitive impairment. Age education and disease lower the score. A low score on the minimental state examination indicates many syndromes and pathological states. Mental retardation is life long, not a decline. Delirium is characterized by altered consciousness and either a hyperactive or retarded state. Dementia, a decline of multiple cognitive functions in clear consciousness, is differentiated from aphasia, a disorder of language; the amnestic syndrome, a disorder of memory; and the fronta/subcortical syndromes, characterized by prominent mood disorder, executive dysfunction and motor abnormalities. Typical examples are Huntington's disease, Parkinson's disease, multiinfarct disease and frontal temporal dementia. Cortical dementia has prominent memory deficits, language disorder and preserved fine motor movement. Examples are Alzheimer disease, Lewy body disease and Creutzfeld Jacob disease.

Alzheimer disease presents with memory disorder which progresses over 3–4 years to aphasia apraxia and agnosia and finally to gait disorder incontinence. Death occurs 8–10 years after onset if patient is untreated. Exciting opportunities for treatment are on the horizon making accurate diagnosis of great importance.

REFERENCE:

1. Folstein MF (1997): Differential Diagnosis of Dementia: The Clinical Process. In The Psychiatric Clinics of North America. 20(1):45–57.

## LECTURE 19
## FRONTIERS OF SCIENCE LECTURE SERIES BETTER THAN PROZAC: CREATING NEW PSYCHIATRIC DRUGS

Samuel H. Barondes, M.D., *Department of Psychiatry, University of California San Francisco, San Francisco, CA 94143-0984*

SUMMARY:

Millions of people take psychiatric drugs. The most popular are selective serotonin reuptake inhibitors, atypical antipsychotics, benzodiazepines, and stimulants, all of which are descendants of chemicals whose influences on behavior were discovered by accident, mainly in the 1950s. The versions that are now widely used have a better balance of favorable properties and noxious side effects than the originals. But in each case there is still a great deal of room for

improvement. Considering that each of these drugs produce very complicated changes in brain functions, the wonder is that they work as well as they do.

This lecture will review the origins of contemporary psychiatric drugs and will describe the search for better ones. The new drugs will be produced in three ways: 1. by continued refinements of those already available, based on an understanding of the mechanisms of their therapeutic and unfavorable effects; 2. by choosing new targets based on a growing understanding of the pathophysiology of mental disorders; 3. by identifying the origins of mental disorders, mainly by genetic research, and then creating remedies based on this information.

## REFERENCE:

1. Barondes, Samuel. *Better Than Prozac: Creating the Next Generation of Psychiatric Drugs.* Oxford University Press, 2003.

## LECTURE 20
## APA'S ALEXANDRA SYMONDS AWARD LECTURE INTERNATIONAL DETERMINANTS OF WOMEN'S MENTAL HEALTH

Donna E. Stewart, M.D., *Women's Health, University Health Network, University of Toronto, 657 University Avenue, M/L-2-004, Toronto, Ontario, Canada M5G 2C4*

## SUMMARY:

As Allie Symonds so clearly understood, women's mental health can only be understood by considering the biological, social, cultural, economic and personal contexts of their lives. Psychological distress for women often has social origins. Discrimination against women in employment, education, food, health care, and resources for economic development renders them vulnerable to physical and sexual violence, psychiatric disorders, and psychologic distress as stated by the World Federation of Mental Health. The United Nations and its 1995 Beijing Platform for Action also recognize that good mental health is inextricably linked to social justice and physical health, and affirm that all women and men have the right to live without discrimination in all spheres of life, including access to health care, education and equal remuneration for equal work. To achieve this, policies and services in all countries, including North America, have to recognize that women and men, owing to their biological differences and social contexts, have different needs, obstacles, and opportunities.

Today, I will outline key issues in international women's mental health and some ideas about how these might be addressed. As an example, I will discuss an innovative project in a formerly poverty-stricken area of Guatemala that has vastly improved the lives of women and enhanced their physical and mental health as well as that of their families and entire village.

## REFERENCES:

1. Stewart DE, Rondon M, Damiani G, Honikman J: International psychosocial and systemic issues in women's mental health. Arch Women Ment Health 2001;4:13–17.
2. United Nations: The world's women 2000: trends and statistics. Publication Number E.00.XVII.14, 2001, New York, USA.

