SYLLABUS &

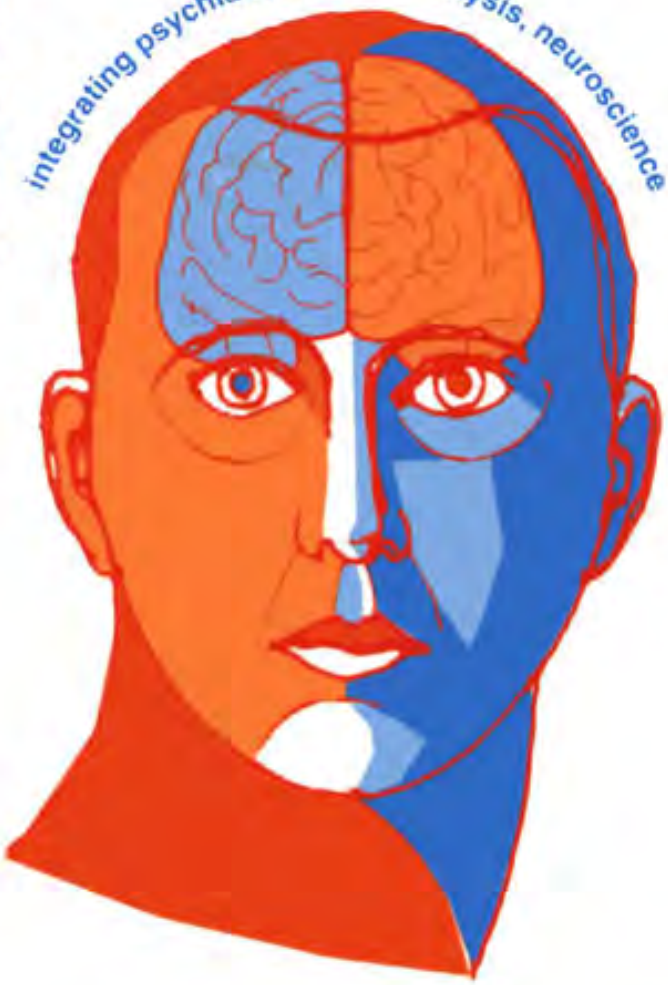
SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

2001 ANNUAL MEETING

mind meets brain

integrating psychiatry, psychoanalysis, neuroscience



New Orleans, LA ■ May 5-10, 2001

PROCEEDINGS SUMMARY

FOR YOUR RECORDS

The Certificate of Attendance below is for your personal records.

This is to certify that

was a registered
participant at the
154th Annual Meeting of the APA
New Orleans, LA, May 5-10, 2001
President's Theme: Mind Meets Brain: Integrating Psychiatry, Psychoanalysis, Neuroscience

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

Daniel B. Borenstein, M.D.

Daniel B. Borenstein, M.D.
APA President

Steven M. Mirin, M.D.
Medical Director

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

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

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

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

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION, May 5-10, 2001, New Orleans, LA

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

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

The APA's Continuing Medical Education Requirement

The Requirement

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

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

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

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

Obtaining an APA CME Certificate

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

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

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

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

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

APA Report Form

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

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

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

Exemptions

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

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

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

CONTINUING MEDICAL EDUCATION
SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

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

New Orleans, LA
May 5-10, 2001

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AMERICAN PSYCHIATRIC ASSOCIATION
1400 K Street, N.W.
Washington, D.C. 20005
May 2001

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FOREWORD

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

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

We wish to express our appreciation to the authors and other contributors for their cooperation in preparing the necessary materials so far in advance of the meeting. Our special thanks are also extended to Sheena Majette, Kendra Grant, Reneé Brown, Robbie Morsette and Frank Berry in the APA Office to Coordinate Annual Meetings.

Philip R. Muskin, M.D., *Chairperson*
Marian I. Butterfield, M.D., *Vice-Chairperson*
Scientific Program Committee

Full Texts

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

2001 ANNUAL MEETING
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1. AIDS and HIV-Related Disorders
2. Alcohol and Drug-Related Disorders
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PRACTICE AREAS/SETTINGS

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17. Other

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32. Psychiatric Rehabilitation
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57. Managed Care and Health Care Funding
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64. Stigma/Advocacy
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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

TOPIC INDEX

Daniel B. Borenstein, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

MIND MEETS BRAIN: Integrating Psychiatry, Psychoanalysis and Neuroscience

The explosion of recent, exciting scientific discoveries is leading toward a convergence of mind and brain as we enter the 21st Century. Psychiatrists were often criticized for their belief in the benefits of psychotherapy and psychoanalysis and their reliance on empirical research studies to support their claims that these treatments are effective. The only controlled psychotherapy studies were for short-term treatments. Behavioral managed care quickly took the position that long-term treatments were generally not appropriate since there was no solid research to support their effectiveness. Short-term psychotherapies, group therapy and psychopharmacological treatments all met "medical necessity" criteria. Long-term psychodynamic treatment was not considered cost-effective. I have argued that no well established treatment should be excluded unless reliable research documented that it was not effective.

Restrictive managed care led to increases in general health care costs, absenteeism and disabilities and to diminished work performance. At the same time that economically-driven patient care was suggesting the advantages of traditional psychiatric treatments, major research advances from brain imaging and neuroscience studies were documenting the benefits of talking therapies. Psychotherapy was found to be as effective as medication in correcting pathological blood flow and metabolism patterns in the brain. Moreover, these changes correlated with clinical improvements in patients. Additional studies demonstrated that psychotherapy led to the development of new neuronal connections in the brain. Daily discoveries in molecular genetics and neuroscience are providing additional insights into the clinical manifestations of psychiatric illnesses. I am optimistic that this work will enrich the quality as-well-as the understanding of human experience.

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MONDAY, MAY 7, 2001

SCIENTIFIC AND CLINICAL REPORT SESSION 1—ISSUES IN SEXUAL DYSFUNCTION

No. 2
CORRELATION BETWEEN PATIENT SELF-ASSESSMENT OF ERECTILE FUNCTION AND THE INTERNATIONAL INDEX OF ERECTILE FUNCTION (IIEF-5)

Joseph Cappelleri, Ph.D., *Department of Clinical Research, Pfizer, Inc., Eastern Point Road, MS 8260-253, Groton, CT 06340-8030;* Richard L. Siegel, M.D., Raymond C. Rosen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to appreciate the value of an independent validation study and to assist patient management and clinical research by quantifying the type of population to enroll in a trial, improving decision making and patient care, and fostering educational initiatives.

SUMMARY:

Introduction: An abridged, five-item version of the International Index of Erectile Function (IIEF-5) possessed favorable statistical properties as a diagnostic tool for grading erectile dysfunction (ED). However, the IIEF-5 has not been validated and compared with subject self-assessment of ED.

Objective: The study purpose was to use an independent validation study to examine the correlation between patient self-assessment of ED and the IIEF-5 with respect to ED severity at baseline and after treatment intervention.

Method: 247 men with clinically diagnosed ED (≥ 6 months) and in a stable heterosexual relationship (≥ 6 months) were enrolled in a 12-week, randomized, double-blind, placebo-controlled study of sildenafil citrate. They were asked to self-report their degree of ED as severe, moderate, minimal/mild, or no problem at baseline and after treatment. They also responded to the five questions on the IIEF-5, which cover erectile function and intercourse satisfaction, where the total score for these patients indicated the following degrees of ED: severe (IIEF-5 score, 1 to 7), moderate (8 to 11), mild to moderate (12 to 16), mild (17 to 21), and no ED (22 to 25). Descriptive profiles of the two diagnostic instruments were compared. Correlations between instruments were evaluated with Kendall's tau-b at baseline, after treatment at 12 weeks, and at change from baseline.

Results: The two measures gave generally similar descriptive profiles of ED severity. Correlations were 0.66 (95% CI, 0.58 to 0.74) at baseline, 0.86 (95% CI, 0.82 to 0.90) after 12 weeks of treatment, and 0.72 (95% CI, 0.67 to 0.77) for change from baseline.

Conclusion: The moderate-to-high correlation between patient self-assessment of erectile function and the IIEF-5 provides a validation of the IIEF-5 for reliable diagnostic classification of ED severity.

REFERENCES:

1. Rosen RC, Cappelleri JC, Smith MD, et al: Development and evaluation of an abridged, 5-item version of the International Index of Erectile Function (IIEF) as a diagnostic tool for erectile dysfunction. International Journal of Impotence Research 1999; 11:319–326.
2. Cappelleri JC, Rosen RC: The sexual health inventory for men (IIEF-5). International Journal of Impotence Research 1999; 11:353–354.

No. 3
SILDENAFIL CITRATE EFFECTIVELY TREATS ERECTILE DYSFUNCTION IN MEN WHO HAVE BEEN SUCCESSFULLY TREATED FOR DEPRESSION

Jean L. Tignol, M.D., *Centre Carreire, Victor Segalen University at Bordeaux, 121 Rue De La Bechade, Bourdeaux Cedex 33076, France;* Otto Benkert, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that sildenafil is effective for the treatment of ED in men who have been successfully treated for depressive illness.

SUMMARY:

Objective: To assess the efficacy and safety of sildenafil citrate to treat erectile dysfunction (ED) in subjects in remission from depression.

Method: Depression was assessed using the 10-item Montgomery-Asberg Depression Rating Scale (MADRS). Men (mean age 53) with ED (mean duration 4.2 years), who had successfully been treated for depression (SSRIs, n = 45; tricyclics, n = 24; other antidepressants, n = 15) were randomized to receive a starting 50-mg dose of sildenafil (n = 83) or matching placebo (n = 85) for 12 weeks. The dosage could be adjusted to 25 or 100 mg based on efficacy and tolerability. Efficacy was determined at baseline and end of treatment using question 3 (Q3, ability to achieve an erection) and Q4 (ability to maintain an erection) of the International Index of Erectile Function (IIEF). Scoring for Q3 and Q4 ranged from 1 (almost never/never) to 5 (almost always/always) with a score of 0 indicating no sexual activity. A global efficacy question (Did treatment improve your erections?) assessed end-of-treatment efficacy.

Results: Total MADRS scores did not change significantly between baseline (6.37) and end of treatment (6.41) for patients receiving sildenafil, suggesting stable remission from depression. Analysis of variance showed significant improvements from baseline scores for IIEF Q3 (1.7 to 3.8 vs. 2.2 to 2.6) and Q4 (1.5 to 3.5 vs. 1.8 to 2.0) in patients receiving sildenafil compared with those receiving placebo ($P < 0.0001$). Significantly more patients receiving sildenafil reported that treatment improved their erections (83%) compared with those receiving placebo (34%, $P < 0.0001$). Adverse events were mostly mild to moderate in severity. There were no serious adverse events. One patient receiving sildenafil discontinued treatment due to severe headache.

Conclusion: In patients with stable remission from depression, sildenafil is effective and well tolerated, with patients reporting significantly improved erections.

REFERENCES:

1. Shabsigh R, Klein LT, Seidman S, et al: Increased incidence of depressive symptoms in men with erectile dysfunction. Urology 1998; 52:848–852.
2. Araujo AB, Durante R, Feldman HA, et al: The relationship between depressive symptoms and male erectile dysfunction: cross-sectional results from the Massachusetts Male Aging Study. Psychosom Med 1998; 60:458–465.

No. 4
PSYCHOTROPIC-INDUCED SEXUAL DYSFUNCTION AMONG OUTPATIENTS

Kenneth P. Rosenberg, M.D., *Department of Psychiatry, Cornell Medical College-Cornell University, 110 East 71st Street, New York, NY 10021;* Kathryn Bleiberg, Ph.D., James H. Kocsis, M.D.

EDUCATIONAL OBJECTIVE:

At the end of this presentation, the participant should be able to appreciate 1) the prevalence of sexual side effects secondary to psychotropics such as typical and atypical neuroleptics anticonvulsants, lithium, and antidepressants, 2) the common failure of patients and clinicians to openly discuss sexual side effects, and 3) the likelihood of noncompliance secondary to sexual side effects. The participant should also be able to treat iatrogenic erectile dysfunction with the available erectogenic agents.

SUMMARY:

Among patients receiving psychotropic medications, the sexual side effects of impaired desire, erectile dysfunction, and orgastic dysfunctions such as delay and satisfaction are frequent. It is our belief that sexual complaints are a common reason for noncompliance and that typically, clinicians ignore sexual dysfunctions among individuals with a history of severe psychiatric disturbances such as bipolar disorder and schizophrenia. We will present the results of two Cornell University Medical Center studies concerning the incidence and treatment of psychotropic-induced sexual dysfunction among psychiatric outpatients. In the first half of our presentation, we will discuss the results of our random survey on the incidence of sexual side effects and noncompliance among outpatients treated in our day treatment programs and clozapine clinic. During the second half, we will present pilot data for five individuals who were treated in a double-blind, crossover study of the efficacy of sildenafil for psychotropic-induced erectile dysfunction. This later study was supported by an independent medical grant from Pfizer. Both studies are aimed at improving the recognition and treatment of sexual side effects among severely mentally ill individuals. At the time of this submission (5/12/00), we are in the process of analyzing our data. At the APA annual meeting, we will present our data on both studies and discuss our experience is evaluating and treating these patients.

REFERENCES:

1. Rosenberg KR: Sildenafil citrate for SSRI-induced sexual side effects, Am J Psych 1999; 157.
2. Balon R, Segraves RT: 1997 Pocket Reference: Effects of Psychotropic Medications on Human Sexuality, MBL Communications Inc., New York, NY 1997, adapted from Primary Psychiatry 1997; 4(1).

SCIENTIFIC AND CLINICAL REPORT SESSION 2—PRESIDENTIAL THEME: "MIND MEETS BRAIN"

No. 5
SELF, OBJECT, AND NEUROBIOLOGY

Richard M. Brockman, M.D., *Department of Psychiatry, Columbia University, 15 West 81st Street, New York, NY 10024-6022*

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to identify neurobiological data as it becomes manifest in the transference through affect and through object ties. This provides a basis from which to practice a psychotherapy that is biologically informed, aimed at neurobiologic, cognitive, and behavioral change mediated through the transference.

SUMMARY:

This presentation will explore clinical object relations and attachment theory in a neurobiological context. Attachment behavior—and I am not making a great distinction between attachment behavior and object relations—is not about the satisfaction of a wish. Attachment is about behavior that is organized thru affect. By removing wish and replacing affect as the central issue in the therapeutic process, the approach to psychotherapy is changed. It moves the practice of psychotherapy from an investigation of the mental to an investigation, as Freud defined it, "on the frontier between the mental and the somatic."

And thus the main body of this presentation will be an exploration of affect in the attachment process, including the neurobiology of attachment, the neurobiology of primitive affect and primitive object ties, how defense mechanisms develop in response to primitive object ties, how different neurobiologic pathways of affect organize perception and thus organize object ties differently and consequently influence the transference, how these different neurobiological pathways become manifest in the transference, how the therapeutic process can modify the processing of affect and perception, and finally how behavior can be changed in the transference through an understanding of the neurobiology of affect, perception, and object relations. These ambitious goals will be demonstrated with clinical examples.

REFERENCES:

1. Milner B, Squires LR, Kandel ER: Cognitive neuroscience and the study of memory. Neuron 1998; 20:445–468.
2. Brockman RM: A Map of the Mind. Madison CT, International Universities Press, 1998.

No. 6
CONCEPTUAL INTEGRATION OF MIND AND BRAIN IN PHILOSOPHY AND PSYCHIATRY

David H. Brendel, M.D., *Department of Psychiatry, McLean Hospital, 33 Pond Avenue #707, Brookline, MA 02445*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the nature of conceptual dichotomies between mind and brain, meaning and causation, and fact and value in philosophy of mind, clinical psychiatry, and psychiatric ethics; to recognize the importance of psychological approaches in psychiatry even as neuroscience expands; and to appreciate the ethical dimensions of pluralistic conceptual models in philosophy and psychiatry.

SUMMARY:

Objective: The purpose of this review article is to examine the status of the conceptual dichotomy between mind and brain in philosophy and psychiatry. The issue is important because this dichotomy continues to confound thinking in clinical psychiatry, psychiatric ethics, and philosophy of mind. This presentation is for philosophically oriented psychiatrists and others with interests in the theoretical underpinnings of the field, particularly at the mind-brain interface.

Method: Important works on the mind-brain dichotomy in clinical psychiatry, psychiatric ethics, philosophy of mind, and cognitive neuroscience are reviewed critically.

Results: Paul Churchland's theory of eliminative materialism highlights the mind-brain dichotomy, stating that advances in neuroscience have restricted, and eventually will eliminate, any need for psychology. The core principles of this theory are questionable, because psychiatrists still need psychology and perhaps always will. Even in cases of known brain pathology (where eliminative materialism seems most plausible), psychological concepts remain critical. The works of Karl Jaspers and contemporary theorists highlight this point.

Conclusion: Philosophers and psychiatrists should generate conceptual models that lead not to elimination of psychology but to explanatory pluralism, the integration of diverse concepts toward the end of better handling clinical challenges. This idea has important implications for psychiatric ethics and the fact/value debate.

REFERENCES:

1. Brendel DH: Philosophy of mind in the clinic: the relation between causal and meaningful explanation in psychiatry. Harvard Rev Psychiatry 2000; 8:184–191
2. Bolton D, Hill J: Mind, Meaning, and Mental Disorder: The Nature of Causal Explanation in Psychology and Psychiatry. Oxford, Oxford University Press, 1996.

No. 7
DREAMING CONTRIBUTES TO ADAPTATION IN THE DEPRESSED: A REVIEW

Milton Kramer, M.D., *101 West 79th Street, Suite 7F, New York, NY 10024*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants will be familiar with the quality of research on the dreams of the depressed the content of their dreams, and the evidence that supports that dreaming plays a functional role and contributes to the waking adaptive state of the dreamer.

SUMMARY:

Objective: To review our knowledge of dream content in the depressed to see if dreaming contributes to waking adaptation.

Method: A Medline search was done for publications about dreams of the depressed since 1975, the date of the last major review. Some 170 articles were found; but only 15 of these articles, containing 17 studies that reported dream content were selected for review. The studies were evaluated along 53 parameters, as had been done for the 14 articles in the pre-1975 review, to establish their scientific adequacy, and their content was summarized.

Results: The scientific adequacy of the studies has not improved over the earlier reviews as only 60% report statistically acceptable results. There is in depression a decrease in the frequency and length of dream reports, which correlates positively with the severity of the depression. The reports generally have commonplace contents. However, there is an increase in death themes in suicidal patients and in bipolars before a manic episode. Family role references are increased in the dreams of the depressed. Masochism in their dreams is a trait characteristic and is more common in women. A focus on the past is neither universal nor unique to depression. Affects such as anxiety are not prominent in their dreams, but the content does have prognostic significance for treatment effectiveness. Dreaming about a highly disruptive life event, e.g., a divorce, predicts a decreased likelihood of a depression one year later. The affective state of the dreamer covaries with the content of the dream. Changes in dream content across the night appear to positively alter the affective condition of the dreamer. And how one feels in the morning is one important determinant of psychomotor performance.

Conclusion: What depressed patients dream about is a factor in their waking adaptive capacity.

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SCIENTIFIC AND CLINICAL REPORT SESSION 3—DEPRESSION IN THE MEDICALLY ILL

No. 8
A SYSTEMATIC REVIEW OF DEPRESSION AS A RISK FACTOR FOR CORONARY DISEASE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to specify for which criteria the evidence on depression supports a role as risk factor for CAD; to understand what kinds of studies could provide the evidence necessary to establish depression as a predisposing risk factor for CAD.

SUMMARY:

Objective: To systematically review the current evidence for and against depression as a major risk factor for CAD.

Method: Using systematic methods where appropriate, we reviewed the English-language literature from 1966–2000 on depression and CAD with respect to seven criteria for risk factor status: 1) strength of association, 2) prediction, 3) specificity, 4) consistency, 5) dose-response effect, 6) biological plausibility, 7) response to treatment.

Results: In more than 50 studies depression is consistently associated with CAD, often at a strength that is similar to some established CAD risk factors. In eight studies depression independently predicts the onset of CAD (overall relative risk = 1.7, 95% CI 1.5–1.9). Specificity varies widely. Nine of 10 studies that examined the dose-response relationship found increased risk for CAD with increasing severity of depression. Due to lack of studies, there is little evidence in the areas of biological plausibility and response to treatment.

Conclusion: The evidence for depression's role as a risk factor for both the onset and the progression of CAD is growing, but is not yet established because of lack of evidence in the areas of specificity, biological plausibility, and response to treatment. Depression is most likely to emerge as a predisposing risk factor for CAD, as are obesity and physical inactivity.

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No. 9
TRAINING PRIMARY CARE PHYSICIANS IN THE DIAGNOSIS AND TREATMENT OF DEPRESSION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to gain an understanding of the benefits of the use of continuing medical education (CME) programs in the training of physicians in the treatment of major depression.

SUMMARY:

Objectives: The aim of the study was to determine if primary care physicians would change their diagnostic and treatment practices after undergoing a training program on major depression.

Methods: The study was conducted in six sites in five Latin American countries with 98 primary care physicians. Phase 1 consisted of assessing during a typical week the clinical practice of the physicians a month prior to the beginning of an educational program. All patients aged 15 and older were screened for major depression. The physicians reported if a diagnosis of major depression was present, and their knowledge and attitudes about depression was assessed. Phase 2 was conducted one month following the program using the same methods.

Results: There was evidence that the educational program was effective in improving knowledge about depression and changing some of the attitudes about the illness, but there was limited evidence of its impact on clinical practice. The change in knowledge although significant was small, and only a few attitude items were found to change with the training program. As for clinical practice, there was no evidence of an improvement in the rate of diagnosis. Agreement remained low between patients' self-reported diagnosis and those the physicians thought were depressed.

Conclusions: The evidence for the effectiveness of a continuing education model for training primary care physicians in the treatment and detection of major depression is weak.

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No. 10
SCREENING FOR DEPRESSION IN HEAD AND NECK CANCER PATIENTS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the psychosocial burden of head and neck cancer, diagnose major and minor depression in cancer patients and evaluate and use brief screening instruments for depression in medically ill populations.

SUMMARY:

Objectives: Head and neck cancer patients receiving radiation treatment are at risk for depression because of the life-threatening nature of the illness and treatment-induced oral morbidity. The objectives of this study are to identify the prevalence of depression and the accuracy of depression screening instruments in this population.

Methods: Sixty outpatients of the Princess Margaret Hospital who had recently completed radiation treatment were evaluated for major and minor depression according to Research Diagnostic Criteria using the Schedule for Affective Disorders and Schizophrenia (SADS). Screening instruments included the BDI, HADS, and CES-D. Accuracy was assessed by calculating the sensitivities, specificities, positive predictive values, and areas under curve (AUC) from Receiver Operating Characteristic (ROC) curves.

Results: The prevalence of major or minor depression was 20%. All of the screening instruments tested were found to be highly accurate. Significant differences between the instruments were not seen, but the optimal cut points for the HADS may be lower than what is suggested in the literature. No cases of major depression were missed by any of the instruments tested.

Conclusions: These results suggest that a significant minority of head and neck cancer patients are depressed in the post-radiation period, and that accurate screening for clinically significant depression is possible using any of the three instruments evaluated here.

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SCIENTIFIC AND CLINICAL REPORT SESSION 4—SECLUSION, RESTRAINT, AND EMERGENCY ISSUES

No. 11
REDUCING RESTRAINT AND SECLUSION: ONE HOSPITAL'S EXPERIENCE

Paul Plasky, M.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478*

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to develop a hospital-based program to address restraint and seclusion use on an inpatient unit, maintaining staff and patient safety while emphasizing less-restrictive alternatives. The participant will learn about the steps involved, from pilot project to hospitalwide application and finally to an ongoing CQI effort.

SUMMARY:

In 1994, McLean Hospital undertook the goal of reducing its use of restraints and seclusion (R/S) initial quality-improvement meetings, with representatives of all hospital disciplines, resulted in a pilot project on a single inpatient unit. We proposed emphasis on chemical over physical restraints; guidelines for the use of medications; multidisciplinary review of extended R/S events; mandatory consultations with the pharmacology and internal medicine services; environmental reviews for safety on the unit; and re-education for all staff. These changes helped reduce the number of monthly R/S episodes by 82 percent.

As we applied these findings hospitalwide, additional strategies emerged. We developed a pocket-size Guidelines for Chemical Restraints, so that the psychiatry residents would carry a list of effective medications along with a clearly stated list of de-escalation techniques and less-restrictive alternatives to R/S. We helped establish a specialized response team of the most skilled staff to lead any R/S and thereby reduce staff injuries. In addition we identified those few patients who required the most R/S so that individualized treatment plans could be implemented. Today our CQI team continues these efforts, focusing on documentation, medication, and other topics.

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1. Fisher WA: Restraint and seclusion: a review of the literature. Am J Psychiatry 1994; 151:1584–1591.
2. Wadeson H, Carpenter WT: Impact of the seclusion room experience. J Nerv Ment Dis 1976; 163:318–328.

No. 12
REDUCING RESTRAINT USE IN A PUBLIC PSYCHIATRIC HOSPITAL

Robert E. McCue, M.D., *Department of Psychiatry, Woodhull Hospital, 760 Broadway, Brooklyn, NY 11206-5317;* Leonel Urcuyo, M.D., Yehezkel Lilu, Ph.D., Teresa Tobias, R.N., Michael Chambers, M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to develop a program to minimize the use of restraint in inpatient psychiatry, even when treating a population at higher risk for violent behavior.

SUMMARY:

Objective: The use of behavioral restraint in psychiatry inpatients can have physically and emotionally damaging effects. However, staff may view the use of restraint as a routine and acceptable means of maintaining safety. Our goal was to reduce the use of restraint in our facility; this paper describes how these efforts were planned, implemented, and analyzed.

Methods: The site of this study was a public psychiatric service with over 2,000 admissions per year that serves an economically disadvantaged urban population. Six interventions that primarily involved changing staff behavior were made to reduce the use of behavioral restraints without jeopardizing safety. The effectiveness of these interventions was measured by comparing the number of behavioral restraint episodes per 1000 patient-days from before and after the interventions. Additional variables for comparison were the duration of each restraint episode and the number of assaults on staff and patients.

Results: There was a significant decrease in mean restraint episodes/1000 patient-days when the 12 months prior to our interventions were compared with the subsequent 11 months (8.5 vs. 4.2, df = 21, p = 0.0018). The mean duration of restraint episodes decreased but was not statistically significant. Assaults on patients and staff were not affected by the reduction in restraint use.

Conclusion: The use of behavioral restraints among psychiatry patients in a public hospital can be reduced by a number of interventions that are focused on educating the staff. This can be accomplished without compromising safety.

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2. Crenshaw WB, Cain KA, Francis PS: Updated national survey on seclusion and restraint. Psychiatric Services 1997; 48:395–397.

No. 13
FACTORS INFLUENCING THE PSYCHIATRIC EMERGENCY ROOM

Davin A. Agustines, B.A., *Department of Psychiatry, Harbor-UCLA, c/o Dr. Chung, 1000 West Carson Street, Box 498, Torrance, CA 90509;* Christopher K. Chung, M.D., Jambur V. Ananth, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the administrative factors that may change the course and prognosis of mental illnesses in the emergency room setting.

SUMMARY:

Objectives: To identify the recent psychiatric ER demographic changes, volume increases, and other characteristic changes; data were collected for the same time periods in 1999 and 2000. These data were correlated to changes in administrative philosophy and resource allocation during the past year.

Methods: 1350 log entries were recorded from 4/1/99 to 6/30/99, and 1539 from 4/1/00 to 6/30/00 were collected. Eleven factors were recorded, including length of stay, demographic data, psychiatric diagnosis, disposition, etc.

Results: There is no significant change in the basic demographic patterns in the psychiatric ER populations; a more ill population exists today, as evidenced by longer emergency room stays as well as more psychiatric ER visits. Disposition patterns for 2000 consisted of 48% returned to community, and 44% sent to inpatient care. Compared with 1999, there is a 14% increase in ER visits and a 32% increase in inpatient unit transfers.

Conclusions: This change seems to be influenced by the administrative philosophy of Department of Mental Health in LA county changing its resource allocation. Not only the biological nature of the mental illness, but also a number of sociocultural and administrative variables are influencing the psychiatric ER populations and their prognosis.

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SCIENTIFIC AND CLINICAL REPORT SESSION 5—SPECIAL ISSUES IN FAMILY AND CHILD PSYCHIATRY

No. 14
SOME LONG-TERM CONSEQUENCES OF ORPHANAGE CARE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that symptoms of emotional or physical distress in middle-aged patients may be a consequence of early affective deprivation and that publically available banks of survey data may obviate the need for costly recruitment of control subjects for special populations, provided identical measurement instruments are used.

SUMMARY:

Objective: To cross-validate findings from a pilot study of the very-long-term psychosocial and physical effects on men of being raised in an orphanage and to examine these effects in women.

Method: 40 men and 41 women, aged 41 to 73, were randomly selected from a self-help group of 185. All were orphaned before the age of 5, 80% at birth. The comparison group was a randomly selected community sample from subjects of a province-wide health survey. They were matched 3:1 with the index group for age, gender, income, ethnicity, and location of residence.

Measurements: Marital status; social integration/isolation; psychological distress/wellbeing; spirituality; chronic physical illnesses; tobacco, alcohol, nonprescription and prescription drug use. All measures had been included in the community health survey.

Results: Significantly fewer ex-orphans were ever married, they were more socially isolated, had fewer supporting others, yet reported

the same degree of satisfaction with their social integration/isolation as the comparison group. They manifested more psychological distress and a lower sense of well-being; more frequently manifested chronic physical illnesses and use of certain prescription medications, but consumed less tobacco and alcohol. Few gender differences were found.

Conclusion: There are discernable very-long-term negative psychosocial and physical consequences for men and women raised in institutions.

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2. Wolff PH, Fesseha G: The orphans of Eritrea: a five-year follow-up study. Child Psychol Psychiatry 1999; 40:1231–1237.

No. 15
FAMILIAL BACKGROUND AND LITERARY CREATIVITY

Albert Rothenberg, M.D., *Department of Psychiatry, Harvard University, P O Box 1001, Canaan, NY 12029-3101*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to provide creative and potentially creative patients, both adults and children, with more effective biological and psychological treatments, including genetic and family counseling and the transmission of genetic trend information.

SUMMARY:

It has long been thought that genius is directly inherited, a supposition fostered by Francis Galton's classical but unreplicated statistical study.

Objective: To assess familial background of outstanding national and international literary creators.

Method: Information regarding parental background was collected from semi-structured research interviews and all available English language biographies for 211 subjects: 49 Nobel laureates in literature, 141 Pulitzer Prize winners in drama, poetry, and fiction, and 21 nonoverlapping winners of the National Book and National Book Critics Circle Awards (NBA/NBCC).

Results: Four probands or 2% had parents in a creative occupation such as writing, painting, or architecture. In distinction, a specific type of familial background was identified in 65% (76% Nobel, 61% Pulitzer, 67% NBA/NBCC) of cases: same-sexed parents had followed a performance-related occupation involving linguistics, persuasion, or artisanship, e.g., journalism, law, ministry, acting, or else gave evidence of unfulfilled literary ambitions. Male probands = 66%; female = 62%. Of the parents in other than performance types of occupations, 30% had been enamored of writing, storytelling, and keeping literary diaries. No specific type of occupation predominated among this group or among the remaining population of nonperformance parents.

Conclusion: Rather than direct parent-child inheritance of literary creativity there are likely indirect familial genetic patterns. Moreover, upbringing in this particular type of family system induces intense motivation for literary creativity because the offspring both identify and compete with the same-sexed parents' unrealized creative goals.

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2. Rothenberg A: Creativity and Madness: New Findings and Old Stereotypes. Baltimore, MD, Johns Hopkins University Press, 1990.

No. 16
SELF-COMFORTING STRATEGIES USED BY ADOLESCENT MALES AND FEMALES

Paul C. Horton, M.D., *234 Hobart Street, Meriden, CT 06450-4380*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to recognize the many and often subtle ways by which adolescents comfort themselves. They will see the profound role of gender in solacer choice and be helped to contemplate the developmental, diagnostic, and bereavement implications of these striking differences.

SUMMARY:

Objective: While there has been much interest in comforting strategies used throughout the life cycle, there have been no large number, normative studies of adolescent usage.

Method: 264 males and females, aged 14 through 17, were surveyed using a set of 51 prompts with space for them to write in additional soothers. The results were analyzed using two-way Analysis of Variance (ANOVA) to test the effects of gender and age on the number and type of solacer.

Results: Adolescents reported using an average of 12.8 comforting strategies. Music was the most frequently selected soother regardless of age or gender followed by another person, talking on the phone, and memories. Gender, but not age, was a powerful discriminator of both choice and frequency of solacing strategies with females selecting the majority of significant items, particularly those suggesting greater emotional maturity.

Conclusions: Comforting object, activity, and sound use are ubiquitous among adolescents. The most frequently selected solacers show the adolescent's continued need for a stabilizing sense of maternal connectedness. Females are more adept in the selection of soothers, and this may have implications for gender differences in the incidence of various psychiatric disorders and in reactions to bereavement throughout the life cycle.

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SCIENTIFIC AND CLINICAL REPORT SESSION 6—ANXIETY DISORDERS

No. 17
PTSD VERSUS PANIC DISORDER: DIFFERENCES IN HPA AXIS/ NORADRENERGIC FUNCTIONING

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to present new findings that illustrate important differences between panic and PTSD as further evidence of true heterogeneity within the anxiety disorders.

SUMMARY:

Objective: How best to define and understand pathological anxiety continues to be a subject of considerable controversy. Panic disorder and PTSD share a number of common clinical features, but have highly distinct clinical presentations. This pilot study was conducted to compare noradrenergic and HPA axis functioning in PTSD, panic disorder, and normal controls, and is the first such study.

Method: Three groups were studied: panic disorder (N = 17), PTSD (N = 7), and healthy controls (N = 16). Cortisol and MHPG levels were examined at baseline and in response to clonidine challenge using ANOVA or nonparametric tests where appropriate.

Results: Compared with the panic group, the PTSD group had significantly lower baseline cortisol, lower baseline MHPG, lower cortisol and MHPG responses to clonidine, and reduced volatility in MHPG and cortisol levels (for all tests, $p < .01$). More differences between panic disorder and PTSD groups were found than between healthy controls and PTSD.

Conclusions: Panic disorder is distinct from PTSD on measures that reflect the functioning of fundamental anxiety and stress response systems. If replicated, such findings inform current models suggesting a diversity of pathological mechanisms, and/or adaptive mechanisms, in the anxiety and affective disorders.

REFERENCES:

1. Coplan JD, Papp LA, Pine D, et al: Clinical improvement with fluoxetine therapy and noradrenergic function in patients with panic disorder. Arch Gen Psychiatry 1997; 54: 643–648.
2. Marshall RD, Klein DF: Diagnostic classification of anxiety disorders: historical context and implications for neurobiology. In Neurobiology of Mental Illness, Charney DS, Nestler EJ, and Bunney BS, (eds), Oxford University Press, New York, Oxford, 1999.

No. 18
BEYOND ONE-YEAR IMIPRAMINE MAINTENANCE IN PANIC DISORDER WITH AGORAPHOBIA

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that the protective effects of imipramine maintenance do not extend beyond the prophylactic phase of treatment and that a substantial degree of prophylaxis continues to be needed beyond the first year of maintenance treatment in panic disorder with agoraphobia patients.

SUMMARY:

Objective: To explore the putative enduring protective effects of imipramine maintenance beyond the prophylactic phase of treatment of panic disorder with agoraphobia.

Method: Eighteen patients, out of the 30 who completed a 12-month randomized study of imipramine maintenance (N = 29) and placebo substitution (N = 27, acute discontinuation), gave written consent to participate in a double-blind, second-year extension (Experiment I) with seven continuing on placebo (PBO-PBO), four continuing on imipramine (IMI-IMI), and seven re-randomized to placebo (IMI-PBO, delayed discontinuation). In addition, 17 patients who exited the double-blind imipramine condition in the first or second years of the study were followed in parallel to the double-blind study (the open discontinuation group). The main outcome of interest was relapse during a one-year at-risk period.

Results: None of the IMI-IMI patients relapsed. The rate of relapse (28.5%) was Identical in the IMI-PBO and PBO-PBO groups. Neither duration of imipramine treatment nor the method of discontinuation (open vs. placebo substitution) nor any of the nine other variables from demographic, clinical, and initial open-treatment domains analyzed in a proportional hazard model predicted relapse in the pooled sample of 51 patients who discontinued imipramine eventually (Experiment 2). The relapse rate after only six months of treatment (acute discontinuation, 10/27 = 37%) was identical to the rate of relapse after an average treatment duration of 18, range 12–30 months (9/24 = 37.5).

Conclusions: The results suggest a substantial need for continued prophylaxis beyond the first year of imipramine maintenance and a lack of specific protective effects beyond the prophylactic phase of treatment.

This study is being funded by NIMH.

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2. Mavissakalian M, Perel JM: Protective effects of imipramine maintenance treatment in panic disorder with agoraphobia. Am J Psychiatry 1992; 149:1053–1057.

No. 19
SOCIAL PHOBIA TREATMENT SURVEY

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

EDUCATIONAL OBJECTIVE:

At the end of this presentation, participants will be able to understand current community treatment practices for social phobia, recognize the gap between the results of treatment research/expert opinion and current clinical practice, and appreciate the need for further research towards developing algorithms for the treatment of social phobia.

SUMMARY:

Objective: To assess the impact of clinical research on the treatment of social phobia in the community.

Method: Data were collected by a computer-administered survey of 277 professionals attending the 153rd annual meeting of the American Psychiatric Association.

Results: Of the respondents, 89% (247/277) were psychiatrists. Sixty-five percent (160/247) would initiate treatment using a combination of medication and psychotherapy. Forty-two percent (103/247) endorsed cognitive-behavioral treatment as the most effective psychotherapeutic approach, and 60% (140/247) endorsed one of the selective serotonin reuptake inhibitors (SSRIs) as the most effective pharmacotherapy for social phobia. Treatment of refractory social phobia varied widely. If an adequate trial of psychotherapy alone had been tried, 82.5% (203/246) would add medication. However, if an adequate trial of medication alone were used, 28% (68/244) reported that they would switch agents. In 61% (37/68), the switch would be to another SSRI. Seventy-two percent (176/244) would apply an augmentation strategy with 30% (51/176) adding an SSRI and 19% (34/176) adding a mood stabilizer. In 33% (82/247) of respondents, difficulties in arriving at an accurate diagnosis were attributed to being unsure of how to elicit the diagnosis. These data will be compared with data collected from a sample of experts in the field.

Conclusions: Psychiatrists' approaches to the treatment of social phobia varied widely particularly in refractory cases. Further research is warranted to develop treatment algorithms for social phobia.

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1. Ballenger JC, Davidson JR, Lecrubier Y, et al: Consensus statement on social anxiety disorder from the International Consensus Group on Depression and Anxiety. Journal of Clinical Psychiatry 1998; 59(Suppl 17):56–60.
2. Van Ameringen M, Mancini C, Farvolden P, Oakman JM: Pharmacotherapy of social phobia: what works, what might work and what doesn't work at all. CNS Spectrums 1999; 4:61–68.

SCIENTIFIC AND CLINICAL REPORT SESSION 7—PERSONALITY DISORDERS

No. 20
PSYCHIATRIC TREATMENT OF BORDERLINE PATIENTS FOLLOWED FOR FOUR YEARS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the naturalistic course of treatment of criteria-defined borderline patients.

SUMMARY:

Objective: The purpose of this study is to describe the psychiatric treatment received by borderline patients at three points in time and to compare these figures with those reported by patients with other forms of Axis II pathology.

Method: Three hundred and sixty-two inpatients (290 borderline patients meeting DIB-R and DSM-III-R criteria for BPD and 72 Axis II comparison subjects) were interviewed about their psychiatric histories during their index admission using a semistructured interview of demonstrated reliability. Over 95% of surviving patients were reinterviewed about their psychiatric treatment at two and four year follow-up.

Results: In general, the utilization rates for most of the modalities studied declined for those in both patient groups, although remaining more common among borderline patients. At the end of four years of follow-up, over 75% of borderline patients were still in psychotherapy and taking psychotropic medications. However, only 36% had been hospitalized during the four-year follow-up period, a substantial decline from the 79% who had prior hospitalizations at baseline and the 60% who were hospitalized during the two-year follow-up period. Much the same pattern emerged for day and/or residential treatment (55% to 50% to 26%). In contrast, the rate of nonintensive outpatient treatment only (one therapy session per week or less and/or one psychopharmacology appointment per month or less) had risen from 7% at baseline to 16% at two-year follow-up to 46% at four-year follow-up. Only intensive polypharmacy remained relatively stable over time, with about 40% of borderline patients taking three or more standing medications at all three time periods.

Conclusions: Taken together, the results of this study suggest that the majority of borderline patients continue to use standard forms of outpatient treatment through four years of follow-up, but only a declining minority use more restrictive and costly forms of treatment. Supported, in part, by NIMH grant MH47588.

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No. 21
PREDICTORS OF OUTCOME IN A 27-YEAR FOLLOW-UP OF 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;* Hallie Zweig-Frank, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentations, the participant should be able to present data on a long-term follow-up of patients with borderline personality disorder.

SUMMARY:

Objective: To present findings on predictors of long-term outcome of borderline personality disorder.

Methods: 64 patients diagnosed with BPD (out of 100 assessed in 1986) were examined after a mean follow-up interval of 27 years. Assessment of outcome included measures of diagnosis (DIB-R, SCID) and functioning (GAF, SCL-90 and SAS-SR). Subjects were also administered two self-report measures of childhood experience: Parental Bonding Index and Developmental Experiences Questionnaire.

Results: DIB scores and GAF scores at 15 years were significant predictors of all measures of long-term outcome (all correlations $p < .01$). In contrast, reports of parenting quality and of childhood abuse or trauma had no relationship to outcome.

Conclusions: Patients with more rapid early recovery from BPD also have a better long-term outcome. The presence of absence of childhood adversity does not seem to affect recovery from the disorder.

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No. 22
CONFIRMATORY FACTOR ANALYSIS OF DSM-IV SCHIZOTYPAL PERSONALITY DISORDER CRITERIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will have a better understanding of the components of schizotypal personality disorder.

SUMMARY:

Objective: Tested the factor structure of the DSM-IV schizotypal personality disorder (STPD) criteria using confirmatory factor analysis (CFA) in a large sample from a multisite study.

Method: 668 primarily treatment-seeking subjects were reliably assessed with the Diagnostic Interview for Personality Disorders-IV, a semistructured diagnostic interview for DSM-IV personality disorders. Associations between the STPD criteria set were exam-

ined, and CFA was performed to test three models: the STPD diagnosis as a unitary construct, a 3-factor model and a 4-factor model.

Results: Internal consistency was adequate (Cronbach's alpha-0.82) and supported by the pattern of correlations among STPD criteria. CFA results suggested that the 4-factor model (*disorganization, cognitive-perceptual deficits, paranoid, interpersonal deficits*) offered the most optimal fit [NFI = .974, CFI = .985, RMSEA = .045] compared with the 3-factor model [NFI = .880, CFI = .890, RMSEA = .114] and the 1-factor model [NFI = .754, CFI = .763, RMSEA = .158]; Improved goodness of fit for the 4-factor model over the 3- and 1-factor models was statistically significant [X^2_{diff} (3) = 181.5, $p < .000$; X^2_{diff} (6) = 422.9, $p < .000$, respectively].

Conclusion: These results suggest that the STPD diagnosis is composed of distinct components that may have utility for better understanding the disorder.

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SCIENTIFIC AND CLINICAL REPORT SESSION 8—ALCOHOL AND DRUG-RELATED DISORDERS

No. 23
LONGITUDINAL PREDICTORS OF ADOLESCENT ALCOHOL DISORDER ONSET

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize processes occurring over time that put adolescents at risk for alcohol disorder; understand how specific risk factors combine to lead to adolescent alcohol disorder; understand how early onset affective or or anxiety disorder could be related to later onset of alcohol disorder.

SUMMARY:

Objective: Previous studies identify numerous factors associated with adolescent alcohol disorder (AAD). However, questions remain about the complex relationships among the factors. Using prospective, longitudinal data, we tested the theory that contextual factors influence symptom trajectories that, in turn, predict AAD onset.

Method: A community sample of 325 families reported contextual factors including parents' emotional and alcohol problems, parenting behaviors, adolescent personality characteristics, and primary affective or anxiety disorder assessed using DSM-III-R criteria. Adolescent emotional distress symptoms, conduct problems, and alcohol use were assessed annually from ages 13 to 16. AAD onset after age 15 was assessed using DSM-III-R criteria. Associations among contextual factors and symptom trajectories were tested using latent growth curve modeling procedures. Associations among alcohol use trajectories and alcohol disorder onset were tested using mixed modeling techniques.

Results: Emotional distress and problem behavior trajectories mediated the relationship between contextual factors and adolescent alcohol use trajectories. Distinct use trajectories predicted AAD onset. Adolescents at significant risk for AAD showed rapidly increasing consumption levels. Adolescents at minimal risk reported moderately increasing use.

Conclusions: Many youth initiate and increase alcohol consumption during adolescence. Those at risk for alcohol disorder exhibit a distinct consumption pattern. This pattern is predicted by emotional distress and conduct problem symptom trajectories that are influenced by specific contextual factors.

Funding for this research was provided through grants from the National Institute of Mental Health (MH43270, MH48165, and MH51361)

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No. 24
DELIRIUM TREMENS: DIAGNOSIS, MISDIAGNOSIS, AND TERMINOLOGY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize clinical tendency to diagnose any delirium that occurs in patients with a drinking history as being due to alcohol withdrawal, recognize the importance of accurate diagnosis of the various causes of delirium for optimal patient care, consider revising the current diagnostic terminology for alcohol related delirium.

SUMMARY:

Objective: To review how the diagnosis alcohol withdrawal delirium is used in a clinical setting. Misdiagnosis can lead to clinical management problems and affect mortality rates.

Method: After retrospective review of 50 randomly selected patients with a discharge diagnosis of alcohol withdrawal delirium from the University Hospital, the two authors reached an alcohol-related diagnosis by consensus.

Results: Of the 50 cases, retrospectively 20 were diagnosed with alcohol withdrawal or delirium tremens (DTs), (14 toxic and six withdrawal). Seventeen of the patients had a delirium secondary to multiple factors, and 13 had no clinical evidence of delirium. Case vignettes describe each category. There were two deaths in this series, both patients with a multifactorial delirium. Four patients were given beer. Hospitalization for DT patients averaged 5.3 days compared with 17.5 days for multifactorial delirium patients.

Conclusion: Hospitalized patients given the diagnosis of alcohol withdrawal are often misdiagnosed. The current diagnostic terminology is confusing and a return to the routine use of "delirium tremens" is recommended. Alcohol should not be used in prevention or treatment of DTs. The mortality rate of DTs with standard drug and nursing care should be close to zero.

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No. 25
CIGARETTE SMOKING AND RISK FOR ANXIETY DISORDERS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that chronic cigarette smoking during adolescence is associated with increased risk for the development of agoraphobia, generalized anxiety disorder, and panic disorder during early adulthood, and that anxiety disorders during adolescence are not associated with increased risk for chronic cigarette smoking during early adulthood.

SUMMARY:

Objective: To investigate the longitudinal association between cigarette smoking and anxiety disorders among adolescents and young adults.

Method: A community-based sample of 688 youths and their mothers from upstate New York were interviewed in 1985–1986 and 1991–1993.

Results: Chronic cigarette smoking during adolescence was associated with risk for agoraphobia, generalized anxiety disorder, and panic disorder during early adulthood after accounting for age, gender, difficult childhood temperament, parental smoking, parental education, parental psychopathology, and alcohol and drug use, anxiety, and depressive disorders during adolescence. Anxiety disorders during adolescence were not associated with chronic cigarette smoking during early adulthood.

Conclusions: Chronic cigarette smoking may be associated with increased risk for certain anxiety disorders during late adolescence and early adulthood.

Funding Sources: National Institute of Mental Health, National Institute on Drug Abuse

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SCIENTIFIC AND CLINICAL REPORT SESSION 9—COMORBIDITY IN MOOD DISORDERS

No. 26
DOES MEDICAL COMORBIDITY IMPACT THE SEVERITY OF DEPRESSION AND ITS TREATMENT?

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the impact of medical comorbidity on the severity of major depression and to understand the favorable outcome of standard antidepressant treatment in subjects with medical comorbidity. We will also discuss the prevalence of medical comorbidity in depressed outpatients and methods for rating the severity of medical comorbidity.

SUMMARY:

Objective: In a group of outpatients with major depression we investigated the impact of medical comorbidity on the severity of depression and antidepressant treatment outcome.

Method: 380 outpatients meeting DSM-IV criteria for major depression were administered questionnaires, physical examinations, and laboratory testing to detect medical comorbidity. We utilized the Cumulative Illness Rating Scale (CIRS) to measure the severity of medical comorbidity (SMC) for each patient. Of those, 316 subjects completed an eight-week open treatment with fluoxetine 20 mg/day. The 17-item Hamilton Rating Scale for Depression (Ham-D-17) was administered five times during the treatment to assess changes in depressive symptoms. We defined the response to treatment as $\geq$ 50% reduction of Ham-D-17 scores from the initial visit to the end of trial. Clinical remission was defined as Ham-D-17 score ≤ 7 for the last two weeks of the trial.

Results: 281 subjects (88.9%) in our sample had low severity of medical comorbidity (low SMC, CIRS scores = 0–3), whereas 35 subjects (11.1%) had moderately severe medical comorbidity (moderate SMC, CIRS scores = 4–9). The subjects with moderate SMC had significantly ($P < 0.05$) higher Ham-D-17 scores at the initial visit (20.7 versus 19.5 for patients with low SMC). However, the response to fluoxetine treatment and the clinical remission were not statistically different between subjects with low SCM and those with moderate SCM.

Conclusion: Depressed outpatients with moderately severe medical comorbidity presented with more severe symptoms of depression at the initial visit compared with patients with low severity of medical comorbidity. However, the presence of moderately severe medical comorbidity did not appear to have an impact on antidepressant treatment outcome. These results underlie the importance of diagnosing and treating depression in subjects with medical comorbidity.

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No. 27
TREATMENT-RESISTANT DEPRESSION AND AXIS I COMORBIDITY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to increase the understanding of the prevalence of comorbid Axis I disorders in treatment-resistant depression.

SUMMARY:

Background: Treatment-resistant depression (TRD) continues to present a treatment challenge to clinicians, occupies over half of annual costs for psychiatric treatment, and causes great frustration to the patient. Although there have been an abundance of studies attempting to define TRD, little information is available as to the cause of TRD. One suggestion is that patients with TRD have more

comorbid disorders that are resistant to antidepressants. The objective of this study was to compare a sample of TRD and non-TRD depressed patients in the comorbidity of Axis I disorders.

Methods: TRD and non-TRD patients were recruited into two studies designed to treat either TRD or non-TRD patients and were assessed for Axis I disorders using the SCID-P for the DSM-III-R and the HAM-D-17. Patients for the two studies were then matched for baseline HAM-D-17 total score and gender.

Results: The results revealed that non-TRD patients had both a higher rate of lifetime GAD and current GAD comorbidity than the TRD patients. No other statistically significant comorbidities were found.

Conclusions: These findings do not support the idea that current or lifetime Axis I comorbidity is more common in TRD or non-TRD. In fact, the only statistical difference showed non-TRD patients with higher comorbidity rates.

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No. 28
THE COMPLEX COMORBIDITY BETWEEN BIPOLAR ILLNESS AND OCD: CLINICAL IMPLICATIONS AND TREATMENT OUTCOME

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EDUCATIONAL OBJECTIVE:

To recognize the comorbidity between obsessive compulsive disorder and bipolar disorder and its impact on clinical features and treatment outcome.

SUMMARY:

Background: Clinical and epidemiological studies on obsessive compulsive disorder (OCD) have largely focused on comorbidity with major depression. Less attention has been devoted to the comorbidity between OCD and bipolar disorder. Our aim is describe the clinical characteristics and treatment outcome of OCD-bipolar patients in a setting of routinary clinical practice.

Method: The sample comprised 68 patients with DSM-III-R diagnoses of obsessive-compulsive disorder (OCD) admitted and treated to the day hospital of the department of psychiatry at the University of Pisa during a three-year period (January 1995 - December 1998). Thirty-eight (55.8%) patients showed lifetime comorbid bipolar disorder (BD) (17, 44.7% bipolar 1 and 21, 55.4% bipolar II). Diagnoses and clinical features were collected by means of structured (SCID) and semi-structured interview (OCD-interview). Assessment of drug treatments, clinical outcome, and adverse effects were made prospectively as a part of routinary clinical care throughout the course of their day hospitalization.

Results: As contrasted to non-bipolar, OCD-bipolar patients had a more episodic course (52.6 vs 16.7%, p = .002) with greater number of concurrent major depressive episodes (2.1 vs 1.1, p = .01). They reported significantly higher rate of sexual (42.1 vs 20%, p = .05), aggressive (30.5 vs 10%, p = .04) and religious obsessions (26.3 vs 6.7%, p = .03) and significantly lower rate of checking rituals (42.1 vs 76.7%, p = .004). OCD-bipolars reported more frequent current comorbidity with Panic Disorder-Agoraphobia (30.5 vs 10.0%, p = .03) and with abuse of different substances (alcohol, sedatives, psychostimulants and coffee) (36.8 vs 13.3%, p = .03). In the history of OCD-bipolars, drug treatment with clomipramine (28.9 vs 3.6%, p = .008) and, to a lesser extent, SSRIs (14.3 vs 0%, p = .04) was associated with (hypo)manic switches. Pharmacological (hypo)mania was more frequent in patients that are not concomitantly treated with a mood stabilizer (32.5 vs 7.1%, p = .01). Combination of multiple mood stabilizers (lithium plus antiepileptics) was necessary in 22 (57.9%) OCD-bipolars, and in four (10.5%) cases the combination with atypical antipsychotics (clozapine, olanzapine, risperidone) was required. Finally, OCD-bipolars tended to show more frequently residual symptomatology (63.16% vs 46.7%), and three (7.9%) patients required hospitalization as inpatients for the appearance of severe mixed episode.

Conclusions: The comorbidity between OCD and bipolar disorder is a substantial clinical issue affecting a large number of patients. Our data suggest that this complex comorbidity has a differential impact on the clinical characteristics and treatment outcome of both disorders. When antidepressants are used in bipolar-OCD patients, SSRIs should be preferred to clomipramine and started after an adequate mood stabilization has been achieved.

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SCIENTIFIC AND CLINICAL REPORT SESSION 10—PSYCHOPHARMACOLOGY TOXICITIES

No. 29
MYOTOXICITY AND NEUROTOXICITY DURING CLOZAPINE TREATMENT

Ilya Reznik, M.D., *Research Department, Ness-Ziona Mental Health Center, p o box 1, Ness-Ziona 74110, Israel;* Roberto Mester, M.D., Lior Volchek, M.D., Moshe Kotler, M.D., Ida Sarova-Pinchas, M.D., Baruch Spivak, M.D., Abraham Weizman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to increase the clinicians' awareness about the possible myotoxicity and neurotoxicity during clozapine treatment. At the conclusion of this presentation, the participant should be able to recognize the signs of myotoxicity and neurotoxicity in clozapine-treated schizophrenic patients.

SUMMARY:

Objective: Recent studies have shown that clozapine (CLZ) has myopathic side effects and causes alterations in motor force control. The aim of this study was to evaluate the neurological and electrophysiological characteristics of schizophrenic patients on long-term CLZ treatment.

Patients and methods: 94 schizophrenic patients treated with CLZ for 18.2 ± 15.5 months were studied retrospectively and prospectively (40% and 60%, respectively) for serum creatine kinase (CK) levels before and after initiation of CLZ treatment. An electrodiagnostic study was performed on patients with CK elevation above normal limits who complained of general weakness, muscular pains, and/or had abnormal clinically significant findings.

Results: In 13 patients (13.8%), abnormal CK levels were found. Six patients complained of some muscular weakness. In two patients

clinical assessment revealed mild general muscular weakness; one revealed decreased tendon reflexes and in both, the CK levels were above 1750 IU/L. On electrophysiologic examinations performed in the six patients with abnormal neurological findings, the motor and sensory nerve conduction velocity were within normal range in all except one patient who exhibited some prolongation of distal latency in the lower limbs. In two patients the electromyography demonstrated a myopathic pattern.

Conclusions: In 2.1% of medically healthy schizophrenic patients treated with clozapine on a long-term basis, signs of myotoxicity were found. It seems warranted to discontinue the CLZ therapy in patients who exhibit abnormal CK levels and myopathic features during the treatment. Further studies are needed in order to provide more objective data on the impact of CLZ treatment on muscular tissue.

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2. Meltzer HY: Neuromuscular dysfunction in schizophrenia. Schizophr Bull 1976;2:106–135.

No. 30
OLANZAPINE AND NMS: CASE REPORT AND LITERATURE REVIEW

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of DSM-IV criteria for NMS, recognize that atypical antipsychotics can induce typical NMS in susceptible patients, understand the need for careful monitoring during the initial stages of treatment with antipsychotic agents.

SUMMARY:

Background: Neuroleptic malignant syndrome (NMS) is a rare and potential life-threatening complication associated with the use of atypical antipsychotics. The case presented is of a 29 y/o male patient suffering from schizophrenia, treated with olanzapine and lithium carbonate, and developing NMS during the first two weeks of treatment. DSM-IV criteria have been used, and of special note were extremely high levels of CPK (59,212 U/L), by far the highest level described by the literature.

Method: A Medline search yielded eight cases of NMS associated with the use of olanzapine, while five other cases were obtained from the Neuroleptic Malignant Syndrome Information Service (NMSIS) database. A total of eight cases met DSM-IV criteria for NMS. Relevant demographic variables, clinical presentations, and concomitant use of other psychotropic agents were compared among the sample and with typical antipsychotics.

Conclusions: Olanzapine can induce NMS in susceptible patients. Although in patients with prior NMS episodes the use of atypicals is recommended, there appears to be a risk of recurrence of NMS. The current concepts regarding pathophysiology, risk factors, and treatment of NMS are discussed in the light of the case presented.

REFERENCES:

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No. 31
A CASE OF KETAMINE PSYCHOSIS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize and diagnose ketamine intoxication and to distinguish it from other psychotic deliria. The participant should be able to delineate the probable specific pharmacological treatment of this delirium based on neurotransmitter interaction.

SUMMARY:

Objective: To describe the diagnosis of ketamine intoxication, to heighten awareness of it as a public health problem in emergency psychiatry, and to argue the utility of making the testing for its presence available in emergency rooms.

Method: The presentation urilizes an interdepartmental (with emergency medicine) case and a review of the literature. Included in this are its mechanism of action, its pathophysiology, the epidemiology of its use, the available methods for determining its presence in patients, and the specific pharmacologic agents that are most likely to reverse its psychotic effects.

Results: Ketamine intoxication is not clinically distinguishable from phencyclidine intoxication except by its shorter duration. But the most likely effective pharmacologic treatments are not the same. At present phencyclidine use is many more times common than ketamine use, but the latter is increasing in large urban centers. Ketamine intoxication can also be fatal. Its presence can be detected by gas chromatography with mass spectroscopy (GCMS) and by high-pressure liquid chromatography (HPLC) neither of which is routinely available in emergency rooms.

Conclusion: Despite the expense of detection, the severity of intoxication, the increase in use, and the concentration in definable geographic areas justify at least central testing capacity in afflicted cities.

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2. Weiner A, Viera L, McKay C, Bayer M: Ketamine, abusers presenting to the emergency department; a case series. Journal of Emergency Medicine 2000; 18:447–451.

SCIENTIFIC AND CLINICAL REPORT SESSION 11—ADDICTION PSYCHIATRY

No. 32
POLYMORPHISMS IN THE 5HT TRANSPORTER GENE AND COCAINE DEPENDENCE

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the importance of genetic factors in cocaine dependence, in particular the possible association between genetic variations in the serotonin transporter and susceptibility to cocaine dependence.

SUMMARY:

Objective: Considerable evidence indicates that serotonergic (5-HT) mechanisms may be involved in cocaine use. The serotonin transporter (5HTT) plays an important role in 5HT neurotansmission by regulating the magnitude of serotonergic responses. We investigated whether allelic variants in the promoter region of the 5HTT gene may confer susceptibility to cocaine dependence (CD).

Method: 202 cocaine-dependent (CD) African-American subjects and 98 controls were studied. Polymerase chain reaction based genotyping of a biallelic repeat polymorphism in the 5′ promoter region (5-HTTLPR) was performed. Genotype distribution and allele frequencies were compared using chi square tests and odds ratios.

Results: Two alleles of the 5′ region containing 484 (S) and 528 bp (L) repeats were detected. Interestingly, frequency of the L allele (65.0%) was significantly higher while the frequency of the S allele (35.0%) was significantly lower among CD patients compared with controls (L = 53.9%, S = 46.1%) ($\chi^2 = 6.83$, df = 1, $p < 0.01$; odds ratio = 1.66). Similarly, CD patients showed a significant excess of the LL genotype (41.1%) and less of the SS genotype (11.2%) compared with controls (LL = 29.7%, SS = 21.8%) ($\chi^2 = 7.43$, df = 2, $p<0.05$). There were no significant correlations between age and gender and L allele frequencies.

Conclusion: The results indicate a possible association between the long allelic variant of 5-HTTLTR and cocaine dependence. Further studies with larger sample sizes are required to confirm these findings. (Funded in part by NIDA grant # DA340-02).

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No. 33
ADDICTIONS PSYCHIATRY AND TREATMENT OUTCOMES IN A THERAPEUTIC COMMUNITY

Gregory C. Bunt, M.D., *Department of Psychiatry, New York University-Daytop Village Inc., 500 8th Avenue, New York, NY 10018;* A. Jonathan Porteus, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the vital role of the addictions psychiatrist in the therapeutic community and demonstrate knowledge of the treatment outcomes of medicated residential clients versus nonmedicated clients.

SUMMARY:

The last decade has seen a resurgence of treatment in residential therapeutic communities and an increased role for the addictions psychiatrist. As a result, therapeutic communities are increasingly incorporating medication into the multimodal therapies that they offer, and some (modified therapeutic communities) have been created exclusively to serve dually diagnosed/MICA patients. In this paper, the authors will elucidate the role of the addictions psychiatrist in a non-MICA therapeutic community by focusing on the impact of psychotropic medication on treatment outcomes for patients receiving medications (n = 100) compared with a sample of residential patients from a cohort not receiving medications (n = 1400). Treatment outcomes include retention, post-treatment abstinence, patients' involvement in treatment, drug use and craving during and after treatment, and level of psychological distress during and after treatment. This study uses data from a continuous outcomes protocol conducted in the residential therapeutic community treatment facilities of the largest substance abuse treatment provider in New York State. The protocol repeatedly assesses patients at intake, throughout treatment, at discharge, and at three months post-treatment.

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No. 34
SPIRITUALITY IN THE DETOXIFICATION PHASE OF SUBSTANCE ABUSE TREATMENT

Camilo A. Martin, M.D., *Department of Psychiatry, VAMC - Gainesville, 1601 SW Archer Road, Gainesville, FL 32608;* Charlie A. Gass, D.M., Alice T. Allen, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand a concrete and practical approach to recovery spirituality during detoxification, intervention, and treatment of substance abuse; to recognize the connection between recovery spirituality and internal values that affect self-esteem, behavior modification, and treatment.

SUMMARY:

Objective: Spirituality is integral to substance abuse treatment (e.g., 12-step model). Yet medical literature on detoxification—the initial step in recovery—rarely mentions spirituality playing any part in its management. This is surprising since (1) theologians view crises as fertile ground for spiritual awakening and (2) peri-detoxification events—social, medical, legal—reveal detoxification to be crisis intervention at its best. This study explores an introduction of spirituality in detoxification.

Method: 72 male and two female veterans admitted to the acute psychiatric inpatient unit of a Veterans Affairs hospital for detoxification from ethanol and/or cocaine were interviewed by a pastoral psychotherapist/chaplain. A spiritual assessment (SA) designed for this study had patients rate (0–10 scale) the importance of spirituality, accountability, forgiveness, trust, tolerance, relationships, and discipline. Change scores between initial and follow-up SAs on each dimension were combined into a 10-item composite change index.

Results: Introducing spirituality in early detoxification (0–8 days) produced a large positive shift in values compared to late introduction (>8 days). Average change for early introduction: 8.5, late introduction: 1.17, a statistically significant difference ($t = 2.022$, df = 72, $p < .05$).

Conclusions: Spiritual therapeutic interventions during detoxification may facilitate the vital incorporation of spirituality in subsequent recovery phases.

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SCIENTIFIC AND CLINICAL REPORT SESSION 12—PREDICTORS IN SCHIZOPHRENIA

No. 35
WHAT PREDICTS FUNCTIONING ACROSS 10 YEARS OF SCHIZOPHRENIC ILLNESS?

Ellen S. Herbener, Ph.D., *Department of Psychiatry, University of Illinois, 1601 West Taylor Street, M/C 912, Chicago, IL 60612;* Martin Harrow, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to identify what premorbid characteristics are particularly useful in predicting psychosocial functioning abilities and level of symptomatology for their schizophrenic patients. This information could also be used to help design effective rehabilitation programs for individuals with schizophrenia.

SUMMARY:

Objective: Major indices of premorbid functioning were compared to determine which premorbid characteristics of schizophrenia best predict psychosocial functioning and symptoms 10 years later.

Method: 123 schizophrenia and schizoaffective patients were studied at index hospitalization and reassessed longitudinally two years, 4.5 years, 7.5 years, and 10 years later. Premorbid social and work functioning, educational attainment, and demographic information was collected at index. We studied specific measures of rehospitalization, social functioning, work functioning, and symptom severity (including positive symptoms, negative symptoms, and depression) at each follow-up over 10 years.

Results: Premorbid work functioning was a significant predictor of later symptoms, work functioning, and global functioning across all four follow-up assessments (all $p < .05$) even after controlling for age of onset, parental education, and social class. Premorbid social functioning predicted some, but not all, major aspects of later functioning.

Conclusions: Although premorbid social functioning is often considered an important indicator of later functioning abilities for individuals with schizophrenia, premorbid work functioning is an even stronger predictor of adjustment. The data suggest that success at work requires intellectual and organizational capacity and motivation as well as interpersonal skills and thus may be a better index of the variety of skills that contribute to long-term psychosocial adjustment.

This research was supported by grant MH-26341 from the National Institute of Mental Health.

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No. 36
PERINATAL BRAIN DAMAGES AND SLOWER DEVELOPMENT INTERACT AS RISKS FOR PSYCHOSIS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this session participants will be familiar with the notion of early life risks for schizophrenia and the possibility of effect modification or interaction in their action.

SUMMARY:

Epidemiological research regarding psychosis, pregnancy and delivery complications, and developmental delay yields contradictory results partly because damaging exposures are poorly defined. Evidence suggests that survivors of perinatal injury are at increased risk of schizophrenia. Perinatal complications may be associated with schizophrenia only when intervening development is attenuated. In the North Finland 1966 birth cohort, 11,017 subjects were studied from mid-gestation over three decades. Perinatal brain damage (PBD) was defined from contemporary pregnancy and birth records. Developmental milestones were assessed at 12 months of age. A national case register and chart review yielded DSM-III-R diagnoses to age 30; 89 had schizophrenia. There was major effect modification. A specific, strong association between PBD and schizophrenia was seen only in subjects with later walking (odds ratio 11.8, $p < 0.001$). No psychosis occurred following PBD with early milestones. This is a startling result. Perinatal injury may be related to schizophrenia only where it causes developmental effects. Alternatively, there may be a necessary interaction between PBD and genetic risk for psychosis, manifest here by attenuated development; we are investigating this. Developmental protection is feasible. Exposures must be precisely defined to avoid misleading results.

Funding: Stanley and Sigrid Juselius Foundations, Academy of Finland

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No. 37
SOCIAL SEQUELS OF MENTAL DISORDERS IN THE 1966 NORTH FINLAND BIRTH COHORT

Matti K. Isohanni, M.D., *Department of Psychiatry, University of Oulu, P.O. Box 5000, Peltolantie 5, Oulu 90014, Finland;* Irene Isohanni, M.Ed., Peter B. Jones, Ph.D., Tim J. Croudace, Ph.D., Marjo-Riitta Jarvelin, M.D., Jari Jokelainen, B.S.C., Kaisa Riala, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to realize that severe mental disorders truncate educational and occupational achievements. These failures may contribute to the "social exclusion" of the mentally ill through reduced opportunities in later occupational life and failure to accumulate social capital.

SUMMARY:

Many studies link educational and occupational failures with mental disorders. We studied the association between educational and occupational performance and hospital-treated mental disorders experienced by the Northern Finland 1966 Birth Cohort (n = 11,017). Educational attainment until the age of 31 was divided into basic, secondary, and tertiary education, and occupation into full-time employment, being on sick leave or student, and retired. By the end of 1997, 80 subjects had schizophrenia, 52 had other psychoses, and

227 had nonpsychotic disorders. They were compared with those having no such hospital treatment (n = 10,222).

People with early-onset disorder stagnated in the basic educational level. Early-onset schizophrenia and all nonpsychotic cases had 3- to 6-fold adjusted odds for this outcome. Many with early onset psychoses completed secondary education, but few the tertiary level. A total of 50%–90% of cases with psychiatric diagnosis severe enough to need hospitalization were not in occupational life at age 31.

Severe mental disorder truncate education. However, later occupation seems to be more critical cause in social underachievements. Failure to enter into modern, demanding occupational life may contribute to the "social exclusion" of the mentally ill through failure to accumulate social capital.

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TUESDAY, MAY, 8, 2001

SCIENTIFIC AND CLINICAL REPORT SESSION 13—ISSUES IN CROSS-CULTURAL PSYCHIATRY

No. 38
BODY DISSATISFACTION AND BMI ACROSS ETHNIC GROUPS

Alayne Yates, M.D., *Department of Psychiatry, University of Hawaii, 1319 Punahou Street, 6th Floor, Honolulu, HI 96826;* Jeanne Edman, Ph.D., Mara Aruguete, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to recognize differences in body satisfaction between various ethnic groups living in Hawaii to understand particular stressors that generate body dissatisfaction in Filipino males living in Hawaii, and the complexity of the relationship between BMI and body satisfaction.

SUMMARY:

Higher body mass index (BMI) is a strong determinant of body dissatisfaction and an established risk factor for eating disorders. This suggests that typically petite Japanese females should be less body dissatisfied than heavier African-American or Samoan women living in Hawaii.

Objective: To explore the relationship between BMI and body dissatisfaction across ethnic groups.

Method: 211 Caucasian, 155 Japanese, 112 African-American, 79 Filipino, 70 Chinese, 70 Hawaiian/part Hawaiian, and 124 multiethnic college students completed Figure Drawings (index of body-dissatisfaction); SLSS, (self-loathing, innovative, exercise-based scale); Eating Disorder Inventory-2; and symptom self-report.

Results: Self-loathing was highly correlated with body dissatisfaction, EDI, and ED symptoms. BMI was correlated with self-loathing for males ($p < .0001$) and females ($p < .0001$) and with body dissatisfaction for males ($p < .0001$) and females ($p < .0001$). Highly significant BMI/ethnic group differences emerged. BMI range was: *males:* Filipino 28.37 to Chinese 21.70; *females* Afro American 24.97 to Chinese 19.35, yet there were no ethnic differences in self-loathing or body dissatisfaction. Japanese females scored low on BMI, yet high on self-loathing and body dissatisfaction, suggesting an exceptionally high risk for ED.

Conclusion: BMI does not necessarily indicate ED risk in other ethnicities.

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No. 39
CREATIVITY AS A RESOURCE FOR MOVING FROM TRAUMA TOWARD CONNECTION

Carol L. Kessler, M.D., *Department of Psychiatry, Mount Sinai Hospital/Adolescent Health Center, 320 East 94th Street, New York, NY 10128*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize unique clinical issues relevant to political violence and appreciate the potential for group therapy that employs such creative techniques as story-telling, dramatization, and mask-making to spark narrative that fills spaces of silenced terror.

SUMMARY:

The challenge chosen by remote Salvadoran villagers as their mental health priority during the community's transition toward peace was early childhood intervention. A project was established wherein volunteer, barely literate women head "kindergartens" for youth, aged 3 to 8. The presenter offered a mental health component by introducing a workshop that stimulates creative expression first among the women and later within the kindergarten class. This workshop was modeled after interventions developed in the aftermath of political terror in Argentina and in Guatemala. Critical issues stemming from the workshop included the women's unresolved traumatic memories and the tension between a desire to silence and forget and a need to find their voice and tell their story. The sparks of creativity, once kindled, provided a web around which to spin tales and a zest for play that easily spread to the children. The hope is that the children's capacity to connect in play, story, and symbol will be stimulated, and their resilience will thereby be fortified.

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1. Martin-Baro I: Political violence and war as causes of psychosocial trauma in El Salvador, Journal Of La Raza Studies 1988; 12:1.
2. Winnicott DW: Playing and Reality. London and New York, Tavistock/Routledge, 1971.

No. 40
HYPERSEXUALITY IN HASIDIC-JEWISH INPATIENTS

Nancy J. Needell, M.D., *Department of Psychiatry, New York Presbyterian Hospital, 525 East 68th Street, Box 140, New York, NY 10021;* John C. Markowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that patients from ultra-religious Jewish backgrounds exhibited hypersexual behavior at rates exceeding that of non-hasidic Jews in one study.

SUMMARY:

Objective: To review whether Hasidic Jewish patients were found to display hypersexual behavior at rates greater than non-Hasidic patients.

Method: Charts of all patients admitted to an inpatient service in one calendar year were reviewed to locate all Hasidic patients (n = 26), who were then paired with a gender/diagnosis/age matched non-Hasidic patient from the same year. These 52 charts were then reviewed in their entirety for evidence of hypersexual behavior.

Results: 69% of Hasidic males and 58% of all Hasidim showed evidence of hypersexual behavior, compared with 19% of both non-Hasidic males and all non-Hasidic comparisons.

Conclusion: Hasidic male patients showed more evidence of hypersexual behavior than non-Hasidic comparison patients.

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SCIENTIFIC AND CLINICAL REPORT SESSION 14—CHILD AND ADOLESCENT DIAGNOSTIC ISSUES

No. 41
DIAGNOSTIC EFFICIENCY 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., William S. Edell, Ph.D., Thomas H. McGlashan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand: 1) how to use conditional probabilities to determine diagnostic efficiency of symptoms, 2) the differences between adolescents and adults with respect to diagnostic efficiency of BPD criteria, and 3) the implications thereof for our understanding of borderline psychopathology in adolescents.

SUMMARY:

Objective: To examine the diagnostic efficiency of borderline personality disorder (BPD) criteria in consecutively admitted adolescent inpatients. For comparison, diagnostic efficiency of BPD criteria was also examined in consecutively admitted adults.

Method: One hundred eighteen adolescents and 105 adults were reliably assessed with the Personality Disorder Examination, a semi-structured diagnostic interview for DSM-III-R personality disorders. Fifty-four adolescents and 50 adults met diagnostic criteria for BPD. Conditional probabilities—sensitivity, specificity, positive predictive power (PPP), and negative predictive power (NPP)—were calculated to determine which BPD criteria were most efficient as inclusion criteria, as exclusion criteria—and which were most efficient overall. Adolescents and adults were analyzed separately, and results were compared.

Results: There were no differences between groups with regard to the base rates of any BPD criteria. The best inclusion criteria (highest PPP) for both groups were "abandonment fears" and "unstable relationships." "Uncontrolled anger" and "chronic boredom" had the most utility as exclusion criteria (highest NPP) for adolescents—though not for adults. Interestingly, the most efficient overall criterion for the adolescents was "identity disturbance."

Conclusions: In hospitalized patients, BPD symptoms and diagnosis appear to be as frequent for adolescents as for adults. Despite many similarities between groups with respect to the diagnostic efficiency of individual BPD criteria, some differences exist that may shed light on the nature of borderline pathology during adolescence.

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No. 42
OVERLAP BETWEEN CHILD DEPRESSIVE INVENTORY AND PROJECTIVES IN UNCOVERING A CHILD'S DEPRESSION

Sidney Fein, M.D., *Department of Psychiatry, Cornell-New York Methodist, 517 6th Street, Brooklyn, NY 11215;* Delrita Abercrombie, Ph.D., Chaneve Jeanniton, B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate how projectives can increase the accuracy in diagnosing depression in children and recognize depressive symptoms in children that may go unnoticed in the more traditional use of nonpsychoanalytic techniques.

SUMMARY:

Childhood depression is often underdiagnosed due to the child's tendency to direct attention away from depression through defenses such as denial, fantasy, or acting out behavior. On self-rating scales, children often deny depression and suicidal ideation. Thus clinicians are advised to integrate findings from self-ratings, projective tests, and behavioral observations into a total evaluation of the child. This study intends to prove that fantasy material should be given more weight diagnostically because children are often unable to verbalize depression on a conscious level.

Seventy-six children from the ages of 7 to 15 with behavioral and learning disorders were evaluated at an outpatient clinic. Each child was assessed for depression and suicide. In this group, 38% were depressed on the CDI. Of these 29 children, 9% had depressive signs on the HTP and 2% had depressive signs on the TAT. In the group that denied depression, 28% had depressive signs on the HTP and 6% had depressive signs on the TAT. On the CDI, 26% of the children had suicidal ideas and 12% had suicidal statements on the TAT. The use of projectives improved the clinician's ability to detect depressive and suicidal signs in children who denied both on self-rating scales.

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No. 43
COMORBIDITY IN CONDUCT DISORDER: GENDER AND AGE DIFFERENCES

Atilla Turgay, M.D., *Family Medicine, University of Toronto, 251 Queens Quay West, #701, Toronto, ON M5J 2N6, Canada;* Ozlem

Erman, M.D., Bedriye Onch, Rubaba Ansari, M.A., Verka Urdarevic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to increase the knowledge of the psychiatrists and other physicians and mental health therapists on the nature of comorbid disorders associated with conduct disorder to improve the treatment outcome.

SUMMARY:

Objective: To study gender and age differences in comorbidity in children and adolescents with conduct disorder (CD)

Methods: The sample consisted of 204 males and 41 females (age range: 4–19) who met the DSM-IV diagnostic criteria for conduct disorder. Offord and Boyle's Ontario Child Health Study Rating Scales and DuPaul (1991) ADHD Rating Scale were also used to support the diagnosis.

Results: ADHD and mood disorders were found very commonly in patients with CD. ADHD was more common in males (94.1%) than in females (82.2%) ($p = 0.014$). The frequency of ADHD decreased in adolescence (in children: 94.5% in adolescence: 77%) ($p < 0.01$). Dysthymic disorder or major depression were found in 18.4% of patients. Mood disorders were more common in females than in males (36.6% vs 14.7%; $p = 0.001$). In both genders, the frequency of mood disorders increased with age. The most common ADHD subtype was combined type (males: 86.9%, females: 97.1%). No statistically significant gender differences were found in the distribution of ADHD subtypes. Conduct disorder alone without comorbidities was found to be an exception.

Conclusions: The early identification and treatment of associated comorbid disorders in patients with CD may improve the outcome.

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SCIENTIFIC AND CLINICAL REPORT SESSION 15—TREATMENT ISSUES WITH SSRIS

No. 44
SILDENAFIL CITRATE IN SSRI ANTIDEPRESSANT TREATMENT EMERGENT SEXUAL DYSFUNCTION

H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 2600 Marble Avenue, NE, Albuquerque, NM 87131;* Alan J. Gelenberg, M.D., Maurizio Fava, M.D., Paula L. Hensley, M.D., John Lauriello, M.D., Wilma M. Harrison, M.D., Richard L. Siegel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to inform physicians about the efficacy of sildenafil for management of antidepressant-associated sexual dysfunction.

SUMMARY:

Objective: To report a multicenter, double-blind, placebo-controlled with extension phase study of sildenafil for SSRI-antidepressant [AD]-associated sexual dysfunction [SD].

Methods: Ninety men with clinically recovered major depression and serotonergic-AD associated SD were randomly assigned to placebo or sildenafil for six weeks double-blind treatment and 17 weeks open-label continuation. Subjects had to be without preexisting sexual dysfunction, minimum eight weeks stable antidepressant dose continued for study duration, HAM-D&A < 10, and significant SD by IIEF, MGH and ASEX sexual function inventories. Sildenafil dose was 50 or 100 mg. CGI-SF (primary), ASEX/MGH (self/clinician-rated) at baseline, 2, 4, 6 weeks, and IIEF at baseline/6 weeks evaluated SD for all domains and overall satisfaction.

Results: SD was multidimensional. Sildenafil demonstrated highly significant improvement in sexual function on primary CGI-SF measures (2.2 v. 4.3; $p < .004$) and secondary ASEX/MGH measures (19.8/20.3 to 13.6/13.8 for sildenafil; 19.7/21.4 to 21.2/22.6 for placebo; $p < .002$) from baseline to week six. Individual ASEX/MGH/ IIEF SD items showed significant improvement ($p < .004$–008). Very/much/improved was 75%/11% for sildenafil/placebo subjects. HAM-D remained <10 without significant sildenafil/placebo differences; responders 4.8 to 3.9, nonresponders 5.3 to 5.6. Open-label sildenafil crossover showed significant improvement for initial nonresponders.

Conclusion: Sildenafil was effective for reversing SRI-antidepressant-associated sexual dysfunction. Subjects continued the antidepressant and dose that effectively treated their depression. Previous reports of sildenafil efficacy for SRI/antidepressant SD are confirmed.

Funding was from Pfizer, Inc.

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No. 45
DO THE SSRIS MAKE YOU "BETTER THAN WELL"?

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to delineate the degree to which the SSRI antidepressant medications do and do not alleviate abnormalities of mood and personality, based on a review of relevant data from over a decade of research.

SUMMARY:

Objective: Following the 1993 publication of Dr. Peter Kramer's book, Listening to Prozac, patients commonly enter treatment with the belief that fluoxetine and other SSRIs will make them "better than well." Dr. Kramer's vivid tales of patients' early responses to SSRIs reported profound medication responses, even personality transformations, suggesting that better-than-normal psychic states were a common outcome.

Method: Review of psychiatric studies over the 12 years since the introduction of SSRI medications.

Results: Epidemiological studies have demonstrated the psychosocial and personality impairment resulting from mood disorders, particularly chronic and recurrent subtypes. Psychopharmacological studies have demonstrated the degree of symptom response to SSRIs is similar to other classes of medications. The interrelationship between depression and temperament has been described, particularly by Robert Cloninger and colleagues. The impact of SSRIs on Axis

II disorders has been investigated (Coccaro and Kavoussi, 1997), as has the effect of the SSRI paroxetine on the personalities of nondepressed normals (Knutson et al., 1998). More recently, studies of major depression (Eskelius and von Knorring, 1997) and dysthymia (Hellerstein et al., 2000) have described the impact of SSRIs on personality in depressed individuals.

Conclusion: Studies suggest that personality impairment is often a significant consequence of chronic and recurrent depression and that SSRIs may partially alleviate such abnormalities. While scores often change in the direction of normality, it is extremely rare for individuals to become "better than well."

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2. Hellerstein DJ, Kocsis JH, Chapman D, et al: Double-blind comparison of sertraline, imipramine, and placebo in the treatment of dysthymia: effects on personality. American Journal of Psychiatry 2000; 157:1436–1444.

No. 46
CHOLESTEROL LEVELS DECREASE WITH FLUOXETINE TREATMENT OF MDD

Shamsah B. Sonawalla, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston, MA 02114;* Lindsay M. Dececco, B.A., Johanna A. Gordon, B.A., Joyce R. Tedlow, M.D., David Mischoulon, M.D., Jerrold F. Rosenbaum M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the end of this presentation, the participant should be able to recognize that patients with major depressive disorder may have elevated cholesterol levels, which may be a correlate of either increased stress or poor nutrition and which may improve to some extent following treatment with an antidepressant.

SUMMARY:

Objective: Research suggests that patients with major depressive disorder (MDD) may have significant differences in cholesterol levels compared with healthy controls. In a previous study, we reported that elevated serum cholesterol levels were associated with a poorer response to fluoxetine treatment among outpatients with MDD. The purpose of this study was to examine the degree of change in cholesterol levels among depressed outpatients with partial or nonresponse to eight weeks of treatment with fluoxetine.

Methods: 322 outpatients with major depressive disorder (MDD) diagnosed by the SCID-P and with a HAM-D-17 score ≥ 16 entered an eight-week open treatment study with fluoxetine 20 mg/day. Nonfasting serum cholesterol levels were assessed for all patients before they started treatment. Of the 322 outpatients, 101 (48.5% women; mean age: 41.2 ± 10.7 years) were either nonresponders (≤25% decrease in HAM-D-17 scores, with a HAM-D-17 score of ≥ 16 at endpoint) or partial responders (>25% and <50% decrease in HAM-D-17 scores at endpoint/week 8) to fluoxetine: post-treatment nonfasting cholesterol levels were also assessed in this subgroup of depressed outpatients.

Results: Of the 101 outpatients, 52.5% (n = 53) were nonresponders and 47.5% (n = 48) were partial responders to fluoxetine. Of these, both pre-treatment and post-treatment cholesterol levels were available for 73 patients. We found that cholesterol levels decreased slightly, but significantly, from a mean of 215.4 ± 48.1 before treatment to a mean of 208.3 ± 46.5 ($t = 2.1$; $p < 0.05$) after eight weeks of open treatment with fluoxetine. There was no significant difference in the degree of change in cholesterol levels among partial responders and nonresponders to fluoxetine. There was also no relationship between the degree of improvement in depression and the degree of change in cholesterol levels from baseline to endpoint.

Conclusion: Our study suggests that cholesterol levels decrease slightly but significantly among depressed outpatients with partial or nonresponse to fluoxetine treatment. Elevated cholesterol level among patients with major depression may be a state marker of increased stress or poor nutrition, which improves to some extent following treatment.

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SCIENTIFIC AND CLINICAL REPORT SESSION 16—HISTORY OF GERIATRIC PSYCHIATRY

No. 47
ANTIPSYCHOTICS IN GERIATRIC PSYCHIATRIC PATIENTS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to explain factors in choice of antipsychotics in geriatric patients.

SUMMARY:

Objective: To determine in a sample of geriatric inpatients the proportion for whom antipsychotics are prescribed and the variables associated with use of an atypical agent.

Method: The authors prospectively monitored the pharmacotherapy of all admissions to a psychiatric inpatient service from January–June 2000. Data from 1996 were retrospectively obtained to compare prescribing practices.

Results: An antipsychotic medication was prescribed for 164 of 208 admissions (78.8%) ≥ 65. Of this group, 85.4% (140) received an atypical agent. The most common diagnoses were dementia (40.9%), major depression (22.4%), schizophrenia, and bipolar disorder. Patients with schizophrenia were more likely to be treated with a typical antipsychotic than were patients with other diagnoses (52.4% vs 23.1%, $p < .01$). Geriatric patients were just as likely as other patients to receive an atypical agent and were less likely to receive more than one antipsychotic concurrently (4.3% vs 12.8%, $p < .01$). Among patients with a diagnosis of dementia or major depression, a larger proportion of the 2000 vs. the 1996 sample received antipsychotics (95.7% vs 65.7%, $p < .001$ and 59.0% vs 36.1%, $p < .05$, respectively).

Conclusions: For this sample, atypical agents were preferred; diagnosis but not age was associated with drug choice. Use of atypicals was much less frequent in patients with schizophrenia. Compared with four years ago antipsychotics, principally atypicals, are more frequently used in depression and dementia.

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2. Maixner SM, Mellow AM, Tandon R: The efficacy, safety, and tolerability of antipsychotics in the elderly. J Clin Psychiatry 1999; 60(Suppl. 8):29–41.

No. 48
CEREBRAL HEMODYNAMICS AND DEPRESSION IN THE ELDERLY

Henning Tiemeier, M.D., *Department of Epidemiology, Erasmus University, P O Box 1738, Rotterdam 3000-DR, Netherlands;* Stef L.M. Bakker, M.D., Peter J. Koudstaal, Ph.D., Albert Hofman, Ph.D., Monique M.B. Breteler, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that depressive symptoms in the elderly can be caused by cerebrovascular disease. This 'vascular depression' hypothesis needs to be developed further and can be tested by assessing cerebral hemodynamics with transcranial doppler sonography in population-based studies.

SUMMARY:

Objective: To investigate the association between cerebral hemodynamics and depression in subjects aged 60 years and overutilizing transcranial doppler sonography.

Methods: In 2,093 men and women who participated in the third survey of the population-based Rotterdam Study we measured cerebral blood flow velocity and vasomotor reactivity in the middle cerebral artery. All subjects were screened for depressive symptoms using the Center for Epidemiological Studies Depression Scale and screen-positive subjects (CES-D score ≥16) had a psychiatric work-up. A distinction was made between subjects with subclinical depressive symptoms only and subjects with depressive syndromes. We controlled for age, gender, education, history of stroke, and cognitive score.

Results: Screen-positive subjects had reduced mean blood flow velocity (mean difference: −2.8 cm/s; 95%CI: −4.9; −0.6) and reduced vasomotor reactivity (mean difference: −0.6%/kPa; 95%CI: −1.1; − 0.1). Mean blood flow velocity was reduced particularly in subjects with depressive syndromes (mean difference: −5.1 cm/s; 95%CI: −8.5; − 1.6), whereas vasomotor reactivity was reduced in subjects with subclinical depressive symptoms (mean difference: −0.9%/kPa; 95%CI: −1.5; − 0.2).

Conclusion: Our findings suggest that in the elderly, reduced vasomotor reactivity may be a causal factor for depressive symptoms but not for depressive syndromes.

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No. 49
INTEGRATING END-OF-LIFE CARE WITH DISEASE MANAGEMENT PROGRAMS

Arthur L. Lazarus, M.D., *6830 Windham Parkway Prospect, KY 40059*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be familiar with barriers and opportunities for reorganizing care to patients near the end of life.

SUMMARY:

Approximately 40% of all expenditures during a person's last year of life are incurred within one month of death. Moreover, the proportion of expenditures related to end-of-life care has changed little over time. Given that the aging of Americans will bring far greater numbers of people with chronic, degenerative diseases than ever before into managed care organizations, there will be a need to develop responses to this demographic shift.

As managed care organizations assume this challenge, there is much they can offer through disease management (DM) and other medical management programs. Disease management's emphasis on chronic conditions, especially when applied to seniors, can be a powerful asset for enhancing the quality and quantity of life of the oldest and sickest members. Surprisingly, however, this initiative was not included among the many thoughtful suggestions of the National Task Force on End-of-Life Care in Managed Care.

DM case managers and health educators are in a position to interact directly with providers and patients and discuss end-of-life issues. The major issues for patients are: understanding their situation; communication and decision-making; advance planning, including do-not-resuscitate orders; and general support, including support for loss and grieving. Case managers participating in disease management programs, whether developed internally by managed care organizations or contracted through vendors, are empowered to conduct assessments, devise treatment plans, coordinate care, and facilitate access to end-of-life care services.

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SCIENTIFIC AND CLINICAL REPORT SESSION 17—HIV-RELATED ISSUES

No. 50
COLLEGE STUDENTS' PERCEPTIONS OF SELF AND OTHERS' RISK FOR HIV

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be aware of how college students' perceptions of risk of HIV infection for themselves and others varies by a number of factors.

SUMMARY:

Objective: College students are relatively knowledgeable about HIV risk behaviors. However, their perceptions of HIV risk are often not congruent with their self-reported behaviors. This study investigates college students' perceptions of risk of HIV for themselves and their peers.

Method: A random survey of undergraduate university students was conducted using the 53-item version of the Health Behaviors Questionnaire. Chi-square tests and analyses of variance were used to test group differences.

Results: Student personal HIV risk assessments are significantly lower than the HIV risk assessments they assign their college student peers. About 27% of students report that they are at "no risk" of

HIV infection, while 30% report they are at "great risk." Over half of students (50%) report that *other students* are at "great risk," and no students (0%) report *other students* are at "no risk." Differences in student-assessed risk for self and others vary by gender (for others) ($p < .001$), race/ethnicity ($p < .01$), dating status ($p < .01$), belief that partner is monogamous ($p < .001$), and alcohol and other drug (AOD) use ($p < .01$). Student sexual orientation was not related to assessment of risk, and depression was not associated with AOD use.

Conclusions: HIV prevention programs for college students are needed that strategically target students by group characteristics.

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No. 51
SERIOUSLY MENTALLY ILL PERSONS WHO ARE HIV POSITIVE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate knowledge about SMI persons who are HIV positive, their treatment patterns and risk behaviors, and unmet needs.

SUMMARY:

Because persons with serious mental illness (SMI) are at high risk for HIV infection, many SMI persons are already HIV+. Yet we know very little about these individuals, their treatment, or their HIV risk behaviors.

Methods: In 1999–2000, we sampled 154 HIV+ SMI (schizophrenia, bipolar, psychotic depression) persons from publicly funded mental health programs in Los Angeles, conducted structured interviews, and abstracted their charts.

Results: Subjects were predominantly male (84%) gay/bisexual (62%), and less than 45 years old (79%). Most (87%) were diagnosed with mental illness prior to becoming HIV+, and 55% had known their HIV status for more than five years. About 25% received their mental health and HIV treatment at the same site. The majority (92%) were taking psychotropic medications; 85% were on antiretrovirals. Not receiving antiretrovirals was associated with lack of insurance (OR = 6.3; p = .01), especially ADAP (OR = 10.2; p = .003) and not having AIDS (OR = 4.8; p = .01). Of the 56% who were sexually active, about 33% did not always use condoms, and of the 12% who used IV drugs, about 1/4 reported sharing needles.

Conclusions: Providers should target HIV+ SMI persons for assistance with insurance benefits and for interventions to reduce risk of HIV transmission to others.

REFERENCES:

1. Sullivan G, Koegel P, Kanouse DE, et al: HIV and people with serious mental illness: the public sector's role in reducing HIV risk and improving care. Psychiatric Services 1999; 50: 648–52.

No. 52
HIV, HEALTH CARE, AND MENTAL HEALTH OUTCOMES OF CHILDHOOD DISRUPTION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the role of developmental disruption in lives of patients with HIV and to utilize this knowledge in treatment planning and be aware of the complicated nature of developmental disruption and that it is more than simply physical or sexual abuse.

SUMMARY:

Developmental trauma has been found to be much more common among certain groups of HIV-positive people than in the general population. However, the relationship between adverse developmental circumstances and infection with HIV and adherence to HIV treatment has remained unclear.

Method: 30 (of a projected 100) patients of a clinic primarily serving gay, lesbian, and HIV+ people were assessed using the Childhood section of the Five-Site Health Risk Survey, the SF-36 Short Form Health Survey, and a semistructured psychiatric evaluation. Reviews of medical and pharmacy records are pending.

Results: Indices of developmental disruption (direct and witnessed abuse, parental or sibling addiction or mental illness, caregiver change) correlated with fewer hours of sleep (correl = 0.387, $p = .02$), more suicide attempts (correl = 0.501, $p = .004$); numbers of major developmental transitions correlated with years of imprisonment (correl = 0.646, $p < .0001$), and negatively with last grade completed (correl = –0.388, $p = .03$). Years since HIV+ diagnosis correlated with weeks without suicidal thoughts (correl = 0.581, $p = 0.01$). Subjects' assessments of their childhoods did not correlate significantly with mental health, health belief, or behavioral outcomes.

Discussion: Developmental disruption leads to adverse behavioral, mental health, and health outcomes in adult life; it has different effects than awareness of illness.

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SCIENTIFIC AND CLINICAL REPORT SESSION 18—TREATMENT OF SCHIZOPHRENIA

No. 53
PLACEBO-CONTROLLED TRIAL OF OMEGA-3 FATTY ACID IN SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be familiar with clinical trial data concerning efficacy of essential fatty acids as a treatment for schizophrenia and major affective disorders.

SUMMARY:

Background: Most patients with schizophrenia experience disabling residual symptoms and cognitive impairment despite medication. Open and small double-blind studies suggest adding omega-3 fatty acids to neuroleptic medications may enhance treatment response and improve residual symptoms.

Methods: Patients (N = 87) meeting criteria for schizophrenia/schizoaffective disorder who had significant residual symptoms of psychosis despite adequate neuroleptic treatment were randomized to eicosapentaenoic acid (EPA) 3 gms daily (N = 43) or placebo (N = 44) in a 16-week, double-blind, supplementation trial. Clinical assessments were performed at baseline and weeks 1, 2, 4, 8, 12, and 16; cognitive battery at baseline and week 16.

Results: Data for the intention-to-treat sample indicated baseline to week 16 mean total PANSS change score was −5.2 ± 9 (−7%) for EPA and −6.7 ± 11 for placebo patients; mean CGI-I score at week 16 (3.5 ± − 0.7) was identical for both groups. MANOVA indicated small statistically significant symptom improvement for both groups, but no time by treatment-group interaction. No difference was found between groups in cognitive tests or in any other clinical measure. Results were similar for the intention-to-treat (N = 87) and completer (N = 75) samples.

Conclusion: Results indicate EPA 3 gms daily for 16 weeks is no more effective than placebo in improving residual symptoms and cognitive impairments in treated patients with chronic schizophrenia. Further research is needed to evaluate potential treatment effects over longer periods and at earlier phases of illness.

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2. Puri BK, Richardson AJ: Sustained remission of positive and negative symptoms of schizophrenia after treatment with eicosapentaenoic acid (letter). Arch Gen Psychiatry 1998; 55:188–189.

No. 54
ATYPICAL ANTIPSYCHOTICS AND HOSTILITY IN SCHIZOPHRENIA: A DOUBLE-BLIND STUDY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that clozapine appears to have specific antiaggressive properties, and that neither risperidone nor olanzapine showed a superiority over haloperidol in reducing hostility.

SUMMARY:

Objective: To compare the specific antiaggressive effects of clozapine compared with olanzapine, risperidone, and haloperidol.

Method: Treatment-resistant inpatients (N = 157) with chronic schizophrenia or schizoaffective disorder were assigned to clozapine, olanzapine, risperidone, or haloperidol in a double-blind, randomized, 14-week trial. The trial consisted of Period 1 (8 weeks, escalation and fixed dose) and Period 2 (6 weeks, variable dose). The PANSS hostility item was the principal outcome measure. Covariates included the PANSS items that reflect positive symptoms of schizophrenia (delusions, suspiciousness/persecution, grandiosity, unusual thought content, conceptual disorganization, and hallucinatory behavior), and the NOSIE sedation item.

Results: The four treatment arms differed in their effect on the hostility item of the PANSS. Clozapine had significantly greater antihostility effect than haloperidol or risperidone. The effect on hostility appears independent of antipsychotic effect on other PANSS items that reflect delusional thinking, disorganized behavior, or hallucinations, and independent of sedation as measured by the NOSIE. Neither risperidone nor olanzapine showed a superiority over haloperidol.

Conclusion: Clozapine retains a relative advantage over other antipsychotics as a specific antiaggressive agent whose effects on hostility appears independent of its effects on other symptoms of psychosis, and of its sedative effect.

Funding Source: NIMH grant (R10 MH53550) provided the principal support for this project. Eli Lilly and Company contributed supplemental funding. Janssen Pharmaceutica Research Foundation, Eli Lilly and Company, Novartis Pharmaceuticals Corporation, and Merck and Co., Inc. provided medications.

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No. 55
FACTORS ASSOCIATED WITH MEDICATION ADHERENCE IN PERSONS WITH SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand factors associated with medication adherence and nonadherence in persons with schizophrenia.

SUMMARY:

Objective: This study reviewed data from the Patient Outcomes Research Team (PORT) to identify factors associated with medication adherence in persons with schizophrenia.

Methods: The PORT surveyed a random sample of 719 persons diagnosed with schizophrenia in two states in urban, rural, inpatient, and outpatient settings using medical record reviews and patient interviews. Factors associated with self-reported compliance ratings were evaluated using Pearson correlations analysis.

Results: Higher levels of medication adherence were associated with belief in the effectiveness of medications (i.e., belief that medications prevent getting sick, $p < .01$), satisfaction with mental health care (i.e., satisfaction with frequency of doctor's appointments, $p < .01$), and a satisfaction with life and emotional well-being (p's < .01). An additional set of factors associated with poor medication adherence included medication side effects (e.g., jitteriness ($p < .01$), interference with memory ($p < .05$), and interference with sex life ($p < .01$)), perceptions of poor mental health ($p < .05$), and increased psychiatric symptoms ($p < .01$). Substance use was also strongly associated with decreased medication compliance ($p < .01$).

Conclusions: Patients reporting greater satisfaction with treatment and mental health services were likely have higher levels of medication adherence, while those having negative treatment experiences as evidenced by side effects and uncontrolled symptoms were less likely to adhere. Future study might consider factors that could enhance patient satisfaction (such as medication type and dose, complexity of medication regimen) and thereby improve medication adherence.

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SCIENTIFIC AND CLINICAL REPORT SESSION 19—BIOLOGICAL ISSUES IN PSYCHIATRY

No. 56
SCHIZOPHRENIA AND BIPOLAR DISORDER: SPECIFIC AND COMMON SUSCEPTIBILITY LOCI

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EDUCATIONAL OBJECTIVE:

The participant should be able to better understand the methods used in psychiatric genetics for detecting susceptibility genes and the main difficulties challenging this objective. In particular, we will discuss the use of linkage analysis and evidence provided by family data that schizophrenia and bipolar disorder may share susceptibility genes.

SUMMARY:

Objective: We report the first stage of a genome scan of schizophrenia (SZ) and bipolar disorder (BP) covering 18 candidate chromosomal areas. In addition to testing susceptibility loci that are specific to each disorder, we also tested the hypothesis that some susceptibility loci might be common to both disorders.

Methods: A total of 480 individuals from 21 multigenerational pedigrees of Eastern Québec were evaluated by means of a consensus best-estimate diagnosis made blind to diagnoses in relatives and were genotyped with 220 microsatellite markers. Two-point and multipoint model-based linkage analyses were performed and mod scores (Z, for max Z_{max}) are reported.

Results: The strongest linkage signals were detected at D18S1145 (in 18q12; Z = 4.03) for BP, and at D6S334 (in 6p 22–24; Z_{het} = 3.47; = 0.66) for SZ. Three other chromosomal areas (3q, 10p, and 21q) yielded positive linkage signals. Chromosomes 3p, 4p, 5p, 5q, 6q, 8p, 11q, 18p and 22q showed no evidence of linkage.

Conclusion: The 18q12 results met the Lander and Kruglyak (1995) criterion for a genome-wide significant linkage and suggested that this susceptibility region may be shared by SZ and BP. The 6p finding provided confirmatory evidence of linkage for SZ. Our results suggest that both specific and common susceptibility loci must be searched for SZ and BP. We are currently renalyzing our data by using dimensional phenotypes in comparison to phenotypes based on classical diagnoses.

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No. 57
COMORBID PANIC DISORDER AS A MARKER OF GENETIC HETEROGENEITY IN BIPOLAR DISORDER

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the relevance of refinements of phenotype in increasing the heritability and reducing the genetic heterogeneity of complex psychiatric disorders, such as bipolar disorder.

SUMMARY:

Objective: Family (MacKinnon et al, 1997) and linkage (MacKinnon et al., 1998) data suggest that comorbidity with panic disorder (PD) defines a genetic subtype of bipolar disorder (BD). We hypothesized that comorbidity for PD may influence the strength of the association between BD and candidate genes. We have carried out a case-control association study of BD patients with (BDPD) or without (BDNPD) lifetime PD. As disturbance in CNS monoamine neurotransmission is of relevance in BD, we have analyzed polymorphic markers at catechol-O-methyltransferase (COMT), tryptophan hydroxylase (TPH) and serotonin transporter (5-HTT) genes, which are involved in monoamine neurotransmission.

Method: Unrelated subjects of Italian descent meeting DSM-III-R criteria for lifetime BD (111) with (49) or without (62) comorbid PD and 127 healthy controls were included in the study. DNA was extracted from blood leukocytes. COMT Val > Met, 5-HTTLPR and TPH IVS7 + 779C > A polymorphisms were analyzed as previously reported. Statistical comparisons were carried out using the chi-square test. Significance was set to $p < 0.016$ after threefold Bonferroni correction.

Results: As compared with controls, a significant increase in the frequency of COMT Met/Met, 5-HTTLPR SS and TPH IVS7 + 779AA genotypes and respective alleles was detected in BDNPD, but not in BDPD.

Conclusions: Our findings support the hypothesis that comorbid PD is a specific marker for a genetic subtype of BD.

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No. 58
ANTIBODIES TO PROTHROMBIN AND THROMBIN IN FIRST PSYCHOTIC EPISODE OF SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that antibodies to prothrombin are significantly decreased in first-episode schizophrenia patients and schizoaffective disorder patients.

SUMMARY:

Background: Immunological aberrations have been reported in patients with schizophrenia, but their significance remains unclear. Antiprothrombin antibodies have recently been linked to CNS manifestations of the antiphospholipid syndrome.

Objective: To measure the levels of antibodies to prothrombin and thrombin in patients with schizophrenia.

Methods: 96 subjects were assessed: 20 first-episode schizophrenic patients (SCZ1); 20 chronic schizophrenic patients in acute exacerba-

tion (SCZ2); 19 bipolar patients; 20 schizoaffective patients; and 17 healthy sex-matched and age-matched controls diagnosed by DSM-IV guidelines. Serum samples were tested for antibodies to prothrombin and thrombin in parallel by enzyme-linked immunosorbant assay.

Results: Antibodies to prothrombin (aPT) were significantly lower in SCZ1 and schizoaffective patients compared with controls ($p = 0.007$ and $p = 0.02$, respectively). Levels similar to controls were found in the SCZ2 and bipolar groups. Antibodies to thrombin were not detected in any of the samples tested.

Conclusions: Antibodies to prothrombin are significantly decreased in patients with first-episode schizophrenia and schizoaffective disorder. Possible explanations of these findings will be discussed.

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SCIENTIFIC AND CLINICAL REPORT SESSION 20—BIPOLAR DISORDERS

No. 59
PERCEPTIONS AND IMPACT OF BIPOLAR DISORDER: HOW FAR HAVE WE REALLY COME?

Lydia J. Lewis, *National DMDA, 730 North Franklin Street, Suite 501, Chicago, IL 60610*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to assess the experiences of individuals with bipolar disorder and compare to a 1992 survey of patients.

SUMMARY:

Objective: Assess the experiences of individuals with bipolar disorder and compare to a 1992 survey of patients.

Method: 4,192 questionnaires were sent to National Depressive and Manic-Depressive Association chapters for distribution to membership. 600 completed surveys were returned, giving a range of error of +/– 4.0% at the 95% confidence level.

Results: 69% of respondents have been misdiagnosed, most with depression (60%). On average, respondents are misdiagnosed 3.5 times, consult four physicians and experience symptoms for ten years before being accurately diagnosed. These findings show minimal improvement since 1992. Despite having under-reported manic symptoms, most blame their misdiagnosis on physicians' lack of understanding of bipolar disorder. In 2000, the illness had a more negative impact on respondents' relationships and employment than in 1992. Those prescribed the newer medications (clozapine, olanzapine, and risperidone) reported greater satisfaction with their doctor than those taking the older medications (carbamazepine, lithium, and valproate). Respondents highly satisfied with their treatment provider have a more positive outlook about their illness and ability to cope with it.

Conclusion: Individuals with bipolar disorder continue to encounter diagnosis, social, and employment problems, indicating a need for increased public and physician awareness.

Funded by an unrestricted educational grant by Eli Lilly and Company.

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No. 60
UNIPOLAR COMPARED WITH BIPOLAR DEPRESSION: SIMILAR DEPRESSIVE SUBTYPES

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the lack of a difference between the clinical presentations of unipolar and bipolar depression.

SUMMARY:

Background: The unipolar and bipolar depressions are distinct entities that need profoundly different short- and long-term treatments. Because of the treatment implications of the distinction between unipolar and bipolar depression, attempts have been made to identify differences in their clinical presentation; some studies have indicated that bipolar depression may present more frequently as an atypical subtype. The purpose of this study is to compare the subtypes of depression between unipolar and bipolar depression.

Methods: 185 outpatients were evaluated by SCID for current and lifetime diagnosis as part of a study of genetics and mood disorder funded by Millennium Pharmaceuticals, Inc. Seventy-four (40%) of the 185 patients were currently depressed. Differences between the proportions of atypical, melancholic, and neither subtype for currently depressed patients were compared with one-tailed Fisher's exact test.

Results: Twenty-six bipolar I and II and 48 unipolar patients were currently depressed. The proportion with atypical, melancholic, and neither subtype did not differ significantly between patients with bipolar compared with unipolar depression. Atypical depression was found in 27% and 21% for bipolar and unipolar depression, respectively (Fisher's exact $p = 0.38$); melancholic in 39% and 54% ($p = .15$); neither subtype in 31% and 25% ($p = .39$). Power to detect a 25% to 30% difference in proportions was .68 and .84, respectively.

Conclusions: These data suggest that bipolar and unipolar depression cannot be distinguished by clinical presentation of subtype.

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No. 61
COGNITIVE FUNCTION IN EUTHYMIC BIPOLAR PATIENTS, SCHIZOPHRENICS, AND CONTROLS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize abnormal cognitive function in bipolar disorder; evaluate the differential impact of cognition in the diagnosis of bipolar and in the diagnosis of schizophrenic disorder.

SUMMARY:

Objective: Studies on cognitive function in bipolar disorder have led to contrasting results, and few data are available on affected subjects during the euthymic phase. We investigated the cognitive function of a cohort of bipolar (n = 40) and schizophrenic (n = 66) patients compared with healthy controls (n = 64).

Method and results: Patients were evaluated in the outpatients setting for at least three months using a computerized version of Wisconsin Card Sorting Test. Schizophrenic patients showed the worst performance, while that of the bipolar patients was intermediate between schizophrenic patients and controls. A discriminant analysis was able to classify correctly 60.59% of the subjects (schizophrenics 48.5%, bipolars 40%, healthy controls 85.9%). The scores of the Wisconsin Card Sorting Test were entered into a principal component analysis, which yielded two factors solution. Even in that analysis bipolar patients showed intermediate features in comparison with the other groups.

Conclusion: These data point out that bipolar patients have subtle neurocognitive deficits even after the resolution of an affective disorder. Other than to observe quantitative differences between groups, the results show different dimensions of cognitive performance within groups suggesting that the deficit of euthymic bipolars could be a dishomogeneous entity, likely more heterogeneous than that in schizophrenia.

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SCIENTIFIC AND CLINICAL REPORT SESSION 21—PSYCHIATRIC EDUCATION

No. 62
USING THE "MORAL ACCOUNTING" METAPHOR TO TEACH PSYCHODYNAMIC FORMULATIONS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the major "accounting" metaphors used by English speakers to describe social relations; to correlate these metaphors with standard psychodynamic concepts to increase an intuitive, "experience-near" understanding of those concepts.

SUMMARY:

Objective: The purpose of the report is to demonstrate the utility of the cognitive model of metaphor—and specifically of the "moral accounting" metaphor—to teach basic psychodynamic and interpersonal concepts to psychiatric residents.

Method: The author bases his report on the work of Lakoff and Johnson in the cognitive science of metaphor and on the application of the "moral accounting" metaphor to teach three groups of residents at various levels of training.

Results: Residents and their supervisors reported increased resident understanding of basic psychodynamic concepts, with active attempts to apply these ideas to patient care.

Conclusion: Residents now enter psychiatry programs with varied backgrounds in psychological concepts. By using metaphors grounded in both the social and the physical experiences of "exchange" the teacher can expand the vocabulary useful to introduce more complex topics as guilt, shame, character defenses, the repetition compulsion, transference, countertransference, and the therapeutic alliance. These physical/cultural metaphors are deeply rooted in language and cognition, and residents can have immediate, intuitive access to them. The metaphors can make psychodynamic ideas more experience-near and useful, via ideas such as "emotional riches," "balancing the books," "interpersonal auditing," and "paying for life's emotional expenses."

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No. 63
A COMPARISON OF EVALUATIONS OF MALE AND FEMALE PSYCHIATRY SUPERVISORS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that supervisors of psychiatry residents may be evaluated differently by gender. Participants will also be able to identify factors that may contribute to these differences in evaluation.

SUMMARY:

Objective: To assess differences by supervisor gender in psychiatry supervisor evaluations by psychiatry residents.

Method: Anonymous supervisor evaluations completed semiannually by psychiatry residents were compiled over a three-year period (1993–1996) by the University of Toronto department of psychiatry postgraduate education office. Using a five-point Likert scale, residents rated supervisor performance in six areas (enthusiasm, clarity, knowledge, clinical, availability and modelling) and provided overall ratings. Male and female supervisors' ratings were compared using t-tests, effect sizes, and chi-square analysis.

Results: Of 298 supervisors receiving a total of 1,765 evaluations, 76 (26%) were women. Comparison of composite ratings found female supervisors were rated significantly lower than male supervisors both overall ($p = .041$) and in the areas of enthusiasm ($p = .025$), clarity ($p = .018$), and knowledge ($p < .0001$). More women than expected were found among those with the extreme low end of evaluations (≤ 2 s.d. below the mean) (Fisher's exact test, $p = .045$ (2 sided).

Conclusions: Psychiatry residents rated female psychiatry supervisors lower than their male counterparts overall, and in the areas of knowledge, clarity and enthusiasm in particular. Future research must assess whether this is due to a greater proportion of junior female supervisors or the tendency of female supervisors to be less productive academically. It would be useful to examine differences in expectations of supervision by gender of the resident and of the supervisor.

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No. 64
TRAINING IN DEPRESSION AND SUICIDE: A NATIONAL SURVEY OF PRIMARY CARE

Donna M. Sudak, M.D., *Psychiatry Residency Training Department, MCP Hahnemann University, 3200 Henry Avenue, Philadelphia, PA 19129;* Howard S. Sudak, M.D., Alec Roy, M.D., Alan Lipschitz, M.D., Herbert Hendin, M.D., John T. Maltsberger, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the differences between primary care residents' and training directors' perceptions of teaching adequacy and clinical competence in the recognition and management of depression and suicide in patients.

SUMMARY:

Context: Suicide is the eighth leading cause of death in the U.S. Specific requirements for nonpsychiatric primary care residents in the recognition and management of depression and suicide are inconsistent and variably applied.

Objective: To measure primary care residents' and training directors' perceptions of the quality of their teaching experience in the recognition and management of depression and suicide and compare these ratings to the confidence directors and residents themselves feel about their actual clinical abilities to recognize and treat depression and suicide.

Design: All U.S. directors of ACGME-accredited training programs in internal medicine, family practice, and pediatrics in 1999 were surveyed. Responding program directors were then sent packets of questionnaires to distribute to the senior residents within their programs.

Results: Over 50% of the directors responded. Family practice directors ranked their didactic teaching about recognition of depression and suicide and their residents' subsequent clinical abilities to recognize and treat depressed individuals and those at risk for suicide higher than the other two disciplines. Family practice residents, however, did not differ significantly from residents in internal medicine and pediatrics. Pediatric residents felt much more confident in their clinical abilities than did their directors. Less than half of directors and residents in internal medicine and pediatrics felt their teaching about depression and suicide was adequate, and less than half of the family practice residents felt their teaching about suicide was adequate. Eighty-three percent to 94% of residents and directors in the three specialties expressed a desire for standardized curricular materials on depression and suicide.

Funding provided through an unrestricted educational grant from Wyeth-Ayerst to the American Foundation for Suicide Prevention.

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SCIENTIFIC AND CLINICAL REPORT SESSION 22—DANGEROUS OFFENDERS

No. 65
CAN PSYCHOLOGISTS HELP PSYCHIATRISTS IN ASSESSING SEX OFFENDERS?

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to inform psychiatrists about ways in which psychologists can help psychiatrists in the assessment of alleged sex offenders by providing information not generally available from routine forensic psychiatric interviews; to provide research data on the ability of psychological tests to inform psychiatrists about sex offenders' potential response bias to minimize or deny symptoms of psychopathology.

SUMMARY:

Objective: We investigated whether sex offenders, motivated to deny psychopathology, can conceal it on the Rorschach. Forensic psychological testing often uses MMPI and Rorschach. While MMPI can detect efforts to "fake-good," it does not specify which symptoms are minimized. The subtler Rorschach may provide information regarding the psychopathology despite minimization efforts.

Method: To study Rorschach minimization, we divided sex offenders (n = 74) according to whether they minimized on the MMPI, and compared their Rorschachs on indices of psychopathology. We predicted: 1) no differences between MMPI minimizers and nonminimizers on Rorschach indices of psychopathology, 2) greater psychopathology in sex offenders than normals and 3) more sexual preoccupation and distorted thinking in sex offenders than normals.

Results: Minimizers produced normal MMPI profiles but still showed psychopathology on Rorschach. As predicted, compared with normals, sex offenders showed substantially more distress, faulty judgment, interpersonal dysfunction, and cognitive distortions. Sex offenders showed intrusion of sexual content with increased distorted thinking.

Discussion: Our data suggest that the Rorschach is less vulnerable to minimization and therefore can help assess emotional disturbance present in subjects attempting to minimize psychopathology. The combination of MMPI and Rorschach is a valuable assessment strategy in that the unique characteristics of each instrument complement the other. Together these two tests provide clinical information unavailable through clinical interviewing. Our study supports the view that because of its complexity, the Rorschach is difficult intentionally to "fake-good."

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No. 66
HETEROGENEITY OF PSYCHOPATHOLOGY AMONG JUVENILE SEXUAL OFFENDERS

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L. McGarvey, Ed.D., Dennis Waite, Ph.D., Bruce J. Cohen, M.D., Robert Diamond, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand the heterogeneity of juvenile sex offenders' psychopathology and sexual deviance related to differences in family background and treatment history. Implications for treatment and management will be discussed.

SUMMARY:

Objective: This study examined the diversity of juvenile sexual offenders' psychopathology and sexual deviance. Etiological differences were profiled.

Method: One hundred incarcerated juvenile sexual offenders were evaluated using the Minnesota Multiphasic Personality Inventory—Adolescent (MMPI-A), Multiphasic Sex Inventory (MSI), and other assessments. Cluster analysis was applied to MMPI-A and MSI scale scores. Chi-square tests were used to assess differences.

Results: Five groups resulted: G1 (27%) cognitive distortions/immaturity (MSI) with no elevated MMPI-A scale scores; G2 (30%) marginal 9—6; G3 (20%) marginal 9—4; G4 (14%) clinically elevated 8—4—9—7—6; G5 (9%) clinically elevated 4 with cognitive distortions/immaturity—victim stance (MSI). Fifty-percent of G2 and 45% of G3 youth were most often rated as severely dysfunctional in school compared with other groups ($p < .05$). G3 and G4 were most likely (50%) to have a history of substance abuse ($p < .05$). G5 was most likely (22%) to have been prescribed antianxiety medication ($p < .05$) and most likely (44%) to have a history of suicidal gestures ($p < .05$). G3 and G5 had highest rates of psychiatric treatment among first-degree relatives ($p < .05$).

Conclusions: Juvenile sex offenders showed meaningful differences in psychopathology and history with implications for treatment/management approaches.

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No. 67
DANGEROUS OFFENDER STATUTES: THE CANADIAN PERSPECTIVE

Louis Morissette, M.D., *Institute Philippe Pinel de Montreal, 10905 Henri-Bourassa East, Montreal, PQ H1C 1H1. Canada.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the legal and clinical criteria for an accused person to be declared a "dangerous offender" or "long-term offender" in Canada.

SUMMARY:

Crime and violence are serious concerns in Canada and the U.S. and our countries have developed different ways to protect themselves against criminals. One legal mechanism is the "dangerous offender" legislation. First, we will review the historical concept of the "dangerous offender" in Canada. Second, the current statutes (since 1997) will be presented: the dangerous offender and the long-term offender. There will be a discussion of the role of the psychiatric evaluation and testimony in the legal proceedings. Also, we will describe a cohort of 30 individuals for whom the prosecution has asked that they be declared a "dangerous offender." We will present their psychiatric diagnoses, their legal histories, and the court decisions. These individuals were evaluated by psychiatrists at Philippe Pinel Institute, a secure psychiatric hospital in Montreal, Canada. This cohort represent all individuals for whom such an evaluation was required in the province of Quebec (7 million habitants) from July 1998 to August 2000.

In conclusion, we will discuss some ethical concerns regarding these statutes and evaluations: use of psychiatry to "control bad individuals," value of clinical prediction of dangerousness and violent recidivism, psychiatric "labelling" of individuals without offering treatment, regional disparities in the use of such statutes, etc.

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WEDNESDAY, MAY 9, 2001

SCIENTIFIC AND CLINICAL REPORT SESSION 23—DEPRESSION ACROSS CULTURES

No. 68
DEPRESSION IN CHINESE PRIMARY CARE PATIENTS

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EDUCATIONAL OBJECTIVE:

At the end of the presentation, the participant should be able to understand the difficulties in the screening and diagnosis of depression among Chinese patients in primary care and the reasons for the underdiagnosis of depression in this population.

SUMMARY:

Objective: To determine the prevalence of major depression among Chinese in primary care using a two-stage design.

Method: In the first screening stage, Chinese patients in nine primary care clinics in the Boston area were asked to complete two questionnaires in Chinese: MHI5 (five questions) and the Screener (21 questions). In the second stage, subjects were interviewed in Cantonese or Mandarin by an experienced clinician using the SCID-III-R. Subjects' acculturation was determined by an acculturation scale.

Results: 560 questionnaires (233M, 327F) were returned, 500 MH15 and 460 Screener were usable. Both questionnaires identified 10% of subjects as cases. Thirty-nine of 50 MH15 cases were interviewed: 15 had current depression (CMDD), 15 lifetime depression (LMDD), one dysthymia (DYS), six other diagnosis (OTH) and two no diagnosis (NOD). Thirty-eight of 46 Screener cases were interviewed: 10 CMDD, 28 LMDD, two DYS, two OTH, and four NOD. However, about 1/3 of those screened negative by MH15 (N = 89) or Screener (N = 90) were diagnosable as CMDD or LMDD by interview. The sensitivity, specificity, and positive and negative predictive values of the MH15 (29.7, 92.9, 38.5, 89.9) and the

Screener (25.5, 92.4, 34.2, 89.9) were comparable. Level of acculturation significantly affects subject's response to screening.

Conclusion: Paper-and-pencil screening for depression is problematic for Chinese subjects, particularly those that are less acculturated. Interview by an experienced clinician may be more culturally acceptable. The relatively low prevalence of depression among the Chinese may be related to a fear of disclosure and a different conceptualization of the disorder.

REFERENCES:

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2. Okazaki S., Sue S: Methodological issues in assessment research with ethnic minorities. Psychological Assessment. 1995; 7, 367–375.

No. 69
ILLNESS BELIEFS OF DEPRESSED CHINESE AMERICANS IN PRIMARY CARE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the prevalence of major depression among Chinese Americans in a primary care clinic and patients' perception of their depression. Patients' chief complaints, conceptualization of the illness, degree of feeling stigmatized by their symptoms, perception of the cause of the problems, and their patterns of help-seeking behavior will be discussed.

SUMMARY:

Objective: To investigate the prevalence and illness beliefs of major depression among Chinese Americans in a primary care setting.

Method: Chinese-American patients in a primary care clinic were screened for depression using the Beck Depression Inventory (cut-off point ≥ 16). Diagnosis of major depressive disorder (MDD) was confirmed using the Structured Clinical Interview for DSM-IV (SCID-P) performed by a psychiatrist. Patients with major depression were interviewed with the Exploratory Model Interview Catalogue (EMIC) to explore their illness beliefs on depression.

Results: Six hundred and eighty patients were screened, and 40 of them were confirmed with MDD. The prevalence of depression among Chinese Americans in primary care was 19.4%, which was comparable to other ethnic groups. Twenty-nine of the depressed patients received EMIC interview. Depressed Chinese patients predominantly complained of somatic symptoms (79%); only two patients (7%) reported depressed mood spontaneously. Most patients felt that the symptoms affected their mind (90%) and their body (79%), yet most patients (70%) did not acknowledge having an illness and had low stigmatization scores (79%) towards their symptoms. Psychological stress was the most frequently perceived cause (86%) of their symptoms. General hospital (41%) and self-care (34%) were the two most commonly used help-seeking methods.

Conclusion: Major depression is common among Chinese Americans in primary care. Yet most patients do not report depressed mood spontaneously and are unaware of the illness. Clinical implications of identifying and treating depressed Chinese-American patients will be discussed.

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No. 70
DEPRESSION IN COLLEGE STUDENTS IN BOMBAY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that depression is prevalent among college students; it is important to screen for depression and plan effective intervention strategies in this population.

SUMMARY:

Objective: Previous studies have reported significant depressive symptoms among college students. However, the presentation of symptoms is frequently unclear, resulting in under diagnosis of depression in this population. The purpose of this study was assess the prevalence and symptom patterns of depression among college students in Bombay.

Methods: We screened 2,273 college students (68% of the total college population) (mean age: 18.2 ± 1.7 years: 41.1% men, 58.9% women) in Bombay, India. Of those, 41.1% (n = 934) students were in the arts section, 43.9% (n = 998) were in the science section, and 15% (n = 341) were in the commerce section. After obtaining written informed consent, the Beck Depression Inventory (BDI) and the Symptom Questionnaire (SQ) were distributed to all students. A total of 56.8% of the students consented to be contacted subsequently, if deemed necessary, on the basis of the screening scores. Students who scored ≥ 16 on the BDI and consented to be contacted were also interviewed using the Hamilton Depression Rating Scale (HDRS). The Statistical Package for Social Sciences (Version 7) was used for data analysis.

Results: 20.7% of the students scored ≥ 16 on the BDI, and 14% had HDRS scores of ≥ 18 (mean HAM-D-17 scale score: 19.5 ± 3.8); 25% men and 17.6% women scored ≥ 16 on the BDI. Significant differences were seen between depressed and nondepressed individuals across all four subscales of the SQ: depression, anxiety, somatization and anger-hostility.

Conclusion: Significant depressive symptoms were noted in 21% of this urban college population in India, comparable to that reported in similar studies in other parts of the world. The predominant manifestations are in the form of cognitive-verbal symptoms rather than somatization, often expected in an Indian population, or anger-hostility, often seen in adolescents. Our study emphasizes the importance of screening for depression among college students and the need to plan effective intervention strategies in this population.

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SCIENTIFIC AND CLINICAL REPORT SESSION 24—PSYCHOTHERAPY ISSUES

No. 71
A 45-YEAR EXPERIENCE WITH OCD PATIENTS WHO FEAR HARMING SOMEONE OR FEAR HARM OR HUMILIATION TO THEMSELVES

Albert H. Schrut, M.D., *NPI, University of California at Los Angeles, 911 Honeywood Road, Los Angeles, CA 90049-1307*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to diagnose, understand, and better treat OCD by multimodal methods in patients whose major symptom is fear of harming others by murder or other forms of violence or fear of harm or humiliation to themselves provoked by their own actions.

SUMMARY:

This study is based on clinical observations in the treatment of 14 patients whose major and sometime sole symptom was fear of harming or being harmed. Reference is made to Eric Kandel's scientific view of the neurophysiology and efficacy of psychotherapy. Treatment by medication combined with an individually designed flexible psychotherapeutic approach is imperative, including behavioral and psychodynamic aspects, education, and family involvement when desirable. Clinical evidence is presented that murderous impulses represent what the patient *least* wishes to occur, unlike the classical view they represent unconscious wishes. Adequate treatment promotes the diminution of the anxiety fueling the symptoms. Individualized psychotherapy reassures the patient that he/she is not morally defective, grants time to deal with underlying personality difficulties, allows collaboration of family or parents in the case of children, and lends respect to the patient as a person. The treatment should be of sufficient duration and quality to permit many patients to utilize the memory of past therapy to miminize or avoid recurrenct bouts. The use of only brief behavioral therapy combined with medication is insufficient for many patients.

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2. Glucksman ML: Psychodynamics and neurobiology: an integrated approach. J Amer Acad Of Psychoanal 1995; 23:179–195.

No. 72
SOLVING THE RIDDLE OF WORKING THROUGH IN PSYCHOTHERAPY

Steven H. Lipsius, M.D., *George Washington University, 2141 K Street, N.W., Suite 404, Washington, DC 20037-1810*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the less-familiar introjective identification as a vehicle for working through from the inside and use the less-intrusive interventions to more effectively treat patients with diagnoses for whom this approach is indicated.

SUMMARY:

"The two most enigmatic words," according to psychoanalyst Peter Giovacchini, are "working through." The objective is to explain and solve this enigma: There are two separate working-through phases, one of them unrecognized. The familiar psychotherapeutic interventions of interpretation and confrontation, adequate for the familiar component of projective identification, are counterproductive to the other, introjective identification. Though known, introjective identification has not been utilized as an effective vehicle for working through. When the therapist is taken inside rather than being projected onto, less-intrusive techniques are called for. The therapist must work within the subjectivity of the patient guiding inner dialogues that tap affects and rework the patient's self-images vis-a-vis internalized others. Damasio's neuroscience findings support reworking psychic structure from the inside and are cited in this communion of mind and brain. The method of case examples illustrates the therapist's guiding the inner working through. As this proposed reconceptualization of core psychotherapeutic processes would alleviate many impasses in psychotherapy, therapists who have practiced long enough to experience this may most appreciate the benefit of being able to change gears when needed. Results are presented that point towards conclusions on when to move to and away from the inner mode.

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No. 73
TELEPSYCHIATRY FOR SUICIDAL OUTPATIENTS: LOWER MORBIDITY, MORTALITY, AND COST

Ann M. Oberkirch, M.D., *Department of Psychiatry, Yale School of Medicine, 26 Perkins Road, Woodbridge, CT 06525*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to learn the fundamentals of telemedicine and telepsychiatry, including developing a familiarity with the basic technology; to learn a new technique for treating lethal or fragile outpatients utilizing traditional care and telepsychiatric contacts.

SUMMARY:

Objective: To introduce a telepsychiatric paradigm melding traditional visits with frequent telepsychiatric contacts for deeply depressed patients.

Method: Nidus points for successful suicides of outpatients were examined. A treatment was designed to offer patients coverage at critical times, usually between visits or during vacations and holidays. Televisits were conducted by telephone, e-mail, or videophone. In times of intense lethality, televisits occurred every few hours. Data are based on 27 years of practice that averaged 50 full visits/week, extensive telephone contacts, e-mail, and videophoning.

Results: The nidus points for suicide commonly occur during lengthy breaks between appointments, including therapist's vacations and holidays. Intensive monitoring during these periods allowed meticulous titration of psychopharmaceuticals, support, and diffusion of lethality. Over a quarter of a century of experience with this treatment model, which included brittle, suicidal patients, resulted in no deaths. In the year 2000, decreased cost was demonstrated by absence of any other treatments during the office holidays even by the most critically ill.

Conclusion: Rapidly changing technology will allow for inexpensive, improved patient care. More flexible HCFA reimbursement guidelines must be developed for these telepsychiatric visits.

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1. Chae YM, Park HJ, et al: The reliability and acceptability of telemedicine for patients with schizophrenia in Korea, Journal of Telemedicine and Telecare 2000; 6:83–90.
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SCIENTIFIC AND CLINICAL REPORT SESSION 25—RISK FACTORS IN SUICIDE

No. 74
SUICIDE MORTALITY IN THE UKRAINE IN 1999

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have an overview of the main characteristics of suicide mortality among the Ukrainian population in 1999.

SUMMARY:

Objective: The aim of this study was to analyze the latest data on suicide rates in the Ukraine and point to the importance of the development of suicide prevention programs.

Method: An analysis was conducted using the 1999 data of suicide rates in the Ukraine. Statistics were obtained from the Center of Statistics (Ukrainian Ministry of Health). Rates of suicide are calculated per 100,000 males and females, as well as for the total population of the Ukraine.

Results: Between 1988 and 1999 the suicide rate increased by 53% (19.0 per 100,000 in 1988, 29.0 per 100,000 in 1999). This is about three times the U.S. rate. In 1999, the suicide rate for men was 4.5 times higher than that for women. The number of suicides among people 35–49 years old was the highest. The suicide rates in different regions of the Ukraine range from 10.3 to as high as 45.1, particularly in the Chernobyl disaster regions. The greatest increases in the number of suicides occured in the industrially developed regions of the country (the highest rate as 40.6 was in Zaporozh'e in 1996). The highest rate for rural populations was observed in 1999 in Sumu—45.1.

Conclusions: Suicide is a significant problem in the Ukraine and is associated with a number of variables. National, comprehensive suicide prevention strategies and programs are needed.

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No. 75
DECREASING SUICIDE MORTALITY IN HUNGARY: WHAT ARE THE MAIN CAUSES?

Zoltan Rihmer, M.D., *Department of Psychiatry, XIII, National Institute of Psychiatry, Hu Vosvolgyi POB 1, Budapest 27 1281, Hungary*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that earlier/better recognition and more appropriate acute and long-term treatment of depression is an important factor in decreasing suicide mortality of Hungary between 1984 and 1997.

SUMMARY:

The objective of this study is to analyze the main causes of decreasing suicide mortality in Hungary.

Method: The suicide rate in Hungary, the sales of antidepressants and several other parameters (unemployment, alcoholism, divorce, quantitative figures of psychiatric care, etc.) are evaluated.

Results: The suicide rate in Hungary has shown a steady decline from 45.9 (1984) to 31.7 (1997), a fall of more than 30%, and this decline was greater after 1990. During the same period there was a six-fold rise in unemployment, a 25% rise in official estimates of alcoholism rates, and 21% rise in divorce. Other former Communist countries showed no substantial changes in their suicide rates after 1990. However, the number of psychiatrists increased from 550 (1986) to 800 (1997), the number of outpatient psychiatric departments increased from 95 (1982) to 136 (1997), and the number of emergency (hot-line) telephone services also increased from five (1984) to 28 (1997). The introduction of the DSM-III-R/DSM-IV-oriented residency training in psychiatry and more extensive medical training on depression and suicide was followed by an increase in the use of antidepressants from 2.6 DDD/1000 persons/day (1984) to 12.0 (1997).

Conclusion: These results suggest that earlier and better recognition and more appropriate acute and long-term treatment of depression is an important factor in the decreasing suicide mortality of Hungary.

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No. 76
SUICIDE RISK FACTORS AMONG TREATED PATIENTS WITH BPD

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that BPD patients with major depression and BPD patients who display impulsive aggression are likely to be at higher risk for suicidal behavior compared with BPD patients without these conditions.

SUMMARY:

Objective: To determine the persistence and recurrence of risk factors for suicide attempts among treated patients with borderline personality disorder (BPD).

Method: Sixty-nine BPD patients defined by the International Personality Disorders Examination were assessed for major depression, substance use disorders, impulsive aggression, and suicidal behavior at six months, one year, and two years following an inpatient hospitalization.

Results: Twenty-two patients (32%) attempted suicide at least once within the follow-up period. Forty-seven patients (68%) were diagnosed with major depression at the follow-up assessments. Higher rates of major depression were diagnosed in BPD patients who attempted suicide during the follow-up period compared with BPD patients who did not attempt ($\chi^2 = 4.9$, df = 1, $p < .05$). Similar rates of substance use disorders were diagnosed among suicide attempters and nonattempters at follow-up. Suicide attempters reported higher rates of serious impulsive aggression toward others, i.e., as-

saults, during the follow-up period compared with nonattempters ($\chi^2 = 4.2$, df = 1, $p < .05$).

Conclusion: BPD patients remain at high risk for attempted suicide following inpatient treatment. Continuing major depression and impulsive aggression are likely to be among important risks for suicide attempts among more severely disordered BPD patients.

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SCIENTIFIC AND CLINICAL REPORT SESSION 26—ETHICS AND JUSTICE

No. 77
WILLINGNESS AND COMPETENCE OF DEPRESSED INPATIENTS TO CONSENT TO RESEARCH

Bruce J. Cohen, M.D., *Department of Psychiatry, University of Virginia, P O Box 800623, Charlottesville, VA 22908;* Ludmila Kryzhanovskaya, Ph.D., Elizabeth L. McGarvey, Ed.D., Relana C. Pinkerton, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand issues involved in assessing competence to consent to research in inpatients with major depressive disorder.

SUMMARY:

Objective: There is concern that depressed individuals may be vulnerable to inappropriate enrollment in research protocols, particularly protocols exposing subjects to greater than minimal risk without direct medical benefit. This study investigates the validity of this concern.

Method: Twenty inpatients with major depressive disorder and 20 community control subjects were asked to consider participation in two research protocols. One offered lower risk (LR) and the potential for medical benefit (phase III antidepressant drug trial). The other offered higher risk (HR) without medical benefit (PET scan following ketamine administration). Consent-related capacities were assessed with the MacArthur Competence Assessment Tool-Clinical Research (MacCAT-CR). Severity of depression was measured with the Beck Depression Inventory.

Results: Depressed subjects were more likely to decline research participation than controls. They were six times more likely to decline the LR study ($\chi^2 = 15.33$, $p < 0.001$) and 1.4 times more likely to decline the HR study ($\chi^2 = 2.68$, n.s). MDD patients received high scores on capacity to consent for both studies. Their preferences for choosing one study over the other did not differ from those of controls.

Conclusions: Depressed inpatients demonstrated both high decision-making capacity and a greater tendency to decline research participation than controls, suggesting that they not more vulnerable to inappropriate enrollment.

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2. Carpenter W, Gold J, Lahti A, et al: Decisional capacity for informed consent in schizophrenia research. Arch Gen Psychiatry 2000; 57:533–538.

No. 78
ARTHUR KRONFELD: PROFESSIONAL AND PERSONAL TRAGEDY OF A GREAT PSYCHIATRIST

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to learn about the last "Russian" period of the world-famous psychiatrist Arthur Kronfeld, and through the prism of his personal tragedy to understand the contradictory relationship between professional, political, and moral domains in psychiatry.

SUMMARY:

Arthur Kronfeld is a well-known significant figure in 20th century psychiatry—the author of fundamental conceptions in general psychopathology, schizophrenia, personality disorders, therapy of mental disorders, clinical psychology, and sexology. But his biography, bringing together science and morality, social and personal tragedy, remains a field for research. The last period of his life, his death and the influence on current Russian psychiatry are the focus of this paper. World authority, intellectual brilliance, personal independence, and humanistic principles of an ethnically Jewish psychiatrist were considered just reasons for prosecution by the Nazi state. Kronfeld and his wife were forced to emigrate to Russia. He became a professor in the Moscow State Research Psychiatric Institute. His clinical and research activity significantly promoted Russian psychiatry but sometimes they were used incorrectly in the service of Soviet psychiatry's doctrines. Kronfeld's idea and the Soviet theory of schizophrenia are considered. Finally, Kronfeld's life in Moscow turned out to be another drama. When the Nazis were around Moscow and his institute was evacuated, he was betrayed by officials and colleagues and left alone in the city where he had arrived with great hopes of salvation. He and his spouse committed suicide. Related facts and tributes are presented. Kronfeld's tragedy is considered as emblematic of the intersection of academic, ethical, professional and sociopolitical issues in psychiatry.

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1. Kretschmer W: Arthur Kronfeld–ein Vergessener. Der Nervenartz 1987; 58:737–742.
2. Kornetov A: Arthur Kronfeld: For 50th anniversary of the death. Korsakoff Journal of Nevrology and Psychiatry, 1991;12:80–87.

No. 79
FALSE CONFESSIONS: THE BANE OF CRIMINAL JUSTICE

Hanus J. Grosz, M.D., *Department of Psychiatry, Indiana University, 7233 Lakeside Drive, Indianapolis, IN 46278;* Alan D. Schmetzer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to learn about false confessions in "show case" trials in the Soviet Union, in political practices of Chinese communists, and in criminal trials in the US; to learn about current coercive interrogative

techniques in the US; and to become familiar with tests that measure interrogative suggestibility and compliance in an interrogative situation.

SUMMARY:

The past century has witnessed false public confessions in Soviet "show trials" and in the testimony of American military personnel held captive by Chinese communists. In the United States, among 350 defendants found wrongfully convicted of a capital offense, the defendant's coerced and false confession played an important role in convicting 49 (14 percent) defendants. In this paper we describe three types of false confessions, the type of psychiatrically most vulnerable defendants, and, with examples, some of the coercive and manipulative methods currently used by interrogators to obtain a confession of guilt. We describe two tests developed in Great Britain: one that measures interrogative suggestibility and acquiescence, and another that measures a tendency towards compliance in an interrogative situation.

This report is for clinicians testifying in criminal courts and also for clinicians who are interested in learning about false confession as a cause of miscarriage of justice in the United States. No special background training or experience is required.

REFERENCES:

1. Bedau HA, Radelet ML: Miscarriages of justice in potentially capital cases, Stanford Law Rev. 1983; 40:21–179.
2. The Lancet: Guilty innocents: the road to false confessions. Lancet 1994; 344:1447–1450.

SCIENTIFIC AND CLINICAL REPORT SESSION 27—ISSUES IN VIOLENCE AND TRAUMA

No. 80
VIOLENCE AND CLINICAL SYMPTOMS IN DIFFERENT DIAGNOSES

Menahem 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 understand the relationship between psychiatric symptoms and physical assaults in different diagnostic group; to understand the course of violence in relation to resolution of symptoms.

SUMMARY:

Objective: To compare inpatient physical assaults in relation to underlying symptoms in different diagnostic groups.

Method: Subjects were 2,460 consecutive admissions to two state hospitals with diagnoses of schizophrenia, schizoaffective, or bipolar disorders. Of these patients, 218 (schizophrenia N = 116, schizoaffective N = 70, and bipolar N = 32) were physically assaultive within two months of admission. Diagnosis was determined by a diagnostic interview (SCID). Psychiatric symptoms were assessed with the Brief Psychiatric Rating Scale (BPRS) and ward behaviors with the Nurses' Observation Scale for Inpatient Evaluation (NOSIE) upon study entry and after four weeks observation.

Results: Of the 2,460 patients, more schizoaffective than bipolar or schizophrenic patients were physically assaultive ($p < .05$). The schizoaffective group continued to evidence more frequent assaults (ANOVA; $F = 3.49$, $df = 2, 217$, $p = 0.03$) over the following two weeks, but not over the last two. Clinically, the schizoaffective group presented with more episodes of agitation (ANOVA; $F = 7.74$, $df = 2, 217$, $p = 0.001$), with more anxiety/depression (BPRS Anxiety/Depression Factor: $F = 3.49$, $df = 2, 209$; $p = 0.03$) and irritability (NOSIE Irritability $F = 3.7$, $df = 2, 199$, $p = .03$) than either the schizophrenic or bipolar patients at the baseline, but not at the endpoint evaluation.

Conclusions: The higher level of physical assaults in schizoaffective patients is associated with agitation and mood disturbances, and the number decreases as these symptoms resolve.

REFERENCES:

1. Krakowski M, Czobor P, Chou J: Course of violence in schizophrenic patients: relationship to clinical symptoms. Schizophrenia Bulletin 1999; 25:505–517.

No. 81
POST-TRAUMATIC SPECTRUM DISORDERS: A RADICAL REVISION OF PTSD

K. Elan Jung, M.D., *Department of Psychiatry, 422 Bay Road, Queensbury, NY 12804*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to highlight the problems of current classification of PTSD; to overview clinical manifestations of PTSD including psychoses, depression, anxiety disorders, and other symptoms, signs, and traits of PTSD; to review theoretical and clinical rationales for the concept of posttraumatic spectrum disorders; and to suggest subclassification of PTSD.

SUMMARY:

Posttraumatic stress disorder (PTSD) has been misclassified and misinterpreted as a subgroup of anxiety disorders. The complexity and severity of clinical manifestation of PTSD requires a fundamental change in the way PTSD has been represented. The author reviewed 309 related references and suggested the following rationales for the revision: Representation of predominant clinical expression; The basic tenets and DSM-IV classification of psychoses, anxiety disorders, affective disorders, personality disorders are adopted to categorize the complex symptoms, signs, and traits of PTSD; These spectrum disorders of PTSD are substantially different from other psychiatric disorders with similar clinical features unrelated to traumas; The etiology, psychopathology, psychopathogenesis, and psychotherapeutic approaches integrate these seemingly unrelated mixtures of psychiatric disorders into one major group: PTSD.

In summary, the author came to the following conclusions:

1. PTSD is not a subgroup of anxiety disorders.
2. PTSD is not a single psychiatric disorder but a major spectrum disorder with vastly different subgroups of psychiatric disorders.

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1. Davidson JRT, Conner KM: Management of posttraumatic stress disorder: diagnostic and therapeutic issues. J. Clinical Psychiatry 1999; 60.
2. Rose, DS, "Worse than death:" psychodynamics of rape victims. American Journal of Psychiatry 1986; 143:7.

No. 82
OPEN STUDY OF NEFAZODONE IN DEPRESSION WITH ANGER ATTACKS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the use of nefazodone in the treatment for major depressive disorder with anger attacks.

SUMMARY:

Objective: To assess the efficacy of nefazodone for depressed patients who also suffer from anger attacks, characterized by sudden outbursts of anger, general irritability, and symptoms of autonomic arousal.

Methods: Sixteen (50% female, mean age 42.5 years) depressed outpatients with anger attacks entered a 13-week trial, including one week of placebo washout and 12 weeks of open, flexible-dose nefazodone (up to 600 mg/day). Subjects were diagnosed by DSM-IV SCID and the Anger Attacks Questionnaire (AAQ) at the screening visit, and were evaluated at each visit using the 17-item Hamilton Depression Rating Scale (HAM-D-17), the Clinical Global Impression Scale (CGI), the Modified Overt Aggression Scale (MOAS), the Symptom Questionnaire (SQ), the Beck Depression Inventory (BDI), the SAS Scale, and the MOAS-Self Rated Version. Three subjects (two female) underwent PET neuroimaging with setoperone for 5-HT2 receptor binding potential and SCH-23390 for D1 receptor binding potential, both at baseline and after six weeks of treatment.

Results: Ten subjects completed the study. Mean attained nefazodone dose was 466 ± 147 mg. HAM-D 17 scores decreased significantly (from 21.5 ± 3.7 to 14.8 ± 8.8, $p<0.004$) as did CGI-S scores (from 4.1 ± 0.7 to 3.0 ± 1.5, $p < 0.02$). Seven of the 16 subjects (47%) no longer reported anger attacks at the final study visit. The weighted MOAS ($p < 0.03$) and MOAS-verbal scale ($p < 0.02$) scores also decreased significantly. Self-reported SQ scores on the Depression and Anger/Hostility scales decreased significantly from baseline to endpoint ($p < 0.05$ for both) while all other scales (Anxiety and Somatic Symptoms) did not change. The percent change in binding potential for 5HT2 was statistically significant for the right mesial frontal, left parietal, right parietal, right temporal, left frontal, and right frontal lobes ($p < 0.05$ for all). No significant change in D1 binding potential was observed in any cortical region.

Conclusion: Nefazodone appears to be an effective treatment for major depression with anger attacks. Nefazodone's effect may be related to changes in 5HT2 receptor binding potential in various regions of the cerebral cortex.

This study was supported by a grant from Bristol-Myers Squibb.

REFERENCES:

1. Fava M, Rosenbaum JF, McCarthy MK et al: Anger attacks in depressed outpatients and their response to fluoxetine. Psychopharmacol Bull 1991; 27:275–279.
2. Hertzberg MA, Feldman ME, Beckham JC, et al. Open trial of nefazodone for combat-related posttraumatic stress disorder. J Clin Psychiatry 1998; 59:460–4.

SCIENTIFIC AND CLINICAL REPORT SESSION 28—PSYCHOPHARMACOLOGY, CHILD AND ADOLESCENT PSYCHIATRY

No. 83
ADDERALL AND METHYLPHENIDATE IN ADHD

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to understand the theory and applications of the drug-placebo response curve. The should also understand the implications of the drug-placebo response curve analysis for understanding clinically relevant differences between methylphenidate and Adderall in the treatment of attention deficit hyperactivity disorder.

SUMMARY:

Objective: Studies show Adderall to be superior to placebo and at least as effective as methylphenidate (MPH) in the treatment of attention deficit hyperactivity disorder. Although these studies provide useful information for clinicians treating ADHD children, their method of data presentation has provided limited information about the clinical significance of drug effects. Thus, we sought to address the issue of clinical significance in comparing the effects of MPH and Adderall.

Method: We completed drug-placebo and drug-drug response curve analyses of a blinded, placebo-controlled study of Adderall and MPH.

Results: The efficacy of Adderall to improve functioning was seen throughout the full range of improvement scores. In contrast, MPH showed a substantial effect for "mildly" and "much improved" but not for "very much improved." Both Adderall and MPH prevented worsening of symptoms. Also, compared with the Conners Teacher Rating Scale, the Clinical Global Impressions scale may be more sensitive to improvements at the well end of the spectrum of functioning.

Conclusions: Drug-placebo and drug-drug response curve methodology is a useful means for displaying the clinical significance of drug effects. These analyses show Adderall to be superior to MPH at higher levels of improvement.

(Funding Source: Shire-Richwood).

REFERENCES:

1. Faraone SV, Biederman J, Spencer TJ, Wilens TE: The drug-placebo response curve: a new method for assessing drug effects in clinical trials. Journal of Clinical Psychopharmacology, (in press).
2. Pliszka SR., Browne RG., Olvera RL., Wynne SK:. A double-blind, placebo-controlled study of Adderall and methylphenidate in the treatment of attention-deficit/hyperactivity disorder. Journal of the American Academy of Child and Adolescent Psychiatry 2000; 39:619–26.

No. 84
COMPARISON OF DURATION OF EFFECT OF OROS MPH WITH MPH TID IN ADHD CHILDREN

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate that Oros MPH qd and MPH t.i.d. significantly improved attention compared with placebo though 12 hours to understand how to assess duration of effect of ADHD treatment and that time of onset of effects of Oros MPH qd was comparable with that of MPH t.i.d.; to appreciate that effects of Oros MPH qd and MPH t.i.d. do not differ significantly through 12 hours following administration of the morning dose.

SUMMARY:

Objective: To compare the duration of effect of once-daily Oros methylphenidate HCl extended-release tablets (Oros MPH qd) and methylphenidate dosed three times daily (MPH tid) in children with attention-deficit/hyperactivity disorder (ADHD).

Background: Oros MPH qd produces a uniquely patterned MPH plasma profile designed to extend the duration of effect and eliminate the need for repeated administration during the day.

Methods: Patients (n = 64) with ADHD, aged 6–12 years, were enrolled in a randomized double-dummy, double-blind controlled study. Treatment duration was seven days, with patients receiving each of the three treatments in a crossover design. On the final day of each treatment, patients attended a laboratory school where ADHD symptoms were assessed at approximately hourly intervals over a 12-hour period.

Results: Significantly higher SKAMP ratings (indicating poorer attention) were observed for placebo compared with both active treatments for all time points after the first assessment one hour after first administration of treatment). There were no statistically significant differences between Oros MPH qd and MPH tid at any of the time points.

Conclusion: The effects of Oros MPH qd and MPH tid on attention lasted through 12 hours and did differ significantly at any time point.

This study was supported by Alza Corporation, on behalf of Crescendo Pharmaceuticals Corporation.

REFERENCES:

1. Modi NB, Lindenmulder B, Gupta SK: Single and multiple dose pharmacokinetics of an oral once-daily controlled release OROS® (methylphenidate HCl) formulation. J Clin Pharm 2000; 40:379–388
2. Swanson JM, Wigal SB, Lerner MA: Comparison of the efficacy and safety of OROS® methylphenidate HCl with methylphenidate t.i.d. and placebo in children with ADHD. Pediatric Res 2000; 47(4):34A (abstract).

No. 85
ONCE-DAILY DOSING OF SLI381 FOR PEDIATRIC ADHD

Joseph Biederman, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-725, Boston, MA 02114;* Frank Lopez, M.D., Samuel Boellner, M.D., Mark C. Chandler, M.D., L. Eugene Arnold, M.D., Ward T. Smith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the therapeutic effects of SLI381 in pediatric ADHD and recognize the benefits of once-daily dosing.

SUMMARY:

Objective: SLI381 is an extended release formulation containing the active ingredient (mixed salt amphetamine product) used in Adderall tablets. The primary objective of this study was to assess, in a naturalistic setting, the efficacy and safety of single-daily dosing of SLI381 compared with placebo.

Method: A multicenter, randomized, double-blind, parallel-group, placebo-controlled study. Subjects, aged 6 to 12 years (mean, 8.5 years), with DSM-IV ADHD combined or hyperactive-impulsive subtype were enrolled at 50 sites. Following a one-week washout of any previous stimulant medication, patients were randomized to receive single-daily a.m. doses of placebo or SLI381 10 mg, 20 mg, or 30 mg for three weeks. The Conners 10-item Global Index Scales, Teacher and Parent versions, were used to assess efficacy.

Results: 584 children were randomized; 563 were included in the intent-to-treat (ITT) population. ITT analysis revealed significant improvement in morning, afternoon, and evening behavior for all active treatment groups versus placebo ($P < 0.001$). Dose-dependent improvements were seen with SLI381. The incidence of spontaneously reported adverse events was low and similar for active treatments and placebo.

Conclusion: The time course and therapeutic effects of SLI381 suggests that this medication is an efficacious once-daily treatment for children with ADHD.

Supported by Shire Richwood Inc.

REFERENCES:

1. McCracken J, Biederman J, Greenhill L, et al: Analog classroom assessment of SLI381 for the treatment of ADHD. Poster presentation at the 47th Annual Meeting of the American Academy of Child and Adolescent Psychiatry. New York, October 26, 2000.
2. McGough JJ, Greenhill L, Biederman J, et al: PK/PD analyses of SLI381 in pediatric ADHD. Poster presentation at the 47th Annual Meeting of the American Academy of Child and Adolescent Psychiatry. New York, October 27, 2000.

SCIENTIFIC AND CLINICAL REPORT SESSION 29—DEPRESSION

No. 86
THE RESPONSE OF PSYCHOTIC-LIKE SYMPTOMS TO FLUOXETINE IN NONPSYCHOTIC MDD

Christina M. Dording, M.D., *Department of Psychiatry, Massachusetts General Hospital, WACC 812,15 Parkman Street, Boston, MA 02114;* Andrea H. Sickinger, B.A., Karen E. Kelly, B.A., Lindsay M. Dececco, B.A., John D. Matthews, M.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the prevalence of psychotic-like symptoms in nonpsychotic major depressive disorder and to recognize that those symptoms often abate during fluoxetine monotherapy.

SUMMARY:

Objective: Traditionally psychotic or delusional depression has been treated psychopharmacologically with the combination of an antidepressant and an antipsychotic agent. Recent studies, however, have suggested that monotherapy in the form of a selective serotonin reuptake inhibitor (SSRI) may be as efficacious as the traditional treatments for delusional depression, including antidepressants plus antipsychotics and ECT. These recent studies, which did not use a standard diagnostic instrument, may have included patients who had psychotic-like symptoms and had been misdiagnosed with delusional depression.

Methods: We evaluated 386 consecutive subjects, all outpatients diagnosed with nonpsychotic major depressive disorder by SCID-P, age range 18 to 65, and with an initial 17-item Hamilton Depression Rating Scale (HAM-D-17) score greater than or equal to 16. They were treated openly with the SSRI fluoxetine 20 mg/day for eight weeks. They were administered a standardized clinician-rated scale for personality disorders (SCID II) prior to entering acute treatment and again following the end of the acute phase of treatment. We assessed possible changes in psychotic-like symptoms detected through the SCID II following fluoxetine treatment.

Results: 187 of the original sample endorsed at least one psychotic-like symptom, including not trusting close acquaintances (item 51), picking up hidden meanings (item 52), believing that others were talking about them (item 57), magical thinking (item 60), or unusual perceptual experiences (item 62). There was a significant reduction overall from baseline to endpoint in the rate of patients endorsing these items. Of those who responded positively to these items at baseline, the percentages of patients no longer endorsing them at the end of fluoxetine treatment were 34% (42/122) for item 51, 44%

(44/101) for item 52, 51% (24/47) for item 57, 46% (16/35) for item 60, and 67% (8/12) for item 62.

Conclusion: Our results show that a significant percentage of patients with SCID-diagnosed nonpsychotic major depressive disorder do in fact endorse subtle psychotic-like symptoms. Approximately half of these symptoms abate during monotherapy with fluoxetine. These results may provide a possible explanation for the relatively high response rates to SSRIs alone observed in samples of depressed patients diagnosed with psychotic depression without the use of more standard diagnostic instruments such as the SCID.

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1. Zanardi R, Franchini L, Gasperini M et al: Double-blind controlled trial of sertraline versus paroxetine in the treatment of delusional depression. American Journal of Psychiatry 1996; 153:1631–1633.
2. Rothschild AJ, Phillips KA: Selective serotonin reuptake inhibitors and delusional depression (letter; comment). American Journal of Psychiatry, 156(6):977–8.

No. 87
PREDICTORS OF STABLE PERSONALITY DISORDERS IN REMITTED DEPRESSED OUTPATIENTS

Amy Farabaugh, M.A., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-812, Boston, MA 02114;* Nicole B. Neault, B.A., Andrea H. Sickinger, B.A., Joel A. Pava, Ph.D., Albert Yeung, M.D., Jonathan E. Alpert, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will learn predictors of stable personality disorders among remitted depressed patients. They will also become familiar with the potential benefits of cognitive behavior therapy in the treatment of personality disorders.

SUMMARY:

Purpose: The purpose of this study is to examine whether remitted depressed outpatients with stable PDs have a different course of acute MDD or present a distinct psychological profile at the time of remission when compared with patients without any PD.

Methods: We evaluated a subset of outpatients (n = 75) with MDD who were enrolled in a parent study designed to test the prophylactic efficacy of fluoxetine alone compared with fluoxetine plus cognitive behavior therapy (CBT) in the treatment of remitted depression. Subjects were treatment responders (defined as HAMD-17 $\leq$ 7 at the end of the acute phase) in the acute phase (fluoxetine 20mg/day) (Time 1 to Time 2) and who then completed the continuation phase (fluoxetine 40 mg/day or fluoxetine 40 mg/day plus CBT) (Time 3). The SCID-P was used to diagnose MDD as well as other comorbid Axis I disorders. The SCID II was used to assess personality disorders. The HAMD-17, the Anxiety Sensitivity Index (ASI), the Dysfunctional Attitude Scale (DAS), and the Beck Hopelessness Scale (BHS) were also used. These measurements were given at the beginning and end of the acute phase.

Results: Out of the 75 patients, 30 patients never met criteria for a PD at Time 2 and Time 3 (remitted MDD patients without a comorbid PD), and 18 patients met criteria for at least one PD at Time 2 and Time 3 (remitted MDD patients with stable PDs). Characteristics of the depression were not significantly related to whether or not patients had a stable PD. MDD patients with stable PDs had significantly higher ASI, DAS, and BHS scores at time of remission, and were more likely to have a comorbid social phobia at Time 1.

Conclusion: Remitted MDD outpatients with stable personality disorders had greater anxiety sensitivity, hopelessness, and dysfunctional attitudes at the end of the acute phase, and were more likely to have an initial comorbid social phobia diagnosis than remitted MDD outpatients who did not meet criteria for a PD at any point. These findings suggest a relationship between a pattern of pathological behavior related to personality disorders and cognitive distortions and the potential usefulness of cognitive behavior therapy in addressing these distortions.

REFERENCES:

1. Akiskal HS, Hirschfeld RM, Yerevanian BI: The relationship of personality to affective disorders. Archives of General Psychiatry 1983; 40:801–809.
2. Fava M, Bouffides E, Pava JA et al: Personality disorder comorbidity with major depression and response to fluoxetine treatment. Psychotherapy and Psychosomatics 1994; 62:160–167.

No. 88
PERSONALITY DISORDERS IN PSYCHOTIC MAJOR DEPRESSION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that patients with major depression with psychotic features (PMDD) endorse greater behavioral disturbances of the psychotic and avoidant personality disorder types than those with major depression without psychotic features (NPMDD).

SUMMARY:

Objective: To evaluate the rates of comorbid personality disorders between a population of patients with major depressive disorder with psychotic features (PMDD) and a matched group of patients with MDD without psychotic features (NPMDD).

Methods: We matched 20 consecutive PMDD patients from an open-label fluoxetine and olanzapine study with 20 NPMDD patients, from an open-label study of fluoxetine, by age (19–68 years old; mean of 38.9 years for PMDD and mean of 37.9 years for NPMDD, p = 0.85) and gender (55% male and 45% female). As part of their initial screening visit, the patients completed the Personality Disorders Questionnaire-Revised (PDQR) as a self-rated measure of personality disorder. In addition, severity of depression was evaluated using the Hamilton Depression Rating Scale (HAM-D-17) and the Clinical Global Impression (CGI) scores.

Results: Patients with PMDD had significantly higher rates of comorbid personality disorders than patients with NPMDD ($p \leq 0.5$) respectively: schizotypal 80% vs. 35%; paranoid 85% vs. 47%; avoidant 75% vs. 45%; dependent 50% vs. 20%; and self-defeating 53% vs. 15%. Those patients with PMDD had significantly higher initial HAM-D-17 (28.1+/–6.1 versus 19.8+/–12.2, $p < 0.0001$) and CGI scores (5.5+/–0.7 versus 4.1+/–0.7, $p < 0.0001$).

Conclusion: Patients with PMDD have higher rates of behavior disturbances consistent with Cluster A and C personality disorders than patients with NPMDD. This is inconsistent with the assumption that PMDD, like melancholia, is associated with relatively lower rates of personality disorders compared with NPMDD.

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SCIENTIFIC AND CLINICAL REPORT SESSION 30—INTERNATIONAL PERSPECTIVES ON PSYCHIATRY

No. 89
LIFETIME AND 12-MONTH PREVALENCE OF MENTAL ILLNESS IN CHILE

Benjamin Vicente, M.D., *Department of Psychiatry, University of Concepcion, Casillia 60-C, Concepcion, Chile;* Robert Kohn, M.D., Pedro Rioseco, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to gain an better understanding of the epidemiology of mental illness among Latin-American populations.

SUMMARY:

Objectives: The goal of this study was to examine the lifetime and 12-month prevalence rate and risk factors for mental illness in Chile. No other psychiatric epidemiological study has provided data on a nationally representative sample in Latin America.

Methods: The Chile Psychiatric Prevalence study was based on a household stratified sample of persons aged 15 and older. The study was conducted in four provinces representing the various geographical regions of the country. DSM-III-R diagnoses were obtained using the CIDI. The response rate was 90.3%, with a total of 2,987 participants. The sample was weighted to the national census of 1992 and analyzed using SUDAAN.

Results: Lifetime psychiatric disorders were present in 30.0% of the respondents, and 12-month disorders in 21.0%. For lifetime disorders 17.0% had an anxiety disorder, 14.0% had an affective disorder, and 4.2% had a substance use disorder. For 12-month prevalence 11.0% had an anxiety disorder, 8.7% an affective disorder, and 2.5% a substance use disorder. Comorbidity was found in 36.9% of those with a lifetime disorder and 25.6% of those with a 12-month disorder. Differences in rates were noted by gender, age group, and for selected disorders by education.

Conclusions: Similar risk factors for mental illness are present in Latin America as found in other surveys conducted in North America.

REFERENCES:

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No. 90
RACE AND PSYCHIATRY IN POST-APARTHEID SOUTH AFRICA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of the long-term impact that racial segregation has with respect to mental health care.

SUMMARY:

Objective: The primary objectives of this study were to examine changes that had occurred in the quality of mental health care five years after apartheid and, in particular, if psychiatric care for black patients had improved. South African psychiatry continues to be in transition following the discriminatory practices of apartheid.

Method: A survey was distributed to South African psychiatrists during a national congress and by mail. The questionnaire focused on the quality of psychiatric care in general for black and white patients; the racial composition of the respondent's psychiatric practice currently; and the racial composition of the psychiatric practice during apartheid.

Results: Mental health care in South Africa was generally viewed as deteriorating. The end of apartheid has done little to improve the quality of care for both black and white patients. Although less pronounced, racial inequality in psychiatric care continues to exist. Psychiatric practices continue to be over-represented with white patients.

Conclusion: There remains a differential in quality of psychiatric care, and further monitoring should continue. There needs to be awareness of the decline in the quality of mental health, continued efforts to improve racial equality, and greater awareness of cultural issues. Limitations to this study included possible social desirability bias, subjective rather than objective measures utilized, and the survey was limited in scope.

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1. Stein DJ: Psychiatric aspects of the Truth and Reconciliation Commission in South Africa. Br J Psychiatry 1998; 173:455–457.
2. Szabo CP, Kohn R, Gordon A, et al: Ethics in the practice of psychiatry in South Africa. South African Medical Journal 2000; 90:498–503.

No. 91
THE WORLD PSYCHIATRIC ASSOCIATION: AN INTERNATIONAL SURVEY OF URBAN MENTAL HEALTH

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will become familiar with the main mental health issues encountered in urban areas.

SUMMARY:

Because of the phenomenon of rapid urbanization that has occurred over the last few decades, approximately 50% of the world population lives in urban areas. Urban environments offer both opportunities and challenges for mental health promotion. Cities experience a greater prevalence of a variety of health problems and risk factors, many of which have social and behavioral determinants. As part of an ongoing effort to assess the mental health need in city dwellers the Section on Urban Mental Health of the World Psychiatric Association is carrying out an international survey on urban mental health based on a questionnaire that was sent to more than 300 psychiatrists worldwide. The questionnaire is divided into three parts. The first part focuses on general issues such as city size, changes in urbanistic aspects, social well-being and general health. The second part deals with specific psychopathology, violence, mental health policies, and the organization as well as access to mental health services. The final part examines in detail factors that may have an effect on mental health, such as environmental (e.g., air pollution, housing), socioeconomic (e.g., poverty, unemployment), and psychosocial factors (e.g., support systems, cultural conflicts). Preliminary data indicate the high prevalence of a variety of problems, especially related

to access to mental health services, lack of social connectedness and socioeconomic instability even in the developed countries. The final results from this survey will be presented, and their implications for mental health will be discussed.

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1. The City and Mental Health: Special Issue Journal of International Mental Health, edited by Mezzich J, Caracci G. Winter 1999–2000, M.E. Sharpe.
2. Marsella AJ: Urbanization, mental health, and social deviancy: a review of issues and research. Am Psychol. 1998;53:624–634.

SCIENTIFIC AND CLINICAL REPORT SESSION 31—SOCIAL AND COMMUNITY PSYCHIATRY

No. 92
MENTAL HEALTH AND STRESS IN HIGHLY EDUCATED EMPLOYEES

Cheryl Koopman, Ph.D., *Department of Psychiatry, Stanford University, MC 5718, Stanford, CA 94305-5718;* Robert A. Matano, Ph.D., Stanley Wanat, Ph.D., Darrah Westrup, Ph.D., Shelly Whitsell, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that high life stress, low work and relationship satisfaction, avoidant coping, harmful/hazardous drinking, and antidepressant use may indicate heightened risk for mental health problems in highly educated employees.

SUMMARY:

Objective: This study examined the relationships of psychosocial factors and demographic characteristics to mental health in a highly educated workforce.

Methods: We mailed a survey to a randomly selected sample of 10% of the employees in a large worksite. The return rate was 60% (N = 504), with 460 providing complete data for this study. Women comprised 63% of the respondents. Mean age was 43.4 years (SD = 11.6). Eighty-eight percent of the respondents had completed a bachelor's degree, and 51% of respondents had completed a masters and/or doctoral degree. Respondents completed the Mental Health Index as well as measures of alcohol-abuse risk factors, avoidant coping, stressful life events, home and job stress and satisfaction, and use of antidepressants.

Results: The final overall multiple regression model significantly predicted Mental Health Index scores [$F (10, 449) = 39.26$, $p < .001$], adjusted overall $R^2 = .46$. Employees who reported stress at home or at the worksite, use of avoidant coping, low satisfaction at work or home, harmful/hazardous alcohol drinking, or current use of antidepressants were at higher risk compared with other employees for having mental health problems.

Conclusion: This study suggests several psychosocial factors that may be useful in identifying employees at high risk for mental health problems who may need psychiatric intervention.

Funding Source: Center for Substance Abuse Prevention, #5 U1K SPO8101-02

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2. Najavits LM: Numbing the Pain: Addiction and Trauma. Understanding and Treating the Addictions. Boston: Harvard Medical School, 1999.

No. 93
THE NEXT STEP GROUP: MULTIMODAL STRATEGIES IN GROUP THERAPY FOR SERIOUS ILLNESS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the importance of combining different approaches to increase long-term effectiveness of group therapy for seriously mentally ill people.

SUMMARY:

Background: As health care resources continue to diminish for the delivery of mental health care services, cost-effective therapies must be established to prevent relapse and foster integrating into the community.

Objective: The purpose of this clinical report is to suggest that an eclectic approach that combines traditional and nontraditional, psychodynamic and behavioral methods makes group therapy effective for people with serious mental illnesses.

Setting: Outpatient psychiatry clinic of an urban 1,000-bed teaching tertiary care center.

Participants: Two heterogeneous groups (five to seven participants in each group) of patients in midlife with schizophrenia, major depression, or severe personality disorders.

Description of Next Step Group: Therapy consists of combination of psychodynamic, behavioral, and self-help networking strategies that encourage contact outside group to enhance interpersonal relationships and greater community involvement.

Targets of therapy: Avoid hospitalization or institutionalization. Medication adherence and promotion of economic stability using principles of self-disclosure and sharing of factual information that simultaneously enhances interpersonal functioning. The first group has completed three years and the other one to two years. The therapy has proven useful as evidenced by the continuing membership, all have maintained or obtained community residence, and most have achieved successful vocational and personal goals relative to their disability.

Conclusion: This small pilot project demonstrates that even the most seriously mentally ill patients can be helped through multimodal group therapy that includes both traditional and nontraditional designs.

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2. Ormont L: The craft of bridging. International Journal of Group Psychotherapy 1990; 40:3–17.

No. 94
PSYCHIATRIC ISSUES IN SPACE: IMPLICATIONS FROM THE SPACE SHUTTLE/MIR PROGRAMS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to list common psychiatric syndromes in space and identify important psychosocial issues that may affect both crewmembers and mission control personnel during long-duration space missions.

SUMMARY:

Objective: Because psychiatrists will become increasingly involved with people participating in long-duration space missions, we examined issues of relevance to psychiatry in our four-and-a-half-year, NASA-funded study of 13 U.S. and Russian crewmembers and 58 U.S. and Russian mission control subjects who were engaged in the Shuttle/Mir program.

Method: Subjects completed the Profile of Mood States, the Group and Work Environment Scales, and a critical-incident log on a weekly basis.

Results: The hypothesized displacement of tension and dysphoria from crewmembers to mission control personnel and from mission control personnel to management was strongly supported by our findings. A number of significant mood and group differences emerged between American and Russian subjects. Significant differences also were found between crewmembers and mission control personnel, although both groups reported significantly less dysphoria than other work groups on Earth. We found little support for the presence of asthenia, a condition reported by Russian space psychologists. Stressors affecting the subjects were identified, and their impact will be described.

Conclusion: Psychiatric issues affect people who participate in space missions, and further empirical work needs to be done in this interesting new area.

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2. Kanas N, Salnitskiy V, Grund EM, et al: Interpersonal and cultural issues involving crews and ground personnel during Shuttle/Mir space missions. Aviation, Space, and Environmental Medicine, in press.

SCIENTIFIC AND CLINICAL REPORT SESSION 32—ISSUES IN THE TREATMENT OF MOOD DISORDERS

No. 95
OLANZAPINE VERSUS DIVALPROEX SODIUM FOR THE TREATMENT OF ACUTE MANIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe a study of a double-blind comparison of divalproex and olanzapine in the treatment of acute mania.

SUMMARY:

Objectives: This study explores the relative efficacy and safety of these two agents with mood-stabilizing properties for the treatment of acute mania.

Methods: A three-week, randomized, double-blind trial compared flexibly dosed olanzapine (5–20 mg/day) to divalproex (500–2500 mg/day) for the treatment of acute manic or mixed episodes of bipolar I disorder. The primary efficacy measure was the Young-Mania Rating Scale (Y-MRS). Several safety measures were employed. At baseline, subjects were hospitalized and acutely ill (Y-MRS ≥20).

Results: Mean Y-MRS improvement for subjects treated with olanzapine (n = 125) was −13.4 (baseline: 27.4) versus −10.4 for those on divalproex (n = 126; baseline; 27.9; p = 0.028). Two *apriori* categorizations defined response rates: 54.4% of olanzapine-treated patients experienced a ≥50% reduction in Y-MRS scores compared with 42.3% of divalproex-treated patients (p = 0.058); 47.2% of olanzapine-treated patients had endpoint Y-MRS ≤ 12, versus 34.1% on divalproex (p = 0.039).

Conclusions: Patients with acute manic or mixed episodes of bipolar I disorder experienced superior clinical response with olanzapine than divalproex.

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1. Bowden CL, Brugger AM, Swann AC, et al: Efficacy of divalproex vs. lithium and placebo in the treatment of mania. JAMA 1994; 271:918–924.
2. Tohen M, Sanger TM, Tollefson GD, et al.: Olanzapine versus placebo in the treatment of acute mania. Am J Psychiatry 1999; 156:702–709.

No. 96
RISK OF POSTPARTUM DEPRESSION IN WOMEN WITH PREGRAVID MAJOR DEPRESSION DISORDER

Ruta M. Nonacs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Lee S. Cohen, M.D., Suzanne M. Bouffard, B.A., Lauren Wise, M.S.C., Bernard L. Harlow, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify risk factors for postpartum depression in women with histories of major depressive disorder.

SUMMARY:

Introduction: Postpartum depression (PPD) is relatively common, occurring in up to 10%–15% of women after delivery. Various risk factors for PPD have been identified in the general population and include depression during pregnancy and inadequate social supports or marital discord. However, the extent to which women with pregravid histories of major depressive disorder (MDD) are at risk during the postpartum period has not been systematically studied.

Methods: A sample of women (N = 47) with pregravid histories of MDD were followed prospectively throughout pregnancy and into the postpartum period using a number of standardized instruments. Rates of relapse were assessed and predictors of risk for PPD were identified using a logistic regression analysis.

Results: Relapse rates were high (48.9%) in this population. Depressive symptoms tended to emerge early, with 19 of 23 patients (82.6%) developing symptoms within the first two postpartum weeks. Primiparous women were at higher risk for PPD. Those with more severe illness (>3 previous episodes) had a worse postpartum outcome. Women who experienced depression during pregnancy were almost three times more likely to develop PPD than those who remained euthymic.

Conclusions: Women with histories of MDD are at high risk for postpartum depression. The women who are at highest risk are those who develop depression during pregnancy and those with a greater number of previous episodes. These women may be easily identified prior to delivery and may therefore be eligible for prophylactic interventions.

REFERENCES:

1. O'Hara MW, Schlechte JA, Lewis DA, et al: A controlled prospective study of postpartum mood disorders: psychological, environmental and hormonal factors. J Abnorm Psychol 1991; 100:63–73.
2. Warner R, Appleby L, Whitton A, Faragher B: Demographic and obstetric risk factors for postnatal psychiatric morbidity. Br J Psychiatry 1996;168:607–611.

No. 97
THE RISING PREVALENCE OF ANTIDEPRESSANT TREATMENT FOR U.S. YOUTH

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify: 1) antidepressant prevalence rates according to health service system (Medicaid or HMO), and by age and gender; 2) trends (1988–1994) for antidepressant subclasses; 3) the influence of physician specialty (primary care vs. psychiatry) on the likelihood of receiving an antidepressant, adjusting for Medicaid patient characteristics and state.

SUMMARY:

Objective: To determine antidepressant (ATD) prevalence and its sociodemographic and clinical correlates in youths 2–19 years old using community-based data sources.

Method: Ambulatory care prescription and clinical service records from two state Medicaid systems (MAM and MWM) and a salaried, group model HMO were organized into seven one-year cross-sectional data sets for the years 1988 through 1994. Measures included ATD total and subclass prevalence, seven-year trends and multivariate modeling of the role of physician specialty in ATD utilization.

Results: The major findings are: 1) ATD prevalence consistently increased across the seven-year span (3- to 5-fold); 2) the 1994 ATD prevalence rate ranged from 1.3% (HMO) to 1.8% (MAM) and 1.9% (MWM); 3) In 1994, despite the expanded use of SSRIs, over half of ATD use was still attributable to TCAs; 4) Males predominated in ATD prevalence among 10–14 year olds, whereas females predominated among 15–19 year olds; 5) For Medicaid youth receiving ATDs, ADHD followed by depression led the primary care diagnoses, whereas that sequence was reversed for youth receiving psychiatric services; 6) ATD-treated youth with psychiatric services constituted 35.2% of the total, whereas the majority (64.0%) had only primary care services.

Conclusions: ATD-treated youth from primary care exceeded that from psychiatric services in the 1990s and warrant attention in outcomes research.

Funding Source: NIMH R01MH55259

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1. Rushton JL, Clark SJ, Freed GL: Pediatrician and family physician prescription of selective serotonin reuptake inhibitors, Pediatrics 105(6):e82.
2. Pincus HA, Tanielian TL, Marcus SC, et al: Prescribing trends in psychotropic medications, JAMA 1999; 279:526–531.

THURSDAY, MAY 10, 2001

SCIENTIFIC AND CLINICAL REPORT SESSION 33—PROMOTION OF MENTAL HEALTH

No. 98
POPULAR HEALTH ADVICE: A HISTORICAL SURVEY

Laura D. Hirshbein, M.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Ann Arbor, MI 48109*

EDUCATIONAL OBJECTIVE:

At the end of this presentation, the participant should understand the primary messages delivered to laypeople in popular magazines on the topic of mental health over the 20th century. The participant should also understand the differences in the advice directed toward women and men.

SUMMARY:

Although the recent surge of interest in self-help psychological literature may appear to be a modern phenomenon, professionals and laypeople have produced a substantial quantity of material on the topic of mental health in the popular press since the late 19th century. An examination of advice literature on mental health over the course of the last century reveals changes and continuities in popular understandings of how to maintain mental health and what constitutes mental illness. This paper surveys mental health advice in the 20th century in Ladies' Home Journal and Newsweek, two magazines that have had large circulations and have informed readers about the similarities and differences in emotional regulation appropriate to men and women. Popular mental health advice has served two functions: It instructed laypeople on how to remain healthy and on what goes wrong to produce mental illness. While mental health advice can be helpful to readers of popular magazines by giving them information, it can also deliver the message that mental illness results from failure of mental health efforts. The lessons learned from this historical survey can be used to better understand public assumptions about mental health and illness and to create more effective mental health campaigns in the future.

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1. Scanlon J: Inarticulate Longings: The Ladies' Home Journal, Gender, and the Promises of Consumer Culture. New York, Routledge, 1995.
2. Fellman AC, Fellman M: Making Sense of Self: Medical Advice Literature in Late Nineteenth-Century America. Philadelphia, University of Pennsylvania Press, 1981.

No. 99
A SYSTEMATIC REVIEW OF SCREENING FOR DEPRESSION IN PRIMARY CARE

Bradley N. Gaynes, M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, CB # 7160, Chapel Hill, NC 27599-7160;* Michael P. Pignone, M.D., C. Tracy Orlean, Ph.D., Jerry L. Rushton, M.D., Cynthia D. Mulrow, M.D., Catherine Mills, M.A., Kathleen N. Lohr, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the accuracy of screening instruments for depression in adult primary care populations, recognize the effectiveness of various treatments in primary care for improving the outcome of depression, and identify under what conditions screening may lead to improved clinical outcomes.

SUMMARY:

Objective: Screening for depression in primary care has not been recommended. In a report for the U.S. Preventive Services Task Force, we systematically reviewed the literature to determine the effectiveness of screening for depressive disorders in primary care.

Method: We systematically searched MEDLINE (1966–1999) and reviewed the Cochrane Collaboration to identify 192 studies involving diagnostic accuracy or randomized controlled trials of screening and treatment for adults in primary care. These articles were abstracted and the data synthesized.

Results: Studies examining the diagnostic accuracy of depression screening instruments report sensitivity of 80% to 90% and specific-

ity of 70% to 85%. Shorter screening tests detect most depressed cases and may perform better than longer instruments. Both pharmacotherapy and psychotherapy reduce depressive symptom duration and severity. Feedback of screening results to providers increases recognition of depression in adults compared with usual care, but the effect of feedback on treatment and outcomes is mixed. Systematic support to ensure adequate management appears key to increasing the likelihood that screening will improve outcomes.

Conclusions: Accurate screening tests and effective therapies for depression are available. Screening in primary care can improve outcomes compared with usual care, particularly when coupled with efforts to ensure adequate treatment.

This study was conducted by the RTI/UNC Evidence-based Practice Center under contract to the Agency for Healthcare Research and Quality, Contract No. 290-97-0011, Rockville, MD. The authors of this article are responsible for its contents, including any clinical or treatment recommendations. No statement in this article should be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services

REFERENCES:

1. Williams JWJ, Mulrow CD, Kroenke K, et al: Case-finding for depression in primary care: a randomized trial. Am J Med 1999; 106:36–43.
2. Wells KB, Sherbourne C, Schoenbaum M, et al: Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. JAMA 2000; 283:212–220.

No. 100
MEDICAL STUDENTS' MENTAL AND PHYSICAL HEALTH PROMOTION: A NORTH AMERICAN SCHOOL SURVEY

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EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to recognize the importance of mental health promotion among medical students for the prevention of physician mental illness. They should also be able to contrast both American and Canadian, and current and past programs.

SUMMARY:

Objective: To investigate programs promoting the mental and physical health of North American medical students, to contrast American and Canadian schools, and to compare results with a 1988 survey.

Method: The 1999 Medical School Health Promotion Survey was designed, piloted, then mailed to 143 medical schools. An SPSS database was used for data analysis.

Results: Among respondent schools, 67(69.1%) had a program, of which 60(84.5%) were designed on site and 14(21.9%) were mandatory. The most common components were stress (88.2%) and time management (77.9%). American programs (49% > 10 years) were significantly older than Canadian ones ($p = 0.017$) and less frequently initiated by students (43.5% versus 88.9%). A 46.6% program increase occurred since 1988. The emphasis shifted from physical to psychological well-being.

Conclusion: The prevalence of health promotion programs for medical students has markedly increased over the past decade. Most are moderately successful and have been designed on site, although few have mandatory attendance. Significant differences between American and Canadian programs, and between current and past programs, exist. Standardized mental and physical health promotion programs should be integrated into medical school curricula. Ongoing program accreditation and outcome studies are needed.

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2. Helmers KF, Danoff D, Steinert Y, et al: Stress and depressed mood in medical students, law students, and graduate students at McGill University. Acad Med 1997; 72:708–714.

SCIENTIFIC AND CLINICAL REPORT SESSION 34—PSYCHIC AND SOMATIC ISSUES IN PSYCHIATRY

No. 101
OVERWEIGHT STATUS OF PARENTS: A LONGITUDINAL STUDY OF OFFSPRING ADIPOSITY

Debra L. Safer, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5722;* W. Stewart Agras, M.D., Sue Bryson, M.S., Lawrence Hammer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the importance of longitudinal studies in exploring the role of familial factors on the development of adiposity in children; to understand the findings from this study and its implications regarding relationships between parent and child measures of adiposity.

SUMMARY:

Objective: To assess longitudinally the relationship between parent and child body mass index (BMI) over the first eight years of life and the role of parental overweight status in the development of childhood adiposity.

Methods: The sample included 114 children followed annually from infancy to age 8 and their 228 biological parents. Weight and height were assessed at baseline for parents (six months postpartum for mothers) and at regular intervals for children. Main outcome measures were: Spearman correlations between parent and offspring BMI over eight years and repeated measures analysis examining the yearly pattern of children's BMI changes from birth to age 8 in relation to parental overweight status.

Results: Significant correlations between parental BMI (both maternal and paternal) and their offspring first emerged at age 7. Children with two overweight parents had consistently elevated BMIs compared with children with either no overweight parents or only one. These differences became significant beginning at age 7.

Conclusions: Parental adiposity status influences offspring BMI and pattern of BMI changes over time. These first emerge at age 7. This study supports the hypothesis that familial factors (biological and/or environmental) affecting the development of adiposity are age specific. Important implications are explored.

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1. Stunkard A, Berkowitz R, Stallings V, Cater J: Weights of parents and infants: is there a relationship? Int J Obes Relat Metab Disord 1999; 23:159–162.
2. Yager J: Weighty perspectives: contemporary challenges in obesity and eating disorders. Am J Psychiatry 2000; 157:851–853.

No. 102
INTEGRATING PSYCHOANALYSIS AND NEUROBIOLOGY IN THE TREATMENT OF MIGRAINES

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand how attachment experiences shape neural substrate and how a treatment approach focusing on attunement, emotional regulation, and micromoments of interactions within attachment experiences can effectively treat intractable psychosomatic conditions.

SUMMARY:

The purpose of this paper is to link recent findings in developmental neurobiology with the treatment of a psychosomatic condition. The remarkable degree to which brain development is experience dependent is a striking example of how neuroscience can be integrated with psychoanalysis. The idea that human connections in early attachment shape neuronal connections from which the mind emerges carries implications, which allow us to expand the scope of psychotherapeutic treatment, especially of disorders that have previously been viewed as resistant to treatment. The successful psychoanalytic treatment of a woman with chronic, intractable migraine headaches is presented. Despite the prevalence of depression and anxiety in patients with migraine headaches, treatment has been frustrating due to the dissociation of painful visceral symptoms from symbolic representation and the frequency of alexithymia; a treatment approach centering on interpretation is often futile. Utilizing a dynamic systems approach, this patient's headaches are viewed as tenacious states of dysregulation and tension born out of insecure/disorganized attachment experiences that were repeatedly activated and engrained as attractor states of brain patterning. A treatment approach focusing on attunement, emotional regulation, and micromoments of attachment markedly reduced the patient's headaches.

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2. Siegel DS: The Developing Mind. New York, NY, The Guilford Press, 1999.

No. 103
UNREMITTING DEPRESSION: CINGULATE DYSFUNCTION AND THE CLEFT-SELF ON TRIAL

Leo I. Jacobs, M.D., *Department of Psychiatry, Advocate Good Shepherd, Hospital 450 West Highway 22, Building II, Barrington, IL 60010*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to integrate pathophysiological data (endocrine/functional brain-imaging related to cortical/limbic interactions), to recognize cingulate mood-cognition modulation in major depression, evaluate hypothesis: Cingulate dysfunction underlies major depression's low (<50%) rate of full remission with traditional psychotherapy/psychopharmacology, diagnose "cleft-self" pathology, and implement psychotherapeutic Socratic dialogue, focusing on justice, ethics, and compassion.

SUMMARY:

Objective: To evaluate psychotherapeutic, values-based Socratic dialogue in treating subjects whose major depression failed to remit with traditional psychopharmacology/psychotherapy and whose residual self-pathology included "cleft-self" features (unattainable personal standards, brutal self-condemnation—possibly related to unempathic upbringings superimposed on genetically determined neurotransmitter dysfunctions—with self as both "tormentor" and "tormented.")

Method: Subjects (n = 12), with depressive histories ranging from 10–45 years, whose pretreatment scores (GAF < 30) improved to GAF-55 (avg.) with traditional psychotherapy/psychopharmacology, then stagnated. All exhibited "cleft-self" features. Using study of the dilemma of Kafka's protagonist in The Trial for transition, psychotherapeutic style shifted to egalitarian Socratic dialogue, addressing "cleft-self" pathology in terms of human values, including compassion, equality, courage, justice, and cognitive freedom. Psychopharmacological regimens were unchanged.

Findings: Over nine months (avg. 20 sessions), all GAF scores (n = 12) rebounded, from GAF 55 (avg.) to a post-study GAF 75 (avg.)

Conclusions: With current identification of the anterior cingulate gyrus as the neural network's crucial component underlying the sense of self, it is hypothesized that values-based Socratic deliberations set the stage for remission through normalization of: 1) cingulate function; 2) precortical executive function, and 3) amygdalar control over rage/fear, possibly interrupting chronic activation of HPA axis. Pre/Post-treatment fMRI studies of similar subjects are urged.

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1. Kocsis JH: New strategies for treating chronic depression. J of Clinical Psychiatry, Supplement 11, 2000.
2. Mayberg HS et al: Cingulate function in depression: a potential predictor of treatment response. Neuro Report 1997; 3:1057–1061.

SCIENTIFIC AND CLINICAL REPORT SESSION 35—ISSUES IN PSYCHOPHARMACOLOGY

No. 104
PROLACTIN LEVELS IN PATIENTS TAKING RISPERIDONE AND ZIPRASIDONE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize prolactin elevations with atypical antipsychotic drugs; to appreciate differences between drugs in elevating prolactin; to understand that prolactin elevation continues over years.