## LECTURE 21
## APA AWARD FOR RESEARCH IN PSYCHIATRY SEARCHING FOR ETIOLOGICAL RISK FACTORS OF SCHIZOPHRENIA

Ming T. Tsuang, M.D., *Department of Psychiatry, Harvard Medical School, Massachusetts Mental Health, 74 Fernwood Road, Boston, MA 02115*

## SUMMARY:

This will be presented from the author's perspective summarizing work done by his team under his directorship of the Harvard Institute of Psychiatric Epidemiology and Genetics. The presentation will be divided into four phases. The first phase starts from 1972, focusing on nosology using blind family studies and long-term outcome strategies at the University of Iowa. The second phase starts from 1982, at Brown University and then continues on at Harvard University, focusing on heterogeneity using neuropsychology, gender differences, obstetric complications, **negative and positive symptoms and antipsychotic treatment and withdrawal.** Phase three starts from 1992, focusing on studies of neuroimaging and working memory, vulnerability markers, as well as genetic linkage studies. Phase four starts from 1998, focusing on high-risk children, schizotaxia, and early detection and intervention aiming toward prevention. The findings of these investigations and implication for the future of preventive psychiatry will be discussed. In conclusion, looking toward the future, in addition to intervention and treatment, early detection of those who are vulnerable to prevent the onset of psychosis will be the main area of research, which has been mainly supported by the NIH and NARSAD Distinguished Investigator Award.

## REFERENCES:

1. Tsuang MT: Stone WS, Faraone SV: Toward reformulating the diagnosis of schizophrenia. *American Journal of Psychiatry* 2000;147:1041–1050.
2. Tsuang MT, Stone WS, Faraone SV: Understanding predisposition to schizophrenia: toward intervention and prevention. Can J Psychiatry 2002; 47(6):518–26.

## LECTURE 22
## FRONTIERS OF SCIENCE LECTURE SERIES THE REVOLUTION IN MOUSE MOLECULAR GENETICS: NEW APPROACHES FOR PSYCHIATRIC RESEARCH

Laurence H. Tecott, M.D., *Department of Psychiatry, University of California San Francisco, 401 Pamassus Avenue, San Francisco, CA 94143-0984*

## SUMMARY:

Advances in mammalian genomics present a challenge for psychiatry in determining the impact of thousands of genes on neural processes relevant to mental disorders. For the exploration of gene function, the mouse has become the mammalian organism of choice. A remarkable degree of homology exists between the human and mouse genome; a mouse version may be identified for 99% of human genes. In accord with their genomic similarities, humans and mice share many features of brain organization, as well as many similar behavioral responses to pharmacological agents and to gene mutations. New technologies enabling the precise experimental manipulation of the mouse genome provide unprecedented opportunities for exploring genetic contributions to the regulation of complex behavior and to the pathophysiology and treatment of psychiatric disease. The formidable array of mouse molecular genetic tools will be described. Essential to the effective use of these technologies is the implementation of strategies for discerning the influence of genetic manipulations on mouse behaviors relevant to psychiatric conditions. Principles in the performance and interpretation of the "mouse psychiatric examination" will be discussed. Limitations in existing behavioral assessement strategies exist, and present a bottleneck in the application of mouse genomics to psychiatric research. New technologies and strategies for discerning the impact of neural gene mutations on mouse behavioral regulation will maximize the extent to which the revolution in mammalian genetics will enhance psychiatric research.

REFERENCES:

1. Heisler LK, Tecott LH: A paradoxical locomotor response in serotonin 5-HT2C receptor mutant mice. J Neurosci 2000;20:RC71.
2. Tecott LH: The genes and brains of mice and men. Am J Psychiatry in press, April.

## LECTURE 23
## APA'S KUN-PO SOO AWARD LECTURE
## REMEMBERING THE PAST AND LIVING IN THE NOW: MODERNIZATION IN EAST ASIAN COUNTRIES AND PSYCHOTHERAPY

Masahisa Nishizono, M.D., *3-21, 6-chome, Fukuoka-shi, 814-0161 Japan*

SUMMARY:

A variety of forms of psychotherapy have developed around the world, each growing out of specific cultural or religious roots. The development of psychoanalysis at the end of the 19th century was significantly influenced by Judeo-Christian culture and beliefs. Sigmund Freud, for example, reflecting his own cultural and religious origins, emphasized the significance of "remembering the past" as a curative factor in psychoanalysis. Morita therapy in Japan, on the other hand, has been substantially influenced by Zen Buddhism and other Asian philosophies. In Morita therapy there is an emphasis on "living in the now," a clear expression of the influence of Zen Buddhism.

Daisetsu Suzuki and Erich Fromm had also pointed out some clear differences in the healing modes of spirits East and the West in their dialog of 1957. Under the current wave of globalization, social change and modernization in East Asian countries, particularly Japan, have accelerated sharply. However, as Alan Roland has pointed out, for the Japanese, the establishment of "the individual self in the Westerner sense" is very difficult. I think that the "Amae-therapy" (T. Doi) in Japan and some cultural consideration on "Han and Jeong" in Korea have been advanced in response to an awareness of such difficulties.