SUMMARY:

In a 52-week, double-blind study, 20 patients with schizophrenia (14 male and six female) were randomized to the ziprasidone group and 11 patients (eight male and three female) to the risperidone group with serial estimation of prolactin. The mean baseline prolactin level was 30.4 ng/ml in the ziprasidone group, decreased to 20.26 at the end of week 6, and 23.6 ng/ml at the end of week 52. The mean baseline prolactin value of 36.7 ng/ml in the risperidone group increased to 71.5 ng/ml at the end of week 6, and to 85.8 ng/ml at the end of week 52. Four of the 11 patients had normal baseline prolactin, which increased in all of them. Of the seven patients who had normal baseline prolactin in the risperidone group, the level decreased in four, did not change in one, and increased in two. These results indicate that (a) both groups had high baseline prolactin levels,

(b) during the treatment, prolactin levels decreased in ziprasidone group and increased in the risperidone group, (c) in patients with normal prolactin levels at the baseline, the levels increased only in the risperidone group, and (d) based on our data, ziprasidone 80–160 mg has little effect on prolactin levels.

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2. Seeger TF, Seymour PA, Schmidt AW, et al: Ziprasidone (CP-88,059): a new antipsychotic with combined dopamine and serotonin receptor antagonist activity. J Pharmacol Exp Ther 1995; 275:101–113.

No. 105
A PLACEBO-CONTROLLED, LONG-TERM TRIAL OF METHYLPHENIDATE IN THE TREATMENT OF ADULTS WITH ADHD

Paul H. Wender, M.D., *PMB 341, 9 Bartlet Street, Andover, MA 01810-3884;* Frederick W. Reimherr, M.D., Barrie Marchant, M.A., Laura Czajkowski, Ph.D., M. Eve Sanford, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to diagnose ADHD in adults utilizing both new diagnostic criteria and ADHD rating scales, prescribe stimulant medication with maximal efficacy, and measure outcome based on target symptoms.

SUMMARY:

Increasingly large number of adults are being diagnosed with ADHD and treated with stimulants. Few psychiatrists use operational diagnostic criteria and, although long-term drug treatment is frequently prescribed, there are no data documenting the efficacy of such treatment. The objective of this study is to provide such diagnostic criteria and to report on a long-term trial of methylphenidate in the treatment of adult ADHD.

Method: 116 patients meeting the Utah Criteria for adult ADHD were entered into a random assignment, double-blind, crossover study of methylphenidate and placebo with two weeks in each condition. Patients who showed a moderate or marked response to methylphenidate were entered into a long-term trial. Outcome was measured with the CGI, GAF, the WRADDS (a structured intereview based scale of ADHD symptoms), and the Weissman Scale of Social Adjustment (WSAS).

Results: 70% of the patients experienced moderate to marked improvement on drug vs. 21% on placebo. After one year of treatment, methylphenidate responders had an average increase on their GAF of 20 points, a decrease of symptom severity of 75%, and a change on the WSAS from moderate impairment to good adjustment. Tolerance to medication did not develop.

Conclusion: ADHD in adults can be defined operationally, treatment with methylphenidate produces marked improvement on a number of measures over a one-year follow-up, and tolerance to the drug did not occur.

REFERENCES:

1. Wender P: Attention Deficit Hyperactivity Disorder in Adults. Oxford University Press, 1995.
2. Wender PH., Reimherr FW, Ward M: A controlled trial of methylphenidate in the treatment of attention deficit disorder, residual type, in adults. American Journal of Psychiatry 1985; 142:547–552.

No. 106
USE OF INTRAVENOUS LORAZEPAM IN PATIENTS WITH CATATONIA-LIKE SYNDROMES

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to review the use of benzodiazepines in catatonia-like syndromes.

SUMMARY:

Few disorders are as enigmatic as catatonia. DSM-IV outlines criteria for catatonia with the presence of at least two of the following symptoms: motor immobility, excessive motor activity, extreme negativism, peculiar voluntary movement, and echolalia or echopraxia. However, there are some patients who have less-severe catatonia-like symptoms such as psychomotor slowing and some degree of negativism, although they do not meet the criteria for catatonia. We describe four such patients who had catatonia-like symptoms and who responded to intravenous lorazepam or a combination of lorazepam with antipsychotic medication. In one patient catatonia-like symptoms reemerged with the decrease in the dosage of lorazepam. This raises the possibility that there may be a spectrum of catatonia-like disorders that may be responsive to benzodiazepines. Further research needs to be done to delineate their common characteristics and explore why they respond to benzodiazepine treatment.

REFERENCES:

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2. Ungvari GS, Chiu HF, Chow LY, et al: Lorazepam for chronic catatonia: a randomized, double-blind, placebo-controlled crossover study. Psychopharmacology (Berl) 1999;142:393–398.

SCIENTIFIC AND CLINICAL REPORT SESSION 36—FORENSICS

No. 107
SCHIZOPHRENIA AND MASS HOMICIDE: WHO, WHAT, AND WHY FROM CASE HISTORIES

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the clinician or forensic examiner should be able to recognize the various ways in which schizophrenia relates to mass homicide, in order to help obviate potential risk and to assess defendants in questions of legal insanity.

SUMMARY:

Mass homicide unrelated to crime concealment has occurred with increasing frequency in recent years. Those perpetrators who are not killed after the fact are invariably identified. This prompts psychiatric examination as an integral component of a criminal defense strategy, as other criminal defenses have no potential likelihood of being successful. Recent reports suggest the high prevalence of schizophrenia among those who carry out rampage killings in the United States. The author presents a psychiatric understanding of those who carry out mass homicides, including four cases in which he conducted the actual forensic examination. The significance of schizophrenia is reviewed, from the role of nihilism, to delusions, to hostility, to the

influence of comorbid depression and suicidality. Psychodynamic themes of powerlessness, identity, and control are also explored.

Implications for assessment and identification of those at greatest risk are also to be presented. This scientific report is aimed at the outpatient and inpatient clinician who need to identify those of greatest vulnerability to one day carry out a mass shooting, and how to obviate risk through interventions that recognize and respond to the psychodynamically significant potential triggers.

The presentation also relates the diagnostic and clinical aspects of the history to resolving questions of criminal responsibility and the requirements of insanity defenses. It is therefore of particular value to the forensic and correctional psychiatrist who may conduct an examination of such a defendant.

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1. Hempel AG, Meloy JR, Richards TC: Offender and offense characteristics of a nonrandom sample of mass murderers. J Am Acad Psychiatry Law 1999;27:213–25.
2. Cantor CH, Mullen PE, Alpers PA: Mass homicide: the civil massacre. J Am Acad Psychiatry Law 2000;28:55–63.

No. 108
BEHAVIORAL TREATMENT OF THE AGGRESSIVE MENTALLY ILL INMATE

Robert L. Trestman, M.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030-1410;* Kathy Coleman, M.S., Clyde McDonald, B.S., Tod Bogdanoff, Psy.D., Giovanny Gomez, Aqil Hashim, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify a collaborative treatment approach developed by mental health and custody staff to address severe behavioral disturbances in the mentally ill inmate population; to identify measures that can be utilized to analyze the effectiveness of such programs.

SUMMARY:

Objective: To determine the effectiveness of an intensive behavioral intervention in a prison setting in reducing the number/severity of episodes of dyscontrol in aggressive mentally ill male inmates.

Method/Design: Comparative analysis.

Setting: A maximum-security prison housing many of the mentally ill male offenders in the Connecticut Department of Correction.

Program: The three-phase program, developed collaboratively by custody and mental health staff, involves restrictive behavioral interventions with a gradual increase in privileges based upon demonstrated behavioral control.

Participants: 35 inmates admitted between 6/26/96–12/29/99 were eligible. Twenty-five participants met the six-month follow-up criteria and are included in the analysis.

Main Outcome Measures: Number and severity of disciplinary reports (DR's) received six months pre-admission, during prison term, and six months post-discharge.

Results: The mean number of tickets received by the 25 inmates in the six months prior to admission was 8.7, during was 3.1, and in the six months post-discharge was 1.7 ($p < 0.05$). The severity of the offenses was also less for inmates during and six months after completion of the program ($p < 0.05$).

Conclusion: This intensive behavioral program is effective in reducing the severity and frequency of behavioral disturbances in a sentenced population of aggressively mentally ill men.

REFERENCES:

1. Ward SC., Bradigan MA, Holanchock H: Intermediate care programs to reduce risk and better manage inmates with psychiatric disorders. Behavioral Sciences and the Law 1997; 15:459–467.
2. Metzner JL: An introduction to correctional psychiatry: Part II. J Am Acad Psychiatry Law 1998; 26:107–115.

No. 109
DISABILITY EVALUATIONS IN THE U.S. AIR FORCE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of the standards and methods used in performing disability evaluations and placing psychiatric restrictions on members of the USAF.

SUMMARY:

Clinical criteria for psychiatric illnesses that are career limiting to active duty USAF personnel are defined in Air Force Instruction (AFI) 48-123. The terms used in the AFI are not sufficiently specific for psychiatrists trained in the standards of the DSM-IV. The presenters will review AFI 48-123 for conditions commonly seen in USAF psychiatric practice presenting a clinical interpretation of the AFI to bring it into line with DSM-IV. Decisions regarding which mental health conditions warrant Medical Evaluation Board (MEB) dispositions will also be discussed. Individuals undergoing disability evaluations require restrictions on military duty described as profiles. The foundation of the current profiling system was developed well before the release of DSM-IV. The general principles and terminology remain in use today through AFI 48-123. The terminology used is clearly outdated, unwieldy and vague regarding fitness for duty. Our objective is to review the current standards for making psychiatric profiles in conjunction with disability evaluations in the USAF and propose a practical interpretation of the current Air Force Instruction.

REFERENCES:

1. Air Force Instruction 48-123, Medical Examinations and Standards, 15 November, 1994.
2. Menninger WC: Psychiatry in a Troubled World. New York, Macmillan, 1948.

SCIENTIFIC AND CLINICAL REPORT SESSION 37—MOOD DISORDERS AND REPRODUCTIVE ISSUES

No. 110
A SIMPLE SCREEN TO IDENTIFY POSTPARTUM MAJOR DEPRESSION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to learn to assess an onset of postpartum major depression by use of a short screening tool called the Edinburgh Postnatal Depression Scale.

SUMMARY:

One out of eight women suffers a new onset of depression after birth; 50% of these episodes go unnoticed in clinical practice. The objective of this study was to determine if the Edinburgh Postnatal

Depression Scale (EPDS) is an effective screen for postpartum major major depression (PPMD). The participants were pregnant women who had a previous PPMD, but were well during the index pregnancy. They completed the EPDS weekly for 20 weeks postpartum. Depression severity was assessed postpartum with the Hamilton Rating Scale for Depression (HRSD). Any woman who scored at least 15 on the HRSD was evaluated twice in a seven-day period. If her second HRSD remained at 15, a SADS-C interview and a confirmed diagnosis of PPMD by an independent psychiatrist and the PI was done. The results showed that 13 (25%) of the subjects experienced a recurrence of PPMD. Sixty percent of all PPMD was identified by a score of 10 or above at four weeks postpartum. Five of the women experienced PPMD in the first two weeks, and they all scored >12 on the EPDS. The EPDS is effective as a tool for screening for PPMD in clinical practice. We recommend its use for all postpartum women.

REFERENCES:

1. Cox JL, Holden JM, Sagovsky R: Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry 1987; 150:782–86.
2. Murray L, Carothers AD: Validation of the Edinburgh Postnatal Depression Scale (EPDS) in non-postal women. J Affective Disord 1990; 157:288–90.

No. 111
INTERPERSONAL PSYCHOTHERAPY FOR ANTEPARTUM DEPRESSION: A CONTROLLED TRIAL

Margaret G. Spinelli, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Suite 131, New York, NY 10025*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should identify symptoms of antepartum depression compared with discomforts of pregnancy, recognize symptoms as precipitants of mother-infant interaction disorders, and demonstrate knowledge of IPT-P as an alternative to pharmacotherapy.

SUMMARY:

Objective: Antenatal depression is a significant risk factor for postpartum depression with a 10% prevalence in all pregnancies. Despite the prevalence and family morbidity, there have been few clinical treatment trials.

Method: In a controlled 16-week clinical trial of interpersonal psychotherapy (IPT) for depressed pregnant women (IPT-P), 50 antepartum women were referred for DSM-IV major depression and randomly assigned to IPT-P or a parenting education program (PEP). Both IPT-P and PEP were manualized. Both groups were seen weekly for 45 minutes, which controlled for patient exposure. Results were assessed by the Beck and Edinburgh Postnatal Depression Scale, Hamilton Depression, and Clinical Global Impressions scales.

Results: Intent-to-treat analysis demonstrated that the IPT-P treatment group reported a greater decrease in depressive symptoms than the PEP control. The treatment group improved twice as much as the control group from entry week 1 to termination week 16. Impaired mother-infant interaction was associated with depressive symptoms in the postpartum period.

Conclusion: The study demonstrated the feasibility of a 16-week psychotherapy treatment for pregnant women. IPT-P appears to be an effective method of treatment and reasonable alternative to pharmacotherapy for depressed pregnant women.

Research Scientist's Development Award for Clinicians: NIMH

REFERENCES:

1. Spinelli M: Interpersonal psychotherapy for depressed antepartum women: a pilot study. Am J Psychiatry 1997; 154:1028–1030.
2. Klerman GL, Weissman MM, Rounsaville BH et al: Interpersonal Psychotherapy of Depression. New York, Basic Books, 1984.

No. 112
DIMINISHED PROLACTIN SECRETION AND RESPONSE TO FLUOXETINE TREATMENT

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the relationship between prolactin secretion and response to fluoxetine treatment in major depressive disorder.

SUMMARY:

Objective: To investigate the association between prolactin secretion following fenfluramine challenge and response to treatment with fluoxetine in outpatients with major depressive disorder.

Methods: We examined prolactin and cortisol responses to oral administration of 60mg of DL-fenfluramine in 24 depressed outpatients entering an eight-week open trial of fluoxetine 20 mg/day.

Results: Fluoxetine responders had a significantly reduced prolactin secretion following both placebo and fenfluramine infusion compared with fluoxetine nonresponders ($p < 0.05$). Cortisol responses did not differ significantly between responders and nonresponders. After adjusting for gender with logistic regression, the relationship between treatment response and prolactin secretion was statistically nonsignificant for both placebo and fenfluramine challenge ($p = 0.10$ and 0.14, respectively).

Conclusions: In our sample of depressed outpatients, reduced prolactin secretion appears to be associated with a greater likelihood of response to fluoxetine treatment. Such a relationship, however, does not remain significant after adjusting for gender.

This study was supported by a NARSAD Young Investigator Award and by an NIMH R-01 grant.

REFERENCES

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SCIENTIFIC AND CLINICAL REPORT SESSION 38—SUICIDE AND THE LIFE CYCLE

No. 113
CHILDHOOD SEXUAL ABUSE AND SUICIDAL BEHAVIOR IN BPD

Paul H. Soloff, M.D., *Department of Psychiatry, University of Pittsburgh/WPIC, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Kevin G. Lynch, Ph.D., Thomas M. Kelly, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize a history of childhood sexual abuse as a significant predictor of suicidal behavior in adults with borderline personality disorder.

SUMMARY:

Objective: Childhood sexual abuse is associated with suicidal behavior in clinical and community samples and is highly prevalent in borderline personality disorder (BPD). We asked if childhood sexual abuse was a risk factor for suicidal behavior in BPD.

Method: A semistructured abuse history was obtained from 61 adult inpatients, outpatients, and volunteer subjects with BPD, defined by the International Personality Disorders Examination. Axis I diagnoses, suicide history, BPD severity, hopelessness, and impulsive-aggression were assessed by standardized semistructured interviews and self-reports. Regression methods tested the relationship of abuse history to attempter status, number of attempts, and known risk factors for suicidal behavior.

Results: Childhood sexual abuse was reported by 28 subjects (45.9%), of whom 27 were suicide attempters. Abused subjects made their first attempt at an earlier age and had more lifetime suicide attempts than nonabused subjects. Childhood sexual abuse predicted adult suicidal behavior but did not predict other known risk factors. The relationship between childhood sexual abuse and suicidal behavior was not mediated by BPD severity, MDE or substance use disorders, hopelessness, or impulsive-aggression. Severity and duration of childhood sexual abuse predicted lifetime number of attempts.

Conclusion: Childhood sexual abuse is a discrete risk factor for suicidal behavior in adults with BPD.

Supported by NIMH Grant R01-MH48463

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2. Paris J, Zweis-Frank H, Guzder J: Psychological risk factors for borderline personality disorder in female patients. Comprehensive Psychiatry 1994; 35:301–305.

No. 114
MULTIPLICITY OF SUICIDE ATTEMPTS IN BIPOLAR DISORDER

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney-NY Presbyterian Hospital, 525 East 68th Street, New York, NY 10021;* Tara M. Singer, M.A., Jessica L. Garno, B.S., Mallay Charters, A.B., Miki Hertz, B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be aware that many bipolar patients make multiple suicide attempts and be able to identify the clinical characteristics associated with single versus multiple attempts.

SUMMARY:

Bipolar disorder has one of the highest rates of suicide attempts of all psychiatric disorders. This study assessed lifetime suicide attempts among bipolar patients in order to identify clinical features associated with suicidality, as well as factors that differentiate single vs. multiple attempters. Eighty-six DSM-IV bipolar patients underwent semi-structured interviews to assess characteristics of lifetime suicide attempts, mood episodes, substance abuse, and hostility.

Results showed that 38% made at least one lifetime suicide attempt. Of those, 34% made one attempt, 47% made two attempts, and 19% made three or more attempts. Attempters did not differ from nonattempters demographically, but had an earlier age of bipolar onset ($p < .002$), had been ill longer ($p < .004$), more often had alcohol or other substance abuse/dependence ($p < .009$), and tended to be hospitalized more frequently ($p < .07$). Attempters were more likely than nonattempters to show high levels of indirect hostility, irritability, resentment, and suspicion ($p < .05$). As compared with single attempters, multiple attempters had an earlier age of onset ($p < .002$), were ill longer ($p < .01$), and were more likely to be purely depressed at their first attempt ($p < .02$). Multiple attempters also had higher levels of resentment and suspicion than single attempters ($p < .04$). Levels of impulsivity vs. premeditation were observed consistently within subjects across multiple attempts ($p < .05$).

The findings suggest that most bipolar patients make multiple suicide attempts, often extending beyond the initial five to 10 years after illness onset. Chronicity, depression, comorbid substance abuse, and indirect aggression may typify the risk profile of bipolar patients who make multiple suicide attempts.

REFERENCES:

1. Jamison KR: Suicide and bipolar disorder. J Clin Psychiatry 2000; 61(Suppl 9):47–51.
2. Oquendo MA, Waternaux C, Brodsky B, et al: Suicidal behavior in bipolar mood disorder: clinical characteristics of of attempters and nonattempters. J Affect Disord 2000; 59:107–117.

No. 115
SUICIDAL YOUTH WITH FIRST EMERGENCY ROOM PRESENTATIONS: SIX-MONTH OUTCOME PREDICTIONS

Ian G. Manion, Ph.D., *Department of Mental Health, Children's Hospital, 401 Smyth Road, Ottawa, ON K1H 8L1, Canada;* Evelyn S. Stewart, M.D., Simon Davidson, M.B., Paula F. Cloutier, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to recognize risk factors for future suicide attempts and ED return among adolescent first suicidal ED presenters.

SUMMARY:

Objective: To examine risk of future documented suicide attempts and emergency department (ED) returns among children and adolescents with first suicidal ED presentations.

Method: A total of 548 consecutive ED presentations of suicidal 7–19 year olds (mean age 14.6+/–2.1) over a one-year period were studied. Multiple logistic regression among 224 first-time presenters was used to predict ED return and suicide attempts.

Results: At six-month follow-up, 32.6% ($n = 73$) had returned to the ED, 24.1% ($n = 54$) attempted suicide, and 14.3% ($n = 32$) required psychiatric admissions. Predictors of ED return were child welfare guardianship (odds ratio OR = 3.12; 95% CI = 1.31-7.45), 15–19 year age range (OR = 2.34; 95% CI = 1.19-4.58), and mood disorder (OR = 2.03; 95% CI = 1.05-3.90). Past foster-home or group-home placement (OR = 3.66; 95% CI = 1.54-8.77), mood disorder (OR = 3.84; 95% CI = 1.79-8.24), and 15–19 year age range (OR = 2.20; 95% CI = 1.04-4.64) predicted future suicide attempts. Substance abuse at presentation was associated with fewer ED returns (OR = 3.09; 95% CI = 1.33-7.13) and attempts (OR = 3.24; 95% CI = 1.22-8.59).

Conclusion: Clinicians should be aware of the above risk factors when assessing and managing suicidal youth with first ED presentations.

Funding Source: CHEO Mental Health Research.

REFERENCES:

1. Gould M, King R, Greenwald S, et al: Psychopathology associated with suicidal ideation and attempts among children and adolescents. J Am Acad Child Adolesc Psychiatry 1998; 37:915–923.

2. Greenhill LL, Waslick B: Management of suicidal behavior in children and adolescents. Psych Clin N Am 1997; 20:641–666.

SCIENTIFIC AND CLINICAL REPORT SESSION 39—PATIENT AND PHYSICIAN AUTONOMY

No. 116
MANAGED CARE AND MALPRACTICE LIABILITY TODAY

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

SUMMARY:

Managed care has led to a diminution of the freedom of the physician to determine treatment while he or she continues to be susceptible to malpractice liability, a situation aggravated by hold-harmless and gag rules. From the outset, courts have held physicians accountable if they did not appeal sufficiently to exhaust all means of overturning determinations denying or limiting treatment. Several lines of approach to liability in physician/insurer/patient relationships have been considered by the courts, often following principles derived from hospital situations. Federal ERISA law pre-empting state laws in the arena of managed care further complicates the legal situation and increases physician risk. Public anger over perceived injustices has led many states to legislate allocation of responsibility for malpractice. Federal courts have begun to review ERISA provisions and decide precedent-setting cases; modification of ERISA by Congress has come to a dead end. This paper summarizes applicable law and reviews 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 WM: Liability for managed care decisions: the Employment Retirement Income Security Act (ERISA) and the uneven playing field, Am Jnl Public Health 1996; 86:863–869.

No. 117
PARITY DISPARITY: MENTAL HEALTH INSURANCE COVERAGE DECISION MAKING

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the relationships among employee benefits managers' opinions regarding parity for mental health and decision making with regard to health insurance coverage.

SUMMARY:

Objective: Employee benefits managers determine health insurance coverage for workers, but little is known about the relationship between managers' opinions on mental health parity and their purchasing decisions.

Method: Benefits managers were identified from national databases and then surveyed by mail.

Data: The 120 managers (62% female, mean age 46, 95% white, 35% with graduate school education) averaged 14 years in the human resource field. Most (63%) benefits managers strongly agreed and several (24%) somewhat agreed with the statement "mental health problems should be covered just like physical health problems." However, there was no correlation between response to this item and restrictions on mental health benefits (even after adjustment for age, sex, education, etc.). Indeed, the only predictor of mental health benefit availability was the percentage of union membership among employees of the manager's company ($p < .05$).

Conclusions: Although employee benefits managers (like the general public) say that mental health problems should be covered just like physical health problems, their purchasing decisions do not reflect those opinions. Conversely, unionization appears to influence availability of mental health benefits. Data from an ongoing survey of benefits consulting firms will also be presented.

Funding Source: National Institute of Mental Health.

REFERENCES:

1. Mechanic D, McAlpine DD: Mission unfulfilled: potholes on the road to mental health parity. Health Affairs 1999; 18:7–21.
2. Rost K, Smith J, Fortney J: Large employers' selection criteria in purchasing behavioral health benefits. Journal of Behavioral Health Services and Research 2000; 27:334–338.

No. 118
THE DOCTOR-PATIENT RELATIONSHIP: AUTONOMY, GENDER, AND PREFERRED PHYSICIAN STYLE

Kalman J. Kaplan, Ph.D., *Department of Psychiatry, University of Illinois, 1601 West Taylor Street, M/C 912, Chicago, IL 60612;* Mark E. Schneiderman, Ph.D., Martin Harrow, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to help make the audience more aware as to the importance of the psychosocial aspects of the doctor-patient relationship and that the best physician communication style may vary from patient to patient.

SUMMARY:

Objective: An increasing trend among patients to become more self-aware in their own health needs has demanded reconsideration of the relationship between patient and physician. The present study examines patient preference for paternalistic versus informative physician styles as a function of: a) general patient autonomy level, b) knowledge of the specific disease, and c) patient gender.

Design: One hundred and thirty-one ambulatory care patients at Michael Reese Hospital and the University of Illinois at Chicago Medical Center were surveyed in an attempt to link physician style (paternalistic or informative) to patients' autonomy level and knowledge of disease.

Results: Higher autonomy level and greater knowledge of the disease increase preference for informative as compared with paternalistic physician styles for female patients (Chi-squares = 4.25 and 3.70 respectively, $p < .05$) but not for male patients (Chi-squares = .11 and .74 respectively, n.s.). Simultaneously, autonomy and degree of knowledge of the specific disease are slightly positively related for men ($r = .28$, n.s.) and significantly negatively related for women ($r = -.31$, $p < .05$).

Conclusions: The results suggest that the doctor's communication style cannot be understood in a vacuum. A particular style may or may

not be appropriate depending on the patient's personality, gender, and awareness.

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SCIENTIFIC AND CLINICAL REPORT SESSION 40—WOMEN'S HEALTH ISSUES

No. 119
MOOD AND ANXIETY DISORDERS AND HEALTH OF MULTIETHNIC MIDLIFE WOMEN

Joyce T. Bromberger, Ph.D., *Department of Epidemiology, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213;* Howard M. Kravitz, M.P.H., Adriana Cordal, M.D., Linda Jansen-McWilliams, M.S., Karen S. Matthews, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the increased risk of negative mental and physical health in midlife women with a history of major depression compared with those without such a history, whether or not they have current depression or anxiety, and understand the risks are similar for African Americans, Caucasians, and Hispanics.

SUMMARY:

Objective: Information about women's health during midlife comes largely from studies of whites. Using data from three sites of the Study of Women's Health Across the Nation, we examined prevalence and correlates of mood and anxiety disorders in a premenopausal multiethnic cohort.

Method: We conducted the Structured Clinical Interview for DSM-IV with 248 black, 167 Hispanic, and 510 white women, aged 42–52, from Chicago, Newark, and Pittsburgh. Women provided self-report data on health, menstruation, and psychosocial factors. We compared prevalence of disorders among the three ethnic groups. Multiple logistic regressions examined the association of self-report data with current major depression (MDD) or anxiety and lifetime MDD (controlling for current disorder).

Results: Rates of disorders did not differ significantly across groups. Current rates ranged from 13% to 21%. Lifetime rates: MDD, 25% to 33%; panic, 4% to 7%; specific phobia, 7% to 11%. Correlates of lifetime MDD were low social support, frequent somatic and mood symptoms, CES-D≥16, and very heavy menses, ps < .005; fibroids and arthritis, ps < .05. The first four, ps ≤ .001, and menses more than 10 days, p = .04, were associated with current disorder.

Conclusions: Data suggest rates of mood/anxiety disorders are high and similar among blacks, Hispanics, and whites and midlife women with a history of MDD are at risk for negative mental/physical health whether or not they have a current disorder.

Founded by NIA & NIMH.

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No. 120
TOPIRAMATE IN PMDD

Mohammad Z. Hussain, M.D., *2727 2nd Avenue West, Prince Albert, SK S6V 5E5, Canada;* Zubaida Chaudhry, M.D., Seema Hussain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate the effectiveness and safety of topiramate in treatment of premenstrual dysphoric disorder.

SUMMARY:

Premenstrual dysphoric disorder afflicts 3%–5% of women. Pharmacological intervention with benzodiazepines, gonadotropin releasing hormone agonists, SSRIs, and mood stabilizers are most often used with varying success. However, a fair number of females prove resistant or intolerant to these approaches, requiring us to move forward and study alternative drug therapy. Food cravings and weight gain are common complaints of this disorder. Topiramate, an anticonvulsant with rich pharmacology, has broad-spectrum activity with demonstrated therapeutic effect as a mood stabilizer and association with weight loss.

Thirty females were treated with topiramate. Seven patients dropped out due to side effects. The age ranged from 24–38 with mean age of 29.8 years. All had prior treatment with SSRIs, 11 with mood stabilizers, and 12 had tried herbal remedies and vitamin B6. Topiramate was given at a dose of 100 mg daily. Patients were rated on BPRS and subjectively at baseline and at monthly intervals following initiation of topiramate. In addition to relief from premenstrual dysphoria, there was weight loss with decreased carbohydrate craving and vulnerability to food overconsumption. Based on this open study, topiramate promises to be an effective treatment for premenstrual dysphoria and for patients with overweight concerns.

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No. 121
VERAPAMIL EFFECTIVENESS IN WOMEN WITH BIPOLAR DISORDER

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Suite 280, Cleveland, OH 44106;* James M. Perel, Ph.D., Kathleen S. Peindl, Ph.D., Catherine M. Piontek, M.D., Susan W. Baab, M.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to critically evaluate the use of verapamil for female patients with bipolar disorder.

SUMMARY:

Objective: Alternative treatments are needed for patients with bipolar disorder who do not respond to, have prohibitive side effects from, or have medical disorders that complicate the use of lithium or anticonvulsants.

Method: We describe our experience with verapamil in a sequential series of women with bipolar disorder. All women who were prescribed verapamil were included. We used the criterion of 50% reduction in scores on the Mania Rating Scale or the Hamilton Rating Scale for Depression to define response.

Results: Treatment was initiated in 28 women who declined conventional treatment. Doses ranged from 200 to 440 mg/day. The

overall response rate was 57%. Seven of the nine patients in mixed states responded: five improved to response criterion on the mania score only, and two responded on both depression and mania scores.

	Responder	Nonresponder	Withdrew	Total
Episode Type:				
Depressed	7 (41%)	8	2	17
Manic/hypomanic	2 (100%)	0	0	2
Mixed	7 (77%)	0	2	9
TOTAL	16 (57%)	8	4	28

Conclusions: These data compare favorably to response rates of other agents. In studies of mania, the mean percentage of drug responders was 40% (± 24%; Keck et al, 2000). Response to verapamil was similar to other agents in that mania was more responsive than depression.

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MONDAY, MAY 7, 2001

SYMPOSIUM 1—RESIDENTS AND THE PHARMACEUTICAL INDUSTRY: HOW TO MAINTAIN ETHICAL INTEGRITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: demonstrate awareness of (1) the evidence on the frequency and impact of the relationship between physicians and the pharmaceutical industry, (2) the ethics and guidelines on this interaction, (3) interventions to address this issue, and (4) specifically an approach at a postgraduate psychiatry program to facilitate a healthy interaction between residents and the industry.

No. 1A
DEONTOLOGICAL AND ETHICAL CONSIDERATIONS IN RESIDENT-INDUSTRY

Francois J. Primeau, M.D., *Department of Psychiatry, McGill University, 1033 Pine Street, West, Montreal, PQ H2W 1X1, Canada*

SUMMARY:

In the context of dwindling public funds for university and hospitals and increased contact of the industry with residents, codes of deontology from professional organizations have fallen short of providing useful guidance to trainees and educators. Not only do the guidelines by the AMA, CMA, and various colleges of physicians on the relation between physicians and the pharmaceutical industry devote little attention to residents, but they also insist mostly on process issues. Quantifying the extent of these contacts may only be part of the answer. This presentation begins by presenting existing guidelines as they apply to residents and then focuses on the ethical considerations of this question, which are larger than those portrayed by codes of deontology: What is the goal of residency training? What is the impact on residents of staff interacting with the industry? Do training programs need to train residents on how to behave ethically in those circumstances? The best interest of patients and the critical thinking of residents and staff doctors remain guiding principles that can inspire codes and regulations that protect physicians from becoming instrumentalized in their service of patients through solid science.

No. 1B
RESIDENTS AND THE PHARMACEUTICAL INDUSTRY: IS A GIFT EVER JUST A GIFT?

Ashley D. Wazana, M.D., *Department of Psychiatry, McGill University, 1033 Pine Street, West, Montreal, PQ H2W 1X1, Canada*

SUMMARY:

The findings from a review of the literature on the extent of and attitudes toward the relationship between physicians and the pharmaceutical industry, and its impact on the knowledge, attitudes, and behavior of physicians will be presented. In brief, physician interactions with the pharmaceutical industry were found to be frequent and generally endorsed and, in spite of their skepticism about the motivation and the knowledge of the pharmaceutical representative, physicians rarely question this interaction. However, there is good evidence for the effect of CME funding and conference travel funding on the prescription rate of the sponsor's product, as well as pharmaceutical representative (PR) speakers on nonrational prescribing. There is also evidence for the impact of interactions with PRs. The implications at the level of existing guidelines and the educational needs of residents will be discussed.

No. 1C
INDUCTION, SEDUCTION, AND DEDUCTION: TEACHING THE RESIDENT ABOUT PHYSICIAN-INDUSTRY INTERACTIONS

Nadeem Bhanji, M.D., *Department of Psychiatry, McGill University, 1033 Pine Street, West, Montreal, PQ H2W 1X1, Canada*

SUMMARY:

Attempts at addressing the growing concern about resident-industry interaction have been by the introduction of practical training. Twenty-five percent to 75% of programs teach about industry marketing techniques and critical appraisal of industry products claims. Yet these attempts leave many residents wanting: family medicine, psychiatry, emergency medicine, and internal medicine trainees residents wanted more teaching both in medical school (45%) and residency (60.6%). The reports of some of the programs that have been implemented are optimistic though, with four demonstrating an effect: increased skepticism of claims of new drugs; increased confidence in managing interactions with PRs; increased critical attitude toward PRs and physician-industry interactions; increased knowledge about bioethical issues. There have also been positive changes in prescription patterns and knowledge of physicians associated with such alternatives to the traditional physician-PR interaction as academic detailing. These programs will be reviewed as well as their limitations. A program's teaching video modeling technique of physician-detailer interaction will also be presented.

No. 1D
THE PHARMACEUTICAL INDUSTRY RELATIONS COMMITTEE AT MCGILL

Annette Granich, M.D., *Department of Psychiatry, McGill University, 1033 Pine Street, West, Montreal, PQ H2W 1X1, Canada*

SUMMARY:

An initiative in 1998 at a Quebec postgraduate psychiatry program (McGill) will be presented. A committee with equal resident and faculty representation was formed to address more formally and openly these pertinent issues. The context for the creation, the objectives, the composition, and the achievement of this committee will be highlighted and a working document for national resident guidelines will also be presented. Participants will be encouraged to discuss their experiences and suggestions for addressing this issue.

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SYMPOSIUM 2—RISK FACTORS FOR SCHIZOPHRENIA AND PREVENTION

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to: (1) understand the importance and nature of risk factors for schizophrenia; (2) how these might lead to schizophrenia especially how environmental risk factors interact with genetic risk factors to lead to schizophrenia, and (3) how this knowledge might lead to prevention of schizophrenia, and some of the practical and ethical implications of this.

No. 2A
EARLY ASSOCIATES OF SCHIZOPHRENIA IN THE 1966 NORTH FINLAND BIRTH COHORT

Juha M. Veijola, M.D., *Department of Psychiatry, University of Oulu, Peltolantie 5, Oulu 90210, Finland;* Peter B. Jones, Ph.D., Juha Moring, M.D., Taru H. Makikyro, M.D., Paula Rantakallio, M.D., Matti K. Isohanni, M.D.

SUMMARY:

Objective: We are examining pregnancy, delivery, and infancy factors associated with development of schizophrenia.

Method: We present associations between schizophrenia and factors occuring in early life in the 1966 North Finland general population birth cohort. The North Finland 1966 Birth Cohort Study included all 12,058 infants born in 1966 in northern Finland. For each individual, standardized assessments were made during pregnancy, delivery, and infancy. The psychiatric morbidity of the offspring has been followed up from the Finnish Hospital Discharge Register.

Results: Until the year 1998, a total of 100 subjects (64 males) with schizophrenia were identified. So far, in the 1966 birth cohort schizophrenia has been found to be associated with a combination of low birth weight (<2500g) and short gestation (<37 weeks), perinatal brain damage, unwantedness of pregnancy, and CNS viral infections during infancy.

Conclusions: Some aspects of causation are established long before schizophrenia is manifest. As unwanted pregnancies, perinatal complications, and CNS viral infections have become more rare, it is possible that these trends have contributed to the reduced incidence of schizophrenia that has been reported.

No. 2B
PRENATAL INFECTION AND ADULT SCHIZOPHRENIA

Alan S. Brown, M.D., *Department of Psychiatry, Columbia University-NYSPI, 1051 Riverside Drive, Unit 2, New York, NY 10032*

SUMMARY:

Recent findings of our epidemiologic studies on the relation between prenatal infection and adult schizophrenia will be presented. The data are derived from the birth cohorts of the Columbia Rubella Study (CRS) and the Prenatal Determinants of Schizophrenia Study (PDS). Previous work suggests that prenatal exposure to rubella, particularly during the first trimester, and second trimester exposure to respiratory infection, may be risk factors for schizophrenia. These studies, however, were generally limited by imprecise classification of exposure. We therefore examined whether clinically and serologically documented maternal infections were associated with adult schizophrenia and other schizophrenia spectrum disorders (SSD) in these two birth cohorts. In the CRS cohort, we found a marked increase in risk of SSD (20.4% or 11/53) among subjects with known prenatal rubella exposure. The association appeared to be accounted for largely by exposure in early gestation. Moreover, we demonstrated that increased premorbid abnormalities predicted the development of SSD in these rubella-exposed subjects. In the PDS cohort, we found that second trimester exposure to physician-diagnosed respiratory infections was associated with a significantly increased risk of SSD, adjusting for maternal smoking, education, and race [RR = 2.13, (1.05 – 4.35), $\chi^2 = 4.36$, df = 1, p = .04]; no associations were shown for first- and third-trimester exposure to these respiratory infections. These findings provide further confirmation for a role of prenatal infection in the etiology of schizophrenia, and therefore have potentially important implications for the prevention of this devastating disorder.

No. 2C
RISK FACTORS FOR THE BRAIN DEVIATIONS ASSOCIATED WITH SCHIZOPHRENIA

Robin M. Murray, M.B., *Department of Psychiatric Medicine, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, England;* Colm McDonald, Tonmoy Sharma, M.D., Chiara Nosarit

SUMMARY:

A neurodevelopmental component to schizophrenia is widely accepted, indeed perhaps exaggerated. The Maudsley twin studies imply that genes that control subtle aspects of neurodevelopment are involved. Concordance in MZ twins is much higher for those twins who present before rather than after 21 years and for those who showed childhood impairments. However, in MZ twin pairs discordant for schizophrenia, the affected twin has more abnormal brain structure than the well cotwin, and ID twins from such discordant pairs have more abnormal brain structure than those from MZ pairs concordant for schizophrenia; early environmental factors such as obstetric complications appear to make a contribution to these abnormalities.

The Maudsley Family Study of some 250 relatives of patients with schizophrenia confirms these findings. The well relatives from families multiply affected with schizophrenia (particularly the "obligate carriers" who appear to be transmitting liability to the disorder) show similar structural brain abnormalities to their affected kin. This implies that these deviations are genetically transmitted but also that possession of this brain structure is not inevitably associated with expression of psychosis. On the other hand, the well relatives of non-familial schizophrenic patients do not show these abnormalities, implying that the abnormalities found in the schizophrenic members of such families may have arisen for nongenetic reasons.

Obstetric complications have attracted much interest as risk factors both for schizophrenia and for the structural brain abnormalities found in a proportion of patients. However, there is little evidence concerning whether obstetric complications act as risk factors for abnormal structure in adult life in the nonschizophrenic population. We have followed-up and carried out MRI scans on 200 adolescents who were born before 33 weeks of gestation. These individuals show increased ventricular volume and decreased hippocampal volume, i.e., abnormalities similar to those found in people with schizophrenia. However, the abnormalities are much more severe than generally found in schizophrenia, and so far the individuals appear to function much better than expected.

In short, the structural brain findings that are associated with schizophrenia can arise either for genetic or environmental reasons. However, in neither case is their presence sufficient for the expression of the disorder. They appear to act as risk factors for the condition.

No. 2D
TRAUMATIC BRAIN INJURY AND RISK FOR SCHIZOPHRENIA

Dolores Malaspina, M.D., *Department of Psychiatry, Columbia University-NY Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Cheryl M. Corcoran, M.D., Stephen V. Faraone, Ph.D., Ming T. Tsuang, M.D., C. Robert Cloninger, M.D., John I. Numberger, Jr., M.D., Mary Blehar, Ph.D.

SUMMARY:

Schizophrenia following a traumatic brain injury (TBI) could be a phenocopy of genetic schizophrenia or the consequence of a gene environment interaction. Alternatively, TBI and schizophrenia could be spuriously associated if those who develop schizophrenia have more TBI for other reasons. We examined the association of TBI with psychiatric diagnosis in members of multiplex bipolar and schizophrenia pedigrees. All individuals were interviewed with the DIGS. In keeping with other studies, we found a three-fold greater rate of reported TBI for subjects with schizophrenia and two-fold excess for those with bipolar and unipolar when the subjects were compared with their never mentally ill family members. However, in multivariate analyses comparing TBI rates for those with psychiatric diagnoses with all other family members and controlling for age and sex, only schizophrenia retained a significant two-fold elevation of TBI. Furthermore, those with a schizophrenia diagnosis from bipolar pedigrees (less genetic vulnerability) had less TBI than those with greater genetic vulnerability from schizophrenia pedigrees. Within schizophrenia pedigrees, TBI was associated with a greater risk of schizophrenia, consistent with synergistic effects between schizophrenia vulnerability genes and TBI. TBI may increase the penetrance of schizophrenia vulnerability genes.

No. 2E
NEURODEVELOPMENTAL GENES AND RISK OF SCHIZOPHRENIA

Hiroshi Kunugi, M.D., *Department of Psychiatry, Teikyo University, 11-1 Kag2Chome Itabashi-Ku, Toyko 173-8605, Japan;* Akihisa Akahane, M.D., Kumiko Fujii, M.D., Hiroshi Tanaka, M.D., Mineko Hattori, Ph.D., Tadafumi Kato, M.D., Shinichiro Nanko, M.D.

SUMMARY:

Objective: Several lines of evidence from neuroimaging and neuropathological studies have formulated schizophrenia as a neurodevelopmental disorder. Given the high heritability estimate of schizophrenia (>80%), genes that play an important role in neurodevelopment might be involved in the pathogenesis of the illness. We have examined possible association of schizophrenia with genes encoding neurotrophic factors such as neurtrophin-3 (NT-3) and brain-derived neurotrophic factor (BDNF).

Method: We searched for polymorphisms in the NT-3 and BDNF genes by using single-strand conformational polymorphism (SSCP) analysis. Possible association was examined for each polymorphism in a case-control design. Furthermore, we examined a possible association between a dinucleotide repeat polymorphism in the NT-3 gene and hippocampal volumes measured by 1.5T MRI scan.

Results: There was a significant association between a dinucleotide repeat polymorphism of the NT-3 gene and schizophrenia. Furthermore, this polymorphism was also associated with hippocampal volume within schizophrenic cases. A novel polymorphism that we found in the 5′-noncoding region of the BDNF gene showed a significant, though weak, association with schizophrenia.

Conclusions: These neurotrophic factors are suggested to play a role in the pathogenesis of neurodevelopmental abnormalities in schizophrenia. It is possible that neurotrophic factors may be of use in prevention.

No. 2F
PREDICTING SCHIZOPHRENIA AND DEPRESSION: WOULD YOU HELP OR HARM?

Peter B. Jones, Ph.D., *Division of Psychiatry, University of Cambridge, Addenbrookes Hospital Hills Road, Cambridge CB2 2QQ, United Kingdom;* Tim J. Croudace, Ph.D., Jim J. Vanos

SUMMARY:

Indicated prevention of schizophrenia or depression is topical. Some such intervention programs are being evaluated. We have applied a screening paradigm in a large, longitudinal general population sample in order to model the possible performance of a realistic teacher assessment at age 15 used to indicate subsequent schizophrenia (rare) or depression (common) arising over the next 30 years. We used the British 1946 birth cohort (n = 5362) where there is a wide range of prospective information on development throughout childhood and adolescence. Adult psychiatric outcomes have been assessed in several ways. Parameters such as the sensitivity, specificity, predictive value, and receiver operating characteristics are presented for these two outcomes based upon teachers' ratings of behavior at age 15, and more complex assessments using data from several ages. The effects of hypothetical indicated preventive interventions given to adolescents deemed to be at high risk through various definitions are assessed using the numbers needed to treat or inconvenience (NNT & NNI) in order to prevent one case. NNTs for schizophrenia are around 20. Whether this is good or bad is as much a matter for society as clinicians and people who are not yet patients. These data inform the debate.

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SYMPOSIUM 3—NEW APPROACHES TO IMPROVE LONG-TERM TREATMENT ADHERENCE IN SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be familiar with factors that influence treatment adherence among people with severe psychiatric disorders. Additionally, participants will have an understanding of pharmacological, psychotherapeutic, and legal approaches to improve poor adherence and clinical outcome while preserving maximum patient autonomy.

No. 3A
TREATMENT ADHERENCE IN SCHIZOPHRENIA

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

Although antipsychotic medications have proven to be highly effective in preventing psychotic relapse and rehospitalization in persons with schizophrenia, treatment adherence remains an enormous problem. Noncompliance in medication taking affects at least one-third to one-half of patients with this illness during the course of a year. The consequences are serious in terms of both morbidity and mortality as well as family burden and social cost.

The reasons for noncompliance are multifaceted and though psychoeducation and other strategies to enhance compliance can be helpful, the results are far from satisfactory. The presentation will review relapse rates on oral medication, depot medication, and the impact of different therapeutic strategies on compliance.

No. 3B
PSYCHOSOCIAL AND PHARMACOLOGICAL STRATEGIES FOR IMPROVING TREATMENT ADHERENCE IN SCHIZOPHRENIA

Stephen R. Marder, M.D., *Department of Psychiatry, VA Greater LA HCCTR, 11301 Wilshire Boulevard, Building 210A, Los Angeles, CA 90073;* Donna A. Wirshing, M.D., William C. Wirshing, M.D.

SUMMARY:

This presentation will present data from recent studies that focused on improving treatment adherence in schizophrenia. The first study (Study 1) compared behavioral skills training with group psychotherapy in outpatients with schizophrenia (N = 80). In the second study (Study 2), patients (N = 62) were assigned to a program that supplemented skills training with weekly sessions designed to promote the use of newly acquired skills in the community. Patients were also randomly assigned to a double-blind comparison of risperidone and haloperidol. We will also present findings from a study (Study 3) in which inpatients were assigned to either supportive groups or a skills training module that focused on improving treatment adherence during the outpatient phase of treatment.

The results from Study 1 indicated that patients who received skills training modules that emphasized medication management were able to learn and retain the skill area information. In addition, patients who received skills training demonstrated greater improvements in social adjustment. Study 2 found that both the newer antipsychotic and the enhancement of skills training contributed to patient satisfaction with medication treatment. Findings from Study 3 indicated that patients who received skills training were more likely to make their first treatment appointment.

No. 3C
"I AM NOT SICK, I DON'T NEED HELP!": HELPING PATIENTS ACCEPT TREATMENT

Xavier Amador, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 2, New York, NY 10032*

SUMMARY:

About 50% of all people with schizophrenia and manic-depression do not understand that they are ill and refuse treatment. Poor insight into illness is one of the best predictors of nonadherence with treatment and a poorer course of illness. Research on the causes of unawareness of illness will be presented. Particular emphasis on new studies finding that neurocognitive deficits are responsible for such lack of awareness, or anosognosia, will be discussed. Finally, empirically based interventions aimed at increasing participation in treatment and improving insight into illness will be described.

No. 3D
CADUCEUS ON THE SCALES OF JUSTICE: LEGAL INTERVENTIONS TO PROVIDE TREATMENT

Jonathan A. Stanley, J.D., *Treatment Advance Center, 3300 North Fairfax Drive, Suite 220, Arlington, VA 22201*

SUMMARY:

Accompanying de-institutionalization was a diametric reconfiguration of our nation's legal mechanisms for the nonvolitional care of those overcome by mental illness. Not only did policies change to encourage the mass emigration from hospitals, treatment laws were transformed to discourage the placement of people with mental illness in them. State after state adopted new laws replete with obstacles to the provision of nonconsensual treatment.

These well-intentioned laws now often prevent the care of individuals who, because of the symptoms of their illness, are incapable of informed treatment decisions. Recognizing that the pendulum has swung illogically far toward protecting an incompetent's right to remain sick, many states have reformed their laws, lessening the statutory bias against treatment.

Addressed will be this ongoing legal recorrection. Most notable is the growing implementation of need for treatment-based standards that permit patients to be helped based on clinical criteria, rather than perceived dangerousness. This paper will also focus on the increasing use of assisted outpatient treatment (a.k.a. outpatient commitment), which allows post-deinstitutionalization mental health providers an alternative for patients in need of close supervision other than either the absolute restriction of inpatient care or the completely unrestricted autonomy of the community.

No. 3E
A ROLE FOR SURGICALLY IMPLANTABLE LONG-TERM NEUROLEPTIC DELIVERY SYSTEM

Steven J. Siegel, M.D., *Department of Psychiatry, University of Pennsylvania, 3400 Spruce Street, Gates Building, floor 10, Philadelphia, PA19104;* Karen Winey, Ph.D., Raquel E. Gur, M.D., Robert H. Lenox, M.D., Neel Ghandi, Debbie Ikeda, B.A., Wendy Zhang, M.A.

SUMMARY:

Nonadherence with prescribed medication remains a major correctable cause for poor clinical outcomes in people with schizophrenia. This presentation describes the development and characterization of a surgically implantable preparation of haloperidol based on the hypothesis that a subset of patients will have superior outcomes with improved medication adherence. Improved adherence could be provided by long-term, low-dose, steady state parenteral delivery of antipsychotic medication from subdermal, surgically implantable neuroleptics, which patients can choose during periods of improved health. Although parenteral delivery of antipsychotic medication is presently available in depot formulations, a significant number of patients fail to adhere with monthly injections, resulting in relapse and rehospitalization. In contrast, a surgically implantable preparation could last up to a year, providing patients with symptomatic improvement and possibly delayed disease progression for periods of time never before possible. Furthermore, low-dose parenteral administration of neuroleptics could reduce both short- and long-term side effects. However, in the event of unacceptable side-effect development, such as NMS, a subdermal implant could be removed. This offers a degree of reversibility not presently available with depot formulations. Finally, surgically implantable formulations could be

employed as a safety net in combination with oral dosing to achieve adjustments as clinically indicated.

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SYMPOSIUM 4—PTSD: A BIOPSYCHOSOCIAL APPROACH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to present data on factors deriving from biological, psychological, and social spheres bearing on the etiology of PTSD

No. 4A
THE STRESSOR CRITERION IN DSM-IV

Naomi Breslau, Ph.D., *Department of Psychiatry, Henry Ford Health System, One Ford Place, Detroit, MI 48202-3450*

SUMMARY:

While the syndrome of PTSD in DSM-IV has changed little from earlier DSM editions, the stressor criterion that defines the etiologic event in PTSD changed materially. The new definition enlarges the variety of experiences that are considered as traumatic events (A1), while it introduces a subjective component, the "response involved intense fear, helplessness, or horror" (A2). The implications of these changes for the prevalence of traumatic events and PTSD, and their associations with risk factors has not been previously examined.

We examined these issues in an epidemiologic survey of 2,180 persons in southeast Michigan. The vast majority (89.6%) has experienced DSM-IV traumatic events, included in A1. Of those, nearly 90% endorsed the subjective component (A2), with little variability across types of events. The lifetime prevalence of exposure meeting both parts of the stressor criterion exceeds 80%. Females, consistently found to be at an increased risk for PTSD, are also at increased risk for A2, controlling for type of trauma. The enlarged DSM-IV stressor criterion yields higher estimates of exposure and PTSD than previous DSM editions and the A2 component does little to offset these effects. The implications of the A2 component for estimating associations with risk factors will be discussed.

No. 4B
INDIVIDUAL DIFFERENCE IN POST-TRAUMATIC RESPONSE

Marilyn L. Bowman, Ph.D., *Department of Psychology, Simon Fraser University, 8888 University Drive, Burnaby, BC V5A 1S6, Canada*

SUMMARY:

Important individual differences account for significant variations in responses to traumatic or toxic life events, but the DSM-IV model is prominently a dose-response model. Studies of prevalence and incidence of posttraumatic stress disorder (PTSD) show that only a minority of those exposed to toxic events develop the disorder. One of the most important factors mediating between the stress-response relationship is temperamental, a tendency to respond to events with negative emotionality. This trait shows considerable stability across the lifespan, much deriving from its strong genetic component. Beliefs also contribute significantly to variations in response to toxic events. The most important beliefs concern ideas about one's own helplessness or resilience, about sources of danger, about the feasibility and desirability of emotional expressiveness or control, and about the locus of control of life events. General intelligence also functions as a moderate buffer. Treatments that assume all those exposed to a dangerous event are at significant risk for long-term mental health consequences, and that focus significantly on the event, fail to take these important individual features of temperament, beliefs, and skills into account. Continuing problems in identifying effective psychological treatments for PTSD may arise from flawed assumptions of the model.

No. 4C
HAS PTSD BECOME A POST-TRAUMATIC NEUROSIS?

Allan Young, Ph.D., *Social Studies of Medicine, McGill University, 3655 Drummond Street, Montreal, QC H3G 1Y6, Canada*

SUMMARY:

The DSM-III editorial task force wished to expunge "neurosis" from the psychiatric nosology. The PTSD classification was a special concern in this respect. In the intervening years, PTSD has, in fact, acquired characteristics of a clinical neurosis: a pathological process of adaptation and defense, driven by episodic memories and based on competing centers of intentionality. This neurosis-like quality is reflected in efforts to (1) popularize the concepts of "partial PTSD," "complex PTSD," and "DESNOS" (to account for psychiatric cases that fail to meet the full PTSD criteria) and (2) interpret the high levels of comorbidity associated with PTSD as conditions secondary to PTSD (thus further representing the process's polymorphous character). The post-1980 period has seen a second development in the way in which PTSD is understood, namely the emergence of explanatory models and research technologies relating to the neurophysiology and neuroanatomy of PTSD. The two developments—interest in PTSD as a neurotic process and as a biological alteration—are nominally connected. In practice, they represent increasingly separate and possibly unbridgeable spheres of interest—clinical and research. This paper is based on interviews with a sample of leading PTSD researchers and an exhaustive analysis of the PTSD literature.

No. 4D
CULTURE, TRAUMA, AND PTSD

Laurence J. Kirmayer, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, QC H3T 1E4, Canada;* G. Eric Jarvis, M.D.

SUMMARY:

Events are traumatic as a result of their meaning to individuals and communities. This meaning is culturally mediated. As a result, culture influences the emergence, form, and course of trauma-related distress in manifold ways including: (1) the perception of events as threatening or traumatic, (2) the coping responses to acute trauma and its aftermath, (3) symptomatic expressions and attributions of

distress, (4) patterns of help seeking and disability and (5) the wider social consequences of trauma. This presentation will review evidence for cultural variations in these aspects of PTSD and trauma-related distress. A major clinical controversy surrounds the therapeutic benefit of disclosure of victimization when individuals live in cultural communities where such disclosure may be culturally dissonant, socially stigmatizing, and politically dangerous. This dilemma will be illustrated with data from an ongoing study of South Asian refugees in Montreal. The psychobiological paradigm of PTSD is clearly insufficient to capture the range of problems experienced by traumatized refugees. Indeed, the diagnosis of PTSD serves specific social functions in the refugee context that may contribute to adaptation or to chronicity. A program of research to determine culturally appropriate clinical strategies for the treatment of the sequelae of trauma will be outlined.

No. 4E
PERSONALITY FACTORS IN SUSCEPTIBILITY TO PTSD

Joel F. Paris, M.D., *Department of Psychiatry, Sir Mortimer B Davis Jewish General Hospital, 4333 Cote Street, Catherine Road, Montreal, PQ H3T 1E4, Canada*

SUMMARY:

Objective: To review literature bearing on the role of personality factors in the development of posttraumatic stress disorder (PTSD).

Methods: A literature review (MEDLINE and PSYCLIT) was conducted on all etiological and epidemiological studies of PTSD since 1980.

Results: Since chronic symptoms develop in a minority of those exposed to trauma, predispositions must play an etiological role. There is evidence that heritable personality traits, particularly neuroticism, predict the development of PTSD. Personality interacts with other risk factors, most particularly previous exposure to psychosocial adversity and levels of social support.

Conclusions: PTSD requires a biopsychosocial model that takes into account the role of preexisting personality profiles.

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SYMPOSIUM 5—PERIMENOPAUSE, MOOD, AND COGNITION: THE ROLE OF REPRODUCTIVE HORMONES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the association between the transition to the menopause and the occurrence of changes in mood and cognition, and to understand the modulation of these changes by reproductive hormones.

No. 5A
THE MODULATION OF NEUROTRANSMITTERS BY GONADAL STEROIDS: AN UPDATE

David R. Rubinow, M.D., *BEB Department, National Institute of Mental Health, Building 10, Room 3N238 MSC 1276, 10 Center Dr, Bethesda, MD 20892-1276*

SUMMARY:

The perimenopause is a time of marked variation in reproductive endocrine activity. Inferences about the role of gonadal steroids in the mood changes and depression that may accompany the perimenopause must be informed by both an understanding of the modulatory effects of gonadal steroids on neural function as well as an appreciation of the contextual factors that govern the steroid effects. Several principles will be emphasized in this presentation: First, the neuromodulatory effects of gonadal steroids are dramatic and widespread. These include regulation of the synthetic and metabolic enzymes of multiple neurotransmitters and neuropeptides (and their receptors) through direct regulation of gene transcription by activated steroid receptors, which are ligand-activated transcription factors. Additionally, membrane (rather than intracellular) steroid receptors have now been identified that rapidly regulate ion channels and second messenger systems. Second, the effects of gonadal steroids are context dependent. Tissue-specific proteins called co-regulators determine the effects on transcription of an activated receptor. Additionally, the receptors affect each other's actions and may be regulated ("crosstalk") by growth factors or classical neurotransmitters. Third, women are differentially sensitive to the effects of gonadal steroids, such that the same levels or changes may have dramatically different effects in different persons. Fourth, reproductive endocrine function and age interact in the regulation of mood, cognition, and libido.

No. 5B
THE RELATIONSHIP BETWEEN DEPRESSION AND THE TRANSITION TO MENOPAUSE: RESULTS FROM A COHORT STUDY

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 115 Parkman Street, WACC 815, Boston, MA 02114;* Claudio N. Soares, M.D., Michael W. Otto, Ph.D., Bernard L. Harlow, Ph.D.

SUMMARY:

The relationship between changes in reproductive endocrine function in women transitioning to the menopause and risk for depression remains an area with more questions than clear answers. This presentation will review data from a large community-based sample of older premenopausal women with and without histories of major depression who were prospectively followed with serial measures of reproductive function and with respect to psychiatric status. Findings of (1) an earlier transition to perimenopause in women with histories of comorbid mood and anxiety disorders compared with those without these disorders and (2) a higher rate of depression in women without previous histories of depression who experienced an "early" transition to the perimenopause will be discussed. The implications of these findings as they relate to the impact of depression and anxiety on end-organ sequelae of early transition to a hypoestrogenic state will also be discussed.

No. 5C
THE ROLE OF ESTROGEN AS AN ANTIDEPRESSANT STRATEGY FOR PERIMENOPAUSAL DEPRESSION

Claudio N. Soares, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Osvaldo P. Almeida, M.D., Lee S. Cohen, M.D.

SUMMARY:

The perimenopause is characterized by endocrinologic and clinical changes, when women experience menstrual irregularities (shortened cycles or longer periods of amenorrhea) and vasomotor symptoms (hot flushes, night sweats).

Previous studies suggest that the perimenopause is a period of higher risk for the occurrence of mood disturbance including depressive symptoms and major depression. Ultimately, some authors suggest the existence of specific subpopulations of women with a particular vulnerability to depression during periods of intense hormonal fluctuations (reproductive-associated mood disturbance), such as the premenstrual phase, the puerperium, and the perimenopause.

We will review in detail data from clinical trials (randomized, double-blind, placebo-controlled) in which the efficacy of estradiol was compared with placebo for the treatment of perimenopausal women suffering from major (N = 34) and minor depression (N = 52). The findings of these studies demonstrate that estradiol delivered transdermally is efficacious for the treatment of major and minor depression in this particular subgroup of women. A full or partial therapeutic response varied between 62% and 80%, while 14% to 22% of patients treated with placebo showed significant improvement ($p < 0.01$).

We will discuss potential risks and benefits of estradiol treatment for perimenopause-related depression.

No. 5D
THE IMPACT OF ESTROGEN THERAPY ON COGNITION IN PERIMENOPAUSAL AND POSTMENOPAUSAL WOMEN

Hadine Joffe, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Preliminary research suggests that estrogen replacement therapy may improve memory for some perimenopausal and postmenopausal women, but these data are limited by methodological problems. Most studies have included heterogeneous groups of women with widely varying ages and educational levels. In addition, no study has excluded women with major depression, which may cause a reversible cognitive dysfunction. Where improvement in cognitive function has been found, it has been attributed to resolution of hot-flush-induced insomnia. However, the potential mediating role of suppression of hot-flush-induced insomnia with estrogen replacement has not been examined.

This presentation will review data available on the effect of estrogen replacement on memory in perimenopausal and postmenopausal women. The lecture will focus on data available about the modifying effects of hot flushes, insomnia, and depression on memory function. In addition, preliminary data from a randomized, double-blind, placebo-controlled trial of estrogen replacement in non-depressed menopausal women will be discussed. The potential mediating role of resolution of hot flushes and improvement of sleep disturbance with estrogen replacement will be explored.

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SYMPOSIUM 6—A DEPARTMENT OF PSYCHIATRY'S EXTENSIONS INTO THE COMMUNITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to establish effective community linkages in key areas that contribute to improved mental health outcomes. These include: (1) effective screening for police officers; (2) work with the courts, schools, and law enforcement to improve outcomes for high-risk youth; (3) development of interagency programs.

No. 6A
OLDER ADULTS: WORK AND PSYCHOLOGICAL WELL-BEING

Patricia Morse, Ph.D., *Department of Psychiatry, LSU Health Science Center, 1542 Tulane Avenue, New Orleans, LA 70112;* Charles Foti, J.D., Howard J. Osofsky, M.D., Roger Scott, B.A., Barbara Jennings, M.S.W.

SUMMARY:

Through the collaborative efforts of the Orleans Parish Criminal Sheriff's Office (OPCSO), the LSU Department of Psychiatry in New Orleans (LSU) and the American Association of Retired Persons (AARP), over 60 older adults (age 55 and over) have returned to the workforce, providing essential services in the field of corrections and contributing significantly to the psychological health of the participants. This innovative program provides 10 weeks of classroom and four months of on-the-job training for inner-city, older, minority adults interested in returning to the workforce. Job placements include working with the medical division, security, the post office, the commissary, the grievance process records department, the clergy, inmates, or in the courtroom. Training stipends for qualifying trainees (must be age 55 and over, meet federal poverty income guidelines, and must be a resident of Orleans Parish) are provided through the Senior Community Services Employment Program (SCSEP) sponsored by the AARP and funded by the Department of Labor (DOL). Program evaluation occurs at regular intervals throughout the program. The training program is evaluated on three levels: (1) the effect of the training on the knowledge, skills, and psychosocial functioning of the trainees; (2) the on-the-job performance of the trainees; and (3) the level of satisfaction and positive functional outcome for the institution (OPCSO). Current psychosocial evaluation data indicate that participation in the program significantly reduces psychological symptomology among the older adult participants, especially depression, as measured by the Brief Symptom Inventory (Derogatis, 1975). Similarly the older adults' self-concept, as measured by the Tennessee Self-Concept Scale (Fitts, 1964), was demonstrated to increase significantly from baseline to completion of the program. This program has served as a model for training older adults to work in correctional facilities and has been

recognized nationally by AARP. Training seniors to work in the jail is a win-win situation. The older adults find employment and new meaning in their life, and the jail gets outstanding hard working employees.

No. 6B
PSYCHIATRY AND WELFARE TO WORK

Charles Foti, J.D., *Criminal Sheriff, Orleans Parish, 2020 Gravier Street, New Orleans, LA 70112;* Edward V. Morse, Ph.D., Diane Glazer, M.S.W., Howard J. Osofsky, M.D.

SUMMARY:

For more than a year, the LSU Medical School Department of Psychiatry in conjunction with Sheriff Charles Foti Jr. and the Orleans Parish Criminal Sheriff's Office (OPCSO) has conducted a rigorous, vocational education and job training program for welfare recipients. Individuals on the rolls of the Office of Family Support (OFS) who pass drug screens and criminal background checks are provided social and job skills training, instruction leading toward the graduate equivalency diploma (GED), and post-certification training leading to commission as a deputy sheriff. The Fresh Start training program, as it is called, has the following primary objectives: (1) to provide students with the safety and security skills necessary to work in a corrections environment; (2) to provide classroom learning skills; (3) to provide job/vocational skills and social skills training; (4) to provide an intensive on-the-job supervised internship; and (5) to provide to those who qualify the opportunity to become a deputy sheriff. All trainees completing this instruction are guaranteed full-time jobs with OPCSO.

Although the economic, political, and social benefits of Welfare reform continue to be debated, the psychological and personal benefits measured as part of this program indicate tremendous success. Participants experience a reduction in psychological symptomology as measured by the Brief Symptom Inventory (Derogatis, 1975) and an increase in self-concept, as measured by the Tennessee Self Concept Scale (Fitts, 1964).

Personal testimonials from participants include comments such as "this program has given me a purpose," "my children are proud of me and that makes me proud of myself," and "for the first time in my life I feel like somebody."

No. 6C
THE VIOLENCE INTERVENTION: A COMMUNITY-BASED PROGRAM FOR CHILDREN AND FAMILIES

Joy D. Osofsky, Ph.D., *Public Health Department, LSU Health Science Center, 1542 Tulane Avenue, New Orleans, LA 70112;* Nancy Freeman, L.C.S.W., Michael Rovaris, M.S.W., Amy Dickson, Psy.D.

SUMMARY:

The Violence Intervention Program for Children and Families (VIP) was developed in 1992 as a response to the crisis of rising violence in New Orleans, with increasing numbers of children being exposed as either victims or witnesses. The philosophy guiding the program is a systems approach designed to work with the whole community to address the problem of violence. VIP aims to decrease violence through a combination of interventions and services to victims and education and prevention forums for police, parents, and children. A key component of the program is education of police officers about the effects of violence on children and families to increase their knowledge and sensitivity when dealing with violent incidents. In 1999, VIP joined with the COPS for KIDS, a summer program designed to prevent youth violence by offering a summer camp for children living in public housing. The VIP program helped supplement the camp by focusing on building self-esteem, anger management education, and therapeutic services to children who were having behavioral problems. The COPS have shown the program's effectiveness in reducing juvenile nonviolent crimes in public housing. This program has been effective in reaching children and families and providing services to those who "fall between the cracks" of the mental health care system.

No. 6D
MENTAL HEALTH EVALUATIONS IN POLICE RECRUITMENT AND RETENTION

Howard J. Osofsky, M.D., *Department of Psychiatry, Louisiana State University HSC, 1542 Tulane Avenue, New Orleans, LA 70112-2865;* Penelope Dralle, Ph.D., Wayne Greenleaf, Ph.D., Ben Lousteau, M.B.A.

SUMMARY:

In the mid-1990s, New Orleans was frequently cited in the press as one of the crime and murder capitals of the United States. Relatedly, there were major concerns about corruption and lapses in quality within the police department. In 1997 a new superintendent of police and the New Orleans Police Foundation turned to the senior author to head a Blue Ribbon Commission and, with the department of psychiatry, to improve the evaluation process for recruits including development of better initial mental health evaluations. Working collaboratively with the police department and city civil service, a comprehensive, efficient evaluation process was developed including psychological assessments and, when indicated, further psychiatric interviews. With the success of this program, the commission then developed ongoing evaluations involving mental health professionals and police department supervisors. Currently, these evaluations occur near the end of training at the police academy, during the initial training experience, and at the end of the first probationary year. The supervisory process has much improved. The program is of major help in the initial recruitment process in determining when remediation is needed. The program is seen as very important in the continuing successful efforts to reduce crime and maintain a high-quality police force.

No. 6E
A JUVENILE, COURT-RELATED AFTER SCHOOL AND WEEKEND THERAPEUTIC PROGRAM

Ernestine S. Gray, J.D., *Judge Juvenile Court, Orleans Parish, 421 Loyola Avenue, New Orleans, LA 70112;* Charles Foti, J.D., Howard J. Osofsky, M.D.

SUMMARY:

Many youth who are seen by the courts for nonviolent crimes have long-standing patterns of truancy and delinquency, limited family supports, and worrisome peer relationships. Many of the available intervention models have limited long-term success in reducing recidivism, decreasing subsequent arrests, and optimizing the likelihood that these youth will fulfill their potential. This year a collaborative initiative has been undertaken by the New Orleans Juvenile Court, the Office of the Criminal Sheriff, the school system, and LSUHSC Department of Psychiatry to provide a voluntary afterschool and weekend diversionary support program for referred youth and their families. Participation requires that the youth and their families commit to the program including regular reports to the court. Initial evaluations include mental health evaluations, assessment of family structure and strengths, educational attainment to date, and peer relationships. Program components include individual, group, and family therapy; educational remediation; and tutoring, behavioral redirection, mentoring, vocational skill building, and community

service. The initial commitment to the full program is six months with flexibility related to student progress. Transitional components, school reassignments when indicated, and follow-up case management are important. The presentation will focus on program development, the interagency collaborative process, mental health needs of these youth and their families, and results to date.

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SYMPOSIUM 7—ARAB PERSPECTIVE ON CHILD AND ADOLESCENT PSYCHIATRY
Arab American Psychiatric Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium presentation, the participant should be able to recognize the influence of ethnicity and the phenomenology of psychiatric symptoms on the assessment, diagnosis, and treatment of children in the Arab culture.

No. 7A
THE VALIDITY OF PSYCHIATRIC DIAGNOSIS: APPLICATION IN CHILDREN

Ahmed S. Aboraya, M.D., *930 Chestnut Ridge, Morgantown, WV 26505;* Abdel F. Amin, M.D.

SUMMARY:

Objectives: The goal of this presentation is to review the status on the validity of psychiatric diagnosis. The author will redefine the elements of validity in psychiatry and advocate their use for clinical and research purposes. The variation of validity criteria among different age groups and different cultural backgrounds will be discussed.

Method: A comprehensive review of the literature on the concept of validity will be analyzed. The author will propose six elements that can lead to the most valid psychiatric diagnosis.

Results: The validity of psychiatric diagnoses haunted clinicians for centuries. Kraepelin used the course and outcome as a valid proof of the existence of two distinct syndromes or disorders, namely schizophrenia and bipolar disorder. Robins and Guze articulated phases of valid diagnosis in psychiatry. These phases included clinical description, laboratory studies, exclusive criteria, follow-up studies, and studies of familial aggregation. Based on the author's research and clinical experience, six elements that compromise the most valid psychiatric diagnosis are proposed. These elements are knowledge, clinical experience, reliable standardized instruments, external validators, and reference definitions.

Conclusions: Validity criteria in psychiatry exist; however they are not fully utilized. Validity criteria need to be adapted for different cultures and for children.

No. 7B
THE ARAB FAMILY STRUCTURES IN ARAB CIVILIZATIONS: A HISTORICAL REVIEW

Nasser F. Loza, M.B., *The Behman Hospital, El Marsad Street, Helwan Cairo, Egypt*

SUMMARY:

The family has been the cornerstone of the social structure within Arab societies. Since ancient civilizations including Pharaonic and Greeco-Roman times, there have been extensive writings about the role of family networks, dynamics within family members, and the role of children and parents. This review will look at different writings including Papyri, teachings of masters to their pupils, as well as the extensive religious writings observed in the Middle East over the centuries. Debates about the efficacy of psychotherapy for children and families, involuntary treatment, and informed consent are discussed. Clinical entities such as eating disorders, substance abuse, and chronic mental illness will also be presented in the context of the Arab family. Conclusions are drawn with special reference to the psychodynamics of Arab families living in the Middle East or in Western cultures and their influence on children.

No. 7C
THE CURRENT STATUS OF CHILD PSYCHIATRY: AN EGYPTIAN PERSPECTIVE

Ahmed M.F. Okasha, M.D., *Neuropsychiatry, Ain Shams University, 3 Shawarby Street, Kasr Elain Cairo 00094, Egypt*

SUMMARY:

Childhood mental disorders occupy a very secondary position on the agenda of health planning where the focus is mainly directed toward life threatening, physical/infectious diseases such as diarrhea and respiratory tract infections. There has not been enough awareness and/or recognition of the fact that mental disorders can start in childhood and that early discovery and intervention could protect the child, the family, and the society in the future. Mental health care services should be integrated in the current school health care and health insurance systems for school children where it is easier to identify early behavioral problems related to learning, articulation, pervasive developmental, mood disorders, and conduct disorders. We cannot overlook the need for a subspecialty in pediatric psychiatry to deal with children's needs that go beyond the care provided by pediatricians and general practitioners. In Egypt, there are only 700 psychiatrists (i.e., one psychiatrist for every 120,000 persons). Less than 1% specialize in child and adolescent psychiatry (i.e., approximately 30 child psychiatrists are expected to provide services to 24 million children). A review on education, training, research, and services of child psychiatry in Egypt will be discussed.

No. 7D
MENTAL HEALTH IN CHILDREN AND ADOLESCENTS IN MOROCCO

Driss Moussaoui, M.D., *University Psychiatric Center, Rue Tarik IBN Ziad, Casablanca 00210, Morocco;* K.H. Chihabeddine

SUMMARY:

If psychiatry is a neglected branch in medicine, child and adolescent psychiatry is the neglected branch in the field of psychiatry. This is even more the case in developing countries. In Morocco, out of 250 psychiatrists, there are less than 10 child psychiatrists. On the other hand, not a single institution for child and adolescent psychiatry exists in the public sector, despite statements by the Ministry of Health (MOH) about the importance of this branch of psychiatry. Associations of relatives in private sector, belonging to

NGOs, create the only existing institutions. The number of studies conducted in the field of child and adolescent psychiatry is very low. In 1995, the MOH found that children at risk for iodine deficiency was approximately 22%. Since then, iodine has been systematically added to salt nationwide. Other epidemiological studies have been conducted in the department of psychiatry of Casablanca on enuresis (N = 500). Prevalence was found to be 41.4%. Another study on "school difficulties" in 11 classrooms of lower/elementary schools concluded that the risk factors of such difficulties included the lack of preschool education and the distance between home and school. The results of other studies will also be presented.

No. 7E
DISCIPLINARY PRACTICES AND CHILD MALTREATMENT AMONG EGYPTIAN FAMILIES IN AN URBAN AREA IN ISMAILIA

Mohamed H. El-Defrawi, M.D., *Department of Neuropsychiatry, Suez Canal University, Ismailia, Egypt;* Fatma Hassan, M.D., Amany Refaat, M.D., Hesham El-Sayed

SUMMARY:

An epidemiological study was conducted in three randomly-selected areas in one district in Ismailia, Egypt. The Arabic version of the World Survey of Abuse Within Family Environment (World-SAFE) was used in a household survey. A total of 602 children met the criteria for inclusion, such as having at least one child in the home between the ages of one and 18 years. The objective of the study was to closely examine the family characteristics and risk factors for child abuse and maltreatment. Data were tabulated and statistical analysis was done at the department of psychiatry, Suez Canal University School of Medicine. This study and another recent related study done on domestic violence against women will be presented. Several risk factors for physical, verbal, and emotional abuse were identified for children and women. Mental health services are needed for counseling and educating parents and children about effective parenting using more of a positive reinforcement and behavioral modification techniques rather than punishment.

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SYMPOSIUM 8—EATING DISORDERS: NEW FEATURES AND NEW TREATMENTS

EDUCATIONAL OBJECTIVES:

By the end of the symposium, participants will be able to discuss new features concerning eating disorders including cognitive deficits in anorexia nervosa, problematic eating behaviors associated with driving, predictors of relapse to CBT in bulimia nervosa, new pharmacotherapies for eating disorders including the use of atypical neuroleptics, and the use of e-mail as an adjunctive treatment for anorexia nervosa.

No. 8A
COGNITIVE FUNCTIONING IN ANOREXIA NERVOSA

David B. Herzog, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, 725 ACC-EDU, Boston, MA 02114;* Bonnie J. Sherman, M.A., Kamryn T. Eddy, B.A., Mark A. Blais, Psy.D., Cathelene E. Connor, B.A., Thilo Deckersbach, Ph.D., Scott L. Rauch, M.D., Cary R. Savage, Ph.D.

SUMMARY:

Studies of cognitive functioning in anorexia nervosa (AN) have shown deficits in verbal and nonverbal memory, attention, problem solving skills, and spatial perception when compared with normal controls or weight-recovered ANs; however, no single cognitive deficit has been consistently demonstrated. Research on two psychiatric disorders commonly associated with eating disorders, obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD), has demonstrated impaired verbal and nonverbal memory, possibly linked to organizational problems that disrupt encoding. Among OCD, BDD, and AN populations, overlapping psychopathology is found in obsessions, compulsions, and body image disturbances. With the possibility of shared biology, it is hypothesized that the specific organizational deficits observed in OCD and BDD populations will also be found in ANs. We will report on the verbal and nonverbal memory function and organizational strategies in 20 women with AN, and 20 nonpsychiatric controls. It is first hypothesized that the ANs will show deficits in these cognitive abilities similar to those seen in OCD and BDD patients; and second, that they will demonstrate strategic organizational deficits that will mediate impairment in verbal and nonverbal memory as is seen in OCD and BDD patients. Confirmation of these hypotheses will provide initial evidence of the linking of these psychiatric disorders. Clinical implications of such findings may allow for more specific biological or psychotherapeutic interventions. Conclusions will be discussed in the context of future directions for studies of brain function.

No. 8B
EATING BEHAVIOR WHILE DRIVING A CAR

James E. Mitchell, M.D., *Department of Psychiatry, Neuropsychiatric Research Institute, 700 First Avenue South, P.O. Box 1415, Fargo, ND 58103;* John B. Glass, M.D.

SUMMARY:

This paper will summarize the results of two studies that examined eating behavior and other potentially problematic behaviors that individuals engage in while operating motor vehicles.

The first study involved administration of a questionnaire. Data were obtained from a series of individuals recruited from the general population who reported eating while driving an average of twice a week. Ten were males and 15 were females. All currently had valid drivers' licenses, but four had previously had their drivers' licenses revoked or suspended. In this series, eight individuals reported a history of binge eating accompanied by lack of a sense of control while driving a car, and five (20%) reported binge eating in parked cars.

In a second study, a series of individuals with eating disorders were surveyed regarding problematic eating behaviors that had occurred while driving a motor vehicle. A subset of these patients used

the car as a place to binge eat, frequently involving multiple visits to fast food establishments. This appears to be a common pattern in a subgroup of patients with bulimia nervosa, and patients with binge eating disorder.

No. 8C
COGNITIVE-BEHAVIOR THERAPY RELAPSE PREDICTORS FOR BULIMIA NERVOSA

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605-1504;* W. Stewart Agras, M.D., James E. Mitchell, M.D., Scott J. Crow, M.D., G. Terrence Wilson, Ph.D.

SUMMARY:

Methods: In a multisite study, 194 BN patients received 20 sessions of CBT over four months. Complete remission from bingeing and purging was achieved in 48. Patients were assessed pre- and post-treatment and four months post treatment with the Eating Disorder Examination (EDE), Tri Factor Eating Questionnaire (TFEQ), Bulimic Thoughts Questionnaire (BTQ), Yale Brown Cornell Eating Disorder Scale (YBC-ED), Rosenberg Self-esteem (RSE), Interpersonal Inventory (II), and Beck Depression Inventory (BDI).

Results: At four months post CBT, 27 patients were abstinent and 21 had relapsed. There were no differences between the groups in ethnicity, SES, comorbid psychiatric diagnosis, age, or body mass index. Those who relapsed had a shorter duration of illness (9.2 ± 6.6 years) compared with the abstinent BN (14.7 ± 9.3 years). The relapsed BN had more depression, lower self-esteem, higher restraint, and higher (more pathological) scores on the YBC-ED and the motivation items of the YBC-ED compared with the abstinent BN immediately after the CBT.

In the four months following CBT, the abstinent BN had 4.6 continuous weeks of abstinence, whereas the relapsed BN had only 3.3 continuous weeks of abstinence.

Multiple logistic regression analysis showed significant predictors of relapse to be the YBC-ED preoccupation change score, the TFEQ restraint pretreatment, the RSE post CBT, and the duration of eating disorder.

Conclusion: The amount of change that occurs with CBT on core eating disorders preoccupations will determine relapse. Restraint and self-esteem are also significant factors influencing relapse.

No. 8D
NEW TREATMENT STRATEGIES FOR ANOREXIA NERVOSA

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, #E-724, Pittsburgh, PA 15213;* Maria Lavia, M.D., Guido Frank, M.D., Amanda Molina, B.S.

SUMMARY:

Because existing treatments for anorexia nervosa (AN) have limited efficacy, many people with AN have a chronic, relapsing illness or die. The first generation of treatment studies focused mainly on attempts to increase the rate of weight gain of emaciated patients in a hospital setting, but many people relapsed after discharge. While newer studies have suggested that specialized treatment protocols may reduce relapse at one to two years follow up, or improve outcome in subgroups of patients, results are modest and such treatments may not be available to many people.

Recent studies suggest that a disturbance of serotonin neuronal pathways contributes to vulnerabilities (altered appetite, anxiety, obsessionality) that may contribute to the pathophysiology of AN. However, SSRIs do not appear to be useful in treating malnourished AN. The possibility that malnutrition may diminish synaptic serotonin release suggests that SSRIs may be more efficacious in a well-nourished state. In fact, our group has reported that fluoxetine, in a controlled trial, significantly reduces relapse, obsessionality, and depression when administered *after weight restoration* in women with AN.

In a search for other treatment possibilities in malnourished AN, our center has conducted open trials of olanzapine, a drug that often increases weight when used in other psychiatric disorders. Preliminary data suggest that olanzapine administration was associated with weight gain and maintenance as well as reduced agitation and resistance to treatment in malnourished AN. While speculative, the effects of olanzapine on appetite and other behavioral symptoms could be related to 5-HT2 receptor blockade.

In summary, there is reason to be optimistic that an understanding of the physiology of this disorder will lead to successful treatments.

No. 8E
ADJUNCTIVE TREATMENT OF ANOREXIA NERVOSA BY E-MAIL

Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*

SUMMARY:

Method: To explore using adjunctive e-mail in treating anorexia nervosa, treatment plans were supplemented by obligatory e-mail emphasizing patients' reports of specific eating related behaviors, but which often include other issues as well. Office visits occurred weekly to once per month. E-mail contact occurs several times per week to daily. Some patients also see other providers.

Results: Most patients have shown good clinical improvement and attribute improvement in part to using e-mail. Non-participation in e-mail is an early indicator of clinical resistance to overall treatment.

Discussion: E-mail has had excellent patient acceptability and adherence. Benefits have been attributed to increased therapeutic contact, "talking" on demand, and confronting one's honesty and eating behaviors daily. Clinician time for reading and responding to e-mails is not substantial. Informed consent and confidentiality issues must be carefully addressed. Controlled trials are warranted to further evaluate how adjunctive e-mail may be used in clinical research and in practice.

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2. Gupta MA: Dangerous driving and eating disorders (letter). J Clin Psychiatry 1992; 53:416
3. Eldredge et al: The effects of extending cognitive behavioral therapy for binge eating disorder among initial treatment nonresponders. International Journal of Eating Disorders 1997:347–352
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SYMPOSIUM 9—PSYCHODYNAMIC PSYCHOTHERAPY: CONTEMPORARY ISSUES
APA Commission on Psychotherapy by Psychiatrists and American College of Psychoanalysts

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose and treat with psychotherapy those with severe Axis I and II disorders and psychological reactions to female reproductive cancers, and to be more conversant with the new area of the psychological impact of computer technology on patients.

No. 9A
PSYCHOTHERAPY IN THE SPECTRUM OF ANTISOCIAL PERSONALITY: POSSIBILITIES AND LIMITATIONS

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, #114, New York, NY 10024-6027*

SUMMARY:

Antisocial personality traits may be found over a wide range of clinical situations. At one end of the antisocial spectrum, we confront persons who are rarely if ever in trouble with the law. These are persons who, for example, may occasionally engage in shoplifting minor items, or in unscrupulous business practices. Next we confront the malignant narcissists, who commit antisocial acts, including violent ones, yet who regain the capacity for loyalty. Further along, are persons with antisocial personality disorder (ASPD) who commit property crimes or who neglect or endanger their families. Then there are persons with ASPD who are violent. Finally, there is the region of full-blown psychopathy exhibiting the intensely narcissistic traits of grandiosity, callousness, and deceitfulness. The effectiveness of psychodynamic psychotherapy is limited to those at the mild end: patients subthreshold for ASPD, and some with malignant narcissism. Those with ASPD who do not meet criteria for psychopathy rarely respond to dynamic psychotherapy, but may respond to cognitive/behavioral approaches—especially if confined within institutional settings. Psychopaths, in contrast, because of their contempt for psychiatry and conviction of their own "normalcy," seldom if ever respond favorably to any form of therapy, and are actually prone to misuse therapy—by learning better how to "con" the authorities into granting them privileges they will then misuse.

No. 9B
DYNAMIC PSYCHOTHERAPY OF WOMEN WITH CANCER OF THE REPRODUCTIVE SYSTEM

Jennifer I. Downey, M.D., *Department of Psychiatry, Columbia University College, 108 E. 91st Street #1A, New York, NY 10128;*

SUMMARY:

Many issues must be considered in formulating a plan for the psychotherapeutic treatment of women with reproductive malignancies. Assessment of the patient is the first step. Areas to be considered include:

(1) The course of the physical illness from first symptom to the present, including treatments, resulting disabilities, and expected prognosis; response of the patient's social support system; and patient's current quality of life.

(2) Past history of reproductive events and difficulties as well as other physical illness and treatments.

(3) Current and past psychiatric history.

(4) Developmental and psychodynamic history including family history; any past exposures to trauma and response to it.

Psychotherapeutic treatment strategies depend on the patient's symptoms, stage of illness, personal assets, level of character organization, and goals. Issues that may arise in the treatment include choosing the goal of support or insight, moderating amount of denial, end of life concerns, the response of significant others as it affects the patient's adaptation and coping, and the influence of transference on the patient's response to illness. Case illustrations will be provided.

No. 9C
THE PSYCHOTHERAPY OF PSYCHOTIC PATIENTS

Gerald J. Sarwer-Foner, M.D., *Department of Psychiatry, Wayne State University Medical School, 3320 Bloomfield Shores Drive, West Bloomfield, MI 48323;*

SUMMARY:

One must understand the shattered sense of "I" and "Me" of psychotic patients, and their use of self-protective ego defenses in order to avoid the "intrapsychic pain" of their own self-blame, guilt, and relative worthlessness. Observing what islands of neurotic and normal ego defenses exist, and how they are used, is necessary. The psychiatrist must have Pacht's sense of being "authentically present" for the patient, and must see the patient as human, not as neuropathologically changed and damaged ("constitutionally psychopathically inferior") person. The patient, therefore, has realistic hope of making progress toward a more integrated and normal humanity. The psychiatrist has to present to the patient, the psychiatrist's understanding of what problems in the patient's growth and psychosexual development as a person, the patient has suffered, and the emotional complexities of the patient's path to the present—"to today." In all of this the psychiatrist must use ego-supportive clarifications, confrontations, interpretations, very often in the here and now, i.e., the drama of the patient's resistance and reaction-repetition of past emotional experiences. The psychiatrist must cope with his/her own reluctance to stay available, "married" in this sense, throughout the length of therapy, in his/her countertransference reactions.

No. 9D
COMPUTERS: CLINICAL EFFECTS OF TODAY'S BLANK SCREEN

Marcia K. Goin, M.D., *Department of Psychiatry, University of Southern California, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90017-4085*

SUMMARY:

Computer technology and the availability through the internet of chat rooms, telemedicine, and computer-assisted psychiatry are creating unique encounters in our patients' worlds. Study of the psychological impact of computer technology is in the early phase of development, but articles expressing warnings in many different areas are emerging. These include concerns about computer addiction and the management of time; on-line sexual addiction; reported "cybersuicide" where the authors describe interactive suicide notes followed by suicide fatalities. Other writers cite examples of the computer catalyzing life enhancing experiences. Whatever the use, it is obvious that the "blank screen" of the computer is a natural vehicle for projection to occur and transference phenomena abound. This presentation will discuss the many domains that the internet technology has introduced into our patients' lives, both positive and negative. The various projections will be explored and discussed. It will alert the audience to the potential dangers of having a computer

in the house, sensitize them to the intrapsychic meanings, and also explore the potential to promote psychological growth.

The internet is now part of our everyday world. Psychiatrists must be sensitive to its use and abuse as it is a powerful force in today's world.

REFERENCES:

1. Stone MH: Abnormalities of Personality—Within & beyond the realm of treatment. NY, WW Norton, 1993
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4. Brenner V: Psychology of computer use: XLVII parameters of internet use, abuse, and addiction: the first 90 days of the Internet usage Usage Survey, Psychological Reports 1997; 80(3 Pt 1): 879–82

SYMPOSIUM 10—TREATING THE PSYCHIATRICALLY ILL HIV PATIENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand the complex medical issues that may lead to brain dysfunction; (2) identify the criteria for diagnosing mood/depression, somatic symptoms, and psychotic disorders; and (3) recognize drug-drug complications and treatment interventions for the psychiatrically ill HIV patient.

No. 10A
TREATMENT APPROACHES TO HIV-RELATED NEUROCOGNITIVE DISORDERS

Francisco Fernandez, M.D., *Department of Psychiatry, Loyola University Medical Center, 2160 South First Avenue, Building 54, #154, Maywood, IL 60153*

SUMMARY:

Neurologic disease is the first manifestation of symptomatic HIV infection in roughly 10% to 20% of persons, while about 30% to 40% of patients with advanced HIV disease will have clinically evident neurologic dysfunction during the course of their illness. The incidence of subclinical neurologic disease is even higher: autopsy studies of patients with advanced HIV disease have demonstrated pathologic abnormalities of the nervous system in 75% to 90% of cases. This research provides substantial evidence that HIV directly infects the brain, resulting in central nervous system impairment and neuropsychiatric disorders, including HIV-1-associated dementia complex and minor cognitive-motor disorder. As HIV/AIDS is increasingly treated as a chronic disorder with the improvement of treatments and longer survival times, the incidence of HIV-related neuropsychiatric sequelae is expected to increase. The involvement of psychiatrists in the diagnosis and treatment of HIV/AIDS patients is essential because of the prevalence of HIV-related neuropsychiatric complications, psychiatric comorbidity, as well as the psychodynamic aspects of HIV infection and disease.

This presentation will address primary infection of the central and peripheral nervous systems, cognitive-motor impairment and dementia, and review new developments in psychopharmacologic interventions and treatments.

No. 10B
MOOD DISORDERS: DEPRESSION

Stephen J. Ferrando, M.D., *Department of Psychiatry, Cornell Medical College, 525 East 68th Street, Box 181, New York, NY 10021*

SUMMARY:

Disturbances of mood can occur frequently in the context of HIV infection. Among the most common psychiatric conditions are depression and mania. The risk of these disorders increases as immune suppression increases. These disorders often occur concurrently with HIV-associated minor cognitive motor disorder and may herald the development of HIV-associated dementia. Manic syndromes reportedly affect nearly 10% of AIDS patients, while major depression has been detected in up to 30% of patients living with HIV. It is crucial that clinicians treating HIV patients recognize the conditions and vulnerabilities specific to HIV disease that may complicate a diagnosis of mood disorder (including organic etiologies, psychoneurotoxicity associated with medications, and/or neuropsychiatric disorders secondary to opportunistic illnesses or lymphoma) as well as the appropriate interventions for treatment.

No. 10C
COMPLICATIONS OF DRUG-DRUG INTERACTIONS

Milton L. Wainberg, M.D., *Department of Psychiatry, New York Psychiatric Institute-Columbia University, 404 Riverside Drive, Unit 5B, New York, NY 10025*

SUMMARY:

The advent and development of powerful antiretroviral treatments have benefited many individuals living with HIV. For many, new HIV treatments have lengthened lives. Between 1997 and 1998, the number of people estimated to be living with AIDS increased by 12% (from 241,000 to 270,000). The metabolism of these drugs by the enzymatic cytochrome P450 system, however, is affected and complicated by the HIV drugs themselves as well as by interactions with other substances. When other drugs and substances—prescription, over-the-counter, illegal, and food and herbal substances—are used, serious complications can occur. Psychiatrists need to be aware of these interactions and follow general guidelines when prescribing HIV as well as psychiatric medications. This session will present the latest data on drug-drug interactions, guidelines for psychopharmacologic treatment, and special issues regarding substance use.

No. 10D
PSYCHOTIC DISORDERS

Francine Cournos, M.D., *Department of Psychiatry, NYS Psychiatric Institute-Columbia University, 5355 Henry Hudson Drive, #9F, New York, NY 10471-2839;*

SUMMARY:

Psychosis is associated with HIV infection in four different ways: (1) as preexisting primary psychiatric disorder that is associated with HIV-related risk behavior; (2) as a complication of substance use disorders, which are themselves strongly associated with HIV infection; (3) as a neuropsychiatric manifestation of HIV disease; and (4) as a complication of the medical disorders caused by immune system suppression. When psychosis and HIV infection coexist, management strategies must include attention to differential diagnosis, drug-drug interactions, and the effect of antipsychotic medications on the central nervous system of HIV-infected people. This presentation will review the causes and treatment of psychosis in the presence of HIV infection and AIDS, drug-drug interactions between antipsychotic medications and antiretroviral treatment, and the severe extra-

pyramidal side effects associated with the use of standard neuroleptics in advanced HIV disease.

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1. Castellon SA, et al: Neuropsychiatric disturbance is associated with executive dysfunction in HIV I infection. J Int Neuropsychol Soc 2000;6(3):336–47
2. Penzak SR, Reddy YS, Grimsley SR: Depression in patients with HIV infection. Am J Health Syst Pharm 2000; 57(4):376–86
3. Tseng AL: Significant interactions with new antiretrovirals and psychotropic drugs. Ann Pharmacother 1999 Apr;33(4):461–73
4. Susser E, et al: HIV infection among young adults with psychotic disorders. Am J Psychiatry 1997; 154(6):864–6

SYMPOSIUM 11—NEW FINDINGS ON PSYCHIATRIC PRACTICE: ACCESS AND PATTERNS OF CARE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should demonstrate increase awareness of current trends in psychiatric practice related to quality, access, and patterns of care, including patterns of comorbidity and split versus integrated pharmacotherapy and psychotherapy.

No. 11A
MEASURING QUALITY OF CARE

John M. Oldham, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Suite 6700, New York, NY 10032-2603*

SUMMARY:

The set of indicators developed by the APA Task Force on Quality Indicators (1999) "is intended to serve as a tool for health care groups, including accrediting organizations; as an approach to evaluate care provided by health plans and organized systems of care; and as a source of direction for additional research and development of new indicators. Indicators address various aspects of care and are applicable to structure, process or outcomes." From tested indicators, a "high confidence" set of indicators will then be selected for priority utilization by organized systems of care and by reviewing and accrediting organizations.

The APA Department of Quality Improvement and Psychiatric Services and the Committee on Quality Indicators has begun to field-test the sample quality indicators already developed, utilizing the APA Practice Research Network (PRN) data. Using nationally generalizable, clinically detailed data from the 1997 and 1999 PRN Study of Psychiatric Patients and Treatments several of the task force's quality indicators have been operationalizable.

This presentation will provide an overview of the rates of conformance in the PRN sample with a number of the quality indicators including conformance with evidence-based practice guideline treatment recommendations. More specifically, rates of PRN conformance with quality indicators for the treatment of schizophrenia, substance abuse, borderline personality disorder, bipolar disorder, and major depression will be presented along with general quality indicators related to access to care and treatment of the severely mentally ill.

No. 11B
INTEGRATED VERSUS SPLIT TREATMENT: PHARMACOTHERAPY AND PSYCHOTHERAPY FOR MOOD DISORDERS

Farifteh F. Duffy, Ph.D., *QIPS, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Joyce C. West, M.P.P., Deborah A. Zarin, M.D., William E. Narrow, M.D., Diane M. Herbeck, M.A., Anna P. Suarez, M.P.H.

SUMMARY:

Objectives: To assess whether patient and health plan factors affected the provision of integrated and split psychopharmacologic and psychotherapeutic treatments for outpatients with mood disorder.

Methods: Nationally representative (weighted), clinically detailed data from the APA/PRN 1997 Study of Psychiatric Patients and Treatments was used. Among outpatients (n = 783) 69% were diagnosed with mood disorder; of those 29% received psychopharmacologic treatment, 11% received psychotherapy, and 59% received "combined" psychopharmacologic *and* psychotherapeutic treatments. This study examined split and integrated patterns for a final sample of 314 outpatients who received "*combined*" treatments. Integrated treatment was defined as when the target psychiatrist reported providing both psychopharmacologic intervention *and* psychotherapy. Split treatment was defined as when psychopharmacologic intervention *and* psychotherapy has been split between the target psychiatrist and other health or mental health providers. For statistical analysis, Wald-χ^2, Wald F-test, and logistic regression were used.

Results: Preliminary findings indicate that 76% (se = 3.3) of the sample received integrated treatment. Furthermore, 34% (se = 5.4) of patients whose psychiatrists reported their treatment recommendations were subjected to one or more utilization management techniques received split treatment compared with 14% (se = 3.2) of patients whose treatment was not affected by utilization management ($p < 0.01$).

Conclusion: Barriers to providing integrated treatment have been a major concern in psychiatry; data suggest the majority of outpatients with mood disorder received integrated treatment in 1997. A number of factors were associated with provision of split or integrated treatments, including patient diagnosis and utilization management techniques.

No. 11C
AXIS I AND AXIS II COMORBIDITY IN PSYCHIATRIC PRACTICE

William E. Narrow, M.D., *APIRE, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Diana J. Fitek, B.A., Diane M. Herbeck, M.A., Steven C. Marcus, Ph.D.

SUMMARY:

Objective: This study analyzed the reports of a nationally representative sample of psychiatrists on comorbid Axis II disorders among their patients with Axis I disorders.

Methods: The data were gathered from a sample of 1,843 psychiatrists participating in the Practice Research Network (PRN)'s 1999 Study of Psychiatric Patients and Treatments, conducted by the American Psychiatric Institute for Research and Education. Data were analyzed to ascertain the prevalence of Axis I and II disorders, comorbidity rates, and functional status and treatments.

Results: The most prevalent personality disorders were in Clusters B and C, found in 6% to 7% of the sample. Cluster A disorders were relatively rare. Overall rates of Axis II comorbidity with the mood, anxiety, and substance use disorders ranged from 17% to 19%. Lower Axis II comobidity rates were found in schizophrenia, schizoaffective disorder, and the adjustment disorders (5.5% to 9%).

Demographic, functioning, and treatment characteristics will also be presented.

Conclusions: Personality disorders have a relatively high prevalence among persons with Axis I disorders. Knowledge of the relationships between Axis I and Axis II disorders and their functional impairments is important for planning effective treatment interventions and will be useful for future nosologic research.

No. 11D
CHARACTERISTICS OF PATIENTS WITH SUBSTANCE USE DISORDERS AFFECTED BY FINANCIAL CONSTRAINTS

Diane M. Herbeck, M.A., *APIRE, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Steven C. Marcus, Ph.D., Clifton R. Tennison, Jr., M.D., Laura J. Fochtmann, M.D.

SUMMARY:

Objective: This research examines clinical and health plan characteristics of patients with substance use disorders (SUD) for whom financial considerations affected access to treatment.

Methods: Psychiatrists participating in the American Psychiatric Institute for Research and Education's Practice Research Network (PRN) provided nationally representative data on the treatment of 1,843 patients, of whom 342 (19.6%) had a SUD. These data were used to determine which clinical and health plan factors were associated with having financial considerations adversely affect treatment. For statistical analysis, Wald-χ^2, Wald F-test, and logistic regression were used.

Results: Twenty-eight percent of SUD patients were reported to have had their treatment adversely affected by financial considerations. These patients were more severely ill than patients whose treatment was not adversely affected by financial considerations, exhibiting higher rates of severe depressive, anxious, and psychotic symptoms; GAF scores below 50; a higher rate of axis IV psychosocial problems; were prescribed a higher mean number of medications; and received treatment through managed behavioral "carve out" health plans.

Conclusions: Although financial constraints affect a significant proportion of both patients with and without SUD, these constraints affect SUD patients differently than patients with other psychiatric disorders. SUD patients affected by financial constraints were more severely disabled, clinically complex, and a population for whom access to effective treatments may be particularly important.

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5. Drake RE, Wallach MA: Dual diagnosis: 15 years of progress. Psychiatr Serv 2000; 51:1126–1129

SYMPOSIUM 12—PTSD IN WOMEN: INTEGRATING MIND AND BRAIN IN TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the unique neurophysiologic, psychodynamic, including ethnic, racial, and war experiences, together with psychopharmacologic factors, involved in diagnosing and treating PTSD in women.

No. 12A
IMMUNE NEUROANATOMIC NEUROENDOCRINE GENDER DIFFERENCES IN PTSD

Rachel Yehuda, Ph.D., *Department of Psychiatry, Bronx VA Medical/Mount Sinai Medical Center, 130 West Kingsbridge Road, #116A, Bronx, NY 10468;*

SUMMARY:

There has been increasing interest in examining possible gender differences in the neurobiology of posttraumatic stress disorder (PTSD). This interest is prompted by recent studies demonstrating that men and women are exposed to different types of traumatic events, and also respond differently to similar events. Women are twice as likely to develop PTSD as men, and have a duration of illness nearly twice as long as that of men. Women also tend to show a different profile of psychiatric and medical comorbidities than men. Whereas women are more likely to develop comorbid depression, men are more likely to develop comorbid substance abuse. Whereas women are more likely to develop a posttraumatic fibromyalgia, chronic pelvic pain, or chronic fatigue, men appear to develop hypertension and show a greater posttrauma mortality. This presentation will discuss possible gender differences in the neurobiology of PTSD and stress and will present an integration of the neurobiological literature on the basis of an analysis by gender. The author will present original data examining gender differences in neuroendocrine, immune, cognitive, and neuroanatomic parameters in PTSD. The focus will be on examining what gender differences do and do not suggest about the universality of the fear response.

No. 12B
THE PSYCHODYNAMICS OF TRAUMA IN WOMEN

Kathryn J. Zerbe, M.D., *The Menninger Foundation, P.O. Box 829, Topeka, KS 66601-0829*

SUMMARY:

Patients who have experienced significant trauma present psychiatrists with a formidable clinical problem. Frequently significant countertransference reactions and boundary violations occur when attempting to intervene with this group of individuals who are comorbid for many other psychiatric illnesses. This presentation will address the most common psychodynamic issues in the treatment of patients who experience physical, emotional, and sexual abuse. Emphasis will be placed on how patients tend to repeat in the therapeutic relationship the traumatic bonds of their past, and why patients tend to persist in their attachment to abusive relationships, despite even malignant consequences. Additionally, the role of shame and stigma will be underscored as will the value of creating "a safe place" for the patient. Finally, the latest data derived from neurophysiologic and neurologic studies will be linked to an evolving hypothesis regarding why psychotherapy relationships are invaluable to this group of patients. The presenter will also discuss the "secondary

traumatization'' that faces the clinician who treats PTSD in an office or hospital setting. Patient guidelines and education tools that can aid both therapist and patient will be reviewed.

No. 12C
DOMESTIC VIOLENCE, PTSD, AND WOMEN OF COLOR

Tana A. Grady-Weliky, M.D., *Department of Psychiatry, University of Rochester, Box 601, 601 Elmwood Avenue, Rochester, NY 14642*

SUMMARY:

Domestic violence is a major health problem, which has significant influence on mental health of women in today's society. Symptoms of posttraumatic stress disorder are among the mental health consequences of domestic violence. There has been limited research on the role of ethnicity and culture in the recognition and treatment of PTSD resulting from domestic abuse. Barriers to effective patient-physician communication among women of color and mental health care providers may be one area that limits the appropriate recognition of domestic abuse, and ultimately, treatment for its mental health effects for example, PTSD. Rodriquez et al. (1998) suggest that an improved understanding of factors that interfere with communication may help facilitate the provision of appropriate health care for immigrant women. Differences may also exist between cultures with regard to level of psychological distress and coping strategies in women who are victims of domestic violence. Torres and Han (2000) noted that nonHispanic white women experienced a higher prevalence of psychological distress compared with Hispanic women with a history of abuse. This finding may help explain differences in help-seeking behaviors among some women of color. This talk will review the available literature on the impact of domestic violence and PTSD among women of color with an emphasis on the differences in help-seeking behaviors and treatment recommendations.

No. 12D
TREATMENT OF PTSD IN WOMEN: LESSONS FROM WOMEN VETERANS

Marian I. Butterfield, M.D., *Department of Psychiatry, Duke-Durham VAMC, 508 Fulton Street, Durham, NC 27705;* Paula G. Panzer, M.D., Catherine Fomeris, Ph.D.

SUMMARY:

Victimization is disturbingly common among women. An estimated 15% to 38% of women have experience childhood sexual abuse and 13% to 20% have experienced adult rape. Prevalence estimates of rape-induced PTSD range between 31% and 94%, which indicate that currently 1.3 million women in the U.S. have rape-induced PTSD. Rape victims may well make up the largest group of individuals suffering from PTSD—a constellation of re-experiencing, avoidance, and arousal symptoms. Until recently, much of the PTSD treatment research has been in veteran men who experienced combat-related PTSD. Now, there is strong evidence that sexual victimization, like war trauma, is a powerful contributor to the development of PTSD in women veterans. Over 1.2 million women have served in the U.S. military. While women veterans may have experienced trauma from a range of sources including war-zone exposures, rape-related PTSD has been a disturbing health problem. Several recent studies report high rates of military sexual trauma and victimization among women veterans seeking treatment. Responding to the challenge of victimization of service women, the Department of Veterans Affairs established extensive programs for sexual trauma screening and treatment in women veterans. Clinical treatment strategies including assessment, triage, diagnosis, and pharmacotherapy of PTSD derived from work with women veterans will be reviewed. Sexual trauma individual treatment group modalities will be presented. Future directions for research in assessment, treatment, and prevention of PTSD in women will be addressed.

No. 12E
PHARMACOTHERAPEUTIC TREATMENT FOR WOMEN WITH PTSD

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425-0742*

SUMMARY:

Posttraumatic stress disorder is a common and devastating disorder. PTSD is twice as common in women as compared with men. Several issues may contribute to this gender differential in prevalence of PTSD. Premorbid depression or dysthymia, which are both more common in women as compared with men, are risk factors for the development of PTSD. Additionally, women are more likely to experience the types of trauma, namely sexual abuse and rape, which are most commonly associated with the development of PTSD. For those reasons, the treatment of PTSD in women is an area of particular concern. Early trials exploring pharmacotherapeutic treatment strategies for PTSD were primarily conducted in male Veteran populations. These trials demonstrated efficacy for the tricyclic antidepressant agents and the monoamine oxidase inhibitors. More recently, placebo-controlled trials have been conducted with the serotonin reuptake inhibitors fluoxetine and sertraline. Several of these trials demonstrate a preferential efficacy of these agents in women as compared with men. Data from a large, controlled trial of sertraline demonstrating this gender differential in treatment efficacy will be presented. Potential mechanisms will be discussed.

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SYMPOSIUM 13—PSYCHIATRY, THE INTERVIEW, AND MEDICAL OUTCOMES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be familiar with new concepts and data relating the interview to improved outcomes. Attendees will be able to apply these tools to improve their own interviews (and outcomes) with patients and their teaching of interviewing to colleagues, residents, and medical students.

No. 13A
NEW CONCEPTS AND DATA ON THE RELATIONSHIP OF THE INTERVIEW TO OUTCOMES

Geoffrey H. Gordon, M.D., *Bayer Institute for Health Care Communication, 488 Wheelers Farm Road, Milford, CT 06468*

SUMMARY:

The last decade has seen an exponential growth in the theoretical and empirical literature relating the interview to medical outcomes. While psychiatrists have traditionally led the medical disciplines in advances in interviewing, many practicing psychiatrists may not be aware of current research and conceptual advances.

This presentation will present a selective review of the key conceptual and empirical advances of the last decade, with special attention to pragmatic issues of relevance to psychiatrists for their current clinical work and teaching. Research findings will be organized along the lines of the three-function model of the medical interview: (1) using the interview to build the relationship; (2) collecting data to assess the patient's problem; and (3) educating and changing patient behavior to manage the patient's problems.

This presentation will conclude with a brief discussion of an internist's view of potential organizational changes in health care to facilitate coordination and integration of psychiatry with general medical care.

No. 13B
ADHERENCE AND BEHAVIOR CHANGE SKILLS FOR THE PRACTICING PSYCHIATRIST

Michael G. Goldstein, M.D., *Bayer Institute for Health Care Communication, 400 Morgan Lane, West Haven, CT 06516*

SUMMARY:

Psychiatrists play a central role in providing patients with health information, educating patients about psychiatric conditions, enhancing patients' adherence to treatment plans, and motivating and assisting patients to alter problematic health behaviors. Even very brief clinician counseling promotes patient behavior change in such areas as smoking cessation and problematic alcohol use. Evidence from clinical trials suggests that several specific communication and counseling strategies promote patient adherence to treatment and patient behavior change. However, most psychiatrists have not received training in these specific skills, which include reflective listening, expressing empathy, rolling with resistance, enhancing self-efficacy, and supporting autonomy. In this presentation, I will briefly review models of clinician-patient interaction that have shown the most promise in promoting patient adherence and patient-behavior change, including the Transtheoretical Model of Change, Social Cognitive Theory, Motivational Interviewing, and Self-Determination Theory. I will also delineate a practical approach for teaching several specific communication and counseling skills that have been derived from these models.

No. 13C
TEACHING SKEPTICAL MEDICAL HOUSESTAFF COMMUNICATION SKILLS WITH PATIENTS

M. Philip Luber, M.D., *Department of Psychiatry, University of Pennsylvania, 7004 Wissahickon Avenue, Philadelphia, PA 19119*

SUMMARY:

Programs that teach medical residents and fellows about doctor-patient communication skills and related psychosocial medicine are often not well received. These programs are perceived as marginal to "real medicine" and have little impact on the way that doctors actually practice. The following six key elements contribute to effectiveness of programs that have been successful:

(1) The program is specifically designed to overcome trainee resistance to teaching about communication skills and psychosocial medicine.

(2) Sentimental notions about the doctor-patient relationship are avoided and practical skills are emphasized.

(3) There is no passive learning.

(4) Management of small group process is attended to in fine detail.

(5) Faculty members are not perceived as outsiders.

(6) Teaching efforts go hand in hand with clinical services and clinical research.

No. 13D
DEPRESSION EDUCATION FOR PRIMARY CARE: THE MACARTHUR FOUNDATION

Steven A. Cole, M.D., *Department of Psychiatry, Care Management, 1979 Marcus Avenue, Suite E-120, Lake Success, NY 11042;* Mary Raju, N.P.

SUMMARY:

Increasing data demonstrate that depression is under-recognized and under-treated in primary care, and is also associated with increased morbidity, mortality, and utilization. This presentation will: (1) review the data indicating that inadequate communication skills plays a role in suboptimal recognition and management of depression in primary care, (2) describe the development and implementation of the MacArthur Foundation Depression Education Program for Primary Care Physicians (DEP), (3) describe the objectives and teaching methods for the communication skills training aspects of DEP, (4) summarize the evidence-based efficacy data on DEP to date, (5) describe ways that DEP has been or can be integrated into more comprehensive disease management initiatives, and (6) provide guidance on ways that practicing psychiatrists can utilize DEP materials for their own work with primary care physicians.

No. 13E
LEARNING AND TEACHING LISTENING SKILLS

Joseph S. Weiner, M.D., *Department of Psychiatry, LIJ Medical Center, 270-05 76th Avenue, Suite C-46, New Hyde Park, NY 11040*

SUMMARY:

Participants will learn to use and teach a pragmatic four-level model of listening. The first level of listening involves empathy for patient suffering. The second level of listening requires thoughtfulness about how intrapsychic conflict affects the patient's symptoms and quality of life. The third level attends to the ways the patient's struggles with mortality issues influence suffering and intrapsychic conflict. The fourth level addresses the importance of attending to our own personal thoughts and feelings about the above.

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SYMPOSIUM 14—TRAUMA AND THE LIFE CYCLE: MULTIDISCIPLINARY PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant would have been provided with an intellectually diverse overview of important contemporary issues in trauma research and theory.

No. 14A
CONTEMPORARY PSYCHODYNAMIC PERSPECTIVES ON TRAUMA DEVELOPMENT

Arieh Y. Shalev, M.D., *Department of Psychiatry, Hadassah University, PO Box 12000, Jerusalem 91120, Israel*

SUMMARY:

The last 20 years have revolutionized our knowledge of psychological trauma and its consequences. Specifically, adherence to intuitively appealing postulates has been replaced by reliance on empirical findings. Studies have, in fact, explored the phenomenology, the epidemiology, and the biology of traumatic stress disorders, and these focused areas of research have shaped the dominant bio-behavioral discourse on human traumatization. Forgotten in this hasty course were the major role played by the meaning of events in shaping their consequences, the historical and structural roots of meaning construction, and the permanent changes to personality, emotional life, self-perception, and appraisal of others induced by trauma. These essential ingredients of psychodynamic theory have potent clinical and theoretical implications. Indeed, a comprehensive theorization is badly needed. Yet, in order to become viable again, a psychodynamic approach must consider all empirical knowledge gained, integrate and organize such knowledge, and provide a template for predicting further development. Can this be done? What constrains such development? What are the assets and the challenges ahead? These will be outlined and amply discussed in this presentation.

No. 14B
INTEGRATING MEDICATION AND PSYCHOSOCIAL THERAPEUTIC MODELS IN PTSD

Randall D. Marshall, M.D., *Anxiety Disorders, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

The efficacy of several trauma-focused psychosocial treatments for adults with PTSD is well established. More recently, large clinical trials have shown efficacy for the SSRIs, and previous studies found efficacy for the tricyclic antidepressants and MAO inhibitors. A review of this literature, however, reveals that a substantial proportion of patients are left with residual symptoms in single-modality clinical trials.

Despite the widespread practice of combination treatment in PTSD and its recommendation in recent treatment guidelines, there are no studies that systematically examine combination treatment. However, several lines of reasoning and research attest to the important role of combination therapy in PTSD and will be reviewed in this presentation. The disorder is amenable to both learning models and affect dysregulation models. Psychosocial treatments are likely to exert effects through mechanisms of learning, whereas medications are likely to produce improvement secondary to stabilization and/or restoration of homeostasis of neural networks regulating mood, anxiety, fear, and sleep. Finally, preliminary empirical and theoretical support for a two-phase treatment model in PTSD will be presented. Phase I would involve stabilization, formation of an alliance, psychoeducation, and preparation for desensitization, followed by trauma desensitization in Phase II. The implications for clinical treatment will be outlined.

No. 14C
VARIABLE FORAGING DEMAND REARING IN PRIMATES: BIOBEHAVIORAL SEQUELAE

Jeremy D. Coplan, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 14, New York, NY 10032;* Eric L. P. Smith, Ph.D., Bruce A. Scharf, Shirn Baptiste, Altamash I. Oureshi, M.D., Jack M. Gorman, M.D., Leonard A. Rosenbaum, Ph.D.

SUMMARY:

Rosenblum developed a primate model of early rearing disturbances in humans, termed variable foraging demand rearing (VFD). He hypothesized that offspring raised by mothers undergoing VFD conditions would develop an anxious temperament in adulthood. Control groups were raised under consistent foraging demands, both low and high demand. Only VFD animals exhibited anxious-like behaviors. Grown VFD animals had increased cerebrospinal fluid (CSF) corticotropin-releasing factor (CRF), and reduced CSF cortisol levels. VFD subjects also displayed CSF elevations of serotonin and dopamine metabolites and somatostatin. And CRF concentrations were stable over a 30-month period, suggesting trait-like stability. In a separate paradigm in which VFD is introduced later in the infant's development, corresponding to late weaning, a significantly different profile (low CRF, high cortisol, high-5-HIAAA) was observed on the above measures, suggesting the timing of the stressor during the infant's development is critical. These and other data to be presented demonstrate pervasive alterations in biological and behavioral functions in the infant of a mother under variable stress, and the persistence of these alterations into adulthood. Relevance to human anxiety and mood disorders is discussed, with emphasis on the developmental phase at which parental/infant stressors occur. Speculations on treatment implications will be presented.

No. 14D
ETHNOCULTURAL FACTORS IN PTSD

Roberto Lewis-Fernandez, M.D., *722 West 168th Street, Unit #13, New York, NY 10032;* Bruce Dohrenwend, M.D., J. Blake Turner, Ph.D., Randall D. Marshall, M.D.

SUMMARY:

Ethnocultural factors have been implicated as influencing the development of PTSD, potentially impacting traumatic exposure risk, interpretation of traumatic experience, symptom constellation, and course. Rarely is it possible to assess aspects of ethnocultural variation empirically using the same methodology across diverse ethnic groups. The National Vietnam Veterans Readjustment Study (NVVRS), a nationwide survey of 3,016 Vietnam Theater veterans, Era veterans, and non-veterans in which minority veterans were oversampled, permits the simultaneous assessment of social, cultural, and clinical factors that influence PTSD.

The overall NVVRS found marked differences across ethnic groups in rates of current PTSD. PTSD was higher in Latinos (27.9%) and African Americans (20.6%) compared with non-Latino whites (13.7%). In this paper, the NVVRS subsample of Theater veterans evaluated with the SCID (N = 343) is examined to explain these findings. Possible ethnic variation in patterns of symptom endorsement across PTSD criteria clusters and in timing of first onset of PTSD (relative to pre-, during, and post-wartime stressors) are exam-

ined in order to clarify the specific contribution of ethnocultural factors to PTSD onset and persistence. Findings will be used to discuss the influence of ethnicity and culture on the experience of trauma and its consequences during the life cycle.

No. 14E
THE COGNITIVE-AFFECTIVE SCIENCE OF TRAUMA AND DEVELOPMENT

Dan J. Stein, M.D., *Department of Psychiatry, University of Stellenbosch, P.O. Box 19063, Tygerberg, South Africa*

SUMMARY:

Cognitive science, a multidisciplinary approach that is crucially influenced by computational models, is currently a predominant paradigm in academic psychology. Potential advantages of this perspective include useful theoretical constructs and rigorous empirical studies. The distinction between implicit and explicit cognitive processes, for example, may be particularly relevant for a number of areas in psychiatry, including that of trauma and development. However, potential disadvantages of the cognitivist perspective include theorizations that are "substrate-neutral" (i.e, independent of their instantiation in brain or silicon), and a relative lack of work on affect. The field of trauma provides cognitivists with a fertile range of exemplars, and arguably encourages a move toward a cognitive-affective science of the brain-mind. An integrative approach to trauma and development that incorporates the best of cognitive science is certainly worth aiming for.

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SYMPOSIUM 15—ADDICTIONS: GAMBLING AND SUBSTANCE ABUSE: CUTTING-EDGE TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should know the best methods, both pharmacologic and behavioral, for treating the major addictions. In addition, the participant will have an understanding of phenomenology of behavioral and substance-induced addictions.

No. 15A
TREATMENT OF COCAINE DEPENDENCE

Marian W. Fischman, Ph.D., *Department of Psychiatry, Columbia University Medical School, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult and few controlled trials reporting success. A combination of pharmacological and behavioral interventions will likely be required for those patients to achieve and maintain abstinence. Antidepressants, with desipramine the most studied, have been tried but results have been inconsistent. Dopaminergic medications such as pergolide, flupenthixol, amantadine, and bromocriptine have thus far not been consistently successful. More recently, a dopamine DI agonist and dopamine DI antagonist have been tested, with promising results for one of them. Other foci have included NMDA antagonists, the partial opioid agonist buprenorphine, and anticonvulsants such as carbamazepine. A current area of interest is the inhibitory and excitatory amino acids, with gabapentin and vigabatrin about to undergo study. Vaccines with different mechanisms of action are also being studied. Several nonpharmacological treatment approaches have been developed. Relapse prevention, a cognitive-based intervention, has been used successfully in pharmacotherapy trials. A behavioral therapy, contingency-based contracting, used in conjunction with community-based reinforcement, is the only nonpharmacological treatment that has been shown to be effective in controlled trials. Although no single treatment is currently suggested, promising approaches will be discussed and new interventions described.

No. 15B
TREATMENT OF HEROIN DEPENDENCE

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032*

SUMMARY:

The increased purity and decreased price of heroin, along with an increased number of addicts have increased the necessity of developing improved medications. The agonists methadone and LAAM decrease opiate use and improve psychosocial outcome but present problems such as high rates of concurrent abuse of alcohol and cocaine and major difficulty in withdrawal. The antagonist naltrexone, while blocking heroin use and decreasing alcohol abuse, has low rates of acceptance by addicts and high drop-out rates. The partial agonist buprenorphine may have the advantages of these three agents but with much easier withdrawal and a ceiling effect on respiratory depression. New medications being studied include the alpha-adrenergic agonist lofexidine for both withdrawal and long-term treatment of craving, a 30-day injectible form of naltrexone, and new approaches to opiate detoxification. Included in the latter are rapid detoxification under anesthesia and the use of NMDA antagonists.

No. 15C
MARIJUANA DEPENDENCE AND CLUB DRUG USE: FUTURE CONCERNS AND POSSIBLE STRATEGIES FOR A GENERATION AT RISK

David M. McDowell, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Marijuana is the most commonly used illicit substance in the United States. In addition, the use of "club drugs" such as MDMA,

Ketamine, or Special K, are increasingly common among the younger generation. Contrary to public perception, heavy and chronic use of marijuana carries with it substantial morbidity as well as the risk of dependence and withdrawal. There is evidence that the use of club drugs, especially MDMA, among young people remains quite problematic. 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 medications focused on withdrawal symptoms. The results of such studies specially aimed at young people will be presented. Psychosocial interventions such as motivational enhancement and relapse prevention therapy have been used for numerous substance abuse conditions and will be discussed in context here.

Large numbers of young people use these club drugs at raves and other nightclub events and in recent years the federal government has focused its attention on the possible dangers at these venues. The potential for both educational strategies and treatment strategies will be discussed as will the pitfalls inherent in that.

No. 15D
GAMBLING ADDICTIONS

Robert W. Johnson, M.D., *2251 Pimmit Drive, Suite C3, Falls Church, VA 22043-2812*

SUMMARY:

Many people gamble, but the rates of problematic gambling are similar to those of chemical dependencies. Increased problems and increased opportunities, especially the increased number of legalized venues for gambling, bring about a complex array of issues. Though a boon to numerous communities and a source of new-found wealth for various others, this increase has also made much greater the likelihood of increased incidents of pathological gambling and addiction.

This presentation will review the evidence that gambling is indeed an addiction and bring up to date the evidence that many of the substances that are addictive have similar effects to gambling. This presentation will also review the theoretical and practical basis for treatment modalities that can be effective. These include psychosocial interventions and pharmacological interventions as well as the treatment of comorbidity in this population. Also presented will be a broad view of gambling as an addiction. The practicing clinician will be offered sound tools for evaluation of how to differentiate problematic from non-problematic behaviors, as well as a review of present and future research regarding treatment of this sometimes serious conditions.

No. 15E
TREATMENT OF COMORBID CONDITIONS

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

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/schizo-affective illness. Although there are established pharmacologic and nonpharmacologic approaches for each of these psychiatric conditions in non-substance abusing patients, the efficacy of these approaches in substance abusing patients is not well established. Several questions will be addressed in this presentation: (1) What are the appropriate pharmacologic treatment approaches for specific dually disordered patients? (2) Should medications with abuse potential be avoided? (3) Is substance use reduced if the psychiatric comorbid condition is treated? (4) What are some possible modifications of currently available nonpharmacologic strategies that might be used for various diagnosed groups? Although there are no definite answers, clinical guidelines will be offered.

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SYMPOSIUM 16—CHILDHOOD SEXUAL ABUSE: PERPETRATORS AND VICTIMS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to: (1) recognize that research into perpetrators and victims of sexual abuse is critical for its prevention and treatment; (2) identify patterns of personality impairment and brain areas associated with deviant sexual arousal in male perpetrators of childhood sexual abuse (pedophiles); (3) appreciate abnormalities in psychophysiological reactivity to individualized scripts and identify brain areas involved in PTSD in victims of childhood sexual abuse.

No. 16A
PERSONALITY PROFILES AND CHILDHOOD SEXUAL HISTORIES OF MALE PERPETRATORS

Lisa J. Cohen, Ph.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, Suite 6K42, New York, NY 10003;* Igor I. Galynker, M.D., Erik Klein, B.A., Aleksey Ten, M.D., Carrie Weaver, M.A., Enid Gertemian-King, B.A., Kenneth Cullen, M.S.W.

SUMMARY:

While the relationship between severe personality pathology and early history of childhood sexual abuse is well established, the literature on the personality pathology of sexual abuse perpetrators is surprisingly underdeveloped. It is hypothesized that deficits in interpersonal functioning (in assertiveness, empathy, and passive aggressiveness) and in self-concept might contribute to the motivation for pedophilic acts, while sociopathy, impulsivity and propensity for cognitive distortions might underlie the inhibitory failure. Moreover, pedophiles will report high rates of sexual abuse in their own childhood. Twenty male heterosexual pedophiles were compared with 24 demographically similar, healthy male controls on three personality instruments, the Millon Clinical Multiaxial Inventory-2 (MCMI-2), the Dimensional Assessment of Personality Impairment-Questionnaire (DAPI-Q), the Temperament and Character Inventory (TCI), and the Sexual History Questionnaire. The data suggested pedophiles

have impaired interpersonal functioning, specifically reduced assertiveness and elevated passive-aggressiveness, as well as impaired self-concept. Of disinhibitory traits, pedophiles demonstrated elevated sociopathy and cognitive distortions. Sixty percent of pedophiles vs. 4% of controls reported that an adult made sexual advances at them in childhood. Thus, our data are consistent with previous reports that point to a discernible profile of personality pathology in pedophiles. Moreover, such pathology may be related to pedophiles' own histories of childhood sexual abuse.

No. 16B
CEREBRAL GLUCOSE METABOLISM AND DEVIANT SEXUAL AROUSAL IN MALE PEDOPHILES

Igor I. Galynker, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, 6 Karpas, New York, NY 10003;* Lisa J. Cohen, Ph.D., Kostantine Nikiforov, M.D., Sara Acker, B.A., Thomas Moesse, Richard N. Rosenthal, M.D., Kenneth Cullen, M.S.W.

SUMMARY:

Childhood sexual abuse perpetrated by pedophiles represents a serious threat to children in this country. Understanding the neural correlates of pedophilia may be critical for the prevention of childhood sexual abuse, which affects 16% of women in the U.S. We investigated sexual arousal and regional cerebral glucose metabolism (rCMRglc) in heterosexual male pedophiles and healthy controls using positron emission tomography (PET) under three experimental conditions: (1) a neutral stimulus, (2) a pedophilic sexual stimulus, (3) an adult sexual stimulus (all stimuli were audiotapes).

Measures of sexual arousal and rCMRglc were compared across stimulus conditions and across groups. Both by self-report and according to phallometric measurements, pedophiles were more aroused than controls under all three experimental conditions. The differences in sexual arousal was the largest with the pedophilic sexual stimulus. Thus it appears that pedophiles appear to have deviant sexual hyperarousal toward prepubescent children, as well as general sexual hyperarousal. By PET, under the neutral stimulus, pedophiles as compared with controls had decreased rCMRglc in the right temporal cortex ($p < .02$), and the left prefrontal cortex ($p < .02$). In pedophiles but not controls, activation with sexual stimuli (compared with the neutral stimulus) was associated with further decreases in rCMRglc in those areas. Such decreased activity in prefrontal and temporal cortices in pedophiles may be associated with impaired inhibition of limbic and subcortical areas that mediate sexual behaviors. Higher cognitive functions, such as assessment of the social appropriateness of sexual behaviors, are also subserved by the prefrontal cortex and appear to be dysfunctional in these perpetrators of sexual abuse. Thus, it appears that pedophiles are both hypersexual (with specific deviant hyperarousal toward prepubescent girls) and might lack neural inhibition of inappropriate sexual behavior. The implications of these findings regarding the etiology of pedophilia and the prevention of childhood sexual abuse will be discussed.

No. 16C
PSYCHOPHYSIOLOGICAL REACTIVITY TO STRESSFUL SCRIPTS IN BPD AND PTSD

Christian G. Schmahl, M.D., *Department of Psychiatry, Yale Trauma Residency Program, 47 College Street, Suite 212, New Haven, CT 06510;* Bernet M. Elzinga, M.S.C., Thomas H. McGlashan, M.D., J. Douglas Bremner, M.D.

SUMMARY:

Borderline personality disorder (BPD) is a highly prevalent condition, which is often related to stressors; however little is known about the biology of BPD. In this study we investigated heart rate, blood pressure, and skin conductance changes in response to standardized neutral scripts as compared with personalized scripts of traumatic and abandonment situations in patients with BPD compared with PTSD and controls. All subjects had a history of sexual and/or physical abuse before age 18. Preliminary data evaluation of 18 subjects revealed greater increases in heart rate and larger blood pressure response in PTSD vs. controls ($p < .05$) with traumatic (but not abandonment) scripts. BPD patients showed a pattern of greater response to abandonment than traumatic scripts. Final results of this study will be presented as well as brain functional correlates of traumatic and abandonment scripts measured with PET.

No. 16D
ROLE OF HIPPOCAMPUS AND MEDICAL PREFRONTAL CORTEX IN ABUSE-RELATED PTSD

J. Douglas Bremner, M.D., *Department of Radiology, Yale University, 950 Campbell Avenue, VAMC 1115 A, West Haven, CT 06516;* Meena Narayan, M.D., Eric Vermetten, M.D., Steven M. Southwick, M.D., Thomas H. McGlashan, M.D., L. Viola Vaccarino, M.D., Lawrence H. Staib

SUMMARY:

Studies in animals and humans suggest that early stress is associated with long-term alterations in two brain areas that play an important role in learning and memory, the hippocampus and prefrontal cortex. In a series of recent studies we have examined neural correlates of memory function in women with early childhood sexual abuse-related PTSD. We replicated our early findings of hippocampal volume reduction as measured with magnetic resonance imaging (MRI) in women with abuse-related PTSD, and showed a 19% reduction in hippocampal volume was specific to PTSD, and not seen in abused women without PTSD, or non-abused non-PTSD ($p < .05$). Using positron emission tomography (PET), we showed that the women without PTSD (but not those with PTSD) activated the hippocampus during verbal memory encoding tasks ($F = 14.94$; $df = 1,20$; $p < .001$). In a second PET study we measured neural correlates of retrieval of neutral (e.g., "horse-apple") and stressful (e.g. "rape-mutilate") word pairs in women with abuse-related PTSD and normal women. We replicated earlier studies showing medial prefrontal dysfunction in PTSD—retrieval of the stressful word pairs was associated with decreased function in medial prefrontal cortex, in addition decreased hippocampal function was seen during stressful word pair retrieval. These results are consistent with dysfunction of hippocampus and medial prefrontal cortex in abuse-related PTSD, and suggest that these areas may be involved in pathological processing of both neutral and emotional cognitions in this disorder.

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SYMPOSIUM 17—PSYCHOTHERAPY IN THE AMERICAS
Inter-American Council of Psychiatric Organizations

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will understand how American indigenous cultures adopted psychotherapies and how they are applied today.

No. 17A
PSYCHOTHERAPY IN THE GENERAL HOSPITAL SETTING: A CULTURAL EXPERIENCE IN LIAISON PSYCHIATRY

Rodolfo D. Fahrer, M.D., *Department of Psychiatry, University of Buenos Aires, J. Salguero 2436, 8 Piso, Buenos Aires 1425, Argentina;* Amelia E. Musacchio de Zan, M.D.

SUMMARY:

Often in liason psychiatry the psychiatrist is called upon for help because communication between the attending doctor and the patient has broken down. A patient lives his illness based upon his development, his cultural background, and the use of defense mechanisms. Psychotherapy of different lengths can be applied depending on the needs of the patient and the surrounding institution. We will demonstrate that cultural deliverance of psychotherapy can shorten periods of hospitalization, enhance the quality of life, and keep the individual culturally bound to his community.

The branches of psychoanalytically oriented psychotherapy will respect the authenticity of the individual and therefore prove to be a flexible method of intervention and a successful tool.

No. 17B
FOLKLORIC ROOTS OF PSYCHIATRY AND DEVELOPMENT OF PSYCHOTHERAPY

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Casilla 17 16 127 C EQ, Quito, Ecuador;* Ricardo Heinlein, Miguel R. Jorge, M.D.

SUMMARY:

Culture is characterized by not being genetically predetermined, but rather the result of the learning process between the individual and the environment. Medicine and the ways in which people experience illness and recovery are part of the broader vision of culture and the healing process. A review of the folkloric roots of psychiatry will be presented in context of psychotherapeutic interventions in the health-illness context in the Latin-American subcontinent. Forms of curanderism, shamnism, and witchcraft are considered by many as well justified empirical techniques of psychotherapy guided by unique theoretical constructs. Instruments and settings with a variety of meanings are still used for diagnosis and management of clinical entities unique to the Andean culture assimilable to contemporary nosological systems, but which merit particular psychotherapeutic interventions.

No. 17C
PSYCHOTHERAPY AMONG INDIGENOUS CARIBBEAN PATIENTS: FOLK TRADITIONS AND FUTURE

Sharon C. Harvey, M.D., *Department of Psychiatry, Bridgade Medical Center, The Garrison, St Michael, Barbados*

SUMMARY:

There is increasing awareness that the cultural manifestations of psychiatric illness are valid, and that they should not be treated as an oddity that departs mainstream psychiatry.

The Caribbean are a heterogenous group of islands and cultures. Added to the influences of African, Dutch, British, Spanish, French, and Portuguese ancestry are the contributions from the indigenous people in the Caribbean countries.

In the practice of psychotherapy in the Caribbean, it is important to bear these factors in mind when presented with psychopathology or problems in the quality of life. This paper will explore these factors and discuss the dilemmas that can result.

No. 17D
PSYCHOTHERAPY IN A VIOLENT SOCIETY

Ruben J. Hernandez-Serrano, M.D., *Department of Psychiatry, University of Central Venezuela, Apartado 17302 El Conde, 101 Caracas 1015A, Venezuela;* Antonio Pacheco, M.D., Roberto E. Chaskel, M.D.

SUMMARY:

The teaching of forensic psychiatry has emphasized the examination of different aspects of violence and its clinical implications amongst the population. Clinical data are supplemented by the Present State Examination. Students analyze the material and participate in the decision-making process regarding intervention.

Psychotherapy has proven to be a good adjunct in offenders, especially when it is culturally bound and not foreign to the individual, to his family, or to the community. Experiences will be shared with the audience to enhance the sensitivity of cultural bound issues that determine the success of psychotherapy.

No. 17E
PHENOMENOLOGICAL AND DESCRIPTIVE LEGACIES IN LATIN-AMERICAN PSYCHIATRY

Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Medicine, 1670 Clairmont Road, Decatur, GA 30033*

SUMMARY:

Between the 1940s and 1970s a singular phenomenological/descriptive school of thought emerged in Latin American psychiatry. Its most outstanding representative was the Peruvian psychiatrist Honorio Delgado. Influenced by European psychiatry, he made clear his intellectual debt to Husserl's phenomenology, but also his objections to a purely mentalistic, anthropological perspective. He delineated the different planes of levels of human functioning and recognized the systematic syndromic and nosological approaches as the rational bases for understanding a psychiatric history, making a diagnosis, and formulating a comprehensive treatment. He set the stage for scientifically based research and the formulations of ideology-free workable clinical hypotheses. He set the stage for scientifically based research in the 50s and 60s in this field to predate current taxonomic systems such as the ICD and the DSM. Latin American psychiatry resisted the excesses of the psychoanalytical and existential schools, and opened a way for significant research and educational accomplishments.

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SYMPOSIUM 18—MIND AND BRAIN: THE CONCEPTS OF PSYCHIATRY
Association for the Advancement of Philosophy and Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the influence of different theories regarding the mind and brain on psychiatric practice. The participant also should be able to analyze underlying conceptual assumptions and implications of differing ways of approaching psychiatric teaching and research.

No. 18A
THE METHODOLOGICAL VIEW OF NEUROSCIENCE AND PSYCHOANALYSIS

Marshal F. Folstein, M.D., *Department of Psychiatry, New England Medical Center, 750 Washington Street/Box 1007, Boston, MA 02111*

SUMMARY:

The operations of psychoanalysis and neuroscience produce two ways to know one world. Psychoanalysis uses methods of the historian to give meaning to the past. Neuroscience uses the methods of natural science to predict the future.

The practice of psychiatry requires mastery of the methods of the historian and the scientist. A discussion of the strengths and weaknesses of those methods was introduced in "The General Psychopathology" of K. Jaspers and recently modified by McHugh and Slavney in the "Perspectives of Psychiatry."

No. 18B
OVERT AND COVERT THEORIES OF MIND IN PSYCHIATRIC EDUCATION

John Z. Sadler, M.D., *Department of Psychiatry, University of Texas Heath Science Center, 5323 Harry Hines Boulevard, Dallas, TX 75390–9070*

SUMMARY:

"Theories of mind" usually refers to particular ways of organizing scientific data about how the mind/brain works. In the setting of this lecture "theories of mind" refers to particular assumptions and beliefs about the nature of human experience, consciousness, and behavior. Philosophical assumptions of this kind do not make up particular psychologics; rather, they provide the network of background assumptions that are the building blocks of psychological theories in the usual sense. Philosophers call these kinds of assumptions—ones that involve core beliefs in human nature and truth—"metaphysical" assumptions.

Good psychiatric education, at the medical-student or residency level, usually involves the presentation of more than one way of understanding the mind, but too rarely addresses the metaphysical assumptions that are in the conceptual background. Often trainees experience one or another theory of mind as inconsistent with their own system of metaphysical background beliefs, resulting in an ill-considered rejection of a way of understanding patients. For this reason, a discussion of the metaphysical assumptions underlying the theories of psychiatry can be educationally fruitful. To illustrate the value of an education in a metaphysical assumption, the relevance of four metaphysical "isms" is presented, with clinical/educational examples: reductionism, naturalism, narrativism, and constructivism.

No. 18C
MIND AND BRAIN DO NOT HAVE TO BE INTEGRATED IF WE DON'T SEGREGATE THEM IN THE FIRST PLACE

Michael A. Schwartz, M.D., *Department of Psychiatry, Tufts University, School of Medicine, 750 Washington Center, NEMC #1007, Boston, MA 02111*

SUMMARY:

The present APA meeting takes as its slogan: "Mind Meets Brain: Integrating Psychiatry, Psychoanalysis, and Neuroscience." In fact, such integration can never occur since mind and brain are not segregated in the first place. In the Eving human being, the mind never exists apart from the brain, and the brain is never devoid of mind.

Nonetheless, mind and brain are real entities—albeit never encountered in isolation in living humans. We disclose them through acts of abstraction: we abstract from—in doing so, we focus on aspects of things (the mental) but at the same time we ignore and conceal other aspects of that same thing (the physical).

Abstract entities such as mind and brain are not necessarily the "building blocks" of an integrated psychiatry. It is just as likely that they are hallmarks of Cartesian bias. When we investigate the living brain through MRI, the observed phenomena are psychophysically neutral as mental as physical. Alternative approaches to these phenomena exist in the philosophical biology of Hans Jonas, and the phenomenology of Husserl and Merleau-Ponty. Embracing these perspectives is challenging in a culture that is overwhelming dualistic, especially in its view of science. We owe our patients nothing less.

No. 18D
MIND/BRAIN THEORIES IN CLINICAL PSYCHIATRY

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

Psychiatric practitioners and researchers often hold certain views regarding the nature of the mind and the nature of the brain that influence the concepts they utilize in their clinical work. In this paper, I will review certain approaches to mind and brain, which I have called the mathematical, biological, philosophical, and common sense approaches, and I will trace their influence in psychiatric theory and practice. I will review in some detail the contribution of Karl Jaspers to formulating a specific version of the scientific method suited to psychiatry, and how this approach influences our thinking about mind and brain today. I will try to relate this discussion closely to current clinical concerns and contemporary research findings. In the end, I will conclude that no one theory of the mind, and no one approach to understanding the brain, serves clinical psychiatry well enough. I will propose a pluralistic approach that focuses on recognizing the strengths and weaknesses of the differing mind/brain theories, and applies them in specific research and clinical settings accordingly. I will argue against eclecticism, or attempts at integration such as the biopsychosocial model, since those perspectives fail to analyze the conceptual assumptions underlying mind/brain theories.

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SYMPOSIUM 19—HOW CAN PSYCHIATRISTS IMPACT THE PROBLEM OF SUICIDE AT THE COMMUNITY LEVEL? APA Alliance

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize current trends in American youth who commit suicide, (2) develop evidence based strategies for suicide prevention that can be taught to local community groups, and (3) know the identifiable signs of psychiatric disorders in adolescents at risk for suicide.

No. 19A
HOW TO PREVENT YOUTH SUICIDE: CHALLENGES FOR PSYCHIATRISTS

Cynthia R. Pfeffer, M.D., *Department of Psychiatry, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

This presentation will present the changing epidemiological trends in youth suicide with an emphasis on how rates differ within age, gender, and racial/ethnic groups. It will illustrate how use of lethal methods must be decreased as an important suicide prevention strategy. Other factors that elevate risk for youth suicide will be discussed including psychopathology, social stress, and environmental context. Empirical studies will be described indicating that more than 90% of youth suicide victims suffer psychiatric disorders involving mood, anxiety, substance abuse, and disruptive disorders. The role of family stress and genetic factors in elevating risk for youth suicide will be presented. Environmental issues, such as methods of discussing suicide in media reports and educational formats, will be highlighted to illustrate the complexities of preventing youth suicide. Psychiatrists must be educated about risk factors, identification of youth at risk, and effective treatments for suicidal youth. These concepts will be presented. Finally, prospective studies illustrate that prevention of youth suicide must be based on early detection of those at risk and development of strategies to lower risk. This will be highlighted in this presentation.

No. 19B
AWARENESS OF SUICIDE RISK IN THE COMMUNITY

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison Street, Suite #955, Chicago, IL 60612*

SUMMARY:

Recent findings on acute and chronic risk factors for suicide will be discussed by Dr. Jan Fawcett. The importance of suicidal communication, especially those made to loved ones, will also be discussed based on findings of Robins' classic studies showing that while 69% of individuals who committed suicide communicated suicidal thoughts within a year of their suicide, 60% did so to spouses, 50% to relatives or friends, and only 18% to helping professionals. The example of Abraham Lincoln's suicidal crisis and how it was successfully managed will be discussed to demonstrate the importance of friends who were sensitive to the dangers, yet responsibly supportive. The value of teaching these facts in community settings to underscore the fact that suicide arises from treatable psychiatric illness and not simply stress or difficult situations will be discussed. Moreover, the importance of realizing that the hopelessness that leads to suicide is a state that can reverse with treatment can oppose the assumption of inevitability that is conveyed by the suicidal individual to friends and family, will be addressed. A simple set of procedures for deciding when sufficient risk is present in order to decide when outside help should be enlisted will be discussed.

No. 19C
YOUTH SUICIDE: UNDERSTANDING AND PREVENTION

Paul Jay Fink, M.D., *191 Presidential Boulevard, Suite C132, Bala Cynwyd, PA 19004;* Jan Fawcett, M.D., Cynthia Pfeffer, M.D.

SUMMARY:

Youth suicide remains a serious problem in America. The Youth Homicide/Suicide Committee of the Philadelphia Interdisciplinary Youth Fatality Review Team (PIYFRT) has been collecting data for five years and studying the nature of the suicides of all children under the age of 21. These findings will be reported. The concern about childhood depression and children learning to have suicide as an alternative is a serious matter that is not being adequately attended to by American psychiatry. We are seeing a number of children who are trying to kill themselves earlier and earlier and sometimes succeeding. The growth and development of children has been seriously affected over the last 50 years by a change in the way in which children are treated, the amount of child abuse that is rampant in our society, and the failure of parents to deal with and appropriately understand the needs of children of all ages. A discussion regarding the choice of violent behavior versus suicidal behavior will be generated. Psychological and psychodynamic understanding of how children deal with their angers and frustrations will be addressed. The Philadelphia Suicide Review Team has statistics and they will be shown to the audience in an effort to bring home the fact that suicide is very real among children and youth.

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SYMPOSIUM 20—THINKING ABOUT MIND AND BRAIN: PSYCHOANALYSTS AND NEUROSCIENTISTS CONVERSE: PART I American Academy of Psychoanalysis and American Psychoanalytic Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will understand better the interaction of biological and psychodynamic processes

as they affect the treatment of patients. Recent advances in the understanding of emotions, memory (procedural and declarative), conscious and unconscious processes, attachment, and transferences in their neurobiological roots will be understood as they potentially contribute to models of psychotherapy.

No. 20A
IS THERE A PLACE FOR AN UNCONSCIOUS IN BIOLOGICAL PSYCHIATRY?

Howard Shevrin, Ph.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Ann Arbor, MI 48105*

SUMMARY:

Recent evidence supports the hypothesis that medications that affect conscious processes do not affect unconscious processes. In an experiment on patients undergoing general anesthesia, it was found that medication succeeded in blocking conscious memory of the surgical procedure, but did not block unconscious memories. In cognitive subliminal priming studies anti-anxiety agents have been found to modify conscious sensitivity to anxiety-related words, but do not affect unconscious sensitivity. In a similar paradigm people on the high end of normal on a depression questionnaire but who are asymptomatic show no conscious sensitivity to depression-related words, but show unconscious sensitivity to the same words. Symptomatically depressed people show both conscious and unconscious sensitivity. An unconscious diathesis may exist for anxiety and depression not reached by current medications, which might explain the high relapse rate once medication is halted. In other research relying on objective brain response indicators of unconscious processes, we have shown that unconscious factors play an important role in social phobia. Some cognitive behavioral therapists have been led by treatment failures to incorporate a role for dynamic unconscious processes. Biological psychiatry might benefit from reconsidering its current disinterest in unconscious processes.

No. 20B
AFFECTIVE NEUROSCIENCE AND SOCIOEMOTIONAL SYSTEMS OF THE BRAIN: IMPLICATIONS FOR UNDERSTANDING PSYCHIATRIC DISORDERS

Jaak Panksepp, Ph.D., *Department of Psychology, Bowling Green State University, Bowling Green, OH 43403*

SUMMARY:

The paradigmatic bases of the emerging field of affective neuroscience will be summarized. After a general summary of the basic sudcortical emotional systems of the mammalian brain, with a focus on separation-distress and play-joy systems, potential implications for a new generation of psychiatric drugs will be introduced. The neurochemistries of the separation response include glutamate, corticotropin releasing factor, oxytocin, vasopressin, prolactin, and various endogenous opioids. Play systems are less well understood, but psychostimulants used to treat ADHD are highly effective play reducing agents, which may explain part of their therapeutic effects. This raises the possibility that extra play may be beneficial for nonpharmacological alleviation of ADHD symptoms. More briefly, the emerging neurochemistries of fear, rage, and seeking behaviors highlight additional avenues of new interventions for psychiatric disorders characterized by imbalances of those affective dimensions.

No. 20C
TOWARD A NEUROBIOLOGY OF THE UNCONSCIOUS

Richard M. Brockman, M.D., *Department of Psychiatry, Columbia University, 15 West 81st Street, New York, NY 10024-6022*

SUMMARY:

There were great debates in the last centuries as to the nature of consciousness and as to the nature of the unconscious. Toward the end of the nineteenth and especially into the beginning of the twentieth century, Freud's perspective of the conscious, the preconscious, and the dynamic unconscious became dominant. In his view the predominant contents of the unconscious were ideas or wishes repressed by the censor (or the ego). Because of the power of Freud's argument, certain other theories were cast into shadow. These included Darwin's theory of inherited emotional behavior, Janet's theory of dissociation, and Pavlov's of associational learning.

What this presentation will do is briefly trace the background that was established by these thinkers, and then show how a contemporary neurobiologic view of the unconscious grew from their ideas. Using case examples, a concept of the unconscious that is based on neuropathway and not on repression, will be demonstrated. According to this view, experience—perception, affect, memory—may be registered in areas of the brain that do not have access to "consciousness", for reasons that have more to do with how and under what conditions they were registered than on their specific content. And thus these experiences may be "unconscious" because of where and how they were encoded and on how and under what conditions they can be retrieved. It is these kinds of experience that I believe are the contents of the unconscious.

No. 20D
PSYCHOANALYTIC AND NEUROBIOLOGIC PERSPECTIVES ON ALEXITHYMIA

Graeme J. Taylor, M.D., *Department of Psychiatry, University of Toronto, 802-180 Bloor Street West, Toronto, ON M5S 2V6, Canada*

SUMMARY:

Alexithymia is a personality construct that was derived initially from psychoanalytic observations that some patients respond poorly to insight-oriented psychotherapies because of difficulties in identifying and describing subjective feelings, an impoverished fantasy life, and an externally oriented cognitive style. These characteristics are thought to reflect deficits in the cognitive processing and regulation of emotions rather than an ego defense style. This presentation reviews research over the past decade that has provided empirical support for the alexithymia construct and examined its association with several other psychoanalytic and personality constructs. At present, investigations of the neural correlates of alexithymia are sparse and conclusions derived from the findings are somewhat speculative. Preliminary findings suggest that alexithymia may be associated with a disruption of transmission of interoceptive emotion information to the anterior cingulate cortex, with deficits in the interhemispheric transfer of sensorimotor information, and with a reduced density of rapid eye movements during REM sleep. Theories and findings from attachment research suggest an integrative model in which alexithymia may be attributed to early developmental experiences that affect the maturation of the orbitofrontal cortex as well as the acquisition of cognitive structures and skills necessary for effective emotion regulation.

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SYMPOSIUM 21—ACHIEVING COMPREHENSIVE CARE FOR THE SUICIDAL INDIVIDUAL

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, individuals will benefit from the insights of a team from an inner-city Canadian Hospital and will be able to achieve comprehensive care for suicidal clients.

No. 21A
A NEEDS-BASED APPROACH TO THE CARE OF SUICIDAL INDIVIDUALS

Ian C. Dawe, M.D., *Department of Mental Health, St Michael's Hospital, 2012 30 Bond Street, Toronto, ON M5B 1W8, Canada*

SUMMARY:

This presentation will introduce the concept of a comprehensive package of care for chronically suicidal individuals from the viewpoint of a Canadian inner-city academic hospital and set the stage for the presentations to come. The presentation will provide an overview of the epidemiology and neurobiology of suicide, along with risk factors such as psychiatric illness, substance abuse, and the availability of means of suicide. The presentation will stress the need for integration of new mental health initiatives into the existing framework of health and social service systems. Clinical and descriptive data will be presented highlighting ongoing work in this area at the University of Toronto.

No. 21B
JOURNEY OF CARE OF THE SUICIDAL PATIENT: ST. MICHAEL'S-STYLE CRISIS PERSPECTIVE

Michele K. Cook, R.N., *Department of Mental Health, St. Michaels Hospital, 30 Bond Street, Room 1017, Crisis Team, Toronto, ON M5B 1W8, Canada*

SUMMARY:

This section of the symposium will focus on risk assessment of the recurrently suicidal, self-harming person. A review of the components of a suicide risk assessment with attention to research findings related to completed suicides within the population of borderline personality disorder will be presented. Emphasis will be placed on the individual's "self capacities" as described by Deiter, Nicholls, and Pearlman. Affect regulation, the ability to maintain self-worth and the ability to maintain a sense of connection, will be discussed within the context of risk assessment, intervening in the emergency setting, management of counter-transference reactions, and choices regarding disposition.

The purpose and goal of this section is to inform participants of a "best practices" guideline for assessing chronically suicidal persons and assisting them, where possible, to regain a baseline level of self-control and coherence.

No. 21C
INPATIENT MANAGEMENT OF THE SUICIDAL PATIENT

Kenneth E. Balderson, M.D., *Wellesley Central Site/Dept of Psychiatry, St Michael's Hospital, 160 Wellesley Street East, Room 326B-J.B., Toronto, ON M4Y 1J3, Canada*

SUMMARY:

This section of the symposium presents the perspective of the inpatient unit in providing integrated care for the suicidal patient. An overview of the literature concerning inpatient care of suicidal individuals will be presented. Basic environmental and procedural measures to minimize patient opportunities to end their lives will be discussed.

As treatment has shifted from inpatient to community-based settings, close coordination with community service providers has become essential. An approach to chronically suicidal patients making use of pre-admission screening evaluations and planned admissions with treatment plan developed out of meetings including the patient and both the inpatient and outpatient teams and informed by dialectical behavior therapy will be described. Managing deviation from the treatment plan and discharge procedures will also be discussed.

No. 21D
COMPREHENSIVE CARE FOR THE SUICIDAL INDIVIDUAL: OUTPATIENT GROUP INTERVENTION

Yvonne Bergmans, M.S.W., *St. Michael's Hospital, 30 Bond Street, Toronto, ON M5B 1W8, Canada;* Ian C. Dawe, M.D.

SUMMARY:

This presentation will focus on the trials and tribulations of developing and operating a group intervention that has meaning for recurrent suicide attempting men and women who primarily carry a suspected or confirmed diagnosis of borderline personality disorder. The challenges of creating a "team" with community providers and family practitioners, diagnostic dilemmas, and working with identified patients largely from the inner city of a large urban center as "co-creators" will be discussed. This section of the presentation will include both demographic descriptive data as well as vignettes to assist in presenting the impact and early results of an eclectic set of interventions for these clients.

No. 21E
COMPREHENSIVE CARE FOR THE SUICIDAL PATIENT: RESEARCH PERSPECTIVES

Anne E. Rhodes, Ph.D., *St. Michael's Hospital, 30 Bond Street, Toronto, ON M5B 1W8, Canada*

SUMMARY:

This section of the symposium follows the presentations of the perspectives of the emergency, inpatient, and outpatient departments in providing integrated care for the suicidal client. The purpose of this presentation is to give an overview of the research concerning care of the suicidal individuals who present to hospital settings and to highlight the implications for future work. The research regarding the results of randomized controlled treatment trials, variations in clinical practice, and the adherence of clients with treatment will be discussed. The issues and initiatives described by the previous presenters will be used to illustrate the approach of an inner-city hospital specializing in the care of adults.

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SYMPOSIUM 22—FRONTIERS OF DEPRESSION IN CHILDREN AND ADOLESCENTS

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should become: (1) cognizant of relationship between maternal depression and child and adolescent depression, (2) aware of longitudinal outcome of depression in youth, and (3) familiar with cutting-edge studies on pharmacotherapy and cognitive behavior therapy of depression in children and adolescents.

No. 22A
NEUROBIOLOGY OF DEPRESSION AND SUICIDAL BEHAVIOR

J. John Mann, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Box 42, New York, NY 10032*

SUMMARY:

Suicide is the eighth leading cause of death in the United States. It is the third leading cause of death in youth. Most youth suicide is a complication of a mood disorder. It is now possible to differentiate the neurobiology of mood disorders from the neurobiological correlates of suicide risk. Such observations help integrate these new findings into a comprehensive clinical and biological model of suicide risk in youth. In a postmortem study of completed suicides, deceased individuals with a history of major depression, and controls, we have found that serotonin transporter changes associated with major depression involve the dorsal-ventral extent of the prefrontal cortex. In contrast, suicide is associated with a localized decrease in serotonin transporter binding in the ventral prefrontal cortex. The diverse psychopathological components of a major depressive episode are consistent with involvement of multiple brain regions. In our proposed stress-diathesis model of suicide, major depression is a stressor. The ventral serotonergic abnormality appears to be independent of the primary psychiatric disorder and related to the diathesis for suicide and perhaps externally directed aggression. The continuation of major depression and a diathesis for suicide is generally required to create a high risk for suicide. The neurobiological diathesis may be genetic and developmentally influenced by childhood experiences.

No. 22B
DEPRESSED MOTHERS IDENTIFIED IN PRIMARY CARE

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032-2603;* Adriana Feder, M.D., Daniel J. Pilowsky, M.D., Mark Olfson, M.D., Milton Fuentes, Psy.D.

SUMMARY:

Studies of depressed mothers have generally been conducted in psychiatric settings with middle-class women. Primary care has an increasing role in early detection and treatment, especially for the poor who have less access to specialized mental health services. Two hundred and seventeen mothers identified from a systematic sample of primary care patients who screened positive for major depression; anxiety, psychotic, and/or substance disorder; or none of these disorders coming to an urban primary care clinic were studied.

Children of depressed mothers had a three times greater risk of having a history of serious emotional problems than children of nonpsychiatric controls, a four times greater risk of having their problems left untreated, and ten times greater risk of poor mother-child relations. Depressed mothers consistently had the highest rates of functional disability and problems in their offspring.

These findings reported by low-income depressed mothers coming to primary care are consistent with numerous findings from psychiatric settings and middle-class samples. This information may be useful in planning treatment interventions with the mothers and/or offspring that can break the intergenerational cycle of depression. An adult primary care clinic has potential for early detection of children with emotional problems, especially for the poor who have limited access to specialty services.

No. 22C
TRENDS IN CURRENT CLINICAL RESEARCH ON CHILD AND ADOLESCENT MAJOR DEPRESSION

Maria Kovacs, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Suite E469, Pittsburgh, PA 15213;* Joel Sherrill, Ph.D.

SUMMARY:

There is growing consensus that MDD is a developmental disorder, with possibly up to 50% of depressed adults having childhood onsets. Major depressive disorder (MDD) is indeed detectable in school-age children and increases markedly around age 15 (12-month rates of about 5%). Studies of MDD presentation and course in clinically referred youths show that it is associated with considerable morbidity: childhood MDD is protracted (average episode length of seven to nine months), recurrent (30% to 70%), has high psychiatric comorbidity (e.g., anxiety disorders being most prevalent), poses a high risk of bipolar switch (up to 20%), and is associated with mood disorder in adulthood (up to about 60%). MDD in youths also occurs in the context of high familial rates of MDD (up to 57% of first-degree relatives affected). Current research seeks to maximize treatment response to psychological and pharmacologic interventions, scrutinize the reasons for the high placebo response rate (up to 60%), and explore preventative strategies. The most consistently identified risk factors for juvenile MDD include history of prior depression as well as prior nondepressive psychopathology, history of physical complaint/illnesses, and parental depression. Consideration of these risk factors may improve response to current treatments.

No. 22D
PHARMACOLOGY OF CHILD AND ADOLESCENT DEPRESSION

Neal D. Ryan, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Room ERC-720, Pittsburgh, PA 15213*

SUMMARY:

To date, randomized, placebo-controlled trials of TCAs in child and adolescent major depression have been disappointing with studies failing to find evidence of superiority of TCAs over placebos. Now, with the availability of NIMH and pharmaceutical industry studies, we are seeing data supporting the hypothesis that SSRIs are effective in child depression. Soon there will also be data about new nonserotonergic compounds. These data suggest that, while depression in youth has strong continuity with adult depression, there are also significant maturational effects that must be understood by the pharmacologist. All available randomized controlled studies to date on the pharmacological treatment of child and adolescent depression will be reviewed. The side effects of SSRIs and other newer agents in youth will be reviewed and treatment guidelines presented.

No. 22E
TREATMENT GUIDELINES AND ALGORITHMS IN DEPRESSED CHILDREN AND ADOLESCENTS

Graham J. Emslie, M.D., *Department of Psychiatry, University of Texas at Southwestern, 5323 Harry Hines Boulevard, Dallas, TX 75235-7200*

SUMMARY:

Significant advances are being made in the treatment of depressed children and adolescents. Recent and ongoing pharmacologic studies have demonstrated the effectiveness of acute treatment with SSRIs over placebo. While some concern has arisen about the potential negative impact of placebo-controlled trials in children and adolescents, most investigators recognize that these trials are necessary to validate the efficacy of medications in this age group. To address these concerns, we compared the one-year outcome of depressed children and adolescents enrolled in an eight-week, double-blind, placebo-controlled trial of fluoxetine, and found that randomization to placebo did not negatively impact long-term outcome or course of illness.

While research data on the medication treatment of MDD in the age group is limited, antidepressants are widely prescribed to children. To address the knowledge gap, a consensus conference was convened that included national experts, providers, administrators, and consumers. A medication algorithm was designed to provide physicians with consistent strategies and tactics to treat this population. Preliminary data on the feasibility study utilizing the algorithm will be presented. In addition, continuation and maintenance treatment will be discussed.

No. 22F
COGNITIVE-BEHAVIORAL TREATMENT AND PREVENTION OF ADOLESCENT DEPRESSION

Greg Clarke, Ph.D., *Center for Health Research, 3800 North Interstate Avenue, Portland, OR 97227*

SUMMARY:

Objective: We review the findings of several prior randomized controlled trials of group cognitive-behavioral (CB) treatment and prevention programs, and then present new findings on the treatment and prevention of depression in at-risk adolescent offspring of depressed adults in an HMO.

Method: Parents were identified as depressed based on medication dispenses and chart reviews. Physician recruitment letters were sent to parents, inviting them to participate. Based on diagnostic interviews, adolescent offspring (age 12 to 18) were classified into three depression severity groups: depressed, demoralized, or resilient. A separate randomized *treatment* trial was conducted with depressed youth (N = 88), and a separate *prevention* trial was conducted with demoralized youth (N = 94). In both trials, youth were randomized to either active CB group intervention (32 hours treatment, or 15 hours prevention), or usual HMO care.

Results: No advantage was found for the CB *treatment* over HMO usual care. However, youth in the CB *prevention* program had significantly ($p = .003$) fewer DSM episodes of depression (9.3%) over 14 months follow-up than control youth (28.8%). Significant main prevention effects were also detected for self-reported depression, suicidal symptoms, and global functioning (all $p < .05$ or better).

Conclusions: Depression risk can be substantially lessened with a brief group CB program.

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SYMPOSIUM 23—RESULTS FROM THE TEXAS MEDICATION ALGORITHM PROJECT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: (1) specify available methods to develop medication guidelines; (2) implement treatment guidelines for schizophrenic, bipolar, and major depressive disorders; and (3) be knowledgeable about whether medication guidelines combined with family/patient education and clinical staff support improve clinical outcomes compared to treatment as usual.

No. 23A
THE TEXAS MEDICATION PROJECT (TMAP): RATIONALE AND STUDY DESIGN

A. John Rush, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9086*

SUMMARY:

Several medications are available to treat schizophrenic, bipolar, and major depressive disorders. Clinicians must organize, sequence, or combine these different treatment options. General medicine has implemented algorithms/disease management protocols (guidelines) to improve the quality of care, hoping to increase the value of the health care dollar. Psychiatry has only recently begun to develop and evaluate such protocols. While systems of care have embraced guidelines, experimental evidence as to their clinical utility is not yet available. The Texas Medication Algorithm Project (TMAP) compared treatment-as-usual (TAU) with algorithm-driven care,

which was combined with a patient/family education package and clinical staff support (ALGO+ED). Overall, 1,605 patients entered the study. Follow-up lasted 12 to 21 months. Independent, nonblinded research outcomes (symptoms, function, side-effect burden, satisfaction, and utilization) were obtained every three months. Two TAU groups were developed for comparisons with ALGO+ED. TAU-nonALGO was TAU in clinics using no algorithm, whereas TAU-ALGO was TAU in clinics using an algorithm for a disorder other than their TAU disorder. This presentation details the overall study design and discusses the specific outcome measures used.

No. 23B
ISSUES AND TENSIONS IN SPECIFYING AND DEVELOPING MEDICATION ALGORITHMS

M. Lynn Crismon, Pharm. D., *Department of Clinical Pharmacy, University of Texas-College of Pharmacy, 200 West University Avenue, PHR 5110, Austin, TX 78712*

SUMMARY:

Guidelines must be specific enough to have clinical utility (i.e., be applicable to most patients) and to aid clinical decision making, while not being so specific that adaptation of recommendations to individual patients is unlikely. Whenever possible, the development of algorithms must rest on scientific evidence. When clear-cut scientific evidence is lacking, clinical consensus is added to provide sufficient specificity to the treatment plan. The Texas Medication Algorithm Project (TMAP) algorithms were based upon evidence-based guidelines provided by the American Psychiatric Association or the Agency for Health Care Policy and Research. These evidence-based recommendations were melded with expert clinical consensus obtained by survey methodology. Once developed, input, critique, and revisions were incorporated based on reviews from providers, clinical staff, patients, family members, and advocates. This presentation details the process used to develop, implement, and subsequently revise treatment algorithms for each major disorder (schizophrenic, bipolar, and major depressive disorders). The medication algorithms for each disorder will be presented. The specific tactics (e.g., how and when to change the dose or to change the type treatment) will be detailed. Issues surrounding the routine use of clinical ratings to provide consistent information for providers about patient status will be discussed.

No. 23C
RESULTS FROM THE TEXAS MEDICATION ALGORITHM PROJECT (TMAP) SCHIZOPHRENIA TREATMENT MODULE

Alexander L. Miller, M.D., *Department Of Psychiatry, University of Texas Health Science Center, 7702 Floyd Curl Drive, San Antonio, TX 78284-7792*

SUMMARY:

Altogether, 466 patients with schizophrenia entered one of three treatments: ALGO+ED (n = 166), TAUnonALGO (n = 144), or TAUALGO (n = 156). This analysis compared ALGO+ED with TAUnonALGO to avoid a clinically relevant effect of implementing another algorithm in a TAU clinic, with 81% providing 12 months of follow-up data. Primary outcomes included symptoms (18-item Brief Psychiatric Rating Scale, $BPRS_{18}$), and function (mental component of the Medical Outcomes Study 12-item Short Form; SF-12) obtained every three months.

Hierarchical linear models estimated effect sizes on change scores adjusted for baseline severity, resources, family, attitudes toward care, and other variables. ALGO+ED affected outcome differently depending on baseline symptom severity ($BPRS_{18}$ total score). For those with moderate-to-severe baseline symptoms ($BRPS_{18}$ score 31–44) (n = 142), patients improved an average of 0.84 points on the $BPRS_{18}$ ($p < .003$). However, during the first three months. ALGO+ED patients had significantly greater symptom reductions by an average of 3.39 points on the $BPRS_{18}$ ($p < .04$) than those in TAUnonALGO. Those with fewer baseline symptoms ($BPRS_{18} \leq 30$) (n = 51) had a significantly greater symptom worsening in TAU than in ALGO+ED. An average of 7.59 points on the $BPRS_{18}$ ($p < .002$) separated the two groups. Change in the mental component of the SF-12 did not distinguish the two groups.

No. 23D
RESULTS FROM THE TEXAS MEDICATION ALGORITHM PROJECT (TMAP) BIPOLAR DISORDER TREATMENT MODULE

Patricia Suppes, M.D., *Department of Psychiatry, Univ. of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Altogether, 409 patients with bipolar disorder entered one of three treatments: ALGO+ED (n = 141), TAUnonALGO (n = 126), or TAUALGO (n = 142). To avoid a clinically relevant, although statistically nonsignificant effect of TAUinALGO doing better than TAUnonALGO patients, analyses compared ALGO+ED with TAUnonALGO, with 79% providing 12 months of follow-up data. Primary outcomes included symptoms (24-item Brief Psychiatric Rating Scale; $BPRS_{24}$) and function (Medical Outcomes Study 12-item Short Form; SF-12) obtained every three months. Secondary outcomes included symptoms (mania and depression), quality of life, and side-effect burden.

Hierarchical linear models estimated effect sizes on change scores (from baseline) adjusted for baseline severity, resources, education, attitudes toward care, and other variables. ALGO+ED affected outcomes differently depending on baseline $BPRS_{24}$ total score. For those with moderate-to-severe symptoms at baseline (n = 139) ($BPRS_{24}$ score 40–59) ALGO+ED patients had greater symptom reduction than TAU patients by an average of 5 points on the $BPRS_{24}$. For those with severe baseline symptoms ($BPRS_{24} \geq 60$) (n = 84), ALGO+ED and TAU had a modest, but equivalent, degree of symptom reduction. For the least symptomatic ($BPRS \leq 39$) (n = 44), ALGO+ED and TAU were not different in terms of change from baseline $BPRS_{24}$ total score. No significant ALGO+ED effect was found on the SF-12. Change in SF-12 did not distinguish the two groups.

No. 23E
RESULTS FROM THE TEXAS MEDICATION ALGORITHM PROJECT (TMAP) MAJOR DEPRESSIVE DISORDER TREATMENT MODULE

Madhukar H. Trivedi, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, #600, Dallas, TX 75235-9101*

SUMMARY:

Altogether, 548 outpatients with major depressive disorder entered one of three treatments: ALGO+ED (n = 182), TAUnonALGO (n = 154), or TAUALGO (n = 212). Since ALGO+ED patients had higher baseline depressive symptom severity than TAU patients, 175 ALGO+ED patients were matched with 175 TAU (from either TAU group) patients based on initial symptom severity and length of illness, with 73% providing 12 months of follow-up data. Primary outcomes included symptoms (30-item Inventory of Depressive Symptomatology—Clinician-Rated) ($IDS\text{-}C_{30}$), and function (mental

component of the Medical Outcomes Study 12-Item Short-Form; SF-12) obtained every three months.

Hierarchical linear models estimated effect sizes on change from baseline scores, adjusted for baseline severity, resources, education, attitudes toward care, and other factors (e.g., gender, ethnicity). All patients improved during the study ($p < .0001$). However, the ALGO+ED group had significantly greater symptom reduction by an average of 4.55 IDS-C points ($p < .004$) than the matched TAU group, with the greatest benefit for patients with moderate to moderately severe baseline depressive symptom severity ($IDS\text{-}C_{30}$ score 33–49). ALGO+ED also had significantly greater reductions ($p < .0001$) in self-reported depressive symptoms and better improvement in SF-12 mental function ($p < .046$) than TAU.

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SYMPOSIUM 24—FIELD TESTING DIMENSIONAL MODELS FOR DSM-V AXIS II

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to understand and use five alternative dimensional approaches to diagnosing personality disorders in DSM-V.

No. 24A
DIMENSIONAL REPRESENTATION OF DSM-IV PERSONALITY DISORDERS

Andrew E. Skodol II, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* John M. Oldham, M.D., Donna S. Bender, Ph.D., Mary C. Zanarini, Ed.D., Ingrid R. Dyck, M.P.H., Charles A. Sanislow, Ph.D., Regina T. Dolan, Ph.D.

SUMMARY:

A dimensional system for representing DSM-IV personality disorders will be presented. Using this system, clinicians describe DSM-IV PDs according to six terms (essentially six-point scales), based on the number of criteria met: absent = 0; traits = 1, 2, or 3 (depending on whether the threshold for diagnosis is at 4 or 5); subthreshold = 3 or 4; threshold = 4 or 5; moderate or severe = 5, 6, 7, or 8; and prototype = 7, 8, or 9 (depending on the total number of criteria for a given disorder). The rating system has been applied to videotapes made in conjunction with an ongoing reliability study in the multisite Collaborative Longitudinal Personality Disorders Study (CLPS), which have been rated by multiple raters at the level of the individual diagnostic criteria. Reliability data will be presented. This dimensional system will also be compared with two other dimensional approaches to Axis II, the SNAP, and NEO-PI-R scales of abnormal and normal personality traits. Dimensional scale scores are correlated with LIFE-Base scales of best six months functioning in past two years in the areas of occupational, social, leisure, and global functioning. This system should prove more useful than current categorical diagnoses by reducing arbitrary distinctions between normal personality, abnormal personality traits, and personality disorders; and by increasing descriptive coverage of personality psychopathology.

No. 24B
A STEPWISE PSYCHOBIOLOGICAL CLASSIFICATION

C. Robert Cloninger, M.D., *Department of Psychiatry, Washington University Medical School, 4940 Childrens Place, Saint Louis, MO 63110*

SUMMARY:

Empirical work with the seven-factor psychobiological model of personality has identified the features that are common to all personality disorders: these are low self-directedness, low cooperativeness, low affective stability, and low self-transcendence. Simple criteria for each of these character traits are described that can be reliably and easily rated by clincians. This allows clinicians to determine whether someone has any personality disorder before subtyping. If someone has a personality disorder, it can next be subtyped by rating three independent dimensions of temperament: novelty seeking, harm avoidance, and reward dependence. The possible combination of these factors correspond to traditional categories, and assure that the categories are mutually exclusive. This stepwise approach is natural and efficient for clinical decision making. Data about the reliability and validity of this rating system are presented from a study of psychiatric outpatients rated by their attending psychiatrist and by psychometric testing.

No. 24C
A TWO-COMPONENT ADAPTATIONAL MODEL FOR CLASSIFYING PERSONALITY DISORDERS

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada;* Kerry L. Jang, Ph.D.

SUMMARY:

A two-component approach to classification is proposed that separates the diagnosis of personality disorder from the assessment of clinically relevant personality traits. Personality disorder is conceptualized as a single diagnostic entity classified on a single axis along with other mental disorders that is defined as the failure to establish an adaptive self-system and adaptive relationships. This definition was based on an evolutionary analysis of the functions of normal personality. Clinically relevant dimensions for describing personality were based on the results of multivariate genetic analyses of data from approximately 1,000 twin pairs. It is suggested that these dimensions form a separate axis for recording personality characteristics that are important for understanding the way personality disorder is manifested that may also be used to record personality characteristics that are relevant to managing any disorder.

Dimensions for recording individual differences are organized into an incomplete hierarchy. Phenotypic and genetic analyses revealed three higher-order clusters: emotional dysregulation, dissocial behavior, and inhibitedness. Each consists of multiple lower-order traits. Not all lower-order traits are included in the higher-order patterns. The lower-order traits were based on unitary genetic dimensions.

Self-report and semistructured interviews for assessing all components will be described and information on their psychometric properties will be reported based on clinical and nonclinical samples. The clinical utility of the instruments will be discussed in terms of ease of use and value in treatment planning.

No. 24D
CLINICAL APPLICATION OF THE FIVE FACTORS OF PERSONALITY

Thomas A. Widiger, Ph.D., *Department of Psychology, University of Kentucky, 115 Kastle Hall, Lexington, KY 40506-0044*

SUMMARY:

The five-factor model has substantial empirical support as a general model of normal and abnormal personality functioning. Numerous studies have provided considerable empirical support both at the level of the five broad domains and 30 more differentiated facets for temporal stability, cross-cultural application, cross-method assessment, and heritability. The model has been shown to be highly useful within health psychology, gerontology, industrial-organizational psychology, and clinical psychiatry. Over 50 published studies have explored its ability to account for personality disorder symptomatology. The model has been used to make predictions of psychological functioning and longevity across much of the life span. This presentation will highlight its empirical support and demonstrate its clinical utility. A four-step procedure for describing comprehensively both adaptive (e.g., treatment facilitating) and maladaptive personality traits will be presented. The four-step procedure includes a clinically meaningful method for distinguishing between normal and abnormal personality functioning and for developing short-hand diagnostic labels for various personality trait configurations. The presentation will include published and unpublished data, as well as case illustrations.

No. 24E
A PROTOTYPE-MATCHING APPROACH TO DIAGNOSIS OF PERSONALITY DISORDERS

Drew Westen, Ph.D., *Department of Psychology, Boston University, 648 Beacon Street, Boston, MA 02215;* Jonathon Shedler, Ph.D.

SUMMARY:

The DSM-IV system for classification of personality disorders (PDs) faces a number of difficulties, including disorders that are overlapping, categories that were not selected empirically, criteria that require clinicians to make present/absent judgments on personality characteristics that often come in shades of gray, diagnostic algorithms that require clinicians to examine over 80 criteria one at a time to make diagnoses, a premature commitment to a categorical view of diagnosis, lack of coverage of the broader (including less severe) range of personality pathology, and a perceived lack of clinical utility. In this presentation we describe an approach to the classification of PDs that attempts to avoid these pitfalls, primarily in three ways: (1) by deriving diagnostic groupings empirically, using data collected from experienced clinicians around the country, so that the data are close to clinical experience, and quantifying and clustering their descriptions statistically to generate diagnoses, so the data are empirically valid; (2) by allowing for both categorical and dimensional diagnosis, and linking these diagnoses to a *functional assessment* of patients' personality; and (3) by allowing clinicians to make diagnoses the way they actually do in clinical practice, by matching their clinical impressions against a prototype, rather than by counting criteria.

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2. Cloninger CR: A practical way to diagnosis of personality disorder: a proposal J Personality Disorders 2000; 14:99–108
3. Livesley WJ, Jang KL: Toward an empirically based classification of personality disorder. Journal of Personality Disorders 2000; 14:137–151
4. Costa PT, Widiger TA (Eds.); Personality Disorders and the Five-Factor Model of Personality (2nd ed.). Washington, DC, American Psychological Association, 2000
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SYMPOSIUM 25—ADHD: A LIFE CYCLE PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the symptomatology, cognitive deficits, and substance abuse risk of ADHD throughout the lifecycle as well and understand novel, nonstimulant therapies.

No. 25A
ADHD ACROSS THE LIFE CYCLE: SYMPTOMATOLOGY AND VALIDITY

Thomas J. Spencer, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Despite controversy, an emerging literature describes adults with ADHD who are impulsive, inattentive, and restless, and have the clinical "look and feel" of ADHD children. Adults with persistent ADHD have high rates of psychosocial dysfunction, lower socioeconomic status, occupational failure, and intellectual performance deficits despite similar levels of intelligence and education as comparison groups. Adults with ADHD described their work difficulties as stemming from dissatisfaction, easy frustration, boredom, and impulsiveness. Adults with ADHD vividly describe a lifetime history of inability to concentrate, multiple failures, disapproval, and demoralization. Despite similarities to the childhood condition, adults with ADHD may display somewhat different symptoms related to differing developmental challenges. The administrative and multitasking demands faced by adults are qualitatively different from those faced by children, who function in more structured family and school settings. As opposed to tasks in early childhood that predominately require simple responses to focused demands, the demands of adulthood require juggling of competing tasks, independence, organization, and planning. Psychopharmacological treatment trials, family-genetic studies, and neuroimaging studies suggest that adult ADHD has neurobiological and a genetic link with childhood ADHD.

No. 25B
NEUROPSYCHOLOGY DEFICITS AND SYMPTOMATOLOGY OF ADHD

Rosemary Tanneck, Ph.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, ON M5G 1X8, Canada*

SUMMARY:

Although there are inconsistencies among studies, studies have revealed a pattern of neuropsychologic deficits that may underlie many of the prototypic clinical symptoms in ADHD. Inattention is a hallmark of ADHD and neuropsychological studies of the disorder have shown deficits in sustained attention, distractibility, and alertness. ADHD individuals also perform poorly on tasks requiring inhibition of responses, organization of cognitive information, planning, complex problem solving, working memory, and the learning and recall of verbal material. While motoric symptoms may decrease, cognitive impairments found in ADHD continue through adolescence into adulthood. Cognitive deficits are thought to contribute to behavioral, academic, and social impairments as well as related delays in skill acquisition. In turn these adaptive functional impairments may result in immaturity, failure, and low self-esteem. This presentation will review the pattern of neuropsychological deficits in ADHD and discuss implications to symptom presentation and treatment modalities across the life cycle.

No. 25C
ADHD AND ALCOHOL OR DRUG ABUSE

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

SUMMARY:

The overlap between attention deficit hyperactivity disorder (ADHD) and alcohol or drug abuse or dependence in adolescents and adults has been an area of increasing clinical, research, and public health interest. ADHD has its onset in early childhood and affects from 6% to 9% of juveniles with high rates of persistence. Substance use disorders (SUD) usually begin in adolescence or early adulthood and affect between 10% to 30% of U.S. adults, and a less defined, but sizable number of juveniles. Importantly, recent work demonstrates a bidirectional overlap between ADHD and SUD.

The study of comorbidity between SUD and ADHD is relevant to both research and clinical practice in developmental pediatrics, psychology, and psychiatry with implications for diagnosis, prognosis, treatment, and health care delivery. The identification of specific risk factors of SUD within ADHD may permit more targeted treatments for both disorders at earlier stages of their expression potentially dampening the morbidity, disability, and poor long-term prognosis in adolescents and adults with this comorbidity.

No. 25D
A NOVEL NONSTIMULANT THERAPY FOR ADHD: NEW DATA FROM CONTROLLED TRIALS

David Michelson, M.D., *Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center DC 0721, Indianapolis, IN 46285;* Joachim Wernicke, M.D., Thomas J. Spencer, M.D., John H. Heiligenstein, M.D., Douglas Faries, Ph.D.

SUMMARY:

Efficacy for nonstimulant therapy for ADHD was initially demonstrated a number of years ago for the tricyclic antidepressant desipramine. However, concerns about safety and tolerability have limited its acceptance. Interest in other nonstimulant agents that are potentially safer, more tolerable alternatives to desipramine and that minimize the risk of abuse potential as treatments for ADHD remains high. Unfortunately, few controlled, systematic assessments have been reported for such agents. However, in recently completed studies, tomoxetine (LY139603), a drug currently in development that enhances noradrenergic neurotransmission by blockade of the norepinephrine transporter, was demonstrated to be efficacious. In two double-blind studies in children and one study in adults, tomoxetine was superior to placebo. A small methylphenidate comparator arm in the pediatric studies suggested some advantages in tolerability for tomoxetine. New acute safety and tolerability data from a large (> 500 patient) pediatric study and information about dose from a fixed-dose efficacy study will also be presented, and provide further data concerning tomoxetine's clinical profile. The weight of data suggest that tomoxetine is a safe and efficacious agent for ADHD, and may provide an alternative to stimulant therapy in this disorder.

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2. Tannock R: Attention deficit hyperactivity disorder: advances in cognitive, neurobiological, and genetic research. Journal of Child Psychology and Psychiatry 1998; 39(1): 65–99
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SYMPOSIUM 26—EXERCISE, ATHLETIC PARTICIPATION, AND MENTAL HEALTH: WHEN IT WORKS AND WHEN IT DOESN'T
International Society for Sport Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand how vigorous exercise exerts its positive impact on mental health, have a better understanding of which psychopharmacological agents to use for which disorder in this population, and appreciate the importance of the family in engaging the athlete into treatment, and, conversely, how the athlete can maintain performance when a family member is emotionally disordered.

No. 26A
EXERCISE AND ITS POSITIVE IMPACT ON MENTAL HEALTH

Robert W. Burton, M.D., *Department of Psychiatry, Northwestern University, 405 North Wabash Avenue, #4605, Chicago, IL 60611;* Ronald L. Kamm, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate knowledge of the psychological benefits of exercise and possible mechanisms involved, and to prescribe exercise for its psychotherapeutic effects.

SUMMARY:

There is sufficient research and literature to support the notion that exercise promotes and is associated with psychological well-being. Elite athletes have been studied and deemed emotionally more healthy than the general population. The available data and the theoretical bases for these conclusions will be examined and discussed. Plausible mechanisms for these effects, such as associative versus dissociative approaches to exercise, exercise as defense mechanism, as well as the roles of naturally occurring substances such as the monoamines and endorphins, will be presented.

Optimal performance states, such as "The Zone," offer the ultimate condition for the examination of "the mind-body problem" that

psychiatry confronts. What are the psychological variables associated with the best athletic performance? Are they applicable to other human endeavors? These and other questions will be posed and debated.

Finally, a thoughtful, mindful approach to exercise and athletic training will enhance the health promoting effects. Prescribing exercise along with an awareness of self and an understanding of how one's emotional state impacts performance will help individuals to reach their potential in a variety of human activities.

No. 26B
WHEN THE ATHLETE HAS AN EMOTIONAL DISORDER: SPECIAL PSYCHOPHARMACOLOGICAL CONSIDERATIONS

Antonia L. Baum, M.D., *Department of Psychiatry, George Washington University, 5522 Warwick Place, Chevy Chase, MD 20815*

SUMMARY:

As we continue to identify areas of need for psychiatric care in the athletic arena and educate so that we may bring athletes into treatment, we must address the question of how best to treat this population.

Survey data of prescribing practices among sport psychiatrists collected in 1996 will be reviewed. Data obtained in the year 2000 will then be presented, highlighting the evolution in the psychopharmacologic treatment of athletes.

Areas of future study will be addressed, including obtaining epidemiological data on psychotherapy in athletes, and the development of prospective studies using psychotropic drugs in athletes.

No. 26C
THE ROLE OF THE FAMILY IN AN ATHLETE'S EMOTIONAL LIFE

Ian R. Tofler, M.D., *8835 Key Street, Los Angeles, CA 90035*

SUMMARY:

An athletic family is a family system that involves parents and children or adult offspring that are involved in intensive youth sports, collegiate athletics, or professional sports.

In many athletic families, conflict and dysfunction result from an imbalance in which the energies of the family are too narrowly and intensely focused on the athletic participation of one or more members of the family.

But a well functioning, supportive family is an essential social support system for an athlete. In fact, many studies document that the family is the source of support that affirms the young athlete's sense of self. Social support is also of great importance in giving an athlete a proper set of tools for dealing with injury, excessive stress, and the pressures of competition.

When the athlete has an emotional disorder, it is the family that can help steer him or her toward treatment and often make the difference, depending on how supportive they are, in what the treatment outcome will be.

Conversely, when a family member becomes emotionally disordered or severely physically ill, like skater Dan Jantzen's sister before the Olympics, the psychiatrist is challenged to help maintain the athlete's performance in the face of this painful reality. This paper will describe a model for athlete—family interaction and development, and various treatment approaches based on that model.

REFERENCES:

1. Sport Psychiatry: Theory and Practice. Edited by Begel D, Burton R. New York, Norton, 2000
2. Fuentes RJ, Rosenberg JM: Athletic Drug Reference, Clean Data, Inc. Durham, N.C., 1999
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SYMPOSIUM 27—WOMEN'S MENTAL HEALTH: A CURRENT PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should demonstrate increased understanding of mental health issues for women, including presentation of specific disorders, response to treatment, consultation issues, sociocultural considerations, and future research directions.

No. 27A
PSYCHIATRIC ASPECTS OF HORMONAL CONTRACEPTION

Julia K. Wamock, M.D., *Department of Psychiatry, University of Oklahoma at Tulsa, 4502 East 41st Street, Tulsa, OK 74135*

SUMMARY:

Hormonal contraceptives are used by one out of four sexually active women in the United States because they provide the most effective reversible method of contraception available. Oral contraceptive pills (OCPs) provide significant health benefits for women in terms of reduction of risk of ovarian cancer, endometrial cancer, ectopic pregnancy, and pelvic inflammatory disease. Research has recently dealt with the unique advantages of OCPs to several populations of women including adolescents, women during the perimopause, and women with anorexia nervosa. For example, in the perimenopausal woman with dysphoric mood symptoms and who also desires contraception, monophasic OCPs offer an estrogen supplementation that can manage hot flushes, stabilize mood, and provide an effective transition through menopause.

The OCP formulations have changed dramatically over the past three decades. Thus, the neuropsychiatric effects identified with older OCPs may not apply to the newer pills. This review will enable psychiatrists to evaluate various types of hormonal contraceptives and their potential effects, particularly on mood, anxiety, and sexual functioning of women. Management options for women with various mood, anxiety, and sexual disorders who use hormonal contraception will be presented.

No. 27B
DEPRESSION IN WOMEN

Susan G. Kornstein, M.D., *Department of Psychiatry, Medical College of Virginia, P.O. Box 980253, Richmond, VA 23298-0253*

SUMMARY:

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

and changing life roles may contribute to minor depressive symptoms during the perimenopausal period as well as an increased likelihood of recurrence among women with previous depressive episodes. This talk will focus on special considerations in the evaluation and management of depression in women across the lifespan.

No. 27C
FEMALE SEXUAL DYSFUNCTION

Anita L.H. Clayton, M.D., *Department of Psychiatry, University of Virginia, 2955 Ivy Road Northridge #210, Charlottesville, VA 22903*

SUMMARY:

Sexuality appears to be mediated only in the presence of an adequate hormonal milieu, including estrogen, testosterone, and prolactin. Numerous neurotransmitters also play a role in functioning in specific phases of the sexual response cycle. While primary sexual disorders may affect over 40% of the female population, secondary sexual disorders also contribute to high rates of sexual dysfunction. Secondary sexual disorders may be caused by a variety of medical conditions, be medication or substance-induced, be related to psychosocial/interpersonal problems, or be due to a combination of factors.

Evaluation of sexual functioning includes the use of assessment instruments, taking a sexual history, identification of all substances that might contribute to sexual dysfunction, measurement of hormone levels (free and total testosterone, thyroid function tests, hemoglobin A_{1C}, prolactin, estrodiol, FSH, and LH levels), and evaluation and treatment of comorbid conditions. Treatments may include psychotherapy, augmentation of hormone levels, the addition of adjunctive therapies, and substitution of new medications for offending agents.

No. 27D
WOMEN WITH CANCER: PSYCHOSOCIAL ISSUES IN BREAST, GYNECOLOGIC, AND LUNG CANCER

Elisabeth J. S. Kunkel, M.D., *Department of Psychiatry, Jefferson Medical College, 1020 Sansom Street, 1652 Thompson Building, Philadelphia, PA 19107;* Emmie Chen, M.S.

SUMMARY:

The participant will discuss some of the common medical and psychological aspects faced by women with breast, gynecologic, and lung cancer (the number one cause of cancer-related death in women). Women with cancer not only face cancer-related taboos, but those with breast and gynecologic cancers also face issues related to changes in sexuality, femininity, and fertility. While increased emphasis on the woman's participation in the medical decision-making process has afforded her more treatment options, it also gives her more responsibility in determining her course of treatment through the continuum of cancer care. While early detection has resulted in improved prognosis for many women's cancers, repeated screening exams can be associated with increased anxiety. Improvements in early detection and cancer treatment have resulted in increasing numbers of cancer survivors who must deal with long-term treatment effects; employment; disability; and sexual, family, and social reintegration. The woman with cancer must abdicate some or all of her responsibilities for child care, housekeeping, and/or work while simultaneously adjusting to changes in her appearance and relationships. A reliable, integrated, system of mental health screening and service delivery is needed in order to assess patients throughout the course of illness and to intervene when appropriate.

No. 27E
CAREER AND WORKPLACE ISSUES FOR WOMEN

Diane K. Shrier, M.D., *Department of Psychiatry, George Washington University Hospital Center, 1616 18th Street NW, Suite 104, Washington, DC 20009-2521*

SUMMARY:

Over the past two decades, increasing research and theoretical attention has been paid to career and workplace issues and how they relate to women's mental health. Women have dramatically increased their numbers in the workplace, while men have not increased substantially their involvement in the private sphere. Thus, women continue to do the overwhelming majority of child care, housework, and emotional maintenance of family. Some women find an increased sense of well-being from juggling multiple roles and from their greater occupational opportunities. Other women suffer from role strain, role overload, and from the effects of continuing high levels of gender discrimination and sexual harassment. More recently, in an era of full employment and prosperity and increasingly overworked and stressed workers and families, there have been demands for change. There is increasing interest in quality of life issues and better integration of personal and work lives for both men and women. Deeply held assumptions are being challenged as to what skills are valued and rewarded and what it means to be a competent, productive, effective worker and how work-family boundaries are defined.

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SYMPOSIUM 28—CULTURAL IDENTITY AND QUALITY OF LIFE
The World Psychiatric Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to recognize key approaches to the assessment of cultural identity and their relationship to quality of life.

No. 28A
ASIAN-AMERICAN CULTURE, SPIRITUALITY, AND QUALITY OF LIFE

Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*

SUMMARY:

Culture and ethnic identity tend to color a person's perceptions, thoughts, and behavior. Asian Americans as a large and diversified group believe in religions such as Hinduism, Jainism, Buddhism,

Taoism, Confucianism, Shintoism, and various sects of these major religions. Spirituality, however, binds them all together. This spiritual dimension of life, although difficult to describe in words, is that aspect of life that rises above our usual preoccupation with our individual selves, personal needs, and desires. Our outlook in life is broader and we become detached from our ego. This spiritual dimension gives one a perspective of eternity and urges to develop spiritual side of life than the material. This deep dimension of each person's identity and character reflects on how life is perceived. As a result a set of values and priorities develop. In sum, Asian-American spirituality colors the way they look at suffering, attachment, loss, bereavement, and death. An understanding of success and quality of life is based on how Asian-American culture and spirituality develops. Audience participation will enhance learning in this symposium.

No. 28B
IDENTIFICATION AT A DIFFERENT PLACE AND TIME

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:

Through the mechanism of narrative, I intend to explore the process of self-identification in the West Indian-American context, particularly in the period between the Second World War and the major civil rights upheaval of the late 1960s and early 70s.

I will focus on certain aspects of my own life story, a single Barbadian, who grew up in that unique West Indian island with its British-colonial culture and later migrated to the United States. As narrator, I examine the longitudinal trajectory of my life story but within a culture that is distinctly different from that in North America, one influenced nevertheless by a context of enmeshed colonialism, racialism, and ubiquitous religious grounding.

I contend that such narrative accounts are important in the exploration of black self-identification throughout the diaspora and essential to the understanding of linkages between cultural identity development and the quality of life an individual may enjoy.

No. 28C
LATINO BICULTURALITY AND QUALITY OF LIFE

Juan E. Mezzich, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, Fifth Avenue & 100th Street, Box 1093, New York, NY 10029-6574;* Maria A. Ruiperez, Ph.D.

SUMMARY:

A strongly emergent model for the description of cultural identity among immigrants is biculturality. Bicultural assessment involves determining the extent to which an immigrant is identified with his/her original culture and, separately, with the mainstream host culture. To accomplish this assessment, a bicultural scale developed by Cortés et al for Puerto Ricans was slightly modified and then extended for use with immigrants of various ancestries.

An empirical validation of this Multi-Ethnic Bicultural Scale (MEBS) has been conducted on Latino, Chinese, and Korean samples, employing a comparison sample of Euro-Americans, in New York City. Across these samples, the time to complete the MEBS ranged from one to four minutes, and the vast majority of the individuals involved judged that the scale was easy to complete. Test-retest reliability of the scale was quite high, with correlation coefficients between 0.83 and 0.85. Latino, Chinese, and Korean samples tended to rate themselves high on the original-culture half of the scale and about medium on the mainstream half, revealing different degrees of biculturality. In contrast, the Euro-American third-generation sample tended to rate themselves very high on the mainstream half and very low on the ethnic-minority half.

When the relationship between biculturality and quality of life (measured with the New York Quality of Life Index) was assessed, substantial biculturality tended to correlate with high quality of life (particularly among Latinos), marginality (low identification with both original and mainstream cultures) tended to correlate with low quality of life, and monocultural polarization (high on either the original or mainstream cultures) appeared to have a variable relationship to quality of life.

No. 28D
EUROPEAN CULTURES, IDENTITY, AND QUALITY OF LIFE

Heinz Katschnig, M.D., *Department of Psychiatry, University of Vienna, Waehringer Guertel 18–20, Vienna A-1090, Austria*

SUMMARY:

European cultural diversity is enormous, cultural identities are numerous, and values and norms vary to a large degree. Languages, as important indicators of cultural identity, are legion as well. If quality of life is regarded as consisting of the three components (1) subjective well-being/satisfaction, (2) functioning in daily activities and social roles, and (3) access to external resources and opportunities—material as well as social (Katschnig 1997), European cultural diversity necessarily determines the specific understanding of quality of life in each culture, since language plays a major role in the understanding of psychological and social phenomenon that are involved when quality of life is assessed. More recently, mass media, migration, and legal harmonization in the process of European unification tend to override traditional specific cultural values and norms. Also the globalization of psychiatric research with widely used and translated assessment instruments, tends to facilitate unification of concepts across cultures and languages. It is, however, questionable, whether culture-free assessment of quality of life is possible and even useful. In the present paper the language used for assessing quality of life will be analyzed for several European cultures in order to assess similarities and dissimilarities.

No. 28E
AUSTRALIAN CULTURES AND QUALITY OF LIFE

Helen E. Herman, M.D., *Department of Psychiatry, Univ. of Melbourne and St. Vincent's Hospital, 41 Victoria Parade, Fitzroy, Melbourne 3065, Australia;* Hilary L. Schofield, Ph.D., Barbara Murphy, Ph.D.

SUMMARY:

Beliefs about quality of life were explored in focus groups with patients, health professionals, and well lay people in Melbourne, Australia. As part of the cross-cultural development of the World Health Organization Quality of Life (WHOQOL) instrument in 15 centers worldwide, the study explored the comprehensiveness and relative importance for Australians of 33 facets of quality of life. The relevance to Australians of the 33 facets was largely confirmed. Self-esteem was rated as one of the most important facets. Sexual activity was rated as the least important facet. In terms of comprehensiveness, two issues not included in the original facet list were deemed important in quality of life for Australians: love and intimacy, and acceptance by society. The former has since been added to the facets addressed in the WHOQOL instrument. Focus group discussions will have a significant role in the further development of the WHOQOL and in exploring its comparability across cultures, and its use in vulnerable groups.

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SYMPOSIUM 29—GROUP THERAPY FOR BREAST CANCER: INTERNATIONAL RANDOMIZED TRIALS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the needs, methods, and outcome results of group psychotherapy for women with breast cancer in studies conducted around the world.

No. 29A
AUSTRALIAN RCTS OF GROUP THERAPY FOR BREAST CANCER: OUTCOME DATA

David W. Kissane, M.D., *Department of Psychiatry, University of Melbourne, 104 Studley Park Road, Melbourne VIC-3101, Australia;* Sydney Bloch, M.D., David M. Clarke, Ph.D., Graeme C. Smith, M.D., Dean P. McKenzie, B.A., Anthony Love, Ph.D., Jillian Ikin, B.A.

SUMMARY:

An RCT (n303) of cognitive-existential group therapy for primary breast cancer was conducted (1994–1997). An RCT of supportive-expressive group therapy for advanced breast cancer (n160, Sept 2000) has continued with open groups since 1996.

DSM-IV psychiatric diagnoses were present in 45%, major depression in 9.6%, adjustment disorder in 27.1%, anxiety disorder in 8.6%.

Analysis was based on intention-to-treat and involved variance component analyses with time and randomization as fixed effects, and therapist, group, and patient as random effects. ANCOVA has adjusted for baseline difference.

Significant change score reductions were found for primary patients in negative affects ($p < 0.01$) and HAD anxiety ($p < 0.01$), while controls showed deteriorated relationships at six months ($p < 0.01$) on the Family Assessment Device, Satisfaction with treatment was high ($p < 0.01$) and groups promoted support, improved coping, increased knowledge, and sense of self-growth. Therapist backgrounds did not influence outcome; the model is generalizable.

Groups proved acceptable to two-thirds of primary patients, who deal especially with acute grief, fear and coping. Only one-third of metastatic patients have been recruited to groups; they develop stronger cohesion, and use humor, creativity, assertiveness, and acceptance of dying alongside authentic living. Baseline predictors of survival will be presented.

No. 29B
GROUP THERAPY FOR METASTATIC BREAST CANCER: A RANDOMIZED TRIAL

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford, CA 94305-5544;* Catherine Classen, Ph.D., Lisa Butler, Ph.D., Janine Glese-Davis, Ph.D., Robert Carlson, M.D., Cheryl Koopman, Ph.D.

SUMMARY:

Background: Advanced breast cancer carries with it considerable psychosocial morbidity. Studies have shown that a substantial minority of metastatic breast cancer patients suffer clinically significant anxiety and depression, as well as traumatic stress symptoms. Supportive-expressive group psychotherapy was developed to help cancer patients face and adjust to their existential concerns, express and manage disease-related emotions, improve social support, enhance relationships with family and physicians, and improve symptom control.

Methods: One hundred and twenty-five women with metastatic breast cancer were recruited into the study. Using Efron's stratified randomized method, 64 women were randomized to the intervention condition and 61 women to the control condition. Intervention subjects were offered one year of weekly supportive-expressive group therapy and all subjects received educational materials. Subjects were assessed at baseline and every four months during the first year. Longitudinal data were collected on 102 participants.

Results: Participants in the treatment condition showed a significantly greater decline in traumatic stress symptoms ($P < .05$) compared with the control condition but there was no difference in total mood disturbance. However, when the final assessment within a year of death was removed, a secondary analysis showed a significantly greater decline in both total mood disturbance ($P = .01$) and traumatic stress symptoms ($P < .01$) for the treatment condition compared with the control condition.

Conclusions: These findings suggest that supportive-expressive therapy, with its emphasis on providing support and helping patients face and deal with their disease-related stress, helps to reduce distress among metastatic breast cancer patients.

No. 29C
SUPPORTIVE-EXPRESSIVE GROUP THERAPY FOR WOMEN WITH BREAST CANCER: A DANISH EXPERIENCE

Anders Bonde-Jensen, Ph.D., *Department of Oncology, Aarhus University, Aarhus, DK 8000, Denmark;* Marianne Lau, Ph.D., Carsten Rose, M.D.

SUMMARY:

Based on previous findings that psychological intervention can enhance quality of life and may change the survival time among women with metastatic breast cancer, a randomized trial was initiated in Denmark in 1996.

The aim of the study was to evaluate the possible effect of the supportive-expressive group therapy, as described by D. Spiegel, upon survival time and psychological parameters as anxiety, depression, and quality of life.

The women were randomized to either conventional oncological treatment and group therapy or conventional oncological treatment.

A total of 140 women were possible candidates for the trial; of these 86 declined participation and 11 patients had rapid progression of their cancer, leaving 43 patients to be randomized in the study.

The implication of these difficulties in recruiting cancer patient to trials involving psychotherapy will be discussed in relation to possible differences in culture, both in the society and the treatment system.

The result from the trial, which now has two years of follow-up concerning the effect of supportive-expressive group therapy upon anxiety, depression, and quality of life will be presented.

No. 29D
SUPPORT GROUP FOR WOMEN AT GENETIC RISK FOR BREAST AND OVARIAN CANCER

Kathryn M. Kash, Ph.D., *Cancer Center, Beth Israel Medical Center, 10 Union Square East, New York, NY 10003;* Mary-Kay Dabney, M.S., Jimmie C. Holland, M.D.

SUMMARY:

Previous research indicated that women who had high levels of anxiety and less knowledge of breast cancer were more likely to undergo genetic testing for cancer. We conducted a randomized trial of a psychoeducational support intervention in order to reduce women's anxiety and improve knowledge of breast cancer. The treatment arm attended group sessions for six consecutive weeks and booster sessions at six months and one year. Both arms completed standardized questionnaires prior to randomization, at the end of six weeks, six months, and one year. There were 247 women who participated in this study; 140 in the treatment arm and 107 in the control arm. There were no differences at baseline on any measures. At the end of six weeks, six months, and one year, there were significantly lower scores in the treatment arm on breast-cancer–specific anxiety ($p < .05$) and trait anxiety ($p < .03$). There were significantly higher scores in the treatment arm on knowledge of risk factors for breast cancer ($p < .01$) and knowledge of breast cancer ($p < .01$). Depression scores were significantly lower in the treatment arm at six weeks and one year ($p < .04$). Support groups are an effective intervention for reducing levels of distress about genetic testing.

No. 29E
PSYCHOSOCIAL DISTRESS AND GROUP INTERVENTION AMONG BREAST CANCER PATIENTS

Luigi Grassi, M.D., *Department of Psychiatry, University of Ferrara, Ferrara 44100, Italy;* Katia Magnani, Ph.D., Marino Gatti, M.D., Diletta Aguiari, Ph.D., Silvana Sabato, Ph.D., Alessandra Marsillo, M.D.

SUMMARY:

Over the last 20 years a number of studies have concentrated attention on the remarkable concomitants of breast cancer diagnosis and treatment on the patients' psychosocial adjustment. Data of the most recent studies indicate that 30% to 40% of breast cancer patients have symptoms suggesting a psychiatric diagnosis or have difficulty in coping with illness with significant consequences on their quality of life. The role of psychotherapeutic intervention among breast cancer patients has been the object of intense research in order to both mitigate the negative psychological effects of the disease and to evaluate the efficacy and effectiveness of the treatment. Group psychotherapy, particularly supportive-expressive group psychotherapy (SEGT) (Spiegel and Classen, 2000) has been shown to have significant effects in reducing both emotional stress symptoms (e.g. anxiety, depression) and physical symptoms (e.g. pain) and in improving quality of life. In order to examine the role of the SEGT in a different cultural context (Italy) we developed a Psychosocial Therapy Project with the aim of verifying the psychosocial impact of breast cancer on a series of 149 patients followed by the Rehabilitation Unit of Ferrara and the role of short-term (16–20) sessions of SEGT in patients presenting psychological stress symptoms. Each patient was individually seen by a psychologist by using a short psychometric package (Brief Symptom Inventory, Openness Scale, Mini-Mental Adjustment to Cancer Scale, Concerns Inventory, Social Support Scale). Patients with symptoms of maladjustment to illness and/or psychological stress symptoms ($n = 48$) participated to the SEGT. Follow-up data were obtained at six months from the participants and the patients with no psychological problems at baseline ($n = 101$). Patients who participated at the SEGT had a significant reduction of all the scores on the psychometric instruments, while 20% of the patients with no disturbance at baseline (and who did not take part in the SEGT program) developed significant psychosocial problems in the following six months. These preliminary data, which need to be confirmed through a RCT, seem to draw to the following conclusions: (1) SEGT represent a effective treatment in improving breast cancer patients psychosocial adjustment; (2) preventive intervention through the SEGT could be useful in increasing coping mechanisms in patients who, even if do not present psychological disorders in the short run could develop emotional problems in the long run.

No. 29F
GROUP THERAPY FOR PRIMARY BREAST CANCER: A RANDOMIZED, MULTICENTER TRIAL

Catherine Classen, Ph.D., *Department of Psychiatry, Stanford University School of Medicine, 401 Quarry Road, Room 2334, Stanford, CA 94305-5544;* David Spiegel, M.D., Cheryl Koopman, Ph.D., Gail Stonisch-Riggs, M.S.W., Joan Westendord, R.N., Gary Morrow, Ph.D.

SUMMARY:

Background: Support group interventions have been shown to benefit cancer patients in research settings. However, there is a need for standardized interventions to be tested in oncology practices if they are ever to be integrated into standard treatment. There is also a need to determine who is most likely to benefit. This study evaluates the effectiveness of a standardized 12-week supportive-expressive group therapy program among primary breast cancer patients in community oncology practices and identifies which patients were most likely to benefit.

Methods: This is a prospective, randomized, controlled, multicenter trial. Three hundred and fifty-three women recently diagnosed with primary breast cancer were recruited from two academic centers and nine community oncology practices in the NCI Community Clinical Oncology Program. Participants were randomly assigned to the intervention arm or to the education control arm. The Profile of Mood States Questionnaire (POMS) was used to assess emotional distress and was administered at baseline, 3, 6, 12, 18, and 24 months.

Results: An intention to treat analysis using the General Linear Model (GLM) procedure did not show a statistically significant a decline in POMS scores over time among the entire sample of women who received group therapy compared with those in the control condition. However, among a subsample of highly distressed participants, intervention patients showed a significantly greater reduction in total mood disturbance on the POMS than did control patients [$F(1,65) = 2.64$, $p = .05$].

Conclusions: Supportive-expressive group therapy is readily transferred to the community setting and is beneficial for distressed women with primary breast cancer.

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TUESDAY, MAY 8, 2001

SYMPOSIUM 30—PROFESSIONAL BOUNDARIES AND TRAINING IN PSYCHIATRY: A COMPREHENSIVE VIEW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) list and describe exercises and videos for teaching about boundaries; (2) list at least five nonsexual boundary issues; (3) give at least two illustrations of cultural issues related to boundaries; (4) discuss regulatory issues related to boundaries in the USA, Canada, and Europe; (5) describe boundaries coaching of other fields.

No. 30A
CRITICAL ISSUES IN EDUCATION ABOUT BOUNDARIES FOR PHYSICIANS AND OTHERS

Gregg E. Gorton, M.D., *Department of Psychiatry, Jefferson Medical, 1201 Chestnut Street, Suite 1400C, Philadelphia, PA 19107*; Steven E. Samuel, Ph.D.

SUMMARY:

Following a 1991–92 survey of psychiatric residency directors, the authors designed and implemented a core course on sexual feelings and boundary management for PGY III/IV residents at Thomas Jefferson University Hospital since 1993. This presentation will briefly review the course, its evolution, and data on its effectiveness. While the students have found it helpful, contacts with other programs and continued research have caused the presenters to become more fully aware of the fact that there are no recognized standards for format, type, or duration of such training. As such, it is difficult to have any points of comparison for evaluating the effectiveness of such training. It is clear that a number of models and methods are in use nationally to teach about boundaries, both within psychiatry, in other medical specialties, and in fields such as psychology, psychiatric nursing, and clinical social work. The authors believe that borrowing from such fields, and also sharing psychiatry's insights with such fields, can be mutually beneficial. They will discuss consultation to other medical specialties, and also a number of newer issues that have emerged such as cultural differences with foreign medical school graduates and also clients of different ethnic groups.

No. 30B
ADAPTING AND EXPANDING BOUNDARIES: TRAINING IN AND OUTSIDE PSYCHIATRY

Gail E. Robinson, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada*

SUMMARY:

In 1991 a Special Task Force of the College of Physicians and Surgeons of Ontario released a report highly critical of how the medical community was handling physician sexual misconduct. Major changes in law followed that affected all regulated health professions, not just medicine, including a zero tolerance policy, mandatory reporting, and a requirement that each field begin addressing professional boundaries. In 2000 the task force was again reconvened, and from a public perspective, evaluated the changes. The presenter will discuss this social and political context. She will also discuss the ever-expanding training taking place on boundary issues other than sexual ones. She will also discuss the application of what has been learned and used in psychiatry with other fields, from law (attorney-client boundaries) to teaching in a variety of settings, to fields as diverse as funeral directing. She will discuss this as a challenge, but also as a "calling" for professionals in our field to use what they have learned to help others in fields that have been slower to examine such issues. These fields all work with clients who are just as vulnerable as those psychiatrists work with and thus can do as much harm with boundary violations.

No. 30C
BOUNDARIES IN A BROADER CONTEXT: A SWISS PSYCHIATRIC PERSPECTIVE

Werner Tschan, M.D., *Psychiatrist FMH, Nevensteinestraat 7, Basel 4053, Switzerland*

SUMMARY:

The presenter has been actively involved in study groups in psychiatry and related fields in Switzerland, which began by focusing on sexual misconduct by psychotherapists but then broadened their perspective to include other specialties and other fields. European work on these issues has been expanding following initial Swiss efforts and a major study in Germany. Germany and the Netherlands have also criminalized therapist-client sex. In September 2000 a major interdisciplinary conference, the First Swiss Congress Against Violence and Abuse of Power, took place in Bern, Switzerland. There was an examination of the social context, the workplace, and settings other than psychotherapy and health care, as well as the relevence of legislation and laws to what is a multiple set of problems. The presentation will examine professional boundaries in this broader context, and also provide the audience with a view of what our European colleagues are doing in the arena of professional boundaries. He will discuss the regulation of psychiatric practice, boundaries training, evaluation of those who have boundary violations, services for victims of professional misconduct, and related topics.

No. 30D
PREVENTIVE AND REMEDIAL BOUNDARIES TRAINING: EFFECTIVE TOOLS AND METHODS

Gary R. Schoener, Psy.D., *Walk-In Counseling Center, 2421 Chicago Avenue, South, Minneapolis, MN 55404*

SUMMARY:

The presenter is a clinical psychologist and clinic administrator who provides consultation and training to health care institutions, individual practitioners, and health care professionals under disciplinary orders of licensure boards. He will describe the development of remedial boundaries training for psychiatrists and other health professionals who have been disciplined, or whose employers feel that this is needed. Examples of individualized programs will be provided. He will also examine preventive education for those in

training as well as those out in the practice fields. He will present and discuss training aids from a number of fields—psychiatry, psychology, social work, nursing, corrections, substance abuse counseling, etc. He will provide resource materials that would help a psychiatrist design a course, a training program, or individualized remedial boundaries training for a wide range of types of professionals in health care and social services. The emphasis will be on the use of film, videotapes, exercises, and other "action-oriented" learning methods. Another emphasis will be the use of illustrations from a variety of fields to provide interdisciplinary training.

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SYMPOSIUM 31—THE ROLE OF ANTIDEPRESSANTS IN THE TREATMENT OF BIPOLAR DISORDER: PRO AND CON

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with the evidence and the reasoning for and against antidepressant use in the treatment of bipolar disorder.

No. 31A
ANTIDEPRESSANT-INDUCED MANIA: OVERVIEW OF CURRENT CONTROVERSIES

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney-NY Presbyterian Hospital, 525 East 68th Street, New York, NY 10021*

SUMMARY:

The role of antidepressants in bipolar disorder has become the focus of increasing controversy. Current teaching favors their limited use, based on their potential to induce manias or accelerate cycling frequency. Yet, current treatment recommendations often derive more from opinion than empirical evidence, as scant research exists to address numerous key areas. The magnitude of risk for antidepressant-induced mania is poorly identified, and actual risk differences across antidepressant classes lack systematic study. Similarly, few studies have documented the widely presumed increased morbidity due to excessive antidepressant use among rapid cyclers, or the assumption that antidepressants worsen mixed states. Lack of consensus operational definitions for antidepressant-induced mania impedes the distinction between drug-induced manias and spontaneous cycling. Whether antidepressants induce mania in dose-dependent fashion or from all-or-none exposure remains unknown, while studies of the assumed protective effects of antimanic drugs yield mixed results.

This presentation will provide an overview of current issues related to antidepressant-induced mania, and conversions from unipolar to bipolar diagnoses, drawing on a large, well-studied bipolar cohort. The phenomenology of antidepressant-induced vs. spontaneous manias will be examined, alongside differential treatment outcome, and the assessment of characteristics that may help to identify patients at risk.

No. 31B
EFFICACY AND SAFETY OF ANTIDEPRESSANTS IN BIPOLAR II DISORDER

Jay D. Amsterdam, M.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 850, Philadelphia, PA 19104*

SUMMARY:

Antidepressant agents are commonly used in the treatment of depressive symptoms in bipolar disorder. Their use for bipolar patients has been controversial due to concerns about causing acute mania. I will present data from two double-blind studies in patients with bipolar disorder, type II, in which the antidepressants fluoxetine and venlafaxine, when used by themselves, appeared effective and safe. We did not observe appreciable evidence of manic switch in those studies when compared with placebo. It may be that antidepressants are less risky in type II than in type I bipolar illness. Further prospective controlled studies will be required to clarify this matter.

No. 31C
LONG-TERM RISKS WITH THE USE OF ANTIDEPRESSANTS IN BIPOLAR DISORDER

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

Do antidepressants cause a long-term worsening of the course of bipolar illness? In this presentation, I will review the controlled literature on this question, most of which concerns the tricyclic antidepressants and is somewhat dated. I will conclude that the TCA literature raises real concerns regarding long-term risks with antidepressants in the treatment of bipolar disorder. I will follow up that review with a discussion of recent research conducted by our group, which agreed with the finding of an association between antidepressant use and the induction of a rapid-cycling course in bipolar illness. These recent data extend those earlier findings to newer antidepressants in current use. I will conclude that the clinical literature suggests that possible long-term negative effects with antidepressants in bipolar illness is a real concern. While the newer antidepressants have a reputation for safety, our data suggest that they too may pose risks that warrant closer examination with controlled studies.

No. 31D
DIAGNOSIS AND TREATMENT OF THE BIPOLAR SPECTRUM: A CLINICIAN'S PERSPECTIVE

Jacob J. Katzow, M.D., *Department of Psychiatry, George Washington University, 3 Washington Circle NW, Suite 406, Washington, DC 20037-2356*

SUMMARY:

The diagnosis and treatment of depressive illness along the bipolar spectrum is complex. In this presentation, I will provide perspectives from an active clinical psychopharmacology practice over three decades. In my experience, the bipolar spectrum is a useful concept for diagnosing and treating patients who do not have classical unipolar depression or classic bipolar I disorder. Many patients fall in between,

with hyperthymic personality, cyclothymia, and bipolar II disorder. Subtle hints of the bipolar spectrum also include response to antidepressants, brief and highly recurrent major depressive episodes, along with positive bipolar family history and past antidepressant-induced hypomania. The long-term destabilizing effects of antidepressants can be a particular problem with these patients. Diagnosing the bipolar spectrum leads to increased use of mood stabilizing agents, with or without antidepressants, and better outcomes.

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SYMPOSIUM 32—PHYSIOLOGY AND BEHAVIOR: THE CONNECTION IN EATING DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should know and be able to discuss the relationship between neuroendocrine abnormalities and personality, cognitive features, and the physiological rational for SSRI treatment in eating disorders.

No. 32A
PERSONALITY FEATURES AND MONOAMINE FUNCTION IN EATING DISORDERS

Francesca Brambilla, M.D., *Department of Psychiatry, Ospedale s. Rafaele, Prinetti 29, Milano 20127, Italy*, Laura Bellodi, M.D., Cinzia Arancio, M.D.

SUMMARY:

Alterations of personality characteristics have been reported in anorexia nervosa (AN), possibly representing a background for the development of the disease. The biological bases of these personality patterns have never been clarified. In 16 anorexics (eight restricted, ANR, eight bingeing-purging, ANBP), seven bulimics (BN) and eight healthy controls, we examined the hypothalamic dopamine (DA) function, measured by the growth hormone (GH) response to the postsynaptic D-2 receptor agonist apomorphine (APO), and in parallel scores of harm avoidance (HA), sensation seeking (SS) and reward dependance (RD) by the Tridimensional Personality Questionaire of Cloninger. The GH responses to APO stimulation were blunted in AN, expression of increased hypothalamic DA secretion. The expected positive correlation between DA secretion and SS or RD scores were present in controls but not in anorexics. In another group of 13 anorexics (five ANR, eight ANBP) and 13 healthy controls, we studied the correlations between aggressiveness and the hypothalamic serotonin (5-HT) function, by measuring the 5-HT-dependent prolactin (PRL) basal secretion and responses to the stimulation with the 5-HT agonist D-fenfluramine (D-Fen) PRL basal levels and responses to D-Fen stimulation were lower than normal in anorexics, expression of reduced 5-HT secretion. However, the amine deficiency did not correlate with the higher than normal aggressivity of patients.

The lack of modulation of personality characters by the amines in AN might be due to the interference of multiple hormonal factors.

No. 32B
COGNITIVE DYSFUNCTION IN EATING DISORDERS: RELATIONSHIPS WITH NEUROENDOCRINE INDICES

Silvana Galderisi, M.D., *Department of Psychiatry, University of Naples, Largo Madonna Delle Grazie, Naples I-80138, Italy*, Armida Mucci, M.D., Palmiero Monteleone, M.D., Annunziata Buongiovanni, M.D., Mario Maj, M.D.

SUMMARY:

Abnormalities of several cognitive functions, including memory, executive control, attention, and visuospatial abilities, have been reported in subjects with eating disorders. Variables involved in the genesis and shaping of these abnormalities have not been clarified yet. In the present study, cognitive functioning was investigated in 29 women, 20 with bulimia nervosa (BN) and nine with anorexia nervosa (AN), and in a group of healthy subjects, matched for age, gender, education, and handedness. Cognitive functions were investigated by tests exploring attention/short-term memory, executive functions, and the ability to learn recurring sequences. Relationships between cognitive functioning and body mass index (BMI), and baseline plasma levels of cortisol, leptin, dehydroeplandrosterone (DHEA), dehydroepiandrosterone-sulfate (DHEA-S), and 17β-estradiol were evaluated.

In subjects with eating disorders, the mean time to perform the spatial recurring sequences task and the verbal subtest exploring executive functioning was significantly longer than in controls. BMI and baseline plasma levels of 17β-estradiol, DHEA, and DHEA-S were positively correlated with accuracy and speed indices of executive functions, while baseline cortisol levels were negatively correlated with the performance on the verbal subtest exploring the same functions.

Neuroendocrine and BMI alterations in eating disorders have a negative effect on executive functions.

No. 32C
ROLE OF LEPTIN IN EATING DISORDERS

Palmiero Monteleone, M.D., *Department of Psychiatry, University of Naples, Largo Madonna Delle Grazie, Naples 80138, Italy*; Antonio Fuschino, M.D., Martiadis Vassilis, M.D., Mario Maj, M.D.

SUMMARY:

Leptin is known to regulate body weight, energy balance, and reproduction. Therefore, investigation of its physiology is of obvious interest in patients with anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED), which are characterized by body weight-related psychopathology, changes of the energy balance, and reproductive alterations. We measured baseline levels of leptin in 21 AN, 32 BN, 14 BED patients, and 25 healthy women, and investigated leptin response to acute changes in caloric intake (fasting/refeeding paradigm) in 12 women with BN and 10 healthy controls.

We found significantly decreased baseline plasma levels of leptin in both AN and BN women, but significantly enhanced concentrations of the hormone in BED women. Moreover, in bulimics, acute fasting induced only a 7% decrease in leptin levels, which was significantly lower than the 58% decline observed in controls. Normal refeeding was associated with a prompt rise in plasma leptin in

both patients and controls, although in the former leptin concentrations did not reach the absolute values of the normal controls.

These findings show an altered leptin physiology in eating disorder patients; the extent to which these changes contribute to pathogenesis and/or the maintenance of the altered eating behaviour remains to be determined.

No. 32D
FLUVOXAMINE IN RELAPSE PREVENTION OF BULIMIA NERVOSA

Manfred M. Fichter, M.D., *Klinik Roseneck, Am Roseneck 6, Prien 83209, Germany*

SUMMARY:

In a double-blind, placebo-controlled study of 72 patients with bulimia nervosa the efficacy of the SSRI fluvoxamine in maintaining the improvement achieved through intensive psychotherapy was tested. Drug and placebo, respectively, were given over a period of 15 weeks (two to three weeks titration phase, 12 weeks outpatient relapse prevention/maintenance phase). The variables assessed concerned bulimic and other aspects of eating disorders, global status, depression, anxieties, obsessive-compulsive behavior, and other aspects of psychopathology. The main analyses of the data were performed from the intent-to-treat sample (N = 72).

In both the intent-to-treat and the completer analyses, the following scales showed fluvoxamine to have a significant effect in reducing the return of bulimic behavior: *(1) Self-ratings:* Eating Disorder Inventory (EDI) — subscale bulimia, urges to binge in previous week and the number of actual binges in the previous week: *(2) Expert ratings:* Psychiatric Status Rating Scales for Bulimia (PSRSB); Structured Interview for Anorexic and Bulimic Syndromes (SIAB-EX) — total score; subscale fasting and subscale vomiting. Two further variables (EDI — total score and SIAB subscale bulimia) showed the superior relapse prevention effects of fluvoxamine compared with placebo for the completer sample, while they did not reach significantly the intent-to-treat sample. Fluvoxamine was also effective in reducing depression, anxiety, and some other areas of general psychopathology in bulimia nervosa.

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SYMPOSIUM 33—EVIDENCE-BASED MANAGEMENT OF SSRI ANTIDEPRESSANT-ASSOCIATED SEXUAL DYSFUNCTION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be informed about antidepressant-associated sexual dysfunction and the empirical data for various treatment management approaches.

No. 33A
SILDENAFIL FOR MANAGEMENT OF ANTIDEPRESSANT-ASSOCIATED SEXUAL DYSFUNCTION

H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 2600 Marble Avenue, NE, Albuquerque, NM 87131*; Paula L. Hensley, M.D.

SUMMARY:

Objective: Sexual dysfunction (SD) is a frequent reversible adverse effect of both depression and antidepressant (ADI) treatment. Effective management can significantly impact mood, quality of life, and morbidity/mortality of the disorders for which antidepressants are prescribed but often discontinued. Recent sildenafil studies relevant for SSRI/AD-SD treatment efficacy are presented.

Method: Four double-blind, placebo-controlled (DBPC) trials of sildenafil treatment of SD are presented: two for depression-associated SD, and two for SSRI/AD SD in patients with major depression [MDD] in remission. Several prior open-label sildenafil studies for MDD-AD-SD provided pilot data for ongoing DBPC trials.

Results: Sildenafil demonstrated significant improvement [p<.001] in HEF measures of erectile dysfunction in subjects with associated subthreshold depression. Mean HAM-D improved for ED-treatment responders (16.8 to 7) compared with non-responders (16.8 to 13.6). Multicenter-DBPC studies of sildenafil for AD-SD in MDD/ remission found significant improvement (p<.002–.004) on CGI/ ASEX/MGH/HEF measures; 75% sildenafil vs 11% placebo subjects. HAM-D remained < 10 without group differences.

Conclusion: Sildenafil significantly (1) improved ED and depression measures in ED subjects, and (2) reversed SSRI/AD-associated SD, allowing remitted MDD subjects to continue the SSRI/AD that effectively treated depression. The clinical implications of correct cause/effect assessment are significant.

No. 33B
AVOIDANCE OF SSRI-INDUCED SEXUAL DYSFUNCTION

Harry A. Croft, M.D., *The Croft Group, 8038 Wurzbach Road, Suite 570, San Antonio, TX 78229-3815*

SUMMARY:

Objective: Although a number of strategies have been proposed for *treatment of* sexual dysfunction (SD) occurring during the course of taking SSRI antidepressants, another strategy might be to *prevent* such dysfunction by initially choosing an antidepressant not known to cause the problem. A review of the literature suggests less SD with bupropion, nefazodone, and mirtazepine.

Method: Double-blind, placebo-controlled comparator studies are presented for bupropion. In addition, double-blind or open-label studies switching patients with SSRI-induced sexual dysfunction to one of the three antidepressants mentioned above are presented.

Results: Three placebo-controlled and/or comparator studies showed efficacy of bupropion. Sexual changes were development of orgasmic dysfunction, and dissatisfaction with SSRI compared with bupropion/placebo. A double-blind study with patients experiencing SSRI-SD showed 71% of SSRI patients compared with 30% on nefazodone experiencing SD. A smaller open trial on patients developing SSRI-SD showed no SD in patients switched to mirtazepine. Two additional open-label switch studies showed less SD on bupropion than SSRIs. Results and methodological problems with these studies will be discussed.

Conclusion: While treatment of SSRI-induced sexual dysfunction is one approach to SD, initially choosing, or later switching to, an antidepressant not known to cause such dysfunction may be useful.

No. 33C
THE PREVALENCE, ASSESSMENT, AND COURSE OF ANTIDEPRESSANT-ASSOCIATED SEXUAL DYSFUNCTION

Paula L. Hensley, M.D., *Department of Psychiatry, University of New Mexico, 2600 Marble Avenue NE, Albuquerque, NM 87131;* George Nurnberg, M.D.

SUMMARY:

Since their introduction over a decade ago, the reported prevalence of SSRI- antidepressant (AD) treatment-emergent sexual dysfunction increased from less than 5% (package insert data) to the currently reported 50% to 70%. Sexual dysfunction also occurs with other classes of antidepressants, including tricyclics, monoamine oxidase inhibitors, and mixed receptor agents. Major confounds affect all prevalence estimates; for example, sexual dysfunction is a diagnostic symptom of depression, gender, assessment method, treatment response, risk factors, base rates, etc. In drug-free patients, depression reportedly has the most effect on libido. With SSRI treatment, a shift occurs to a greater impairment in arousal (lubrication/erection) and delayed/absent orgasm, typically delayed ejaculation in men, and anorgasmia in women.

Comparative studies of SSRIs indicate differences in the magnitude of sexual dysfunction between and within studies, but are consistent regarding the distribution of drug effects on the specific phases of sexual function. Although systematic studies of the natural course of SSRI-induced sexual dysfunction are lacking, indirect empirical evidence for tolerance occurs in numerous studies that utilized placebo groups or followed patients over time. This literature suggests a 35% to 70% remission rate of antidepressant-induced sexual dysfunction. The strategies that incorporate this "adaptation" response (drug holiday, watchful waiting, dose reduction) will be discussed.

No. 33D
PSYCHOTROPIC ANTIDOTES FOR ANTIDEPRESSANT-RELATED SEXUAL DYSFUNCTION

Lawrence A. Labbate, M.D., *Department of Psychiatry, Medical University of South Carolina, VA Medical Center, 109 Bee Street, #116, Charleston, SC 29401*

SUMMARY:

Sexual dysfunction, especially erectile dysfunction and orgasm delay, commonly accompanies treatment with antidepressants. A number of psychotropic antidotes are reported to be helpful for treating antidepressant-induced sexual dysfunction. Although many of these antidotes are commonly employed in clinical practice, there is limited published evidence to support this practice. This report critically reviews the published medical evidence, highlighting the methodological limitations of controlled and uncontrolled studies, possible aspects of sexual functioning that may be improved, mixed findings in studies, toxicity of combined agents, and the lack of sufficiently powered studies to provide treatment guidelines in this vexing clinical area. Antidote treatments to be covered in this report include bupropion (open-label case reports, case series, and a small placebo-controlled trial) methylphenidate (case reports), dexamphetamine (case reports), amantadine (case reports and a small placebo-controlled trial), buspirone (open-label case series and a small placebo-controlled trial), nefazodone (open-label case reports), cyproheptadine (case reports), yohimbine (case reports), gingo biloba (open-label case series).

No. 33E
ASSESSING SEXUAL DYSFUNCTION IN WOMEN: IMPACT OF SEX HORMONES

Julia K. Warnock, M.D., *Department of Psychiatry, University of Oklahoma at Tulsa, 4502 East 41st Street, Tulsa, OK 74135*

SUMMARY:

Sexual dysfunctions (SD) are common in women, but during the perimenopausal and postmenopausal periods women will experience physiologic changes associated with a decline in ovarian function that can significantly impact sexual functioning. The focus of this presentation is to review the variety of physiologic changes associated with each phase of the sexual response cycle, which is mediated by the ovarian hormones.

Estrogen replacement in the perimenopausal or postmenopausal woman is associated with numerous physiologic changes that can be associated with improvement in a number of sexual disorders including dyspareunia, desire disorders, and arousal disorders. For example, sexual arousal in the female requires adequate levels of estrogen to permit the lubrication response. The positive effect of testosterone on sexual functioning in women has been accumulating over the past several decades. Several controlled studies have demonstrated the positive effects of combination estrogen and androgen hormone replacement therapy on sexual activity and sexual interests in both surgical and naturally postmenopausal women.

Patients with adequate estrogen replacement who have complaints of low desire and a free testosterone of less that 2pg/ml may benefit from physiologic levels of androgen replacement therapy for treatment of hypoactive sexual desire disorder (HSDD). Other options in the treatment of selected sexual disorders in the perimenopausal and postmenopausal woman are discussed.

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SYMPOSIUM 34—CLINICAL ISSUES IN BIPOLAR DISORDER: THE STANLEY FOUNDATION BIPOLAR NETWORK

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should further appreciate important clinical issues in bipolar disorder as represented by work from the Stanley Foundation Bipolar Network.

No. 34A
THE TREATMENT OF BIPOLAR DEPRESSION

Robert M. Post, M.D., *Biological Psychiatry, NIHM, 900 Rockville Pike, Building 10, RM 3N-212, Bethesda, MD 20892*; Lori L. Altshuler, M.D., Patricia Suppes, M.D., Kirk D. Denicoff, M.D., Ralph Kupka, M.D., Willem A. Nolen, M.D.

SUMMARY:

Treatment of the depressed phase of bipolar illness remains a major conundrum for the clinician. Depression is the major cause for morbidity and mortality in the illness, yet it has received relatively little systemic study. Given this deficit, the first double-blind, randomized protocol in the network compared the acute and long-term efficacy of bupropion, sertaline, and venlafaxine added to at least one mood stabilizer in a double-blind fashion. Moderate improvement on the CGI-BP was achieved in more than half of the patients in the acute 10-week phase of treatment and was associated with a 12% rate of switch into hypo/mania in the first 67 patients randomized to one of these three antidepressants. Of the 49 who entered an intended one year continuation phase another six patients (12%) also switched. There was a trend for more of those with a history of 20 or more prior manic episodes to be overrepresented in the group who switched during acute or continuation antidepressant treatment. Open and double-blind studies also suggest the promise of lamotrigine in the treatment of bipolar depression and systemic comparisons between this agent and traditional antidepressants should be explored. The relatively low switch rates compared with some studies in the literature achieved by these three antidepressants with different mechanisms of action further support the utility of these agents as adjuncts to mood stabilizers in the treatment of bipolar depression. However, these conclusions are limited by the lack of a placebo-treated group and the current inability to directly examine the effects of each antidepressant separately as the study is ongoing and drug assignment remains blinded.

No. 34B
EARLY TRAUMA AND BIPOLAR DISORDER

Gabriele S. Leverich M.S.W., *Biology Psychiatry Branch, National Institute of Mental Health, 10 Center Drive, MSC 1272, Bethesda, MD 20892-1272*; Patricia Suppres, M.D., Kirk D. Denicoff, M.D., Willem A. Nolen, M.D., Ralph Kupka, M.D., Karen A. Autio, B.A.

SUMMARY:

There is growing awareness of the association between extreme stressors occuring in childhood and adolescence and subsequent development of psychopathology. We predicted that a history of early physical or sexual abuse would be associated with an adverse course of bipolar illness. A total of 298 outpatients with bipolar I and II disorder in the Stanley Foundation Bipolar Network completed a self-rated questionnaire on demographics, a history of physical and/or sexual abuse as a child/adolescent, as well as course of illness variables and prior suicide attempts, and Axis II comorbidity (on the PDQ4+). Diagnosis was made by SCID interview and severity of illness rated prospectively for one year. Those who endorsed a history of child/adolescent physical abuse (n=81;27), compared with those who did not, had a history of an increased number of Axis I and II comorbid disorders, including drug and alcohol abuse, a greater number of medical illnesses, an earlier onset of bipolar illness, faster cycling frequencies, and a higher incidence of psychosocial stressors occuring prior to the first and most recent affective episode. Differentially, physical abuse was associated with increasing severity of mania, while sexual abuse was associated with an increased incidence of suicide attempts. The association of early abuse with a more severe retrospectively reported course of bipolar illness was confirmed prospectively during year of clinician ratings. These data suggest that a history of early physical or sexual abuse in patients with bipolar disorder is associated with many indices of a more severe course of illness. Increased appreciation of the possible adverse impact of early traumatic experiences and of approaches to early intervention for these patients with bipolar disorder may help lessen the risk of increased morbidity and suicidality.

No. 34C
GENDER DIFFERENCES IN BIPOLAR DISORDER: ALCOHOL ABUSE COMORBIDITY

Mark A. Frye, M.D., *Department of Psychiatry, UCLA NPI&H, 300 UCLA Medical Plaza, #1544, Los Angeles, CA 90095*; Lori L. Altshuler, M.D., Kirk D. Denicoff, M.D., Paul E. Keck, Jr., M.D., Susan L. McElroy, M.D., Patricia Suppes, M.D.

SUMMARY:

The impact of alcohol use on the presentation and course of bipolar disorder has received little systematic study. The lifetime prevalence rate of alcohol abuse comorbidity in bipolar disorder is the highest of all Axis I diagnoses; by prevalence data alone, this represents an enormous public health problem. We examined the lifetime prevalence rate of this comorbidity and its subsequent course of illness in 267 patients enrolled in the Stanley Foundation Bipolar Network (SFBN). Gender differences in alcohol use, as confirmed by structured diagnostic interview, and self-reported course of illness variables were examined by chi-square and independent sample t-tests. A total of 49% (57/116) of men vs. 29% (44/151) of women reported a history of alcohol abuse or dependence ($p < 0.001$). The relative risk compared with the general population, however, was greater for women (29% vs. 4.6%, OR = 6.3) vs. men (49% vs. 25%, OR = 1.96). Bipolar women with history of alcohol use were more likely than women without such history to have a greater number of prior major depressive episodes (p=0.012), hospitalizations for depression (p=0.06), other psychiatric illness (p=0.01), and exhibit an ultra rapid cycling course of illness (p=0.04). None of these measures was more prevalent in the bipolar men with alcohol use than men without such history. Further examination of the relationship between gender, bipolar depression, and alcohol abuse or dependence may be an important step in developing more effective treatment approaches for both mood stabilization and alcohol relapse prevention.

No. 34D
CORRELATES AND MANAGEMENT OF OVERWEIGHT IN BIPOLAR DISORDER

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, Cincinnati, OH 45267-0559*

SUMMARY:

Increasing data indicate that bipolar disorder is often associated with overweight and obesity. However, the clinical correlates and management of overweight and obesity in bipolar disorder have received relatively little systematic investigation. In this presentation, data indicating that bipolar disorder, overweight, and obesity are in fact related, are reviewed. The clinical correlates of overweight and obesity of 504 patients (55% of whom are overweight or obese) enrolled in the Stanley Foundation Bipolar Network, including illness variables, eating disorder comorbidity, and psychotropic medication exposure, are presented. Strategies to manage overweight and obesity in bipolar disorder are then presented, such as use of mood-stabilizing and antidepressant agents with anorectic or anti-binge eating properties.

No. 34E
NEW ANTIEPILEPTICS IN THE TREATMENT OF BIPOLAR DISORDER

Paul E. Keck, Jr., M.D., *Biological Psychiatry Department, UCMC College of Medicine, 231 Bethesda Ave/PO Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Two major groups of medications, new antiepileptic drugs (AEDs) and atypical antipsychotics, are under active study as potential treatments for various aspects of bipolar disorders. The new AEDs are being studied for several reasons. First, two AEDs, carbamazepine and valproate, have been efficacious in randomized controlled trials in the treatment of acute mania and as maintenance treatment. Second, anecdotal evidence from patients with epilepsy suggests that some new AEDs may have thymoleptic activity. Third, many of the new AEDs have novel mechanisms of action that may shed light on the pathophysiology of bipolar disorder and broaden the therapeutic armamentarium.

Nine new AEDs—gabapentin, pregabalin, famotrigine, topiramate, zonisamide, tiagabine, oxcarbazepine, acamprosate, and leviracetam—have been or are being studied as potential treatments for patients with bipolar disorder. The Stanley Foundation Bipolar Network (SFBN) has conducted pilot studies of gabapentin, lamotrigine, topiramate, zonisamide, tiagabine, acamprosate, and leviracetam. Safety and preliminary efficacy data from these trials will be presented. In particular, the efficacy of each agent in the treatment of acute manic, mixed and depressive symptoms, and as preventative treatment will be discussed. (e.g., "classic" ICDs).

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SYMPOSIUM 35—SUBSTANCE USE AND PSYCHOSIS: TACKLING THE CHICKEN-AND-EGG PROBLEM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, 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 patients.

No. 35A
USING THE PSYCHIATRIC RESEARCH INTERVIEW FOR SUBSTANCE AND MENTAL DISORDERS TO DIAGNOSE PSYCHOTIC DISORDERS IN SUBSTANCE ABUSERS

Deborah S. Hasin, Ph.D., *Department of Epi/Psychiatry, Columbia University, 1051 Riverside Drive, Box 123, New York, NY 10032*; Sharon Samet, M.S.W., Jakob Meydan, M.S.

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.

No. 35B
AUTONOMOUS DRUG-INDUCED PSYCHOSIS: STATE OF THE EVIDENCE

Nashaat N. Boutros, M.D., *Department of Psychiatry, West Haven VAMC-Yale University, 950 Campbell Avenue, Suite 116A, West Haven, CT 06516*; Malcolm B. Bowers, Jr., M.D.

SUMMARY:

Objectives: Schizophrenia is a heterogeneous disorder. In order to fully understand the pathophysiology of the disorder, the balance between genetic and environmental factors influencing the emergence of psychotic symptoms needs to be more fully characterized. In this review, we examine the evidence for an etiologic role for drugs of abuse in the emergence of chronic psychotic symptoms.

Methods: Medline and PsychLit searches extending from 1965 to 2000 were performed for articles cross-referenced for drugs, psychostimulants, narcotics, cannabis, and hallucinogens, all cross-referenced to psychosis. Papers comparing patients with persistent drug-induced psychosis (DIP) to those with idiopathic schizophrenia were also reviewed.

Results: The literature suggests that a number of drugs of abuse can cause a state of chronic psychosis. The evidence is strongest for amphetamines and hallucinogens. Recent data regarding methamphetamine psychosis suggest that increased stress is a sufficient stimulus to induce symptom recurrence in the absence of continued drug use.

Conclusions: The literature provides enough presumptive evidence that patients with chronic psychotic disorders who have histories of prolonged premorbid drug abuse, particularly young males with family histories of alcohol or drug use, may represent a continuum of substance-facilitated to substance-caused psychotic disorders.

No. 35C
ILLNESS COURSE OF SUBSTANCE-INDUCED AND PRIMARY PSYCHOTIC DISORDERS

Carol L.M. Caton, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 56, New York, NY 10032*; Deborah S. Hasin, Ph.D., Michael B. First, M.D., Ellen M. Stevenson, M.D., James L. Curtis, M.D., Gary L. Lefer, M.D., Patrick Shrout, Ph.D.

SUMMARY:

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

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

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

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

No. 35D
DIFFERENTIAL DIAGNOSIS OF PSYCHOSIS IN DRUG ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, # 9F, New York, NY 10003*

SUMMARY:

Overview: The high prevalence of comorbid substance use disorders (SJD) and non-substance-related (NSR) psychotic disorders is well documented. An underrecognized group of patients with substance-induced psychosis are often treated acutely for NSR psychotic disorders.

Method: To discriminate between substance-induced psychosis and schizophrenia in patients with both prominent delusions or hallucinations and SUD, 211 inpatients with SUD were sorted between those with consensus diagnoses of schizophrenia and those with substance-induced delusional disorder or hallucinosis and then into two data sets. A discriminant function derived by logistic regression predicted psychiatric diagnosis for Set A (N = 130), coded as a dichotomous criterion and was tested on Set B (N = 8).

Results: A discriminant function utilizing six predictors for Set A correctly classified 76.2% of all patients, (83.1% of schizophrenia). Formal thought disorder and bizarre delusions significantly predicted schizophrenia, OR of 3.55:1 and 6.09:1. Suicidal ideation (OR = 0.32:1), V cocaine abuse (0.18:1), detox history (0.24:1), or methadone maintenance (0.18:1) have inverse relationships to schizophrenia. The model predicted 72.5% with schizophrenia in Set E. Cluster analytic strategies confirm thought disorder as a major predictor for schizophrenia, and heroin use, methadone maintenance, and IV cocaine use as major predictors of substance-induced psychosis.

Discussion: DSM-IV diagnosis of new onset NSR psychosis in the context of SUD may only be made after extended sobriety. Presenting symptoms and clinical history differ in patients with psychosis due to SUD versus schizophrenia. A validated model may aid acute differential diagnosis and treatment planning among patients with SUD.

No. 35E
THE IMPACT OF SUBSTANCE ABUSE: DEPENDENCE ON DIAGNOSING PATIENTS WITH PSYCHOSIS

Mark J. Sedler, M.D., *Department of Psychiatry, State University of New York, Putnam Hall South Campus, Stony Brook, NY 11794*; Joseph Schwartz, Evelyn Bromet, Ph.D.

SUMMARY:

Introduction: It is hypothesized that comorbid substance abuse or dependence impedes the determination of an accurate diagnosis. This study explores this hypothesis using data from the Suffolk County Mental Health Study, a prospective study of nearly 700 individuals presenting with psychotic symptoms.

Methods: Subjects participated in structured interviews at baseline, six months, and 24 months. Using all available information, consensus research diagnoses were generated. Treating the 24-month diagnosis as the "gold standard," we examined how the agreement of this diagnosis with the two earlier diagnoses varies depending on the presence/absence of a comorbid substance abuse/dependence diagnosis.

Results: Overall, the agreement of the baseline and six-month diagnoses with the 24-month diagnosis is somewhat poorer for those with a lifetime diagnosis of substance abuse or dependence. This difference is greatest in the major depressive disorder group and least in the schizophrenia/schizoaffective group. Detailed results, including a comparison between those with a current substance abuse/dependence disorder at the time of hospitalization and those with a past disorder, will be presented.

Conclusion: The presence of a substance abuse/dependence disorder hinders the determination of an accurate diagnosis in patients experiencing an initial hospitalization for psychotic symptoms. The extent of this hindrance differs across diagnostic categories.

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SYMPOSIUM 36—BLACK RAGE, WHITE SUPREMACISTS, PSYCHIATRY, AND CRIMINAL LAW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the antecedents of racially-motivated crime, the

different forms of group hatred expressed through crime, and their relevance to assessment of criminal responsibility in insanity defenses, evaluation of diminished capacity, and death penalty cases.

No. 36A
BLACK RAGE: MYTHS AND REALITIES

Michael M. Welner, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, #806, New York, NY 1001*

SUMMARY:

This discussion focuses on the psychiatric significance of black rage, as defined by the criminal defense bar and psychiatrists inspired by justice and socioeconomic inequalities during the civil rights movements in the 1960s.

Numerous myths and facts have surrounded the controversial analysis of black male aggression. The different theories and approaches advanced from social science and criminal defense circles are explored for their relatedness to psychiatric diagnostic study.

The symposium examines how the concept "black rage," as it is known, has been able to attach to criminal law. The chronicled sociocultural influences associated with black rage are viewed through the lens of psychiatric assessment to propose scenarios for how such influences may culminate, at least in part, in crime.

No. 36B
WHITE SUPREMACISTS: PSYCHIATRY BENEATH THE HATE

James F. Hooper, IV, M.D., *Taylor Hardin, 1301 Jack Warner Parkway, NE, Tuscaloosa, AL 35404*

SUMMARY:

White supremacists who commit violent crime may have a group affiliation. These individuals may just as likely commit crime without the communication or knowledge of an affiliated group, a phenomenon known as "lone wolf." Still, the loosely organized nature of white supremacist bodies underscores the fragility of those drawn to them. Defining that fragility may be a challenge for today's correctional or forensic psychiatrist.

Key clinical issues pertinent to the evaluation and assessment of the white supremacist criminal are presented. The author reviews pertinent diagnostic considerations, important elements of history, and their relatedness to the defendant.

Case histories will be presented to facilitate the understanding of pertinent psychiatric issues native to white supremacists in the correction mental health system. Forensic psychiatrists attending the program will gain insight into the relationship between white supremacist thinking and its utility in the examination for the insanity defense and diminished capacity.

No. 36C
ETHNIC RAGE: GUIDELINES FOR FORENSIC PSYCHIATRIC ASSESSMENT

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

SUMMARY:

The different forms of ethnic rage as they relate to the appreciation of wrong, their applicability or lack thereof to wider shared attitudes, and relevance to aggravating and mitigating statutes of the death penalty, are discussed. Racism is considered from the psychiatric perspective, along with a consideration of how it adapts to legal models of diminished capacity and the insanity defense.

One of the important academic aspects of this presentation will be to address the potentials, as well as the limitations, for how sociological ideas such as ethnic and black rage can be adapted to psychiatric examinations in the context of Daubert and Frye requirements for admissibility. In addition, guidelines for assessing the significance of ethnic rage, psychiatrically, are proposed that incorporate cross-cultural realities into existing diagnostic approaches to hostility.

No. 36D
CROSS-CULTURAL ASPECTS OF ETHNIC RAGE

Andres J. Pumariega, M.D., *Professor and Director, Child and Adolescent Psychiatry, James H. Quillen College of Medicine, East Tennessee State University, Box 70567, Johnson City, TN 37614-0567*

SUMMARY:

One can go as far back as many of the religiously-motivated wars and purges (such as the Crusades and the Inquisition) and, more recently, the Balkan ethnic cleansing, the Palestinian Infatida, and the reaction of the Cuban-American community to the Elian Gonzales saga as examples of the expression of ethnic rage.

A broader range of factors contributing to ethnic rage needs to be considered when examining this phenomenon from a truly cross-cultural perspective. The history of a population's trauma and losses are important factors, leading to a shared sense of loss and inquiry. The adverse effects of minority status (including discrimination, economic margination, and adverse impact on family structure) can play significant roles in contributing to shared distress and anger. One particular adverse impact which can contribute to violence in culturally diverse populations is the effect of gender role strain resulting from socioeconomic and acculturation impact on the family where traditional gender roles are questioned, resulting in a diminished sense of self esteem for males. Another set of factors are the lack of culturally accepted means for the expression of frustration and rage, especially in a mainstream society which is moving towards more homogeneous means of affective expression. Amongst majority cultures, the fear of being displaced in the power structure of the society or losing privilege can also lead to such intense emotions, often justified by rage emanating from minority populations. Such rage is often channeled and expressed within the context of political conflict, which in itself further can contribute to the fueling of such emotions. However, histories of political oppression can serve as another trauma or loss, which is associated with these emotions.

This presentation will focus on the contributions of these factors to the phenomenon of ethnic rage. It will also focus on the importance of a cultural competence approach towards addressing ethnic/racial rage. This includes work in both clinical settings (such as forensic assessment and dealing with potentially violent patients), and also in the area of prevention, where too little attention has been paid given the pervasiveness of this phenomenon.

REFERENCES:

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SYMPOSIUM 37—THE BIOPSYCHOSOCIAL MODEL: SOCIAL PERSPECTIVES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize (1) the role of social psychiatry in the biopsychosocial model, (2) the importance of providing well integrated psychiatric services, and (3) the negative impact of services fragmentation.

No. 37A
THEORETICAL PERSPECTIVES

Gerald J. Sarwer-Foner, M.D., *Department of Psychiatry, Wayne State University Medical School, 3320 Bloomfield Shores Drive, West Bloomfield, MI 48323*

SUMMAY:

Social psychiatry is the scientific study of how the social field of forces at a particular time in a culture and country, impact on medicine, and the medical specialty of psychiatry. The following issues are discussed as examples: health care systems—integrated, partial, or absent for the population of a country—be they governmental, mixed, or for-profit managed care; the influences of population dynamics, immigration, youth, and aging populations; the role of employment, unemployment, and welfare; the distinctions to be made in funding health care—the differences between "psychiatry" and "mental health"; the role of epidemiology incidence, prevalence, or disease; its importance for planning and achieving a proper range and spectrum of psychiatric services for a defined population; the importance of training, and creating recruitment incentives to have the necessary numbers of psychiatrists for these tasks; the planning for research and its funding; the ongoing funding for new technology and equipment to meet these objectives over definitive planning cycles; the importance of a sophisticated and informed population on these issues; the necessity to have these issues discussed and debated as situations change, but the principles continue to exist, and need ongoing definitions.

No. 37B
INTEGRATIONAL PERSPECTIVES

Tanya M. Luhrmann, Ph.D., *Department of Human Development University of Chicago, 5730 South Woodlawn, Chicago, IL 60637*

SUMMARY:

This paper describes the accidental demise of the biopsychosocial model in psychiatry—or at least, the striking and in ways unintended biologization of the field. The scientific evidence suggests that mental illness nearly always arises out of a complex combination of biological vulnerability, psychological experience, and cultural context, and that the best treatment for patients is nearly always a combination of psychopharmacology, and psychotherapy. Some evidence even suggests that the combination is cheaper for the provider. But managed care has been driving psychotherapy out of psychiatry. This has happened not only because of the reimbursement structure, but also because of the way that psychiatrists learn to understand their patients. For all the talk of integration, two very different models of mental illness dominate residency training: a disease model and a psychodynamic model. The presenter carried out a four-year ethnographic study of psychiatric training, and will describe the way that the presence of these two different models influence the training of young psychiatrists, and the way that everyday features of the training process undermined biopsychosocial integration.

No. 37C
PSYCHOTHERAPY PERSPECTIVES

Edward F. Foulks, M.D., *Department of Psychiatry, Tulane University School of Medicine, 1430 Tulane Avenue, TMC-SL77, New Orleans, LA 70112-2699*

SUMMARY:

Outcome studies continue to indicate the value added by psychotherapy to treatments of mental disorders (Scott, 1992). Such evidence emphasizes how essential psychotherapy remains to the design of treatment systems, the education and training of providers, the provisions of health insurance, and clinical research endeavors. The scarce resources for the provision of psychotherapy in most of today's public and private treatment systems has seriously compromised the ability of mental health professionals to provide state-of-the-art treatments, as well as to provide training venues that include quality role modeling of experienced psychotherapists for medical students and psychiatry residents. Whether psychotherapy is or is not a basic part of the treatment of people who suffer from mental disorders is not necessarily a controversy that will be resolved by marketplace forces or by efficiency or effectiveness outcome studies. This paper will address strategies to ensure that our patients and our students will continue to experience the most humane, effective, evidenced-based psychological treatments. These strategies will include research, advocacy, funding, and fidelity to practice guideline principles, particularly in academic training programs where role modeling is essential.

No. 37D
BIOLOGICAL PERSPECTIVES

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University School of Medicine, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

The reintegration of patients suffering from serious mental illness into society is one of the major goals being pursued by psychiatrists and other mental health professionals. In this respect, the major advances gained recently in the field of neurosciences have led to optimism and a promising outlook. For instance, new psychopharmacological agents have produced very positive outcomes in the treatment of depressive disorders as well as psychotic conditions.

Despite these recent advances in biological psychiatry, particularly in the area of neuropharmacology as well as in neurosciences at-large, many factors still play a prominent role in achieving full reintegration into society for these severely ill mental patients. Many of these factors are related to psychological issues such as noncompliance or to social issues such as lack of health/mental health insurance coverage. It is therefore a fact that we must still rely on the biopsychosocial model when pursuing the prompt reintegration of patients into the community.

In this presentation, the biological perspectives will be addressed within the umbrella of the biopsychosocial model.

No. 37E
SOCIAL PERSPECTIVES

Joel S. Feiner, M.D., *Department of Psychiatry, University of Texas at Southwestern, 233 West 10th Street, Dallas, TX 75208*

SUMMARY:

Social and community psychiatry draws upon the social sciences in the way that biological psychiatry relates to the basic sciences and addresses issues beyond the person but interactive with the person's biology and psychology. *Social Psychiatry* is a research and theoretical discipline employing "social science and psychological variables to predict, explain, and seek proper interventions to solve psychiatric problems," (Borus) often in term of social forces. Social psychiatry is the public health dimension of psychiatry.

The second area is the organization of *service delivery systems*, for populations at risk using epidemiological and public health orientations. This area has, until recently, been a function of government and has primarily focused upon persons with severe and persistent mental illness. Recently, the private sector has joined this effort. The third dimension includes *therapeutic interventions*, which engage more than one person in a shared therapeutic experience.

Economics has never been as preeminent as it is today in the provision of psychiatric care. *Advocacy* joined to social action and the quest for social justice, is part of the definition of some community psychiatrists, especially since the 1960s. These efforts involve alliances with consumers, families, and community advocates.

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4. Borus F: Community psychiatry, in The New Harvard Guide to Psychiatry. Edited by Nicholi AM. The Belknap Press of Harvard University Press, Cambridge, Mass., 1988

SYMPOSIUM 38—THE USE OF CHOLINESTERASE INHIBITORS IN CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to distinguish the differences in efficacy and tolerability among the existing cholinesterase inhibitors; select and use cholinesterase inhibitors in clinical practice.

No. 38A
EVIDENCE-BASED MEDICINE AS APPLIED TO TREATMENT DECISIONS IN ALZHEIMER'S DISEASE

Lon S. Schneider, M.D., *Department of Psychiatry, Univ. of Southern CalKeck School of Medicine, 1975 Zonal Avenue, KAM-400, Los Angeles, CA 90033*

SUMMARY:

Purpose: To understand how evidence-based medicine can be applied to treatment decisions on Alzheimer's disease.

Methods: The systematic reviews (meta-analyses) of the Cochrane Collaboration of medications used to treat Alzheimer's disease will be presented along with the methods, odds ratios, and numbers needed to treat and numbers needed to harm statistics. We will then exemplify how this data are applied to clinical decision making and practice.

Results: The efficacy and effectiveness of individual cholinesterase inhibitors, vitamin E, selegiline, and other medications will be portrayed by Peto odds ratios, and their confidence intervals will be used to portray the variabilities of outcomes. The outcomes of cholinesterase inhibitor treatment will be shown to be heterogeneous in clinical practice.

Conclusions: Evidence-based medicine can be used to inform clinical practice and manage clinical expectations of treatments for Alzheimer's disease.

No. 38B
EFFICACY AND RISKS OF MARKETED CHOLINESTERASE INHIBITORS

Pierre Tarriot, M.D., *Department of Psychiatry, Monroe Community Health Services, 435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

By early 2001, there will likely be four cholinesterase inhibitors on the market in the U.S.: tacrine, donepezil, rivastigmine, and galatamine. Because there are no head-to-head studies directly comparing these agents, one is obliged to make inferences based on available data sets. These include published and unpublished data ranging from large and fairly definitive placebo-controlled trials to observational data, pilot studies, and case series. The presentation will provide an overview of the critical findings as they relate to efficacy, tolerability, and safety. Efficacy data will include assessments of cognitive function, ability to function on a day-to-day basis, and changes in behavior. Safety and tolerability data will include adverse experience and safety reports from clinical trials as well as available post-marketing reports. The comparisons will be offered in a simplified and standardized format in order to provide a foundation for a provocative panel and audience discussion about how we weigh our expanding treatment options in this important therapeutic area, and how we convey this to our patients and families.

No. 38C
LONG-TERM TREATMENT: IS THERE EVIDENCE FOR SAFETY AND EFFICACY?

Lon S. Schneider, M.D., *Department of Psychiatry, Univ. of Southern CA/Keck School of Medicine, 1975 Zonal Avenue, KAM-400, Los Angeles, CA 90033*

SUMMARY:

This segment of the symposium will be a moderated discussion. The goal will be to translate the information presented in the other parts of the symposium into good evidence-based, informed clinical practice. The discussion will be moderated by Dr. Lyketsos and will center around six questions. Each question represents a critical juncture or decision that clinicians face in day-to-day practice when considering and using cholinesterase inhibitors. Dr. Lyketsos will present each question to the panel of other speakers and to the audience. He will then provide a short (two to three minute) response of his own. Then he will moderate a discussion with the panel and the audience regarding other responses to the question. At the end, Dr. Lyketsos will summarize the consensus "best answers" to each question. The six questions are:

(1) In what patients are cholinesterase inhibitors best used?

Possibilities include: mild-moderate Alzheimer's disease, severe Alzheimer's disease, other dementias, age-associated memory impairment, other mild memory loss, other neuropsychiatric patients

(2) Which cholinesterase inhibitors should clinicians choose first and why?

(3) How do we dose and titrate the cholinesterase inhibitors: how and how long?

(4) How do you assess outcome to treatment with cholinesterase inhibitors?

(5) When and how do you switch to a different cholinesterase inhibitor?

(6) How do you decide on long-term use or discontinuation of a cholinesterase inhibitor?

No. 38D
ASSESSING EFFICACY IN DAY-TO-DAY PRACTICE: OPPORTUNITIES AND BARRIERS

William E. Reichman, M.D., *Department of Psychiatry, UMDNJ-RWJ Medical School, 671 Hoes Lane, Piscataway, NJ 08856*

SUMMARY:

In multi-site clinical trials, the standard assessments of efficacy of presumed cognition-enhancement agents, such as the cholinesterase inhibitors, rely on using structured neuropsychological testing, an individualized, clinician-designed evaluation of the patient, and caregiver report. In Alzheimer's disease (AD) treatment trials, the standard methodology for the measurement of cognitive function has been the Alzheimer's Disease Assessment Scale-Cognitive portion (ADAS-COG). This extensive test battery, while evaluating several domains of cognitive function, is not designed to be used in non-research clinical settings for routine clinical decision making. These trials also employ structured ratings scales, that by caregiver report, measure the patient's performance in the activities of daily living. Such trials also include a clinical global impression (CGI) and a clinical global impression of change (CGIC) based on the clinician's own examination of the patient and reports of the patient's caregiver. While these research tools may be reliable and valid for assessment in clinical trials, they are unproven as translatable tools for the clinician to adopt in clinical practice. Given these caveats, this talk will review some of the existing and proposed methodologies that may be practically applied to routine clinical practice for the longitudinal assessment of cognition and functional performance of patients with AD.

No. 38E
USING THE CHOLINESTERASE INHIBITORS IN CLINICAL PRACTICE

Constantine G. Lyketsos, M.D., *Department of Psychiatry, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Osler 320-JHH, Baltimore, MD 21287*

SUMMARY:

Purpose: To evaluate the evidence for efficacy and safety of cholinesterase inhibitors over one year and the longer treatment periods.

Methods: Randomized controlled trials and open-label treatment periods of one year or more of cholinesterase inhibitors will be described and examined in order to understand and evaluate the evidence for efficacy and safety. Treatment efficiency will be described and calculated both in controlled trials and open-label series. This will be exemplified in part by calculating the number of patients needed to be treated in order for one patient to benefit from treatment over the course of a year or more.

Results: Long-term treatment with cholinesterase inhibitors under the best of circumstances in selected patients is clearly efficacious; however, it is not efficient treatment as most patients do not benefit or comply with medication over this period of time and adverse effects increase in frequency overtime.

Conclusion: Longer-term treatment with cholinesterase inhibitors involves effectiveness issues that are different from those in short-term treatment.

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2. Cummings JL: Cholinesterase inhibitors: a new class of psychotropic agents. Am J Psychiatry 2000; 157:4–15
3. Rabins PV, Lyketsos CG, Steele DC: Practical Dementia Care. Oxford University Press, 1999
4. Morris JC, et al: Metrifonate benefits cognitive, behavioral, and functional measures in Alzheimer's disease. Neurology 1998; 50:1222–1230
5. Cummings JL: The cholinergic hypothesis. Am J Ger Psychiatry 1998; 6(suppl):S64–S78

SYMPOSIUM 39—PERSONALITY AND PSYCHOPATHOLOGY: A BEHAVIOR-GENETIC PERSPECTIVE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand how behavior genetics methodology may be used to clarify the etiological factors underlying comorbidity; understand more about the relationship between personality and mental disorders especially anxiety, substance abuse, and externalizing disorders.

No. 39A
BEHAVIORAL-GENETIC PERSPECTIVES ON THE COMORBIDITY OF BEHAVIOR

Kerry L. Jang, Ph.D., *Department of Psychiatry, University of BC, 2255 Wes Brook Mall, Vancouver, BC V6T 2A1, Canada*

SUMMARY:

Alcohol use and abuse is frequently associated with specific personality characteristics and family environments. The phenotypic, genetic, and environmental basis of this relationship is examined in a sample of 324 monozygotic and 335 dizygotic twin pairs. The simultaneous multivariate genetic analyses of personality, family environment, and alcohol misuse showed that family environmental variables had little relationship to alcohol misuse. Significant relationships between personality factors and family environmental variables were found suggesting that personality factors play a role in selecting and modifying aspects of the family environment, but this relationships path could not be further extended to include a relationship with alcohol misuse. Analyses suggest that it is largely the narcissistic aspects of antisocial personality that are related to alcohol misuse and that family environmental variables have little relationship with alcohol misuse.

No. 39B
CAUSAL CONNECTIONS BETWEEN IMPULSIVE PERSONALITY TRAITS AND EXTERNALIZING DISORDERS

Robert F. Krueger, Ph.D., *Department of Psychology, University of Minnesota, 75 East River Road, Minneapolis, MN 55455*; Brian M. Hicks, B.S., William G. Iacono, Ph.D., Christopher Patrick, Ph.D., Matt McGue, Ph.D., Scott R. Carlson, B.A.

SUMMARY:

Extensive evidence links personality traits entailing nontraditional values, impulsiveness, and thrill seeking to forms of psychopathology that involve antisocial behavior and substance dependence. Might

these correlations indicate that personality and psychopathology stem partially from the same underlying etiologic factors? Evidence from the Minnesota Twin Family Study supports this interpretation. Specifically, statistical models were fit to interview, parent-report, and self-report data obtained from male and female 17-year-old twins. Four diagnostic variables (adult antisocial behavior, conduct disorder, alcohol dependence, drug dependence) were modeled along with a broad personality factor encompassing nontraditional values, impulsiveness, and thrill seeking. Model fitting analyses indicated close genetic relationships among these variables, supporting the hypothesis that personality traits and mental disorders are linked at an etiologic level. These findings have key implications for psychiatric nosology and hence, for clinical practice. Specifically, the findings suggest that antisocial behavior and drug dependence are often comorbid because they share etiologic influences, and that they should be classified together under the broad rubric of impulse control (or "externalizing") disorders.

No. 39C
BORN FEARFUL: HERITABILITY OF AVOIDANT AND SOCIAL ANXIETY RELATED TRAITS

Murray B. Stein, M.D., *Department of Psychiatry, University of CA at San Diego, 8950 Villa La Jolla Drive, Suite 2243, La Jolla, CA 92037*

SUMMARY:

Social phobia, particularly the generalized form, is strongly familial. There is some continuity from extremes of normative personality (e.g., shyness) to social phobia to personality disorder (e.g., avoidant personality disorder). If these traits/disorders are heritable, what is the endophenotype?

In one study, we examined the distribution of anxiety-related quantitative traits in relatives of patients with generalized social phobia (GSP) and comparison subjects. First-degree relatives of GSP probands scored significantly higher than first-degree relatives of not socially phobic probands on measures of trait and social anxiety, and on the harm avoidance subscale of the Tridimensional Personality Questionnaire. One large factor, accounting for 84% of the variance, was strongly associated with being a first-degree relative of a GSP proband. In a second study, we examined heritability of negative evaluation fears (which feature prominently in the cognitive psychology of social phobia) in a twin sample. We found negative evaluation fears to be moderately (48%) heritable. Genetic correlations between Brief-FNE scores and the submissiveness, anxiousness, and social avoidance facets of the Dimensional Assessment of Personality Problems (DAPP) were extremely high (r_g ranging from 0.78–0.80).

Implications for studying the heritability of social anxiety disorder and related conditions are discussed.

No. 39D
ETIOLOGICAL RELATIONSHIPS AMONG PERSONALITY DISORDERS AND AXIS I DISORDERS

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada*

SUMMARY:

Within the DSM-III and DSM-IV tradition personality disorders and other mental disorder are conceptualized as distinct entities and placed on separate axes. Despite this distinction, there is a close relationship between the two axes as indicated by extensive patterns of comorbidity. The mechanisms underlying comorbidity, however, are unclear. Associations between personality disorders and other mental disorders could reflect the occurrence of distinct disorders (true comorbidity), conceptual overlap due to the failure to identify distinct nosological entities, or common etiological factors. The data from a sample of approximately 1,000 twin pairs will be used to explore the etiological relationships between personality disorder traits and mental disorders, especially anxiety disorder. The intent is to show how behavior genetic methods may be used to clarify comorbid relationships.

Data will be presented to show that a broad factor of emotional dysregulation underlies a wide range of Axis I disorders, especially the Cluster B disorders and borderline pathology. The results of twin study will be used to demonstrate that this factor is organized around the trait of anxiousness. On the basis of these results a model of borderline pathology will be presented. Subsequently, evidence will be presented to show that anxiousness also has an etiological relationship with Axis I disorders, and, in particular, anxiety disorders.

The results will be discussed in terms of their implications for theories of etiology and the classification of mental disorders. The findings raise questions about the relationship between Axis I and II disorders and the validity of continuing to classify personality disorder on a separate axis.

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SYMPOSIUM 40—THE USE-OF-FORCE IN PSYCHIATRY: WHEN IS IT HELPFUL AND WHEN IS IT NOT? PART I

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify the various settings and specific populations in which force is used with persons who have or appear to have psychiatric disorders and the clinical, social, political, and ethical ramifications of the use of force.

No. 40A
SECLUSION AND RESTRAINT UPDATE

Nicholas Meyers, J.D., *American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*

SUMMARY:

The issue of how force is used in psychiatric facilities has been around for many years. However, reports of increased and unnecessary injuries and deaths related to seclusion and restraint have spurred greater interest in the subject. In response to growing public concerns, several legislative initiatives have been introduced in Congress. The Health Care Financing Administration created proposed rules for how seclusion and restraint should be handled and monitored in HCFA-funded facilities or programs. Accrediting organizations have attempted to create reasonable guidelines for the use of seclusion and restraint. Various professional psychiatric organizations have

entered into the debate over this very emotional and contentious issue. This presentation will summarize many of the legislative and regulatory initiatives and the attempts by professional groups to impact them.

No. 40B
USE OF FORCE WITH OLDER ADULTS

Cornelia K. Beck, Ph.D., *Department of Psychiatry, University of Arkansas, 4301 West Markham Slot 808, Little Rock, AR 72205*

SUMMARY:

Elders with dementia or other psychiatric illness are frequently found in residential and nursing facilities. Their behavior, when disruptive or agitated, can often provoke confusion and frustration in their care providers and family members. This presentation will review some of the data available on how and when elders are subjected to inappropriate or excessive force. The nursing home and home health care industries have been subject to more significant regulatory oversight than other psychiatric facilities. The presentation will conclude with recommendations for methods for intervening with agitated and disruptive elderly patients, which reduce or eliminate the risks of death or serious injury.

No. 40C
USE-OF-FORCE ISSUES FOR PERSONS IN POLICE CUSTODY AND CORRECTIONS SETTINGS

Randolph T. Dupont, Ph.D., *Department of Psychiatry, University of Tennessee at Memphis, 135 North Pauline, Suite 633, Memphis, TN 38105*; Fred C. Osher, M.D.

SUMMARY:

The role of law enforcement in mental illness crisis events has become recognized over the past 20 years. Recent high-profile public incidents involving the use of force with mentally ill individuals has led communities to demand a better method of intervention. Attention has been focused on the increasing tendency toward inadvertent criminalization of mental illness through misdemeanor arrests. This has led to police-based intervention programs, which emphasize jail diversion for individuals who are mentally ill and a major federal initiative in this area. Recent studies have found these models are effective in reducing arrest rates among those with mental illness, and further investigations have begun to establish the active ingredients in such programs. Further data have indicated these strategies are effective at lowering injury rates and minimizing the need for higher levels of use of force.

The best known strategy for law-enforcement-based crisis intervention for mentally ill individuals is the Crisis Intervention Team model that originated in Memphis in 1988. Despite this program's success, significant barriers to change exist in both the law enforcement and mental health delivery systems. Similar concerns have been expressed with regard to corrections settings, in which mentally ill persons are disproportionately represented and whose psychiatric treatment needs often go unmet. This program will review recent best practice models for police and corrections intervention with mental-illness-related crisis events and corresponding attempts to reduce the use of force.

No. 40D
THE USE OF FORCE: CONSUMER PERSPECTIVE

Frank D. Burgman, *G. Pierce Wood Memorial Hospital, 5847 SE Highway 31, Arcadia, FL 34622*

SUMMARY:

When, if ever, *is force* necessary in dealing with persons whose *behavior* is *difficult to manage?* The italicized words in this question are red flags to mental health consumers. Except in cases of extreme emergency, force is never justified. Most difficult situations can be successfully de-escalated verbally or by removal to a quiet place.

Our *behavior* is a product of our illness and the environment in which we live, including the people that we interact with. Absent a true treatment partnership, you will find it *difficult to manage* our behavior. We are doomed to failure, if you insist on doing things *to* us rather than *with* us in partnership.

We will discuss the literature available from consumer sources, along with the summary of findings of a consumer/professional symposium on force that occurred in 1993–94. A consumer-driven assessment tool will be presented, with participants being asked to assess one another, with a brief discussion of the experience. A best practice model for reduction of seclusion and restraint will be presented and discussed.

No. 40E
THE USE OF FORCE: STAFF PERSPECTIVE

Richard O'Dea, R.N., *Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18103*

SUMMARY:

Although much has been written and publicized recently about the risks and consequences to patients in psychiatric facilities when force is exercised by staff in the form of seclusion or restraint, little has been said about the risks or consequences of dangerous behavior for staff. When is it appropriate for staff to intervene and when not? How well are staff trained to handle such situations? How much does resource limitation affect their ability to protect patients and themselves? Can training and reporting requirements, such as those in the HCFA rules, compensate for insufficient staff ratios?

REFERENCES:

1. American Psychiatric Association: Statement of the American Psychiatric Association to the Senate Labor-HHS Appropriations Subcommittee Hearing on Seclusion and Restraint. Congressional Record, April 13, 1999
2. Sloane PD, Mathew LJ, Scarborough M, et al: Physical and pharmacologic restraint of nursing home patients with dementia. JAMA 1991; 265:10:1278–1282
3. Dupont RT, Cochran SC: Police response to mental illness crisis: barriers to change. Journal of American Psychiatry and the Law, in press
4. Weiss EM: Deadly restraint. Hartford Courant, October 11, 1998
5. Bensley L, Nelson N, Kaufman J, et al: Patient and staff views of factors influencing assaults on psychiatric hospital employees. Issues in Mental Health Nursing 1995; 16:433–446

SYMPOSIUM 41—BIPOLAR DISORDER: CURRENT GUIDELINES, PRACTICES, AND EFFECTIVENESS RESEARCH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be knowledgeable on current evidence- and expert-consensus-based treatment recommendations for bipolar disorder; the extent to which clinicians provide care consistent with these recommendations; and be familiar with participants with two large-scale research projects testing bipolar disorder treatment algorithms: NIMH's national clini-

cal effectiveness study of somatic and psychosocial treatments and a quality improvement initiative in the state of Texas.

No. 41A
CURRENT TREATMENT GUIDELINE RECOMMENDATIONS FOR BIPOLAR DISORDER

Robert M.A. Hirschfeld, M.D., *Psychiatry & Behavioral Science, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

This presentation will provide an overview of key clinical treatment recommendations from the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Bipolar Disorder, the Texas Medical Algorithm Project (TMAP), and the Expert Consensus Guideline on the Medication Treatment of Bipolar Disorder. Although the primary focus of the presentation will be to review key treatment recommendations from these guidelines, the session will also introduce and compare and contrast the evidence- and expert consensus-based approaches used to develop these guidelines. For the APA guideline, recommendations pertaining to the treatment of manic, depressive, and mixed episodes will be summarized, highlighting recommendations pertaining to psychiatric management, psychopharmacologic treatments, electroconvulsive therapy, psychotherapeutic treatments, the formulation and implementation of a treatment plan, and clinical features influencing treatment. Recommendations pertaining to the maintenance phase of treatment as well as the discontinuation of maintenance medication will also be addressed. For the Expert Consensus Guideline, psychopharmacologic treatment recommendations for the treatment of mania, bipolar depression, and rapid cycling bipolar disorder will be summarized. Strategies for initial and subsequent treatments for nonresponders will be described along with recommendations for maintenance treatment. Research gaps in the evidence base that need to be addressed to inform future practice guidelines for the treatment of bipolar disorder will be outlined.

No. 41B
SYSTEMATIC TREATMENT ENHANCEMENT PROGRAM FOR BIPOLAR DISORDER (STEP-BD) STUDY DESIGN AND SAMPLE CHARACTERISTICS

Gary S. Sachs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, 5th floor, Boston, MA 02114*; Michael E. Thase, M.D., Steve Wisnewski, Leslie F. Leahy, Ph.D., Jennifer Conley, M.A.

SUMMARY:

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) is an NIMH-funded project designed to study the effectiveness of somatic and psychosocial interventions for bipolar disorder. STEP-BD aims to enroll 5,000 patients in 20 centers, which have agreed to use a common set of model practice procedures. In contrast to the usual restrictive clinical trial entry criteria, STEP-BD is designed to access sample bipolar patients representative of those treated in routine clinical practice. These broad inclusion and minimal exclusion criteria and a hybrid design that includes randomized and nonrandomized treatment pathways are intended to maximize the generalizability of the findings from STEP-BD. In order to improve the interpretability of the findings, STEP-BD utilizes innovative design features such as randomization strata, and an interpolated design testing the relative effectiveness of four psychosocial interventions. We will present the overall study design, demographic data, and baseline clinical data (lifetime and current diagnoses), including comorbid diagnoses for patients entering STEP-BD during its first year of enrollment.

No. 41C
THE TEXAS IMPLEMENTATION OF MEDICATION ALGORITHMS FOR BIPOLAR DISORDER

Patricia Suppes, M.D., *Department of Psychiatry, Univ. of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Treatment guidelines are used widely in general medicine and are increasingly being generated and disseminated in psychiatry. However, few studies have been completed evaluating the relative impact of treatment algorithms on clinical symptoms, course of illness, or economic impact. The Texas Medication Algorithm Project (TMAP) examined the effects of a systematized treatment guideline and a patient/family education program on these outcomes in over 400 patients with bipolar I disorder or schizoaffective disorder, bipolar type. Initial results from this open, controlled study, including clinical findings and implications for implementation of treatment guidelines in public mental health systems, will be discussed.

The Texas state legislature has mandated implementation of treatment guidelines for serious mental illnesses in the public mental health system. The goals of this initiative, referred to as the Texas Implementation of Medication Algorithms (TIMA) project, include ensuring more uniform treatment of serious psychiatric illness. Significant state funding for newer classes of medications (e.g., atypical antipsychotics) is linked to TIMA. Recently, a consensus conference was held to update and revise the TMAP guidelines in preparation for their mandatory dissemination and implementation in TIMA. The consensus group (including advocates, consumers, public mental health physicians and administrators, and nationally recognized academicians) modified, updated, and expanded the original TMAP algorithms. The updated algorithms will be presented. Additionally, procedures by which the work group revised and prepared algorithm materials in preparation for widespread implementation with little external support will be discussed.

No. 41D
TREATMENT OF BIPOLAR DISORDER IN ROUTINE PRACTICE

Joyce C. West, M.P.P., *APIRE, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; David A. Kahn, M.D., Deborah A. Zarin, M.D., Steven C. Marcus, Ph.D., Victoria E. Cosgrove, B.A., Mark H. Townsend, M.D.

SUMMARY:

Objectives: The primary aims of this study were to: (1) characterize patterns of psychosocial and psychopharmacologic treatment for patients with bipolar disorder; (2) assess levels of conformance with key practice guideline recommendations; and (3) identify factors associated with nonconformance with key guideline recommendations.

Methods: Nationally representative, clinically detailed data from the 1999 American Psychiatric Practice Research Network (PRN) Study of Psychiatric Patients and Treatments were used. Patterns of psychosocial and psychopharmacologic treatment for the 192 patients with a diagnosis of bipolar disorder in the acute phase of the illness were examined. In addition, factors associated with guideline nonconformance were assessed.

Results: 74.2% (SE = 3.8) of the patients received a mood stabilizer; 67.0% (SE = 4.3) received psychotherapy; and 97.4% (SE = 1.6) received psychiatric management at the current visit or in the

past 30 days. The most commonly prescribed mood stabilizer was valproate (43.6%, SE = 4.1), followed by lithium (32.1%, SE = 4.0), and carbamezapine (7.7%, SE = 2.8). Other psychopharmacologic treatments that were provided included antidepressants (54.2%, SE = 4.6), antipsychotics (40.3%, SE = 4.3), and benzodiazepines (29.6%, SE = 3.7).

Conclusions: Most patients in the sample received multiple treatment modalities and a significant proportion did not receive treatment that was consistent with key practice guideline treatment recommendations, including a quarter of the patients in the acute phase of their illness who did not receive a mood stabilizer. More research is needed to better understand reasons for guideline nonconformance and how it affects treatment effectiveness.

REFERENCES:

1. American Psychiatric Association: APA Practice Guidelines. Washington, DC, American Psychiatric Association, 1996
2. Sachs GS, Printz DJ, Kahn DA, Carpenter D, Docherty JP: The Expert Consensus Guideline Series Medication Treatment of Bipolar Disorder 2000. Postgrad Med 2000; Apr Spec. No: 1–14
3. Rush JA, Rago WV, Crismon ML, Toprac MG, et al: Medication treatment for the severely and persistently mentally ill: The Texas Medication Algorithm Project. J Clinical Psychiatry 1999; 60:284–291

SYMPOSIUM 42—TEACHING ETHICS TO PSYCHIATRIC RESIDENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be prepared to teach ethics to psychiatric residents and recent graduates.

No. 42A
TEACHING ABOUT BOUNDARY VIOLATIONS IN A PSYCHIATRY ETHICS COURSE

Peter B. Gruenberg, M.D., *433 North Camden Dr, Suite 1136, Beverly Hills, CA 90210-4415*

SUMMARY:

The concept of the psychotherapeutic framework is discussed. Boundary crossings and boundary violations are explained. Clinical examples of each are examined.

No. 42B
PRACTICAL ETHICS IN TREATMENT OF CHILDREN

William Arroyo, M.D., *4034 Witzel Drive, Sherman Oaks, CA 91423*

SUMMARY:

This section will address the area of ethics as it applies to providing psychiatric care to children and families. The following challenges, which will be discussed in this section, are commonly faced by young psychiatrists.

Confidentiality issues change during the development period. Furthermore, the complex context of the family in the treatment of a child and relevant confidentiality aspects are paramount to providing care. Obtaining informed consent for the perscription of many off-label psychotropic agents to the child and family involves discussion of related matters to both child and parents.

Children often invoke strong nurturant feelings in young adult psychiatrists who themselves are nurturing their own offspring. Sometimes these feelings tempt these young psychiatrists to treat these children as their own, thereby violating boundaries.

The involvement of various key adults, especially family members, in the treatment of children is a new approach for those residents who are customarily working with an adult who is often the sole participant in that adult's treatment. It is not uncommon for young inexperienced trainees to be tempted to treat the other key adults as "nonpatients."

Hospitals, especially those that serve children, are struggling for their financial survival. Hospital administrations frequently apply pressure on trainees to err conservatively and hospitalize a child, which would also meet the administration's need for maintaining a high census of inpatients.

No. 42C
TEACHING ABOUT THE ETHICS OF CONFIDENTIALITY

David S. Wahl, M.D., *2426 Daisy Lane, Golden, CO 80401*

SUMMARY:

Four case examples will be presented that provide specific material to elucidate principles of confidentiality. The cases will be selected from resident-specific clinical circumstances such as training clinics, supervisory relationships, and personal relationships. Examples will demonstrate issues of confidentiality among professionals. Consequences of violations of confidentiality after death and disclosure of information outside the clinical setting will be included.

No. 42D
ETHICAL ASPECTS OF GIFTS FROM PATIENTS

Edward Hanin, M.D., *211 East 70th Street, New York, NY 10021-5209*

SUMMARY:

This presentation will focus on the ethical aspects of receiving gifts from patients. The circumstances that may arise and the procedures and protocols for handling such issues as they come up in treatment so as to avoid both negative impact on the physician-patient relationship as well as questions of exploitation of the therapeutic relationship by the physician will be included. This will be done in the context of the APA Ethics Committee's Ethics Primer of the American Psychiatric Association and as part of a broader presentation on the teaching of the ethics of psychiatric practice.

No. 42E
FORENSIC ISSUES IN THE PRACTICE OF ETHICAL PSYCHIATRY

Wade C. Myers, M.D., *Department of Psychiatry, University of Florida, PO Box 100234/JHMHC, Gainesville, FL 32603*

SUMMARY:

Most psychiatrists face forensic issues in their day-to-day practice of medicine, even if they do not actually practice forensic psychiatry. This underscores the importance of educating residents and practitioners about the fundamentals and new developments in this area of psychiatry. There are a number of useful and practical documents available to help guide us in the ethical practice of forensic psychiatry and in managing forensic issues as they arise. The challenge is how to effectively impart this knowledge to psychiatrists. The backbone of any such document stems from the APA's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. The American Academy of Psychiatry and the Law adopted in 1987, and revised in 1989 and 1991, the AAPL Ethical Guidelines for the

Practice of Forensic Psychiatry. These guidelines primarily cover the areas of confidentiality, informed consent, honesty and striving for objectivity, and qualifications. The AAPL guidelines state that "...forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry." The American Academy of Forensic Sciences has also generated ethical standards for the practice of forensic medicine, and are readily applicable to psychiatry. Their standards emphasize competence in one's claimed area of expertise, avoidance of conflicts of interest, maintaining objectivity, and the duty to help deter or, if necessary, report unethical behavior by other forensic scientists.

REFERENCES:

1. Gruenberg PB: Boundary violations in American Psychiatric Ethics Committee Primer of Psychiatric Ethics of the American Psychiatric Association. Washington, DC, American Psychiatric Press, 2000
2. Schetky DH (ed): Ethics. Child and Adolescent Psychiatric Clinics of North America, WB Saunders, Philadelphia, 1995
3. American Psychiatric Association Ethics Committee: Ethics Primer of the American Psychiatric Association. Washington, D.C., American Psychiatric Press, 2000

SYMPOSIUM 43—MUSIC THERAPY: INTEGRATED ART AND SCIENCE IN HEALTH CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) define music therapy as an integration of art and science, (2) describe outcome data regarding the efficacy of music therapy in the treatment of dementias and other psychiatric disorders, neurologic disorders, and cancer, (3) explain the term *Mozart effect,* and (4) describe the potential benefit of group drumming on the immune system.

No. 43A
THE MOZART PHENOMENON: MYTH AND REALITY

Bryan C. Hunter, Ph.D., *Music Department, Nazareth College, 4245 East Avenue, Rochester, NY 14618*

SUMMARY:

In the past half decade the music of Mozart has gained enormous public attention with regard to its potential health and educational benefits. The phenomenon, which began as scientific inquiry, has rapidly evolved and given rise to what has nearly become a household phrase: *The Mozart effect.* Unfortunately, the phrase is used by influential people in research, the music products industry, and market advertising to mean different things. In one instance the term has even been trademarked.

While the original scientific inquiry focused on the benefits of music on cognitive development in children, the now popularized phrase is being used in reference to virtually any educational, therapeutic, or spiritual benefit that music may offer to human beings. This paper will review the development of this phenomenon and the status of the original area of scientific inquiry regarding the impact of music on children's cognitive development. In addition, a clarification and overview of the now popular phrase will be presented and contrasted with music therapy applications that are based in scientific research.

No. 43B
MUSIC THERAPY IN NEUROLOGIC REHABILITATION: A SCIENTIFIC MODEL OF RHYTHMICITY IN BRAIN FUNCTION

Michael H. Thaut, Ph.D., *CBRM, Colorado State University, Fort Collins, CO 80523*

SUMMARY:

One of the primary functions of music observed in cultures around the world is the stimulation of movement. Music therapists have historically applied this function in using music therapeutically in physical rehabilitation.

This presentation will focus on data from neurological research in the areas of sensorimotor control and cognition, which link brain and behavior function in music, rhythm perception, and rhythm production to biomedical applications in the therapy of patients with neurological disorders. Scientific evidence and models will be presented showing how the structural attributes of music and rhythm can prime and train motor control, speech and language functions, and cognitive functions, e.g., in the areas of memory and attention. The research evidence has led to the development of the field of neurologic music therapy, which is defined by (a) its application to neurological disorders, (b) its basis on a neuroscience model of music perception and music production, and (c) a standardized system of treatment techniques based on research evidence.

No. 43C
MUSIC THERAPY OUTCOME RESEARCH IN PATIENTS WITH ALZHEIMER'S DISEASE

Alicia A. Clair, Ph.D., *MEMT, University of Kansas, 311 Bailey Hall, Lawrence, KS 66611*

SUMMARY:

Alzheimer's disease and other dementias generally occur in older persons. The tremendous growth in numbers of aged persons in recent years has concomitantly increased the frequency of the diagnoses. Efforts to provide care have taxed family caregivers emotionally and physically to the point of compromising their health and well-being in many cases. Health care challenges for persons with dementias include opportunities both for them and their family caregivers to maintain the highest functioning levels possible.

Music therapy applications, which engage individuals in middle- to late-stage dementias, and their caregivers, have provided for maintenance of function far into the disease process. Primarily, these applications have aroused responses that engage meaningful participation, provide for ambulation and adherence to physical exercise regimens, support ADLs, and diminish difficult behaviors and stress.

This presentation will illustrate through videotape the outcomes of music therapy with persons who have middle- to late-stage dementia. It will demonstrate the integration of caregivers into the therapeutic process, and will provide guidelines for using music to facilitate and maintain responses in persons with severely compromised function.

No. 43D
MUSIC THERAPY IN PSYCHOSOCIAL CARE AND PAIN MANAGEMENT

Deforia L. Lane, Ph.D., *Cancer Department, University Hospitals, 11100 Euclid Avenue, Cleveland, OH 44106-5065*

SUMMARY:

The presentation will describe the use of music therapy with oncology patients at the Ireland Cancer Center, a major National Cancer Institute designated treatment center. Music therapy assess-

ment, goals, objectives, interventions, evaluation, documentation, and funding sources will be discussed. In addition, outcome research on music therapy's impact on immune functioning, pain perception, and anxiety will be presented. The presentation will include didactic and experiental learning, and will offer guidelines for implementing music therapy in private practice and medical facilities.

No. 43E
THE EFFECT OF DRUMMING ON IMMUNE SYSTEM MODULATION

Barry B. Bittman, M.D., *Wellness Center, Meadville Medical Center, 18201 Conneaut Lake Road, Meadville, PA 16335*

SUMMARY:

This presentation is an overview of the potential role of group drumming as a complementary intervention in traditional disease-based whole person medical care. Drumming, one of the oldest healing rituals, has been increasingly used in music therapy interventions over the past decade. An interdisciplinary team of researchers at the Mind-Body Wellness Center of Meadville, Pennsylvania, and Loma Linda University School of Medicine in California have conducted the first known investigation of group drumming intervention that demonstrates short-term immunoenhancing neuroendocrine and immunologic alterations in normal subjects. Specifically, the controlled study investigated the role of group drumming music therapy as a composite activity in the context of modulation of stress-related hormones and enhancement of specific immunologic measures associated with NK cell activity and cell-mediated immunity. The main outcome measures documented were plasma cortisol, plasma dehydroepiandrosterone (DHEA), plasma DHEA: cortisol ratio, natural killer (NK) cell activity, lymphokine-activated killer (LAK) cell activity, plasma interleukin-2 (IL-2), and plasma interferon-gamma (IFN-γ). In addition, the presentation will review the psychosocial and biological rationale for exploring various control and experimental paradigms designed to separate drumming components for the ultimate determination of a single experimental model. The research elucidates biological support for the role of drumming as a complementary therapeutic strategy in the traditional medical arena.

REFERENCES:

1. Shaw GL: Keeping Mozart in Mind. San Diego, CA, Academic Press, 2000
2. Thaut MH, Kenyon GP, Schauer ML, McIntosh GC: The connection between rhythmicity and brain function: Implications for the therapy of movement disorders. IEEE Engineering in Medicine and Biology 1999; 18(2):101–108
3. Clair AA: Therapeutic Uses of Music With Older Adults. Baltimore, MD, Health Professions Press, 1996
4. Lane D: Effects of music therapy on immune function of hospitalized patients. Quality of Life 1994; 3:74–80
5. Bittman BB, Berk LS, Felten DL, et al: Composite effects of group drumming music therapy on modulation of neuroendocrine-immune parameters in normal subjects. Alternative Therapies, in review

SYMPOSIUM 44—CULTURAL INFLUENCES ON THE PSYCHIATRIC TREATMENT OF WOMEN

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have increased awareness of the impact of cultural issues in the psychiatric treatment of women.

No. 44A
MENTAL HEALTH TREATMENT OF CHINESE WOMEN: ISSUES AND OPPORTUNITIES

Henry Chung, M.D., *Chinatown Health, 125 Walker Street, 2nd Floor, New York, NY 10013*

SUMMARY:

Chinese and Chinese American women in psychiatric treatment often present with atypical symptoms suggesting the presence of anxiety-related disorders. However, a careful diagnostic assessment will often reveal the presence of depressive disorders. Clinicians who utilize key elements of the cultural formulation will be more likely to make an appropriate diagnosis and begin appropriate treatment. Understanding the cultural context for the patients' symptoms can lead to improved therapeutic alliance and treatment adherence.

No. 44B
CULTURAL ISSUES IN THE PSYCHIATRIC TREATMENT OF ORTHODOX JEWISH WOMEN

Michelle E. Friedman, M.D., *205 West End Avenue, New York, NY 10023*

SUMMARY:

Orthodox Judaism comprises a spectrum of religious ideologies and practices ranging from "Centrist" or "Modern" Orthodoxy, which is the most integrated with general American culture, to the "Yeshivish" and "Hassidic" cultures, which are far more insular. The general underlying tenet is adherence to the laws and traditions as outlined in the five books of the Bible and later Rabbinic literature, which contain prescriptions for every aspect of life. These include diet, clothing, sexual mores, education, recreation, and spiritual life.

The goal of this presentation is to acquaint the participants with the broad definitions of these categories. The Orthodox culture differs from other ethnic groups in that it does not hearken back to one homeland and more important, the communities work actively to maintain separatism from modern American culture. In fact, many of the precepts of the Orthodox world may seem quite at odds with current Western values. Different gender roles with a major emphasis on childbearing and homemaking for women, modesty and sexual restrictiveness, limited access to popular culture, all define aspects of Orthodox Judaism.

Practitioners treating this population need to be familiar with these basic values and practices so as to establish empathic and respectful rapport with their patients. In addition, practitioners will better understand the cultural language that psychiatric pathology expresses itself in among Orthodox patients.

No. 44C
CULTURAL INFLUENCES IN PSYCHIATRIC TREATMENT OF INDIAN WOMEN

Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*

SUMMARY:

Indian culture is rooted in the subcontinent of India and spread to all parts of the world wherever its people migrated. Indian culture in itself is very diverse. This diversity includes language, food habits, dressing, and ways of communication. India has religious diversity whereby Hindus, Muslims, Christians, Sikh, Zorastrians, and Jews live side by side. However, all Indians share culture values, traditions, rituals, and the way their females fit in the society. These cultural factors influence the way in which psychiatric symptoms are perceived and tolerated. Referral, to a psychiatrist is usually done by a family friend or respected person from the society. Stigma of

having a mental illness brings shame to the entire family, which is another cultural reason that prevents seeking help. Indian women, especially immigrants, have experienced losses of loved ones who are back in the home country. They have to raise children in an unfamiliar, culturally diverse environment, and deal with the issues of financial stability in the new land. Many women become victims of violence in the household created by their frustrated husbands, also immigrants. Culturally, Indian men are the breadwinners, decision makers, and the ultimate power house. Conflicts arise when women begin to take charge and shift their role from dependency to independence. In this symposium participants will have the opportunity to discuss how to sort out cultural issues in Indian women and help them find a balance between two worlds in which they live.

No. 44D
TREATING LATINO WOMEN PATIENTS: CLINICAL CHALLENGES

Silvia W. Olarte, M.D., *Department of Psychiatry, New York Medical College, 37 East 83rd Street, #1, New York, NY 10028*

SUMMARY:

Latinos are expected to be the most numerous minority in the United States by the year 2020. Initially, most of the Latino immigration to this country stemmed from Puerto Rico and Mexico, with a limited immigration from Cuba in the mid 60s. Recently, the Latino immigrants come from all Latin-American countries and for a variety of personal reasons stemming from political persecution to desire to pursue the "American dream." While these immigrants have in common language and most often spiritual beliefs, each country is diverse in its culture and their cultural nuances are crucial to understand the migrant experience of the Latino population. Both women and men are influenced differently by this experience. This presentation will highlight the specific problems of the Latino woman when confronted with the new culture and its clashes with her known gender role and cultural expectations. Concepts like "machismo," "marianismo," "respeto," "compadres," will be discuss and their role clarified in the diagnosis and treatment of the Latino woman.

No. 44E
EMERGING ISSUES IN PSYCHIATRIC TREATMENT FOR AFRICAN-AMERICAN WOMEN

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

SUMMARY:

It has long been believed that black women, as double minorities, have a double advantage over others. Described as "two-fers," it is believed that the two negative statuses of black and female cancel each other out and enable black women to parlay the dual negative status into a positive experience. This theory gives little acknowledgment to the possibility that instead of being a double advantage, black women actually face a significant psychological burden.

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1. Tracy LC, Mattar S: Depression and anxiety disorders, in Kramer EJ, Ivery SL, ed Ying YW (eds.) Immigrant Women's Health. San Francisco, CA, Jossey-Bass, pp 205–219
2. Burl VK, Rudolph M: Treating an Orthodox Jewish Woman with Obsessive-Compulsive Disorder: Maintaining Reproductive and Psychologic Stability in the Context of Normative Religious Rituals
3. Immigrant Mental Health: Conflicts & concerns of Indian immigrants in the U.S.A. - Psychology developing societies, Sage Publications, New Delhi/Newbury Park/London, 1992
4. Comas-Diaz L, Greene B (Eds): Women of color. Integrating Ethnic and Gender Identities in Psychotherapy. Guilford Press, New York/London, 1994
5. Okazawa-Rey M, Robinson T, Ward JV: Black women and the politics of skin color and hair, in Women, Power and Therapy: Issues for Women. Brande (ed), Haworth Press, 1988

SYMPOSIUM 45—FEEDING, EATING, AND EATING DISORDERS: THE DEVELOPMENT OF DISORDERED EATING

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize a range of influences upon the development of disordered eating, including biological, social, and cultural factors.

No. 45A
EARLY INFLUENCES ON DISORDERED EATING

W. Stewart Agras, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 1322, Palo Alto, CA 94305*

SUMMARY:

Relevant studies concerning the influence of eating disordered (ED) mothers on their children will first be reviewed. Data from three studies emanating from a developmental study of children from infancy to eight years will then be presented. The first study examined the interactive influences between ED mothers and their infants. Infant daughters of ED mothers were found to suckle differently from the infants of non-ED mothers and to delay their weaning from the bottle significantly longer than the infant's of non-ED mothers. In the second study of the same cohort, the relations between maternal and paternal feeding characteristics and early disturbed eating patterns of their five-year-old children were examined. Maternal disturbed eating assessed five years previously predicted aspects of disturbed childhood eating. In the third study from the same cohort, although the prevalence of disturbed eating at this age did not vary by gender, maternal influences on disturbed eating (dieting, excessive weight, and shape concerns) were more important than paternal influences and specifically focused on their daughters. This may be one mechanism for the transmission of disturbed eating and body image patterns. The potential importance of these interactions for the development of eating disorders and their prevention will be discussed.

No. 45B
THE ASSOCIATION OF TELEVISION EXPOSURE WITH DISORDERED EATING AMONG ETHNIC FIJIAN ADOLESCENT GIRLS

Anne E. Becker, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-725, Boston, MA 02114;* Rebecca Burwell, M.P.H., Stephen E. Gilman, S.M., David B. Herzog, M.D., Paul Hamburg, M.D.

SUMMARY:

Objective: This study investigates the association of television exposure with disordered eating in Fiji.

Method: A prospective, multi-wave, cross-sectional design was used in which separate cohorts of ethnic Fijian adolescent girls were assessed before and after prolonged regional television exposure.

Subjects for each cohort were recruited from two secondary schools in Nadroga, Fiji, in 1995 (N = 63) and 1998 (N = 65). Subjects responded to a modified 26-item Eating Attitudes Test (EAT-26) and self-report questions about television viewing. Thirty key informants from the 1998 cohort also participated in open-ended, semi-structured interviews to elicit attitudes about diet, weight, and body shape relative to local cultural traditions and exposure to television.

Results: Key indicators of disordered eating—high EAT-26 scores and reports of self-induced vomiting to control weight—were significantly higher in the cohort with prolonged novel television exposure ($p < 0.05$). In addition, narrative data indicated that subjects were interested in weight loss partly in an effort to emulate Western television characters.

Conclusions: Prolonged novel exposure to television appears to be associated with disordered eating among ethnic Fijian adolescent girls in Fiji. This naturalistic experiment allows insight into the mediation of disordered eating by cultural processes.

No. 45C
CULTURAL CHANGE AS A RISK FACTOR FOR EATING DISORDER: THE CASE OF EASTERN EUROPE

Katarzyna Bisaga, M.D., *Department of Child Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 74, New York, NY 10031*

SUMMARY:

Objective: The role of cultural factors in the development of eating disorders has been widely recognized. Specifically, a cultural change has been postulated to increase the risk for eating disorder. Recent socio-economic changes in Eastern Europe provide an opportunity to explore this culture-change hypothesis.

Method: Studies of eating disorders conducted in Eastern European countries prior to and after the recent socio-economic changes are reviewed.

Results: Studies available prior to the changes of 1989 indicate a preexisting vulnerability for development of eating disorders in Eastern European countries. Most of the studies conducted following the political change lack the comparison of baseline rates of disorders prior to the change, but so far the reported rates of eating disorders and abnormal eating behaviors have been stable.

Conclusions: The postulated increase in the rates of eating disorders in the context of cultural transitions in Eastern Europe has not been documented in spite of the evidence that this socio-cultural transition has been associated with increase in general ill health and other selected mental health problems. The longer-term effects of present socio-cultural changes upon the development of problematic eating merit further study.

No. 45D
GENDER DIFFERENCES IN 5HT FUNCTION: A RISK FACTOR FOR ANOREXIA NERVOSA?

Evelyn Attia, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit 98, New York, NY 10032-2603*

SUMMARY:

Several groups have found gender differences in measures of serotonergic activity, with women being more vulnerable to 5-hydroxytryptamine (5-HT) manipulation than men. Women and female non-human animals have higher levels of CNS 5-HT, its precursor tryptophan and its metabolite 5-HIAA, as well as greater receptor densities in recent functional imaging studies. Women also appear more sensitive to physiologic and psychologic manipulation of serotonergic function measured by challenge studies. Anorexia nervosa (AN) is an illness that affects primarily women, and is believed to involve disturbances in several neuroendocrine measures, including those associated with serotonergic activity.

This talk will review published data about gender differences in serotonin function, as well as data regarding serotonin activity in women with anorexia nervosa at different stages of illness to suggest that women may be biologically more vulnerable than men to develop AN.

No. 45E
BODY-FAT DISTRIBUTION BEFORE AND AFTER WEIGHT GAIN IN ANOREXIA NERVOSA

Laurel Mayer, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit 98, New York, NY 10032*; B. Timothy Walsh, M.D., Richard Pierson, Jr., M.D., Claire Barrett, B.A., Erin Killory

SUMMARY:

Purpose: To explore the pattern of body fat distribution before and after weight gain in patients with anorexia nervosa (AN).

Methods: Body composition was measured in 19 subjects with AN before and after weight normalization (90% IBW) and in 19 controls matched for BMI to weight-restored patients by anthropometry (calipers, tape measure) and DEXA (percent body fat).

Results: Groups were well matched (BMI 19.83+0.9 in both groups) except for age (controls 29.9+4.8yrs vs AN subjects 25.6+5.6yrs, p=0.02). Before refeeding, body composition for AN subjects was significantly lower than controls: X_{BMI} for AN subjects = 15.9+2.1kg/m2 (controls 19.83+0.9kg/m2, $p<0.001$) and mean percent body fat was 10%+5 (controls 24%+4%, $p<0.05$). With weight regain, these measures of body composition increased significantly in the patients, and were not significantly different from controls. Arm, waist, hip, and thigh circumferences increased uniformly by ~20% within the patient group. However, when compared with controls, patients had significantly larger waist (700mm+44 vs 664mm+29) and hip (892mm+30 vs 833mm+30) circumferences and smaller arm (233mm+11 vs 253mm+21) and leg (449mm+20 vs 479mm+265) circumferences ($p<0.01$)

Discussion: While refeeding patients with AN may restore weight to a normal range, the pattern of weight distribution suggests that weight gain tends to be distributed centrally and away from the periphery. This may lead to the persistence of body image disturbances, and may predispose patients to relapse.

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SYMPOSIUM 46—NATIONAL BIOETHICS ADVISORY COMMISSION (NBAC) REVISITED: IMPLEMENTATION OF INDEPENDENT CAPACITY ASSESSMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should (1) demonstrate knowledge of NBAC recommendations for informed consent and capacity assessment of vulnerable subjects, and (2) identify strategies for the provision of additional safeguards for vulnerable research subjects.

No. 46A
NATIONAL BIOETHICS ADVISORY COMMISSION (NBAC) RECOMMENDATION FOR INDEPENDENT CAPACITY ASSESSMENT: OVERVIEW AND IMPLICATIONS FOR RESEARCH

Catherine A. Roca, M.D., *NIMH, 10/3N242 10 Center Drive, MSC 1277, Bethesda, MD 20892*; Donald L. Rosenstein, M.D., David R. Rubinow, M.D.

SUMMARY:

The National Bioethics Advisory Commission (NBAC) published its recommendations for research with persons with mental disorders that may affect decision-making capacity in December 1998. Specific issues the NBAC report addressed included the recommendation that for greater than minimal risk research an institutional review board (IRB) should require that an independent professional assess a potential subject's capacity to consent. Although this recommendation would permit an IRB "to use less formal procedures to assess potential subjects' capacity if there are good reasons for doing so," the NBAC report offers little practical guidance for the implementation of this recommendation. Furthermore, there is no consensus within the psychiatric research community concerning when and how independent capacity assessment should be employed in clinical research. Several fundamental questions remain unanswered: (1) Which studies/patient populations should include the provision of independent capacity assessment? (2) Who should perform these assessments, and how independent from the research team/institution should they be? (3) Who is qualified to perform capacity assessments and what methods/instruments should be employed? and (4) What are the logistical and cost considerations involved? A brief overview of the NIMH Intramural Program's attempts to address these issues will be discussed.

No. 46B
METHODS TO ASSESS DECISION-MAKING CAPACITY

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

Objective: To provide a conceptualization of decision-making capacity and to offer a model for its assessment in the research context.

Methods: The elements of decision-making capacity are derived from an examination of case law and statutes, as well as the bioethical, medical, psychological, and legal literatures. The approach to assessment is illustrated by the MacArthur Competence Assessment Tool-Clinical Research version.

Results: All jurisdictions employ a compound standard of decision-making capacity based on two or more of the following components: evidencing a choice, understanding, appreciation, and reasoning. These components can be operationalized in a structured format that is transferable across specific research projects. Studies to date have been performed with subjects with schizophrenia, depression, and Alzheimer's disease. Examples of data from those studies will be provided. Difficulties that may arise in the process of doing structured assessments of decision-making capacity for consent to research will also be addressed.

Conclusions: A generally accepted model of decision-making capacity has emerged over the last two decades. This model is subject to operationalization and efficient applications in the research setting.

No. 46C
VALIDATING INFORMED CONSENT: PROCESS AND VERIFICATION

William T. Carpenter, Jr., M.D., *Department of Psychiatry, MD Psychiatric Research Ctr, PO Box 21247, Baltimore, MD 21228*; Robert R. Conley, M.D.

SUMMARY:

Objective: Assuring valid informed consent in schizophrenia research subjects.

Methods: Issues raised by the National Bioethics Advisory Commission (NBAC) regarding decisional capacity and consent validity in mental illness research are identified and procedures are developed to address these issues.

Results: Data from schizophrenia research subjects show reduced decisional capacity. Analyses reveal underlying cognitive impairment rather than symptoms account for this finding. The use of an informed consent educational process resulted in normalization of informed consent performance in most subjects suggesting that valid consent can be obtained despite impaired cognition or psychotic symptoms. This was verified with a test of factual understanding at the time of consent and re-verified one and three months later.

Conclusions: Issues raised by NBAC can be addressed with an informed consent process. The procedures can be implemented without undue burden. A test at the time of written consent can document factual understanding and prevent inadequately informed subjects from entering protocols.

No. 46D
GREATER THAN MINIMAL RISK RESEARCH WITH VULNERABLE SUBJECTS: A VIEW FROM THE NATIONAL INSTITUTE OF MENTAL HEALTH INTRAMURAL RESEARCH PROGRAM

Donald L. Rosenstein, M.D., *NIMH, 10 Center Drive, Building 10, 3N240, Bethesda, MD 20817-1277*

SUMMARY:

Investigators at the NIMH Intramural Research Program (IRP) have conducted mechanistic and medication-free studies of schizophrenia for decades. Historically, informed consent for these studies has been obtained from subjects by the investigators themselves. In recent years, the IRB review and informed consent procedures for these and similar protocols at the NIMH IRP have changed significantly. In early 1999, following the NBAC recommendation for independent capacity assessment (ICA) in greater than minimal risk research, the NIMH IRP began to explore various approaches to the provision of additional safeguards for vulnerable research subjects. These approaches will be described with regard to a medication-free schizophrenia protocol (determined by the NIMH IRB to be greater than minimal risk, no direct medical benefit research). The discussion

will address the use of consent monitors, an ICA team, a modification of the McCAT-CR capacity assessment instrument, and a process for evaluating the appropriateness of surrogate decision makers. In our experience, ICA for greater than minimal risk research with vulnerable psychiatric patients is feasible, but is a complex and time-intensive process. The independent assessment of surrogate decision makers in the research enterprise warrants further exploration.

REFERENCES:

1. Report and recommendations of the National Bioethics Advisory Commission: Research involving persons with mental disorders that may affect decision-making capacity. Vol 1, December, 1998
2. Berg J, Appelbaum PS: Subjects' capacity to consent to neurobiological research, in Ethics in Psychiatric Research: A Resource Manual for Human Subjects Protection. Edited by Pincus H, Lieberman JA, Ferris S. Washington, DC, American Psychiatric Press, 1999
3. Carpenter WT, Gold JM, Lahti AC, Queern CA, et al: Decisional capacity for informed consent in schizophrenia research. Arch Gen Psychiatry 2000; 57:533–538
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SYMPOSIUM 47—TREATMENT PATHWAYS (ALGORITHMS) IN MANAGING DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) understand the theories and models pertinent to developing algorithms, (2) be knowledgeable of the evidence with regard to the efficacy of medication algorithms for the treatment of major depression, and (3) specify and resolve specific obstacles to implementing such algorithms.

No. 47A
THEORY AND MODELS OF TREATMENT ALGORITHMS

Michael Linden, M.D., *Department of Psychiatry, Klinik Seehof, Lichterfelder Allee 55, Teltow 14513, Germany*

SUMMARY:

In spite of a multitude of medical guidelines, evidence is still missing that they achieved their goal of improving patient care. There are even data suggesting that treatment according to guidelines can harm patients, which can be explained by the fact that the evidence on which guidelines are based often cannot be generalized to routine conditions.

Before new guidelines are published, the nature of medical decision problems must better be understood, as well as the ways physicians come to decisions, what physicians have to learn in order to make rationally based decisions, and how guidelines should be formulated so that they can be used by physicians. Finally, before official accreditation and publication, guidelines should be empirically tested and shown that they actually can improve patient outcome.

Published treatment guidelines and algorithms will be analyzed and described in respect to their rationale and structure, from simple prescriptive recommendations over decision trees to complex meta-heuristics. Examples will be given of empirical studies that aimed at testing the feasibility, impact, and outcome of these guidelines in patient care.

No. 47B
ALGORITHM-GUIDED TREATMENT VERSUS TREATMENT AS USUAL: RANDOMIZED TRIAL IN INPATIENTS WITH DEPRESSION

Michael Bauer, M.D., *Department of Psychiatry, UCLA, 300 UCLA Medical Plaza, Los Angeles, CA 90095–6968*; Mazda Adli, M.D., Ursula Kiesslinger, M.A., Peter Neu, M.D., Michael Smolka, M.D., Michael Linden, M.D.

SUMMARY:

Objective: To compare outcomes of 148 inpatients with depression receiving either treatment following an algorithm, the Standardized Stepwise Drug Treatment Regime (SSTR), or standard treatment as usual (STU).

Method: The Berlin SSTR consists of 10 different sequential treatment steps; patient response at algorithm decision points (assessed at two-week intervals) determines subsequent procedures; main outcome measures: time to remission, time of hospitalization, remission rates.

Results: Forty (53%) of 74 patients entering the SSTR group achieved remission as study completers, as compared with 29 (39%) of 74 in the STU group (survival analysis, log rank=13.8; p<0,001). In the SSTR group, 41 (55%) patients completed treatment and 40 (97%) of these achieved remission. In the STU group, 62 (77%) patients completed treatment but only 29 (46%) of these achieved remission (survival analysis, log rank=25.1; p<0,001). Considering only study completers, SSTR-treated patients showed a significantly lower mean score on depression ratings throughout treatment. The time required for remission was significantly shorter in the SSTR group than in the STU group; the time in hospital showed a trend toward shorter duration in the SSTR group.

Conclusion: A systematic treatment algorithm may have a marked influence on the outcome of hospitalized depressed patients.

Supported in part by grants from Janssen-Cilag, Lilly Deutschland, and Wyeth Pharma, Germany.

No. 47C
TEXAS MEDICATION ALGORITHM PROJECT (TMAP): RESULTS FOR MAJOR DEPRESSIVE DISORDER

Madhukar H. Trivedi, M.D., *Department of Psychiatry, University of TX Southwestern Medical Center, 5959 Harry Hines Boulevard, #600, Dallas, TX 75235-9101*

SUMMARY:

The Texas Medication Algorithm Project (TMAP) is one of the first large-scale effectiveness studies to evaluate medication algorithms for major psychiatric disorders in clinical practice. TMAP compared treatment-as-usual (TAU) with algorithm-driven care combined with a patient/family education package (ALGO+ED). Two TAU groups were developed for comparisons with ALGO+ED, one for use in clinics using no algorithm (TAUnonALGO) and another for use in clinics using an algorithm for another disorder (TAUALGO). Altogether, 548 outpatients with major depressive disorder entered one of three treatments: ALGO+ED (n=182), TAUnonALGO (n=154), or TAUALGO (n=212), with 73% of the sample providing 12 months of follow-up data. Primary outcomes included symptoms (30-item Inventory of Depressive Symptomatology—Clinician-Rated) ($IDS\text{-}C_{30}$), and function (mental component of the Medical Outcomes Study 12-item Short-Form; SF-12) obtained every three months.

Effect sizes were estimated on change from baseline scores, adjusted for baseline severity, resources, education, attitudes toward care, gender, and ethnicity. All patients improved during the study (p<.0001). Moreover, the ALGO+ED group had significantly greater symptom reduction than the matched TAU group (p<.004).

ALGO+ED also had significantly greater reduction ($p<.0001$) in self-reported depressive symptoms and better improvement in SF-12 mental function ($p<.046$) than TAU.

No. 47D
ISSUES IN IMPLEMENTING ALGORITHMS: TEXAS MEDICATION ALGORITHM PROJECT (TMAP) AND STAR*D EXPERIENCES

A. John Rush, M.D., *Department of Psychiatry, Univ. of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9086*

SUMMARY:

Treatment sequences using medication, psychotherapy, or their combination can be specified using scientific evidence and clinical consensus. This presentation discusses administrative, clinical, procedural, attitudinal, and other obstacles encountered when implementing treatment algorithms in the Texas Medication Algorithm Project (TMAP), as well as possible solutions. For example, limited physician time can be addressed by shifting the role functions of caseworkers/nurses to provide additional assistance. Physician unfamiliarity with algorithm medications can be addressed via plus telephone-based supervision for the first several cases. Simplified medical records using a checklist system is another potential solution to wide practice variation across physicians.

Approximately 50% of patients treated with antidepressants require a "next step." The issue confronting practitioners and patients is how to select the next best treatment. Sequenced Treatment Alternatives to Relieve Depression (STAR*D), an NIMH-funded, multisite clinical trial now underway across the United States, aims at defining the most effective treatment steps following a first treatment, and for those requiring it, a second or third choice.

Many patients have difficulties with adherence. Misunderstanding or lack of information about medications and other treatments often lead to incorrect conceptualizations of their illness and its treatment. Materials developed for TMAP on patient/family education will be presented.

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1. Linden M: Therapeutic standards in psychopharmacology and medical decision-making. Pharmacopsychiatry 1994; 27:41–45
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4. Rush AJ, Crismon ML, Toprac MG, Shon SS, 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

SYMPOSIUM 48—THE TRAUMA OF BEREAVEMENT: A NEW PARADIGM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify the clinical significance of trauma distress during bereavement and its implications for diagnosis, prognosis, and preliminary biopsychosocial strategies for treatment.

No. 48A
MEASUREMENT AND DIAGNOSIS OF TRAUMATIC GRIEF

Holly G. Prigerson, Ph.D., *Department of Psychiatry, Yale University, 34 Park Street, Room 522, New Haven, CT 06519*; Selby C. Jacobs, M.D., Paul K. Maciejewski, Ph.D., Stanislav Kasl, Ph.D., Gabriel K. Silverman, B.A.

SUMMARY:

In this presentation, an overview of results suggesting that traumatic grief (TG) is a distinct syndrome deserving a separate place in the DSM will be provided. Results will demonstrate that symptoms of TG: (1) form an independent, internally consistent symptom cluster that is distinct from symptoms of depression and anxiety; (2) have risk factors (eg, parental loss/abuse, dependent relationships), clinical correlates, and responses to pharmacotherapy and psychotherapy distinct from those associated with depression; (3) predict substantial morbidity (e.g., high blood pressure, suicidality); (4) the underutilization of health services, even after controlling for severity of depressive symptomatology and other important confounding influences; and (5) often persist for years, if not decades. While these findings suggest the need for separate diagnostic criteria for TG, no criteria set has been agreed upon or tested. To promote the development of uniform criteria, a panel of leading experts in bereavement and in psychiatric nosology convened and, ultimately proposed, a working criteria set for TG. The criteria include Cluster A — the Separation Distress symptoms (e.g., yearning, searching, excessive loneliness) and Cluster B — Traumatic Distress symptoms (e.g., numbness, disbelief, bitterness, feeling a part of oneself has died). Preliminary results that test the performance of the proposed consensus criteria will be presented, and future directions, including the need for treatment development to ameliorate these symptoms, will be discussed.

No. 48B
TRAUMATIC GRIEF THERAPY

M. Katherine Shear, M.D., *Department of Psychiatry, University Pittsburgh Medical Cntr/WPIC, 100 North Bellefield Avenue, Room 768, Pittsburgh, PA 15213*

SUMMARY:

Grief is a universal human experience associated with preoccupation with the lost loved one, sadness, and other painful emotions and social withdrawal. Depending on the circumstances of the death, grief can be very intense and/or prolonged. In all cases, there is a period of grief following the loss of a close relationship that comprises a transition to life without the loved one. Observations of persistent, troubling, and clinically significant grief-related impairment have been extensively reported but, until recently, there has been no operational definition of deviant bereavement reactions and no reliable way of measuring symptoms. No specific treatments have been developed for complicated grief conditions. The recent development of the Inventory of Complicated Grief (ICG) has greatly improved this situation. This instrument provided a way of identifying people with clinically significant grief-related syndrome, and for measuring the outcome of treatments targeting this syndrome. We have new developed such a treatment, called Traumatic Grief Treatment and completed pilot testing that shows it to be highly promising. The purpose of this presentation is to describe this manualized 16-session psychotherapy intervention and to present results

from 21 patients who agreed to undergo this therapy. We will illustrate these results with case vignettes from patients we have treated.

No. 48C
BEREAVEMENT AFTER VIOLENT DYING: DESCRIPTION AND CONCEPTUAL FRAME

Edward K. Rynearson, M.D., *Department of Psychiatry, Mason Medical Center, P.O. Box 1980, MS D1-SPL, Seattle, WA 98111*

SUMMARY:

Violent dying from homicide, suicide, or accident is followed by an intense and prolonged traumatic response to the imaginary reenactment of the dying in a significant minority (30% to 40%) of family members that interferes with functioning for many months or years. Since 1989, the author (ER) has served as the medical director of a community-based support intervention (Homicide Support Project) for families in the greater Seattle area following a homicidal death. We have treated over 1,000 family members, published studies documenting the intense level of trauma distress in survivors, and developed manualized, short-term group interventions. Through a grant from the U.S. Department of Justice, we have trained clinicians at 14 sites across the U.S. who are using our protocols for screening and outcome. This presentation describes the Homicide Support Project and the rationale for focused screening and an outline of our short-term intervention, which may be applied in group or individual therapy.

No. 48D
CLINICAL SCREENING BATTERY, TREATMENT IMPLICATIONS, AND SHORT-TERM GROUP INTERVENTION OUTCOMES

Jennifer L. Favell, Ph.D., *Homicide Support Project, Virginia Mason Medical Center, P.O. Box 1930 MS D1-SPL, Seattle, WA 98111*

SUMMARY:

The Restorative Retelling and the Criminal Death Support group models are 10-week interventions for treating family members and friends of homicide victims. The focus is on the synergism of traumatic grief, depression, death imagery, intrusive, avoidant and physiological hyperarousal, and comorbid drug/alcohol use.

Data analyses (not yet available) will be presented on the use of a clinical screening battery consisting of the Inventory of Traumatic Grief, the Beck Depression Inventory, the Impact of Events Scale-Revised, the Death Imagery Scale, and the Drug/Alcohol Screening Test. Batteries were collected on a total of 80 adult co-victims in treatment groups in Seattle, San Diego, and the Bronx. A cohort of 40 adolescents incarcerated at Echo Glen Children's Center, Snoqualmie, Washington, will also be included.

No. 48E
PHARMACOLOGIC TREATMENT OF BEREAVEMENT COMPLICATIONS

Sidney Zisook, M.D., *Department of Psychiatry, UCSD, 9500 Gilman Drive, # 0603R, La Jolla, CA 92095*

SUMMARY:

One of the consistent rewards of working with bereaved individuals is observing them overcome often seemingly insurmountable turmoil. Bereavement is testimony to the adaptive capacities of humankind. Not only do most bereaved individuals get through their acute distress and anguish, but often they grow through the experience, astounding even themselves by their evolving autonomy, wisdom, and perspective. Yet, under certain circumstances in particularly vulnerable persons, bereavement can lead to persistent and agonizing grief experiences (i.e., traumatic bereavement) or precipitate or intensify an independent psychiatric disorder. In either of these situations, psychotherapeutic or pharmacologic interventions may be indicated. Although the published data on pharmacologic management of bereavement-related conditions are relatively sparse, what data there are support efficacy and a positive risk: benefit ratio. No published studies support the outworn notion that medications interfere with grief; they consistently show that medications not only help the conditions for which they are prescribed, but by so doing, simultaneously aid grief resolution. These points will be illustrated by discussing both open and controlled pharmacologic studies on traumatic bereavement and depression. Two studies using tricyclic antidepressants, three with serotonin reuptake inhibitors, and one with bupropion-SR will be reviewed. Following the review, guidelines for medication management will be proposed.

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1. Prigerson HG, Shear MK, Jacobs SC, Reynolds CF III, et al: Consensus Criteria for Traumatic Grief: a preliminary empirical test. British Journal of Psychiatry 1999; 174:67–73
2. Shear MK, Frank E, Foa E, et al: Traumatic grief therapy: a pilot study, submitted for publication
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SYMPOSIUM 49—PSYCHOTHERAPY VIEWED FROM A BASIC SCIENCE SOCIAL BRAIN PERSPECTIVE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) describe the "basic science social brain perspective" and explain how this has implications for a different view of psychotherapy including psychopharmacology, (2) demonstrate how ideas stemming from an evolutionary psychological point of view extend biological views of psychotherapy, notably across-species contrasts and comparisons and the neo-darwinian perspective on memes in the context of hypnosis.

No. 49A
SOCIOPHYSIOLOGICAL EXEGESIS OF MICHELS' "THINKING WHILE LISTENING"

Russell Gardner, M.D., *Department of Psychiatry, Medical College of Wisconsin, 214 Du Rose Terrace, Madison, WI 53705-3323*

SUMMARY:

Robert Michels described psychoanalytic psychotherapy as now practiced. The therapist listens so the patient's productions influence the therapist's theory-conditioned mental state while paying special attention to, and remarking on, patterning of speech content and discordances in its flow and amongst the redundant channels of presentation. The therapist participates in, and helps explain, transference dramas that reflect unconscious scenarios in the patient's life.

This exegesis highlights similarities and differences between psychotherapy as a human communication and communications of other animals. In common, the therapist communicates nurturance while maintaining a greater rank. However, despite a relative alpha status, he is also the patient's ally, similar to that portrayed in DeWaals' chimpanzees, but restricted to the treatment. Flexible social rank relatedness with great sociotropy along with use of story-lines uniquely characterize humans. Another human-specific factor emphasizes the patient's personal story-line. In good therapy, the patient rewrites this story for greater adaptation to his present life. Description of psalics used by both participants assist discussion of communicational contrast-comparisons. Psalics are propensity states antedating language in communication and are defined by their presence in normal and mentally ill humans and in non-human animals. This analysis points to sociophysiological principles that assist eventual genome-brain-behavioral analyses.

No. 49B
PSYCHIATRY AND BIOLOGICAL PSYCHOTHERAPY

Frank G. Koerselman, M.D., *Department of Psychiatry, University of Utrecht-Medical Center, Heidelberglaan 100, Utrecht CX-3584, Netherlands*

SUMMARY:

Medicine aims at restoring dysregulations of the organism's adaptation. Doctors treat dysregulations of functional (i.e. digestive, respiratory) tracts that consist of interconnected organ systems. They do so at different levels ranging from the molecular (medication) to the individual and social level (revalidation). Therefore, they have to *translate* the patient's complaints into organismic dysfunction, and back into its social consequences.

Psychiatry is concerned with man's "*mental tract*" consisting of numerous interwoven neuronal subsystems, and connected to sensory, nervous, endocrine, and immune pathways. Its key function is information processing, ultimately aimed at survival of the individual and species. This relates meaning to evolutionary themes like physical safety, attachment and loss, territorial power, or reproduction. So the psychiatrist has to translate his patient's complaints into dysfunctions of the mental tract.

In doing so the psychiatrist corrects dysregulated neuronal systems with medication, but he also revalidates dysfunctional information processing with communicative techniques, i.e., with psychotherapy. All of this makes clear how much psychiatry is in need of a new nosology that concentrates on real biological mental (dys)functions. Only then will psychiatrists be able to become "biologists of the mind" in combining functional pharmacotherapy with a "*biological psychotherapy.*"

No. 49C
MEMES, MUTUAL SUGGESTION, AND PSYCHOTHERAPY

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health Sciences University, V7MHCV, Box 1035, Portland VAMC, Portland, OR 97207-1035*

SUMMARY:

Memes are proposed cultural replicators, purportedly subject to a cultural selection analogous to natural selection of genes. Their analysis, "mimetics," postdicts such seeming anomalies as the evolution of language, prominence of false belief systems, and genetic altruism. As rigorous science, this analysis is problematic due to the observed context dependence of psychological realities, and resulting untestability. Reciprocity theory provides an alternative, by predicting a coevolutionary tension between honest and deceptive communications. A hypothesized added step is needed: two or more individuals detect one another's deceits but respect them, act as though deceived, and thereby "legitimize" what is now a new "psychological reality." Covert aspects of this process correspond with "mutual suggestion." By this model, memes are necessarily dyadic, inseparable from their mode of transmission, and reinforced sufficiently to convey an image of objectivity. This hypothesis has been tested and confirmed by otherwise paradoxical data from over two centuries of hypnosis research: that human experience, consciousness, and volition occur on multiple levels, and that their structures are profoundly dependent on the context within which they are defined. Psychotherapeutic implications include communication at multiple levels, remaining cognizant of mutual suggestion, and skilled use of reframing to imply and enhance greater mental health.

REFERENCES:

1. Gardner R: The brain and communication are basic for clinical human sciences. British Journal of Medical Psychology 1998; 71:493–508
2. Michels R: Thinking While Listening, Invited Presentation, APA, May, Chicago, IL. Recorded at meeting
3. McGuire, MT, Troisi A: Darwinian Psychiatry. New York, Oxford University Press, 1998
4. Beahrs JO: Hypnotic transactions, and the evolution of psychological structure. Psychiatric Medicine 1992; 10(1):25–39

SYMPOSIUM 50—HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART III

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to (1) develop an individual strategy for launching a successful private practice while maximizing your strengths and interests; (2) learn techniques that will give you the necessary edge to succeed in a competitive marketplace.

No. 50A
PERSONAL FACTORS LEADING TO A SUCCESSFUL PRIVATE PRACTICE

Ann S. Maloney, M.D., *123 East 37th Street, New York, NY 10016-3030*

SUMMARY:

Dr. Maloney will discuss the biggest risks for failure and individual issues that must be accounted for if you are to be successful. Ways to avoid being pulled into unethical behavior are addressed. Having an attorney review your office contracts and avoiding getting taken advantage of in the business and professional world will be detailed. Broad issues for professional success will be covered, including recognizing your own professional value, developing a business plan, and keeping your financial expectations realistic.

No. 50B
OFFICE LOCATION AND DESIGN FOR EFFICIENCY AND SUCCESS

Barry W. Wall, M.D., *184 Waterman Street, Providence, RI 02906*

SUMMARY:

Dr. Wall will discuss the details of office location and design. We 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. 50C
STREAMLINING OVERHEAD AND MANAGING YOUR BUSINESS IN PRIVATE PRACTICE

Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*

SUMMARY:

Dr. Young will discuss streamlining all aspects of your practice to limit overhead while maximizing earnings and quality. Tips about minimizing personal and office expenses will be offered. Setting fees, billing, scheduling appointments, missed appointments, and other areas will be covered.

Dr. Young will also outline necessary insurance, retirement, and banking systems, as well as taxes and areas of potential difficulty for psychiatrists starting a new practice.

Finally, the roles of technician, manager, and entrepreneur, which are essential to success in a small business, will be discussed as they apply to psychiatric practice.

No. 50D
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 your door. Concepts of branding so that you are distinguishable from the rest of your peers are examined. Marketing also requires persistent visibility and developing name recognition within a region, and then within the segments of that region that you are best equipped to serve.

Dr. Callahan has developed an extensive list of different ideas and ways to do this, which you can tailor to your own area and strengths. The focus in the start-up phase of practice is on methods that will cost you time, but not money since time is usually more available than money in this phase.

REFERENCES:

1. Logsdon, L: Establishing A Psychiatric Private Practice, Washington, D.C. American Psychiatric Press, Inc., 1985
2. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996
3. Gerber, ME: The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About It. Harper-business, ISBN 0887307280, 1995
4. APA Office of Healthcare Systems and Financing: Practice Management for Early Career Psychiatrists, 1998

SYMPOSIUM 51—THINKING ABOUT MIND AND BRAIN: PSYCHOANALYSTS AND NEUROSCIENTISTS CONVERSE: PART II

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to relate recent neurobiological findings regarding affect activation to contemporary psychoanalytic affect theory.

No. 51A
AFFECT THEORY: NEUROBIOLOGICAL FINDINGS AND PSYCHOLOGICAL STRUCTURES

Otto F. Kernberg, M.D., *Department of Psychiatry, New York Hospital/Cornell, 21 Bloomingdale Road, White Plains, NY 10605-1504*

SUMMARY:

Recent neurobiological findings regarding affect activation include the integration of structural analysis of brain areas activated during affective responses as studied by imaging technics, the pathophysiology of the HPA axis related to chronic stress, and the neurotransmitters released during particular affect activation.

The psychoanalytic exploration of affects as basic interpersonal communicative systems has placed affects as the "building blocks" of both drives and an internalized world of self and object representations. The new knowledge in both fields of inquiry may be related in a systemic understanding of the behavioral, neurocognitive, and psychophysiological aspects of affect activation. This facilitates combined and integrative methods of research in this area, but also raises the danger of a premature and reductionistic effort to integrate neurobiological and psychoanalytic formulations.

No. 51B
A BIOLOGICAL ANALYSIS OF TRANSFERENCE

Mark G. Barad, M.D., *Department of Psychiatry, UCLA, 695 Charles Young Drive, South, Los Angeles, CA 90095-1761*

SUMMARY:

Transference, the misapplication of a fixed template of interpersonal behavior and experience to inappropriate targets, is central to all psychodynamic psychotherapy, but its anatomical and physiological substrates remain completely undefined, leaving psychiatry without means, beyond the intuitions of trained therapists, to analyze or manipulate the transference.

However, transference shares important characteristics with behaviors widely conserved throughout the animal kingdom, and particularly among social mammals. For example, transference is a critical period phenomenon, depending on patterns fixed during an early window of developmental plasticity that closes long before adulthood. Further, transference characteristically involves two major issues in social relationships, those of basic attachment and trust, termed pre-oedipal, and of competition within and without the family, termed oedipal. Promising rodent models exist for each of these features. Even the therapeutic "analysis of transference" may be modeled by behavioral extinction of fear, which is not simply erasure, but rather the embedding of an intact, though often unconscious, pattern of fear, inside and inhibitory pattern of learned safety. Scientific analysis of these animal models may yield both a testable biological hypothesis of how psychodynamic psychotherapy works and a variety of pharmacological adjuncts to make such therapy more effective and more efficient.

No. 51C
PRIMITIVE DREAMS AND NEUROPSYSIOLOGICAL MARKERS OF BORDERLINE OR PSYCHOTIC STATES

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, #114, New York, NY 10024-6027*

SUMMARY:

Contrary to Freud's original dictum—that in dreams the ego cannot conceive of its own death—dreams of being dead do occasionally occur in patients with borderline or other severe personality disorders, or in those with psychosis. Such dreams are apt to occur at times

of high interpersonal stress. Patients of these types will also at times report extremely primitive dreams in which the body is grossly mutilated, where animals or monsters are about to consume one's body, etc. Higher functioning patients (those considered neurotic in the older nosology) almost never report such dreams. The dreams of death or mutilation serve, in effect, as neurophysiological markers of serious psychopathology, and are in some cases the first indication of severe pathology to come to the attention of the clinician. Examples will be given of these dreams of death and mutilation in borderline, schizotypal, and other patients, along with recommendations for how therapists may deal most effectively with such material. The theoretical implications will also be discussed; namely, the relationship to posttraumatic stress disorder, and what brain pathways may be involved in the failure, during REM sleep, to block out such primitive dream material.

No. 51D
EARLY EMPIRICAL PSYCHOANALYTIC RESEARCH AND MODERN NEUROSCIENCE

Samuel Slipp, M.D., *Department of Psychiatry, NYU School of Medicine, 220 Chesnut Street, Englewood, NY 07631*

SUMMARY:

The earliest studies to validate psychoanalysis were by subliminal stimulation, where visual stimuli were presented below perceptual awareness. The effect of specific subliminal stimuli on specific unconscious fantasies could be measured by behavioral and emotional consequences. One message, Mommy and I are One, was found to be ameliorative for many conditions, probably due to the inborn need of infants to bond with mother for survival, and forming the core of the self.

We tested my double-bind theory of neurotic depression, in which the child is pressured to achieve, accompanied by an implicit threat of rejection. But when the child does achieve, it is not gratified, thus blocking individuation. We found with depressed women and with underachieving high school boys and girls that when the relationship with the mother was pressured and intrusive, the Mommy and I are One message was not ameliorative. Recent subliminal studies combined with neuroimaging found the amygdala is activated, which is consistent with its role in unconscious processing of emotions. The importance in therapy of creating a condition of safety and respecting the patient's autonomy helps create a good mother transference so old memories can be detoxified and new pathways from the cortex to the amygdala established.

REFERENCES:

1. Kernberg DF: Aggression in Personality Disorders and Perversion. New Haven, Yale University Press, 1992
2. Kendel ER: Biology and the future of psychoanalysis: a new intellectual framework for psychiatry revisited. Am J Psychiatry 1999; 156:505–24
3. Koenigsberg HW, Kernberg OF, Stone MH, Appelbaum AH, et al: Borderline Patients, NY, Basic Books, pp 207–28, 2000
4. Whalen PJ, Rausch SL, Etcoff NL, et al: Masked presentations of emotional facial expressions modulate amygdala activity, without explicit knowledge. The Journal of Neuroscience 1998; 18:411–418

SYMPOSIUM 52—PSYCHOTHERAPEUTIC ASPECTS OF HIV

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) list the current and future epidemiological and cultural challenges in HIV psychiatric care, (2) acknowledge HIV counseling and testing as an important and routine practice, (3) identify psychotherapeutic methods and strategies in working with HIV infected patients, (4) recognize the issues and challenges with HIV risk patients and consequential interventions.

No. 52A
EPIDEMIOLOGY: SHIFTING POPULATIONS, SHIFTING CULTURAL CONCERNS

Warren M. Liang, M.D., *Department of Psychiatry, University of Cincinnati, PO Boc 670559, Cincinnati, OH 45267*

SUMMARY:

The rate of new HIV infections in the United States is dramatically lower than at the start of the epidemic; however, infection rates have remained steady, at approximately 40,000 new cases per year. Dramatic progress in treatment, resulting from a major investment in clinical research, has resulted in delayed onset of AIDS for many individuals and restoration of better health for many already diagnosed with AIDS. Yet, major questions remain unanswered regarding the best use of these treatments, and differential access to these treatments underscores deficiencies in U.S. health care delivery and financing systems. Along with these questions, we now have a much broader understanding of the communities affected by HIV. Nonetheless, the continuing stigmatization of the groups affected by HIV and the behaviors associated with the disease create an impediment to successful public health and psychiatric interventions. This session will outline the latest epidemiology, discuss communities at particular risk, and provide suggestions to help address challenges and barriers in psychiatric practice to patients from these communities.

No. 52B
WHAT ROLE DO PSYCHIATRISTS HAVE IN PROVIDING BASELINE AND CONTINUING HIV COUNSELING AND TESTING?

Robert S. Stasko, M.D., *Department of Psychiatry, George Washington University, 730 24th Street, #12, Washington, DC 20037*

SUMMARY:

Despite their potential to reduce the incidence of HIV infection through primary prevention, it is estimated that many physicians and psychiatrists do not conduct routine identification of patients' risk behaviors and offer consequential HIV counseling and testing. This may reflect perceptions that few patients are at risk, that patients will self-disclose during consultations, or that a psychiatrist-initiated approach is unacceptable to patients presenting for non-HIV–related psychiatric problems.

Because of the dramatic impact that HIV/AIDS has on the lives of individuals and entire communities, ongoing risk assessment and HIV counseling and testing should be as common as any other routine practice or medical test. In this session, faculty will introduce risk assessment tools for sexual and substance abuse using behavior histories, compelling ideas about the ongoing practice of assessment and HIV counseling and testing, and outline some the challenges

to patients and psychiatrists regarding the counseling and testing process.

No. 52C
PSYCHOTHERAPY WITH PEOPLE LIVING WITH HIV

Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130*

SUMMARY:

HIV infection cuts across so many biopsychosocial areas and issues, no single school of practice or therapeutic approach can serve the HIV+ patient's needs throughout the course of illness. As patients experience emotional milestones, such as finding out the HIV diagnosis, considering disclosure issues, initiating or continuing healthy behaviors, beginning complex and difficult treatment regimens with adherence challenges, and confronting ambiguity regarding long-term treatment benefits and serious side effects and risks, psychiatrists are in a unique position to assist patients with these and other overlapping psychosocial issues that will be encountered. However, unless a clinician is prepared to act flexibly and compassionately with the infected person, the therapeutic relationship could be jeopardized. During this session, faculty will discuss some of the challenges that HIV+ persons have to deal with, offer guidelines as to how to conduct psychotherapy, identify the strengths and limitations of various approaches, and outline some of the unique challenges that psychiatrists may have to deal with on a personal and professional basis.

No. 52D
THERAPEUTIC INTERVENTIONS WITH THE HIGH-RISK PATIENT

Kenneth B. Ashley, M.D., *Department of Psychiatry, Beth Israel Hospital, 85 East 10th Street, #1F, New York, NY 10003-5407*

SUMMARY:

Although HIV disease can be seen as typically caused by behaviors under voluntary control, high-risk behaviors are often difficult to change. This can make successful psychiatric interventions difficult because of the powerful momentary gratification of unprotected sexual pleasure, emotional and mental escape, heightened physical/sexual intimacy, and the use of substances. At other times risky behaviors can reflect cultural or sex-role expectations or the effects of mental illness. Because of the strong link between HIV-risk behaviors and psychiatric and psychosocial variables, it is important to consider prevention and risk factors with all patients, especially those engaging in high-risk behaviors. While prevention interventions are primarily aimed toward those uninfected, it is also important to consider prevention and risk factors with patients who have HIV disease in order to minimize the transmission of HIV to others. During this presentation faculty will outline the issues involved in working with patients engaging in high-risk behaviors, point out challenges to and barriers with risk/harm reduction, and offer psychotherapeutic methods and strategies for working with uninfected patients as well as those living with HIV.

REFERENCES:

1. Fleming PL, et al: Tracking the HIV epidemic: current issues, future challenges. Am J Public Health 2000; 90(7):1037–41
2. Guglielmo WJ: Why more doctors aren't testing for HIV. Med Econ 1999; 76(11):180–2, 187–8, 191–2
3. Farber EW, McDaniel JS: Assessment and psychotherapy practice implications of new combination antiviral therapies for HIV disease. Professional Psychology: Research and Practice 1999; 30(2):173–9
4. Peterson JL, DiClemente RJ (Eds): Handbook of HIV Prevention. New York, Kluwer Academic/Plenum Publishers, 2000

SYMPOSIUM 53—A MOST COMMON CHALLENGE: THE DUAL-DIAGNOSED PATIENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will understand the biopsychosocial care and treatment of patients with both bipolar disorders and substance-related disorders, especially with alcohol, cocaine, or opioids.

No. 53A
TREATMENT OF PATIENTS WITH BIPOLAR DISORDERS AND ALCOHOLISM

Richard J. Frances, M.D., *Silver Hill Foundation, 208 Valley Road, New Canaan, CT 06840,* Avram H. Mack, M.D.

SUMMARY:

Alcohol problems are the principle comorbidity of bipolar disorder with 60% to 80% of bipolar patients exhibiting abuse or dependence. Bipolar disorder frequently contributes to a need for inpatient treatment in manic depressive alcoholics. Dual diagnosis patients tend to have poorer prognosis, higher rates of suicide, higher relapse rates for both disorders, and are more costly to treat. Bipolar illness and alcoholism both often start in adolescence and young adulthood and lead to social stigma. Treatment of the dual diagnosis patient requires close attention to both disorders.

If a bipolar patient stops taking a mood stabilizer, the greatest danger for alcohol relapse results from a recurrence of mania with disinhibition occurring even in patients who follow a solid AA program. Depression can also lead to self-medication with alcohol. Similarly a relapse to alcohol will contribute to a relapse to depression, affects compliance, and reduces effectiveness of medication. Patients with alcoholism and bipolar illness tend to have significant denial leading to poor compliance. Patients and families need motivational psychoeducation regarding treatment of both illnesses. Considerable flexibility and support are essential therapist qualities.

Aspects of modifications of psychotherapeutic technique required to provide integrated treatment, and tailoring psychopharmacologic approaches to this population will be highlighted.

No. 53B
TREATMENT OF COMORBID BIPOLAR DISORDER AND COCAINE ADDICTION

David A. Gorelick, M.D., *Clinical Pharmacology, NIH NIDA IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224-0180*

SUMMARY:

Past or current abuse of cocaine and other stimulants is found in up to one-third of patients with bipolar affective disorder. Comorbid cocaine addiction is important to detect because it adversely affects the course of illness and outcome of treatment. Diagnosis can be difficult because stimulant intoxication can mimic mania and stimulant withdrawal can mimic depression. Data from urine drug testing and collateral sources of information can be helpful in making the diagnosis. A history of cocaine use is associated with shorter interval to first psychiatric hospitalization, greater number of hospitalizations, greater suicide risk, less chance of remission, and more difficulty

in treating tactile hallucinations. Cocaine use may also increase the risk of neuroleptic-induced acute dystonic reactions. Lithium and anticonvulsants such as carbamazepine and valproate are the primary medications used in treatment. There is some evidence that treatment of the bipolar disorder will also reduce concurrent cocaine use. There is limited evidence that anticonvulsants may be more effective than lithium in this patient population. Psychosocial approaches such as contingency management to improve treatment compliance and relapse prevention counseling can be helpful.

No. 53C
TREATMENT OF PATIENTS WITH BIPOLAR DISORDERS AND HEROIN ABUSE

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032*

SUMMARY:

Although bipolar disorder is commonly comorbid with substance abuse, it is least frequent with heroin compared with the other major drugs of abuse. Possible reasons for this will be discussed. Treatment for both disorders should progress concurrently since either left untreated can destabilize the other. Although a variety of medications exist for effective treatment of either disorder, there does not appear to be overlap so no one medication can treat both conditions at this time. In comparison to treatment of other abused substances, heroin dependence has the greatest range of available medications. These include full agonists such as methadone and LAAM, partial agonists such as buprenorphine, and antagonists such as naltrexone. Advantages and disadvantages of each medication will be discussed as well as which patients may be most suitable. Alpha-adrenergic agonists such as clonidine can both effectively manage the withdrawal syndrome and may have a role in ameliorating craving. The role of mood stabilizers or anticonvulsants in treating the protracted withdrawal syndrome is worth exploring. The most interesting new development for the near future is the sublingual combination of buprenorphine and naloxone, which may be able to be prescribed in office-based settings and thus lead to mainstreaming of heroin dependence treatment.

No. 53D
GROUP PSYCHOTHERAPY FOR BIPOLAR PATIENTS WITH SUBSTANCE ABUSE

Mark J. Albanese, M.D., *Department of Psychiatry, Tewksbury Hospital, 365 East Street, Tewksbury, MA 01876*; Edward J. Khantzian, M.D.

SUMMARY:

Epidemiologic studies reveal that the prevalence of substance use disorders is higher among bipolar patients than in the general population. A substance use disorder is associated with poorer treatment outcomes for bipolar patients. Research indicates that outcomes are improved when both substance abuse treatment is integrated with psychiatric care, and psychopharmacological interventions are enhanced by psychosocial modalities such as group therapy.

This paper will review the literature on group psychotherapy for bipolar patients with substance use disorders. It will go on to describe the group program in our state hospital's integrated inpatient dual-diagnosis treatment track. We will focus on Khantzian's Modified Dynamic Group Therapy (MDGT), which is a therapeutic offspring of the self-medication hypothesis (SMH) of the addictions. The SMH understands substance abuse as an attempt to provide control for affective dyscontrol. MDGT focuses on the interplay between affect dysregulation and substance use.

No. 53E
INDIVIDUAL PSYCHOTHERAPY WITH THE DUAL-DIAGNOSED PATIENT

George E. Woody, M.D., *Philadelphia VAMC, University and Woodland Avenue, Philadelphia, PA 19104*

SUMMARY:

Studies have now been completed providing data on the role of psychotherapy for addictive disorders. These studies have used random assignment, standardized treatments, a wide range of outcome measures, and obtained high follow-up rates. The two largest—Project MATCH and the NIDA Cocaine Collaborative Study—compared psychotherapy with addiction focused approaches such as drug counseling or 12-step facilitation. In general, patients receiving psychotherapy demonstrated substantial improvement in the target symptoms of drug or alcohol use and usually in other areas as well. In project MATCH, improvements were generally similar among patients in all treatment groups. In the NIDA cocaine psychotherapy study, patients receiving drug counseling did better than psychotherapy patients.

In two of the studies done with methadone patients, psychotherapy was associated with significantly more improvement among those with high levels of psychiatric symptoms.

These findings, taken together, suggest that a substance-focused treatment such as drug counseling or 12-step facilitation is essential in substance abuse treatment and in many cases is sufficient. Psychotherapy can be used with positive effects, but its special effects may be limited to patients with moderate to high levels of psychiatric symptoms, and who are also receiving a potent pharmacotherapy that reduces the compulsive drug use associated with substance dependence.

REFERENCES:

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2. Goldberg JF, Garno JL, Leon AC, et al: A history of substance abuse complicates remission from acute mania in bipolar disorder. Journal of Clinical Psychiatry 1999; 60:733–740
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4. Albanese MJ, Khantzian EJ: Self-medication theory and modified dynamic group therapy. Group psychotherapy of substance abuse. Edited by Brook DW, Spitz HI. Washington, DC, American Psychiatric Press, in press
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SYMPOSIUM 54—
PSYCHOPHARMACOLOGY OF BPD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand the specific pharmacologic treatment choices available in the treatment of borderline personality disorder, and appreciate the indications, benefits, and side effects of each choice.

No. 54A
OLANZAPINE TREATMENT OF FEMALE BORDERLINE PATIENTS

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

SUMMARY:

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

Method: We conducted a double-blind, placebo-controlled study of olanzapine in 28 female subjects meeting Revised Diagnostic interview for Borderlines (DIB-R) and DSM-IV criteria for BPD. The subjects were randomly assigned to olanzapine or placebo in a 2:1 manner. Treatment duration was six months. Primary outcome measures were self-reported changes on the interpersonal sensitivity, anxiety, anger/hostility, psychoticism, paranoia, and depression scales of the Symptom Checklist 90 (SCL-90). Secondary outcome measures were changes on the positive scale of the Positive and Negative Syndrome Scale (PANSS), the Hamilton Depression Inventory (HDI), the Dissociative Experiences Scale (DES), and the Global Assessment of Functioning scale (GAF).

Results: Nineteen subjects were randomized to olanzapine; nine to placebo. Using a last observation carried forward paradigm and controlling for baseline severity, olanzapine achieved a significantly greater percent change than placebo on all of the above measures except the DES. Using random effects regression modeling of panel data and controlling for baseline level of severity, olanzapine was associated with a significantly greater rate of improvement over time than placebo in the areas of interpersonal sensitivity, anxiety, anger/hostility, paranoia, dissociation, positive PANSS symptoms, and CAF. Weight gain was modest in the olanzapine-treated group and no serious movement disorders were noted.

Conclusions: Olanzapine appears to be a safe and effective agent in the treatment of women with criteria-defined borderline personality disorder, significantly affecting all four core areas of borderline psychopathology (i.e., affect, cognition, impulsivity, and interpersonal relationships).

Supported, in part, by Ell Lilly.

No. 54B
DIVAPROEX SODIUM TREATMENT OF WOMEN WITH BPD

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

SUMMARY:

Objective: The intent of this study was to compare the efficacy and safety of divalproex sodium and placebo in the treatment of women with borderline personality disorder (BPD) and comorbid bipolar II disorder.

Method: We conducted a placebo-controlled, double-blind study of divalproex sodium in 30 female subjects meeting Revised Diagnostic Interview for Borderlines (DIB-R) and DSM-IV criteria for BPD and modified DSM-IV criteria for bipolar II disorder. Subjects were randomly assigned to divalproex sodium or placebo in a 2:1 manner. Treatment duration was six months. Primary outcome measures were changes on the interpersonal sensitivity and anger/hostility scales of the Symptom Checklist 90 (SCL-90). Secondary outcome measures were changes on the Hamilton Depression Inventory (HDI) and the Overt Aggression Scale Checklist (OASCL).

Results: Twenty subjects were randomized to divalproex sodium; ten subjects to placebo. Using a last observation carried forward paradigm and controlling for baseline severity, divalproex sodium proved to be superior to placebo in diminishing interpersonal sensitivity and hostility as measured by the SCL-90 and OASCL. Adverse effects were infrequent.

Conclusions: Compared with placebo, divalproex sodium is a safe and effective agent in the treatment of irritability and hostility in women with borderline personality disorder and bipolar II disorder.

Supported, in part, by Abbott Laboratories.

No. 54C
SSRIS IN BPD: UNRESOLVED ISSUES

Paul S. Links, M.D., *Department of Psychiatry, St. Michael's Hospital-University of Toronto, 30 Bond Street, Toronto, ON M5B 1W8, Canada*; Ian C. Dawe, M.D., Rahel Eynan-Harvey, M.A.

SUMMARY:

Introduction: Specific serotonin reuptake inhibitors (SSRIs) are one of the most studied medications in borderline personality disorder (BPD). Five published, randomized, controlled trials exist; however, in two, the samples included mixed personality disordered groups. Cocarro and Kavoussi (1997) demonstrated efficacy of fluoxetine versus placebo in non-depressed but aggressive personality disordered subjects. Vekes et al. (1998) studied a mixed personality disordered group at risk for recurrent suicidal behavior and demonstrated the efficacy of paroxetine in reducing attempts in certain subjects.

Method: This is a study of a randomized, double-blind trial of paroxetine versus placebo in subjects with BPD. Outcomes were assessed at 24 and 48 weeks after randomization.

Results: A total of 200 subjects were screened for the study but only 12 reached the point of randomization. A high dropout rate (40%) and previous exposure to paroxetine (56%) adversely affected implementation of the study and appreciation of the results.

Conclusion: In general, SSRIs are effective in reducing impulsivity and aggression independent of any effects on depressive symptoms, but future research must study patients meeting the full criteria for BPD, and the subjects need to be assessed over longer periods for both functional and symptomatic outcome. In order to achieve this end, a multicenter collaborative study is needed to refine pharmacologic interventions in BPD. Unresolved is the efficacy of SSRIs in modifying the course and outcome of BPD.

No. 54D
MEDICATION CHOICE IN BPD

Kenneth R. Silk, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, CFOB 2915, Ann Arbor, MI 48109*; Lawrence Thompson, Ph.D., Joann Heap, C.S.W., Naomi Lohr, Ph.D.

SUMMARY:

Introduction: No specific medication is indicated for the treatment of borderline personality disorder, (BPD), yet most BPD patients are treated with medication. Further, there are few placebo-controlled studies of medication treatment for BPD.

Method: A survey designed to determine which medications were preferred for the treatment of BPD was conducted of all the M.D./D.O. psychiatrists (residents, fellows, and faculty) in the department of psychiatry, University of Michigan. Respondents were asked for (1) their first choice and then their second choice of medication, (2) the source of the information that led to the medication choice, and (3) for what symptoms or symptom complexes the medications were to address.

Results: Eighty-five of 114 questionnaires were returned (response rate = 74%). Almost 50% of the respondents would use an SSRI as their first-choice medication, 20% a mood stabilizer, 20% a non-

SSRI antidepressant, and 10% an antipsychotic. Second choice of medications: antipsychotics 37%, mood stabilizers 33%, SSRIs 13%, non-SSRI antidepressants 9%, and anxiolytics 5%. Reasons for medication choice: 77% because it made valid clinical sense, 66% because of what they read in the literature, 64% because it was suggested by a teacher or supervisor, and 25% because it had been recommended by a colleague. Gender and age of clinician appeared to influence the category of most preferred medication.

Conclusion: Even within one institution, no specific medication is routinely used for BPD.

No. 54E
IMPULSIVITY: THE PRIMARY TARGET SYMPTOM 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:

Introduction: There are no medications that are specifically indicated for the treatment of borderline personality disorder (BPD), and more work is needed in order to appreciate better the specific target symptoms of various pharmacologic interventions used in patients with BPD.

Method: A review of the literature on the impact and success of pharmacologic interventions in BPD was undertaken. The review was conducted by examining the literature on all clinical drug trials of BPD as published in MEDLINE since 1980.

Results: The review revealed that the medications that have been shown to have clinical benefit in BPD, which include neuroleptics, SSRIs, and mood stabilizers, appear to be most effective against impulsive symptoms; and these medications appear to be least effective against the affective lability that characterizes the disorder of BPD. It is further of interest that similar observations may apply to the effects of psychotherapy in BPD.

Conclusion: These findings could be accounted for if impulsivity is thought of as a final common pathway emerging from complex interactive mechanisms. It is also possible that treatment of BPD may interfere with cyclic relationships between impulsivity and other symptoms and symptom clusters known to occur in patients with BPD. In conclusion, it appears that impulsivity is a primary target symptom in the treatment of BPD.

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SYMPOSIUM 55—PSYCHOANALYSIS AND PSYCHOTHERAPY LONG-TERM OUTCOME

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand some aspects of the therapeutic interventions and outcomes in psychoanalysis and long-term psychotherapy in treatment-resistant disorders.

No. 55A
THERAPIST INTERVENTIONS IN COMPLETED PSYCHOANALYSES: THE PENN PSYCHOANALYTIC TREATMENT COLLECTION

Elisabeth Banon, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 3755 Cote Ste-Catherine Road, Montreal, QC H3T 1E2, Canada*; John C. Perry, M.D., Lester Luborsky, M.D., Carmella Roy, M.D.

SUMMARY:

Psychoanalytic theory on technique predicts that structural change comes about with expressive work, more specifically with interpretations of the transference. We examined therapist interventions in a sample of patients having completed psychoanalysis with emphasis on patterns of change in technique between early and late sessions. Our sample consisted of 17 subjects from the Penn Psychoanalytic Collection whose analysis was entirely audiotaped with selected sessions later transcribed. Subjects were seen four times weekly for a total number of sessions at completion ranging between 400 and 1,500. Two early and two late (90% completion point) sessions per subject were coded using the Psychodynamic Interventions Rating Scale (PIRS) by an independent rater blind to session number and to defensive functioning. Therapist interventions were divided into three categories: supportive, expressive, and therapy-defining. Expressive interventions were subdivided into transference and defense interpretations, each rated on a level of 1 to 5, quantifying depth of interpretation. We derived an expressive to supportive level of intervention (ESLI) ranging from 7, entirely expressive to 1, entirely supportive. Overall, from early to late sessions, analysts tended to be less active and more expressive (0.5 point increase in ESLI). They delivered significantly fewer therapy-defining interventions and significantly more expressive interventions. However, only defense and not transference interpretations increased significantly. As well, only defense interpretations increased in depth. These findings on analyst technique will be examined in the context of change in subjects' defensive functioning.

No. 55B
CHANGES IN DEFENSIVE FUNCTIONING IN COMPLETED PSYCHOANALYSES: THE PENN COLLECTION

Carmella Roy, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, QC H3T 1E4, Canada*; John C. Perry, M.D., Elisabeth Banon, M.D., Lester Luborsky, M.D.

SUMMARY:

Psychoanalytic theory predicts that patients completing analysis should improve in their dynamic functioning. Our aim is to examine whether a sample of patients who had completed their psychoanalysis showed improvements in their defense mechanisms.

Seventeen subjects from the Penn Collection were seen four times weekly, for a total number of 148 to 1,666 sessions. Up to three early and three late sessions were randomized and blinded. Defenses were rated by two raters blind to other data using the Defense Mechanism Rating Scales (DMRS). Descriptive measures of functioning were rated by two other raters.

The median intraclass correlation for the Defense Summary Scores was 0.69. At termination, most subjects improved on their Overall Defensive Functioning (ODF) score, used fewer immature defenses, and used more mature defenses. The mean effect size (ES) of the ODF for the sample was 0.52 ($p = 0.06$) and the ES for the percentage of mature defenses used was 1.69 ($p=0.009$). The mean ES for general functioning using the HSRS was 0.90 ($p=0.002$).

Together, these data portray how much change occurs in a naturalistic sample of outpatients who completed psychoanalysis and indicate that psychoanalysis does improve defensive functioning.

No. 55C
A FOLLOW-ALONG STUDY OF CHANGE IN LONG-TERM PSYCHOTHERAPY

Michael P. Bond, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, QC H3T 1E4, Canada*; John C. Perry, M.D., Joan Oppenheimer, B.A., Natali Sanilan, M.P.S.

SUMMARY:

Objective: We examined changes in the first 20 subjects with comorbid psychiatric disorders who have completed up to three years of individual dynamic psychotherapy with experienced therapists. An individual's defense mechanisms should change more slowly compared with descriptive measures such as mood and global functioning. We predicted that minimal change would be evident after six months of therapy, whereas change would be substantial at three years.

Methods: Subjects were admitted into the ICFP-McGill Psychotherapy Follow-along Study with either depression (major depression or dysthymia or both), an anxiety disorder, or personality disorder. All sessions were tape recorded. Sessions at intake, six months, and 2.5 years were rated using the Defense Mechanism Rating Scales (DMRS). Descriptive measures and the Defense Style Questionnaire (DSQ) were obtained independently.

Results: Improvement was not generally evident at six months but was significant by the third year for most measures such as GAF and SCL-90-R. Overall defensive functioning (ODF) improved (ES = .8) by showing a decrease in action defenses (e.g., acting out, passive-aggression) and an increase in high adaptive level defenses (e.g., self-observation), also predicting greater global improvement.

Conclusions: Subjects with comorbid depressive, anxiety, and personality disorders improve significantly by the third year. Those with improved defensive functioning show the most robust change overall.

No. 55D
THE AUSTEN RIGGS FOLLOW-ALONG STUDY: FIVE-YEAR OUTCOME

John C. Perry, M.D., *Department of Psychiatry, Sir Mortimer B Davis Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, QC H3T 1E4, Canada*; Barbara Zheutlin, M.S., Eric M. Plakun, M.D., Stephen Beck, M.P.S., J. Christopher Fowler, Ph.D., Stephanie Speanberg, M.S.W.

SUMMARY:

Objective: Individuals with treatment-resistant disorders may require treatments of longer duration than most pharmacological and psychotherapy trials currently entail. The sample (N=210) entered residential treatment at the Austen Riggs Center and was followed for up to seven years to determine their long-term course and outcome.

Method: Follow-along interviews assessed subjects' mood and impulse symptoms, social role, and defensive functioning over years of follow-up (subsample N=65).

Results: Most subjects continued in some form of psychotherapy with or without medications for the initial years after intake. Most measures showed volatility in the first one to two years of follow-up but showed significant change by three years. Significant improvement (ES ~ 1.0) was obtained for mood, impulse symptoms such as suicidal ideation and attempts and global functioning. Significant but smaller ESs were found for social role and defensive functioning.

Conclusions: Overall, treatment-resistant disorders demonstrated meaningful improvement by 3+ years of follow-up, which in most cases was not evident in a one or two-year time frame. The importance of improved dynamic personality functioning was indicated by improvement of defensive functioning and on other measures as well. Further study of the predictors of improvement are warranted but long-term psychiatric treatment (commonly psychotherapeutic) appears effective among this important patient group.

No. 55E
THE IMPACT OF PSYCHOTHERAPY ON THE BRAIN

Glen O. Gabbard, M.D., *Department of Psychiatry, Menninger Clinic, P.O. Box 829, Topeka, KS 66601-0829*

SUMMARY:

Advances in neuroscience research have gotten to the point where we can begin to document the impact that psychotherapy has on the brain. An overview of these research findings suggests ways that we can make preliminary hypotheses about the principal modes of therapeutic action in psychoanalysis and psychoanalytic psychotherapy. Included in this survey will be the effects of family therapy interventions on the development of antisocial behavior, the impact of psychodynamic psychotherapy on serotonin metabolism, and the alteration of neural network activation through psychoanalysis and long-term psychoanalytic psychotherapy.

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SYMPOSIUM 56—CLOSING THE EFFICACY/EFFECTIVENESS GAP IN PSYCHOPHARMACOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should recognize the limitations of randomized clinical trials (i.e., efficacy) when

an approved drug is then used on a larger scale in the real world (i.e., effectiveness) and to understand the importance of social, vocational, and personal clinical outcomes beyond symptom control.

No. 56A
THE GAP BETWEEN RESEARCH VERSUS CLINICAL OUTCOMES OF PHARMACOTHERAPY

Henry A. Nasrallah, M.D., *Department of Psychiatry, University of Mississippi, 1500 East Woodrow Wilson Drive, Jackson, MS 39216*

SUMMARY:

Controlled research trials that are conducted to develop a new pharmacologic agent for psychiatric disorders like schizophrenia are generally designed to measure the impact of the compound on the main symptoms of the disease, such as positive, negative, and mood symptoms. Adverse effects are also noted. However, when the drug is approved and launched, clinicians start using the same drug in thousands of patients and do not necessarily aim for the same efficacy parameters as in the research trials.

In the "real world," the outcomes measures that really matter go beyond symptomatic efficacy, and include such parameters as relapse and rehospitalization, tolerability of the drug, consistency of adherence to treatment and compliance with the drug regimen, patient satisfaction, quality of life, social functioning, vocational functioning, morbidity and mortality, family burden, and the costs of disease management. All these clinical outcomes represent the effectiveness of the medication, which transcends its efficacy and takes into account the ability of the drug to impact the patient's life in a positive manner that leads to overall wellness, not simply a remission of symptoms. There is a widely recognized "efficacy-effectiveness gap" that results from the research versus the clinical paradigms of measuring the effects of a pharmacological agent on an illness.

In this presentation, an overview of the various factors that account for this "gap" will be discussed. Specific examples will be described and suggestions for treatment optimization in psychopharmacology will be provided, including patient factors, physician factors, and institutional factors. Future studies in psychopharmacology should combine both efficacy and effectiveness end points in their research design in order to measure and predict the impact of pharmacotherapy to restore overall wellness, not simply the reduction of the acute symptoms. Such research can help optimize pharmacotherapy for psychiatric patients in real-world settings.

No. 56B
POLICIES REGARDING NOVEL ANTIPSYCHOTIC PRESCRIBING

Greer Sullivan, M.D., *Department of Psychiatry, University of AR, 2200 Fort Roots Drive, 16 MIR/NLR, North Little Rock, AR 72114*; Dana M. Perry, B.A., Wen D. Grimes, M.A., Helen Weatherbee, J.D.

SUMMARY:

Novel antipsychotic medications represent a treatment that has been shown to be more efficacious for persons with schizophrenia. However, because these newer medications are far more expensive than the typical antipsychotics, many public agencies or facilities have regulated or restricted their use. Major publicly-funded agencies that pay for the majority of medications for persons with schizophrenia are state Medicaid agencies and Veterans Affairs facilities. In this study we surveyed all eligible state Medicaid programs (N = 46 eligible) and all VA facilities (N = 141) about their policies regarding novel antipsychotics. (Eligible Medicaid programs were those that had not contracted out a majority of their care to "carve out" managed care companies.) We received completed surveys from 46 (100%) Medicaid programs and 132 (94%) VAs. This presentation will describe these policies in terms of their restrictiveness and characterize the variation in policies. Finally, aspects of the policies will be related to the extent to which novel antipsychotics have penetrated into the relevant populations of persons with schizophrenia served by these agencies or facilities, and to the variation in the types of novel antipsychotics prescribed.

No. 56C
STRATEGIES FOR IMPLEMENTING SCHIZOPHRENIA GUIDELINES

Richard R. Owen, Jr., M.D., *Department of Psychiatry, University of AR Medical Science-Centra VAHSI, 2200 Ft. Roots Drive, Building 58, North Little Rock, AR 72114-1706*; Teresa J. Hudson, Pharm.D.

SUMMARY:

Objectives: One strategy for reducing the efficacy-effectiveness gap involves implementing evidence-based practice guidelines. Data from a multi-site study of guideline implementation strategies for schizophrenia will be presented.

Methods: Computerized pharmacy data were extracted from 13 candidate VA sites. Seven sites were selected and received basic education about schizophrenia guidelines. Three of these sites received an intervention employing a nurse coordinator to promote providers' guideline adherence and patients' treatment adherence. Chart reviews and patient interviews provided data on processes and outcomes of care. Data analysis first examined prescribing variation among the 13 candidate sites. When data collection is completed, analyses will be conducted to determine the effectiveness of the intervention with regard to improving guideline adherence and patient outcomes.

Results: Discharge prescriptions were examined for 599 inpatients in the 13 VAMCs with a primary diagnosis of schizophrenia in 1997. Novel antipsychotics were prescribed for 47% of patients. Logistic regression found significant variation in novel antipsychotic prescribing by facility ($p=0.025$) and ethnicity ($p=0.0002$), with non-Caucasians approximately half as likely as Caucasians to be prescribed novel agents. To date, 401 subjects have been enrolled in the intervention study, which will be completed in 2000. Study results will be presented and discussed.

No. 56D
THE QUALITY OF MEDICATION TREATMENT FOR SCHIZOPHRENIA

Alexander S. Young, M.D., *MIRECC, VA VISN 22, 11301 Wilshire Boulevard, Building 210A, Los Angeles, CA 90073*; Greer Sullivan, M.D.

SUMMARY:

Objective: The quality of care can be evaluated by measuring treatment outcomes or processes. In schizophrenia, issues related to sampling and illness severity represent serious challenges to the usefulness of routine outcome measurement. While more research has focused on evaluating processes, different approaches have been tried and little is known about how they compare.

Method: We randomly sampled 224 patients receiving treatment for schizophrenia at two large clinics. Patients were interviewed, charts abstracted, and pharmacy data obtained. We compared quality measurement based on pharmacy data with quality measurement that includes data from charts or from patient interviews.

Results: At these clinics, 44% and 31% of patients received poor quality medication management. Chart documentation was poor, and quality assessment based on the chart detected 20% and 49% of cases of poor care. Assessment based on pharmacy data detected

between 11% and 96% of cases of poor care, depending on the method.

*Conclusions:*Data source has a strong effect on quality measurement. Charts may be of limited usefulness unless evaluation and documentation practices are improved. Although many cases of poor care could not be detected without data from patients, pharmacy data may help screen for quality problems.

Funding: The VA and NIMH

No. 56E
ADMINISTRATIVE BARRIERS TO CLOSING THE EFFICACY AND EFFECTIVENESS GAP

Kathryn J. Kotria, M.D., *Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza, M5BCM350, Houston, TX 77030-3411*

SUMMARY:

Data support the superiority of newer generation medications in treating individuals with severe and persistent mental illness. Along with medications, psychosocial and rehabilitation programs result in better occupational outcomes for this population. Clinical reality in many systems is far removed from best-care practices. Because of legislative policy and underfunding. In many states the mental health system erects barriers to care. These barriers include restricting access to newer generation medications, restricting access to or not providing nonpharmacologic treatment interventions, or denying care altogether. Such barriers result in high levels of frustration in providers, primary consumers, and advocacy organizations. One strategy that can positively impact legislative policy is forming coalitions of stakeholders in the mental health system. Such coalitions include psychiatrists, representatives of provider organizations, primary consumers, advocacy groups, and pharmaceutical companies. Through a united effort, substantial funds have been obtained for newer generation medications and concomitant rehabilitation and supportive services. Nevertheless, the crisis in funding remains. To convince legislators to allocate resources to best-practice mental health care, further data must be obtained that determines the cost savings of optimal pharmacotherapy and rehabilitation programs. This requires academic-public liasons to design large-scale studies that cross institutional and administrative barriers.

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SYMPOSIUM 57—VOYEURISM IN THE NEW MILLENNIUM: A PRIME-TIME OBSESSION?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the session, the participants should be able to understand the concept of voyeurism and different theoretical models. Also, s/he should be able to demonstrate an understanding of the nature of voyeurism in the cinema, the Internet, and its potential impact on adolescents.

No. 57A
FROM SCOPOPHILA TO SURVIVOR: PSYCHIATRIC APPROACHES TO VOYEURISM

Jonathan M. Metzl, M.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Ann Arbor, MI 48109–0722*

SUMMARY:

This paper examines psychiatric definitions of voyeurism, and theorizes their relevance to the understanding of contemporary cultural life. Its central argument is that the overwhelming popularity of television shows such as "Survivor" and "Big Brother," Web sites such as "Jennycam," and other examples of a sudden American fixation with observing heretofore private aspects of others' lives, force us to revisit the notion of voyeurism. The paper begins with an overview of classic psychoanalytic definitions of the term, paying particular attention to Freud's discussion of "scopophila." Literally the "pleasure in looking," scopophila saw voyeurism as an often pathological fixation with a mother's hidden parts, grown up into such conditions as sadism and fetishism. I explain how the gendered implications of scopophilia—and specifically the notion that the observer completes himself by the act of watching others—has been an important concept both in psychoanalytic criticism and in feminist critiques of popular culture. Subsequently, I turn to address the relevance of psychoanalytic concepts in the understanding of television, internet, and other types of "real-time" voyeurism. To be sure, these contemporary instances often have "classical" gender overtones—two "Survivor" women were offered large sums to pose in Playboy immediately after expulsion from the island, for example. At the same time, such shows are intimately connected to contemporary notions of technology, surveillance, and other concepts for which post-Freudian and cultural studies modes of thinking are equally important.

No. 57B
VOYEURISM AND CINEMA

Lee H. Rome, M.D., *Department of Psychiatry, University of Michigan, 3511 Bemis Road, Ypsilanti, MI 48197*

SUMMARY:

Classic movies such as Alfred Hitchcock's Rear Window and Michael Powell's Peeping Tom, as well as recent films (The Truman Show and Ed T.V.) illustrate our culture's (if not our species') fascination looking at intimate behavior or being looked at performing such behavior. Writers ranging from Freud and Lacan in the past to film scholar Laura Mulvey today, have theorized about the erotic pleasure of gazing at forbidden behavior that, for most of us, has been an increasingly repressed psychological reality as we leave childhood and mature. From their beginning, movies have served as a powerful means for us to displace subclinical voyeuristic impulses and drives. This presentation will explore the dynamics of

exhibitionism, voyeurism (and, its more general cousin, scopophilia) in the cinema, using examples from illustrative films. Numerous issues will be discussed, including whether subclinical cinematic scopophilia is related to full DSM criteria voyeurism and questioning the theoretical dichotomy that intimate gazing and being viewed are respective active male and passive female traits.

No. 57C
VOYEURISM AND THE INTERNET

Robert A. Kowatch, M.D., *Department of Psychiatry, University of Cincinnati, 231 Bethesda Avenue, P O Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

The Internet webcam has provided a huge opportunity for virtual voyeurism. There are several thousand webcam sites that allow adolescents to view anything from plants growing (www.camcentral .com/Gardens-Plants.html) to live sado-masochistic sex (www .slavedove.com). These Webcam sites allow this from the relative safety and anonymity of a personal computer. Recent associated innovations include technology like one-on-one webcam sessions and cyber-dildonics, which make the webcam experience much more direct and less "virtual."

This presentation will provide a brief overview of the technology involved in Internet webcams, provide an overview of the variety of webcam sites available, and attempt to explore the question, "What is the potential impact of these webcam sites upon an adolescent's developing sexuality?"

No. 57D
ADOLESCENTS, VOYEURISM, AND THE INTERNET

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

Surprisingly, there is little written about voyeuristic behavior among adolescents. It is almost a foregone conclusion that adolescents, in particular adolescent males, will be obsessed with sex, and in turn, pornography. Yet the Internet introduces a new realm of potential exposure that few would have imagined before 1995. Soft-core, hard-core, and perversions are readily available to any youth in the world. Is this exposure potentially dangerous? Will there evolve a new form of voyeurism that is far more pernicious than we may have seen before? Will courtship disorders as described by Freud and Scher and Hucker, become the norm?

This presentation will review material within the context of its potential impact, on adolescents, in particular, male adolescents. It will review pertinent literature concerning the impact of pornography on the development of adolescent psychosexual development, particularly voyeurism, exhibitionism, frotteurism, and preferential rape patterns. Potential interventions will be discussed.

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SYMPOSIUM 58—BEYOND MIND AND BRAIN: CONSIDERING THE PATIENT'S WORLD VIEW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should (1) recognize that their own world view, implicit and explicit, is part of every psychotherapy and influences their work, (2) appreciate that each patient in psychotherapy has a world view that must be explored in order to obtain a thorough understanding of the patient, (3) understand the differences between a scientific and religious world view and how these differences impact clinical work.

No. 58A
THE WELTANSCHAUUNG OF SIGMUND FREUD: CLINICAL IMPLICATIONS

Armand M. Nicholi, Jr., M.D., *Harvard Medical School, 209 Musterfield Road, Concord, MA 01742-1648*

SUMMARY:

Sigmund Freud spent the last 30 years of his life writing extensively about his world view (Weltanschauung). By focusing on those issues that he said fascinated him all of his life, he spelled out in detail his philosophy concerning the basic "problems of our existence."

This world view, proffered along with his clinical and theoretical contributions, continues to influence the practice of psychodynamic psychiatry in the United States. Scholars in the history of science argue that a scientist's contributions can be understood only in light of the world view embraced by that scientist and of the presuppositions that view implies. The world view of the scientist influences not only what he investigates but how he perceives what he investigates. Freud's world view, nevertheless, has received little attention in the psychiatric literature.

This paper explores Freud's specific world view and discusses whether it preceded or resulted from his scientific discovers. The author will draw upon the philosophical and autobiographical writings of Freud as well as on personal interviews with Anna Freud.

No. 58B
CLINICAL PSYCHIATRY AND SPIRITUALITY: ANOTHER LEVEL OF INTEGRATION

Allan M. Josephson, M.D., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*

SUMMARY:

This presentation reviews three conceptual areas that inform psychiatric practice and the interaction between each of these areas and a spiritual world view. The areas to be considered are: the developmental perspective, etiologic formulations, and clinical phenomenology.

First, the developmental perspective will be reviewed and compared with a spiritual perspective (e.g., the developmental need for trusting relationships and the spiritual impulse trust in a power beyond one's self.) Second, behaviors arising from moral and ethical failures will be described as leading to some psychiatric syndromes and some psychiatric syndromes will be described as having ethical and moral implications. Third, several aspects of behavioral phenomenology (e.g., self-centered behavior) will be reviewed from a clinical, descriptive perspective and from the vantage point of a spiritual perspective.

This presentation will describe clinical implications for the doctor-patient relationship of an integration of the clinical/scientific and spiritual/religious perspectives. This integration of spiritual and psychiatric themes will be discussed as one component of "mind meeting brain." While spirituality does not directly translate to the concept of mind, it is an important experiential component of many patients' lives. It will be proposed that a psychiatrist can practice clinical science that can be integrated with religious and spiritual principles. Practical areas of discussion will include countertransference and the need for therapist self-examination, clinical application of an ethical psychotherapy that may require divulging one's world view, an analysis of how clinicians can handle conflicts between their world view and accepted clinical models of psychiatric practice.

No. 58C
SUFFERING AND THE PATIENT'S WORLD VIEW

John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 61727-0433*

SUMMARY:

Integrated treatment of a patient who suffers involves helping him or her to put it into perspective. This paper considers the relationship between world view and suffering, and uses case examples to consider the role of the clinician in helping patients who have naturalistic, spiritual, or ambivalent world views to integrate their suffering.