REFERENCES:

1. Roland A: In Search of Self in India and Japan, Toward A Cross-Cultural Psychology, Princeton University Press, Princeton, 1988.
2. Suzuki DT, Fromm E, Martino D: Zen Buddhism and Psychoanalysis, George Allen and Unwin, London, 1960.

## LECTURE 24
## APA'S SOLOMON CARTER FULLER AWARD LECTURE
## CULTURE/RACISM AND ETHNIC DIVERSITY WITH PAST CORRECTIVE ACTIONS, SUCCESSES, AND FAILURES

James H. Carter, M.D., *Duke University Medical Center, Box 3106, 2213 Elba Street, Durham, NC 27710-0001*

SUMMARY:

It is often said that many of us speak with great sincerity of the value for improved cultural diversity, but we usually speak about this in abstract terms vis à vis: literature, art, food, and music. As behavioral scientist, we cannot continue to allow culture, race, ethnicity, and gender to divide us. It is asserted that psychiatrists use their training and experience to help achieve a just society.

Historically, it has been taboo for psychiatrists to acknowledge or discuss racism. Among the reasons given, is that "racism is not a mental disorder and should not be medicalized." Perhaps the real fear is that racism may someday be viewed as a psychiatric disorder and noted in the Diagnostic and Statistical Manual of the American Psychiatric Association.

It is strongly recommended that the APA support a strategic research agenda designed to guide future research initiatives into the problem of racism and to monitor the training of future psychiatrists to assure adequate skills for treating a racially diverse population. It is vitally important to produce a new generation of psychiatrists who are sensitive to issues of culture and race, given the demographic changes rapidly occurring in America today. Psychiatrist are encouraged to become involved with the efforts of schools and community programs that encourage cultural diversity.

REFERENCES:

1. Spurlock J: Black Psychiatrist and American Psychiatry. The American Psychiatric Association, Washington, DC, 1999.
2. Fernando S: Mental Health, Race and Culture. St. Martin's Press, New York, 1991.

# MEDICAL UPDATES

## 1. ETHNICITY AND PHARMACOGENETICS

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street, B4, Torrance, CA 90502,* Nyapati R. Rao, M.D.

### EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participants should be able to demonstrate a clear understanding of inter-individual and cross-ethnic variations in psychotropic responses, factors responsible for these ethnic differences, and how such new knowledge will assist them in their clinical practice.

### SUMMARY:

Inter-individual and cross-ethnic variations in psychotropic response are substantial and clinically significant, and are determined by both genetic and environmental factors. Most genes controlling the expression of drug metabolizing enzymes as well as the function of brain are highly polymorphic. Together they determine therapeutic response of the psychotropics. The expression of these genes are influenced by environmental factors such as diet. Culture also profoundly influences patients expectations of treatment response, adherence, as well as interactions with clinicians. With the continuing advance in the field, it is very likely that pharmacogenetic panels could be developed for routine clinical use, such that the results derived from such tests would be used to inform clinicians regarding the choice of medications, dosing strategies as well as risks for different side effects. This should thus contribute substantially to the establishment of an increasingly more rational and knowledge-based way to practice psychopharmacology in the next century.

### REFERENCES:

1. Lin KM, Smith MW: Psychopharmacotherapy in the Context of Culture & Ethnicity, In Ruiz P (Ed) Ethnicity and Psychopharmacology, Review of Psychiatry Series Vol. 19, No. 4), Washington, D.C., American Psychiatric Association, pp. 1–36, 2000.
2. Lin KM: Biological differences in depression and anxiety across races and ethnic groups. Journal of Clinical Psychiatry, 2001;62 (suppl 13); 13–19.

## 2. MENOPAUSE: WHAT PSYCHIATRIST NEED KNOW

Louann Brizendine, M.D., *282 Eureka Street, San Francisco, CA 94114-2437,* Natalie L. Rasgon, M.D.

### EDUCATIONAL OBJECTIVES:

To be able to discuss the contributions of perimenopause and menopause to symptoms of depression in women with and without a previous history of depression; to be able to discuss the pros and cons of estrogen replacement therapy in perimenopausal and menopausal women; to be able to discuss the contribution of low testosterone levels to decreased libido in perimenopausal and menopausal women; to be able to discuss the pros and cons of testosterone replacement therapy in perimenopausal and menopausal women.

### SUMMARY:

The contributions of perimenopause and menopause to the symptoms of depression in women with and without a previous history of depression has been looked at in many studies over the past two decades. In this presentation, I will present the data in this area and discuss the pros and cons of estrogen replacement therapy. The contribution of low testosterone levels to decreased libido in perimenopausal and menopausal women who are being treated for depression has also been an area of increasing interest, but little in the way of controlled studies. I will present the current data available in this area and discuss the pros and cons of testosterone replacement in this population.