Individuals with a spiritual world view may draw upon their transcendent source of meaning and/or faith community, but struggle with distressing questions: What is the purpose of my pain? How can God allow this to happen to me? Am I being punished? To help them effectively, clinicians need a working knowledge of their patient's faith traditions, a model for integrating spirituality into their own therapeutic approach, and the ability to enlist outside resources.

Patients with a naturalistic world view may also feel that their misfortune is unfair, but are more likely to search for meaning within the context of their own actions and value system. Rather than accept that a painful event occurred by chance, they may ask, "What did I do to make this happen?", or "What does this say about me as a person?" Therapists can often help such patients put their pain into the context of the kind of person they have always been.

Patients unsure of their beliefs may need help to clarify and reassess these in light of painful experience.

No. 58D
WORLD VIEWS AND HOPE IN PSYCHIATRY

Leigh C. Bishop, M.D., *Menninger Clinic, PO Box 829, Topeka, KS 66601-0829*

SUMMARY:

Not until recent years has clinical research focused as intently on the subject of hope. Yet Menninger, Frank, and others have given prominent place to hope in their understandings of psychiatric care and healing. Research from Beck, Wetzel, and others underscores the relationship between hopelessness and suicidality, while Abramson et al have proposed a subtype of depression based on hopelessness. Reasonably or otherwise, patients tend to regard physicians and psychiatrists as having special authority in matters related to hope. Questions of hope, in contrast to questions of mere prognosis, invite considerations of the relationship between world view and psychotherapy. Hope may be of at least two types: proximate hope and ultimate hope. Proximate hope has to do with the expectation that valued outcomes in day-to-day life may be realized. Ultimate hope is related to the expectation that the world and one's life has meaning. Such hope is closely related to the individual's world view. The need for hope, as it relates to various dimensions of the patient's illness, serves to highlight certain constructive advantages that may obtain when the therapist makes an appropriate disclosure of his or her world view to the patient. Case material will describe examples of disclosures of the therapists' world view in the course of psychotherapy, as well as salient features of these disclosures that had a significant influence on the treatment result.

No. 58E
A CLINICIAN LOOKS AT PATIENTS AND THEIR WORLD VIEWS

Irving S. Wiesner, M.D., *Swarthmore Medical Center, Yale Avenue and Chester Road, Swarthmore, PA 19081*

SUMMARY:

Patients' religious beliefs of philosophical position determine how they will understand and respond to their psychiatric disorders. This "world view" must be understood and respected by the clinician if diagnosis and treatment are to be accurate and effective.

This presentation will describe the clinical evaluation of the patient's degree of adherence to either a naturalistic or supernaturalistic world view. The clinician can gain valuable information about world view through assessing patients' concepts of God, their use of prayer and ritual, and their involvement in a community of like-minded others.

Specific issues such as guilt, forgiveness, suffering, sexuality, and death will be addressed from the clinical perspective and from the perspective of the religious contrasted with the materialistic or naturalistic world views.

The doctor-patient relationship can be strengthened, diagnostic thoroughness enhanced, and compliance in treatment increased when the psychiatrist understands and deals with this integral component of patients' lives.

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SYMPOSIUM 59—BODY IMAGE DISORDERS IN MEN

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should (1) be able to recognize and diagnose body image disorders (e.g., eating disorders, BDD, muscle dysmorphia) in boys and men, (2) be familiar with signs and symptoms of anabolic steroid abuse in boys and men, and (3) be familiar with treatment strategies for men with a body image disorder.

No. 59A
THE PREVALENCE OF BODY IMAGE DISORDERS AMONG THE MALE POPULATION

David Castle, M.D., *Department of Psychiatry, Fremantle Hospital, Alma Street, Fremantle 6160, Australia*

SUMMARY:

In Western societies, it has traditionally been assumed that it is women who worry most about physical appearance. However, it is increasingly the case that males are concerning themselves with the way they look and are taking action to enhance their physical image. Serial polls in Psychology Today show an increasing proportion of U.S. men (across all ages) who are dissatisfied with their physical appearance (from 15% in 1972, through 34% in 1985, to 43% in 1997). In particular, men are concerned with body shape, accepting as ideal a muscle-bound physique (muscle dysmorphia). Some spend excessive amounts of time exercising, body building, and dieting; others use steroids and related substances to enhance physique. In extreme cases, concern with physical appearance can become all-consuming and meet criteria for body dysmorphic disorder (BDD).

Another particular focus of concern for some males pertains to shape and size of the penis, and some resort to surgical interventions to address this. A particular culture-bound syndrome amongst males (koro) is that the penis is shrinking into the body.

Concern about hair is also a common male concern, with various cures for baldness being pursued, and wigs and hair implants becoming more popular.

A distorted view of bodily appearance is at the core of anorexia nervosa, which is also becoming more common amongst men.

No. 59B
BODY IMAGE IN MALES

Arnold Anderson, *Department of Psychiatry, University of Iowa Hospitals and Clinics, 2880 JPP, 200 Hawkins Drive, Iowa City, IA 52242*

SUMMARY:

Ideals for the male body have changed over the past 20 years toward increased lean muscularity, complete absence of fat, and tallness, shown in advertisements, media, and action toys. Measurement of body image and body dysmorphia have become increasingly quantitative, including both verbal tests and computer imaging. Body image distress is described in four groups: heterosexual males, gay males, eating disordered males, and with "reverse anorexia," often associated with body building and anabolic steroid abuse. Males' body image distress is equal to females, but differs in specifics: males emphasize shape more than weight, perceive obesity at a different BMI, are self-conscious waist-up rather than waist-down. Weight and shape goals in athletic males varies according to the performance and appearance demands of the sport. Males score lower on measures of distorted body image, but are equally distressed on depression inventories and the MMPI, suggesting that the questions asked on eating disorders screening are not asking male-specific. Ten male-specific questions are discussed. Therapeutic interventions integrate psychotherapics, including cognitive-behavioral, interpersonal, and dynamic methods, as well pharmacotherapy, especially SSRIs, anti-OCD medications, and neuroleptics.

No. 59C
BDD: AN UNDERRECOGNIZED BODY IMAGE DISORDER IN MEN

Katharine A. Phillips, M.D., *Butler Hospital/Brown University, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Body dysmorphic disorder (BDD), a distressing and/or impairing preoccupation with an imagined or slight defect in appearance, is an underrecognized body image disorder that is as common in men as in women. BDD in men is characterized by time consuming and distressing preoccupations with perceived appearance flaws that can focus on any body area, most commonly, the skin, hair, nose, and body build (usually thinking they are too small and inadequately muscular). Most men with BDD perform compulsive behaviors, such as camouflaging (e.g., with a hat or clothes), mirror checking, and comparing their appearance with others. A majority of men with this disorder experience functional impairment, nearly half have been psychiatrically hospitalized, and nearly 20% attempt suicide. Compared with women with BDD, men are more likely to focus on genitals, hair thinning, and body build, and they are more likely to have muscle dysmorphia. They are also more likely than women to be unmarried and have lifetime substance abuse or dependence (nearly 50%). Unlike in the general population, men with BDD are as likely as women with BDD to seek surgery or medical (e.g., dermatologic) treatment for their perceived appearance flaws. These treatments are received by a majority of men with this disorder, usually with a poor outcome. In contrast, serotonin-reuptake inhibitors and cognitive-behavioral therapy are often effective. This presentation will discuss the clinical features of BDD in men, present recent findings on efficacious treatment, and provide guidelines for diagnosing BDD in boys and men.

No. 59D
BODY IMAGE AND MUSCLE DYSMORPHIA IN MEN

Roberto Olivardia, M.A., *Department of Psychiatry, McLean Hospital, 115 Mill Street, c/o Dr. Pope, Oaks Building, Belmont, MA 02478*

SUMMARY:

The Somatomorphic Matrix (SMM) is a newly developed computer instrument that is the first to assess body image in men according to two axes of fat and muscle mass. New findings using the SMM in a sample of 154 men found that men chose an ideal body with significantly greater muscularity and less body fat than their actual and perceived bodies. Men thought that women wanted them to be significantly more muscular and leaner than the ideal male body chosen by a sample of 77 women. Muscle belittlement, or believing one is less muscular than he actually is, significantly positively correlated with depression and significantly negatively correlated with self-esteem measures.

Muscle belittlement is a major aspect of muscle dysmorphia, which will also be discussed in this presentation. Muscle dysmorphia is an unrecognized, often disabling condition characterized by the preoccupation that one's body is too small and not muscular enough. Symptoms include long hours of lifting weights, avoidance of social situations, camouflaging one's perceived lack of muscularity, and anabolic steroid use. Case examples of this newly recognized condition will be presented. For example, one man became housebound and suicidal because he felt he looked too thin. Treatment of muscle dysmorphia has not been well studied, although it would be expected to respond to other treatments that appear effective for BDD, such as SSRIs and cognitive-behavioral therapy. Treatment resistance is high in this population, since the though of ceasing steroid use (and not being as muscular) generates a high level of anxiety. Shame and embarrassment often prevent these men from seeking help.

No. 59E
ILLICIT ANABOLIC STEROID USE: RISK FACTORS AND PSYCHOSEXUAL EFFECTS

William R. Yates, M.D., *Department of Psychiatry, University of Oklahoma at Tulsa, 4502 East 41st Street, Tulsa, OK 74135*

SUMMARY:

In a time when therapeutic uses of testosterone are being examined, illicit anabolic steroid use continues to pose significant public health challenges. Prevalence studies suggest significant illicit use of anabolic steroid compounds beginning in adolescent populations. The motivation for illicit steroid use appears to have a least two origins—one is to increase strength, aggressiveness, and speed for athletic competitive advantage. A second motivation appears to be primarily cosmetic. Risk factors for illicit anabolic steroid use include male gender, competitive athletic participation, and personality factors including antisocial personality. At doses greater than three times physiological replacement, testosterone appears to induce adverse psychiatric effects in a minority of users. Although some tout testosterone as an aid to sexual performance, studies do not support a prosexual effect of testosterone in men with normal baseline sexual functioning. The illicit use of anabolic steroid compounds shares some features with typical drugs of abuse like cocaine. However, anabolic steroid users appear to rarely use the drugs for a psychoactive effect and rarely present for treatment in substance abuse treatment facilities. Psychiatrists need to understand the motivation, risk factors, and consequences of illicit anabolic steroid use.

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SYMPOSIUM 60—REDUCTION OF CHRONIC BENZODIAZEPINE USE: A MYTH AND REALITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, the listener will be aware of the disadvantages of chronic benzodiazepine use, the risks of overdoses, and the attitudes that hamper the implementation of a reduction program. The listener will also be familiar with effective, evidence-based treatment programs to reduce chronic benzodiazepine use.

No. 60A
BENZOREDUX STUDY: A TWO-PHASE APPROACH TO REDUCE CHRONIC BENZODIAZEPINE USE

Richard C. Oude Voshaar, M.D., *Department of Psychiatry, UMC St. Radbond, Postbus 9101, Nijmegen 6500HB, Netherlands*; W.D.J. Gorgels, M.D., Audrey J. Mol, M.S.C., Anton J.L.M. Van Balkom, M.D., Rien M. Breteler, Ph.D., Frans G. Zitman, M.D.

SUMMARY:

The benzoredux study is a population-based study evaluating the efficacy of two consecutive treatment interventions aimed at the reduction of chronic benzodiazepine (BZ) use in primary care. Phase I comprised the mailing of a letter sent by the general practitioner (GP) to all chronic BZ users, suggesting to quit their use. Non-quitters of phase I were asked to participate in phase II, which was a randomized controlled trial comparing the efficacy of a gradual BZ reduction program with (condition A, n=73) and without group therapy (condition B, n=73), and a control condition (condition C, n=34). After a baseline and end of treatment assessment, patients were followed up at six, 12, and 18 months. Main outcome measures were BZ use, dependency, psychological functioning, and the use of health care services.

Patients in conditions A (n=73) and B (n=73) were gradually tapered off by the GP after being transferred to an equivalent dosage of diazepam for two weeks, whereafter the dose was reduced by 25% a week. Patients in condition A received additional group therapy led by a registered psychologist experienced in cognitive-behavioral therapy.

The short-term efficacy of the intervention in phase II will be presented with respect to BZ use, dependency, and psychological functioning questionnaires. Preliminary results show an overall success rate of 55% of the patients being able to quit BZ consumption completely, with no statistical differences between conditions A and B.

No. 60B
HOW TO STOP CHRONIC BENZODIAZEPINE USE IN DEPRESSED PATIENTS

Jaap E. Couvee, M.S.C., *Medical Department, SB Farma BV, Jaagpad 1, Ryseyk, ZH 22806 C, Netherlands*; Frans G. Zitman, M.D.

SUMMARY:

Objective: Evaluation of short-term and long-term efficacy of a treatment intervention program in chronic benzodiazepine users (CBU) with major depressive syndrome (MDS).

Method: The program consisted of three phases: (1) Transfer to long-acting benzodiazepine (diazepam, four weeks), (2) a 12-week treatment of MDS with paroxetine versus placebo, (3) if response (HAM-D < 8) after six weeks, start tapering off diazepam over four weeks. Follow-up study, after two years, consisted of retrospective evaluation of psychoactive treatment in medical records.

Results: A total of 230 patients entered phase I; 74% women, mean age 56(13), mean diazepam equivalents 9 mg daily, on average patients were users for six years (0.3–27), mean HAM-D score was 17(5).

Of the 199 patients randomized, 75% in the paroxetine group versus 61% in placebo group were successfully treated after six weeks (HAM-D<8; p=0.067). A total of 122 patients started tapering off diazepam; 65% succeeded; 67% in the paroxetine group and 64% in the placebo group (p=0.72). The tapering-off group had significantly lower HAM-D scores while treated with paroxetine (p= 0.009), but this did not result in less withdrawal symptoms. Thirteen percent of patients remained benzodiazepine free throughout the two-year follow-up period 26% of patients who successfully completed the program versus 6% of patients who had dropped out at any phase during the program. Response categories to will be presented.

Conclusion: Two-thirds of patients who want to participate are able to change their chronic use. Treatment with an antidepressant does not improve the success rate in tapering off. We found the program to be safe and feasible for primary care.

No. 60C
MEMORY IMPAIRMENT IN PATIENTS WHO ATTEMPTED SUICIDE BY BENZODIAZEPINE OVERDOSE

Bas Verwey, M.D., *Department of Psychiatry, Ziekenhuis Rynstate, Postbus 9555, Amhem 6820, Netherlands*; Paul Eling, Ph.D., Henu Wientjes, Ph.D., Frans G. Zitman, M.D.

SUMMARY:

It has been demonstrated in many studies that benzodiazepine (BZ) can induce anterograde amnesia, the phenomenon whereby information is poorly remembered when presented after BZ has been taken. As BZ are involved in almost half of the suicide attempts, we examined prospectively whether anterograde amnesia occurs in this group of patients and studied the correlation with sedation.

We demonstrated that, in a verbal recall test, patients performed more poorly on the first day of admittance to the hospital than on the second day with respect to both immediate and delayed recall. Secondly, impairment was found in a photo recognition task. The results of our study also show that anterograde amnesia is not necessarily accompanied by a lowering of consciousness.

The fact that the type of memory loss is typical for BZ implies that the role of BZ is an important factor. However, these arguments do not exclude the possibility that impairment of memory results from the turmoil caused by acute admittance to the hospital and the diagnostic and treatment procedures in the acute ward. The results support the hypothesis that the efficacy of psychiatric consultation in patients who made a suicide attempt with BZ can be compromised by memory impairment, even in patients who don't seem to be sedated. The implications of this finding for the assessment of suicide attempters in the acute phase are discussed.

No. 60D
BENZODIAZEPINE CRAVING

Audrey J. Mol, M.S.C., *Department of Psychiatry, UMC St. Radboud, R. Postlaan 10, Nijmegen 6525 GC, Netherlands*; Richard C. Oude Voshaar, M.D., Wim J. Gorgels, M.D., Marinus H.M. Breteler, Ph.D., Anton J. Van Balkom, Ph.D., Eloy H. Van de Lisdonk, Ph.D., Frans G. Zitman, Ph.D.

SUMMARY:

Considerable controversy still exists about the concept of craving. Nonetheless, craving is regarded as an important component of substance dependence. Little is known about craving and benzodiazepine (BZ) use. This is remarkable since about 40% of the BZ users in general practice may be dependent according to the DSM-III-R and ICD-10 criteria. In an attempt to fill this gap in craving research, we developed the Benzodiazepine Craving Questionnaire (in Dutch). Similar to Tiffany's questionnaire with regard to craving in cocaine and smoking. The patients (n = 207) in our study were actual as well as former BZ users participating in the benzoredux study, a two-phase intervention study to evaluate strategies for the reduction of chronic BZ use in general practice.

Contrary to our expectations, the first results show that the Benzodiazepine Craving Questionnaire is Rasch homogeneous, incorporating items from all five categories used by Tiffany et al. to represent distinct conceptualizations of craving. This suggests that among BZ users craving is a unidimensional construct, rather than multidimensional as found by Tiffany et al. in smokers and cocaine users. The above-mentioned findings will be presented along with the scores on the questionnaires of our study population and the clinical implications.

No. 60E
ASSESSING BENZODIAZEPINE DEPENDENCE: DEVELOPMENT OF THE BENZODIAZEPINE DEPENDENCE SELF-REPORT QUESTIONNAIRE

Cornelis C. Kan, M.D., *Department of Psychiatry, University of Hospital Nijmegen, P.O. Box G101, Nijmegen, Netherlands*; Frans G. Zitman, M.D., Rein M. Breteler

SUMMARY:

In this presentation, the development of the Benzodiazepine Dependence Self-Report Questionnaire (Bendep-SRQ) is reviewed and guidelines are provided for its application in medical practice. Research on the psychometric properties of the Bendep-SRQ has been carried out on 217 general practice patients, 250 psychiatric outpatients, 99 outpatients of community-based addiction centers, and 33 self-help patients. Using factor and Rasch analyses, four Rasch-homogeneous scales were delineated: Problematic Use, Preoccupation, Lack of Compliance, and Withdrawal. The reliability results (subject and item discriminability, test-retest stability) of these scales were sufficiently good. The concurrent and discriminant validity of the scales were supported by the results of factor analyses of the Bendep-SRQ, SCL-90, DSM-III-R/ICD-10 benzodiazepine dependence, and ASI-R scales. A cross-validating study yielded similar results. The Bendep-SRQ scales were standardized by means of Rasch latent trait standardization. The scores of the Bendep-SRQ scales constitute a multidimensional benzodiazepine dependence severity profile, which is easily generated by online administration *(http://baserv.uci.kun.nl/~fzitman/Bendep-SRQ.html)* and interpreted using a histogram that summarizes the standardization results. The Bendep-SRQ is recommended as a practical instrument for screening, diagnosis, monitoring, clinical decision making, and scientific research.

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SYMPOSIUM 61—REFORM, RESIDENT TRAINING, CONTEMPORARY PRACTICE, AND THE PUBLIC'S HEALTH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the symposium's conclusion, the participant should have a perspective on current issues confronting training of psychiatric residents, whether current approaches are adequate to train a relevant psychiatric workforce, and whether reform strategies and new training models are needed to establish contemporary practice to better address the nation's mental health needs.

No. 61A
ALIGNING RESIDENT TRAINING AND WORKFORCE PROFICIENCY: IS REFORM NECESSARY?

Leighton Y. Huey, M.D., *Department of Psychiatry, University of Connecticut, 263 Farmington Ave, Farmington, CT 06030-1410*

SUMMARY:

A highly proficient workforce is critical in delivering quality mental health services. Workforce proficiency—its scope, sophistication, engagement of patients and families, effectiveness, and whether contemporary—is determined greatly by the context within which preprofessional training occurs, how health systems promote proficiency, and the vision of health system administrators. The shift in mental health reflects payer and patient demands for levels of care that are appropriate, cost-effective, and timely. Psychiatry is redefined by benefit of a focus on (1) the importance of careful, consistent diagnostic assessment; (2) epidemiological studies showing widespread prevalence and comorbidity of psychiatric disorders; (3) controlled studies of psychotherapy and psychopharmacotherapy focusing on efficacy; (4) multidisciplinary collaboration; (5) commitment to elucidating underlying brain mechanisms; (6) understanding the impact of psychiatric disorders on physical disorders; (7) reconfiguring psychiatry's relationship to other areas of medicine; (8) incorporating a public health perspective; (9) attending to outcomes, utilization, costs, and value. These factors should directly affect contemporary training of psychiatrists. The degree to which training is aligned with these factors will be considered. Specific examples of where there may be lacking of alignment will be provided.

No. 61B
CHANGING ACADEMIC PSYCHIATRY FOR CLINICAL CARE

Joseph A. Flaherty, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, MC 913, Chicago, IL 60612*

SUMMARY:

Psychiatry department chairs have experienced more radical change in the last decade than at any other recent decade. The national need to support faculty through patient revenue came at the same time that behavioral health care was taking over markets entirely and reducing the structure. In order to survive, departments, varying on the managed care saturation of their locale, have had to adapt and change quickly. From a chair's perspective, the most difficult tasks have included: (1) getting faculty to see that the push for change was neither personal, a failure in leadership, nor limited to their medical school; (2) developing information systems both for financial management as well as to begin measuring clinical productivity; (3) incorporating residents and education into the change process; (4) making a clearer distinction of clinical and tenure tracks; (5) learning to live and work in the world and vernacular of business; (6) developing clinical programs that meet the needs of managed care; and (7) making the clinical enterprise more valued and patient friendly. The effect on education and training when the pressure for clinical work comes at a time of tremendous opportunity for research growth given NIH budget increases will also be discussed.

No. 61C
THE DARTMOUTH EXPERIENCE: REFORM IN PSYCHIATRY RESIDENCY, FIVE YEARS OUT

Ronald L. Green, M.D., *Department of Psychiatry, Dartmouth-Hitchcock, 1 Medical Center Dr, Lebanon, NH 03756; Bradford Watts, M.D.*

SUMMARY:

The department of psychiatry at Dartmouth Medical School undertook an intensive one-year period of self-study in 1994 in order to reexamine our clinical care delivery system and the goals and objectives of the psychiatric residency embedded in the system. Regarding the latter, we began by enumerating the knowledge, skills, and attitudes we thought necessary for optimal practice consistent with emerging developments in health care reform. These reforms call for an outcomes-based, consumer-oriented, cost-effective, high-quality care delivery system. With these objectives in mind, we reconfigured our psychiatric service providers into several multidisciplinary, integrated, longitudinal treatment teams that included psychiatry residents and their faculty mentors as key members. These teams manage, concurrently, inpatients, outpatients, and perform medical-surgical inpatient consultations. Each team as well is responsible for its own utilization management, developing quality improvement initiatives, and incorporating a research program centered on outcomes data. As much as possible training experiences are embedded in this longitudinal system. After five years several of the initiatives have been particularly successful: activities centered around inpatient care and continuity clinics. Some of the activities, however, have not been successful: consultation psychiatry and neurology training as a longitudinal rotation. We hope our experience will prove useful to any department contemplating similar reforms in psychiatric education.

No. 61D
STRATEGIES FOR CATALYZING CHANGE IN RESIDENCY TRAINING PROGRAMS

Michael Hoge, Ph.D., *Department of Psychiatry, Yale University, 25 Park Street, 6th Floor, New Haven, CT 06519*

SUMMARY:

The delivery of behavioral health care has changed dramatically over the past decade. Health care reform, managed care, and consumerism have called into question traditional assumptions regarding the provision of mental health and substance abuse treatment. We are in a new era of contemporary clinical practice in which accountability, standards, outcomes, efficiency, and consumerism are guiding principles. Unfortunately, most residency training programs have not kept pace with changes in the field. The attention given in residency curricula to these new dimensions of contemporary clinical practice remains sparse. The types of change that are needed in residency training programs have been articulated by numerous leaders in the field over the past decade. The current challenge is to implement strategies that will overcome the numerous barriers to revamping residency programs in order to make them more relevant to the current health care environment. This presentation will outline five potential strategies for catalyzing change, and will consider the pros and cons of each. The strategies are: development of model/portable curricula, implementation of residency training demonstration programs, interventions with department faculty, accreditation and licensing changes, and inclusion of residents in managed care panels.

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SYMPOSIUM 62—PSYCHOTROPIC USE DURING PREGNANCY AND LACTATION: MORE DATA AND EVOLVING DEBATE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will understand available information regarding use of psychiatric medications during pregnancy, the peripartum period, and lactation. This will include areas for which there exists debate regarding "safest" practice across these critical times.

No. 62A
PSYCHOTROPIC USE DURING PREGNANCY AND LACTATION: WEIGHING THE RISKS

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 115 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

Pregnancy has frequently been referred to as a time of emotional well-being conferring "protection" against psychiatric disorder. However, recent data do not support this clinical lore. While the prevalence of psychotropic drug use during pregnancy is high, data-driven guidelines for their use are sparse. This presentation will review reproductive safety data of psychiatric medications including antidepressants, benzodiazepines, and mood stabilizers and will highlight treatment guidelines for use of these compounds. The focus of the presentation will be a delineation of areas where there is a question regarding the "safest" or "best practice" use of these compounds during pregnancy. For example, questions about the generalizability of reproductive safety data across a family of compounds, i.e. SSRIs, will be discussed along with the questionable rationale of switching to antidepressants for which there are more data supporting safety following documentation of pregnancy. Refining treatment guidelines for psychotropic drug use during pregnancy minimizes risk of fetal exposure to these agents on one hand and risk to mother (and fetus) from psychiatric disorder on the other.

No. 62B
PSYCHOTROPIC MEDICATION USE DURING THE PERIPARTUM PERIOD

Kimberly A. Yonkers, M.D., *Department of Psychiatry, Yale University School of Medicine, 200 College Street, Suite 301, New Haven, CT 06510*

SUMMARY:

It is increasingly recognized that women are not "protected" against psychiatric illness during pregnancy. In fact, among medical illnesses in general, psychiatric disorders are likely to be some of the most common medication-requiring illnesses in pregnant and immediately postpartum women. Further, some women will have an onset of illness after parturition. Thus, clinicians need to be informed about the strategies required when managing women with psychiatric illness who are in the immediate postpartum period. While the therapeutic index of a number of psychotropics is wide and there is no dose-response relationship, some medications, including the mood stabilizer lithium, have narrower indexes and require adjustment as the mother transitions from pregnancy to the immediate postpartum period. Further, a number of medications have fetal effects and clinicians need to be aware of how the mother's medication may affect her neonate in the immediate postpartum period. This presentation will review the changing physiology of the mother at parturition and will critically review the changing pharmacodynamics of several psychotropic agents. Finally, it will include a review of the effects of the mother's medication on the newborn shortly after parturition.

No. 62C
CONTROVERSIAL ISSUES IN THE TREATMENT OF PREGNANT AND BREASTFEEDING WOMEN

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Suite 280, Cleveland, OH 44106*

SUMMARY:

Although advances have been made in the treatment of depression during pregnancy and the postpartum period, new information also inevitably creates new questions. There are several areas in which the translation of research to clinical care has created controversy, to be addressed through debate in this symposium:

1. What information should be given to women about both treatment options and the effects of depression during pregnancy? How should this information be structured?
2. What is the optimal way to manage depression near term? Some clinicians continue medications to reduce risk for recurrence in the mother; others recommend tapering medication to reduce the fetal load at birth.
3. Should a woman change from one medication to another if little is known about outcome during pregnancy for treatment with the agent she is taking? Does the recommendation differ for women who are pregnant compared with breastfeeding?
4. How should we handle education of patients in the face of conflicting data? An example is the finding of increased minor physical anomalies and neonatal adaptation difficulties (Chambers et al, 1996) for women exposed to fluoxetine during the third trimester?
5. What can we do to assist clinicians who fear a malpractice suit if a woman has a negative pregnancy outcome?

No. 62D
MONITORING THE NURSING INFANT: MEASURES AND INTERPRETATIONS

Zachary S. Stowe, M.D., *Department of Psychiatry, Emory University Medical School, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

With respect to ensuring minimal fetal exposure and proper monitoring documentation, the use of psychotropic medications during breast feeding poses an interesting series of questions for the clinician. All psychotropic medications studied are excreted into human breast milk; therefore, the infant is always exposed. Several investigators have utilized the milk/plasma (M/P) ratio as a means for calculating infant exposure. However, numerous assumptions (e.g., similar metabolic capacity, full versus partial breast feeding, gradient in breast milk) are needed to apply such a method. Hence, direct infant serum collection and assay has emerged as the standard for infant monitoring. The current literature contains approximately 175 cases of nursing infant serum measures, yet is devoid of any scientifically derived method for the interpretation of such measures. The variability inherent in laboratory assay techniques and the nonstandardization between laboratories limits direct clinical utility. Further, values of

nonstandardized assay reflect the absolute exposure (ng/ml) and do not address the highly variable binding affinity of psychotropic medications. A final clinical challenge not often discussed is if an infant is exposed to a medication, what measures should be monitored to assess the impact of the exposure and should certain medications be avoided? The range of opinions varies from most conservative (e.g., monitor the infant more often than the adult) to the more practical (e.g., no problems have been noted to date, so don't stress child with potentially unnecessary procedures). The confounds of clinical application of the literature will be discussed, as well as methods for minimizing potential infant toxicity and legal liability issues.

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SYMPOSIUM 63—THE PSYCHIATRIC CONSEQUENCES OF STRESS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should (1) appreciate the presentation of PTSD across the lifespan and in different settings, (2) recognize the role of psychobiological and psychosocial factors in the development of psychiatric complications of stress, and (3) treat with some confidence some presentations of PTSD.

No. 63A
PTSD IN A DEVELOPMENTAL MATRIX: EVALUATION AND TREATMENT

Robert S. Pynoos, M.D., *Department of Psychiatry, UCLA, 300 Medical Center Plaza #2235, Los Angeles, CA 90024*

SUMMARY:

The application of a developmental psychopathology model is central to the study of traumatic stress among children and adolescents. Developmental issues influence the appraisal of threat, maturation of emotional regulation, and considerations of protective intervention that mediate traumatic helplessness. Child intrinsic factors, social ecology, and the developmental epidemiology of exposure influence vulnerability, resilience, and intersection with other anxiety disorders. Manifestations of PTSD, course, and mediating and moderating factors have developmental determinants. Investigation of the neurobiology of child and adolescent PTSD must incorporate knowledge about the maturation and consolidation of key neurophysiological pathways, neurohormonal systems, and neuroanatomical structures. Evaluation and monitoring of recovery must include the interplay of PTSD, other comorbid conditions, and multiple domains of proximal and distal development. Treatment issues will be discussed in regard to five foci of intervention: traumatic experience(s), trauma and loss reminders, traumatic bereavement, secondary adversities, and developmental progression. The treatment literature in regard to early and late intervention will be reviewed in regard to various treatment modalities, including psychopharmacology. In addition, an overview of the UCLA trauma psychiatry intervention protocols will be provided, including school-based programs for children and adolescents exposed to large-scale disasters, chronic community violence, war, and extreme intrafamilial violence.

No. 63B
INNER-CITY VIOLENCE AND PTSD

William B. Lawson, M.D., Department of Psychiatry, *Howard University Hospital, 2041 Georgia Avenue, NW, Washington, DC 20061*

SUMMARY:

Posttraumatic stress disorder was once thought to be a consequence of extraordinary exposure to violence in the military. Recent findings have expanded the focus of PTSD to childhood abuse and rape. However, urban violence in America has also been found to contribute to a number of adverse psychiatric consequences including PTSD. First, exposure to urban violence is common for many inner-city youth and can rival combat exposure in frequency and degree. Secondly, it leads to a number of psychiatric complications including PTSD that are underdiagnosed or misdiagnosed. The underdiagnosis of PTSD in ethnic minorities is a special issue that is complicated by differences in culture, stereotypical views of the diagnostician, and lack of access to mental health providers. Complications include substance abuse, problems with parents and schools, gang membership, and correctional system involvement. Treatment, either pharmacological or psychosocial, may be delayed or inappropriate. The lack of social support for treatment in contrast to the support for addressing suburban school violence further complicates addressing this important issue.

No. 63C
COLLECTIVE TRAUMA AND AFRICAN-AMERICAN HEALTH DISPARITIES

Mindy J. Fullilove, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, Unit 29, New York, NY 10032-2603*

SUMMARY:

In assessing community damage due to the 1972 Buffalo Creek flood, Kai Erikson proposed the term "collective trauma" to describe the effects on group life of the loss of the "communality," that is, the network of relationships that make up the human surround. He was convinced that collective trauma interfered with community-wide recovery and contributed to the prolonged effects of the disaster. He hypothesized that the contemporaneous experience of urban renewal would have similar effects. Urban renewal sponsored by the federal Housing Act of 1949 fell particularly heavily on African-American settlements: it has been estimated that two-thirds of those people displaced by urban renewal were African American. A growing number of studies of the African-American experience of urban renewal provide support for Erikson's hypothesis and raise the question: to what extent did the collective trauma suffered in the 1950s and 1960s contribute to current excess morbidity and mortality among African Americans? This is, in many ways, a question about the effects of disturbances in social relationships and mental health on all health and social outcomes in a community. This presentation will review existing data to shed light on this intriguing question.

No. 63D
PSYCHOBIOLOGY OF PTSD

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, Room 623, New Haven, CT 06519*

SUMMARY:

The many psychobiological abnormalities associated with PTSD will be described and it will be shown how they relate to clinical problems. Specifically, there will be a review of alterations in brain structure and function as demonstrated by neuroimaging studies. Also discussed will be the many alterations in neurobiological mechanisms that have been detected in PTSD patients. Specific attention will be focused on the adrenergic, serotonergic, and hypothalamic-pituitary-adrenocortical systems. Finally, important new areas for research will be identified that may have important implications for treatment.

No. 63E
PHARMACOTHERAPY FOR PTSD

Matthew J. Friedman, M.D., *National Center for PTSD, VA Medical Center (116-D), White River Juncti, VT 05009-0001*

SUMMARY:

The presenter will discuss the latest findings with respect to drug treatment for PTSD. Specific attention will be drawn to selective serotonin reuptake inhibitors, other drugs acting on serotonergic mechanisms, antiadrenergic agents, traditional antidepressants, anticonvulsants, anxiolytics and antipsychotic agents. Will show how effective drug actions can be understood in light of our emerging understanding of the pathophysiology of PTSD. Finally, he will show what new classes of medications will be developed in the near future to normalize the altered psychobiology of pTSD patients.

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3. Erikson K: Everything in its Path: Destruction of Community in the Buffalo Creek Flood. NY, Simon and Schuster, 1976

WEDNESDAY, MAY 9, 2001

SYMPOSIUM 64—FINDINGS FROM MULTISITE COLLABORATIVE LONGITUDINAL STUDY OF PERSONALITY

EDUCATIONAL OBJECTIVE FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should demonstrate an understanding of important clinical and research issues pertaining to Personality disorders.

No. 64A
CONFIRMATORY FACTOR ANALYSIS OF THE DSM-IV BPD CRITERIA

Charles A. Sanislow, Ph.D., *Department of Psychiatry, Yale University School of Medicine, PO Box 208098, New Haven, CT 06520-8098*; Carlos M. Grilo, Ph.D., Leslie C. Morey, Ph.D., John G. Gunderson, M.D., Andrew E. Skodol II, M.D., Mary C. Zanarini, Ed.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objective: To test the factor structure of the DSM-IV borderline personality disorder (BPD) criteria using confirmatory factor analysis (CFA).

Method: A total of 668 primarily treatment-seeking subjects were reliably assessed with the Diagnostic Interview for Personality Disorders-IV, a semistructured diagnostic interview for DSM-IV personality disorders. We examined the associations between the BPD criteria set, and performed CFA to test two models: (1) the diagnosis as a unitary construct, and (2) an earlier reported three-factor model by Sanislow and colleagues.

Results: Internal consistency was adequate as measured by Cronbach's alpha (0.86) and by inter-criteria correlations. Goodness-of-fit estimates for the one-factor model were acceptable [NFI = .947, CFI = .960; RMSEA = .066]. A test of the three-factor model (disturbed relatedness, behavioral dysregulation, and effective dyscontrol) proposed by Sanislow and colleagues also provided acceptable indices of fit [NFI = .951, CFI = .963; RMSEA = .067] and offered a slightly better fit statistically [X^2diff (3) = 8.1, $p < .001$]. Importantly, the three-factor model is also supported by the conceptual basis that three different classes of criteria compose BPD (personality traits, symptomatic behaviors, and symptoms).

Conclusion: The BPD diagnosis is a valid construct. Three homogeneous components with conceptual utility were replicated. These findings outline components of BPD that may exhibit differential stability, and inform treatment formulations.

No. 64B
A SCHEDULE FOR NONADAPTIVE AND ADAPTIVE PERSONALITY: DIMENSIONAL REPRESENTATION OF FOUR PERSONALITY DISORDERS

Leslie C. Morey, Ph.D., *Department of Psychology, Texas A & M University, College Station, TX 77843-4235*; Megan B. Warner, M.A., Charles A. Sanislow, Ph.D., Donna S. Bender, Ph.D.

SUMMARY:

Many have discussed the merits of examining underlying maladaptive traits that underlie the personality disorders. The FFM is one model that has been studied in relationship to personality disorders. This model has been criticized for being restricted to a normal range population, and thus not necessarily applicable to a clinical population. The SNAP (Schedule for Nonadaptive and Adaptive Personality) represents a dimensional personality model that attempts to assess those traits that are pertinent to both normal and abnormal range personality. Although it appears to be a promising model, there is limited research describing the relationship of this model to DSM-based categorical diagnoses. In this study, trait scores on the SNAP were compared among the four study groups and the depressed controls. These analyses were conducted using diagnoses that were allowed to co-occur, as well as mutually exclusive diagnostic groups in which primary diagnoses were assigned using prototypicality judgments from treating clinicians. One-way ANOVAs demonstrated that the means of all 12 lower-order trait scales as well as the three higher-order trait scales revealed differences among the diagnostic groups under both comorbid and mutually exclusive diagnostic groups. These results compare favorably with similar analyses conducted searching for differences on FFM variables in the same data set.

No. 64C
12-MONTH REMISSION OF MAJOR DEPRESSIVE DISORDER: INFLUENCE OF PERSONALITY DISORDERS

Carlos M. Grilo, Ph.D., *Department of Psychiatry, Yale Psychiatric Institute, PO Box 208038/184* Liberty Street, New Haven, CT 06519;

Robert L. Stout, Ph.D., Ingrid R. Dyck, M.P.H., Andrew E. Skodol II, M.D., Charles A. Sanislow, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objective: To report findings regarding the short-term (12-month) course of major depressive disorder (MDD) as a function of Axis II personality disorder (PD) comorbidity.

Method: Subjects were 288 adult patients (187 females and 101 males) selected from the 668 participants in the Collaborative Longitudinal Study of Personality based on meeting criteria for current MDD at baseline entry. DSM-IV Axis (including MDD) and all Axis II disorders were reliably assessed by highly trained evaluators using semistructured diagnostic interviews (SCID-I and DIPD-IV, respectively). The course of MDD was assessed with the Longitudinal Interval Follow-up Evaluation (LIFE) at six- and 12-month followups.

Results: Lifetable survival analyses were employed with Cox proportional hazards regression tests for significance. MDD was divided into study groups with 0, 1, 2, and 3 or more Axis II PDs. Overall, remission rates for MDD ranged from approximately 68% (no PDs present) to 48% (several PDs present) ($p < .01$). Differences in remission patterns were observed by gender. Females were less likely than males to remit from MDD. For males, a graded effect was observed—more PDs were associated with lower likelihood of remission. In contrast, females with one or more PDs evidenced similar remission rates, and had lower remission rates than females having no PD.

Discussion: A pattern of truncated remission in MDD with increasing PD comorbidity was observed with some gender differences in remission patterns.

No. 64D
GRAPHICAL METHODS FOR DYNAMIC RELATIONSHIPS BETWEEN AXIS I AND AXIS II DISORDERS

Robert L. Stout, Ph.D., *Decision Science Institute, 120 Wayland Avenue, Suite 7, Providence, RI 02906-4318*; Jenifer Allsworth, M.A., Jason Machan, M.A., Ingrid R. Dyck, M.P.H., Martin B. Keller, M.D.

SUMMARY:

While there are data that Axis I and Axis II disorders are correlated cross-sectionally, we have little information about the relative time course of changes across these disorders. One of the foci of the CLPS study is the relationship over time between Axis I and Axis II. We will present event history analyses showing significant relationships between major depression and borderline personality disorder (hazard ratio for major depression as a predictor of BPD = 0.681, p = .0003, and the hazard ratio for borderline as a predictor of major depression = 0.523, p = .0001), and between social phobia and avoidant personality disorder (hazard ratio for social phobia as a predictor of avoidant PD = 0.391, p = .0001, hazard ratio for avoidant PD as a predictor of social phobia = 0.524, p = .0003). We will then describe graphical methods to explore the nature of these dynamic associations, and display the associated graphs. The graphs indicate that "remission" involves a process occurring over several months both before and after the nominal date of the event. For some subjects, however, Axis I and Axis II changes do *not* seem to be related.

No. 64E
EARLY REMISSIONS IN BORDERLINE PATIENTS

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*; Donna S. Bender, Ph.D., Charles A. Sanislow, Ph.D., Regina T. Dolan, Ph.D., Leslie C. Morey, Ph.D., Elizabeth H. Schaefer, Ed.D.

SUMMARY:

From a naturalistic follow-along study (Collaborative Longitudinal Study of Personality Disorders), 18 borderline patients (10%) underwent early (within six mos) remissions. Surprisingly, none of the 18 early remitters relapsed when followed up at two years. Examination of the reasons for these remissions revealed different and often multiple pathways. Only in two instances could we conclude retrospectively that the BPD diagnosis was invalid: once due to an incomplete resolution of a bipolar (manic) episode, and once due to a patient's fabrications to get into a hospital. In seven instances the remission of an Axis I disorder preceded the BPD remission and seemed causally related. Contrary to expectations, the implicated Axis I disorder was MDD only once, whereas sobriety following substance abuse seemed critical in four instances. In eight instances, a change in the life situation seemed to account for the remission. These changes involved finding new stabilizing relationships (N=3) or leaving high-stress relationships or work situations (N=5). Although none of the 18 patients had deep sustained involvement in treatments that could account for the remissions, in 10 patients therapeutic interventions helped the patients to leave stressful situations (N=7) or helped support the Axis I remission (N=5). One therapy seemed to have a more primary role, i.e., by discontinuing phen-phen. Implications of these results for understanding borderline psychopathology and for treatment are discussed.

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SYMPOSIUM 65—UPDATE ON DEFICIT SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant will be able to list the major differences in deficit and nondeficit schizophrenia vis-à-vis course of illness, treatment, and clinical features.

No. 65A
THE ITALIAN MULTICENTER STUDY OF DEFICIT SCHIZOPHRENIA

Silvana Galderisi, M.D., *Department of Psychiatry, University of Naples, Largo Madonna Delle Grazie, Naples 1-80138, Italy*; Giovanni B. Cassano, M.D., Maria Del Zompo, M.D., Giordano Invernizzi, M.D., Alessandro Rossi, M.D., Antonio Vita, M.D., Mario Maj, M.D.

SUMMARY:

The expression "deficit schizophrenia" (DS) refers to a relatively homogeneous patient subgroup, characterized by the persistent pres-

ence of primary negative symptoms. Differences in clinical, historical, and biological variables have been found between patients with deficit and nondeficit schizophrenia.

The Italian multicenter study was designed to characterize deficit schizophrenia by integrating clinical, neuromorphological, neuropsychological, and genetic data. The study design involved the enrollment of (1) 60 patients meeting criteria for deficit schizophrenia, (2) 60 age- and sex-matched patients with a DSM-IV diagnosis of schizophrenia, but not meeting criteria for DS, and (3) 120 age- and sex-matched healthy controls. According to the study protocol, enrolled patients had to complete a historical evaluation, a psychopathological assessment, and a neurological, neuropsychological, and neuroradiological examination. Blood samples were also collected from both patients and controls to study the association between DS and genes coding for neuronal growth factors.

The relevance of study findings to the hypothesis of DS as a separate disease will be discussed.

No. 65B
THE TREATMENT OF NEGATIVE SYMPTOMS

Donald C. Goff, M.D., *Department of Psychiatry, Harvard Medical School, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

Several pharmacologic approaches have been shown to improve negative symptoms of schizophrenia, although it remains uncertain whether negative symptoms in deficit syndrome patients are responsive to currently available treatments. Results from clinical trials targeting negative symptoms will be reviewed for conventional and atypical antipsychotics, as well as results from path analyses calculating direct and secondary effects upon negative symptoms. Augmentation strategies with dopamine agonists, selective serotonin reuptake inhibitors, and glutamatergic agents (positive modulators of NMDA receptors and of AMPA receptors) will also be reviewed. Finally, the potential roles of psychosocial interventions, including social skills training, cognitive behavioral treatment, and cognitive remediation will be discussed.

No. 65C
FAMILY STUDIES OF EYE TRACKING AND THE HETEROGENEITY OF SCHIZOPHRENIA

Dolores Malaspina, M.D., *Department of Psychiatry, Columbia University-NY Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Eye tracking dysfunction has been associated with schizophrenia since the 1908 seminal publication by Diefendorf and Dodge reporting impaired smooth pursuit eye movements in schizophrenia patients that were evident during routine physical examinations. A new generation of interest in eye movements was initiated in the 1970s when Philip Holzman demonstrated that disrupted eye tracking is present in both schizophrenia patients and in a significant proportion of their healthy relatives. This finding suggested that disrupted eye movements might be a trait marker for schizophrenia vulnerability, which could serve as an endophenotype in genetic linkage studies designed to identify schizophrenia genes. Of further interest, eye tracking dysfunction might also provide clues to the pathophysiology of schizophrenia. This presentation discuss information about eye tracking from family studies that is relevant to the etiology of schizophrenia. It will also present data on the relationship of eye movement quality to particular features of schizophrenia, particularly the relationship of the eye movement abnormalities to negative symptoms and the deficit syndrome. Finally, data from challenge studies and functional imaging findings will be presented that illustrate the neural circuitry underlying eye movement dysfunction in schizophrenia patients.

No. 65D
COURSE OF ILLNESS IN DEFICIT SCHIZOPHRENIA

Cenk Tek, M.D., *Department of Psychiatry, University of Maryland, MPRC, p o box 21247, Baltimore, MD 21228*; Robert W. Buchanan, M.D., Brian Kirkpatrick, M.D.

SUMMARY:

Previous studies have suggested that deficit schizophrenia is a stable subtype of schizophrenia, and that patients with the deficit schizophrenia have a different course of illness than other people with schizophrenia. Our group initially reported lower levels of premorbid functioning in deficit schizophrenia compared with other subtypes. This has been replicated in multiple clinical- and population-based samples by our group and others. Lower levels of function persist throughout the course of illness in deficit schizophrenia. These differences in outcome could not be attributed to more severe positive psychotic symptoms, disorganization or to greater anxiety, depressive mood, or substance abuse in the group with deficit schizophrenia.

The diagnosis of deficit schizophrenia was previously reported to be predictive of low functioning many years later in an inpatient sample. We have replicated this finding in a clinical sample of 220 outpatients with schizophrenia. In our study persons with deficit schizophrenia had lower levels of functioning and quality of life even after accounting for positive, disorganization, and negative symptoms at the time. It appears that lower social and occupational functioning emerges to be another stable, important feature of deficit schizophrenia in addition to, and perhaps independent from, persistent idiopathic negative symptoms. Possible reasons and implications of lower functioning will be discussed.

No. 65E
A SEPARATE DISEASE WITHIN THE SYNDROME OF SCHIZOPHRENIA

Brian Kirkpatrick, M.D., *Department of Psychiatry, MD Psychiatric Residential Center, PO Box 21247, Baltimore, MD 21228-0747*; Robert W. Buchanan, M.D., David Ross, M.D., William T. Carpenter, Jr., M.D.

SUMMARY:

Patients with deficit schizophrenia exhibit a particular set of enduring, idiopathic negative symptoms. Research from multiple centers has shown that deficit patients differ from other people with chronic schizophrenia relative to signs and symptoms other than negative symptoms, course of illness, biological correlates, treatment response, and etiological factors. These differences cannot be attributed to more severe positive psychotic symptoms or a greater duration of illness in the deficit group. A parsimonious explanation for these differences is that schizophrenia is a heterogeneous syndrome, and deficit schizophrenia represents a disease that is separate from the other psychotic disorders we now call schizophrenia. The alternative interpretation that deficit patients are at the severe end of a single disease continuum is not supported by risk factor and biologic features data. We outline a series of studies designed to falsify one of these hypotheses, i.e., multiple diseases vs. a single disease.

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1. Carpenter WT Jr, et al: Biol Psychiatry 1999; 46:352–360
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5. Kirkpatrick B, Buchanan RW, Ross DE, Carpenter WT Jr. A separate disease within the syndrome of schizophrenia. Archives of General Psychiatry, in press

SYMPOSIUM 66—WOMEN'S RESILIENCY TO ADVERSITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize adversities faced by women (stalking, sexual abuse, breast cancer, sexually transmitted disease, academic discrimination) and to select treatment strategies that capitalize on women's resilience.

No. 66A
A PROSPECTIVE STUDY OF DEPRESSION IN PREGNANT WOMEN: RISK FACTORS RELATED TO POSTPARTUM RELAPSE

Shaila Misri, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, 2B-250, Vancouver, BC V6Z 1Y6, Canada*; Xanthoula Kostaras, B.S.C.

SUMMARY:

This prospective study of pregnant and postpartum women involved a collaborative effort between the departments of Reproductive Psychiatry, Pediatrics, Pharmaceutical Sciences and Infant Psychiatry at the University of British Columbia. Of the 100 women who were screened for participation, 56 completed the study. All participants had a diagnosis of major depression and were being treated with an SSRI. They were recruited in various trimesters of their pregnancies, and were evaluated for mood and anxiety up to eight months postpartum. All mothers were breastfeeding during the postpartum period. This presentation will focus on the subgroup of women who relapsed in the postpartum period despite adequate treatment leading to euthymia in pregnancy. Risk factors associated with this relapse will be discussed.

No. 66B
STALKING: AN OVERVIEW OF THE PROBLEM

Gail E. Robinson, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada*; Karen M. Abrams, M.D.

SUMMARY:

Stalking or criminal harassment is defined as the willful, malicious, and repeated following or harassing of another person. The behavior includes such things as following, surveilling, making multiple phone calls, harassing the victim's employer or family, interfering with personal property, or sending threatening or suggestive gifts or letters. The offender's behavior is terrorizing, intimidating, and threatening, and restricts the freedom of and controls the victim. Most stalkers are male. It is estimated that one in 20 women will be stalked at some point in her lifetime. In 90% of women murdered by a current or estranged intimate, the murders are preceded by some form of stalking. The majority of stalking cases are related to failed intimate relationships. Celebrities, people in positions of authority or prominence, as well as health care providers are at an increased risk for attracting stalkers. Stalkers may also suffer from erotomania or obsessional love, with a primary psychiatric diagnosis.

Victims suffer from depression, anxiety, shame, embarrassment, guilt, and helplessness and often fear for their lives. They often lose friendships, jobs, and financial security. Victims experience added stress because of society's failure to acknowledge the seriousness of this problem.

No. 66C
ATTACHMENT, ABUSE, AND PSYCHOPATHOLOGY RISK: HUMAN PAPILLOMAVIRUS

Susanne I. Steinberg, M.D., Department of Psychiatry, *St. Mary's Hospital, 3830 Lacombe Avenue, Room 3712 Annex, Montreal, QC H3T 1M5, Canada*; Angela Lambrinos, M.S.C., Harriet Richardson, M.S.C., Eduardo L. Franco, Ph.D.

SUMMARY:

Screening for human papillomavirus, known to be a precursor of cervical cancer, involves an expensive polymerase chain reaction technique. We propose a cost-effective method for the identification of women at highest risk and at priority for definitive testing.

Objectives: To identify whether specific Axis I and Axis II disorders, or a history of abuse or attachment styles vary amongst women with persistent HPV or SIL compared with controls.

Methods: From a total cohort of 631, 33 women were selected and the interviewers were blind to the pap smear results. Structured Clinical Interviews for the DSM-IV (SCID I & II), Women Abuse Screening Tool (WAST), Measures of Parental Style (MOPS), semi-structured validated Support & Attachment Style Interview (ASI), were employed. Quotes from the student's interviews will complement the quantitative findings.

Results: Preliminary data revealed an increase in partner abuse in women with persistent HPV (36.4%) compared with SIL (7.1%) and controls (18.2%). Similarly, father abuse was most common in the HPV persistent group compared with the others. Insecure attachment styles were more often reported by index groups (SIL-83%; HPV persistent-63%). The control group revealed a higher rate of secure attachment styles (71%). More index cases suffered the following Axis I disorders: substance abuse, major depression, social phobia, and Axis II disorders: histrionic, borderline, narcissistic, obsessive compulsive personality disorder).

Conclusion: These computerized screening measures could focus definitive diagnostic procedures (DNA sequencing) upon the most vulnerable population. These results require further confirmation.

No. 66D
ATTRIBUTIONS OF CAUSE AND RECURRENCE IN LONG-TERM BREAST CANCER SURVIVORS

Donna E. Stewart, M.D., *Women's Health, University of Toronto, 200 Elizabeth Street, M/L-2-004, Toronto, ON M5G 2C4, Canada*; A. Cheung, M.D., S. Duff, Felicia Wong, M. McQuestion, T. Cheng, Laura Purdy

SUMMARY:

This survey sought to determine to what women survivors of breast cancer attributed the cause and lack of recurrence of their breast cancer, and whether these views were associated with psychological or behavioral variables.

Methods: Women who had survived breast cancer without recurrence for at least two years were surveyed by mail about their

views of the cause and lack of recurrence of their breast cancer, and psychological and behavioral variables.

Results: Three-hundred and seventy-eight (75.6%) women breast cancer survivors responded who had been recurrence free for a mean of 8.6 ± 11.8 years. Women (n = 322) attributed the cause of breast cancer to stress (42.2%), genes (26.7%), environment (25.5%), hormones (23.9%), don't know (16.5%), diet (15.5%), and breast trauma (2.8%). Women (n = 330) attributed prevention of cancer to positive attitude (60.0%), diet (50.0%), healthy lifestyle (40.3%), exercise (39.4%), stress reduction (27.9%), prayer (26.4%), complementary therapies (11.2%), don't know (5.1%), luck (3.9%), and tamoxifen (3.9%). Attributions of breast cancer cause or lack of recurrence were associated with specific psychological and behavioral variables.

Discussion: Despite lack of evidence substantiating stress as a cause of breast cancer, many breast cancer survivors believed this. An even higher percentage of survivors believed their positive attitude had prevented breast cancer recurrence. Attribution beliefs clearly affected survivors' health behaviors.

Conclusion: Health care providers should consider the personal beliefs of patients about cancer cause and recurrence, which may be at variance with scientific evidence. This may assist in framing the management of patients in personally meaningful ways, which may increase a sense of control, enhance mood, adherence, satisfaction, quality of life, and health behaviors.

No. 66E
CHALLENGES FOR WOMEN IN ACADEMIC MEDICINE

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Suite 280, Cleveland, OH 44106*

SUMMARY:

Data from the Association of American Medical Colleges (AAMC) reflect that full professors are 30% men and 10% women. Few women have achieved advanced leadership positions. The Study on Status of Women Faculty in Science at MIT, known widely as the "MIT Report" on gender discrimination, made headline news. The breakthrough was that processes more subtle than overt discrimination contribute to the cumulative disadvantage of women. These factors are often denied by making attributions to the women themselves ("they don't work as hard as men"); to the fairness of later-career processes, which do not consider the cumulative disadvantage ("tenure and promotion committees administer policies fairly for men and women"); and by pointing to rare women who achieve as evidence that gender is not a factor in advancement. Awareness and problem solving about discrimination is imperative, but will not occur until the disparity is viewed as a problem with real consequences for organizations.

To advance in academic medicine, women must obtain mentoring, avoid noninfluential committee work, limit teaching, develop networks outside the primary organization, practice negotiation skills, use language effectively, and be persistent. Innovative AAMC-sponsored programs and the Executive Leadership in Academic Medicine Program for women address these needs.

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SYMPOSIUM 67—CLINICAL ISSUES AND ETHICAL CONCERNS REGARDING ATTEMPTS TO CHANGE SEXUAL ORIENTATION: AN UPDATE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of the symposium, the participant will be able to identify the clinical and ethical issues involved with attempts to change sexual orientation. In addition, the participant will understand the current state of research in this area and potential outcomes of sexual re-orientation therapy.

No. 67A
OVERVIEW OF THE RESEARCH PROBLEMS AND ETHICS OF THERAPY TO CHANGE SEXUAL ORIENTATION

Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130*

SUMMARY:

It has been over 25 years since the American Psychiatric Association removed homosexuality form the DSM as a disorder, and yet therapists continue to try to change the sexual orientation of people who present uncomfortable with their sexual and emotional orientation. All controversy over the efficacy and ethics of trying to change sexual orientation is rooted in the fundamental issue of whether homosexuality is inherently pathological or normal. To date, few therapists have argued for the right to treat heterosexually-oriented people such that they become more comfortable with a homosexual orientation and behavior. Those who would favor treating homosexually-oriented people to change to heterosexual base their arguments on the a priori assumption that heterosexual orientation is superior, and that therapists are simply helping their patients achieve the goals they bring of making such a change. Those who argue that it is unethical to try to change sexual orientation base their arguments on the a priori assumption that homosexuality is not per se pathological, and treatment, if any, ought to be geared toward helping people become more ego syntonic with their sexual and affectional desires.

This presentation will discuss the research methodology of sexual orientation change therapy, and the ethical issues such practice raises in the context of the political and social environment that continues to pathologize homosexuality. It will clarify the distinction between the possibility of people changing their sexual behaviors and object choices over the course of a lifetime from the intent of certain therapists to change people's orientation from homosexual to heterosexual. Problems with the existing research methodology and the ethics of therapists having an agenda to change orientation based on pathology will be discussed on theoretical as well as clinical grounds.

No. 67B
SUBJECTS WHO CLAIM TO HAVE BENEFITED FROM SEXUAL REORIENTATION THERAPY

Robert L. Spitzer, M.D., *Biometrics Department, NYS Psychiatric Institute, 1051 Riverside Drive, Unit 60, New York, NY 10032*; Jerome Wakefield, M.D.

SUMMARY:

It is widely assumed that sexual orientation, once established, is irreversible and therefore attempts to alter it are always doomed to failure. However, some clinicians and religious ministries claim they help some highly motivated people to change their sexual orientation from homosexual to heterosexual. We studied 75 males and 25 females who report such change, sustained for at least five years, following psychotherapy and/or participation in an ex-gay ministry. Subjects were recruited from a variety of sources and were administered a 30- to 40-minute structured interview that assessed components of sexual orientation during adolescence, the year prior to therapy, and the year prior to the interview. Most subjects reported substantial changes from homosexual to heterosexual orientation following therapy on a variety of measures, including sexual attraction and behavior, and sexual fantasies during masturbation, while daydreaming, and during heterosexual intercourse. We present reasons why the subjects' self-reports of change appear to be, by and large, valid, rather than gross exaggerations, brain washing, or wishful thinking. We, therefore, conclude that some individuals who participate in a sexual reorientation therapy apparently make sustained changes in sexual orientation. However, the study provides no information as to how frequently such changes are possible. The study conclusions should not be misused to justify coercive treatment.

No. 67C
CLINICAL AND RELIGIOUS ATTEMPTS TO CHANGE HOMOSEXUAL ORIENTATIONS: AN EMPIRICAL STUDY

Ariel Shidlo, Ph.D., *420 West 24th Street, #1B, New York, NY 10011*; Michael Schroeder, Psy.D.

SUMMARY:

This study examined the impact of sexual orientation conversion interventions on persons with a homosexual orientation. Interventions included psychotherapy as well as Christian-based pastoral and peer counseling. Subjects were recruited through advertisements in gay and non-gay print press, Internet ads, and direct mailings to both ex-gay Christian counseling programs and a mental health organization claiming to "cure" homosexual persons. Interviews were conducted between 1995 and 2000. A semi-structured interview, which lasted on average 90 minutes, was conducted on the telephone. Areas of inquiry included assessing changes in sexual orientation, perceived damage, and helpfulness of the intervention; motivations for seeking conversion therapies; and subjects' perception of what took place in their counseling sessions. Subjects were also asked questions designed to assess practitioner compliance with informed consent. In a sample of 215 subjects, a majority reported failure to change sexual orientation and experiences of significant harm. A small subset reported feeling helped. Follow-up interviews were conducted with this subgroup. A developmental model is offered to describe the journey of homosexual persons through conversion therapies. Based on this empirical data, the authors also present a typology that provides examples of ethical violations and poor practice by conversion therapists.

No. 67D
ETHICAL ISSUES IN EFFORTS TO BAN REORIENTATION THERAPIES

Mark Yarhouse, Psy.D., *Department of Psychology, Regent University, 1000 Regent University Drive, Virginia Beach, VA 23464*; Warren Throckmorton, Ph.D.

SUMMARY:

The purpose of this review article is to identify the ethical issues in efforts to ban reorientation and alternative therapies for patients who report distress due to their experiences of same-sex attraction and/or behavior and seek change. The three primary arguments cited in the literature in favor of such a ban will be discussed: (1) homosexuality is no longer a mental illness, (2) those who request change do so because of internalized homophobia, and (3) sexual orientation is immutable. The author will then present three arguments in favor of providing services to persons who report distress due to their experiences of same-sex attraction and/or behavior: (1) respect for the autonomy and self-determination of persons, (2) respect for valuative frameworks and creeds, and (3) service provision in response to a stated need in light of the scientific evidence that efforts to change thoughts, behaviors, and feeling-based sexual orientation can be successful for some persons. Guidelines will also be offered for how clinicians can proceed in a way that is scientifically and professionally responsible, ethical, and respectful of all persons in a diverse and pluralistic society.

No. 67E
ETHICAL CONCERNS RAISED WHEN PATIENTS SEEK TO CHANGE SAME-SEX ATTRACTIONS

Jack Drescher, M.D., *420 West 23rd Street, # 7D, New York, NY 10011-2174*

SUMMARY:

Since the American Psychiatric Association removed homosexuality from its diagnostic manual in 1973, mainstream mental health organizations have maintained that an individual's sexual orientation should be respected. Reparative therapists, however, argue that homosexuality is always a symptom of mental illness that should be treated. They have further argued that all therapists have an ethical responsibility to refer individuals with anti-homosexual religious beliefs to reparative therapists in order to change their sexual identities.

This paper argues that such recommendations are unwise because they are derived from a misleadingly narrow reading of ethical guidelines. Rather than an issue regarding ethical patient care, this argument is a reflection of the culture wars surrounding homosexuality. This paper places those struggles in historical context. It examines reparative therapists' pathologizing of and attempts to "cure" or change same-sex attractions. Reparative therapists insist on social and traditional gender conformity as a therapeutic goal, and in doing so operate from an essentialist view of anti-homosexual morality. Reparative therapies rely upon gender stereotyping that disrespect a patient's same-sex attractions. Furthermore, as some reparative therapists actively support political activities opposed to granting civil rights to lesbians and gay men, these activities raise ethical issues relevant to the entire psychotherapeutic endeavor. Inevitably, the decision about these issues affects all patients and clinicians.

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4. Haldeman DC: The practice and ethics of sexual orientation conversion therapy. J of Consult and Clin Psych 1994; 62:221–227
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cused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies), 2000

SYMPOSIUM 68—STATE VERSUS TRAIT DISTURBANCES FOUND IN EATING DISORDERS: RECENT FINDINGS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will recognize the recent scientific findings regarding the psychobiology of anorexia nervosa, bulimia nervosa, and binge eating disorder, with particular attention to disturbances believed to be stably trait related, and those associated with state of acute illness.

No. 68A
5HT FUNCTION IN WOMEN WITH ANOREXIA NERVOSA

Evelyn Attia, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit 98, New York, NY 10032-2603*; Sara Wolk, M.A., Thomas Cooper, M.A., Wahida Karmaly, Lauren Escott

SUMMARY:

Anorexia nervosa (AN) is a serious psychiatric illness characterized by self-starvation and cognitive distortions regarding issues of food, weight, and body shape. Risk factors for developing this illness are likely multifactorial, but the remarkably stable clinical features of AN suggest that AN may be associated with common and relatively invariant biological disturbances. The severe starvation and physiologic consequences that characterize patients with AN make biological study of these patients difficult, as abnormalities may reflect the acute state of starvation and may not describe the more stable trait factors associated with the illness. In contrast, assessments made in recovered women may inform us about trait-related features, possibly features that contribute to the pathogenesis of AN.

This presentation will review data from a series of patients with AN at different stages of illness. Plasma measures of serotonin-precursor tryptophan will be presented from AN patients at different stages of illness and recovery. Indirect measures of serotonin function, such as cerebrospinal fluid (CSF), monoamine metabolite 5-hydroxyindoleacetic acid (5-HIAA), as well as results from tryptophan-depletion challenge tests will be described after short-term and long-term weight restoration. Plans for direct measures of serotonin activity in these patients using positron emission tomography (PET) will be described.

No. 68B
RESTING ENERGY METABOLISM IN ANOREXIA NERVOSA

Laurel Mayer, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia University, 1051 Riverside Drive, Unit 98, New York, NY 10032*; B. Timothy Walsh, M.D., Michael Rosenbaum, M.D., Rudolph Leibel, M.D., Richard Pierson, Jr., M.D., Erin Killory

SUMMARY:

Purpose: To determine if weight-restored patients with anorexia nervosa have disturbances in resting energy expenditure (REE).

Methods: REE, body composition, and leptin levels were measured in 19 patients with anorexia nervosa and 11 control women. Patients were tested before and after weight gain. Control subjects were tested at usual body weight and after losing 10% of body weight.

Data and Results: REE/FFM of patients at low weight (27.9±2.7 kcal/day/kg) was significantly different from the mean REE/FFM of control subjects at usual weight (31.3±5.0 kcal/day/kg) (p=0.001), but not from the mean REE/FFM of control subjects at reduced weight (27.4±4.5kcal/day/kg) (p=NS). The mean REE/FFM of weight-restored patients (31.4±3.5kcal/kg/day) was not significantly different than that of controls at usual body weight (31.3±5.0 kcal/day/kg) (p=NS). Leptin levels, however, were significantly higher than predicted for patients with anorexia nervosa at low weight.

Conclusions: At low weight, patients with anorexia nervosa have a reduced REE/FFM compared with normal weight controls, but not significantly different than would be predicted due to weight loss alone. Following normalization of body weight, the REE/FFM of patients with anorexia nervosa returns to values similar to controls. Leptin concentrations, however, were higher than predicted, and may suggest that the relationship between leptin and fat mass is altered at extremely low fat masses.

No. 68C
PSYCHOBIOLOGICAL STUDIES OF WOMEN WITH 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*; Robyn J. Sysko, Ellen Zimmerli, Ph.D., Michael J. Devlin, M.D., Janet Guss, Harry Kissileff

SUMMARY:

Characterizing the psychobiological disturbances among individuals with eating disorders allows us to generate informed hypotheses concerning the underlying pathophysiology of these illnesses. Studies of gastrointestinal physiology and eating behaviors in patients with bulimia nervosa (BN) lend support to the idea that these patients manifest a disturbance in the regulation of satiety over the course of a meal.

For example, earlier studies have found that the post-prandial release of cholocystokinin (CCK), a statiety-mediating hormone, is blunted in patients with BN. In order to determine the degree to which this abnormality is due to slowed gastric emptying, we subsequently administered nutrients directly to the duodenum and measured satiety and CCK release, finding that CCK release more closely approached normal levels under these conditions. Additionally, using a gastric barostat, our group has explored the hypothesis that the enhanced stomach capacity known to be present in patients with bulimia may reflect disturbances in gastric pressure-volume relationships over the course of a meal.

This presentation will review these and other related studies, and will address the question of whether these disturbances are a function of illness-related behavior, or more stable trait abnormalities.

No. 68D
EATING BEHAVIOR IN BINGE EATING DISORDER: IMPLICATIONS FOR TREATMENT

Michael J. Devlin, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, New York, NY 10032-2603*; Claudia Kamenetz, Katherine G. Meehan

SUMMARY:

Studies of eating behavior in obese patients with binge eating disorder (BED) have reported that BED subjects, when asked to consume a meal in a laboratory setting, eat larger amounts than equally obese subjects without BED. In addition, patients with BED display abnormalities in the experience of satiety, which resemble,

in some ways, those seen in bulimia nervosa. However, the causal relationships between altered satiety mechanisms, disturbed eating patterns, and obesity are as yet unclear.

Obesity and binge eating are clearly related: we have recently observed a significant correlation (r^2=.2, p<.05) between degree of obesity and binge meal size in a sample of 22 patients with BED who participated in a laboratory study of binge eating. What is not known is whether the observed binge eating patterns contribute to the onset and/or maintenance of obesity in these patients, or result from the patient's obesity and attempts to lose weight. In other words, although we have begun to identify features that distinguish obese patients with BED from their non-binge eating counterparts, we are not yet able to confidently distinguish whether these features reflect longstanding trait abnormalities or illness-related states.

This paper will present the latest findings from studies of eating behavior and satiety regulation in patients with BED, review what is known about the course of obesity and binge eating in these patients, and discuss the clinical implications for initial treatment and relapse prevention in obese patients with BED.

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3. Devlin MJ, Walsh BT, Guss JL, Kissileff HR, Liddle RA, Petkova E: Postprandial cholecystokinin release and gastric emptying in patients with bulimia nervosa. Am J Clin Nutr 1997; 65(1):114–120
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SYMPOSIUM 69—MODEL RESIDENCY PROGRAMS ON RELIGION AND SPIRITUALITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the importance of religious/spiritual issues in clinical training of psychiatric residents and to understand how sixteen model residency programs have implemented curricula on religious/spiritual issues.

No. 69A
PSYCHIATRIC RESIDENCY TRAINING ON RELIGION/SPIRITUALITY: AN OVERVIEW

Francis G. Lu, M.D., *Department of Psychiatry, University of California, San Francisco, 1001 Potrero Avenue, SFGH Suite 7M, San Francisco, CA 94110*; Christina M. Puchalski, M.D.

SUMMARY:

For the first time, the 1995 ACGME accreditation standards for psychiatry residency programs included didactic curricula on religion/spirituality. This led to the publication of Model Curriculum for Psychiatry Residency Training Programs: Religion and Spirituality in Clinical Practice (1996) to provide training directors with guidance. Knowledge, skills, attitudes, objectives, as well as implementation strategies, will be reviewed. Starting in 1998, 16 psychiatric residency programs have been awarded the John Templeton Award for Curricular Development in Spirituality and Medicine. These programs include Harvard-Longwood, California Pacific, Loma Linda, University of Pittsburgh, Baylor, Bronx-Lebanon, Jefferson, East Tennessee, Georgetown, Southern Illinois University, the Cleveland Clinic, University of Pennsylvania (child), Wright State (child), University of New Mexico, Emory (child), and the University of Alabama. Best teaching strategies and methods from these programs will be presented.

No. 69B
THE EMORY SPIRITUALITY, RELIGION, AND CULTURE IN CHILD AND ADOLESCENT PSYCHIATRY CURRICULUM

Sandra Sexson, M.D., *Department of Psychiatry, Emory University, 1256 Briarcliff Road NE #313, Atlanta, GA 30306*; Shamina J. Henkel, M.D.

SUMMARY:

The Emory Division of Child and Adolescent Psychiatry spirituality curriculum adds a focus on spirituality and religion that augments the overall curriculum, which emphasizes the integration of cultural issues throughout the developmental spectrum while facilitating residents' understanding of themselves as they work with patients from very diverse backgrounds. This presentation will describe an integrated biennial schedule that accesses for trainees a basic fund of knowledge about world faith traditions and how these religious traditions may impact health and the provision of health care in the context of life experiences and developmental rituals. The course focuses on the implications of the trainee's and the patient's religious/spiritual beliefs and practices in the overall process of child and adolescent psychiatric assessment, treatment, and prevention. A didactic/process curriculum addressing the impact of the major faith traditions on human and family development, experiential learning techniques for our residents to integrate this information, along with clinical aspects of the integration of religion/spirituality into the day-to-day functions of the child and adolescent psychiatrist (work with community religious professionals, religious/spiritual case formulations, and management plans) will be presented. Two rotation experiences that provide hands-on opportunities to incorporate tenets gleaned from this course into the practice of child and adolescent psychiatry will be described.

No. 69C
THE UNIVERSITY OF ALABAMA CURRICULUM ON RELIGION, SPIRITUALITY, AND PSYCHIATRY

Nathan B. Smith, M.D., *Department of Psychiatry, University of Alabama, 1530 3rd Avenue, South, SPC 121, Birmingham, AL 35294-0018*

SUMMARY:

This presentation describes the activities in the Religion and Spirituality in Psychiatry program in the UAB Psychiatry Residency Training Curriculum. With the goal of demonstrating the importance and relevance of spirituality and religion to competent care of psychiatric patients, to a large degree, the program is designed to integrate material on spirituality and religion into courses in the current curriculum. While the format of the majority of the activities is lecture or discussion, some of the activities are designed specifically to encourage residents to better understand the role their own cultural, religious, and spiritual experiences influence their understanding of the patients in their care. The program spans the four years of training and covers the following topics: the historical relationship between psychiatry and religion, definitions of relevant religious and spiritual concepts, traditions and practices of major religions, interviewing

and assessing patients' religious/spiritual beliefs and attitudes, recognizing healthy and unhealthy religiosity and spirituality, potential problems with transference and countertransference about religious issues, concepts of religious and spiritual development, collaboration with chaplains and other clergy, religious and spiritual aspects of end-of-life issues, and mental health research on religion and spirituality.

No. 69D
EXPECTABLE AND SURPRISING CONSEQUENCES OF TEMPLETON AWARD: A THREE-YEAR FOLLOW-UP AT BAYLOR

James W. Lomax II, M.D., *Department of Psychiatry, Baylor University College of Medicine, One Baylor Plaza, MS350, Houston, TX 77030*; Linda B. Andrews, M.D., Arif M. Shoaib, M.D.

SUMMARY:

In the three years subsequent to being recognized as a Templeton award-winning curriculum in psychiatry and religion, the Baylor program has had both expectable and unanticipated consequences for its residents and residency educators. Involving hospital chaplaincy programs in the residency program has led to reciprocal involvement of the residents and residency director in the educational programs of the hospital's Clinical Pastoral Education Program. Surprising and unanticipated connections have been forged with the Islamic Society of Greater Houston resulting in many activities. Most dramatic of this was the participation of a Baylor resident in a medical mission trip to Kosovo, which included the conduct of a research project studying children's experiences of war. Material from these and other endeavors related to our curriculum in religion and spirituality will be presented. Participants should be stimulated to consider analogous possibilities within their local community.

REFERENCES:

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3. Larson D, Lu F, Swyers J (eds): Model Curriculum for Psychiatry Residency Training Programs: Religion and Spirituality in Clinical Practice. Rockville, MD, National Institute for Healthcare Research, 1996
4. Terr L: Childhood traumas: an outline and overview. Am J Psychiatry 1991; 148(1):10–20

SYMPOSIUM 70— PSYCHOPATHOLOGICAL PATHWAYS FOLLOWING TRAUMATIC LIFE EXPERIENCE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should learn the prevalence of traumatic experiences in the general population in the U.S. and Australia, and the range of associated psychopathologies; and understand patterns of comorbidity and symptom constellations associated with particular traumatic events at different stages of the life cycle and their treatment implications.

No. 70A
MULTIPLE COMORBIDITIES OR TRAUMA-SPECTRUM DISORDERS IN THE U.S. NATIONAL COMORBIDITY SURVEY

Joseph F. Spinazzola, Ph.D., *Department of Psychiatry, Boston University School of Medicine, 209 Babcock Street, Brookline, MA 02446*; Cassandra Kisiel, Ph.D., Allison Tracy, Ph.D., Bessel A. Van Der Kolk, M.D.

SUMMARY:

Objective: This study presents comorbidity and symptom profiles following trauma and childhood adversity (depending on age at onset, duration, and perpetrator) through secondary data analysis of the U.S. National Comorbidity Survey.

Method: The sample consists of 5,720 subjects, representing approximately 97% of the N=5877 stratified probability sample of noninstitutionalized civilians, aged 15–54, with lifetime exposure to one or more traumas. Trauma histories and psychiatric outcomes were measured through a series of standardized diagnostic interviews. High magnitude stressors (e.g., rape, natural disasters) and childhood adversities (e.g., verbal aggression, parental psychopathology) as well as diagnostic and symptom-based outcomes were assessed.

Results: The data analysis plan consists of two phases: (1) cluster analyses of trauma/adversity types, trauma-specific characteristics (e.g., age at onset), Axis 1 disorders and symptomatology; cluster analyses will be conducted on randomly selected subsamples (e.g., 10%) of the overall trauma sample; (2) contingency table analysis to assess the association between common trauma profiles and common symptomology profiles.

Conclusions: The relative utility of two competing models of trauma sequelae will be presented in light of study findings: multiple psychiatric comorbidities versus trauma spectrum disorders as clustered in the Disorders of Extreme Stress (DESNOS).

No. 70B
TRAUMATIC STRESS AS AN ANTECEDENT TO PSYCHOTIC DISORDER

Alexander McFarlane, M.D., *Department of Psychiatry, Adelaide University, 28 Woodville Road, Woodville SA 5011, Australia*; Gavin Andrews, Lorna Peters, Ph.D.

SUMMARY:

The National Mental Health and Well Being Survery, surveyed a stratified sample of 10,600 people over the age of 18 years. Using ICD criteria, PTSD was the most common anxiety disorder using ICD-10 criteria, with a 12-month prevalence of 3.3%. This paper will present the role of traumatic events as antecedents to other psychiatric disorders. A series of analyses, excluding those subjects with PTSD, will explore the role of a traumatic event as a risk factor for all psychiatric disorders and suicidal thinking. The 12-month patterns of comorbidity will be presented. From a theoretical perspective these data raise a series of questions about the specifity of traumatic stress as a cause of PTSD. Furthermore, the relationship between PTSD, comorbid depression, and other anxiety disorders raises important questions about the current diagnostic criteria and their overlap.

No. 70C
SIMPLE AND COMPLEX PTSD AMONG THE DUALLY DIAGNOSED

Walter E. Penk, Ph.D., *Department of Psychology, ENRM Veterans Hospital, 200 Springs Road, Bedford, MA 01730*; Jill Rierdan, Ph.D.,

Marylee Losardo, M.S., Tatjana Mesheda, M.S., Charles Drebing, Ph.D.

SUMMARY:

This presentation explores simple vs. complex PTSD among dually-diagnosed patients in treatment who also meet criteria for two other co-occurring disorders—addictions and such serious mental disorders as schizophrenia and bipolar disorders. The sample consists of 385 dually-diagnosed patients to whom an extensive battery of tests was administered, including the Structured Clinical Interview for DSM-IV (SCID) and the Minnesota Multiphasic Personality Inventory-2. Measures of complex PTSD were based on administration of DESNOS (Disorders of Extreme Stress Not Otherwise Specified interview) administered to the 157 patients meeting SCID-criteria for PTSD.

Results show that frequently-used standardized measures of "simple" PTSD (e.g. MMPI-2 PTSD and Life Experiences Survey PTSD scales developed among nonpsychotic populations) are less clinically useful in classifying PTSD among dually-diagnosed patients than is the addition of DESNOS measures of "complex" PTSD. Adding DESNOS measures of "complex" PTSD to classic DSM-IV measures of "simple" PTSD improves classification of PTSD among patients in treatment with serious mental disorders and addictions. Results are discussed in terms of the history of developing DSM-IV criteria for classifying PTSD among nonpsychotic patients; omitting nonpsychotic patients limits understanding of the role of trauma among the dually-diagnosed.

No. 70D
TRAUMA, PTSD, AND DISORDERS OF EXTREME STRESS IN WOMEN WITH SEVERE MENTAL ILLNESS

Julian Ford, Ph.D., *Department of Psychiatry, University of Connecticut Health, 263 Farmington Avenue, MC 6228, Farmington, CT 06030*; Debra Fournier, B.A., Katherine Moffitt, Ph.D.

SUMMARY:

Adults in treatment for severe persistent mental illness (SMI) are highly likely to experience multiple psychological traumas during their lives. This study investigated the prevalence, patterns of interrelationship, and impact on illness severity and health care services utilization of: (a) exposure to developmentally adverse interpersonal trauma (DAIT) at different developmental epochs (i.e., early childhood, middle childhood, adolescence, adulthood) and (b) persistent adult sequelae of psychological traumatization, including two traumatic stress syndromes (i.e., posttraumatic stress disorder [PTSD] and disorders of extreme stress [DESJ]), major depression, and substance abuse, using standardized assessment instruments in a racially and culturally diverse sample of low-income women in community mental health treatment for severe mental illness. Principal results include: (1) 100% lifetime prevalence of exposure to *at least* three (of 12 possible) *distinct types* of psychological trauma; (2) 40% current, 75% lifetime prevalence of PTSD and of DES, with substantial comorbidity *and* independence of the two traumatic stress syndromes; (3) DES was the primary, and PTSD a strong but secondary, correlate of psychiatric illness and substance abuse severity and health care utilization.

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4. Ford JD: Disorders of extreme stress following warzone military trauma: associated features of post traumatic stress disorder or comorbid syndrome? J Consult Clin Psythol 1999; 67:3–12

SYMPOSIUM 71—THE WORLD PSYCHIATRIC ASSOCIATION GLOBAL PROGRAM TO REDUCE THE STIGMA OF SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe the methodology of a number of local and national campaigns to combat the stigma of schizophrenia.

No. 71A
THE GERMAN PROGRAM

Wolfgang Gaebel, M.D., *Department of Psychiatry, Heinrich-Heine University, Bergische Landstrasse 2, Duesseldorf D-40629, Germany*

SUMMARY:

In Germany, the WPA Antistigma Program is to be adopted, implemented, and evaluated in a multicenter version. The involved centers in Dusseldorf (Prof. Dr. W. Gaebel, A. Baumann, M.A., coordinating center), Leipzig, Kiel, Itzehoe, Hamburg, and two centers in Munich, founded the German association, "Open the Doors." Each of these centers focusses on different aspects of the program within a local antistigma campaign, complementing the efforts. Multilevel interventions in specific target groups are undertaken to achieve changes in knowledge, attitudes, and behavior. In cooperation with a multicenter Germanwide Research Network on Schizophrenia, which is funded by the German government, the effects of the antistigma interventions on course and outcome of the illness will be evaluated in centers with and without specific interventions. Attitude and pre- and post-intervention surveys in the public and in patient and other target groups, as well as media analyses, serve for identification of the main focus of stigma and discrimination and evaluation of the program effects.

No. 71B
WORLD PSYCHIATRIC ASSOCIATION ANTISTIGMA PROJECT: THE CAMPAIGN IN CANADA

Julio E. Arboleda-Florez, M.D., *Department of Psychiatry, Queens University, Hotel Dieu Hospital, 166 Brock Street, Kingston, ON K7L 3N6, Canada*; Heather Stuart, Ph.D.

SUMMARY:

Stigma is a major contributor to difficulties mental patients experience in accessing mental health services. Stigma contributes to worsening of their mental conditions and relapses. Stigma leads to discrimination, and negative public attitudes to mental patients that stigma generates prevent or immunize governments to be more responsive to the needs of the mentally ill. This leads to poor social supports and uneven distribution of funds for research on mental conditions. The Programme of the World Psychiatric Association aims at sensitizing the public about these issues. It has been designed

to (1) increase the *awareness* on the nature of schizophrenia and treatment options available, (2) improve public *attitudes* to persons with schizophrenia and their families, (3) generate *action* to eliminate discrimination and prejudice. The program was pilot tested in Calgary, Alberta, and has now moved to other countries. This presentation will highlight aspects of the program with emphasis on its implementation at the pilot site, provide information on how the pilot testing was organized in Calgary, and findings and results of the evaluation.

No. 71C
THE CAMPAIGN IN SPAIN

Juan J. Lopez-Ibor, Jr., M.D., *Department of Psychiatry, San Carlos University Hospital, Nueva Zelanda 44, Madrid 28035, Spain*

SUMMARY:

The pilot study of the WPA program was carried out in Madrid in 1999. A survey was undertaken to identify target population and specific messages, showing little knowledge about the disease and a small amount of stigma. It was decided not to carry out an awareness campaign in the population—which has the risk of increasing stigma as it also increased awareness—but to explore the amount of stigma in the environment closer to the patient such as patients themselves, relatives, neighbors, and health services staff. The degree of stigma was much more significant. Activities related to this group of people were undertaken by training psychiatrists to identify stigma and discrimination and to fight it. The outcome showed a great satisfaction among patients, relatives, and physicians. A pilot media campaign was also undertaken. In previous years there was no information about schizophrenia in mass media, only news on incidental problems of patients with schizophrenia. After the campaign, news on the disease itself appeared in the mass media. The Madrid experience shows that the WPA program strategies, based on doing population research and adapting the campaign to local needs, are most appropriate and that an antistigma campaign can be carried out with success. The same experience was repeated in 2000 in the whole of Spain. Health authorities in Madrid were very helpful with the campaign, which was supported by an unrestricted grant from Eli Lilly.

No. 71D
THE CAMPAIGN IN EGYPT: DEVELOPMENT, ACTIVITIES, AND ACHIEVEMENTS

Mohamed H. El Defrawi, *Department of Psychiatry, Suez Canal University, 68 Kasr El-Aini, Cairo 11451, Egypt*; Ismail Yosef, Magda Fahmy, Wafaa Hagag, Ashraf Tantany, Fathela Nusseir, Moheb Salem

SUMMARY:

The Egyptian antistigma activities started in Ismailia in the Suez Canal area in April 1999. Initial activities focused on patients with schizophrenia and their families to obtain evidence of stigma and life experiences. Later, we campaigned within the medical community with medical students, nurses and nursing students, physicians, and paramedics. Sixth-year medical students (n = 50) carried out surveys and educational antistigma activities in the community as part of their research activities. They worked in secondary schools in Ismailia where more than 3,000 secondary school students were contacted; results showed dramatic changes in student knowledge and attitudes. Prizes were awarded in student art competitions relating to supporting people with schizophrenia. Similar surveys and campaign activities were initiated with university students at Suez Canal University (n=800), in secondary schools (n=1,335), and with college students (n=350) in Arish (North Sinai). Presentations have been made to Moslem and Christian clergymen, TV and radio broadcasters, journalists and media personnel, and nongovernmental social agencies. TV reports and presentations (n=7) and radio messages included in regular programs (n=4) were broadcast. Materials included leaflets, brochures, and video.

No. 71E
THE CAMPAIGN IN INDIA

Srinivasa Murthy, M.D., *Department of Mental Health, World Health Organization, Avenue Appia 20, Geneva 0027, Switzerland*

SUMMARY:

In India, the majority of persons with schizophrenia live with their families. The Indian initiative included a systematic study of the knowledge of the illness, the personal experience of stigma and discrimination, and the perceived methods to fight the stigma. The subjects were 463 ill persons and 651 family members in four metropolitan cities of India. The survey indicated that 65% of the respondents had experienced discrimination. Stigma experience was greater in the urban population, among women, and in the occupational and social areas. Based on this survey, a program of fighting stigma through empowerment of the families was initiated. This included (1) sharing of information about the nature of the illness, its treatment, and outcome; (2) teaching skills to increase family cohesion to decrease discrimination within the family, (3) measures to enhance knowledge of the illness among the immediate neighbors and among immediate contacts in the social and occupational areas. The family members also began correcting the misrepresentation of mental illness in the mass media.

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SYMPOSIUM 72—EUROPEAN PERSPECTIVES ON THE BIOLOGY OF PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand the specific areas under exploration in order to better appreciate the biology of personality disorders, and to be familiar with the particular methodologies used in those explorations.

No. 72A
CHILDHOOD ABUSE AND THE HPA AXIS IN ADULT FEMALE PATIENTS

Thomas Rinne, M.D., *Department of Psychiatry, CG7 Buitenamstel, A. J. Ernststraat 887, Amsterdam 1081-HL, Netherlands*; Wim Brink-Vanden, Ph.D., Jaap G. Geokoop, Ph.D., Roel Rijkode, Ph.D., E. Ronald Kloet, Ph.D.

SUMMARY:

Background: A high incidence of childhood abuse is reported in borderline patients. Animal studies reveal that early sustained stress alters hypothalamic-pituitary-adrenal (HPA)-axis function. Therefore, we hypothesized that sustained traumatic stress in childhood affects the HPA axis of traumatized BPD patients.

Objective: (1) To investigate whether a probable alteration of HPA-axis function is associated with borderline pathology and/or with a history of sustained childhood abuse, and (2) to investigate whether fluvoxamine treatment restores the functional alteration of the HPA-axis.

Method: A combined dexamethasone/corticotropin-releasing-hormone-test (DEX/CRH-test) was conducted in 24 severely and 15 not or mildly traumatized female borderline patients before and after 12 weeks of fluvoxamine treatment. The results of the pre- and post-fluvoxamine treatment DEX/CRH challenge are then compared with the test results of a matched healthy control group (n=11).

Results: At pretreatment the severely traumatized borderline patients show a hyperfunction of the HPA axis as reflected in a significant higher ACTH and cortisol response to the DEX/CRH challenge when compared with the not traumatized patients and the healthy controls. After fluvoxamine treatment, the ACTH and cortisol responses to DEX/CRH are significant decreased.

Conclusion: Sustained and severe childhood abuse induces a long lasting hyperfunction of the HPA axis in borderline patients, and fluvoxamine treatment appears to correct this HPA axis alteration.

No. 72B
DIMENSIONAL PSYCHOBIOLOGICAL STUDIES IN BPD

Jose L. Carrasco, M.D., *Department of Psychiatry, Fundacion/Jimenez-Diaz, Avda Reyes Catolicos 2, Madrid 28040, Spain*; Marina Diaz-Marsa, M.D.

SUMMARY:

Introduction: The idea of borderline personality disorder (BPD) as a separate entity is controversial. The clinical features, etiology, pathophysiology, and temperament of BPD suggest heterogeneity. Modern classifications consider BPD a dysfunctional personality pattern. But borderline conditions may not be personality disorders; rather different personality patterns might underlie this diagnosis. Biological studies have explored the relationship of BPD to mood disorders using the dexamethasone suppression test; BPD's relationship to impulsive disorders has been studied with tests of serotonin function.

Objective: To investigate the temperament pattern of BPD and its relationship to biological measures of impulsiveness and stress response.

Methods: Nonmedicated BPD patients: temperament studies use the TCI (Cloninger), EPQ (Eysenck), and impulsiveness scales. Personality patterns are investigated dimensionally with features from other personality disorders. HPA sensitivity is studied via level of plasma cortisol suppression following administration of 0.5 and 0.25 mg of dexamethasone (DST). Tryptophan depletion is provoked following administration of a tryptophan-free aminoacid mixture to test functioning of serotonin neurotransmission.

Results: BPD patients have high suppression on DST that is associated with specific temperament and clinical features of BPD. Response to tryptophan depletion is also associated with specific clinical features.

Conclusion: BPD is heterogeneous with different biological dimensions and temperament patterns.

No. 72C
STUDIES ON TEMPERAMENT MARKERS ON EATING DISORDERS

Marina Diaz-Marsa, M.D., *Department of Psychiatry, Fundacion J. Diaz, Av Reyes Catolicos 2, Madrid 28040, Spain*; Jose L. Carrasco, M.D.

SUMMARY:

Introduction: Historic clinical descriptions and recent literature suggest some relationship between eating disorders (ED) and impulsive, obsessive, and affective disorders. Dysfunctions of temperament may not only underlie these relationships but may also explain clinical differences among the eating disorders. Several biological factors have been described as related to temperament. Low platelet MAO has been related to sensation seeking, extraversion, and impulsiveness. Other biological measures include the tryptophan depletion test (TDT) and the dexamethasone suppression test (DST).

Objective: To explore differences in temperament features between anorectic and bulimic patients.

Methods: (1) Nonmedicated patients with ED undergo temperament studies with the TCI (Cloninger), EPQ (Eysenck), and impulsiveness scales. (2) Biological studies include: (a) platelet MAO activity determined by isothopic methods using C14-benzylamine as substrate; (b) tryptophan depletion is provoked with a tryptophan-free aminoacid mixture and low-tryptophan diet (TDT); (c) plasma cortisol supression is investigated following administration of doses of 0.5 and 0.25 mg dexamethasone (DST).

Results: Temperament and biological studies suggest heterogeneity within the group of eating disorders and are also associated with specific clinical aspects of the disorders.

Conclusion: Biological temperament traits may play a role in the vulnerability to eating disorders and may shape the clinical picture of these disorders.

No. 72D
SCHIZOTYPY: A GENETIC, EPIDEMIOLOGICAL AND DEVELOPMENTAL PERSPECTIVE

Marco Battaglia, M.D., *Department of Psychology, San Raffaele University, Prinetti 29, Milan 20127, Italy*; Svenn Torgersen, Ph.D., Andrea Fossati, M.D., Cesare Maffei, M.D.

SUMMARY:

Introduction: Family studies suggest that schizotypal personality disorder (SPD) is one possible phenotype of familial-genetic liability to the schizophrenia spectrum. SPD is usually stable over time and does not evolve into schizophrenia. Evidence of psychometric and biological heterogeneity of the SPD construct is available; however, this evidence may also implicate a heterogeneity of causal factors.

Method: A twin study was conducted to determine whether there are subclasses or subgroups embedded within the schizotypal construct, and what is the subclass relationship to the schizophrenia spectrum.

Results: Three different latent classes are recognizable within the SPD construct, with considerable interclass differences for the extent that genetic and nongenetic factors influence the phenotype. Specifically, a class made up of aloofness, odd appearance, and odd speech

had a narrow-sense heritability of .5, with all within-family similarities explained exclusively by genetic factors.

Conclusion: There is at present no direct information on the degree of stability of genetic and nongenetic contributors to the variance in SPD over time, and little is known about its childhood behavioral precursors. In addition, genetic effects on psychopathology should not automatically be equated with specific determinants acting early on development. However, there is some evidence that aloofness and oddness may be recognized early in childhood, have a tendency for aggregation within those families at heightened risk for the schizophrenia spectrum, and correlate with some neuropsychological impairments.

No. 72E
SEROTONERGIC AND COGNITIVE IMPAIRMENT IN PERSONALITY-DISORDERED OFFENDERS

Mairead Dolan, Ph.D., *Mental Health Service-Salford, Bury New Road, Manchester M25 3BI, United Kingdom*

SUMMARY:

Introduction: Reduced serotonin (5-HT) function and deficits on neuropsychological tasks have been reported separately in aggressive populations. We investigated whether these impairments are independent or interactive mechanisms underlying impulsivity in aggressive personality disordered (PD) offenders and controls and whether they are associated with changes in quantitative brain measures.

Method: Fifty-one PD offenders and 24 controls, recruited from maximum security psychiatric hospitals, were characterized using the Special Hospital Assessment of Personality and Socialisation. Subjects underwent assessment of 5-HT function (d-fenfluramine challenge), neuropsychological testing, and had a diagnostic MRI scan. A subgroup had measurement of frontal and temporal lobe volumes on MRI.

Results: Nonpsychopathic (low impulse) offenders had enhanced 5-HT function compared with controls and high impulse-primary/secondary psychopaths ($p<.05$). Psychopaths had poorer frontal, but not temporal, function than controls and nonpsychopaths ($p<.01$). There were no significant differences in frontal or temporal lobe volumes. Impulsivity correlated negatively with 5-HT ($p<.01$) and frontal ($p<.05$) function. Aggression correlated inversely with frontal and temporal function ($p<.05$), but did not correlate with 5-HT function. 5-HT did not directly correlate with frontal or temporal volume or function.

Conclusion: Impulsivity appears to be contributed to by both impaired frontal and 5-HT function. Impaired neuropsychological function alone makes a contribution to aggression.

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SYMPOSIUM 73—AN EIGHT-WEEK RANDOMIZED TRIAL OF FLUVOXAMINE FOR PEDIATRIC ANXIETY DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to treat anxiety disorder in children in an effective manner using fluvoxamine.

No. 73A
BACKGROUND AND SIGNIFICANCE OF THE RESEARCH UNITS OF PEDIATRIC PSYCHOPHARMACOLOGY (RUPP) PEDIATRIC ANXIETY DISORDER TRIAL OF FLUVOXAMINE

Laurence L. Greenhill, M.D., *Department of Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, Unit 74, New York, NY 10032*

SUMMARY:

Objective: There are very few large-scale, randomized, controlled trials of psychotropic medications in the treatment of Axis I pediatric anxiety disorders. Controlled treatment studies have been single-site, small-numbered trials. Positive findings have been difficult to replicate. Methodological differences were apparent between successful large trials with adult anxiety disorder patients and the trials employing child subjects.

Methods: The prevalence of child-onset anxiety disorders was determined from epidemiological surveys. Previously published trials were reviewed to determine the methodological challenges involved in planning a new randomized, controlled trial for children with separation anxiety disorder (SAD), social phobia (SP), and generalized anxiety disorder (GAD).

Results: Based on review of adult studies of anxiety disorders, sample-size estimates suggested that previous child psychiatry studies might be too small to detect moderate-sized effect sizes. In addition, there was no clinician-rated structured interview tested in children that could be used repeatedly to determine change over time.

Conclusion: A large, randomized, controlled trial was necessary to test the efficacy of psychotropic agents in children with anxiety disorders. A new rating scale had to be developed for clinicians to use to rate change in anxiety symptoms.

No. 73B
MODERATORS AND MEDIATORS OF TREATMENT EFFECT IN THE RUPP PEDIATRIC ANXIETY DISORDER TRIAL OF FLUVOXAMINE

Benedetto Vitiello, M.D., *NIMH, 6001 Executive Boulevard, Room 7147, Bethesda, MD 20892-9633*

SUMMARY:

Objective: The RUPP anxiety study is a controlled clinical trial of the efficacy of fluvoxamine in 128 youths with anxiety disorders. The primary analysis has found a large, statistically significant, effect size in favor of the active medication. It is now important to examine the patient, parent, and clinical variables that might have influenced and/or contributed to this outcome.

Methods: The impact of possible moderators (age, sex, symptoms severity, parental education, comorbidity) and mediators (dosage, adherence, side effects, belief of random assignment) will be examined using random regression model with the primary continuous outcome measure of the study (Pediatric Anxiety Rating Scale total

score). Also, using dichotomous classification of patients into improved and not improved, based on Clinical Global Impression, a regression analysis will be used to estimate the relative influence of each variable on this binary outcome.

Results: To be presented and discussed.

Conclusions: By informing on the impact of relevant variables, these analyses will help identify patients more likely to benefit from pharmacotherapy of anxiety and clarify mechanisms of treatment.

No. 73C
DATA FROM THE INTENT-TO-TREAT DATA ANALYSIS: RUPP PEDIATRIC ANXIETY DISORDER TRIAL OF FLUVOXAMINE

Daniel S. Pine, M.D., *Intramural Research Program, National Institute of Mental Health, Bldg 10, Room 4N222/MSC 1381, Bethesda, MD 20892*

SUMMARY:

Background: Selective serotonin reuptake inhibitors (SSRIs) are effective treatments for adult mood and anxiety disorders as well as for pediatric major depressive and obsessive-compulsive disorder. The current study examines the efficacy of the SSRI fluvoxamine, in a child and adolescent population.

Methods: Children (N=128, ages 6–17) meeting criteria for either social phobia, separation anxiety, or generalized anxiety disorder, were randomly assigned to receive either fluvoxamine or placebo treatment for eight weeks under double-blind conditions. Children were assessed using both anxiety symptom rating scales and global measures of improvement. The trial used a flexible dosing up to 300mg fluvoxamine total dose/day.

Results: Fluvoxamine produced a significantly greater decrease in psychiatrist-rated anxiety symptoms ($p<.001$). Fluvoxamine treatment also produced significantly ($p<.001$) higher rates of psychiatrist-rated clinical response than placebo treatment.

Conclusion: Fluvoxamine is a highly effective treatment for children suffering from significantly impairing social phobia, separation anxiety, or generalized anxiety disorder.

No. 73D
USE OF THE PEDIATRIC ANXIETY RATING SCALE IN THE RUPP PEDIATRIC ANXIETY DISORDER TRIAL OF FLUVOXAMINE

John T. Walkup, M.D., *Department of Psychiatry, Johns Hopkins University Hospital, 600 North Wolfe Street, CMSC 343, Baltimore, MD 21287-3325*; Mark A. Riddle, M.D.

SUMMARY:

Objective: There is little clinical literature on the long-term pharmacological treatment of childhood anxiety disorders. This presentation reports on the outcome of long-term open fluvoxamine treatment of separation anxiety (SAD), social phobia (SP), and generalized anxiety disorder (GAD) in children.

Methods: Children ages 6–17 years with SAD, SP, GAD, who completed an eight-week, double-blind, placebo-controlled trial (N= 120) were eligible to participate in this six- to eight-month open trial. Evaluations of clinical outcome included clinician-rated, self, and parent reports. The primary outcome measures were the Pediatric Anxiety Rating Scale and the Clinician-Global Impression-Improvement Rating Scale. Adverse events were recorded at each visit. Laboratory evaluation and EKGs were done routinely to assess long-term safety.

Results: Outcomes will be reported for the intent-to-treat population and for those who completed the long-term trial. Time course of response over long-term treatment will also be reported. Adverse events will be described with specific attention to adverse events of interest to child and adolescent psychiatrists.

Conclusion: The implications for the long-term treatment of childhood anxiety will be discussed.

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SYMPOSIUM 74—PSYCHIATRIC MANAGEMENT IN NEUROLOGICAL DISEASE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be aware of: (1) the neurological features of brain diseases, (2) specific psychiatric disorders commonly presenting in particular neurological disorders, (3) psychiatric management principles within the context of these illnesses, (4) basic approaches to managing specific neurological diseases.

No. 74A
PSYCHIATRIC ASPECTS OF PARKINSON'S DISEASE

Matthew A. Menza, M.D., *Department of Psychiatry, RWJ Medical School, 675 Hoes Lane, Room D207A, Piscataway, NJ 08854*

SUMMARY:

Parkinson's disease (PD) is the second most common neurodegenerative illness in the elderly and is frequently complicated by a range of neurobehavioral disorders. These disorders are generally poorly understood, but remain very important from a clinical perspective. Depression, anxiety, drug-induced psychosis, dementia, sleep disorders, and personality changes may all complicate the clinical course and management of these patients. Depression, with a reported prevalence approximately 40%, is the most common problem and is associated with a faster progression of physical symptoms, a greater decline in cognitive skills, and a greater decline in ability to care for oneself. While psychosis in untreated PD patients is very rare, antiparkinsonian medications, including levodopa, can cause hallucinations, delusions, agitation, mania, confusion, and hypersexuality. These drug-induced disorders cause impairment of function, increased caregiver burden, and often lead to nursing home placement. Dementia, typically of a subcortical type, occurs in approximately 40% of Parkinson's disease patients with the clinical picture of impairment in memory and visuospatial skills. Recently, it has become clear that there are a number of variants of classic PD, including diffuse Lewy body disease, that have greater cortical involvement and hence greater decline of cortical functions. Management of these behavioral concomitants of PD will be discussed.

No. 74B
PSYCHIATRIC MANAGEMENT IN HUNTINGTON'S DISEASE

Neal G. Ranen, M.D., *Health Pathways, 310 Pine Grove Commons, York, PA 17403*

SUMMARY:

Although there is currently no treatment that can halt or reverse the inexorable progression of Huntington's disease, there are a number of symptomatic treatments, particularly for the psychiatric disturbance. Psychiatric disorders in HD include mood disorders, irritability and aggressiveness, apathy, psychosis, anxiety disorders, obsessive compulsive disorder, and sexual disorders. All will be discussed. In treating depression, while most experience has been with nortriptyline and the SSRIs, all of the marketed antidepressants are used, including MAOIs. For bipolar disorder, typically Bipolar II, lithium has been effective only rarely; the antiepileptics such as carbamazepine or sodium valproate are preferred. Treatment of irritability should begin with attempts to identify possible underlying triggers. Medication interventions include SSRIs, carbamazepine, clonazepam, and atypical antipsychotic agents. Apathy not associated with depression tends to respond poorly to medication even psychostimulant use. Initiating and participating in activities with the patient in order to sustain energy and attention is more likely to be successful. In prescribing antipsychotics, care must be taken not to worsen the movement disorder—although such agents may dampen chorea, they may worsen the voluntary motor disturbance, including loss of balance and coordination, rigidity, and deteriorated gait, features actually more highly associated with functional impairment than chorea.

No. 74C
PSYCHIATRIC MANAGEMENT IN WILSON'S DISEASE

Edward C. Lauterbach, M.D., *Department of Psychiatry, Mercer University School of Medicine, 665 First Street, Macon, GA 31207*

SUMMARY:

Wilson's disease (WD) is an autosomal recessive illness linked to chromosome 13q14. The gene carrier frequency is 1%. One in every 40,000 live births will develop the disease. Gene mutations impair hepatobiliary copper excretion, leading to systematic copper accumulation. Consequently, WD can result in a wide variety of systematic manifestations. The three most common initial presentations of WD are hepatic, neurological, and psychiatric. Acute and chronic liver failure with cirrhosis have been observed in hepatic WD. Hepatic presentations usually occur in childhood or adolescence due to highly dysfunctional mutations. Brain manifestations present later. Many neurological features have been reported and can vary with age at onset and disease progression, but cerebellar signs, dysarthria, and movement disorders predominate. Predominantly psychiatric presentations occur in one-third of WD cases. Psychiatric symptoms may be the only presenting manifestations in 20% of cases. Early recognition is critical to a satisfactory treatment response. Unfortunately, however, the diagnosis is missed in two-thirds of psychiatric presentations. The majority of patients are affected by psychiatric disorders at some point in the illness, with personality changes and mood disorders predominating. Various treatments can lead to satisfactory outcomes. Principles of diagnosis, treatment, and psychiatric management will be reviewed.

No. 74D
PSYCHIATRIC MANAGEMENT OF STROKE

Robert G. Robinson, M.D., *Department of Psychiatry, University of Iowa School of Medicine, 200 Hawkins Drive, #2880 JPP, Iowa City, IA 52246*

SUMMARY:

The neuropsychiatric disorders following stroke include both typical psychiatric disorders seen in patients without brain injury such as depression, mania, and anxiety disorders, and disorders that are unique to patients with brain damage such as pathological crying, catastrophic reactions, and anosognosia (i.e., unawareness of deficits). Numerous investigations, moreover, have demonstrated a high prevalence of disorders such as post-stroke depression (i.e., 20%), minor depression, (i.e., 20%), anxiety disorder, (i.e., 25%), pathological laughing and crying (i.e., 20%), catastrophic reactions (i.e., 19%) and anosognosia (i.e., 20%). It is therefore remarkable that so little progress has been made in demonstrating the most effective treatments of these disorders. The only double-blind clinical trials that have been conducted examined depressive disorder and pathological crying. Pathological crying has been found to respond to treatment with either nortriptyline or citalopram, the selective serotonin reuptake inhibitor (SSRI). Depression has also been shown to respond to nortriptyline or citalopram. A recent study, however, found that nortriptyline was significantly more effective than fluoxetine in the treatment of this depression. There have been only anecdotal reports of treatment of anxiety disorder mania, catastrophic reactions, or anosognosia. In spite of significant progress made in the identification and clinical correlates of these disorders, remarkably little effort has been devoted toward treatment trials.

No. 74E
PSYCHIATRIC MANAGEMENT IN MULTIPLE SCLEROSIS

Randolph B. Schiffer, M.D., *Department of Neuropsychiatry, Texas Technical Health Science Center, 3601 4th Street, Lubbock, TX 79430*;

SUMMARY:

Multiple sclerosis (MS) is a chronic, immune-mediated demyelinating disease affecting the central nervous system (CNS). Common clinical features include optic neuritis from optic nerve lesions; diplopia, internuclear ophthalmoplegia, facial weakness and numbness, and vertigo from brainstem lesions; ataxia from cerebellar lesions; spasticity and weakness from upper motor neuron lesions; bowel and bladder urgency, frequency, and retention from autonomic lesions; and paresthesias and hypesthesia from sensory tract lesions. Cognitive impairment of one or more cognitive abilities is present in 54% to 65% of patients in clinic-based studies, and in 43% to 46% in community-based studies. Euphoria also occurs in MS, characterized by a persistent frame of mind, not a fluctuating affective state. Pathological laughing and crying occur when patients display fluctuating affective expression that is exaggerated or completely discordant with their emotional state. The prevalence of psychosis in MS patients is not known, although it occurs much less frequently than affective disorders. As many as 10% of MS patients may fulfill criteria for bipolar disorder compared with less than 1% of the general population. The lifetime incidence of major depression in MS patients is as high as 60%. Sexual dysfunction occurs in approximately 78% of males and 45% of females with MS. Males most often report erectile dysfunction, while females have decreased vaginal lubrication. Pharmacologic and nonpharmacologic therapies are reviewed for these neuropsychiatric disorders.

No. 74F
NEUROPSYCHIATRIC ASPECTS OF AIDS

Francisco Fernandez, M.D., *Department of Psychiatry, Loyola University Medical Center, 2160 South First Avenue, Building 54, #154, Maywood, IL 60153*

SUMMARY:

HIV infection has become a major health and social issue of this era and because of its complex nature, the diseases it causes may well continue to defy complete cure for some time to come. In

addition to its devastation of an individual's constitutional health, it has been shown to attack the central and peripheral nervous systems and cause a range of neurological syndromes and organic mental disorders with sometimes insidious courses. This presentation will review the neurobehavioral syndromes and neuropathology associated with HIV infection and review the major research findings concerning the pathogenesis of neuro-AIDS. Treatment of the various neuropsychiatric entities will be discussed in relationship to the special characteristics and needs of this growing population.

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SYMPOSIUM 75—CRITICAL ISSUES IN EARLY INTERVENTION OF THE PSYCHOSIS PRODROME

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants will be familiar with issues relating to prodromal diagnosis and intervention.

No. 75A
EARLY DETECTION BY SCREENING RELATIVES OF SCHIZOPHRENIC PATIENTS

Scott W. Woods, M.D., *Department of Psychiatry, Yale University, 34 Park Street, Room B38, New Haven, CT 06519*; Tandy J. Miller, Ph.D., Lawrence Davidson, Ph.D., Keith A. Hawkins, Psy.D., Michael J. Semyak, M.D.

SUMMARY:

The present study aimed to determine whether screening a population of relatives of current schizophrenic patients was likely to be an efficient means to accrue a sample of early first-episode or prodromal patients for a prediction study or an intervention study.

Method: The risk of new-onset schizophrenia cases in any one year in a population of relatives depends on the number of schizophrenic probands and four additional factors: (1) the age of onset distribution for schizophrenia, (2) the lifetime risk of the at-risk group of relatives selected, (3) the number of at-risk relatives per proband, and (4) the age distribution of the at-risk relatives. Estimates are made for each of these parameters, and calculations are presented.

Results: The base model suggests that screening all siblings and children of patients with schizophrenia would yield approximately 19 new cases of schizophrenia per year per 10,000 relatives screened. The results of the calculation are relatively insensitive to reasonable variation of the model parameter estimates.

Conclusion: The yield of new cases obtained by screening relatives of current patients appears to be low if the purpose is to recruit a sample for an early intervention study over a relatively short period of time.

No. 75B
DIAGNOSING AND RATING THE PSYCHOSIS PRODROME

Tandy J. Miller, Ph.D., *Department of Psychiatry, Yale Medical School, P O Box 208098, New Haven, CT 06520-8098*; Thomas H. McGlashan, M.D., Joanna Rosen, Ph.D., Scott W. Woods, M.D.

SUMMARY:

Strategies for identifying and treating patients at imminent risk for developing schizophrenia are being tested internationally. Such investigations require the ability to diagnose the prodrome, rate its severity, and rate changes in symptoms over time.

Methods: We have developed the SIPS (Structured Interview for Prodromal Symptoms) and the SOPS (Scale of Prodromal Symptoms) based on clinical criteria that predict the onset of psychosis within one year in up to 40% of identified cases. We have conducted preliminary studies concerning the reliability, validity, and sensitivity to change of these instruments.

Results: The inter-reliability of the SIPS was tested in a trial of 19 cases. For the prodromal vs. not prodromal judgment, agreement among raters was 93% (kappa = 0.82). The SIPS demonstrated predictive validity for the conversion to psychosis, yielding a positive predictive value of .44. The SOPS intra-class correlation was 0.93 for the total score, and above 0.80 for all four subscales. In addition, the SOPS has demonstrated good construct validity and superior sensitivity to change compared with competing instruments.

Discussion: Preliminary data suggest that the presence and severity of prodromal symptoms and states can be measured with adequate reliability and validity using operational criteria and a structured interview.

No. 75C
PSYCHOSIS PRODROME, CONVERSION, AND NEUROPSYCHOLOGICAL COURSE

Keith A. Hawkins, Psy.D., *Department of Psychiatry, Yale University, CMHC Room 530 34 Park Street, New Haven, CT 06519*; Kimberly B. Edwards, Michelle Bobulinski, Ph.D., Ralph E. Hoffman, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

In the prodromal state Yale PRIME subjects (N = 32) exhibited neuropsychological weaknesses that lie between those reported for schizophrenia samples (e.g., Goldberg et al, 1990) and controls. Subjects converting to psychosis (n = 8) re-tested an average of 16 days post-conversion demonstrated a further decline in neuropsychological status, whereas nonconverters maintained or improved upon their entry status. Several considerations argue against this being a simple reflection of transient state or medication effects. None of the converters required hospitalization, and all received treatment prior to re-testing. Neuropsychological data collected even with hospitalized patients typically display considerable stability across time and clinical states, and antipsychotic medications tend to improve rather than diminish performance (Goldberg et al., 1990). These findings support the notion that (1) among subjects showing probable prodromal signs, neuropsychological features could facilitate the identification of true positives; (2) a decline in neuropsychological functioning may accompany a first psychotic episode, and (3) prevention of first-break psychosis may result in a relative preservation of neuropsychological capabilities.

No. 75D
MEDICATION PRESCRIBED BY COMMUNITY PROVIDERS FOR PATIENTS IN SCHIZOPHRENIC PRODROMAL STATES

Adrian Preda, M.D., *Department of Psychiatry, Yale Medical School, P O Box 208098, New Haven, CT 06520-8098*; Tandy J. Miller, Ph.D., Scott W. Woods, M.D., Joanna Rosen, Ph.D., Lubnee Somjee, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

The purpose of this study was to investigate if there is a pattern of prior psychiatric diagnosis and treatment in patients diagnosed as prodromal for schizophrenia.

Methods: The charts of 36 subjects meeting criteria for schizophrenic prodromal syndrome based on recently validated diagnostic criteria were reviewed for histories of prior psychiatric diagnosis, psychiatric hospitalization, and treatment with psychotropic medications.

Results: The majority of our prodromal patients carried a prior psychiatric diagnosis (86%), the most frequent being depression NOS (17%) and ADHA/ADD (14%). Additionally, 73% of these patients had a history of some type of prior mental health intervention, eg, 61% received psychotropic medications in the past, most frequently antidepressants (42%) and stimulants (13%).

Discussion: The nonspecificity of prodromal symptoms, the risk of increased labeling, the difficulty of identifying psychotic versus depressive symptoms, and the relative superiority of side effects profile of antidepressant versus antipsychotic medications could all contribute to an overdiagnosis of depressive syndrome with an underdiagnosis of psychotic syndrome in this population. Further study of a nonselected population seen in primary care settings is indicated.

No. 75E
SHORT-TERM OUTCOME OF PRODROMAL PATIENTS TREATED AT CONVERSION TO PSYCHOSIS

Joanna Rosen, Ph.D., *Department of Psychiatry, Yale University, P O Box 208098, New Haven, CT 06520-8098*; Thomas H. McGlashan, M.D., Tandy J. Miller, Ph.D., Lubnee Somjee, Ph.D., Scott W. Woods, M.D.

SUMMARY:

Because delays in treatment of psychosis may be associated with poorer outcome, intervention focus has shifted to the earliest stages of the illness.

Methods: A subpopulation of eight patients will be described who received treatment for psychosis at onset while participating in a prospective treatment study of the prodrome to psychosis. The dimensional nature of conversion in these previously identified prodromal patients will be illustrated. The project's definition of psychosis takes this dimensional nature into account and will be discussed. Possible prodromal predictors of treatment response upon conversion, such as role functioning, social relatedness, treatment compliance, and positive and negative symptom presentation at baseline, conversion, and remission, will be discussed.

Results: Patients who were regularly monitored during the prodromal phase and treated with antipsychotic medication upon conversion to schizophreniform psychosis appeared to have a greater short-term recovery than patients treated for first-episode schizophreniform psychosis through usual community detection (for example, Sanger et al, 1999).

Discussion: Receiving treatment upon conversion to psychosis seems to be associated with lower symptomatology, both at conversion and upon short-term follow-up.

No. 75F
ETHICAL ISSUES IN THE PRE-ONSET TREATMENT OF SCHIZOPHRENIA

Thomas H. McGlashan, M.D., *Department of Psychiatry, Yale Medical School, P.O. Box 208038, New Haven, CT 06520*; Tandy J. Miller, Ph.D., Scott W. Woods, M.D., Joanna Rosen, Ph.D., Lawrence Davidson, Ph.D., Adrian Preda, M.D., Philip Markovich, B.S.

SUMMARY:

Clinical trials are currently under way testing whether treatment in the pre-onset or prodromally symptomatic phase of schizophrenia can prevent or delay onset of psychosis. The author and colleagues are currently conducting such a study, a randomized, double-blind, placebo-controlled clinical trial of atypical antipsychotic medicine in prodromally at risk patients.

Among the ethical issues raised by this research, the following are paramount. First, persons placed on antipsychotic medication may be symptomatic but they do not (yet) meet existing diagnostic criteria for a psychotic disorder. Second, such persons may not be prodromal to psychosis or they may be prodromal for other disorders. Such "false positive" cases could be "labeled" or stigmatized unnecessarily and receive antipsychotic treatment inappropriately, especially treatment that can have side effects.

This presentation will first outline the rationale for intervention before onset. It will then detail the usual, current practice of treating persons who appear to be prodromally at risk for psychosis and the reasons for this practice. The recent developments in medication safety and in clinical predictability of true positive prodromal states will be elaborated next. The presentation will finish with a discussion of the currently known risks and benefits of early intervention and which research strategies appear to be ethical and which appear not (yet) to be ethical, and why.

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SYMPOSIUM 76—MIND/BRAIN, REDUCTION, AND SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) identify the relationships of current research in cognitive neuroscience to psychopathology and mind/brain issues, and (2) discuss the relevance of "reduction" concepts to current cognitive neuroscience and genetic research in psychiatry.

No. 76A
UNDERSTANDING ANXIETY: CONCEPTUAL, CLINICAL, AND NEUROSCIENTIFIC CONSIDERATIONS

Gerrit Glas, M.D., *Department of Psychiatry, University Medical Centre Utrecht, P O Box 85500, Utrecht GA-3508, Netherlands*

SUMMARY:

Neuroscientific understanding of anxiety and anxiety disorders is largely based on animal models, either acute fear responses (fight, flight, freeze, faint) or chronic fear states resulting from sensitization. Cognitive/behavioral models presuppose these "animal" explanations through viewing them as elicitors of acute alarm responses that in turn refer to the aforementioned biology. Clinical practice, however, shows that intermixed with concrete fear symptoms there often exists a more diffuse anxiety, which on closer inspection seems related to specifically human themes like isolation, meaninglessness, and/or fragmentation of the self. How may these latter themes be assimilated by the neurobiological processes of "anxiety"? Are the differences between human and animal anxiety reflected even at the level of brain functioning? And if so, what are the implications for the understanding of anxiety from clinical, conceptual, and neuroscience perspectives? These questions will be explored by briefly reviewing the relevant neurobiological and clinical evidence and by addressing the conceptual issues from neurophilosophical and systems perspectives.

No. 76B
MIND AND BRAIN IN SCHIZOPHRENIA: TWO SIDES OF THE SAME COIN?

Aaron L. Mishara, Ph.D., *Department of Psychology, Rutgers University, P O Box 819, Piscataway, NJ 08855*

SUMMARY:

The relation of mind and brain is central to psychiatry. Proponents of neurophilosophy (Churchland & Churchland, 1998) state that mental experiences and concepts, e.g., subjective conscious experience, qualia, intentionality, volition, social cognition, embeddedness in cultural context, can be reduced to neuroscience. Are they correct? In order to address this question, I will examine leading neurocognitive and phenomenological models of schizophrenia. Chris Firth's proposal is that a single cognitive mechanism underlies the signs and symptoms of schizophrenia; an impairment in self-monitoring involving a disruption of the internal model of self-generated motor programs. Jeffrey Gray's proposal is that "over-attention" in schizophrenia is related to a disrupted comparator system. Ludwig Binswanger's classical discussion of delusions in terms of a disrupted schema linking present perceptual experience with previous learning is a third perspective. The similarities among these models will be discussed. Rather than reducing mind to brain, I will propose that the disrupted cognitive mechanisms common to these models (i.e., "mind") and the implicated brain system (i.e., "brain") must be seen as two sides of the same coin: each side depends upon, but also temporarily conceals, its complement.

No. 76C
ONTOLOGICAL REDUCTION AND INTEGRATION IN PSYCHIATRIC GENETICS RESEARCH

John Z. Sadler, M.D., *Department of Psychiatry, University of Texas Health Science Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Biomedical theory has been characterized as overlapping and interacting "levels of aggregation," which in turn are characterized by particular varieties of "ontological reduction," Ontological reduction is the simplifying of complex phenomena into descriptions apropos to a particular research theory, procedure, or program, or "level of aggregation." Using schizophrenia as an example, I describe psychiatric genetics (PG) research as a series of ontological reductions. I compare the processes of ontological reduction involved in PG research with that of classical pathophysiological explanations, such as the mechanism of sickle cell crisis. PG research will be shown to pose a particular ambiguity ("ontological ambiguity") that is not characteristic of classical pathophysiological explanations, one which poses unique problems to scientific explanation and public understanding of PG. Implications of ontological reduction and ontological ambiguity in PG will be briefly discussed.

No. 76D
THE COGNITIVE NEUROPSYCHIATRY OF DISORDERS OF WILL AND VOLITION

Sean A. Spence, M.D., *Department of Psychiatry, University of Sheffield, The Longley Centre Norwood Grange Drive, Sheffield S5-7JT, United Kingdom*

SUMMARY:

Specific brain regions subserve the performance of consciously chosen, or willed actions in healthy controls. In particular, left dorsolateral prefrontal cortex (DLPFC) is activated when subjects chose a direction of movement or which word to say, compared with generating movements or utterances specified by the examiner. Neuropsychiatric disorders affecting action-generation consistently implicate DLPFC. Indeed, this focus of dysfunction distinguishes those with "hysterical" motor symptoms from controls deliberately feigning disorder. Data will be presented from studies of subjects with neuropsychiatric disorders affecting volition: schizophrenia, depression, Parkinson's disease, hysteria, and deliberately feigned dysfunction. Agency, the subjective sense of possession of an act, is disturbed in those experiencing the schizophrenic symptoms of alien control. In these patients (and those with organic causes of alien phenomena), there is dysfunction of the right parietal region. Hence, these studies suggest that we may begin to map the complex functions of action and agency onto specific cognitive, neuroanatomical systems.

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4. Spence SA, et al: Prefrontal cortex activity in people with schizophrenia and control subjects. Evidence from positron emission tomography for remission of 'hypofrontality' with recovery from acute schizophrenia. Br J Psychiatry 1998; 172:316–323

SYMPOSIUM 77—CHILDHOOD-ONSET DEPRESSION: A MULTIGENERATIONAL MULTIDISCIPLINARY STUDY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with risk factors for childhood-onset depression (specifically, developmental impairment in mechanisms that regulate dysphoric emotion) and their relationship to genetic markers, psychophysiologic processes, and parent-child interaction patterns.

No. 77A
RISK FACTORS FOR CHILDHOOD-ONSET DEPRESSION: UNDERSTANDING AND TREATMENT

Maria Kovacs, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'hara Street, Suite E469, Pittsburgh, PA 15213*; Joel T. Sherrill, Ph.D.

SUMMARY:

Childhood-onset major depressive disorder (COD) is debilitating (median episode length about nine months), highly recurrent (up to 60%), poses a high risk of bipolar switch (up to 20%), and is associated with subsequent affective and substance abuse problems in adulthood. The developmental unfolding of the phenotype in youths occurs in the context of high familial transmission (risk of MDD in first-degree relatives is increased 2.5 fold compared with normals) and dysfunctional family interactions. To investigate the confluence of factors that confer risk for COD, our program project utilizes a multigenerational, multidisciplinary, multi-perspective approach within and across a set of three studies. The overall perspective is entirely developmental in nature and acknowledges the importance of context for phenotypic expression. The overarching hypothesis is that impairment in the developmental unfolding of emotional regulatory mechanisms is a marker of risk for COD. The risk posed for COD is subject to genetic influences, and is detectable in intra-individual physiologic processes, and in parent-child interactional patterns.

No. 77B
MOLECULAR GENETIC STUDIES OF CHILDHOOD-ONSET DEPRESSION

James L. Kennedy, M.D., *Department of Psychiatry, University of Toronto/Clarke Institute, 250 College Street (R-31), Toronto, ON M5T 1R8, Canada*; Bernard Devlin, Ph.D., Maria Kovacs, Ph.D., Karen Wigg, B.S.C., Cathy L. Barr, Ph.D., Nicole A. King

SUMMARY:

Numerous family and twin studies have implicated a strong genetic etiology in childhood-onset depression (COD). We are applying the technology of molecular genetics to investigate COD in the context of a comprehensive multidisciplinary behavioral and physiologic research program. Our first hypothesis is that some cases of COD are referable to unstable DNA, given that large expansions of unstable trinucleotide repeats are associated with early age of onset in other neuropsychiatric disorders such as Huntington's disease, and Fragile X. We have preliminary evidence for unstable expansion at the locus ERDA-1 on chromosome 17 cosegregating with a child depression proband and major affective illness in the mother. We expect COD to be influenced by multiple genes, and we are testing candidates in the serotonin and dopamine systems, with a current sample size of 65. Variation in the promoter polymorphism of the serotonin transporter gene showed a trend toward prediction of risk (chi sq = 4.808, $p = 0.09$). The dopamine D4 receptor gene showed significant prediction of risk (chi sq = 9.382, $p = 0.032$). Furthermore, highly innovative preliminary data have been generated comparing genotype to the endophenotype of right frontal asymmetry of the EEG, and selected indices of clinical typology.

No. 77C
EEG ASYMMETRY AND VAGAL TONE IN CHILDHOOD-ONSET DEPRESSION: PROBANDS AND OFFSPRING

Nathan A. Fox, Ph.D., *Department of Human Development, University of Maryland, 3304 Benjamin Building, College Park, MD 301405*; Jeffrey Cohn, Ph.D., Anita Keener, Ph.D., Erika Forbes, B.A.

SUMMARY:

Emotion regulation involves skills necessary to modulate and control expression of emotional arousal and the processes that are entailed therein. Such competencies are mediated by the frontal lobes and arousal control systems from the autonomic nervous system. Deficits in affect regulation may underlie maladaptive behavior and affective disorders that emerge in childhood and later in adulthood. Patterns of frontal EEG asymmetry and vagal tone are key indicators of variations in emotion regulatory behavior. As part of a multidisciplinary study, we evaluated the hypothesis that relative right frontal EEG asymmetry and low vagal tone are trait markers of emotion dysregulation and documented history of prior depression. Preliminary data suggest that proband women exhibit right frontal EEG asymmetry, particularly if they are symptomatic with depression. As well, probands with current symptoms exhibit low vagal tone compared with probands who are asymptomatic. Developmental data indicate that parental history of depression predicted children's behavior problems ($F(1,26)=4.30$, $p<.05$). Amongst the offspring of probands, greater left frontal and greater right parietal activation were associated with anxious behaviors ($rs=.39$ and $-.48$, $p<.05$) and normative levels of vagal tone. Analyses examine relations between proband and offspring for both behavioral and electrophysiological markers of depression and maladaptive behavior.

No. 77D
PARENTING RISK FACTORS AMONG OFFSPRING OF CHILDHOOD-ONSET DEPRESSED MOTHERS

Daniel Shaw, Ph.D., *Department of Psychology, University of Pittsburgh, Pittsburgh, PA 15213*; Joel T. Sherrill, Ph.D., Michael Schonberg, B.A., Joella Lukon, B.S.

SUMMARY:

Children of clinically depressed parents are more likely than other children to develop psychopathology. Moreover, the children of parents whose depression began in childhood demonstrate an increased risk of earlier and more severe psychopathology, particularly childhood depression. Despite the increased risk for offspring of childhood-onset depressed (COD) parents, the mechanisms of intergenerational transmission are not understood. This study draws upon the unifying construct of emotion regulation to examine parent-child relationship factors that may account for the intergenerational transmission of COD. We hypothesize that mothers diagnosed with COD would show greater impairment in the ability to down-regulate offspring's negative affect (i.e., distress, anger) and maintain or reinforce positive affect, in comparison with mothers without a history of COD. Laboratory-based observational data reveal that COD mothers are less effective in helping their children regulate emotional

displays. Specifically, compared with non-COD mothers, mothers with COD in interaction with their children show fewer displays of contingent positive affect ($t = 3.40$, $p < .01$), less responsiveness to their children's distress ($t = 3.19$, $p < .01$), and lower overall involvement ($t = 2.16$, $p < .05$) and positivity toward their offspring ($t = 2.95$, $p < .01$).

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SYMPOSIUM 78—PSYCHIATRIC DISTURBANCES IN PARKINSON'S DISEASE: RECOGNITION AND MANAGEMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to (1) recognize the behavioral disturbances present in PD, (2) discuss the neurobiological mechanisms underlying psychopathology in these patients, and (3) treat the concomitant psychiatric manifestations of the disease

No. 78A
MULTIDISCIPLINARY MANAGEMENT OF PSYCHIATRIC MANIFESTATIONS OF PARKINSON'S DISEASE

Melanie Brandabur, M.D., *Department of Neurology, University of Illinois at Chicago, 912 South Wood Street, MC796, Chicago, IL 60612*

SUMMARY:

Parkinson's disease is a movement disorder presenting with tremor, bradykinesia, rigidity, and postural reflex impairment. In many patients, treatment of PD is complicated by the development of psychiatric side effects, including hallucinations, vivid dreams or nightmares, confusion, delusions and/or hypersexuality. The occurrence of dementia in up to 50% of PD patients seems to predispose to psychiatric phenomena. Additionally, 30% to 40% of patients suffer from depression, and also suffer anxiety and sleep disorders.

Successful treatment of these behavioral alterations is a challenge. Psychiatric management facilitates optimal medical therapy of disturbing symptoms with minimal motoric impairment. Neuropsychologists can assess dementia and provide cognitive rehabilitation. A physical therapist can provide instruction on exercise, mobility, and safety issues, while a PharmD is helpful in assisting with medication compliance and monitoring for polypharmacy and drug interactions. As the patient becomes more impaired, nursing and social service personnel can supply additional support, resources, and education, especially to the caregiver and family members. In today's health care environment, a multidisciplinary approach offers many advantages in the treatment of PD, providing the comprehensive care needed and avoiding or delaying institutional placement of these patients.

No. 78B
TREATMENT OF DEPRESSIVE DISORDERS IN PATIENTS WITH PARKINSON'S DISEASE

F. Moises Gaviria, M.D., *Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC913, Chicago, IL 60612*

SUMMARY:

Approximately half of PD patients meet criteria for a clinical depression, presenting with emotional and autonomic symptoms of the entity but often without the feelings of guilt that patients with major depression tend to have. Several studies have shown that mood changes in these patients do not correlate with the severity of motor symptoms, suggesting that this is not a reactive response but an affective disorder with neurobiological basis.

Deficits in mesocorticolimbic dopaminergic systems and the presence of Lewy bodies in the ventral tegmental area (VTA) have been implicated in the pathogenesis of depression in PD, as noradrenergic and serotonergic dysfunction can also contribute. Among the agents used in pharmacological treatment of depression in PD are levodopa, dopamine agonists, selegiline and other MAO-B inhibitors, tricyclic antidepressants, SSRIs and other newer drugs such as venlafaxine, bupoprion, mirtazapine, and nefazodone. All of these medications have demonstrated efficacy in amelioration of depressive symptoms in PD patients, and furthermore, some of them may also demonstrate antiparkinsonian effects. Depressive PD patients refractory to medical treatment may benefit from electroconvulsive therapy. Interestingly, many of them also experience notable improvement, although transitory, in their motoric function after the utilization of ECT.

No. 78C
MANAGING PSYCHOTIC SYMPTOMS IN PARKINSON'S DISEASE

David A. Medina, M.D., *Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC913, Chicago, IL 60612*

SUMMARY:

The prevalence of psychotic symptoms in PD has been reported as up to 30%, and may represent the most problematic behavioral features associated with this condition. Although PD patients can have hallucinations and delusions before the initiation of dopaminergic therapy, these phenomena are usually regarded as secondary to these medications. However, the development of psychosis in PD seems to be a more complex phenomena, which likely involves a variety of components, including the pharmacodynamics of dopaminergic agents, the presence of dementia, previous psychiatric history, the distribution of Lewy bodies within cerebral cortex, polypharmacy, and other factors associated with aging.

Regarding to their treatment, if the psychotic symptoms are mild, it is recommended to use conservative measures than utilizing pharmacological interventions. However, if they disable the patient, interruption or lowering of anticholinergic agents, amantadine, and dopaminergic therapy will be necessary. If this is unsuccessful, neuroleptic therapy should be considered. Since atypical neuroleptics may have

a lower risk of extrapyramidal side effects, their use is recommended in these cases. Pharmacological properties and clinical findings that support the utilization of atypical neuroleptics, particularly clozapine, for the control of psychotic symptoms in PD, will be discussed.

No. 78D
FUNCTIONAL NEUROIMAGING AND NEUROBIOLOGICAL CORRELATES OF COGNITIVE IMPAIRMENT IN PATIENTS WITH PARKINSON'S DISEASE

Glenn T. Stebbins, Ph.D., *Department of Neurology, Rush University, 1645 West Jackson, Suite 450, Chicago, IL 60612*; Maria C. Carrillo, Ph.D., John D. E. Gabrieli, Ph.D.

SUMMARY:

Impairments of working memory (WM) have been found in normal aging and Parkinson's disease (PD). It is hypothesized that dysfunction of fronto-striatal memory system accounts for these impairments. In this presentation we present the results of two studies: a behavioral investigation of the effects of striatal damage on WM and non-working memory (non-WM) performance in young normal (YNC), old normal controls, (ONC), and PD: and a functional neuroimaging study of differential activation patterns during WM and non-WM tasks in YNC, ONC, and PD. WM and non-WM cognitive abilities were measured in 15 YNC, 16 ONC, and 15 non-demented PD, matched for gender and education. Significant differences on all WM measures (min. $F=12.44$, $p<.0001$) were found between all groups (all p's <.01). There were no significant differences between groups for non-WM performance (F's<1). Neuroimaging results revealed a significant decrease in frontal and parietal activation during WM task in PD and ONC compared with YNC, with greater decrease in PD. The hypothesis that decrement in WM performance found in healthy aging and PD share a common behavioral and neuroanatomic substrate, as well as the cognitive effects of dopamine replacement/agonist therapy, will be discussed.

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SYMPOSIUM 79—PSYCHOBIOLOGY AND PHARMACOTHERAPY OF BPD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be better informed about the genetic and neurobiologic vulnerabilities of BPD patients and about BPD practice guideline pharmacotherapy recommendations.

No. 79A
BIOLOGICAL CORRELATES OF BPD

Emil F. Coccaro, M.D., *Department of Psychiatry, University of Chicago, 5841 South Maryland Avenue, MC#3077, Chicago, IL 60615*

SUMMARY:

Research into the biological correlates of borderline personality disorder (BPD) include data related to familial/genetic, neurotransmitter based, and neuroimaging characteristics of patients with BPD. Familial and genetic studies strongly suggest that components of BPD, rather than the disorder itself, are transmitted in families. These components are most succinctly characterized as impulsive aggression and mood instability. Impulsive aggression is correlated inversely with central serotonin (5-HT) function and correlated directly with other (e.g., vasopressin, catecholaminer) facilitory neurotransmitters. Mood instability may have a catecholaminergic component as well, but recent research also suggests a role for the cholinergic system. This presentation will review the current state of the field regarding the biological aspects of BPD. This includes reviewing data from family, genetic, neurochemical, neuroendocrine, and neuroimaging studies of BPD. Data from clinical psychopharmacological trials will also be presented to highlight the relevance of biology in the etiology and treatment of BPD.

No. 79B
PSYCHOBIOLOGY OF HUMAN PERSONALITY

C. Robert Cloninger, M.D., *Department of Psychiatry, Washington University Medical School, 4940 Childrens Place, Saint Louis, MO 63110*

SUMMARY:

There have been extensive advances during the past decade in understanding the psychobiology of human personality using a variety of research approaches. These approaches include (1) twin and adoption studies of the genetic architecture of personality; (2) mapping of specific genes using molecular genetic techniques of linkage and association; (3) brain imaging studies correlating personality with individual differences in regional distribution of evoked potentials, PET, and fMRI features; (4) neurochemical correlates of human personality; and (5) personality correlates of individual differences in response to pharmacological and psychological manipulations in treatment. Results of these studies, which include research on patients with personality disorders and research on quantitative personality dimensions in the general population, are reviewed. The results of these advances indicate that human personality is composed of multiple quantitative dimensions with distinct neurobiological correlates. Personality traits explain nearly 50% of the variance in response to antidepressants.

No. 79C
LONGITUDINAL PATTERNS OF MEDICATION UTILIZATION IN BPD

John M. Oldham, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Suite 6700, New York, NY 10032-2603*; Andrew E. Skodol II, M.D., Donna S. Bender, Ph.D., Regina T. Dolan, Ph.D., John G. Gunderson, M.D.

SUMMARY:

There is increasing recognition that symptom-targeted pharmacotherapy can be a valuable component of treatment for the personality disorders. Borderline personality disorder (BPD), is a disabling condition common among treatment-seeking populations. When clinically prominent, several BPD DSM-IV criteria involve symptoms

or behaviors, e.g., frantic anxiety, impulsivity, suicidality, affective instability, inappropriate intense anger, and paranoid ideation, that should be considered for such targeted pharmacotherapy. Systematic data, however, regarding medication practice patterns in the treatment of BPD, are sparse. Controlled studies are beginning to be done, and those available in the literature have been reviewed by the APA work group developing practice guidelines for BPD. In addition to controlled studies, however, standardized prospective data about medication usage patterns in BPD patients will provide informative guidance. Such data are being obtained in the NIMH-sponsored Collaborative Longitudinal Personality Disorder Study. In an initial analysis of baseline data, lifetime patterns of medication use in patients with BPD (n=175) were compared with lifetime use in control patients with major depressive disorder (MDD) (n=97). Patients with BPD were significantly more likely to have received mood stabilizers than were patients with MDD, controlling for number of current and past comorbid Axis I disorders, but antidepressant usage did not differentiate the two groups. However, BPD patients with comorbid MDD were more likely to have received antidepressants and mood stabilizers than BPD patients without MDD. Prospective data are being collected, and longitudinal medication usage patterns for the first two years of the study will be presented.

No. 79D
PHARMACOTHERAPY OF BPD

Paul H. Soloff, M.D., *Department of Psychiatry, University of Pittsburgh/WPIC, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Pharmacotherapy of borderline personality disorder (BPD) requires an evidence-based, symptom-specific approach, informed by our understanding of the neurobiology of personality dimensions. In the patient with BPD, cognitive-perceptual distortions, affective dysregulation, and impulsive-behavioral dyscontrol are the symptom domains most amenable to pharmacologic management. Pharmacotherapy is indicated for state symptoms, during periods of acute decompensation, and trait vulnerabilities, which represent the biologic diathesis to future episodes. Cognitive-perceptual target symptoms may include stress-related derealization, illusions, and ideas of reference, as well as trait characteristics such as chronic suspiciousness. The target symptoms of affective dysregulation may include mood lability, rejection sensitivity, depressive mood crashes, and temper outbursts. Impulsive-behavioral symptoms may include impulsive-aggression, hinge behaviors, and self-injurious or suicidal behaviors. Using an evidence-based approach, treatment algorithms for the cognitive-perceptual, affective, and impulsive-behavioral symptom domains of BPD have been developed to assist clinical judgment, and have been incorporated in the draft APA Practice Guidelines for the Treatment of Borderline Personality Disorder. This presentation will describe these evidence-based algorithms and their empirical rationale.

No. 79E
CLINICAL MANAGEMENT OF SUICIDALITY IN BPD

Maria A. Oquendo, M.D., *Department of Neuroscience, New York State Psychiatric Institute, 1051 Riverside Drive, Box 42, New York, NY 10032*; J. John Mann, M.D.

SUMMARY:

Borderline personality disorder (BPD) is associated with significant morbidity and mortality due to self-mutilation and suicidal acts. Although BPD alone confers risk for suicidality, it is often comorbid with major depression, dysthymic disorder, and psychoactive substance use disorders. These conditions constitute factors that further increase the risk for suicidal behavior in BPD. The presence of comorbid conditions influences treatment decisions regarding pharmacotherapy, psychotherapy, and hospitalization. Thus, clinical interventions for suicidal behavior hinge on the diagnostic assessment. Interventions that ameliorate suicidal behavior often target comorbid conditions and also symptoms of BPD, which increase the risk for suicidal acts, such as dissociation and mood instability. Selective serotonin reuptake inhibitors, mood stabilizers, and typical and atypical antipsychotics have been advocated in the management of suicidality in BPD. Their utility may be related to antidepressant and mood stabilizing properties and may also involve decreasing impulsivity or aggression, important contributing factors to suicidal acts in BPD. Dialectical behavioral therapy may be useful for the prevention of both suicidal and self-mutilatory behavior. Interventions geared at reducing substance use are also critical in the prevention of suicidal behavior in this population. The application of these approaches toward managing suicidality in different treatment settings will be discussed.

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SYMPOSIUM 80—SPECIAL TOPICS IN WOMEN'S MENTAL HEALTH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize gender differences related to some specific psychiatric disorders, and to understand the particularities that may affect the diagnosis and treatment in women.

No. 80A
ALCOHOLISM AND DRUG ABUSE IN WOMEN

Monica L. Zilberman, Ph.D., *Addiction Center, University of Calgary, Foothills Hospital 1403 29th Street NW, Calgary, AB T2N 2N9, Canada*; Hermano Tavares, Ph.D.

SUMMARY:

Prevalence estimates of drug abuse/dependence among women are increasing as a consequence of an earlier age of onset of drug use and the greater vulnerability of this subgroup to the drug effects. Existing data have indicated that drug dependence in women may present with particular features, including greater comorbidity with depressive and anxiety disorders and more severe medical consequences, such as hepatic and cardiovascular impairment. In addition, these features may vary from substance to substance; the progression

of alcohol dependence among females, for example, appears to be faster than that observed in males, the so-called telescoping effect (TE). The same TE is also found among heroin addicts, but it is still controversial among cocaine addicts. Moreover, although the importance of craving episodes in relapse to drug use has been recognized, no systematic data are available yet. All these controversial issues will be addressed during the presentation. At last, novel treatment strategies such as women-only groups and gender-specific family approaches will be critically reviewed and discussed.

No. 80B
PATHOLOGICAL GAMBLING IN WOMEN

Hermano Tavares, Ph.D., *Department of Psychiatry, University of Sao Paulo, R Dr Ovidio Pires de Campos S/N, Sao Paulo, SP 05403-010, Brazil*; Monica L. Zilberman, Ph.D., Fabio J. Beites, M.D., Valentim Gentil, M.D.

SUMMARY:

Prevalence estimates of pathological gambling in the general population range from 1% to 4%. Despite estimates that one-third of gamblers are female, most of the existing literature is based on research in males.

The authors compared 25 women entering an outpatient treatment program for pathological gambling with a male sample (n=31). They were diagnosed according to DSM-IV and selected by SOGS, followed by a semistructured interview for demography and progression of the gambling behavior prior to treatment.

Women were more often single (56% vs. 23%; p<.05) and started gambling significantly later than men (35.3 vs. 21.2 years; p<.0001). The progression of the disorder was 2.5 times faster in women than in men. There was no difference in the age of seeking treatment (44.0 vs. 42.5 years). In addition, women more often reported gambling as a way of escaping from problems and avoiding bad feelings (88% vs. 58%; p=.01).

Findings from this study, resembling gender differences in other addictions, in particular the faster progression among women, challenge pharmacodynamic hypotheses for this phenomenon and suggest taking gender into account when devising treatment strategies for pathological gambling.

No. 80C
THE ROLE OF ESTROGEN IN PERIMENOPAUSAL DEPRESSION

Claudio N. Soares, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*; Lee S. Cohen, M.D.

SUMMARY:

The World Health Organization defines perimenopause as the period resulting from the progressive loss of ovarian follicular activity. The perimenopause is characterized by endocrinologic and clinical changes, when women experience menstrual irregularities (shortened cycles or longer periods of amenorrhea) and vasomotor symptoms (hot flushes, night sweats).

Previous studies suggest that the perimenopause is a period of higher risk for the occurrence of mood disturbance including depressive symptoms and major depression. The extent to which demographic and reproductive-related characteristics and habits may influence the occurrence of depressive symptoms during the perimenopause depend on the population investigated.

We will review data derived from different settings (gynecologic clinics versus community-based studies). Essentially, women attending "menopause clinics" represent a group with a heightened psychiatric morbidity, although they are not representative of the population of perimenopausal women overall. Conversely, cross-sectional and community-based studies suggest that depressive symptoms in that subpopulation may be associated with a history of reproductive-related problems (premenstrual complaints, vasomotor symptoms, surgical menopause), presence of current stressors (e.g., marital problems), poor health conditions, lack of exercise, and cigarette smoking.

Ultimately, we discuss the existence of specific subpopulations of women with a particular vulnerability to depression during periods of intense hormonal fluctuations (reproductive-associated mood disturbance), such as the premenstrual phase, the puerperium, and the perimenopause.

No. 80D
COMORBID DEPRESSION AND ANXIETY DISORDERS IN COUPLES PRESENTING FOR IN-VITRO FERTILIZATION

Rajesh M. Parikh, M.D., *Department of Psychiatry, Jaslok Hospital Research Center, 15 Dr. G. Deshnukh Marg, Bombay 400026, India*; Shamsah B. Sonawalla, M.D., Firuza R. Parikh, M.D.

SUMMARY:

Significant psychological distress is reported in patients undergoing in-vitro fertilization (IVF). Several studies have reported high prevalence rates of anxiety and depression in this population. The presentation will discuss significant findings from three studies carried out by the authors at an assisted reproduction center in Bombay. These studies evaluated the prevalence of depression and anxiety in couples presenting for IVF and reported a high prevalence of depression and anxiety in this population. In one study, which evaluated 30 consecutive couples, 40% of the study group met DSM-IV criteria for an Axis 1 mood or anxiety disorder: 15% had major depressive disorder, 18.3% had dysthymic disorder, and 6.7% had an anxiety disorder. Women had a significantly higher prevalence of depressive and anxiety disorders compared with men, regardless of the etiology of infertility. However, men had a depressive or anxiety disorder only in the presence of a male factor as the etiology for infertility. Suicidal ideation was present in 30% of the study group, and was reported by significantly more women (50%) than men (10%). Across all scales, the factors of anxiety, depression, and somatization were significantly higher than other factors. Seventy percent of couples had at least one partner with a psychiatric diagnosis. Another study covering 105 couples had similar findings.

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SYMPOSIUM 81—THE ROLE OF RELIGION IN THE LIVES OF OUR PATIENTS: CLINICAL APPROACHES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to appreciate the need to understand the role of religion in the

lives of many of our patients, and the manner in which faith or belief colors psychiatric mind and brain disorders and the relationship between the clinician and the patient.

No. 81A
RELIGION AS A FRAMEWORK IN UNDERSTANDING AND RESPONDING TO MENTAL ILLNESS

Irving S. Wiesner, M.D., *Swarthmore Medical Center, Yale Avenue and Chester Road, Swarthmore, PA 19081*

SUMMARY:

The traditionally religious patient has an understanding of the nature of man, the nature of God, and the purpose of life on earth and beyond that must be taken into consideration in the course of psychiatric diagnosis and treatment. This mandate is expressed in the APA's guidelines that affirm the usefulness of obtaining information on the religious or ideological orientation and beliefs of patients and properly attending to them in the course of treatment.

In preparation for the several specific faith tradition presentations that follow, a groundwork will be established dealing with suffering, guilt, and forgiveness. Some religious traditions believe that the underlying causes of the chemical imbalances and the dysfunctional and dysphoric aspects of mental illness can be explained by expanding the field to include the concepts of evil, and the consequences of not obtaining or granting forgiveness both relating to God as well as significant others. Additionally, positive consequences of humility, repentance, and obedience to the religious principles of the faith are felt to be both preventative and healing of mental disturbances. These explanations offer at times complementary and at times alternative paradigms that religious patients bring to the therapeutic encounter.

No. 81B
THE ROLE OF RELIGION IN THE LIVES OF OUR PATIENTS: A HINDU APPROACH

Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*

SUMMARY:

Hindu religious understanding is that there is one Creator and a supreme reality that is the ground for one's divinity. This divine force is Self or Atman or the Higher Power. This Self is in all creatures and is not different from the ultimate reality called God. Hindu religion believes in reincarnation.

From the Hindu perspective, the nature of evil is based on one's own Karma. The theory of Karma is to evolve from a self-centered, materialistic life, to a more selfless life. It is believed that our happiness and suffering are based on the kind of Karma we may have done in this life or previous lives. However, it gives us an opportunity to negate the undesirable fruits of our Karma by our efforts to change.

Our ultimate purpose in life is to understand that the soul and the body are separate. The soul is immortal and takes many bodies before reaching Salvation. This concept is utilized in comforting people who have lost loved ones to death or are suffering. Several clinical scenarios will offer opportunities to the participants for discussion.

No. 81C
THE SPECIAL NEEDS OF THE ORTHODOX JEWISH PATIENT

Abba E. Borowich, M.D., *166 Valley Road, New Rochelle, NY 10804-3744*

SUMMARY:

As Senator Joseph Lieberman exemplifies, Orthodox Jews adhere to a set of rules and standards that help define their lives. Nevertheless, the span of behaviors, customs, and traditions subsumed under the general heading of "Orthodox" is very broad. Subgroups range from the "traditional" or "observant" on the left, to the Hassidim on the extreme right.

In order to best serve this population, psychiatrists need to familiarize themselves with the norms, practices, and values inherent in this group. Pathology is best understood when normality is clearly delineated. This is particularly true when normative behaviors can easily be misidentified as pathological and vice versa.

Within the limitations of the time alloted, the wide range of orthodoxy will be discussed, common standards will be delineated, and special problems will be addressed by a psychiatrist with over 30 years of experience dealing with these issues. It is hoped that members of the audience will be sensitized to provide a more culturally-attuned therapy to these people.

No. 81D
PERSONHOOD AND THE PURSUIT OF HAPPINESS: A CATHOLIC PERSPECTIVE

Judith A. Hughes, M.D., *45 Flagg Street, Worcester, MA 01602-1450*

SUMMARY:

An objective definition of the human person consistent with Catholic teaching is a subsisting being of human origin possessing an intrinsic guiding force toward fulfillment through unconditional, perfect, and infinite truth, goodness, love, beauty, and being. This definition provides a foundation for a clinical evaluation that brings philosophy, religion, and spirituality to the cognitive assessment of a person of faith. One's view of happiness is a determinant of purpose in life. One achieves greater approbation of the objective definition of person by progressing through four levels of happiness: (1) LAETUS: sensual gratification from an external stimuli, (2) FELIX: ego-gratification from personal power and control, (3) BEATITUDO: the gratification of investing the self in goods beyond the self, and (4) GAUDE: the receiving and giving of ultimate good, truth, love, beauty, and being. Clinical descriptions will be provided of how the patient's level of happiness influences their perception of the ten categories of individual and cultural discourses: happiness, success, self-worth, love, suffering, ethics, freedom, personhood, rights, and the common good. Therapeutic goals for the Catholic patient should move toward happiness levels 3 and 4. Clinical skills in cognitive therapy, rhetoric, behavioral modification, and clergy collaboration are recommended.

No. 81E
CLINICAL CHALLENGES WITH PROTESTANT PATIENTS: SIN, GUILT, AND FORGIVENESS

Mark E. Servis, M.D., *Department of Psychiatry, UC Davis Medical Center, 2230 Stockton Boulevard, Sacramento, CA 95817*

SUMMARY:

The psychiatrist treating patients of Protestant faith is often presented with challenges stemming from the patient's religious perspectives on sin, guilt, and forgiveness. Protestant theology offers elaborate and cogent ideas about sin, guilt, confession, forgiveness, and redemption that conflict with traditional psychiatric and psychodynamic perspectives. An understanding of Protestant beliefs about sin, guilt, and forgiveness is useful in helping the Protestant patient achieve a healthy psychological and spiritual state. Protestant patients are frequently confused about their own spiritual perspective on when guilt is appropriate and what forgiveness means. Clinical examples of patients with healthy and pathological concepts of sin, guilt, and

forgiveness are useful in delineating differences between healthy and unhealthy Protestant religious beliefs. For psychiatrists, the challenge lies in determining whether or when to address the patient's spiritual beliefs. A delicate balance is called for between using the religious perspectives of patients to inform their assessment and treatment, and ignoring the spiritual perspective on a patient's problem. An integration of psychiatric understanding with Protestant perspectives on sin, guilt, and forgiveness can provide an optimal treatment approach for Protestant patients.

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SYMPOSIUM 82—UPDATE ON TREATMENT OF STIMULANT ABUSE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should recognize stimulant abuse in patients, diagnose its common psychiatric comorbidities, and treat it effectively using both psychosocial and pharmacological modalities.

No. 82A
RECOVERY-ORIENTED PSYCHOSOCIAL TREATMENTS

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854*; Jonathan Krejci, Ph.D., Marc Steinberg, M.A., Sylvia Atdjian, Carolyn Eick, M.A., David A. Smelson, Psy.D.

SUMMARY:

Psychosocial interventions continue to be the cornerstone of cocaine addiction treatment. This presentation will provide a practical overview of the core psychosocial treatments for treating addiction, including relapse prevention, 12-Step Facilitation, Motivational Enhancement Therapy, Community Reinforcement Approach, and couples/family therapies. Specific goals and techniques used in these approaches will be presented. Psychotherapy in the treatment of addiction is crucial in developing a therapeutic alliance that promotes recovery, increases motivation to change, develops general and specific coping skills to reduce the likelihood of relapse, and facilitates developing alternative highs. Psychotherapy can also help the patient improve interpersonal functioning; improve their understanding of the nature of addiction and the course of recovery; find meaning, purpose, and sense of connection in their lives; and maintain compliance with treatment. Treatment-matching issues will be discussed including motivational level, social support, relapse potential, recovery status, history of prior treatments and response, co-occurring mental illness, and other substance use disorders and compulsive behaviors/process addictions. Psychosocial treatment models from the recovery community will be presented including the Matrix/Neurobehavioral Model of Stimulant Treatment and the Pavillion/Integrated Model for Recovery. Participants will learn about resources and training materials on psychosocial treatments for stimulant and other addictions.

No. 82B
PSYCHOTHERAPY AND COUNSELING APPROACHES FOR COCAINE ABUSE TREATMENT

David R. Gastfriend, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Psychotherapy/counseling approaches for treatment of stimulant abuse may be considered in two domains: therapy modality and level of care. Several therapy modalities have been formally studied in rigorous, manual-driven, multisite designs. The NIDA Cocaine Collaborative Treatment Study compared cognitive therapy, supportive-expressive therapy, individual drug counseling (all delivered with group drug counseling), and group drug counseling by itself. Individual + group drug counseling produced the best outcome, regardless of severity of psychiatric comorbidity. Level of care matching has also been studied in three studies of the Patient Placement Criteria Published by the American Society of Addiction Medicine (ASAM PPC). These trials were made possible using 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. Preliminary results suggest that matching patients to level of care based on their clinical and psychosocial characteristics (including attitude toward treatment) improves treatment outcome and efficiency. Together, these findings suggest that patients with stimulant abuse require psychosocial treatments with a coherent recovery-oriented message; adequate treatment intensity; and consideration of motivational, relapse prevention, and environmental support needs.

No. 82C
PHARMACOLOGICAL TREATMENT OF STIMULANT ABUSE

David A. Gorelick, M.D., *Clinical Pharmacology, NIH NIDA IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224-0180*

SUMMARY:

Numerous pharmacological treatments for stimulant abuse have been evaluated, but none has been consistently effective in controlled clinical trials. Some medications showing promise, but not yet rigorously evaluated, include the selective MAO inhibitor selegiline, anticonvulsants such as phenytoin and vigabatrine, and the combination of bupropion plus bromocriptine. Some promising new approaches undergoing preclinical or phase I clinical evaluation include compounds (e.g., GBR 12909) that bind to the presynaptic dopamine transporter, a major site of action for cocaine; antibodies that bind cocaine peripherally, thus preventing it from entering the brain (cocaine vaccine); and enhancement of cocaine metabolism with the naturally occurring enzyme butyrylcholinesterase. A particularly difficult group of patients to treat are those abusing other drugs in addition to stimulants, e.g., "speedballers." Buprenorphine, a partial mu-opiate agonist, has shown some promise in the treatment of such patients.

No. 82D
PSYCHIATRIC COMORBIDITY IN STIMULANT ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, #9F, New York, NY 10003*

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 nonsubstance-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. 82E
METHAMPHETAMINE ABUSE: UPDATE 2001

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 (Baberg 1996). Among the most serious medical consequences may be an increase in HIV risk. Methamphetamine use has been closely linked to high-risk HIV behavior, 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 medical and nonmedical treatment of methamphetamine abuse and dependence and its sequelae.

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SYMPOSIUM 83—POLITICS OF ADMINISTRATIVE RELATIONSHIPS IN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should recognize how the relationship between the psychiatrist administrator and the nonmedical administrators will influence the psychiatrist's role in the behavioral health system, (2) identify factors influencing the development of this relationships across various management settings, and (3) understand both the positive and negative forces which influence the development of constructive and collaborative partnerships in administration.

No. 83A
DEFINING ADMINISTRATIVE ROLES: DIVIDE AND COOPERATE

Clifton R. Tennison, Jr., M.D., *Helen Ross McNabb, 1520 Cherokee Trail, Knoxville, TN 37920-2205*

SUMMARY:

The medical director-CEO relationship can be critical in defining and implementing effective care and oversight. Ethical (Moffic 1997, Mosher 1994) and clinical (Staton 1991, Langsley 1983) concerns suggest a division of labor between the business and the provision of health care. Several surveys (AACP 1984 & 1985, NCPA) clarified the demedicalization of community mental health and predicted similar dissatisfaction in practical suggestions for this relationship (Tennison 1989, 1998) coupled with create adaptive, functional role descriptions. Many of the community psychiatrists' struggles have been related to issues of leadership (Urbaitis 1989, Muentz 1995) and much of our success as service planners, builders, supervisors, providers, and evaluators is dependent on leadership style, competence, and relationships. The author's coleadership role with his CEO had helped assure successful organizational change and survival, demonstrating the usefulness of carefully crafted collaborative roles. The medical director must assume a variety of roles in order to serve the organization and its patients, and to work with the CEO to win the support of consumers, advocates, payers, and grantors.

No. 83B
DEVELOPING RELATIONSHIPS AND ENHANCING ROLES IN A MANAGED CARE ORGANIZATION

William G. Wood, M.D., *Value Options Behavioral Health, 3110 Fairview Park Drive, Falls Church, VA 22042*

SUMMARY:

Blind allegiance, to whatever or whomever, serves no one. Nowhere is this truer than in today's managed health care arena. Accusations of compromised ethics are hurled across the great divide that

separates groups such as our own American Psychiatric Association and managed care workers. The highly charged tone of recent interactions has served only to polarize and paralyze.

Psychiatrists, and doctors generally, are a single-minded lot. Struggles between our nonmedical colleagues and us have been fierce at times, and oftentimes not very productive. Consider the debate of the 1970s and 1980s, which pitted community psychiatrists again nonpsychiatrist CMHC administrators; the battles of the 1950s through the 1970s, with state hospital psychiatrists and hospital administrators vying for the high ground; and current battles with nonmedical psychotherapists. Much valuable time was wasted in vituperative mud slinging; only when we put aside our rage at being challenged and engaged in honest debate did we and our patients benefit. In this presentation, the speaker will use his experiences as a managed behavioral health care executive to consider ways to transcend the politics of administrative organization and interdisciplinary division. An approach to enhancing the value of the psychiatric administrator to the BHMCO will be considered.

No. 83C
PSYCHIATRIST/ADMINISTRATOR ALLIANCES IN PUBLIC PSYCHIATRY

Thomas A. Simpatico, M.D., *Mental Health Department, State of Illinois, 4200 North Oak Park Avenue, BCNO, Chicago, IL 60634*; Christopher G. Fichtner, M.D.

SUMMARY:

In the context of a symposium on clinician-administrator relationships within behavioral health systems, this presentation works from the view that an understanding of the systemic context of roles and relationships is essential to the development of working collaborations between clinicians and nonclinicians in administrative, managerial, and leadership roles. Such an understanding includes recognition and appreciation of the various interests, demands, and multiple competing agendas that converge upon individuals in positions of leadership within systems, as well as an appreciation of the ways in which role shapes experience of these phenomena. Within a systems-theory framework, the use of group dynamics concepts, a group-as-a-whole perspective, and image and metaphor in the characterization and analysis of organizational culture, are powerful tools for fostering collaboration in the face of divergent influences on clinicians and administrators who must work together to achieve common goals. Even psychiatrists in different clinical-administrative roles may be influenced to prioritize issues quite differently within a common system, analysis at the systems level facilitates collaboration in such instances. This presentation will illustrate the use of these concepts and strategies by clinician-administrators working to improve patient care quality within a public system.

No. 83D
NAVIGATING IN ROUGH WATER: WHEN IT DOESN'T WORK

Gordon H. Clark, Jr., M.D., *Integrated Behavioral Health, 1 Forest Avenue, Portland, ME 04101*

SUMMARY:

This presenter will provide three examples from his own career of "When It Doesn't Work." Circumstances and personalities often create organizational scenarios that are untenable for physician's who wish to maintain quality and integrity in systems where they have an administrative role. The discussion will focus on characteristics of organizations that create such circumstances and how these experiences affected the presenter and how he responded. He will offer some additional suggestions of how psychiatrists in administrative leadership roles can arm themselves with expertise and colleagueship. While administrative expertise and colleagueship may not prevent bad situations from occurring, they can at least serve to sustain one in the face of such adversity.

No. 83E
THE VALUE OF MEDICAL LEADERSHIP: MORE THAN A DREAM?

Kathleen A. Daly, M.D., *Edelman Westside Medical Health Center, 11080 West Olympic Boulevard, Los Angeles, CA 90064*

SUMMARY:

A successful administrative structure that includes, but is not directed by, physicians is uncommon, but achievable. Success is contingent upon the executive director (nonmedical leadership) valuing medical input and securing a pivotal role for their medical counterpart. Their relationship must be based upon mutual respect, trust, and clarity in authorization. A medical director who is valued and has an active advocacy role will be more effective in recruiting quality psychiatrists. Authority over the medical treatment of patients and supervision of the staff is necessarily the case in all facilities. Even when a physician has authority over the medical staff, if a medical director does not have an integral role in the management structure, authority is limited and that model is replicated throughout the system of care as staff will mirror the relationships of their supervisors. If the medical director is peripheral to the decision making in an organization, then the psychiatrist on a team will more likely be peripheral to treatment of the patient. When physicians are not in leadership roles on interdisciplinary treatment teams, their role is often limited to management of medications and a wealth of clinical experience is lost, resulting in a lower quality of patient care and less opportunity to learn and exchange information among clinicians.

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SYMPOSIUM 84—OUTREACH TO BUSINESS: THE AMERICAN PSYCHIATRIC ASSOCIATION BUSINESS INITIATIVE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) understand the relationship between quality mental health care and the corporate bottom line, (2) conceptualize mental health issues in employees' lives and the business environment, (3) recog-

nize special concerns of the business world about direct and indirect effects of mental illness, and (4) describe the APA Business Initiative.

No. 84A
QUALITY MENTAL HEALTH CARE AND THE CORPORATE BOTTOM LINE

Norman A. Clemens, M.D., *Department of Psychiatry, Case Western Reserve University, 1611 South Green Road, Suite 301, Cleveland, OH 44121-4128*

SUMMARY:

We are all painfully aware of the shortcomings of today's health care delivery systems. The most important shortcoming in regard to mental health care is the high percentage of individuals (employees) who are not receiving adequate or proper diagnosis and treatment. This failure takes its toll on the employee, and, importantly, on the employer as well. And employers are beginning to realize that mental health problems, if left untreated, can manifest themselves in costly increases in disability, absenteeism, employee turnover, violence, general medical costs, as well as in decreases in productivity—all of which affect the corporate bottom line. This growing awareness in the business community of the importance of high quality and easily accessible mental health care is what the APA's new Business Relationship Initiative is designed to foster and promote. We are reaching out to business leaders to enhance their appreciation and support for both the value of quality mental health care and the important role that psychiatry plays in delivering it. We also intend to help psychiatrists better understand and deal with issues affecting employers. The ultimate goal of this activity is to work collaboratively with business to develop optimal approaches for delivering quality mental health care.

No. 84B
ORGANIZATIONS AND THEIR IMPACT ON PRODUCTIVITY AND HEALTH

Leonard T. Sperry, M.D., *Barry University, 11300 NE Second Avenue, Campus Box 460, Miami Shores, FL 33161*

SUMMARY:

Evidence is mounting that corporate productivity and the health and well-being of its employees are linked and that the structure and culture of a corporation can impact both. Both psychiatrists and executives need to understand this link and how it can be enhanced. Structure involves not only reporting relationship and scope of authority, but also reward and control systems. Culture is the constellation of shared experiences, beliefs, assumptions, customs, and actions that characterize an organization, and is largely determined by the values held by senior executives, corporate history, and the senior executive's vision of the organization. Both structure and culture have been primary targets of corporate change in the past two decades, i.e., reengineering through downsizing, job redesign, etc., and culture transformation through modifying norms, morale, and disability proneness. While reengineering and culture transformation have the potential to increase both productivity and health, they can also impair one or both. This presentation will describe both structure and culture and relate them to productivity and health and specify ways in which psychiatry can positively impact and advocate for both productivity and health. Directed discussion with other panel presenters and participants will complement this audiovisual presentation.

No. 84C
HELPING BUSINESS TO UNDERSTAND PSYCHIATRIC SKILLS

Marcia K. Goin, M.D., *Department of Psychiatry, University of Southern California, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90017-4085*

SUMMARY:

Health care costs are rising and employers are making hard decisions about how and where to spend their money. Convincing them that psychiatric care is a priority item is a major challenge, not easily achieved, but essential for the health of our country. Employers' misperceptions about psychiatrists and psychiatry abound. Market research studies have shown that although employers recognize depression, anxiety, and substance abuse as the most common workplace mental disorders, they distrust the mental health care community, and see psychiatric services as indefinable, unscientific, and having unidentifiable outcomes! They want help with containing and preventing violence in the workplace. They see psychiatrists as unavailable to help patients on disability return to work. As psychiatrists reaching out to talk to employers, we must appreciate their misperceptions and find substantial and creative ways to address them.

This presentation will identify the barriers to engagement and propose methods to overcome them. It will present an overview of the concerns and misperceptions held by business people and a format to demonstrate that psychiatric illness is diagnosable and treatable. Psychiatric treatment is affordable and without such care other medical costs increase.

No. 84D
PATIENTS' WORKPLACE LIVES: CAREER, PERFORMANCE, AND DEVELOPMENT

Jeffrey P. Kahn, M.D., *Cornell University Medical Center, 300 Central Park West, #1C, New York, NY 10024-1513*

SUMMARY:

Family and personal relationships are the cornerstones of psychotherapeutic work with the emotional lives of our patients. Diagnoses are essential for using medication to address the biochemical factors that cause emotional distress. Likewise, we need to closely understand career and workplace issues if we want to consider the broad scope of our patients' emotional and practical concerns. Three aspects are of particular interest. First, each workplace is a distinct social environment, with varied organizational cultures and structures, and complex personal interactions. Second, patients are concerned about their work performance and success, and may want or need to develop their personal and interpersonal workplace skills. Finally, many also focus on long-term career strategies and developmental needs. Issues in all of these areas are closely interrelated with other interpersonal and diagnostic factors. Helping our patients understand their workplace concerns in the encompassing context of personal treatment allows them to maximize the value of their treatment. Workplace concerns can be addressed through more focused approaches such as executive coaching as well. And beyond what individuals can gain from individual treatment, the psychiatric perspective can also enhance workplace programs in management skill development and career planning.

No. 84E
SPECIAL CONCERNS OF BUSINESS CONFLICT MANAGEMENT, DISABILITY, VIOLENCE, AND EMPLOYEE TURNOVER

Stephen H. Heidel, M.D., *Integrated Insights, UCSD School of Medicine, 9370 Sky Park Court, #140, San Diego, CA 92123*

SUMMARY:

Business organizations bring together people with diverse backgrounds, skills, and values, and then ask them to work together to perform specific tasks and to achieve goals with limited resources. These demands place stress on all parties and problems invariably arise. Psychiatrists who are knowledgeable about the workplace are uniquely qualified to address some of these concerns, including managing conflict between employees, assisting with a strategy to manage threats of violence, addressing the psychiatric and psychosocial aspects of disability claims, and curtailing turnover that is due to psychiatric and/or psychological issues. Psychiatrists interested in applying their skills in the workplace should view these special concerns as an opportunity to expand their practice.

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SYMPOSIUM 85—QUALITY OF LIFE IN PATIENTS WITH SCHIZOPHRENIA: RESEARCH IN EUROPE AND THE AMERICAS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium the participant should be able to understand the history, development, and recent research of the subject of quality of life of persons suffering from schizophrenia in Europe and the Americas, but principally in France and the United States.

No. 85A
QUALITY OF LIFE: HISTORY AND DEVELOPMENT IN THE U.S.

Anthony F. Lehman, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Suite 388, Baltimore, MD 21201*

SUMMARY:

Quality of life concerns have gained considerable currency throughout the entire field of health care during the past decade. Underlying this interest in quality of life is the fundamental question about what difference medical treatments *really* make in patients' lives, reflected by the well-known medical aphorism, "The surgery was a success, but the patient died." Driving this movement toward quality of life research are both a humanitarian concern about the overall well-being of patients and concerns about costs. Although definitions vary, the "quality of life" concept encompasses what a person is capable of doing (functional status), access to resources and opportunities to use these abilities to pursue interests, and sense of well-being. The former two dimensions are often referred to as objective quality of life and the latter as subjective quality of life. Within these overarching dimensions of quality of life, life domains have been identified, for example, health, family, social relations, work, financial status, and living situation. Quality of life is thus a complex notion. Three quality of life perspectives can be identified to frame core issues regarding QOL assessment in health care: (1) the general quality of life framework, (2) the health-related quality of life framework, and (3) the disease-specific quality of life framework.

No. 85B
THE DEFINITION AND EVALUATION OF QUALITY OF LIFE

Pierre Lalonde, M.D., *Hospital Louis Lafontaine, 6070 Sherbrooke East Bureau 106, Montreal, QC H1N 1C1, Canada*

SUMMARY:

Quality of life and quality of care are complementary concepts. The evaluation of quality has many facets: subjective evaluation of the satisfaction of the patient and his or her family, objective evaluation of the care provided using specific criteria, and objective evaluation of the social functioning, occupational skills, etc.

This presentation will focus on a definition of these concepts of quality and their interdependence. Some measurement scales will be presented and commented on.

No. 85C
SCHIZOPHRENIA AND QUALITY OF LIFE ACROSS EUROPE

Viviane Kovess, M.D., *MGEN, 3 Square Max Hymans, Paris 75748, France*; Jose M. Caldas de Almeida, M.D., Mauro G. Carta, M.D., Jacques M. Dubuis, M.D., Jacques Pellet, M.D., Jean-Luc Roelandt, M.D., Hans Salize, Ph.D.

SUMMARY:

This presentation will report on a long lasting project set up to follow schizophrenic patients across seven European countries and describe the care given to them. The patients were assessed for their clinical symptoms and their social dysfunction by diverse instruments (SCAN and others) and the interventions, which were proposed to them, were recorded by the systematic use of the NFCAS and a record of the diverse actions taken (Mannheim Service recording sheet). A network of clinicians and researchers (ERGOS) set up a one-year prospective cohort study, which include patients with a clinical life-time diagnosis of schizophrenia according to ICD-10 (F20) diagnostic criteria for research, aged between 18 and 65 years old, and who had in 1993 at least one contact with the mental health services. Patients were eligible for the study independently of whether they were receiving inpatient or outpatient care. A total of 504 patients were included and 484 were followed up (of whom 326 had a MSRS), the mean age was 38 years, onset appears 22 years before this evaluation, 59% were outpatients, 24% in day care, and 15% hospitalized.

Quality of life was measured using the Baker and Intagliata scale at entry and one year after in some of the centers. Results will compare quality of life across centers by domains and using a global index. Quality of life will be correlated with presence of clinical and social problems, need for care, and interventions provided during the one-year follow up.

No. 85D
QUALITY OF LIFE FOR PATIENTS WITH SCHIZOPHRENIA TREATED IN DAY HOSPITALS

Francois C. Petitjean, M.D., *Department of Psychiatry, Hospital Ste. Anne, 1 Rue Cabanis, Paris 75674, France*; Corinne Launay, M.D., Franck Salone, Jean-Claude Demant, M.D.

SUMMARY:

Deinstitutionalisation has led to an increasing interest for the assessment of the quality of life of patients with schizophrenia treated in the community. Among the various instruments recently developed in this field, the Lancashire Quality of Life People (LQLP) has been widely used internationally.

We will present data from a study carried out in 1998, using a French version of this scale. Results point to important differences, in terms of objective as well as subjective quality of life, between patients treated in a day hospital and those treated in an outpatient clinic (Petitifan et al. 1999). The same study shows correlations between the global level of symptomatology (assessed by CGI and PANSS) and patients' satisfaction in certain areas (living conditions, social and family relations, health, well-being).

The first results of a new study, begun in June 2000 involving 150 patients treated in different day hospitals, will also be presented. Conventional and atypical neuroleptics will be compared, in terms of their impact on patients' subjective quality of life (assessed with the LQLP), in this new multicenter project.

No. 85E
QUALITY OF LIFE IN SCHIZOPHRENIA: A TWO-YEAR FOLLOW-UP STUDY OF 145 OUTPATIENTS

Oliver J. Canceil, M.D., *SHU S14, Hopital Sainte Anne, 1 rue Cabanis, Paris F-75014,* France; Marcos Sampaio-Meireles, M.D., Marie-Chantal Bourdel, Jean-Pierre Olie, Marie F. Poirier-Littre

SUMMARY:

Different clinical dimensions influence in various ways quality of life. Quality of life is a multidimensional concept, which refers to several parameters such as objective life conditions and their subjective perception, habilities (in work, social, and familial interactions), subjective feeling of well-being, psychological characteristics.

We have followed up a representative population of 145 schizophrenic outpatients in a district of Paris. Diagnoses were made using standardized interviews (C.I.D.I. or D.I.G.S. - II) according to ICD - 10 and DSM-IV criteria.

Two evaluations were performed: (1) at inclusion time and (2) two years later. Objective life conditions, socio-demographic and therapeutic data were obtained from a questionnaire. Quality of life was assessed according to Q.I.S. (Heinrichs et al., 1984), S.O.F.A.S. (DSM-IV, 1994—a global measure of socio-occupational functioning) and S.A.S. (Weissman, 1974—a measure of social adjustment, one of quality of life dimensions).

Clinical dimensions were evaluated using the PANSS.

Quality of life in its several dimensions is strongly influenced by the intensity of the illness, the burden of negative symptomatology, and illness duration at inclusion time.

Data analysis at two years follow-up and their correlations to the results at inclusion time will be presented.

No. 85F
QUALITY-ADJUSTED LIFE YEAR (QALY) MEASUREMENT IN PERSONS WITH SCHIZOPHRENIA

Jeffrey M. Pyne, M.D., *Department of Psychiatry, CAVHS, 2200 Fort Roots Drive, Building 58, North Little Rock, AR 72114-1727;* Greer Sullivan, M.D., D. Keith Williams, Ph.D.

SUMMARY:

The quality-adjusted life year (QALY) is a generic and preference weighted measure. The QALY is the recommended unit of effectiveness in cost-effectiveness analyses. A QALY combines quality and quantity of life into a score between 0.0 (equated to death) and 1.0 (equated to perfect health). The scores in between these bounds represent health states that are rated according to their relative desirability. The cost per QALY saved with a new intervention, compared with usual care or placebo, is a useful gauge for measuring the value of the new intervention. A lower cost-effectiveness ratio suggests a more desirable intervention. To date, there are very few papers using generic QALYs to measure treatment outcomes in schizophrenia. We examined the relationship between symptoms of schizophrenia and three generic QALY measures: Quality of Well-Being (QWB), VA-adapted SF-36 (SF-36V), and World Health Organization Disablement Assessment Schedule (DAS). General psychopathology and depression were significantly correlated with all three QALY measures. The QWB and DAS were also significantly correlated with positive, negative, and thought disturbance symptom severity scores. The above results can inform the choice of QALY measure for use in future schizophrenia treatment studies.

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SYMPOSIUM 86—CATATONIA AND NMS: PAST, PRESENT, AND FUTURE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand current trends in the nosology, etiology, laboratory investigation, and treatment of catatonia and neuroleptic malignant syndrome (NMS) and understand the historical roots of catatonia and NMS.

No. 86A
DEVELOPMENT OF THE CONCEPT OF CATATONIA: A HISTORICAL OVERVIEW

Stephanie Kruger, M.D., *Department of Psychiatry, University of Dresden, 178 Dresdner Street, Chemnitz 09131, Germany;* Peter Braunig, M.D.

SUMMARY:

In this talk, the historical roots of the concept of catatonia will be presented. The presentation is intended to lead to a better understanding of the current clinical and scientific discussion of the complex catatonic syndrome. In the first half of the 19th century, French psychiatrists described stuporous melancholia, (melancholia attonita). Based on this, Kahlbaum (1874) subsumed psychoses with predominant motor, behavioral, and vegetative signs under the term catatonia or tension insanity. He considered catatonia a separate diagnostic entity. In modern diagnostic terms, Kahlbaum's cases of catatonia were for the most part affective disorders with catatonic signs. Kraepelin (1899) incorporated *chronic* catatonias in his concept of dementia preacox. Based on Wernicke's (1900) work, Kleist (1905) and Leonhard (1936 - 1957) formulated their concept of

bipolar catatonia (motility psychosis/periodic catatonia) and of chronic catatonic schizophrenia. In the early 20th century, observations of "psychogenic catatonia" originated in Charcot's descriptions of hysteria and were published in great detail in the anecdotal literature. Around the same time, catatonic syndromes in children with schizophrenia, in individuals with mental retardation, and in organic brain disorders were extensively described. Another milestone in the development of the contemporary concept of catatonia was the description of the acute, febrile catatonia by Stauder in 1934.

No. 86B
THE NOSOLOGY OF CATATONIA

Gabor S. Ungvari, M.D., *Department of Psychiatry, Chinese University, Prince of Wales Hospital Shatin, Hong Kong, NT, China*

SUMMARY:

The nosology of catatonia is characterized by two contemporary but diametrically opposed views, both of which have roots in classical European psychiatry. The prevailing syndrome concept, or "anosological" position, was formulated by Gelenberg and regards catatonia as a rather ubiquitous syndrome comprised of a variety of motor and complex behavioral symptoms that aggregate in a random fashion. Catatonic syndromes associated with different medical and psychiatric conditions are thought to be clinically indistinguishable. The syndrome concept has gained favor due to the therapeutic action of benzodiazepines. Researchers have generated testable hypotheses concerning the pathophysiology of catatonia and the validity of the syndrome concept predominantly through the use of treatment response.

The second, or nosological position, was originally proposed by Kahlbaum and has been actively pursued by Leonhard and his followers. Leonhard's system of classification describes, and partially validates, eight separate clinical subtypes of catatonia, each with distinct and persistent motor and associated clinical features, long-term outcome, family history, and treatment response. Leonhard's nosological concept hypothesizes that each clinical entity of catatonia is the manifestation of impairment in specific brain regions. A comparison of the two perspectives on catatonia reveals their entirely different theoretical and methodological underpinnings.

No. 86C
LABORATORY FINDINGS IN CATATONIA

Joseph W. Lee, M.D., *Department of Psychiatry, Graylands Hospital, Brockway Road Mt. Claremont, Perth, WA 6010, Australia*

SUMMARY:

Catatonia is a behavioral neurologic syndrome of diverse etiology. The pathophysiology of catatonia remains unclear. To date there is no specific diagnostic test for catatonia. Catatonia, defined by a constellation of predominantly motor signs, is essentially a clinical diagnosis. Nevertheless, various laboratory findings of potential clinical and pathophysiological significance have been reported.

This presentation will review the related literature of laboratory findings in catatonia. Of particular interest are the findings of low serum iron and raised serum creatine phosphokinase (CPK) in catatonia and neuroleptic malignant syndrome (NMS).

It has been argued that NMS is a malignant variance of catatonia. Various authors have reported the conversion of catatonia, particularly the malignant type, into NMS following exposure to neuroleptics. Along with a review of published findings, new data on serum iron and CPK will be presented.

The pathophysiological significance of the finding of low serum iron in malignant catatonia and NMS, the potential values of serum iron and CPK in the subtyping of catatonia, and the predictive value of low serum iron in the progression of catatonia to NMS, will be discussed.

No. 86D
CATATONIA IN THE CONTEXT OF MEDICAL ILLNESS

Brendan T. Carroll, M.D., *Department of Psychiatry, VA Medical Center-Chillicote, 17273 State Route 104, #116A, Chillicote, OH 45601*; Harold W. Goforth, M.D.

SUMMARY:

Catatonia is a complex motoric syndrome. Efforts to localize a distinct neuropathological finding have yielded multiple results. The majority of neurochemical research studies have focused upon the role of the dopaminergic system in the etiology of catatonia and NMS; however, it is clear from animal and drug studies that isolated derangement of the dopaminergic pathway is not a sufficient impetus for the development of catatonia. These studies point to the interaction of the serotonergic, GABA, and glutamate systems in producing the classic motoric signs associated with catatonia. One theory seeks to incorporate these four distinct transmitter systems into a single neurochemical model.

Meanwhile, structural CNS lesions are associated with the development of catatonia. There is no single site in which a lesion results in catatonia. This is also true for the associated conditions of akinetic mutism and the apallic syndrome. Like catatonia, they are not site-lesion specific but are circuit specific. Brain imaging studies in catatonia identify the multiple CNS regions involved in this circuit. Medical catatonias have served as a lathe, which has sharpened neurochemical and neuropathological understanding of medical catatonias and NMS.

No. 86E
NMS AND OTHER DRUG-INDUCED CATATONIAS

Andrew J. Francis, M.D., *Department of Psychiatry, SUNY Stony Brook, Health Sciences Center T-10, Stony Brook, NY 11794*

SUMMARY:

Objective: To review literature on features and treatment of drug-induced catatonia (DIC) and compare these with recent systematic data relating catatonia and NMS (neuroleptic malignant syndrome).

Method: Medline search for DIC, and analysis of 16 NMS cases (DSM-IV and Caroff-Mann criteria) using the Bush-Francis Catatonia Rating Scale (BFCRS).

Results: Reported cases of DIC from typical, high-potency neuroleptics greatly outnumber those of atypical agents and non-neuroleptic drugs. Similarly, more NMS cases to date are reported with typical neuroleptics. Of 16 cases of NMS, 15 met research and DSM-IV motor criteria for catatonia, and the symptom profile on the BFCRS was similar to idiopathic catatonias. Benzodiazepines that are established treatments for catatonia (e.g., lorazepam) appear to hasten recovery from NMS. Some DIC cases may respond to benzodiazepines, but data are sparse.

Conclusions: NMS and drug-induced catatonia are both more common with typical neuroleptic agents. Catatonia is highly prevalent in systematically studied NMS. Benzodiazepines are effective for catatonia, and possibly for NMS. Sporadic cases also suggest some drug-induced catatonias respond to benzodiazepines. The clinical overlap, similarity of motor features, and possible treatment response to benzodiazepines, suggest common mechanisms in catatonia, NMS, and drug-induced catatonia.

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SYMPOSIUM 87—ADVANCE DIRECTIVES IN PSYCHIATRY: TREATMENT RESEARCH AND END OF LIFE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify potential uses of advance directives in psychiatric treatment, research, and the end of life. Participants will become familiar with research, policy, ethical approaches, and survey instruments used to guide decisions influencing future care and treatment.

No. 87A
PSYCHIATRIC ADVANCE DIRECTIVES: AN EMERGING FORM OF PSYCHOSOCIAL INTERVENTION?

Patricia Backlar, Ph.D., *Department of Philosophy, Portland State University, PO Box 751, Portland, OR 97207*

SUMMARY:

Psychiatric advance directives (PADs) and research advance directives are modeled on advance directives (ADs) for end-of-life care. Yet, they differ in substance and there are critical distinctions between them. PADs are intended for persons who have experienced the sort of crisis they anticipate will recur. Patients are able to use such experience to plan for similar situations in the future, or perhaps to prevent them. Pilot research shows that patients, caregivers, and families find PADs to be acceptable. Yet as currently implemented, PADs were generally ignored by clinicians in outpatient and inpatient facilities. The study results show that a piece of paper by itself may not change attitudes, remedy a lack of resources, or improve clinical outcomes. In a fragmented treatment system complicated by disparate treatment locations, PADs' most tangible significance may be as a mechanism by which patients (playing the central role as self-advocate) in collaboration with their providers, prepare a document, which when needed, is easily retrieved. The processes involved in the collaborative development of PADs—assessment of past crises, recognition of prodromal symptoms, surrogate appointment—may be a psychosocial intervention that encourages stakeholder communication and enhances patient recovery.

No. 87B
RESEARCH ADVANCE DIRECTIVES IN PSYCHIATRY

Donald L. Rosenstein, M.D., *NIMH, 10 Center Drive, Building 10, 3N240, Bethesda, MD 20817-1277*

SUMMARY:

The safety and ethical conduct of research involving psychiatric patients have come under increased scrutiny in recent years. One approach to the provision of additional safeguards for research with vulnerable psychiatric subjects has been to encourage the use of research advance directives. Despite the appeal of this strategy and the recommendation by the National Bioethics Advisory Commission to allow prospective authorization, research advance directives are rarely employed in psychiatric research. This presentation will address several issues and obstacles related to research advance directives. The development of policy and procedural approaches to prospective research authorization must accommodate research subjects with diverse clinical presentations (e.g., unexpected loss of decisional capacity, progressive loss of decisional capacity, episodic decisional incapacity, and adults with mental retardation or autism who never had decisional capacity). The NIH Clinical Center designed an advance directive policy and form to address some of the important distinctions between clinical care and research participation. Categories of research (based on risk levels and prospect of direct medical benefit) are detailed so that subjects can indicate their future research preferences. Major educational, research, and implementation efforts will be necessary before research advance directives can fairly be considered an effective safeguard for vulnerable psychiatric research subjects.

No. 87C
END-OF-LIFE CARE AND MENTAL ILLNESS: A MODEL FOR ALL DISCIPLINES

Philip J. Candilis, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*; Mary E. Foti, M.D.

SUMMARY:

End-of-life care is often affected by the stereotyping of patients by age, diagnosis, or cultural identity. Two of the most influential stereotypes arise from the presumed incompetence of many patients to contribute to end-of-life discussions, and the fear that the discussions themselves will be destabilizing. This paper presents a model for end-of-life discussions that combines competence assessment with health care preferences in a psychiatric population that faces these common stereotypes.

The model, which draws on clinical research in competence and suicide risk assessment, has important implications for all patients who are marginalized or stereotyped during treatment discussions. It is a model that allows collaborative development of advance directives and easy access during future hospitalization, overcoming the usual barriers to end-of-life communication.

Two instruments are introduced for guiding advance planning: a competence assessment tool and a health care preferences instrument that combines treatment-specific scenarios and a values history. The current data and ethical arguments justifying a structured approach using these tools among psychiatric patients are presented.

No. 87D
COGNITIVE VARIABLES IN THE INFORMED-CONSENT ASSESSMENT PROCESS

Jacob C. Holzer, M.D., *Unit R1, Medfield State Hospital, 45 Hospital Road, Medfield, MA 02052-1099*

SUMMARY:

Assessment of a patient's capacity to make informed decisions may require evaluating various standards, such as ability to communicate a choice, understand and appreciate facts surrounding a condition, and ability to weigh risks and benefits. The evaluation process is subjective and fluid, with multiple factors contributing to the outcome. Instruments designed to provide data on competency, along with a better understanding of cognitive variables associated with decision-making processes, can strengthen the evaluation of a pa-

tient's decision-making capacity. This presentation will review the competency evaluation process, with a focus on the role of cognitive spheres/variables that may correlate with, and provide further data on, competency assessment. Outcome from research studies in this area, in psychiatric and brain-injured patients, will be provided.

REFERENCES:

1. Backlar P: Anticipatory planning for psychiatric treatment is not quite the same as planning for end-of-life care. Community Mental Health Journal 1997; 33(4):261–268
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SYMPOSIUM 88—PSYCHOCUTANEOUS MEDICINE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) identify and classify psychocutaneous problems; (2) better recognize psychological etiologies, exacerbating factors, and emotional sequelae of common skin conditions; and (3) organize and integrate rational and effective psychocutaneous treatments.

No. 88A
INTRODUCTION: OVERVIEW AND CLASSIFICATION SYSTEM FOR PSYCHOCUTANEOUS DISEASE

Donald J. Kushon, Jr., M.D., *Department of Psychiatry, Hahnemann University, Mail Stop 403, 245 North 15th Street, Philadelphia, PA 19102*

SUMMARY:

Psychocutaneous disorders can be grouped into six categories. The first four involve specific clinical entities (primary psychiatric disorders, psychophysiological disorders, cutaneous sensory disorders, and exaggerations of normal cutaneous physiology) and the last two involve clinical situations (secondary psychiatric complications of skin disorders and nonpsychiatric disorders responsive to psychotropic medications).

No. 88B
STRESS AND CUTANEOUS BIOLOGY

Francisco Tausk, M.D., *Department of Dermatology, Johns Hopkins University, 601 North Caroline Street, Baltimore, MS 21287*

SUMMARY:

In the past two decades numerous studies have shown the close connection between the central nervous and endocrine systems and the immune system, with the emergence of a new discipline termed psychoneuroimmunology (PNI). More recently, investigators have discovered the effects of peripheral nerves and neuropeptides in mediating physiologic changes in the skin, which may help to explain why the evolution of many skin diseases appears to correlate with psychological and emotional status. Stress also has a profound effect on immunity, inducing changes in lymphocyte populations that may favor the development or exacerbation of numerous autoimmune, infectious, and neoplastic diseases. Understanding the changes in diseases secondary to the influence of PNI and the corticosteroid/adrenergic responses during stress may help us develop treatment strategies aimed at the overall improvement of these patients.

No. 88C
PRURITUS: PSYCHOGENIC AND CENTRAL FACTORS

Iona Ginsberg, M.D., *Department of Psychiatry, Columbia University, 55 East 86th Street, New York, NY 10028*

SUMMARY:

Itch is an unpleasant sensation provoking the desire to scratch and may be associated with an itch/scratch cycle in that the more people scratch, the more they itch. Many skin diseases, notably urticaria and atopic eczema, are associated with itch. Many substances have been implicated as possible modulators in addition to histamines such as neuropeptides, oploids, eicosanoids, growth factors, and cytokines. Pruritus can also occur in such systemic disorders as cholestatic liver disease, renal disease, and lymphoma. When patients have itching without skin disorder or other medical disease, psychogenic pruritus may well be considered. Such patients present a complex clinical picture, often without marked overt psychopathology but depression is often a factor. Pruritus may be associated with cutaneous compulsions and sometimes with neurotic excoriations. Treatment may be directed toward the compulsive elements using SSRIs as well as toward depression or other psychiatric disorders that may be present. Some experimental approaches to treatment will be discussed as well. Psychotherapy can be helpful in appropriate patients.

No. 88D
TREATMENT OF SELF-MUTILATION

Sylvia G. Garnis-Jones, M.D., *849 Upper Wentworth, Suite 302, Hamilton, ON L9A5H4, Canada*

SUMMARY:

Self-mutilation is a facet of a much broader spectrum of factitial disease. The diagnostic classification of self-mutilation is varied with different definitions of the disorder ranging from terms such as neurodermatitis, factitious dermatitis, and dermatitis artefacta. Whatever the definition, individuals with self-inflicted skin lesions are difficult to treat. This presentation will focus on the management of patients with self-inflicted skin lesions who were referred to the Psychodermatology Clinic at McMaster University for assessment. These individuals were examined simultaneously by a psychiatrist and a dermatologist, leading to a treatment approach incorporating dermatological management and novel antipsychotic agents.

No. 88E
INTEGRATION OF PSYCHOTHERAPY AND PSYCHOANALYSIS INTO DERMATOLOGY PRACTICE

Caroline S. Koblenzer, M.D., *University of Pennsylvania, Department of Dermatology, 1812 Delancey Place, Philadelphia, PA 19103*

SUMMARY:

Studies show that emotional factors affect the disease process for 30% to 70% of patients attending dermatology offices. These patients can usefully be classified into three groups:

(1) Psychiatric disease that presents with skin symptoms.

(2) Inflammatory cermatoses that are triggered or exacerbated by stress.

(3) The somatopsychic effect.

Clearly, empathy and supportive psychotherapy are parts of any positive doctor-patient interaction, and will apply to all three categories. This presentation will focus specifically on the inflammatory dermatoses. Criteria for case selection for psychotherapy or psychoanalysis will be offered, and techniques for introducing the concept suggested. Case reports will illustrate the clinical application.

No. 88F
PSYCHOPHARMACOLOGY

Donald J. Kushon, Jr., M.D., *Department of Psychiatry, Hahnemann University, Mail Stop 403, 245 North 15th Street, Philadelphia, PA 19102*

SUMMARY:

The availability of atypical antipsychotic and antidepressant drugs has expanded the treatment options for patients with psychocutaneous disorders. Atypical antipsychotics have a broader range of efficacy and produce fewer side effects. This presentation will review selected psychotropic agents useful in pschocutaneous medicine.

No. 88G
NON-PHARMACOLOGIC MANAGEMENT OF PSYCHOCUTANEOUS PROBLEMS

Richard G. Fried, M.D., *903 Floral Vale Boulevard, Yardley, PA 19067*

SUMMARY:

Psychocutaneous interventions include a wide variety of techniques designed to decrease stress and improve the emotional and functional status of the individual. It is important to state that most interventions are proven therapies utilized in "mainstream" psychological practice. Interventions include biofeedback, progressive muscle relaxation, guided imagery, hypnosis, individual and group psychotherapy, patient support groups, and psychoeducational materials. Subtle, intangible physician and nurse interactions with patients often have significant Psychocutaneous effects as well. Interventions traditionally conceptualized as "indulgence procedures" may also have salutary effects on the patient's skin and psyche. Specifically, cosmetic procedures such as alpha hydroxy acid peels, microdermabrasion, laser ablation of facial vessels, surgical or laser removal of benign growths, and improvements in skin pigmentation may lead to substantial and meaningful emotional and functional changes. Other "indulgence" procedures such as facials and massage produce similar favorable efforts.

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SYMPOSIUM 89—THE USE OF FORCE IN PSYCHIATRY: WHEN IS IT HELPFUL AND WHEN IS IT NOT? PART II

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify the various settings and specific child and adolescent populations in which force is used with persons who have or appear to have psychiatric disorders and the clinical, social, political, and ethical ramifications of the use of force.

No. 89A
SECLUSION AND RESTRAINT IN CHILD AND ADOLESCENT FACILITIES

Wanda Mohr, Ph.D., *Psychiatric Nursing, Indiana University Medical Center, Indianapolis, IN 46202-5107*

SUMMARY:

The topic of physical restraint has assumed national prominence in the wake of both media and JCAHO reports of patient deaths proximal to their use. These deaths have galvanized the advocacy and professional communities to seek solutions ranging from promoting best practices to seeking regulatory oversight. For many years, restraints have been an assumed part of the "tool kit" available to staff members to provide "control" and security of patients, staff, and the milieu. Though labeled as interventions, they are neither therapeutic nor safe, especially when used with children. Moreover, they are based on a number of refutable and often unexamined assumptions. In the past two years, their use has been scrutinized, with most settings moving away from restraints and toward prevention and early intervention of violent behavior. This presentation will discuss and refute some of the assumptions used to justify the use of restraints. It will speak to the dangers inherent in their use with children and adolescents using data synthesized from the literature on death proximal to restraint use. A public health model of prevention and early intervention championed by the National Association of State Hospital Program Directors will be presented, which can serve as a potential paradigm for changing practice. Finally, the policy objectives on restraint regulations articulated by the advocacy community and the emergence of regulatory and legislative initiatives will be discussed.

No. 89B
EXCESSIVE USE OF FORCE: THE FAMILY PERSPECTIVE

Andrea Eberle, M.D., *Board of Directors, National Alliance for Mental Illness, 9601 Lile Drive, Suite 790, Little Rock, AR 72205*

SUMMARY:

Families have known the impact of seclusion and restraints on people with mental illnesses for some time. They have been the recipients of their stories of fear and terror and witness to their posttraumatic nightmares, anxiety, and suspicion for some time before the debate on the use of these techniques came to the glare of the public light. Family members have also been the main advocates against the use of these techniques on an individual basis, and more recently at a policy level. The presenter will share her own experience

with the application of seclusion and restraint techniques in the treatment of her daughter. This will include vivid descriptions of the actual techniques utilized in an adolescent residential facility, the impact these had on her daughter's recovery, and the impact on her personally and her family as well. The presenter will also discuss the impact of these experiences in shaping her role as an advocate for children's mental health services. This will lead to a discussion of the role and position that NAMI has taken in the current policy debate and the future direction of this debate from the family advocacy perspective.

No. 89C
SECLUSION, RESTRAINT, AND HOLDING OF CHILDREN AND ADOLESCENTS: A CLINICAL COMMUNITY PERSPECTIVE

Charles W. Huffine, Jr., M.D., *University of Washington, 3123 Fairview Avenue East, Seattle, WA 98102-3051*

SUMMARY:

Unlike policymakers and researchers, clinicians are on the front lines in making critical decisions around the use of behavioral interventions, especially when issues of safety are involved. Unfortunately, many clinical and policy decisions around the use of such interventions are made with little experienced clinical input. The presenter will discuss the current concerns raised by advocates regarding the use and abuse of restraints and seclusion in the care of children from a clinical perspective. These concerns stem from reports of deaths and serious injury on inpatient units and in residential treatment programs. The presenter will note the broad areas of consensus between clinicians and advocates regarding the need for policy, training, and reporting of injuries and deaths. Disagreements center around medical accountability for restraint or seclusion, as embodied in the now famous "one hour rule." Dr. Huffine will explore this issue from the perspective of community child and adolescent psychiatric practice, expanding the discussion to consider other care settings for emotionally disturbed children: therapeutic classrooms, outpatient settings, juvenile justice facilities, and intensive wraparound programs. He will also address the broader area of the use of physical contact with patients in the treatment context, which is an important extension of this debate.

No. 89D
USE OF SECLUSION, RESTRAINT, AND FORCE IN JUVENILE JUSTICE SETTINGS

Debbie R. Carter, M.D., *Department of Psychiatry, UCHSC, 4200 E. 9th Ave. C249-27, Denver, CO 80262*

SUMMARY:

Isolation by seclusion and/or restraint is an intervention for behavioral management employed in a number of settings, both in mental health and juvenile corrections. A number of studies support that mental health and juvenile correctional programs serve youth with similar behavioral and emotional disorders. Residential programs that serve troubled youth typically have guidelines and protocols to maintain the safety of the youth, staff, and other residents. However, these are often shaped by the treatment philosophy of the program, and the differing philosophies between mental health and correctional facilities consequently inform staff decisions on the indications and approach to the use of these interventions. In Colorado, the department of human services has adopted seclusion and restraint protocols specifically designed to address the needs to the population of incarcerated mentally ill youth. This presentation focuses on the philosophical differences in the use of seclusion and restraints between mental health and corrections, the clinical risks of such practices in correctional settings, models to prevent abuse of these interventions, and a summary of the Colorado experience.

No. 89E
MANAGING AND TREATING BEHAVIORAL DYSCONTROL IN PEOPLE WITH DEVELOPMENTAL DISABILITIES

Ruth M. Ryan, M.D., *The Community Circle, 1556 Williams Street, Denver, CO 80218*

SUMMARY:

For several decades, seclusion and restraint were used abusively for "behavior management" in many institutions for people with mental retardation and other developmental disabilities. As a result of these abuses, the planned use of mechanical restraint, chemical restraint, and forced seclusion has been made illegal in community and institutional settings that serve persons with developmental disabilities. Though violation of the letter and spirit of these regulations is widespread, there are indeed some settings where the regulations are followed. Up to 60% of persons with developmental disabilities served in public systems have significant mental health needs. Thus, a significant number of persons with acute and chronic mental illnesses and developmental disabilities are served successfully without the use of mechanical restraints, seclusion, or sedation. This presentation will describe findings in settings serving individuals with developmental disabilities where seclusion and restraint were discontinued, and will list alternatives that have been found useful and successful.

No. 89F
PHARMACOLOGICAL APPROACHES: WHEN ARE THEY INDICATED?

Andres J. Pumariega, M.D., *Department of Psychiatry, East Tennessee State University, 107 Hillrise Hall, Box 70567, Johnson City, TN 37614-0567*

SUMMARY:

Pharmacological interventions have been frequently cited in the debate over seclusion and restraints under the heading of "chemical restraints." The use of injectable sedatives and antipsychotics have been similarly abused in clinical settings with similar contexts as those breeding the overuse of seclusion and restraints: inadequate levels of staffing and training, poorly designed physical facilities, and inadequate intensity and skill in the application of behavioral and pharmacological interventions. All of these conditions are found in treatment settings for children and adolescents, which are chronically underfunded and require higher levels of clinical expertise. Although there has been some change in the agents used for acute episodes (shifting from antipsychotics to rapid-acting minor tranquilizers), a mounting literature suggests that the appropriate use of a wide variety of prophylactic medications with children can reduce agitation and impulsivity, which are antecedents of aggressive episodes. The presenter will draw from experience in the inpatient treatment of aggressive adolescents as well as the literature to review appropriate prophylactic and intervention strategies, including the use of mood stabilizers, antianxiety agents, stimulants, and novel antipsychotics. The use of these agents with behavioral and environmental interventions will also be discussed.

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THURSDAY, MAY 9, 2001

SYMPOSIUM 90—MANAGEMENT OF SCHIZOPHRENIA WITH COMORBID DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will be familiar with the current state of knowledge regarding some of the common and challenging comorbid clinical conditions in schizophrenia and be better able to manage these patients.

No. 90A
MANAGEMENT OF SCHIZOPHRENIA WITH DEPRESSION

Samuel G. Siris, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

This presentation approaches the issue of depression in schizophrenia from the standpoint of making a differential diagnosis. This differential includes comorbid medical conditions and side effects of agents used in their treatment; acute or chronic use and/or discontinuation of substances (including "street" drugs, alcohol, nicotine, and caffeine); acute and chronic disappointment reactions; the negative symptom syndrome; depression as a component of EPS secondary to neuroleptic use, including akinesia and akathisia; the possibility of other dysphoric or anhedonic reactions to neuroleptic medications; depression as an intrinsic component of decompensation either on a biological or psychological basis; schizoaffective disorder; and the possibility of an independent coexisting affective diathesis. Treatment strategies considered in relationship to these various situations include reducing or otherwise adjusting neuroleptic dosage; changing antipsychotic agents, including the use of atypical antipsychotics; the rational use of adjunctive tricyclic, SSRI, and MAOI antidepressant medications; the potential role of benzodiazepines, lithium, anticonvulsants, and ECT; and the importance of psychosocial approaches. An orderly path for considering diagnosis and treatment will be presented.

No. 90B
MANAGEMENT OF SCHIZOPHRENIA WITH 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:

While the anxiety symptoms such as obsessive-compulsive (OC) and panic symptoms in schizophrenia have long been recognized, its underlying biological and clinical implications remain obscure. Prior to DSM-III-R, diagnostic conventions precluded simultaneously diagnosing schizophrenia and anxiety disorders. As a result, obsessive-compulsive disorder (OCD) and panic disorder (PD) in schizophrenia were believed to occur only rarely and carry no significant clinical implications. However, recent epidemiological and clinical studies have shown much greater prevalence rates and significantly worse clinical course among the subgroup of schizophrenia with comorbid OCD and PD. Recent research and pharmacological advances suggest a distinct neurobiological basis for these comorbid symptoms in schizophrenia. The subgroup of schizophrenia with coexisting anxiety symptoms may be conceptualized categorically, e.g., as reflecting presence of two distinct disorders, or dimensionally, e.g., as representing one of many phenomenological symptom dimensions in schizophrenia. While further studies are warranted, current evidence suggests that schizophrenia with comorbid anxiety disorders would benefit from in-depth clinical evaluation and individualized treatment interventions for optimal outcome. This presentation will examine the existing clinical, epidemiological, and neurobiological evidence and suggest a novel approach for their clinical management.

No. 90C
SCHIZOPHRENIA AND SUBSTANCE ABUSE

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854*

SUMMARY:

Substance abuse is common among individuals with schizophrenia and dramatically impacts clinical care. Substance abuse is associated with poor outcome, noncompliance, homelessness, violence, illegal activity, and increased utilization of costly inpatient and emergency room services. This presentation will provide an overview of assessing and treating comorbid substance abuse. Using the Stages of Change model, this presentation will briefly discuss how to assess the patient's motivational level to stop using each specific substance and to continue medication treatment for the schizophrenia. Clinical experience and research studies suggest that integrating and blending mental health and substance abuse treatment improves outcomes for individuals with co-occurring schizophrenia and substance abuse. The presentation will review specific medication treatment issues for this population, including substance abuse treatment medications and the use of atypical antipsychotics. The presentation will describe how to blend mental health and addiction psychosocial treatments in providing comprehensive outpatient treatment. Results from several research studies will be presented, and the implications for a motivation-based, dual-diagnosis treatment model. Improving and maintaining motivation to change is important throughout the recovery process.

No. 90D
CLINICAL MANAGEMENT OF PERSISTENT AGGRESSIVE BEHAVIOR IN SCHIZOPHRENIA

Leslie L. Citrome, M.D., *Clinical Research/CREF, Nathan Kline Institute, 140 Old Orangeburg Road, Building 37, Orangeburg, NY 10962-2210*; Jan Volavka, M.D.

SUMMARY:

Violent or threatening behavior is a frequent reason for the admission to a psychiatric inpatient facility, and that behavior may continue after the admission. The distinction between transient and recidivistic

assaultiveness is clinically important: a small group of recidivistic patients may cause the majority of violent incidents. Patients with persistent aggressive behavior must first be assessed for the possibility of comorbid conditions. Short-term sedation with lorazepam is a safe and effective choice for the acute episode. 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 in reducing aggressivity in patients with schizophrenia or schizoaffective disorder. Risperidone also appears promising in reducing hostility. Both of these agents appear to have selective antiaggressive activity in addition to their antipsychotic properties, making them particularly suitable for patients who are both aggressive and have schizophrenia. Beta blockers, well studied in the treatment of aggressive behavior in brain injured patients, may also be helpful as an adjunctive agent to neuroleptics for aggression and schizophrenia. Adjunctive serotonin-specific reuptake inhibitors are another option for this population. The simultaneous use of multiple psychotropic agents will be discussed.

No. 90E
LONG-TERM OUTCOME: INFLUENCE OF COMORBID CONDITIONS

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

SUMMARY:

The course of schizophrenia is determined by a number of factors. General prognostic factors influence outcome, Outcome is usually better for women than men; a later age of onset predicts better long-term course; early cognitive and intellectual impairment are associated with poorer course. Maintenance antipsychotic treatment prevents relapse and data suggest that each relapse confers an added burden that makes a subsequent relapse more likely. This cascade of events increases the likelihood of poorer long-term outcome.

Comorbid psychiatric conditions and syndromes appear to represent yet another added burden that negatively affect outcomes. Methodological problems beset the researcher who studies these questions. First, long-term studies are rare and often patients with comorbid conditions may be specifically excluded. Second, with the exception of substance and alcohol abuse and dependence, comorbid syndromes are not routinely identified. Third, examination of differential long-term outcomes specifically for patients with and without comorbid conditions is even rarer than long-term studies.

This presentation will review data specifically regarding substance and alcohol abuse and dependence as well as studies that have compared long-term outcomes for patients with other comorbid conditions.

Finally, recommendations regarding strategies to ascertain the influence of comorbid conditions on long-term outcome will be proposed.

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SYMPOSIUM 91—WHEN A SUBSTANCE ABUSER PRESENTS IN YOUR OFFICE: WHAT DO YOU DO?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) evaluate the initial needs of a substance abuser presenting in the ambulatory setting, (2) ascertain an empirically-based strategy for beginning care, (3) determine care based on the patient's specialized needs.

No. 91A
INPATIENT VERSUS OUTPATIENT TREATMENT FOR ABUSE: A REEXAMINATION

Laura F. McNicholas, M.D., *Department of Psychiatry, VA Medical Center, University and Woodland Avenue 7 East, Philadelphia, PA 19104*; James R. McKay, Ph.D., A. Thomas McLellan, Ph.D.

SUMMARY:

Traditionally, treatment for substance use disorders took place in an inpatient setting; recently, treatment has moved more into the outpatient arena. This presentation will discuss (1) the components of treatment in both the inpatient and outpatient settings, (2) the goals of inpatient versus outpatient treatment in the current health care environment, (3) the outcomes of treatment modalities in each setting, and (4) the advantages and disadvantages of inpatient and outpatient treatment. Data will be presented on criteria for patient placement in inpatient and outpatient treatment programs. The issue of treatment in the private office setting as well as in established treatment programs will be discussed in the context of the established criteria for patient placement. Studies now under way that explore the benefits of inpatient or outpatient treatment settings for specific patient populations will be discussed.

No. 91B
THE DUALLY DIAGNOSED PATIENT

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, # 9F, New York, NY 10003*

SUMMARY:

Most treatment for patients with concurrent substance use (SUD) and non-substance-related (NSR) mental disorders is not delivered in a specialty mental health or addiction setting (Narrow et al., 1993). Several important concepts will be presented regarding office-based evaluation and treatment planning for patients presenting with SUD and comorbid NSR mental disorders. The first theme pertains to problems extrinsic to patients, such as the lack of integrated treatment systems for comprehensive diagnosis and appropriate, integrated treatments, which have a significant impact on the way patients are perceived and directed into treatment. The second theme pertains to

the following intrinsic patient characteristics: (1) the dual diagnosis concept is inadequate—the concept is reductionistic, but adds no specificity in exchange for a loss in descriptive resolution; (2) comorbidity has a negative effect upon the trajectory of illness: that concurrent NSR mental disorders affect addiction treatment outcome and substance abuse affects the course of NSR mental disorders is well-described; and (3) patients typically present for treatment with a confusing array of psychiatric symptoms and physical findings. Although a set of working diagnoses should be decided upon, the clinician should remain wary of premature closure, which can subject the patient to incorrect and potentially harmful treatment. The exercise of considering phenomenology, time course, and etiology will help the clinician to derive the most efficacious treatment. Integrative guidelines that incorporate findings from current research will be presented to inform the decisional process of clinicians.

No. 91C
EVALUATION AND TREATMENT OF THE COCAINE-DEPENDENT PATIENT

Roger D. Weiss, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

This presentation will review evaluation methods and potential treatment strategies for evaluating and treating cocaine-dependent patients in office practice. Important evaluation issues include (1) careful attention to diagnosing coexisting psychiatric disorders and substance use disorders, since abuse of multiple substances is common in this population; (2) differentiation of cocaine-induced psychiatric symptoms from an independent psychiatric disorder; and (3) attention to potential gender differences in cocaine dependence. Pharmacotherapeutic treatment approaches will then be reviewed. While many medications have been studied for the treatment of cocaine dependence, no medication has been reliably effective. Promising medications include disulfiram and the use of antidepressants for patients with coexisting depression. Pharmacotherapeutic strategies with psychiatrically ill cocaine-dependent patients will be discussed. Finally, the results of psychotherapeutic studies will be reviewed, including the NIDA Collaborative Cocaine Treatment Study, which showed that 12-step individual drug counseling was the most successful treatment approach with this population, outperforming cognitive therapy and psychodynamically-oriented supportive-expressive therapy. The potential role of self-help groups with this population will also be reviewed.

No. 91D
THE INITIAL EVALUATION OF SUBSTANCE USE IN ADOLESCENTS

Joyce A. Tinsley, M.D., *Department of Psychiatry, Mayo Clinic W-9A, 200 First Street, SW, Rochester, MN 55905-0001*

SUMMARY:

The evaluation of adolescent substance misuse is problematic for several reasons. For instance, the adolescent may be motivated to hide his or her substance use from authorities such as parents, school officials, and the clinician. The influence of the peer group is often greater than that of the family. Experts who are unaccustomed in dealing with this age group may feel inept when asked to assess an adolescent.

The evaluator may feel more confident when armed with basic knowledge about adolescent development, common comorbid conditions, and how to interact with the patient. In addition, feeling comfortable in the role of investigator is advantageous. Interactions with family and outside agencies are often crucial in an initial evaluation.

This presentation aims to provide the information needed for clinicians to develop a strategy for assessing patients suspected of having an adolescent substance use disorder.

No. 91E
FAMILY AND SOCIAL SUPPORT: NETWORK THERAPY

Marc Galanter, M.D., *Department of Psychiatry, New York University Medical Center, 550 First Avenue, New York, NY 10016*

SUMMARY:

Network therapy is an approach to treating substance abusers that employs the support of a small group of the patient's family members and friends in therapy sessions. This is designed to aid in engaging the patient in treatment and moving him or her toward a constructive recovery. The approach is presented here with results of empirical studies supported by NIDA, and illustrated by videotape segments of patient sessions. It is premised on the value of participation of collaterals in ambulatory sessions to help the therapist to undercut denial and establish norms for maintaining abstinence and dealing with potential relapses. Because substance-abusing patients must contend with the prime issues of denial, craving, and relapse, it is important that the therapist have support in addressing the distortions of reality that can compromise a stable treatment. This approach is particularly helpful in the initial stages of treatment when it is important to secure the patient's involvement in treatment and acceptance of abstinence from addictive drugs. The network sessions alternate with individual sessions, but as the patient is stabilized, they are scheduled less frequently. While network sessions focus specifically on establishing a secure abstinence, individual sessions may deal as well with other issues in the patient's life.

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SYMPOSIUM 92—TREATMENTS REDUCING PERSONALITY DYSFUNCTION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

After attending this symposium, the participant should have an understanding of how to treat some specific symptoms of personality disorders. The participant will understand that while personality disorders may not be eliminated, there may be some options for reducing dysfunction.

No. 92A
DRUG TREATMENT OF PERSONALITY DISORDER TRAITS

James H. Reich, M.D., *Department of Psychiatry, Harvard Medical School, 2255 North Point Street, #102, San Francisco, CA 94123*

SUMMARY:

This presentation will be on drug treatment of personality disorder traits. Recent work on the biology of personality disorders has uncovered biological abnormalities in many personality disorders. These new findings have been followed by new drug treatments to reduce personality disorder symptoms. Although not a cure for personality disorders, drug treatments are quite useful in reducing some symptoms. Drug treatment should be used as part of an overall treatment program involving psychotherapy. The presentation will first describe an approach to diagnosing personality traits and how to decide those that might be amenable to treatment. It will then describe a cluster approach to treatment. These clusters are aggressive symptoms, impulsive symptoms and minor mood fluctuations, anxiety symptoms, and brief psychotic symptoms. In addition, the topics of concurrent alcohol abuse and indications and contraindications of the use of benzodiazepines will be discussed. Case examples will illustrate the key points.

No. 92B
THE INTERRUPTED CAREER GROUP

Elsa F. Ronningstam, Ph.D., *71 Elm Street, Belmont, MA 02178*; David Anik, M.D.

SUMMARY:

Objective: This paper reports on the Interrupted Career Group, a therapy group for people whose professional and personal lives have drastically changed due to personality and/or mood disorder and whose attempts to resume their careers were unsuccessful.

Method: Eighteen people with interrupted careers were instructed to specify and pursue a career and life track that integrated previous skills and activities with present life situation and psychiatric limitations. Participants were specifically encouraged to discuss feelings of envy, shame, rage, and humiliation accompanying such pursuits.

Results: Sixty percent of the participants were successful in reducing their symptoms. They utilized the group to discuss emotional and practical aspects of resuming an integrated track that resulted in actual changes. These changes were sometimes in both vocational/educational activities and emotional functioning, but sometimes mostly in emotional functioning. Those who were not successful tended to have more severe psychiatric disability or were those unable to successfully use the group due to problems with motivation.

Conclusions: Strong primitive feelings of shame, envy, rage, and humiliation can interfere with efforts to resume an interrupted career. An interactive group process focusing on such feeling can lead to improved emotional and vocational functioning.

No. 92C
TREATING EMOTIONAL DYSREGULATION

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada*

SUMMARY:

Empirical evidence suggests a largely genetic factor of emotional dysregulation accounting for much of the variance of personality traits underlying personality disorders. This factor is found in many personality disorders. Treatment of this factor is an important aspect of personality disorder treatment.

This factor is related to the normal personality dimension of neuroticism. Although it embraces a larger range of symptoms, clinically it resembles borderline personality disorder. Emotional lability is organized around the affective traits of anxiousness and affective lability. More specific traits include dependency (insecure attachment and submissiveness), social apprehension, cognitive dysregulation, and identity problems. The large genetic component has implications for treatment. First, the management of these traits should focus on helping individuals adapt to their traits rather than change the traits. Second, effective treatment may require a diverse combination of pharmacological and psychosocial treatments.

Intervention strategies should be based on an analysis of how environmental factors influence genetic predispositions. These include increasing tolerance and acceptance of basic traits, modulating trait expression, and promoting more adaptive behavioral expressions of these traits.

No. 92D
TREATMENT OF A PERSONALITY DISORDER ASSOCIATED WITH TRAUMA

David P. Bernstein, Ph.D., *Department of Psychiatry, Bronx VAMC/ Fordham University, 130 Kingsbridge Road, #116-A, Bronx, NY 10568*

SUMMARY:

Objective: Patients with a history of chronic or severe trauma often present with personality disorders (PDs) and comorbid PTSD. These cases are often difficult to treat because PTSD symptoms can contribute to the patient's interpersonal difficulties. For example, the social isolation symptoms of PTSD may work against the patient's recovery from avoidant PD symptoms. In this presentation, I discuss a model for working with this difficult to treat population. It draws on both the cognitive-behavioral and psychodynamic literature.

Method: The approach is illustrated by the case of a Vietnam veteran with obsessive-compulsive personality disorder (OCPD) and comorbid PTSD and panic disorder.

Results: The patient had severe and prolonged combat exposure while in Vietnam and exhibited a variety of OCPD symptoms. These included perfectionism, rigidity, over conscientiousness, and excessive devotion to work. The two-year treatment, proceeded in the following four phases: evaluation, cognitive treatment for PTSD and panic symptoms, treatment of personality disorder symptoms, and resolution and termination. The cognitive treatment for PTSD and panic symptoms incorporated both imaginal exposures to traumatic stimuli and cognitive restructuring of his persistent feelings of guilt. After his PTSD symptoms had diminished, the focus shifted to the patient's rigid and perfectionist tendencies. The patient modified some of these traits after understanding that they were a response to his earlier feelings of guilt and terror. After two years of treatment the patient was more able to enjoy himself, was less perfectionist, and showed markedly diminished scores on scales of PTSD and of OCPD traits.

Conclusion: This case suggests that traumatic stress reactions may represent an underlying diathesis for personality disorder symptoms in some individuals. After PTSD symptoms are addressed, comorbid PD symptoms may be more amenable to treatment.

No. 92E
AN INDEPENDENT, RANDOMIZED, CONTROLLED TRIAL OF DIALECTICAL BEHAVIOR

Clive J. Robins, Ph.D., *Department of Psychiatry, Duke University Medical University Medical Center, Box 3362, Durham, NC 27710*; Cedar Koons, M.S.W.

SUMMARY:

Dialectical Behavior Therapy (DBT), developed by Linehan and her colleagues at the University of Washington, has been shown to have efficacy in treatment of borderline personality disorder (BPD), and this treatment model is being widely adopted in clinical practice. This presentation will describe the principle features of the treatment and results from the first randomized trial of DBT conducted at an

independent site. Twenty women veterans who met criteria for BPD were randomly assigned to DBT or to treatment as usual (TAU) for six months. Compared with patients in TAU, those in DBT reported significantly greater decreases in suicidal ideation, hopelessness, depression, and anger expression. In addition, only patients in DBT demonstrated significant decreases in number of parasuicidal acts, anger experienced but not expressed, dissociation, and a strong trend on number of hospitalizations, although treatment group differences were not statistically significant on these variables. Patients in both conditions reported significant decreases in depressive symptoms and in number of BPD criterion behavior patterns, but no decrease in anxiety. Results suggest that DBT can be provided effectively independent of the treatment's developer, and that larger efficacy and effectiveness studies are warranted. Implications for clinical practice will also be discussed.

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SYMPOSIUM 93—SOCIAL ANXIETY IN SCHIZOPHRENIA ASSESSMENT AND TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should (1) recognize that social anxiety is a very common comorbid disorder of considerable severity among patients with schizophrenia; (2) become aware of the relationship between insight into illness and social anxiety, and of the impact of comorbid social anxiety on service utilization in schizophrenia; (3) learn about possible treatment strategies targeting comorbid social anxiety in schizophrenia.

No. 93A
A COMPARISON OF SOCIAL ANXIETY SYMPTOM PATTERNS IN SCHIZOPHRENIA AND SOCIAL ANXIETY DISORDER

Robert G. Stern, M.D., *Department of Psychiatry, UMDNA-RWA Medical School, 189 New Street, New Brunswick, NJ 0890*; Jane Luterek, Ph.D., Richard G. Heimberg, Ph.D.

SUMMARY:

Objectives: The present study examined differences in the pattern of social anxiety between patients with schizophrenia and patients with social phobia.

Methods: In two patient groups, social anxiety was assessed with the Liebowitz Social Anxiety Scale (LSAS). The LSAS ratings obtained from patients with schizophrenia (n=56) were then compared with those of a sample of treatment-seeking individuals with social anxiety disorder (n=333).

Results: The LSAS scale and sub-scales were found to be internally consistent in the schizophrenic sample (alpha = .87 to .96). The scores of 73.2% of the schizophrenic patients were above the empirically-determined cut-off score for SAD and 39.3% were above the cut-off score for generalized SAD, the most severe and impairing form of SAD. In comparing individuals with schizophrenia with those with SAD, schizophrenic patients scored similarly on the total avoidance scale of the LSAS ($M = 28.07$, $SD = 18.33$; $t = -1.92$, $p > .05$). However, schizophrenic patients scored significantly lower on the total anxiety scale of the LSAS ($M = 27.03$, $SD = 18.29$; $t = -3.70$, $p < .001$).

Conclusions: These preliminary findings suggest that the LSAS is a valid measure of social anxiety in schizophrenia. Possible implications for the treatment of social anxiety in patients with schizophrenia will be discussed.

No. 93B
SCHIZOPHRENIA WITH COMORBID SOCIAL PHOBIA: EPIDEMIOLOGY AND SERVICE USE

William E. Narrow, M.D., *APIRE, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*; Donald S. Rae, M.A., Robert G. Stern, M.D.

SUMMARY:

This presentation will describe the prevalence, clinical and sociodemographic characteristics, and mental health service use of persons with comorbid schizophrenia and social phobia. Data are from the NIMH ECA program, a community-based epidemiological study. Comparisons were made with persons who had schizophrenia not comorbid with social phobia. The prevalence of schizophrenia with comorbid social phobia was 0.29% and without social phobia was 0.71%. Persons with comorbid social phobia had lower socioeconomic status and substantially higher rates of substance use disorders compared with those who did not have comorbid social phobia. Overall, 35.3% of persons with comorbid social phobia received treatment in the past year, compared with 49.9% of persons without comorbid social phobia. Only about one-third of either group received any specialty care in the past year. On average, persons with comorbid social phobia made less than half the number of mental health visits compared with those without comorbidity (seven vs. 15 visits per person per year). These initial findings suggest that social phobia is a common co-occurring disorder in schizophrenia, and that special attention should be paid to ensuring adequate access to specialty services, and to the identification and treatment of substance use disorders in these patients.

No. 93C
TREATING SOCIAL ANXIETY IN SCHIZOPHRENIA: A GROUP-BASED COGNITIVE-BEHAVIOR THERAPY APPROACH

David Castle, M.D., *Department of Psychiatry, Fremantle Hospital, Alma Street, Fremantle 6160, Australia*; Paula Nathan, Patrick Kingser, Steven Halperin, Peter Drummond, Ledley Jeffreys

SUMMARY:

Objective: To ascertain the extent and degree of social anxiety comorbidity in schizophrenia patients, and offer a cognitive-behavioral (CBT) group-based intervention targeting those specific symptoms.

Methods: In two separate studies, schizophrenia patients were screened for social anxiety symptoms using the Brief Social Phobia Scale (BSPS). Those who were screen-positive were randomly allo-

cated to either CBT group-based intervention or waitlist control condition. Pre-, post-, and follow-up assessments included the BSPS; the Social Interaction Anxiety Scale (SIAS); the Calgary Depression Scale (CDS); and a measure of quality of life, the Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ).

Results: A total of 29 patients completed the study, across both groups. Treatment groups showed significant gains across all measured domains (i.e., social functioning, mood, and quality of life), and maintained these gains at follow up.

Conclusions: The recognition and treatment of social anxiety in schizophrenia is feasible, and results in enhanced functioning and improved quality of life for sufferers.

No. 93D
SOCIAL ANXIETY AND PREMORBID PERSONALITY IN SCHIZOPHRENIC PATIENTS TREATED WITH CLOZAPINE

Stefano Pini, M.D., *Department of Neuroscience, University of Florence, Viale Ugo Bassi 1, Florence 50137, Italy*; Leonardo Quercioli, M.D., Adolfo Passagli, Ph.D.

SUMMARY:

Objective: Anxiety as a distinct disorder in schizophrenia has been rediscovered. In fact, the concept of comorbidity has recently won widespread favor within the scientific community, and the use of atypical neuroleptics in schizophrenia has been reported to lead to the emergence of anxiety symptoms.

Method: We report 12 cases of paranoid schizophrenic patients who developed social phobia during clozapine treatment and their response to fluoxetine augmentation. Patients were assessed using SCID-P, SCID-II, SANS and SAPS, BPRS, Liebowitz's Social Anxiety Scale (LSAS), and the Complaints Questionnaire (FBF). Patients were reevaluated after 12 weeks of cotreatment with clozapine and fluoxetine.

Results: In eight (66.6%) patients, symptoms responded (> = 35% LSAS score reduction) to an adjunctive regimen of fluoxetine. In seven (58.3%) cases, an anxious personality disorder (avoidant 33.3%, dependent 25%) was identified, but no significant differences emerged comparing the prevalence of personality disorders in 16 paranoid schizophrenics that did not show social phobia under clozapine.

Conclusion: Results are discussed in light of a clinical therapeutic approach that overcomes the implicit hierarchy of classification. Considering that the onset of anxiety-spectrum disorders can occur during the remission of psychotic symptoms in clozapine-treated schizophrenics, a comprehensive approach to pharmacological therapy of schizophrenia should be adopted.

No. 93E
INTERPERSONAL SENSITIVITY, SOCIAL ANXIETY DISORDER, AND INSIGHT INTO ILLNESS IN PSYCHOTIC PATIENTS

Pini Stefano, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa 56100, Italy*; Liliana Dell'osso, M.D., Marco Saettoni, M.D., Alessandra Papasogli, M.D., Xavier Amador, Ph.D., Paola Rucci, D. Stat., Giovanni B. Cassano, M.D.

SUMMARY:

Background: Interpersonal sensitivity and social anxiety are frequent features of psychotic disorders. We analyzed the relationship of the former dimension with social anxiety disorder, psychotic symptoms, and insight into illness.

Method: Consecutively hospitalized patients with schizophrenia (n = 46), schizoaffective disorder (n = 32), and psychotic bipolar disorder (n = 166) or unipolar depression (n = 30) were assessed in the week prior to discharge by the SCID-P, BPRS, HSCL-90, SANS, and the Scale for Unawareness of Mental Disorders (SUMD).

Results: Social anxiety was found in 14.2% of the sample. Patients with social anxiety had significantly higher scores in the HSCL-90 "interpersonal sensitivity" and higher current awareness of illness than patients without social anxiety. Linear regression analyses showed that social anxiety comorbidity and high level of insight into illness were associated with interpersonal sensitivity. Schizophrenia diagnosis and different types of delusions did not predict interpersonal sensitivity.

Conclusions: In a sample of psychotic patients in remission, interpersonal sensitivity, a dimension of social anxiety, is correlated with high level of insight but not with psychotic features. A hypothetical pathway from high interpersonal sensitivity to persecutory delusions is put forward.

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SYMPOSIUM 94—CLINICAL APPLICATIONS OF CULTURAL PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should recognize how to apply cultural psychiatric knowledge and experience broadly into various subfields of psychiatry in order to promote culturally relevant practices for patients of diverse ethnic/cultural backgrounds.

No. 94A
CULTURAL ISSUES IN CONSULTATION-LIAISON PSYCHIATRY

Jon M. Streltzer, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813-2427*

SUMMARY:

Consultation-liaison psychiatry involves assessment of psychopathology in the medically ill, resolution of conflicts within the medical

milieu, and in general aims to optimize medical management and the psychological health of patients. Cultural issues can be important in all these areas, as exemplified by research and case analysis.

Many medical conditions have been demonstrated to have strong cultural aspects. A few examples are death and dying, pain, compliance, women's medical issues including premenstrual tension and menopausal depression, care of the elderly, and proper behaviors when interacting with the doctor.

There is a "medical culture" that also strongly influences medical practice and interacts with the individual cultures of the patient, the nurses, the attending physician, and the consultant psychiatrist, as well as other cultural issues. The medical culture varies in different countries, and also among generations.

In medical education, there is increasing recognition of the need for cultural issues to be included in the curriculum of medical students, and in primary care training programs. One way to foster the desired cultural sensitivity is for the consultation-liaison psychiatrist to include cultural formulations when addressing consultation problems.

No. 94B
CULTURE AND ADDICTION

Joseph J. Westermeyer, M.D., *Department of Psychiatry, University of Minnesota, VAMC, 1 Veterans, 116A, Minneapolis, MN 55417*

SUMMARY:

Addicts experience a decline in activities reinforcing ethnic identity and supporting ethnic organizations. Recovery involves a cultural component along with physical and psychological components. Elements of cultural recovery involve regaining a viable ethnic identity, a functional social network committed to the person's recovery, a religious or spiritual or moral recommitment, recreational or avocational activities, and social role and status either in the recovering community or in the society at large or in both of these.

Especially early in recovery, "substitute" networks can facilitate full recovery. A "subculture" of therapists and self-help groups can guide the individual toward health and stability. These "recovery subcultures" can support, confront, and guide the person in avoiding dangerous situations that might precipitate a relapse.

The recovering person reaches a point where further progress involves branching out from the recovery subculture. This movement involves risks: i.e., exposure to substance use or potential failure at a new enterprise. If the recovery subculture, composed of both professionals and lay-peers, has done its work well, the recovering person should be prepared for this step—often one of the final steps in recovery following years of adjustment to sobriety.

No. 94C
CULTURAL ASPECTS OF GERIATRIC PSYCHIATRY

Iqbal Ahmed, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813*

SUMMARY:

Several factors affect the aging process across cultures such as ethnicity, minority status, socioeconomic status, immigration, age cohorts, gender, and intergenerational relationships. In addition to other sociocultural variables, ethnicity and culture are known to influence attitudes toward aging, mental illness, treatment compliance, help-seeking behavior, and institutionalization. Ethnocultural factors and the aging process also affect medication utilization and affects, as well as the psychotherapeutic process.

Ethnic elders have differences in the prevalence and phenomenology of psychopathology, and in the utilization of mental health care. This may be due to cultural factors, but may in fact be related to other issues such as age or cohort effects, prejudice, socioeconomic status, and accessibility. Understanding of these factors can lead to the development of effective and culturally sensitive care delivery systems for the ethnic elderly. Using clinical examples, guidelines will be presented to assist in the culturally sensitive and culturally relevant evaluation and treatment of the elderly.

No. 94D
CULTURAL PSYCHIATRY ON INPATIENT UNITS: THE ETHNIC/MINORITY PROGRAMS AT THE UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO/SAN FRANCISCO GENERAL HOSPITAL

Francis G. Lu, M.D., *Department of Psychiatry, University of California, San Francisco, 1001 Potrero Avenue, SFGH Suite 7M, San Francisco, CA 94110*; Kenneth K. Gee, M.D., Jo Ellen Branin-Rodriguez, M.D., J. Charles Ndlela, M.D., Alastair Donald, M.D., Mark Leary, M.D., Robert L. Okin, M.D.

SUMMARY:

This presentation will review cultural aspects of assessment and treatment on psychiatric inpatient units based on the 20-year experience of the Ethnic/Minority Psychiatric Inpatient Programs at the UCSF Department of Psychiatry at San Francisco General Hospital. Our programs are located on five acute diagnostic and treatment units with a total of 97 beds. Each unit has developed a focus reflecting the cultural diversity of San Francisco (30% Asian, 16% Latino, 11% Black, 15% Lesbian/Gay/Bisexual/Transgender). Our nationally recognized Ethnic Minority Psychiatric Inpatient Programs have won the American College of Psychiatrists Creativity in Education Award in 1999 and the American Psychiatric Association Certificate of Significant Achievement in 1987. Key aspects of the programs include multidisciplinary, bilingual, bicultural staffing; milieu program including groups and decor; specialized diagnostic and assessment processes such as the use of the DSM-IV Outline for Cultural Formulation; community linkage; multidisciplinary training; and evaluation.

No. 94E
ETHNIC/CULTURAL CONSIDERATIONS FOR PSYCHOPHARMACOTHERAPY

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street/B4 South, Torrance, CA 90002*

SUMMARY:

Although often neglected, inter-individual and cross-ethnic variations in response to psychotropics are substantial and clinically significant. Recent studies demonstrated that both genetic and environmental factors are responsible for such variations. Most genes controlling the expression of drug metabolizing enzymes as well as the function of brain receptors and transporters are highly polymorphic. Together they determine therapeutic response as well as propensity for side effects and appropriate dosing. Environmental factors, such as diet, also exert significant influences on the expression of these genes and thus the metabolism of medications. In addition, culture also profoundly influences patients' expectations of treatment response, adherence, as well as interactions with clinicians. Coupled with recent advances in gene array technologies, it is very likely that pharmacogenetic panels could be developed for routine clinical use, such that the results derived from such tests would be used to inform

clinicians regarding the choice of medications, dosing strategies and risks for different side effects. Advances in the field of pharmacogenetics should thus contribute substantially to the establishment of an increasingly more rational and knowledge-based way to practice psychopharmacology in the next century.

No. 94F
CULTURE AND PRACTICE OF PSYCHOTHERAPY

Wen-Shing Tseng, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, Honolulu, HI 96813-2427*

SUMMARY:

The influence of cultural factors in the practice of psychotherapy will be examined from technical, theoretical, and philosophical dimensions.

"Technical adjustments" in psychotherapy refer to the way the therapist directs the process of therapy to fit the background of the patient. This may involve preparation for starting therapy, adjustment of the therapist-patient relationship, management of cultural transference and countertransference, performing culturally suitable communication and interpretation, and selection of modes of therapy.

Beyond technical adjustments, it is also necessary to make "theoretical modifications" relating to therapy to fit the patient's cultural background. Some of the examples are concepts of self and ego-boundaries, interpersonal relations, theories of personality development, theories of defense mechanisms, and the efficacy of expression or suppression as therapeutic mechanisms.

Finally, the therapist needs to take into consideration the patient's (as well as the therapist's) "philosophical orientation" toward human beings, society, and life, and the closely related concepts of normality, maturity, and health.

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SYMPOSIUM 95—THE DIFFICULT-TO-TREAT PSYCHIATRIC PATIENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to enumerate the available somatic and psychotherapeutic options for difficult to treat patients with bipolar disorder, schizophrenia, posttraumatic stress disorder and eating disorder; to evaluate the expected treatment outcomes for these treatments, singly or in combination; to prioritize the next steps based on the relative merits of these therapeutic interventions.

No. 95A
THE DIFFICULT-TO-TREAT PATIENT WITH EATING DISORDERS

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell University Medical College, 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 the 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 treatment refractory patients and the treatment approaches used to facilitate their recovery.

No. 95B
THE DIFFICULT-TO-TREAT PATIENT WITH PTSD

Randall D. Marshall, M.D., *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 nonresponders, 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.

No. 95C
THE DIFFICULT-TO-TREAT PATIENT WITH BIPOLAR DISORDER

Frederick K. Goodwin, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue, N.W., 8th Floor, Washington, DC 20037*

SUMMARY:

Bipolar disorder often is a refractory illness. Treatment resistance is particularly prominent in particular diagnostic subtypes of bipolar disorder, such as mixed episodes and rapid cycling, and it also

appears to be associated with chronic antidepressant treatment. Clinical correlates of treatment resistance include onset of illness with a major depressive episode, substance abuse, mood-incongruent psychotic features, and psychiatric and medical comorbidities.

Management involves replacing or combining lithium treatment with anticonvulsants or atypical antipsychotic agents. Other adjuncts include benzodiazepines, thyroid hormone, and ECT for the most refractory cases. Antidepressants should be used cautiously, mainly in the acute depressive episode, and always with concomitant mood stabilizers. Above all, the treatment of bipolar disorder, whether refractory or not, is complex, and requires careful attention to the therapeutic alliance.

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SYMPOSIUM 96—BIPOLAR DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should provided an update and clinical guidance regarding the management of bipolar depression.

No. 96A
BIPOLAR DEPRESSION: PHENOMENOLOGY AND DIAGNOSIS

Hagop S. Akiskal, M.D., *Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive (La Jolla), San Diego, CA 92093-0603*

SUMMARY:

This paper presents emerging new data on a neglected affective state: bipolar depression. The focus is on whether or not clinical features differentiate between unipolar and bipolar. In line with Kraepelin's observations on the inhibited nature of the depressive phase of manic depressive illness, work conducted in Pittsburgh in the early '70s found that many of these patients were best characterized as hypersomnic. Several prospective studies on bipolar transformation in both juvenile and young adult depressives actually validated the foregoing observations. However, subsequent studies have not always agreed with these observations. This is probably due to two reasons. One is that complex presentations with mixed features have been described in bipolar disorder that could, statistically, cancel out the anergic features. Furthermore, new studies have shown that bipolar II is associated with a great deal of anxious comorbidity and trait mood lability. So, depending on the proportion of bipolar I, and bipolar II included, results would differ. Based on international collaborative data to be presented, the author submits that uncomplicated bipolar depression is anergic, but mixed states, comorbidity, and temperamental features pathoplastically alter its clinical picture.

No. 96B
THE NEUROBIOLOGY OF BIPOLAR DISORDER

L. Trevor Young, M.D., *Department of Psychiatry, McMaster University, 1200 Main Street, West, Room HSC 4N81, Hamilton, ON L8N 3Z5, Canada*

SUMMARY:

As with most psychiatric disorders, pinpointing the exact neurobiology of bipolar disorder has been a considerable challenge. Nonetheless, recent studies have improved our understanding with clear suggestions around the brain structures and biochemical pathways involved in this disorder. The author will present recent findings from animal models and clinical studies comparing the neurobiological findings in both bipolar disorder and major depressive disorder. Consistent findings suggests that changes in a variety of signal transduction pathways and their links to the regulation of transcription factors may be particularly relevant to the understanding of both these disorders. Both cortical and limbic regions are supported as major regions of interest in these illnesses. The author will integrate these findings starting from the membrane level to regulation of gene expression within the nuclear. Findings from post-mortem brain studies and brain imaging studies will be discussed with more basic studies on the mechanism of action of mood stabilizing and antidepressant drugs. Although it is not possible to describe the neurobiology of depression or mania separately, comparing data from subjects with bipolar disorder and depression may help us understand any similarities that may exist.

No. 96C
PHARMACOLOGICAL TREATMENT OF BIPOLAR DEPRESSION

Russell T. Joffe, M.D., *Dean and Vice President, McMaster University Medical Center, 1200 Main Street West, Room 2E1, Hamilton, ON L8N 3Z5, Canada*; L. Trevor Young, M.D., Glenda M. MacQueen, M.D.

SUMMARY:

The depressed phase of bipolar illness remains a major therapeutic challenge. There are few controlled data to guide rational clinical treatment decisions. One of the major unresolved issues remains whether mood stabilizers or antidepressants is the preferable approach to the treatment of acute bipolar depression. In this presentation, the antidepressant efficacy of antidepressants and mood stabilizers will be critically reviewed. The literature on antidepressant efficacy as well as issues related to switch into mania and cycle acceleration will also be evaluated. In addition, studies examining the efficacy of antidepressants vs. mood stabilizers will be reviewed. Our own acute, double-blind trial of the second mood stabilizer vs. an antidepressant in acute bipolar depression will be described. The implications of the findings of this study, namely that there is no significant difference between the two treatment strategies, antidepressant vs. mood stabilizer, at the end of the six-week trial, will be placed in clinically useful perspective.

At the conclusion of this presentation, participants will have a much better understanding of the relative efficacy of mood stabilizers and antidepressants in the treatment of acute bipolar depression. They will also be aware of a clinical approach to the management of patients with acute bipolar depression.

No. 96D
ECT IN BIPOLAR DISORDERS

Charles H. Kellner, M.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425*

SUMMARY:

ECT remains an important treatment for a significant minority of patients with bipolar disorder who are inadequately responsive to pharmacotherapy Bipolar depression responds equally well to ECT as does unipolar depression. Despite being a powerful antidepressant, ECT is not commonly associated with switching to mania. The literature on ECT-induced hypomania/mania is scant and controversy exists about whether manic symptoms during a course of ECT represent a true switching process or what has been called an "ECT-induced euphoric state." ECT's potent mood-stabilizing (i.e. antimanic as well as antidepressant) effects may explain the low rate of manic switches.

ECT has been used clinically as continuation and/or maintenance therapy for both phases of bipolar disorder, but controlled data demonstrating its effectiveness in this application are lacking and urgently needed. Likewise, data on post-ECT prophylactic pharmacotherapy are limited, but beginning to appear. In a trial with severely depressed inpatients (n=68, 28% bipolar) Lauritzen et al. compared paroxetine to imipramine for post-BCT relapse prevention and found paroxetine to be superior. As more data are gathered on the safety of concurrent use of ECT and antidepressant medications, it may be possible to further decrease the state of post-ECT relapse by combining these modalities.

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SYMPOSIUM 97—PSYCHIATRIC PRACTICE IN PRISON

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should better understand issues confronting prison psychiatric practice, including correctional health care standards, clinical characteristics of mentally ill prisoners, the role of prison psychiatrist, existential/spiritual issues of prisoners, and models for prison-based mental health units.

No. 97A
PSYCHIATRISTS INSIDE PRISON: THE LAY OF THE LAND

Lee H. Rome, M.D., *Department of Psychiatry, University of Michigan, 3511 Bemis Road, Ypsilanti, MI 48197*

SUMMARY:

The unique mission, culture, patient population, and security environment of correctional facilities pose formidable challenges to all psychiatrists working in prison. Clinicians are often unprepared to deal with the many potential obstacles encountered in correctional facilities. These issues include the paramilitary custody hierarchy, the punitive purpose of incarceration, dual agency and related role ambiguity, the use of mental health status and symptoms for secondary gain by some prisoners, Axis II comorbidity, counter-transference and related under/over-diagnosis and boundary crossings/violations, frequently limited institutional and community resources, intra- and inter-facility transfer disputes, less than supportive bureaucracy, and the sometimes medicalized and often ignored existential/spiritual issues of people in prison.

After surveying the common obstacles facing prison psychiatrists, approaches for minimizing their impact will be discussed. Mitigation strategies and practice models emphasizing role definition, empathic communication, pragmatism, and the integrated effort of all staff will be presented.

No. 97B
DO MENTALLY ILL CRIMINALS BELONG IN PRISON?

James E. Dillon, M.D., *Huron Valley Center, 3511 Bemis Road, Ypsilanti, MI 48197*

SUMMARY:

The provocative and politically charged expression, "criminalization of the mentally ill," presupposes that the subjects of "criminalization" could be managed more humanely and just as safely outside the penal system. We previously have argued, however, that changes in civil commitment patterns have had limited impact on the numbers of mentally ill in prisons, where mentally ill subjects with the most serious and recalcitrant criminal histories and the poorest treatment prognoses have consistently represented a disproportionate number of offenders. In support of this proposition, Mullen et al. compared conviction rates among schizophrenic men before and after deinstitutionalization in Australia. They concluded that rising crime rates among the mentally ill paralleled crime rates generally, and were strongly associated with comorbid substance abuse rather than with deinstitutionalization *per se.* In this presentation, we review data on rates of mental illness in prisons and present new data concerning the criminal histories of severely mentally ill prison inmates receiving treatment in residential and hospital settings. We conclude that the severity and frequency of criminal behavior among such patients can justify use of the criminal justice system, imperfect as it may be, to achieve both social and treatment purposes.

No. 97C
EXISTENTIAL AND SPIRITUAL ISSUES FOR PEOPLE IN PRISON

Fleet W. Maull, M.A., *Naropa University, 855 Broadway, Suite 303, Boulder, CO 80302*

SUMMARY:

Being incarcerated and removed from one's social networks and community causes individuals to face a number of existential and spiritual issues. Prisoners, just by the fact of incarceration, experience the first two of Sudnow's four stages of dying (social and psychological death) to varying degrees. Incarceration strips the prisoner of much that gave their lives meaning: their social roles of citizen, worker, and community leader; their relationships with family and friends; their access to familiar surroundings; and their wealth and possessions. The prisoner's status as a non-citizen, as someone who is "less than," even less than human, is constantly reinforced in the correctional environment. Considered a criminal, the prisoner is demonized and buried in shame and guilt by the criminal justice

system, media, and public opinion. Living in a "total institution" environment, incarcerated individuals are in danger of psychological and spiritual deterioration into a state of dependence and learned helplessness. Faced with all this, how can prisoners find meaning in their life and spiritual strength to survive with any degree of wholeness or integrity as human beings? This presentation will address these questions systematically and propose a new vision of correctional programs and facilities as communities of spirit and transformation.

No. 97D
CORRECTIONAL HEALTH CARE STANDARDS: A HISTORICAL REVIEW AND RECENT DEVELOPMENTS

Jeffrey L. Metzner, M.D., *Department of Psychiatry, University of Colorado, 3300 East First Avenue, Suite 590, Denver, CO 80206-5808*

SUMMARY:

This presentation will provide a historical review of correctional health care standards beginning with a report published in the 1898 edition of the American Journal of Insanity. The influence of various commissions, professional societies, and court decisions will be briefly summarized. Recent developments in this area will be highlighted.

No. 97E
TREATMENT, TRAINING, AND CLINICAL STUDIES IN A PRISON-BASED MENTAL HEALTH UNIT

Richard S. Jackson, M.D., *47500 Five Mile Road, Plymouth, MI 48170*

SUMMARY:

This presentation, in part, will describe a specialized prison-based mental health intermediate care program referred to as a residential treatment program (RTP). Prisoners in this program are housed on a unit where mental health treatment takes place. The treatment team consists of a psychiatrist, two psychologists, a social worker, and an activity therapist. Treatment consists of psychotropic medications, individual and group therapy, and extensive cognitive/behavioral programs.

Given that patients are treated on the unit for a prolonged period of time and display a wide variety of psychiatric symptoms, this unit has been developed into an academic-like treatment unit. Adult, child, and forensic psychiatry residents from two local residency programs complete correctional psychiatry rotations in the RTP. In light of the lengths of stay and the variety of psychotropic medications prescribed, the unit serves as an excellent resource for treatment outcome studies. These studies involve the use of diagnostic interviews and monitoring with a variety of rating scales. Treatment protocols and strategies for effective psychotropic medication management of mentally ill prisoners will be reviewed.

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SYMPOSIUM 98—REDUCING DURATION OF UNTREATED FIRST PSYCHOSIS: THE TREATMENT AND INTERVENTION IN PSYCHOSIS STUDY (TIPS)

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to gain knowledge about how duration of untreated first-episode psychosis can be reduced and how the change affects the patient samples presenting for treatment.

No. 98A
EARLY DETECTION AND INTERVENTION: RATIONALE

Thomas H. McGlashan, M.D., *Department of Psychiatry, Yale Medical School, P.O. Box 208038, New Haven, CT 06520*; Per Vaglum, M.D., Svein Frils, M.D., Erik Simonsen, M.D., Jan O. Johannessen, M.D., Ingrid Melle, M.D., Tor K. Larsen, M.D.

SUMMARY:

This presentation explores the rationale for early detection and intervention in schizophrenia. The most compelling reason is the disorder's severity and chronicity and our knowledge that existing treatments are limited and palliative. This suggests that researchers pay closer attention to schizophrenia's earliest phases when the vulnerability to psychosis becomes expressed and the neurobiological deficit processes driving symptom formation appear to be the most active. The evidence is reviewed that brain plasticity may be retained or even reversed despite deficit processes. This includes the retrospective and prospective linkage of earlier psychiatric treatment and better long-term outcome. While the evidence to date does not demonstrate that reducing the duration of untreated psychosis (DUP) changes the natural history of schizophrenia, it is suggestive enough (for both biological and psychosocial treatments) to support active clinical investigation. Such an investigation will be the substance of this presentation. A multisite study of first-episode psychosis is under way in Scandinavia (Jan 1997-Dec 2000) to reduce the duration of untreated psychosis and to measure its effect on the presentation and course of schizophrenia. This presentation discusses the study design, protocol, contrast groups and sites, and the baseline demography of the first two-year sample (1997—98) at all sites.

No. 98B
DOES DURATION OF UNTREATED PSYCHOSIS BIAS SCHIZOPHRENIA STUDY SAMPLES?

Per Vaglum, M.D., *Behavioral Sciences, University of Oslo, P.O. Box 1111 Blindern, Oslo N-0317, Norway*; Svein Friis, M.D., Ingrid Melle, M.D., Stein Opjordsmoen, M.D., Tor K. Larsen, M.D., Erik Simonsen, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objectives. The overall multicenter study aims to see if an early detection (ED) program can reduce DUP in first episode schizophrenia.

This presentation addresses whether there are systematic differences between included patients and refusers concerning sex, age,

diagnoses, substance abuse, being outpatient/inpatient, ED, and DUP in a study of early psychosis.

Methods. We calculated the percent of study-appropriate patients who refused to participate by each of the above variables.

Results. Of 322 study-appropriate patients, 67 (21%) refused to participate. Refusers proved to be significantly older, to come less often from the ED program and more often have a DUP ≥ six months. In a multivariate logistic regression analysis, only ED and DUP remained significant. Only 11% refused to participate among patients with DUP ≤ 4 weeks, gradually increasing to 48% among those with DUP > 48 months.

Conclusion. A considerable number of patients refused study participation. Both an ED program and a short DUP decreased the risk for refusal. The increased study refusal in long DUP patients introduces a bias against finding a potential relationship between DUP and outcome. Therefore, it is crucial that studies report not only the percentage of refusers, but also their median DUP.

No. 98C
REDUCING DURATION OF UNTREATED PSYCHOSIS: THE TIPS HISTORICAL CONTROL STUDY

Tor K. Larsen, M.D., *Rogaland Psychiatric Hospital, Armauerhansensy 20, P O Box 1163, Stavanger N-4004, Norway*; Jan O. Johannessen, M.D., Erik Simonsen, M.D., Ingrid Melle, M.D., Svein Friis, M.D., Per Vaglum, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

Background: At Rogaland Psychiatric Hospital in Stavanger, Norway, a study of first-episode psychoses, was carried out during 1993 and 1994 (Larsen et al, 1996). In 1997 a service for early treatment and intervention in psychosis (the TIPS-project) was established. In this historical comparison study, we compare the early detection (ED) sample included during the first two years of the TIPS study (N = 66) with the historical control (HC) sample, which was detected "as usual" in 1993–94 (N = 43). The aim is to test if a program designed to reduce the duration of untreated psychosis (DUP) in one geographical area actually reduces DUP. This program includes educational initiatives, medical/social detection networks, and early detection teams of clinicians.

Results: A significant reduction in DUP was found between the 1993–94 sample and the 1997–98 sample (mean 114 to 25 weeks; median; 26 to 4.5 weeks), largely accounted for by a reduction in DUP among males. In the ED sample the number of schizophrenia spectrum cases increased. There was a complementary reduction in the frequency (incidence) of schizophrenia for 1997–98 compared with 1993–94. ED patients also were younger, healthier premorbidly, and had less severe psychopathology but more substance abuse.

Significance: These results clearly show that in a geographical area with long DUP, early intervention programs including education efforts and early detection teams, can reduce DUP.

No. 98D
TIPS STUDY: DURATION OF UNTREATED PSYCHOSIS AND BASELINE CLINICAL SEVERITY IN FIRST-EPISODE PSYCHOSIS

Ingrid Melle, M.D., *Department of Psychiatry, Ullevaal Hospital, Kirkeveien 166, Oslo N0407, Norway*; Stein Opjordsmoen, M.D., Tor K. Larsen, M.D., Svein Friis, M.D., Thomas H. McGlashan, M.D., Ulrik Haahr, M.D., Per Vaglum, M.D.

SUMMARY:

Method: The four-year study evaluates the effect of an early detection (ED) program on duration of untreated psychosis (DUP) in one catchment area (ED area), compared with two other catchment areas without an ED program but with identical treatment programs ("Ordinary Detection" [OD] areas).

Results: The presentation includes baseline clinical data on 145 patients (70 ED, 75 OD) from the first two study years. There were no significant baseline differences between sites in gender, diagnoses, education, employment, or Premorbid Adjustment Scale (PAS) scores. ED area patients were significantly younger. The preliminary analyses indicate that the ED program was followed by a significant reduction in DUP. Median duration of untreated psychosis was four weeks (0-416) (ED area) versus 14 (0-966) (OD areas) (p=0.01, MWU). ED area patients were less symptomatic and better functioning at start of treatment (means, std.dev, ED scores first, all tests two-sided t-tests, p<0.01): PANSS total sum scores 65.0 (± 18.6) versus 75.5 (± 20.6), GAF symptom scores 30.6 (± 6.4) versus 26.7 (± 7.2). Preliminary one-year outcome data will be presented.

Significance: DUP can be decreased in a treatment system, and it results in a sample that is less severely ill at baseline.

No. 98E
TIPS: STABILITY OF COGNITIVE FUNCTIONING IN PATIENTS WITH FIRST-EPISODE PSYCHOSIS

Stein Opjordsmoen, M.D., *Department of Psychiatry, Ulleval Hospital, Olso 0407, Norway*; Bjorn Rund, Ph.D., Ingrid Melle, M.D., Svein Friis, M.D., Per Vaglum, M.D., Tor K. Larsen, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

The role of cognitive dysfunction in the course of schizophrenia is an important topic of research. The primary aim of this study was to examine the stability of representative cognitive functions in a group of patients with a first episode schizophrenia spectrum disorder.

We report results from one-year follow-up of 69 patients. We used a test battery consisting of eight different neuropsychological tasks, which through factor analyses generated seven dimensions of cognitive functioning: working memory, verbal learning, executive functions, impulsivity, perseverations, finger tapping, backward masking.

Results showed a remarkable degree of stability in all seven cognitive dimensions. No significant differences were found between baseline and one-year follow-up scores on any dimension. When split into subgroups, a significant improvement was revealed on verbal learning for schizoaffective patients.

Our results are in line with research showing that cognitive impairment is mostly stable in patients with schizophrenia. A few specific functions seem to improve after the initial onset of the psychosis. The present results support the growing body of neurocognitive research suggesting that cognitive deficits are in place by onset of the disorder and change very little thereafter.

No. 98F
TIPS: FIRST-EPISODE PSYCHOSIS DIAGNOSTIC STABILITY OVER ONE YEAR

Ulrik Haahr, M.D., *Roskilde County Hospital Ital Fjorden, 14–16 Smelegade, Roskilde DK-4000, Denmark*; Erik Simonsen, M.D., Ingrid Melle, M.D., Tor K. Larsen, M.D., Svein Friis, M.D., Per Vaglum, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

Background: In first-episode psychosis it is of major interest to predict the prognosis as early as possible, especially to predict how brief psychosis and schizophreniform disorder may evolve.

Material and methods: This study includes 122 patients from the multisite TIPS project in the period January 1, 1997-December 31, 1998. Patients were assessed by raters trained to reliability assess between sites. Assessments at baseline and at one-year follow-up included SCID-1, GAF, PANSS, PAS (Premorbid Adjustment Scale), and DUP (duration of untreated psychosis).

Results: The diagnostic distribution at baseline/follow up was: schizophrenia (S) 29%/49%, schizophreniform disorder (SF) 25%/7%, schizoaffective disorder (SA) 12%/14%, affective disorder with mood-incongruent psychotic symptoms (AD) 12%/16%, delusional disorder (DD) 7%/4%, brief psychosis (BP) 7%/4%, and other psychosis (OP) 10%/6%. The proportion of patients who kept their diagnosis was: S = 100%, SF 23%, SA 87%, AD 93%, DD 63%, BP 63%, and OP 58%. The SFs who changed to S versus those who didn't at one year had poorer premorbid scores (PAS) in early childhood and late adolescence.

Conclusion: There was high prospective diagnostic consistency for most diagnostic groups, except SF. SF underwent the greatest change, mostly to S, and premorbid adjustment predicted this change.

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SYMPOSIUM 99—TOWARD A NEUROBIOLOGY OF DISSOCIATION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should have a basic knowledge of physiologic, neurochemical, neuroendocrine, and brain function abnormalities that may underlie dissociative conditions in childhood and adulthood.

No. 99A
DISSOCIATION AND CHILD DEVELOPMENT

Frank W. Putnam, Jr., M.D., *Mayerson Center, Children's Hospital, 3333 Burnet Avenue, Cincinnati, OH 45229-3039*; Jennie Noll, Ph.D., Lisa Horowitz, Ph.D., Penelope Tricket, Ph.D., George Bonannd, Ph.D.

SUMMARY:

Two developmental processes have been empirically associated with increased levels of dissociation. The first is early childhood trauma, typically child abuse and neglect, which is significantly related to increased dissociation in more than a dozen child and adolescent studies and scores of adult studies. Recently two prospective studies implicated a profound disturbance in the primary caretaker relationship, type D attachment, during early childhood with increased dissociation in adolescence. In this presentation, we examine impact of dissociation on longitudinal outcomes in sexual abused (N=74) and matched, nonabused girls (N=89).

Results: In the first study, high levels of dissociation, as measured by the ADES and Peritraumatic Dissociation Scale, are predictive of the development of PTSD and somatization as well as stress-related decreases in heart rate during a trauma narration task. In the second study, increased levels of dissociation predict revictimization in adolescence. Odds ratios indicate that for every one unit on the ADES, subjects have an increased rate of ~8% of being physically victimized, and ~6% of engaging in self-harm after the age of 14. Early childhood, trauma-related, dissociation impacts life course by increasing susceptibility to PTSD, somatization, and re-victimization, and by altering psychophysiological responses to stressors.

No. 99B
DISSOCIATION, CHILDHOOD ABUSE, AND HEART RATE IN DELINQUENT YOUTHS

Cheryl Koopman, Ph.D., *Department of Psychiatry, Stanford University, MC 5718; Stanford, CA 94305-5718*; Victor G. Carrion, M.D., Shiv Sudhaker, B.A., Hans Steiner, M.D.

SUMMARY:

Objective: This study examined the relationships of dissociative symptoms and childhood abuse to mean heart rate during a stressful speech task.

Methods: Participants in this study included 41 delinquent adolescents (25 females and 16 males) of diverse ethnic backgrounds. Their dissociative symptoms were assessed using the SCID-D. We assessed their experience of five types of traumatic childhood life events (including sexual abuse, physical abuse, emotional abuse, physical neglect, and witnessing violence). Adolescents were then randomized to one of two stressful speech conditions: (1) to describe their worst experience ever, or (2) to a free association task.

Results: The results were similar to those of Griffin, et al (1997) in showing that individuals with the highest dissociative symptoms had the lowest mean heart rates during the stressful speech task ($p < .05$). Females' mean heart rates during speech were higher than were those of males ($p < .05$). The experience of the traumatic childhood life events was associated with higher mean heart rates during the stressful speech task ($p < .05$).

Conclusions: These results provide further support to suggest that there is a form of posttraumatic stress in which dissociative symptoms are predominant, one in which there is a suppression of autonomic physiological responses to stress.

No. 99C
DEPERSONALIZATION: HPA AXIS DYSREGULATION AND ASSOCIATION CORTEX DYSFUNCTION

Daphne Simeon, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave Levy Place, Box 1230, New York, NY 10029-6574*; Orna Guralnik, Psy.D., Erin A. Hazlett, Ph.D., Eric Hollander, M.D., Monte S. Buchsbaum, M.D.

SUMMARY:

Two studies on the neurobiology of depersonalization will be presented: Study 1 examined HPA axis function and Study 2 examined brain metabolic activity. In Study 1, nine subjects with DSM-IV depersonalization disorder (DPD), without lifetime PTSD or current major depression, were compared with nine healthy comparison (HC) subjects of comparable age and gender. DPD subjects demonstrated comparable elevated basal cortisol levels and significant hyposuppression to low-dose dexamethasone administration compared with HC subjects. Thus, dissociation may be associated with HPA axis

resistance, in contract to the sensitization found in PTSD. In Study 2, brain glucose metabolism and its relationship to dissociation was assessed. PET scans coregistered with MRI from eight DPD subjects were compared with those of 24 HC. Depersonalized subjects showed significantly lower metabolic activity in right Brodmann areas 22 and 21, and significantly higher activity in parietal Brodmann areas 7B and 39 and left occipital Brodmann area 19. Dissociation and depersonalization scores within the DPD group were significantly positively correlated with metabolic activity in area 7B. Thus, depersonalization may be associated with functional abnormalities in unimodal and cross-modal sensory association areas (visual, auditory, and somatosensory), as well as areas responsible for an integrated body schema.

No. 99D
NEURAL RESPONSES TO EMOTIONAL EXPRESSIONS IN DEPERSONALIZATION

Mary L. Phillips, M.D., *Department of Psychiatric Medicine, Institute of Psychiatry, 1103 Denmark Hill, London SE5 8AZ, England*; Anthony S. David, M.D., Kate Pietura, M.D., Kathryl Abel, M.D., Nicholas Medford, M.D., Matt Allen, M.D., Mauricio Sierra, M.D.

SUMMARY:

While reports have emphasized emotional blunting as a symptom of depersonalization, there has been little investigation of its neural basis. Employing functional magnetic resonance imaging (MRI), we have previously demonstrated in depersonalized patients compared with patient and normal controls, reduced experience of emotion and a failure to activate the insula, with increased prefrontal cortical activation, when viewing aversive scenes. We examined neural responses to neutral, fearful, and disgusted facial expressions in six patients with primary depersonalization, six normal volunteers, in addition to seven volunteers after ketamine, known to induce depersonalization, versus placebo infusion (using a double-blind paradigm). Volunteers experienced symptoms of depersonalization only after ketamine infusion. Emotional faces activated predicted regions (e.g. amygdala and visual cortical regions) in normals and volunteers during placebo infusion, but not depersonalized patients or volunteers after ketamine infusion. Depersonalized patients also demonstrated increased activation of prefrontal cortex to these stimuli. These findings indicate a similarity between neural responses to emotional stimuli in primary depersonalization and depersonalization induced by ketamine. Both studies indicate that the neural basis of emotional blunting of depersonalization is associated with an absence of activation of emotion-sensitive regions combined with increased activation in regions associated with interpretation and control of emotions.

No. 99E
PSYCHOPHARMACOLOGIC INSIGHTS INTO DISSOCIATION

John H. Krystal, M.D., *Department of Clinical Neuroscience, VA Connecticut Healthcare, 950 Campbell Avenue, West Haven, CT 06516*; Steven M. Southwick, M.D., Dennis S. Charney, M.D., Amit Anand, M.D., D. Cyril D'Souza, J. Douglas Bremner, M.D.

SUMMARY:

There is a pressing need to develop treatments for dissociative states that emerge in the context of primary dissociative disorders or in the context of posttraumatic stress disorder. This presentation will summarize a series of studies that suggest that dissociative states may emerge in the context of posttraumatic stress disorder when noradrenergic or serotonergic systems are activated by yohimbine and mCPP, respectively. Healthy subjects, who do not normally exhibit dissociation following mCPP, exhibit these symptoms when pretreated with iomazenil, a drug that impairs the inhibitory function of GABA. Deficits in cortical inhibition are also produced by the NMDA glutamate receptor antagonist, ketamine, which "disinhibits" the release of the excitatory neurotransmitter glutamate at subanesthetic doses. Ketamine also produces dissociative symptoms in healthy subjects that are attenuated by drugs that facilitate GABA function or directly attenuate glutamate release. One glutamate release inhibitor, lamotrigine, reduces the perceptual effects of ketamine and the symptoms of dissociation in some patients with primary depersonalization disorder. Together these data suggest that disturbances in cortical glutamate function may contribute to the genesis of dissociative states and several new classes of drugs may play a role in the treatment of dissociation in the context of PTSD or other dissociative disorders.

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SYMPOSIUM 100—STABILITY VERSUS CHANGE IN PERSONALITY TRAITS AND DISORDERS: A DEVELOPMENTAL VIEW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize those aspects of personality disorder psychopathology that are stable over time, those that may change, and mechanisms or processes that influence stability vs change.

No. 100A
LINKING CHILDHOOD PERSONALITY WITH MALADAPTATION ACROSS TIME

Rebecca L. Shiner, Ph.D., *Department of Psychology, Colgate University, 13 Oak Drive, Hamilton, NY 13346*

SUMMARY:

Four personality traits—mastery motivation, academic conscientiousness, surgency, and agreeableness—were measured in a community sample of 205 children (ages 8–12), who were followed up 10 years later. Childhood personality was examined in relation to concurrent and longitudinal competence and maladaptation in three domains—academic success vs. failure, rule-abiding vs. antisocial conduct, and good vs. poor social competence with peers. Childhood personality traits evidenced robust, conceptually coherent relationships with maladaptation, both concurrently and across time. For example, children low on agreeableness engaged in more antisocial

behavior and children low on mastery motivation experienced more academic failure, both concurrently and across a 10-year span. Discontinuity in the relationship between childhood personality and maladaptation was also evident; for example, low childhood academic conscientiousness predicted childhood academic failure only modestly but predicted late adolescent academic failure more strongly. Childhood personality also added to the prediction of later maladaptation, beyond childhood IQ and earlier maladaptation in the same domain. Thus, childhood personality predicted *change* in children's maladaptation over the years from childhood to late adolescence. These results document the importance of childhood personality for children's emerging competence vs. maladaptation across the years from childhood through late adolescence.

No. 100B
CHANGE IN PERSONALITY DISORDER SYMPTOMS BETWEEN ADOLESCENCE AND ADULTHOOD

Jeffrey G. Johnson, Ph.D., *Department of Psychiatry, Columbia University, Box 60 NYSPI, 1051 Riverside Drive, New York, NY 10032;* Patricia R. Cohen, Ph.D., Andrew E. Skodol II, M.D.

SUMMARY:

A community-based prospective longitudinal study was conducted to investigate change in personality disorder symptoms between early adolescence and early adulthood among individuals in the community. Personality disorder symptoms were assessed in 1983 (mean age=14), 1985–86 (mean age=16), and 1991–93 (mean age=22) in a representative sample of 816 youths from upstate New York. Results indicated that total personality disorder symptom levels declined 28% during both adolescence and early adulthood. Personality disorder symptoms were moderately stable during the first two-year interval. When compared with the findings of previous studies conducted in adult samples, personality disorder symptoms were as stable during this two-year interval as they have been reported to be among adults over similar intervals. The stability of personality disorder symptoms declined slightly as the inter-assessment interval increased. Individuals who had personality disorders during adolescence tended to have elevated personality disorder symptom levels during early adulthood. The present findings indicate that personality disorder symptoms tend to decline steadily in prevalence during adolescence and early adulthood. However, adolescents with personality disorders often have elevated personality disorder symptoms as young adults, and the stability of personality disorder symptoms appears to be similar during adolescence and early adulthood.

No. 100C
THE LONGITUDINAL STUDY OF PERSONALITY DISORDERS: PREDICTORS OF CHANGE, HINTS ABOUT MECHANISM

Mark F. Lenzenweger, Ph.D., *Department of Psychology, Harvard University, 33 Kirkland Street, Room 1220, Cambridge, MA 02138*

SUMMARY:

The Longitudinal Study of Personality Disorders (LSPD), begun in 1990, is a large-scale, prospective, multiwave study of all personality disorders in a nonclinical sample (N=250). The LSPD subjects have been assessed on two different measures of Axis II personality disorder as well as measures of personality, temperament, sex-role conformity, and Axis I psychopathology at three time points. The present report discusses the predictors of change and stability in personality disorder features over time, using a variety of specialized techniques employed in longitudinal research, as well as describes the potential mechanisms of change.

No. 100D
TWO-YEAR STABILITY OF PERSONALITY DISORDER CRITERIA

M. Tracie Shea, Ph.D., *Department of Psychiatry, Brown University-Butler Hospital, 700 Butler Drive, Providence, RI 02912;* Robert L. Stout, Ph.D., Shirley Yen, Ph.D., Andrew Skodal, M.D., Leslie C. Morey, Ph.D., Mary C. Zanarini, Ed.D., Charles A. Sanislow, Ph.D.

SUMMARY:

There is an absence of knowledge regarding the stability of the criteria that comprise the Axis II personality disorders (PDs). It is unknown, for example, whether some criteria are more persistent and hence more central to the disorder, in contrast to more fluctuating criteria, which may represent changing manifestations of the core psychopathology. The CLPS, a multisite, longitudinal study of schizotypal, borderline, avoidant, and obsessive-compulsive PDs, includes assessment of individual criteria over time. Monthly ratings for each criterion are based on information derived from a structured interview at six and 12 months and then yearly assessments post-intake. This presentation will report findings on the stability of criteria over two years of prospective follow-up for over 500 PD subjects. Preliminary findings from the six-month interview showed that remission rates (defined as absent for ≥ 2 consecutive months) varied considerably among the criteria. The remission rates for the most and least stable criteria for each of the four PDs were as follows: STPD: Odd beliefs (5%) and unusual experience (21%); BPD: intense anger (7%) and self-injury/suicide (54%); AVPD: socially inept (11%) and avoids jobs with interpersonal contacts (27%); OCPD: rigid and stubborn (7%) and workaholic (24%). The implications of the findings for definition and assessment of PDs will be discussed.

No. 100E
PERSONALITY STABILITY/CHANGE AND THE NATURAL COURSE OF AXIS II PERSONALITY DISORDERS

Paul T. Costa, Ph.D., *LPC, National Institute on Aging, 5600 Nathan Shock Drive, Baltimore, MD 21224*

SUMMARY:

Life-span views of personality continuity and change as well as cross-cultural studies of age differences in personality traits suggest that there are intrinsic developmental sequences of personality maturation that have important implications for understanding the nature and course of personality disorders. Past age 30 there is little change in the average level of personality traits and surprisingly high stability of individual differences. However, significant mean level differences from adolescence to adulthood show that three of the factors (neuroticism, extraversion, and openness) decrease, whereas the other two (agreeableness and conscientiousness) increase with age.

These developmental sequences suggest hypotheses about age changes in the prevalence of the PDs. For example, neuroticism declines and neuroticism is a feature common to many PDs, and correspondingly PDs should be less often diagnosed in middle-aged and older adults. Conscientiousness and agreeableness increase with age, and as low scores on these dimensions are key features of the antisocial PD we would expect—and find—declines in antisocial PD with age. These parallels between developmental personality trends in normal individuals and in diagnoses of PDs in psychiatric patients are striking and provide another line of evidence for regarding both as manifestations of the same underlying structures.

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SYMPOSIUM 101—BULIMIA NERVOSA: RECENT RESEARCH FINDINGS IN BIOLOGY AND TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to better understand biologic variables and new treatment approaches in bulimia nervosa and to maximize treatment efficacy utilizing the evidence-based treatments that have demonstrated efficacy in randomized controlled trials of treatment for bulimia nervosa.

No. 101A
BINGE EATING, MOOD REGULATION, AND 5HT FUNCTION IN BULIMIA NERVOSA

David C. Jimerson, M.D., *Department of Psychiatry, Beth Israel Hospital, 330 Brookline Avenue, Boston, MA 02215-5491*; Barbara E. Wolfe, Ph.D., Erand Metzger, M.D.

SUMMARY:

Objective: Clinical studies of bulimia nervosa (BN) suggest that diminished CNS serotonergic function may contribute to impaired satiety and recurrent binge eating. Thus, BN is associated with attenuation of serotonin-stimulated hormone release in hypothalamic-pituitary neuroendocrine pathways. More than half of patients with BN have current or past history of major depression, however. This study assessed whether diminished serotonergic neuroendocrine and behavioral responses were present in a subset of bulimic patients with no history of major depression.

Methods: Results were analyzed for 12 women with current BN and 13 women who had recovered from the disorder, all of whom were free of current or past major depression. Controls included 20 healthy women with no history of major psychiatric disorder. Placebo-adjusted serum prolactin responses and ratings of mood, hunger, and satiety were measured following single-dose administration of a serotonin agonist medication, and were analyzed by analysis of covariance.

Results: In comparison with controls, prolactin responses were significantly blunted ($p<.05$) for patients with current BN, although not for remitted individuals.

Conclusions: These findings suggest that bulimia nervosa is associated with diminished serotonergic neuroendocrine responsiveness independent of a history of depressive illness. Further studies are needed to compare clinical characteristics and treatment response patterns for bulimic patients with or without a history of major depression.

No. 101B
EATING DISORDERS: GENES OR JEANS?

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, #E-724, Pittsburgh, PA 15213*; Guido Frank, M.D.

SUMMARY:

Anorexia and bulimia nervosa have not traditionally been viewed as heritable illnesses. However, recent family and twin studies lend credence to the potential role of genetic transmission of a vulnerability to develop an eating disorder. Several lines of evidence suggest that people with eating disorders may have a trait-related disturbance of serotonin (5-HT). These data include persistent alterations after recovery such as (1) elevated CSF 5-HIAA, the major 5-HT metabolite; (2) reduced regional binding of a 5HT2a radioligand on PET studies; and (3) altered behavioral response to challenge studies. Finally, SSRI medication is efficacious in these disorders. Altered CNS 5-HT activity could contribute to restricted eating, behavioral overcontrol, obsessive exactness and perfectionism, and negative effective states.

The Price Foundation has funded an international, multisite study to identify genetic factors contributing to the pathogenesis of anorexia and bulimia nervosa (AN, BN) by recruiting affective relative pairs and trios. For the AN affected relative pair sample, there were 229 relative pairs who are informative for linkage analysis. Of the proband-relative pairs, 63% are AN-AN, 20% are AN-BN, and 16% are AN-NOS. Analysis of a genome scan is in progress. For the BN-affected relative pair sample, almost 400 affected pairs have been collected. A third sample, consisting of 800 AN trios will be collected between 2000 and 2001. These studies represent the first large-scale molecular genetic investigation of AN and BN. Our successful recruitment of over 4,000 subjects, consisting of affected probands, affected relatives, and their biological parents, will provide the basis to investigate genetic transmission of eating disorders via a genome scan and assessment of candidate genes.

No. 101C
PSYCHOBIOLOGY OF 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*

SUMMARY:

Patients with bulimia nervosa appear to have a disturbance in the development of satiety. Their binge meals clearly consist of many more calories than even large meals of controls. Yet, it appears that patients only develop full satiety after the consumption of such binge meals. Among the factors that normally contribute to the development of safety during a meal are physiological reactions of the stomach and small intestine. In the last 10 years, consistent data have merged from several laboratories suggesting that the functioning of the stomach and small intestine is not normal in bulimia nervosa. This presentation will review ongoing studies of (1) cholecystokinin (CCK) release, (2) gastric emptying, and (3) 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 bulima nervosa. Such disturbances may contribute to patients' difficulties recovering from this illness, and may provide opportunities for novel treatment interventions.

No. 101D
COGNITIVE-BEHAVIOR THERAPY AND PHARMACOTHERAPY IN THE TREATMENT OF BULIMIA NERVOSA

Allan S. Kaplan, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street EN8-231, Toronto, ON M5G 2C4, Canada*

SUMMARY:

The objective of this presentation is to critically review the existing literature examining the controlled trials that have evaluated the effectiveness of cognitive-behavioral therapy (CBT) and pharmacotherapy in the treatment of bulimia nervosa (BN). The results of an extensive literature review reveal over 25 published studies that have evaluated the effectiveness of individual CBT in BN compared with other treatments. These studies report a mean reduction of binge eating and purging of approximately 80%; mean remission rates range from 50% to 70% for binge eating and from 40% to 60% for purging. There are over 20 published controlled trials of antidepressant pharmacotherapy comparing a variety of antidepressant drugs with placebo. These studies find no clear difference in efficacy between the various drugs studied. Mean reduction in binge eating and purging is 70%, while mean remission rates are reported to be approximately 30%. There is a significant relapse rate, between 30% to 45%, in patients followed on drugs for up to six months. There are six published studies comparing antidepressant medication to CBT utilizing various paradigms. These studies indicate that CBT alone is generally superior to a trial of a single antidepressant for the core symptoms of binge eating and purging. Two studies show that the combination of CBT and medication is superior than either alone; in particular, there is greater improvement in mood and anxiety when antidepressant therapy is added to CBT. Future studies will need to focus on identifying specific predictors of response to both CBT and pharmcotherapy in BN.

No. 101E
NEW TREATMENT APPROACHES FOR BULIMIA NERVOSA

James E. Mitchell, M.D., *Department of Psychiatry, Neuropsychiatric Research Institute, 700 First Avenue South, P.O. Box 1415, Fargo, ND 58103*

SUMMARY:

Bulimia nervosa has now been the focus of controlled treatment studies for approximately 20 years. During this period of time, pharmacological approaches using primarily antidepressant drugs and psychotherapy approaches focusing on cognitive-behavioral techniques have been shown to be effective. Overall, CBT approaches appear to be associated with higher levels of remission. Limited research suggests that the combination may provide optimal treatment when both are available.

This presentation will review several recent and a few current ongoing studies that evaluate new treatment models for bulimia nervosa. These include:

1. Studies that examine nonresponders to cognitive-behavioral therapy or interpersonal therapy, that suggest that 10% to 38% of nonresponders to psychotherapy will respond to medication with serotonin reuptake inhibitors.

2. Use of self-help approaches, which appear to be quite useful for some patients alone, and which do improve outcome for patients receiving fluoxetine treatment.

3. An ongoing study using telemedicine as a technique to compensate for the lack of availability of cognitive-behavioral therapy in many rural areas.

4. A new stepped care approach, which is now being evaluated in a multicenter, randomized study.

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1. Wolfe BE, Metzger ED, Levine JM, Finkelstein DM, et al: Serotonin function following remission from bulimia nervosa. Neuropsychopharmacology 2000; 22:257–263
2. Kaye WH, et al: A search for susceptibility loci for anorexia nervosa: Methods and Sample description. Biological Psychiatry 2000; 47:794–803
3. Devlin MJ, Walsh BT, Guss JL, Kissileff HR, et al: Postprandial cholecystokinin release and gastric emptying in patients with bulimia nervosa. Am J Clin Nutr 1997:114–20
4. Walsh BT, Wilson GT, Loeb KL, et al: Medication and psycotherapy in the treatment of bulimia nervosa. American Journal of Psychiatry 1997; 154(4):523–535
5. Agras WS, Crow SJ, Halmi KA, Mitchell JE, et al: Outcome predictors for the cognitive-behavioral treatment of bulimia nervosa: data from a multisite study. Am J Psychiatry 2000; 157:1302–1308

SYMPOSIUM 102—BPD: INTEGRATING MIND AND BODY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to identify the manner in which constitution, development, neurobiology, and culture affect the understanding and treatment of patients with the diagnosis of borderline personality disorder. Clinical and theoretical discussions will facilitate understanding of the mind/body integration.

No. 102A
HETEROGENEITY WITHIN BPD

John M. Oldham, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Suite 6700, New York, NY 10032-2603*; Andrew E. Skodol II, M.D., Donna S. Bender, Ph.D.

SUMMARY:

The term "borderline" has been in clinical use for decades, reflecting an early notion of a group of patients on the border between the neuroses and the psychoses. This view, that this multisymptomatic condition represented a schizophrenia-spectrum illness, was revised after criteria were developed for Axis II disorders for the DSM-III, and schizotypal PD was identified as the personality disorder on the schizophrenia spectrum. Borderline PD was then proposed to be on the affective or mood disorders spectrum, but later described as a disorder of impulse control. In fact, the polythetic system uniformly adopted for Axis II by DSM-III-R and DSM-IV guarantees significant heterogeneity within each diagnostic category. Clarkin et al., in 1983, determined that using DSM-III criteria there were 56 different "official" ways to be diagnosed with BPD, and this number would now be greater since a ninth criterion was added in DSM-IV. It is important to recognize this inherent heterogeneity within the definition of BPD, since it crucially guides treatment planning, depending on the predominant symptomatology in a given patient. Furthermore, extensive intra-Axis II comorbidity is common, and Axis I/II comorbidity is the rule rather than the exception, further accentuating the variability between one borderline patient and another. Data will be presented from the Collaborative Longitudinal Personality Disorder Study (CLPS) exemplifying typical diagnostic heterogeneity in a

large borderline cohort, and the implications for treatment will be discussed.

No. 102B
EMOTION, MOTIVATION, AND THE BORDERLINE PERSONALITY: A NEUROBIOLOGY PERSPECTIVE

Regina Pally, M.D., *11980 San Vicente Boulvard, #810, Los Angeles, CA 90049-6606*

SUMMARY:

Adaptive psychological functioning depends on adequate regulation of affect states. This presentation will discuss how the symptoms of borderline personality disorder, such as intensity and lability of affect, impulsive and self-destructive behavior, and difficulties with attachment and interpersonal interaction, can be understood in terms of impairments in the fronto-limbic brain system, which regulate affect. Some impairments may be present at birth and some may develop in the interactions with caretakers. The borderline personality will be discussed in relation to how the brain is organized around a reward-and-punishment motivational system and how emotion coordinates the body and brain's response, to maximize rewards and minimize punishments. Emotion activates the complex network of perceptions, memories, neurotransmitters, hormones, autonomic changes, and behaviors that provide an optimal response to a situation. Through the unconsciously processed learning inherent within the emotional system, human beings build up a repertoire of adaptive responses. As the frontal cortex matures it develops the ability to regulate emotion and to even override it, through inhibition systems, which permit the conscious voluntary selection and initiation of adaptive behavior.

No. 102C
PSYCHOANALYTIC PERSPECTIVES ON BPD

John F. Clarkin, Ph.D., *Department of Psychiatry, New York Hospital, CMC, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

The distinction between temperament and character proposed by Cloninger et al. is useful in treatment planning for borderline personality disorder. While the temperament of the borderline patient may be addressed with medication, the characterological aspects of BPD are best treated with psychotherapy. A psychoanalytic model of character acknowledges that the borderline patient is attempting to actualize certain patterns of relatedness that reflect unconscious wishes. The patient subtly attempts to impose a certain way of experiencing and/or responding on the clinician. The way the internal object relations of the patient are recreated in the transference-countertransference dimensions of the clinical interaction provide a privileged glimpse of the characteristic and problematic patterns of relatedness that have chronically caused difficulties in the patient's relationships with others. Psychoanalytic psychotherapy focuses on the systematic elaboration of these patterns and the unconscious wishes that lie behind them.

No. 102D
CULTURAL PERSPECTIVES ON THE BORDERLINE PERSONALITY

Leslie A. Horton, M.D., *Department of Psychiatry, University of Southern California, 1958 Lemoyne Street, Los Angeles, CA 90026*

SUMMARY:

This presentation will address the anthropological contribution to the study of personality disorders, specifically borderline personality disorder. It will delineate anthropology's deliberate holistic perspective and methodology and its relevance for a biocultural understanding of personality disorders. It will consider the relationship between culture and emotion, address the cultural meanings and contexts associated with behaviors identified with borderline personality disorder, and outline relevant cultural schemas having to do with interpretations of reality and conceptualizations of the self that have been internalized in individuals with this disorder. Research on the anthropology of consciousness, of relevance to depersonalization and trance-like states, will also be discussed. The argument that Western culture's lack of meaningful adolescent rites of passage is a contributing factor in the emergence of borderline personality will then be considered.

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1. Oldham JM: Integrated Treatment for Borderline Personality Disorder, in J Integrated Treatment. Edited by Kay J. American Psychiatric Press Review of Psychiatry, Volume 20. Washington, DC, American Psychiatric Press, Inc, in press
2. Rolls ET: The brain and emotion. Behavioral and Brain Sciences 2000; 23:177-234
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4. Peters L: Rites of passage and the borderline syndrome. Anthropology of Consciousness 1994; 5(1):1–15

SYMPOSIUM 103—INTEGRATING CLINICAL RESEARCH WITH CLINICAL PRACTICE: NATIONAL INSTITUTE OF MENTAL HEALTH EFFECTIVENESS TRIALS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand distortions that typically occur when results from efficacy trials are extrapolated to a clinical sample; understand challenges in designing public health studies that aim at "bridging science and service," recognize the distinction between internal and external validity.

No. 103A
NATIONAL INSTITUTE OF MENTAL HEALTH APPROACHES TO INTERVENTION TRIALS

Barry D. Lebowitz, Ph.D., *Adult and Geriatric, National Institute of Mental Health, 6001 Executive Boulevard, Room 7160, MSC 9635, Bethesda, MD 20892-9635*

SUMMARY:

The development of a new public health approach to the conceptualization and design of clinical trials permits us to address a new set of issues in clinical therapeutics. Traditional treatment studies have selection criteria that are so limiting and conditions of treatment delivery that are so optimized that generalization and widespread application are very difficult. A public health approach examines the appropriate uses for treatments once they have gained regulatory approval. NIMH is using this approach in a new set of large-scale multisite trials in bipolar illness, schizophrenia, Alzheimer's disease, and depression. These trials have created new opportunities for research and at the same time have raised important questions about clinical trial design, methodology, and infrastructure in the field. Issues will be raised about selection of appropriate comparators, testing of sequential treatment strategies, subject response burden,

use of nonacademic sites, and the role of academic investigators and institutions.

No. 103B
THE SYSTEMATIC TREATMENT ENHANCEMENT PROGRAM FOR BIPOLAR DISORDER

Gary S. Sachs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, 5th floor, Boston, MA 02114*; Michael E. Thase, M.D., Leslie F. Leahy, Ph.D., Jennifer Conley, M.A., Andrew A. Nierenberg, M.D., Phillip Lavori, Ph.D., Michael H. Allen, M.D.

SUMMARY:

STEP-BD is designed to address public health issues related to bipolar disorder. Effectiveness research, such as STEP-BD, faces many design challenges: how to recruit a representative sample of patients for studies that largely use readily available treatments; implementation of a common intervention strategy across diverse treatment settings; functional outcomes for patients in multiple phases of illness; testing innovative treatments; integration of psychosocial interventions; and, avoiding biases due to subject drop out and last-observation-carried-forward data analyses. To maximize external validity, STEP-BD has developed a common intervention model for implementation across diverse treatment settings. The public health objective is further attained through the development of patient education materials and the ongoing training of doctors.

STEP-BD uses a novel hybrid design that offers patients treatment under the care of psychiatrists trained to deliver best-practice care using model practice procedures consistent with expert recommendations. The methodology used for the selection of 20 clinical treatment centers, training study personnel, and clinical outcomes will be discussed. This presentation will describe the general approach to integrating psychosocial treatment and sequential pharmacology as offered in the STEP-BD treatment pathways for bipolar depression and relapse prevention. We will present demographic data from the first year of study enrollment.

No. 103C
SEQUENCED TREATMENT ALTERNATIVES TO RELIEVE DEPRESSION (STAR ^{4} D)

A. John Rush, M.D., *Department of Psychiatry, Univ. of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9086*

SUMMARY:

There are many effective treatments for depressed patients, including antidepressant medications and time-limited, depression-targeted, psychotherapies. However, only 50% of patients respond to the first antidepressant treatment. How to select the next best treatment is not well known. STAR^{4}D compares several "next step" treatments following a first treatment, and following even a second or third treatment effort.

To generate findings that are directly applicable to practice, STAR^{4}D will enter 4,500 outpatients with major depressive disorder from over 40 primary and specialty care practice sites across the U.S. Patients and family members receive education about depression. Clinicians follow protocols to implement different treatments, including medications and/or psychotherapy. A follow-up phase evaluates the longer-term benefits of treatment. Patients and clinicians are not masked to the treatments used. Masked outcome assessments conducted by telephone interviewers and an interactive voice response system are used to compare the effectiveness of different treatments, which are randomly assigned. Outcomes include symptoms, function, side-effect burden, patient satisfaction, and service utilization and treatment costs. Ancillary studies will be conducted using this research infrastructure (for additional information on the project, see www.edc.gsph.pitt.edu/stard).

No. 103D
EFFECTIVENESS TRIALS OF ANTIPSYCHOTIC DRUGS

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, Univ. of North Carolina School of Medicine, Room 7025, Neurosciences Hospital, CB716, Chapel Hill, NC 27599*; Lon S. Schneider, M.D., Joseph McEroy, M.D., Pierre Pariot, M.D., Scott Stroup, M.D., John Adiao, M.D., Barry D. Lebowitz, Ph.D.

SUMMARY:

The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) program will evaluate the effectiveness of atypical antipsychotic medications in adults with schizophrenia and in adults with Alzheimer's disease.

The CATIE schizophrenia trial will evaluate the effectiveness of atypical and conventional antipsychotic medications in up to 1800 patients with schizophrenia. The initial treatment phase involves randomly assigned, double-blinded treatment comparing olanzapine, perphenazine, quetiapine, and risperidone. Ziprasidone will be used upon final FDA approval. Clozapine will be a possible treatment for persons who fail their initial treatment due to poor efficacy.

The CATIE Alzheimer's disease trial is a randomized-treatment assignment, parallel group, and double-blinded treatment comparing risperidone, olanzapine, quetiapine, citalopram, and placebo in 450 AD patients with defusion, hallucinations, or agitation severe enough to warrant the use of antipsychotic medications.

Both trials involve multiple phases that will allow participants who fail on an initially assigned treatment to continue on to subsequent randomly assigned medications. Outcome measures will extend beyond efficacy and safety to include quality of life, cognitive functioning, and service use. Cost-effectiveness analyses will be performed. Both studies will enroll a broad range of "real world" patients, including those with comorbid conditions that would exclude them from most clinical trials.

REFERENCES:

1. Norquist G, Lebowitz B, Hyman S: Expanding the frontier of treatment research. Prevention and Treatment 1999; (2): Article 0001a online
2. National Advisory Mental Health Council. Bridging Science and Service. A Report of the National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup. Rockville, MD: NIH Publication, No. 99-4353, 1999

SYMPOSIUM 104—NEW ANTIDEPRESSANTS: LIGHT AT THE END OF THE TUNNEL?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the key issues that face the development of a true advance in a next generation antidepressant and understand the implications of these issues for clinical practice.

No. 104A
UNMET NEED: WHAT JUSTIFIES THE SEARCH FOR A NEW ANTIDEPRESSANT?

John F. Greden, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0999*

SUMMARY:

Despite more than 40 available antidepressants, powerful arguments can be made for development of newer agents. More than 320 million people worldwide and 18 million in the U.S. have major depressive disorder (MDD) at any moment, and they have higher mortality, higher disability, and health care costs two to three times higher than nondepressed patients, not counting mental health costs. The World Health Organization (WHO) categorizes MDD as the most disabling diagnosis in the world. The "unmet need" argument is buttressed by modest remission rates for all currently used antidepressants. While 70% may respond, only 30% achieve firm "remission," suggesting that treatment "resistance" may be the norm with current agents. In addition, onset of action is delayed for all available agents, measured in weeks rather than days. All available agents have meaningful side effects, adverse events, and drug-drug interactions, thus minimizing patient adherence. Finally, since inadequately treated MDD is a lifetime, episodic, recurrent disorder, the most important unmet need is to develop antidepressant options that are shown to have long-term effectiveness, long-term acceptance, long-term safety, and long-term cost-benefits when used for extended maintenance. The unmet need is great. There are prospects in the pipeline, but new measurement tools and a changed paradigm must be developed to assess new antidepressant candidates.

No. 104B
METHODOLOGICAL CHALLENGES IN THE STUDY OF NEW ANTIDEPRESSANTS

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

SUMMARY:

The study of antidepressants is a high risk endeavor. Despite the use of an effective antidepressant, a placebo-controlled clinical trial all too often provides results that are confusing at best, and in the worst case, clinically uninterpretable. There are many factors that may contribute to this outcome; several more tangible issues will be discussed in this presentation. For example, accuracy of diagnostic assessment is crucial, as is the precise measurement of the clinical symptoms that will define the efficacy of the medication of interest. Unfortunately, standardized diagnostic assessments that can be easily, yet reliably administered in a multisite clinical trial setting are only recently becoming generally available. Our group has pioneered the use of computerized administration of diagnostic and symptom rating tools that hold promise in circumventing some of these issues. On the other hand, the development of symptom rating tools that may be sensitive to true drug changes and more accurately discriminate drug effects from disease symptoms, has remained a problematic area of research metholodology. Recent attempts at innovations in clinical study design and analysis also hold promise for future work. Improvements in clinical trial methods remain as important as innovations in neurochemical bench research if we are to move to the next generation of antidepressant pharmacotherapy.

No. 104C
IS THERE ROOM TO IMPROVE MONOAMINE-BASED THERAPIES?

Mark A. Demitrack, M.D., *Lilly Research Labs, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*

SUMMARY:

Most available medications that have demonstrated effective action as clinical antidepressants for the past several decades have been based on a neurochemical model that assumes that levels of the classical neurotransmitters serotonin, norepinephrine, and dopamine, are either inadequately available or fundamentally dysregulated in patients with major depression. Though agents based on these pharmacologic approaches have undoubtedly been useful for clinical management, it is less clear that any fundamental advancement in antidepressant efficacy will be achieved by further developments in this area. In this presentation, two major examples of potential improvements in monoamine-based antidepressant development will be presented, and their implications for future work explored. Advances in understanding the human receptor subtypes that are targets of serotonin action have led us and others to examine the role of receptor-specific modulation of reuptake inhibition. One of the best recent examples of this approach is the use of the serotonin 1A receptor antagonist pindolol to augment the synaptic availability of serotonin. Clinical evidence that supports as well as questions this approach will be considered. Another area of interest is the view that dual or triple reuptake mechanisms are more effective than medications that exert their action on one neurotransmitter system alone. Taken together, these pieces of evidence suggest exciting opportunities based in "traditional" approaches.

No. 104D
BEYOND MONOAMINE-BASED THERAPIES: CLUES TO NEW APPROACHES

Phil Skolnick, Ph.D., *Lilly Research Labs, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*

SUMMARY:

Therapies that offer distinct advantages over currently available antidepressants are most likely to develop from targets beyond the monoaminergic synapse. During the past decade, an increased understanding of the intracellular signaling events produced by conventional antidepressants has led to several new therapeutic approaches. Thus, studies focused on the cascade of events produced by activation of adenylate cyclase (a consequence of elevating synaptic levels of biogenic amines) suggest an increased expression of brain-derived neurotrophic factor (BDNF) may be integral to the antidepressant actions of conventional agents. Strategies directed at modulating BDNF expression may thus represent a means of producing an antidepressant action bypassing the monoaminergic synapse. Defining pathways downstream of BDNF can, in turn, reveal additional targets. For example, the ability of BDNF to dampen glutamatergic function is consistent with an emerging body of preclinical evidence that N-methyl-D-aspartate (NMDA) antagonists possess antidepressant properties. However, grounding the search for novel agents on the "primary" (i.e., well described) signal transduction pathways used by conventional agents may, by definition, provide only an incremental therapeutic benefit. Advances in molecular technologies (e.g., "gene chips") may geometrically increase the number of potential targets and uncover novel pathways contributing to the pathophysiology of depression.

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2. Kobak KA, Taylor LH, Dottl SL, Greist JH, et al: A computer administered telephone interview to identify mental disorders. JAMA 1997; 278(11):905–10
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with fluoxetine antidepressant treatment. Lancet 1997; 349(9065):1594–7
4. Skolnick P: Antidepressants for the new millennium. Eur J Pharmacol 1999; 375(1–3):31–40

SYMPOSIUM 105—CHANGING PERSPECTIVES FOR PSYCHIATRIC DIAGNOSIS: IMPLICATIONS FOR THERAPEUTIC INNOVATION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to consider impending changes in the basis of psychiatric diagnoses, understanding fundamentals of causal case reasoning, and its implications on the development of novel therapeutics from the perspectives of FDA, industry, and NIMH.

No. 105A
ALZHEIMER'S DISEASE SUBSYNDROMES

Peter V. Rabins, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 North Wolfe Street, Meyer 279, Baltimore, MD 21287-7279*

SUMMARY:

The validity of neuropsychiatric and behavioral syndromes of AD is supported by their consistency across patients, prevalence, response to treatment, and prognostic (predictive) validity. This presentation will present data from a random sample of nursing home residents and from a study of elderly residents of Cache County, Utah, that support the existence of "psychotic" and "depressive" subsyndromes of AD as well as a group of subjects in which single behavioral/neuropsychiatric symptoms exist.

No. 105B
PSYCHIATRIC SYNDROMES IN ALZHEIMER'S DISEASE: CAUSE OR EFFECT?

Brian Lalor, M.D., *Department of Psychiatry, St. James's Hospital, St. James Street, Dublin 8, Ireland*

SUMMARY:

Three major psychiatric syndromes have been suggested to occur in Alzheimer's disease (AD): psychotic, affective, and agitation/circadian rhythm disturbance. Factor analytic profiles of individual behavioral and psychiatric symptoms in AD point to the validity of the psychotic and affective clusters in this illness. Furthermore, plausible biological substrates relating to specific neurotransmitter deficits and regional brain dysfunction have been suggested for the association between these psychiatric syndromes and AD. While the psychosis of AD has some features in common with functional psychotic illnesses, there are distinctive aspects, notably, misidentifications and neuropsychological delusions. Likewise, there may be distinctive features to the depressive syndrome of AD, with motivational or apathetic symptoms predominating particularly early in the disease course. Furthermore, the positive response to cholinergic treatment of both the psychotic and depressive cluster lends some experimental support for a causative link between specific neurotransmitter deficits and the development of psychiatric syndromes.

No. 105C
FDA PERSPECTIVE: PSYCHIATRIC SYNDROMES IN ALZHEIMER'S DISEASE

Thomas P. Laughren, M.D., *HFD-120, Food & Drug Administration, 5600 Fishers Lane, Rockville, MD 20857-0001*

SUMMARY:

While psychiatric disturbances represent an important clinical component of Alzheimer's disease (AD), drug development in this disorder has largely focused on cognitive impairment. One obstacle in drug development for psychiatric aspects of AD has been the difficulty in identifying, defining, and naming the different clinical entities that fall under this broad umbrella. In general, two types of clinical entities are considered appropriate targets for new claims, i.e., specific diseases or syndromes, e.g., congestive heart failure or rheumatoid arthritis, or nonspecific signs or symptoms not unique to a single disease or syndrome, e.g., pain or fever. In either case, the FDA uses similar criteria to evaluate a proposed clinical entity as an appropriate target for a new claim, i.e., it must be accepted in the relevant clinical/academic community, it must be operationally definable, and it must identify a reasonably homogeneous patient group. At a recent meeting of the Psychopharmacological Drugs Advisory Committee, agreement was reached that a unique psychosis of AD could be defined and recommendations were proposed for the clinical studies needed to support such a claim. Further work is needed to define other psychiatric syndromes in AD.

No. 105D
DEVELOPMENT OF PSYCHIATRIC TREATMENTS: INDUSTRY CHALLENGES AND OPPORTUNITIES

Alan F. Breier, M.D., MC 541, *Eli Lilly and Company, Lilly Corporate Center DC 0538, Indianapolis, IN 46285*; Jamie S. Street, M.D.

SUMMARY:

As psychiatric disorders become more delineated from varying perspectives—genomic, pathophysiological, cultural, and etiological—the opportunity for disease management will expand. Recognition of individuals at risk, identification of potential preventive interventions, as well as treatment or curative measures, will provide multiple options for addressing patient therapy. In order to enhance the availability of therapeutic interventions to the clinical community, their development will require a strong alliance among researchers, regulatory agencies, and industry in defining target disease entities, identifying or developing appropriate rating instruments, and understanding desired outcomes. Alzheimer's disease (AD) provides a current example of employing this tripartite approach for striking an effective balance between rigorous definition of clinical disease processes and the pressing need to approve new pharmacological treatments.

Psychosis due to AD recently has been addressed by the FDA with input from experts in the field and industry. This area is evolving rapidly in both knowledge and potential therapies. Other psychiatric syndromes due to AD should be considered for upcoming roundtable discussions and consensus on probable indications and acceptable clinical approaches, in order to accelerate drug development and provide pertinent information to the medical community. This will foster efficient planning for clinical trials, and encourage thorough discussion of necessary methods and assessment tools.

No. 105E
SHIFTING PARADIGMS: PROMOTING RESEARCH

Jason T. Olin, Ph.D., *Adult and Geriatric Treatment, National Institute of Mental Health, 6001 Executive Boulevard, Room 7166, msc 9635, Bethesda, MD 20892-9635*

SUMMARY:

Why don't treatments ever work as well in actual practice as they do in clinical trials? For studies done in accordance with a regulatory model, the inclusions and exclusions are so limiting, the conditions of treatment delivery are so optimized, and the outcomes so narrowly defined, that generalization is virtually impossible. Research following the regulatory model is specifically geared to the legal requirements of drug approval and registration. There is now a need in the field to expand our research to a public health model. In a public health model, exclusion criteria are minimal (and based only on concerns for safety). Age, gender, and comorbidity are no longer the basis for exclusion, but rather present important dimensions to assure sample representativeness and clinical generalizability. Outcomes are broadly construed, to include performance, relationships (family, interpersonal etc.), function, disability, quality of life, morbidity, mortality, institutionalization, and health care resource use. Settings are widely selected from a full range of academic and nonacademic institutions, specialty and primary care, public and private facilities. Sample sizes are sufficiently large as to assure adequate power.

No. 105F
POLICY AND PSYCHOPHARMACOLOGY: A COLLABORATION PARADIGM THAT MEETS PUBLIC HEALTH NEEDS

Rick A. Martinez, M.D., *CNS Medical Affairs, Janssen Pharmaceutical, 1125 Trenton-Harbourton Road, Titusville, NJ 08560-0200*

SUMMARY:

In 1995 Janssen Pharmaceutics initiated a clinical development plan to seek a label change for risperidone by evaluating its efficacy and safety in patients with Alzheimer's Disease with behavioral disturbances. At the time no antipsychotic had been approved by the FDA for this purpose, yet physicians commonly prescribe this class of medication for a variety of behavioral phenomena in dementia.

Nineteen years earlier this unmet research need appeared on the federal radar screen at the 1978 President's Commission on Mental Health and the Elderly. Twenty-two years later, on March 9, 2000, the commission's legacy that shifted national research priorities for geriatric psychopharmacology culminated in an influential consensus of expert opinion. This presentation will review these events and interpret their relevance to the future of medication development.

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SYMPOSIUM 106—HOW PSYCHIATRY DEFINES EVIL

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant will have a greater understanding of psychiatry's efforts to define and understand evil, as well as its implications for civil and criminal law.

No. 106A
PSYCHIATRY'S EFFORTS TO DEFINE AND UNDERSTAND EVIL

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

SUMMARY:

Over time, occasional attempts have been made to intellectually distinguish wickedness. The closest in current nomenclature is antisocial personality disorder, although other constructs, such as psychopathy, sadism, and malignant narcissism have been employed.

This presentation reviews psychiatric literature to present earlier efforts of the mental health sciences to explain, define, and account for evil. Distinctions between these categories, as well as their relatedness to psychiatric illness, will be reviewed.

The author will also examine the reluctance within the mental health sciences to open the Pandora's Box of defining evil. Specific reference will be made to literature, as well as implications in forensic cases.

Finally, the symposium will discuss antisocial personality and psychopathy, the two most utilized diagnostic constructs associated with evil, illustrating their utility and limitation in addressing the needs of the court.

No. 106B
PERSONALITY AND EVIL: PSYCHIATRIC UNDERSTANDING

Michael H. Stone, M.D., *Department of Psychiatry, Columbia University, 225 Central Park West, #114, New York, NY 10024-6027*

SUMMARY:

Research and clinical experience have yielded some consistencies in perspective as to what represents evil. How this translates into personality has important implications for assessment and approaching treatment. This presentation will review current understanding of evil from a personality dynamics and psychoanalytic perspective.

The presenter will utilize case examples to illustrate the concepts raised. Confounding variables will be presented, as well as the interplay of psychiatric illness. The role of the environment as an external mediator on the expression of evil will also be factored into personality considerations.

No. 106C
PSYCHOLOGICAL TESTING AND EVIL

Bruce Ebert, M.D., *775 Sunrise Avenue, Suite 16D Roseville, CA 95661*

SUMMARY:

The current state of forensic mental health evaluation is increasingly appreciative of standardized scales that promote the consistent measurement of terms that relate to behavior and emotion. This

presentation will therefore include a review of evil as measured through psychological testing.

From the Hare Psychopathy checklist, to the PAI, to the Rorschach, a number of instruments illustrate the presence or absence of qualities associated with the different representations of evil. The presenter will explore the variety of assessment instruments available, the information they reveal, as well as their limitations in truly illuminating the qualities of diagnostic and psychodynamic significance.

No. 106D
THE DEPRAVITY SCALE: DEVELOPMENT AND POTENTIAL IN ASSESSMENT

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

SUMMARY:

In an effort to better quantify evil so as to bring specificity and the rigor of the scientific method to these designations, the author has developed The Depravity Scale. This device assesses the history of the defendant's actions before, during, and after the offense and incorporates his mental state and feelings as reflected by available history and evidence. In that regard, The Depravity Scale assesses the individual independent of his background and history, is color blind, and does not consider factors otherwise accounted for by other provisions of the statute.

The implications of research and designation of evil affect a variety of areas of the law. The participant will gain an understanding of the applicability of The Depravity Scale to areas of the law such as criminal law, personal injury, employment law, and family law. Discussants will explore critical challenges in defining evil and the sometimes uneasy relationship between psychiatry, morality, and theology.

REFERENCES:

1. Welner M: Defining evil. The Forensic Echo 1998; (2) 6: 4–12
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TELECOMMUNICATIONS SESSION 1—DIGITAL PROSPECTS: TELEPSYCHIATRY AND MULTIMEDIA APPLICATIONS

No. 1
EVALUATION OF A WEB-BASED INTERVENTION FOR DEPRESSION IN PREGNANT WOMEN

Sheila Marcus, M.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Riverview Building, Ann Arbor, MI 48109-0722;* Heather A. Flynn, Ph.D., Kristen L. Barry, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the complex issues involved in the detection and treatment of depression in pregnancy and the potential utility of computer-based interventions in a busy health care clinic.

SUMMARY:

In recent years, women have increasingly relied on the Internet to learn about important health care information. A number of Web sites have been developed that focus on issues related to pregnancy. Pregnancy and the postpartum is a vulnerable period for the onset or recurrence of depression. Despite the fact that depression is an extremely debilitating illness and may lead to a number of negative health and psychosocial outcomes during pregnancy, depression is underdiagnosed and undertreated. Most women do not seek specialty care for depression, but will be seen in primary care or obstetrics settings. Therefore, efforts aimed at improved detection and intervention for depression within the context of busy health care settings are critical.

We have developed a multimedia Web-based intervention for women at risk for depression to be administered in primary care clinics. This is a self-guided, confidential site that includes comprehensive information about depression including signs and symptoms, etiology, complicating factors, treatment options, how to find help, and a complete set of local and national referral sources. We will present results from a study evaluating the effectiveness of this intervention in reducing symptoms of depression, improving overall functioning, and increasing appropriate referral behavior. The discussion will center on the potential impact of this kind of an intervention on health outcomes and the doctor-patient relationship.

No. 2
USE OF A CD-ROM MULTIMEDIA INTERACTIVE SYSTEM TO TEACH INTERVIEWING SKILLS

Alfredo Calcedo-Barba, M.D., *Department of Psychiatry, University Complutense, Facultad Medicina Ciudad University, Madrid 28040, Spain;* Juan J. Lopez-Ibor, Jr., M.D., Maria I. Lopez-Ibor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the utility of the system in teaching interviewing skills.

SUMMARY:

In the session will be presented an innovative system designed to help medical students and general practitioners in learning interviewing skills. The system will be shown functioning. The system includes 1) video material with an unprepared dramatized interview performed by two family physicians. The complete interview is included in the CD-ROM, 2) brief on-line comments of what is happening in the interview, 3) detailed on-line comments that the student can read when he or she pauses the video reproduction. Once the student has finished the reading returns to the point in the video where he/she had paused, 4) A 40-page text with the basic elements of interviewing techniques. This text is illustrated with video clips to teach the student real-life situations, 5) a self-evaluation mode where the interview is reproduced without the online comments and multiple-choice questions are made. When the patients fails the answer the system explains which was the correct answer, 6) a bibliography of publications related to the field of interviewing skills. All these material has been inserted in a CD-ROM. The authors will discuss the development and advantages that this system brings to the academic community for teaching and evaluation purposes. It will be compared with the traditional systems such videotapes and analyzing interviewing transcriptions.

No. 3
PRISON TELEPSYCHIATRY: REALITIES AND PROSPECTS

Zebulon C. Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, 19 East 93rd Street, New York, NY 10128;* Susan Ducate, M.D., Robert D. Miller, M.D., William M. Tucker, M.D., Alexander Bardey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium participants will be able to describe how programs are developed and carried out, costs (equipment, telephone, and staff) in setting up and maintaining effective telepsychiatric services, the differences between such services and face-to-face encounters, and prospects for the growth of such services in prisons.

SUMMARY:

This symposium will present five widely varying experiences with telepsychiatry and prison systems. Four papers are set in state prison systems: Colorado, New York with women and psychiatry residents, New York with men and expert consultations, and Texas. One paper describes the very specific evaluations on New York City prisoners that must be done for outpatient commitment under Kendra's Law in New York State. All of the papers will describe a) equipment, b) staffing in corrections, inprison medical and mental health, and the remotely located telepsychiatry providers, c) positives and negatives in the liaisons among the three groups, d) the patients encountered and what was done for them, e) real costs in equipment and staffing, f) present status of projects, g) future plans. Generally, it is clear that staff time preparing for escorting patients to, during, and from telepsychiatry sessions, telephone costs, etc., may not be offset by the ease of conducting sessions once they are set up. All presenters will contrast their live patient and telepsychiatry experiences and comment on educational uses: interviewing, use of videotapes in supervision, etc. Outcomes vary from Colorado having stopped its program, while Texas now has full-time psychiatrists doing telemedicine exclusively.

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1. Marcus SM., Flynn HA., Barry KL. et al: Depression in pregnancy and postpartum: a review of critical issues. Postgraduate Obstetrics and Gynecology 2000; 20:1–7.
2. Chi-Lum B: Friend or foe? consumers using the Internet for medical information. J Med Pract Manage 1999; 14:196–198.
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TELECOMMUNICATIONS SESSION 2—DIGITAL SYSTEMS: INFORMATION SYSTEMS IN THE OFFICE

No. 4
ELECTRONIC MEDICAL RECORD: PSYCHIATRIC SURVIVAL TOOL FOR THE DECADE

Daniel A. Deutschman, M.D., *Behavioral Health Center, S.W. General Hospital, 18051 Jefferson Park Road, Middleburg Heights, OH 44130;* Arnold M. Rosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the clinical utility, implementation, costs, user and patient response, productivity and quality gains, opportunities for research, and future development of EMR developed and used by psychiatrists over the last decade; to understand the power of EMR to assist psychiatrists in facing the regulatory and reimbursement challenges of the next decade.

SUMMARY:

Electronic medical records (EMR) will play a major role in mental health care delivery in the future. EMR assist psychiatrists in meeting the challenge of Medicare and NCQA data regulations and declining managed care reimbursements. They also improve quality of care and practice productivity. We will compare and contrast two EMR developed and implemented by psychiatrists over the last decade: 1) Medication management system, prescription writing and medication tracking software updates prescription data files, prints prescriptions and tracks practice prescribing patterns. Features include the ability to understand directions, graph patient's entire medication history as a flowsheet and report when prescriptions will expire. 2) Behavior98, a comprehensive EMR, contains all of the elements of the clinical interview in electronic format. It offers prescriptions, lab requests, visit summaries, data analysis, diagnostic and medication decision support, outcome measures, patient data entry, electronic scheduling, and opportunities for clinical research.

We will discuss unique features, clinical utility, implementation issues, cost, user and patient response, productivity gains and future development plans. EMR will position psychiatrists to better face the regulatory, quality, and productivity challenges of the decade ahead.

No. 5
THE CAPER SYSTEM: PATIENT ASSESSMENT AND TREATMENT PLANNING SOFTWARE

Peter F. Fore, M.D., *VA Chicago HCS, P.O. Box 8195 MC 116AAI, Chicago, IL 60680;* Richard Weaver, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the benefits to clinicians, patients, and administrators of using computer software to generate progress notes, patient assessments, treatment plans, and outcome monitors.

SUMMARY:

CAPER (*C*omputer-assisted, *A*ssessment, *P*sychotherapy, *E*ducation and *R*esearch) is a PC-based software system for writing patient progress notes, treatment plans, clinical reports, psychological testing, clinical assessment, and tracking of outcome measures. It was developed at the Salt Lake City VA Medical Center by Richard A. Weaver, PhD. and his team. It has been used at the Salt Lake City VA and at the Chicago VA.

The CAPER system is clinician designed and oriented. It has more than 180 standardized patient assessment instruments and is customizable so that others can be added. Input can be by clinician, patient, or clerk with scoring and graphing by the computer. The results from these assessment tests are ideal for maintaining data on outcomes. The system also features progress notes with templating, an electronic treatment planner, and a report writer to ease documentation tasks for clinicians. All components can be customized. The report writer can be set up for standardized intake assessments. The system runs in a Windows environment and has an intuitive feel. It is designed to have multiple users and run on a network, though it can run on a single machine. In large systems, patient treatment plans and tests can be easily recalled as the patient moves from one treatment setting to another.

No. 6
BOOTING UP YOUR PRACTICE: COMPUTERIZED RECORD KEEPING IN PSYCHIATRY

Theron C. Bowers, Jr., M.D., *10600 Fondren 217, Houston, TX 77096*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize barriers in establishing a computer-based record-keeping system as well as recognizing benefits and areas for using a clinical electronic database system in a psychiatric practice.

SUMMARY:

Although the computer is a common tool in many or most psychiatric practices, its use remains confined to primarily administrative jobs such as billing and scheduling. As psychiatry is a cognitive-based speciality with a primary task of collecting and evaluating patient information, electronic database management has numerous potential benefits for psychiatrists in all areas of practice. This presentation will explore issues regarding computerized clinical database management in psychiatric practices.

This program will examine potential barriers and challenges in maintaining electronic records. The presentation will also illustrate the benefits and goals of an efficient computerized clinical system by demonstrating a patient-tracking computer program based on a relational database. Using this program, we will show the basic requirements of a patient-tracking system, such as records of progress notes, mental status examinations, and medications. We will also demonstrate more advanced and specialized features in tracking a patient's progress and monitoring medication side effects. Finally, there will be instructions on implementing a computerized record-keeping system in private practice with a focus on effectively utilizing data in a variety of clinical reports.

No. 7
INTERFACED INFORMATION SYSTEMS: NETWORKED OFFICE

Carmen Sugai, M.D., *4521 Jamestown Avenue #2, Baton Rouge, LA 70808;* Edward Sugai, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the benefits of interfaced, integrated, information systems in an outpatient office setting to help improve the business and clinical operation.

SUMMARY:

This session will help identify the benefits and uses for interfaced, heterogeneous information systems in an office setting. With the advent of reduced-cost computing, networked information systems

can help improve the overall efficiency of operations and also assist in collaborative treatment processes. The presentation will show how several different information applications can help in an office setting for assessment, measurement, charting, and billing. The topics will be relevant to practitioners dealing with managed care organizations and to allied health professionals. The demonstration will be PC-based but the concepts will apply to any networked office setting. This will apply to small office operations as well as departments that are part of a larger corporate information system operation.

REFERENCES:

1. McDonald CJ: The barriers to electronic medical record systems and how to overcome them. J. of the American Medical Informatics Assoc 1997; 4:213–221.
2. Tang PC, LaRosa MP, Gorden SM: Use of computer-based records, completeness of documentation, and appropriateness of documented clinical decisions. J of the American Medical Informatics Assoc 1999; 6:245–251.
3. Weaver RA, Sells JE, Christensen PW: Computer-assisted assessment, psychotherapy, education and research, in Mental Health Computing. Edited by Miller MJ, Hammond KW, Hile MG. Springer Press, 1996.
4. Weaver RA, Christensen PW, Sells J, et al: Computerized treatment planning. Hospital and Community Psychiatry 1994; 45:825–827.
5. Lieff JD: Clinical databases. Psychiatric Annals. 1994; 24:33–36.
6. Powsner SM: Clinical psychiatric software: limitation and problems. Advances in Medical Psychotherapy. 1993; 6:89–98.
7. Bazoli F: Putting patients at the center. Internet Health Care 2000.
8. J McCormack: Hardware lessons. Health Data Management 2000.

TELECOMMUNICATIONS SESSION 3—DIGITAL EFFECTS: TECHNOLOGY IN THE CLINICAL PRACTICE

No. 8
THE IMPACT OF ELECTRONIC PSYCHIATRIC RECORDS ON PATIENTS AND THE DOCTOR-PATIENT RELATIONSHIP

Heather A. Flynn, Ph.D., *400 East Eisenhower Parkway 2A, Ann Arbor, MI 48100-0740;* Sheila Marcus, M.D., Norman E. Alessi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should recognize the imminence of implication for the electronic medical records, the importance of incorporating the patient perspective, and the implications of the patient perspective on the doctor-patient relationship.

SUMMARY:

Information technology is moving at an extremely rapid pace. It is clear that policies and implications for all domains of human life are slow to follow. Health care is perhaps the most poignant arena in which to consider that technology critically affects people's lives. Health care information technology cannot be considered without simultaneously considering the impact on the patient and on the doctor-patient relationship. The tension between patient privacy and "need to know" as individuals are treated in a complex and integrated healthcare system will be one of the fundamental health care and information management debates of the next decade. The intimate nature of psychiatric practice raises immediate confidentiality concerns whenever information is shared electronically.

This presentation explores the impact of electronic psychiatric records on patients and their relationship with their health care providers. The presenters will describe the results of a study examining the patient perspective on the electronic medical record. The majority of patients surveyed expressed significant overall concern about the use of EMR. A number of specific concerns about confidentiality, stigma, and discrimination were also expressed by patients. The potential impact of patient perceptions regarding the EMR on patient disclosure and the therapeutic alliance will be discussed. The audience will be actively engaged in examining their own beliefs and feelings about electronic systems of information and will comment on their own patients' concerns and implications for the therapeutic alliance.

No. 9
DIGITAL PHENOMENOLOGY OF DEPRESSION

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 Medical Center Drive, Ann Arbor, MI 48104-6462;* Milton Huang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn about the potential applications of motion capture technology in the study of depression; to learn about the methodological issues that have to be dealt with in using motion capture systems to study depression.

SUMMARY:

Psychomotor alterations have long been noted to be an essential component of mood disorders. Reports by Burton, Kraepelin, and Bleuler noted the presence of psychomotor slowing among depressed and speeding up among manic patient. Yet the significance of these motor components is not clear. Some suggest that the motor component is the central deficit in depressive illnesses rather than mood. Alterations in motion have been used to predict response to treatment intervention and track treatment outcome. We are currently in the process of pursuing investigations concerning the potential role of motion alteration in depression. They include baseline psychomotor parameters in several motion protocols; gait, sitting-standing, and reach in depressed patients as compared to normals. To be studied are limb and body segments and angular velocity between normal and depressed populations.

Motion sampling is accomplished using a motion capture system by VICON, a three-dimensional motion measurement and analysis system comprising specialized camera, PC, and associated software. The system tracks the trajectories of a large number of retro-reflective markers in the field of view of five infrared video cameras. These studies have the potential to create a new methodology for the characterization of mood disorders using motion alterations of body motion as the principal component; create new paradigms of movement sampling, shorter in duration and specific per body segment, limb, or joint within an array of sampling protocols; and allow the creation of three-dimensional data sets that can be used both for morphometric analysis and the recreation of virtual humans.

No. 10
USING VIRTUAL REALITY TO TREAT ACROPHOBIA

Milton Huang, M.D., *Department of Psychiatry, University of Michigan, 1500 Medical Center Drive, Ann Arbor, MI 48104-6462*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants will understand how virtual reality can be used in phobia treatment and will recognize

some of the individual variables that affect how virtual exposure compares to in-vivo exposure.

SUMMARY:

Objective: The ability of virtual reality to simulate real environments has been used by many groups to treat specific phobias through exposure to feared virtual stimuli. This research seeks to compare the effect of virtual environments to real environments for exposure treatment.

Method: Subjects were diagnosed by structured interview for DSM-IV-specific phobia to fearful height. Baseline measures of fear were obtained with a behavior approach test including physiologic and subjective measures in a real environment. Subjects were then randomized to 90 minutes of in vivo, virtual, or relaxation treatment. Measures of change from the single session of treatment were obtained through a repeat approach test.

Results: In-vivo and virtual exposure can produce similar levels of subjective and behavioral change although individual variables affect this. Virtual exposure does not seem as effective in producing physiologic change.

Conclusion: In some cases, virtual reality based exposure can be as useful as tool as in-vivo exposure for treatment of phobias depending on individual characteristics and treatment goals. Further research is needed to confirm these findings.

Funding source: University of Michigan department of psychiatry

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8. Dantzler A, Osser DN: Algorithms for the pharmacotherapy of acute depression in patients with bipolar disorder. Psychiatric Annals 1999; 29:270–284.

No. 11
INTERNET ALGORITHMS FOR THE PHARMACOTHERAPY OF DEPRESSION: JAVA VERSION

David N. Osser, M.D., *Taunton State Hospital, 60 Hodges Avenue Extension, Taunton, MA 02780;* Robert D. Patterson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate new, platform-independent software that offers psychopharmacology consultation on patients who present with acute depression; to recognize the value of computerized algorithm-based disease management systems for clinical training, improving the effectiveness of patient care, and for outcome research.

SUMMARY:

In this presentation, we will show the updated flowcharts and clinical recommendations in the most recent version of the Algorithms for the Pharmacotherapy of Depression. This is one of the evidence-supported, computerized algorithms created in the Psychopharmacology Algorithm Project at the Harvard department of psychiatry. The present submission is the first JAVA version of the software for presenting these algorithms. JAVA is Sun Microsystems' programming language that is "platform-independent:" it can be run on any type of computer or over the Internet. Previous versions of the Harvard algorithms were in DOS, a language for IBM-type computers, and more recently in HTML, a basic Internet language.

Another new functionality of the depression algorithm in this JAVA version is the ability to provide consultation reports, showing the questions asked by the computer (the "virtual consultant") and the answers provided by the clinician, followed by the concluding recommendations. These reports can be added to patient records. The software also has editing tools for authors that make it much easier to make changes in the decision trees.

The presentation will also display some of the new prescribing support information available. We will present parameters for completing adequate trials of antidepressants, switching procedures, side-effect management, and an algorithm for dealing with noncompliance.

TELECOMMUNICATIONS SESSION 4—DIGITAL DANGERS: SEX, SUICIDE, AND ADDICTIONS ON THE WEB

No. 12
CAUGHT IN THE WEB: SEX, SUICIDE, AND ADDICTIONS ON THE INTERNET

Keith Cheng, M.D., *Department of Psychiatry, OP02, Oregon Health Sciences University, 3181 SW Sam Jackson Park Road, Portland, OR 97201;* Kyle P. Johnson, M.D., Joshua F. Boverman, M.D., Laura Proud, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of how Internet use can interact with psychopathology.

SUMMARY:

With each passing year, the World Wide Web gains more influence in commerce, communications, and entertainment. At the same time these Web activities have been linked to various negative outcomes. The purpose of this symposium is to broaden mental health professionals' awareness of how Internet use interacts with psychopathology, with the possible results of sexual exploitation, addiction, or suicide. This presentation will focus on four examples of Web-based activities: chat rooms, gambling, day trading, and pro-suicide Web sites. While these are not destructive by themselves, given certain circumstances, problems can arise. Pedophiles use adolescent chat rooms with the aim of gaining face to face encounters with children. Casino-style gambling, once limited by geography, is now available to anyone with a credit card and Internet access. Likewise, day trading opened the door for untrained individuals to trade stocks, but for those with addictive tendencies this can be financially disastrous. Finally, a suicidal individual can look for instructional sites on how to kill oneself. The presentation of this material will include a brief literature review, case studies, and examples taken from the Web.

REFERENCES:

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2. Strasburger VC, Donnerstein E: Children, adolescents, and the media in the 21st century. Adolescent Medicine 2000; 11:51–68.

Component Workshop 1
PHYSICIAN DISABILITY: TREATMENT, INSURANCE, AND CONFLICTS
APA Committee on Physician Health, Illness, and Impairment

Co-Chairpersons: Michael H. Gendel, M.D., *3300 East First Avenue #590, Denver, CO 80206–5808,* Linda Logsdon, M.D., *26111 West Fourteen Mile Road, Franklin Village, MI 48025–1949*
Participants: Richard F. Limoges, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand a disability insurance product, both for herself or himself, and for patients; (2) treat disabled physicians with enhanced ability to recognize the potential therapeutic pitfalls involved and potential ethical conflicts; 3) better prepare an independent disability evaluation; 4) understand the legal context of disabled physicians.

SUMMARY:

Dr. Limoges will present information about the extent of the problem of disabled physicians, the need for disability insurance coverage, and the importance of obtaining it early in one's career. He will review the nomenclature of disability (clinical and insurance related), review the types of disability policies, and what each means should disability occur. He will present examples of ethical conflicts that may arise for treating psychiatrists asked to communicate with the insurer.

Dr. Myers will discuss treating disabled physicians, including transference and countertransference feelings the psychiatrist may experience and how to manage them, secondary gain, the difficulties of helping the disabled psychiatrist return to work, and psychiatrists' limitations.

Dr. Gendel will review the principles and practice of independent psychiatric evaluations of disabled physicians, and information about other forensic aspects of disability, including legal precedents, ADA and accomodation, and licensure implications.

Each presenter will speak for 15 to 20 minutes, discussant 5 to 10 minutes. Audience participation: 1/2 hour discussion.

Workshop is for any psychiatrist, trainee, or medical student. Those in early career, and those who treat or examine disabled physicians are targeted.

REFERENCES:

1. Metzner, JL, Struthers DR, Fogel MA: Psychiatric disability determinations and personal injury litigation, in Principles and Practice of Forensic Psychiatry. Edited by Rosner. New York, Chapman and Hall, 1994 pp 232–241
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Component Workshop 2
CONTINUING THE DIALOGUE ON RACISM AND PSYCHOPATHOLOGY
APA Committee of Black Psychiatrists

Chairperson: Michelle O. Clark, M.D., *P.O. Box 347189, San Francisco, CA 94134–7189*
Participants: George L. Mallory, M.D., Carl C. Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) elaborate on the current controversy regarding whether or not racism is a mental illness and (2) formulate treatment strategies for correcting this behavioral disturbance.

SUMMARY:

The dialogue on race called for by our nation's leadership coupled with recent events and writing on the subject caused the committee to present a similar workshop last year. Due to the overwhelming response and continued professional and public attention to the issues, we agreed to continue to explore this. The presenters will review the rationale for proposing extreme racism (violence based upon racial hatred) as a mental illness. Opposing opinions that question such nosology and challenge the ability to treat these disturbances will be addressed. They will also lead the participants in discussion and formulation of treatment strategies for this behavioral disturbance.

REFERENCES:

1. Poussaint AF: They Hate. They Kill. Are they Insane? NY Times, August 26, 1999, p21
2. Bell CC: Racism: A symptom of the Narcissistic Personality Disorder. Journal of the National Medical Association 1980; 97(7):661–5

Component Workshop 3
MEDICARE AND MEDICAID: PROBLEMS AND PROGRESS
APA Medicare Advisory Committee

Chairperson: Edward Gordon, M.D., *388 Hardscrabble Road, North Salem, NY 10560*
Participants: Irvin L. Muszynski, Seth P. Stein, J.D., Lloyd I. Sederer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand problems in dealing with Medicare and Medicaid the interactions of the systems, billing and coding problems, audit and review problems.

SUMMARY:

The panel and the audience will interact in an ongoing discussion of problems in dealing with Medicare and Medicaid. These will include applications of correct coding, how to respond to pre and post payment audits, and appeals of denials variations in Medicare and Medicaid policy in different parts of the United States will be discussed. This session is intended for the assistance of individuals in private or group practices who are responsible for the treatment of patients insured by Medicare and other insurers either as primary or secondary. This is a presentation of the APA Medicare Advisory Committee.

REFERENCES:

1. Schmidt CW: CPT Handbook for Psychiatrists, second edition AMA, 2001

Component Workshop 4
THE GREAT BEYOND: MAKING CAREER DECISIONS AT THE END OF RESIDENCY TRAINING
APA Committee of Early Career Psychiatrists

Co-Chairpersons: Ronald C. Albucher, M.D., *2215 Fuller Road, 116A, Ann Arbor, MI 48105,* Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025–4749*
Participant: Samson J. Cho, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will have a clearer sense of how to think through various employment options, making better choices for their future careers.

SUMMARY:

Psychiatric residents spend their lifetime training and preparing to be psychiatrists one day, but what does a psychiatrist do in day to day work, and how do people make employment decisions that will "actualize" their full potential? Our panel of early career psychiatrists will discuss career options from a first-hand perspective, including the likes and dislikes of their choices, opportunity for continued growth, quality of life, salary, and "perks," among other topics. Tips for thinking through the various options, and interviewing for the position you want will also be covered. There will be time for audience participation as well. Represented options will include: private practice, community mental health, VA, corporate/administrative, fellowship training, and academia.

REFERENCES:

1. Schreter RK: Earning a living: a blueprint for psychiatrists. Psychiatric Services 1995; 46(12):1233–5
2. Lazarus A: Opportunities for psychiatrists in managed care organizations. Hospital & Community Psychiatry 1994; 45(12):1206–10

Component Workshop 5
THE INTERPRETATION OF DREAMS: FANTASY AND REALITY IN RESIDENCY TRAINING
APA/GlaxoWellcome Fellows

Chairperson: Michael A. Scarf, M.D., *University of Rochester, 300 Crittenden Boulevard, Box Psych, Rochester, NY 14642-8409*
Participants: Thomas G. Cobb, M.D., Rebecca A. Kornbluh, M.D., Mark S. Groves, M.D., Ariel K. Dalfen, M.D., Laura B. Dunn, M.D., Lyle B. Forehand, Jr., M.D., Joseph M. Smurda, M.D., Bernard J. Biermann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) identify common factors leading medical students to choose a career in psychiatry, (2) recognize current levels of satisfaction among psychiatric residents, (3) understand how factors influencing choice of psychiatry as a career may relate to current satisfaction.

SUMMARY:

There is no consensus in the literature regarding why students choose psychiatry as a career. As a corollary, concern about attracting students to psychiatry makes it important to understand how various dimensions of psychiatry residents' training experience compare with their expectations of training. To examine these issues, we conducted a multicenter survey of U.S. residents. We used a combination of the Resident Satisfaction Questionnaire in addition to items assessing residents' reasons for choosing psychiatry. We will discuss factors cited by residents as being the most influential in their choice of psychiatry. We will also describe residents' level of satisfaction with this choice and with specific aspects of their training. In addition, we will explore how residents' pre-training expectations of psychiatry correlate with current levels of satisfaction. Finally, we will propose recommendations for enhancing the quality of training experiences for psychiatry trainees. A better appreciation of factors influencing career choice as well as degree of satisfaction with that choice may help those interested in psychiatry training address specific areas that can enhance both training of current residents as well as recruitment of future trainees.

REFERENCES:

1. Elliott RL, Yadkowsky R, Vogel RL: Quality in psychiatric training: development of a resident satisfaction questionnaire. Academic Psychiatry 2000; 24(1):41–46

Component Workshop 6
PSYCHIATRISTS IN THE SCHOOLS: REDUCING THE IMPACT OF TRAUMA
APA Committee on Psychiatry and Mental Health in the Schools

Chairperson: Lois T. Flaherty, M.D., *18765 Kenlake Place, NE Kenmore, WA 98028*
Participants: Veronica L. Williams, M.D., Edward M. Stephens, M.D., Amy M. Ursano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the consequences of untreated trauma in school children and help schools develop effective intervention plans.

SUMMARY:

Schools are increasingly called upon to provide more than traditional educational services. The dramatic growth of school-based mental health programs is an illustration of the importance being placed on addressing social and emotional problems that constitute "barriers to learning." School interventions are an effective way to treat psychological trauma. This workshop is for mental health professionals experienced in working with children and adolescents. Systematic approaches will be described to help children who have been victims of natural disasters, community violence, and divorce.

While schools usually intervene quickly to help victims of trauma that captures the headlines, more isolated occurrences may be ignored, even though their impact is just as severe. Child and adolescent survivors have long-term as well as short-term needs. We will review both short-and long-term approaches with special emphasis on long-term interventions to promote recovery.

Over 50% of children in the U.S. will experience the trauma of parental loss through divorce or other reasons. Schools can provide valuable help to these children but they try to be neutral, so as not to be accused of partiality toward one parent or another. Dr. Stephens will discuss interventions based on over 30 years of clinical work.

Teachers can be of enormous help to children going through crises. While there are important differences between teachers and psychotherapists, teachers can play a therapeutic role with children, giving empowerment and a sense of support. We will describe how mental health consulation can help teachers help children in crisis.

REFERENCES:

1. Adelson SL: Psychiatric public health opportunities in school-based health centers. Adolescent Psychiatry 2000; 24:75–89
2. Weist, MD, Paskewitz, DA, Warner BS, Flaherty LT: Treatment outcome of school-based mental health services for urban teenagers. Community Mental Health Journal 1996; 32:149–157

Component Workshop 7
PSYCHIATRIC VIEWS ON TALKING ABOUT HOMOSEXUALITY TO KIDS
APA Committee on Gay, Lesbian, and Bisexual Issues

Chairperson: Jack Drescher, M.D., 420 West 23rd Street, #7D, New York, NY 10011-2174
Participants: Diana C. Miller, M.D., Daniel W. Hicks, M.D., Kenneth B. Ashley, M.D., Howard C. Rubin, M.D., Serena Y. Volpp, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate knowledge of the issues involved in talking to elementary school-aged children about gay and lesbian issues.

SUMMARY:

Teaching children about gay and lesbian identities remains a controversial subject. "It's Elementary" is an educational video designed to show parents and educators how children respond to such efforts. After viewing excerpts from the video, a panel of psychiatric experts will address several important issues with audience participation. These include, but are not limited to, the issues of age-appropriateness when talking about cultural beliefs regarding homosexuality, the differing cognitive capacities of children to process such information, and the developmental question of how children incorporate the moral values of the culture in which they live.

REFERENCES:

1. Cabaj R, Stein T (eds): Textbook of Homosexuality and Mental Health. Washington, D.C., American Psychiatric Press, 1996
2. Piaget J: The Moral Judgment of the Child. New York, The Free Press, 1965

Component Workshop 8
MAKE THE MEDIA WORK FOR YOU: TELEVISION INTERVIEW TIPS AND TECHNIQUES
APA Joint Commission on Public Affairs

Co-Chairpersons: Michael Blumenfield, M.D., *Department of Psychiatry, New York Medical College, 16 Donellan Road, Scarsdale, NY 20853,* Mary H. Davis, M.D., *Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232-5070*
Participants: William E. Callahan, Jr., M.D., John Blamphin

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to evaluate a media opportunity, prepare a communications objective and speaking points, and participate effectively in a television or other media interview

SUMMARY:

News media—newspapers, magazines, radio, television, and the new internet media—offer psychiatry an unprecedented opportunity to reach millions of people daily with positive messages about the reality of mental illnesses and the effectiveness of psychiatric diagnosis and treatment. The APA Division of Public Affairs reports a significant increase in requests from media for formal and informal interviews with psychiatric experts on a variety of subjects. District branches report a similar increase in interview requests. In this session, participants will gain first-hand experience in evaluating media opportunities, identifying their communications objective, and developing effective speaking points or "soundbites." Using workshop participant volunteers, professional media trainers will demonstrate appropriate interview techniques: how to deliver a brief 10-second soundbite, handle hostile questions, dress appropriately for the situation, and how to do effective radio and television interviews. Interview topics will focus on key APA issues: parity, scope of practice, patient protection, and confidentiality.

REFERENCES:

1. Blamphin J: How to Handle the News Media. Psychiatric Research Report 1996; 12(3)
2. Meeting with the media and staying out of trouble. San Francisco Medicine, (reprint), in Spokesperson Training Program Manual, AMA, 1989

Component Workshop 9
TO RETIRE OR NOT TO RETIRE, THAT IS THE QUESTION
APA Committee on Senior Psychiatrists and APA Lifers

Chairperson: Irvin M. Cohen, M.D., *15 Memorial Point Lane, Houston, TX 77024-7313*
Participants: Abram M. Hostetter, M.D., Hugo Van Dooren, M.D., Philip M. Margolis, M.D.

EDUCATIONAL OBJECTIVES:

The workshop is designed to (1) aid APA members debating retirement by defining the psychological positives and negatives of continuing the role of practicing psychiatrist vs. leaving the practice of medicine, and (2) aid those already retired to improve adjustments through learning what strategies minimize problems and predispose to successful retirement.

SUMMARY:

Close to 50% of physicians 50 years or older plan to leave medicine in the next one to three years, according to a new survey. This represents a change in the traditional pattern of physician retirement, and is likely the consequence of the numerous changes that have occurred in clinical practice in recent years. No medical specialty has been more affected by these changes than psychiatry, so it is probable that more psychiatrists than ever are now considering this major life change. Making the decision is often accompanied by serious conflict, and failure to plan adequately can be followed by psychologic complications. This workshop will discuss the various aspects of psychiatrist retirement in the hope of aiding those now in the process of considering it, as well as assisting the recently retired to minimize post-retirement maladjustment. The first presenter, Dr. A. M. Hostetter, is a successful practicing psychiatrist who is confronting the decision of whether or not to retire: if so, just when, if not, why not. Dr. I. M. Cohen will discuss the results and lessons learned from a recently completed statistically validated survey of the reasons for and reactions to retirement of 323 Houston, Texas physicians. Dr. H. Van Dooren will synthesize these presentations, to be followed by questions from the audience and interactive discussion moderated by Dr. P. M. Margolis.

REFERENCES:

1. Year 2000 Survey of Physicians 50 Years Old and Older. Texas Healthcare 2000; 3(6):18–19
2. Lees E, Liss S, Cohen IM, Kvale JN: Emotional Impact of Retirement on Physicians. Inst on Aging, U. Texas-Houston Health Sci Ctr, 2000, May, Submitted for Publication

Component Workshop 10
STUDENTS AND SCHOOLS AT RISK: WHERE IS THE VIOLENCE?
APA Alliance

Chairperson: Gail S. Fuller, R.N., *26548 North Shore Place, Hartford, SD 57033*
Participants: Betty Ann J. Muller, M.D., Joseph M. Bertrand, A.T.T.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) appreciate the multiple factors associated with violence, (2) develop an understanding of a child psychiatrist's role in school systems, (3) understand school system's legal responsibility when violence occurs in its environment, (4) be able to the legal system to assist school administrators in preventive measures against violence in schools.

SUMMARY:

Our elementary and high schools across the nation have the daunting task of educating our children and adolescents in an atmosphere of disappointing educational performance with tensions and suspiciousness between students and between teachers and students. The recent outbreak of lethal violence in several schools located in diverse communities in this country highlights the perceived failure of our school system and represents a shared nightmare.

Dr. Muller will present her experience in providing child psychiatry consultation in a variety of school settings. Mr. Bertrand will present his experience in providing legal counsel to schools, especially in regard to a high-profile case of school violence as well as legal paradigm for preventive violence. This workshop offers the audience an opportunity to view videotapes of several diversified school environments. The audience will be invited to identify the schools at the highest risk for outbreaks of violence. A discussion of risks for violence in school settings will ensue.

This workshop is appropriate for anyone interested in the educational environments of children and adolescents, including but not limited to social workers; psychologists; adult, child and adolescent psychiatrists; licensed counselors; educators; and parents.

REFERENCES:

1. Mattison R: School consultation: a review of research on issues unique to the school environment. Journal of the American Academy of Child and Adolescent Psychiatry 2000; 39:402–428
2. Schwab-Stone M, et al: No safe haven II: the effects of violence exposure on urban youth. Journal of the American Academy of Child and Adolescent Psychiatry 1999; 38:359–367

Component Workshop 11
MUSIC IN THE LIVES OF PSYCHIATRISTS
APA San Diego Psychiatric Society

Chairperson: Edward A. Siegel, M.D., *255 Hill St. Solana Beach, CA 92075-1141*
Participants: John P. Feighner, M.D., Dominick Addario, M.D., Stephen R. Shuchter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be dramatically sensitized to the relationship that music has in the lives of our patients and in the lives of the professionals who treat them. The attendee will learn how this relationship can be used to both add depth to the doctor-patient relationship and to also provide markers for therapeutic success.

SUMMARY:

From the womb to the tomb, our lives are intertwined with music. Exploring the relationship that each person has with music can often lead to greater knowledge and understanding of that person, as well as provide underutilized avenues to effective therapy.

This entertaining workshop will feature performances by four very different types of psychiatrists who have not been out of touch with the place that music can have in their own lives and in the lives of others. Renowned clinical researcher John Feighner, M.D., will begin the program with some classical and jazz piano. Then gerontologist and medico-legal specialist Dominick Addario, M.D., will follow with a Louis Armstrong trumpet presentation. Next, UCSD Director of Outpatient Psychiatric Services Steve Shuchter, M.D., will share some rock 'n roll featuring an appearance (or apparition) of Elvis. Finally, general outpatient psychiatrist Ed Siegel, M.D., will provide a musical montage on the piano before being joined by "the cast" and members of his regular sing-along group for a grand finale.

It is anticipated that a lively discussion among the participants and the audience will ensue. There are no special background requirements.

REFERENCES:

1. Campbell DG: The Mozart Effect: New York, Avon Press, 1997
2. McIntyre J: Notes on music. Psychiatric News 1994; 29:1

Component Workshop 12
A MODEL INFANT PSYCHIATRY PROGRAM FOR ABUSE AND NEGLECT CASES
APA Committee on Pre-School Children

Co-Chairpersons: Michael S. Scheeringa, M.D., *Tidewater Building-TB52, Tulane University, 1440 Canal Street, New Orleans, LA 70112,* Charles H. Zeanah, M.D., *Tulane University School of Medicine, Tidewater Building-TB52, 1440 Canal Street, New Orleans, LA 70112-2715*
Participants: Julie A. Larrieu, Ph.D., Anna T. Smyke, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) recognize the ingredients of one model infant psychiatry program designed to assess and treat abused and neglected children; (2) recognize that the developmental differences in this age group involve age-specific, parental, and parent-child relational factors; and (3) demonstrate knowledge of the treatment principles for infants and toddlers.

SUMMARY:

Charles Zeanah, M.D., an internationally-recognized expert in infant psychiatry, has directed a multidisciplinary team that assesses and treats abused and neglected children under four years of age for the last six years. This unique state-supported effort takes referrals directly from child protective service and works closely with that agency. Dr. Zeanah will provide an overview of how the program works and the assessment instruments. Dr. Larrieu, who has worked with the team from the beginning, will present the longitudinal outcome data showing the decrease in recidivism. Dr. Smyke will present the treatment program and discuss the advantages and disadvantages of working with infants and toddlers within the context of a state-supported child protection program. Infant psychiatry is a growing field and we hope to increase its exposure to APA members and to simultaneously introduce younger members to this field as a possible career choice. The audience will be provided with ample time to ask questions and present experiences from their personal work for discussion with the presenters.

REFERENCES:

1. Zeanah CH (ed.): Handbook of Infant Mental Health. New York, The Guilford Press, 2000
2. Zeanah CH, Boris NW, Scheeringa MS: Psychopathology in infancy. Journal of Child Psychology and Psychiatry 1997; 38:81–99

Component Workshop 13
THE INTERFACE BETWEEN RELIGION AND EXISTENTIAL PSYCHOTHERAPY
APA Committee on Religion, Spirituality, and Psychiatry

Chairperson: George T. Harding IV, M.D., *Department of Psychiatry, Loma Linda University, 11374 Mountain View Avenue, Dover Building, Loma Linda, CA 92354*
Participants: Irvin D. Yalom, M.D., T. Byram Karasu, M.D., William N. Grosch, M.D., Chaplain Clark S. Aist, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize some of the similarities and differences between existential psychotherapy and religious or spiritual approaches, (2)

understand how existentialist thinking challenges and advances both psychiatry and religion, and (3) express some of the limitations and pitfalls of an existential viewpoint.

SUMMARY:

This workshop is sponsored by the Committee on Religion, Spirituality and Psychiatry (formerly Committee on Religion and Psychiatry) to respond and interact with Dr. Irvin D. Yalom, the nineteenth Oskar Pfister awardee and the audience.

Panelists include a psychiatry department chair, a director of chaplain services, and a liaison from the American Association of Professional Chaplains (co-sponsor of the award) and a psychiatrist-chaplain.

They will address the issues raised by the lecture, articulate questions, and stimulate participation by the audience.

The workshop is to further the dialogue between psychotherapy and religious or spiritual issues for the enrichment of both the psychiatric profession and the religious community. Those assembled will be interested in how existential thought deals with issues of ultimate concern like death, freedom, isolation, and meaning. The relevance of existential thinking to psychiatry and the spiritual life of the patients we serve will be explored.

REFERENCES:

1. Yalom ID: Existential Psychotherapy. New York, Basic Books, Inc., 1980
2. Karasu TB: Spiritual psychotherapy. American Journal of Psychotherapy 1999; 53:2

Component Workshop 14
RBRVS CODING AND DOCUMENTATION UPDATE
APA Committee on RBRVS, Codes, and Reimbursements

Chairperson: Chester W. Schmidt, Jr., M.D., *Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, A4C, Baltimore, MD 21224-2735*
Participants: Tracy R. Gordy, M.D., Edward Gordon, M.D., Melodie Morgan-Minott, M.D., Joseph M. Schwartz, M.D., Steven S. Sharfstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participants will be knowledgeable about (1) current developments in coding including 90862; (2) potential changes in Medicare practice expense payments; and (3) the new HCFA documentation guidelines for E/M codes.

SUMMARY:

Each year brings surprising developments and changes to the Medicare program, which usually impact commercial insurers as well. The goals of the workshop are to inform practitioners about the most important changes that may affect their practices. This year's update will focus on the following issues: First, a component of physician payment under Medicare RBRUS is reimbursement for practice expenses. HCFA, directed by Congress, is modifying practice expense payments. The implications for practitioners and APA action will be discussed. Second, the code for psychopharmacologic management has come under intense scrutiny by third-party Medicare carriers across the country. The actions of the carriers will be reviewed and specific suggestions for coping with practice issues offered. Third, HCFA has just released the new documentation guidelines for E/M codes. The new requirements for documentation will be presented and discussed in relationship to the existing guidelines. Time will be reserved for questions and answers about the above topics as well as other issues raised by the participants.

REFERENCES:

1. CPT - 2000
2. CPT Advisor - July 1997
3. Schmidt CW Jr: CPT Handbook for Psychiatrists, Second Edition. Washington, DC, American Psychiatric Press, Inc., 1998

Component Workshop 15
XTC AND K, ETC.: THE NEW ABC'S OF ADOLESCENT SUBSTANCE USE
APA Committee on Treatment Services for Addicted Patients

Co-Chairpersons: Bernard J. Biermann, M.D., *University of Pittsburgh, 3811 O'Hara Boulevard, Pittsburgh, PA 15213-2593,* Sheila B. Blume, M.D., *South Oaks Hospital, 400 Sunrise Highway, Amityville, NY 11701*
Participants: Teresa Frausto, M.D., Ramon Solhkhah, M.D., Deborah Deas, M.D., Pamela Swedlow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate understanding of unique aspects of adolescent substance use, including how patterns of use differ from adult populations; (2) demonstrate understanding of "club drugs" and other recent trends among adolescent substance users; and (3) recognize assessment and treatment challenges in this population, including diagnosis, comorbidities, and treatment availability.

SUMMARY:

This workshop is geared toward clinicians that are involved in treatment of adolescents and young adults and will focus on aspects of substance abuse and treatment unique to this population. Issues to be addressed will include trends in substance use, including club drugs and the reemergence of heroin. Other issues will include diagnostic assessment and treatment challenges. We will focus on the difficulties in distinguishing novelty seeking behavior and experimentation from substance abuse and dependence. The issue of treatments will be explored, including availability and efficacy of treatments geared toward this population and the challenges associated with getting young patients motivated and engaged in treatment. To accomplish these objectives, clinicians with experience and expertise in the areas of child and adolescent psychiatry and addiction psychiatry will present brief talks focusing on an overview of recent trends among adolescent substance users, a look at "club drugs" (ecstasy, GHB, ketamine, etc.), and assessment and treatment of adolescents and young adults. The audience will be invited to participate in a discussion of these issues, including clinical experiences with adolescent substance users, assessment, comorbidities, and treatment successes and failures.

REFERENCES:

1. McDowell, DM: MDMA, Ketamine, GHB and the "club drug" scene, in Textbook of Substance Abuse Treatment. Edited by Galanter M, Kleber HD. Washington, DC, American Psychiatric Press, 1999
2. Weinberg NZ, Rahdert E, Colliver JD, Glantz, MD: Adolescent substance abuse: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry 1998; 37:252–261

Component Workshop 16
MISSION IMPOSSIBLE: TREATING THE UNDIAGNOSABLE CHILD
APA Committee on Children with Mental or Developmental Disorders

Chairperson: Carl B. Feinstein, M.D., *Department of Psychiatry, Stanford University, Stanford, CA 94305-5719*
Participants: Roxanne Dryden-Edwards, M.D., Gabrielle Carlson, M.D., Robert L. Hendren, D.O., Donald J. Mordecal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have gained increased expertise in the diagnosis and treatment issues involved in the care of severely disordered youngsters with mixed and pervasive patterns of psychiatric symptoms and developmental deficits.

SUMMARY:

This component workshop, sponsored by the Committee on Children with Mental or Developmental Disorders, addresses one of the most difficult challenges facing psychiatrists: diagnosing and treating severely disordered youngsters who meet criteria for several DSM diagnoses. Diagnostic uncertainty, sociological biases, difficulties applying neurodevelopmental principles, and the absence of established treatment guidelines are all major obstacles to a successful outcome. This workshop will begin with a case presentation by Dr. Dryden-Edwards of a severely disordered youngster with multiple diagnoses. This will serve as a stimulus for brief (10-minute) presentations by the other panelists. Dr. Carlson will review how the DSM system relates to this type of clinical situation. Dr. Hendren will discuss neurodevelopmental assessment strategies. Dr. Feinstein will review how sociologic and racial profiling interfere with treatment. Dr. Mordecai will address multimodal treatment. Each of the presentations will highlight unsolved problems in our field. The intent throughout is to generate discussion involving presenters and audience by raising questions. Thirty-five minutes are allotted for audience participation and dialog with presenters. This workshop is intended primarily for child and adolescent psychiatrists in active clinical practice.

REFERENCES:

1. Lewis, M: Borderline features in childhood disorders, in Psychosis and Pervasive Developmental Disorders in Childhood and Adolescence. Edited by Volkmar FR. Washington, D.C., American Psychiatric Press, Inc., 1996, pp 89–105
2. Cohen DJ, Volkmar FR: Issues for research, in Psychosis and Pervasive Developmental Disorders in Childhood and Adolescence. Edited by Volkmar FR. Washington, D.C., American Psychiatric Press, Inc., 1996, pp 249–286

TUESDAY, MAY 8, 2001

Component Workshop 17
DEFINING BOUNDARIES IN MEDICAL EDUCATION: ETHICS APPLIED BY ROLE PLAYING
APA Rhode Island Psychiatric Society's Committee on Women

Co-Chairpersons: Alison M. Heru, M.D., *Department of Psychiatry, Brown University/Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906-9980,* Christine E. Rayner, M.D., *662 Angell St., Providence, RI 02906*
Participants: Patricia R. Recupero, M.D., Marilyn Price, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand, apply, and communicate appropriate teacher/learner boundaries.

SUMMARY:

Doctor/patient boundaries, particularly sexual ones, have been a medical-legal issue for several years. Teacher/learner boundaries in medical education are similarly important. This workshop will begin with a summary of the legal and ethical principles associated with teacher/learner boundaries. The results of two surveys will be reviewed: (1) a survey of trainees and faculty as to the abstract delineation of the boundaries, and (2) a survey of trainees regarding experiences of boundary violations.

The workshop will then present a role-playing learning experience for trainees. Videotapes of role playing by residents will be presented. Improvised role playing helps the young physicians to pull on their own past experiences in medical school and residency, and to rework these with their colleagues. The exploration of boundary violations in a peer group facilitates learning in a nonthreatening supportive environment. The residents who have participated in this program have a greater depth of understanding about boundaries, and appreciate the role of the profession as a whole in monitoring physician/patient boundaries as well as teacher/learner boundaries.

Discussion will focus on the definitions of boundaries and their applications in medical school and residency training.

REFERENCES:

1. Wertheimer A: Exploitation. Princeton, 1996
2. Dorian BJ, Dunbar C, Frayn D, Garfinkel PE: Charismatic leadership, boundary issues and collusion. American Journal of Psychotherapy 2000; 54:(2)

Component Workshop 18
PREDICTION OF DANGEROUSNESS IN PATIENTS
APA Task Force on Psychiatric Aspects of Violence

Co-Chairpersons: Paul J. Fink, M.D., *191 Presidential Boulevard, C132, Bala Cynwyd, PA 19004-1216,* Bradley R. Johnson, M.D., *6812 N Oracle Road, Suite 114, Tucson, AZ 85704*
Participants: Renee L. Binder, M.D., Judith Becker, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able (1) to undue the myth that psychiatrists are unable to do accurate risk assessments for short-term violence, (2) to help the audience learn criteria by which they can distinguish between those who will and will not be violent, and (3) to understand the nuance of dangerousness in the mentally ill patient and how to discern imminent danger.

SUMMARY:

Many believe that psychiatrists do not have the ability to predict whether a patient will be violent or not. Although psychiatrists cannot predict who will be violent with 100% accuracy, they can do valid risk assessments concerning the likelihood of short-term violence by psychiatric patients. We also know what will exacerbate the possibility of violence, the most likely situation being an untreated schizophrenic who is also on alcohol or drugs and who has a history of violence. There are many such markers that will be discussed in the workshop. Adequate time will be available for members of the audience to actively participate in the discussion and give their own experiences.

Component Workshop 19
THE INDIVIDUAL VERSUS THE STATE: PATIENTS' PRIVACY AND ABUSES OF PSYCHIATRY
APA Committee on Misuse and Abuse of Psychiatry and Psychiatrists

Chairperson: Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Medicine, 1670 Clairmont Road, Decatur, GA 30033*
Participants: Abraham L. Halpern, M.D., John H. Halpern, M.D., Jose E. De La Gandara, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) recognize potential sources of misuse or abuse of psychiatry in existing laws related to government agencies' actions on individuals who may be undergoing psychiatric treatment, and (2) apply this knowledge and its implications to the appropriate management of the therapeutic encounter.

SUMMARY:

In the course of its work the APA's Committee on Misuse and Abuse of Psychiatry and Psychiatrists has come across a number of existing legal bodies or texts currently in full operation in the United States that may potentially contain sources of misuse and abuse of our profession and our professionals. The workshop will offer the audience an opportunity to become familiar with some examples of these texts, as well as potential situations, and specific actions taken by the courts. It is important to be constantly aware of these possible implications and make a conscious decision as to whether or not to share these concerns with the patient in the course of psychotherapeutic or other clinical encounters. At the same time, the impact of these actions on the strength of the therapeutic relationship, transferential and counter-transferential issues, and decisions by the patient as to the degree of openness and trust that he/she can use vis-à-vis the therapist will be examined. The relationship between the individual and governmental agencies is a "fact of life" in any kind of society or political system. Some examples of this nature will also be examined in the international arena. The audience (which may be composed of clinicians, trainees, members of the legal profession, and other mental health professionals) will actively participate in a question and answer period.

REFERENCES:

1. Danoff L: The Foreign Intelligence Surveillance Act: law enforcement's secret weapon. J Am Acad Psychiatry Law 2000; 28:213–224
2. Halpern AL: Use and misuse of psychiatry in competency examination of criminal defendants. Psych Annals 1975; 5:124–150

Component Workshop 20
LEGAL, ETHICAL, AND PRACTICE IMPLICATIONS OF DOT-COM PSYCHIATRY
APA Council on Psychiatry and Law and APA Committee on Information Technology

Chairperson: Jeffrey L. Metzner, M.D., *Department of Psychiatry, University of Colorado, 3300 East First Avenue, Suite 590, Denver, CO 80206-5808*
Participants: Ronnie S. Stangler, M.D., Nicholas Terry, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to provide mental health professionals with an overview of the rapidly evolving (e)mental health services with a focus on legal, ethical, and practice issues in B2B and B2C services and transactions.

SUMMARY:

Professor Nicholas Terry will provide an overview of the current technological advances that have resulted in the creation of vertical portals used for B2B and B2C services and transactions. These terms will be explained and illustrated in language that will not require computer expertise by the audience. Liability issues related to informational duties (e.g. "e-Tarasoff") and standards, informed consent, confidentiality, privacy, and others will be addressed.

Ronnie Stangler, M.D., will summarize ethical and practice issues related to the use of the Internet for providing mental health services. Her presentation will include issues related to e-mail, prescribing medications in cyberspace, ethical issues, and current/evolving practice guidelines developed by national organizations such as the AMA and the Psychiatric Society for Informatics.

Participation from the audience will be encouraged in order to obtain further resources and ideas in this rapidly changing area to help the sponsoring APA components (Council on Psychiatry and Law and Committee on Information Technology) conceptualize future policy recommendations in this area by the APA.

REFERENCES:

1. Terry NP: Cyber-malpractice: legal exposure for cybermedicine: American Journal of Law and Medicine 1999; 25:327–66
2. Wiesemann RV: Note: on-line or on-call? Legal and ethical challenges emerging in cybermedicine. Saint Louis Law Journal, Summer 1999

Component Workshop 21
THE COLOR OF DEATH: SUICIDE AND ITS MYTHS IN SPECIAL POPULATIONS
APA/Center for Mental Health Services Minority Fellows and APA/AstraZeneca Minority Fellows

Co-Chairpersons: N. Kalaya Okereke, M.D., *431 Yorkshire Street, Apartment #7, Salem, VA 24153-7041,* F. Ada Ifesinachukwu, M.D., *Department of Psychiatry, Texas A&M University School of Medicine, P.O. Box 17901, Austin, TX 78760-7901*
Participants: Serena Y. Volpp, M.D., Veronica L. Williams, M.D., Angelica Long-Harrell, M.D., Andres J. Pumariega, M.D., Debbie R. Carter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the prevalence of suicide in special populations, e.g., young African-American males, gays and lesbians, immigrant and indigenous populations; (2) understand the associated relevant factors to suicide in these populations; and (3) learn preventive skills to incorporate in training and practice.

SUMMARY:

Suicide is an increasing problem in many minority populations. Though it was previously shown that minorities have an overall lower rate of suicide than non-minorities, recent studies have shown that the incidence of suicide is rising dramatically in several minority populations. Thus, the myth that minorities are at a much lower risk for suicide that non-minorities requires revision.

Three examples of special populations in which suicide has become an increasing problem are young African-American males, gays and lesbians, and immigrant and indigenous populations. For example, although black youths have historically had lower suicide rates than whites, during 1980 to 1995 the suicide rate for black youths more than doubled. Also, the burden of secrecy associated with one's sexual orientation often causes significant distress, particularly when making one's sexual orientation known. This often results in stigma, social isolation, and even verbal and physical abuse, which can be associated with depression and suicide. Finally,

immigrants and indigenous peoples face challenges that are unique to their particular experiences in America. For example, acculturation and the related social stress play a role in the increased rate of depression and suicide in certain immigrant populations.

Suicide prevention in these special populations includes community outreach, dismantling barriers to treatment in these groups, and dispelling myths of both patients and practitioners. This session is geared toward residents, fellows, and practitioners of psychiatry. The audience will participate by open discussion with panelists and workshop presenters.

REFERENCES:

1. Suicide among black youths—United States, 1980–1995. MMWR—Morbidity and Mortality Weekly Report 1998; 47:193–6
2. Remafedi G: Sexual orientation and youth suicide. The Journal of the American Medical Association 1999; 282:1291–2

Component Workshop 22
THE COST OF PTSD: A CRISIS WE CAN PREVENT
APA Consortium on Treatment Issues

Co-Chairpersons: Robert F. Dobyns, M.D., *Building G, Unit 4, 4131 Spicewood Springs Road, Austin, TX 78759,* Sandra L. Bloom, M.D., *The Sanctuary Horsham Clinic, 13 Druim Moir Lane, Philadelphia, PA 19118*
Participants: Richard J. Kessler, D.O., Lawrence C. Sack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize: (1) the relationship between maladaptive infant-parent attachment, intergenerational neurophysiological changes, PTSD, and the prevalence of interpersonal violence; (2) the impact on MR/DD populations; (3) the clinical and cost effectiveness of a model for prevention of maladaptive attachment; and (4) ways to implement prevention programs.

SUMMARY:

This workshop is for clinicians interested in the prevention of maladaptive infant attachment, its abnormal neurobiology, subsequent PTSD, and the associated emotional and financial costs.

Disruption in early infant attachment due to child abuse and neglect is epidemic in our country. Attachment disruption in the first 36 months of life can cause significant neuroanatomical and neurochemical changes in the brain and subsequent PTSD. Rates of drug abuse, teen pregnancy, and violent behavior are also related to these disruptions in early infant attachment. Rates of various psychiatric syndromes are also increased in this population.

Special populations such as the MR/DD are especially impacted.

Since we know the genesis of PTSD due to child abuse and neglect, how can we prevent it?

Several effective models are in existence presently. They all use home visiting in various forms. An effective model uses home visiting from birth until the age of 60 months. The decrease in child abuse and neglect is substantial in measure. The decrease in subsequent teen and adult morbidity is also impressive.

Treatment of PTSD is not enough to stop the crisis. More cases are created each year than can ever be treated. Prevention using sound psychodynamic and neurobiological models is much more effective. Participants in the workshop will interact with the presenters to create strategies that encourage health care systems, political leaders, schools, and parents to implement effective prevention models.

REFERENCES:

1. Bloom S: Creating Sanctuary. New York, N.Y., Routledge, 1997
2. Zeanah, C: Handbook of Infant Mental Health. New York, N.Y., The Guilford Press, 1993
3. Olds D, et al: Long-term effects of home visitation on maternal life course and child abuse and neglect. JAMA 1997; 278(8):637–643

Component Workshop 23
FEAR, FANTASY, AND THE REALITY OF PSYCHIATRIC PRACTICE IN THE NEW MILLENNIUM FOR IMGS
APA Committee of International Medical Graduates

Chairperson: Gopalakrishna K. Upadhya, M.D., *Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*
Participants: Chowallur D. Chacko, M.D., Fructuoso R. Irigoyen-Rascon, M.D., Moitri N. Datta, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize fears and anxieties of IMGs after their residency training in setting up private practice, and getting into academia and research. The fantasies and realities of a constantly changing psychiatric world will be explored with concrete recommendations.

SUMMARY:

The assessment of workforce in psychiatry has been an intensely debated item in recent years. Earlier federal studies have indicated that psychiatry was a significant shortage specialty. However, a 1998 study in JAMA found that 40% of those reporting difficulties finding a job after residency were IMGs, with a disproportionately higher unemployment rate compared with the USMGs. The general misperception that somehow IMGs are inferior to their USMG colleagues adds to the stresses and strains of graduating residents and fellows limiting their choices in finding the right opportunities and pursuing interests in their chosen fields. Their own fears and fantasies further complicate the multiple difficulties faced by the frustrated, yet well trained and fully qualified IMGs.

This panel explores these vital issues concerning graduating residents and fellows with the realities of American psychiatry today. It elaborates on speakers sharing their personal and professional experiences with concrete remedial solutions in helping newer psychiatrists in attaining their goals. Case vignettes will be provided to make specific points so that myths concerning mismatches between programs and IMG psychiatrists will be hopefully diminished in the near future.

REFERENCES:

1. The Future Direction for Psychiatry: An Environmental Scan Prepared for The American Psychiatric Association by Katherine Snowden in collaboration with Drs. Munoz, Lazarus, Goln & Tasman, 1998
2. Mullan F, Politzer RM, Davis CH: Medical migration and the physician workforce: international medical graduates and American medicine. JAMA 1995; 17(19)

Component Workshop 24
STALKING: THE PSYCHIATRIC TRAINEE AT RISK
APA Committee of Residents and Fellows

Co-Chairpersons: Geoffrey M. Gabriel, M.D., *Fellow, Geriatric Psychiatry, Walter Reed Army Medical Center, Washington, DC 20307-5001,* Kira D. Stein, M.D., *760 Westwood Plaza, Los Angeles, CA 90024*
Participants: Alexa L. Bagnell, M.D., Jessica G. Roberts, M.D., Surender P. Punia, M.D., Jason M. Andrus, M.D., Samson J. Cho, M.D., Alexandra C. Oblora-Oputa, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the types of stalking and how to avoid escalation, and

(2) recognize unique aspects of stalking as it pertains to psychiatric residents.

SUMMARY:

Violence directed against psychiatrists is an established fact of clinical practice. While the topic of the emergent treatment and management of the aggressive patient is taught in residency training, most trainees have minimal experience in behavioral management of the threatening patient. This lack of training often leads to denial, immobilization, and avoidance in the face of physical or psychological threats against the trainee.

This workshop is designed to provide the trainee with background in one particular form of clinician directed violence—stalking. Topics to be covered include legal aspects, recognition, avoiding escalation, consultation and supervision, and countertransference management. Clinical cases demonstrating the above topics will be presented for discussion.

REFERENCES:

1. Lion JR, Herschler J: The stalking of clinicians by their patients, in The Psychology of Stalking: Clinical and Forensic Perspectives. Edited by Meloy JR. New York, Academic Press, 1998, pp 165–173
2. American Psychiatric Association Task Force on Clinician Safety: Clinician Safety (Task Force Report 33). Washington, DC, American Psychiatric Association, 1993

Component Workshop 25
NOVEL CAREER DEVELOPMENTS IN ADDICTION PSYCHIATRY
APA Council on Addiction Psychiatry

Co-Chairpersons: Lydia O. Fazzio, M.D., *110 East 13th Street, #4E, New York, NY 10003,* Marianne T. Guschwan, M.D., *155 E. 31st Street, Suite 25-L, New York, NY 10016*
Participants: Shelly F. Greenfield, M.D., Sheldon I. Miller, M.D., Jonathan I. Ritvo, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participant should be able to (1) identify current trends in recruitment for addiction psychiatry, (2) list factors influencing psychiatric career choices, (3) identify main sources of information for career development, (4) identify opportunities in addiction, (5) understand training requirements for an addictions career.

SUMMARY:

Addiction psychiatry offers exciting prospects for a fulfilling career at the cutting edge of today's developments in brain science and social policy. Addiction psychiatry encompasses a vast array of sociocultural issues stemming from the diversity of its patient population and the scope of the substance use problem. The field is constantly stimulated by new findings in neuroscience, pharmacology, and public policy. Fellowship opportunities are expanding nationwide to fill the increasing demand for trained addiction specialists. Addiction fellows can take advantage of generous funding opportunities and multiple roles in a variety of settings. These can range from clinical and academic careers to policy and administrative roles as well as several innovative options. The numerous opportunities ensure that it will be a dynamic, long lasting, prosperous career choice for those who select it. Our distinguished panel of nationally known experts in addictions, will spotlight areas of specialization including research, administration, academic/clinical, and nontraditional uses of addiction training.

In summary, this workshop will prove most valuable to residents and early career psychiatrists by helping them identify dynamic opportunities in a rapidly expanding field. There will be ample opportunity for questions and open discussions with panelists.

REFERENCES:

1. Substance abuse disorders: a psychiatric priority. Am J Psychiatry 1991; 148(10):1291–300
2. Position statement on training needs in addiction psychiatry. Am J Psychiatry 1996; 153(6):852–3

Component Workshop 26
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART I
APA Committee of Early Career Psychiatrists

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*
Participants: Jacqueline Melonas, J.D., Martin G. Tracy, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) know 10 key tips to avoiding lawsuits and malpractice, (2) know the three most frequent reasons why psychiatrists are successfully sued, (3) understand different types of malpractice insurance, and which one is best for you.

SUMMARY:

This is part one in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium, all on one day. It has been offered for the last three years and directed by faculty who have succeeded using this information. Even if you are not in private practice this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices.

In part one, we focus on risk management, avoidance of malpractice suits, ways to maximize quality, and high-risk issues that you must address in your practice. Drs. Callahan and Young are joined by experts in the field Jackie Melonas, R.N., J.D., vice president, Risk Management, Professional Risk Management Services, and Martin Tracy, J.D., President/CEO, Professional Risk Management Services. Other sessions cover coding for maximum billing, marketing, office location and design, streamlining your practice, and business/financial principles.

REFERENCES:

1. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996
2. Practice Management for Early Career Psychiatrists. APA Office of Healthcare Systems and Financing, 1998

Component Workshop 27
STUDIES ON INTEGRATION OF MENTAL HEALTH AND PRIMARY CARE IN THE VETERANS ADMINISTRATION
APA Consortium on Organized Service Systems

Co-Chairpersons: Laurent S. Lehmann, M.D., *Department of Veterans Affairs, (111C) VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420-0002,* Frederick G. Guggenheim, M.D., *UAMS, 4301 West Markham, Slot 554, Little Rock, AR 72205-7101*
Participants: Benjamin G. Druss, M.D., Bradford L. Felker, M.D., Lisa B. Dixon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to describe mechanisms of mental health and primary care service integration and measures of their efficacy. They will also be able to discuss the management of diabetes in patients with serious mental disorders.

SUMMARY:

This workshop will present several studies addressing the value of mental health integration with medical care. Dr. Benjamin Druss of the VA Connecticut (West Haven) Health Care System will present the results of a randomized trial of integrated primary care medical services for patients with mental disorders. Improved quality and health outcomes were found in the study patients. Dr. Bradford Felker of the VA Puget Sound Health Care System will address treatment of patients with depression and mixed depression and anxiety in primary care settings. Dr. Lisa Dixon of the VA Maryland (Baltimore) Health Care System will discuss a study of persons with schizophrenia, major affective disorders, and those without mental disorders on diabetes-related health behaviors, outcomes, and quality of care.

Dr. Frederick Guggenheim, chair of psychiatry at the University of Arkansas School of Medicine, and Dr. Larry Lehmann, VA chief consultant for mental health will serve as co-chairs for the workshop. Each presenter will have 20 minutes to present and answer questions from the audience. As discussant, Dr. Lehmann will take 15 minutes, allowing a further 15 minutes for questions and open discussion at the end of the program.

This program is intended for clinicians and health care services delivery researchers interested in integration of mental health and other medical care.

REFERENCES:

1. Dixon L, Weiden P, Delahanty J, et al: Diabetes and schizophrenia. Schizophrenia Bulletin, in press
2. Felker, B, Yazel J, Short D: Mortality and medical comorbidity among psychiatric patients: a review. Psychiatric Services 1996; 47:1356–1363

Component Workshop 28
PUTTING YOUR BEST FOOT FORWARD: THE ART OF SELF-PRESENTATION
APA Committee on Women

Chairperson: Smita H. Patel, M.D., *10701 Barnwood Lane, Potomac, MD 20854*
Participants: Donna E. Stewart, M.D., Leslie H. Gise, M.D., Marian I. Butterfield, M.D., Sara K. Gardiner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the importance of planning your career path, (2) identify specific self-presentation skills psychiatrists need for procuring employment, (3) identify components of an effective employment interview and contract negotiation, and (4) demonstrate how to speak more effectively to both professional and lay audiences.

SUMMARY:

As psychiatrists we need to be able to present ourselves effectively. Psychiatrists invest a great deal of time developing expertise in understanding and treating mental disorders and have considerable skill in helping patients develop and maximize their own potential. Paradoxically, psychiatrists get little training in planning their own careers and developing presentation skills that can foster their success. For example, presentation skills are crucial to procure successful employment and to maximize professional advancement. Presentation skills are also central to communicating to the public about our profession and combatting ignorance about mental illness in our communities. This interactive workshop will bring together faculty with expertise in career planning and development and review how to (1) plan your career path, (2) prepare a competitive CV, (3) conduct an effective employment interview, (4) negotiate a successful contract, (5) communicate effectively through public speaking, and (6) express your views to the media.

Developing our skills in self-presentation will help us as psychiatrists to express our views. This benefits both our profession and our patients. Workshop participants will have the opportunity to interact with faculty to strengthen their skills in these areas.

REFERENCES:

1. Myers IB, McCaulley MH: Manual: A Guide to the Development and Use of the Myers-Briggs Type Indicator. Consulting Psychologists Press, 1988
2. Bring Your Best: A Guide to Career Planning. Content developed by Kennedy MM. Communication Consultant's, Inc., 1989

Component Workshop 29
CAREER DEVELOPMENT IN ACADEMIC PSYCHIATRY FOR ASIAN PSYCHIATRISTS
APA Committee of Asian-American Psychiatrists

Co-Chairpersons: Nang Du, M.D., *Department of Psychiatry, San Francisco General Hosp, 1001 Potrero Avenue, Unit 7C, San Francisco, CA 94110-3518,* Jacquelyn B. Chang, M.D., *341 Spruce Street, Suite C, San Francisco, CA 94118*
Participants: Ming T. Tsuang, M.D., Francis G. Lu, M.D., Nallni V. Juthani, M.D., Edmond H.T. Pi, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participants should understand (1) the new changes in academic medicine and psychiatry, (2) the academic path options and opportunities in developing an academic career, (3) the importance of research, teaching, publication, mentorship, role models, networking, and strategies for academic career success.

SUMMARY:

The environment of academic medicine and psychiatry have changed profoundly in recent years due to the decline of government supports and funding to teaching medical schools and the radical transformation of the health care delivery system. Asian-American psychiatrists who consider careers in academic psychiatry need updated information and practical knowledge to navigate in the new challenging academic arena. This workshop will put together the lessons learned from experiences of academic Asian-American psychiatrists. It will examine academic path options and opportunities in developing academic careers. The workshop panel will discuss the importance of research, teaching, publication, mentorship, networking, and strategies for an academic career success. The role of organized psychiatry in networking for career development such as the APA National Minority Mentorship Network (NMMN) and APA minority groups' activities will be explored. The experiences from this workshop can be generalized and adapted to other ethnic minorities and other psychiatrists as well.