### REFERENCES:

1. Harlow BL, Wise LA, Otto MW, Soares CN, Cohen LS: Depression and its influence on reproductive endocrine and menstrual cycle markers associated with perimenopause: the Harvard Study of Moods and Cycles. Arch Gen Psychiatry 2003; 60(1):29–36.
2. Burger HG, Davis SR. The role of androgen therapy. Best Pract Res Clin Obstet Gynaecol. 2002; 16(3):383–93. Review.

## 3. YOGIC BREATHING: NEUROPHYSIOLOGIC THEORY AND CLINICAL APPLICATIONS FOR TREATMENT OF STRESS RELATED DISORDERS

Richard P. Brown, M.D., *41 Pearl Street, Kingston, NY 12401,* Philip R. Muskin, M.D.,

### EDUCATIONAL OBJECTIVES:

To learn the medical benefits of Sudarshan Kriya yoga. To review research data on treatment of depression. To discuss a neurophysiological model of how Sudarshan Kriya influences the neurodendocrine and stress response systems. To review clinical applications to adult depression, anxiety, PTSD, criminal and juvenile delinquent groups. Note benefits for growth of compassion and sensitivity as healers for mental health professionals

### SUMMARY:

A brief discussion of Ujjayi, Bhastrika, and Sudarshan Kriya breathing techniques will lead into a discussion of their benefits on cardiovascular function, lipid profile, immune function, antioxidant levels, decreased stress hormone levels, well-being, and mood. Clinical research data in the treatment of depression will be reviewed. A neurophysiological model of action of these breathing techniques and testable hypotheses will be presented. Clinical experience in treatment of depression, anxiety, PTSD will be noted. Programs for the treatment of children, violent criminals, and teen gang members will be discussed. Contraindications and adverse effects will be considered.

If time permits, a preliminary exposure to breathing and meditation will allow participants to experience the effects for themselves.

### REFERENCES:

1. Janakiramaiah N, Gangadhar B N, Naga Venkatesha Murthy P J, Harish M G, Subbakrishna D K, Vedamurthachar A: Antidepressant efficacy of Sudarshan Kriya Yoga (SKY) in melancholia: a randomized comparison with electroconvulsive therapy (ECT) and imipramine. J Affect Disord 2000; 57(1–3):255–259
2. Fokkema DS: The psychobiology of strained breathing and its cardiovascular implications: a functional system review. Psychophysiology 1999; 36(2):164–75.

## 4. CLUB DRUGS: A PRIMER FOR MENTAL HEALTH PROFESSIONALS

David Smith, M.D., *Haight Asbury Free Clinic, 558 Clayton Street, San Francisco, CA 94117,* Julie K. Schulman, M.D.

### SUMMARY:

A variety of psychoactive substances, including MDMA (Ecstasy) and various stimulant and sedative drugs, have been designated as "club drugs." Basic pharmacology, effects, routes of administration of MDMA, methamphetamine and related stimulants, and gamma hydroxybutyric acid (GHB) will be presented by David E. Smith,

M.D. Socioeconomic parameters and relevance of club setting will be discussed as well as treatment approaches and prevention implications and diagnosis, intervention approaches and referral to further treatment.

## REFERENCES:

1. Kalant H: The pharmacology and toxicology of "ecstasy" (MDMA) and related drugs. CMAJ 2001; 165(7).
2. Galloway GP, et al: Abuse and therapeutic potential of gamma-hydroxybutyne acid. Elsevier, Alcohol 20 2002; 263–269.

# PRESIDENTIAL SYMPOSIUM

## MORAL AND PHILOSOPHICAL ISSUES IN PSYCHIATRY

*Chairperson*: Deborah Spitz, M.D.

1. **Values-Based Medicine (VBM): A First for Psychiatry**
   Kenneth Fulford, D.Phil.
2. **What is Good Diagnostic Practice?**
   John Z. Sadler, M.D.
3. **Ethical Issues in Behavioral Genetics**
   Kenneth F. Schaffner, M.D.
4. **Personal Identity and Mental Disorder**
   Jennifer Radden, Ph.D.
5. **The Self in a Scientifically Driven Psychiatry**
   James E. Phillips, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: recognise clinical skills required for effective practice in the context of conflicting values; identify ethical and cross-cultural issues in diagnosis; discuss ethical problems in genetic testing; clarify issues of self and identity in psychiatric disorderw and forms of treatment.