REFERENCES:

1. Lu FG, Lee K, Prathikanti S: Minorities in academic psychiatry, in Handbook of Psychiatric Education and Faculty Development. Edited by Kay J, Silberman EK, Pessar L. Washington, D.C., American Psychiatric Association, 1999
2. Yager J, Burt VK: A survival guide for aspiring academic psychiatrist: personality attributes and opportunities for academic success. Academic Psychiatry 1994; 18(4):197–210

Component Workshop 30
GENETICS, ETHNICITY, AND ALZHEIMER'S DISEASE
APA Council on Aging and APA Committee on Ethnic Minority Elderly

Chairperson: Josepha A. Cheong, M.D., *Department of Psychiatry, University of Florida Health Science Center, PO Box 100256, Gainesville, FL 32610-0256*
Participants: Jacobo E. Mintzer, M.D., Helen H. Kyomen, M.D., Kenneth M. Sakauye, M.D., Warachal E. Faison, M.D., Frank W. Brown, M.D.

EDUCATIONAL OBJECTIVES:

Participants in this workshop will be able to: (1) Identify the genetic factors associated with Alzheimer's Disease, (2) Understand the implications of genetics and ethnicity in the use of cognitive enhancers in the Alzheimer's Disease patient, (3) Understand the possible use of genetic information in clinical trials.

SUMMARY:

Alzheimer's disease (AD) is a slowly progressive degenerative dementia disorder characterized by gradual deterioration of cognitive, functional, and behavioral capacities. It is a devastating disease and the most common and prevalent memory disorder in the general population. In the past decade, scientists have discovered a genetic component to AD. Although the predictive value of genetic testing for AD is known, very little is known about the effect of a patient's genetic background on responsiveness to cognitive enhancers. Cognitive enhancers are being widely used in the general population but in varying degrees in ethnic minority populations with AD. The varying degree of cognitive enhancer usage may be attributed to various genetic, cultural, and economic factors.

To address the issue of genetics, ethnicity, and AD, the APA Committee on Ethnic Minority Elderly, along with several other sponsors, had developed and conducted the GRACE conference—"Genetics, Response and Cognitive Enhancers"—a mini-consensus conference bringing together experts from academia, industry, and clinical practice. The purpose of the GRACE Conference was to identify the biological and genetic basis for varying response to Cognitive enhancers among ethnic minority elderly. This workshop will serve to summarize and disseminate the findings of the GRACE conference to the general membership of the APA.

REFERENCES:

1. Hendrie HC, Hall KS, Hui S, et al: Apolipoprotein E genotypes and Alzheimer's Disease in a community study of elderly African Americans. Annals of Neurology 1995; 37, 118–120
2. Chang et al: Clinical and epidemiologic studies of dementias: cross-ethnic perspectives, in Psychopharmacology and Psychobiology of Ethnicity. Edited by Lin KM, et al. American Psychiatric Press Inc, 1993

Component Workshop 31
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART II
APA Committee of Early Career Psychiatrists

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*
Participants: Tracy R. Gordy, M.D., Chester W. Schmidt, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) understand the use of codes for insurance to accurately reflect your work with patients, (2) understand documentation requirements consistent with the codes you use, and (3) know where to go to get updated information on coding throughout your career.

SUMMARY:

This is part two in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium, all on one day. It has been offered for the last three years and directed by faculty who have succeeded using the information. Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices.

In part two we focus on the complexities of using the insurance industry's procedure codes to accurately reflect your work with patients. Even if you intend to have a fee-for-service, cash-based practice, many patients will require "superbills" for insurance so they can get reimbursed. There are documentation requirements for each code, and not understanding them and following them can leave you prosecuted for fraud. Drs. Callahan and Young are joined by the two nationally recognized experts on coding who work with APA and AMA to make these codes and guidelines work. Chester Schmidt, M.D., and Tracy Gordy, M.D., will present and answer questions.

REFERENCES:

1. Practice Management for Early Career Psychiatrists. APA Office of Healthcare Systems and Financing, 1998
2. Logsdon L: Establishing A Psychiatric Private Practice. Washington, D.C., American Psychiatric Press, Inc., 1985

Component Workshop 32
LEGAL ISSUES IN PSYCHIATRIC PRIVATE PRACTICE
APA Committee on Private Practice

Chairperson: Thomas K. Clesla, M.D., *1301 20th Street, Suite 212, Santa Monica, CA 90404-2054*
Participant: Daniel H. Willick, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the rules of confidentiality, the obligation to create and maintain medical records and what to do when patient records are requested or subpoenaed, become familiar with common situations leading to malpractice claims and with the principles of malpractice prevention, understand the special problem of licensing board investigations.

SUMMARY:

In a litigious and business-oriented health care climate, private practioners of psychiatry must be more than just clinically competent. They must also understand many legal issues. Daniel H. Willick, J.D., Ph.D., general counsel to the California Psychiatric Association and the Southern California and Orange County Psychiatric Societies, will address the most important of these issues.

Participants will learn the legal and ethical foundations of confidentiality including exceptions to the rules. They will review the obligation to create and maintain medical records emphasizing prescriptions and psychotherapy progress notes. They will learn what to do when patients' records are requested or subpoenaed.

Contractual relationships with payers, including HMOs, Medicare, and Medicaid programs will be covered. Participants will gain a clear understanding of other professional relationships, including

their rights and duties as members of hospital medical staffs and the obligations and risks inherent in working with nonphysician psychotherapists.

Mr. Willick will review common situations leading to malpractice claims, strategies for their prevention, and what to look for in malpractice insurance policies. He will also address the special problems associated with licensing board investigations.

The format of this workshop will provide ample time for interactive discussions of specific cases presented by workshop participants.

REFERENCES:

1. Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law, 2nd ed. Baltimore, Williams & Wilkins, 1991
2. McBeth JE, Wheeler AM, Sither JW, Onek JN: Legal and risk management issues in the practice of psychiatry. Washington, DC, Psychiatrists' Purchasing Group, 1994

WEDNESDAY, MAY 9, 2001

Component Workshop 33
DEVELOPING A STATEWIDE PSYCHIATRIC DISASTER PLAN
APA Committee on Psychiatric Dimensions of Disasters

Chairperson: Sheila G. Jowsey, M.D., *Department of Psych, Mayo Clinic, 200 1st St SW, Rochester, MN 55905-0001*
Participants: Alan Q. Radke, M.D., Mark D. Williams, M.D., David R. Johnson, M.D., Steve M. Kubas, M.D., Jennifer S. Lahmann, M.D., Joseph C. Napoli, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able (1) to better understand the psychiatrist's role in disaster mental health provision, (2) to recognize important steps to be undertaken in forming a statewide psychiatric disaster plan, and (3) to demonstrate an increased awareness of available resources for education and certification in disaster preparedness.

SUMMARY:

The Minnesota Psychiatric Society, through its Disaster Preparedness Committee, has formed the first formal psychiatric disaster plan in the nation. Although other groups of mental health professionals are already involved in this area, psychiatrists can play an important role in disaster prevention and planning. This workshop will describe steps taken in initiating our disaster plan so that other states may more easily generate interest in disaster preparedness, provide training for their members, and develop liaisons with local and statewide community resources. Topics presented include the process of forming a committee and developing a disaster plan, an overview of the role of psychiatrists and other mental health providers in a disaster, coordination with the American Red Cross as well as relevant state and federal agencies, providing relevant information to other health care providers in a disaster, and practical strategies for assisting on site during a disaster. We will also discuss making contact with national experts to help facilitate this process. Time will be available at the end of the presentations for input from others with experience or involvement in a similar process and for general questions.

REFERENCES:

1. Shalev AR: Debriefing following traumatic exposure, in Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos. Edited by Ursano R, McCaughey B, Fullerton C. London, Cambridge University Press, 1994
2. Fullerton CS, Ursano RJ: Posttraumatic Stress Disorder: Acute and Long-Term Responses to Trauma and Disaster. Washington, DC, American Psychiatric Press, 1997

Component Workshop 34
TRANSGENDER ISSUES: FEMALE TO MALE
APA Northern California Psychiatric Society's Committee on Lesbian, Gay, Bisexual, and Transgender Issues

Chairperson: Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco, CA 94110*
Participants: Robin A. Dea, M.D., Patrick Califia-Rice, M.A., Jamison Green, M.F.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to better assess gender identity and gender dysphoria, understand consequences of transitioning and other issues in female-to-male (FTM) transgendered people, and understand the controversy over the diagnosis of gender identity disorder.

SUMMARY:

A panel of mental health professionals and transgender activists will discuss challenges and controversies in the care of transgendered people, with a focus on female-to-male (FTM) transgender issues. Clinical issues to be presented include approaches to the presentation of gender dysphoria in psychotherapy; assessment of gender identity in patients considering transitioning; and discussion of consequences, risks, and benefits of starting hormonal therapy. Differences in transitioning for FTM transgendered people versus male-to-female, and variance in gender expression and sexual orientation within the FTM transgender community will be discussed. Barriers to mental health treatment (including economics, power dynamics, resistance, resentment, and fear) and approaches to overcoming them will be presented. Concerns in the use of gender identity disorder (GID) include diagnosing members of a socially stigmatized group based on impairment in social and occupational functioning, and negative impacts of the GID diagnosis on the transgender community. Alternatives will be proposed. Audience participation will be encouraged, with ample time alloted for questions and discussion of issues raised.

REFERENCES:

1. Califia P: Sex Changes: The Politics of Transgenderism. Cleis Press, San Francisco, 1997
2. Devor H. FTM: Female-to-Male Transsexuals in Society. Bloomington, IN, Indiana University Press, 1997

Component Workshop 35
USING PRACTICE GUIDELINES IN RESIDENCY TRAINING
APA Steering Committee on Practice Guidelines

Chairperson: John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*
Participants: David A. Garfield, M.D., Sheila H. Gray, M.D., Amarendra Das, M.D., Margaret T. Lin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have an understanding concerning the overall progress of the APA practice guidelines effort and obtain feedback/answer questions on the use of the guidelines in residency training and guideline dissemination issues.

SUMMARY:

The APA practice guidelines project has moved forward using an evidence-based process designed to result in documents that are both scientifically sound and clinically useful to practicing psychiatrists.

A residency training module was developed recently whereby psychiatric residents taught each other practical application of the APA practice guidelines. Data on the effectiveness of this training module will be presented.

Other applications of residency training will be presented via the resident perspective including educating residents about the concept of practice guidelines and their use in improving quality of clinical care, educating residents about an evidence-based approach to clinical care, and case studies.

Persons attending the workshop are invited to comment on issues relating to dissemination of practice guidelines to psychiatric residents.

REFERENCES:

1. Cabana MD, Rand CS, Powe NR, Wu AW, et al: Why don't physicians follow clinical practice guidelines? A framework for improvement. JAMA 1999; 282(15):1458–65
2. Christakis DA, Rivara FP: Pediatricians' awareness of and attitudes about four clinical practice guidelines. Pediatrics 1998; 101:825–30

Component Workshop 36
PSYCHIATRY IN THE NEUROSCIENCE CURRICULUM: PROMISE AND PERIL
APA Committee on Medical Student Education

Chairperson: Carl B. Greiner, M.D., *UNMC Department of Psychiatry, 600 South 42nd Street, P.O. Box 985575, Omaha, NE 68198-5575*
Participants: H. Jonathan Polan, M.D., Linda F. Pessar, M.D., Kristin J. O'Dell, M.D., Michael J. Vergare, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify both "best practices" and errors in integrated curriculum design.

SUMMARY:

Developing an integrated curriculum has been a major issue in health science education. "Best practices" included significant preparatory work by faculty and students. Faculty attended lectures by other presenters and participated in team teaching. Student test scores were monitored for learning success.

Psychiatry is increasingly being taught as part of a neuroscience curriculum. The integrated teaching of brain and mind with improved clinical correlations is promising. However, the perils include poorly considered curricular formulations, such as combining psychiatry and orthopaedics teaching.

Dr. Polan will review the neuroscience curriculum at Cornell Medical School, which has effectively included psychiatry. Dr. Pessar will discuss the challenges of designing a new neuroscience curriculum. Dr. O'Dell will present learning concerns from a resident perspective. Dr. Greiner will provide a critique of "wrong directions" taken in curriculum development and "warning signs" for educators. Dr. Vergare will host the discussion.

Although a prime audience will be current educators, medical students and residents would find this a helpful way to conceptualize their learning experiences. Significant time for group discussion will be available.

REFERENCES:

1. Polan JH: Acquired immunodeficiency syndrome: a biopsychosocial paradigm of illness, in Behavioral Science for Medical Students. Edited by Sierles FS. Baltimore, Williams and Wilkins, 1993
2. Lewin LO: Performance of third-year primary-care-track students in an integrated curriculum at Case Western Reserve University. Acad Med 1999; 74(1 Suppl):S82–89

Component Workshop 37
MIND, BRAIN, AND ENVIRONMENT: HOW CAN CLINICIANS ADDRESS SOCIAL ILLS?
APA Committee on Poverty, Homelessness, and Psychiatric Disorders

Chairperson: Hunter L. McQuistion, M.D., *Project Renewal Incorporated, 200 Varick Street, New York, NY 10014-4810*
Participants: Carl I. Cohen, M.D., Carles Muntaner, M.D., Leslie A. Horton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will learn how economic and other social factors influence individual and community mental health, fostering more effective clinical intervention and patient advocacy.

SUMMARY:

The biopsychosocial model of psychiatry is ascendant and psychiatrists routinely seek to understand how their patients' problems are exacerbated or caused by environmental stress. However, especially if the stressors are chronic, persuasive, and apparently nonspecific, it can be challenging to unravel just how they influence patients' mental health. This workshop will focus on how macro-environmental stressors, particularly those of economics and class, have profound effects on general mental health, as well as the manifestation of psychiatric disorders. The presentation will augment clinical psychiatry with social epidemiological and anthropological perspectives and accomplish this by presenting clinical case material and data concerning the interaction of the environment with mind and brain. As a result, it will help the audience fully integrate these broad social stressors into case formulation and will lead to exploring how psychiatrists can help their patients, both clinically and as advocates. This, in turn, will evoke discussion of how such activity has implications for psychiatry's role within society.

REFERENCES:

1. Cohen CI: Overcoming social amnesia: the role for a social perspective in psychiatric research and practice. Psychiatric Services 2000; 51:72–78
2. Link BG, Pholan J: Social conditions as fundamental causes of disease. Journal of Health and Social Behavior (Extra Issue) 1995; 80–94

Component Workshop 38
CAREER CHANGE FOR PSYCHIATRISTS AND PATIENTS YOUNG AND OLD
APA Committee on Psychiatry in the Workplace

Chairperson: Harry Prosen, M.D., *Department of Psychiatry, Medical College of Wisconsin, 9455 W Watertown Plank Road, #1066, Milwaukee, WI 53226-3559*
Participants: Leonard T. Sperry, M.D., Marcia Scott, M.D., Stephen H. Heidel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to assess work-related illness and distress in patients and colleagues, assist patients and colleagues in anticipating and managing career shifts related to development and job change, and assist organizations

in recognizing and dealing with the impact of organizational change on health and development.

SUMMARY:

Career change is commonplace today because of dramatic positive changes in health, longevity, the nature of illness, and the nature of the work itself over the past 20 years. Young psychiatrists face new demands as they fill complex roles in business organizations and must deal with language and value differences. Mature physicians face changing interests rather than simply retirement. Patients cope with shifting supervision, job demands, and technology as work organizations merge or downsize. They often experience failure, anger, disaffection, depression, or physical illness that leads to disability or premature retirement. Employers both suffer from and contribute to workers' emotional and behavioral difficulties and need assistance in moderating the impact of work and organizational change on employee health and work function.

The Committee on Psychiatry in the Workplace will address the changing needs of psychiatrists in dealing with their own and their patient's work and developmental problems. The discussion will also cover approaches to consulting with employers on job and organizational changes that impact employee health and disability.

REFERENCES

1. Lowman RL: Counseling and Psychotherapy of Work Dysfunctions. Washington, DC, American Psychological Association, 1993
2. Sperry L: Corporate Therapy and Consulting. New York, Brunner-Mazel, 1996

Component Workshop 39
CAREER CHOICES IN PSYCHIATRY
APA Assembly Committee of Area Member-in-Training Representatives

Co-Chairpersons: Mary Ann Schaepper, M.D., *3130 Sawtelle Boulevard, Apt 305, Los Angeles, CA 90066-1438,* Cathryn A. Galanter, M.D., *190 Bleecker Street, #24, New York, NY 10012*
Participants: Barry W. Wall, M.D., Patricie A. Harris, M.D., Blaine S. Greenwald, M.D., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will recognize (1) several pros and cons of a career in general, child and adolescent, forensic, and addiction psychiatry; (2) several pros and cons in choosing a private, academic, community, or managed care setting; (3) how choosing a fellowship or general practice, and in which setting, could impact their career.

SUMMARY:

Not only are more specialty training programs available to psychiatric trainees, but as well the choices in which to practice continue to grow. Residents must ask themselves: Should I specialize or not, and then, in which work setting will my career goals best be met? This workshop will (1) help residents learn more about three specialty areas in psychiatry—child and adolescent, forensics, and addictions; (2) help them learn more about four work settings—private, community, academic, and managed care; (3) help them formulate questions about deciding between a general psychiatric practice and a subspecialty; (4) help them formulate questions about which work setting suits them; (5) give them suggestions about what they can do now to help decide. After a brief introduction, several early career psychiatrists will describe their fields, and how they made their career decisions. They will discuss why they chose the field they did, what post-residency training that they pursued, and the pros and cons of their fields. In addition, they will discuss why they chose the work setting they did, and the pros and the cons of each. Next, there will be an interactive exchange when participants can ask questions of the panelists. During the final half hour, attendees will be divided into small groups led by each of the four panelists. Participants will join the group that most interests them for a targeted exploration of that field. They can rotate between groups to get more information about each.

REFERENCES

1. Kaplan HI, Sadock BJ: Synopsis of Psychiatry. Baltimore, MD, Williams and Wilkins, 1998
2. American Medical Association, Graduate Medical Education Directory 2000–2001, Chicago, IL

Component Workshop 40
NEW REGULATORY REQUIREMENTS FOR SECLUSION AND RESTRAINTS
APA Committee on Standards and Survey Procedures

Chairperson: Charles E. Riordan, M.D., *Hospital of St. Raphael, 1450 Chapel St, New Haven, CT 06511-4405*
Participants: Robert A. Wise, M.D., Rachael Weinstein, M.P.A., Nicholas Meyers, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to identify key changes in regulatory requirements and accreditation expectations in the area of seclusion and restraint, and have the knowledge to implement appropriate systems in inpatient and residential facilities to meet these new requirements.

SUMMARY:

Over the past few years the regulation of seclusion and restraint in both general hospitals, psychiatric hospitals, and residential care settings has been a major focus of national attention following a series of articles in the Hartford Courant. The response to these articles included legislative reaction by the federal government and regulatory actions by HFCA creating new conditions of participation in the Medicare program. The Joint Commission has also created new standards in this area that are reflective both of its concerns for quality and its need to have equivalent standards to those of HFCA in order to enable hospitals to achieve "deemed status" through its processes. The American Psychiatric Association has been active in advocating for clinically reasonable strategies to protect patient's safety while recognizing the valid clinical need for seclusion and restraints in many circumstances. Conflicting standards and public demands have sometimes made clinical practice difficult. The need to find practical ways to conduct good clinical care while adhering to a variety of regulatory demands has become increasingly challenging over the last 24 months. Discussants will present disparate views of this complex issue.

REFERENCES

1. US reconsiders use of seclusion and restraints in psychiatric patients. BMJ 1999; 10:319(7202):77
2. Jones DW: Pennsylvania hospital continues to reduce seclusion and restraints. JT Comm Perspect 1997; 17(2):17

Component Workshop 41
HOW TO ENHANCE MOTIVATION IN PATIENTS WITH SUBSTANCE ABUSE PROBLEMS
APA Committee on Training and Education in Addiction Psychiatry and American Academy of Addiction Psychiatry

Co-Chairpersons: Jonathan I. Ritvo, M.D., *Department of Psychiatry, University of Colorado, 4200 East 9th Street, Denver, CO 80262,* Richard S. Schottenfeld, M.D., *CMHC/ SAS, 34 Park Street, New Haven, CT 06519*
Participants: William M. Greenberg, M.D., Joyce A. Tinsley, M.D., David R. McDuff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to determine a substance-abusing patient's stage of change and identify and use stage-specific strategies for enhancing motivation.

SUMMARY:

The session will provide an overview of the stages-of-change model and motivational enhancement techniques. It will review research data supporting the efficacy of motivational interventions in a variety of populations and practice settings. Case-based presentations will be used to illustrate stages of change and motivational enhancement techniques. The session will use interactive modalities such as role playing, video, or audiotapes to give participants an opportunity to develop skills in using motivational enhancement techniques. Discussion will also be directed to (1) problems encountered by participants in clinical situations and (2) opportunities for teaching this as a structured and measurable brief psychotherapy skill in training medical students and residents. This session is intended for practicing clinicians and trainees who wish to refine their ability to engage patients with substance abuse problems.

REFERENCES

1. Miller WR, Rollnick S: Preparing people to change addictive behavior. New York, NY, Guilford Press, 1991
2. Miller WR, Zweben A, DiClemente CC, Rytcharik RG: Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence. Rockville, MD, NIAAA Project MATCH Monograph Series Vol. 2. NIH Publication No. 94-3273

Component Workshop 42
A COLLABORATIVE EFFORT TO DEFINE AND MEASURE PSYCHIATRIC COMPETENCIES
APA Council on Medical Education and Career Development

Chairperson: Nyapati R. Rao, M.D., *Department of Psychiatry, Brookdale Hospital, One Brookdale Plaza, Brooklyn, NY 11212*
Participants: Sherwyn M. Woods, M.D., Sheldon I. Miller, M.D., James H. Scully, Jr., M.D., Ronald O. Reider, M.D., Marijo B. Tamburrino, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should able to understand the background for the development of the emphasis on physician competencies and appreciate the collaborative efforts of various organizations in psychiatry to define and measure competencies in our field.

SUMMARY:

This workshop is about competencies, a term that has practically swept from nowhere into talk about psychiatric education and now dominates it. What does this term really mean? Where does it come from? What effects will it have, and when, on residency, medical student and subspecialty training? In response, the Accreditation Council on Graduate Medical Education (ACGME) has endorsed six general competencies for residents and charged individual specialties to define these competencies in a manner that is germane to that specialty and develop methods of assessing them. The competencies are in the areas of patient care, medical knowledge, interpersonal and communicational skills, professionalism, practice-based learning and improvement, and systems-based practice. In psychiatry, representatives of several organizations, including the American Board of Psychiatry and Neurology, the Residency Review Committee, the American Association of Directors of Psychiatric Residency Training, the American Academy of Child and Adolescent Psychiatry, and an APA Task Force on Competency in Graduate Education are involved in defining and developing methods of measuring these core competencies. In this workshop the background information on psychiatry's interest in competency will be provided and the new RRC requirements will be examined. Representatives of the organizations mentioned above will discuss the competency initiative from their respective organizations' perspectives. Ample time will be available for discussion.

REFERENCES:

1. Yager J, Borus JF, Robinowitz CD, Shore JH: Developing minimal national standards for clinical experience in psychiatric training: How many patients of what type should residents evaluate and treat prior to graduation and certification? Am J Psychiatry 1988; 145:1409–1413
2. Yager J, Docherty JP, Tischler GL: Preparing psychiatric residents for managed care: Values, proficiencies, curriculum and implications for psychotherapy training. Journal of Psychotherapy Practice and Research 1997; 6:108–122

Component Workshop 43
HISPANICS AND ALTERNATIVE MEDICINE
APA Committee of Hispanic Psychiatrists

Chairperson: Oscar E. Perez, M.D., *1400 North El Paso Street, Building A, El Paso, TX 79902*
Participants: Alberto G. Lopez, M.D., Ricardo P. Mendoza, M.D., Roberto Lewis-Fernandez, M.D., Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the common herbal medications used by Hispanic patients, better understand the scientific literature supporting benificial claims of these herbs, and should be better equipped to diagnose and treat psychiatric conditions among Hispanic Americans.

SUMMARY:

Hispanics have so many things in common, and it is not only language. There are beliefs and the superstitions our ancestors used to believe in such as herbal remedies, forces of nature, and forces out of this world, and they are passed from generation to generation. Curanderismo, espirituismo, santeria, and use of herbs are some of these examples.

We are living in an era of science and technology, but we still find ourselves believing in our grandmother's remedies. We can follow doctor's instructions, but still look for other alternatives or solutions.

So what do we American Hispanics believe in? How does it affect our lives?

The purpose of this workshop is to give a better understanding of alternative healing practices, which ones are used, and how they are used.

At the end of this presentation, the participant will be better equipped to diagnose and treat psychiatric conditions among Hispanic Americans.

REFERENCES:

1. Ruiz P: Assessing, diagnosing and treating culturally diverse individuals: a Hispanic perspective & nbsp. Psychiatric Quarterly 1995; 66 (4):329–341
2. Garrison V: Doctor, espiritista or psychiatrist? Health-seeking behavior in a Puerto Rican neighborhood of New York City. Medical Anthropology 1977; 1(2):65–191

Component Workshop 44

SUCCESSFUL MODELS OF PSYCHIATRIC CARE IN THE NURSING HOME

APA Committee on Long-Term Care and Treatment for the Elderly and APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly

Chairperson: Deborah A. Banazak, D.O., *Michigan State University, A231 East Fee Hall, East Lansing, MI 48824*
Participants: Judith H. W. Crossett, M.D., Colleen J. Northcutt, M.D., Sharon S. Levine, M.D., Jacobo E. Mintzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to have increased awareness of new innovative models of mental health service delivery for nursing home patients, and be able to discuss barriers to mental health service delivery in nursing homes.

SUMMARY:

Mental illness is a significant problem in the nursing home setting, with many patients experiencing psychiatric symptoms. Mental health needs are currently poorly addressed in many regions due to financial, attitudinal, and geographical barriers. Obtaining efficient competent psychiatric consultation in a community nursing home can be difficult. Need exists to think "out of the box" in terms of creative solutions for this dilemma. This workshop will present several innovative models of mental health service provision in the nursing home setting. Telemedicine offers one such solution to access and geographical barriers by affording expedient access to expert care. Dr. Jacobo Mintzer will present a current project using video cameras within the nursing home to provide a media for psychiatric consultation. Second, we will present a collaborative model using nurse practitioners to provide mental health evaluation and treatment as another means to expand psychiatric service delivery. Finally, Drs. Levine and Northcott will describe the unique characteristics of international health care by describing the Canadian model of nursing home consultation-liaison. Barriers, advantages, and applications for each model will be discussed throughout the workshop.

REFERENCES:

1. Banazak DA, Glettler E: From policy to practice: physician's views on OBRA: mental health resources in long-term care. JAMDA 2000; 1:14–20
2. Greene JA, Loebel P: Manual of Nursing Home Practice for Psychiatrists. Washington, DC, AAPI Press, 2000

Component Workshop 45

THE ADMINISTRATIVE PSYCHIATRY CREDENTIAL

APA Committee on Psychiatric Administration and Management

Co-Chairpersons: William H. Reid, M.D., *17 Applehead Island, Horseshoe Bay, TX 78657,* W. Walter Menninger, M.D., *Menninger Clinic, 5800 SW 6th Street, Topeka, KS 66606*
Participants: Paul Rodenhauser, M.D., Dave M. Davis, M.D., Stuart B. Silver, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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.

REFERENCES:

1. Information Bulletin for Applicants Committee on Psychiatric Admin and Mgmt, APA
2. Rosenhauser P: Mental Health Care Administration a Guide for Practitioners, Ann Arbor, MI; U of Mich Press, 2000

THURSDAY, MAY 10, 2001

Component Workshop 46

RESPONSES TO THE SURGEON GENERAL'S REPORT ON MENTAL HEALTH

APA Council on Psychiatric Services, American Association for Social Psychiatry, American Association of Community Psychiatrists, and American Orthopsychiatric Association

Co-Chairpersons: Zebulon C. Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, 19 East 93rd Street, New York, NY 10128,* Kenneth S. Thompson, M.D., *IPHP, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*
Participants: Howard H. Goldman, M.D., Altha J. Stewart, M.D., Joel S. Feiner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to say (1) what led to the report, (2) how it was produced, (3) how its recommendations can be implemented by the APA and allied psychiatric organizations, and (4) what events are planned to follow up on the report with government and citizens as partners.

SUMMARY:

In December 1999 the Surgeon General of the United States issued the first report dealing with mental health. It calls for a public health approach, showing that mental disorders are disabling, and that mental health and mental illness can be seen as points on a continuum, with mind and body being inseparable. Stigma has deep roots and remains very strong. Key findings are summarized for neuroscience and treatment research, services reorganization, and the emergence of powerful family and consumer movements. One in five Americans has a mental disorder in any one year: 15% of

the adult population and 21% of children use some form of mental health service during any year. Recommendations include: (1) continue to build the scientific base; (2) overcome stigma; (3) improve public awareness of effective treatment; (4) ensure the supply of services and providers; (5) ensure delivery of state-of-the-art treatment; (6) tailor treatment to age, gender, race, and culture; (7) facilitate entry; (8) reduce financial barriers. The report was written as a set of findings for organizations to respond with more specific recommendations and plans. Participants will do this for APA and allied organizations after a brief introduction from Howard Goldman, the report's senior scientific editor.

REFERENCES:

1. U. S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999
2. Kessler RC, et al.: Lifetime and 12-month prevalence of DSM-III-R psychiatric diagnoses in the United States. Results from the National Comorbidity Survey. Arch Gen Psychiat 1994; 51:8–19

Component Workshop 47

FINDING COMMON GROUND: GAYS AND LESBIANS TOGETHER

APA New York County District Branch's Committee on Gay and Lesbian Issues

Co-Chairpersons: Steven T. Wozniak, M.D., *Blanton-Peale Counseling Center, 3 West 29th Street, 5th Floor, New York, NY 10001,* Julie K. Schulman, M.D., *516 East 83rd Street, #4W, New York, NY 10028*
Participants: Mary E. Barber, M.D., Serena Y. Volpp, M.D., Lisa R. Fortuna, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the issues that promote divisions between gay men and lesbian women as well as the issues that provide commonality.

SUMMARY:

What divides lesbian and gay communities? Are there specific interpersonal, cultural, psychological, or cognitive differences between these two groups that contribute to their separateness? What role does gender bias—against women and men—play? Does anti-homosexual bias contribute to these divisions? How do mental health care providers encourage and combat these perceptions?

Various aspects of this issue will be the focus of this interactive workshop. The session is designed to raise awareness of and sensitivity to this challenging issue. Discussants will explore the topic as related to patient care, mental health communities, social and cultural phenomena, as well as developmental and biological models of sex and gender. Participants are encouraged to provide relevant case material and their perspectives on these questions.

The workshop is open to anyone who treats lesbian and gay clients or is interested in this subject. No previous knowledge is required.

REFERENCES:

1. Cabaj RP, Steints, (eds.): Textbook of Homosexuality and Mental Health. Washington, DC, American Psychiatric Press, Inc., 1996
2. Gilligan C: In a Different Voice: Psychological Theory and Woman's Development. Cambridge, MA, Harvard U. Press, 1982

Component Workshop 48

RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE

APA Psychiatrists' Purchasing Group, Inc.

Co-Chairpersons: Alan I. Levenson, M.D., *75 North Calle Resplendor, Tucson, AZ 85716-4937,* Ellen R. Fischbein, M.D., *355 Highland Avenue, #101, Cheshire, CT 06410-2551*
Participants: Martin G. Tracy, J.D., Jacqueline Melonas, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize diagnostic categories that reflect the highest risk for suit; to be familiar with risks presented by organized systems of care as well as common risk management issues that arise out of supervisory relationships; to gain insight into general methods of protecting against risks inherent in these relationships; to understand the part malpractice insurance plays in an overall risk management strategy.

SUMMARY:

Malpractice suits pose a significant problem for psychiatrists, regardless of whether they work in private practice, academic, or institutional settings. At least 8% of practicing psychiatrists are sued each year. It is important that psychiatrists understand the sources of malpractice suits and become aware of malpractice in terms of their own work as clinicians, teachers, and administrators. The workshop will present data from the APA-sponsored Professional Liability Insurance Program, identifying common sources of malpractice actions against psychiatrists. The nature of malpractice lawsuits will be described and data will be presented on the cause and outcome of such lawsuits. Special emphasis will be placed on malpractice as it relates to the process of supervision, working with nonpsychiatrists providers, and the changes managed care brings to psychiatric practice, as well as the risk associated with new forms of telecommunication. Information will be provided regarding malpractice insurance policies and questions that must be addressed when purchasing such a policy. Finally, risk management/risk prevention techniques for practicing psychiatrists, residents, educators, and administrators will be discussed.

REFERENCES:

1. Meyer DJ, Simon RI: Split Treatment: Clarity between psychiatrists and psychotherapists. Psychiatric Annals (Part I, May 1999; Part II, June 1999)
2. Sederer L, Ellison J, Keyes C: Guidelines for prescribing psychiatrists in consultative collaborative, and supervisory relationship. Psychiatric Services 1998; 49(9):1197–1202

Component Workshop 49

THE USE OF ANABOLIC AND ANDROGENIC STEROIDS IN HIV DISEASE

APA Commissions on AIDS

Chairperson: Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130*
Participant: Stephen J. Ferrando, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) identify clinical manifestations of hypogonadism and other somatic symptoms in HIV disease and treatment, (2) describe assessment and treatment issues regarding anabolic and androgenic replacement therapy, and (3) acknowledge countertransference issues regarding the treatment of HIV dysfunction with patients living with HIV disease.

SUMMARY:

Patients with HIV disease who are living longer because of multiple antiretroviral therapies often complain of sexual dysfunction, mood disorders, fatigue, and loss of body mass. Psychiatrists may be consulted around issues of sexual function and libido, and may be the physician to recommend laboratory testing and replacement or augmentation therapy. Psychiatrists who treat people with HIV need to understand the complex relationship of anabolic and androgenic steroids to health.

This workshop will briefly present the clinical manifestations of hypogonadism in HIV disease and the use of testosterone and other anabolic and androgenic steroids for replacement therapy and as adjunctive therapy for mood disorders and lypodystrophy syndrome. Current medical research and clinical reports will be discussed. The discussion will focus on assessment and treatment issues for both patients and providers, addressing short- and long-term concerns. Countertransference issues of other health care providers toward HIV-infected people wanting to resume an active sexual life will also be discussed.

REFERENCES:

1. Currier JS: How to manage metabolic complications of HIV therapy: what to do while we wait for answers. AIDS Read 2000; 10(3):162–9
2. Kotler DP: Body composition studies in HIV-infected individuals. Ann N Y Acad Sci 2000; 904:546–52

Component Workshop 50
TREATMENT OF CHILD AND ADOLESCENT VICTIMS OF CRIME: NEW GUIDELINES FROM CALIFORNIA
APA Committee on Family Violence and Sexual Abuse

Co-Chairpersons: Graeme Hanson, M.D., *Department Child & Adolescent Psychiatry, Langley Porter UCSF, 401 Parnassus Avenue, San Francisco, CA 94143-0984,* Michele Winterstein, Ph.D., *4001 Long Beach Boulevard, Long Beach, CA 90807*
Participant: Bradley D. Stein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the complex issues involved in evaluating and treating child and adolescent victims of crime, many of whom are victims of abuse and neglect; (2) conduct an appropriate assessment for such victims, taking into account developmental stage and complex systems issues; and (3) provide treatment informed by the special needs of these patients.

SUMMARY:

Many children and adolescents become victims of crime. Younger children, especially, are subject to abuse and neglect, which are criminal acts. Evaluating the mental health needs of such children and adolescents is a complex process and involves an assessment of how developmental stage affects the impact of the crime, the complex relationship of the victim to the perpetrator, the often conflicting mandates of the various systems involved, and the wide range of psychological reactions children may display as a result of being a victim.

Many children and adolescents are provided mental health treatment under the various federal/state Victims of Crime programs. There are a few guidelines regarding appropriate/effective assessment and treatment strategies.

California has recently developed such guidelines. These guidelines are multifaceted and designed to assist clinicians treating young victims of crime. The guidelines include a review of the Victims of Crime program; strategies for assessment and treatment; special situations e.g., children with pre-existing mental health problems; the particular needs of infants and toddlers; role of medication, etc.

Brief vignettes will be presented for audience discussion and questions.

REFERENCES:

1. Lewis MD: Trauma reverberates: psychological evaluation of the caregiving environment of young children exposed to violence and traumatic loss, in Islands of Safety: Assessing and Treating Young Victims of Violence: Edited by Osofsky Fenichel E. Arlington, VA, Zero to Three, pp. 1999; 9(3)
2. Domestic Violence and Children: The Future of Children 1999; 9:(3), Los Altos, CA

Component Workshop 51
PRACTICE GUIDELINES, STANDARDS, AND QUALITY INDICATORS: APA INITIATIVES
APA Council on Quality Improvement

Chairperson: Sara C. Charles, M.D., *1300 North Lake Shore Drive, #15A, Chicago, IL 60610*
Participants: John M. Oldham, M.D., Charles E. Riordan, M.D., John S. McIntyre, M.D., Rhonda J.R. Beale, M.D., James C. MacIntyre, M.D.

EDUCATIONAL OBJECTIVES:

At the close of this presentation, the participant should recognize at least five major initiatives of quality improvement that are the focus of the health care field and the American Psychiatric Association.

SUMMARY:

As the public has demanded accountability in health care, the APA Council on Quality Improvement has worked steadily to expand APA's influence on the quality of psychiatric care. The APA has developed evidence-based practice guidelines for use by the individual psychiatrist that can be adapted for use by managed care and managed behavioral health care organizations. Accrediting organizations, such as the JCAHO, have received APA's recommendations about standards for health care facilities and systems. Spurred by the integration of quality indicators into national accreditation programs (e.g., performance and outcome measures), the APA has identified measures for psychiatric care of the general population and for children and adolescents and has made recommendations to entities such as the Health Care Financing Administration and NCQA. The council also monitors the efforts of the American Board of Medical Specialties and the Council of Medical Specialty Societies toward ensuring and measuring the competencies of individual physicians. In response to the 1999 report of the Institute of Medicine, the APA is creating a Committee on Patient Safety to identify quality improvement approaches to prevent or reduce undesirable outcomes in psychiatric practice. The chairs of each APA component addressing these issues will present highlights and findings.

REFERENCES:

1. Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2000, American Psychiatric Association, Washington, D.C., 2000
2. Report of the APA Task Force on Quality Indicators, American Psychiatric Association, March 1999 (available on www.psych.org//pract of psych/tf toc.cfm)

Component Workshop 52
PSYCHIATRIC DISCHARGE IN THE CRIMINAL JUSTICE SYSTEM
APA Consortium on Special Delivery Settings

Chairperson: Cassandra F. Newkirk, M.D., *39 Hendrickson Drive, Belle Mead, NJ 08502-4110*
Participants: Ludwik S. Szymanski, M.D., Heather Barr, J.D., Erik J. Roskes, M.D., Hunter L. McQuistion, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the special needs of those with mental illness and mental retardation being discharge from the criminal justice system, and incorporate innovative examples of reintegration of the ex-offender with mental illness and mental retardation back into the community.

SUMMARY:

This session is designed for psychiatrists working at any phase of the criminal justice system. It is estimated that anywhere from 6% to 15% of inmates in jails and prisons suffer from a major mental illness or mental retardation, excluding substance abuse disorders. While some systems offer more intensive mental health and mental retardation services than others, reintegration of these offenders back into the community at the time of discharge is an area that has not been dealt with very successfully. Unless it is, many of these people will return to the criminal justice system after failing to navigate the maze of the community mental health system. It is anticipated that this workshop will be a springboard to raise the consciousness of psychiatrists working in the criminal justice system and to motivate more clinicians to become involved in looking at programs that work. Very little has been done in the way of outcome studies in regard to the programs that do exist. Panelists will share their programs, including the successes and the areas that have not worked so well. This will be a workshop in which audience participation is welcome as a means of sharing experiences and challenging others to look more intensely at this most complex problem.

REFERENCES:

1. American Psychiatric Association: APA guidelines: psychiatric services in jails and prisons. Washington, DC, American Psychiatric Association, 1999
2. Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program: National Institute of Justice www.ncjrs.org/txtfiles1/175046.txt

Component Workshop 53
COPING WITH MEDICAL ILLNESS
APA Committee on Consultation-Liaison Psychiatry and Primary Care Education

Chairperson: Francisco Fernandez, M.D., *Department of Psychiatry, Loyola University Medical Center, 2160 South First Avenue, Building 54, #154, Maywood, IL 60153*
Participants: James L. Griffith, M.D., Karl Goodkin, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participant should be able to: (1) describe the psychological basis of coping in the medically ill; (2) define different types of coping and correlate these with changes in neuroendocrine and immune measures, and with their neuroanatomical referents; and, (3) acquire skills in a brief, resilience-based model for psychotherapy with medically ill patients.

SUMMARY:

Emotions may contribute to health and illness through a variety of pathways. Early attempts to evaluate these pathways tended to focus on emotional responses to stressors such as illness. Early models of illness in psychosomatic medicine, stimulated by findings in psychoanalysis, yielded specific recommendations for therapy in the treatment of psychosomatic dysfunctions and disorders. Subsequent studies have focused on cognitive and behavioral responses and how specific patterns of coping may be associated with specific physiologic responses. Efforts to use cognitive-behavioral therapy outcome data for a focused coping skills enhancement approach in various medical disorders have been reported as successful. This workshop will present a historical overview of coping in the context of medical illness. The neuroscientific correlates of different types of coping will be described. A resilience-based model for psychotherapy with medically ill patients to facilitate and enhance coping will be introduced. Brief presentations of the major foci of research in these areas will be followed by interactive discussion of clinical vignettes from both the presenters and the audience.

REFERENCES:

1. Griffith JL, Griffith ME: The body speaks: working with mind-body problems from a narrative perspective, in Therapeutic Conversations. Edited by Gilligan S, Price R. New York, WW Norton, 1993
2. Goodkin K, Feaster DJ, Tuttle R, et. al.: Bereavement is associated with time-dependent decrements in cellular immune function in a symptomatic HIV-1 seropositive homosexual men. Clinical and Diagnostic Laboratory Immunology 1996; 3(1):109–118

Component Workshop 54
MORE ALIVE THAN DEAD: CHANGING STRATEGIES IN HIV PSYCHOTHERAPY
APA New York County District Branch's AIDS Committee

Co-Chairpersons: Kristina Jones, M.D., *Department of Psychiatry, St Vincents Hospital, 153 West 11th Street, New York, NY 10011,* Kenneth B. Ashley, M.D., *Department of Psychiatry, Beth Israel Hospital, 85 East 10th Street, #1F, New York, NY 10003-5407*
Participants: David B. Goldenberg, M.D., Kyle S. Kato, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to understand and appreciate some of the psychotherapeutic issues associated with the new medical treatment regimens for patients with HIV and AIDS.

SUMMARY:

In this workshop, the panel members will present clinical psychotherapy case material that illustrates the impact of HAART (Highly Active Anti-Retroviral Therapy) for HIV/AIDS. After the panel presentation, there will be a facilitated discussion between audience and presenters.

Biological advances in the treatment of HIV have changed the psychiatric focus from one based on death, grief, and organic mental disorders, to one that centers on living with a disease of uncertain prognosis. Regaining physical health poses huge psychological challenges for patients who had not expected to live. Therapists now deal with those who are struggling to cope with new life challenges, while accomodating to the myriad side effects of antiretroviral therapy. Therapists will discuss containing anxiety, adherence strategies and risk behavior, countertransference toward patients on long-term disability, survivor guilt, and new techniques for enhancing the psychological growth of patients during this stage of the HIV/AIDS epidemic.

REFERENCES

1. Goldenberg D, Boyle B: HIV and psychiatry: Part I. The AIDS Reader 2000; 10(1):11–1

2. Shernoff M, Smith R: HIV Treatment: Mental Health Aspects of Antiviral Therapy. UCSF AIDS Health Project Monograph Series Number 4 2000; 1–3

MONDAY, MAY 7, 2001

Issue Workshop 1
PSYCHIATRIC ILLNESS AND THE WORKPLACE

Chairperson: Steven E. Pflanz, M.D., *Department of Mental Health, FE Warren Air Force Base, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

To understand the relationship between work stress and mental health and the role of the mental health professional in working with patients and employers to minimize the impact of job stress on the emotional health of workers.

SUMMARY:

Increasingly, both industry and mental health professionals are recognizing that work stress is a major factor in determining the mental health of employees. Psychiatrists and other mental health professionals are often faced with patients suffering from emotional distress that is attributed to job stress. Importantly, 15% of American workers experience at least one episode of psychosocial disability every year. Mentally ill workers exhibit decreased productivity, increased workforce turnover, higher absenteeism, and increased medical care utilization. These combined factors cost industry $150 billion annually. The relationship between the work environment and the mental health of employees has received little research attention. Nonetheless, 30% of American workers report exposure to mental stress at work, and 14% believe that their experience of work stress could be deleterious to their mental health. At work, both exposure to sudden traumatic events and to chronic daily stress can produce or exacerbate psychiatric symptoms. In this workshop we will discuss the complex relationship between the work environment and mental health. We will examine the common sources of job stress and the mechanisms by which work stress can lead to psychiatric illness. Lastly we will explore how the mental health professional can forge a partnership with patients and employers to reduce work stress and ameliorate or eliminate psychiatric illness in working patient populations.

REFERENCES:

1. Pflanz SE: Psychiatric illness & the workplace: perspectives for occupational medicine in the military. Military Medicine 1999; 164:401–406.
2. Pflanz SE, Skop B: Occupational stress & mental illness in the military: investigation of the relationship between occupational stress and mental illness among active duty visitors to a military health clinic. Southern Medical Journal 1998; 91:S63.

Issue Workshop 2
SCHUMANN, MANIC-DEPRESSIVE ILLNESS, AND THE CREATIVE PROCESS

Chairperson: Richard Kogan, M.D., *15 East 77th Street, New York, NY 10028*
Participant: Kay R, Jamison, Ph.D.

EDUCATIONAL OBJECTIVES:

To appreciate the connection between Robert Schumann's mental illness and his musical output; to understand the relationship between manic-depressive illness and the creative process.

SUMMARY:

Robert Schumann represents one of the best examples of the blurred boundary between creative genius and mental illness. The foremost exponent of the Romantic movement in music, he ignored traditional styles and instead wrote magnificent music that was based purely on a desire to express his inner state of mind. Psychiatrist and award-winning concert pianist Richard Kogan (first prize: Chopin Competition) will trace the course of Schumann's manic-depressive illness and his career as a composer and will attempt to demonstrate the connections between the two. He will discuss, for instance, how Schumannn:

1) composed voluminously during hypomanic periods but stopped writing completely toward the end of his life when a severe depression culminated in a suicide attempt and eventual self-starvation in an insane asylum;

2) at age 21 invented two imaginary companions, Florestan (passionate and assertive) and Eusebius (introspective and passive), who episodically appear during his compositions; and

3) wrote powerful music at the urging of inner voices but was ultimately tormented by his auditory hallucinations.

Dr. Kogan will perform excerpts form Schumann's music (Carnaval, Fantasy, Traumerei) to illuminate the discussion. He and Dr. Kay Redfield Jamison, author of Touched With Fire: Manic-Depressive Illness and the Artistic Temperament, will explore how extreme fluctuations in mood can be both potentially beneficial and harmful to the creative process.

REFERENCES:

1. Ostwald P: Schumann: The Inner Voices of a Musical Genius, Northeastern University Press, 1985.
2. Jamison KR: Touched With Fire: Manic-Depressive Illness and The Artistic Temperament, Simon & Schuster, 1993.

Issue Workshop 3
WORKING-THROUGH IN PSYCHOTHERAPY

Chairperson: Steven H. Lipsius, M.D., *George Washington University, 2141 K Street, N.W., Suite 404, Washington, DC 20037-1810*

EDUCATIONAL OBJECTIVES:

To recognize a second mode of transference, introjective identification, and understand the unique interventions to employ them for this inner working-through process; be able to more effectively treat patients within the diagnostic categories for which this approach is indicated.

SUMMARY:

The greatest enigma in psychoanalysis is the concept of working-through, as best expressed by psychoanalyst Peter Giovacchini. A proposed solution to this enigma for psychotherapy is the subject of this workshop. In short, what has been recognized as the traditional transference is only one mode of this transference. Furthermore the traditional psychotherapy interventions of interpretation and confrontation, useful in managing this recognized mode of transference, namely, projective identification often resulting in impasses in psychotherapy. When the therapist is taken within, rather than projected onto, less-intrusive interventions are required. The most internalized object relations contain an element of the subject's self. These subject-relations processes enable therapeutic facilitation of innermost dialogues between self and others. Reworking psychic structure is correlated with Damasio's neuroscience underpinnings, nearly seamless mind-brain union. Case examples will help participants silently resonate with that inner working through process. Extensive audience discussion will help members differentiate the two processes, recognizing the different countertransference signals, and coordinating the two therapeutic process. Experienced therapists are most likely to

appreciate the advantage of having two cylinders to drive the engine of the working-through process.

REFERENCES:

1. Giovacchini P: Working through: a technical dilemma. Reprinted in Classics in Psychoanalytic Technique, edited by Langs R. Northvale NJ, Jason Aronson, Revised Edition, 1990, pp, 475–490.
2. Rucker NG, Lombardi KL: Subject Relations, Unconscious Experience and Relational Psychoanalysis. New York, Routledge, 1998.

Issue Workshop 4
TELEPSYCHIATRY: LEGAL AND ETHICAL ISSUES

Chairperson: Nancy H. Halleck, J.D., *Counsel, SNMG, EDISON, 431 New Kamer Road, Albany, NY 12205*
Participant: Deborah Cross, M.D., Jay L. Zucker, J.D., Fredrick W. Burgess, J.D.

CANCELLED

EDUCATIONAL OBJECTIVES:

To recognize legal issues involved in the practice of telepsychiatry. These issues include licensure and credentialing of psychiatrists practicing telepsychiatry across state lines and confidentiality issues. The workshop will also attempt to get the audience thinking about ethical issues surrounding telemedicine.

SUMMARY:

This workshop will attempt to raise awareness of the various legal issues facing psychiatrists and other mental health care providers whose practices include telepsychiatry. The growth of technology has made the practice of telemedicine possible and, in many circumstances, very effective. However, state and federal laws have not kept pace with the technology, particularly in the case of licensing and credentialing. The gap has created a number of legal and ethical dilemmas for practitioners. The panel will offer a brief discussion of licensure, credentialing, confidentiality, and ethical issues arising from telemedicine. We will then open the discussion to the audience, hoping to share anecdotes or problems the audience has faced in practice. Through discussion we would like to come to some conclusions regarding what is needed to reform laws to either further regulate or to facilitate this practice. This workshop will be useful to practitioners who wish to explore legal issues facing physicians or other mental health care providers whose practice includes telepsychiatry, doing peer review work across state lines, or forensic psychiatry.

REFERENCES:

1. McMenamin JP: Telemedicine and the law. Virginia Medical Quarterly 1996; 123:184–187, 189.
2. Tachakra S. Mullett STH, Freij R, Sivakuman A: Confidentiality and ethics in telemedicine. Journal of Telemedicine and Telecare 1996; 2.1 supp.:68–71.

Issue Workshop 5
HOSPITAL-BASED PROGRAM FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PATIENTS

Chairperson: Douglas L. York, M.P.H., *Behavioral Health, Westchester Medical Center, Valhalla, NY 10595*
Participants: Neil A. Zolkind, M.D., Maralee Walsh, Ph.D., Donna Festa, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to develop, implement, and market a successful mental health program targeting the LGBT community.

SUMMARY:

This workshop is designed to provide clinicians and administrators with a framework to develop, implement, and market a successful hospital based health program targeting LGBT persons.

The mental health needs of LGBT individuals are often inadequately addressed. Studies have shown that mental health needs of LGBT persons are adversely affected by institutional heterosexism and internalized homophobia. Providing culturally competent practice in a hospital-based program can improve clinician/patient communication, assessment, and treatment. Development of a culturally sensitive environment and program can lead to improved care and patient satisfaction.

The goals of the workshop are to 1) address issues of access to care, 2) provide data supporting a specialized program, 3) highlight issues unique to the LGBT community, 4) address staff sensitivity training, and 5) discuss successful approaches to overcoming development and operational obstacles.

The executive director of the Behavioral Health Center, psychiatric medical and program directors, and the coordinator of the GATEWAY program, will each present specific examples and illustrations drawn from their professional perspective on the administrative, clinical, educational, and financial issues related to the development of specialized programming for LGBT individuals.

Utilizing a highly interactive format, a panel of four participants will provide a summarization of their individual areas of expertise pertaining to the creation and operation of the GATEWAY program. Program evaluation data will support the summaries presented. Media utilized in this process will include video vignettes and LCD computer projection. The panel chair will ensure that the workshop allows participants the opportunity to share commentary, their own personal and professional experiences, and correlate both with the experiences of the GATEWAY program.

REFERENCES:

1. Millman M: Access to health care in America. National Academy Press, Washington, DC, 1993.
2. Schatz B, O'Hanlan K: Anti-Gay Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians. American Association of Physicians for Human Rights/ Gay Lesbian Medical Association, San Francisco, May 1994.

Issue Workshop 6
E-SUPPORTING CLINICAL PRACTICE: GUIDELINES AND THE PSYCHIATRIC RESEARCH NETWORK

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*
Participants: Kenneth Z. Altshuler, M.D., Madhukar H. Trivedi, M.D., G. Richard Smith, Jr., M.D.

EDUCATIONAL OBJECTIVES:

By the end of this workshop participants will be able to describe the major elements and advantages of computer-facilitated use of practice guidelines in clinical care, and describe approaches for using Web-based practice assessments, focusing on clinical charactistics and outcomes.

SUMMARY:

Computer and Web-based technologies increase psychiatry's practice and services research capabilities in exciting ways. This workshop features updates on two projects likely to impact how we practice in the future. We first describe CompTMAP, computerized guidance using the algorithms of the Texas Medication Algorithm Project. The program displays courses of illness and treatments. Depending on prior course, the computer program offers psychiatrists

ranges of appropriate treatment options. The psychiatrist may select one of these options, but can also choose to do otherwise. The program prints prescriptions, chart notes, and appointment cards, and accumulates pooled data for future refinement. This illustrative presentation will demonstrate the program's functionality in action, allowing the audience to lead the presenters through a series of several case visits.

We next describe applications of Web-based technology to practice-based outcomes assessment. Through use of the Internet, measuring patient characteristics, processes of care, and the outcomes of care is now feasible and affordable as part of routine care. This presentation demonstrates the application of this approach to outcomes assessment and discusses the advantages clinicians will find when such a system is used. The APA's Psychiatric Research Network may employ such methods in future studies.

REFERENCES:

1. Rush AJ, et al: Implementing guidelines and systems of care: experiences with the Texas Medication Algorithm Project (TMAP). J Practical Psychiatry and Behavioral Health, 1999; 5:75–86.
2. Smith GR Jr, et al: Implementing outcomes management systems in mental health settings. Psychiatric Services 1997; 48:364–368.

Issue Workshop 7
ABPN UPDATE: REQUIREMENTS FOR ABPN EXAMINATION

Chairperson: Thomas A.M. Kramer, M.D., *UAMS Psychiatric Clinic, Mail Slot 766, 4301 West Markham, Little Rock, AR 72205-7101*
Participants: Glenn C. Davis, M.D., Michael H. Ebert, M.D., Larry R. Faulkner, M.D., Burton V. Reifler, M.D., Pedro Ruiz, M.D., James H. Scully, Jr. M.D., Elizabeth B. Weller, M.D., Daniel K. Winstead, M.D.

EDUCATIONAL OBJECTIVES:

To assist residents, early career psychiatrists, and others 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 early career psychiatrists.

Residents and early career psychiatrists will be encouraged to ask questions about certification, recertification, and subspecialization in addition to the specifics of the Part I and Part II written and oral examinations for certification. Participants will be urged to discuss child and adolescent psychiatry, addiction psychiatry, forensic psychiatry, geriatric psychiatry, clinical neurophysiology, and pain management.

REFERENCES:

1. Shore J, Scheiber SC.: Certification, Recertification and Lifetime Learning. Washington, D.C. APPI Press, 1994.
2. American Board of Medical Specialties: Recertification for Medical Specialists, ABMS, Evanston, IL 1987.

Issue Workshop 8
TOWARDS A RATIONAL, INTEGRATED TREATMENT APPROACH TO MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED PATIENTS

Co-Chairpersons: Harvey Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504,* Susan Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504*
Participants: Michael M. Scimeca, M.D., Sheldon Travin, M.D., David W. Preven, M.D.

EDUCATIONAL OBJECTIVES:

Participants will be made aware of efficacious method of treating the MRDD population.

SUMMARY:

Until quite recently questions had been raised about the efficacy of specific psychiatric treatments, including psychotherapeutic and psychopharmacologic interventions, for the mentally retarded and developmentally disabled. Most psychiatric treatments for this population were focused on decreasing aggression, and the primary therapeutic tool for decades was sedation.

This workshop will review the rapidly growing focus on diagnosing and appropriately treating a wide range of accompanying psychiatric disorders, often affective in nature, in this population. The experiences of the panelists in treating the MRDD population on both an inpatient and an outpatient basis will be reviewed, as will the slowly growing literature in this field.

The difficulties in incorporating a significant MRDD population into an existing general psychiatric inpatient unit and the special needs of the coexisting outpatient population will be reviewed.

Workshop participants will be asked to share their experiences in this type of treatment. Finally the impact of countertransferential factors in this treatment will be evaluated.

REFERENCES:

1. Masi G, et al: Psychiatric illness in mental retardation, an update on pharmacotherapy. Pan Minerva Medica, 1997; 39:299–304.
2. Bepil N: Psychoanalytic psychotherapy with men with intellectual disabilities; a preliminary outcome study. British Journal of Medical Psychology 1998; 71:1–11.

Issue Workshop 9
SLEEP PROBLEMS IN DUAL-DIAGNOSIS PATIENTS: PHYSIOLOGY AND MANAGEMENT

Chairperson: R. Jeffrey Goldsmith, M.D., *3438 Burch Ave. Cincinnati, OH 45208-2004*

EDUCATIONAL OBJECTIVES:

To recongnize the impact of alcohol and drugs on sleep physiology; to treat safely the sleep problems of dual-diagnosis patients.

SUMMARY:

This workshop is intended for general and addiction psychiatrists, as well as sleep medicine doctors, psychotherapists, and nurses. Sleep disorders are almost universal among the dual-diagnosis population. The workshop will review normal sleep physiology and the common sleep disorders. There will be discussion. Then the presenter will review the impact of alcohol and drugs on sleep physiology. Data on 100 dual-diagnosis patients and their sleep problems will be presented. Sleep disturbances of the mood, anxiety, and psychotic disorders will be presented, followed by a discussion. Finally, the

safe management of sleep disorders in the alcohol-dependent and drug-dependent population with psychiatric comorbidity will be presented. The risks and benefits of benzodiazepines will be addressed. The workshop will end with a discussion.

REFERENCES:

1. Gillin JC, Drummond SPA: Medication and substance abuse. In Principles and Practice of Sleep Medicine, 3rd Edition, edited by Kryger, Roth, and Dement, New York, WB Saunders Co., 2000, pp. 1176–1196.
2. Uhde T: Anxiety disorders. In Principles and Practice of Sleep Medicine, 3rd Edition, edited by Kryger, Roth, and Dement, New York, WB Saunders Co., 2000, pp. 1123–1139.

Issue Workshop 10
NONSEXUAL BOUNDARY VIOLATIONS

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline, MA 02445*
Participants: Linda M. Jorgenson, J.D., Carl P. Malmquist, M.D., Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to accurately assess the potential for negative clinical and/or legal ramifications resulting from nonsexual boundary crossings in therapeutic relationships.

SUMMARY:

Little disagreement exists among professionals that sexual boundary violations are harmful to patients and practitioners. Delineating acceptable nonsexual boundaries and identifying violations thereof are, however, more difficult tasks that often tread close to the line distinguishing sound clinical judgment from unethical conduct. Difficulties are most pronounced in cases involving gifts, money, business transactions, and social relationships between patient and therapist. While not all nonsexual boundary violations eventually cross the line into a sexual encounter, there are patient reports of psychiatrists who "do everything but." This workshop will approach the subject of nonsexual boundaries from clinical and legal perspectives and examine the responses of the legal and psychiatric communities to the issue.

Three cases, ranging from the ambiguous to the extreme, will be presented: (1) a psychiatrist involved with a patient in the purchase and sale of personal property; (2) a psychiatrist who inherited a substantial amount of money from a former patient; and (3) a psychiatrist who invited a patient to participate in activities outside of therapy sessions and charged for the time. Panelists will discuss the cases and the possible motivations for and effects of the behaviors involved on therapist and patient. Audience participation in the discussion will be encouraged.

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
NEUROANATOMY AND NEUROPHYSICS OF THE UNCONSCIOUS

Chairperson: Vincenzo R. Sanguineti, M.D., *Jefferson Medical College, 1015 Chestnut Street, Suite 825, Philadelphia, PA 19107-5567*

EDUCATIONAL OBJECTIVES:

The participant should be able to: 1) achieve familiarity with the fundamental designs, the laws, and the arguments about nonlinear dynamic structures and/or quantal structures to the nonconscious operations of the human mind; 2) understand the relationship between this presynaptic layer and the synaptic brain structures; 3) integrate the different sources of data that drive thought production.

SUMMARY:

This highly interactive workshop will discuss the basics for a better understanding of unconscious mental operations. It will consist of three segments:

Segment #1: "Warm-up"

a) The concept of the dynamic unconscious has been scientifically fuzzy at best. Faculty will guide participants to jointly list from their clinical experience an outline of core unconscious characteristics and operations that will be used as reference in segment #3.

b) Psychiatry has of late been primarily involved with neurobiology and with the stochastic operations of neuronal ensembles. The most significant and documented breakthroughs (as in the area of emotions) will be outlined. Faculty and participants will discuss these findings as they may pertain to sites and laws governing unconscious operations.

Segment #2: The "science of consciousness" jointly expounded by many other disciplines offers new and strong evidence to the anatomical sites and to the laws governing unconscious systems and their transduction into consciousness. Faculty will illustrate evidence: a) for anatomical sites, b) for specific sets of physical laws.

Segment #3 (general discussion) The faculty will then join the audience in exploring the "fitting" between these findings and the characteristics of the unconscious as outlined in the first segment.

REFERENCES:

1. Hameroff SR, Scott AC: A Sonoran afternoon: a discussion on the relevance of quantum theory to consciousness. In: Toward a Science of Consciousness: The Second Tucson Discussions and Debates. Cambridge, Mass, MIT Press 1998; pp. 635–644.
2. Sanguineti VR. Workings of the mind: consciousness and the unconscious. In Landscapes in my Mind: The Origins and Structure of the Subjective Experience. IUP, Madison, CT, 1999, pp. 53–68.

Issue Workshop 12
CLOZAPINE AUGMENTATION IN REFRACTORY SCHIZOPHRENIA

Chairperson: Jean-Pierre Lindenmayer, M.D., *Department of Psychiatry, Manhattan Psychiatric Center, Unit M10A, Wards Island, New York, NY 10035*
Participants: John W. Rosenberger, M.D., Joseph I. Friedman, M.D., Richard H. McCarthy, M.D., Zafar Sharif, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be knowledgable about adjunctive treatment strategies for patients with schizophrenia who have had an incomplete response to clozapine and about their efficacy.

SUMMARY:

Clozapine remains the best-documented pharmacological treatment option for treatment refractory schizophrenia. However, a significant number of patients treated with clozapine respond only partially or with significant side effects and present the clinician with a major challenge for treatment and management. Unfortunately, there are presently no controlled, double-blind studies available examining the effects of various augmentation strategies for these patients that could guide the clinician in the choice of such a strategy for a given patient and that could enhance the response to clozapine. This panel will review a number of clozapine augmentation strategies that have been used by clinician-researchers in the treatment of these

difficult patients. Specifically, we will present strategies on how to optimize clozapine monotherapy through monitoring of clozapine plasma levels, on the efficacy of augmenting with typical, atypical antipsychotics as well as with anticonvulsants, and on how to combine ECT with clozapine. Discussion with audience participation will focus on sharing results on the efficacy of such augmentation strategies in various clinical settings and on the development of a putative treatment algorithm.

REFERENCES:

1. Lieberman J, Kane J, Johns C: Clozapine: guidelines for clinical management. J Clin Psychiatry 1989; 50:329–338.
2. Lindenmayer JP., Apergi S: Clozapine plasma levels as predictors of outcome. Psychiatric Annals 1996; 26:405–411.

Issue Workshop 13
MAKING TELEPSYCHIATRY WORK FOR YOUR SYSTEM
Psychiatric Society of Informatics

Chairperson: William M. Tucker, M.D., *New York State Office of Mental Health, 44 Holland Avenue, 8th Floor, Albany, NY 12229*
Participants: Alan Q. Radke, M.D., Harry Karlinsky, M.D., Gerald Segal, M.S.

EDUCATIONAL OBJECTIVES:

To recognize the range of clinical applications demonstrated by three different systems of telemedicine, understand the technical and clinical resources required to establish and maintain each of these systems, and anticipate the reactions of patients and local providers to the use of such a system.

SUMMARY:

Clinical applications of telepsychiatry are expanding as technology improves and costs of both hardware and broad-bandwidth transmission lines diminish. Already they include treatment-team videoconferencing, continuing psychiatric education for groups of any size, and individual patient consultations. Linking small groups of clinicians spread across a wide geographic area and providing optimal care to patients in rural areas and jails are clear priorities. Public systems serving defined populations may be able to avoid problems of licensure, credentialing, and reimbursement, and can focus instead on developing guidelines for the field, particularly regarding critical mass of consultants, funding, and effectiveness of virtual rather than face-to-face contacts. Challenges include prioritization of issues and system maintenance by local end-users, scheduling of centrally-based consultants to maximize system capacity, and security and confidentiality of information.

Three such public systems—in Minnesota, British Columbia, and New York—will be described. Both technical and clinical issues will be covered in detail. Each presenter will demonstrate aspects of his system through videotaped segments of actual system applications. Participants will be encouraged to engage presenters in issues that would enable them to conceptualize the adaptation of such systems to their own practice environments.

REFERENCES:

1. Alessi NE: The global forum on telemedicine: a bridge to the 21st century. Telemed J 1999; 5:213–4.
2. Karlinsky H: Telepsychiatry: under-appreciated barriers to implementation. ITCH 2000, Victoria, BC.

Issue Workshop 14
FROM PLAY THERAPY TO PILLS AND BACK AGAIN: CHILD TREATMENT IN THE DECADE OF THE MIND

Chairperson: Peter D. Ganime, M.D., *Department of Psychiatry, UMDNJ-Meridian, c/o Ganime 335 Garrison Way, Conshohocken, PA 19428*
Participants: Joanne Dunnigan, M.S.W., Grace Hickey, Psy.D., Phillip Repasky, M.A., Diane Beebe, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants should better understand how genetics, early childhood development, individual and family psychodynamics, psychopharmacology and systems theory all provide the basis for modern treatment of young children and their families. Attendees will appreciate the importance of selecting the right treatment for children in need.

SUMMARY:

Effective therapy of young children is both a science and an art. Greater understanding of neurobiology and early childhood development acquired over the past decade has resulted in more treatment options, but it has also generated controversy and confusion. When does a child need psychotherapy, and when is drug treatment necessary? If medication is effective, are other treatments necessary? When should family therapy be prescribed, and when will parent education and training suffice? Selecting appropriate treatment modalities and coordinating multiple therapeutic approaches is a challenging and critical task.

This workshop will bring together representatives from various disciplines to discuss their views about treating very young children and their families. The goal of multimodal interdisciplinary treatment is to provide a balanced holistic approach to child therapy, and discussants will present their experiences trying to achieve this. Videotaped vignettes will be used to illustrate some of the topics presented so that attendees will be drawn into the discussion.

REFERENCES:

1. Mayes I: Addressing mental health needs of infants and young children, Child and Adolescent Psychiatric Clinics of North America 1999; 8:209–224.
2. Keren M., Feldman R, Tyano S: Assessment of caregiver-child interaction in the context of a preschool psychiatric evaluation. Child and Adolescent Psychiatric Clinics of North America 1999; 8:281–296.

Issue Workshop 15
A UNIVERSITY DEPRESSION-MANAGEMENT PROGRAM

Chairperson: Stuart J. Eisendrath, M.D., *1975-15th Avenue, San Francisco, CA 94116-1313*
Participants: Ellen Haller, M.D., Jonathan E. Lichtmacher, M.D., David H. Taylor, M.D., Anne M. Fleming, M.D., L. Alison McInnes, M.D., Yoon K. Jung, B.S., Margaret Fritch, M.S., Sharon Hall, Ph.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop, participants should be able to understand the key elements of a depression management program in an academic setting. They should have an awareness of hurdles to developing a program as well as strategies to overcome them.

SUMMARY:

The treatment of major depression in academic medical centers has often been idiosyncratic, depending on a variety of supervisor and trainee factors, with little attention paid to evidence-based treatments or clinical outcomes. Our faculty initiated a depression management task force to develop a program aimed at translating scientific knowledge into clinical practice and improving the treatment of patients and the education of psychiatric residents. Task force members reviewed the literature and sought consultation and feedback to develop a disease management program, including evidence-based psychotherapies, medication guidelines, long-term management, outcomes assessment, and patient education. Psychiatry residents now deliver both interpersonal and cognitive behavioral psychotherapies as well as medication management. Viewing depression as a chronic disease, the program offers maintenance and prevention components to decrease relapse and recurrence. Treatment outcome assessments provide feedback regarding program effectiveness and individual change and lay the foundation for future clinical research. Outcome information guides clinical decision making while providing information necessary for external review such as by JCAHO and HEDIS. In this workshop, five task force members will review the problems and solutions involved in implementing the program. This will be an interactive workshop where participants will be able to share ideas and questions about developing similar programs in their academic settings.

REFERENCES:

1. Lin EHB, Simon GE, Katon WJ: Can enhanced acute-phase treatment of depression improve long-term outcomes? A report of randomized trials in primary care. Am J Psychiatry 1999; 156:643–645.
2. Horn SD: Overcoming obstacles to effective treatment: use of clinical practice improvement methodology. J Clinical Psychiatry 1997; 58:Suppl 1:15–19.

Issue Workshop 16
DISASTER PSYCHIATRY: LAPA FLIGHT 3142

Chairperson: Daniel L. Mosca, M.D., *Emergency Medical Aid System, Rosario 38 3A, Buenos Aires 1424, Argentina*
Participants: Marcelo R. Muro, M.D., Liliana Sanchez, Psy.D.

EDUCATIONAL OBJECTIVES:

The participants should be able to recognize the main symptoms of the initial reaction and those that appear during the treatment of the survivors and the relatives of those who have been killed in a disaster.

SUMMARY:

On August 31, 1999, a Boeing 737-200 of LAPA airlines failed in its attempt to take off from the Jorge Newbery airport in downtown Buenos Aires and crashed through the boundary fence, hitting two cars as it crossed a busy highway, coming to rest a few yards from a gas station. Fire broke out and engulfed the plane killing 65 passengers, three crew members, as well as two people on the ground; 33 passengers and two crew members survived the crash, some of whom were severely burned.

S.A.M.E. (Emergency Medical Aid System), a city government organization that handles all medical emergencies in the city of Buenos Aires, arrived on the scene and took charge of the situation. The Human Factors Team, a part of S.A.M.E., which treats emergency personnel for work-induced stress, also treats the general public in disaster scenarios. This team was immediately summoned and treated the survivors and the relatives of the victims on the spot and also during the days immediately following the tragedy. Subsequently, treatment continued for those still requiring it.

The brief presentations will describe the treatment of the survivors and victims' relatives and the impact of the disaster on the emergency personnel. The participants will be encouraged to discuss their experiences and share their knowledge in this area.

REFERENCES:

1. Ursano RJ, Fullerton CS, Norwood AE: Psychiatric dimensions of disaster: patient care, community consultation, and preventive medicine, Harvard Rev Psychiatry, 1995; pp. 196–209.
2. van der Kolk BA, McFarlane AC, Weiseeth L: Traumatic Stress: The Effects of Overwhelming Experience on Mind Body and Society. New York, The Guilford Press, 1996.

Issue Workshop 17
TWO DOGMAS OF PSYCHOANALYSIS

Chairperson: Avak A. Howsepian, M.D., *Veterans Administration, 2615 East Clinton Avenue, Fresno, CA 93703*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should understand some of the most powerful arguments against psychoanalysis's most basic theoretical commitments, viz. psychic determinism and the existence of unconscious mental processes, and how alternative models of the mind might interact with research in neuroscience.

SUMMARY:

Charles Brenner has famously stated that the psychoanalytic hypotheses concerning unconscious mentation and psychic determinism have been so abundantly confirmed that they can be viewed as "established laws of the mind." Brenner claims, for example, that if psychic determinism were false, then some mental events would occur at random. We shall first examine whether Brenner's claim is plausible. Second, we shall examine some of Freud's "manifold proofs" regarding the existence of unconscious mental processes. In the course of doing so, I introduce William James's arguments against unconscious mentation and Donald Levy's arguments for the indispensability of the psychoanalytic unconscious and discuss whether any of these arguments ultimately succeed. Key questions for discussion: (1) Are Brenner's "two fundamental hypotheses" dispensible? (2) Can there be an empirically adequate genuinely *psychoanalytic* theory that dispenses with these hypotheses? (3) What would be the theoretical and practical advantages of doing so? (4) How ought the truth or falsity of psychoanalytic theories inform and be informed by research in neuroscience?

This session is intended for anyone interested in the theoretical foundations of psychoanalysis, the integration of psychoanalysis and neuroscience, and the relationship between philosophy and psychoanalysis. A basic knowledge of philosophy, psychoanalysis, and neuroscience will be presumed.

REFERENCES:

1. Levy D: Is the psychoanalytic unconscious a dispensible concept? in Freud Among the Philosophers New Haven, Yale University Press, 1996, pp. 57–82.
2. Freud S: The unconscious, in the Standard Edition of the Complete Psychological Works Edited and translated by Strachey J, London Hogarth, Vol. 14, 159–215.

Issue Workshop 18
THE IMPACT OF SUICIDE ON CLINICIANS

Chairperson: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262*
Participants: Jane Tillman, Ph.D., Edward R. Shapiro, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enumerate psychotherapists' responses to a patient's suicide

and list steps in coming to grips with such tragic but often inevitable events. They will have engaged discussion about such experiences with senior colleagues with expertise on the issue.

SUMMARY:

It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. Mental health clinicians often have less contact with death in their work with patients than clinicians from other medical environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect on clinicians than on nonpsychiatric colleagues because of the powerful responses to the act of suicide, as well as the intentional empathic attunement and emotional availability to patients that is part of mental health clinical work. This workshop offers an initial half-hour presentation from a pilot study that found seven thematic clinician responses to the suicide of a patient: initial shock; grief and sadness; changed relationships with colleagues; dissociation; grandiosity, blame and humiliation; crises of faith in treatment; and an effect on work with other patients. Exploring therapist responses offers an opportunity to anticipate and avoid professional isolation and disillusionment and may help professionals provide and receive help during such crises. The remainder of the workshop will be a highly interactive opportunity for participants to discuss their own experiences with patient suicides with workshop presenters experienced with the issue.

REFERENCES:

1. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138–148.
2. Powell J, Geddes J, Deeks J, et al: Suicide in psychiatric hospital inpatients. British Journal of Psychiatry 2000; 176:266–272.

Issue Workshop 19
HOW TO DEVELOP A LECTURE

Chairperson: Marianne T. Guschwan, M.D., *155 E. 31st Street, Suite 25-L, New York, NY 10016*
Participant: Susan Tapert, Ph.D.

EDUCATIONAL OBJECTIVES:

The workshop participant will be provided with: guidelines as to how to prepare and deliver a lecture to various audiences, suggestions as to how to handle questions after the lecture, tips to effectively utilizing Power Point slide presentations, existing resources to refer to that will provide lecture outlines and slides.

SUMMARY:

This workshop is geared toward residents, fellows, and early career psychiatrists and anyone else who would like to learn more about developing lectures. The workshop will begin by discussing the following: 1. How to prepare a lecture, 2. How to deliver a lecture, 3. How to handle questions, 4. How to close.

These topics will include how to gear lectures toward medical students versus residents versus fellows, i.e., what are the *must include* topics, what information is optional, and what not to include. The latter half of the workshop will be a demonstration of how to prepare effective slides on Power Point showing dos and don'ts. The presenters will also demonstrate the use of Web sites to prepare a lecture or lecture series. The attendees will be provided resources available for outlines, slides and other information.

REFERENCES:

1. Tufte ER: The Visual Display of Quantitative Information Cheshire, Ct, Graphics Press, 1997.
2. Bakshian AB: The American Speaker, Washington DC, Georgetown Publishing House, 1997.

Issue Workshop 20
RECENT ADVANCES IN FEMALE SEXUAL MEDICINE

Chairperson: Barbara D. Bartlik, M.D., *Department of Psychiatry, Cornell University Medical College, 865 West End Avenue #7E, New York, NY 10025*
Participants: Laura Berman, Ph.D., Marina Rozenberg

EDUCATIONAL OBJECTIVES:

Participants will become familiar with the most recent developments in female sexuality and their clinical applications. These include issues surrounding testosterone, the EROS-CTD device, vaginal creams, oral medications such as sildenafil (Viagra), herbal remedies, improved lubricants, pheromones, female-friendly erotic videos, and new methods of assessing sexual dysfunction.

SUMMARY:

This workshop will introduce participants to new methods of evaluating and treating the sexual problems of women. Areas that will be covered include research measurements of genital blood flow, vaginal PH, and the ability to detect fluctuations in temperature and vibration. In addition, several new and potential treatments for female sexual dysfunction (FSD) will be discussed, including oral medications such as sildefanil, over-the-counter nutritional supplements, medicated vaginal creams, and improved lubricants. The Eros-CTD device, the first FDA approved treatment for FSD, will be described. Eros-CTD is a tiny flexible cup that fits over the clitoris, providing gentle suction and facilitating blood flow. Furthermore, the new genre of erotic videos, which are geared toward a woman's taste, will be introduced. Moreover, human pheromones will be covered. These are now manufactured in a synthetic form and are being studied for their ability to sexually attract the opposite gender through the sense of smell. The importance of testosterone to women's sexual health will be underscored, with particular attention to issues regarding supplementation. Presentations will be brief and highlighted with interesting visuals. Participants are encouraged to ask questions pertaining to the areas they are most interested in.

REFERENCES:

1. Bartlik B, Goldberg J: Female sexual arousal disorder. In Leiblum, S. & Rosen, R. (editors), Principles and Practice of Sex Therapy, Third Edition, pp 85–115.
2. Berman JR, Berman LA, Goldstein I: Female sexual dysfunction. The Female Patient, 1998; 23:45–51.

Issue Workshop 21
THE ART OF HEALING: USE OF ART THERAPY AND GROUP PSYCHOTHERAPY FOR TREATMENT OF TRAUMATIZED IMMIGRANT POPULATIONS

Co-Chairpersons: Abbas Azadian, M.D., *Department of Psychiatry, Clark Institute, 33 Princess Street Suite 102, Toronto, ON N5A 4P4, Canada,* Mary E. Sanderson, R.A.T., *Canadian Center Victim of Torture, 194 Jarvis Street, Toronto, ON M5B 2B7*
Participant: Rosemary Meier, M.D.

EDUCATIONAL OBJECTIVES:

This workshop will demonstrate the potential of art therapy in combination with group psychotherapy in the treatment of an immigrant population. By experiencing the use of art material first hand, participants will gain an understanding of the value of art in a

psychotherapy group format in the treatment of traumatized refugee population.

SUMMARY:

The treatment of traumatized patients is challenging and difficult. It is especially difficult to treat a traumatized refugee population. Uncertain future, settlement difficulties, as well as limited knowledge of language are all factors that make working with this population difficult. Traumatized refugees feel alone and unsupported and have limited ability to communicate or express their emotions in the language of the host country.

A group therapy setting can provide a much-needed sense of support and of not being alone. Use of art can be extremely helpful in facilitating expression of emotion. In this workshop participants will have the opportunity to create their own art if they desire to and share it with the others as time permits. Extensive case materials and art of clients will be used to demonstrate the advantages of the use of these modalities in the treatment of this population. Therapeutic factors of an art-therapy-group will be discussed and demonstrated with case materials and art of facilitators own practice. Difficult situations in treatment will be explored using case vignettes.

REFERENCES:

1. Sanderson M: Art therapy with victims of torture: a new frontier. Canadian Art Therapy Journal, 1995:9:1.
2. Yalom ID: The Theory and Practice of Group Psychotherapy. 4th edition. Basic Books, 1995.

Issue Workshop 22
TEACHING BEHAVIORAL SCIENCES TO FAMILY DOCTORS

Chairperson: Jonathan S. Davine, M.D., *East Region Mental Health, 2757 King Street East, Hamilton, ON L8G 5E4, Canada*

EDUCATIONAL OBJECTIVES:

To understand longitudinal method of teaching behavioral sciences to family medicine residents; to understand CME initiatives in a shared care family medicine/psychiatry program.

SUMMARY:

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

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

There will be question and answer periods with the audience after the presentation of each of these two models. As well, participants will be encouraged to share their own experiences in this educational area.

REFERENCES:

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

Issue Workshop 23
ALCOHOLISM PHARMACOTHERAPY: A CASE-BASED REVIEW FOR CLINICIANS

Chairperson: Lance P. Longo, M.D., *Department of Psychiatry, Sinai Samaritan, 1020 North 12th Street, 4th Floor OHC, Milwaukee, WI 53233*
Participants: Michael J. Bohn, M.D., Robert M. Swift, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify indications, contraindications, and prognostic variables that influence safe and efficacious medication—patient matching in alcohol dependent individuals. A variety of brief case presentations will highlight relevant aspects of the clinical history and presentation to consider when choosing pharmacotherapeutic interventions for alcohol withdrawal and relapse prevention.

SUMMARY:

Several medications currently exist for the treatment of alcoholism, and a variety of others are under investigation. Safety and efficacy data for naltrexone, antabuse, anticonvulsants, and antidepressants will be summarized, and preliminary findings on acamprosate and nalmefene will be presented. Prognostic indicators such as family history, craving, motivation and compliance, cognitive abilities, social support system, impulsivity, and other comorbid psychiatric or medical conditions will be discussed.

A series of everyday-practice case vignettes will highlight indications and contraindications important to consider when recommending a pharmacologic agent for a particular patient. The audience will be encouraged to share their clinical experiences during a panel discussion of these cases. This workshop is designed to bridge the information gap between research and "real world" clinical practice.

REFERENCES:

1. Longo LP: Progress and issues in alcoholism pharmacotherapy. Primary Psychiatry 1999; 6:65–77.
2. Garbutt JC, West SL, Carey TS, et al: Pharmacologic treatment of alcohol dependence: a review of the evidence. JAMA 1999; 281: 1318–1325.

Issue Workshop 24
BALANCING CAREER AND FAMILY

Chairperson: Margery S. Sved, M.D., *Dorothea Dix Hospital, South Boylan Avenue, Raleigh, NC 27603-2176,* Emily A. McCort, M.D.

EDUCATIONAL OBJECTIVES:

To learn and share strategies to better balance the demands of a career in psychiatry with family responsibilities.

SUMMARY:

Since the first few hectic years of a psychiatrist's career often coincide with child-rearing years, learning how to balance career and family is a crucial skill for members-in-training and early career psychiatrists. During this workshop, the speakers will draw on their own experiences with raising children while working and will discuss issues such as parental leave, child care, career tracks, part-time vs. full-time practice, leisure time, and self care. This will be an interactive workshop, and participants will be encouraged to share their stories, successes, tips, and mistakes.

REFERENCES:

1. Potee R, Gerber A, Ickovics J: Medicine and motherhood: shifting trends among female physicians from 1922–1999. Academic Medicine 74:911–919.
2. Tinsley J. Pregnancy of the early career psychiatrist. Psychiatric Services 51:105–110.

Issue Workshop 25
NARCISSISM BELOW SEA LEVEL: A DUTCH VIEW OF FUTURE GAY DEVELOPMENTS

Co-Chairpersons: Nicolaas F.J. Hettinga, M.D., *CMHC, Riagg Amsterdam-NRD, Keizersgrach 810, Amsterdam 1017-ED 00220, Netherlands,* Rudolf A.M. Feijen, M.D., *Langestraat 43–45, Amsterdam 1015 AK, Netherlands*
Participants: Wilco Tuinebreljer, Bastiaan L. Oele, M.D., Wilhelm G.W. Vanderplaats, M.D.

EDUCATIONAL OBJECTIVES:

To make a distinction between healthy and pathological narcissism in gay people. Recent sociological developments in which individualism leads to narcissistic solutions concerning the demands of a homosexual identity. This will be viewed in contrast with non-Western cultures, resulting in a broader perspectivc of the term homosexuality.

SUMMARY:

In the Netherlands, known for its liberal attitude towards homosexuality, emancipation has been supported by politics and mental health care. Immigration from many non-Western countries with different attitudes towards homosexuality challenges these attainments. Dr. Wilhelm VanderPlaats presents a HIV project in a CMHC, comparing mental health problems in HIV-infected people with premorbid symptomatology. Dr. Rudolf Feijen and Dr. Wilco Tuinebreijer will take a closer look at necessary narcissistic growth to fulfill the formation of a healthy gay individual. They will also question whether the so-called emancipated gay culture doesn't enhance narcissistic pathology.

Dr. Nicolaas Hettinga will position the term homosexuality in a cross-cultural context, in which male-male (and female-female) sexuality is often valued in a completely different way. Dr. Bastiaan Oele will close the presentation with needed changes in therapeutic insights and techniques for gays of the next generation, who will represent a mixture of many cultural backgrounds. The presenters invite the participant to discuss the following issues: homosexuality and narcissism, the dangers of an increasing individualism in our society, the consequences of homosexuality as seen in a broader cross-cultural context, and the meaning of this for adequate treatment of gay patients.

REFERENCES:

1. Kirkpatrick RC: The evolution of human homosexual behavior. Current Anthropology 2000; Vol 41, #3.
2. Cabaj RP, Stein TS (eds): Textbook of Homosexuality and Mental Health. Washington DC, American Psychiatric Press, 1996.

Issue Workshop 26
COMPUTER ODYSSEY 2001: UPDATES FOR NEW COMPUTER PURCHASERS

Co-Chairpersons: Lawrence K. Richards, M.D., *714 South Lynn Street, ChampaignEffingham, IL 61820-5817,* Alan W. Newman, M.D., *1440 Canal Street #TB53, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVES:

Is to hand the members attending an up to date understanding of the world of Personal Computers, (PC) which are now more powerful than the supercomputers of 1975. While not a "hands on" experience, confidence for purchasing will be "installed" by sharing evaluative information, a beginners' handout, and useful approaches.

SUMMARY:

As digitalization continues to advance, science's contributions in computer engineering and computer science continue to make computers faster and more capable. Psychiatrists with old computers and those just entering this "world' will enjoy "incorporating" the authors' "input" regarding improvements available to the new PC purchaser in 2001. There will be an emphasis on Lap Top PC's (LT) and their hardware, as hardware controls both price and capacity, but software isn't ignored.

Medical metaphors and comparisons to concepts already learned by physicians are used to "insert the program" that physicians are already well prepared to become computer literate. Practical applications from science courses, such as temperature changes, atmospheric/"milieu" conditions, and fundamentals of electricity, are "linked" with knowledge of human "behavior" and concepts associated with the medical specialities of medicine, pediatrics, psychiatry and surgery so as to increase the confidence of busy, beleaguered physicians that they are in a prime state of readiness to buy a new Y2001 PC! This confidence is increased by clear descriptions of the basic ingredients of a computer. Those physical components called hardware and the digitally produced "programs" called software, which use the hardware to operate and thereby cause the computer to "come alive," are discussed in a clear, concise, reasonably non-technical way. A handout covering the most basic hardware components, their units of measurements and function, and their interrelatedness will be provided; the authors are well equipped to elaborate upon these realities, and the audience will be given full opportunity to "access" their knowledge. Those attending should leave with solid ideas on how to decide what they want to buy. All that remains then is to go out and price choices and choose among "support systems."

The following "entries" reflect the expanse of pertinent information and updates the W/S authors will cover or be prepared to discuss: size, shape, weight, main-frame, desk top, lap top, towers, cables, inputs, mouse & pads, keyboards, scanners, cameras, drives, (Hard, Disk, Floppy, Diskette, Optical, CD, ROM, Readable, ReWritable, DVD) outputs, printers, monitors, drivers, dialogue box, windows, displays, active matrix, SVGA, XGA, SXGA, TFT, Networks, BIOS, MSFT, AAPL, HP, DELL, COMPAQ, GATEWAY, etc., updateable, bits & bytes, (Kilo, Mega, Giga, Tera) Teraflops, Cray, Supercomputer, Tera, Intel, AMD, Processors, Megahertz, Power, (surges, sources, settings, meter, "NiMH," Lithium ion and economies) Cache, SDRAM, internal and external transmission, Modems, (phone and cable) I'NET, E-mail, E-machines, I-opener, ISP, servers, browsers, drivers, USB, IEEE, HTTP, HTML, WWW, domains, (.com, edu, gov, mil, net, org,) ODF, OCR, Speech Recognition, PC cards, PCMCIA cards, sound cards, graphics cards, video cards, BUS, ZV, supports, slots, sockets, ports, docks, bays, trays, cookies, menus, files, folders, documents, icons, clicks, (right and left) bars, (task and tool) defaults, profiles, programs, settings, standby, hibernate, shutdown, surge protection (phone and power line) . . . and NERD.

REFERENCES:

1. Mansfield R, Weverka, P: Windows 98 for Busy People. p271–20.00 2nd Ed Osborne Books Banning, CA, 1999.
2. Langer M: Quicken 2000, p 530–25. Osborne/McGraw Hill, Berkeley, CA, 1999.

Issue Workshop 27
UNDERSTANDING THE DYNAMICS OF ABUSIVE RELATIONSHIPS

Chairperson: Gary J. Maier, M.D., *Mendota Mental Health Institute, 301 Troy Drive, Madison, WI 53704-1521*

EDUCATIONAL OBJECTIVES:

To identify the need to diagnose couples involved in an abusive relationship, identify a model that will differentiate an abusive fight from a fair fight, identify control tactics used by an abuser to maintain power and control over a victim, be able to counsel an abused woman on the need to seek professional, therapeutic and legal help to break the cycle of abuse and as necessary, end an abusive relationship, counsel an abuser on the need to seek professional help to identify and change the habit of abuse.

SUMMARY:

The goal of this workshop is to raise the consciousness of clinicians of the need for better diagnosis and treatment of battering men and battered women. Using a model that defines the stages of a fair fight so it can be contrasted with the stages of an abusive fight, the workshop leader will present examples of the differences so participants can discuss the factors that must be considered when making the "diagnosis of abuse." The importance of considering "relational" dynamics will be introduced.

The participants will then discuss three cases of abuse that involve "couples" at different stages of abusive relationships. Management/ treatment issues will be discussed. These will range from no intervention through building a support group to legal remedies including the use of restraining orders and divorce.

Finally, the workshop leader will present a protocol for managing abusive relationships, enriched by the participant discussion. The participants will then discuss the practical implementation of the protocol as it applies to real abusive relationships in the context of the support system in their communities.

REFERENCES:

1. Maier GJ: Understanding the dynamics of abusive relationships. Psychiatric Times, September, 1996.
2. Jones A, Schecheter S: When Love Goes Wrong. New York, N.Y. Harper Perennial, 1992.

Issue Workshop 28
MENTAL HEALTH EDUCATION FOR THE PRIMARY CARE PHYSICIAN

Co-Chairpersons: Linda Gask, M.D., *Royal Preston Hospital, Sharoe Green Lane, Preston, UK PR2 9HT,* Amelia E. Musacchio de Zan, M.D., *Mental Health, University of Buenos Aires, Santa Fe 3802, 7th Floor, Buenos Aires 1425, Argentina*
Participants: Pedro Ruiz, M.D., Rodolfo D. Fahrer, M.D., David A. Baron, D.O.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participant should be able to exhibit knowledge of effective methods of educating PCPs in the diagnosis and treatment of mental disorders, and identify effective strategies for engaging physicians in psychiatry and mental health CME activities.

SUMMARY:

Worldwide there is recognition of the central role that primary care physicians play in the recognition and management of psychiatric and mental health problems. A wide range of educational materials have been designed for use in these settings, but dissemination of knowledge and skills remains patchy and often ineffective. Psychiatrists are frequently called upon to take a leadership role in this task. In this workshop we will consider a range of key tasks and skills. How to develop goals and objectives utilizing appropriate "action verbs," how to make the most of a lecture, the educationally sound way to use audiovisual tools (how to construct effective slides and video-feedback techniques for skill acquisition), and how to make role-play more acceptable. We will also consider the need to adapt the "message" to the intended audience, and how to develop a dissemination program.

We will encourage the audience to share skills throughout the workshop and engage in mutual learning through discussion of real problems and experiences. We can share experiences and training materials from across the American and European continents and the World Psychiatric Association. This is a joint workshop from the WPA sections of Education and Psychiatry, Medicine & Primary Care.

REFERENCES:

1. Gask L, Goldberg D, Lesser AL, Millar T: Improving the psychiatric skills of the general practice trainee. Medical Education, 1988; 22:132–138.
2. Matorin AA, Ruiz P: Training family practice residents in psychiatry: an ambulatory care training model. International Journal of Psychiatry in Medicine, 1999; 29:327–336.

Issue Workshop 29
INTERGENERATIONAL ASPECTS OF TRAUMA AND AGGRESSIVE BEHAVIOR

Chairperson: Andrei Novac, M.D., *Department of Psychiatry, University of California, 400 Newport Center Dr, Suite 309, Newport Beach, CA 92660-7604*
Participants: Rita R. Newman, M.D., Rachel Yehuda, Ph.D.

EDUCATIONAL OBJECTIVES:

To become familiar with the biopsychosocial model of intergenerational transmission of trauma; recognize different types of aggressions; understand the relationship between trauma exposure and proneness to aggression.

SUMMARY:

The persistent trend of humankind to victimize each other has been the subject of preoccupation of researchers and clinicians alike. Mental health professionals are often called to render an opinion regarding aggression in work-related settings, in court/criminal procedings, and more recently, in the war crime tribunals.

Victims of traumatic stress are known to exhibit a large gamut of behavioral changes, which ranges from severe psychopathology (PTSD, major depression) to behavioral peculiarities considered to be "adaptive."

The participants in this workshop are members of the Intergenerational Aspects of Trauma area of interest at the International Society of Traumatic Stress Studies (ISTSS), who have been examining the relationship between trauma exposure and the proneness to aggression in the next generation. Two separate types of aggression will be described, and the possible mechanism of transmission of trauma to the next generation will be discussed. The defense mechanism of dehumanization/depersonification and its link to the biology of intergenerational transmission will be presented.

Clinical examples drawn from the experience of the presenters (in Vietnam veterans, Holocaust families, victims of domestic violence, etc.) will be discussed with audience participation.

REFERENCES:

1. Yehuda R, Bierer L, Schmeidler J, et al: Low cortisol and risk for PTSD in adult offspring of holocaust survivors. Am J Psychiatry 2000; 157:1252–1259.

2. Novac A: Traumatic stress and human behavior: current biopsychosocial considerations. Psychiatric Times, in press.

Issue Workshop 30
FUNDING OPPORTUNITIES FROM THE NATIONAL INSTITUTES OF HEALTH
National Institutes of Health

Chairperson: Lucinda Miner, Ph.D., *NIDA, 6001 Executive Boulevard, Bethesda, MD 20892*
Participants: Ernestine Vanderveen, Ph.D., Walter Goldscmidts, Ph.D.

EDUCATIONAL OBJECTIVES:

To describe the overall function of the National Institutes of Health and its role in extramural research, differentiate among the various types of research-training funding opportunities, discuss criteria for eligibility and review of awards, understand differences in stipends, other means of support, and deadline dates, and discuss important components of the review criteria.

SUMMARY:

The purpose of this workshop is to clarify the National Institutes of Health (NIH) grant-application process for inexperienced applicants. Specifically representatives of the National Institute on Drug Abuse, the National Institute of Mental Health, and the National Institute on Alcohol Abuse and Alcoholism will discuss research training opportunities. The NIH offers a variety of funding mechanisms designed to support research training. These include the National Research Service Awards for pre- and post-doctoral fellows as well as the Career Development Awards, or "K" awards. Some of these awards have been specifically designed to support research training for clinicians.

The first half of the program will consist of an overview of the grant application, application review, grant administration, and the funding processes. The second half of the workshop will feature successful recipients of federal grants who will offer their insights into pursuing and obtaining federal research support. Ample time will be allotted for workshop participants to ask specific questions of the presenters.

Issue Workshop 31
CURRENT AND FUTURE TRENDS IN PSYCHIATRY AND EMPLOYMENT LAW

Chairperson: Michael M. Welner, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, #806, New York, NY 10001*
Participants: Joseph P. Merlino, M.D., Ron Honberg, J.D., Lewis A. Opler, M.D., William F. Foote, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with challenges to the examination of the sex harassment plaintiff; become acquainted with the industrial or occupational psychopath; and demonstrate awareness for new opportunities in accommodating the mentally ill at the workplace.

SUMMARY:

Psychiatry continues to face new challenges as the science becomes more enriched and employment law becomes increasingly reliant upon forensics. Novel technologies, harassment and discrimination statutes, and new challenges of e-commerce call upon mental health understanding. Since the role of the psychiatrist consultant may be pivotal, the science faces important challenges to distinguish what it can and acknowledge its limits.

This workshop explores several frontier areas from the employment law–psychiatry interface. The workshop explores challenges to history gathering in the examination of sex harassment plaintiffs, given political pressures to label past history irrelevant. The new economy's fluid workforce and small office settings with loose boundaries are fertile ground for the industrial psychopath. The workshop will present history, based upon literature and case examples, of how psychopathy at the workplace differs from traditional psychopathy models and from pathological narcissism per se.

With the Americans With Disabilities Act, people receiving treatment for psychiatric illness have protections needed to better integrate into the work setting. The workshop presents, utilizing case examples, a review of how the ADA, in practice, is working to enhance opportunity and to facilitate occupational reintegration. Clinicians who attend this workshop will receive guidance on how they can use their position to stabilize an important component of their patient's support system, as well as the ethical limits of such intervention.

REFERENCES:

1. US Department of Justice: Enforcing the ADA: A Tenth Anniversary Status Report July 2000. Rosman JP, McDonald JJ: Forensic aspects of sexual harassment. Psych Clin N Amer 1999; 32:129–145.

TUESDAY, MAY 8, 2001

Issue Workshop 32
DOES THE MIND MEET THE BRAIN IN RESIDENCY? AND WHAT ABOUT THE BODY?

Chairperson: Avram H. Mack, M.D., *Department of Psychiatry, Harvard-Longwood, 330 Brookline Avenue, Rabb 2, Boston, MA 02215*
Participants: Stuart C. Yudofsky, M.D., William E. Greenberg, M.D., James J. Strain, M.D., Tana A. Grady-Weliky, M.D.

EDUCATIONAL OBJECTIVES:

To discuss recent advances in neuroscience, psychoanalysis, and somatic research and how they are taught together in both undergraduate and graduate psychiatric education.

SUMMARY:

In this workshop, four psychiatrists with expertise in neuroscience, psychoanalysis, and somatic disorders who are also closely involved in psychiatric education will discuss how these fields can be taught together during psychiatric education. They will also discuss their views of the ways in which these fields may coalesce in the future. Much of the workshop will be devoted to an active discussion on these topics between the panel and the audience. Audience members will be able to directly ask questions of these four experts.

REFERENCES:

1. Price BH, Adams RD, Coyle JT: Neurology and psychiatry: closing the great divide. Neurology 2000; 54:8–14.
2. Kandel ER: A new intellectual framework for psychiatry. American Journal of Psychiatry 1998; 155:457–69.

Issue Workshop 33
REINVENTING DEINSTITUTIONALIZATION IN THE 21ST CENTURY

Chairperson: Richard H. McCarthy, M.D., *Department of Psychiatry, Cornell University, 21 Bloomingdale Road, White Plains, NY 10605-1504*
Participants: Rami Kaminsky, M.D., Steven M. Silverstein, Ph.D., Andrew Bloch, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants will be aware of the rationale for targeting severely ill chronic state mental hospital

inpatients for comprehensive reassessment and rehabilitation treatment planning. Competing models to provide these services will be presented as well as initial results of one program.

SUMMARY:

In spite of several waves of deinstitutionalization, the introduction of more effective medications, assessment methods, and rehabilitation techniques, many state psychiatric facilities continue to maintain a group of difficult-to-discharge patients. Concurrently, American psychiatry has evolved towards short-term, crisis-oriented, community-based treatment. While these methods are of significant utility in the treatment of the newly ill and the beneficiaries of deinstitutionalization, they are not helpful for the residual and more difficult-to-treat cohort that continues to reside in publicly funded inpatient facilities.

Academic medical centers frequently contain faculty whose specific interests and skills are highly applicable to the treatment of these patients but who rarely work with this population. In an effort to address this maldistribution of resources, the New York State Office of Mental Hygiene began "the Second Chance Initiative." The intent of this initiative was to engage New York's academic psychiatry programs in comprehensive reassessment of the long-stay inpatient population in the state's psychiatric centers and to design treatment, discharge, and aftercare methods specific to their special problems.

This workshop will discuss this program's development and data on its effectiveness, elucidate the difficulties it faced, and likely areas of future development.

REFERENCES:

1. Bachrach LL: Deinstitutionalization. in, New Directions for Mental Health Services. Josey Bass Press, San Francisco, 1983.
2. Kanter JS: Clinical issues in treating the chronic mentally ill. in New Directions for Mental Health Services. Josey Bass Press, San Francisco, 1985.

Issue Workshop 34
NEUROPSYCHOTHERAPY

Co-Chairpersons: David M. Roane, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003,* Elizabeth S. Ochoa, Ph.D., *Beth Israel Medical Center, 317 E 17 Street, 9 Fierman, New York, NY 10003*

EDUCATIONAL OBJECTIVES:

To understand the role of psychotherapy in the treatment of individuals with neurologic illness; discuss how neuroanatomy, neuropsychologic impairment, and psychopathology are related and which specific psychotherapeutic interventions are appropriate for this population; and evaluate neuropsychiatric patients from an integrationist model utilizing both psychotherapy and psychopharmacology.

SUMMARY:

Recent advances in neuroimaging and psychopharmacology have resulted in improved diagnosis and treatment of neurological patients with psychiatric problems. However, our understanding of the exact relationship between the brain and behavior remains incomplete. Additionally, neuropsychiatric treatment requires a broad approach that addresses psychosocial as well as neurological sequelae of brain illness. Thus, a range of treatments should be employed with this patient population.

This workshop, with a psychiatrist and a neuropsychologist acting as coleaders, will make the case for including psychotherapy in the treatment of patients with brain disease. Participants will be engaged in a discussion of the benefits and limitations of psychotherapy in the management of patients with various forms of central nervous system dysfunction such as head injury, multiple sclerosis, and Parkinson's disease. We will outline an approach to patient evaluation that attempts to understand the relationship between the neuroanatomical lesion, the neuropsychological deficit, and the pathological thinking or behavior. We will demonstrate the application of a number of psychotherapeutic modalities to a range of neurological illnesses. The importance of combining psychotherapy with psychopharmacology will be emphasized. Case examples will be used to generate audience participation directed towards an elucidation of the differential therapeutics of neuropsychiatry.

REFERENCES:

1. Forest DV: Psychotherapy of patients with neuropsychiatric disorders. In The American Psychiatric Press Textbook of Neuropsychiatry 3rd ed., edited by Yudofsky SC, Hales RE, Washington, DC, American Psychiatric Press, 1992, pp 983–1017.
2. Miller L: Psychotherapy of the Brain-Injured Patients. New York, W.W. Norton & Co, 1993.

Issue Workshop 35
WOMEN'S LEADERSHIP AND CAREER DEVELOPMENT

Chairperson: Linda F. Pessar, M.D., *94 Greenaway Rd, Eggertsville, NY 14226-4110*
Participants: Carol A. Bernstein, M.D., Carol C. Nadelson, M.D., Carolyn B. Robinowitz, M.D.

EDUCATIONAL OBJECTIVES:

Workshop objectives are to familiarize participants with impediments to women's career development in academic psychiatry, and efforts to address them. At the conclusion, participants should be able to identify factors that may have a negative impact on their careers and be able to identify strategies to address these difficulties.

SUMMARY:

The number of women in medicine has grown dramatically over the last 30 years. In 1999, 44% of first-year medical students were women. While this rise has increased the proportion of women faculty, academic advancement for both tenured and untenured women remains problematic. Factors leading to the disparity in advancement between men and women include institutional issues such as lack of part-time tenure tracks, few senior faculty women available to provide mentoring, professional isolation, and exclusion from informal male-dominated professional networks, as well as psychosocial factors such as women's discomfort with competition and conflict, and competing demands of family responsibilities.

This workshop will provide a 45-minute overview of research about women in academic medicine and consideration of special issues for women in residency, faculty, and administrative positions. The remaining 45 minutes will be spent in discussion between the audience and workshop presenters who occupy senior positions in academic psychiatry.

REFERENCES:

1. Nonnemaker L: Women physicians in academic medicine: new insights from cohort studies, N Eng J Medicine 2000; 342:399–405.

2. Fried LP, Francomano CA, et al: Career development for women in academic medicine: multiple interventions in a development of medicine. JAMA 1996; 276:898–905.

Issue Workshop 36
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 OBJECTIVES:

To conceptualize personality disorder patients according to the cognitive model, recognize therapeutic alliance issues in treatment of personality disorders, set goals and plan treatment for patients with characterological disturbance, combine pharmacotherapy and cognitive therapy for personality disorder patients, describe and implement cognitive techniques.

SUMMARY:

Cognitive therapy, a short-term, structured, problem-solving-oriented psychotherapy, has been shown in over 120 trials to be effective in treating Axis I disorders. In the past 10 years cognitive therapy methods have been developed for Axis II disorders, and outcome research has verified the utility of this treatment approach. Cognitive therapy for personality disorders requires substantial variation from Axis I treatment. A far greater emphasis is placed on developing and maintaining a therapeutic alliance, modifying dysfunctional beliefs and behavioral strategies, and restructuring the meaning of developmental events.

In this workshop, a variety of case examples of patients with personality disorders will illustrate the principles of cognitive therapy, conceptualization of individual patients, developing the therapeutic relationship, planning treatment, and the adjunctive use of medication. Role plays will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout, and a final segment will instruct 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 Dickstein L., Riba MB, Oldham JM. (Eds.). American Psychiatric Press Review of Psychiatry, Vol. 16, Washington, D.C.: American Psychiatric Press, 1997.

Issue Workshop 37
BALANCING POWER IN THE PSYCHIATRIST-PATIENT ALLIANCE FOR THERAPEUTIC SUCCESS

Co-Chairpersons: Steve S. Abdool, M.A., *Homewood Health Center, 150 Delhi Street, Guelph, ON N1E 6K9, Canada,* Diane K. Whitney, M.D., *Center for Addict Mental Health, 250 College Street, Toronto, ON M5T 1R8, Canada*
Participant: Wilson M. Lit, M.D.

EDUCATIONAL OBJECTIVES:

To critically examine the concept and ramification of power structures in therapeutic relationships, and systematically determine and implement ethically justifiable approaches to enhance therapeutic alliance and success.

SUMMARY:

Power exists in all relationships, but the extent and implications of its presence in the therapeutic relationship is rarely acknowledged. The complex social and political constructs of power concepts, underpinned by a range of values, beliefs, attitudes, and experiences, have extensive impact on the alliance.

The "power over" aspect of the therapeutic relationship allows for involuntary commitment and forced treatment for the perceived "good" of the patient. This preponderance of power and locus of authority and control in the hands of clinicians pose serious risk for misuse and abuse. Indeed, the ethical requirement to establish healthy professional boundaries is primarily based on the premise that the power imbalance creates the potential for exploitation. In contrast in the "power with" or voluntary helping frame, power can become transformative. In this situation the therapeutic relationship can assist patients/clients to change, develop and recover.

In this workshop, participants will critically examine the notion of power and shared-care decision-making in the psychiatric encounter. In so doing, participants will briefly appraise the biomedical engineering, contract, covenant, healing, and authoritarian models of clinician-patient relationship to determine the most feasible for modern psychiatric practice. Participants will further explore approaches to augment an appropriate balance of power and control in the alliance, partly through skills to reduce and eliminate transference and countertransference pitfalls and to enhance information exchange and shared negotiation. The workshop will be very interactive, use real case scenarios, and draw on the experiences of participants.

REFERENCES:

1. Guggenbuhl-Craig A: Power in the Helping Professions. Woodstock, Connecticut, Spring Publications, 1999 (new edition).
2. Lebacqz K: Professional Ethics: Power and Paradox. Nashville, Tenn., Abingdon Press, 1985.

Issue Workshop 38
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 90002*
Participants: William B. Lawson, M.D., Edmond H. T. Pi, M.D., Ricardo P. Mendoza, M.D.

EDUCATIONAL OBJECTIVES:

To understand the role of the pharmacokinetic, pharmacodynamic, and pharmacogenetic mechanisms in the psychopharmacological approaches in treating ethnic minority groups; to better select the most appropriate psychopharmacological treatment of ethnic minority patients; and to better recognize drug-to-drug reactions when using psychopharmacological agents.

SUMMARY:

Research efforts have profoundly advanced the field of ethnopsychopharmacology during the last 10–15 years. As a result of this, much knowledge has been secured with respect to the role of pharmacokinetics, pharmacodynamics, and pharmacogenetics in the psychopharmacological treatment of ethnic minority patients who suffer from psychiatric disorders and conditions. These research advances have gained much relevance given the multiethnic and pluralistic aspects of the United States population. Additionally, the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has greatly recognized the role of ethnicity, race, and

culture when diagnosing and treating multiethnic populations in the United States and abroad.

In this workshop we will address and discuss the most recent research advances and findings with respect to the psychopharmacological treatment of African Americans, Hispanic Americans, Asian Americans and Pacific Islanders, and Native Americans. Particular attention will be given to the metabolic mechanisms, drug-elimination patterns, and ethnic variations in drug responses as well as the environmental factors that could play a role in ethnopsychopharmacology. This workshop should stimulate further thinking and research efforts in the field of ethnopsychopharmacology.

REFERENCES:

1. Ruiz P, Varner RV, Small Dr, Johnson BA: Ethnic differences in the neuroloptic treatment of schizophrenia. Psychiatric Quarterly 1999; 70:163–179.
2. Ruiz P (ed.): Ethnicity and Psychopharmacology, Washington, D.C., American Psychiatric Press, Inc., Review of Psychiatry Series, Volume 19, No. 4, 2000.

Issue Workshop 39
CHILDREN OF PSYCHIATRISTS

Co-Chairpersons: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 South Preston, Suite 214, Louisville, KY 40292,* Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0704, Ann Arbor, MI 48109-0704*
Participants: David Benedek, M.D., Luisa Isbell, Daniel Weintraub, M.D., Katherine H. Johnson

EDUCATIONAL OBJECTIVES:

To be more aware of, informed about, and sensitive to the common and unique attitudes, experiences, and issues children of psychiatrists may and do experience directly and indirectly across their early developmental years through all stages of adulthood.

SUMMARY:

For the year 2001, the Children of Psychiatrist workshop participants will each speak for 12 minutes about their unique personal experiences, with the initial very willing and generous consent of psychiatrist-parents! Both unique positive and challenging issues they experience will be highlighted as well as their personal recommendations for the audience of psychiatrist-parents and children of psychiatrists.

Furthermore, many early career psychiatrists and residents, as future and current parents, are justifiably concerned about how to parent effectively and happily as they simultaneously continue in their professional roles and responsibilities.

Such issues as boundaries between personal and professional lives as well as ever-increasing knowledge about child and young adult healthy development, role modeling of communication skills, expression of emotions, and satisfactions and concerns about balancing personal and professional issues and lives will be discussed.

REFERENCES:

1. Olsen RD, Sande, JR, Olsen GP: Maternal Parenting Stress in Physician's Families, Clinical Pediatrics 1991; 30:586–590.
2. Lumley J: Patterns of Life After Graduation, Medical Journal of Australia 1979; 1:566–568.

Issue Workshop 40
WOMEN AND SUICIDE: HORMONES AND GENES

Co-Chairpersons: Jose de Leon, M.D., *Department of Psychiatry, University of Kentucky, 627 West 4th Street, MHRC 627, Lexington, KY 40508-1207,* Kay R. Jamison, Ph.D., *Department of Psychiatry, Johns Hopkins University, 720 Rutland Avenue/Meyer 4-181, Baltimore, MD 21205*
Participant: Enrique Baca-Garcia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have a basic understanding of: the clinical significance of the influence of sexual hormones in female suicide attempts and the potential of genetic studies to further clarify this subject.

SUMMARY:

Suicide attempts are more frequent in women, but more men complete suicide. In young women (ages 15–45) suicide is the second leading cause of death in the world after tuberculosis.

Studies in the last 40 years using patient's report have suggested that suicide behavior may be more frequent in the perimenstrual weeks, before and after the menses. In two recent studies using hormonal levels, we verified that the menstrual phase increases the risk of suicide.

Vulnerability to suicide is probably better understood in the context of a model of stress-diathesis for suicidal behavior. Some biological factors such as low serotonergic activity may contribute to suicide risk. Several genes influence serotonergic function. According to the results of our most recent study, allelic variations of the serotonin transporter gene appeared not to influence male suicide. However, these allelic variations did appear to influence female suicide. Moreover, these variations appeared to interact with hormonal levels.

A dialogue will then be established so that the audience can discuss their own experiences with the influence of sexual hormones in female suicide attempts. Then ideas will be exchanged with the participants regarding the possible clinical implications of these findings.

REFERENCES:

1. Jamison K: Night Falls Fast—Understanding Suicide. New York, Alfred A. Knopf, 1999.
2. Baca-García E, Diaz-Sastre C, de Leon J, Saiz-Ruiz J: The relationship between menstrual cycle phases and suicide attempts. Psychosom Med 2000; 62:50–60.

Issue Workshop 41
GRAPHOTECHNOLOGY: HOW TO SAVE TIME AND REVEAL CLUES IN HANDWRITING ANALYSIS

Co-Chairpersons: Sheila M. Kurtz, M.S., *Department of Graphology, 57 East 11th Street, 9th Floor, New York, NY 10003,* Barnard L. Collier, B.A., *Graphotechnology, Inc., P.O. Box 815, Montauk, NY 11954*

EDUCATIONAL OBJECTIVES:

To acquaint physicians with scientific roots of graphotechnology and demonstrate the graphologic clues to physical/behavioral factors. A participant will recognize in a patient's handwriting the indications of depressed emotional range (President Richard Nixon), murderous camouflage ('Son of Sam'); exquisite concentration: ('god') immense intelligent enthusiasm: (Thomas Alva Edison), and more.

SUMMARY:

This workshop is for psychiatrists who wish to explore the use of graphotechnology (computer-assisted handwriting analysis as an accurate, time-saving probe to help discover and delineate communications skills, achievement traits, emotional range, stress/energy levels, thinking patterns, and possible physical strengths or impairments. The workshop exercises in graphology testing include: 1) a preliminary self-administered analysis and "walk-in-another-man's shoes" handwriting exchange among physician participants; 2) discussion of scientific, therapeutic, investigative, and mercantile aspects of graphology, including state-of-the-art technology; 3) a brief review of graphotechnology in the executive marketplace, including team building (Utah Jazz basketball; major North American and European corporations); executive compatability (governmental, administrative); integrity screening (banks, investment firms, intelligence agencies); and jury selection. 4) a neurobiologist with speciality in EEG and EKG research and development and a psychiatrist with a scientific interest in graphology will fill out the panel of four, including Sheila Kurtz, president of Graphology Consulting Group, New York City/London and Barnard Law Collier, director, Graphotechnology, Inc. New York. 5) A Powerpoint graphics program and the Computerized Handwriting Analysis Program (CHAP) will help illustrate the concepts.

REFERENCES:

1. Chedru F, N Geschwind: Writing disturbances in acute confusional states. Neuropsychologia 10:343–353.
2. Sulner HF: Mental disorders: their effect upon handwriting. American Bar Association Journal 45:931–4.

Issue Workshop 42
THE USE OF THE MOCK TRIAL IN PSYCHIATRIC STAFF EDUCATION

Chairperson: Stewart Levine, M.D., *Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003*
Participants: Harold I. Schwartz, M.D., Henry Pinsker, M.D., Raphael A. Morris, M.D., Jose A. Genua, M.D.

EDUCATIONAL OBJECTIVES:

This session is for the psychiatrist or mental health professional who is interested in learning how to plan and conduct a mock trial that will enrich the education of residents and staff regarding the interface between medicine and the law and that will provide an intense focus on forensic issues and how trials are conducted.

SUMMARY:

The mock trial is an effective educational tool that is seldom used in the education of psychiatrists and mental health professionals. It is useful not only for teaching about the interface between medicine and the law, but also about many ethical and legal issues. The adversary format provides an intense focus on many aspects of diagnosis, medical reasoning, treatment planning documentation, and forensic issues such as malpractice, liability, fiduciary relationships, and the conduct of trials and depositions. When a mock trial is based on a recent case, it serves an important quality assurance function. Cohen wrote about a mock trial that used attorneys as part of a seminar for psychiatric residents, pediatricians and junior faculty. Levine and Pinsker wrote about the use of a mock trial as a regular component in the educational program for the multidisciplinary staff. The panel will draw on its more than 15 years of experience with mock trials to provide information and guidance intended to encourage participants to plan and conduct mock trials within the time and personnel constraints of the typical educational program. The presentation will elicit a discussion between the panel and the audience regarding how to plan and conduct a mock trial in different types of educational programs. Audience participation will allow an exchange of ideas about how to use and improve this powerful teaching technique.

REFERENCES:

1. Cohen SN, Folberg HJ, Jack WH, Lings J: Meeting a training need: an interdisciplinary seminar of family law and child psychiatry. Bulletin of the American Academy of Psychiatry and the Law. 1977; 5:336–343.
2. Levine S, Pinsker H: The mock trial in psychiatric staff education. 1994; 22:127–132.

Issue Workshop 43
ECSTASY AND THE RAVE SCENE: A CANADIAN PERSPECTIVE

Co-Chairperson: Clare Roscoe, M.D., *1 Anderson Avenue, Toronto, ON M5P 1H2, Canada,* Antonia Seli, M.D., *30 Erskine Avenue #5, Toronto, ON M4P 1Y2, Canada*

EDUCATIONAL OBJECTIVES:

To identify the key components of raves and various club drugs, understand the history, trafficking routes, and pharmacology of the designer drug Ecstasy, recognize the psychological effects and psychiatric sequelae of Ecstasy use, appreciate the medical complications/causes of death and the controversy over MDMA's long-term neurotoxicity.

SUMMARY:

The participants of this workshop will step into the rave culture, surrounded by techno music, lights, and video imagery, while learning the inside story of Ecstasy. The designer drug Ecstasy (MDMA) and the rave scene have received much media attention recently. This has contributed to a growing social and political tension between the youth culture and those who seek to understand this movement. Raves emerged in western culture in the late 1980s and with them came new music, fashion, community, and drugs. Various "club drugs" have been reportedly used at raves including Ecstasy, and this drug's use has risen dramatically. Described as a "love drug," Ecstasy has various positive and negative psychological effects, with an increasing literature suggesting there may be long-term psychiatric implications. In addition, there has been an increase in Ecstasy-related fatalities, emphasizing the need to enhance knowledge of potential medical complications and emergency room treatment. Finally, MDMA's neurotoxic potential has been well documented in animal studies, but the controversy continues as to whether serotonin neurotoxicity occurs in humans. With new studies suggesting that Ecstasy *can* cause lasting damage in humans, a growing population of regular users may be at increased risk for long-term psychiatric sequelae.

REFERENCES:

1. Parrott AC, Lasky J: Ecstasy (MDMA) effects upon mood and cognition: before, during and after a Saturday night dance. Psychopharmacology 1998; 139:261–268.
2. Kish S, Furukawa Y, Ang L, et al: Striatal serotonin is depleted in brain of human MDMA (Ecstasy) user. Neurology 2000; 55:294–296.

Issue Workshop 44
INTEGRATED TREATMENT PROGRAMS FOR PREGNANT, MOTHERING WOMEN AND THEIR CHILDREN

Co-Chairperson: Linda L.M. Worley, M.D., *Department of Psychiatry, UAMS, 4301 W Markham Slot 789, Little Rock, AR 72205-1990,* Barbara A. Schindler, M.D., *Department of Psychiatry, MCP Hahnemann University, 3300 Henry Avenue APH, Room 220, Philadelphia, PA 19129*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be energized to pull various disciplines together to develop integrated treatment programs for addicted mothers and their children. They will be prepared to critically evaluate existing programming in their region, bringing home creative ideas.

SUMMARY:

The treatment of addicted women with young children is extremely challenging. Women who are pregnant or have young children are reluctant to seek treatment for fear of losing parental custody. Others with no safe alternative for child care can not enter "adult only" treatment programs. Providers of treatment for substance abuse are funded by different sources than providers of mental health care, setting the stage for an adversarial relationship rather than one of teamwork and cooperation. Many addicted women have underlying mental illness(es) such as depression, posttraumatic stress disorder, and/or anxiety disorders that have not been recognized and effectively treated. This increases the woman's risk for relapse and interferes with her ability to engage fully in treatment. The incidence of exposure to sexual, physical, and emotional abuse is astounding in this population and integrated treatment programs play a key role in intervening in the perpetual cycle of intergenerational abuse.

Participants will be given an overview of several evolving integrated residential treatment programs (from separate states) for pregnant and mothering women and their children. Innovative approaches will be introduced that will lead into a discussion between participants and workshop leaders. An active interchange of creative ideas will be encouraged as a means to further improve and evolve integrated treatment programming across the nation.

REFERENCES:

1. The development and evaluation of an alcohol and drug prevention and treatment program for women and children: the AR-CARES program. Journal of Substance Abuse Treatment 1999; 16:265–275.

Issue Workshop 45
DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BPD

Co-Chairperson: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262,* Edward R. Shapiro, M.D., *Admissions, Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enumerate principles in the dynamic psychotherapy of self-destructive borderline patients, 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 formidable psychotherapeutic challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, little has been written to help clinicians establish a viable doctor-patient relationship with these patients. This workshop begins with a 30-minute 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 to the patient; (7) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior; and (8) provision of an opportunity for reparation. After the presentation, the remaining hour 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 problem in doctor-patient relationships.

REFERENCES:

1. Plakun EM: Prediction of outcome in borderline personality disorder. Journal of Personality Disorders 1991; 5:93–101.
2. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138–148.

Issue Workshop 46
HEALING OF SPIRIT AND BODY THROUGH DANCE AFTER TRAUMA

Chairperson: Russell J. Gardner, M.D., *NASBI, 214 DS Rose Terrace, Madison, WI 53705-3323*
Participants: Doug Rosenberg, M.F.A., Chiao-Ping Li, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: (1) narrate the story of a car accident causing severe physical injuries to the directors of a modern dance company; (2) describe the dance choreography results of this experience including how this modified their trauma experience; (3) integrate this with the ally- and story-using capacities of the human mind.

SUMMARY:

Post-traumatic stress disorder may result from subcortical reactions to the traumatic stimulus. LeDoux points out that reactions to fear-producing stimuli stem largely from the amygdala; messages traveling from it to the cortex greatly outnumber those in the reverse direction. Conquering the subcortical reactions may happen, however, with story-using in its multiple forms, unique to humans amongst animals. Li Chaio-Ping, choreographer, dancer, and director of a contemporary dance company, and Douglas Rosenberg, visual artist and Ms. Li's collaborator, remained alive after a severe car collision. The accident and subsequent disability affected her choreography and stage-design elements that he furnishes. The dances reflected their reliving of the experience and its aftermath, the process contributed to their healing in body and spirit. Both will present a narrative of the event and its aftermath and show a videotape documentation of the performance entitled: Venous Flow, States of Grace, a work that was created subsequent to and inspired by the accident. Following this the psychiatrist discussant will react from the perspectives of how humans use their cortices via story composition and performance to subdue and harness the unruly amygdala. Audience members will be invited to react to each speaker after their talk. Finally Ms. Li and Mr. Rosenberg will invite the audience members to participate in a brief exercise in which they will be asked to contribute personally traumatic narratives which Li and Rosenberg will use to create a short, participatory performance.

REFERENCES:

1. LeDoux, J: The Emotional Brain, Simon & Schuster, 1996.
2. Gardner R: The brain and communication are basic for clinical human sciences. British Journal of Medical Psychology. 1998; 71:493–508.

Issue Workshop 47
CLINICAL PATHS ACROSS CULTURAL AND RACIAL BARRIERS: HOW TO DO IT

Co-Chairperson: Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago, IL 60617-2746,* Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 836 West Wellington Avenue, Chicago, IL 60657*
Participants: Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize barriers to cultural competence, to identify the effects of racism on patient care, and to diagnose and treat patients of different races more effectively.

SUMMARY:

Many clinical encounters involve a clinician of one race and a patient of another. Racial stereotypes, misconceptions, and attitudes pervade every society. They are part of every patient's daily experience and an inevitable part of the psychology of every clinician. There is evidence that many patients prefer, and outcomes may improve, when clinician and patient are of the same race, but very often this is not possible—and it is probably not necessary. But despite all the talk of cultural competence, there are few practical guidelines to help the practicing psychiatrist provide excellent care for a patient of another race. It is impossible to be culturally competent about all the myriad cultures in North America, but it is possible—and rewarding—to ask, listen, and learn. Start with the culture closest to you and expand your knowledge and practice from there. This workshop provides just those practical guidelines practicing clinicians need and a forum for clinicians at any stages of their careers to share their own experiences, concerns, and suggestions with each other and with a lively, diverse, and expert faculty. Cultural competence is attainable.

REFERENCES:

1. Helms JE, Cook DA: Using Race and Culture in Counseling and Psychotherapy: Theory and Process: Boston, MA Allyn and Bacon, Inc. 1999.
2. Ridley C: Overcoming Unintentional Racism in Counseling and Therapy. Thousand Oaks, CA: Sage, 1995.

Issue Workshop 48
BEYOND THE LECTURE HALL: INTEGRATING EDUCATIONAL CONCEPTS

Chairperson: Janet E. Osterman, M.D., *21 Ocean View Dr, Hingham, MA 02043-1224*

EDUCATIONAL OBJECTIVES:

The participants will be discuss the advantages and disadvantages of teacher-centered, learner-centered, and mixed-economy models as applied to psychiatric education, be able to identify effective teaching intervention for the adult learner, and learn techniques to organize a teaching program based upon educational theories and methods.

SUMMARY:

Few medical educators have formal knowledge of educational theories and methods, yet they are responsible for teaching future physicians. Effective teaching is a skill that can be developed through knowledge of educational theory and methods.

This workshop will review educational theories from teacher-centered learning systems (such as the lecture) to learner-centered learning systems (such as problem-based learning) and mixed-economy models. Teacher-centered and learner-centered systems present both advantages and challenges in developing effective psychiatric curricula in classroom and clinical settings.

Effective and efficient educational methods are essential to providing high-quality psychiatric education. A well-formatted lesson plan, a fundamental educational tool, provides structure to the learning environment for student and teachers and allows for planned integration of courses with multiple instructors. Instructions in developing and implementing a lesson plan from goals and objectives through assessment will be presented, and participants in this workshop will have an opportunity to create a simple lesson plan.

REFERENCES:

1. Curry RH, Hershman WY, Saizow RB: Learner-centered strategies in clerkship education. Am J Med 1996; 100:589–595.
2. Spencer JA, Jordan KR: Learner centered approaches in medical education. Br Med J 1999; 318:1289–1283.

Issue Workshop 49
THE EMPEROR'S NEW CLOTHES: POLYPHARMACY AND KIDS

Chairperson: Jacquelyn M. Zavodnick, M.D., *1655 Oakwood Drive, Suite N-122, Narberth, PA 19072-1017*

EDUCATIONAL OBJECTIVES:

Demonstrate knowledge of the principles of medication selection for children and adolescent. The participant should be able to discuss ethical, physiologic, neuromaturational, social, research, and evidence-based issues in pharmacological treatment.

SUMMARY:

The rate of acceptance of adult psychotrophic medication models by child and adolescent psychiatry has been exponentially increasing. Previously, new adult treatments were slow to move into pediatric usage. Are we now moving too quickly into uncharted territory? Where some uses truly relate to possible "safer" profiles (e.g., olanzepine versus haloperidol), other uses appear premature as there has not even been adequate research in adults (e.g., lamictal for bipolar disorder). Other dilemmas include the initiation of multiple drugs, the parents' understanding of the state of knowledge about the medication, the metabolic and kinetic differences between children and adults, and the immaturity of neurotransmitter pathways in children.

The workshop will begin with a brief slide presentation of the issues involved in medicating children and adolescents. The participants will then join in with cases to review in terms of the framework presented. General and specific questions will also be addressed.

REFERENCES:

1. Zavodnick J: Combined drug therapy debate (continued). J Am Acad Child Adolesc Psychiatry 1997; 36:1.
2. Jensen P, Bhatara V, Vitiello B, et al: Psychoactive medication prescribing practice for U.S. children: gaps between research and

clinical practice. J Am Acad Child Adolesc Psychiatry 1999; 38:557–565.

Issue Workshop 50
PSYCHIATRIC ADVERSE EVENTS DURING REBATRON TREATMENT OF HEPATITIS-C

Chairperson: R. Jeffrey Goldsmith, M.D., *3438 Burch Ave, Cincinnati, OH 45208-2004*
Participant: Debra Palton, R.N.

EDUCATIONAL OBJECTIVES:

To recognize the array of psychiatric adverse events resulting from interferon-alpha treatment to manage the psychiatric adverse events resulting from interferon-alpha and ribavirin treatment of hepatitis C.

SUMMARY:

This workshop is intended for the general and addiction psychiatrist, as well as nurses and physicians. Hepatitis C is a new pandemic that is affecting more than 4 million Americans today. Because of the subacute nature of the initial and chronic infection phase of HCV, it is easy not to appreciate that the morbidity and mortality are increasing exponentially. HCV is already the leading cause of liver transplant in the U.S. An overview of the HCV natural history and epidemiology will begin the workshop, addressing the special populations of African Americans and substance-dependence patients. Past research of the psychiatric adverse events of interferon will be presented. Dialogue will follow each topic.

The Cincinnati VAMC Hepatitis C Clinic was set up in 2000 to manage a VA multicenter study of HCV, funded by Schering Plough. The population of veterans who are seropositive for HCV have considerable psychiatric comorbidity. Data on the first 50 patients will be presented concerning their baseline psychiatric comorbidity and their reaction to interferon-alpha plus ribavirin. Multidisciplinary, prophylactic management of the psychiatric symptoms will be described, as well as the efficacy of those measures. There will be time to discuss the findings.

REFERENCES:

1. Dusheiko G: Side effects of alpha interferon in chronic hepatitis C. Hepatology 1997; 26(Suppl 1):112S-121S.
2. Renault PF, Hoofnagle JH, Park Y, et al: Psychiatric complications of long-term interferon alfa therapy. Arch Intern Med 1987;147:1577–1580.

Issue Workshop 51
HOW THE THEORY OF EVOLUTION IS FUNDAMENTAL TO OUR BIOPSYCHOSOCIAL MODEL

Chairperson: John R. Evaldson, M.D., *200 West DeVargas Street, Suite #3, Santa Fe, NM 87501-2679*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should have an understanding of how evolutionary theory integrates a diverse base of knowledge about human development, behavior, and illness; at all levels of complexity, from the molecular through the organ individual, and population; and that treatment can be enriched by these understandings.

SUMMARY:

The theory of evolution integrates diverse cross-disciplinary knowledge of who humans are, how we develop, behave, adapt, and get ill and well. This workshop will present a broad sweep of information, arguing that evolutionary theory should be a fundamental underpinning for our biopsychosocial model. Through lecture, case material, and question and answer, the participant will be offered an opportunity to consider and debate this argument. This workshop should be of benefit to psychiatrists, psychologists, or other mental health practitioners or advanced students, whether their approach be biological, psychological, psychoanalytic, or behavioral. The two broad themes, that humans are affiliative and cooperative, and humans are competitive and aggressive, will be presented through a human life cycle from conception to the next generation of mating. Examples of evolutionary-derived adaptations that have a fundamental influence on human development and psychology will be presented. These topics will include molecular genetics, the development of neurotransmitter systems, attachment and separation, sexual and aggressive instincts and the contexts in which they arise, some behavior, anxiety, and mood disorders, puberty and mating.

REFERENCES:

1. Nesse RM: Is depression an adaptation? Arch Gen Psychiatry 2000; 57:14–20.
2. Jensen PS, et al: Evolution and revolution in child psychiatry: ADHD as a disorder of adaptation. J Am Acad ChildAdolesc Psychiatry 1997; 36:1672–1681.

Issue Workshop 52
COGNITIVE-BEHAVIORAL TREATMENT: PROLONGED EXPOSURE FOR TREATMENT OF TRAUMA VICTIMS

Co-Chairpersons: Abbas Azadian, M.D., *Department of Psychiatry, Clark Institute, 33 Princess Street Suite 102, Toronto, ON N5A 4P4, Canada,* Ari E. Zaretsky, M.D., *Department of Psychiatry, Mt. Sinai Hospital, 600 University Avenue, #941A, Toronto, ON M5G 1X5, Canada*

EDUCATIONAL OBJECTIVES:

To demonstrate knowledge about various theoretical basis of cognitive behavioral treatment (CBT) of posttraumatic stress disorder. Participants should be able to use basic techniques of CBT in treatment of trauma patients.

SUMMARY:

Treatment of trauma patients, especially those with severe trauma, has been challenging. There is no single treatment modality with clear superior effectiveness. Clinicians need to be versatile and capable of using various modalities as needed. Prolonged exposure is a treatment modality with proven efficacy in trauma patients. In this treatment modality, cognitive and behavioral techniques are used in combination with relaxation and stress-management methods. In this workshop we review the theoretical foundation of prolonged exposure briefly, which includes the work of J. Lang, A. Beck, and E. Foa. We then focus on component of prolonged exposure including basic techniques, cognitive restructuring techniques, and stress inoculation training. Patient selection and selection of the adequate treatment for specific patients will be the next area to be discussed. Case materials including taped sessions will be presented throughout the workshop to explore difficult areas of treatment.

Participants are encouraged to bring their own case material for discussion, as there will be ample opportunity for discussion throughout this workshop. At least a third of workshop will be allocated to question-and-answer and panel interaction.

REFERENCES:

1. Hembree EA, Foa EB: Posttraumatic stress disorder: psychological factors and psychological interventions. J Clinical Psychiatry, 2000; 61 (suppl 7).

2. Foa EB, Rothbaum BO: Treating the Trauma of Rape. New York, NY, Guilford Publication, 1997.

Issue Workshop 53
THE CONSUMER PERSPECTIVE IN PSYCHIATRIC EDUCATION

Co-Chairpersons: Fernando Rodriguez-Villa, M.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478,* Anne Whitman, Ph.D., *MDDA Cole Resource Center, 115 Mill Street, Belmont, MA 02418*
Participants: Kenneth S. Duckworth, M.D., Moe Armstrong, M.B.A.

EDUCATIONAL OBJECTIVES:

The participants in this workshop will come to recognize that collaboration with consumer colleagues in the education of residents will improve the residents' understanding of the nature of illness, the recovery process, and such issues as social stigma, the nuances of the doctor/patient relationship, the challenges of returning to work, and the network of community resources available to consumers.

SUMMARY:

This session is for the clinicians responsible for the training of psychiatric residents and those interested in collaboration with consumers. The seminar will discuss the research concerning the effects of using consumers as trainers for mental health service providers including residents. The session will discuss two innovative and model programs (Massachusetts Mental Health Center in Boston and McLean Hospital in Belmont) in the training of residents. These models include consumer participation in the didactic curriculum as well as the clinical setting and co-leading groups in an inpatient environment. The workshop faculty will share their experience in developing these programs. The session will highlight how collaboration with consumer colleagues in the training of residents has helped the residents improve their understanding of the recovery process and sensitivity to such issues as social stigma, medications, the nuances of the doctor/patient relationship, and community resources. This session will be highly interactive in nature with the audience providing their own ideas and concerns about consumer collaboration in the training of residents.

REFERENCES:

1. Cook JA, et al: A randomized evaluation of consumer vs. nonconsumer training. Community MHJ 1995; 31:229–238.
2. Wohlford P, et al (eds.): Consumer impact on mental health services in Serving The Seriously Mentally Ill: Public-Academic Linkages in Services, Research and Training, pp. 99–102.

Issue Workshop 54
FOLKTALES AND MOVIES: USING THE MEDIA TO LEARN ABOUT CULTURE

Co-Chairpersons: Sandra Sexson, M.D., *Department of Psychiatry, Emory University, 1256 Briarcliff Road NE #313, Atlanta, GA 30306,* Arden D. Dingle, M.D., *Child & Adolescent Psychiatry, Grady Health Systems, 80 Butler Street SE/Box 26064, Atlanta, GA 30335*

EDUCATIONAL OBJECTIVES:

To recognize the usefulness of a seminar approach for teaching cultural issues in psychiatry, learn to utilize media to teach cultural issues, become familiar with potential resources on cultural issues, and learn about a cultural seminar based on folktales and movies.

SUMMARY:

This workshop will present a creative framework for integrating cultural issues into the curriculum of a psychiatry residency program. The process and content of a cultural seminar will be modeled, with workshop participants discussing their cultural perspectives and reactions to representative fairytales and movie clips.

The seminar meets monthly with the child and adolescent psychiatry residents and two co-leaders. The focus of discussion is either fairytales/folktales or movies. In addition to active participation, each resident is the leader of a session, responsible for choosing the background material for and facilitating discussion of a particular culture. The cultures are chosen from those present in the U.S. All group members are encouraged to share personal/professional ideas and experiences. Discussion topics are used to illustrate the relevance of cultural issues to child and adolescent psychiatry, both practically and theoretically.

This seminar has increased the residents' awareness of the impact of cultural factors on themselves as physicians and their patients. It has been a forum in which similarities and differences among the group can be explored in a supportive and neutral environment. Residents have had the opportunity to be educators, often about subjects and populations that they are quite knowledgeable about.

REFERENCES:

1. Miller FC: Using the movie Ordinary People to teach psychodynamic psychotherapy with adolescents. Academic Psychiatry 1999; 23:174–179.
2. Fritz GK Poe RO: The role of the cinema seminar in psychiatric education. Am J Psychiatry 1979; 136:207–210.

Issue Workshop 55
POEMS ON PSYCHIATRY

Chairperson: Charles R. Joy, M.D., *4406 Sunnydale Boulevard, Erie, PA 16509-1651*

EDUCATIONAL OBJECTIVES:

To appreciate the extent to which poetry can succinctly express insights related to the practice of psychiatry, to recognize powerful emotional details related to his/her identifications with poems on psychiatry, to express personal experiences of practicing psychiatry in a highly refined fashion through the use of poetic technique.

SUMMARY:

The dynamic energies, the interpersonal relationships, and the sublimations and other distortions inherent in the practice of psychiatry provide a fertile substrate for the creation of poetry. Moreover, poems about psychiatry written by a psychiatrist and shared with an audience of psychiatrists provide a unique opportunity to identify and express powerful insights into the practice of psychiatry. A presentation of poems about psychiatry provides an engaging paradigm for the integration of mind and brain, psychiatric art and psychiatric science. In this workshop participants will have the opportunity to appreciate such poetry, discuss their associations to the poems, and then create their own poems in a structured writing exercise. Participants at this workshop in 2000 particularly enjoyed the writing exercise. The chair of this workshop has extensive experience writing and presenting original poetry inspired by the practice of psychiatry. Selections will include "Something Different," first place winner at the APA Arts Association Exhibition in 1991, and "At The Preschool," (Mediphors, 1998). Themes will include: the price of empathy, the risks of intervention, the experience of assessment (for Wraparound services), and more. Emotions will be engaged as participants experience psychiatry through the modality of poetry.

REFERENCES:

1. Joy CR: What if Lashika. The Pharos 1999; 1:8.
2. Joy CR: This work. West Virginia Medical Journal 1999; 95:205.

Issue Workshop 56
COMMUNITY PSYCHIATRY: HOW TO AVOID BEING A PSYCHOTECH SLAVE CHAINED TO THE PILL BOX

Chairperson: Charles W. Huffine, Jr., M.D., *University of Washington, 3123 Fairview Avenue East, Seattle, WA 98102-3051*

EDUCATIONAL OBJECTIVES:

To set up a community psychiatry practice, combine community and private practice, apply the latest developments in biomedical research/practice to community settings, and advocate for patients in the face of adverse social realities. Participants will also learn how to use professional societies, relationships with key system players, and passion for reform to achieve leverage in system reform efforts.

SUMMARY:

Treating patients who face difficult social issues often involves community psychiatrists working in settings that are part of that problem: programs that are underfunded, underskilled, and in desperate need of clinical direction. The goal of this workshop will be to empower members-in-training and early career psychiatrists to forge working relationships in their agencies that will support good quality practice. Often the centers that serve our patients have difficulty understanding or addressing both their clientele's social and clinical needs and are reluctant to involve their psychiatric staff administratively as part of the team that addresses dilemmas. This workshop will focus on a positive way of addressing the inherent problems facing our clientele and their systems of care. The speaker will describe his own evolution from line clinician to becoming part of a policy team in his county and will encourage discussion of participants' experiences.

REFERENCES:

1. Ranz J, McQuistion HL, Stueve A. The role of the community psychiatrist as medical director: a delineation of job types. Psychiatric Services 51(7):930–932.
2. Faulkner LR, Goldman CR. Estimating psychiatric manpower requirements based on patients' needs. Psychiatric Services 48(5):666–70.

Issue Workshop 57
EARLY CAREER PSYCHIATRIST: ROLE OF MENTORSHIP

Co-Chairpersons: Gabriela Cora-Locatelli, M.D., *15595 NW 15th Avenue, Miami, FL 33169-5644,* Edward F. Foulks, M.D., *Department of Psychiatry, Tulane University School of Medicine, 1430 Tulane Avenue, TMC-SL77, New Orleans, LA 70112-2699*
Participants: Linda B. Andrews, M.D., Vinay Kapoor, M.D., Anu A. Matorin, M.D.

EDUCATIONAL OBJECTIVES:

The conclusion of the workshop the participants should be able to appreciate the central and vital role of mentoring relationships in the career development of young psychiatrists and its impact on their professional progress. The discussion will also highlight the potential for growth for both the protégé and the mentor in this relationship.

SUMMARY:

Mentorship has long been recognized as an important and vital development tool for professional progress. Young psychiatrists struggle with choices of career direction, including choice of psychiatric practice (e.g. academic, private practice, community, administration, research, and direct clinical care in their work). They may be uncertain about work settings, networking, memberships in professional organizations, and division of their professional/personal life. Many early career psychiatrists may lack a research background and need encouragement and advice to define their research priorities, to write protocols, to apply for funding, and to submit their work to appropriate publications. Mentors also serve as role models for their protégés in areas such as leadership and management skills, which are critical to the success in and outside academic centers. Additionally, a large number of early career psychiatrists in the U.S. are international medical graduates who have lost their mentors in their countries of origin and, thus for them to establish new and trusting professional relationship with senior faculty is of paramount importance. This workshop will focus on what one should consider when choosing a mentor. The audience will be encouraged to share their personal experiences and the importance and significance of their mentoring relationships in the development of their careers.

REFERENCES:

1. Palepu A, Friedman RH, Barnett RC, et al: Junior faculty members' mentoring relationships and their professional development in U.S. medical schools. Academic Medicine 1998; 73:318–323.
2. Silver MA, Marcos LR: The making of the psychiatrist-executive. American Journal of Psychiatry 1989; 146:29–34.

Issue Workshop 58
CLINICAL AND FORENSIC ASPECTS OF SEXUAL HARASSMENT IN SCHOOLS

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline, MA 02445*
Participants: Elissa P. Benedek, M.D., Linda M. Jorgenson, J.D., Carl P. Malmquist, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be familiar with the legal criteria for sexual harassment of students and the clinical manifestations that have been associated with this. They will also become aware of the areas of potential ambiguity.

SUMMARY:

In May 1999, in *Davis v. Monroe County Board of Education,* the U.S. Supreme Court held that students harassed by fellow students may sue their schools for money damages under Title IX of the Education Amendments of 1972. The petitioner in *Davis* alleged that a fifth grade boy taunted and touched her numerous times over a five-month period, and three teachers and the principal allegedly failed to help her.

This case brings into focus an issue that has troubled parents, teachers, children, and psychiatrists over the past years. A survey conducted by the American Association of University Women (AAUW, 1993) indicated that 81% of the respondents, students in grades 8 to 11, reported having been subjected to what the study defined as sexual harassment. How should one set the boundary between "normal" even sadistic behavior that is part of ordinary behavior, and conduct that rises to the level of sexual harassment in a legal context?

This workshop will describe assessment methodologies utilized by experienced forensic psychiatrists in the evaluation of psychiatric injuries caused to the students by sexual harassment. A videotape will present an adolescent complaining of harassment. The clinical

criteria and legal aspects will be discussed with audience participation.

REFERENCES:

1. *Davis v. Monroe County Board of Education,* 119 S. Ct. 1661 (1999).
2. Benedek E, Schetky D, eds: Adolescent Forensic Psychiatry: A Clinical Guide to Evaluation. Washington, DC: American Psychiatric Press, 2001.

Issue Workshop 59
STUDENTS DISCUSSING WHY THEY HAVE CHOSEN A PSYCHIATRIC CAREER IN 2000

Co-Chairpersons: Michael F. Myers, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 4L9, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 South Preston, Suite 214, Louisville, KY 40292*
Participants: Asher Simon, Joyce Adams

EDUCATIONAL OBJECTIVES:

To understand more clearly students' current perceptions of the 21st century and why these presenters have chosen to become psychiatrists.

SUMMARY:

This innovative workshop will deal with a major ongoing crisis: student recruitment into psychiatry. Dr. Dickstein will discuss the past decade's applicant decline and recommendations for reversing this. Two senior medical students, who spent elective time with these faculty, will offer personal odysseys to choosing psychiatry. Simon Asher will discuss experiences observing Dr. Myers in an outpatient setting treating physician-patients, who, at their most fragile, represented a unique perspective of seeing one's teachers, colleagues, and peers as patients. Emergent themes were: essential maintenance of balance between medicine and personal life, destigmatizing psychiatric illness, the necessity of programs enabling medical students and physicians to easily access mental health services.

Joyce Adams will elaborate on her belief that psychiatry is an opportunity to practice the art of medicine because it requires ability to communicate with patients and to ascertain problems without patients always being capable of expressing their problems. She will offer her vision and goal as a psychiatrist to treat patients as whole people physically, emotionally, spiritually.

Dr. Myers will summarize his decades of inspiring students to enter our field.

REFERENCES:

1. Mogul KM, Dickstein LJ (eds): Career Planning for Psychiatrists, American Psychiatric Press, Inc., Washington, D.C., 1995 (Based on 1987 APA course).
2. Feifel D, Moutier CY, Swerdlow NR: Attitudes toward psychiatry as a prospective career among students entering medical school, American Journal of Psychiatry 1999; 156:1397–402.

WEDNESDAY, MAY 9, 2001

Issue Workshop 60
SPIRITUAL/RELIGIOUS ASSESSMENT IN CLINICAL WORK

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, University of California, San Francisco, 1001 Potrero Avenue, SFGH Suite 7M, San Francisco, CA 94110,* Christina M. Puchalski, M.D., *National Institute of Health Research, 6110 Executive Boulevard, Suite 908, Rockville, MD 20852*
Participant: David B. Larson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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 on the Psychiatric Evaluation of Adults and the DSM-IV Outline for Cultural Formulation, cultural issues including religion/spirituality should be incorporated in history taking, assessment, and treatment planning. Yet clinicians may be unfamiliar with methods of religious/spiritual assessment. This workshop will review cases that demonstrate methods of interviewing, assessment, and treatment planning. Participants will be invited to critique and comment on these issues and use them as a stimulus for discussion of their own clinical work. Specific issues discussed will include the importance of respectful rapport, the use of the DSM-IV Outline for Cultural Formulation, the DSM-IV diagnosis of religious or spiritual problem, and the use of religious/spiritual consultations and interventions such as with chaplains.

REFERENCES:

1. Puchalski C: Taking a spiritual history allows clinicians to understand patients more fully. J of Palliative Medicine 2000; 3:129–137.
2. Model Curriculum for Psychiatric Residency Training Programs; Religion and Spirituality in Clinical Practice. Edited by Larson DR, Lu FG, Swyers JP. May 1996, revised, July 1997.

Issue Workshop 61
HOMEOPATHIC MEDICINE AND PSYCHIATRY

Chairperson: Edward B. Gogek, M.D., *P.O. Box 3967, Prescott, AZ 86302-3967*

EDUCATIONAL OBJECTIVES:

After this workshop, participants will understand the principles of homeopathy, the basic science explaining its mechanism of action, and the most important clinical research validating its efficacy. They should know how homeopathy differs from other forms of alternative medicine and the psychiatric conditions for which it is useful.

SUMMARY:

As homeopathic treatment becomes more widespread and more mainstream, even clinicians with no interest in alternative medicine will have to talk to their patients about homeopathy and sometimes communicate with alternative practitioners. Psychiatrists who are open to alternatives often find homeopathy fits in very well with psychiatric practice. Although difficult to master, homeopathy is the branch of alternative medicine that works best for psychiatric patients. This workshop will present an overview of classical homeopathy. The first half of the workshop will cover homeopathic basic science, the scientific research explaining and validating homeopathy, and the homeopathic treatment of psychiatric disorders. The second half will be question and answer/discussion. Homeopathy is a controversial topic, and open dialogue is the best way to approach many of the issues important to physicians. The presenter is a psychiatrist who uses homeopathy in his private practice. Besides his traditional medical and psychiatric training, he also studied at the Hahnemann College of Homeopathy.

REFERENCES:

1. Bellavite P, Signorini A: Homeopathy: A Frontier in Medical Science. Berkeley, CA, North Atlantic Books, 1995.
2. Kleijnen J, Knipschild P, ter Riet G: Clinical trials of homeopathy. British Medical Journal 1991; 302:316–323.

3. Linde K, Clausius N, Ramirez G, et al: Are the clinical effects of homoeopathy placebo effects? a meta-analysis of placebo-controlled trials. Lancet 1997; 350:834–843.

Issue Workshop 62
TREATING PHYSICIANS: CUTTING-EDGE ISSUES

Chairperson: Michael F. Myers, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 4L9, Canada*
Participants: Gerald Schnelderman, M.D., Nada L. Stolland, M.D., Leah J. Dickstein, M.D., John D. Wynn, M.D.

EDUCATIONAL OBJECTIVES:

To appreciate fears in physician-patients, recognize common transference and countertransference dynamics, and treat physicians and their loved ones more effectively.

SUMMARY:

When physicians become patients, there are unique factors that can inform or impede accurate diagnosis and treatment. In 12-minute segments, the presenters will address the following: 1) how physician-patients tend to react psychologically to illness in themselves, including intriguing patterns of help-seeking and transference, as well as how treating psychiatrists may respond and behave when treating physicians, i.e., countertransference and beyond (Dr. G. Schneiderman); 2) when the patient is a physician's loved one and how this affects the physician internally and his/her interaction with the treatment team (Dr. N. Stotland); 3) dynamic and practical issues when treating husbands, wives, and partners of physicians (Dr. M. Myers); 4) special challenges when treating physicians who are members of minority groups, i.e., racial, ethnic, religious, sexual orientation, and so forth (Dr. L. Dickstein); 5) implementing a comprehensive treatment program that encompasses individual care, group therapy, lecturing to physician colleagues, consulting to hospitals and medical associations, program development for physicians, and other forms of advocacy (Dr. J. Wynn). One-third of the workshop time will be protected for questions and answers with the audience.

REFERENCES:

1. Goldman LS, Myers M, Dickstein LJ: The Handbook of Physician Health. Chicago, American Medical Association, 2000.
2. Schneiderman G: Doctors treating doctors. Bulletin of the Canadian Psychiatric Association 2000; 47–49.

Issue Workshop 63
PSYCHODYNAMICS IN TREATMENT-REFRACTORY DEPRESSION

Co-Chairpersons: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262,* Edward R. Shapiro, M.D., *Admissions, Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enumerate components of a psychodynamic formulation, construct psychodynamic formulations, and begin to use them to advance treatment of patients with treatment refractory depression comorbid with prominent Axis II pathology.

SUMMARY:

Although algorithms help clinicians select biological treatments for patients with treatment-refractory depression, the subset of these patients presenting with prominent Axis II pathology often fail to respond to medications alone. Doctor-patient relationships with this subset often become chronic crisis management, with frustration common for both parties. Since training programs and the field currently de-emphasize psychodynamic notions like transference and countertransference, which may be useful in integrating a treatment approach to these patients, clinicians may be at a disadvantage in usefully framing the overall problem. This workshop describes an often effective approach to this subset of treatment-refractory patients. The approach uses a psychodynamic formulation to integrate biological and psychotherapeutic treatments. Essential elements of a psychodynamic formulation are reviewed, including attending to the patient's life context and its repeating metaphors, and identifying transference-countertransference paradigms likely to be contributing to treatment refractoriness. The formulation is used to guide interpretation in the psychotherapy, but also to guide adjunctive family work, integrate the psychopharmacologic approach, and maximize medication compliance. After a half-hour presentation, sample cases will be offered to initiate a discussion with workshop participants, who will be encouraged to present their own cases for discussion.

REFERENCES:

1. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure and clinical application. American Journal of Psychiatry 1987; 144:543–550.
2. McLaughlin J: Clinical and theoretical aspects of enactment. Journal of the American Psychoanalytic Association 1991; 39:595–614.

Issue Workshop 64
NATURE AND NURTURE: DEVELOPING COMPREHENSIVE SERVICES FOR YOUNG CHILDREN

Chairperson: Peter D. Ganime, M.D., *Department of Psychiatry, UMDNJ-Meridian, c/o Ganime 335 Garrison Way, Conshohocken, PA 19428*
Participants: Joanne Dunnigan, M.S.W., Grace Hickey, Psy.D., Phillip Repasky, M.A., Diane Beebe, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will understand how a comprehensive behavioral health evaluation and treatment service that addresses the needs of young children and their families can be developed. A multidisciplinary approach to diagnosis and treatment supporting and strengthening the caregiver-child bond will be emphasized.

SUMMARY:

Very young children with behavioral health needs are a challenging population, and their caregivers often face daunting obstacles securing services for them. Increasing demand for these services is being experienced by child-serving systems nationally. Rapid access to skilled, competent care, appropriate medication prescribing, and ensuring smooth coordination of multidisciplinary treatment team efforts are some of the challenges faced by agencies trying to meet this demand. Pressures from managed care, realistic concerns about the need for conservation of financial resources, and appropriate expectations that cost-effectiveness will be demonstrated through monitoring of treatment response and outcome are additional challenges that need to be met. Over the past decade newly acquired knowledge about mind and brain has led to an appreciation of the fact that both nature *and* nurture are important in child development. Treatment programs targeting this very young population must address this issue also. This workshop brings together a group of mental health practitioners representing various disciplines such as psychiatry, psychology, psychiatric nursing, social work, and health care administration who work with very young children and their

families. They will present a forum where these matters will be discussed. Videotaped vignettes will be used to facilitate audience participation.

REFERENCES:

1. Mayes LI: Addressing mental health needs of infants and young children. Child and Adolescent Psychiatric Clinics of North America 1999; 8:209–224.
2. Bagnato S, Neisworth JT: Collaboraion and teamwork in assessment for early intervention. Child and Adolescent Psychiatric Clinics of North America 1999; 8:347–363.

Issue Workshop 65
CRISIS-STABILIZATION UNITS: ALTERNATIVE TO HOSPITAL OR DE FACTO HOSPITAL?

Chairperson: Neil D. Price, M.D., *3 Hackmatack Drive, Scarborough, ME 04074-9449*
Participants: Patrick S. Maidman, M.D., David A. Moltz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify differences and similarities between crisis units and psychiatric hospitals and understand the community pressures forcing crisis stabilization units to function as small hospitals.

SUMMARY:

Crisis stabilization units can be an effective alternative to psychiatric hospital for many patients. However, a combination of factors including decreasing numbers of hospital beds and managed care's limiting both access to hospital and duration of time in hospital has led to increased pressure on crisis-stabilization units to admit sicker patients. Often, because no other community options are available, medical directors of crisis units are being asked to admit patients who historically have required psychiatric hospital to stabilize an acute episode of illness.

Our presenters are each community psychiatrists and directors of crisis-stabilization units. They will describe the unique aspects of their units, including admission criteria and the role of the psychiatrist and will discuss how they cope with community pressures pushing them to deliver hospital-type care on a crisis-unit budget. Workshop participants will be encouraged to join in a discussion of this important issue confronting community psychiatry, and we will enlist their help to debate the key question: Are crisis stabilization units becoming de facto psychiatric hospitals?

REFERENCES:

1. Segal SP, Watson MA, Akutsu PD: Quality of care and use of less restrictive alternatives in the psychiatric emergency service. Psychiatr Serv 1996; 47:623–7.
2. Druss BG, Bruce ML, Jacobs SC, Hoff RA: Trends over a decade for a general hospital psychiatric unit. Adm Policy Ment Health 1998; 25:427–35.

Issue Workshop 66
TREATING HAREDI (VERY ORTHODOX) JEWS IN THE UNITED STATES AND ISRAEL
The Mesorah Society for Traditional Judaism and Psychiatry

Chairperson: Abba E. Borowich, M.D., *166 Valley Road, New Rochelle, NY 10804-3744*
Participant: David Greenberg, M.D.

EDUCATIONAL OBJECTIVES:

To recognize some of the more distinguishing features of Haredi Jews, a culturally isolated group; understand the interactions and differentiations between pathology, national origin and tradition and, thus, be better able to provide a more culturally attuned therapy to them.

SUMMARY:

They are little known in the United States even though their numbers grow substantially each year. In Israel, they are so well known that they have exerted virtual control over many aspects of Israeli life—at times, bringing the government to a standstill. In America, they attempt to interact as little as possible with contemporary society. In Israel, their reach extends to almost all of the population.

This workshop will attempt to introduce the audience to the lifestyles of Haredi Jews in the United States and Israel and explore the typical problems faced by them that require psychiatric intervention. Although their religious training and values are similar, Haredi Jews differ substantially from each other in their practices, beliefs, and traditions. This distinction is further magnified when they live in different countries with dissimilar pressures and cultures. The treating clinician is thus faced with unique challenges in trying to best serve them.

Two psychiatrists, an American and an Israeli with many years experience treating these groups, will be featured. Each will demonstrate the normative and pathological presentations routinely encountered in practice and compare and contrast the attendant cultural influences. Audience members will be encouraged to share their clinical experiences in order to amplify the issues discussed.

REFERENCES:

1. Friedman M: The Haredim (Ultra-Orthodox Society): Sources, Trends, Processes. Jerusalem, Jerusalem Institute for Israeli Studies, 1992.
2. Heilman SC: Defenders of the Faith: Inside Ultra-Orthodox Jewry. New York, Schocken, 1992.

Issue Workshop 67
A REVIEW OF PATIENT ASSAULTS ON STAFF

Co-Chairpersons: Brandon Z. Erdos, M.D., *Department of Psychiatry, Boston University, 39 Braddock Park, Apt. 4, Boston, MA 02116,* Douglas H. Hughes, M.D., *Department of Psychiatry, Boston University, 78 Monmouth Street, Brookline, MA 02446*
Participant: Janet E. Osterman, M.D.

EDUCATIONAL OBJECTIVES:

To briefly outline which hospital staff members are most frequently assaulted by patients; describe what types of assaults are experienced by hospital staff, describe both the physical and mental sequelae of the employee victim, and outline one method of treatment of the employee victim after a critical incident.

SUMMARY:

Patient assault against psychiatric emergency service staff is both a reality and a concern. A variety of studies have shown that between 40% and 70% of staff members have experienced a patient assault at some point during their career. The effects of violence can be devastating to the employee victim leading to permanent physical and/or psychological injury. Some staff rationalize violence as an occupational hazard, believing that they should be able to cope and handle work associated violence. Despite these beliefs, staff victims suffer from many of the same physical and psychological sequelae as victims of natural disaster or street crime. This presentation will briefly review the epidemiology and effects on staff victims. A proposed six-step treatment plan, which is voluntary for the employee victim, is described. The goals of treatment are to assist victims in coping by decreasing feelings of hopelessness and to provide a

supportive emotional atmosphere until victims can properly integrate the traumatic event.

REFERENCES:

1. Hughes D: Suicide and violence assessment in psychiatry. Gen Hosp Psychiatry 1996; 18:416–421.
2. Hughes D: The acute psychopharmacologic management of the violent and psychotic patient, Psychiatric Services 1999; 50:1135–1137.

Issue Workshop 68
SPIRITUAL STRUGGLES: THE NEW PRIORITY IN TREATMENT

Co-Chairpersons: Stephen M. Soltys, M.D., *108 Glen Ridge Court, Irmo, SC 29063*, Larry R. Wagner, Ph.D., *Columbia International University, 7435 Monticello Road, Columbia, SC 29230*

EDUCATIONAL OBJECTIVES:

To answer questions from a pastoral counselor who is looking for an appropriate referral, identify the advantages and pitfalls of treating patients who are also under the care of a pastoral counselor, establish rapport with patients whose religious beliefs question the need for psychiatric intervention, and discuss the compatibility of pharmacological therapy and one's faith.

SUMMARY:

Pastoral counselors are a significant force in the delivery of mental health services. In addition to being easily accessible and less expensive, pastoral counselors are a trusted source of spiritual consolation. As the demands on their time and limitations of their training become apparent, clergy scramble to find clinicians who are sympathetic to the values and beliefs of their parishioners. The referral challenge is highlighted in Shafranske's (2000) study that indicated religion and spiritually are less important in the lives of mental health professionals than in the public at large.

In this workshop, a psychiatrist and a psychologist who is a former pastor will discuss patients' growing desire to incorporate spiritual issues into their treatment. Participants will examine the unique challenges of providing pharmacological therapy to patients who are being concurrently treated by a pastoral counselor. One of the most important challenges is to build rapport with patients who approach a secular setting with trepidation. Compliance issues will be examined in the context of the patient's guilt for lacking enough faith to get well.

REFERENCES:

1. Shafrankse EP: Religious involvement and professional practices of psychiatrists and other mental health professionals. Psychiatric Annals 2000; 30:525–532.
2. Sperry L: Spiritually and psychiatry: Incorporating the spiritual dimension into clinical practice. Psychiatric Annals 2000; 30:518–523.

Issue Workshop 69
WHAT EVER HAPPENED TO PSYCHOTHERAPY?

Chairperson: Edmundo J. Ruiz, M.D., *1103 N Seymour Ave, Laredo, TX 78040-5381*
Participants: Homero R. Sanchez, M.D., James B. Stone, M.D., Higinio Zuniga, M.D.

EDUCATIONAL OBJECTIVES:

The objective of this workshop is to provide an opportunity for interaction within the audience regarding the controversial issue of increased pharmocotherapy usage and decreased psychotherapy.

SUMMARY:

There is a saying, "Life is strange, nothing lasts, people change." What used to be mind over body or how the mind affects the body, has become how the body affects the mind. For the past several years, the APA conferences have been dedicated to brain dysfunction and to chemotherapy. Now the question is, "What comes first?" Is it distress affecting the brain or the brain affecting the mind? Is seems that pharmacotherapy has taken preference over psychotherapy. Can we ignore transference, countertransference, defense mechanisms, consciousness, unconsciousness, family dysfunctions, anxiety, sibling rivalry, social interactions, resistances, and all related issues? There was a time when tranquilizers were introduced and minorities were given more medication and less psychotherapy than was given to the majority population. Some, even now, have the belief that minorities are not suitable for psychotherapy. Now pharmacotherapy and organic therapy have become preferential treatment for many. So, whatever happened to individual, family, and group psychotherapies, as well as to all the social issues? How do managed care, HMOs and insurance restrictions affect necessary services to our patients?

REFERENCES:

1. Gharney MD: Stress More Toxic To Brain Than Researcher Thought. Psychiatric News, May 2000.
2. Bettman BD: Limited Discussion of Psychotherapy at APA Convention, Letter to Psychiatric News, May 2000.

Issue Workshop 70
WORKING WITH SMALL BUSINESSES

Co-Chairpersons: R. Mark Webb, M.D., *6200 Brooktree Road, Suite 115, Wexford, PA 15090* Melissa M. Hankins, M.D., *190 Kennedy Drive, Apartment 8, Malden, MA 02148*

EDUCATIONAL OBJECTIVES:

To recognize that psychiatric practice requires small business skills too; to recognize that the above knowledge will help psychiatrists to empathize with both employer and employee patient; the workplace strains the vulnerable employee; analyze business needs using a systems model.

SUMMARY:

The new committee on relationship to business is now meeting with business leaders to discuss the relationship between mental health and productivity and the role of psychiatry in keeping employees productive. In order to respond to the anticipated demand for psychiatric services, we can prepare now to develop relationships to small businesses by acquiring the skills needed to increase awareness of workplace issues and basic concerns of employers, as well as the role of work and function in the lives of our patients. This workshop is designed for all psychiatrists who treat working patients and wish to understand better the influence of workplace role changes, disputes, and loss on a person's function. This workshop will integrate organizational theory, interpersonal theory, and clinical experience with small businesses to motivate psychiatrists to seek relationships with small businesses as a way of diversifying their practices and promoting mental illness awareness among the business community. We will discuss five common problems in small businesses that have presented to me clinically: 1) impaired employees, 2) impaired employers, 3) low morale, 4) dismissals, and 5) disability.

REFERENCES:

1. Sperry L: Psychiatric Consultation In the Work Place. 1st edition Washington, DC: APA Press, 1993.

2. Sperry L: Understanding organizations: a primer for occupational medicine physicians Occupational Medicine 1996; 2:651-661.

Issue Workshop 71
EDUCATING PATIENTS AND FAMILIES ABOUT ECT

Chairperson: Harold A. Sacheim, Ph.D., *New York State Psychiatric Institute, 1051 Riverside Drive, #126, New York, NY 10032*
Participant: Shoshana Peyser, Ph.D.

EDUCATIONAL OBJECTIVES:

Participants should be able to identify the psychoeducational needs of people considering or receiving treatment with ECT. Participants will be provided with a model program and acquire specific skills in its implementation.

SUMMARY:

Despite ECT's proven benefits, there is a well-documented controversy that surrounds its use, and it is the most harshly criticized and often most feared treatment within psychiatry. Negative beliefs about ECT can impact adversely upon people and their families in their decision making to receive ECT. Even when a person overcomes the potential barriers to obtaining treatment, he or she can be affected by negative beliefs about ECT during the process of receiving treatment. Psychoeducation has been shown to maximize people's ability to benefit from various psychiatric treatments and is a logical intervention with ECT. There have been several interventions cited in the literature and include pre-ECT teaching and educational video interventions. This workshop will describe the comprehensive psychoeducational program that has been implemented at New York State Psychiatric Institute as a model that has been used by health care professionals in effectively educating patients and their families about ECT. Attendees will have the opportunity to understand the psychoeducational needs of people receiving ECT and learn specific methods of how to implement an ECT psychoeducational program.

REFERENCES:

1. Baxter LR, Roy-Byrne P, Liston EH, Fairbanks L: Informing patients about electroconvulsive therapy: Effects of a videotape presentation. Convul Ther 1986; 2:25–29.
2. Dillon P: Electroconvulsive therapy patient/family education. Convul Ther 1995; 11:188–191.

Issue Workshop 72
DO I NEED AN MBA TO TRANSFORM MY CAREER?

Chairperson: Arthur L. Lazarus, M.D., *Humana Incorporated, 500 West Main Street, Louisville, KY 40202*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant 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 "lifecycle," and the resources needed to complete such a program. In addition, workshop participants will have a chance to learn about marketplace opportunities for physician executives. 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. MD/MBA: Physicians on the New Frontier of Medical Management, edited by Lazarus A, Tampa, Florida, The American College of Physician Executives, 1998.

Issue Workshop 73
DISTANCE-LEARNING OPTIONS

Co-Chairpersons: Howard J. Osofsky, M.D., *Department of Psychiatry, Louisiana State University HSC, 1542 Tulane Avenue, New Orleans, LA 70112-2865,* Paul M. Balson, M.D., *Medical Director, Louisiana Office of Mental Health, 1201 Capitol Access Road, Baton Rouge, LA 70821-4049*
Participant: Andrew P. Twyman, M.S.W.

EDUCATIONAL OBJECTIVES:

To understand the range of options available for distance-learning, to determine those distance-learning options that are most appropriate for various situations and settings, and to be an informed consumer of distance-learning options that may be offered by various pharmaceutical companies.

SUMMARY:

This workshop will focus on providing the participant with opportunities to learn about and experience three different modes of distance learning. There will be a brief overview of three distance learning modalities, 1) videoconferencing from a central location to one or more viewing locations, 2) archived information available on the Internet, and 3) combination of live Internet broadcasting and archived information. After the overview each of the modalities will be demonstrated, and audience participants will be invited to test each of the modalities. The participants will then be asked to rate each one of the modalities to determine which best meet their learning needs and to offer comments as to why they chose that particular modality.

REFERENCES:

1. Gawande AA, Bates DW: Medscape General Medicine, September 11, 2000, special article-The Use of Information Technology in Improving Medical Performance Part II. Physician-Support Tools.
2. Scherger J: Primary care in 2010, Hippocrates 14:2000–2000, Massachusetts Medical Society.

Issue Workshop 74
MARIJUANA AND PSYCHIATRY: DILEMMAS FOR THE CLINICIAN

Chairperson: David H. Friar, M.D., *University of Hawaii, PO Box 395, Volcano, HI 96785-0395*
Participants: David A. Wolkoff, M.D., Ernest P. Alalmalo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will have a better grasp of dilemmas facing the clinician with regard to marijuana;

will have examined their own current practices; and will be more knowledgeable about the current official policies on marijuana of relevant medical specialty organizations.

SUMMARY:

Psychiatrists in clinical practice face myriad challenges and questions related to the uses and abuses of marijuana. Is it important to differentiate recreational marijuana use from abuse? How do we deal with patients who use marijuana in conjunction with psychiatric medications? Is there any legitimate medical role for marijuana in psychiatry? For those practicing in states that have legalized marijuana for medical use, what do we tell our patients? Are federal restrictions on discussing marijuana with patients compatible with good patient care? The relationship of psychiatry to marijuana is a complex and controversial area, which cuts across medical, ethical, legal, social, and political dimensions. These questions are not expected to yield definitive answers, but to stimulate thought. The guiding theme will be pragmatic rather than dogmatic: how can a conscientious psychiatrist in clinical practice respond?

Workshop participants will be given several scenarios illustrating challenges and questions faced by psychiatrists in practice. While these scenarios will serve as the starting point for discussion, participants will be encouraged to contribute from their own knowledge and experience. Video, audio and role-playing illustrations may be used as well. Handouts will include policy statements from a number of medical, psychiatric, and addiction medicine organizations.

REFERENCES:

1. Marijuana and Medicine: Assessing the Science Base, edited by Joy JE, Watson SJ, et al. Division of Neuroscience and Behavioral Health, Institute of Medicine, National Academy Press, Washington, DC 1999.
2. Public Policy Statement on Marijuana, American Society of Addiction Medicine, Chevy Chase, Maryland, July, 1998.

Issue Workshop 75
HOW TO DETECT DECEPTION

Chairperson: Alan R. Hirsch, M.D., *Smell & Taste Treatment Research, 845 N Michigan Avenue, Suite 990W, Chicago, IL 60611-2201*
Participants: Charles J. Wolf, M.D., Rodgers M. Wilson, M.D., Carl M. Wahlstrom, Jr., M.D., David E. Hartman, Ph.D.

EDUCATIONAL OBJECTIVES:

To enhance clinical skills in the recognition and detection of deception.

SUMMARY:

Psychiatrists routinely need to assess the veracity of patients' histories and determine any disingenuousness manifested during the physical examination. Yet psychiatrists are only 57% accurate in recognizing deception. Moreover, they lack insight into their poor lie-detecting ability; their confidence is inversely proportional to their accuracy. "Mental health professionals who claim they cannot be fooled may have been fooled already."

In order to improve the ability to detect deception, objective methods of detecting deception including formal analysis of verbal and nonverbal communication will be presented. These techniques will be demonstrated by use of videotapes and with audience participation. Specific conditions associated with mendacity will also be addressed including the differential diagnosis, malingering in criminal proceedings, lying in children, and use of neuropsychiatric testing as an aid for the determination of honesty.

REFERENCES:

1. Rogers R (ed): Clinical Assessment of Malingering and Deception, New York, Guilford, 1988.
2. Resnick PJ: Detection of malingered mental illness. Behavioral Sciences and the Law, 1984; 2:21–38.

Issue Workshop 76
MID-CAREER PSYCHIATRY: STAYING FRESH AND CREATIVE

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, NM 87131-5326*
Participants: Jerald Kay, M.D., Carol C. Nadelson, M.D., Carolyn B. Robinowitz, M.D., Zebulon C. Taintor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to describe strategies used by mid-career psychiatrists to stay fresh and creative by using any of the following methods: 1) becoming expert in specific aspects of routine activities; 2) cultivating supplementary activities in parallel with ongoing routines; and 3) developing sequential careers.

SUMMARY:

Clinical practice and academic medicine are being sorely pressed by changes that distort the nature of traditional physician-patient relationships, reduce physician autonomy and resources, and increase administrative burdens. These changes increase physician distress and contribute to increasing complaints about professional burnout. Each of the panelists has successfully negotiated mid-career renewals, based on developing new career and personal interests to supplement and enrich their initial professional roles, and/or by means of quasi career switches. In addition, the panelists have mentored, supervised, and "colleagued" thousands of psychiatrists who have struggled successfully (and in some instances unsuccessfully) to maintain themselves as generative and stimulated professionals. This workshop will explore the strategies used by the presenters and their professional acquaintances and will engage participants in further discussion and exploration of these issues. Discussants will consider a variety of transitions, bearing on work focus, time allocation, work settings, geography, and intrapsychic shifts. Particular topics to be addressed include how career development is being altered by changing practice patterns, special concerns of women, and how technological innovations may offer new opportunities for changing the nature of practice.

REFERENCES:

1. Lazarus A (ed): Career Pathways in Psychiatry, Transition in Changing Times. Hillsdale, New Jersey; Analytic Press, Inc., 1996.
2. Csikszentmihalyi M: Creativity: Flow and the Psychology of Discovery and Invention. New York, Harper Perennial, 1997.

Issue Workshop 77
CURRENT AND FUTURE TRENDS IN PSYCHIATRY AND CRIMINAL LAW

Chairperson: Michael M. Welner, M.D., *Department of Psychiatry, The Forensic Panel, 224 West 30th Street, #806, New York, NY 10001*
Participants: Robert D. Miller, M.D., Abraham L. Halpern, M.D., Ann Burgess, D.N., Robert L. Sadoff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with the distinguishing qualities of the drug-facilitated rapist; understand important psychiatric issues relating to geriatric crime; and demonstrate an awareness of recommended guidelines for the

potentials, as well as the limitations, of utilizing telepsychiatry in the forensic examination.

SUMMARY:

Psychiatry continues to face new challenges as the science enriches and criminal law becomes increasingly reliant upon forensics. Novel technologies, shifting demographics, and new types of crime may benefit from mental health understanding. Since the role of the psychiatrist expert witness may be pivotal, the science faces important challenges to distinguish what it can and acknowledge its limits.

This workshop explores several frontier areas from the criminal law-psychiatry interface. Drug-facilitated rape is appreciated as a crime whose perpetrator resembles—and differs from—other rapists and sex offenders in important respects. Results from record review of the largest confirmed sample to date are presented to identify patterns, subtypes, and important psychosocial aspects. With the aging of the population, geriatric offenders are increasingly identified with crimes peculiar to their setting and challenges of aging. The presenter will share important findings in the geriatric offender population.

Telecommunications technology enables interviewing from remote locations. In many clinical settings, telepsychiatry has afforded consultation and clinical intervention that otherwise would not be available. Forensic examination, however, requires clinical and diagnostic assessment standards that may be compromised by a less-intimate interview. The workshop reviews some of the potentials and pitfalls and presents guidelines for telepsychiatry specifically applicable to the assessment setting.

REFERENCES:

1. Welner M, Lipman B, et al: The rapist: psychological and criminological findings In: Drug-Facilitated Rape, edited by LeBeau M, Mozayani A. New York, Academic Press (in print)
2. Baigent M, Lloyd C, et al: Telepsychiatry: 'tele' yes, but what about psychiatry? Journal of Telemedicine and Telecare 1997; 3:3–5.

Issue Workshop 78
USING HAMLET TO LEARN ABOUT TEACHING, INTERVIEWING, AND THERAPEUTIC INTERACTION

Chairperson: Dinko Podrug, M.D., *52 E End Ave # 17BC, New York, NY 10028-7954*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, having looked at interactions between "Hamlet" characters in a novel light, the participant should be able to better appreciate his own patient interactions, and have a new method to draw clinically relevant insights from his other literary knowledge.

SUMMARY:

Many forays have been made by psychiatrists, especially educators, into literature, trying to utilize insights of a writer or fascinating literary characters to inform and teach clinical matters. However, all of these approaches are content-centered, based on textual interpretation, even when utilizing plays. Informed by a conceptualization that therapist-patient interaction is not only one of interpreting and intervening, but of doing so in the field of emotional and other forces unleashed by their encounter, this workshop's idea of how to use literary material is based on learning from characters' interactions. "Hamlet" is particularly suited for this method because so much of the action develops around two opposing attempts to find truth and psychological information through conversational inquiries (interviewing) and spying or trickery. The king's and his aides' efforts to find out what is the meaning of Hamlet's depression and his intentions are matched by Hamlet's attempts to discover if his father's ghost was truthful about his murder. The audience will be shown videotape excerpts and helped to recognize Hamlet's resentment of and ingenious responses to being "played" for information, his and others' sensitivity and instant negative reaction (closing off communication) to each other's divided loyalties, etc. Clinical parallels are elicited from/supplied to the audience.

This workshop is based on a decade-long course teaching residents, mostly IMGs, interviewing and basics of therapeutic interaction.

REFERENCES:

1. Myerson PG (Topic Editor): Psychiatry and literature. Seminars in Psychiatry, No. 3, 1973.
2. Podrug D: Teaching psychiatric interviewing to beginning IMGs. In Psychotherapy Training of IMG residents, NR Rao, Chairperson, Issue Workshop, 1997 APA Annual Meeting.

Issue Workshop 79
INTERNATIONAL PROBLEMS WITH PERSONALITY DISORDERS IN THE WORKPLACE

Co-Chairpersons: James H. Relch, M.D., *Department of Psychiatry, Harvard Medical School, 2255 North Point Street, #102, San Francisco, CA 94123*
Giovanni de Girolamo, M.D., *National Mental Health Project, National Institute of Health, Viale Regina Elena 299, Rome 00161, Italy*
Participants: Julien D. Guelfi, M.D., Lisa Ekselius, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop the listener should understand several ways in which personality disorders can cause dysfunction in the workplace. They should also have an understanding of how culture can modify understanding of the disorder, presentation and potential interventions.

SUMMARY:

Personality disorders, as do other forms of mental illness, take their toll in the workplace. As personality disorders are found in all countries, this is an international phenomenon. Each culture has a different history in its evolution of the concept of personality disorders. This workshop will examine the problem by using psychiatrists from four distinct cultures: Swedish, French, Italian, and American. Discussants will discuss how personality disorders may present in each culture and will follow with a clinical example. Themes that will be addressed include how different cultures change the presentations of disorders, acceptable behavior, and acceptable interventions. For example, animated discussion of work problems with coworkers (often with hand gesticulations) would be acceptable in Italy and France, but less so in the United States and Sweden. Another example would be that in the longer leave times available in Sweden and Europe allow for the use of "time outs" not available in the United States. The workshop is designed to be interactive with much audience participation.

REFERENCES:

1. Munich RL. The VIP as a patient: syndrome, Dynamic, and treatment. In, Review of Psychiatry, volume 8, Tasman A, Hales R, and Frances A (Eds.) American Psychiatric Press, Washington DC, 1989 pp. 580–593.

2. Ronningstam E, Gunderson J. Changes in pathological narcissism. American Journal of Psychiatry 152:253–257, 1995.

Issue Workshop 80
FOR BETTER OR FOR WORSE: SPOUSES OF PATIENTS WITH DEMENTIA

Chairperson: Sheila M. Loboprabhu, M.D., *Department of Psychiatry, Baylor University, One Baylor Plaza, Suite 619D, Houston, TX 77030*
Participants: James W. Lomax II, M.D., Victor Molinari, Ph.D., Kimberly A. Arlinghaus, M.D., Kristin A. Kassaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will have a more informed sense of the feelings and perspectives of spouses as they care for patients with progressive memory impairment. The goal is to facilitate understanding of the experiential, spiritual, ethical, and forensic aspects of caregiving for the patient with dementia.

SUMMARY:

Caring for a patient with dementia is challenging and stressful for all involved. This is especially so for the spouses of patients with dementia who often struggle to cope with multiple demands while negotiating the complexities of medical care. This workshop will attempt to identify and explore the experiential, spiritual, ethical, and forensic aspects of caregiving for the patient with dementia. The value systems that enable spouses to care for the patient in such challenging circumstances will be explored. The panelists assert that the competent clinician ensures that concerns, feelings, and questions of spouses are adequately addressed in order to deliver comprehensive clinical and supportive care. Special emphasis will be placed on the role of the consultation-liaison psychiatrist and the geriatric psychiatry treatment team as they work with spouses in the management of moderate to severely demented patients. Case examples from a large teaching hospital will be used to illustrate specific problems encountered. These will be supplemented with brief didactic presentations intended to familiarize attendees with some of the major ethical and spiritual issues that spouses struggle with. Audience participation will be encouraged as clinical examples are used to elicit experiences from each practitioner's career and life.

REFERENCES:

1. Mace N, Rabins P: The 36-Hour Day. Baltimore, Johns Hopkins University Press, 1999.
2. Caron W, Boss P, Mortimer J: Family boundary ambiguity predicts Alzheimer's outcomes. Psychiatry 1999; 62:347–356.

Issue Workshop 81
DOES JOHNNY NEED METHYLPHENIDATE?

Chairperson: Antonio J. Gracia, M.D., *2607 Bemiss Rd, Valdosta, GA 31602-1401*
Participants: Betsy Nix, L.M.S.W., Brenda McCorvey, R.N., Clint Stone, M.S.U.

EDUCATIONAL OBJECTIVES:

To facilitate the diagnosis and treatment of ADD/ADHD through the use of the protocol delineated in abstract.

SUMMARY:

In order to facilitate the diagnosis of ADD, ADHD, a protocol is presented that assesses the patient's posture, mannerisms, attention, and checks memory with hypothetical situations that need to be repeated. It also evaluates capacity to abstract with questions that have to do with differences, similarities, and function of things. The ability to do simple math is done by the nickel-and-dime test, where a patient is asked to come up with a certain amount using X number of coins. If the tentative diagnosis is made of ADD or ADHD, a sample dose of methylphenidate of 5 mg, 10 mg, or 20 mg, according to age and weight, is dispensed. Within an hour of taking the medication the protocol is repeated, and it is assessed for accuracy, promptness of response, and timing in the simple math questionnaire. Methylphenidate is usually effective in 50%–60% of the patients. If on the follow-up questionnaire there is improvement, physician may feel comfortable writing the prescription for this medication. A 10-minute video will be presented demonstrating how patients perform on these tests.

REFERENCES:

1. Kollins SH, Shapiro SK, Newland MC, Abramowitz A: Discriminative and Participant-Rated Effects of Methylphenidate in Children Diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Experimental & Clinical Psychopharmocology. vol 6 (4), Nov 1998, pp 375–389.
2. Solanto MV: Neuropsychopharmocological Mechanisms of Stimulant Drug Action in Attention-Deficit Hyperactivity Disorder: A Review and Integration. Behavioral Brain Research. vol 94 (1), Jul 1998, pp 127–152.

Issue Workshop 82
TREATING PTSD COMPLICATED BY MEDICAL PROBLEMS: MIND AND BRAIN MEET BODY

Co-Chairpersons: Gordon D. Strauss, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 S. Preston Street, Room 209, Building A, Louisville, KY 40202-1702,* Michelle A. Florella, D.O., *9004 Harrods Landing Drive, Prospect, KY 40059-9390*

EDUCATIONAL OBJECTIVES:

To list the aspects of combat-related posttraumatic stress disorder that complicate the formation of a therapeutic alliance, to discuss the evidence that Vietnam veterans with PTSD are more likely to have general medical illnesses.

SUMMARY:

Among the many challenges in treating Vietnam veterans who suffer from combat-related PTSD and have pronounced Axis II pathology is the greater incidence and prevalence of general medical conditions in this population. This, on top of a pervasive lack of trust, anger, and hostility aimed at medical and other forms of authority and the seemingly intractable nature of their symptoms, makes these patients seem impossibly difficult, especially for psychiatric residents.

While these patients are difficult to treat, it is possible for them to make dramatic, if gradual, changes. The workshop will examine two cases: both are Vietnam veterans, both have prominent characterologic symptoms, and both have severe life-threatening medical conditions. A PGY-4 psychiatric resident has treated both for the past three years. She will present her work with these patients, reviewing the challenges to establishing a meaningful doctor-patient relationship with each and focusing on how the vicissitudes of their medical conditions interacted with both their PTSD and their character pathology. Both patients, who know each other, were profoundly affected by the congestive heart failure and subsequent heart transplant of one of them last summer.

In addition to verbal and video presentations of the cases and discussion by both the resident and her long-term case supervisor, the audience will be encouraged to interact with the presenters in several ways: by sharing their experiences in working with medically ill patients with severe psychopathology, by offering their own analyses of these two cases, and by considering how the psychiatrist's identity as a physician may be useful in cases like these.

REFERENCES:

1. Beckham JC, Moore SD, Feldman ME, et al: Health status, somatization, and severity of posttraumatic stress disorder in Vietnam combat veterans with posttraumatic stress disorder. Am J Psychiatry 1998; 155:1565–1569.
2. Schnurr PP, Spiro A: Combat exposure, posttraumatic stress disorder symptoms, and health behaviors as predictors of self-reported physical health in older veterans. J Nervous & Mental Disease 1999; 187:353–359.

Issue Workshop 83
TRAINING IMG RESIDENTS: CHALLENGES AND OPPORTUNITIES

Co-Chairpersons: Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456,* Richard Balon, M.D., *Department of Psychiatry, Wayne State University Psychiatric Center, 2751 East Jefferson, Suite 200, Detroit, MI 48207*
Participants: Vinay Kapoor, M.D., Anu A. Matorin, M.D., Pedro Ruiz, M.D., Tarek A. Okasha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should have an increased awareness about the challenges and opportunities faced when training IMG's. Additionally, they should be able to identify and implement proposed strategies to promote and enhance the quality of training for IMG residents.

SUMMARY:

International medical graduates (IMG's) currently constitute about 40% of psychiatry residents training in the United States. They have made major contributions in providing psychiatric services to our major U.S. teaching hospitals, academic centers, and psychiatric institutions. However, IMG's face unique challenges in the process of integrating and adapting into U.S. residency training programs. This workshop will focus on current issues related to the training of IMG residents such as sociocultural factors, limited exposure to psychotherapy training, and adaptation to competency-based measures and exams. In most instances, IMG's come from countries where the health care system is markedly different than the system used in the U.S. Additionally, IMG residents must navigate throughout a complex U.S. health delivery system, including adaptation to medical record keeping, writing medical orders, medical-legal issues, hospital regulations, and third-party-payer guidelines. Special emphasis will be given to the problem resident and to developing innovative solutions that can be incorporated into training program curriculum. This workshop will also provide a forum for sharing ideas and developing workable solutions to enhance the quality of training of IMG residents in the United States.

REFERENCES:

1. Brauzer B, Lefley HP, Steinbook R: A Module for training residents in public mental health systems and community resources. Psychiatric Services 1996; 47:192–194.
2. Bienenfeld D, Klykylo W, Knapp V: Development of competency-based measures for psychiatry residency. Academic Psychiatry 2000; 24:68–76.

Issue Workshop 84
NEUROIMAGING: INTEGRATING BIOETHICS WITH CLINICAL AND BASIC SCIENCES

Chairperson: Igor Elman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 16 Blossom Street, Boston, MA 02114*
Participants: Hans C. Breiter, M.D., David R. Gastfriend, M.D., Katherine Karisgodt, B.A., Jasmin S. Roman, B.A.