### SUMMARY:

As psychiatry has become theoretically more complex and clinically more effective, it has forced us to reexamine traditional views of mind and brain, autonomy and responsibility, identity and continuity within personality, and what is universal versus that which is culture-bound. Values are embedded in our psychiatric thinking and practice, but too often we fail to realize how they influence what we see and how we construct the world. This symposium, aimed at the general psychiatrist, explores some of the moral and philosophical issues raised by modern diagnostic thinking and treatment interventions, paying particular attention to the ethical and value-laden issues that underlie our reasoning and behavior as clinicians. Bill Fulford, philosopher and psychiatrist, will present a new paradigm for responding to the complexity of values in clinical decision-making. John Sadler, psychiatrist, will discuss conceptual issues in diagnosis. Ken Schaffner, philosopher and psysician, will discuss ethical issues in behavioral genetics. Jennifer Radden, philosopher, will explore issues of identity in psychiatric disorders. James Phillips, psychiatrist, will discuss self and subjectivity in psychiatric treatment. There will be opportunity for panelists to comment on one another's presentations, and for discussion from the audience.

### REFERENCES:

1. Fulford, KWM, Murray, TH, and Dickenson, D, eds (2002) Many Voices. Introduction to Healthcare Ethics and Human Values: and Introductory Text with Readings and Case Studies. Malden, USA and Oxford: Blackwell Publishers.

## THE FOUNDATION OF MEDICAL EHTICS/ INFORMED CONSENT

*Chairperson*: William T. Carpenter, Jr., M.D.
*Co-Chairperson:* Dilip V. Jeste, M.D.
*Discussant:* Paul S. Appelbaum, M.D.

6. **Decisional Capacity for Informed Consent in Schizophrenia**
   William T. Carpenter, Jr., M.D.
7. **Enhancing Decisional Capacity in Psychiatric Patients: Use of Multimedia and Other Tools**
   Dilip V. Jeste, M.D.
8. **The MacCAT Family: Studying Patients' Competence to Decide**
   Thomas Grisso, M.D.
9. **The Therapeutic Misconception and Consent in Research: Where Do We Go From Here?**
   Charles Lidz, M.D.
10. **Capacity to Consent to Schizophrenia Research: Structured Assessments and Clinician Judgments**
    Scott Y. Kim, M.D.

### EDUCATIONAL OBJECTIVES:

To understand the basic requirements for informed consent, the role of decisional capacity, and methods for achieving valid informed consent in decisionally challenged patients. To appreciate the potential for therapeutic misconception in treatment research.

### SUMMARY:

This symposium provides an overview of recent studies addressing key issues in informed consent, with a particular focus on decisional capacity. All of the studies build on the work of Paul Appelbaum and his colleagues.

Grisso will describe the development and application of the MacArthur Competence Assessment Tools (MacMat), which he and Appelbaum developed, and which form the basis for many of the studies presented in this symposium.

Carpenter will present MacMat data from schizophrenia research subjects, including methods for improving and sustaining informed consent. Jeste will present similar data from middle-aged and elderly patients. Both will show that cognitive impairment is the critical determinant of decisional incapacity, and remediation procedures are effective in improving informed consent.

Despite increasing empirical data a policy vacuum creates uncertainty regarding informed consent issues in decisionally impaired persons. Kim will discuss areas of emerging consensus and propose solutions for unresolved issues.

Medical research subjects often fail to appreciate differences from ordinary clinical care. Appelbaum termed this the "therapeutic misconception." Lidz will present results of empirical investigation of this phenomenon, and propose changes in informed consent procedures to address this problem.

Appelbaum will discuss the presentations and invite audience participation.

### REFERENCES:

1. Appelbaum PS, Roth LH, Lidz CW, Benson P, Winslade W: False Hopes and Best Data: Consent to Research and the Therapeutic Misconception, Hastings Center Report, 17:2, 20–24, 1987.
2. Grisso T, Appelbaum PS: Assessing Competence to Consent to Treatment: A Guide for Psysicians and Other Health Professionals. New York, Oxford University Press, 1998.

# RESEARCH ADVANCES IN MEDICINE

## UNDERSTANDING THE LATEST DEVELOPMENTS IN DEPRESSION: ITS RELATIONSHIP TO THE BRAIN AND THE HEART, AND IMMUNE RESPONSE

*Chairperson*: David M. McDowell, M.D.
*Participants*: Robert S. Robinson, M.D., Margaret E. Kemeny, Ph.D., David Buchholz, M.D.. K. Ranga R. Krishnan, M.D.

### EDUCATIONAL OBJECTIVES:

Participants will learn the consequences of untreated post stroke depression as well as how to effectively treat it. Participants will also identify depression as a significant independent risk factor for myocardial infarction, cardiovascular mortality and altered immune response. Participants will identify various types of headaches and the options that may be used in treatment, particularly in psychiatric populations.