EDUCATIONAL OBJECTIVES:

To recognize ethical and practical questions faced by clinicians and scientists conducting nontherapeutic research that involves the administration of drugs of abuse to human volunteers, understand current biological explanations of addiction and how these can inform efficient psycho- and pharmacotherapy, and appreciate the importance of computerized assessment tools and biological markers in clinical and research work with substance-abusing populations.

SUMMARY:

Research involving administration of drugs of abuse to human subjects poses many ethical and scientific challenges. While it advances understanding and treatment of addictions, concerns have been raised about its potential to worsen participants' clinical status. Also, because of its complexity such research requires a multidisciplinary collaborative effort, with little published data on how to establish a meaningful and cross-fertilizing interaction between clinicians and basic neuroscientists. The aims of this workshop are: to encourage the participants to grapple with the pros and cons of experimental cocaine administration to cocaine-dependent individuals and to share with the audience how an integrated team approach in the clinical and laboratory arena helps resolve ethical and scientific dilemmas on our NIDA-funded fMRI Cocaine Brain Mapping Program Project.

Dr. Elman will provide an overview of the historical and legal context for the discussion of the issues pertinent to research-based administration of drugs of abuse to humans. He will present the results of a long-term outcome study in 21 cocaine-dependent subjects infused with cocaine and 19 non-infused controls. Dr. Breiter, will review developments in the neuroanatomy and neurophysiology of the reward circuitry that promise to provide fresh insights into the clinical management of cocaine dependence. Dr. Gastfriend will describe the results of the studies derived from our population of nontreatment seekers undergoing cocaine infusions, including the relationship between motivation for treatment and clinical outcomes, veracity of subjects' self reports based on hair radioimmunoassays and clinical correlates of physiologic responses to cocaine. Ms. Karlsgodt and Ms. Roman will present recent findings on gender differences in cocaine craving and their relationships to stress exposure. The audience will be asked to share insights and opinions after each presentation and during the general discussion.

REFERENCES:

1. Elman I, Krause S, Karlsgodt K, et al: Clinical outcomes following cocaine infusions in non-treatment seeking individuals with cocaine dependence. Biological Psychiatry, In press.
2. Breiter, HC, Gollub, RL, Weisskoff, et al: Acute effects of cocaine on human brain activity and emotion. Neuron 1997; 19:591–611.

Issue Workshop 85
IMPLEMENTING MULTIDISCIPLINARY DIAGNOSIS AND MANAGEMENT OF PSEUDOSEIZURES

Co-Chairpersons: Martin A. Goldstein, M.D., *Department Neurology, McLean Hospital, 115 Mill Street, Belmont, MA 02478,* Cynthia L. Harden, M.D., *New York Hospital-Cornell, 525 East 68 Street, New York, NY 10021*

EDUCATIONAL OBJECTIVES:

To appreciate empiric and technologic challenges inherent to diagnosing pseudoseizures, better understand the pathogenesis of pseudoseizures, recognize key diagnostic and prognostic features of pseudoseizures, be knowledgeable of a pseudoseizure management algorithm, and apply an interdisciplinary approach to treating pseudoseizures.

SUMMARY:

Psychogenic pseudoseizures are among the most subtle challenges in all of medicine. Reasons for this include:

(1) Difficulty of confirming the "pseudo" part by dysconfirming the seizure part–(a) theoretical: Behavioral features are not reliable criteria to distinguish pseudoseizures from actual seizures. Rather than confirm pseudoseizure, video electroencephalographic telemetry is used to "capture" seizure activity. When telemetry is negative, then pseudoseizure arises as a diagnosis of exclusion. Thus, pseudoseizure is never a laboratory-proven diagnosis; the absence of epileptiform activity merely suggests the diagnosis of pseudoseizure. (b) technological: Video EEG telemetry using surface electrodes is a specific but insensitive means of detecting epileptiform activity. Routine surface electrode recording can fail to record discharges which can underlie pseudoseizure-like behavior. Hence failure to electrophysiologically capture a behavioral event does not necessarily rule out an epileptiform basis for that event.

(2) Many things can put the "pseudo" in pseudoseizure: Pseudoseizure is best regarded as a description of a behavioral event rather than a diagnosis itself. Pseudoseizure phenomenology spans a wide differential diagnosis including somatoform disorders (e.g., conversion disorder), dissociative disorders, factitious disorders, personality disorders, and malingering.

(3) Multi-system involvement: Because diagnosis often begins with a neurologic investigation and ends with a psychiatric evaluation, an interdisciplinary approach involving diverse subspecialties (from epileptologists to psychodynamic psychiatrists) is required. Further, high prevalence of neurologic and psychiatric comorbidity mandates ongoing collaboration.

To improve management of this often neglected patient population, an interdisciplinary panel (neurologists, psychiatrists) will (1) review the clinical challenges, (2) present exemplary cases, (3) describe diagnostic and prognostic heuristics, and (4) outline management guidelines. Questions from the audience will be used to highlight general principles while the panel models the functioning of a multidisciplinary approach.

REFERENCES:

1. Bowman ES: Nonepileptic seizures: psychiatric framework, treatment, and outcome. Neurology 1999; 53:S84–S88.
2. Harden CL: Pseudoseizures and dissociative disorders: a common mechanism involving traumatic experiences. Seizure 1997; 6:151–5.

Issue Workshop 86
BEYOND REDUCTIONISM: CLINICAL IMPLICATIONS

Chairperson: Ian E. Alger, M.D., *500 East 77th Street, #132, New York, NY 10162*
Participants: Clarice J. Kestenbaum, M.D., Lewis A. Opler, M.D., Eric R. Marcus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants will have an increased awareness of how collegial collaboration can enhance a more holistic clinical approach informed by both psychosocial and psychobiologic models of practice.

SUMMARY:

Four senior clinicians, specializing to varying degrees in psychotherapy and biomedical psychiatry, and treating a wide spectrum of patients from children and adolescents, to the elderly, and with diagnoses ranging from schizophrenia and mood disorders, to learning disabilities, anxiety disorders, and dysfunctional relationship will present case examples from their own practices to describe how they have participated collaboratively in clinical consultations. In this process they have learned from their patients and from each other the need for a more holistic approach.

Today's psychiatrist has to find the right balance between being a general psychiatrist and one with expertise in any one of a number of therapeutic areas; for example, psychodynamic, psychopharmacologic, psychoanalytic, child and adolescent, behavioral, family and group, forensic, and others. This workshop will discuss the reductionistic errors that can occur when there is too narrow a clinical focus.

The ongoing discussion among panelists and audience will explore how today's psychiatric education and practice can foster a convergence of the psychosocial and the molecular, of talk therapy and drug therapy.

REFERENCES:

1. White CM, Opler LA, Castro E, et al: The holistic approach and the future of psychiatry. World J of Psychosynthesis 1981; 13:19–22
2. Luhrmann TM: Of two minds: the growing disorder in American psychiatry. NY, A. Knopf, 2000.

Issue Workshop 87
PSYCHIATRIC ILLNESS IN PSYCHIATRISTS: OVERCOMING STIGMA
National Alliance for the Mentally Ill

Co-Chairpersons: Michael F. Myers, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 4L9, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 South Preston, Suite 214, Louisville, KY 40292*
Participants: Carol S. North, M.D., Marian Fireman, M.D., Elizabeth A. Baxter, M.D., Suzanne E. Vogel-Scibilia, M.D., James P. Scibilia, M.D., Laurie M. Flynn

EDUCATIONAL OBJECTIVES:

To understand how stigma affects morbidity and mortality in psychiatrists; to render better care when psychiatrists request treatment for themselves.

SUMMARY:

Despite two decades of identifying common stressors in the lives of psychiatrists and successfully establishing treatment resources, stigma remains a significant obstacle to care when a psychiatrist becomes mentally ill. In this workshop, the co-chairs (Drs. Myers and Dickstein) will make brief introductory comments about stigma both in the training setting and beyond. Dr. North will then present epidemiological research on psychiatric illness in psychiatrists including the implications of her results. Drs. Fireman, Baxter, and Vogel-Scibilia will give first-person accounts of living with psychiatric illness and its many ramifications (confidentiality, disability insurance, accessing state-of-the-art care, licensing-board issues, hospital credentialing, advance directives, and so forth). Dr. James Peter Scibilia will discuss the joys and challenges of being the spouse of a psychiatrist with bipolar illness. Ms. Laurie Flynn, former executive director of the National Alliance for the Mentally Ill, will focus on advocacy and the ways in which NAMI can assist individual psychiatrists and the American Psychiatric Association in fighting stigma.

REFERENCES:

1. North CS: Welcome Silence: My Triumph Over Schizophrenia. New York, Simon & Schuster, 1987.

2. Baxter EA: The turn of the tide. Psychiatric Services 1998; 49:1297–1298.

Issue Workshop 88
THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chairperson: Steven E. Pflanz, M.D., *Department of Mental Health, FE Warren Air Force Base, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

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. Often mental health professionals pay more attention to films that achieve critical acclaim for their artistic merits. The value of these films is undeniable. However, to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the facilitator will discuss briefly the portrayal of psychiatry in contemporary films during the 1990s, focusing on The Prince of Tides, Basic Instinct, As Good As It Gets, Good Will Hunting, Analyze This, and Grosse Pointe Blank. Each of these films achieved both critical acclaim and box office success and was seen by millions of Americans. To generate discussion, short film clips from these movies will be viewed. The majority of the session will be devoted to audience discussion of these and other films and how we understand contemporary film to influence the image of psychiatry in America.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, D.C., American Psychiatric Press, Inc., 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Films in Psychotherapy. New York, John Wiley & Sons, Inc., 1998.

Issue Workshop 89
MAKING THE MEDIA WORK FOR YOU

Chairperson: Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 836 West Wellington Avenue, Chicago, IL 60657*

EDUCATIONAL OBJECTIVES:

To conduct a successful media interview. Participants will work, hands-on, with different case scenarios for interviews. Participants will come away with the skills they need to teach the public about psychiatry and to demonstrate what accessible, honest, caring, and knowledgeable professionals we 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 may feel intimidated and worry that they will look funny on camera or 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, such as an "open" comprehensive dissertation with a "fan" versus a two-minute "headline" interview with a cold interviewer. 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; 26:281–7.
2. Sabbagh LB: Managing the media interview. Compr Ther 1998; 24:33–5.

Issue Workshop 90
COMPARATIVE EFFICACY OF ANTIDEPRESSANTS AND PSYCHOTHERAPY FOR DEPRESSION

Chairperson: Sidney L. Werkman, M.D., *2918 33rd Pl NW, Washington, DC 20008-3527*
Participants: Frederick M. Quitkin, M.D., Alan A. Stone, M.D., Myrna M. Weissman, Ph.D.

EDUCATIONAL OBJECTIVES:

To better evaluate and utilize the various levels of data gained from psychiatric training experiences, clinical observations, and controlled research studies that form their thinking about the treatment of depression.

SUMMARY:

The development of antidepressant medications has made it feasible to study a variety of depression treatment strategies comparatively. As a result, psychiatrists can now make better-informed decisions about the efficacy of therapies with competing claims and rationales. Speakers will discuss the database of outcome studies available and their methods of integrating research data and clinical experience in the treatment of depressed patients.

Presenters and the audience will have the opportunity to weigh issues of diagnosis, "allegiance," complications, and placebo effects that can influence psychiatric training and the process of depression treatment, with the aim of sharpening clinical decision making.

REFERENCES:

1. Karasu BT, et al: Practice guideline for the treatment of patients with major depressive disorder (revision), Am J Psychiatry 2000; 157:4.
2. Quitkin FM, et al: Validity of clinical trials of antidepressants. Am J Psychiatry 2000; 157:327.

Issue Workshop 91
PRIVATE PRACTICE AND THE WORLD PSYCHIATRIC ASSOCIATION

Chairperson: Michael C. Hughes, M.D., *Hughes Family Psychiatric Center, 2801 Ponce de Leon Boulevard, Suite 430, Coral Grables, FL 33134*
Participants: Theodore Hovaguimian, M.D., Norman Sartorius, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should: understand the basic values, clinical practices, and ethical principles for

private psychiatric practice worldwide; recognize problems and opportunities presented by scientific advancements and increasing clinical management by third party payors: compare and contrast private practice for different countries, cultures, and governments.

SUMMARY:

The WPA consists of 115 member societies, spanning 99 countries and representing more than 150,000 psychiatrists worldwide, with 50% estimated to be in private practice. Now a maelstrom of change is affecting private psychiatric practice virtually everywhere, not only through scientific advances but primarily with increasing oversight and management by for-profit business and governmental agencies becoming more than third party payors, intruding into the doctor-patient relationship.

The Section on Private Practice of the WPA has a work in progress to explicate essential elements of private practice: values, practices, and ethical principles. Now is a propitious moment to clarify excellence for our profession to emulate and defend but also to support the development of our own guidelines. This presentation will review our work and assimilate contributions from this workshop discussion toward formulating a position statement for presenting to the WPA World Assembly. Issues to be considered include: the doctor-patient relationship, confidentiality, choice, professional standards, commitment to the patient, fee for service, and continuity of care.

T. Hovaguimian, M.D., chair of the Section on Private Practice of the WPA, will present an overview of the project, emphasizing commonalties and variations in private practice. M. Hughes, M.D. of the Committee on Private Practice of APA and past chair, will complete the presentation of the statement and outline areas for audience discussion. N. Sartorius, M.D. past president WPA and past Secretary WHO, will discuss applications of our statement in the light of problems and opportunities worldwide.

REFERENCES:

1. Hovaguimian T: Cherish or perish: the values of private psychiatry. In Manage or Perish: The Challenges of Managed Health Care in Europe. Edited by Gutman J. Sartorius N. New York, Kluwer Academic/Plenum Publishers, 1999.
2. Hughes M: Private practice and managed care: the American experience. In Manage or Perish: The Challenges of Managed Health Care in Europe. Edited by Gutman J. Sartorius N. New York, Kluwer Academic/Plenum Publishers, 1999.

Issue Workshop 92
UPDATE ON THE PRACTICE GUIDELINE ON BPD

Chairperson: John M. Oldham, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Suite 6700, New York, NY 10032-2603*
Participants: John S. McIntyre, M.D., Katharine A. Phillips, M.D., David Spiegel, M.D., Paul H. Soloff, M.D.

EDUCATIONAL OBJECTIVES:

To provide an update concerning the overall progress of the APA practice guidelines effort and the development of the borderline personality disorder guideline.

SUMMARY:

The APA practice guidelines project has moved forward using an evidence-based process designed to result in documents which are both scientifically sound and clinically useful to practicing psychiatrists. The borderline personality disorder guideline focuses on the evaluation, selection and application of both psychosocial treatments and pharmacologic interventions and provides a framework for clinical decision making.

The foundation for treatment of each disorder is psychiatric management, which is combined with specific treatments in order to optimize patient outcome. Formulating and implementing a treatment plan utilizing psychiatric management in conjunction with specific pharmacologic and psychosocial treatments will be discussed in the context of borderline personality disorder. The guideline has been sent to more than 650 individuals and organizations for review. It is scheduled to go to the APA Assembly for approval in May.

REFERENCES:

1. Zarin DA, Pincus HA, McIntyre JS: Editorial on Practice Guidelines. Am J Psychiatry 1993; 150:2.
2. American Psychiatric Association: Practice Guideline for Treatment of Patients with Bipolar Disorder. Am J Psychiatry 1994; 151:12(suppl).

Issue Workshop 93
FOUNDATION OF THE WORLD FEDERATION OF PSYCHIATRIC TRAINEES

Co-Chairpersons: Victor J.A. Buwalda, M.D., *Free University, Pamasusweg 28-III, Amsterdam 1068, Netherlands,* Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0704, Ann Arbor, MI 48109-0704*

EDUCATIONAL OBJECTIVES:

To recognize the foundation of the World Federation of Psychiatric Trainees; to be familiar with the aims and goals of the WFPT; to understand ways to collaborate on important topics such as psychotherapy and other interesting topics, and to understand the differences between different trainee programs throughout the world.

SUMMARY:

The purpose of this workshop is to familiarize participants with the foundation of the World Federation of Psychiatric Trainees and discuss its goals. During the annual meeting of the European Federation of Psychiatric Trainees, Berlin August 31, some of these goals were defined:

1.) Facilitate possibilities for trainees in psychiatry to join at international meetings (APA, WPA);

2.) Provide a forum in which trainees can discuss topics, ideas and thoughts concerning international worldwide psychiatric training programs where they can learn about the diversity and richness of the current training of psychiatrists in the world;

3.) Stimulate and expand the use of educational networks for trainees;

4.) Explore ways in which trainees can promote and improve their own training both national and worldwide;

5.) Establish collaborative links with other institutions interested in training and professional development of trainees;

6.) Promote and facilitate the international exchange of trainees in their training program.

An organization, with the EFPT as an example, should be established and should facilitate possibilities for residents around the world so they can meet each other at international meetings. Also some guidelines are needed for the continuation of the organization, and topics of interest should be selected, like the place of psychotherapy in the training program.

REFERENCES:

1. Beinum van B, Castle D., Cameron M: The European forum for all psychiatric trainees. Psychiatric Bulletin 1993; 17:679–680.

2. Gribbin N.: The European Federation of Psychiatric Trainees (EFPT). European Psychiatry 1999; 14:468–9.

Issue Workshop 94
EIGHT-DAY TREATMENT OF PANIC WITH MODERATE TO SEVERE AGORAPHOBIA

Chairpeson: David A. Spiegel, M.D., *Center Anxiety/Related Disorders, Boston University, 648 Beacon Street, 6th Floor, Boston, MA 02115-2015*

EDUCATIONAL OBJECTIVES:

To understand the principles of sensation-focused therapies for panic disorder and ungraded massed exposure for agoraphobia; describe and implement an intensive treatment program for panic disorder with moderate to severe agoraphobia; and appreciate the advantages, difficulties, and therapeutic challenges of such a treatment.

SUMMARY:

Cognitive behavioral therapies (CBTs) have been shown to be effective for panic disorder with limited agoraphobic avoidance. When agoraphobia is more severe, a situational exposure component commonly is added. These treatments typically are administered over a period of several months. This workshop will describe a new eight-day intensive treatment program for panic disorder with moderate to severe agoraphobia, which is being conducted at the Center for Anxiety and Related Disorders at Boston University. The treatment combines an abbreviated, largely self-study version of CBT with brief, therapist-assisted, ungraded massed situational and interoceptive exposure followed by instruction in relapse-prevention strategies. Because its primary focus is on the experience of distressing internal sensations, it has been called Sensation-Focused Intensive Therapy (S-FIT). Initial results have been dramatic, and the program has received media attention, being featured on twice each on "20/20" and "48 Hours." This workshop will include description of the program orally and in handout materials, with particular emphasis on how S-FIT differs from standard CBTs, presentation of illustrative videoclips from the "20/20" and "48 Hours" programs and patient interviews, and presentation of preliminary outcome data. Some aspects of this treatment are controversial and ample opportunities will be provided for audience interaction.

REFERENCES:

1. Spiegel DA, Barlow DH: 8-day treatment of panic disorder with moderate to severe agoraphobia: preliminary outcome data. Poster presentation at the 34th Annual Convention of the Association for Advancement of Behavior Therapy, November 18, 2000, New Orleans, LA.
2. Heinrichs N, Spiegel DA, Hofmann SG: Panic disorder with agoraphobia, in Handbook of Brief Cognitive Behaviour Therapy. Edited by Bond F, Dryden W. Chichester, New York, John Wiley & Sons (in press).

Issue Workshop 95
MIND MEETS BRAIN IN FAMILY THERAPY: BRIDGES FOR HEALING

Chairperson: Roy O. Resnikoff, M.D., *Department of Psychiatry, University of California, 1104 Pearl Street, La Jolla, CA 92037-4211*

EDUCATIONAL OBJECTIVES:

At the end of this workshop the participants should be able to use a dimensional model for integrating (1) pharmacotherapy used both in a medical problem solving model and communication enhancing model, (2) foreground versus background stages of family therapy, (3) instrumental versus expressive-relational approaches, and (4) biological versus environmental causes.

SUMMARY:

A four-dimensional model from the presenter's new book Integrating Family Therapy and Psychopharmacology: A Dimensional Approach will be described. The dimensions include: (1) foreground versus background stages of family therapy, (2) instrumental versus expressive-relational family therapy approaches, (3) biological versus environmental causes, and (4) therapist versus family dimensional interaction. Clinical examples from all four stages of family therapy will be presented (surface symptoms, communications/boundary issues, personality issues and polarities, life transition/spiritual). Discussion of each example will be included. Participants will be able to present clinical situations for supervision and discussion. Participants will further appreciate their own preferences along the dimensions presented. (Intended for practitioners with some interpersonal therapy and pharmacotherapy experience).

REFERENCES:

1. Resnikoff R, Lapidus D: Psychopharmacology in conjunction with family therapy. J. of Family Psychotherapy 1998; 9:1–18.
2. Resnikoff R: Bridges for Healing: Integrating Family Therapy and Psychopharmacology. Brunner-Routledge, 2001, Philadelphia (release date December 6, 2000).

Issue Workshop 96
CONFIDENTIALITY AND SEXUAL HISTORY ISSUES IN SEXUAL HARASSMENT CASES

Chairperson: Rita R. Newman, M.D., *Department of Psychiatry, St. Barnabas Medical Center, 1046 South Orange Avenue, Short Hills, NJ 07078-3131*
Participants: Liza H. Gold, M.D., Annette J. Hollander, M.D., Louise F. Fitzgerald, Ph.D., Naomi J. Weinshenker, M.D.

EDUCATIONAL OBJECTIVES:

This workshop is designed to provide clinicians with knowledge about existing federal laws concerning confidentiality and past sexual history, and to assist the clinician in the assessment and treatment of patients who are victims of sexual harassment or discrimination while taking care to safeguard their confidentiality.

SUMMARY:

Psychiatrists assessing patients' complaints of sexual harassment or discrimination must resolve the conflict between patient confidentiality and the realities of the legal system. This workshop will update attendees on harassment/discrimination law and how this influences the way we proceed with evaluation and treatment.

The scope of the mental examination raises discovery issues that are fiercely contested, including those of the confidentiality of psychological records and the relevance of the plaintiff's sexual history in view of the protection offered by Federal Rule of Evidence 412, the "rape shield law." The purpose of this law is to protect victims against the invasion of privacy, potential embarrassment, and sexual stereotyping associated with public disclosure of intimate sexual details and infusion of sexual innuendo into fact-finding processes. This protection was designed to encourage victims to seek legal recourse against their harassers. Under this rule, discovery of plaintiff's private non-work-related sexual activities is not allowed. This could result in redacting therapy notes and/or limiting examination by a defendant's doctor.

Confidentiality and the plaintiff's sexual history are among the most frequently contested discovery issues in harassment suits. Familiarity with the legal context and psychiatric ethics governing these subjects can enable the psychiatrist to effectively address the conflicts they engender in sexual harassment/discrimination evaluations.

REFERENCES:

1. McDonald JJ: Mental and Emotional Injuries in Employment Litigation: 2000 Cumulative Supplement. Washington DC, The Bureau of National Affairs, Inc., 2000a.
2. Strubbe MR, Linderman B, Kadue DD: Sexual Harassment in Employment Law: 1999 Cumulative Supplement. Washington DC, The Bureau of National Affairs, Inc., 1999.

THURSDAY, MAY 10, 2001

Issue Workshop 97
MOBILE COMPUTING IN PSYCHIATRY WITH PERSONAL DIGITAL ASSISTANTS

Chairperson: John Luo, M.D., *University of California Davis Health Systems, 2230 Stockton Boulevard, Sacramento, CA 95817*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should become familiar with the potential uses and limitations of personal digital assistants in the practice of medicine.

SUMMARY:

The practice of psychiatry requires management of enormous amounts of information. The demands to provide timely and appropriate care are tremendous, involving storage and retrieval of and access to patient care information as well as reference material. Personal digital assistants (PDAs) provide one mechanism to facilitate this need accurately and with minimal effort. They provide an excellent medium for patient tracking, medical calculations, storage of reference materials, lookup of information, decision-making guides, and even Internet access. In particular, their mobility and ease of use are clearly solutions to this information-management need.

REFERENCES:

1. Wofford MM; Secan R; Herman, C; Moran, WP; Wofford, JL. Clinical documentation: the handheld computer as a survival tool. MD Computing, 1998; 15(6):352–4, 356, 358.
2. Walker, L. The hand-held computer: no longer a toy. Healthcare Informatics, 1990; 7:54.

Issue Workshop 98
DOMESTIC VIOLENCE IN THE PSYCHIATRIC EMERGENCY DEPARTMENT

Chairperson: Satyanarayana Chandragiri, M.D., *7600 Stenton Avenue, Apt. 15J, Philadelphia, PA 19118*
Participants: Satyajit Satpathy, M.D., Brigid B. Bautista, M.D.

EDUCATIONAL OBJECTIVES:

To recognize domestic violence in patients presenting to the psychiatric emergency department, to identify the training needs of the professionals working in the psychiatric emergency services with emphasis on domestic violence, develop a protocol for intervention that is applicable to their practice setting.

SUMMARY:

Battered women comprise a large proportion of those referred to psychiatric emergency services. A strong association has been found between domestic violence and psychiatric illness, suicide, and alcohol and drug abuse. They also carry more medical than trauma diagnoses. Being a female and having a history of child abuse are factors identified for being an adult victim of domestic violence. Despite a high prevalence of domestic violence, there is a low rate of detection by the doctors and nurses. The reasons for this may be low disclosure by victims, lack of training of health professionals, inappropriate attitudes, lack of legal mandate, time constraints, lack of social work services, etc. Partner violence in many ethnic, religious, and sexual minorities attending the psychiatric emergencies is also neglected. Clinicians often struggle and focus on the chief complaints and may miss or dismiss abuse.

This workshop will address the clinical issues of domestic violence in psychiatric emergency departments. This discussion will focus on the ability of the professionals in identifying domestic violence and evolving a treatment plan. Difficulties in evolving an ideal treatment plan will be the focus of discussion. This workshop will foster a dialogue and stimulate discussion of these issues between participants.

REFERENCES:

1. Roberts GL, O'Toole BI, Lawrence JM, Raphael B: Domestic violence victims in a hospital emergency department. Medical Journal of Australia 1993; 159:307–310.
2. Lamberg L: Domestic violence: what to ask, what to do. JAMA 2000; 284:554–556.

Issue Workshop 99
MENTAL HEALTH IN A JAIL

Chairperson: Ole J. Thienhaus, M.D., *Department of Psychiatry, University of Nevada, Manville Building #354, Reno, NV 89557*
Participants: Joan Williamson, R.N., Melissa P. Piasecki, M.D.

EDUCATIONAL OBJECTIVES:

To understand the specific characteristics of working as a mental health professional in a county jail; appreciate psychiatry in the jail as a form of community mental health service, impacted by the delivery system's constraints; discuss transference and countertransference issues occuring between inmates and professionals.

SUMMARY:

Three brief lectures will summarize characteristics of correctional medicine and psychiatry in a jail setting. One lecture will outline functions of a jail, contrasting them with those of penitentiaries. The system characteristics will be highlighted, especially the importance of boundaries and the negotiation of transitioning them. The role of the mental health clinicians as a group separate from inmates and correctional personnel will be outlined. A second lecture will summarize the function of a mental health unit within the jail in facilitating case identification and clinical response, minimizing the need for aversive correctional interventions, and permitting efficient use of a psychiatrist's limited time. An outline of institutional transference vicissitudes will follow and include a discussion of projective identification as it can impact both caregivers and patients. Finally, the reality of managed care constraints imposed by the administrative arrangements of service delivery in the correctional center context will be discussed. Audience participation will consist of an extended discussion period between audience members and presenters.

REFERENCES:

1. Gilbert KG: Working on the inside: proper restraints. Psychiatr Times 2000; 17:26–28.

2. Sohr F: The Difficult Patient. Miami, FL, MedMaster Inc. Publ., 1996.

Issue Workshop 100
PROSPERING: MARKET DYNAMICS IN THE NEW POLITICAL CRUCIBLE

Chairperson: Stuart B. Silver, M.D., *4966 Reddy Brook Lane, Columbia, MD 21044*
Participants: Dave M. Davis, M.D., Gary E. Miller, M.D., W. Walter Menninger, M.D., Philip E. Veenhuis, M.D.

EDUCATIONAL OBJECTIVES:

To describe the new forces affecting how to manage psychiatric practice to achieve increased service, revenue, and profitability.

SUMMARY:

The workshop will examine administrative strategies to enhance participants' abilities to attract referrals, operate efficiently, and achieve patient satisfaction. Special attention will be paid to the impact of the new national political leadership on issues of mental health funding, reimbursement, and operating requirements. Audience participation will be solicited in examining current administrative dilemmas in achieving success and prosperity in the new market place. A panel of experts in psychiatric administration will engage participants in this discussion.

REFERENCES:

1. Mosina JP, Emerice CE, Black SC: Stop Managing Costs, 1999.
2. Mechanic D: Mental Health and Social Policy. 4th ed, 1999.

Issue Workshop 101
TEACHING PSYCHOPHARMACOLOGY TO RESIDENTS USING EVIDENCE-BASED ALGORITHMS

Chairperson: David N. Osser, M.D., *Brockton VA Medical, 940 Belmont Street, Brockton, MA 02401*
Participants: Dan O. Ioanitescu, M.D., Jessica R. Oesterheld, M.D., James J. Levitt, M.D.

EDUCATIONAL OBJECTIVES:

Participants will understand the rationale supporting the idea that psychiatry residents could achieve a better and earlier grasp of clinical psychopharmacology by focusing on evidence-supported treatment algorithms, coupled with detailed examination of representative high-quality empirical clinical research papers. Participants will consider the findings from an evaluation questionnaire.

SUMMARY:

It is apparent that the movement to encourage evidence-based medicine has had only a limited impact on physicians' practices. New research findings and "expert opinion" conveyed in lectures and paper media are only slowly adopted into practice. The marketing efforts of the free-spending, behemoth pharmaceutical firms routinely drown out attempts to be objective about the "evidence," as indicated by how frequently the drug companies induce physicians to succumb to non-evidence-based prescribing.

In this workshop, we would like to engage students and teachers of psychopharmacology in a discussion of how best to teach this subject in a way that is most likely to induce a lifelong respect for evidence-supported practice. Presenters from two institutions will describe their experiences organizing and teaching yearlong psychopharmacology courses that were organized around systematic reviews of published evidence-supported treatment algorithms.

A resident will present results of a questionnaire obtaining the residents' impression of the success of one of the programs. A view noting the limitations of algorithms from one of the course co-directors will be included. Many issues of training and practice will be raised that should spark a lively debate among those attending this workshop.

REFERENCES:

1. Osser DN, Editor: The Harvard psychopharmacology algorithm project. Psychiatric Annals 1999; 29:248–316.
2. Schneider LS: How do physicians translate research into practice? Primary Psychiatry 2000; 7:60–62.

Issue Workshop 102
IF THERAPY IS NEEDED BUT NOT AVAILABLE, WHAT SHOULD WE DO?

Chairperson: Theodor Bonstedt, M.D., *6070 Anchorline Ct, Fort Myers, FL 33917-3174*
Participants: Janet W. Eustis, M.S.W., Raymond A. Johnson, M.D., Debra M. Patterson, M.A.

EDUCATIONAL OBJECTIVES:

To use creative solutions for situations when a patient needs and wants psychotherapy, but no therapist is available due to economic constraints.

SUMMARY:

In the age of managed care and multiplicity of effective psychotropic medications, a common problem is lack of an available therapist for a patient who clearly has an emotional problem aggravating his symptoms yet is not being helped sufficiently by medications. As a psychiatrist leading case-management teams in a CMHC, this presenter has effectively used the following approaches to help such patients: 1) strong effort to include in treatment any accessible family member(s), 2) an increase in frequency of "med checks," 3) strengthening psychotherapeutic skills on the part of case managers working with such patients, 4) fostering involvement of such patients not only in support groups, but also in any benevolent activity group, chosen by the patient (e.g., church, drop-in center, supervised volunteering, etc.). The audience will be asked, after the first 25 minutes of presentation, to discuss their own experience with this problem and which types of patients benefit the most from which intervention.

REFERENCES:

1. Walsh J: Clinical Case Management with Persons Having Mental Illness. Brooks/Cole, 1999, pp. 15–16 & 91.
2. Kelly J, Stephens I: Community case management for mental illness. Aust Nurs J 1999; 6:24–26.

Issue Workshop 103
IMPLEMENTING OUTPATIENT COMMITMENT IN NEW YORK CITY: A FORENSIC PERSPECTIVE

Co-Chairpersons: A. Sasha Bardey, M.D., *Department of Psychiatry, Bellevue Hospital, First Avenue @ 27th Street, New York, NY 10016,* Deborah S. Rose, Psy.D., *Bellevue Hospital Center, First Avenue @ 27th Street, New York, NY 10016*
Participant: Gary R. Collins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with the New York State Assisted Outpatient Treatment (AOT) statute, understand the development and evolution of AOT within the correctional health system, and recognize the many legal, ethical, and administrative challenges faced during the implementation of AOT.

SUMMARY:

In November 1999 New York passed a statewide statute enabling involuntary outpatient commitment of individuals with serious mental illness. Bellevue Hospital Center was selected to operate and implement the Assisted Outpatient Treatment (AOT) program for both Manhattan and for Riker's Island, a New York City jail serving 125,000 detainees and inmates annually. It is estimated that 20% of the Riker's Island population is diagnosed with a major mental illness. While a large proportion of these individuals receive and accept psychiatric care while incarcerated, many are nonadherent with follow-up community treatment. As a result, these patients pose a significant risk of relapse and dangerousness to themselves and others. Bellevue Hospital Center, having earlier conducted a five-year outpatient commitment study, has held the unique position of experiencing direct coordination of the outpatient commitment process and was therefore able to capitalize on lessons learned while also predicting and preventing potential obstacles. With an enhanced focus on serving the forensic community, this presentation will examine and discuss the following challenges encountered during the evolution of AOT: (a) assessing and anticipating the discharge needs of incarcerated psychiatric patients via direct examination or teleconferencing technology, (b) developing and sanctioning appropriate psychiatric treatment plans for historically noncompliant patients, (c) securing comprehensive community resources for often recalcitrant individuals, (d) coordinating civil and criminal court personnel and proceedings, (e) facilitating continuity of care and communication among traditionally fragmented treatment providers and correctional systems, and (f) ensuring and monitoring treatment compliance with court orders along a continuum of clinical interventions. These authors will further explore the clinical gains of outpatient commitment and the effects on recidivism and psychiatric morbidity.

REFERENCES:

1. Swanson JW, Swartz MS, Borum R, et al: Involuntary outpatient commitment and reduction of violent behavior in persons with severe mental illness. British Journal of Psychiatry 2000; 176:324–331.
2. US Department of Justice, Bureau of Justice Statistics: Mental health and treatment of inmates and probationer. 1999.

Issue Workshop 104
MEMORY SCREENING PROGRAM FOR COMMUNITY-DWELLING ELDERS: A PRACTICAL APPROACH

Co-Chairpersons: Janet M. Lawrence, M.D., *Geriatric Department, McLean Hospital, 115 Mill Street, Belmont, MA 02478,* Donald A. Davidoff, Ph.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478*
Participant: Debra Katt-Lloyd, B.S.

EDUCATIONAL OBJECTIVES:

The participant will understand the rationale for, and usefulness of, a memory screening program for community dwelling elders. They will learn two specific screening instruments and the advantages and significance of each. They will also learn how to address the special needs of this population and some techniques to ensure that detection is followed by appropriate referral.

SUMMARY:

In the past several years pharmacological agents specifically targeted to retard the cognitive decline inherent to Alzheimer's disease have come to market. These treatments are known to be most effective during the earlier stages of the disease when they can maximize quality of life. It has thus become more worthwhile to make appropriate diagnoses as early as possible so as to take advantage of these treatments. Societal prejudices have also shifted and many older people are now openly asking questions about whether age-related memory changes are normal.

There has been interest in developing community-screening programs for cognitive impairment, but limited information about their efficacy. This workshop is for participants of all disciplines who work with older patients to give them the practical and theoretical knowledge necessary to run such a program. Drawing upon their experience in running a successful large-scale regional memory screening day in 1999, the presenters will engage the audience in addressing the issues that are involved. This will include a discussion of appropriate screening methods, with the opportunity to compare the familiar Mini Mental State Examination with the newer Seven Minute Screen. Participants will learn to use the latter, address the potential benefits and limitations of each screen, and discuss the ideal screening instrument. Practical aspects of development of a screening program in the community or private office practice, assessment of the efficacy of the program, and ethical issues involved will also be addressed.

REFERENCES:

1. Goldberg TH: Update: preventive medicine and screening in older adults. JAGS 1999; 47:122–123.
2. Solomon O, Hirschoff A, Kelly B, et al: A 7-minute neurocognitive screening battery highly sensitive to Alzheimer's Disease. Arch Neurol 1998; 55:349–355.

Issue Workshop 105
ADMINISTRATIVE PSYCHIATRY: HOW TO PREPARE TO MEET THE CHALLENGE

Chairperson: Paul Rodenhauser, M.D., *Department of Psychiatry, Tulane University, 1440 Canal Street, TB-53, New Orleans, LA 70112-2699*
Participant: Michael J. Vergare, M.D.

EDUCATIONAL OBJECTIVES:

To recognize and develop the management and leadership skills necessary for a career in administrative psychiatry.

SUMMARY:

While educational opportunities for clinical advancement are plentiful for members-in-training and early career psychiatrists, those looking to advance in administrative roles often find it difficult to access programs devoted to management-skills development. This session will focus on an overview of basic concepts related to developing leadership skills relevant to complex health care systems. The transition from resident to staff to manager will be examined. Skills and qualities that facilitate and interfere with administrative collaboration will also be highlighted. This workshop will be interactive, with participants strongly encouraged to share their own challenges and suggestions regarding careers in administrative psychiatry.

REFERENCES:

1. Mental Health Care Administration: A Guide for Practitioners, Edited by Rodenhauser P. The University of Michigan Press, 2000
2. Textbook of Administrative Psychiatry, edited by Talbott JA, Hales RE, Keill S., American Psychiatric Press, Inc. Washington DC, 1992

Issue Workshop 106
COGNITIVE-BEHAVIORAL THERAPY TRAINING FOR RESIDENTS: HOW TO TEACH, MEASURE, AND ATTAIN RESIDENT COMPETENCY

Chairperson: Donna M. Sudak, M.D., *Psychiatry Residency Training Department, MCP Hahnemann University, 3200 Henry Avenue, Philadelphia, PA 19129*
Participants: Judith S. Beck, Ph.D., Hinda F. Dubin, M.D., Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVES:

To review model curricula for training in CBT, observe and participate in demonstrations of models and methods for training, use the Cognitive Therapy Rating Scale for evaluating competency, and use nationally available resources to improve faculty expertise in CBT within their own department.

SUMMARY:

Starting in January 2001 ACGME requirements for residency training in psychiatry mandated that training programs demonstrate that residents achieve competency in five forms of psychotherapy, including cognitive-behavioral therapy (CBT). Given that CBT has a rich literature regarding therapist training and evaluation of therapist competency, a fairly uniform standard of resident training could be disseminated and evaluated. This workshop will teach participants the key features of a curriculum in cognitive therapy that has been discussed with noted educators in the field and adapted for residency training. The audience will review key features of a didactic program, participate in a demonstration of some of the educational methods available for training residents, and be shown the usefulness of the Cognitive Therapy Rating Scale as one method of assessing resident competence. We anticipate substantial discussion of the barriers to the use of this model in specific residency situations and to problem solve with the audience about these, as well as discussing the difficulty of measuring psychotherapy competence in general. Additionally, the audience will receive information about national resources available to enhance the training of faculty members in CBT.

REFERENCES:

1. Shaw, et al: Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. Journal of Consulting and Clinical Psychology 1999; 67:837–846.
2. Shaws & Dobson: Competency judgments in the training and evaluation of psychotherapists. Journal of Consulting and Clinical Psychology 1988; 56:666–672.

Issue Workshop 107
HOW TO GIVE A MORE EFFECTIVE LECTURE: PITH, PUNCH, AND POLISH

Chairperson: Philip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106*

EDUCATIONAL OBJECTIVES:

To improve techniques for holding audience attention, involving the audience, and using slides effectively.

SUMMARY:

This workshop will provide practical advice on how to make a psychiatric presentation with pith, punch, and polish. Instruction will be given on planning a scientific paper presentation and a half-day course. The workshop leader will cover the selection of a title through to the choice of closing remarks. Teaching techniques to hold the audience's attention include the use of humor, anecdotes, and vivid images. Participants will be taught to involve the audience by breaking them into pairs to solve problems by applying recently acquired knowledge.

Participants will be told that they should never read while lecturing, display their esoteric vocabulary, or rush through their talk, no matter what the time constraints. Tips will be given for making traditional word slides and innovative picture slides. Advice will be given on the effective use of videotape vignettes. A videotape will actually be used to illustrate common errors made by lecturers. The workshop will also cover how to select material for handouts. Finally, participants will be encouraged to make a three minute presentation with slides or without slides and receive feedback from workshop participants.

This is a revision of a very popular workshop given at the last two APA meetings.

REFERENCES:

1. Brookfield SD: Becoming a Critically Reflective Teacher, Jossey-Bass, 1995.
2. Edwards MJ, McMasters KM, Acland RD, et al: Oral presentations for surgical meetings, Journal of Surgical Research 1997; 68:87–90.

Issue Workshop 108
BIOBEHAVIORAL INTEGRATION OF ADDICTION TREATMENT

Chairperson: Richard J. Frances, M.D., *Silver Hill Foundation, 208 Valley Road, New Canaan, CT 06840*
Participants: Sheldon I. Miller, M.D., Robert B. Millman, M.D., Sheila B. Blume, M.D., Marc Galanter, M.D., Lionel P. Solursh, M.D., Frances R. Levin, M.D.

EDUCATIONAL OBJECTIVES:

Participants will gain a greater knowledge of biobehavioral approaches to addiction treatment and will understand the value of integrating addiction, psychiatric, and medical treatment, addressing problems at the level of brain, behavior, medical problems, social and occupational, marital and legal problems.

SUMMARY:

This will be the 33rd year of a workshop dialogue with leaders in addiction psychiatry that has been an annual event at APA. This year's theme will be biobehavioral integration of addiction treatment. Biobehavioral integration focuses upon the interaction of substance dependency with other psychiatric and medical comorbidity. The effects of intoxication, withdrawal, chronic effects, and medical complications interact in complex ways with other disorders and can camouflage or be camouflaged by other problems. Integration of treatment approaches also means developing administrative systems that can provide delivery of care in a sophisticated way for the myriad of the addicted patients' medical and additional psychiatric problems as well as dealing with the complexity of family, job, legal, and financial issues. Barriers to good care can be financial, political, and reductionistic approaches. Most patients still are faced with separate addiction and mental health treatment systems; most addicted patients who go to primary care doctors still don't get their problems adequately diagnosed and treated. The format for this workshop consists of brief presentations by the panelists followed by an intense and lively discussion with participants.

REFERENCES:

1. Frances RJ, Miller ST: Clinical Textbook of Addictive Disorders (Second Ed.) New York, N.Y., Guilford Press, 1998.
2. Kranzler HR, Rounsaville BJ, eds: Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders, New York, NY, Marcel Dekker, Inc., 1998.

Issue Workshop 109
ACHIEVING COMPREHENSIVE CARE FOR CHRONICALLY SUICIDAL INDIVIDUALS

Chairperson: Ian C. Dawe, M.D., *Department of Mental Health, St Michael's Hospital, 2012 30 Bond Street, Toronto, ON M5B 1W8, Canada*
Participants: Yvonne Bergmans, M.S.W., Paul S. Links, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be familiar with the epidemiology and neurobiology of suicide, the crisis evalua-

tion of suicidal clients, and the inpatient and outpatient treatment options for managing these difficult clients. Participants will gain insight into the need for comprehensive integrated programs to effectively deal with suicidal clients.

SUMMARY:

This workshop will outline a comprehensive package of care for chronically suicidal individuals from the viewpoint of a number of mental health professionals affiliated with and working in a Canadian inner-city academic hospital. The various presentations will track the care of a suicidal individual from the emergency department, through the inpatient unit, and into the community. Special focus will be on the academic research that guides and supports the treatment of such individuals, along with the implications for future work in this area.

The workshop is cosponsored by the University of Toronto's Arthur Sommer Rotenberg Chair in Suicide Studies and the Mental Health Service of St. Michael's Hospital in Toronto, Ontario, Canada. The presenters will include an RN crisis clinician, an emergency psychiatrist, an inpatient psychiatrist, a suicide intervention consultant, and a research scientist. Topics covered will include the epidemiology and neurobiology of repeat suicide attempters, the engagement and retention of clients, the management of transference and countertransference, the utility of inpatient hospital treatment, the use of medications, and a group-based psychosocial and psychoeducational approach to the management of these clients in the community. Clinical and descriptive data will be presented highlighting ongoing work in this area at the University of Toronto.

REFERENCES:

1. Maris RW, Berman AL, Silverman MM: Comprehensive Textbook of Suicidology. New York, The Guilford Press, 2000.
2. Jacobs DG: The Harvard Medical School Guide to Suicide Assessment and Intervention. San Francisco, Jossey-Bass Inc., 1999.

Issue Workshop 110
TEACHING THE CLINICAL ESSENTIALS: THE ROLE OF THE PSYCHIATRIST

Chairperson: David C. Lindy, M.D., *CMHS, Visiting Nurse Services, 1250 Broadway, 3rd Floor, New York, NY 10001*
Participants: Neil Pessin, Ph.D., Howard W. Telson, M.D., Christina Fragola, C.S.W., Annette Culrino, C.S.W., Stephanie Moeller, M.A.

EDUCATIONAL OBJECTIVES:

To gain an appreciation for the concept of "clinical essentials," the importance of teaching them to mental health staff, and the role of psychiatrists in achieving this educational goal.

SUMMARY:

Today's psychiatrists often function within mental health systems in which clinical responsibility is delegated to nonmedical providers. At the same time, the clinicians caring for the sickest patients within these systems are frequently the least experienced and trained. Psychiatrists, with their extensive training in clinical data gathering, differential diagnosis, and treatment planning, can provide a critical function as educators for mental health providers less familiar with these essential clinical tools.

The Visiting Nurse Service of New York's Community Mental Health Services (CMHS) frequently utilizes clinical staff with BA/BS degrees or new MSW graduates to care for severely ill patients. To supplement their training, we designed the "CMHS U" to present the clinical essentials of psychiatry in 10 teaching modules. A multidisciplinary planning committee established "clinical essentials." Nonmedical committee members clearly appreciated the perspective provided by committee psychiatrists. All clinical staff attend the CMHS U, which creates a common language and baseline of knowledge. Modules include introductions to the DSM system of diagnosis, psychopharmacology, and how to present cases. All faculty are drawn from our staff and include many of the CMHS psychiatrists.

This workshop is designed to promote discussion regarding the role of psychiatrist as clinical teacher within mental health systems. Workshop participants will be able to review examples of CMHS U training modules. We will invite workshop participants to share their experiences in establishing clinical essentials for their programs and teaching them to staff.

REFERENCES:

1. Diamond RJ, Goldfinger SM, Pollack D, Silver M: The role of psychiatrists in community mental health centers: a survey of job descriptions. Community Mental Health Journal 1995; 31:571–81.
2. Ranz J, McQuistion HL, Stueve A: The role of the community psychiatrist as medical director: a delineation of job types. Psychiatric Services 2000; 51:930–2.

Issue Workshop 111
THE IMPORTANCE OF PSYCHIATRIC MANAGEMENT FOR INPATIENT CARE AND TREATMENT

Chairperson: Roger Peele, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue, 8th Floor, Washington, DC 20037-2396*
Participants: Barbara Rosenblum, M.D., Joseph M. Jeral, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to explicate the use of psychiatric management that enhances the inpatient care and treatment of psychiatrically ill.

SUMMARY:

Assuring the mind meets the brain on an acute inpatient unit, where patients stay only a few days, challenges psychiatry. This workshop demonstrates how to use the "psychiatric management" of APA's Practice Guidelines to achieve the extensive needs—psychological, biological and social—of the psychiatrically ill during short hospitalizations.

Addressing psychiatric management, the guidelines call for a broad array of interventions and activities that should be instituted by psychiatrists for all patients. They can be divided into the following six activities:

1. Perform a diagnostic evaluation.
2. Evaluate the functional impairments.
3. Evaluate the risk safety of the patient.
4. Establish a therapeutic physician-patient relationship.
5. Educate the patient and the relevant supporters of the patient.
6. Determine the specifics of the treatment plan.

The guidelines devote only a few words to 2 through 5 supra. We have found it important to expand 2 through 5 so that each inpatient receives more than medications and group therapies.

This workshop will provide three psychiatric management workbooks for each of the participants for three illnesses: major depression, bipolar, and schizophrenia. There will be a 10-minute presentation of each of the three followed by a discussion with the audience to share experiences that assure that hospitalized patients obtain a broad therapeutic experience, even through brief, through the concept of psychiatric management.

REFERENCES:

1. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2000. Washington, American Psychiatric Publishing Group, 2000.

2. Frank JD, Frank JB: Persuasion and Healing. Baltimore, Johns Hopkins University Press, 3rd ed., 1993.

Issue Workshop 112
GROUP PSYCHOTHERAPY WITH SUBSTANCE ABUSERS
American Group Psychotherapy Association

Co-Chairpersons: David W. Brook, M.D., *Community Medical, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1044A, New York, NY 10029,* Henry I. Spitz, M.D., *Columbia University, 101 Central Park W, New York, NY 10023-4204*
Participant: Philip J. Flores, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand the developmental, neurobiological, and psychosocial bases for the use of a variety of group psychotherapeutic approaches in the treatment of substance abusers; to evaluate which group approaches are most appropriate; and to treat substance abusers using a variety of group psychotherapeutic techniques.

SUMMARY:

Group psychotherapeutic approaches are a major method of treatment for substance abusers, and this topic is of critical importance for the treatment of people at risk for substance abuse. Theoretical and technical issues will be presented that are relevant to both the evaluation and treatment of substance abusers using a variety of group approaches.

Group approaches discussed will include multiple-family therapy groups, cognitive-behavioral groups, network therapy, modified psychodynamic group therapy, relapse-prevention groups, behavioral-educational groups, harm-reduction groups, psychodynamic groups, self-help groups, and others. A broad overview of the literature will be presented, and a developmental approach will be used to look at risk and protective factors and their relationship to group treatment approaches. Issues involving comorbidity will be addressed, as will the uses of group approaches in a variety of settings including inpatient, outpatient, and partial hospitalization. The presenters will use specific clinical examples and material from group sessions as illustrations.

In a brief experiential group, participants will become familiar with issues and techniques.

Active audience participation in the form of questions and answers about specific or general theoretical or treatment issues will be encouraged. Participants will be asked to present specific clinical examples or problems for discussion. This issue workshop is cosponsored by the American Group Psychotherapy Association.

REFERENCES:

1. Flores P: Group Psychotherapy with Addicted Populations. New York, Haworth Press, 1997.
2. Brook DW, Spitz HI, (Eds): (In press). Group Therapy of Substance Abuse. Washington, DC, American Psychiatric Press.

Issue Workshop 113
ASPERGER'S DISORDER: FROM QUANDARY TO QUAGMIRE

Chairperson: Donna L. Londino, M.D., *2434 Persimmon Rd, Augusta, GA 30904-3389*
Participants: Robert Kaltenbach, Ph.D., Elizabeth Sirota, M.D.

EDUCATIONAL OBJECTIVES:

To demonstrate an accurate understanding of the current diagnostic criteria for Asperger's disorder; to recognize the diagnostic overlap between Asperger's disorder, high functioning autism, and simple schizophrenia; to treat this population using a multidisciplinary approach.

SUMMARY:

Asperger's syndrome is a relatively new diagnosis to mental health professionals and to the mental health field. First described by Hans Asperger in 1944, it remained somewhat obscure until the 1980s. It now is a distinct entity included in the DSM-IV, and the renewed interest has led to an increasing number of individuals who carry the diagnosis of Asperger's disorder. Observant clinicians agree on core clinical features, in particular, social impairment, but have become increasingly aware of the overlap and possible confusion with other psychiatric disorders.

Through this workshop, an overview of Asperger's syndrome will be presented to include current knowledge and research and comparisons of Asperger's disorder with autistic spectrum disorders and schizophrenic negative symptoms. Participants will have an opportunity to view video clips of individuals who carry the diagnosis of Asperger's and then to engage in a discussion of common clinical features of the disorder, treatment interventions, and future research endeavors, which may help psychiatrists and mental health professionals more accurately diagnose this disorder and offer beneficial therapeutic interventions for the individual and the family.

REFERENCES:

1. Bowler DM: "Theory of mind" in Asperger's syndrome. J Child Psychology and Psychiatry 1992; 5:877–893.
2. Schultz RT, Gauthier I, Klin A: Abnormal ventral temporal cortical activity during face discrimination among individuals with autism and Asperger's syndrome. Archives of General Psychiatry 2000; 57:331–340.

Issue Workshop 114
PSYCHIATRIC DISABILITY: THE ROLE OF PSYCHIATRIC ASSESSMENT

Chairperson: Edward A. Volkman, M.D., *Temple University, 3401 North Broad Street, Philadelphia, PA 19140-5103*
Participants: Janice Volkman, J.D., Deborah Balley, V.E.

EDUCATIONAL OBJECTIVES:

The participant should know the meaning of "meeting a listing," and be able to enumerate psychiatric disorders that meet that criterion. The participant should know how to present impairment to the satisfaction of the ALJ, and the criteria set employed by VE's to determine suitable work context.

SUMMARY:

The audience will participate in two ways. After brief introductory presentations by the administrative law judge (ALJ) and the vocational expert (VE), the audience will be asked to discuss each of the three cases that will be handed out at the workshop. At the end of the formal presentations and case discussions there will be a period for summary discussion.

The ALJ presentation will aim at familiarizing the audience with disability law, its terms of art, and the criteria set used by judges to determine disability. The VE presentation will focus on the methods of determining the limitation parameters of the various psychiatric diagnoses. The cases will be taken from actual cases heard in the Office of Hearings and Appeals (OHA), with identifying data deleted or altered to preserve the confidentiality of the claimants. The will be chosen to focus on the role the psychiatric assessment played in the ultimate determination of entitlement to disability.

REFERENCES:

1. Wylonis L: Psychiatric disability, employment and the Americans with Disabilities Act. Psychiatric Clinics of North America 1999; 22:147–58.
2. Appelbaum PS: Discrimination in psychiatric disability coverage and the Americans with Disabilities Act. Psychiatric Services 1998; 49:875–6, 881.

Issue Workshop 115
PERSONAL AND INTERPERSONAL DIFFICULTIES IN ORGANIZATIONAL SETTINGS

Chairperson: Stewart Gabel, M.D., *Department of Psychiatry, Childrens Hospital, 1056 East 19th Avenue, Denver, CO 80218*

EDUCATIONAL OBJECTIVES:

To discuss common psychiatric difficulties found in organizational settings, discuss common interpersonal conflicts in organizational settings, and review approaches aimed at understanding and improving individual and interpersonal difficulties in organizational settings.

SUMMARY:

Personal psychiatric difficulties and interpersonal conflicts are extremely common in organizational settings and contribute greatly to lost productivity and supervisor and coworker frustration and dissatisfaction.

This workshop will discuss briefly various types of personal difficulties encountered in organizational settings, such as anxiety and mood disorders, stress-related problems, substance abuse/dependence, and personality disorders. It will highlight interpersonal conflicts encountered in organizational settings when personal difficulties or disorders cause conflict with supervisors or with coworkers, or when individuals with different personality styles, aspirations, or organizational agendas clash to the detriment of their own and overall organizational functioning.

The emphasis will be on psychologically minded understandings of the problems and conflicts encountered in organizational settings, clarity about the boundaries between understanding and action based on psychological mindedness compared with psychotherapy, and approaches that can be taken in organizational settings to improve and/or resolve individual and interpersonal difficulties.

The workshop will be interactive throughout. After the brief initial presentation the discussion will emphasize illustrations and examples from the workshop leader's and participants' experiences. Questions and answers will be encouraged throughout.

REFERENCES:

1. Gabel S, Oster G: Mental health providers confronting organizational change: process, problems, strategies. Psychiatry. Interpersonal and Biological Processes. 1998; 61:302–316.
2. Sperry L, Kahn JP, Heidel SH: Workplace mental health consultation. a primer of organizational and occupational psychiatry. Gen Hosp Psychiatry. 1994; 16:103–111.

Issue Workshop 116
STRESS DISABILITY ASSESSMENT AND COMPENSATION SEEKING: ELUSIVE TRUTH

Chairperson: Landy F. Sparr, M.D., *Department of Psychiatry, Oregon Health Sciences University, PO Box 1034/PVAMC P-7-MHDC, Portland, OR 97006*
Participants: Neil A. Matteucci, M.D., Michael Maxwell, M.S., Nina P. Sparr

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to develop a strategy for performing credible stress disability evaluations.

SUMMARY:

Traumatic mental injury and resultant stress disability have increasingly become a fact of life in all forms of victim compensation systems. Some have seen PTSD as threatening to overwhelm the personal injury, workers' compensation, and disability insurance litigation systems. U.S. Chamber of Commerce statistics show that the number of mental stress claims under workers' compensation jumped nearly 800% between 1979 and 1990, making stress-related disorders the nation's fastest-growing disease category. The Department of Veterans Affairs (VA) administers a system that provides benefits including monetary compensation, treatment, and rehabilitation services for veterans with "service-connected" disabilities. In VA parlance, service-connected disabilities are disorders that developed during military service, including those directly related to combat. Nearly two-thirds of the VA budget is allocated for compensation, pension, or survivor benefits for veterans or their families. Most recent estimates are that over 2 million veterans receive service-connected monetary compensation; approximately 14% have a primary psychiatric disability and approximately 75% of those are for PTSD. Currently, determination of a service-connected PTSD disability award rests heavily on the individual psychiatric examination. Although DSM-IV criteria are used in determining the PTSD diagnosis, differences exist among examiners. In the absence of either standardized instruments and/or collateral claims investigation, reliability and validity of these diagnostic determinations may be highly variable. Due to the availability of financial compensation, it has been hypothesized, and even empirically demonstrated, that many veterans may be malingering or "over reporting" their psychiatric symptoms to maximize their disability odds. Consequently, it has been further suggested that verbal descriptions of traumatic incidents are not enough and that acceptance of the patient's symptom description is insufficient. This workshop will use preliminary data to examine the feasibility of using collateral resources such as co-combatant (co-worker) and/or family verification, and standardized testing for routine disability assessment. Panel members will solicit audience experiences.

REFERENCES:

1. Gold PB, Frueh BC: Compensation-seeking and extreme exaggeration of psychopathology among combat veterans evaluated for posttraumatic stress disorder. J Nerv Ment Dis 1999; 187:680–684.
2. Mossman D: Veterans Affairs disability compensation: a case study in countertherapeutic jurisprudence. Bull Am Acad Psychiatry Law 1996; 24:27–44.

Issue Workshop 117
STRATEGIES FOR PROMOTING COLLABORATIVE RESEARCH IN DEVELOPING COUNTRIES

Co-Chairpersons: Victoria E. Wells, M.D., *Department of Pediatrics, University of Cincinnati, 202 Goodman Drive, P.O. Box 670840, Cincinnati, OH 45267-0840,* Lawson R. Wulsin, M.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, ML0559, Cincinnati, OH 45267*
Participants: Pius A. Kigamwa, M.D., Athanase Hagengimana, M.D.

EDUCATIONAL OBJECTIVES:

To understand strategies for overcoming common obstacles to collaborative research in developing countries.

SUMMARY:

Psychiatric research in developing countries is difficult to conduct for logistic, cultural, financial, and political reasons. However, recent improvements in international travel, e-mail, the cell phone, and the

Internet have opened new options for collaboration between U.S. psychiatrists and researchers in developing countries.

We'll begin with the common obstacles to research: 1) limited funding sources, 2) barriers to communication or travel, 3) scarcity of physical or human resources, 4) competing demands on the researchers' time, and 5) environmental or political interference, drawing on our experiences with studies of the 1994 genocide in Rwanda and the 1998 Nairobi embassy bombing. Members of the audience will contribute examples from other regions. The presenters will then discuss two examples of strategies that have overcome some of these obstacles. Members of the audience will contribute brief vignettes that illustrate effective research strategies. Please include: 1) project aims, 2) collaborators, 3) site, 4) obstacles, 5) strategies to overcome the obstacles, 6) lessons learned. Bring several copies of a one-page project summary or an overhead to facilitate discussion.

This workshop will collect these vignettes, relevant funding sources, common effective strategies, and lessons learned for a descriptive paper on collaborative research in developing countries.

REFERENCES:

1. Desjarlais R, Eisenberg L, Good B, Kleinman A: World Mental Health: Problems and Priorities in Low-Income Countries. New York, Oxford University Press, 1995.
2. Murray C, Lopez A: The Global Burden of Disease and Injury. Cambridge, Harvard University Press, 1996.

Issue Workshop 118
OXYMORON: FINE UNIVERSITY AND SO-SO PUBLIC CARE

Co-Chairpersons: Milton H. Miller, M.D., *Harbor-UCLA Medical Center, 1000 West Carson Street, Box 498, Torrance, CA 90509,* Karl S. Burgoyne, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson Street, Box 498, Torrance, CA 90509,*
Participants: Jim Allen, M.B.A., Peter C. Whybrow, M.D., Marvin Southard, D.S.W., Norman Sartorius, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: identify the needs within public mental health systems for academic enrichment; identify the needs of academic institutions for linkage with public systems; and recognize that public-academic linkage can be undertaken on more than a small symbolic basis.

SUMMARY:

Most people agree that universities and public systems have a responsibility to each other, and that they should be closely linked. But, in real life, the linkages between university medical centers and public systems are scant, transient, and mutually disappointing for many reasons. Part of what is wonderful about "university" is its partial protection against the disruptions of public life. That such protection is essential to the underpinnings of university is reflected in a millennium of history to assure "academic freedom," competitive examinations for admissions, and tenured employment.

Life in public systems has fewer protections. Public systems report to elected officials, and there is often urgency of accountability to political challenges arising from fiscal crisis, social upheaval, and the need for a public scapegoat.

This workshop's participants include the leaders of two of the largest medical systems, i.e., the department of psychiatry and biobehavioral sciences at UCLA and the Los Angeles County Department of Mental Health. In aggregate, the systems employ 4,000 professionals and trainees and provide services to more than 100,000 individuals. What connects the participants is both the shared belief that linkage between them is essential AND shared participation in moving beyond theory in the implementation of program collaboration.

REFERENCES:

1. Talbott JA, Has academic psychiatry abandoned the community? Academic Psychiatry 1991; 15:106–114.
2. Douglas EJ, Faulkner LR, Talbott JA, et al: Administrative relationships between community mental health centers and academic psychiatry departments: a 12-year update. Am J Psychiatry 1994; 151:722–727.

Issue Workshop 119
MULTISYSTEMIC THERAPY: INTEGRATING PSYCHIATRY

Co-Chairpersons: Debbie R. Carter, M.D., *Department of Psychiatry, UCHSC, 4200 E 9th Avenue C249-27, Denver, CO 80262,* Erica Viggiano, M.S.W., *Department of Psychiatry, UCHSC, 4200 East 9th Avenue, Box C249-27, Denver, CO 80262*
Participant: Lori Gorshow, M.S.W.

EDUCATIONAL OBJECTIVES:

Multisystemic therapy is an evidenced-based therapy for youth with comorbid conditions. At the conclusion of the workshop participants will be able to describe the theory of MST and its application to psychiatric populations, complete an assessment, and identify characteristics of optimal therapist collaboration.

SUMMARY:

Multisystemic therapy (MST) is a family- and community-based systems therapy focused on intervening in the context of the ecology surrounding multiproblem youth. Originally established to decrease juvenile delinquency, this evidence-based therapy has been found to be effective with a subset of high-risk youth populations with mental illness, serious substance abuse, and/or externalizing behaviors that can trigger removal from the home for treatment. In this workshop a theoretical overview of MST, major outcome studies, applications of MST in adolescent psychiatric and other special populations will be reviewed. MST case studies will be presented and participants will practice using the MST analytic process to design psychiatric interventions within the context of an intensive home- and community-based family therapy model. At the conclusion of this workshop participants will be able to design psychiatric interventions compatible with an ecological treatment approach.

REFERENCES:

1. Hengler SW, Rowland MD, Randall J, et al: Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: clinical outcomes. J Am Acad Child Adolesc Psychiatry 1999; 38:1331–1339.
2. Hengler SW, Schoenwald SK, Borduin CM, et al: Multisystemic Treatment of Antisocial Behavior in Children and Adolescents, New York, Guilford, 1998.

Issue Workshop 120
COMMUNITY REINTEGRATION FOR SEVERELY MENTALLY ILL PATIENTS LEAVING JAIL

Co-Chairpersons: Thomas A. Klotz, M.D., *3750 Mayfair Dr, Los Angeles, CA 90065-3209,* Brock H. Summers, M.D., *716 Moon Ave, Los Angeles, CA 90065-4023*
Participants: Linda Richardson, Ph.D., Debbie Innes Gomberg, Ph.D., Michael Maloney, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will demonstrate knowledge of factors impeding community reintegration of the severely mentally ill and methods employed in three innovative

programs in Los Angeles County to circumvent those impediments. Results of the programs will be reviewed.

SUMMARY:

Homelessness, financial destitution, relapse of chemical dependency, and fragmentation of care all conspire to defeat efforts toward rehabilitation and community reintegration of severely mentally ill inmates being released from jail. We will describe three innovative programs to circumvent these problems and detail preliminary results of each. Two are California state legislative initiatives as implemented in Los Angeles County; the third is an L.A. County Jail mental health initiative. The state-funded CROMIO (Community Reintegration of Mentally Ill Offenders) program identifies dually diagnosed inmates at high risk for re-incarceration and randomizes them to an intensive case management intervention or a standard treatment comparison group; outcome measures reflecting treatment compliance and recidivism will be described. The state-funded "AB34" project for the severely mentally ill has the goals of decreasing homelessness, increasing treatment compliance, and decreasing incarceration for these patients. For incarcerated patients, the project links homeless mentally ill inmates to wraparound aftercare services during incarceration. The county initiative takes a similar approach toward a geographically defined population within the county enhancing coordination of aftercare services extant in the community by earlier identification of inmates needs and available resources while the patient is incarcerated.

REFERENCES:

1. Lamb HR, Weinberger LE, Gross BH: Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: a review. Psychiatric Services 1999; 50:907–913.
2. Rivera C: Helping Hands for Mentally Ill. Los Angeles Times, June 9, 2000.

Issue Workshop 121
SHOULD SUBSTANCE ABUSE TREATMENT BE COERCED?

Chairperson: Mitchell S. Rosenthal, M.D., *164 W 74th Street, New York, NY 10023-2301*
Participants: Sally L. Satel, M.D., James R. McDonough

EDUCATIONAL OBJECTIVES:

Workshop participants should leave this session knowing how coerced treatment is provided, why it is effective, and why a growing number of public officials and treatment professionals believe it serves the best interests of both society and drug abusers.

SUMMARY:

With more than 2 million Americans behind bars, and 75 percent of those arrested in places likc New York City testing positive for drugs, public officials are looking favorably at treatment alternatives to incarceration. Court-mandated treatment for nonviolent drug law offenders is a means of reducing prison and jail populations and keeping otherwise law-abiding drug abusers from being locked up. As drug courts proliferate and more states turn to broad-gauged ATI (alternative to incarceration) programs, a growing number of substance abusers are being brought into treatment and kept there by coercion. Nevertheless, the notions that successful treatment outcome requires strong patient motivation from the outset or that it must wait until patients "hit bottom" persist, although research has consistently found coerced treatment to be as effective as voluntary treatment. This workshop will explore the issue of coerced treatment and afford participants the opportunity to discuss with panelists the proper role of coercion, the reasons for its effectiveness, its impact on public policy, and the benefits—to both society and the individual—of imposing treatment upon men and women who would, of their own volition, reject such care.

REFERENCES:

1. Miller NS, Flaherry JA: Effectiveness of coerced addiction treatment: a review of clinical research. Journal of Substance Abuse Treatment; 2000; 18:9–16.
2. Satel SL: Drug Treatment: The Case for Coercion, Washington, DC, American Enterprise Institute for Public Policy Research, 1999.

Issue Workshop 122
MIND MEETS BRAIN IN PRACTICE: THE McLEAN NEUROPSYCHIATRIC CONSULTATION SERVICE

Chairperson: Martin A. Goldstein, M.D., *Department Neurology, McLean Hospital, 115 Mill Street, Belmont, MA 02478*
Participants: Miles Cunningham, M.D., Jennifer Woehr, Psy.D., Alonso Montoya, M.D., Julie Brody, D.P., Martin Goldstein, M.D., JoAnne Savoie, Ph.D.

EDUCATIONAL OBJECTIVES:

To appreciate the historical basis for and empiric data supporting enhanced collaboration between psychiatry and neurology, to understand how neurologists, psychiatrists, neuropsychologists, and psychodynamic clinicians can form a consultation service, and to apply an interdisciplinary approach to complex cases.

SUMMARY:

Historians of science have observed that there are moments when there occurs a confluence of theoretical development and technological advancement that provides novel opportunity for a "synthesis" (Hundert 1990). In this final year of the Decade of the Brain, psychiatry and neurology are accelerating their interdisciplinary rapprochement. Leaders in neurology and psychiatry have independently expounded initiatives that call for expanded integration with the other field. But although the historical arc from Freud's Project for a Scientific Psychology is now reaching fruition, large-scale practical implementation of collaborative clinical efforts has not yet materialized.

To provide a model for clinical realization of psychiatry's and neurology's mutual rhetorical overtures, we will present the conceptual basis and clinical operation of the Comprehensive Neuropsychiatric Service at McLean Hospital. Composed of psychiatrists, neurologists, and neuropsychologists, and led by a behavioral neurologist trained by Norman Geschwind, this service provides routinely scheduled neuropsychiatric consultations for the largest teaching hospital of the Harvard Medical School department of psychiatry.

Representative members will discuss each discipline's component role, followed by an explanation of overall team framework. Statistics from a multiyear consult database will be used to demonstrate impact on patient diagnosis and management. Model cases will be presented to provide an example of team function. Finally, extensive time will be devoted to audience participation. Our goal is to highlight how emerging nexuses among psychiatry, neurology, and neuropsychology can be implemented into the structure and function of a multidisciplinary treatment team.

REFERENCES:

1. Price BH, Adams RD, Coyle JT: Neurology and psychiatry: closing the great divide. Neurology 2000; 54:8–14.

2. Kandel ER: A new intellectual framework for psychiatry. American Journal of Psychiatry 1998; 155:457–69.

Issue Workshop 123
COMMUNITY MEETINGS ON AN INPATIENT PSYCHIATRIC UNIT

Co-Chairpersons: Christopher L. Lange, M.D., *2707 Deerridge Drive, Silver Spring, MD 20904,* John C. Bradley, M.D., *4485 Sugarberry Court, Evans, GA 30809*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to identify the purpose and benefits of holding a community meeting; recognize the variables in the running of an inpatient community meetings; and use the lessons learned in the workshop to tailor a therapeutic community meeting for their inpatient ward.

SUMMARY:

Community meetings are a ubiquitous finding on any inpatient psychiatric ward. However, they are an often unappreciated therapeutic modality in the treatment of the acutely ill psychiatric patient. Their proper use can facilitate socialization skills, aid in the fostering of autonomy and generally enhance life skills training.

This program will define the therapeutic purpose and review different components of the community meeting in the therapeutic milieu. This allows participants to tailor their unit's community meeting to meet the needs and limitations of their particular inpatient service. The presenter will discuss what he believes to be the optimum utilization of the community meeting as a therapeutic modality. The majority of the workshop will be spent on a mock community meeting based on a real-life agenda. Opportunities will be created to change the parameters and discuss the impact the changes had on the meeting.

This program is of special interest to psychiatric residents who may be struggling with proper management of this modality. This lecture will arm them with tools to use in their arsenal of the treatment of psychiatric inpatients. For the experienced clinician, this report will serve as a review of the principles of large group dynamics of psychiatric patients.

REFERENCES:

1. Clark DH: The therapeutic community-concept, practice, and future. British Journal of Psychiatry 1965; 111:947–954.
2. Jones M: Training in social psychiatry at the ward level. American Journal of Psychiatry 1962; 118:705–708.

Issue Workshop 124
INTEGRATING BEHAVIORAL HEALTH WITH PRIMARY CARE THROUGH DISEASE MANAGEMENT

Co-Chairpersons: Arthur L. Lazarus, M.D., *Humana Incorporated, 500 West Main Street, Louisville, KY 40202,* David S. Brody, M.D., *MCP-Hahnemann University, Mail Stop 427, 245 North 15th Street, Philadelphia, PA 19102-1192*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with the epidemiology of behavioral disorders in primary care, screening instruments, and outcome management tools used in the primary care setting, and strategies to improve overall patient health through disease management programs.

SUMMARY:

Behavioral disorders result in significant pain and suffering, large economic costs to society, and a drain on the general medical sector. A large percentage of primary care office visits involve patients whose symptoms are caused solely or significantly by emotional distress. Despite the high prevalence of behavioral disorders in primary care, patients with depression, anxiety, and substance abuse are frequently misdiagnosed.

Primary care physicians are playing an increasingly prominent role in delivering behavioral health services. Barriers to accessing care, however, may thwart treatment, and time pressure may make it difficult for primary care physicians to provide effective behavioral health services. It is, therefore, important to develop strategies to integrate behavioral care with primary care.

A variety of strategies have been developed and evaluated to improve primary care recognition and management of behavioral disorders. While many of these strategies have been effective, they have not been widely disseminated because of the unique expertise and/or additional resources required for implementation. This workshop will discuss the incentives for large health care systems to implement strategies to improve behavioral health care in primary care settings and will present realistic approaches for achieving this goal, including a novel disease management program. With isolated exceptions, there are almost no disease management programs being offered for patients with mental illnesses who are seen in general medical settings.

REFERENCES:

1. Brody DS, Khallq AA, Thompson TL: Patients' perspectives on the management of emotional distress in primary care settings. J Gen Intern Med 1977; 12:403–406.
2. Lazarus A: Screening for behavioral disorders in primary care. Managed Care Interface 1999; 12:52–55.

Issue Workshop 125
CAREER ADVANCEMENT FOR WOMEN PSYCHIATRISTS: THE ROLE OF MENTORSHIP

Co-Chairpersons: Anu A. Matorin, M.D., *UT-HSC-Houston, 1300 Moursund, Houston, TX 77030,* Sandra Sexson, M.D., *Department of Psychiatry, Emory University, 1256 Briarcliff Road NE #313, Atlanta, GA 30306*
Participants: Cynthia W. Santos, M.D., Donna M. Mancuso, M.D., Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants would have increased awareness of the challenges and opportunities facing women psychiatrists in their quest for career advancement. This workshop will also provide a forum for exchange of ideas focusing on innovative solutions related to this topic.

SUMMARY:

Women physicians have made notable contributions and historic strides in the medical profession. By 2010, women are expected to account for approximately one-third of all American physicians. At present, in psychiatry women's representation is even more dramatic. However, despite the numerical gains made by women in medicine, female physicians continue to be underrepresented in administrative and leadership positions. This presentation will focus on issues affecting career advancement for women psychiatrists, including lack of mentors and role models, professional prejudices and stereotypes, lack of fair and balanced measures for faculty promotion in academic medical centers, sociocultural and psychological factors, sexual harassment, and special issues related to family needs. This workshop will also address the unique opportunities created for career advancement through mentorship, utilizing both personal and professional experiences. This workshop will additionally provide a forum for exchange of ideas regarding professional mentorship in an effort to

find innovative solutions to ameliorate the barriers facing women psychiatrists in their quest for career advancement.

REFERENCES:

1. Matorin AA, Collins DM, Abdulla A, Ruiz P: Women advancement in medicine and academia: barrier and future perspectives. Texas Medicine 1997; 93:60–64.
2. Robinowitz CB, Nadelson CC, Notman MT: Women in academic psychiatry: politics and progress. Am J Psychiatry 1981; 138:1357–1361.

Issue Workshop 126
SUBJECTIVITY: CRUCIAL KEY TO THE THERAPEUTIC ALLIANCE

Chairperson: Vincenzo R. Sanguineti, M.D., *Jefferson Medical College, 1015 Chestnut Street, Suite 825, Philadelphia, PA 19107-5567*

EDUCATIONAL OBJECTIVES:

The participant should better understand the structure of the subjective experience and the sources of contributing data; grasp the unique character of each individual mental state; use such information to gain deeper awareness and empathy in relating to patients.

SUMMARY:

This highly interactive workshop will offer basic information on subjectivity accessible to all mental health practitioners. It will consist of three segments: Segment #1: The faculty will examine the immense structural complexity of the human brain and the correlated overriding uniqueness of each individual mental state. Participants will be encouraged to discuss the information at a personal level; Segment #2: The faculty will discuss the hierarchy of systems that participate to the emergence of mind out of brain and the sources of data contributing to thought formation. Visual schemata will aid the audience to join in such a search; Segment #3: The visual illustration of a specific individual mind will guide the audience to explore major components of the subjective landscape and to experience the centrality of the subjective stance in dealing with any sort of human interaction. Some clinical vignettes will exemplify the application of the subjective viewpoint to the practice of psychiatric care and of psychotherapy.

REFERENCES:

1. Scott AC: Stairway to the Mind: The Controversial New Science of Consciousness. Springer-Verlag, New York, 1995.
2. Sanguineti VS: Landscapes in My Mind: The Origins and Structure of the Subjective Experience. I.U.P., CT, 1999.

Issue Workshop 127
LEADERSHIP IN ORGANIZATIONAL TRANSITIONS

Chairperson: Stewart Gabel, M.D., *Department of Psychiatry, Childrens Hospital, 1056 East 19th Avenue, Denver, CO 80218*

EDUCATIONAL OBJECTIVES:

To discuss specific objectives of leaders during their management of rapid organizational change, leadership directed processes to facilitate successful organizational change, specific situations such as grief and mourning, and resistance to change that may impede necessary organizational change.

SUMMARY:

This workshop will explore goals and essential tasks of leaders during rapid organizational transitions. A sequential but overlapping model emphasizing leadership directed change will be discussed. Leaders should: 1) be perceived by the organization's members as having personally bonded with the organization, its members, goals, and purpose; 2) ensure the development of an inclusive process to evaluate internal and/or external problem areas that require change; 3) ensure the development of a plan that includes organizational members at all levels for the transition to new models or approaches to care; 4) address the leader's own potential conflicts about required changes or new models that are anticipated; 5) facilitate the mourning process for those in the organization who are grieving the loss of programs that are no longer viable; 6) supervise the implementation of an integrated, comprehensive, and inclusive transitional plan for the organization; 7) supervise the revision of the transitional plan when this is necessary, and 8) supervise the development of procedures to solidify new programmatic structures while accepting the need for organizational change on a regular basis.

These areas will be discussed in an interactive manner with an emphasis on specific illustrations. Questions and answers will be encouraged throughout. This workshop repeats, with minor modifications, the workshops of the previous two years by the same name.

REFERENCES:

1. Bridges W: Managing Transitions. Making the Most of Change. New York, Addison-Wesley Publishing Co., Inc., 1991.
2. Gabel S: Leadership in the managed care era: challenges, conflict ambivalence. Administration and Policy in Mental Health, 1998; 26:3–19.

Issue Workshop 128
MIND AND BRAIN DO NOT NEED TO BE INTEGRATED IF WE DON'T SEGREGATE THEM IN THE FIRST PLACE

Chairperson: Michael A. Schwartz, M.D., *Department of Psychiatry, Tufts University, School of Medicine, 750 Washington Center, NEMC #1007, Boston, MA 02111*
Participant: Elena B. Bezzubova, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to understand the brain-mind dualism in psychiatry, to compare methodologies of biological and psychosocial approaches, to learn about phenomenology as a natural clinical methodology. The participants will learn about clinical phenomenology and its role for psychiatry in diagnostics and therapy and explore a theoretical background as well.

SUMMARY:

Psychiatry has been caught in the snare of brain-mind dualism. The very domain of psychiatry tends to be divided into two approaches: biological psychiatry based in brain science and psychosocial psychiatry built with mind-oriented psychological and sociocultural concepts. As a result psychiatry finds less and less room for its original presence as a clinical discipline. Its clinical reality is not neuronal patterns and biochemical reactions or sociocultural discourse and psychoanalytical constructions, but phenomena of a human being's life thoughts, beliefs, emotions, memory, perceptions, characterological features, and behavior. This clinical reality forms the basis for psychiatric systematics, including DSM-IV. An approach that provides a way to see and understand these phenomena, while avoiding biological reductionism and psychosocial speculation, is the discipline of phenomenology, whose well-articulated methodology focuses on phenomena per se. The workshop considers phenomenology as a way to get free from brain-mind dualism, turning psychiatry to its real subject—a human being with problems of mental health. The participants will be encouraged to share their opinions and clinical experience about the brain-mind paradigm of psychiatry. Dialogue between supporters of brain-oriented and mind-oriented

paradigms will be provoked. Discussion about clinical phenomenology and recent publication of its classic manual "General Psychopathogy" by Karl Jaspers will be developed. In conclusion a phenomenological perspective to integrate clinical reality with the data of neuroscience and psychosocial theories will be explored.

REFERENCES:

1. Mishara AL, Schwartz MA: Psychopathology in the light of emergent trends in the philosophy of consciousness, neuropsychiatry and phenomenology. Curr Opin Psychiatry 1997; 9.
2. Schwartz MA, Wiggins OP, Spitzer M: Psychotic experience and disordered thinking: a reappraisal from new perspectives. J Nervous and Mental Disease 1997; 3:176–187.

Issue Workshop 129
HALLUCINOGENS: ILLICIT USE, RELIGIOUS USE, AND CURRENT PSYCHIATRIC RESEARCH

Co-Chairpersons: Charles S. Grob, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson Street, Torrance, CA 90509,* John H. Halpern, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to assess Internet-derived information about hallucinogens; understand how drugs become mislabeled hallucinogens; and differentiate illicit recreational use of hallucinogens from rare, legal religious use in the United States. Finally, an update on American psychiatric research on hallucinogens will be reviewed.

SUMMARY:

The 1998 National Household Survey on Drug Abuse estimates that 22 million Americans have ingested a hallucinogen at least once in their lives, and the 1999 NIDA Monitoring the Future study reports that 12.2% of high school seniors have tried LSD and 8.0% "ecstasy." Despite these statistics, hallucinogens have received scant recent attention, and major textbooks of psychiatry, medicine, and addiction typically offer only brief discussions of these drugs. By contrast, the Internet makes available thousands of pages about hallucinogens—including information on how to obtain and ingest them—to anyone curious enough to search online.

This workshop will help psychiatrists appreciate the extent and quality of Internet-based information about hallucinogens accessible to their patients. We will review the literature about the long-term consequences of hallucinogen use, with emphasis on the methodologic limitations of available studies. We will then present preliminary new findings on the long-term neurocoginitive effects of hallucinogens, and discuss other current and upcoming research studies involving these agents. Finally, we will discuss the legally sanctioned, religious use of hallucinogens by some 300,000 members of the Native American Church. The experiences of these individuals may offer insights into the risks and benefits of hallucinogen use.

REFERENCES:

1. Halpern JH, Pope HG (in press): Hallucinogens on the Internet: a vast new source of underground drug information. American Journal of Psychiatry.
2. Grob CS (in press): Deconstructing ecstasy: the politics of MDMA research. Addiction Research.

Issue Workshop 130
REHABILITATION EDUCATION: INTERNATIONAL COMPARISONS

Chairperson: Zebulon C. Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, 19 East 93rd Street, New York, NY 10128*
Participants: Michael Stark, M.D., Ida Kosza, M.D., Jacques M. Dubuls, M.D., Robert Cancro, M.D.

EDUCATIONAL OBJECTIVES:

Participants will describe a) gaps in promoting psychiatric rehabilitation and education for psychiatrists in the US, France, Germany, and Hungary, b) prospects for requiring psychiatric rehabilitation, c) the influence of different national health care systems on promoting education, d) having psychiatrists able to prescribe rehabilitation as they do medications.

SUMMARY:

Although there is a general consensus that psychiatric rehabilitation is effective and becoming increasingly widely practiced, it has not been addressed systematically in requirements for psychiatric education, being most frequently found in continuing education courses. Considerations of continuity and integration of care and overall direction argue that psychiatrists should be able to prescribe psychiatric rehabilitation as they do medications: modality, dose, frequency, duration, and route. The organization of a nation's health systems may in itself promote rehabilitation education, especially France, where sector teams directed by psychiatrists care for patients wherever they are. Efforts to reduce problems caused by the separation of inpatient and outpatient care in Germany may offer solutions for the United States, where care is more fragmented than in any other developed country. Hungary shows how service and educational systems can be completely redesigned. Presenters will review their countries' educational systems, basic requirements for psychiatry training, and how training in psychiatric rehabilitation (as described in WHO, WPA, and APA consensus statements) can be integrated (using evaluations of NYU's required rotation, now in its seventh year), and similar experiences garnered by the presenters from the World Association for Psychosocial Rehabilitation and the World Psychiatric Association Section on Rehabilitation.

REFERENCES:

1. Psychosocial Rehabilitation: A Consensus Statement, Geneva, Division of Mental Health and Prevention of Substance Abuse, World Health Organization, 1996.
2. Thompson T, et al: Report of APA Presidential Initiative Advisory Committee on Psychosocial Rehabilitation of the Severely and Persistently Mentally Ill. 1999, Washington D.C., available from American Psychiatric Association.

Issue Workshop 131
CRIMES OF INFAMY: PERSONAL INSIGHTS

Chairperson: Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106*

EDUCATIONAL OBJECTIVES:

To understand why mothers murder their children and to develop insights into murders due to lust and paranoid fear.

SUMMARY:

This workshop will review a number of high-profile cases in which Dr. Resnick has been personally involved. The motives of Susan Smith and Amy Grossberg, who both pleaded guilty in the homicides of their children, will be contrasted. The case of Jeffrey Dahmer will be used to illustrate the motives of a necrophiliac lust murderer. The cases of Russell Weston, the accused U.S. Capitol shooter, and Theodore Kaczinski, the convicted Unabomber, will show how paranoid fear and hatred can lead to murder. Jury perceptions of the insanity defense will be explicated in relation to the cases of John DuPont, the convicted murderer of the wrestler David Schultz, and John Salvi, the convicted murderer of abortion clinic personnel in Boston.

The trials and tribulations of psychiatric participation in criminal cases of national interest will be discussed. Participants will be encouraged to ask questions and share their own experiences in dealing with the press in evaluating highly publicized cases.

REFERENCES:

1. Resnick PJ: Child murder by parents: a psychiatric review of filicide, Am J Psychiatry 1969; 126:73–83.
2. Johnson BR, Becker JV: Natural born killers?: the development of the sexually sadistic serial killer, J Am Acad Psychiatry Law 1997; 25:335–348.

RESEARCH ADVANCES IN PSYCHIATRY

FROM THEORY TO THERAPY: DRUG DISCOVERY, TESTING, AND CLINICAL USE

Chairperson: Herbert Pardes, M.D.
Co-Chairperson: Daniel K. Winstead, M.D.
Participants: Perry Molinoff, M.D., Philip Morgan, Ph.D., Cathryn M. Clary, M.D., Stephen M. Stahl, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to understand the process by which medications are created and the complex testing procedure that leads to their use clinically. Participants will learn what information animal testing provides for the clinician, as well as the parameters of clinical trials.

SUMMARY:

For many clinicians, the process by which medications are discovered and tested is a mystery. How do scientists create a new medication and how has this process of discovery changed over the years? Once discovered what is learned from testing the medication in animals that applies to the medication's eventual use in patients? What does the knowledge obtained in the animal testing indicate for the clinical trials and what should clinicians take from clinical trials in their use of a medication once it is on the market? Finally, why does it seem that medications do not seem to work exactly as would be indicated by the research both therapeutically and in terms of side effects? This Research Advances in Psychiatry session will focus on solving the mystery of drug discovery and testing. Each of the panelists will focus on a different component of the process, starting with drug discovery and proceeding through animal testing and clinical trials. To conclude the panel, Dr. Stephen Stahl will discuss why the clinical use of a medication is often different than what has been found in the pre-marketing clinical trials. Ample time will be provided for panel discussion and questions from the audience.

REFERENCES:

1. Stone, M: Healing the Mind: A History of Psychiatry from Antiquity to Present; New York: Norton, 1997.
2. Tasman, A ed: The Doctor-Patient Relationship in Pharmacotherapy Improving Treatment Effectiveness; New York: Guilford, 2000.
3. Shorter, E: From Freud to Prozac, in, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac; New York: John Wiley and Sons, 1997.

CONTINUOUS CLINICAL CASE CONFERENCE PART I AND II: COGNITIVE BEHAVIORAL THERAPY: A CASE OF COMORBID MAJOR DEPRESSION, PERSONALITY DISORDER, AND EPISODIC ALCOHOL ABUSE

Anton C. Trinidad, M.D., *The Greater Washington Institute for Cognitive Therapy, 5113 Leesburg Pike, Suite 106, Falls Church, VA 22041,* Stephen P. McDermott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this two-day presentation, the participant will be familiar with the utility of CBT techniques on comorbid disorders, learn modifications and variations of CBT of personality disorders compared to standard CBT, and observe flexible theoretical paradigms of Cognitive Therapy such as schema-focused and nonstructured interventions.

SUMMARY:

In this case presentation, we will discuss and present videotaped session vignettes of a woman who is presently in treatment for Recurrent Major Depression, a mixed cluster B Personality Disorder and Episodic Alcohol Abuse. This patient was switched from supportive psychotherapy to a more intensive cognitive therapy due to lack of efficacy in the former modality. We hope to demonstrate that in such cases, flexibility and innovation in the use of CBT techniques will attain better outcomes. This concept dovetails with recent trend and changes in the basic tenets of CBT. Interactive dialogue with attendees will be highly encouraged. It is expected that the audience has studied and have at least some clinical experience with basic and standard Cognitive Behavioral Therapy.

REFERENCE:

1. Beck, AT and Freeman, A: Cognitive Therapy of Personality Disorders, Guilford Press, New York: 1990.

CLINICAL CASE CONFERENCES

MONDAY, MAY 7, 2001

1. A NEUROSCIENCE PERSPECTIVE ON TRANSFERENCE IN PSYCHOTHERAPY

Glen O. Gabbard, M.D., *Menninger Clinic, 5800 Southwest 6th Avenue, Box 29, Topeka, KS 66606.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will demonstrate knowledge of how cognitive neuroscience findings enhance our understanding of the role of transference in psychotherapy.

SUMMARY:

Transference has long been the cornerstone of psychoanalytic psychotherapy and psychoanalysis. Cognitive neuroscience research has substantially advanced in recent years, and we are now at a point where we can begin the process of integrating "mind" and "brain" concepts. Using a conceptual model based on connectionist networks, it is possible to offer a novel perspective on the role of transference in psychoanalytic psychotherapy and a brain-based understanding of the therapeutic action of the treatment.

Using clinical case material, this presentation will emphasize that it is more appropriate to speak of a series of transferences rather than a unitary transference neurosis. Other issues that will be discussed in light of the case material is the notion of analytic anonymity, the role of constructivist thinking in understanding transference, and the controversy about whether transference is ever completely resolved in psychoanalytic treatment.

REFERENCES:

1. Gabbard GO: A Neurobiologically Informed Perspective on Psychotherapy. *Br J Psychiatry* 177:117–122, 2000.
2. Westen D: The Scientific Status of Unconscious Processes: Is Freud Really Dead? *J Amer Psychoanal Assoc* 47:1061–1106, 1999.

TUESDAY, MAY 8, 2001

2. A VITAL ROLE FOR PSYCHOTHERAPY IN NEUROPSYCHIATRY: BODY IMAGE ANXIETY IN HUNTINGTON'S DISEASE

Stuart Taylor, M.D., *Department of Psychiatry, Columbia University, College of Physicians and Surgeons, CPMC PH 16/Box 427, 622 West 168th Street, New York, NY 10032,* Gary J. Tucker, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to identify, evaluate and respond to common features of Huntington's Disease, including specific neuropsychiatric symptoms, functional difficulties, and patient's psychological reactions to the illness.

SUMMARY:

Although rare, Huntington's Disease (HD) is a paradigmatic illness in contemporary psychiatry. The characteristic triad of motor symptoms, cognitive impairment and Axis I symptoms is complicated by personal reactions to genetic aspects of the illness, and by disturbances in body image. A great deal is known about the neuropsychiatry and neuropsychology of HD, and the literature is optimistic about cellular and molecular genetic therapies.

On the other hand, the clinician is faced primarily with the subjective experience—hopes, fears and agonies—of patients and their families. In this essential context, knowledge itself is not curative. For example, subjective and social aspects of body image are underdiscussed in the literature on neurodegenerative disease (such as HD and Parkinson's Disease), even though they are obvious factors and are recognized as important aspects of illness elsewhere in medicine (perhaps most notably in oncology and transplant medicine).

In this conference, the presentation, evaluation and course of a man with HD will be fully described. The man's perceptions of and reactions to his illness, including both denial of his symptoms and preoccupation with chorea and his body image posed difficulties for his treatment. The case will illustrate how a psychotherapeutic approach to the man's understandable concerns was crucial 1) in instituting a complicated pharmacotherapy and in achieving functional adaptations necessitated by his illness, and 2) in helping him to accept his illness and integrate it into his life story. The case also shows how the clinical psychiatrist plays an essential and challenging role in a healthcare system that demands mastery and application of new neuroscientific information, in less time, while focusing on the patient's individual experience.

REFERENCES:

1. Folstein S: *Huntington's Disease: A Disorder of Families,* Baltimore: John Hopkins, 1989.
2. Harper PS: *Huntington's Disease,* 2nd Edition, London: Saunders, 1996.
3. Snowdon JS, et al: Awareness of Involuntary Movements in Huntington's Disease, *Arch Neurol* 55:801–5, 1998.

WEDNESDAY, MAY 9, 2001

3. VOCAL CORD DYSKINESIA: A DYNAMIC INTERCHANGE BETWEEN MEDICINE AND PSYCHIATRY

Geoffrey M. Gabriel, M.D., *Department of the Army, Walter Reed Army Medical Center, Washington DC, 20307-5001,* Harold J. Wain, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be familiar with the evaluation and treatment of vocal cord dyskinesia using the biopsychosocial framework.

SUMMARY:

There are numerous perplexing disorders that bridge the gap between Medicine and Psychiatry. When symptoms lack anatomical correlates, a psychiatric disorder is often rendered by exclusion. In these cases, the literature is often muddied by a variety of approximate diagnoses. The interaction of biological and psychological factors in the development and maintenance of vocal cord dyskinesia (VCD) will be discussed in this clinical case conference. A historical perspective regarding the various labels applied to this particular disorder will be reviewed. The somatization process, the role of dissociation, and a biopsychosocial approach to the conceptualization and treatment of this disorder will be discussed. Emphasis on the evaluation and treatment processes in the context of a consultation liaison psychiatry model will be described. Finally, the influence of patient motivational factors in overcoming the symptom complex will be explored. Case studies and video tapes will be employed to enhance and emphasize the clinical hypotheses.

REFERENCES:

1. Lacy TJ, McManis SE: Psychogenic Stridor. Gen Hosp Psych 16:213–223, 1994.
2. Ramirez J, Leon I, Rivera LM: Episodic Laryngeal Dyskinesia: Clinical and Psychiatric Characterization. *Chest* 90:716–721, 1986.

THURSDAY, MAY 10, 2001

4. ASSESSMENT OF PROGNOSTIC FACTORS IN THE ALCOHOLIC PATIENT

Kathy L. Coffman, M.D., *St. Vincent Medical Center, Comprehensive Liver Disease Center, 2200 West Third Street, Suite 500, Los Angeles, CA 90057,* Thomas P. Beresford, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will have an overview of the ingredients necessary for assessing the prognosis of alcoholic patients from a clinical standpoint, whether for planning treatment or in consultation for expensive medical services, such as organ transplantation.

SUMMARY:

The patient is a 42 year old male type II alcoholic with less than one week abstinence. He attended Alcoholic's Anonymous, court ordered after a drunk driving charge. He has not been abstinent from alcohol for more than a month since 1989. He has been on disability for 1 1/2 years. He has few hobbies and is not active in any religious group. His companions are other former gang members in the local tavern. A recent toxicology screen was positive for marijuana. The discussion will center on positive and negative prognostic factors for long-term sobriety.

REFERENCES:

1. Beresford, TP: Predictive Factors for Alcoholic Relapse in the Selection of Alcohol Dependent Persons for Hepatic Transplant, *Liver Transplantation and Surgery,* 3:280–291, 1997.
2. Coffman, K: The Question of Screening Alcoholic Liver Transplant Candidates, *Current Opinion in Organ Transplantation,* 3:68–71, 1998.

FORUMS

1. ALONG THE DEATH TRAIL: INSIDE THE MIND OF AN EXECUTION TEAM

Chairperson: Ira Glick, M.D.
Co-Chairperson: Howard J. Osofsky, M.D.
Participants: Michael J. Osofsky, Robert Michels, M.D., Robert S. Pynoos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be aware of the steps in the process leading to executions at Louisiana State Penitentiary at Angola.

SUMMARY:

Extensive interviews with 50 members of the execution team, who have varied responsibilities, will be reviewed. They include correctional officers, individuals who sit with the inmate and his family and with victims families, counselors, members of the strap-down team, those who start the IVs, the executioners, the wardens, and high state officials. Many describe their sense of professionalism, how in being correctional officers they are obligated to carry out the law and the sentences of the court, how they try to maintain their professionalism and limit over-involvement to avoid security breaches and perhaps diffuse issues of responsibility. At the same time, they emphasize their efforts in being considerate and maintaining the dignity of the inmates and their families. Most are religious. Some describe their internal pressures, mood disturbances, sleepless nights, and post-traumatic stress symptoms. A number describe the impact of the inmates' poverty, what all victims, how painful it must be to be the mother of the inmate, how victims use the execution process for healing, and how they—and other individuals at Angola—deal with the death of the inmate. Some become tearful as they recall the inmate; a number recall with relief (and a diminution of guilt) inmates' expressions of appreciation for their acts of kindness; others describe the difficulty of the work, their struggles and efforts to draw on their religious beliefs or their actions. Although most support the death penalty, a number describe either their ambivalent feeling or their growing opposition to the death penalty. There is a sense, among these professional correctional officials, of a somewhat contradictory rigid and machismo type of professionalism combined with a humane sense of concern and personal soul searching. Their struggles are profound, specifically related to their roles, and more generally reflective of the concerns at society at large.

REFERENCES:

1. Johnson R: Death Work: A Study of the Modern Execution Process, Wadsworth Publishing Company, 1998.
2. Trombley S: The Execution Protocol: Inside America's Capital Punishment Industry, Crown Publishers, Inc., 1992.

2. WHY HARRY? WHY NOW? UNDERSTANDING THE HARRY POTTER PHENONMENON

Chairperson: Leah J. Dickstein, M.D.
Participants: Professor JoAnne M. Isbey, Elissa P. Benedek, M.D. and Daniel P. Dickstein

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will have learned from professionals the distinct and varied reasons why Harry Potter children's books have had such extraordinary success worldwide among girls and boys, their parents, teachers and other adults from varied backgrounds.

SUMMARY:

Mrs. Isbey, a Michigan professor of English, will open the session to explain the intense interest the Harry Potter books have evoked worldwide in latency aged children, adolescents and adults worldwide because of the writing style and content.

Elissa P. Benedek, M.D., child and forensic psychiatrist and author of children's books, will discuss the texts from these vantage points as a professional treating children.

Daniel P. Dickstein, M.D., pediatrician and child psychiatry resident, will offer his insights about current issues in children's lives which may enlist their being so engrossed and enthralled with the Harry Potter characters.

Finally, Leah J. Dickstein, M.D., former elementary school teacher, like J.E. Rowling, and psychiatrist, will discuss her understanding of this current phenomena. Ample time will be scheduled for audience discussion and participation.

REFERENCES:

1. Rowling JK: Harry Potter and the Sorcerer's Stone, Arthur A. Levine, Inc. Scholastic Press, Inc. New York, 1998.
2. Rowling JK: Harry Potter and the Goblet of Fire, Arthur A. Levine, Inc. Scholastic Press, Inc 2000.

3. DAYCARE: IMPACT ON KIDS

Chairperson: Nada L. Stotland, M.D.
Participants: Carol Nadelson, M.D., Tanya Roster Anderson, M.D., David Rue, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to identify parents' concerns about daycare, consider cultural variations in attitudes towards daycare, use findings from the recent literature to counsel families about daycare, and use accurate information about daycare in their treatment of children.

SUMMARY:

The entry of most parents and many grandparents and other relatives, into the paid workforce has given rise to an increasing use of daycare for children. Daycare is controversial, however; the subject arouses strong feelings, gets embroiled in political debates, and is rife with misinformation. Psychiatrists are faced with decisions about the care of their own children and with clinical situations in which day care plays a role. The family may be anxious or guilty about using daycare, may blame daycare for a child's problems, or may overlook the effects of a particular daycare situation on their child. Psychiatrists may also have to work with daycare providers as part of comprehensive treatment planning for a disturbed child. This forum offers a rich array of perspectives; among the presenters are a psychiatrist who developed a daycare center when her own children were young; a child psychiatrist whose children were cared for at home; and a child psychiatrist who will soon be making decisions about the care of her own children. They will present data from the published literature and engage each other and the audience in a lively discussion of the impact of daycare on kids.

REFERENCES:

1. Cost, Quality, and Child Outcomes Study Team: Cost, Quality and Child Outcomes in Child Care Centers (2nd Edition) Denver CO: University of Colorado at Denver, Economic Department, 1995.
2. NICHD Early Child Care Research Network: Child Care in the First Year of Life, Merrill-Palmer Quarterly, 1997; 43: 340–360.

4. SUBSTANCE ABUSE IN THE SEVERELY MENTALLY ILL

Chairperson: Rodrigo A. Munoz, M.D.
Participants: Pedro Ruiz, M.D., Ivan Montoya, M.D., Ismael Roldan, Maria Clara de Cleves, Marian Butterfield, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be more informed of the recently developed information regarding the extent, severity and consequences of the use of addictive drugs among psychiatric patients.

SUMMARY:

There is extensive evidence that mental illness greatly increases the risk for substance abuse. In systems in which mental disorders and chemical dependence belong to different programs with differing goals, many patients are under-treated or mistreated. This is true in many cities and in many public health programs where the first diagnosis is the only considerations in treatment planning.

This forum explores the history of conflicts in planning for unified treatment of chemical dependence and other psychiatric disorders. It presents evidence favoring an integrated approach.

Points developed by SAMSHA that are discussed here, include new training strategies for administrative and clinical personnel, making accommodations in progress so as to recognize the needs of patients with several diagnoses, screening for disabilities, enhancing treatment planning, and offering individually tailored follow-up strategies.

REFERENCES:

1. Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities, SAMHSA, Washington, DC, 1998.
2. A Guide for Substance Abuse Services for Primary Care Physicians, SAMSHA, Washington, DC.

5. HERE'S LOOKING AT YOU! SELF-REFLECTION IN PSYCHOTHERAPY

Chairperson: Jerald Kay, M.D.
Participants: Bernard D. Beitman, M.D., Glen O. Gabbard, M.D., James L. Griffith, M.D., Joan Lange

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an overview of psychopathology and psychotherapy's role in health. Long neglected by researchers yet silently crucial to psychotherapeutic progress, the self-reflective function will be viewed from several different perspectives in this noon forum.

SUMMARY:

The remarkable adaptability of human beings is derived greatly from the human ability to alter our cognitive-cortical maps for our inhabited territories. We perform these cartographic manipulations through the process of self-reflection by activating our "observing selves" or "observing egos," comparing what we know with what we are currently learning and then altering our maps to fit the new information. Dr. Beitman will describe the many names for the self-reflective function; its use in normal relationships for knowing the experiences of others as well as the self; its disuse in various psychiatric anosognosias including alcoholism, schizophrenia, and autism; and its central role in psychotherapy as essential to the process of gaining understanding of maladaptive patterns as well as utilizing countertransference for therapeutic gain by both parents.

Reflective functioning refers to the ability to understand one's own behavior and others' behaviors in terms of mental states (thoughts, feelings, motivations) in addition to appreciating and recognizing that such perceived states are subjective, fallible, malleable and based on but one of a range of possible perspectives. Dr. Gabbard will describe how this concept emerged out of attachment theory, and the evidence that this capacity develops in the first few years of life and is related to the quality of the caregiver-child relationship. It is largely a function of procedural memory as it is established in the first few years of life. Traumatic experience in childhood may result in an absence of reflective functioning or a poorly developed capacity for it. Psychotherapy of borderline patients with histories of childhood trauma require careful attention to promoting greater reflective function.

The reflecting team in clinical consultations and interview questions is crafted around the reflecting position. These innovations in family therapy provide structured experiences in reflection for family members during therapy and for trainees during supervision. Organized around the three positions in a dialogue-speaking, listening, reflecting-family members in a reflecting team consultation first listen to a spontaneous discussion by members of an observing team of clinicians that discloses the clinicians' perceptions and thoughts about the interview. The family members then provide reflections in response to the team's conversation. Dr. Griffith will describe the rationale and guidelines for reflecting team consultations using a brief segment of a videotaped family interview, together with research data validating salutary effects on the therapeutic alliance. He will also describe how this model for structured experiences in reflection can be incorporated into individual psychotherapy.

REFERENCES:

1. Deikman AJ: The Observing Self: Mysticism and Psychotherapy. Beacon Press, 1982.
2. Fonagy P, Target M: Attachment and reflective function: Their Role in Self-Organization. Development and Psychopathology, 9: 679–700, 1997.

6. PRESIDENTIAL FORUM: CONFIDENTIALITY AND MEDICAL RECORD PRIVACY IN THE 21ST CENTURY

Chairperson: Daniel B. Borenstein, M.D.
Participants: Professor Latanya Sweeney, Margo P. Goldman, M.D., Richard K. Harding, M.D., Marcia K. Goin, M.D., and Paul W. Mosher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be aware of current information about psychiatrist-patient confidentiality and medical record privacy as they are impacted by data bases, electronic transmissions, research, laws and regulations and steps that can be taken to protect private, confidential patient communications.

SUMMARY:

Following an overview by the chair of the multiple areas in which the privacy of psychiatrist-patient communications is endangered, specific information will be provided to help the practitioner and academician to avoid unnecessary breaches of confidentiality. Paul Mosher, M.D. will focus more specifically on the meaning, importance and benefit of the US Supreme Court's Jaffee vs. Redmond decision. Marcia Goin, M.D. will present confidentiality issues in Internet Communications. Margo Goldman, M.D. is chair of the Committee on Confidentiality. Her lecture will discuss protecting patient privacy while doing research using patient records. Richard Harding, M.D. will describe the impact of the regulations issued by the Department of Health and Human Services as a result of the 1996 Health Insurance Portability and Accountability Act (HIPAA) on practicing physicians. Professor Latanya Sweeney, a nationally recognized expert, will demonstrate the ways in which multiple electronic data bases can be cross-referenced to reveal the identity

of individual health care records. The experts will respond to questions from the audience after the formal presentations.

REFERENCES:

1. Jafee vs. Redmond, 518 U.A. 1: 64 Federal Regulation at 59941/3, 1996.
2. Borenstein DB: Confidentiality, in Psychiatric Peer Review: Prelude and Promise. Edited by JM Hamilton, Washington, DC, American Psychiatric Press, 1985.

7. TRAUMA, PTSD, AND PERSONALITY DISORDERS: UNDERSTANDING THE CONNECTIONS

Chairperson: Randall D. Marshall, M.D.
Participants: Marylene Cloitre, Ph.D., Bessel van der Kolk, M.D., Kenneth R. Silk, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be better able to develop a clinical treatment plan based on the patient's trauma history, personality disorder diagnosis, and presence of PTSD symptoms.

SUMMARY:

This forum will attempt to sort through the considerable complexity, ambiguity, and confusion that permeates our current understanding of the relationships between psychological trauma, PTSD, and the personality disorders. The discussants will present a brief overview of salient findings and observations from their work, followed by an open dialogue with participants focusing on both conceptual and practical dilemmas.

For many day-to-day clinical situations there is no empirical knowledge base that could inform clinical practice. For example, most clinical trials in PTSD have not examined comorbid personality disorder as a predictive factor. Likewise, the few rigorous clinical trials in BPD have not examined the role of trauma in treatment response. Discussion will focus on how clinicians might formulate a therapeutic approach depending on whether an individual presents with PTSD only, PTSD with personality disorder, personality disorder and a trauma history but no PTSD, or personality disorder only with no significant trauma history. The evolving concept of "complex PTSD"-referring to a patient with a history of multiple traumas who, under the current nosology, would meet criteria for several Axis I and Axis II diagnoses-will be discussed.

REFERENCES:

1. Ford J: Disorders of Extreme Stress Following War-Zone Military Trauma: Associated Features of PTSD or Comorbid but Distinct Syndromes? J Consulting Clinical Psychology 67:3–12, 1999.
2. Gunderson JG, Sabo AN: The Phenomenological and Conceptual Interface Between BPD and PTSD, Am J Psychiatry; 150:19–27, 1993.

8. DIAGNOSTIC AND STATISTICAL MANUAL (DSM) RESEARCH PLANNING PROCESS

Chairperson: David Kupfer, M.D.
Co-Chairperson: Darrel Regier, M.D.
Participants: Anthony Lehman, M.D., Michael First, M.D., Daniel Pine, M.D. Dennis Charney, M.D., Bruce Rounsaville, M.D. Renato Alarcon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have acquired knowledge about the current DSM research planning process and become familiar with the gaps in the current DSM and recommend research strategies for addressing these before DSM-V is developed.

SUMMARY:

The research planning process for the DSM-V is underway. A joint APA and NIH research initiative led to the development of six workgroups, which will examine particular topic areas/issues related to revising the DSM-IV. The workgroups include: disability and impairment; problems/gaps in the current classification system; neurosciences; developmental issues and diagnosis; implications of the diagnostic nomenclature and its use; and cross-cultural issues. In this forum, workgroup chairpersons will present and discuss the white papers written to raise the level of discussion and stimulate research to support the development of the DSM-V. Strategies for the international implementation of these research agendas will also be discussed.

REFERENCES:

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-IV-TR), Fourth Edition, 2000.
2. American Psychiatric Association: DSM-IV Sourcebooks, Vols 1–4, 1997.

9. THE PHARMACEUTICAL INDUSTRY AND THE APA: CONTROVERSIES AND APPROACHES

Chairperson: Stephen M. Goldfinger, M.D.
Participants: Ian E. Alger, M.D., Harvey Bluestone, M.D., Jacqueline M. Feldman, M.D., Charles R. Goldman, M.D., Philip R. Muskin, M.D., James W. Thompson, M.D., David S. Wahl, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the 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 to 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 andmember concerns about these issues, in 1999 the APA established the Committee on Commercial Support and this year the Board of Trustees established a taskforce on the issues at the industry/APA interface.

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 fuidelines 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, shich is now a leader for policymaking in this arena.

In this forum, members of the committee will briefly present an overview of out activities and issues. 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.

REFERNCES:

1. Friedberg M, Saffran B, Stinson TJ, et al: Evaluation of Conflict of Interest in Economic Analyses of New Drugs Used in Oncology; JAMA; 282:1453-1457, 1999.
2. ACCME's Essential Areas, Elements, and Decision-Making Criteria Accreditation Council for Continuing Medical Education, pp 7-10, July 1999.

10. MENTAL ILLNESS: SURGEON GENERAL'S REPORT ON CULTURE, RACE, AND ETHNICITY

Chairperson: Carl C. Bell, M.D.
Participants: Pablo Hernandez, M.D., Francis G. Lu, M.D., James W. Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an overview of Dr. Satcher's Surgeon General's Report on culture, race and ethnicity.

SUMMARY:

As America's population becomes increasingly diverse, shedding their proclivity toward Euro-American "ethnocentric monoculturalism" is important for psychiatrists. Cultural sensitivity is critically important if the nation is to correct the disparities in mental health care of Non white populations. Psychiatry must begin to extend itself to become more "welcoming" on Nonwhite populations. Dr. Satcher's Surgeon General's Report on Culture, Race, and Ethnicity begins to provide leadership on how to make the invitation. The panelists will provide a brief overview of the report. Each panelist will focus on African-American, Asian-American, Latino-American, and Native American and Pacific Islander issues covered in Dr. Satcher's Report. Accordingly, each panelist will focus various aspects of history, assessment and treatment, access to service, and needed research to improve psychiatric services to Nonwhite populations.

REFERENCES:

1. Chunn J, Dunston P, Ross-Sheriff, F (eds): Mental Health and People of Color: Curriculum Development and Change, Washington, DC, Howard University Press, 1983.
2. Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity: Work in Progress.

11. VIRTUAL PSYCHIATRY: FROM HUMANOID TO CYBERSPACE, THE FUTURE OF PSYCHIATRY AND VIRTUAL REALITY

Chairperson: David M. McDowell, M.D.
Participants: Norman Alessi, M.D., Randall Marchall, M.D., Milton Huang, M.D., Doug Wright

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be familiar with trends that will effect psychiatry in the future, will gain knowledge about the future trends most likely to make dramatic impact on the way we understand the himan mind, will have a better understanding of various approaches to psychiatrists and philosophers in the mear and distant future; and will be able to understand treatments that are as yet not readily available but are likely to be made so in the near future.

SUMMARY:

This seminar will bring together several accomplished psychiatrists, as well as the well-known playwright and screenwriter Doug Wright to discuss issues critical to the evolving concepts of identity and reality. It will serve as a forum to discuss the impact that changes in technology may have on psychiatry, and of human interaction as well. Dr. Dave McKowell is the Medical Director of the Substance Treatment and Research Service, as well as a member of the Scientific Program Committee. He will serve as chair and moderator and will give an overall view of the topic as well. He will comment on what one might expect in the twenty-first century and what the coming of automation and may mean for all of us. Norman Alessi, M.D. is a noted psychiatrist and expert in technology, and he will discuss this topic as well. Randall Marchall, M.D., Director of the Trauma Studies Unit at Columbia University/New York State Psychiatric Institute, is an expert in trauma and will focus on the potential pitfalls that embracing new paradigms may cause. Milton Huang, M.D. is a distinguished philosopher/psychiatrist, who will discuss the origins of personal identity. Finally, Doug Wright, the OBIE nominated playwright and Golden Globe nominated screenwriter will discuss his views on identity formation and how those may be transformed in the coming years. He will use historical examples, some from his recent movie *Quills* to elucidate the history and transformation of communication from the middle ages to the present day and then through to the near and far away future. This will be a casual and lively forum and one the participants hope will be enjoyable for anyone interested in the topics of identity, the future of psychiatry, and the meaning of human interaction.

REFERENCES:

1. Akil H, Watson SJ: Science and the Future of Psychiatry; Archives of General Psychiatry, 57(1):86-87, 2000.
2. Duhl LJ: The Future of Psychiatry: Communities in Action; Bulletin of Menninger Clinic, 62(1): 1-14, 1998.
3. Regestein QR: Psychiatrists' Views of Managed Care and the Future of Psychiatry; General Hospital Psychiatry, 22(2): 97-106, 2000.

INDUSTRY-SUPPORTED SYMPOSIUM 1—SLEEP: A WINDOW ON MIND AND BRAIN
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should better understand molecular and genetic influences on sleepiness, recognize the role that light plays in regulation of sleep and mood, understand how violent behaviors may occur in sleep, diagnose and treat sleep apnea, and use new and more effective treatments for insomnia.

No. 1A
THE PATHOGENESIS OF NARCOLEPSY AND HYPERSOMNIA

Emmanuel Mignot, M.D., *1301 Welch Road, Room P112A, Stanford, CA 94305*

SUMMARY:

Our understanding of the pathophysiology of narcolepsy is rapidly emerging. In humans, narcolepsy is genetically complex, HLA associated, and environmentally influenced. Human narcolepsy is currently treated symptomatically with stimulents and antidepressants.

Narcolepsy research is facilitated by the existence of a unique animal model of narcolepsy, canine narcolepsy. Canine narcolepsy is typically sporadic, but autosomal recessive transmission has been reported in several breeds (canarc-receptor-2 gene (HCrtr2). This was quickly followed by the discovery that preprohypocretin knockout mice also have narcolepsy. Hypocretins are excitatory neuropeptides encoded by a single gene selectively expressed in a small subset of lateral hypothalamic neurons. Hypocretin neurons project widely in the central nervous system. Two hypocretin receptors with differential neuroanatomical distribution are currently known.

Human narcolepsy is not associated with hypocretin ligand or receptor mutations, but is associated with undetectable CSF hypocretin levels. We have identified a single hypocretin gene mutation in a narcoleptic patient. Together with the observation that hypocretin-1 is potently wake-promoting in vivo, these results demonstrate that narcolepsy-cataplexy is due to a hypocretin deficiency. HLA association in humans suggests a possible autoimmune disorder directed against hypocretin-containing cells in the hypothalamus. Models of the narcolepsy symptomatology will be presented.

No. 1B
INFLUENCES OF LIGHT ON SLEEP AND MOOD

Barbara L. Parry, M.D., *9500 Gilman Drive, La Jolla, CA 92093-0804*

SUMMARY:

The effects of light on human physiology have been ignored for the most part until recently. Light intensities greater than normal room light have the capacity to suppress human melatonin secretion and shift circadian rhythms. Morning bright light advances circadian rhythms; evening light delays them. In animal species, this critical light information allows the organism to adapt to its external environment by adjusting its physiological and behavioral rhythms to the diurnal and seasonal cycles. In humans, we are just beginning to discover the myriad of ways in which light affects human rhythms: We now know that light of sufficient intensity, timing, and wavelength can affect mood, particularly in patients with seasonal affective disorder (recurrent winter depression), non-seasonal mood disorders, and premenstrual dysphoric disorder. In fact, light treatments may induce mania in predisposed individuals. Appropriately timed light interventions also can improve the symptoms of jet lag, shift work, delayed and advanced sleep phase syndromes, and sleep maintenance insomnia. In certain disorders, light treatments may act as a pharmacological intervention. Light's potential therapeutic armamentarium will be reviewed as well as areas for further investigation.

No. 1C
VIOLENT BEHAVIORS ARISING FROM THE SLEEP PERIOD

Mark W. Mahowald, M.D., *701 Park Avenue, Minneapolis, MN 55415*

SUMMARY:

Increasingly, practitioners are asked to render legal opinions regarding forensic issues pertaining to violent or injurious behaviors arising from the sleep period. Automatic behaviors (automatisms) resulting in acts that may result in illegal behaviors have been described in many different conditions. Those automatisms arising from wakefulness are reasonably well understood. Recent advances in sleep medicine have made it apparent that some complex behaviors, occasionally resulting in forensic science implications, are exquisitely state-dependent, meaning that they occur exclusively, or predominately, during the sleep period, and therefore, may be without conscious awareness or culpability. The most common conditions resulting in violence arising from the sleep period are disorders of arousal (sleepwalking and sleep terrors), rapid-eye movement sleep behavior disorder (RBD), nocturnal seizures, and psychogenic dissociative states. Each of these conditions is readily diagnosable, and, more importantly, usually treatable. Guidelines for the clinical and forensic evaluation of such behaviors have been developed.

No. 1D
SLEEP APNEA: WHY TREAT IT?

Meir H. Kryger, M.D., *R2034, 351 Tacheave, Winnipeg, MB Canada R2H 2A6*

SUMMARY:

Sleep apnea is a condition in which patients stop breathing while they sleep. During the actual events there occur cardiorespiratory changes including hypoxemia, and changes in autonomic nervous system activity. The apneic episodes generally terminate and breathing resumes when the patient has had an arousal from sleep. These arousals disrupt sleep structure. Because of the abnormal cardiorespiratory physiology it is not surprising that these patients may develop medical complications, primarily those involving the cardiovascular system including arterial hypertension. Several epidemiologic studies have shown that sleep apnea is an independent risk factor for hypertension. The severe sleep disruption leads to neuropsychiatric symptoms that range from problems in memory, concentration, and psychomotor performance. In the most severe cases patients may have a great deal of difficulty staying awake even in situations that demand attention (for example, operating a motor vehicle). Patients may become irritable and have symptoms that suggest a mental disorder. Because these patients may be referred to a psychiatrist, these practitioners, should be able to recognize the possibility of sleep apnea and to refer patients for definitive treatment, which most often is the use of nasal CPAP nightly. Most of the neuropsychiatric symptoms in these patients respond to definitive therapy of the episodes of obstruction.

No. 1E
NEW OPTIONS IN THE TREATMENT OF INSOMNIA

Milton K. Erman, M.D., *9834 Genesee Avenue, Suite 328, La Jolla, CA 92037-1223*

SUMMARY:

Sleep is a dynamic process, over the night and over the life cycle. Insomnia is well recognized as a symptom of, as well as a consequence of, psychiatric disorders, including major depression and anxiety disorders. Changes in sleep associated with aging also increase susceptibility to a variety of sleep disorders, most prominently insomnia.

Insomnia is the sleep disorder most prevalent in the general population, as well as in medical and psychiatric patient populations. The impact of insomnia on function has been well elucidated in recent research and surveys, showing reductions in mood and overall health status, increases in absenteeism and health care utilization, and increased risks of depression.

Advances in our understanding of sleep physiology, as well as new medications that allow greater flexibility in treatment, have provided us with new options in treatment of insomnia. These new hypnotic agents allow for more flexible patterns of administration, with improved safety profiles and reductions in the risks of side effects. These agents are particularly well suited for combination with behavioral strategies for the treatment of insomnia.

This presentation will review basic sleep physiology, summarize the multiple and complex causes of insomnia, and present new treatment options for patients with insomnia.

REFERENCES:

1. Lin L, Faraco J, Li R, Kadotani H, et al: The sleep disorder canine narcolepsy is caused by a mutation in the hypocretin (orexin) receptor gene. Cell 1999; 98:365–376
2. Mahowald MW, Schenck CS: Parasomnias: sleepwalking and the law. Sleep Medicine Reviews 2000; 4, in press
3. Kryger M: Management of obstructive sleep apnea-hypopnea syndrome: overview, in Principles and Practice of Sleep Medicine. Edited by Kryger M, Roth T, Dement WC. Saunders, Philadelphia, 2000; pp 940–954
4. Gillin J, Ancoli-Israel S, Erman M: Sleep and sleep-wake disorders, in Psychiatry. Edited by Tasman A, Kay J, Lieberman JA. Philadelphia, W.B. Saunders, 1997, pp 1217–1248

INDUSTRY-SUPPORTED SYMPOSIUM 2—ADVANCES IN THE TREATMENT OF DEPRESSION IN WOMEN: BEYOND CLINICAL LORE
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant will be familiar with a range of treatments for mood disorder associated with significant female reproductive life events such as postpartum depression, premenstrual dysphoric disorder, and perimenopausal mood disturbance.

No. 2A
GENDER-BASED DIFFERENCES IN THE TREATMENT OF DEPRESSED WOMEN

Susan G. Kornstein, M.D., *P.O. Box 980253, Richmond, VA 23298-0253*

SUMMARY:

The women's health movement has sparked a growing interest in sex-related differences in psychiatric disorders. Depression has emerged as an important area of focus, as epidemiologic studies have consistently shown that major depression is twice as common in women as in men. In addition to the difference in prevalence, recent studies show gender differences in symptom presentation, course of illness, and response to various treatments.

This talk will provide an overview of gender issues in the assessment and treatment of depression. Studies that have examined gender differences in antidepressant treatment response will be reviewed, as well as differences with regard to tolerability and adverse effects. Data will be presented from a recent study of chronic depression demonstrating differential responsivity by gender to a tricyclic antidepressant versus a selective serotonin reuptake inhibitor. The need for a gender-specific approach to the evaluation and management of depression will be emphasized.

No. 2B
TREATMENT STRATEGIES OF PMS AND PMDD

Teri B. Pearlstein, M.D., *345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Selective serotonin reuptake inhibitors (SSRIs) are generally considered the first-line treatment option for premenstrual symptoms due to the several studies reporting their efficacy for emotional and physical symptoms, and their easy tolerability. Treatment with SSRIs during the luteal phase may be equally effective and this treatment is currently undergoing study in large trials. Studies have indicated that medications that suppress ovulation also alleviate premenstrual emotional and physical symptoms. However, the use of such medications, such as the gonadotropin-releasing hormone (GnRH) agonists, leads to prolonged low estrogen levels and cardiac and osteoporosis health risks. Some studies indicate that replacement hormone strategies with GnRH agonists may reintroduce psychological symptoms. A large study of women with premenstrual syndrome reported that calcium was effective in reducing emotional, behavioral, and physical promenstrual symptoms. Further study of psychosocial and other somatic treatments is needed.

No. 2C
CHALLENGES AND CONTROVERSIES IN THE TREATMENT OF CHILDBEARING WOMEN

Lee S. Cohen, M.D., *115 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

Pregnancy is frequently considered a time of emotional well being for women and has been viewed as "protective" with respect to risk for developing psychiatric disturbance. Data supporting this impression are sparse. A number of recent studies suggest that women continue to suffer from disorders such as major depression and bipolar illness during pregnancy and are at risk for relapse if they discontinue maintenance treatment with antidepressants or mood stabilizers during pregnancy. During the postpartum period, women who suffer from depression frequently defer pharmacologic treatment because of concerns regarding the unknown effects of breastfeeding newborns while using these compounds.

This presentation will review available data regarding risk for relapse of major depression and bipolar illness following discontinuation of antidepressants and mood stabilizers, respectively. Risks associated with the use of psychiatric medications during pregnancy will be reviewed as will the impact of untreated psychiatric disorder on fetal well being. In addition, available data that attempt to quantify infant exposure to psychotropics following maternal use of these agents will be reviewed. Treatment guidelines for psychotropic drug use during pregnancy and lactation will also be presented.

No. 2D
CRITICAL ISSUES IN MOOD AND COGNITION FOR MENOPAUSAL WOMEN

Hadine Joffe, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Reproductive aging causes significant changes in gonadal-steroid modulation of the central nervous system. Estrogen withdrawal may cause depressive and cognitive difficulties in perimenopausal women through a direct CNS effect. Alternatively, these neuropsychological symptoms may be an indirect consequence of hot flushes and sleep disturbance. Estrogen replacement improves mood in some menopausal women, enhances short-term memory function in some menopausal and postmenopausal women, and may reduce the risk of Alzheimer's disease. A potential mediating role of suppression of hot flushes and improvement of sleep disturbance in the therapeutic benefits of estrogen replacement in menopausal and postmenopausal women has not been examined.

This presentation will review neuropsychological symptoms that occur in menopausal women.

REFERENCES:

1. Kornstein SG, Wojcik BA. Gender effects in the treatment of depression. Psychiatric Clinics of North America Annual of Drug Therapy 7:23–57, 2000
2. Thys-Jacobs, et al. Am J Obstet Gynecol 1998; 179:444–452
3. Joffe H, Cohen LS. Estrogen, serotonin, and mood disturbance: where is the therapeutic bridge? Biological Psychiatry 1998; 44:798–811

INDUSTRY-SUPPORTED SYMPOSIUM 3—SUICIDE RISK AND BIPOLAR DISORDER: NEUROBIOLOGY AND TREATMENT

Supported by the American Foundation for Suicide Prevention and Solvay Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to make a better selection of the most appropriate medication and nonmedication interventions to reduce the risk of suicide and suicide attempts in bipolar adults and youth. The clinicians should also have increased their knowledge of the neurobiological underpinnings of mood disorders and suicide risk.

No. 3A
CLINICAL FACTORS AFFECTING SUICIDE RISK IN BIPOLAR DISORDER

Kay R. Jamison, Ph.D., *720 Rutland Avenue/Meyer 4-181, Baltimore, MD 21205*

SUMMARY:

Suicide is a too frequent cause of death in manic depressive illness. This talk will focus on the rates of suicide and suicide attempts in bipolar illness; clinical states most frequently associated with suicide; significant clinical, psychological, and environmental risk factors; genetic and seasonal factors; and the necessity of understanding and treating the psychological issues of importance to the suicidal, or potentially suicidal, bipolar patient.

No. 3B
NEUROBIOLOGY OF SUICIDE AND BIPOLAR DISORDER

J. John Mann, M.D., *1051 Riverside Drive, Box 42, New York, NY 10032*

SUMMARY:

The risk for suicidal behavior is best understood using a stress-diathesis model. Biological findings related to suicide mostly implicate abnormalities in the serotonergic system that pertain principally to the diathesis for suicidal behavior. Individuals who have committed suicide have a serotonergic abnormality that appears to be localized to the ventral prefrontal cortex. This brain region has been demonstrated to be involved in behavioral inhibition. Alterations in serotonergic input to this area may underlie the predisposition to act on powerful emotions, including suicidal feelings. Studies of suicide attempters suggest serotonergic abnormalities may exist in association with serious suicide attempts, regardless of diagnosis. Other studies have shown that there is a diffuse serotonergic abnormality in the prefrontal cortex associated with major depression that is distinct from the abnormality associated with the diathesis for suicide attempts. Bipolar depression has been shown to differ from unipolar depression on PET imaging and in response to serotonin challenges. The presence of serotonergic abnormalities in bipolar patients at high risk for suicide may explain the potential benefit of serotonergic enhancement by medications such as SSRIs or lithium in ameliorating that risk.

No. 3C
EFFICACY OF MOOD STABILIZERS IN SUICIDE PREVENTION

Ross J. Baldessarini, M.D., *115 Mill Street, MRC 316, Belmont, MA 02478-1048*; Leonardo Tondo, M.D.; John Hennen, Ph.D.

SUMMARY:

Major affective disorders are potentially fatal due to suicide, substance use comorbidity, accidents or risk-taking, and stress-sensitive general medical diseases. Despite the clinical and public health significance of this problem, research on treatment effects on mortality remains remarkably limited. However, studies designed to evaluate long-term treatment effects in bipolar disorder provide consistent evidence of substantial reduction of rates of suicides and attempts during maintenance treatment with lithium. With long-term lithium treatment, suicide attempt rates, at least, may approach estimated base rates in the general population. The basis of this benefit is not well defined. Carbamazepine may not be as effective, clozapine has been evaluated only in schizophrenia, and other proposed mood stabilizers have not been evaluated regarding mortality. Findings with antidepressants in unipolar depression suggest possible beneficial effects of some older antidepressants on suicide risk, though they themselves can be lethal in acute overdose. Available research is generally not supportive of similar benefits with safer modern antidepressants. However, long-term treatment studies in depression that evaluate mortality remain rare. Clearly, there is a need to evaluate the impact of treatment on all forms of premature mortality in various types of affective illness.

No. 3D
CLINICAL MANAGEMENT OF THE SUICIDAL BIPOLAR PATIENT

Frederick K. Goodwin, M.D., *2150 Pennsylvania Avenue, N.W., 8th Floor, Washington, DC 20037*

SUMMARY:

The great majority of suicides occur as a consequence of untreated or inadequately treated psychiatric illness, principally severe depression and bipolar disorder (lifetime risk 15% to 19%). In bipolar disorder, the great majority of suicides occur during a depressed or mixed episode.

Effective management begins with an understanding of those risk factors that are especially relevant to the bipolar patient. These include a bipolar II pattern, comorbid substance abuse, severe anxiety, cycling within an episode, a history of aggressive and/or impulsive behavior, and a family history of suicide.

What about pharmacological management? First, the approaches that are most effective in treating or preventing depressive episodes and mixed states should confer some protection against suicide. These approaches will be reviewed, emphasizing the role of lithium, the anticonvulsants, the atypical neuroleptics, antidepressants, and combinations, depending on the nature of the presenting symptoms. Beyond this there is now an impressive body of evidence that lithium treatment is associated with a dramatic reduction in suicide in bipolar illness. There is no comparable data for other putative mood stabilizers. The intriguing question is whether this lithium effect reflects a specific anti-suicide effect in addition to its role in preventing or attenuating episodes.

No. 3E
EVALUATION OF SUICIDE RISK IN BIPOLAR DISORDER IN CHILDREN

David Shaffer, M.D., *722 West 168th Street, Unit 78, New York, NY 10032-2603*

SUMMARY:

The relationship between suicide and bipolar disorder in adults has been well demonstrated, but the relationship is less clear for children and adolescents. Among existing psychological-autopsy studies, only the study by Brent (Brent et al. 1994) identified bipolar suicides (13 percent). Two other relatively large studies of adolescent suicide (Shaffer et al. 1996; Martunnen et al. 1991) failed to identify antecedent bipolarity. Personal communication with several investigators who specialize in bipolar illness has similarly failed to provide any examples of completed suicide in adolescents diagnosed as bipolar. This might be because of the relative rarity of bipolar illness in youth, some as-yet-unexplained later-onset suicidogenic manifestation of bipolar illness, or the difficulty in establishing the diagnosis. The difficulties in establishing a diagnosis of bipolar disorder in children include differentiating it from other disinhibiting conditions and other conditions that cause irritability, such as ADHD and ODD. These difficulties will be illustrated. Even though suicide attempts and suicides are frequently associated with a psychiatric disorder, in most instances the choice of treatment will be based on suicide alone. This has not proven to be very successful, and the results of a meta-analysis will be discussed. The few treatments that have been shown to be helpful are dialectical behavior therapy and the use of neuroleptics and/or SSRI antidepressants. The presentation will conclude with a review of the controversy surrounding the apparent induction of suicidal ideation by SSRIs.

REFERENCES:

1. Goodwin FK, Jamison KR (eds.): Manic-Depressive Illness, New York, Oxford University Press, 1990
2. Mann JJ: The neurobiology of suicide. Nature Medicine 1998; 4:25–30
3. Baldessarini RJ, Tondo L: Antisuicidal effects of lithium in major mood disorders, in The Harvard Medical School Guide to Assessment and Intervention in Suicide. Edited by Jacobs D. Jossey-Bass, San Francisco, CA, 1998, pp 355–371
4. Goodwin FK, Jamison KR (eds.): Manic-Depressive Illness. New York, Oxford University Press, 1990
5. Biederman J, Klein RG, Pine, DS, & Klein DF: Resolved: mania is mistaken for ADHD in prepubertal children [see comments]. J Am Acad Child Adolesc Psychiatry 1998; 37: 1091–1096
6. Hawton K, Townsend E, Arensman E, Gunnell D, Hazell P, House A, van Heeringen K: Psychosocial versus pharmacological treatments for deliberate self harm, Cochrane Database Syst Rev CD001764, 2000

INDUSTRY-SUPPORTED SYMPOSIUM 4—TO SWITCH OR AUGMENT? CONTEMPORARY APPROACHES TO RESISTANT DEPRESSION
Supported by Pharmacia Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to describe serotonin receptor, HPA, and neuroimaging changes in depression and changes with treatment. They should be familiar with the antidepressant switching and augmentation strategies as well as evidence for the use of nonpharmacological treatments.

No. 4A
NEUROLOGICAL MECHANISMS OF TREATMENT RESISTANCE: THE ROLE OF STRESS

Juan F. Lopez, M.D., *205 Zina Pitcher Place, Ann Arbor, MI 48109*

SUMMARY:

Disturbances of the hypothalamic-pituitary-adrenal (HPA) axis and the serotonin (5-HT) system are the two most commonly reported abnormalities in depressive illness and suicide. The HPA axis is the classic neuroendocrine system that responds to stress. Its final products, glucocorticoids, target components of the limbic system, particularly the hippocampus. We will review results from animal and human studies that indicate that many of the 5-HT receptor changes observed in depression and suicide may be a result of or worsened by the HPA overactivity in this population. These studies indicate that stress and glucocorticoids are capable of modulating 5-HT receptors in particular, those receptors associated with mood. Furthermore, suicide victims with a history of depression show changes in brain chemistry consistent with a history of exposure to elevated glucocorticoids. Chronic antidepressant administration reverses the overactivity of the HPA axis and prevents many of the 5-HT receptor changes observed after stress. However, not all antidepressants are equally effective at preventing the HPA and 5-HT receptor abnormalities. These data may provide a biological understanding of how stressful events may increase the risk for depression and suicide in vulnerable individuals and may help us elucidate the neurobiological underpinnings of treatment resistance.

No. 4B
THE NEURAL BASIS OF ANTIDEPRESSANT RESPONSE AND NONRESPONSE

Wayne C. Drevets, M.D., *904 Beacon Square Court, #107, Gaithersburg, MD 20878*

SUMMARY:

PET studies of depression demonstrate neurological abnormalities in the orbital and medial prefrontal cortex (PFC), amygdala, and related parts of the striatum and thalamus. Some of these appear mood-state-dependent and localize to regions where blood flow in-

creases during normal and other pathological emotional states. Others persist following remission and are found in areas where postmortem studies demonstrate histopathological changes in primary mood disorders. Brain mapping, lesion analysis, and electrophysiological data suggest these latter regions participate in modulating limbic activity, evidenced by reductions of metabolism in amygdalar and ventral anterior cingulate regions where metabolism correlates positively with illness severity during depressive episodes. Persistence of abnormal amygdala metabolism is associated with treatment nonresponse and elevated risk for relapse. Preclinical evidence indicates that antidepressants that inhibit norepinephrine reuptake exert more prominent and persistent effects on catecholaminergic and glutamatergic function in the medial PFC and on limbic-hypothalamic-pituitary-adrenal axis activity than agents that selectively inhibit serotonin reuptake. These differences may relate to differential capabilities for inducing remission across drug classes.

No. 4C
WHEN TO AUGMENT ANTIDEPRESSANTS

Andrew A. Nierenberg, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

Twenty years after DeMontigny extrapolated from basic science to clinical practice to introduce lithium augmentation, reports of other potential augmentors (especially of SSRIs) have been reported every few years: thyroid, tricyclics, buspirone, bupropion, stimulants and dopaminergic agents, mirtazapine, reboxetine, atypical antipsychotics, and newer anticonvulsants. Double-blind, randomized, controlled trials of these augmenting agents, however, are few and far between. Some randomized, controlled trials confirm, while others fail to show, superiority over placebo. Like lithium, many of these augmentation trials have a rationale for mechanisms of synergy; others are simply empirical. This presentation will review antidepressant augmentation 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 STAR*D project should provide data for comparing selected strategies within the next few years.

No. 4D
THE USE OF SWITCHING IN DEPRESSION TREATMENT

Charles DeBattista, M.D., *402 Quarry Road, Administrative Office, Stanford, CA 94305-5717*

SUMMARY:

About one half of patients who begin an antidepressant will either not respond to the treatment of first choice or not be able to tolerate an optimal therapeutic trial. In daily practice, the decision about what to do next is a frequent challenge to which there are literally dozens of potential options. This presentation will emphasize the family of strategies that involve switching to an alternative treatment. The conceptual rationale for switching will be discussed, as will the practical pros and cons of switching relative to augmenting. Key issues, including the safety and tolerability of cross titration, the value of within-class switches, and the evidence that switching across classes actually improves outcomes, will be examined critically. Finally, indications for switching antidepressant nonresponders immediately to electroconvulsive therapy or, conversely, to psychotherapy, will be considered.

No. 4E
THE ROLE OF NONPHARMACOLOGICAL INTERVENTION FOR TREATMENT-RESISTANT DEPRESSION

Lauren B. Marangell, M.D., *One Baylor Plaza, BCM 350, Houston, TX 77030*

SUMMARY:

Despite the numerous medications available for the treatment of depression, many patients respond only partially or not at all. This presentation highlights the use of nonpharmacological treatments for patients with resistant depression, including the use of electroconvulsive therapy, vagus nerve stimulation, and psychosocial interventions. Electroconvulsive therapy (ECT) is an important acute intervention. Recent data indicate that altered stimulation parameters may produce clinical response with less adverse cognitive effects. Unfortunately, relapses and recurrence are common when ECT is discontinued. Vagus nerve stimulation (VNS) may provide an alternate long-term method of stimulating the central nervous system. Stimulation is delivered to the left cervical vagus nerve using a device that is commercially available for treatment of refractory partial onset seizures. Preliminary data indicate that VNS may have a role in the acute maintenance and treatment of resistant depression. Data from randomized clinical trials also indicate that the combination of psychotherapy and medication may be more efficacious for patients with chronic depression. Baseline predictors of response will be discussed.

REFERENCES:

1. Lopez JF, Vazquez DM, Chalmers DT, Watson SJ: Regulation of 5-HT receptors and the hypothalamic-pituitary-adrenal axis. Implications for the neurobiology of suicide. Ann NY Acad Sci 1997; 836:106–134
2. Drevets WC, Price JL, Simpson JR, Todd RD, et al: Subgenual prefrontal cortex abnormalities in mood disorders. Nature 1997; 386:824–827
3. Thase ME, Howland RH, Freidman ES: Treating antidepressant nonresponders with augmentation strategies: an overview. Clinical Psychiatry 1998; 59(suppl 5):5–12
4. Rush AJ, George MS, Sacheim HA, Marangell LB, et al: Vagus nerve stimulation (VNS) for treatment-resistant depressions: a multicenter study. Bio Psychiatry 2000; 47:276–286

INDUSTRY-SUPPORTED SYMPOSIUM 5—THE NEW BIOLOGY OF DEPRESSION AND ANTIDEPRESSANT TREATMENT
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will learn current concepts in the biology of depression, will understand images of the depressed brain, and will learn how antidepressants are thought to treat depression.

No. 5A
THE DEPRESSED BRAIN IMAGED

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

SUMMARY:

Frontal, cingulate, and striatal changes in blood flow and metabolism have been repeatedly reported in patients with depression. Complementary studies examining treatment effects build on these earlier

reports, with results suggesting common involvement of a distributed limbic-cortical network in the pathogenesis of affective disorders. In this evolving depression model, an imbalance in dorsal neocortical and ventral limbic-paralimbic activity characterizes the depressive state, with inhibition of paralimbic and striatal regions and normalization of hypofunctioning cortical sites necessary for disease remission. Normal functioning of rostral anterior cingulate, with its direct connections to various components of this network, also appears to be critical for recovery, as pretreatment metabolism in this region uniquely predicts antidepressant response. Involvement of these same limbic-cortical pathways has also been demonstrated in studies of normal transient sadness. Furthermore, altered patterns of response with acute mood provocation in both depressed and euthymic unipolar and bipolar patients have been identified. These data suggest a more generalized vulnerability to normal emotional stressors in all affective disorder patients, with implications for understanding mechanisms of illness predisposition and relapse. Together, these studies support the hypothesis that depression is a systems-level disorder, affecting discrete but functionally linked pathways involving specific cortical, subcortical and limbic sites.

Support: NIMH MH49553, NARSAD, Charles Dana Foundation, Stanley Foundation, Eli Lilly.

No. 5B
THE NEUROBIOLOGY OF MOOD DISORDERS

Dennis S. Charney, M.D., *25 Park Street, Room 623, New Haven, CT 06519*

SUMMARY:

There have been major advances in our understanding of the neurobiology of depression. The role of the monoamines, serotonin, and norepinephrine, has remained a focus. However, given the complexity of these systems, more refined hypotheses have been developed. In addition, it has become clear that other neurotransmitter systems, neuropeptides, and intracellular molecular mechanisms may be equally or even more important in the etiology and treatment of depression. This presentation will update the audience on recent findings pertaining to these areas. Possible new approaches to the treatment of depression based upon this work will be presented.

No. 5C
WHAT DO ANTIDEPRESSANTS DO? UNDERSTANDING ANTIDEPRESSANT MOLECULES, NEUROTRANSMITTERS, AND RECEPTORS

Pierre Blier, M.D., *100 Newell Drive, Suite L4100, Gainesville, FL 32610*

SUMMARY:

Most available antidepressants drugs block the inactivation processes of one or more of the following monoamines: serotonin (5-HT), norepinephrine (NE), or dopamine. By inhibiting either the respective reuptake carriers or monoamine oxidase, such drugs induce a rapid, but preferential, increase of monoamines in the cell body region of neurons. This triggers negative feedback mechanisms. With treatment prolongation, the efficacy of these feedback actions is gradually attenuated allowing a net enhancement of transmission. These neuronal mechanisms may include the cell body autoreceptors controlling firing rate, the terminal autoreceptors mediating neurotransmitter release, and terminal heteroreceptors (receptors sensitive to a given monoamine but which are not located on a terminal releasing that particular transmitter). Although several antidepressant drugs are exquisitely selective for one neuronal element, they may induce profound alterations in the function of another neurotransmitter system. This notion will be described using the effect of 5-HT reuptake inhibitors on NE neuronal firing activity, the alpha$_2$ adrenergic antagonist mirtazapine on 5-HT neuronal firing, and the impact of bupropion on 5-HT neuronal firing through its NE releasing action. These physiological actions will also be presented in a useful fashion to optimize treatment of depressed patients nonresponsive to a first antidepressant drug trial.

No. 5D
HEALING THE DEPRESSED BRAIN: SIGNAL TRANSDUCTION AND NEURAL PLASTICITY

Eric J. Nestler, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-9070*; Ronald S. Duman, Ph.D.

SUMMARY:

Investigators have administered antidepressants to rodents and characterized the changes in signal transduction pathways and gene expression that occur after repeated and acute administration. These investigations have demonstrated molecular changes related to behavior in animal models of depression.

Work over the past decade has identified dramatic effects of diverse types of antidepressant treatments on several signal transduction cascades. This talk will focus on antidepressant regulation of the cAMP pathway and related changes in gene expression. Behavioral studies support the involvement of these changes in antidepressant action. One gene induced by these treatments is brain-derived neurotrophic factor (BDNF).

This body of research has provided a model wherein repeated perturbation of monoamine systems leads to gradually developing adaptations in the cAMP pathway, which—through the regulation of target genes such as BDNF—produce the neural plasticity that underlies the therapeutic actions of these treatments.

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INDUSTRY-SUPPORTED SYMPOSIUM 6—GLUCOSE CONTROL AND DIABETES MELLITUS DURING ANTIPSYCHOTIC TREATMENT
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to recognize diabetes mellitus and recognize antipsychotic medications that can increase the risk of hyperglycemia. Participants will be able to describe the long-term health complications of hyperglycemia and understand options for monitoring and initial management of plasma glucose.

No. 6A
DIAGNOSIS, CLASSIFICATION, AND PATHOGENESIS OF HYPERGLYCEMIA

Harold E. Lebovitz, M.D., *416 Henderson Avenue, Staten Island, NY 10310*

SUMMARY:

Diabetes mellitus represents a series of syndromes in which the blood glucose is inappropriately high for the physiologic state. The newer diagnostic criteria for diabetes mellitus are a fasting plasma glucose ≥126 mg/dl or a plasma glucose ≥200 mg/dl 2 hr after a 75 g oral glucose challenge. Diabetes mellitus is classified by etiology: (1) type 1 diabetes is caused by beta cell destruction leading to absolute insulin deficiency; (2) type 2 diabetes is due to varying degrees of insulin resistance and insulin deficiency; (3) other types of diabetes are those in which the specific cause is known, such as genetic defects of beta cell function or insulin action, diseases of the exocrine pancreas, endocrinopathies, or drug or chemically induced; (4) gestational diabetes is that occurring during pregnancy. Type 2 diabetes is the common form accounting for 85% to 95% of cases. Type 2 diabetes is a polygenetic disease. The clinical occurrence of the disease, however, is largely determined by the environment. Ingestion of high calorie, high fat diets leads to obesity, which causes an impairment of insulin action (insulin resistance). Lack of significant physical activity also leads to insulin resistance. Insulin resistance is ordinarily overcome by appropriate increases in insulin secretion. If the pancreatic beta cells cannot compensate with a great enough increase in insulin secretion, hyperglycemia ensues. Any factor or drug that either increases insulin resistance or interferes with insulin secretion in a genetically susceptible individual will induce type 2 diabetes. Type 2 diabetes affects about 10% to 12% of the population 40 years and older. Poorly controlled type 2 diabetes leads to the chronic complications of microvascular and macrovascular disease.

No. 6B
CARDIOVASCULAR RISK INCREASES WITH GLUCOSE LEVELS REGARDLESS OF DIABETES STATUS

Hertzel C. Gerstein, M.D., *1200 Main Street West, Room 3V38, Hamilton, Ontario, Canada L8N 3ZS*

SUMMARY:

Diabetics have a two- to four-fold higher rate of cardiovascular events than nondiabetics; the annual risk of fatal and nonfatal cardiovascular events in middle-aged diabetics is 2% to 5%. Large prospective studies show that higher glucose levels predict a higher incidence; risk of a cardiovascular event rises 10% to 20% per 1% rise in HbA_{1c}.

There is growing epidemiologic evidence to support the possibility that this glucose-cardiovascular risk correlation extends below plasma glucose thresholds diagnostic of diabetes (ie, thresholds that identify people at risk for eye and kidney disease). In a meta-regression analysis of all prospective studies that included nondiabetics, a two-hr plasma glucose of 7.8 mmol/L increased risk of a cardiovascular event by 58% compared with a level of 4.2 mmol/L. Another study showed that even after excluding people with diabetes, glucose intolerance, or fasting plasma glucose ≥6.1 mmol/L, myocardial infarction cases were almost three times more likely to have a fasting plasma glucose >5.2 mmol/L than controls.

Plasma glucose is a continuous risk factor for cardiovascular events. Conditions or interventions that increase the prevalence or dysglycemia may also increase subsequent cardiovascular risk. Conversely, glucose lowering might decrease cardiovascular risk in diabetics and nondiabetics; such a possibility requires explicit testing in large trials.

No. 6C
ANTIPSYCHOTIC-RELATED CHANGE IN GLUCOSE REGULATION

John W. Newcomer, M.D., *4940 Children's Place, Box 8134, St. Louis, MO 63110-1002*

SUMMARY:

Abnormalities in glucose regulation including type 2 diabetes are more common in schizophrenia than in the general population. Hyperglycemia and new-onset type 2 diabetes are also associated with antipsychotic treatments, particularly clozapine and olanzapine. Increased adiposity can decrease insulin sensitivity, and antipsychotics can increase adiposity. However, hyperglycemia and type 2 diabetes have also been reported during antipsychotic treatment in the absence of weight gain. We examined plasma glucose and insulin levels in patients with schizophrenia and healthy controls during a modified oral glucose tolerance test, comparing glucoregulatory effects of different antipsychotics with the effect of no medication in healthy controls, matching for age and adiposity. Clozapine and olanzapine treatment was associated with elevated fasting plasma glucose levels, in comparison with untreated healthy controls. Clozapine and olanzapine treatment, and to a lesser extent risperidone, was associated with elevated plasma glucose levels following oral glucose loading, in comparison to healthy controls. Increases in plasma insulin levels will also be described. Antipsychotic-associated changes in glucose regulation can occur independent of changes in adiposity. As hyperglycemia can increase risk for the development of cardiovascular disease, clinicians should consider glucose control along with other factors that can impact long-term health outcome.

No. 6D
ATYPICAL ANTIPSYCHOTIC AGENTS: DIABETES AND BERGMAN'S MINIMAL MODEL ANALYSIS

David C. Henderson, M.D., *25 Staniford Street, Boston, MA 02114*

SUMMARY:

Recently, atypical antipsychotic agents have been linked to hyperglycemia, diabetic ketoacidosis, and adult onset diabetes mellitus. It is not clear if the potential impairment in glucose metabolism is a direct effect of the drugs or related to other factors. This talk will focus on two recent studies examining the impact of atypical antipsychotic agents on glucose metabolism in subjects with schizophrenia.

In a five-year naturalistic study we found that 30 of 82 (36.6%) clozapine patients were diagnosed with diabetes during the five-year follow-up. Weight gain, valproate, and clozapine total daily dose were not significant risk factors. Patients experienced significant weight gain that continued until approximately month 46.

In a cross-sectional study, examining clozapine, olanzapine, and risperidone subjects, we performed a frequent sampled intravenous glucose tolerance test with Bergman's Minimal Model Analysis. There was a significant difference in insulin sensitivity (SI), comparing clozapine with risperidone, and olanzapine with risperidone. There was no significant difference between the three groups for glucose effectiveness (SG), though there was a trend comparing clozapine with risperidone. Preliminary results suggest that clozapine patients experience higher rates of diabetes and there is a significant difference between the three drugs for insulin sensitivity with clozapine and olanzapine exhibiting significant impairment.

No. 6E
INHIBITION OF GLUCOSE TRANSPORT BY ANTIPSYCHOTIC DRUGS

Donard S. Dwyer, Ph.D., *1501 Kings Highway, Shreveport, LA 71130*; Timothy D. Ardizzone, B.S.; Harold B. Pinkofsky, M.D.; Arthur M. Freeman III, M.D.; Ronald J. Bradley

SUMMARY:

Glucose is an essential source of energy for the brain, yet little is known about the regulation of its transport into neurons. In studying neuronal regulation of glucose uptake, it has been found that many of the antipsychotic drugs, including the newer atypical medications, inhibit the transport of sugars into certain cell lines. In addition, these drugs decrease the rate of cell division (in PC12 cells) and increase the expression of glucose transporter (GLUT) proteins. The antipsychotic drugs with these properties include chlorpromazine, fluphenazine, pimozide, and clozapine. Metabolites of clozapine were also evaluated and desmethylclozapine retained its activity, whereas the n-oxide derivative was inactive. To define the possible mode of action of the drugs, various agonists and antagonists of D1 and D2 dopamine receptors were tested for their effects in the transport assay. The data suggested that the drugs affect glucose transport via a mechanism that is independent of the dopamine receptor. The possibility that the drugs directly affect GLUT function is currently being explored. In light of these findings, it is worth noting that treatment with certain antipsychotic drugs is associated with weight gain, hyperglycemia, and the induction of diabetes in some patients.

REFERENCES:

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5. Dwyer DS, Liu Y, Bradley RJ: Neurosci. Lett 1999; 274:151–154

INDUSTRY-SUPPORTED SYMPOSIUM 7— PTSD: CLINICAL CHARACTERISTICS AND TREATMENT OPTIONS
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) review recent findings concerning the neurobiology of PTSD, (2) discuss how comorbidities can impact the presentation and course of PTSD, (3) describe psychotherapeutic approaches for managing PTSD, and (4) identify new developments in the pharmacotherapeutic treatment of PTSD.

No. 7A
PTSD: DIAGNOSTIC ISSUES AND COMORBIDITY

Kathleen T. Brady, M.D., *171 Ashley Avenue, Charleston, SC 29425-0742*

SUMMARY:

Recent survey data indicate that PTSD is a common psychiatric disorder with profound effects on health, psychosocial functioning, and quality of life. Individuals with PTSD often present with somatic complaints, making recognition of the disorder difficult. In addition, studies indicate that individuals with PTSD are more likely to have other chronic medical illnesses. The presentation of PTSD in a general medical setting will be discussed. PTSD is also commonly comorbid with other psychiatric disorders. In the National Comorbidity Study, 79% of women and 88% of men with PTSD met criteria for at least one other psychiatric disorder (Kessler et al., 1995). The most common comorbid conditions were affective disorders, substance use disorders, and other anxiety disorders. The presence of psychiatric comorbidity can have substantial impact on the presentation of PTSD, making diagnosis more difficult. Recent studies have investigated specific treatments for PTSD and a number of comorbid disorders. Results from several studies of the treatment of PTSD and substance use disorders will be discussed. The presence of specific comorbidity in individuals with PTSD may be important in choosing the most appropriate treatment.

No. 7B
SYMPATHETIC NERVOUS SYSTEM DYSREGULATION IN PTSD

Steven M. Southwick, M.D., *333 Cedar Street, New Haven, CT 06504*

SUMMARY:

When animals and humans are threatened, multiple brain regions and neurochemical systems become activated in an attempt to process and respond to meaningful stimuli. These complex neurobiologic systems interact with one another as the organism attempts to cope with impending danger. While acute neurobiologic responses to stress tend to be adaptive, under some circumstances chronic reactions to stress may become maladaptive, particularly in individuals who develop posttraumatic stress disorder. During WWII the term physioneurosis was coined to describe the chronic physiologic hyperarousal that resulted from severe psychological trauma. This presentation will review research findings related to the neurobiology of posttraumatic stress disorder, with a particular focus on alterations in sympathetic nervous system responsivity. Studies involving civilians, veterans, and children will be included. Relevant evidence from psychophysiologic, endocrine, receptor binding, IV challenge, brain imaging, and pharmacologic treatment trials will be presented. The possible relationship between sympathetic nervous system hyperre sponsivity and PTSD symptoms will also be discussed. Additionally, this presentation will focus on fear conditioning and the neurobiology of traumatic memory.

No. 7C
ADVANCES IN THE PHARMACOTHERAPY OF PTSD

Charles R. Marmar, M.D., *401 Parnassus Avenue, San Francisco, CA 94143*; Thomas C. Neylan, M.D.; Frank B. Schoenfeld, M.D.

SUMMARY:

Posttraumatic stress disorder (PTSD), a major public health problem with a lifetime prevalence of 7.8%, has been until recently a relatively neglected area of psychopharmacological research. An overview of advances will be presented focusing on randomized controlled trials of tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, alpha and beta-adrenergic agents, and mood stabilizing medications. Limitations of benzodiazepines will be discussed. Specific pharmacotherapeutic strategies for managing nightmares, insomnia, irritability, and aggressivity will be presented. Pharmacotherapy for acute PTSD will be contrasted with medications for chronic PTSD. The role of adrenergic

agents in early preventative intervention will be related to models of central adrenergic activation and memory for traumatic events. Benefits and risks of pharmacotherapy for children and adolescents with PTSD will be discussed. Predictors of pharmacotherapy response will be reviewed, emphasizing the role of gender, trauma type, and comorbidity. Recent open trial results with novel medications will also be presented.

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No. 7D
PSYCHOTHERAPY OF PTSD

Barbara O. Rothbaum, Ph.D., *1365 Clifton Road, NE, Atlanta, GA 30322*

SUMMARY:

The psychotherapy literature for posttraumatic stress disorder (PTSD) will be succinctly reviewed and discussed, focusing on cognitive behavioral treatments (CBT), and the various CBT techniques will be briefly described. The results of the treatment guidelines for PTSD commissioned by the International Society for Traumatic Stress Studies (ISTSS) will be reviewed. In those guidelines, due to the strength of the literature base in this area, only peer-reviewed empirical studies were included. Exposure therapy involves assisting patients in recalling their traumas in and recounting them repeatedly in a therapeutic manner until discomfort decreases. The evidence is very compelling from many well-controlled trials with a mixed variety of trauma survivors that exposure therapy is effective. In fact, no other treatment modality has this strong evidence for its efficacy. Stress inoculation training (SIT), an anxiety management training package of techniques, cognitive processing therapy (CPT) developed for rape victims, cognitive therapy, and combination approaches all have some evidence for their efficacy, as well. The Expert Consensus Guidelines for PTSD recommendations for psychotherapy also will be briefly reviewed.

INDUSTRY-SUPPORTED SYMPOSIUM 8—SYMPTOMATIC AND FUNCTIONAL RECOVERY: ATTAINABLE GOALS IN TREATING DEPRESSION?
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize the difference between remission and response, (2) describe how adding psychotherapy might improve overall remission rates or speed onset of remission, (3) describe the pharmacological differences among newer generation antidepressants, and (4) define additional steps needed to improve a partial response in the treatment of depression.

No. 8A
WHAT IS REMISSION WHY IS IT IMPORTANT AND WHEN DOES IT OCCUR?

Lauren B. Marangell, M.D., *One Baylor Plaza, BCM 350, Houston, TX 77030*

SUMMARY:

Treatment of depression aims to achieve complete symptom remission and complete restoration of day-to-day functioning with as minimal side-effect burden as possible. Failure to achieve remission is associated with both functional impairment and a poorer prognosis. In order to understand the importance of full remission and to translate this into a clinically meaningful concept, it is imperative that clinicians understand the various assessments of quality of life and functional status. Data from randomized, controlled trials (RTCs) may help guide clinicians to improve the overall outcome, including the quality of life for depressed patients. This presentation will evaluate the various definitions of response, remission, and recovery utilizing data from RCTs. The clinical consequences of attaining response or remission in acute-phase treatment for the longer-term course of illness during continuation or maintenance phase treatment will be discussed. Differences among the available symptomatic and functional measures will be described with the intent of making these scales meaningful for clinicians. The presentation will also comment on treatment baseline clinical and demographic characteristics that might be associated with earlier as opposed to later onset of remission.

No. 8B
ARE ALL ANTIDEPRESSANT MEDICATIONS EQUIVALENT IN ATTAINING REMISSION?

Michael E. Thase, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

It is commonly stated that all of the antidepressants approved by the United States Food and Drug Administration are comparably effective. This presentation will show that this belief is the result of the following four factors: (1) studies directly comparing two active antidepressants are usually not large enough to reliably detect smaller but still meaningful differences in efficacy, (2) important individual and subgroup differences in responsivity are commonly "lost" in studies of heterogeneous groups, (3) antidepressants with stronger effects may be "handicapped" in clinical trials by greater attrition due to side effects, and (4) such differences often lead clinicians to use the agents as third- or fourth-line strategies, where there is a lower inherent probability of success. Drawing upon both published meta-analyses and newer data, this presentation will demonstrate that: (1) tertiary amine TCAs are more effective than SSRIs for treatment of severely ill, hospitalized patients; (2) older, nonselective MAOIs are significantly more effective than TCAs, but not SSRIs, for treatment of outpatients with reverse neurovegetative features; and (3) among the newer antidepressants, only venlafaxine at higher doses appears to be more effective than SSRIs. The possible mechanisms that might explain these differences in efficacy will be explored and clinical implications will be discussed.

No. 8C
DOES COMBINING MEDICATIONS OR MEDICATION SEQUENCES LEAD TO REMISSIONS?

Jack M. Gorman, M.D., *1051 Riverside Drive, Unit 32, New York, NY 10032*

SUMMARY:

It is well known that many different medications are effective for many patients, but no one medication is a panacea. Furthermore, outcomes, even if positive, often lead to a response without full symptomatic remission. Clinicians must typically decide on further treatment steps to move from a response without remission to complete remission. Dose increases, augmenting one medication with another, and switching from one medication to another, have all been used to improve a partial response to monotherapy. This presentation will review the open, unmasked, and randomized, controlled trial evidence for the efficacy of augmenting and switching treatments to achieve remission. Whether some medication sequences result in either earlier remission or a greater likelihood of remission will be discussed.

No. 8D
WHAT IS THE ROLE OF PSYCHOTHERAPY IN ATTAINING REMISSION?

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

SUMMARY:

Psychotherapy can subserve several different aims in the treatment of depression, including use (1) as a monotherapy to obtain symptomatic response or remission, (2) in combination with medication to achieve better response or remission rates, (3) to ameliorate the psychosocial (e.g., occupational, marital, parental, and other functional impairments) sequelae of prior depressive illness, and (4) to increase adherence to recommended medication treatment(s). Over the last three decades, psychotherapy as a monotherapy in the acute-phase treatment of depression has been a major focus. These data will be reviewed to identify both the likelihood and timing of symptomatic remission. Psychotherapy combined with medication at the beginning of acute-phase treatment has been the subject of more recent studies. These studies will be reviewed to determine whether this combination does indeed improve remission rates or speeds the onset of remission. The role of psychotherapy in reducing relapses/recurrences will be reviewed. Whether psychotherapy to ameliorate psychosocial difficulties results in more remissions or a better prognosis will be discussed. Finally, the role of psychoeducation to improve medication adherence will be discussed.

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4. Keller MB, McCullough JP, Klein DN, et al: A comparison of nefazodone, the cognitive-behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. N Eng J Med 2000; 342:1462–1470

INDUSTRY-SUPPORTED SYMPOSIUM 9—CRITICAL DECISIONS IN THE LIFETIME TREATMENT OF SCHIZOPHRENIA
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

The participant should understand the early stages of the schizophrenic illness and the potential for neuroprotective treatment, the recurrent nature of schizophrenia illness, studies of the treatment of the chronic and treatment resistant patient to illustrate the late stages of the illness, the cognitive dimension of schizophrenic illness and its relation to functional outcome, and apply the newest results of controlled studies of adolescent onset psychomia.

No. 9A
FIRST EPISODE: ESTABLISHING NEUROPROTECTION

Diana O. Perkins, M.D., *CB 7160, Neurosciences Hospital, Chapel Hill, NC 27599*

SUMMARY:

In the earliest phases of illness, the psychotic symptoms of schizophrenia typically remit with antipsychotic treatment. Most patients (80% to 85%) will subsequently have a re-occurrence of psychotic symptoms, and with repeated relapses treatment-resistant symptoms often emerge. Evidence from epidemiological studies suggests that longer duration of psychosis and repeated psychotic episodes may negatively influence illness course and prognosis. In addition, emerging evidence from recent neuroimaging studies suggests that clinical progression may be associated with neuroanatomical progression, including ventricular enlargement and decrease in gray matter volumes. These findings lend support to the hypothesis that clinical progression schizophrenia may be the result of a neuroprogressive or neurotoxic process, and that antipsychotic treatment may interrupt this process. In this presentation, studies relevant to the neuroprogressive hypothesis of schizophrenia will be critically reviewed. New results from an ongoing first-episode study that address the question of neuroprogression in schizophrenia will be highlighted.

No. 9B
CONSEQUENCES AND THE COST OF RELAPSE

Gerald A. Maguire, M.D., *101 The City Drive, Route 88, Irvine, CA 92868*

SUMMARY:

Schizophrenia requires aggressive treatment throughout the life cycle. The clinician should provide the optimization of treatment to reduce the episode relapses within the illness. Preliminary data suggest that recurrences may deleteriously impact the course of the illness, leading to treatment resistance or reduced level of response. Second- and third-generation relapse prevention studies indicate that novel antipsychotic medications have demonstrated increased efficacy compared with conventional agents in reducing relapse. Hypothesis will be discussed to suggest the manner in which relapse prevention may lead to a more favorable clinical response.

No. 9C
NEUROPLASTICITY AND THE DEVELOPMENT OF TREATMENT RESISTANCE IN PATIENTS WITH SCHIZOPHRENIA: STRATEGIES FOR PREVENTION

Jeffrey A. Lieberman, M.D., *Room 7025, Neurosciences Hospital, CB716, Chapel Hill, NC 27599*

SUMMARY:

It is widely believed that ultimately, 30% to 60% of patients with schizophrenia are unresponsive or only partially responsive to treatment with standard antipsychotic medication. A small proportion (10% to 15%) are refractory in the first episode of illness while others (20% to 50%) become resistant in the course of their illness over repeated psychotic episodes. The pathophysiological process and clinical factors that contribute to the development of treatment resistance are not well defined. Moreover, neurodevelopmental models of the pathogenesis of schizophrenia do not adequately explain this aspect of the illness.

Recent pathophysiological hypotheses have been proposed that describe neurobiological processes that can lead to progression of illness and diminished treatment response. These hypotheses involve dysfunction of specific elements of DA and glutamate natural systems which produce neuroplasmic changes and, if progressive, can lead to potentially inversible neurobiologic effects.

Antipsychotic drugs have the potential to ameliorate neurobiologic consequences. The potent affinities of aypical antipsychotic drugs for 5-HT, NE and other non D-2 DA neuroreception and their ability to antagonize NMDA antagonist mediated cellular and behavioral effects has suggested the possible role of these agents preventing disease progression and restoring functionally to neural systems damaged by the effects of chronic diseases.

This presentation will describe data indicating that treatment resistance may evolve over the course of schizophrenia, in the context of patients' source of illness and maturational development and the effects of pharmacologic treatment at early and late ranges of the illness.

No. 9D
CRITICAL DECISIONS IN THE TREATMENT OF ADOLESCENT AND PEDIATRIC PSYCHOSIS

Linmarie Sikich, M.D., *CB 7160, Chapel Hill, NC 27599-7160*

SUMMARY:

This presentation will examine the use of antipsychotic medications in adolescents and children presenting with both overt and subtle psychotic symptoms. Results from an ongoing, double-blind trial comparing risperidone, olanzapine, and haloperidol in 8 to 19 year olds with active psychotic symptoms will be presented. Treatment duration in the double-blind trial may be as long as five months. Open follow-up information regarding long-term side effects and relapse is available for an additional 12 months. Findings from a systematic review of 40 psychotic youth treated openly with a variety of antipsychotics in the UNC Developmental Neuropharmacology Clinic will also be reported. Many of these were treated with multiple agents, allowing comparisons. These studies indicate that children and adolescents are often more likely to experience adverse effects when treated with antipsychotic medications, particularly the atypical agents as compared with adults. Youth appear especially sensitive to extrapyramidal symptoms and weight gain. Differences in the side effect profile observed with various agents will be discussed. In addition, the long-term tolerability and incidence of relapse in youth who initially respond to antipsychotics will be examined. Potential approaches to examining treatment adherence will be discussed.

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1. Liebermann JA: Is schizophrenia a neurodegenerative disorder? A clinical and neurobiological perspective. Biological Psychiatry 1999; 46(6):729–39
2. Keefe RSE. The Assessment of neurocognitive treatment responses and its relation to negative symptoms in schizophrenia. In: The Assessment of Negative Symptom and Cognitive Deficit Treatment Response, Keefe RSE & McEvoy JP, eds. American Psychiatric Press (Autumn, 2000)

No. 9E
COGNITION ACROSS THE LIFETIME

Richard S.E. 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 test of attention, sensory, factor functions, and executive functions are more strongly correlated with outcome than in any other aspect of the illness. This impairment is not limited to patients with chronic schizophrenia. Patients in the first episode of psychotic illness also demonstrate severe impairments. The importance of neurocognitive function in the early stages of illness 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, quetiapine, and olanzapine enhance neurocognitive functions in patients with chronic schizophrenia. Very recent data from a multi-site study of over 250 patients suggest that the neutrocognitive enhancement found with olanzapine in first-episode patients may exceed that found with low-dose haloperidol. Specifically, olanzapine has a superior enhancing effect on measures of attention and motor function. Since neurocognitive function is strongly associated with social and occupational functioning, treatment-related improvement in neurocognitive function will likely be associated with improvements in these important aspects of the quality of everyday life.

INDUSTRY-SUPPORTED SYMPOSIUM 10—TO WORK AND TO LOVE: FOCUS ON QUALITY OF LIFE IN MOOD AND ANXIETY DISORDERS
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the impact of psychiatric disorders on the quality of life of patients affected with mood and anxiety disorders, and understand the potential changes associated with treatment.

No. 10A
MEASURES OF QUALITY OF LIFE

Jean Endicott, Ph.D., *1051 Riverside Drive, Unit 123, New York, NY 10032*

SUMMARY:

Quality of life has increasingly been recognized as an important aspect of clinical status and outcome that should be considered in clinical trials. In 1975, "quality of life" was added as a key term in medical indexes and 705 articles on clinical trials were listed in Pub Med for the period from January 1999 to May 2000. Quality of life has been noted to be as important to many as is the absence of physical or mental pain, has been found to be correlated with severity of illness but not as highly as one might expect, can be

differentially changed by treatments, is likely to be related to staying in treatment, and may be related to the risk for relapse.

There have been many efforts to define and measure the construct and although many different procedures have been used to assess quality of life, the measures available often differ greatly in their coverage and sensitivity to change over time. Measures may be global or multidimensional, may or may not include items on symptoms or impaired functioning, may or may not have sections on housing, neighborhoods, or income, may or may not focus upon the "good life" or enjoyment and satisfaction with aspects of life, and may or may not be disease specific or generic. Because no single measure has been found to be clearly superior to all others, the choice among them should be determined by the clinical issue or research question under consideration. Furthermore, when reading articles descriptive of patient status or outcomes in terms of quality of life, attention should be paid to the coverage and nature of the measures used.

No. 10B
IMPROVING QUALITY OF LIFE FOR PATIENTS WITH BIPOLAR DISORDERS

Holly A. Swartz, M.D., *Western Psychiatric Institute and Clinic, 3811 O'Hare Street, Pittsburgh, PA 15213*

SUMMARY:

For almost three decades since the introduction of lithium, manic-depressive illness has been thought of as our "good prognosis" disorder. The data, however, fail to support this concept. In both naturalistic studies and controlled treatment trials, the long-term prognosis for most individuals with bipolar disorder is quite poor. Most subjects in these studies do not experience well intervals that exceed two years. In addition, while efforts to develop new treatments have generally targeted manic episodes, it is the depressive episodes that grind on for months at a time for which we have no truly efficacious treatments (Hlastala et al., 1997). Finally, many patients with bipolar disorder suffer almost constantly with subsyndromal depressive symptoms that seriously compromise quality of life. We have developed a bipolar disorder-specific psychotherapy which, when combined with pharmacotherapy, leads to marked improvements in such low-grade depressive symptoms and quality of life. This presentation will focus on how interpersonal and social rhythm therapy (IPSRT-Frank et al., 1994) targets these symptoms and leads to greater life satisfaction in this patient population.

No. 10C
QUALITY OF LIFE IN THE ANXIETY DISORDERS

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

SUMMARY:

Emerging data from epidemiologic and clinical samples have documented the significant suffering and impairment in quality of life associated with the anxiety disorders including panic disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and obsessive-compulsive disorder. The associated distress and disability is manifested in a variety of spheres of psychosocial and physical functioning including diminished vocational and educational attainment, impaired social and marital relationships, role limitations due to diminished physical function, over-utilization of medical resources, and decreased overall life satisfaction. Impairment in quality of life is associated with subsyndromal conditions, as well as disorders meeting full diagnostic criteria.

An increasing number of studies have documented the positive impact of effective pharmacologic and psychosocial interventions on quality of life. In addition, changes in quality of life may be a particularly sensitive discriminator of response to active treatment compared with placebo response. In this symposium, we will examine the impairment in quality of life experienced by individuals with anxiety disorders, review changes seen with treatment, and discuss ways that evaluation of quality of life can be integrated into clinical practice.

No. 10D
THE IMPACT OF DEPRESSION AND ITS TREATMENT

Mark H. Rapaport, M.D., *8950 Villa La Jolla Dr, #2243, La Jolla, CA 92037*; Cathryn M. Clary, M.D.; Lewis L. Judd, M.D.

SUMMARY:

Our conceptualization of depression—its diagnosis, impact on quality of life, and long-term prognosis—has changed drastically during this decade. These changes reflect political and economic pressures, but more importantly, a greater understanding of the dimensionality of depression, its social and individual "costs," and the impact of treatment on all aspects of depression. This presentation reviews the epidemiological evidence demonstrating the profound personal and societal costs, decreased productivity, and diminished quality of life associated with depression. Then we will present recent clinical studies describing the disability associated with depressive disorders. Finally, we will present data showing that effective pharmacological and nonpharmacological treatment of depression is associated with improvement in quality of life. We will discuss factors that influence the degree of improvement observed with the treatment of depression. By the end of this presentation the audience will appreciate (1) impairment and costs associated with depression, (2) distinctions between epidemiological and clinical data assessing costs and quality of life in depression, and (3) how treatment interventions can improve quality of life.

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INDUSTRY-SUPPORTED SYMPOSIUM 11—MEETING THE CHALLENGE OF SCHIZOPHRENIA AND CO-OCCURRING ADDICTIONS
Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the obstacles and options for effective treatment of patients with schizophrenia and co-occurring addictions; recognize the role of a new generation of antipsychotic medications for these conditions, and learn how they can be combined with non medication strategies.

No. 11A
SCHIZOPHRENIA AND CO-OCCURRING DISORDERS: THE SCOPE OF THE PROBLEM AND IMPACT ON OUTCOMES

Lisa B. Dixon, M.D., *701 West Pratt Street, Room 476, Baltimore, MD 21201*

SUMMARY:

Comorbid substance abuse disorders have emerged as one of the greatest obstacles to the effective treatment of persons suffering from schizophrenia. Estimates of the prevalence of such comorbidity vary, but as many as half of persons with schizophrenia may suffer from a comorbid drug or alcohol disorder. Youth, being male, and lower educational attainment are associated with greater risk for addiction. Persons with schizophrenia and comorbid addiction tend to have earlier onset of schizophrenia than those without comorbid addiction. Drug choice tends to be correlated with the pattern of ambient drug use in the community. Comorbid substance disorders are associated with a variety of poorer outcomes including increased psychotic symptoms, poorer treatment compliance, violence, family burden, housing instability and homelessness, medical problems and HIV, poor money management, and greater use of crisis-oriented services, and higher costs of care. Data from the Schizophrenia Patient Outcomes Research Team (PORT) will be presented on comorbid diagnosis and a variety of outcomes including conformance to schizophrenia treatment recommendations. A critical obstacle to treatment includes the separation of the substance abuse and mental health treatment systems. This separation has handicapped our ability to develop efficacious treatments for dual diagnosis patients and to implement efficacious treatments that have been developed.

No. 11B
THE NEUROBIOLOGY OF ADDICTION AND SCHIZOPHRENIA IN RELATION TO THE ACTION OF ANTIPSYCHOTIC DRUGS

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

SUMMARY:

Abnormalities of the dopaminergic, serotonergic, and adrenergic systems are believed to be important in the pathophysiology of both addictions and schizophrenia. For example, psychosis is believed to be related to increased dopaminergic activity in the mesolimbic system, whereas abused drugs also increase dopamine in this region. It is noteworthy that increased mesolimbic dopamine is experienced as a reward by nonpsychotic as well as psychotic individuals. Dopamine D1 and D2 receptor stimulation and blockade have been shown to have important effects in relation to addiction and psychosis. Serotonin has an important influence on mood, impulsivity, and craving, which contributes to addictive behavior. The atypical antipsychotic drugs have complex effects on these three pathways, which lead to their antipsychotic effect, mood stabilizing effect, and, in some instances, to diminished craving. All of these drugs increase dopamine and norepinephrine release in the prefrontal cortex with leaser effects in the mesolimbic system. The evidence that amperozide, a serotonin-based antipsychotic related to the atypical antipsychotic drugs, is able to greatly diminish craving for alcohol and cocaine in animals and possible mechanisms will be discussed.

No. 11C
PHARMACOTHERAPY OF COMORBID SUBSTANCE USE DISORDERS

Alan I. Green, M.D., *74 Fenwood Road, Boston, MA 02115-6106*

SUMMARY:

Comorbid substance use disorder occurs commonly in patients with schizophrenia and is associated with poor outcome. The most commonly abused substances in this population include alcohol, cannabis, and cocaine. Typical antipsychotic medications, while useful for the treatment of positive symptoms of psychosis, are not usually helpful in limiting substance use in this population and may themselves contribute to the use of substances in these patients. This talk will review new preliminary data suggesting that the novel antipsychotic clozapine is efficacious in patients with schizophrenia and comorbid substance use disorder, and may also specifically limit substance abuse (alcohol, cannabis, and cocaine) in such patients. A neurobiologic formulation to help understand the role of clozapine in this population will be presented. In addition, the potential role of other novel antipsychotics (including the novel experimental agents) will also be discussed. Lastly, the clinical relevance of these data for the treatment of patients with schizophrenia, those with chronic disorders, as well as those in the early phase of illness, will be reviewed.

No. 11D
INTEGRATING PHARMACOTHERAPY AND DUAL RECOVERY THERAPY

Douglas M. Ziedonis, M.D., *675 Hoes Lane, Room D349, Piscataway, NJ 08854*

SUMMARY:

Clinical experience and research studies suggest that integrating and blending mental health and substance abuse treatment improves outcomes for individuals with co-occurring schizophrenia and substance abuse. The presentation will focus on how to integrate pharmacotherapy and dual recovery therapy in providing comprehensive outpatient treatment. The presentation will review pharmacotherapy issues and how currently available atypical antipsychotic agents are working for this population. Using the stages of change model, this presentation will briefly focus on the importance of assessing the patient's motivational level to stop using each specific substance and to continue medication treatment for the schizophrenia. Results from a sample of 600 dually diagnosed patients at a community mental health center will be presented, and the implications for a motivation-based dual diagnosis treatment model. Improving and maintaining motivation to change is important throughout the recovery process. The presentation will outline the treatment matching techniques from our NIDA-funded study of dual recovery therapy. Dual recovery therapy blends social skills training, relapse prevention, motivational enhancement therapy, and recovery concepts from 12-Step.

No. 11E
BEST SYSTEMS AND PRACTICES FOR DUAL DIAGNOSIS

Robert E. Drake, M.D., *2 Whipple Place, Suite 202, Lebanon, NH 03766*; Kim T. Mueser, Ph.D.

SUMMARY:

Recent research elucidates many aspects of the problem of co-occurring substance use disorder (SUD) in patients with severe mental illness, which is often termed dual diagnosis. This presentation provides a brief overview of current research on the epidemiology, adverse consequences, and phenomenology of dual diagnosis, followed by a more extensive review of current approaches to services, assessment, and treatment. Accumulating evidence shows that comorbid SUD is quite common among individuals with severe mental illness and that these individuals suffer serious adverse consequences of SUD. The research further suggests that traditional, separate services for individuals with dual disorders are ineffective, and that integrated treatment programs, which combine mental health and

substance abuse interventions, offer more promise. In addition to a comprehensive integration of services, successful programs include assessment, assertive case management, motivational interventions for patients who do not recognize the need for substance abuse treatment, behavioral interventions for those who are trying to attain or maintain abstinence, family interventions, housing, rehabilitation, and psychopharmacology. Further research is needed on the organization and financing of dual-diagnosis services, and on specific components of the integrated treatment model, such as group treatments, family interventions, and housing approaches.

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5. Drake RE, Mueser KT: Psychosocial approaches to dual diagnosis. Schizophrenia Bulletin 2000; 26:105–118

INDUSTRY-SUPPORTED SYMPOSIUM 12—MEN OVER 50: AN ENDANGERED SPECIES

Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have knowledge of the most important condition that contributes to morbidity and mortality in men over 50 and the importance of depression as a comorbid illness.

No. 12A
DEPRESSION AND SUICIDE IN MEN OVER 50

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

SUMMARY:

Many studies have documented that depression is two to three times more prevalent in women than in men. However, past the age of 50 that difference markedly decreases and if one considers only cases of late-onset depression, i.e., first episode past age 50, sex prevalence is equal. This appears to be true not only for major depressive disorder but for dysthymia as well. The relative increase in male depression may be due in part to the prevalence of disorders in men after age 50 that are associated with affective disorder, including cardiovascular and cerebrovascular disease, erectile failure, cognitive impairment, and hypogonadism.

Perhaps the most critical consequence of the increased prevalence of depression in older men is the virtual epidemic of suicide in men over 60. Suicide rates in men are generally twice that of women from adolescence through middle age. However, past the age of 60, the suicide rate in men, specifically Caucasian males, increases dramatically, whereas the rate for women does not change with age. Suicide in younger adults has been linked to dysfunction in the serotonin system, particularly decreased serotonin activity. However, the increased rate of suicide in older men may be associated with a different pathophysiology, notably ischemic disease, which is more prevalent in men, and is also associated with late-onset affective disorder.

No. 12B
VASCULAR DISEASE AND DEPRESSION

K. Ranga R. Krishnan, M.D., *Box 3950, Durham, NC 27710*

SUMMARY:

Men have high rates of vascular disease, which often begins at a younger age than in women. A new paradigm of late-life depression known as "vascular depression" has now been recognized. The concept of vascular depression as a depressive subtype rests on the well established association between cerebrovascular disease and depressive symptoms. Our studies have focused largely on structural changes (lesions that appear to be vascular in nature) seen on brain magnetic resonance imaging scans. Older patients with late-onset depression tend to have a greater burden of these vascular lesions in periventricular and deep white matter areas and in subcortical gray matter nuclei. New and exciting data on the localization of lesions to the medial orbital frontal cortex will also be presented. The current focus of research in individuals with such structural changes is their longitudinal course and outcome. Studies in the past five years have provided substantial support that vascular depression is a distinctive subtype of late life depression. The scientific importance of this paradigm is obvious: if vascular lesions of the brains of old people lead to secondary depressions with clinical characteristics similar to primary depressions, then those lesions may provide important clues to the brain sites involved in depression in general. A similar research strategy proved useful in schizophrenia, once the significance of the psychoses associated with temporal lobe disease was appreciated. The clinical importance of such a new subtype of late-life depression also is obvious: prevention of those late-onset depressions may most powerfully be exerted through control of cerebrovascular risk factors. In men in particular this may be a factor that is important to keep in mind. Also, with the increasing knowledge that depression may contribute to later development of vascular disease, long-term management of depression, even when the person is young, may be critical. That is an admittedly novel concept for a major psychiatric disorder, but it is a logical direction in which the available data may lead us.

No. 12C
TESTOSTERONE DECLINE IN AGING MEN: DOES ANDROPAUSE EXIST?

Stuart N. Seidman, M.D., *1051 Riverside Drive, Unit 98, New York, NY 10032*

SUMMARY:

There is a progressive decline in hypothalamic-pituitary-gonadal (HPG) function in aging men: testosterone (T) levels decline through both central (pituitary) and peripheral (testicular) mechanisms and there is a loss of circadian rhythm of T. By age 75, mean plasma T levels have decreased 35% compared with young adults, and more than 25% of men over age 75 are clinically hypogonadal. Age-related hypogonadism, which has been termed "andropause," is thought to be responsible for a variety of symptoms experienced by older men, such as weakness, fatigue, reduced muscle and bone mass, impaired hematopoiesis, oligospermia, sexual dysfunction, depression, anxiety, irritability, insomnia, and memory impairment. There is good evidence that the age-associated decrease in T levels may contribute to these symptoms and studies of T replacement have documented symptom relief, particularly with respect to muscle strength, bone mineral density, and hematopoiesis. Data are presented on two new studies bearing on this relationship: (1) a placebo-controlled clinical

trial of T replacement in hypogonadal men with major depressive disorder (MDD); and (2) an evaluation of T levels in older men with MDD, dysthymia, and no depressive illness. Results suggest that age-related HPG hypofunction may have particular etiologic importance in late-onset male dysthymia.

No. 12D
AGE, SEXUAL DYSFUNCTION, AND DEPRESSION

Raymond C. Rosen, Ph.D., *675 Hoes Lane, Piscataway, NJ 08854*

SUMMARY:

The prevalence of sexual dysfunction increases with age. Hypoactive sexual desire disorder occurs in approximately 16% of men between age 18 and 59, but increases significantly above the age of 60. Erectile dysfunction, defined as the inability to obtain and maintain an erection sufficient for satisfactory intercourse or other sexual expression, is a para-aging phenomenon. In the Massachusetts male-aging study, the prevalence of mild erectile dysfunction remained constant (17%) between the ages of 40 and 70; however there was a doubling in the number of men reporting moderate ED (17% to 34%) and a tripling of complete ED (5% to 15%). It is estimated that between 18 to 30 million American men suffer from ED, with most cases of severe illness concentrated in the group of men over the age of 60.

Not only does erectile dysfunction increase with age but it is also strongly associated with depressive illness. A secondary analysis of the MMAS data showed that all men with a CSED score of greater than 16 (which is correlated with diagnosis of major depressive disorder) had some degree of erectile dysfunction and 44% had complete erectile failure. Erectile dysfunction is also more common in men with vascular disease, which is itself associated with depressive illness. Perhaps most intriguing are the results of a study that treated men with erectile dysfunction and comorbid depressive illness, which showed that successful treatment of erectile dysfunction was accompanied by resolution of the depressive symptoms.

The diagnosis of erectile dysfunction in older men is crucial. If undiagnosed and untreated, erectile dysfunction negatively impacts quality of life. However, new treatments for ED have proven very effective, well tolerated, and relatively safe.

No. 12E
DEPRESSION AND DEMENTIA IN OLDER MEN

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

SUMMARY:

Biological, psychological, and social influences complicate effective diagnosis and treatment of depression and dementia in older men. Testosterone modulates both mood and cognition, and at around age 50, men begin to secrete progressively lower amounts of testosterone. Approximately 20% of men over age 60 have below-normal levels, and this gradual decline in endogenous testosterone may lead to depression, nervousness, fatigue, poor concentration and memory, decreased libido, and erectile dysfunction. Such symptoms, along with other age-related illnesses such as hypertension, stroke, and heart disease, may lead to disability and marital discord, and men unaccustomed to dependent roles may have particular difficulty adjusting. Negative self-perceptions from diminishing virility and masculinity may further contribute to depressive symptoms. An older man's poor relationship with his wife and feelings about low appreciation of older persons are additional predictors of late-life depression, which itself is a risk factor for future cognitive decline. As an older man's dementia progresses, sexual and physical aggressiveness can become particularly troublesome. While awaiting results of research on hormonal interventions for cognition and mood, consideration of these multiple influences and complicated interactions will help clinicians individualize psychotherapeutic and pharmacological management of older men with depression and dementia.