### SUMMARY:

Post stroke depression has attracted worldwide interest and new themes of research have emerged. Pooled data studies conducted throughout the world have found high prevalence rates. Treatment options have been demonstrated to be effective. Dr. Robinson will discuss trials of medications and effects of other factors demonstrating significant decline in morbidity and mortality in these patients.

There is accumulating evidence that affective experience can impact the functioning of the immune system, with complications for immune-mediated diseases. Dr. Kemeny's presentation will summarize research demonstrating that depression that can affect the immune system and will highlight findings related to three new areas of research.

Nearly all headaches are forms of migraines that can be controlled by:

1) avoiding quick fix drugs that cause rebound
2) reducing trigger exposure and if necessary
3) raising the migraine threshold with preventive medications—including options that may also serve psychiatric purposes.

Dr. Buchholz will discuss the new and improved understanding of headaches.

Depressed individuals have been found to have and approximately 3-4-fold increase in the risk of subsequent cardiovascular morbidity and mortality. Early identification and aggressive treatment can significantly reduce negative consequences for these patients. Dr. Krishnan will discuss studies of clinical and demographic characteristics of these patients,their treatment and outcomes.

### REFERENCES:


1. Narushima K, Kosier JT, Robinson RG. Preventing post stroke depression: a 12-week double blind randomized treatment trial and 21-month follow-up. Journal of Nervous Mental Disorders 190(5): 296–303, 2002.
2. Kemeny ME & Gruenewald TL. Affect, cognition, the immune system and health. In Mayer, E.A. & Saper, C. (Eds.) The biological basis for mind body interactions. Progress in brain research series. (pp. 291–308). Amsterdam: Elsevier Science B.V.
3. Buchholz D, Reigh SG. The menagerie of migraine. Seminars in Neurology 16:83–93, 1996.
4. Glassmen AH, O'Connor CM, Califf RM, Swedberg K, Schwartz P, Bigger JT Jr, Krishnan KR, et al. Sertraline treatment of major depression in patients with acute MI or unstable angina. JAMA. 2002 Aug 14;288(6): 701–9.

## SESSION I OF THE REVIEW OF PSYCHIATRY

### 2003 PSYCHIATRY UPDATE: TRAUMA AND DISASTER RESPONSES AND MANAGEMENT

*Section Editors:* Robert J. Ursano, M.D., Ann E. Norwood, M.D.

1. **Terrorism With Weapons of Mass Disruption: Chemical, Biological, Nuclear, Radiological, and Explosive**
   Robert J. Ursano, M.D.
2. **Early Intervention for Trauma-Related Problems**
   Patricia J. Watson, Ph.D.
3. **Neurobiological Mechanisms of Psychological Trauma**
   Omer Bonne, M.D.
4. **Children, Disaster, and the September 11th World Trade Center Attack**
   Roy Lubit, M.D.
5. **The Psychiatric Epidemiology of Disaster Responses**
   Carol S. North, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this section's sessions, the participant should be able to discuss children's responses to disasters. The participant should demonstrate a basic understanding of intervention strategies following a disaster and the epidemiology of psychiatric disorders following mass casualty situations. The participant should be able to discuss psychiatric implications of the use of biological, chemical, and radiological devices.

### SUMMARY:

This section covers trauma and disaster responses and management. The literature on the psychological impact of disasters is reviewed with special attention to risk and protective factors. Early post-trauma interventions are examined including psychological debriefing, cognitive-behavioral therapy, treatment of traumatic grief, and pharmacotherapy. Children's responses to trauma and disasters are summarized. Challenges in the delivery of mental health services to children in the aftermath of a disaster are discussed. The epidemiology of psychiatric disorders following disasters is examined. The literature on disaster-related PTSD and other psychopathology, psychosocial responses to disasters, and associated factors are reviewed to serve as an empirical basis to point toward directions for intervention. The psychological and social responses to a special form of disaster, terrorism, are examined with respect to the consequences of the use of chemical, biological, or radiological weapons. Finally, the neurobiological mechanisms of psychological trauma are presented.

### REFERENCES

1. Friedman MJ, Davidson JRT, Mellman TA, et al: Pharmacotherapy, in Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies. Edited by Foa EB, Keane TM, Friedman MJ. New York, Guilford Press, 2000, pp 326–329.
2. Holloway HC, Norwood AE, Fullerton CS, et al: The threat of biological weapons: Prophylaxis and mitigation of psychological and social consequences. J Am Med Assoc 1997; 278:425–427.
3. North CS, Nixon SJ, Shariat S, et al: Psychiatric disorders among survivors of the Oklahoma City bombing. J Am Med Assoc 1999; 282:755–762.
4. Pynoos RS, Goenjian AK, Steinberg AM: A public mental health approach to the postdisaster treatment of children and adolescents. Child Adolesc Psychiatr Clin N Am 1998; 7:195–227.



## MOLECULAR NEUROBIOLOGY FOR THE CLINICIAN

*Section Editor:* Dennis S. Charney, M.D.

6. **Molecular Neurobiology and Substance Abuse**
   Lisa Monteggia, Ph,D.
7. **Molecular Neurobiology and New Drug Targets for Mood and Anxiety Disorders**
   Husseini K. Manji, M.D.
8. **Molecular Neurobiology and Schizophrenia: Implications for Etiology and Treatment**
   To Be Announced
9. **Molecular Neurobiology and Neuropsychiatric Disorders in Children: Present and Future**
   Jeremy Veenstra-VanderWeele, M.D.
10. **Molecular Genetics and Psychiatric Disorders: A Role in Diagnosis and Treatment?**
    Francis J. McMahon, M.D.

### EDUCATIONAL OBJECTIVES:

By the completion of this session, attendees should be able to list the most important research findings in understanding the biological basis of attention-deficit hyperactivity disorder (ADHD), Tourette's syndrome, obsessive compulsive disorder (OCD), and adult onset psychiatric disorders, such as schizophrenia, drug addiction, and mood and anxiety disorders.

### SUMMARY:

A number of important research findings, including genetic, postmortem, neuroimaging and immunologic techniques, are summarized in patients with attention-deficit hyperactivity disorder (ADHD), Tourette's syndrome, obsessive compulsive disorder (OCD). In addition, the current status and challenges of molecular genetic research on complex adult-onset psychiatric disorders is discussed. Particular emphasis is placed on the relevance of recent molecular neurobiological findings to the etiology and treatment of schizophrenia and the molecular mechanisms and neural circuitry of reward and how they might relate to vulnerability to addictive behaviors. Finally, an up-to-date review of the leading pathophysiological hypotheses of mind and anxiety disorders is discussed.

### REFERENCES:

1. Charney DS, Barlow DH, Botteron K, et al: Neuroscience research agenda to guide development of a pathophysiologically based classification system, in A Research Agenda for DSM-V. Edited by Kupfer DJ, First MB, Regier DA. Washington, DC American Psychiatric Association, 2002, pp. 31–83.
2. Chowdari KV, Mirnics K, Semwal P, et al: Association and linkage analysis of RGS4 polymorphisms in schizophrenia, Hum Mol Genet 11: 1373–1380, 2002.
3. Cook E, Stein M, Krasowski M, et al: Association of attention deficit disorder and the dopamine transporter gene. Am J Hum Genet 56: 993–998, 1995.
4. Manji HK, Duman RS: Impairments of neuroplasticity and cellular resilience in severe mood disorder: implications for the development of novel therapeutics, Psychopharmacol Bull 35(2): 5–49, 2001.
5. McGaugh JL, Izquierdo I: The contribution of pharmacology to research on the mechanisms of memory formation. Trends Pharmacol Sci 21(6): 208–210, 2000.

## SESSION III OF THE REVIEW OF PSYCHIATRY

### STANDARDIZED EVALUATION IN CLINICAL PRACTICE

*Section Editor:* Michael B. First, M.D.

11. **Is There a Place for Research Diagnostic Methods in Clinic Settings?**
Monica A. Basco, Ph.D.

12. **Integrating the Assessment Methods of Researchers Into Routine Clinical Practice: The Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project**
Mark Zimmerman, M.D.

13. **Use of Structured Assessment for the Diagnosis of Childhood Disorders in Clinical Settings**
Christopher Lucas, M.D.

14. **Risk Factors for Suicidal Behavior: The Utility and Limitations of Research Instruments**
Maria A. Oquendo, M.D., Batsheva Halberstam, B.A., J. John Mann, M.D.

15. **Nationwide Implementation of Global Assessment of Functioning as an Indicator of Patient Severity and Service Outcomes**
William W. Van Stone, M.D., Kathy Henderson, M.D., Rudolf H. Moos, Ph.D., Robert A. Rosenheck, M.D., Mary Schon, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the reasons why structured assessments would enhance the quality of diagnostic and symptomatic assessment in clinical settings and understand the ways in which structured diagnostic instruments and rating scales can be integrated into various types of practice settings.

### SUMMARY:

In research settings, investigators routinely use structured interviews and rating scales in order to insure reliable and valid research methodology. Although the need for reliable and valid assessments is no less important in clinical settings, such instruments are infrequently used by clinicians, presumably because of a lack of appreciation for their benefits as well as a perception that using such instruments would be too costly and time-consuming to administer.

This session includes five presentations that document reasons why clinicians can benefit from using structured assessments and provide details about how they can be used in specific clinical settings. The initial three presentations focus on the use of structured interviews to improve the validity and reliability of diagnostic assessments. The first presentation discusses the use of the SCID in community outpatient mental health settings in the state of Texas and the second presentation describes the use of the SCID in a clinical private practice setting, with each presentation arguing that a more valid and comprehensive assessment is achieved using this instrument. The third presentation examines the use of the DISC in outpatient child psychiatry settings. The fourth presentation considers the use of rating scales (both clinician-administered and self-report), for assessing one of the most important clinical issues, namely suicidal risk. The final presentation discusses issues involved in the implementation of a program to require the routine use of a rating scale, namely the GAF Scale, in the Veteran's Administration mental health care delivery system.

### REFERENCES:

1. Basco, MR, Bostic, JQ, Davies, D, et al.: Methods to improve diagnostic accuracy in a community mental health setting. Am J Psychiatry 157:1599–1605, 2000
2. Zimmerman, M, & Mattia, JI: Psychiatric diagnosis in clinical practice: Is comorbidity being missed? Compr Psychiatry 40:182–191, 1999d
3. Malone KM, Szanto K, Corbitt EM, Mann JJ. 1995. Clinical assessment versus research methods in the assessment of suicidal behavior. Am. J. Psychiatry 152:1601–7
4. Moos, R., Nichol, A., & Moos, B. (2002). Global Assessment of Functioning (GAF) ratings and the allocation and outcome of mental health care. Psychiatric Services, 53, 730–737.

## SESSION IV OF THE REVIEW OF PSYCHIATRY

### GERIATRIC PSYCHIATRY

*Session Editor:* Alan M. Mellow, M.D.

16. **Depression and Anxiety in Late Life**
Alan M. Mellow, M.D.

17. **Dementia**
Myron F. Weiner, M.D.

18. **Late-Life Psychosis**
George T. Grossberg, M.D.

19. **Late-Life Addictions**
Frederic C. Blow, Ph.D.

20. **Geriatric Psychiatry at the Crossroads of Public Policy and Clinical Practice**
Christine M. deVries, M.A.

### EDUCATIONAL OBJECTIVES:

After attending this symposium, attendees will be familiar with the recent advances in the diagnosis and treatment of the major psychiatric disorders of late life, including depression, anxiety, psychosis, dementia and substance abuse. Attendees will also be familiar with the public policy implications of the current organization and financing of psychiatric care for older persons in the U.S.

### SUMMARY:

In the 1980's and 1990's geriatricians, be thay psychiatrists, psychologists, neurologists, internists, internists or others were often characterized as "crusaders", fighting for the proper treatment of older patients, who were often neglected. They continually pointed out that the elderly were subject to ageist biases, had many barriers to diagnosis and treatment, and importantly, did not have the benefit of a coherent knowledge base to inform clinical practice, because the elderly had been excluded from much of the mainstream clinical research that had moved medicine forward so dramatically in the past several decades. Although many of the barriers to good care for the olderly remain, and most geriatricians still wear their "crusader" mantles, considerable progress has been made. With the aging of the population, the demographic imperative is now well-accepted by all. In geriatric psychiatry, a deeper understanding of the neurobiology of aging, as well as a growing knowledge base from fields as wide-ranging as molecular biology, genetics, neuroimaging, pharmacology and health services research has yielded a mature subspecialty that has attracted the efforts of clinicians, investigators and those involved with public policy. In this symposium, we review recent advances in the areas relevant to psychiatric disorders in the elderly: depression, anxiety, dementia, psychosis and substance abuse, as well as the public policy implications of the organization and financing of mental health care for the elderly in this country.

### REFERENCES:

1. Barry KL, Oslin D, Blow FC: Alcohol problems in older adults: prevention and management New York, Springer Publishing, 2001.
2. Boorson S, Bartels SJ, Colenda CC et al: Geriatric mental health services research: Strategic plan for an aging population. Report

of the health services work group of the American Association for Geriatric Psychiatry. Am J Geriatr Psychiatry. 9: 191–204, 2001.
3. Grossberg GT, Manepalli J: The older patient with psychotic symptoms. Psychiatr Serv 46:55–59, 1995.
4. Lebowitz BD, Pearson JL, Schneider LS, et al: Diagnosis and treatment of depression in late-life. Consensus statement update. JAMA 278:1186–1190, 1997.
5. Weiner MF, Lipton AM (Eds.), The Dementias: Diagnosis, Treatment, and Research. Washington, D.C., American Psychiatric Press, in press.

# SYLLABUS INDEX

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# NOTES