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INDUSTRY-SUPPORTED SYMPOSIUM 13—ISSUES IN THE LONG-TERM TREATMENT OF DEPRESSION
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify factors complicating maintenance treatment of major depressive disorder, and address clinically significant issues in the long-term treatment of depression.

No. 13A
WEIGHT CHANGES DURING LONG-TERM ANTIDEPRESSANT TREATMENT

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

SUMMARY:

Weight gain that continues despite achieving remission of depressive symptoms can be either a residual symptom of depression or a side effect of the antidepressant. Weight gain is in fact a relatively common problem during long-term treatment with antidepressants, and it is an important contributing factor to noncompliance. In addition, a risk of significant weight gain may frequently affect the degree of acceptability of a given pharmacological treatment. Many patients are reluctant to be treated with an antidepressant that may affect their weight. Therefore, clinicians need to consider this issue when presenting patients with the relative risks and benefits of the proposed therapeutic options. Unfortunately, there are very few studies in the literature that have specifically examined this issue, making it quite difficult to estimate the relative risk for weight gain across antidepressants. Tricyclic antidepressants (TCAs) appear to be more likely to cause weight gain during long-term treatment than the selective serotonin reuptake inhibitors (SSRIs) or the newer antidepressants, with the exception of mirtazapine, which may be placed between the SSRIs and the TCAs in terms of relative risk for weight gain. The SSRIs, which are typically weight neutral in the short term, are associated in some cases with weight gain in the long term. In particular, paroxetine may be more likely to cause weight gain than the other SSRIs during long-term treatment, and bupropion and

nefazodone may be less likely to cause weight gain than some of the SSRIs in the long term, although more studies are necessary to confirm these impressions.

No. 13B
ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION

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

SUMMARY:

Sexual activity is a complex behavior requiring adequate levels of sex steroids, appropriate neurotransmitter function, and psychosocial factors. Individuals with major depressive disorder (MDD) may have multiple factors contributing to sexual dysfunction including preexisting primary sexual disorders, illness effects, and side effects of antidepressant medications. Assessment of sexual functioning must be gender- and phase-specific, and performed at initial assessment to determine premorbid psychosexual adjustment and illness effects, and throughout treatment to document medication effects.

Approximately 70% to 80% of patients with MDD experience sexual dysfunction related to the depressive illness, with effects in all phases of the sexual response cycle. Tricyclic antidepressants, monoamine oxidase inhibitors, and serotonin reuptake inhibitors adversely affect sexual functioning via several possible mechanisms. Strategies to manage antidepressant-induced sexual dysfunction include waiting for tolerance to develop (5% to 10% of those affected), dosage adjustment, prescribing drug holidays, switching to an antidepressant with minimal effects on sexual functioning (bupropion, mirtazepine, and nefazodone), or adding an antidote/adjunctive agent for sexual dysfunction. Minimizing potential negative effects on sexual functioning in patients with major depression may enhance medication compliance and long-term outcomes.

No. 13C
THE ROLE OF PSYCHOTHERAPY IN THE LONG-TERM TREATMENT OF DEPRESSION

Gabor I. Keitner, M.D., *593 Eddy Street, Providence, RI 02903*

SUMMARY:

It is now recognized that major depression is a recurrent disorder. With this recognition has come increasing emphasis on developing and testing treatments that not only lead to remission of the depression but also prevent relapse and recurrence. Maintenance pharmacotherapy has been shown to be effective in sustaining symptomatic improvement over many years. A series of studies over the past decade have also shown that various forms of psychotherapy (cognitive behavioral therapy, interpersonal therapy, well-being therapy, mindfulness-based cognitive therapy) are also useful in maintaining remission, as well as preventing relapse and recurrence, either alone or in combination with pharmacotherapy. Data from these studies will be presented. Common ingredients from these psychotherapies will be highlighted in order to help therapists build a more specific framework for the long-term management of patients with depression.

No. 13D
IDENTIFICATION OF DEPRESSIVE RELAPSE

P. Murali Doraiswamy, M.D., *Room 3547, South Hospital, Box 3018, Durham, NC 27710*

SUMMARY:

Major depression is increasingly recognized as a chronic illness and the majority of patients will require some form of long-term antidepressant therapy. The goals of continuation treatment are to reduce the risk of relapse and recurrence and to maximize quality of life. Despite treatment as many as half of all depressive patients may have a relapse. Criteria for relapse have been defined in the DSM-IV as well as in several authoritative expert opinions. In practice, clinicians have to often differentiate relapse from treatment-emergent side effects from subthreshold symptomatic worsening of individual symptoms such as sleep or anxiety. There are now placebo-controlled trials of all of the newer antidepressants showing efficacy in reducing relapse rates. However, these trials have for the most part used differing entry criteria, varying lengths of treatment, and different endpoint criteria. In general, predictors of relapse can include a variety of factors such as inadequate therapy, suboptimal acute response, lower compliance due to undesirable side effects, comorbid psychiatric or medical illness, and psychosocial factors. This presentation will review these data in relation to the changing paradigms that will be used to evaluate the long-term effectiveness of antidepressant therapy in psychiatric practice.

No. 13E
MANAGEMENT OF DEPRESSIVE BREAKTHROUGH DURING LONG-TERM TREATMENT

Jonathan E. Alpert, M.D., *WAC-812, 15 Parkman Street, Boston, MA 02114*

SUMMARY:

The reappearance of depression despite ongoing treatment is a common clinical challenge in the long-term management of major depression. Relapses are conceptualized as reemergence of the depressive syndrome during continuation treatment while recurrences are defined as development of a new depressive episode during more extended maintenance treatment. Periodic subsyndromal depressions (sometimes referred to as roughenings) also appear to be prevalent. Depressive breakthrough refers to the problem of relapse, recurrence, or roughening during active treatment. Although abundant evidence supports the superiority of antidepressants over placebo in the prevention of relapses and recurrences, controlled studies show that as many as 10% to 30% of patients will experience reappearance of depression during continuation and maintenance treatment. Observational studies suggest that, in less controlled treatment settings, as many as 40% to 80% of patients experience depressive breakthrough during the first five years following remission. The causes of depressive breakthrough are unknown, but may include true loss of antidepressant efficacy (tolerance or "poop out"), pharmacokinetic alterations, waning of placebo-pattern responses, noncompliance, development of comorbid illness, or changes in the underlying depressive illness. This presentation focuses upon the small and gradually expanding literature addressing the evaluation and optimal management of depressive breakthrough.

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INDUSTRY-SUPPORTED SYMPOSIUM 14—ALCOHOLISM AND BIPOLAR DISORDER: TREATMENT OPTIONS CIRCA 2000
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be able to further appreciate the assessment and treatment of primary alcoholism and alcohol withdrawal, and further appreciate the impact alcohol has on suicidality, long-term course of bipolar illness, and mood stabilization response.

No. 14A
NEW PHARMACOTHERAPIES FOR ALCOHOL DEPENDENCE

Barbara J. Mason, Ph.D., *1400 NW 10th Avenue, Suite 307A(D-79), Miami, FL 33136*

SUMMARY:

The first months following cessation of drinking are a period of risk for relapse. Pharmacological interventions may be particularly relevant during this early interval to reduce relapse to heavy drinking and to support abstinence. However, pharmacological treatment options for alcohol dependence have been limited. Aversive therapy with disulfiram was the only pharmacological treatment for alcohol dependence available in the United States until recently, despite high rates of adverse drug reactions, drinking relapse, and medication noncompliance. This presentation will review clinical studies of three newer medications with demonstrated efficacy for alcohol dependence in double-blind, placebo-controlled trials: acamprosate, naltrexone, and nalmefene. Acamprosate is available internationally and is being studied in the United States as a nonaversive pharmacotherapy to maintain abstinence in recently detoxified alcoholics. Naltrexone an opioid antagonist, was approved by the FDA in 1994 as a nonaversive prescription drug for alcohol dependence on the basis of two small, placebo-controlled trials (N=186) and a large, open-label safety study (N=570). The results of recent naltrexone studies are more modest but reinforce earlier reports regarding reduced risk of relapse to heavy drinking among subjects who are highly compliant with treatment. Nalmefene is a newer opioid antagonist under investigation that is structurally similar to naltrexone but with a number of potential pharmacological and clinical advantages for the treatment of alcohol dependence. Available data will also be reviewed regarding the safety and efficacy of these medications in combination.

No. 14B
ANTIEPILEPTIC DRUGS IN ALCOHOL WITHDRAWAL AND RELAPSE

Hugh Myrick, M.D., *IOP 4 North, 67 President Street, P.O. 250861, Charleston, SC 29425*

SUMMARY:

This presentation will focus on the role of antiepileptic drugs in the treatment of alcohol withdrawal and relapse prevention. Mood stabilizing antiepileptic drugs may offer several advantages in the treatment of substance use disorders with and without comorbid psychiatric conditions. In the treatment of alcohol withdrawal, these advantages include a lack of abuse potential and less cognitive impairment as compared with benzodiazepines. Studies that have utilized the antiepileptic drugs carbamazepine, divalproex, and gabapentin will be discussed. While the acute phase of alcohol withdrawl is only evident for two to five days, pre-clinical and human studies of alcohol withdrawal indicate a variety of brain perturbations can be detected for weeks to months after the clinical signs of alcohol withdrawal have disappeared. It is during the protracted withdrawal phase that many subjects relapse to substance use. Characteristics of this protracted phase such as sleep disturbance, aggressivity, and impulsivity are found in both substance abuse disorders and psychiatric disorders and may respond to antiepileptic drugs. Studies investigating the use of antiepileptic drugs in the treatment of these dimensional aspects of functioning will be discussed.

No. 14C
SUICIDALITY, IMPULSIVITY, AND ALCOHOLISM

Joseph F. Goldberg, M.D., *525 East 68th Street, New York, NY 10021*

SUMMARY:

This presentation will focus on the impact of alcohol abuse/dependence relative to impulsivity and suicide risk among individuals with affective illness and other forms of major psychopathology. Suicidality arises across a spectrum of psychiatric disorders that often includes affective illness, psychosis, personality disorders, substance abuse, and impulse control disorders. The extent to which suicidal behavior reflects the severity of an underlying process (such as depression or impulsive aggression), or an outcome state (e.g., related to the demoralization of chronic illness), remains an unresolved issue. Spanning these phenomena, comorbid alcohol use disorders have been associated with poor treatment outcome, long-standing psychosocial impairment, and heightened longitudinal suicide risk. Data will be reviewed concerning suicidality and alcohol abuse/dependence in unipolar, bipolar, and schizophrenic patients, and ways in which alcoholism may heighten suicide risk via promoting mood instability, impulsivity, and self-directed aggression.

No. 14D
BIPOLAR DISORDER AND COMORBID ALCOHOLISM: COURSE OF ILLNESS AND TREATMENT

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

SUMMARY:

The comorbidity of a lifetime prevalence of an alcohol use disorder in persons with bipolar disorder is very high. Clinical studies indicate that comorbid alcoholism may adversely impact the presentation, course, and outcome of bipolar illness. In this presentation, epidemiologic and clinical data on bipolar disorder and alcoholism will be reviewed. The potential complications of comorbid alcoholism on the presentation, outcome, and treatment of bipolar disorder will be discussed.

No. 14E
ANTIEPILEPTIC DRUGS AND LITHIUM IN THE TREATMENT OF BIPOLAR ILLNESS AND ALCOHOL USE DISORDERS

Patricia Suppes, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

The ECA study reported a 60.7% lifetime prevalence rate for substance abuse in the bipolar I population, with the most common substance abused being alcohol (46.2%). Two studies have reported decreased lithium responsivity and poor outcome for mania with either a history of, or concurrent, alcohol abuse. It is unclear whether the lithium nonresponsivity is related to the actual comorbidity or to the high prevalence of dysphoric manic symptoms or rapid cycling, which by itself, can present with higher rates of lithium failure. Alternatively, several mood stabilizing antiepileptic drugs have been shown to have "anti-kindling" properties and are clinically efficacious in the treatment of both bipolar disorder and alcohol withdrawal. Clinical guidelines for these anticonvulsants will be reviewed.

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INDUSTRY-SUPPORTED SYMPOSIUM 15—TREATING PSYCHOTIC DISORDERS: WHAT IS THE STATE OF THE ART? Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the treatment options for managing the broad spectrum of psychotic symptoms; outline the pharmacological and clinical differences among conventional, atypical, and combined therapies for schizophrenia; recognize treatment options for psychotic depression; outline treatment options for bipolar disorder using anticonvulsants and atypical antipsychotics; diagnose and treat pediatric and geriatric psychosis.

No. 15A
ISSUES IN MANAGING PSYCHOSIS IN GERIATRIC PATIENTS

Dilip V. Jeste, M.D., *3350 La Jolla Village Drive, San Diego, CA 92161*; Jonathan P. Lacro, Pharm.D.; Michael Caligiuri, Ph.D.

SUMMARY:

Psychosis in elderly patients is more often secondary than primary. The former may be due to dementias such as Alzheimer disease, medications such as dopaminergic drugs used in the treatment of Parkinson disease, or anticholinergic drugs that are either prescribed or over the counter. Primary psychotic disorders include schizophrenia, delusional disorder, psychotic mood disorders, and psychoses not otherwise specified. Treatment of geriatric patients is complicated by factors such as physical comorbidity, sensory deficits, and cognitive impairment. The risk of motor side effects of neuroleptics is considerably greater in older than in younger adults. We have found a high incidence of parkinsonsism in elderly psychotic patients treated with very low doses of typical neuroleptics (average 43 mg chlorpromazine equivalent daily). Early development of parkinsonism is a risk factor for tardive dyskinesia. The risk of tardive dyskinesia is several folds higher in geriatric patients than in younger adults even after controlling for duration and dosage of conventional neuroleptics. Use of anticholinergic drugs (to treat parkinsonian symptoms) in the elderly patients is complicated by central and peripheral side effects. The newer atypical antipsychotics are safer than the typical neuroleptics in terms of motor side effects. Nonetheless, they too have their own adverse effects and other limitations. There is a need for continued research on developing more effective and safer drugs as well as nonpharmacologic therapies such as cognitive-behavioral and skills training interventions in geriatric psychosis patients. Recent data on the use of newer pharmacologic and nonpharmacologic therapies in older patients will be presented.

No. 15B
TREATMENT OF DEPRESSION WITH PSYCHOSIS

Robert N. Golden, M.D., *CB#7160/Neurosciences Hospital, Chapel Hill, NC 27599-7160*

SUMMARY:

The presence of psychotic features in a major depressive episode effects the pharmacological response pattern and should be taken into account in treatment planning. Studies examining the efficacy of antidepressants and phenothiazine neuroleptics in patients with delusional depression found that the response rate to neuroleptic alone was low (approximately 20%), and the response rate to a tricyclic antidepressant alone is lower (approximately 40%) than what is seen in nonpsychotic depression. The combination of a neuroleptic with either a tricyclic or SSRI yields response rates in psychotic depression that are comparable with those seen with antidepressant monotherapy in the treatment of nonpsychotic depression. Amoxapine, an antidepressant whose active metabolite is a potent dopamine receptor antagonist, is approximately as effective as the combination of an antidepressant plus antipsychotic in the treatment of psychotic depression, but as with any "fixed combination" treatment, there is no flexibility in adjusting the antipsychotic component independently of the antidepressant. Recent reports from Italy describe clinical efficacy of SSRI monotherapy in the treatment of delusional depression, but to date these finding have not been replicated in this country. New data suggest antidepressant activity for atypical antipsychotic medication, which could offer the advantages of monotherapy for psychotic depression without the risk of the extrapyramidal side effects associated with typical antipsychotics. Electroconvulsive therapy remains a well established treatment for psychotic depression.

No. 15C
EMERGING TREATMENTS IN ACUTE MANIA AND BIPOLAR DISORDERS

Terence A. Ketter, M.D., *401 Quarry Road, Room 2124, Stanford, CA 94305-5723*; Po W. Wang, M.D.

SUMMARY:

Therapy of bipolar disorders is a rapidly evolving field. A series of new anticonvulsants have been recently marketed. Gabapentin is generally well tolerated, and may have anxiolytic, analgesic, and hypnotic effects. Lamotrigine is also generally well tolerated (aside from rash in 1/10 and serious rash in 1/000 patients), and may have utility in bipolar disorder patients with depression and rapid cycling.

Topiramate can yield sedation and weight loss. Oxcarbazepine may have a psychotropic profile similar to carbamazepine. The roles of tiagabine, levetiracteam, and zonisamide in bipolar disorders remain to be established. Newer (atypical) antipsychotics block receptors associated with psychosis (dopamine) as well as mood (serotonin), have utility in the treatment of negative symptoms of schizophrenia (which resemble depression), and have fewer neurological adverse effects than older agents. Clozapine may have mood stabilizing properties. Emerging evidence suggests that risperidone may have either mood stabilizing or antidepressant properties. Olanzapine has been approved for the treatment of mania, and may provide benefit in depression and nonpsychotic mixed states. Additional agents such as quetiapine and ziprasidone are currently being examined in bipolar disorders. Clinical studies of these new anticonvulsants and antipsychotics promise to offer important new options in the treatment of bipolar disorders.

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No. 15D
TREATING THE SPECTRUM OF SYMPTOMS IN SCHIZOPHRENIA

Jeffrey A. Lieberman, M.D., *Room 7025, Neurosciences Hospital, CB716, Chapel Hill, NC 27599*

SUMMARY:

The presentation of schizophrenia is diverse and complex, with symptoms ranging from severe depression to paranoid delusions. Thus, successful treatment of schizophrenia requires the management of a broad spectrum of symptoms, including positive and negative symptoms and cognitive deficits. Conventional antipsychotics provide long-term relief of acute psychosis, which consists primarily of positive symptoms. Clinical management of the negative symptoms such as depression and alogia required adjunctive therapy. This combination was not optimal for long-term treatment due to the neurological adverse events associated with conventional neuroleptic use. The introduction of atypical antipsychotics offered new options in treating the spectrum of symptoms among schizophrenic patients. This newer class of drugs offer effective reductions in both positive and negative symptoms with fewer extrapyramidal side effects. This program will discuss the broad range of symptoms presented in schizophrenia and the comparative effects of conventional and atypical drugs, as well as combined and adjunctive therapies.

No. 15E
TREATMENT OF PEDIATRIC PSYCHOSIS

Judith H.L. Rapoport, M.D., *9000 Rockville Pike, Building 103N202, Bethesda, MD 20892-1600*

SUMMARY:

Childhood onset psychoses tend to be more severe, more chronic, and more treatment resistant compared with later onset forms of the disorder. Clinicians unfamiliar with childhood disorders often are confused by the surprising frequency of circumscribed hallucinations or delusions seen in pediatric populations. Diagnostically, many children and adolescents currently being treated as schizophrenic probably suffer from psychotic mood disorders: a drug-free observation period is often needed to make this distinction.

Drug treatment of the pediatric psychoses needs to take into account the likelihood of comorbid developmental and behavioral disorders. In addition, young patients may be more susceptible to adverse effects of atypical antipyschotics such as weight gain, drowsiness, and extrapyramidal symptoms.

This presentation will update practicing clinicians about diagnosis, indications, and treatment guidelines for psychotic pediatric populations.

INDUSTRY-SUPPORTED SYMPOSIUM 16—PROVIDING COMPLETE TREATMENT FOR PATIENTS WITH BIPOLAR DISORDER

Supported by the National Depressive and Manic-Depressive Association and Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the challenges of identifying bipolar and nonbipolar disease, discuss the experience related to functional outcomes for the bipolar patient, apply understanding of the effects of acute mania and strategies for maintenance in their practice, and discuss gender characterization of bipolar illness and the associated reproductive issues.

No. 16A
MANIC AND MIXED EPISODES: THE CHALLENGE OF IMPROVING FUNCTIONAL OUTCOME

Paul E. Keck, Jr., M.D., *231 Bethesda Ave/PO Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Data from several well-designed, longitudinal outcome studies of patients with bipolar disorder hospitalized for an acute manic or mixed episode have begun to shed light on clinical and demographic factors associated with functional outcome. In reviewing these recent studies, the impact of phenomenology, co-occurring psychiatric disorders, age, sex, race, socioeconomic status, and treatment compliance on outcome will be examined. Similarly, data from recent clinical trials of divalproex, risperidone, olanzapine, and ziprasidone in acute mania will be examined regarding improvement in several important symptom domains, proportion of patients responding to these treatments, predictors of response, and proportion of patients actually achieving remission in short-term trials. Potential strategies for improving functional outcome following an acute manic or mixed episode will be addressed.

No. 16B
NEW HORIZONS IN THE TREATMENT OF BIPOLAR DISORDER

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

SUMMARY:

The depressed phase of bipolar illness often warrants sophisticated psychiatric intervention, yet even our favorite treatment strategies for bipolar depression are often unproven or supported by only the scantiest empirical data. Vigorous treatment is often necessary, but can be complicated by induction of mania, mixed states, or rapid cycling. This presentation will highlight the differences between treating bipolar and nonbipolar depressions and will review the most recent recommendations of expert panels. The use of mood stabilizers, various classes of antidepressants, and electroconvulsive therapy will be evaluated within the framework of a systematic treatment algorithm. Novel pharmacologic and nonpharmacologic interventions, including psychotherapy, also will be discussed.

No. 16C
WOMEN AND BIPOLAR DISORDER

Lori L. Altshuler, M.D., *300 Medical Plaza, Suite 1544, Los Angeles, CA 90024*; Mark A. Frye, M.D.; Victoria Hendrick, M.D.

SUMMARY:

The scant literature available on gender in bipolar illness reports definite differences between men and women in some illness factors. 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. Women with bipolar disorder have unique issues related to their illness and the reproductive cycle. For example, mood states are exacerbated premenstrually in some women, and during pregnancy dosages must be adjusted to counter the decreased serum levels resulting from the expansion of the mother's blood volume. 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.

No. 16D
MAINTENANCE TREATMENTS: PATIENTS WITH BIPOLAR DISORDER

Joseph F. Goldberg, M.D., *525 East 68th Street, New York, NY 10021*

SUMMARY:

Lithium remains the sole pharmacotherapy currently approved by the FDA for the maintenance therapy of bipolar disorder, yet naturalistic studies often indicate substantial relapse rates during routine lithium prophylaxis. Simultaneously, as polypharmacotherapy becomes increasingly prevalent, new psychotropic agents with possible anti-manic and/or antidepressant efficacies enter mainstream use at a pace far ahead of the literature on controlled trials. The degree to which newer treatments possess true mood-stabilizing properties (i.e., antimanic and antidepressant effects without inducing or exacerbating any phase of illness) remains an area for which little data exist, although preliminary evidence has begun to support the prophylactic value of divalproex as well as lamotrigine (particularly among rapid cyclers). Furthermore, open trials have begun to suggest both an acute and long-term role for atypical antipsychotics to treat both manic and depressive symptoms, both as mono- and adjuvant therapies. Current practice often favors eliminating ancillary drugs during maintenance treatment, although it remains uncertain whether ongoing polypharmacotherapies enhance long-term outcome for bipolar illness. Factors such as medication noncompliance, cost, side effects, and pharmacologic interactions pose additional concerns for both patients and clinicians.

This presentation will review current information on the relative merits and liabilities of existing pharmacotherapies for long-term treatment in bipolar disorder. Data from open and controlled long-term mono- and polypharmacotherapy trials will be reviewed regarding lithium, anticonvulsants, atypical antipsychotics, and other somatic therapies, alongside recommendations from current practice guidelines.

No. 16E
THE FACE OF BIPOLAR ILLNESS: RESULTS OF A NATIONAL DEPRESSIVE AND MANIC-DEPRESSIVE ASSOCIATION SURVEY

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

SUMMARY:

The National Depressive and Manic-Depressive Association (National DMDA) is a support and advocacy group for those who suffer from depression and manic depression. In 1993, results from the association's first randomized survey were presented at the annual meeting of the American Psychiatric Association. That survey quantitatively described the experiential aspects and daily life challenges for patients randomly selected with manic depression. The results, for the first time, revealed the prolonged struggle many people with the disorder undergo as they try to understand and manage their illness, especially with respect to employment, finances, education, substance abuse, and their personal relationships.

Respondents reported that when their illness was not being managed, 46% had to stop working outside the home, 57% had financial difficulty, 41% interrupted their education, 41% abused alcohol or drugs, and 59% experienced a strained or failed relationship (including marriage).

The findings showed that for many patients, their disorder began in early life, but that the correct diagnosis was delayed for years. Fifty-nine percent reported signs and symptoms of the illness during adolescence or before, but 50% did not receive intervention for more than five years. Seventy-three percent report having been diagnosed with a something other than bipolar at least once, usually with a form of unipolar or schizophrenia. The average length of time from seeking treatment to correct diagnosis was eight years. On average, respondents saw 3.3 medical doctors before receiving a correct diagnosis.

A more comprehensive review of these results, a narrative review of the bipolar experience, and the status of the second and current survey will be presented.

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INDUSTRY-SUPPORTED SYMPOSIUM 17—MAOIS REVISITED
Supported by Somerset Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand (1) the mechanism of action of MAOIs as enzyme inhibitors and antidepressant drugs, (2) clinical pharmacology and treatment applications of MAO inhibitors, and (3) new developments in antidepressant therapies with selective inhibitors of MAO-A and B isozymes.

No. 17A
AN UPDATE ON MAO AND BEHAVIOR

Lynn Wecker, Ph.D., *12091 Bruce B. Downs Boulevard, Tampa, FL 33612*

SUMMARY:

Monoamine oxidases (MAO) are enzymes located in the outer mitochondrial membrane of cells that catalyze the oxidative deamination of biogenic monoamines in brain and peripheral tissues. Two isoforms of MAO exist, type A and type B. These isoforms are encoded by different genes (both exhibiting some degree of polymorphism), are differentially distributed throughout body tissues, and demonstrate both substrate specificity and inhibitor selectivity. MAO-A is predominantly located in catecholaminergic neurons; in the brain, the highest level of this enzyme is in the locus coeruleus. In contrast, MAO-B is present in serotonergic and histaminergic neurons, and the highest concentration of this isoform in the brain is in the raphe nuclei. MAO-A preferentially deaminates serotonin (5-HT) and norepinephrine (NE), whereas MAO-B preferentially oxidizes phenylethylamine (PEA): dopamine (DA) can be deaminated by both forms of the enzyme, depending on the species. In addition to differences in neuroanatomical localization and substrate specificity, MAO-A and MAO-B exhibit differential susceptibility toward inhibition by certain compounds, i.e., clorgyline is a potent MAO-A inhibitor, whereas deprenyl/selegiline is a more potent MAO-B inhibitor. Recent studies have demonstrated that specific amino acid sequences in MAO-B and MAO-A determine both substrate and inhibitor selectivity. Furthermore, evidence has indicated that genetic alterations in these enzymes may be associated with susceptibility to numerous neuropsychiatric disorders including Parkinson's disease, addiction, stress-related disorders, and aggression. Understanding the roles and molecular biology of MAO-A and MAO-B in brain is essential for understanding the relationship between enzyme activities and behavioral disorders, knowledge which is ultimately necessary for the development of the next generation of neuropharmacological compounds.

No. 17B
CELLULAR ANTIDEPRESSANT MECHANISM OF MAO INHIBITORS

Pierre Blier, M.D., *100 Newell Drive, Suite L4100, Gainesville, FL 32610*

SUMMARY:

MAO inhibitors rapidly exert a robust decrease on the firing rate of norepinephrine (NE) and serotonin (5-HT) neurons because of their capacity to enhance the brain levels of these neurotransmitters. However, with treatment prolongation over 21 days using the MAO-A inhibitor clorgyline or the nonselective MAO inhibitor phenelzine, the firing rate of 5-HT neurons gradually recovers to normal, due to a desensitization of the 5-HT autoreceptor, whereas that of NE neurons remains dampened because their ∞-adrenergic autoreceptors remain normosensitive. Deprenyl, a MAO-B inhibitor, does not alter these parameters, but nevertheless it increased brain levels of NE and of dopamine. Following a three-week treatment with clorgyline, phenelzine, or tranylcypromine, another nonselective MAO inhibitor, 5-HT transmission is enhanced in the hippocampus. This is likely due to an increased level of brain 5-HT as a result of MAO inhibition and the desensitization of the ∞2-adrenergic receptors located on 5-HT terminals. Interestingly, the regimen of deprenyl that did not alter 5-HT or NE neuronal firing, or MAO-A activity, increased 5-HT transmission as well. These changes in 5-HT transmission are pivotal to the antidepressant response because a dietary paradigm to deplete 5-HT produces a rapid relapse in depressed patients improved by MAO inhibitors.

No. 17C
CLINICAL USE OF MAO INHIBITORS

Jay D. Amsterdam, M.D., *3600 Market Street, Room 850, Philadelphia, PA 19104*

SUMMARY:

Monoamine oxidase (MAO) inhibitors are highly effective in the treatment of major depression. They have been under-utilized in the U.S. because of the necessity for dietary restrictions and the potential for hypertensive events. Despite these limitations, MAO inhibitors have been shown to be highly effective in more than 50% of patients with treatment-resistant depression, atypical depression, bipolar depression, and in patients with obsessive-compulsive disorder and panic disorder.

Recent advances in MAO inhibitor development have resulted in a new generation of drugs with favorable safety profiles that can be used without dietary restrictions. The introduction in many countries of selective, reversible MAO inhibitors, which provide a greater margin of safety and tolerability, has rekindled interest in these highly effective antidepressants. Studies with newer agents have shown them to be effective monotherapy for depression, and possibly in combination with other psychotropic drugs. The recent application of transdermal technology with the selective MAO-β inhibitor selegiline has resulted in what may be a safe and effective antidepressant with nonselective central MAO-α and β enzyme inhibition, without the need for using a tyramine-restricted diet.

This presentation will provide an overview of the historical background and current clinical use of MAO inhibitors in the management of major depression. It will support the view that MAO inhibitors are safe and highly effective antidepressant agents when used cautiously in selected patients with depression.

No. 17D
NEXT GENERATION OF MAO INHIBITORS

Andrew A. Nierenberg, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

The classic monoamine oxidase inhibitors (MAOIs) phenelzine, tranylcypromine, and isocarboxazid were among the first agents found empirically as antidepressants. While effective for atypical depression and treatment-resistant depression, as well as the depressed phase of bipolar disorder, the MAOIs have been largely supplanted by the SSRIs and other third-generation antidepressants. The potential for the tyramine effect and its associated hypertensive crisis has limited the use of the MAOIs; a special diet and vigilance about interactions with medications are necessary. The next generation of MAOIs is characterized by reversibility and selectivity of

the inhibition of MAO (in contrast to the classic MAOIs). These reversible inhibitors of MAO-A (RIMA) are free of the tyramine effect, so that no dietary restrictions are needed and fewer adverse drug interactions occur. The risks and benefits of this class of medications, including moclobemide and brofaromine, will be discussed.

No. 17E
TRANSDERMAL SELEGILINE IN DEPRESSION

J. Alexander Bodkin, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Objective: Selegiline was introduce in Hungary as a potential antidepressant, but met the same limited acceptance as other MAO inhibitors, due to the "cheese effect." Selegiline has now been formulated into a transdermal delivery system that is without the "cheese effect" at robust antidepressant dosages. Pivotal antidepressant trials of the selegiline transdermal system (STS, 20 mg) have been conducted, and will be presented.

Method: Two double-blind, parallel group, placebo-controlled trials of six and eight weeks, were conducted with the STS in outpatients with major depressive disorder at a transdermal dosage of 20 mg selegiline/24 hs. Outcome measures included change in the 17- and 28-item HDRS, MADRS, and CGI. The studies randomized 177 and 309 subjects, respectively. The second trial was conducted without tyramine restrictions.

Results: Both trials demonstrated a significant ($p < 0.05$) separation of drug from placebo in primary and secondary outcome measures. Study #1 demonstrated change beginning at week 1 of treatment. Adverse events did not differ between drug and placebo, other than minor skin irritation at the patch site. High completion rates were observed (#1 = 86%, #2 = 72%).

Conclusion: The STS is a rapidly effective, safe treatment for major depression, permitting full MAOI antidepressant efficacy without dietary restrictions or troublesome side effects.

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INDUSTRY-SUPPORTED SYMPOSIUM 18—ADVANCES IN THE TREATMENT OF GERIATRIC DEPRESSION
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss recent advances in geriatric depression.

No. 18A
DIAGNOSIS AND TREATMENT OF DEPRESSION IN THE OLDER PATIENT

J. Craig Nelson, M.D., *20 York Street, EP-10-835C, New Haven, CT 06504*

SUMMARY:

Depression is common in elderly patients, especially among those with medical illness and in institutional settings. Yet the diagnosis of depression can be a challenge. Often patients do not experience sadness or report depression to their physician. In older patients somatic symptoms are common and these can easily be attributed to medical illness, which is often present. Nevertheless, inquiry about all of the symptoms of major depression will help to confirm the diagnosis. Psychological or ideational symptoms, which are less common in medical illness, are more specific for depression. Family members may be more aware of the change than the patient. Finally, it is the development of a constellation of symptoms over a period of a few months that helps to distinguish depression from other disorders. Depression, when present, takes a heavy toll in the elderly. It interferes with functioning. In older patients this may take the form of impaired ADLs. Depression contributes to suffering and impairs quality of life. Older males have the highest suicide rate of any age group. Depression has other fatal consequences. Depressed elders admitted to a nursing home are more likely to die than their nondepressed peers. Depression worsens the course of medical illness. For example, patients with heart disease or stroke are more likely to die if depressed. For these reasons treatment of depression is crucial. Few treatments in medicine more directly affect the quality of life of our older patients than treatment of depression.

No. 18B
BENEFITS OF DIFFERENT CLASSES OF ANTIDEPRESSANTS FOR GERIATRIC DEPRESSION

Alan F. Schatzberg, M.D., *401 Quarry Road, Administration, Stanford, CA 94305-5717*

SUMMARY:

Geriatric depression is increasingly becoming a focus of investigation in psychopharmacology. The advent of the SSRIs has led to widespread use in all ages (including geriatrics) although there is a great deal of skepticism and debate about the comparative efficacy of these agents in geriatric patients. Some investigators have argued that the older tricyclic antidepressants are more effective than the SSRIs in geriatric or more severely ill patients, suggesting that an effect on norepinephrine systems may be important in this age group. This presentation will first review the pharmacological properties of available antidepressants and then a series of five recent trials in geriatric depression (fluoxetine vs. placebo; citalopram vs. placebo; reboxetine vs. placebo; paroxetine vs. mirtazapine; and vanlafaxine vs. fluoxetine vs. placebo). These data suggest that remission rates on SSRIs are relatively low and that noradrenergic agents may enjoy some advantages in efficacy over SSRIs, although some of them also have greater side effects. The implications of these data for the selection of specific antidepressants in the treatment of geriatric depression are discussed.

No. 18C
DNA MICROARRAY TECHNOLOGY AND THE TREATMENT OF DEPRESSION

Greer M. Murphy, M.D., *MSLS P-104 Psychiatry Neuroscience Lab, Stanford, CA 94305*

SUMMARY:

Prediction of antidepressant response in individual patients based on DNA sequences holds great promise for clinical psychiatry. In elderly depressed patients a method for identifying those individuals at risk for medication side effects would be especially valuable. However, the practical association of genetic variants with drug efficacy and tolerability is not straightforward. One difficulty is that response to a particular drug may be dependent on multiple genetic loci, each of which has numerous alelic variants. DNA microarrays represent a dramatic miniaturization of a variety of important molecular biological and genetic techniques. Microarrays permit rapid genotyping of large numbers of samples at multiple genetic loci. We utilized DNA microarray technology to genotype at the CYP2D6 and CYP2C18 loci geriatric patients treated with nortriptyline, mirtazapine, and paroxetine. The effects of common mutant alleles at these loci on antidepressant levels, side effects, and efficacy will be presented. Other potential applications of microarray technology to pharmacogenetics and to clinical practice will be discussed.

No. 18D
PHARMACOLOGY OF ANTIDEPRESSANTS PERTINENT TO OLDER PATIENTS

Bruce G. Pollock, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

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

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INDUSTRY-SUPPORTED SYMPOSIUM 19—CHEMICAL RESTRAINTS: CLINICAL, RESEARCH, AND ETHICAL IMPLICATIONS
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to treat the psychotic, aggressive, potentially violent patient in an emergency setting, taking into account the impact of using forced medications on both the patient and the overall treatment plan; recite new data on use of the atypical antipsychotics in the emergency department and in depot formulations for long-term treatment.

No. 19A
ATYPICAL ANTIPSYCHOTICS IN THE EMERGENCY SETTING

Glenn W. Currier, M.D., *300 Crittenden Boulevard, Rochester, NY 14542-8409*

SUMMARY:

Management of acute psychotic illness poses particular challenges, the aim being essentially to stabilize difficult and dangerous, aggressive and violent symptoms. A rapid response to treatment is essential to limit the risks of violence or deliberate self-harm. Furthermore, a satisfactory response to treatment of acute psychosis has prognostic value on the longer-term treatment response to schizophrenia because antipsychotic drugs started in the acute phase tend to be continued in the post-acute phase. The choice of drug and route of administration in the acute phase are therefore important. This presentation will discuss the use of atypical antipsychotic medications for treatment of psychotic agitation in the psychiatric emergency setting. Furthermore, the advantages and disadvantages of oral versus intramuscular medications will be examined.

No. 19B
DEPOT ANTIPSYCHOTICS: AN ALTERNATIVE TO FORCED MEDICATIONS

Sally A. Berry, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Violence is a growing problem in today's society. Potential for violent behavior exists among the seriously mentally ill population. Serious mental illnesses such as schizophrenia and schizoaffective disorder often share comorbidity with substance abuse. Patients suffering from agitation associated with acute psychosis, mania, and/or intoxication frequently do not respond to reasonable pleas to control violent impulses. Hence, physicians and courts have relied on forced medications to control violence in the seriously mentally ill population. Forced medications are fraught with problems including induction of serious side effects and complicating underlying medical illnesses. An alternative to forced medications is finding treatments to control illnesses so that violent presentations occur less frequently. Treatment of serious mental illnesses is often hampered by noncompliance. Long-acting formulations of antipsychotic medications can increase medication compliance, thereby decreasing illness exacerbation and associated violence. To date, two antipsychotics are available in depot formulations. Both are conventional antipsychotics associated with extrapyramidal side effects and relatively high liability to produce tardive diskinesia compared with the atypical antipsychotics. The safety profile of these medications must be weighed against other treatment alternatives. A depot formulation of the atypical

antipsychotic risperidone is now being tested in Phase III clinical trials. The pharmacology of this formulation will be discussed.

No. 19C
PREVENTING PSYCHOLOGICAL TRAUMA FOLLOWING FORCED MEDICATION

Terence M. Keane, Ph.D., *150 South Huntington Avenue, Boston, MA 02130*

SUMMARY:

Experiencing a psychiatric emergency is an event that is extremely distressing. When an individual is then medicated under duress, the outcome can become even more complicated for that person. It can be accompanied by a sense of helplessness, being assaulted, and being violated. Moreover, the event can be experienced as terrifying and horrific. For a small proportion of patients it may lay the foundation for a traumatic life event. Posttraumatic stress disorder (PTSD) is a debilitating psychiatric condition that occurs in some people following exposure to such traumatic events. The purpose of this presentation will be to discuss the prevention and treatment of PTSD in individuals who are exposed to forced medication. Forced medication can be perceived as a traumatic event that can lead to PTSD. As is the the case with other forms of trauma exposure, active interventions can be employed to minimize the impact of the experience. Cognitive-behavioral interventions can be individually tailored to assist patients in the recovery process. The presentation will cover the components of a CBT intervention that has been successfully utilized in the prevention of PTSD among individuals exposed to traumatic events. Recommendations for their application following forced medication during a psychiatric emergency will be discussed.

No. 19D
DEALING WITH THE NEW LEGAL FRAMEWORK FOR CHEMICAL RESTRAINTS

Paul S. Appelbaum, M.D., *55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

Chemical restraints is a term that has evolved to denote the emergency use of psychotropic medications for the prevention of violent or self-injurious behavior. A varying set of legal rules governs the use of chemical restraints. Emergency use of medication is usually free from the rules regulating involuntary medication in general. However, many states have developed regulations on the use of chemical restraints that are analogous Sin those put into place for seclusion and restraint practices. Typically, these define the circumstances in which chemical restraint can be used, the precautions to be employed, and the documentation required. In addition, the Health Care Finance Administration has more recently developed a set of regulations for facilities receiving federal funding, in effect covering every hospital in the country. Use of chemical restraints, if such use violates ordinary standards of care with regard to indications, dosages, monitoring, and the like, may result in malpractice claims as well. Although some regulation of chemical restraint use seems warranted, given the potential for abuse, it is important that rules be structured so as not to preclude effective approaches to treatment or to place staff or patients at undue risk of harm.

No. 19E
HISTORICAL LEGAL TRENDS AND CIVIL LIBERTIES IN FORCED MEDICATIONS

Renee L. Binder, M.D., *401 Parnassus Avenue, Box F, San Francisco, CA 94143*

SUMMARY:

There are many legal principles that have needed to be balanced as the courts and legislatures have dealt with the issue of forced medications. These include patient autonomy vs. paternalism, patients' liberty interest, patients' right to privacy, police power, parens patriae, and patients' right to treatment. In general, legal trends support the use of involuntary medications only during emergency situations or when the patient is incompetent to make a decision about medications (e.g., Riese v. St. Mary's and Rogers v. Commissioner).

Whether forced medications should be part of outpatient commitment statutes is controversial. It has been argued that since medications are an essential part of treatment for the seriously mentally ill, forced medications should be allowed. Nevertheless, most statutes do not allow forced medications. In any event, it may not be constitutional to give forced medications under outpatient commitment criteria. Recent studies that review the clinical consequences of including or not including forced medications as part of outpatient commitment will be summarized. At this time, the results of these studies are inconclusive.

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INDUSTRY-SUPPORTED SYMPOSIUM 20—ATYPICAL ANTIPSYCHOTIC DRUGS: HOW DO THEY WORK? Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should understand how atypical antipsychotic drugs differ from typical agents at the level of basic molecular neuroscience, including in terms of kinetics at dopamine receptors, induction of gene expression in cells, and modification of neuronal circuitry.

No. 20A
WHAT REALLY IS "ATYPICAL" ABOUT ATYPICAL ANTIPSYCHOTICS: LESSONS FROM PET IMAGING STUDIES

Shitij Kapur, M.D., *250 College Street, Toronto, ON Canada M5T 1R8*; Robert B. Zipursky, M.D.; Gary J. Remington, M.D.

SUMMARY:

While the mechanism of atypicality is not known, it has been suggested a high affinity for 5-HT_2 or D_4 receptors may be responsible for an atypical profile. A series of recent findings question these hypotheses: (1) even haloperidol can give an atypical antipsychotic

effect if its D_2 occupancy is adjusted into a narrow therapeutic window; (2) the freedom from EPS of the atypical antipsychotics relates not to high 5-HT_2 occupancy, but to their low D_2 occupancy; (3) if D_2 occupancy is too high, high 5-HT_2 occupancy cannot protect from EPS and prolactin elevation; (4) increasing the D_2 occupancy of clozapine, by the addition of a strong D_2 blocker, causes clozapine to lose some aspects of its atypicality. These PET findings are supported by animal data wherein manipulating D_2 effects alone, holding 5-HT_2 and D_4 effects constant, can switch an atypical drug into typical and vice versa. Based on these findings we propose that a fast k_{off} (dissociation) from the D_2 receptor is, in and of itself, a sufficient condition for atypical antipsychotic effect. The presentation will end by providing a new framework for relating drug effects to the various aspects of schizophrenia.

No. 20B
UNDERSTANDING THE ACTION OF ANTIPSYCHOTIC DRUGS AT THE LEVEL OF GENE EXPRESSION

Barbara K. Lipska, Ph.D., *10 Center Drive, Bldg 10, Room 4N306, Bethesda, MD 20892-1385*

SUMMARY:

Neurochemical mechanisms underlying the therapeutic and adverse side effects of antipsychotic drugs are not well understood. Classical antipsychotics cause extrapyramidal side effects (EPS), whereas the so-called atypical antipsychotics have much lower propensity for EPS. While all clinically effective antipsychotic drugs acutely block dopamine D2-like receptors, chronic administration that leads to various downstream secondary changes is required for a full therapeutic response and responsible for delayed deleterious side effects. These slower neuroadaptive changes include complex alterations in gene expression. In this presentation recent advances in research concerning molecular sequelae following neurotransmitter receptors blockade by typical and atypical antipsychotic drugs will be discussed. It has been shown that these drugs may differentially regulate various intracellular messenger pathways, including second messengers such as cAMP, protein phosphorylation systems, third messengers such as CREB-like transcription factors, fourth messengers such as Fos-like proteins, and finally many other downstream target genes including genes coding for NMDA receptors, neurotensin, and trophic factors which implicate synaptic rearrangements and plasticity. In addition, these changes may occur in region- and neuron-specific manner. Although at present there is no clear evidence to implicate any of these changes in antipsychotic drug action, because of the time course and regional specificity they constitute important candidates for such action.

No. 20C
INTRINSIC CIRCUITRY IN CORTEX: RECEPTORS, DRUG ACTION, AND COGNITION

Patricia S. Goldman-Rakic, Ph.D., *333 Cedar Street SHM C303, New Haven, CT 06520-8001*

SUMMARY:

Basic information on receptor localization and function is essential for understanding the signaling pathways and molecular mechanisms that are critical to optimal neurotransmission in prefrontal circuits. We have used electronmicroscopy, electrophysiology, and biochemistry to localize neurotransmitter receptors in the circuits that mediate cognitive processes mediated by prefrontal neurons. Receptors of different subtype specificities are sequestered in different compartments of the same cell and in different components of cortical circuits. The dopamine D1 receptor is prominent in the spines of cortical pyramidal neurons, while the serotonergic 5-HT2 receptor is associated with proximal dendrites of the same cell. Both receptor subtypes are also present in specific classes of inhibitory interneurons. With this knowledge, we have examined the actions of dopamine and serotonin receptors in identifiable local prefrontal circuits both in vitro and in vivo. We have also examined the effect of monoamine agonists and antagonists on cognitive behavior in nonhuman primate models of etiology and treatment of mental disorders. The studies of neurotransmitters and neurotransmitter receptors in known circuits in the prefrontal cortex of nonhuman primates are establishing a rational basis for development of drug therapies for depression, age-related memory decline, Parkinson's disease, and schizophrenia, all of which exhibit some form of monoamine dysfunction.

No. 20D
BEHAVIORAL AND NEUROCHEMICAL PREDICTORS OF ANTIPSYCHOTIC DRUG ACTION

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

SUMMARY:

In the past 20 years considerable progress has been made in characterizing the effects of antipsychotic drugs, both typical and atypical, in several validated animal models that represent an incremental advance over the relatively crude tests used previously. Thus, blockade of apomorphine-induced stereotypy and catalepsy effects of putative antipsychotic agents have now been replaced by studies of prepulse inhibition (PPI) and latent inhibition (LI). These rodent models clearly more closely mimic the behavioral deficits observed in schizophrenia. This presentation will summarize the data concerning this activity of typical and atypical antipsychotic drugs in these two paradigms. In addition, the effects of antipsychotic drugs on regional brain mRNA expression for neurotensin (NT), a 13 amino acid neuropeptide with antipsychotic-like activity, will be described. Finally, the effects of NT receptor antagonist treatment has been shown to block antipsychotic drug effects in PPI. These studies provide novel data on the utility of these behavioral and neurochemical tests to identify novel antipsychotic agents, and the importance of the integrity of NT neurotransmission in their mechanism of action.

No. 20E
THERAPEUTIC INSIGHTS FROM THE CLINICAL SEARCH FOR GENES

Daniel R. Weinberger, M.D., *10 Center Drive, Building 10, Room 4S-237B, Bethesda, MD 20892-1379*

SUMMARY:

Schizophrenia is a complex heritable disorder, thought to result from multiple genes interacting with the environment. Recent evidence suggests that what is heritable is not the diagnostic symptoms, per se, but dimensions of biological variation in subsyndromes, such as patterns of cognitive dysfunction, abnormalities of frontal lobe function, deficits in information processing. Focusing on genes that may be associated with schizophrenia or these subsyndromes may offer new insights into the mechanism of action of atypical antipsychotic drugs and identify new molecular targets for future drug development. A noncoding polymorphism of the 5-HT-2 gene has been associated with poor response to treatment with clozapine, suggesting that a variant near by may be important. Likewise, a polymorphism in the D3 gene has been linked to tardive dyskinesia, suggesting a possible indentifier of molecular pathways involved in the pathogenesis of this effect. Finally, the recent emphasis on cortical function as a regional functional target of these new agents suggests

that variants in genes related to cortical function might explain variations in the effects of these drugs. Recently, a functional polymorphism in the COMT gene has been shown to account for 4% of the normal human variation in prefrontal executive cognition and frontal lobe function, and also to be associated with schizophrenia.

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INDUSTRY-SUPPORTED SYMPOSIUM 21—CRITICAL QUESTIONS IN ANXIETY DISORDERS
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) better understand the cost burden in and barriers to effective treatment in anxiety disorders, and (2) effectively apply the new treatments available for social anxiety disorder and generalized anxiety disorder.

No. 21A
COST BURDEN OF ANXIETY DISORDERS

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

SUMMARY:

A review of the epidemiologic literature suggests that anxiety disorders have the highest overall societal costs of all psychiatric disorders, and are among the highest of any class of physical or mental disorders. The reasons for these high costs are reviewed in this presentation. The most important reasons include high prevalences; early ages of onset; high rates of chronicity; strong effects on the subsequent onset and persistence of secondary mood disorders, secondary substance use disorders, and a wide range of adverse life situations; high levels of role impairment; and strong effects on overuse of the health care system for treatment of vaguely defined physical complaints. Comparative effects of different anxiety disorders across each of these domains shows that the greatest societal burdens are associated with social anxiety disorder, PTSD, and generalized anxiety disorder. Life-course analysis suggests that most of these adverse effects occur prior to the time of first-treatment contact and in conjunction with life-course changes that are not reversed with treatment. These results argue that public health efforts should be directed at early outreach and treatment efforts. The presentation closes with a discussion of promising initiatives involving early outreach and treatment of primary anxiety disorders.

No. 21B
ANTIDEPRESSANTS AND ANXIOLYTICS: DO THEY ALL WORK IN SOCIAL PHOBIA?

Jonathan R.T. Davidson, M.D., *Box 3812, Durham, NC 27710*

SUMMARY:

Antidepressants, anxiolytics, and anticonvulsants have all been used effectively to treat social anxiety disorder (SAD). However, not all drugs in these categories are necessarily effective for this disorder. Among the antidepressants, MAOIs and SSRIs appear more effective than RIMAs and tricyclics. Among anxiolytics, clonazepam and, possibly, alprazolam are more effective than buspirone and atenolol. Among anticonvulsants, gabapentin and pregabalin are effective, but valproate appears to be less promising. Evidence to support these assertions will be presented. Aspects of SAD, which respond to medication, will be identified to include fear, avoidance, physiologic distress, and cognitions. Differences between the two subtypes of SAD (generalized and nongeneralized) will be described, and the treatment implications of this dichotomization will be discussed. Goals of treatment and methods of measuring treatment impact will be reviewed.

No. 21C
SHOULD GAD BE TREATED LONG TERM?

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

SUMMARY:

Patients with generalized anxiety disorder (GAD) are less likely to make a satisfactory recovery at six-month, two-year, and five-year follow up compared with patients with major depressive disorder. Following recovery, many patients with GAD relapse. Recent studies suggest that the older standard treatments for GAD, like benzodiazepines and buspirone, are not effective enough in many cases. Rickels et al. in 1993 showed that the antidepressant imipramine was better than the benzodiazepine diazepam in the treatment of GAD. Since then there has been an increasing shift toward the use of antidepressants as first-line treatments in GAD. Four short-term and two long-term, double-blind, placebo-controlled studies support the short- and long-term efficacy of venlafaxine XR in the treatment of GAD. This medication exerts its best effect on the target symptoms of worry, anxiety, and tension, which are very sensitive in tracking outcome over time. Although severe cases do less well in the first three months of treatment than mild to moderate cases, they do as well long term as milder cases. Persistence with treatment over a longer time frame is therefore critical in getting optimal results for the more severely impaired patients.

No. 21D
TREATMENT OF COMORBID ANXIETY AND BIPOLAR DISORDERS

Susan L. McElroy, M.D., *231 Bethesda Avenue, Cincinnati, OH 45267-0559*

SUMMARY:

Increasing epidemiological data show that bipolar disorder significantly co-occurs with anxiety disorders at rates that are significantly higher than those in the general population. Clinical studies have also demonstrated high comorbidity between bipolar disorder and panic disorder, OCD, social phobia, generalized anxiety disorder, and post-traumatic stress disorders. This research further suggests that bipolar disorder with comorbid anxiety symptoms or disorders is characterized by an earlier age of onset, poorer outcome, and unfavorable response to lithium-based treatment. However, little con-

trolled data are available regarding the treatment of bipolar disorder complicated by a concurrent anxiety disorder. In this presentation, epidemiological and clinical data on the overlap of bipolar and anxiety disorders are reviewed. In addition, available research examining (1) mood stabilizers in bipolar disorder with anxiety symptoms and disorders, (2) mood stabilizers in anxiety disorders, and (3) anxiolytic agents in bipolar disorder will be summarized. Preliminary suggestions for the treatment of bipolar disorder with various anxiety disorders will then be suggested.

No. 21E
BARRIERS TO THE EFFECTIVE TREATMENT OF ANXIETY DISORDERS

Mark Olfson, M.D., *1051 Riverside Drive, Box 24, New York, NY 10032*

SUMMARY:

It is well established that a great majority of adults with anxiety disorders do not receive professional mental health treatment. Results from epidemiological surveys and practice-based research will be reviewed to highlight common obstacles to effective treatment. Strategies for overcoming these obstacles will be discussed.

The successful treatment of anxiety disorders depends on appropriate help seeking behavior; an accurate diagnostic assessment; an informed selection of treatments; and patient acceptance, adherence, and retention in treatment. At each stage of this process, barriers may interfere with the provision of effective treatment.

Common barriers to appropriate help seeking include financial considerations, uncertainty over where to receive treatment, a belief that treatment is unnecessary or ineffective, the stigma of receiving mental health care, and disorder-specific factors. Once patients enter treatment, inaccurate diagnostic assessment and improper treatment selection may erode the quality of care and reduce the likelihood of successful outcomes. Illness beliefs, cultural factors, perceived risks and benefits of treatment, and the level of trust in the clinical relationship help determine patient acceptance of treatment. Adherence to prescribed treatments may be more closely related to the medication side-effect profile, regimen complexity, patient understanding of medication effects, and perceived risks and benefits of the medications. Finally, retention in treatment may be influenced by financial factors as well as perceptions of the ongoing need for treatment including patient perceptions of the likelihood and consequences of recurrence following cessation of treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 22—MANAGEMENT OF ANXIETY: AN INTERNATIONAL PERSPECTIVE

Supported by Solvay Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will more clearly understand contributing factors for refractory anxiety in pediatric anxiety disorders, OCD, and social anxiety; integrate psychological and neurobiological approaches; and be aware of the role of anxiety in suicide.

No. 22A
THE FUNCTIONAL IMPACT OF ANXIETY DISORDERS: FOCUS ON SOCIAL PHOBIA

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

SUMMARY:

Studies in the past few years have revealed that anxiety disorders can markedly compromise quality of life (QOL) and psychosocial functioning. Significant impairment can also be found in individuals with subthreshold forms of anxiety disorders. Effective pharmacological or psychotherapeutic treatment has been shown to improve QOL of patients with certain anxiety disorders, whereas data are as yet lacking for others. It is expected that a more thorough understanding of their impact on QOL will lead to increased public awareness of anxiety disorders as serious mental disorders, worthy of further investment in research, prevention, and treatment. Dr. Stein will highlight work from his group and others that document the burden of illness associated with social phobia. As a disorder that starts early in life, is often chronic, and is often a precedent to comorbid disorders such as major depression, social phobia exemplifies the seriousness of anxiety disorders and the need for the development of early, effective interventions.

No. 22B
INTEGRATING NEUROSCIENCE AND PSYCHOTHERAPY: THE STUDY OF HUMAN EMOTIONS

Donatella Marazziti, M.D., *Via Roma 67, Pisa, Italy 56100*

SUMMARY:

In the past few years, emotions and feelings, such as attachment, parental bonding, and even love, which were neglected for centuries by experimental sciences, have become the topic of extensive neuroscientific research in order to elucidate their biological mechanisms.

Love, the most human feeling, can be viewed as the result of different components probably subserved by distinct neural substrates. We would propose that the ideative, cognitive part of love, typical of the early, romantic phase of the relationship, can be understood along dimensions comprising also psychiatric conditions such as obsessive-compulsive disorder (OCD), paranoia, and mania. Although similarities between romantic love, early parental love, and OCD have already been reported, this is mainly a speculative model and, as such, an extreme oversimplification of a complex feeling. However, recently, we have shown a similar dysfunction of the 5-HT system in subjects who had recently fallen in love and in OCD patients. We hypothesize that the common 5-HT abnormality can be due to the involvement of common dimensions shared by different conditions yet to be identified. We believe that the identification of

the neural substrates of human feelings and emotions and of the dimensions crossing normal and pathological states will constitute one of the most exciting topics of the neurosciences in this new millenium, and this approach promises to reconcile psychology and psychiatry, both with the same basis in the human brain.

No. 22C
CHILDHOOD ANXIETY DISORDERS: NIMH INITIATIVES

Benedetto Vitiello, M.D., *6001 Executive Boulevard, Room 7147, Bethesda, MD 20892-9633*

SUMMARY:

Anxiety disorders are the most prevalent psychiatric disorders in children and often are the harbinger of adulthood anxiety disorders. The last decade has witnessed an increased interest in studying the effects of treatment interventions for these children. Several important conclusions can be drawn from the current data. Cognitive-behavioral therapy (CBT) is highly effective for children with anxiety disorders, and the effects seem to be maintained over time. Moreover, several industry-funded clinical trials have indicated that selective serotonin reuptake inhibitors (SSRI) are effective and well tolerated for the treatment of children with obsessive-compulsive disorder (OCD). A substantial number of patients, however, fail to improve. Current research is testing the potential added benefit of combining CBT with SSRI for children with OCD. Some data support the need to continue SSRI treatment in the long term, after improvement in the short term, but the evidence is not univocal. For children with generalized anxiety disorder, separation anxiety, and social phobia, both CBT and pharmacotherapy with fluvoxamine have been shown to be of benefit. In particular, a recently completed NIMH-sponsored study found that pharmacotherapy was highly effective, compared with placebo, for children with these anxiety disorders.

No. 22D
REFRACTORY OCD: AN INTERNATIONAL PERSPECTIVE

Eric Hollander, M.D., *One Gustave Levy Place, Box 1230, New York, NY 10029*; Stefano Pallanti, M.D.; Sherie L. Novotny, M.D.; Daphne Simeon, M.D.; Sallie Jo Hadley, M.D.; Carol Bienstock, B.A.

SUMMARY:

OCD is among the most common psychiatric disorders, affecting 2% to 3% of the population and presenting in slightly different forms across most countries. OCD is currently ranked tenth among all medical illnesses in worldwide disability. The SSRIs remain the treatment of choice for OCD, but a therapeutic trial may require higher doses and a longer lag time to reach full effect. Nevertheless, up to 40% to 60% of patients are resistant to a single SSRI trial, and only 25% of patients who fail one SSRI trial respond to a second. Data from a very recent multicenter trial in OCD provide new data to contrast SSRI responders and nonresponders, and clarify dose and length of time to response issues. The International Consortium on Treatment Refractory OCD includes four U.S. sites and four European/Middle Eastern sites, and has collected data contrasting 200 OCD responders with 200 OCD nonresponders on OCD symptom factors, demographics, age of onset, gender, definitions of adequate trial, and criteria for response. This database provides unique insights on evaluating and managing refractory OCD patients across various cultures and ethnic groups. This information will help the clinician manage these common and difficult to treat refractory OCD patients.

No. 22E
ANXIETY AND SUICIDE

Jan A. Fawcett, M.D., *1725 West Harrison Street, Suite #955, Chicago, IL 60612*

SUMMARY:

The accurate prediction of suicide risk in the individual patient in time to intervene remains a major difficulty for the clinician. A prospective study allowing contrasts between patients who commit suicide and a comparison group of the majority of depressed patients who survived over a ten-year follow up demonstrated that standard risk factors such as prior attempts and suicidal communications to a clinician were chronic (2–10 years), but not discriminating acute risk factors. Anxiety symptoms, such as severe psychic anxiety and panic attacks were significantly associated with suicide within one year of assessment. A second study of chart notes within a week of inpatient suicide from the records of 76 cases, also show a high (79%) incidence of severe anxiety/agitation, contrasting with denial of suicide intent documented in the same time period in 67% of cases. These data will be reviewed along with subsequent reports of anxiety symptoms associated with serious suicide attempts that partly replicate these findings. An analysis of the forms of the presentations of anxiety in suicidal patients will be illustrated with case vignettes. The potential for prevention of suicide by recognition and aggressive treatment of anxiety in depressed patients will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 23—TREATMENT-RESISTANT DEPRESSION ACROSS THE LIFE SPAN
Supported by Pharmacia Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will become familiar with the clinical and therapeutic issues that emerge in the treatment of depressed patients who do not respond to standard treatments.

No. 23A
THE PHENOMENOLOGY AND COURSE OF TREATMENT-RESISTANT DEPRESSION

Patrick J. McGrath, M.D., *1051 Riverside Drive, Unit 51, New York, NY 10032-2695*; Jonathan W. Stewart, M.D.

SUMMARY:

Despite vigorous treatment with currently available antidepressant medications, 30% or more of patients with depression have an inade-

quate response to treatment, and an even larger proportion do not experience full remission. Such patients are now constituting a larger proportion of psychiatric practice than previously, as primary care practitioners treat more cases of depression and refer those who have not had an adequate response. Substantial data are now becoming available to describe the characteristics of patients who have not responded to initial treatment with antidepressant medication, in terms of their depressive subtype, course of illness before treatment, and psychiatric comorbidity. We shall present data from a large trial of subjects whose depression did not respond adequately to a vigorous trial of an SSRI and characterize the clinical features relevant to such lack of response. We shall discuss this data with the aim of assisting psychiatrists in identifying which of their patients are at highest risk of inadequate benefit from treatment and in selecting treatment options for these patients.

Funding provided NIMH Grant R10 MH56058 and by the Office of Mental Health of the State of New York

No. 23B
PHARMACOLOGICAL TREATMENT OPTIONS

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

SUMMARY:

Studies suggest that 30% to 45% of depressed patients do not respond fully to antidepressant treatment of adequate dose and duration. Clinicians are then faced with the dilemma of choosing one of several possible pharmacological strategies: to augment the failed antidepressant, to use a higher dose of the same antidepressant, to combine two classes of antidepressants, or to switch to another antidepressant. The choice between augmentation, higher dose, combination, or switching strategies is often determined by a variety of factors, including the nature of the patient's response to the failed antidepressant, the clinician's personal biases and views about these options, the patient's willingness to take more than one medication, and the patient's ability to withstand potential adverse drug reactions that might arise from those strategies. If the initial drug trial has resulted in a partial remission without significant adverse drug reactions, then either the augmentation or the higher dose strategies are typically recommended. If, however, a partial remission is accompanied by extremely bothersome side effects, then switching is often considered a more feasible strategy. If the failed drug has led to no or only minimal improvement, switching is frequently chosen as a strategy, but no data are available to show that this strategy is superior to the augmentation or combination strategies in this situation. This presentation will review the evidence for the efficacy of these different strategies in the treatment of depressed patients who have not responded to an adequate trial with antidepressants.

No. 23C
MANAGEMENT OF DEPRESSION IN THE MEDICALLY ILL: PRACTICAL APPROACHES TO TREATMENT

Prakash S. Masand, M.D., *750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Depression in the medically ill patient is often under-recognized and under-treated. The comorbidity of depression in the medically ill has important prognostic and treatment implications. For instance, studies have shown that patients with cardiovascular disease and stroke who have comorbid depression have increased mortality and morbidity compared with matched patients without comorbid depression. The presentation will address phenomenological issues in the diagnosis of depression in medically ill populations including patients with cardiovascular illness, neurological illness, cancer, chronic pain syndromes, and endocrine disorders amongst others. The presentation will pay particular attention to treatment issues for depression in these medically ill populations including a discussion of side effects and drug interactions as they pertain to the medically ill, particularly those on concomitant medications that may interact with psychotropics.

No. 23D
JUVENILE BIPOLAR DISORDER: AN OVERLOOKED CONDITION

Janet Wozniak, M.D., *15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Objective: This presentation provides a discussion of a subset of depressed children who also present with the severe mood disturbance of juvenile bipolar disorder (BPD) outlining clinical presentation, patterns of comorbidity, and treatment approaches to help clarify current diagnostic controversies. As early-onset depression is often a harbinger of BPD, and as treatments for depression may exacerbate BPD, the differential diagnosis is of great clinical concern.

Method: The presenter summarizes recent research in the field of juvenile bipolar disorder and provides clinical guidance for diagnosing and treating the condition, as well as guidelines on how to differentiate the condition of juvenile bipolar disorder from uncomplicated depression.

Results: Data from several studies will be summarized and focus will be placed on the clinical applications of these studies, which provide a basis for practical guidelines for diagnosing and managing difficult cases of depression in bipolar disorder children. Data from studies of children and adolescents ascertained for the presence of bipolar disorder will be presented. Treatment data, which stress the need for combined pharmacotherapy, will be discussed.

Conclusion: Diagnosing and treating bipolar disorder in depressed children and adolescents may be difficult to do, but initial guidelines can provide clinicians with useful information resulting in thoughtful treatment strategies.

No. 23E
TREATMENT ADVANCES IN GERIATRIC DEPRESSION

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

SUMMARY:

Geriatric depression appears to respond to antidepressants used in the treatment of younger adults. However, age-related clinical characteristics may influence the course of geriatric depression. We have observed that overall elderly depressives have a similar recovery rate as that of younger adults. However, late onset of first depressive episode was the strongest predictor of chronicity in the elderly, while weak social support predicted chronicity in younger depressives. Depression with onset during senescence includes a large group of patients in whom neurological disorders play an important role. Cognitive impairment or ventriculomegaly may impair the plasma level efficacy relationships of the antidepressant nortriptyline (NT). We have found evidence that clinical, neuropsychological, and electrophysiological abnormalities suggestive of prefrontal dysfunction are associated with chronicity of geriatric depression. Similarly, executive impairment is a predictor of early relapse and recurrence of geriatric depression. In contrast, memory dysfunction does not appear to influence response to antidepressant treatment but predicts devel-

opment of irreversible dementia on long-term follow up. Based on these findings, we proposed that a "depression-executive dysfunction syndrome" exists, and argued that dysfunction of striato-pallido-thalamo-cortical (SPTC) pathways contributes to its pathophysiology and treatment response.

So far, serotonin and norepinephrine enhancing agents have been used as antidepressants in geriatric depression. However, neurotransmitters of the SPTC pathways include dopamine, acetylcholine, and enkephalins. Agents that can enhance or inhibit these neurotransmitter systems are available and need to be used experimentally in elderly patients with drug-resistant depression and evidence of SPTC dysfunction.

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2. Fava M: New approaches to the treatment of refractory depression. Journal of Clinical Psychiatry 2000; 61(suppl 1):26–32
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INDUSTRY-SUPPORTED SYMPOSIUM 24—NEUROBIOLOGY, DEPRESSION, AND THE SPECIFICITY OF TREATMENT RESPONSE

Supported by Organon Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should understand the implications and limitations of transmitter-based classification of antidepressants. Further, it should be clear that even though all antidepressants overlap in their action, they have a distinct spectrum of activity that varies significantly by antidepressant class.

No. 24A
5HT AND NOREPINEPHRINE IN DEPRESSION

Pedro L. Delgado, M.D., *7303 AHSC, 1501 North Campbell Avenue, Tucson, AZ 85724*; Francisco A. Moreno, M.D.

SUMMARY:

This presentation will review data on specific symptoms of depression induced by acute catecholamine depletion using alpha methyl para tyrosine (AMPT) compared with those induced by acute tryptophan (TRP) depletion in treated and untreated depressed patients.

Methods: Data from 123 depressed patients (44 catecholamine depletion and 79 TRP depletion) who participated in one of several prior studies were pooled for analysis. Change from baseline during depletion was calculated for Hamilton Depression (Ham-D), Hamilton Anxiety (Ham-A), and side-effect checklist (SC) scales.

Results: Both TRP and catecholamine depletion led to significant ($p < .05$) increases in HAM-D, Ham-A, and SC scores. On the Ham-D, both TRP and catecholamine depletion significantly increased core symptoms of depression. TRP, but not catecholamine depletion, significantly increased suicidal thinking. The magnitude of increase in loss of interest, retardation, psychic anxiety, loss of energy, and decreased concentration was significantly greater for catecholamine than TRP depletion. On the Ham-A, catecholamine depletion significantly increased anxious mood, cognitive impairment, depressed mood, and increased autonomic and behavioral manifestations of anxiety, while TRP depletion only increased somatic and gastrointestinal symptoms of anxiety. Catecholamine depletion increased ratings of drowsy and impaired concentration, while TRP depletion increased headache and nausea on the SC.

Conclusions: The symptoms evoked by norepinephrine (NE) depletion were more similar than different to those evoked by serotonin (5-HT) depletion. NE depletion impaired cognitive symptoms to a greater extent than 5-HT depletion and only 5-HT depletion increased suicidal thinking. The similarities and differences in symptoms suggest that NE and 5-HT incompletely overlap in modulating brain areas mediating the symptoms of depression. This may have relevance to putative differences between 5-HT-selective, NE-selective, and dual action antidepressants.

No. 24B
THE ROLE OF DOPAMINE IN DEPRESSION AND ANTIDEPRESSANT TREATMENT

Alexander H. Glassman, M.D., *1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Though most clinicians think of antidepressant treatments as either adrenergic or serotonergic, considerable evidence would implicate dopamine as well. Dopamine's traditional psychiatric link is to schizophrenia through the activity of dopamine blocking drugs. In the 1980s, studies in addiction focused attention on dopamine's role in reward systems. More recently this has been seen as more a motivational than simply a reward system and data suggest its importance in depression as well as addictions. In particular, the marked propensity for smokers with a history of depression to get depressed if they abstain from smoking has focused interest on the role of dopaminergic systems in depression. Stimulants have long been seen as useful adjuncts to the treatment of depression as well as ADHD, and the pharmacology of these drugs always involves both dopamine and norepinephrine. Bupropion alters both dopamine and norepinephrine and is an equally antidepressant but has a clinical response profile very different than the SSRIs. The irreversible MAO inhibitors have been the most effective antidepressants and differ from other antidepressants in that they increase all three biogenic amines. Recently there is evidence that pure dopaminergic drugs like bromocriptine, piribedil, and pramipexole can also augment antidepressant activity. In many ways dopamine's activity in depression is more comprehendible than either serotonin or norepinephrine.

No. 24C
BRAIN STRUCTURE AND FUNCTION IN MAJOR DEPRESSION

Harold A. Sackeim, Ph.D., *1051 Riverside Drive, Unit 126, New York, NY 10032-1013*

SUMMARY:

Brain imaging studies have revealed anatomically-distributed structural and functional abnormalities in major depression. Young bipolar patients have an excess of MRI signal abnormalities, termed hyperintensities. In unipolar illness, these abnormalities are usually seen in older individuals, and are linked to cerebrovascular disease. The location of these abnormalities implicate disconnection of cortical-striatal-thalamic loops in the etiology of vascular depression. Other structural abnormalities in mood disorder patients include

volume loss in the specific prefrontal regions and possibly the hippocampus, implicating frontal-limbic pathways. Functional imaging studies have found that major depression is associated with metabolic reductions in dorsolateral and medial prefrontal cortex and basal ganglia. The magnitude of prefrontal deficit covaries with symptom severity. There is also some suggestion that functional activity may be increased in specific paralimbic/limbic regions, including orbital medial prefrontal cortex and areas in the anterior cingulate. Response to sleep deprivation is consistently associated with reduced anterior cingulate activity, and ECT results in marked reductions in widespread prefrontal regions. Regardless of class, antidepressant medications may also result in reduced activity in paralimbic/limbic areas. Thus, the state of depression and its resolution may depend more on the modulation of specific brain networks or systems than particular biochemical substrates.

No. 24D
THE BIOLOGY OF DEPRESSIVE SUBTYPES AND TREATMENT RESPONSE

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

SUMMARY:

The development of pharmacological agents that appear to selectively affect either serotonin or norepinephrine has renewed interest in distinguishing neurotransmitter systems and coupling them with clinical phenomenology. Parallel to this development, a number of investigators have documented differences in response to antidepressants among depressive subtypes. Does considering depressive subtype, treatment response, and neurotransmitter systems in parallel, help illuminate the psychobiology of depression?

For the atypical and delusional subtypes there is consensus on the specifics of treatment response, and there is strong circumstantial evidence for melancholia. Delusional depression does not respond to treatment with antidepressants alone but requires combination antidepressants and antipsychotics or ECT. Dopamine has long been associated with delusional phenomenology (also with refractory depression) and is undoubtedly important in treatment of this subtype. Atypical depression does not respond to TCAs; open favorable data on SSRIs has not been replicated; and historically, as best as can be constructed, ECT is also ineffective. However, atypical depression does respond favorably to MAOIs and open data suggest buproprion is effective as well. Affecting neurotransmitters systems other than norepinepherine or serotonin may be critical for effective treatment of the atypical subtype. Perhaps most intriguing are the data that melancholia does not respond to SSRIs but does respond to tricyclics as well as other antidepressants that affect norepinepherine, e.g. venlafaxine, mirtazapine, reboxetine, and to ECT. Data from humans involving cyclic AMP-dependent protein kinases and from animals involving strain-specific response to antidepressants further implicate norepinepherine as being critical in the biology of melancholia. This presentation will review the question of whether subtype of depression can be linked to neurotransmitter systems through the specificity of treatment response.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 25—PSYCHOSIS OF ALZHEIMER'S DISEASE: NEW KNOWLEDGE, NEW TREATMENT STRATEGIES
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to formulate a diagnostic approach based on the latest research findings, and understand the efficacy and side-effect profiles of atypical and conventional neuroleptics.

No. 25A
EFFICACY OF ANTIPSYCHOTIC AGENTS

Ira R. Katz, M.D., *3600 Market Street, Room 759, Philadelphia, PA 19104*

SUMMARY:

Recent randomized clinical trials of both atypical and conventional neuroleptics in the treatment of the psychological and behavioral symptoms of dementia have advanced our understanding of the psychopathology of these conditions and our knowledge about how to treat them. There is an emerging consensus that psychoses (hallucinations or delusions) due to dementia constitute distinct syndromes, separable from less specific behavioral symptoms such as aggression or agitation. However, the inclusion/exclusion criteria of even the most recent studies are less specific. Some recent studies include patients with psychoses and those with other behavioral disturbances; others include psychoses in dementia as well as other late-life psychoses. In this context, it is important to evaluate the recent literature with respect to the treatment of the psychoses associated with late-life dementias. This presentation will review both the published literature and other available data to estimate the magnitude of placebo and specific drug responses in patients with this syndrome. It will review available data on outcomes with respect to psychotic symptoms, associated behavioral symptoms, and day-to-day functioning, comparing drug effects in these patients with the wider groups of patients included in these trials.

No. 25B
PRACTICAL STRATEGIES FOR THE TREATMENT OF PSYCHOSES DUE TO DEMENTIA

Jacobo E. Mintzer, M.D., *67 President Street, PH-141, Charleston, SC 29425*

SUMMARY:

The psychoses due to dementia have only recently been validated as specific syndromes and knowledge about their diagnosis, natural history, and treatment responses is evolving rapidly. Nevertheless, it is possible at this time to translate current knowledge into recommendations for care. This session will present an early draft of a treatment algorithm designed to serve as a basis for discussion. It will consider the differential diagnosis of the psychoses due to dementia, the evaluations that should be conducted before treatment is initiated, appropriate indications for the use of antipsychotic medications, choice of agents, dosages, durations of treatment, and practical approaches for the evaluations of the outcomes of care. It will

also consider practical approaches to monitoring for side effects and strategies for the management of patients who cannot tolerate or do not respond to an initial course of treatment. It will discuss the importance of supplementing pharmacologic treatment with behavioral, interpersonal, and environmental approaches to care. Finally, it will discuss how the goals and strategies for treatment differ as a function of the context of care, whether the patients are residing in the community with their families, in assisted-living facilities, or in nursing homes.

No. 25C
PSYCHOSIS OF DEMENTIA

Lon S. Schneider, M.D., *1975 Zonal Avenue, KAM-400, Los Angeles, CA 90033*

SUMMARY:

Our understanding of the behavioral and psychological symptoms associated with dementia (BPSD) has advanced in recent years as a result of knowledge derived from clinical neuroscience, behavioral research, and clinical trials. Empirical findings have informed advances in the assessment of symptoms, the diagnosis of syndromes, and the regulatory environment in which care is delivered and treatments developed; these advances are, in turn, stimulating further research. In this context, there is a growing consensus that the psychoses due to dementia represent specific syndromes, characterized by distinct, less specific behavioral symptoms such as aggression and agitation. This presentation will review the recent literature and available data with respect to the nature of the psychotic symptoms that occur in patients with dementia, and the association of these symptoms with specific dementia diagnoses and with nonspecific behavioral symptoms. It will review evidence with respect to which symptoms are likely to be persistent in the absence of specific treatments, which are likely to remit, which are likely to be associated with behavioral symptoms, and which are likely to be benign. The goal will be to formulate an approach to diagnosis that can guide treatment decisions and an agenda for future research.

No. 25D
EFFECTS OF OTHER PSYCHOTHERAPEUTIC MEDICATIONS

Constanine G. Lyketsos, M.D., *600 North Wolfe Street, Osler 320-JHH, Baltimore, MD 21287*

SUMMARY:

A number of medications are currently used for the treatment of the behavioral and psychological symptoms of dementia (BPSD), including antipsychotic medications, mood-stabilizing anticonvulsants, certain antidepressants, acetylcholinesterase inhibitors, and other agents. Use of some of these medications is supported by findings from randomized clinical trials, while use of others has been suggested on the basis of clinical experience. With increasing recognition that psychoses due to dementia constitute specific syndromes, it is important to review what is known about the specificity of their treatment. It is now approximately four years since the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias of Late Life concluded that "Antipsychotics are the only pharmacologic treatment available for psychotic symptoms in dementia." It is time to review recent research findings to evaluate the extent to which this is still true. It is also time to reevaluate the Practice Guideline's statement, that "They are also the most commonly used and best-studied pharmacologic treatment for agitation, and there is considerable evidence for their efficacy," by reviewing current evidence about relative efficacies and the specificities of treatment responses for antipsychotics versus other agents in the wider area of BPSD.

REFERENCES:

1. Katz IR, Jeste DV, Mintzer JE, Clyde C, et al: Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized, double-blind trial. Risperidone Study Group. J Clin Psychiatry 1999; 60:107–115
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3. Ippen CG, Olin JT, Schneider LS: Can caregivers independently rate cognitive and behavioral symptoms in Alzheimer's disease patients? A longitudinal analysis. Am J Geriatr Psychiatry 1999; 7:321–330
4. Tariot PN: Treatment of agitation in dementia. Clin Psychiatry 1999; 60(suppl 8):11–20

INDUSTRY-SUPPORTED SYMPOSIUM 26—MOVING TOWARD A MORE COMPREHENSIVE MANAGEMENT OF PATIENTS WITH SCHIZOPHRENIA
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to construct a comprehensive management strategy for treating the multiple phases of schizophrenia.

No. 26A
ACUTE PSYCHOTIC AGITATION: EXPLORING NEW OPTIONS

Alan J. Mendelowitz, M.D., *7559 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

The assessment and treatment of agitated psychiatric patients in the emergency room and crisis center settings remains one of the most important clinical contacts that mental health practitioners make with patients.

This setting may be the first point of clinical contact for many patients and is often where antipsychotic treatment is initiated. The initial evaluation of these patients requires rapid evaluation, assessment, and quick decision making regarding diagnosis, issues of safety, use of the optimum medication regimen in the least restrictive clinical setting.

The initial assessment of patients in an emergency room or crisis center requires the clinician to consider a broad range of psychiatric illnesses that can present with psychotic agitation. The decision as to whether this patient requires medication or can respond to support and limit setting must be carefully reviewed.

The initiation of medication to treat psychotic agitation in the emergency room is an important clinical decision. The initial treatment strategies that are available will be reviewed with special attention to the benefits and limitations of the use of intramuscular vs. oral administration. A comparison of bonzodiazapenes, typical antipsychotics, and atypical antipsychotics will be examined.

No. 26B
BEYOND THE ACUTE PHASE: ISSUES IN STABILIZATION

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

SUMMARY:

Stabilization can be conceptualized as the transitional period following symptom exacerbation and treatment response. Often, during this period, many of the acute symptoms are better, but the patient remains fragile and at high risk for complications such as rehospitalization or suicide. Therefore, the stabilization phase can be very treacherous, both for the clinician and the patient. From the patient's point of view, stabilization of acute psychotic symptoms means increased demands in terms of attempting to return to the community. The clinician has to balance competing goals of safety and protection with rapid return to the community.

This presentation will review some recent data on the stabilization phase, and also cover issues pertaining to the transition between inpatient and outpatient care that often parallels the stabilization phase. Specific topics will include:

(1) issues relating to the transition between inpatient and outpatient care, and review of the rates of disconnected transitions and "no shows" to outpatient appointments,

(2) the assessment and management of suicidal behavior during the post-discharge stabilization period, including post-psychotic depression and the pharmacologic treatments available for this high risk time, and

(3) Review of the course of symptom resolution during stabilization, and comparison of the time course of positive and negative symptom improvement during the stabilization period between older, conventional antipsychotics, and the newer atypical antipsychotics.

No. 26C
PSYCHOSOCIAL TREATMENT FOR SCHIZOPHRENIA: STRATEGIES FOR THE NEW ERA

Nina R. Schooler, Ph.D., *75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Increasingly, psychosocial treatments for schizophrenia go beyond the provision of general support to treatments that are designed to address specific deficits or problems that characterize schizophrenia. Treatments are being developed that can be tailored to the cognitive deficits of individuals, that target specific symptoms such as persistent delusions or hallucinations, and that address limitations in the environments in which these patients live.

This presentation will first highlight some of the newer psychosocial treatment models for which there is evidence from well designed research studies of efficacy. In particular, we will review newer family strategies, skill training, cognitive-behavioral therapy, cognitive adaptation training, and vocational rehabilitation.

There is only limited information available regarding the interaction of newer antipsychotic medications and psychosocial treatment. However, the presentation will consider some possible models regarding the relationship of newer medications to psychosocial interventions. Finally, state of the art psychosocial treatments are not available to all who could benefit from them. The last portion of the presentation will consider some reasons for this and address the needs for translation from the research setting to the clinic.

No. 26D
RAISING THE BAR FROM SYMPTOM REDUCTION TO DISABILITY REDUCTION

Michael F. Green, Ph.D., *760 Westwood Plaza, C9-420, Los Angeles, CA 90024-1759*

SUMMARY:

There is increasing awareness that many patients with schizophrenia have difficulty in community functioning even when psychiatric symptoms are well controlled. These deficits in social functioning, vocational outcome, and independent living contribute to the high levels of disability in schizophrenia. The determinants of disability have been difficult to identify. However, the literature is consistent in pointing to neurocognitive deficits (e.g. problems in attention, memory, and problem solving) as key determinants for functional outcome. This presentation will review assessments for functional outcome and neurocognition in schizophrenia. The importance of neurocognitive deficits for acquiring skills in psychosocial rehabilitation will be emphasized. Finally, a relatively new approach to training, errorless learning, will be described.

No. 26E
IMPROVING THE OVERALL HEALTH OF PATIENTS WITH SCHIZOPHRENIA

Daniel E. Casey, M.D., *3710 SW U.S. Veterans Hospital Road, Portland, OR 97201*

SUMMARY:

The overall health of patients with schizophrenia is currently receiving increasing attention. While the atypical antipsychotic medicines substantially improve multiple domains of mental health, they must also be evaluated in the context of physical health. Prior to the development of atypical agents, ample evidence documents that patients with schizophrenia have significantly higher morbidity and mortality rates from physical diseases. The risk ratio for death from natural causes is approximately 1.4 compared with the general population. This is due to multiple factors. Approximately 75% of patients with schizophrenia smoke more than two packs of cigarettes per day compared with about 25% of the general population. Additionally, patients with schizophrenia have higher rates of obesity (higher body mass index-BMI). Consistent with higher BMIs, patients also have higher rates of diabetes and cardiovascular diseases. There is considerable evidence to also document that patients with schizophrenia get less medical care for these diseases than the general population. Atypical antipsychotic drugs are having a complex impact on the physical health of patients with psychosis. As a class of drugs, these agents greatly reduce the risk of extrapyramidal syndromes and tardive dyskinesia, thus removing a neurological burden. However, these atypical agents appear to have a differential effect rather than a class effect on other health parameters. For example, some drugs are associated with weight gain and abnormalities in glucose and lipid metabolism, but others are not. Thus, new cases of diabetes and cardiovascular diseases are emerging and existing cases are more difficult to manage. These emerging health issues, combined with the currently existing unmet medical needs, are providing new challenges to improving the outcomes of schizophrenia. These data will be reviewed and strategies for monitoring and managing these overall health issues will be presented.

REFERENCES:

1. Stelbel VG, Aller MH, Gordon S: Management of acute psychosis in the emergency sotting. Psychiatric Annals 2000; 30:238–247
2. Oilson M, Mechanic D, et al: Predicting medication noncompliance after hospital discharge among patients with schizophrenia. Psychiatric Services 2000; 51:216–222
3. Fenton WS, Schooler NR: Evidence-based psychosocial treatment for schizophrenia. Schizophrenia Bulletin 2000; 26(1):1–3
4. Green MF, Kern RR, et al: Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the "right stuff"? Schizophrenia Bulletin 2000; 26:119–136
5. Casay DE: The relationship of pharmacology to side effects. Journal of Clinical Psychiatry 1997; 58(suppl 10):55–62

INDUSTRY-SUPPORTED SYMPOSIUM 27—OPTIMIZING TREATMENT OUTCOMES IN PATIENTS WITH CHRONIC DEPRESSION, PART 1
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) list and define the disorders that constitute "chronic depression," (2) outline the advantages and disadvantages of pharmacotherapy, psychotherapy and combination treatment for chronic depression, (3) list four reasons why patients may not be completely satisfied with their treatment for chronic depression, (4) list four pharmacoeconomic and psychosocial outcomes that would be desirable to achieve when treating chronic depression.

No. 27A
PHARMACOTHERAPY AND PSYCHOTHERAPY: NEW DATA ON THE LONG-TERM TREATMENT OF CHRONIC DEPRESSION

Martin B. Keller, M.D., *345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

The recurrent and chronic nature of major depression indicates that successful management necessitates long-term treatment. Experts generally agree that treatment continue for at least four to six months after initial response is achieved. Long-term prophylactic treatment is recommended for recurrent and chronic major depression, although a consensus has not been reached regarding the optimal duration of treatment. Evidence suggests the need for remission of symptoms, not just response. Failure to achieve remission in recurrent and chronic major depression results in persistent psychopathological and psychosocial consequences. A dichotomy in treatment approaches to chronic major depression persists—i.e., between pharmacotherapy and psychotherapy. Compelling new evidence suggests that a combination of these treatment approaches provides enhanced efficacy compared with either monotherapy alone in the treatment of chronic depression. At the conclusion of the continuation phase of a long-term treatment study in which patients with chronic major depression received nefazodone pharmacotherapy; cognitive behavioral analysis system of psychotherapy, (CBASP), a psychotherapy developed specifically for chronic depression; or a combination thereof, approximately 75% of patients who achieved remission (HAM-D-24 total score of ≤ 8) in the acute treatment phase maintained remission across all three treatment groups. Among significant responders (HAM-D-24 total score of >8 but ≤15 with a 50% decrease from baseline), approximately 50% of patients in all three treatment groups went on to achieve remission with continuation therapy. These findings have significant implications for the maintenance treatment of chronic depression, on which new data will be presented in this forum.

No. 27B
ACHIEVING REMISSION IN THE TREATMENT OF CHRONIC DEPRESSION

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

SUMMARY:

Most medical conditions are treated to attain a state of remission. This often includes the normalization of biological parameters associated with the underlying pathophysiology (e.g., blood glucose levels in diabetes). Only recently has remission become the preferred goal when treating depression and other mental illnesses—typically defined as the complete absence of symptoms and a return to normal levels of daily function. This presentation addresses a number of clinically relevant questions in the attainment and maintenance of remission. The importance of remission as related to functional restoration and a better overall prognosis will be discussed. Evidence will be reviewed indicating a greater likelihood of attaining remission if intervention occurs earlier rather than later. Factors that delay the onset of remission or reduce the likelihood of attaining remission will be highlighted. Whether treatments differ in their capacity to attain remission will be evaluated, as will the duration of acute phase treatment (medication or psychotherapy) required to determine if and when remission occurs. Strategies such as augmenting one treatment with another (medication/psychotherapy) or switching from one treatment to another will be reviewed. Finally, the implications for clinical practice (e.g., measuring symptom severity or functional capacity) and for the provision of adequate mental health care coverage by third party payors will be noted.

REFERENCES:

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2. Rush AJ, Koran LM, Keller MB, et al: The treatment of chronic depression, Part 1: study design and rationale for evaluating the comparative efficacy of sertraline and imipramine as acute, crossover, continuation, and maintenance phase therapies. J Clin Psychiatry 1998; 59:589–597

INDUSTRY-SUPPORTED SYMPOSIUM 27—OPTIMIZING TREATMENT OUTCOMES IN PATIENTS WITH CHRONIC DEPRESSION, PART 2
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

To (1) list and define the disorders that constitute "chronic depression," (2) outline the advantages and disadvantages of pharmacotherapy, psychotherapy and combination treatment for chronic depression, (3) list four reasons why patients may not be completely satisfied with their treatment for chronic depression, (4) list four pharmacoeconomic and psychosocial outcomes that would be desirable to achieve when treating chronic depression.

No. 27A
MAXIMIZING PATIENT SATISFACTION DURING THE LONG-TERM TREATMENT OF DEPRESSION

Susan G. Kornstein, M.D., *P.O. Box 980253, Richmond, VA 23298-0253*

SUMMARY:

As with most psychiatric disorders, noncompliance among depressed patients can jeopardize successful treatment response and increase risk of relapse and recurrence. Among patients with major depression, nearly 70% of patients are noncompliant. The long-term management of depression requires attention to patient adherence,

for which patient satisfaction is essential. Patient satisfaction can be described with regard to not only symptom reduction, but also quality of life. To ensure satisfaction with antidepressant therapy, efficacy, safety, and quality-of-life issues need to be balanced. Since all antidepressants are associated with some side effects, it is important to understand which side effects patients can tolerate in the short and long term. Prescribing an antidepressant that maximizes efficacy and minimizes treatment-emergent adverse effects, such as sexual dysfunction and weight gain, should be the goal. In addition, certain antidepressants may worsen sleep disturbance and anxiety, while others improve these key symptoms of depression without the need for concomitant treatment. This presentation reviews the efficacy and safety profiles of the SSRIs and newer antidepressants. Data from a long-term study of chronic depression will be presented on maximizing patient satisfaction and compliance.

No. 27B
PHARMACOECONOMIC AND PSYCHOSOCIAL OUTCOMES IN THE MANAGEMENT OF CHRONIC DEPRESSION

James M. Russell, M.D., *404 University Boulevard, Galveston, TX 77555-0197*

SUMMARY:

There are substantial economic benefits when chronically depressed individuals receive effective treatment. Depression is at least as disabling as many other chronic medical illnesses. Depressed patients in the Medical Outcomes Study were as disabled as those with congestive heart failure. Despite the high economic burden of this prevalent and disabling condition, little work has been done to evaluate the cost-effectiveness of different depression treatment interventions. In the current economic environment, it is increasingly important to not only evaluate the efficacy of treatments, but their overall cost-effectiveness. In addition to reducing clinical symptoms, cost-effective depression treatment interventions must also consistently restore the functional and economic capacity of depressed individuals.

In two randomized trials evaluating chronic depression, the positive impact of treatment on functional capacity will be reviewed. Special emphasis will be placed on economic variables such as lost days from work, productivity while at work, and changes in economic status. In the most recent of these two trials, comparing nefazodone, CBAS-psychotherapy, and their combination, results of a prospective, randomized, cost-effectiveness analysis are described.

Results from this study will clearly demonstrate that the highest-cost treatment, combined nefazodone and psychotherapy, is as cost-effective as the lowest-cost treatment, nefazodone alone. Health policy implications of these results will be discussed and reviewed.

REFERENCES:

1. Thase ME: Long-term nature of depression. J Clin Psychiatry 1999; 60(suppl 14):2–9
2. Hays 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

INDUSTRY-SUPPORTED SYMPOSIUM 28—WOMEN'S MENTAL HEALTH: ANTIDEPRESSANT THERAPY DURING THE CHILDBEARING YEARS, PART 1
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the importance of identifying and treating depression in women; recognize the symptoms and treatment options for PMDD; consider the risks and benefits of antidepressant therapy during pregnancy; consider the consequences of postpartum depression on both mother and child; and understand the association between menopause the depression.

No. 28A
THE EPIDEMIOLOGY OF DEPRESSION THROUGHOUT THE FEMALE LIFE CYCLE

Vivien K. Burt, M.D., *300 Medical Plaza, Los Angeles, CA 90024*

SUMMARY:

Women are twice as likely as men to suffer from depression. The reasons for this probably relate to psychosocial and biological factors. It is likely that female sex hormones have psychoactive effects that may explain why depression is more common in women than in men. For some women, reproductive life events represent times of increased vulnerability for mood disorders. Puberty marks the beginning of the increased risk for depression in women. For some women, the premenstrual days may be associated with depressive and anxious symptoms as well as physical discomfort. During the six months postpartum, women are at risk for postpartum depression and other postpartum disorders. Miscarriage and the perimenopause are also associated with depressive symptoms in vulnerable women, particularly those with psychiatric histories. While pregnancy does not increase the risk for depression, women with histories of depression are at risk for recurrence and are prone to relapse if their antidepressant medications are discontinued abruptly during the acute or continuous phases of treatment. Viewing the female life cycle longitudinally, and using reproductive transitional events as markers, guidelines for prophylaxis and treatment to minimize severity in cases of recurrence are discussed.

No. 28B
DIAGNOSIS AND TREATMENT OF PMDD

Elias Eriksson, Ph.D., *PO Box 431, Goteborg, Sweden S-40530*

SUMMARY:

Premenstrual dysphoria (PMD) is a severe form of premenstrual syndrome, afflicting approximately 5% of all women of fertile age. The cardinal symptoms are irritability and anger that surface regularly between ovulation and menstruation and disappear completely within a few days after the onset of bleeding; in addition, sadness, tension, and carbohydrate craving are common complaints. In a large number of recent trials, serotonin reuptake inhibitors (SRIs) have been shown to reduce the symptoms of PMD much more effectively than placebo; in contrast, the nonserotonergic antidepressants appear to be ineffective. The onset of action of SRIs is much shorter when used for PMD than when used for other disorders; patients with PMD thus can restrict the medication to the luteal phase of the cycle (intermittent treatment). The observation that the SSRIs may effectively reduce the symptoms of PMD is of considerable clinical importance, since previously no effective treatment for this common condition—apart from those disrupting ovarian cyclicity—has been available. It is also of theoretical importance since it lends support to the hypothesis that a major role for brain serotonergic transmission is to modulate sex-steroid-driven behavior.

No. 28C
THE IMPLICATIONS OF ANTIDEPRESSANT THERAPY DURING PREGNANCY

Lori L. Altshuler, M.D., *300 Medical Plaza, Suite 1544, Los Angeles, CA 90024*

SUMMARY:

Because the onset of mood and anxiety disorders often occurs during the childbearing years, many women may be taking psychotropic medications when they conceive. Since these medications easily diffuse across the placenta, their impact on the fetus is of concern. However, discontinuation may lead to relapse with resulting psychiatric symptoms affecting both mother and fetus. There is a paucity of data on the use of antidepressants in pregnancy, making treatment options challenging for the clinician. Data available for lithium, benzodiazepines, and anticonvulsants point to increased risks for congenital malformations in the children of mothers exposed to these agents in the first trimester of pregnancy. Data available on antidepressant exposure in utero suggest a relative safety of use of tricyclic antidepressants and SSRIs during pregnancy, although larger studies are needed. Very little is known about behavioral effects among offspring of mothers exposed in utero to antidepressant agents. The few human studies do not suggest long-term effects, but given the very limited data, no definitive conclusions can be drawn. The data available on antidepressant use in pregnancy and clinical outcomes of the infants will be reviewed.

REFERENCES:

1. Burt VK, Altshuler LL, Rasgon N: Depressive symptoms in the perimenopause: prevalence, assessment, and guidelines for treatment. Harv Rev Psychiatry 1998; 6:121–32
2. Ericksson E: Serotonin reuptake inhibitors for the treatment of premenstrual dysphoria. Int Clin Psychopharmacol 1999; 14(suppl 2):S27–33
3. Altshuler LL, Hendrick V, Cohen LS: Psychotropic drug use during pregnancy: weighing the risks. J Clin Psychiatry 1998; 59(suppl 2):S29–33

INDUSTRY-SUPPORTED SYMPOSIUM 28—WOMEN'S MENTAL HEALTH: ANTIDEPRESSANT THERAPY DURING THE CHILDBEARING YEARS, PART 2
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the importance of identifying and treating depression in women; recognize the symptoms and treatment options for PMDD; consider the risks and benefits of antidepressant therapy during pregnancy; consider the consequences of postpartum depression on both mother and child; and understand the association between menopause and depression.

No. 28A
THE TREATMENT OF POSTPARTUM DEPRESSION: RISKS AND BENEFITS TO MOTHER AND CHILD

Zachary S. Stowe, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322;* Amy L. Hostetter, B.A.

SUMMARY:

In the weeks following childbirth, certain women are at elevated risk for depression. Risk factors include a previous history of depression, inadequate social supports, and a conflictual relationship with the spouse/partner. Primary care clinicians frequently miss the diagnosis unless they are educated on the use of screening instruments. The identification and treatment of postpartum depression is important not only to help the mother but also to prevent potential adverse outcomes in the child. A number of studies have found that children of mothers who experienced postpartum depression show poorer outcomes on cognitive and behavioral measures when compared with children of non-depressed women. Once diagnosed, women suffering from postpartum depression typically respond well to treatment. Treatment strategies should take into account the clinical characteristics that distinguish postpartum depression from depression occuring at other times in women's lives. This lecture will review 1) risk factors for postpartum depression, 2) strategies for making the diagnosis, and 3) pharmacologic and nonpharmacologic treatments.

No. 28B
ANTIDEPRESSANT TREATMENT GUIDELINES FOR WOMEN OF CHILDBEARING AGE

Victoria Hendrick, M.D., *3615 Moore St, Los Angeles, CA 90066-3044*

SUMMARY:

The postpartum period has historically been associated with a time of increased vulnerability to psychiatric illness. Previous reports have demonstrated the profound rise in psychiatric admissions for women during the first three months postpartum. Despite the long-standing awareness of psychiatric illness following childbirth, there is sparse etiological data that has been replicated. Recent prospective investigations have confirmed that depressive or anxiety symptoms during pregnancy increase the risk for postpartum illness. The treatment of women during the postpartum period, particularly if breastfeeding, represents a unique and important clinical decision. The data on the treatment of postpartum depression is limited, while the data on the use of medications during breastfeeding has rapidly expanded. However, at this time, there exists a relative absence of consensus regarding the most safe and efficacious treatment for women who suffer from depression following pregnancy during breastfeeding. This presentation will introduce a set of guidelines for the administration of antidepressants and mood stabilizers in breastfeeding women.

REFERENCES:

1. Hostetter A, Stowe ZN: Postpartum affective disorders: identification and treatment. Psychiatric Issues in Women: Emerging Treatments and Research. Edited by Lewis-Hall, Panetta, Williams, Herrera. (in press)
2. Cohen LS, Rosenbaum JF: Psychotropic drug use during pregnancy: weighing the risks. J Clin Psychiatry 1998; 59(suppl 2):18–28

INDUSTRY-SUPPORTED SYMPOSIUM 29—COMPARING ATYPICAL ANTIPSYCHOTIC THERAPIES: MAKING SENSE OF THE DATA, PART 1
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

To learn about results of all head-to-head comparative clinical trials of various atypical antipsychotics and understand how these data compare with results from all placebo-controlled and conventional antipsychotic-controlled trials with these agents, to understand the similarities and differences between different atypical antipsychotics with regards to efficacy, tolerability, and effectiveness, to become aware of common barrier and pitfalls in achieving optimal effectiveness.

No. 29A
EXAMINING THE EFFICACY OF ATYPICAL ANTIPSYCHOTICS: IS THERE A DIFFERENCE?

Alan J. Mendelowitz, M.D., *7559 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

The standard of treatment for patients with psychotic symptoms has changed immensely over the last decade. The introduction of a new and atypical generation of antipsychotic medications has had a tremendous impact on the way clinicians prescribe antipsychotics. With four atypical antipsychotics available and more on the horizon, the clinician is faced with the clinical question of which medication to choose for patients. Over the last few years there have been several studies comparing the atypical antipsychotics to each other in short-term studies with long-term extensions. The question of what we can learn from these studies will be examined.

In examining the differences between these agents, it is important to closely review the methodology of the studies to understand if this had an impact on the results. In addition to examining potential differences in the efficacy of the atypical antipsychotics, we will review differences in their side-effect profiles, as well as examine the question of whether there is a difference in the speed of onset among the various agents.

No. 29B
EPS AND THE ESSENCE OF ATYPICALITY: ARE ALL ATYPICAL ANTIPSYCHOTICS THE SAME?

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

SUMMARY:

Previously, clinicians worked with antipsychotic drugs that almost invariably caused extrapyramidal side effects (EPS) at the dose at which they were clinically effective. By definition, all atypical antipsychotic agents are significantly better than conventional agents with regard to EPS; i.e., they are clinically effective at doses at which they do not cause EPS. This EPS advantage of atypical antipsychotics translates into several important clinical benefits, including better negative symptom efficacy, lesser dysphoria, less impaired cognition, and a lower risk of tardive dyskinesia; in fact, this "EPS advantage" is the basis of the clinical advantages provided by the class of atypical antipsychotics. While all atypical agents share this "EPS advantage," there are important differences between the various atypical antipsychotics with regard to the ease and consistency with which this EPS advantage can be realized. Pharmacologically, different atypical antipsychotics differ in the degree of separation between the dose response curves for their antipsychotic and EPS effects. Clinically, this pharmacological difference translates into different degrees of risk to cause EPS with increasing doses of the atypical antipsychotic. Clinical settings in which these differences are particularly relevant will be discussed. Placebo-controlled and conventional antipsychotic-controlled comparisons of the atypical antipsychotics will be summarized and all head-head studies comparing atypical agents will be reviewed with regards to the above issues. Since the EPS advantage of the atypical agents is the basis of their several advantages over conventional neuroleptics, it is critical that they be used in such a manner that EPS is avoided.

No. 29C
RELATIVE TOLERABILITY OF NOVEL ANTIPSYCHOTICS: IMPACT ON WEIGHT GAIN AND SEXUAL FUNCTION

Donna A. Wirshing, M.D., *11301 Wilshire Boulevard, Building 210 B151, Los Angeles, CA 90073*

SUMMARY:

The novel antipsychotic drugs (NAPDs) offer significant advantages over conventional antipsychotic drugs (CAPDs) due to their favorable extrapyramidal side effect (EPS) profiles. Unfortunately these medications are associated with other side effects, such as weight gain and sexual problems. Compounding obesity onto serious mental disorders such as schizophrenia, schizoaffective disorder, and manic-depressive illness increases our patients' morbidity and mortality. Both obesity and sexual dysfunction can negatively impact treatment adherence. This session aims to provide the participant with up-to-date information about the relative liabilities of novel antipsychotic medications on weight gain and sexual dysfunction. This session will provide a review of the literature on phenomena that are associated with novel-antipsychotic-induced weight gain such as diabetes, hypercholesterolemia, and hypertriglyceridemia. Additionally, this session will provide some guidelines for monitoring these side effects. We will also review the literature on the treatment of APD-associated weight gain and sexual dysfunction.

REFERENCES:

1. Tran PV, Hamilton SH, Kuntz AJ, et al: Double-blind comparison of olanzapine versus risperidone in the treatment of schizophrenia and other psychotic disorders. J Clin Psychopharmacol 1997; 17(5):407–418
2. Tandon R, Milner K, Jibson MD: Antipsychotics from theory to practice: integrating clinical and basic data. J Clin Psychiatry 1999; 60(supplement 8):21–28
3. Wirshing DA, Wirshing WC, Kysar L, et al: Novel antipsychotics: comparison of weight gain liabilities. J Clin Psychiatry 1999; 358–363

INDUSTRY-SUPPORTED SYMPOSIUM 29—COMPARING ATYPICAL ANTIPSYCHOTIC THERAPIES: MAKING SENSE OF THE DATA, PART 2
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: To learn about results of all head-head comparative clinical trials of various atypical antipsychotics and understand how these data compare with results from all placebo-controlled and conventional antipsychotic-controlled trials with these agents; to understand the similarities and differences between different atypical antipsychotics with regards to efficacy, tolerability, and effectiveness; to become aware of common barrier and pitfalls in achieving optimal effectiveness.

No. 29A
BEYOND EFFICACY AND SYMPTOM CONTROL: EFFECTIVENESS AS THE BEST MEASURE OF ANTIPSYCHOTIC DRUG THERAPY

Henry A. Nasrallah, M.D., *1500 East Woodrow Wilson Drive, Jackson, MS 39216*

SUMMARY:

Controlled research trials that are done to develop new drugs for a psychiatric disorder like schizophrenia are generally designed to measure the impact of the compound on the main symptoms of the disease, such as positive, negative, and mood symptoms. Adverse effects are also noted. On the other hand, when the drug is approved and launched, clinicians start using the same drug in thousands of

patients and do not necessarily aim for the same efficacy parameters as in the research trials.

In the real world, the outcome measures that really matter go beyond symptomatic efficacy and include such parameters as relapse and rehospitalization, tolerability of the drug, consistency of adherence to treatment and compliance with the drug regimen, patient satisfaction, quality of life, social functioning, morbidity and mortality, family burden, and the costs of disease management. All these clinical outcomes represent effectiveness of the medication, which transcends its efficacy and takes into account the ability of the drug to impact the patient's life in a positive manner that leads to overall wellness, not simply a remission of symptoms. There is a widely recognized "efficacy-effectiveness gap" that results from the research versus the clinical paradigms of measuring the effects of a pharmacological agent on an illness. In this presentation, an overview of the various factors that account for this "gap" will be discussed including patient factors and institutional factors.

No. 29B
OPTIMIZING OPTIMISTICALLY: GETTING THE MOST OUT OF THE ATYPICAL ANTIPSYCHOTICS

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

SUMMARY:

The atypical antipsychotics have helped many patients achieve outcomes hardly thought possible even a few years ago. One of the key steps to achieving these better outcomes goes beyond just prescribing them, but to prescribing them correctly. These technical aspects of medication use—including choice of medication, switching, titrating, length of treatment trial, and target dosing—are sometimes referred to as "optimizing" the therapeutic regimen.

This talk will cover some of the technical aspects of "optimizing" atypical antipsychotics. Specific areas include (1) choice of antipsychotic, (2) switching technique, (3) dose titration techniques, (4) length of therapeutic trial, and (5) target dosing. Moving beyond "optimizing" the regimen, the next step is to help "optimize" the patient's life. This broader concept of "optimization" can be achieved by considering how the symptom response will fit into other aspects of the patient's life. This level of optimization needs to include nonpharmacologic aspects of treatment, such as the therapeutic alliance, psychoeducation, and rehabilitation. The latter part of this talk will discuss examples of integrating medication response with the recovery process.

REFERENCES:

1. Wells KB: Treatment research at the crossroads: the scientific interface of clinical trials and effectiveness research. American Journal of Psychiatry 1999; 156:5–10
2. McEvoy J, Scheifler P, et al: Treatment of schizophrenia 1999. J Clin Psychiatr 1999; 60(suppl 11):1–80
3. Weiden P, Scheifler P, Ross R, Diamond R: Breakthroughs in Antipsychotic Medications: A Guide for Consumers, Families, and Clinicians. New York, Norton, 1999

INDUSTRY-SUPPORTED SYMPOSIUM 30—MOOD AND ANXIETY DISORDERS IN UNDERSTUDIED POPULATIONS, PART 1
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize symptoms of depression and anxiety disorders in children and adolescents, increase knowledge about treatment strategies for mood and anxiety disorders in youth, describe the risk/benefit assessment for the mother and infant associated with treatment of psychiatric disorders in the pregnant and breastfeeding woman, treat depression/anxiety in patients with cancer, and treat mood disorders in menopausal women.

No. 30A
MAJOR DEPRESSION IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *1519 Rebecca Skaly Bldg, 101 University Blvd, Galveston, TX 77550-0188*

SUMMARY:

Major depression in children and adolescents is a severe disorder and has significant adverse effects on a child's academic, peer, and family functioning. There is a high recurrence rate and significant risk for suicide in depressed youth. Switch to mania or hypomania is common with prepubertal-onset depression. There is increasing evidence for continuity between depression in adolescence and adulthood. Therefore, early recognition and treatment of depression in children and adolescents is essential. Recent studies support the efficacy and safety of selective serotonin reuptake inhibitors (SSRIs) and question the usefulness of tricyclic antidepressants (TCAs) in this age group. There is increased interest in the study of newer antidepressants for childhood depression. This presentation will focus on diagnostic issues, familial association, and course of depression in children and adolescents. The status of current treatments, including psychotherapy and pharmacotherapy, will be discussed. Medication treatment strategies will be presented.

No. 30B
OCD AND SOCIAL ANXIETY DISORDER IN CHILDREN AND ADOLESCENTS

John T. Walkup, M.D., *600 North Wolfe Street, CMSC 343, Baltimore, MD 21287-3325*

SUMMARY:

Anxiety disorders in children are common and impairing conditions that often go unrecognized and untreated. Recent research in childhood anxiety disorders, including biological studies and short-term and long-term treatment studies provides a new model for diagnosis and treatment of childhood anxiety.

The presenter will review the current literature and studies underway in childhood anxiety disorders including OCD and social phobia. The author will present a model for the evaluation and treatment of childhood anxiety including strategies for complex cases.

Childhood anxiety is amenable to treatment but requires a rigorous assessment and modern treatment strategies including pharmacotherapy and cognitive behavioral therapy. A pharmacological algorithm for complex cases will be presented.

Children with anxiety disorders, if treated with modern pharmacotherapy and cognitive behavioral therapy, can experience significant improvement. Treatment of complex cases draws on strategies developed for the treatment of mood disorders and OCD.

No. 30C
USE OF ANTIDEPRESSANTS IN PREGNANT AND BREASTFEEDING WOMEN

Zachary S. Stowe, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

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 underscores the high probability that the clinician will encounter such situations. In the absence of enough data to provide scientifically derived 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. The definition of exposure, placental passage, and breast-milk excretion will be discussed during this presentation, as will information on how to interpret the available data so that it becomes clinically relevant to psychiatric practice.

REFERENCES:

1. Weissman MM, Wolk S, Goldstein RB, et al: Depressed adolescents grown up. JAMA 1999; 281:1707–1713
2. Labellarta M, Ginsburg G, Walkup J, Riddle M: Treatment of pediatric anxiety disorders. Biological Psychiatry 1999; 46:1567–1578
3. Liewellyn A, Stowe AN: Psychotropic medications in lactation. J Clin Psychiatry 1998; 59(suppl 2):41–52

INDUSTRY-SUPPORTED SYMPOSIUM 30—MOOD AND ANXIETY DISORDERS IN UNDERSTUDIED POPULATIONS, PART 2
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES:

To recognize symptoms of depression and anxiety disorders in children and adolescents, increase knowledge about treatment strategies for mood and anxiety disorders in youth, describe the risk/benefit assessment for the mother and infant associated with treatment of psychiatric disorders in the pregnant and breastfeeding woman, treat depression/anxiety in patients with cancer, and treat mood disorders in menopausal women.

No. 30A
THE CANCER PATIENT WITH DEPRESSION

Dominique L. Musselman, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Cancer is the second most common cause of death in the United States, superceded only by heart disease. Depressive and anxiety disorders, though commonly encountered in patients with cancer, are frequently underdiagnosed and undertreated. The challenge of diagnosing depression in patients with cancer is complicated by neurovegetative symptoms that may be secondary to either the neoplasm or cancer therapy. Cancer patients may be at higher risk for development of anxiety or depressive disorders due to alterations in their hypothalamic-pituitary-adrenal axis activity and/or immune function. We present the results of a double-blind, placebo-controlled trial of patients with malignant melanoma who received pretreatment with paroxetine prior to high-dose interferon therapy. Pretreatment with antidepressants of patients undergoing certain cancer treatments may prevent and/or ameliorate the development of fulminant psychiatric disorders, thereby improving quality of life, compliance with cancer therapy, and survival.

No. 30B
PSYCHIATRIC IMPLICATIONS OF THE MENOPAUSE

Dwight L. Evans, M.D., *305 Blockley Hall, 423 Guardian Drive, Philadelphia, PA 19104*

SUMMARY:

The menopause represents a period in the female life cycle of increased risk for psychological symptoms, including mood disturbances. Perimenopausal woman appear to be at greatest risk. New-onset illness as well as exacerbation of existing disorders may be common. Depression occuring during the menopause is related to a variety of factors, including life stressors, hot flashes, and changing reproductive function. Estrogen and progesterone have marked effects on neurotransmitter system function. A growing body of literature suggests that menopause-related estrogen deficiency may be associated with an increased risk of depression. Thus, estrogen replacement therapy is being studied as both primary treatment and augmentation therapy in menopausal depression. The selective serotonin reuptake inhibitors (SSRIs) and other serotonergic antidepressants are also being studied in the treatment of menopausal symptoms (e.g., hot flashes) in woman undergoing treatment for breast cancer. This presentation will review the prevalence, etiology, risk factors, and treatment considerations for mood disorders in menopausal woman.

REFERENCES:

1. Burr VA, Altshular LL, Rasgon N: Depressive symptoms in the perimenopausal prevalence, assessment, and guidelines for treatment. Harv Rev Psychiatry 1998; 5:121–132

INDUSTRY-SUPPORTED SYMPOSIUM 31—WEIGHING THE OPTIONS FOR MANAGING BIPOLAR DEPRESSION, PART 1
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES:

To be aware of somatic and psychosocial interventions with efficacy for acute and prophylactic treatment of bipolar depression, list the therapeutic options for refractory bipolar depression, and understand factors that influence duration of continuation phase treatment.

No. 31A
INITIAL TREATMENT OPTIONS FOR BIPOLAR DEPRESSION

Russell T. Joffe, M.D., *1200 Main Street West, Room 2E1, Hamilton, ON Canada L8N 3Z5*

SUMMARY:

Bipolar depression presents a major therapeutic challenge. Furthermore, there are limited empirical data to guide rational treatment decisions. Antidepressants may be effective in acute bipolar depression, but may increase the risk of switch into mania and cycle acceleration. On the other hand, mood stabilizers, with the possible exception of lamotrigine, may be less effective as acute antidepressants. The literature on the efficacy of various treatment options in acute bipolar depression will be critically reviewed. Particular attention will be paid to comparative data between antidepressants and mood stabilizers including a recent double-blind controlled study of antidepressant vs. a second mood stabilizer in acute bipolar depression. The consequences of treatment including cycle acceleration

and switch into mania with the various treatment options will be critically evaluated. A rational clinical approach to the initial management of bipolar depression will be reviewed.

No. 31B
ALTERNATIVES FOR PATIENTS REFRACTORY TO AN INITIAL COURSE OF TREATMENT

Claudia Baldessano, M.D., *3600 Market Street, 8th Floor, Philadelphia, PA 19104*

SUMMARY:

The depressed phase of bipolar disorder represents a challenge to both clinicians and patients and their families. Not only do standard therapies often fail, but effective acute-phase treatments sometimes appear to worsen outcomes by shortening cycle length or inducing mixed states and frank manic episodes. The alternative to vigorous acute phase therapy, namely "watchful waiting" with continued mood stabilization and psychotherapeutic support, is often not an acceptable alternative because of the ongoing burden of disability and subjective suffering. This talk will review the major sequential strategies available for treatment of bipolar depressions that have not responded to first-line therapies. Important options to be reviewed will include monoamine oxidase inhibitors, electroconvulsive therapy, thyroid augmentation, psychostimulants and other dopaminergic agonists, atypical antipsychotics, and the novel anticonvulsant lamotrigine. Adjunctive nonpharmacologic interventions, including sleep deprivation, phototherapy, and cognitive behavior therapy, also are useful on occasion. A treatment algorithm will be presented, with treatments sequenced on the basis of evidence of efficacy and potential risks.

REFERENCES:

1. Young LT, Joffe RT, Robb JC, et al: Double-blind comparison of the addition of a second mood stabilizer vs. an antidepressant to an initial mood stabilizer for treatment of patients with bipolar depression. Am J of Psychiatry 2000; 57:124–126
2. Thase ME, Sachs GS: Bipolar depression: pharmacotherapy and related therapeutic strategies. Biological Psychiatry (in press)

INDUSTRY-SUPPORTED SYMPOSIUM 31—WEIGHING THE OPTIONS FOR MANAGING BIPOLAR DEPRESSION, PART 2
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES:

To be aware of somatic and psychosocial interventions with efficacy for acute and prophylactic treatment of bipolar depression, list the therapeutic options for refractory bipolar depression, and understand factors that influence duration of continuation phase treatment.

No. 31A
INTERPERSONAL AND SOCIAL RHYTHM THERAPY PREVENTS DEPRESSIVE SYMPTOMATOLOGY IN BIPOLAR I DISORDER

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

SUMMARY:

Recent studies point to the relatively poor long-term prognosis for many bipolar I patients. We are conducting a randomized controlled trial comparing interpersonal and social rhythm therapy (IPSRT) with an intensive clinical management (CM) paradigm, both in the context of protocol-guided maintenance pharmacotherapy. We report on the first year of preventative maintenance treatment for the initial 86 subjects included in this trial. Fluctuation of symptoms during the preventative phase of the trial was examined by defining the symptomatic state of each subject for each month. A mixed-effects multinomial logistic regression analysis was used to compare the states of subjects in the two treatment conditions. There was a significant month-by-treatment interaction ($p < .0006$) indicating that relative to subjects assigned to CM, over time subjects assigned to the IPSRT group were significantly more likely to remain in a euthymic than a depressed state. There was no significant difference between the treatments when comparing the manic/mixed state to the euthymic state.

IPSRT may have an important role in preventing depressive symptomatology in patients with bipolar I disorder and, thus, in improving the quality of long-term remission they experience.

No. 31B
BIPOLAR DEPRESSION: CONTINUATION-PHASE OPTIONS

Gary S. Sachs, M.D., *50 Staniford Street, 5th floor, Boston, MA 02114*

SUMMARY:

Following remission of an acute episode of depression, patients enter the continuation phase during which effective acute-phase treatment is sustained to ensure a stable remission. The critical decision to be made is, how long should the continuation phase last? There are very few data to guide this decision, and no controlled study has been published.

Expert recommendations for continuation of standard antidepressants range from two months to indefinitely. Altshuler et al. reported refractory bipolar depressed patients receiving antidepressant medication often experienced negative outcomes (treatment-emergent mania = 35%, cycle acceleration = 26%). Resolving this dilemma is not simple since the same investigator separately reported that after discontinuation of antidepressant medication, bipolar patients frequently suffer recurrence of depression.

Strategies that reduce the potential for negative outcomes of both types include determining the duration of continuation treatment based on the patients pattern of illness, selection of agents with low propensity to cause affective switch, use of daily mood charting, and gradual taper of antidepressant medications.

Use of these strategies allows an individualized iterative approach to treatment.

REFERENCES:

1. Frank E, Kupfer DJ, Ehlers CL, et al: Interpersonal and social rhythm therapy for bipolar disorder: integrating interpersonal and behavioral approaches. Behavior Therapist 1994; 17:143–149
2. Altshuler LL, Post RM, Leverich GS, et al: Antidepressant-induced mania and cycle acceleration: a controversy revisited. Am J Psychiatry 1995; 152:1130–1138

INDUSTRY-SUPPORTED SYMPOSIUM 32—THE IMPULSIVE AGGRESSIVE SPECTRUM: CHALLENGING POPULATIONS, PART 1
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

To understand the mechanisms of aggression and how they relate to neuropsychiatric disorders, such as borderline personality disorder, intermittent explosive disorder, bipolar illness, PTSD, and substance

use disorder, and treat these spectrum disorders with state-of-the-art pharmacologic intervention.

No. 32A
THE IMPULSIVE AFFECTIVE SPECTRUM

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

SUMMARY:

Impulsivity is a basic aspect of behavior that is prominent in bipolar disorder and in similar less episodic conditions including personality disorders, intermittent explosive and related disorders, and substance abuse. It may be responsible for much of the morbidity and mortality associated with these illnesses. Yet there is little information about the measurement of impulsivity in these conditions or methods for identifying disturbances of impulsivity. We will explore neurochemical, neurophysiological, and behavioral mechanisms of impulsivity and impulsive aggression. These models have direct consequences for diagnosis and treatment of impulsive spectrum disorders. Despite the heterogeneity of mania, impulsivity is the sine qua non of manic episodes, and it must be reduced if treatment is to be successful. Laboratory and personality measures demonstrate both state- and trait-related increases in impulsivity in bipolar disorder and provide leads for detection and monitoring of impulsivity disturbances. Data from studies of personality disorders, variants of intermittent explosive disorder, substance abuse, and disruptive behavior disorders in adolescents all demonstrate that impulsivity is a measurable common factor in these conditions. The pharmacologic treatment of impulsivity appears to be similar regardless of its diagnostic context.

No. 32B
VERY BAD BEHAVIORS

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

SUMMARY:

We're often flooded with examples of very bad behavior in our every day lives and in the media. These behaviors may lie along a continuum from the mildly offensive to the dangerous. This presentation will examine these bad behaviors as an outgrowth of impulse control disorders and personality disorders. These behaviors have been viewed from many different perspectives throughout the ages, regarded as deadly sins, morally reprehensive behavior, legal infractions, or manifestations of specific psychiatric disorders. This presentation will examine the medical factors that contribute to these bad behaviors and the specific disorders that are characterized by bad behaviors. Specifically, the impulse control disorders such as intermittent explosive disorder, pyromania, trichotillomania, pathological gambling, as well as sexual compulsions will be described. In addition, the personality disorders characterized by impulsive aggression, such as borderline personality disorder and antisocial personality disorder, will be examined. Other factors that contribute to this behavior including attention deficit disorder/hyperactivity disorder, reward deficiency syndromes, and bipolar spectrum disorders will be highlighted. Brain mechanisms that facilitate the target dimension of impulsive aggression will be elucidated. Treatment approaches that may effectively modulate this dimension across the various disorders will be described. As such, the clinician may have greater success in managing these very bad behaviors.

No. 32C
SUBSTANCE ABUSE, SENSITIZATION AND IMPULSIVITY

Stephen M. Strakowski, M.D., *231 Bethesda Ave., Suite 7005 Cincinnati, OH 45267-0559*

SUMMARY:

Impulsivity is a common characteristic seen in individuals with substance use disorder. In this presentation, studies of the prevalence and impact of alcohol and other substances of abuse on impulsivity will be discussed. The neurobiologic and mechanistic connections between impulsivity and substance use disorders also will be reviewed. Finally, pharmacotherapeutic and psychotherapeutic treatment options will be discussed, including data on the effect of anticonvulsant agents on impulsivity and aggressivity in an alcohol-dependent population.

REFERENCES:

1. Barratt ES, Stanford MS, Kent TA, Feithous A: Neuropsychological and cognitive psychophysiological substrates of impulsive aggression. Biological Psychiatry 1997; 41:1045–1061
2. Hollander E, Cohen L, Simon L: Impulse-control disorders measures. Handbook of Psychiatric Measures. Washington, D.C. American Psychiatric Association, 2000, pp 687–712
3. Brady KT, Myrick H, McElroy S: The relationship between substance use disorders, impulse control disorders, and pathological aggression. Am J Addict 1998; 7:221–30

INDUSTRY-SUPPORTED SYMPOSIUM 32—THE IMPULSIVE AGGRESSIVE SPECTRUM: CHALLENGING POPULATIONS, PART 2
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

To understand the mechanisms of aggression and how they relate to neuropsychiatric disorders, such as borderline personality disorder, intermittent explosive disorder, bipolar illness, PTSD, and substance abuse disorder, and treat these spectrum disorders with state-of-the-art pharmacologic intervention.

No. 32A
MOOD STABILIZERS AS ADJUNCTIVE TREATMENT OF PSYCHOSIS

Daniel E. Casey, M.D., *3710 SW U.S. Veterans Hospital Road, Portland, OR 97201*

SUMMARY:

Psychotic disorders are primarily characterized as disorders of thought and perception, particularly the schizophrenias. However, many patients with psychosis also have disturbances in affect, which is a cardinal feature of the schizoaffective subtype of schizophrenia. Additionally, disturbances in impulsivity, hostility, and aggression are common clinical features across the entire range of psychotic diagnoses. Thus, mood stabilizers are increasingly being used as adjunctive treatment in both the acute and long-term management strategies for psychoses. Lithium was the first mood stabilizer to be regularly used in this setting, and now depakote is the most commonly prescribed adjunct to manage mood disturbances as well as impulsivity and aggression in psychosis. While these drugs are best studied in the bipolar disorders, increasing evidence is supporting the use of these drug strategies in other areas. Mood stabilizers are most commonly used in the maintenance phase of schizoaffective disorder.

Data supporting the use of these medicines in maintenance treatment will be reviewed and summarized. Mood stabilizers are also often used in the acute management of schizophrenic psychoses; however, there are fewer studies in this area. In addition, some reports note a beneficial role of mood stabilizers in the management of treatment-refractory psychosis. Data in these two clinical domains will also be reviewed. Areas of opportunity and need for further research in all phases of treatment will be discussed. Finally, recommendations for the use of mood stabilizers in managing syndromes of disturbed affect, impulsivity, hostility, and aggression in psychosis will be proposed.

No. 32B
AGGRESSION, VIOLENCE, AND PSYCHOPATHOLOGY: A DEVELOPMENTAL APPROACH

Hans Steiner, M.D., *401 Quarry Road, Room 1136, Stanford, CA 94305-5340*

SUMMARY:

This presentation will summarize existing research with nonclinical and clinical child and adolescent populations, presenting a clinically useful model of the aggression system in humans. We will focus on how subtypes of aggression (i.e., affective and predatory) develop in children and can be detailed by pathological events to form certain syndromes. Of particular interest are disruptive behavior disorders (oppositional defiant disorder, conduct disorder, intermittent explosive disorder) and trauma-related syndromes (PTSD, dissociative disorders), which have a high likelihood of manifesting as adolescent delinquency and adult criminality. The link to adult personality disorders (antisocial personality, borderline personality) will be elucidated. These disorders can be conceptualized as a continuum of disturbances of the aggression system under the impact of genetic, constitutional, and environmental factors. Also discussed will be maximally effective intervention strategies in different phases of development (preschool, school age, adolescence, and young adulthood), which include preventive measures, psychotherapy, and psychopharmacology. By matching methods to intervention targets according to developmental principles, we can maximize our chances of being successful in treating these conditions that are characterized by a high persistence of pathology.

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INDUSTRY-SUPPORTED SYMPOSIUM 33—RECOGNITION AND TREATMENT OF ALZHEIMER'S DISEASE: PRACTICAL LESSONS FROM NEW RESEARCH
Supported by Eisai Inc., Pfizer Inc.

EDUCATIONAL OBJECTIVES:

To understand the impact of pharmacologic and nonpharmacologic approaches to treatment; describe emerging research; and use screening techniques to effectively assess and recognize the disease early in its course.

No. 33A
ALZHEIMER'S DISEASE: INTEGRATING MIND AND BRAIN

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

SUMMARY:

Integrating mind and brain is an underlying imperative in the care of the patient with Alzheimer's disease (AD). This late-onset degenerative disorder affects brain function through the deposition of neuritic plaques and development of neurofibrillary tangles, as well as the occurrence of a marked cholinergic deficit. The consequences of these physical changes in the brain are manifested in the mental life of the patient. There is cognitive decline with progressive impairment in memory, visuospatial, and language functions. Simultaneously, there is a disruption of the emotional life of the patient with reduced interest, difficulty with self-expression, impaired understanding of others, and loss of attachment. Neuropsychiatric disturbances may occur including agitation, depression, anxiety, delusions, and hallucinations. Management of the patient must address and integrate both the psychiatric and neurologic aspects of the mind/brain impact of AD. Antioxidant therapies slow illness progression, and cholinesterase inhibitors help compensate for the cholinergic deficit. Psychotropic medications and nonpharmacologic interventions may help ameliorate the behavioral abnormalities that often accompany AD. Working with caregivers may help alleviate their distress and facilitate the interaction between patient and family. Appropriate care of the AD patient may improve their quality of life and reduce the adverse impact of the disease.

No. 33B
AN UPDATE ON BRAIN IMAGING AND GENETIC RISK IN ALZHEIMER'S DISEASE ASSESSMENT RESEARCH

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, particularly early in the disease course. For assessing dementia or age-related memory complaints, structural brain imaging studies (e.g., CT, MRI) generally provide nonspecific information about atrophy or white-matter disease and rarely uncover treatable lesions. By contrast, 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 Alzheimer disease, 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. This presentation will highlight the latest breakthroughs in preclinical detection, how they may be useful in developing treatments to prevent Alzheimer's disease or delay its onset, and present a strategy that includes PET scanning early in the diagnostic evaluation to clarify management plans.

No. 33C
PATHOGENESIS AND TREATMENT STRATEGIES IN ALZHEIMER'S DISEASE

Rachelle S. Doody, M.D., *6550 Fannin, Suite 1801, Houston, TX 77030*

SUMMARY:

The clinical syndrome of Alzheimer's disease includes memory loss and other cognitive disturbances, accompanied by functional loss and variable noncognitive disturbances. It is reasonable to think about Alzheimer's disease as a disease across the lifespan, with rare genetic cases identifiable even before birth, and with all cases, both genetic and nongenetic, passing through a long clinically asymptomatic period prior to diagnosis. This "lifespan" view of Alzheimer's disease suggests that there may be multiple time points in which to initiate interventions, and that the types and goals of therapy will differ depending on when the interventions are made. Studies of genetic mutations that cause Alzheimer's disease suggest that metabolism and abnormal accumulation of beta amyloid protein are central to the development of Alzheimer's disease. Experimental studies with transgenic mice genetically engineered to carry human Alzheimer's disease mutations suggest that immunization may be both a prevention and a treatment strategy. Epidemiologic studies have raised the possibility of other strategies to reduce the likelihood of developing Alzheimer's disease or to delay the onset, including estrogen, antioxidants, and anti-inflammatory drugs. However, clinical trials using these agents to treat already established Alzheimer's disease have not yielded convincing evidence of major treatment effects. Studies of their disease-reduction potential are underway.

No. 33D
THE INTERFACE OF DEPRESSION AND DEMENTIA

Davangere P. Devanand, M.D., *722 West 168th Street, Unit 72, New York, NY 10032-2603*

SUMMARY:

The interface between depression and dementia presents a number of difficult diagnostic and management issues. Elderly depressed patients often present with concomitant cognitive impairment, and the standard teaching is that if the depression is successfully treated the cognitive impairment should also improve. However, recent evidence from epidemiologic and clinical studies suggests that many of these patients with depression and concomitant cognitive impairment develop dementia on follow-up. Cognitive enhancers can also play a role in the treatment of depressed patients with mild cognitive impairment. In particular, cholinesterase inhibitors may have a positive impact on cognition in these patients, consistent with the notion that these medications may have a pro-cognition effect across a broad spectrum of cognitively impaired patients. In patients with dementia, particularly Alzheimer's disease, depression is common. Separating depressive symptoms from nonspecific symptoms of dementia, such as anhedonia and insomnia, can make it difficult to accurately diagnose depression in these patients. Antidepressant treatment studies in these patients suggest a weak therapeutic effect, and a few studies have reported negative results. Evaluation and monitoring of both target antidepressant symptoms and cognitive deficits is advisable if an antidepressant trial is instituted.

No. 33E
LONG-TERM BENEFITS OF EARLY PHARMACOLOGIC TREATMENT

Pierre N. Tariot, M.D., *435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

Cholinesterase inhibitors were developed primarily for relief of cognitive dysfunction in Alzheimer's disease (AD), but observational data suggest that they may show some promise in altering the course of illness as well. This conclusion is supported by data from one-year, placebo-controlled studies. These findings are consistent with laboratory studies indicating that there may be cholinoprotective or neuroprotective effects of chronic administration of cholinesterase inhibitors, and that early and prolonged therapy may be rational. There are other options as well. Basic and preclinical evidence suggests the potential benefit of antioxidant therapies; similarly, evidence suggests a role for estrogens in the maintenance of normal brain function and that loss of estrogen may contribute to the development of AD. Epidemiologic studies suggests that estrogen replacement therapy might delay the onset of AD, although the impact of therapy for AD in place may be limited. There is reasonable scientific evidence indicating a role for altered inflammatory processes in AD, supported by epidemiologic studies suggesting that anti-inflammatory medications can delay time of onset of illness. The conclusion is that agents with the ability to modify the course of dementia or delay onset will become a reality sooner than later.

No. 33F
REDISCOVERING NONPHARMACOLOGIC APPROACHES TO BEHAVIOR AND FUNCTION

Kevin F. Gray, M.D., *3504 Linewood, Dallas, TX 75216*

SUMMARY:

Alzheimer's disease disrupts not only cognition, but also personality and behavior, areas where psychiatrists are well qualified to work with families and other caregivers to improve treatment outcomes and quality of life. Optimizing nonpharmacologic management techniques can help empower caregivers, delay nursing home placement, and may reduce or even eliminate the need for behavioral pharmacotherapy in some patients. Working closely with family members and caregivers is critical since they are important sources of information about cognitive and behavioral changes and often implement and monitor treatment. Modulating the environment is helpful because patients with cognitive impairment are often sensitive to their environment and function best with moderate stimulation. Overstimulation will worsen confusion and may even result in agitation, whereas understimulation may cause the patient to withdraw. A variety of community supports also is available. This presentation will review a systematic approach to problem behaviors in Alzheimer's disease and emphasize nonpharmacologic principles of environmental assessment and targeting specific symptoms.

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INDUSTRY-SUPPORTED SYMPOSIUM 34—EVERYDAY CHALLENGES IN MANAGING PATIENTS ON PSYCHOTROPIC MEDICATIONS

Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

To define successful remission of psychiatric illnesses; list potential factors leading to remission; outline the safety and tolerability profiles of medications used to treat psychotic disorders; recognize challenges in the diagnosis and treatment of psychosis in childhood/adolescent and geriatric populations.

No. 34A
APPROACHES TO OPTIMIZING THERAPIES ACROSS PSYCHIATRIC DIAGNOSES: REMISSION IS THE GOAL

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

SUMMARY:

Historically the treatment of psychiatric illnesses has focused on treating specific symptoms, such as mania in bipolar disorder or positive symptoms in schizophrenia. This approach, however, is at the expense of managing the disorder as a whole. Consequently the goals and expectations associated with psychiatric illnesses remained ill defined.

With the advent of newer classes of psychiatric drugs, treatment expectations have risen considerably. Thus some clinical trials have indicated that atypical antipsychotics are more effective than conventional antipsychotics at improving both positive and negative symptoms in schizophrenic patients. Moreover, the newer antipsychotics are markedly less likely to induce extrapyramidal side effects than the older agents. Analagous studies in patients with unipolar depression have focused on strategies for improving remission rates. These include combination pharmacotherapy, augmentation strategies, and combined pharmacotherapy-psychotherapy studies.

As a result of these advances, treatment goals have shifted from mere symptom reduction to remission. The new classes of drugs for psychotic disorders provide realistic options for achieving remission.

No. 34B
OPTIMIZING PATIENT OUTCOMES ACROSS PSYCHIATRIC DIAGNOSES: FOCUS ON SAFETY AND TOLERABILITY

John M. Zajecka, M.D., *1725 West Harrison Street, #955, Chicago, IL 60612*

SUMMARY:

There has been a rapid growth in the last few years of evidence-based therapies, coupled with a greater understanding of a biological, psychosocial, and developmental diathesis in the etiology and perpetuation of many psychiatric disorders. The evolution of these findings provides clinicians with a variety of effective treatments to achieve remission and maintain the response for a growing number of psychiatric disorders. Optimal treatment should ensure acute and long-term recovery, as well as optimizing safety, tolerability, and adherence to treatment. Optimizing all of these facets of treatment first requires a systematized approach to choosing appropriate management strategies at the initiation of treatment, as well as assessing and managing adverse events that may occur throughout acute and long-term treatment. General and specific assessment and management strategies will be presented for affective, psychotic, and anxiety disorders, as well as comorbid conditions that reinforce the goal of optimizing both efficacy and safety/tolerability.

No. 34C
SPECIAL CHALLENGES WHEN USING PSYCHOTROPIC MEDICATIONS IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *1519 Rebecca Skaly Bldg, 101 University Blvd, Galveston, TX 77550-0188*

SUMMARY:

A number of issues need to be addressed when using psychotropic medications in children and adolescents. Accuracy of diagnosis is essential, as well as identification of comorbid disorders. Knowledge of the expected course of childhood disorders is important in guiding treatment. Unfortunately, there are few controlled investigations of the efficacy and safety of psychotropic medications for the treatment of many childhood disorders, such as major depression, bipolar disorder, and anxiety disorders. It is important for clinicians to be aware of data, ranging from case reports to multisite studies, about the use of psychotropic medications in children and adolescents. Informed consent is an important component of medication treatment; parents need to be apprised of what is known and not known about psychotropic medications for the treatment of their children's disorders. Dosing, treatment duration, and polypharmacy are other issues of concern with psychotropic medications in youth.

No. 34D
SPECIAL CHALLENGES WHEN USING PSYCHOTROPIC MEDICATIONS IN THE GERIATRIC POPULATION

K. Ranga R. Krishnan, M.D., *Box 3950, Durham, NC 27710*

SUMMARY:

In treating psychiatric disorders in the elderly there are three important considerations in terms of medication use. First is to recognize any possible alterations in the pharmacokinetics and pharmacodynamics of the drug. Often the renal clearance is reduced and, on occasion, hepatic metabolism is changed. The second issue revolves around concomitant medical problems that the patient might have. These conditions can dictate choice of drug. For example, patients with cardiac disease that affects conduction may be unable to receive drugs that can prolong conduction. The third and equally important factor is drug-drug interactions. Elderly subjects are usually on multiple medications. These medications can inhibit or alter the metabolism of other medications. These interactions could include enzyme interactions, protein-binding interactions, pharmacodynamic interactions, and interactions involving clearance of the medications. Examples of these interactions will be provided to illustrate these concepts.

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INDUSTRY-SUPPORTED SYMPOSIUM 35—OFF-LABEL ON THE TABLE: USING NEW PHARMACOLOGICAL AGENTS

Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES:

To understand the boundaries for use of psychotropic agents; to weigh the importance of symptoms, diagnosis, and diagnostic spectrum when selecting atypical antipsychotics, antidepressants, or mood stabilizers for individual patients.

No. 35A
SYMPTOM, SYNDROME, OR SPECTRUM: HOW DO WE SELECT MEDICATIONS? A CLINICAL CASE VIGNETTE

William M. Glazer, M.D., *100 Beach Plum Lane, P.O. Box 121, Menemsha, MA 02552*; Jerrold F. Rosenbaum, M.D.

SUMMARY:

How do clinicians select medications in a given patient? Most clinicians will say that their patients rarely fit a DSM-IV "category" perfectly. While clinicians select the best diagnostic category to apply to a given patient, this category may not drive the choice of treatment agent. Do clinicians select pharmacologic agents based on symptoms/behaviors, on syndrome definition, or do they use the model of the "diagnostic spectrum," i.e., the idea that multiple diagnoses are interrelated and therefore treatable by the same medication? The presenters will articulate this complexity via a clinical case vignette. The case involves a patient who exhibits aggressive behavior accompanied by other behaviors that would raise valid arguments for multiple Axis 1 and 2 diagnostic categories, including depression, bipolar "spectrum," cluster B and anxiety (OCD/panic/PTSD). Using a "team-teaching" approach, the presenters will discuss the differential diagnosis for the patient and debate how various aspects of the patient's clinical presentation drive the selection of a pharmacologic agent. As chair and co-chair of the symposium, Drs. Glazer and Rosenbaum will extend this discussion between presentations.

No. 35B
ATYPICAL ANTIPSYCHOTICS IN THE TREATMENT OF AGGRESSIVE BEHAVIORS

Paul E. Keck, Jr., M.D., *231 Bethesda Ave/PO Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Agressive behavior is a nonspecific syndrome occurring across a number of major psychiatric disorders including dementia and psychotic and mood disorders. The prevalence of violence, directed toward self and others, among these disorders will be reviewed in both clinical and forensic populations where data are available.

The data regarding the efficacy and safety of typical and atypical antipsychotic medications in the treatment of aggression and hostility will be reviewed. Particular attention will be paid to evidence regarding specific effects on aggressive behavior apart from antipsychotic and antimanic effects of these agents. Data from clinical and forensic settings regarding neuroleptics, clozapine, risperidone, olanzapine, quetiapine, ziprasidone, iloperidone, and aripiprazole will be presented.

No. 35C
THE ROLE OF ANTIDEPRESSANT MEDICATIONS FOR AGGRESSIVE BEHAVIORS

Jonathan E. Alpert, M.D., *WAC-812, 15 Parkman Street, Boston, MA 02114*; Maurizio Fava, M.D.

SUMMARY:

Antidepressant medications have been known to inhibit aggression in some but not all animal models of aggression, such as mouse-killing behavior of rats, postpartum female aggression in mice, and isolation-induced aggressive behavior in mice. Since antidepressant medications can affect several neurotransmitter systems that are known to be involved in pathological aggression in humans as well (e.g., serotonin), it is not surprising that a number of studies have shown significant antiaggressive effects of antidepressants in psychiatric and neurological populations. In particular, antidepressant medications such as the serotonin reuptake inhibitors (SSRIs) have shown to be effective in reducing aggressive behavior among depressed patients with anger attacks. These patients display a blunted prolactin response to fenfluramine challenge compared with depressed patients without anger attacks, suggesting that pathological aggression in depression is accompanied by a reduction in serotonergic activity. The antiaggressive effects of antidepressants are not limited to depressive conditions, as SSRIs have been found to be more effective than placebo in managing aggression and irritability in conditions such as Alzheimer's disease, PMDD, PTSD, autistic disorder, schizophrenia, and personality disorders. The fact that clomipramine, a tricyclic antidepressant with potent serotonin reuptake inhibition, was found to be more effective in treating anger in autistic children than desipramine, a relatively noradrenergic agent, is certainly consistent with the view that antidepressants affecting the serotonergic neurotransmission may be relatively more efficacious in managing aggressive behaviors in humans. However, further studies are needed to further evaluate the safety and efficacy of antidepressants and to compare the relative efficacy of different antidepressants in the treatment of pathological aggression.

No. 35D
THE ROLE OF MOOD STABILIZERS FOR AGGRESSIVE BEHAVIOR

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

SUMMARY:

Impulsive aggression is a widespread behavioral problem. It can occur in the context of psychiatric disorders including bipolar disorder, personality disorders, psychosis, and substance abuse; disturbances of brain function such as dementia, delirium, and intoxication; and in severe stress or overstimulation of any cause. The physiological and clinical characteristics of impulsive aggression differ from those of premeditated aggression. Impulsive, but not premeditated, aggression is associated with neuropsychological abnormalities that are reversed by treatment with anticonvulsants. Impulsive aggression has neurochemical characteristics like those of overstimulation in general and is associated with apparent deficits in serotonergic and possibly GABA function that are absent in premeditated aggression. Clinically, impulsive aggression is marked by a "short fuse," no reflection before the act, and inability to modulate severity of the aggression. Lithium was the first nonsedative treatment found effective for impulsive aggression. Since then, anticonvulsants, including carbamazepine, valproate, dilantin, and others, have been found ef-

fective for impulsive aggression in affective disorders, intermittent explosive disorder, and medical disorders affecting the CNS including delirium and dementia, The physiology and treatment of impulsive aggression appear similar regardless of the diagnostic context.

No. 35E
SYNTHESIS: SPECTRUM VERSUS SIGNAL

Jerrold F. Rosenbaum, M.D., *15 Parkman Street, ACC 812, Boston, MA 02114*; William M. Glazer, M.D.

SUMMARY:

If clinicians were to adhere rigidly and literally to the DSM-IV system and FDA guidelines, they would be restricted in the range of options for clinical care, and effectiveness of care would suffer. Consider the symposium's patient example as a case in point. If one followed FDA labeling and the DSM-IV conventions literally, one could only treat this patient's depression, not his dysregulated aggression. Consequently, most clinicians range far afield from FDA labeling or the DSM-IV nomenclature. So how DO we practice? Some clinicians assume that the psychiatric nosological system has completely evolved and that all patient suffering is accurately reflected in the diagnostic spectrum. While this perspective may have heuristic merit, it may be also be fatuous. Other clinicians observe that symptoms cause impairment and distress regardless of the diagnostic fit. Such clinicians are likely to treat their patients's clinical signal, i.e., the symptoms or behaviors that cause the pain. While this empirical approach may help the patient, it risks idiosyncratic therapeutic approaches and difficulty being informed by available research. This presentation will utilize the team teaching approach to delineate and synthesize the dialectic-spectrum vs. signal.

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INDUSTRY-SUPPORTED SYMPOSIUM 36—MEN, WOMEN, AND SCHIZOPHRENIA: DOES ANATOMY DETERMINE DESTINY? Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

To discuss clinical differences in the clinical manifestations of schizophrenia in men and women; to understand neurobiological and psychosocial theories that could account for male-female differences in schizophrenia; and to explain the treatment implications of male-female differences in schizophrenia, including differential risks for medication side effects.

No. 36A
NORMAL SEXUAL BRAIN DIMORPHISM: IMPLICATIONS FOR SCHIZOPHRENIA IN MEN AND WOMEN

Jill M. Goldstein, Ph.D., *74 Fenwood Road, Boston, MA 02115*

SUMMARY:

Schizophrenia is expressed differently in men and women in terms of age at onset, premorbid history, symptom expression, and course of illness. An understanding of sex differences in schizophrenia may have etiological consequences, given that studies have demonstrated sex differences in genetic transmission and a higher incidence in men. Since understanding schizophrenia is an understanding of where and when brain development goes awry, sex differences in the brain may provide a window into understanding the nature of the illness. Although inconsistent, studies have reported sex differences in cognition and structural and functional brain abnormalities in schizophrenia. This is not surprising since animal and human imaging studies have shown a normal sexual brain dimorphism, and brain damage in other neurobehavioral syndromes has sex-mediated consequences. This presentation will briefly summarize sex differences in the expression of schizophrenia and argue that an understanding of normal sexual dimorphism will provide clues to explaining sex differences in the expression of the illness. A brief summary of processes involved in normal sexual dimorphism will be presented. Recent findings from our studies as well as others demonstrate sex differences in brain abnormalities in schizophrenia that have implications for understanding differential symptomatology and cognitive performance in men and women.

No. 36B
OUTCOME AND TREATMENT RESPONSE IN SCHIZOPHRENIA: INFLUENCES OF GENDER

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

SUMMARY:

Gender confers distinctive illness characteristics among male and female patients with schizophrenia. Male patients manifest the illness earlier, with greater premorbid dysfunction and with an onset of psychotic symptoms some three to four years before females. Female patients tend toward a more benign illness course, which is characterized by fewer negative symptoms, lower propensity to commit suicide, fewer rehospitalizations, better response to (typical) antipsychotic medication, and (speculatively) enhanced response to psychosocial interventions. While these observations may derive from direct pathoplastic effects of gender that attenuate the illness in females, gender differences in medication compliance and tolerability are also likely to be important determinants of treatment response; the latter may be particularly relevant for the new pharmacotherapy of schizophrenia. This presentation will review gender-specific characteristics of course and outcome. Emerging data on gender differences in response to each of the atypical antipsychotic medications and data on the adjunctive use of estrogen in the treatment of females with schizophrenia will be presented.

No. 36C
MALE-FEMALE DIFFERENCE IN SCHIZOPHRENIA: A BIOPSYCHOSOCIAL PERSPECTIVE

Mary V. Seeman, M.D., *250 College Street, Toronto, ON Canada M5T 1R8*

SUMMARY:

Objective: The goal of this paper is to speculate about the multiple causes of male/female difference in schizophrenia, with the ultimate

aim of better understanding schizophrenia etiology. *Hypotheses:* Male/female differences in onset age, neurocognition, neuroimaging, symptoms, course of illness, and response to treatment are probably each caused by different mechanisms. *Method:* Study review of male/female difference in schizophrenia. *Results:* Later onset age is probably a result of the protection of pubertal hormones. The greater prevalence of negative symptoms in men is secondary to the greater prevalence of brain anoxia and exposure to toxins. Other symptom differences can be explained by gender-dimorphic brain specialization. Neurocognitive differences are probably associated with brain changes as seen in neuroimaging. They result from differential difficulties in neurodevelopment and, perhaps, from the secondary effects of large therapeutic drug doses. Drug response differences are probably connected to the effects of estrogen on neurotransmitter receptors. Course of illness differences can be best explained by the timing of important events and stresses in the lives of women and men. *Conclusions:* Examining the many ways in which men and women express schizophrenia differently can tell us much about the various risk factors associated with the illness.

No. 36D
NEUROENDOCRINE SIDE EFFECTS OF ANTIPSYCHOTIC TREATMENT ON MEN AND WOMEN

Diana O. Perkins, M.D., *CB 7160, Neurosciences Hospital, Chapel Hill, NC 27599*

SUMMARY:

The availability of efficacious antipsychotic drugs that have minimal effects on prolactin secretion means that clinicians have the opportunity to avoid inducing hyperprolactinemia when treating psychosis. This has reactivated interest in neuroendocrine side effects and generated controversy about the clinical meaning and relevance of: 1) neuroleptic-induced hyperprolactinemia (NIHP) and 2) the reduction in prolactin levels that follows switching from traditional neuroleptics to 'atypical' prolactin-sparing antipsychotics.

Women usually have a greater prolactin response to typical neuroleptic regimes than do men, but the clinical relevance of this is uncertain. Increases in prolactin correlate poorly with the clinical potency of the antipsychotic and are influenced by the pharmacologic and pharmacokinetic profile of the compound, dopamine-binding properties, individual variability in prolactin production, and sensitivity to feedback inhibition of prolactin release, and effects of reproductive hormones.

All drugs that cause hyperprolactinemia can cause gender-specific reproductive and sexual side effects. The most serious potential medical consequences such as decreased bone mineral density are due to hypogonadism, a known sequela of hyperprolactinemia. In addition, antipsychotic-induced hormonal changes affect psychopathology, cognition, and mood in complex, poorly understood ways. This lecture will critically review and discuss clinical aspects of antipsychotic-induced neuroendocrine side effects in both men and women.

No. 36E
GENDER DIFFERENCES IN LATE-LIFE SCHIZOPHRENIA AND ITS TREATMENT

Dilip V. Jeste, M.D., *3350 La Jolla Village Drive, San Diego, CA 92161*; Laurie L. Lindamer, Ph.D.; Jonathan P. Lacro, Pharm.D.; Enid Rockwell, M.D.

SUMMARY:

Studies of middle-aged and elderly patients with schizophrenia provide a unique opportunity to examine gender and aging interactions in terms of age of onset of illness, clinical presentation, course, and treatment response. Our ongoing longitudinal studies have involved more than 300 patients with schizophrenia in the latter half of their life. The results show a consistent tendency for a later onset of schizophrenia in women than in men. Late-onset schizophrenia is associated with fewer negative symptoms, less severe cognitive deficits in abstraction and learning, and a need for lower daily doses of neuroleptics compared with early-onset schizophrenia. The risk of tardive dyskinesia increases with age at initiation of neuroleptics and length of treatment. We have found a 31% cumulative annual incidence of tardive dyskinesia with typical neuroleptics in the older patients with schizophrenia, with the severity being higher in women with late-onset schizophrenia than in women with early-onset schizophrenia or men with late-onset schizophrenia. The risk of tardive dyskinesia is, however, several times lower with the atypical antipsychotics both in women and men. We have also been studying the effects of estrogen augmentation of antipsychotics in postmenopausal women with schizophrenia. The preliminary findings are encouraging. Clinical use of antipsychotics along with possible augmentation with estrogen in women with late-life schizophrenia will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 37—IMAGES OF ANXIETY: A NEW LOOK AT GAD AND PTSD
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES:

To describe the application of neuroimaging technology to clinical psychiatric practice; to understand the impact of comorbidity for the outcome of GAD and PTSD; to design rational treatment regimens for GAD and PTSD.

No. 37A
UPDATE ON NEUROIMAGING

Jack M. Gorman, M.D., *1051 Riverside Drive, Unit 32, New York, NY 10032*

SUMMARY:

Modern neuroimaging technology has broadly expanded our ability to study brain structure and function in the anxiety disorders. Neuroimaging techniques are broadly divided into two forms, structural and functional. Structural studies are now almost entirely done with magnetic resonance imaging (MRI). The standard research magnet is 1.5 tesla in strength, although larger magnets are increasingly employed. The most important finding in the anxiety disorders using MRI imaging to date has been the finding of decreased size of the hippocampus in patients with posttraumatic stress disorder. Func-

tional imaging measures cerebral blood flow, cerebral metabolism, various brain constituents, and neuroreceptors and uses single photon emission computed tomography (SPECT), positron emission tomography (PET), magnetic resonance spectroscopy (MRS), and functional MRI (fMRI). SPECT studies have shown decreased dopamine receptor binding sites in patients with social anxiety disorder. PET studies have shown sites of brain activation during panic attacks. MRS studies have shown greater increases in lactate level during hyperventilation in patients with panic disorder compared with controls. fMRI studies have similarly shown areas of brain activation in normal volunteers experiencing fearful emotions.

These studies are highly suggestive of synchrony between animal and human brain activations during fearful responding and further indicate likely neurotransmitter and neuroreceptor targets for therapeutic intervention.

No. 37B
THE ANXIOUS BRAIN: GAD AND PTSD

Jeremy D. Coplan, M.D., *1051 Riverside Drive, Unit 14, New York, NY 10032*

SUMMARY:

The exposure to a traumatic event may result in posttraumatic stress disorder (PTSD), leading to three groups of symptoms: intrusive memories, avoidance behavior, and hyperarousal. Several MRI studies have shown that PTSD is associated with reduction in volume of the hippocampus, a brain area involved in learning and memory. Positron emission tomography (PET) studies in different PTSD populations show dysfunction of medial prefrontal cortex, including anterior cingulate and orbital prefrontal cortex, in response to traumatic reminders. Medial prefrontal cortex dysfunction has been hypothesized to underlie amygdala hyper-responsiveness. In fact, recent functional MRI studies demonstrate that PTSD patients exhibit exaggerated amygdala responses to masked fearful stimuli. Administration of the norepinephrine stimulant yohimbine to patients with PTSD led to incremental hyperarousal, and neuronal metabolism on PET tended to decrease in patients and increase in healthy subjects. In contrast to the rich array of neuroimaging studies in PTSD, a paucity exists in GAD. In general, activation studies have revealed the involvement of many brain areas depending on the condition and the paradigm. However, the orbitofrontal cortex and the anterior cingulate are implicated across most studies and may represent the "nodal point between somatic and cognitive symptoms" of any form of anxiety.

No. 37C
THE COMORBIDITY FACTOR IN GAD AND PTSD

James C. Ballenger, M.D., *67 President Street, P O Box 250861, Charleston, SC 29425*

SUMMARY:

Despite increased awareness of risk factors, symptoms, comorbidities, and treatment response, anxiety disorders remain markedly underdiagnosed and inadequately treated. The findings of large-scale screening studies in general medical settings reveal that up to one-third of patients have significant anxiety symptoms, but more than half of these patients are not diagnosed or treated. Rates of disability are high in this group. The anxiety disorders are associated with high rates of comorbidity, particularly secondary depression and alcohol/substance abuse. In recent decades, the age of highest prevalence of depression has become younger, with age at onset now in the late teens to early 20s. In contrast, it is only the comorbid anxious depressions that occur earlier. Patients with generalized anxiety disorder (GAD) are 62 times more likely than healthy controls to develop comorbid depression. Patients with posttraumatic stress disorder (PTSD) also are at risk of secondary depression, substance abuse, suicide, and excessive health care utilization. Early diagnosis and aggressive treatment of comorbid anxiety-depression has the potential to greatly reduce the costs of social, family, educational, and occupational dysfunction. This presentation will review evidence for the high rates of comorbidity in GAD and PTSD and provide clinical practice guidelines.

No. 37D
AN UPDATE ON PTSD

Rachel Yehuda, Ph.D., *130 West Kingsbridge Road, #116A, Bronx, NY 10468*

SUMMARY:

Post-traumatic stress disorder (PTSD) describes a condition that can occur following exposure to traumatic life events and develops in about 14% of persons at some point during their lives. It has became increasingly clear, however, that many trauma survivors do not develop this disorder following exposure to trauma, and among those who do, most show a remission of symptoms within a few months or years, whether they are treated or not. It has also been recently observed that other psychiatric disorders such as major depression, panic, substance abuse, and eating disorders can be precipitated by traumatic events, even in the absence of PTSD. Thus, PTSD appears to represent a specific type of response, but not an inevitable or singular response, to traumatic events. Advances in the last few years have allowed for a clearer understanding of the biological and environmental factors that increase the risk for the development of PTSD following trauma. This presentation will present findings about risk for PTSD and will discuss the implications of these factors both for understanding the fundamental nature of PTSD and how to treat this disorder.

No. 37E
CURRENT CONCEPTS IN THE DIAGNOSIS AND TREATMENT OF GAD

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

SUMMARY:

The DSM-IV refined the diagnosis of generalized anxiety disorder (GAD) into a syndrome of worry, anxiety, and tension that was difficult for the patient to control and persisted for at least six months. The concept was neither controversial nor difficult to implement in clinical practice. Criteria D and F were a greater source of disagreement and debate and of differing interpretation and application in clinical studies. For example, some felt that GAD should be allowed to be comorbid with major depressive disorder, while others interpreted Criterion F to preclude this possibility. The result was that many studies in GAD did not apply Criteria D and F rigorously in using the diagnosis. This hampered the reproducibility of research efforts in the disorder. Some consensus is now emerging on how best to resolve this difficult issue in a way that enlightens both clinical practice and research efforts.

The major findings from the five acute and two long-term studies with venlafaxine XR and the three acute studies with paroxetine will be presented. The results of these studies suggest that both these treatments are very effective in the treatment of GAD and represent a major advance in safety and efficacy over earlier treatments for this disorder.

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INDUSTRY-SUPPORTED SYMPOSIUM 38—RESPONDING TO THE CHALLENGE OF TREATING BIPOLAR DISORDER

Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES:

To understand the evidence base supporting the use of lithium in bipolar disorder; to understand the potential for combination treatment trials in bipolar disorder; to understand the potential role of signaling pathways and cellular resiliency in the pathophysiology and treatment of mood disorders.

No. 38A
NOVEL ASPECTS OF LITHIUM THERAPY IN BIPOLAR DISORDER

Guy M. Goodwin, M.D., *Headington, United Kingdom OX3 7JX*

SUMMARY:

Lithium still provides the gold standard for long-term treatment of bipolar disorder. The placebo-controlled evidence to support its use is superior to that for the alternatives. The need for further long-term studies of prophylaxis to compare new drugs head to head with lithium is increasingly pressing. To be useful such studies will have to be very large, and if they are to be very large they must be designed in a way that makes them extremely user friendly for busy clinicians. A culture needs to be established in ordinary clinical practice to facilitate the entry of patients with bipolar disorder into simple trials that can determine moderate but worthwhile benefits for one treatment or treatment combination. The BALANCE trial will start patients on a fixed-dose combination of valproate and lithium. It is then planned to randomize patients to either monotherapy or to continue on the combination. The advantage of this design is that it affords both a head-to-head comparison of the monotherapy and evidence of the added benefit that one might expect to be obtained in a large patient sample by adding the two drugs.

No. 38B
MOLECULAR MECHANISMS UNDERLYING MOOD STABILIZATION IN BIPOLAR DISORDER

Husseini K. Manji, M.D., *4201 Saint Antoine Drive, UHC 9B-29, Detroit, MI 48201*

SUMMARY:

The "molecular medicine revolution" has resulted in a more complete understanding about the pathophysiology of a variety of diseases. This remarkable progress reflects in large part the elucidation of the basic mechanisms of signal transduction, and the application of the powerful tools of molecular biology to the study of human disease. Although we have yet to identify the specific abnormal genes in bipolar disorder, the identification of critical signaling pathways as targets for mood stabilizers is providing important new leads. It has been found that mood stabilizers have major effects on cellular signaling circuits, in particular on G proteins, PKC isozymes, and the AP-1 family of transcription factors. Furthermore, preliminary clinical studies suggest that PKC inhibitors may represent a novel class of antimanic agents. Recent studies have also identified a completely novel target for lithium and valproate—the major neuroprotective protein bcl-2. Consistent with these effects, mood stabilizers have been shown to exert robust neurotrophic and neuroprotective effects not only in preclinical paradigms, but also in humans. Together, these studies suggest that mood disorders may be associated with impaired "cellular resiliency," findings that may have major implications for our understanding of bipolar disorder and for the development of improved therapeutics.

No. 38C
EXPLORING NOVEL TREATMENT STRATEGIES FOR BIPOLAR DISORDER

Patricia Suppes, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Recently there has been increasing interest for the role of third-generation anticonvulsants, gabapentin, lamotrigine, and topiramate, for the treatment of bipolar disorder. These drugs are distinguished by an increased ease of use, as screening bloodwork and therapeutic monitoring are not routinely required. The clinical utility of these newer medications appears to be somewhat different. While two controlled trials of gabapentin have failed to show efficacy in bipolar disorder, one placebo-controlled study has demonstrated efficacy in social phobia. The controlled trials of lamotrigine have shown acute efficacy in bipolar depression, while one placebo-controlled maintenance study has demonstrated an ability to prevent recurrence in patients with rapid-cycling bipolar disorder. One controlled trial of topiramate appears to have failed for methodologic reasons, but other studies are ongoing. This presentation will review the most recent data regarding the potential efficacy of gabapentin, topiramate, and lamotrigine in bipolar disorder.

No. 38D
COMBINATION TREATMENT WITH ATYPICAL ANTIPSYCHOTIC AGENTS IN BIPOLAR DISORDER

Carlos A. Zarate, Jr., M.D., *361 Plantation Street, Worcester, MA 01605*; Sarah R. Cavanagh, B.A.

SUMMARY:

The treatment of bipolar disorder commonly requires a combination of medications. The selection of pharmacological agents is usually decided based on short- and long-term efficacy and drug interactions and side-effect profiles. Emerging data suggest that the novel antipsychotic agents may not only exert antipsychotic effects, but may also possess thymoleptic activity. Two double-blind studies found that the novel antipsychotic drug olanzapine was superior to placebo in acute mania, and for this reason it has received FDA approval for this indication. In addition, two recent double-blind, controlled studies have found that both risperidone and olanzapine when used in combination with mood stabilizers prove superior in efficacy to mood stabilizers alone in the treatment of acute mania. There are now more double-blind, controlled studies examining the combination of novel antipsychotic drugs and a mood stabilizer (lithium or valporate) in acute mania than there are examining the combination of valporate and lithium, the latter combination being the most commonly prescribed cotherapy treatment in the United

States. In this presentation, research on the use of novel antipsychotics in the treatment of mania will be reviewed. In addition, guidelines and algorithms for the use of these agents in bipolar disorder will be proposed.

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INDUSTRY-SUPPORTED SYMPOSIUM 39—CURRENT AND FUTURE MANAGEMENT OF INSOMNIA AND PSYCHIATRIC ILLNESSES

Supported by Sanofi-Synthelabo, Inc.

EDUCATIONAL OBJECTIVES:

To become knowledgeable about the prevalence of insomnia and related sleep disorders among patients with various psychiatric disorders; the ways that pharmacologic and behavioral interventions for insomnia interact with the pathophysiology of these disorders to provide symptomatic relief.

No. 39A
THE CORRELATION BETWEEN INSOMNIA AND PSYCHIATRIC ILLNESSES

Ruth M. Benca, M.D., *600 Highland Ave, Madison, WI 53792-0001*

SUMMARY:

Sleep disturbances are perhaps more strongly correlated with psychiatric disorders than with any other medical illnesses. Approximately one-third to one-half of people who complain of chronic sleep disturbance also meet criteria for primary psychiatric disorders. Clinical populations of patients with sleep abnormalities show an even greater comorbidity of psychiatric disorders. Although sleep abnormalities may be secondary to psychiatric illness, epidemiological studies suggest that sleep disturbance can also precipitate psychiatric disorders, particularly mood disorders. Sleep disturbance often precedes psychiatric illness and may predict onset of depression. Although the causal relationships between sleep disturbance and psychiatric illness are not yet fully understood, insomnia is strongly correlated with a number of clinically and socioeconomically important outcomes. People with insomnia have higher rates of psychological distress, worse psychomotor function, poorer quality of life on self-report measures, poorer perceived health, and greater utilization of health care resources. They also have increased absenteeism and increased rates of accidents. Some recent studies have suggested that daytime function improves in insomniacs following treatment, but more research is needed to determine the consequences of treating sleep disturbance in psychiatric patients and those with primary insomnia.

No. 39B
THE NEUROBIOLOGY OF SLEEP IN HEALTH AND PSYCHIATRIC ILLNESS

Daniel J. Buysse, M.D., *3811 O'Hara St., Room E-1127, Pittsburgh, PA 15213-2593*

SUMMARY:

Normal sleep is a dynamic, homeostatic process that helps to define and orchestrate human circadian rhythms. From an electrophysiologic standpoint, sleep can be characterized by the 90-minute (infraradian) oscillation between rapid eye movement (REM) and nonREM periods. NonREM sleep, usually accounting for between 75% and 85% of total sleep time, is further defined by a progressive decrease in cortical arousal culminating in the desynchronous slow waves of deep (Stages III and IV) sleep. Across a typical night, nonREM sleep becomes "lighter" (i.e., there is little slow wave sleep after the first two nonREM period), and REM periods become longer and more intense, usually culminating in awakening after the fourth or fifth REM period. Core body temperature is lowest early in the night, when the hypothalamic-pituitary-adrenocortical axis is inactive and coincident with the pulsatile nocturnal surge of growth hormone. Brain metabolic activity shows similar shifts, with decreased glucose utilization in nonREM sleep and increased blood flow and glucose metabolism in paralimbic structures during REM sleep. Normal sleep patterns are partly influenced by genetic factors and change predictably with healthy aging. Disturbances of serotonergic, noradrenergic, cholinergic, and various peptidergic neurotransmitters, singly and in combination, can disrupt or distort the neurophysiologic, hormonal, and/or cerebral metabolic aspects of sleep; some disturbances are observed in most psychopathologic states. This presentation will illustrate the neurobiological changes in sleep commonly observed in the major psychiatric disorders and examine the evidence regarding the specific or nonspecific nature of these alterations.

No. 39C
SAFETY AND TOLERABILITY ISSUES IN THE TREATMENT OF INSOMNIA

David J. Greenblatt, M.D., *136 Harrison Avenue, Boston, MA 02111*

SUMMARY:

Since sleep disorders commonly coexist with other medical or psychiatric illness, safe pharmacologic treatment of sleep problems requires an understanding of the mechanisms and consequences of drug interactions. The class of hepatic drug-metabolizing enzymes known as cytochromes P450 (CYPs) mediate the metabolism of most drugs used in clinical practice. Induction or inhibition of CYP activity due to drug interactions can have a major impact on the safety and efficacy of the agent whose metabolic profile is affected by the interaction. The biotransformation of the benzodiazepine hypnotic agents triazolam and estazolam, and of the sedating antidepressant trazodone, is mediated by one specific CYP isoform designated as C4P3A4. Inhibition of CYP3A4 activity by cotreatment with other drugs such as ketoconazole, itraconazole, nefazodone, or ritonavir can greatly increase plasma levels of triazolam, whereas induction of CYP3A4 by rifampin can reduce plasma levels of triazolam to a clinically ineffective range. Hypnotic agents (such as zolpidem) whose metabolism is mediated by multiple CYPs rather than a single CYP are less likely to be affected by drug interactions of this type. Knowledge of the CYP enzyme system can provide a rational framework for understanding drug interactions and facilitate the selection and clinical use of hypnotic agents.

No. 39D
COMPARATIVE MANAGEMENT OF INSOMNIA: WORLDWIDE PERSPECTIVES

Goran Hajak, M.D., *University of Göttingen, Robert-Koch-Str. 40, 37075 Göttingen*

SUMMARY:

The advantages and disadvantages of therapies aimed at restoring normal sleep will be discussed during this presentation. The review will begin with a comparison of the different mechanisms of action and will explore the pharmacokinetic profiles of the various agents and their impact on clinical effects. The presentation will cover differences in parameters such as dose, onset of action, lipophilicity, metabolites, half-life, and receptor-binding affinities. Possible adverse effects of sleep aids, such as residual sedation and psychomotor impairment, daytime anxiety, anterograde amnesia and cognitive impairment, rebound insomnia, and drug tolerance and dependence will also be covered. The presentation will conclude with a discussion of the worldwide perspective of the treatment insomnia within the context of psychiatric disorders.

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INDUSTRY-SUPPORTED SYMPOSIUM 40—CLINICAL CHALLENGES IN ANXIETY, PART 1
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

To understand the challenges associated with the treatment of anxiety disorders in clinical practice and to discuss potential strategies to improve outcome.

No. 40A
ANXIETY DISORDERS: MOVING FROM BETTER TO WELL

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

SUMMARY:

Despite the availability of a number of effective pharmacologic and psychosocial interventions for the treatment of anxiety disorders, most patients remain at least somewhat symptomatic despite initial treatment, and others fail to respond at all. Studies examining the acute and long-term outcome of pharmacologic and psychosocial treatment generally suggest that only about 25%–50% of patients fully remit during treatment, with the remainder remaining somewhat or completely symptomatic over time. A number of patient factors may contribute to refractory anxiety states including the presence of comorbid affective, anxiety, substance abuse and personality disorders, psychosocial stressors, unresolved cognitive or psychodynamic issues, and persistent sleep disturbance and other medical factors. Important treatment issues that need to be considered in order to optimize treatment include attention to adequacy of dose and duration, pharmacokinetics side effect and compliance issues with pharmacotherapy, as well as the development of a comprehensive treatment plan addressing relevant psychodynamic, cognitive-behavioral, and psychosocial factors.

In this presentation we will review studies examining treatment outcome for a variety of anxiety disorders, examine patient and treatment related factors that may contribute to incomplete or unsatisfactory outcome, and discuss their relevance for clinical practice.

No. 40B
INNOVATIVE PHARMACOLOGICAL APPROACHES TO TREATMENT-RESISTANT ANXIETY DISORDERS

James W. Jefferson, M.D., *7617 Mineral Point Rd. Suite 300, Madison, WI 53717*

SUMMARY:

The availability of a vast array of pharmacotherapies for the treatment of anxiety disorders has done much to improve quality of life for patients with these conditions. Unfortunately, a substantial minority fail to respond or improve only partially with standard treatments. In such situations, it is essential to reconfirm diagnostic accuracy and search for confounding comorbid conditions (both psychiatric and medical). It is also necessary to assess carefully basic considerations such as compliance and more complex issues such as drug and nutritional interactions that might render otherwise effective treatment either ineffective or not tolerated. Pharmacologic strategies for dealing with treatment resistance include the use of larger than conventional doses of conventional drugs and conventional doses of unconventional drugs. While the use of augmentation and combination therapies in treatment-resistant anxiety disorders is less well established than for major depression, there have been, nonetheless, promising advances in this area. Finally, the combination of pharmacotherapy and psychotherapy (especially behavioral approaches) offers considerable hope when either treatment alone has failed.

No. 40C
NOVEL ANXIOLYTICS IN DEVELOPMENT AND ABROAD

Stuart A. Montgomery, M.D., *P.O. Box 8751, London, England W13 8WH*

SUMMARY:

Anxiety disorders are approached a little differently in Europe than in the U.S. Anxiety disorders are regarded as chronic disorders associated with substantial long-term disability and are therefore likely to be treated over the long term. The efficacy of treatments needs to be demonstrated in both the short and long term prior to licensing.

The long-term efficacy or safety of the benzodiazepines and buspirone has never been adequately demonstrated, and therefore these treatments are not regarded as appropriate and the alternatives are thought to have priority.

The selective serotonin reuptake inhibitors, which have been shown to be effective in short-term treatment of OCD, panic disorder, social phobia, and more recently GAD, have all been tested for efficacy in long-term treatment. SNRIs have been shown in GAD to reduce dropouts due to lack of efficacy compared with placebo over six months. In addition, a number of novel anxiolytics now in development offer potential promise for the treatment of the anxiety disorders in the future.

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INDUSTRY-SUPPORTED SYMPOSIUM 40—CLINICAL CHALLENGES IN ANXIETY, PART 2
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

To understand the challenges associated with the treatment of anxiety disorders in clinical practice and to discuss potential strategies to improve outcome.

No. 40A
CLINICAL CHALLENGES: ANXIETY AND SUBSTANCE ABUSE

Kathleen T. Brady, M.D., *171 Ashley Avenue, Charleston, SC 29425-0742*

SUMMARY:

The relationship between anxiety and substance use disorders is complex. Substances of abuse, either with acute intoxication or during withdrawal states, are often involved in producing anxiety. In addition, anxiety disorders are commonly found among individuals with substance use disorders. The prevalence of comorbid substance use and anxiety disorders in epidemiologic samples and clinical samples will be reviewed. In particular, acute withdrawal from alcohol, opiates, and sedative hypnotics are all associated with substantial anxiety symptoms. Anxiety is also one of the key features of protracted abstinence syndromes, which may be related to relapse to substance use. Anticonvulsant agents have demonstrated efficacy in the treatment of alcohol withdrawal. Many of these same anticonvulsant agents have demonstrated efficacy in the treatment of anxiety disorders. Potential neurochemical connections between the interface of anxiety disorders and substance use disorders will be discussed. Particularly, data concerning commonalities in changes in the GABAergic and glutaminergic system will be reviewed. The implications of these neurochemical commonalities for developing optimal treatments for comorbid anxiety and substance use disorders will be discussed.

No. 40B
PTSD: PHENOMENOLOGY AND TREATMENT APPROACHES

Naomi M. Simon, M.D., *27 Richfield Road, Arlington, MA 02474*

SUMMARY:

Posttraumatic stress disorder (PTSD) has been the focus of extensive research over the past decade. Increasing identification of the disorder has spurred advances in the development of effective pharmacologic and cognitive behavioral therapies. However, although many patients with PTSD improve significantly with treatment, a significant proportion do not achieve full remission of their symptoms. Thus, continued efforts to find new treatments and to improve and refine available therapeutic strategies are warranted.

This presentation will review the phenomenology and epidemiology of posttraumatic stress disorder, examine recent advances in our understanding of its neurobiologic underpinnings, and discuss approaches to treatment of this common and disabling disorder.

No. 40C
INTEGRATED PSYCHOSOCIAL STRATEGIES WITH PHARMACOTHERAPY

Michael W. Otto, Ph.D., *15 Parkman Street, WACC-815, Boston, MA 02114*

SUMMARY:

Numerous clinical trials and meta-analytic reviews provide evidence for the efficacy of a number of psychosocial strategies—most notably cognitive-behavior therapy (CBT) and interpersonal therapy—in treating Axis I disorders. Within the anxiety disorders, CBT has been shown to be effective as a first-line treatment, a combination treatment strategy with medications, a useful adjunct or alternative treatment for patients who are partial or nonresponders to pharmacotherapy, and as a strategy for medication discontinuation. The purpose of this presentation is to discuss elements of CBT that can be integrated within standard clinical practice. Particular emphasis will be placed on the adoption of self-directed exposure assignments as a crucial feature of standard pharmacotherapy. Additional topics will include the use of CBT for medication adherence, and the regular provision of supportive, informational, and cognitive-restructuring interventions in the context of pharmacotherapy. Problems in the combination of psychosocial and pharmacologic treatments will be discussed, as will the role of CBT in aiding medication discontinuation should patients want to end their pharmacologic treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 41—A NEW ERA FOR MANAGING PSYCHOSIS: REBUILDING LIVES FOR PATIENTS AND FAMILIES, PART 1
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

Integrate appropriate data from recent trials involving atypical antipsychotics and cholinesterase inhibitors into a treatment arma-

mentarium of psychotic disorders, augment pharmacotherapy with psychosocial intervention to improve outcomes, and understand the implications of the new glutamate model of schizophrenia on future treatment practice.

No. 41A
INTEGRATING PHARMACOLOGICAL AND PSYCHOSOCIAL TREATMENTS: IMPROVING SOCIAL AND VOCATIONAL OUTCOMES

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

SUMMARY:

Treatment guidelines from the American Psychiatric Association, the Patient Outcomes Research Team (PORT), and other sources concur that the optimal long-term treatment plan for patients with schizophrenia should include antipsychotic medications, case management strategies, and psychosocial rehabilitation. In addition, substantial evidence supports the effectiveness of educational programs for patients and their family members that focus on the nature of schizophrenia and its treatment. This talk will provide an overview of the sources for these recommendations as well as strategies for combining these treatments. The focus of this talk will be on the use of pharmacological strategies that can enhance response to psychosocial treatments. These strategies include targeting negative and neurocognitive symptoms and minimizing drug side effects such as weight gain and sexual disturbances. In addition, innovative strategies such as the use of drugs affecting the glutamate system will be discussed. Recent studies such as the VA Cooperative Study of clozapine and the recent studies of the presenter that combined newer antipsychotics with behavioral skills training will be reviewed. This talk will also examine the role of the family and advocacy groups in supporting the recovery of patients with schizophrenia.

No. 41B
THE TREATMENT OF JUVENILE-ONSET PSYCHOSIS

Patrick D. McGorry, Ph.D., *Locked BPG 10, Parkville Victoria, Australia 3052*

SUMMARY:

Childhood and adolescent psychotic disorders have been less studied than their adult-onset counterparts. The epidemiology of juvenile-onset psychotic disorders remains an open topic for research. Reported phenomenology of bipolar disorder in children and adolescents indicates a highly variable presentation with a developmental trend towards increased resemblance to the adult phenotype with increasing age of onset. Several outstanding issues related to diagnosis and long-term management remain. In addition, the extent of the role of antipsychotic agents in the acute and maintenance treatment of psychotic disorders in younger patients warrants further discussion. Currently available conventional antipsychotics are limited mainly by tardive and withdrawal dyskinesias, excessive sedation, weight gain, and enhanced serum prolactin levels. Younger patients show greater sensitivity to these known side effects. Controlled clinical trials in adults have found that the atypical antipsychotics offer significant advantages over the conventional agents. To help clarify the role of these agents in treating psychosis in children and adolescents, a review of studies of conventional and atypical antipsychotic agents in juvenile-onset psychosis will be undertaken.

No. 41C
THE OLDER PATIENT AND FAMILY

Soo Borson, M.D., *1959 NE Pacific St/Box 356560, Seattle, WA 98195*

SUMMARY:

Psychoses associated with schizophrenia, affective disorders, and dementias present substantial challenges to patients, families, and clinicians who care for older adults. The vulnerability of elderly persons to extrapyramidal syndromes and cognitive impairment induced or exacerbated by drug therapies now mandates preference for atypical antipsychotic agents in the treatment of late-life psychotic disorders. The decisive safety advantages offered by these agents, when used alone or in combination with other psychotropics and medications for comorbid medical illness, can prevent or reverse the functional deterioration associated with neurological and cognitive side effects of older drugs. In addition, a new class of psychotropic agents—cholinergic modulators introduced for the symptomatic treatment of cognitive deficits in Alzheimer's disease—has shown promise for treating a number of different neurobiological syndromes and may prove useful in ameliorating cognitive impairment and negative symptoms of schizophrenia and other primary mental illnesses. Data will be presented that demonstrate the value of both atypical antipsychotics and cholinesterase inhibitors in optimizing functional outcomes in diverse neuropsychiatric disorders of late life, and in alleviating the burden of care.

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INDUSTRY-SUPPORTED SYMPOSIUM 41—A NEW ERA FOR MANAGING PSYCHOSIS: REBUILDING LIVES FOR PATIENTS AND FAMILIES, PART 2
Supported by Janssen Pharmaceutica

EDUCATIONAL OBJECTIVES:

Integrate appropriate data from recent trials involving atypical antipsychotics and cholinesterase inhibitors into a treatment armamentarium of psychotic disorders, augment pharmacotherapy with psychosocial intervention to improve outcomes, and understand the implications of the new glutamate model of schizophrenia on future treatment practice.

No. 41A
CONSUMER ORGANIZATIONS IMPROVE MEDICATION COMPLIANCE

Ira D. Glick, M.D., *401 Quarry Road, Suite 2122, Stanford, CA 94305-5490*; Lisa B. Dixon, M.D.

SUMMARY:

Although patient and family support organizations for people with Axis I disorders have grown exponentially and expanded their services over the past two decades, their members and services have not been integrated effectively with mental health teams. This presentation describes the changing needs of patients and their families as they relate to mental health teams, changes in the family therapy field, and concerns of mental health providers as well as the organizations. Abundant anecdotal evidence of satisfaction and effectiveness of services provided by support organizations exist suggesting that controlled trials should be carried out. Support organizations need to become full partners on the treatment team, and their services should be part of a multimodal, quality treatment plan. For the mental health team, working with consumer organizations will also improve patients' medication compliance.

No. 41B
ENHANCING OUTCOMES WITH ATYPICAL ANTIPSYCHOTICS: WEIGHT, AKATHISIA, AFFECT, AND INSIGHT

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

SUMMARY:

While atypical antipsychotics are often more effective and generally safer than traditional neuroleptic agents, they can cause side effects that can impede optimal outcomes. In this presentation, I will review their side effects and methods of managing them, as well as some of their advantages in relation to enhancing overall treatment outcomes in schizophrenia. Weight gain, for instance, is generally more common with atypical than typical antipsychotic agents. It is more common with agents with greater antihistaminic effects. Methods of management include cognitive behavioral therapy and supervised exercise programs. Extrapyramidal symptoms are also common, although less frequent than with typical neuroleptics. Akathisia, in particular, continues to be a problem with all atypical antipsychotic agents and can be misinterpreted as agitation, psychosis, or mania. Tardive dyskinesia, on the other hand, is quite uncommon and seems much less problematic than with typical neuroleptics. Typical neuroleptic agents also tend to cause dysphoric affect, whereas atypical antipsychotic agents can improve depressive mood. Unlike typical neuroleptic agents, atypical antipsychotic drugs do not tend to impair frontal lobe function, impairment of which has been associated with lack of insight in schizophrenia. Improved insight may enhance compliance, which has also been reported with atypical antipsychotics.

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INDUSTRY-SUPPORTED SYMPOSIUM 42—TREATMENT OF DEPRESSION IN WOMEN: FROM ACUTE REMISSION TO SUSTAINED RECOVERY, PART 1
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

Participants in the symposium will learn practical treatment approaches for managing premenstrual dysphoric disorder, postpartum depression, and perimenopausal mood disturbance as well as information regarding the significant impact of untreated depression on female reproductive endocrine function.

No. 42A
PMDD: HOW IT AFFECTS WOMEN'S LIVES

Kimberly A. Yonkers, M.D., *200 College Street, Suite 301, New Haven, CT 06510*

SUMMARY:

Between 11% and 32% of women endorse severe or extreme premenstrual symptoms. In many instances, impaired health-related quality of life accompanies premenstrual symptoms. In one study, women with premenstrual dysphoric disorder (PMDD) showed levels of impairment in social activities and marital relationships that rival what is seen with depressive disorders. A community survey found that 21%–30% of women have difficulty with completing home-based tasks or have discord in family relationships attributable to premenstrual symptoms. Among 310 women retrospectively reporting premenstrual problems in an ob-gyn primary care practice, 26% claimed that premenstrual symptoms led to arguments with family or friends on at least three occasions in the preceding three months. In this same cohort, 15% indicated that premenstrual symptoms led to difficulty with sex, and 10% asserted that premenstrual symptoms led to feelings that life is not worth living. Work impairment can be difficult to measure in women of childbearing age, since many women decide not to work outside the home while their children are young. Even with this caveat, one community study found that 14% of women said symptoms greatly interfered with work, and in 16% absenteeism due to severe premenstrual symptoms occurred in the preceding year. These data, as well as additional information on the impact of premenstrual symptoms on health-related quality of life and changes with treatment, will be presented.

No. 42B
POSTPARTUM DEPRESSION: FROM ACUTE TREATMENT RESPONSE TO FUNCTIONAL RECOVERY

Lee S. Cohen, M.D., *115 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

Postpartum depression is a highly prevalent illness, with several studies describing rates as high as 10%–15%. Women with histories of depression and particularly those with bipolar disorder or depression during pregnancy appear to be at highest risk for postpartum mood disturbance. Despite maternal suffering associated with puerperal depression and the impact of maternal depression on child development, treatment studies are sparse. To date, only three antidepressant clinical trials have been published.

This presentation will review the clinical features of postpartum mood disturbance and available information regarding subgroups of women at greatest risk for developing the illness. Data from several new antidepressant treatment studies of postpartum depression will

be presented as well as data regarding functional recovery of these women both acutely and over time. Recommendations regarding appropriate screening strategies for postpartum depression will also be presented. Long-term follow-up data of women treated for postpartum depression will also be discussed, with a focus on the importance of sustained remission of puerperal illness. Acute recovery and sustained remission minimizes maternal morbidity frequently seen with incompletely treated postpartum depression.

No. 42C
SEX-BASED DIFFERENCES IN MOOD AND ANXIETY DISORDERS

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

SUMMARY:

Sex-based differences in the course and treatment of mood and anxiety disorders are not yet well defined. Epidemiological studies suggest that women develop depression and anxiety disorders at two to three times the rate of men. This striking finding underscores the possible relationship between illness onset and course of symptoms with hormonal changes associated with the female reproductive life cycle. In addition, men and women appear to differ in terms of how they metabolize psychotropic medications. These pharmacokinetic based differences in women may be dependent on their menstrual status. Both premenopausal and postmenopausal women have distinct responses to antidepressants. Premenopausal women appear to respond better to SSRIs and MAOs while men and postmenopausal women respond preferentially to TCAs. The objective of this presentation is to review these important sex based differences in the course and treatment of mood and anxiety disorders.

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INDUSTRY-SUPPORTED SYMPOSIUM 42—TREATMENT OF DEPRESSION IN WOMEN: FROM ACUTE REMISSION TO SUSTAINED RECOVERY, PART 2
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

Participants in the symposium will learn practical treatment approaches for managing premenstrual dysphoric disorder, postpartum depression, and perimenopausal mood disturbance as well as information regarding the significant impact of untreated depression on female reproductive endocrine function.

No. 42A
THE NEUROENDOCRINOLOGY OF MATERNAL DEPRESSION AND STRESS DURING PREGNANCY

Donald J. Newport, M.D., *1639 Pierce Drive NE Suite 4003, Atlanta, GA 30322*; Zachary S. Stowe, M.D.; James R. Strader, Jr., B.S.

SUMMARY:

The treatment of psychiatric illness during pregnancy has stimulated vigorous debate and investigation of the reproductive safety of psychotropic medications. However, a facet of the risk-benefit assessment not often discussed is the impact of maternal mental illness on neuroendocrine function. Laboratory data have demonstrated profound multisystem adverse effects of stress during pregnancy. Previous human studies in pregnant women with major depression have demonstrated elevated maternal cortisol, decreased serum prolactin, and thyroid indices indicative of hyperthyroidism. The degree to which these alterations are directly transmitted to the fetus via umbilical circulation remains unclear. The placenta contains both P450 enzymes and peptidases that may serve to regulate fetal exposure to such neuroendocrine changes and psychotropic medications. The potential impact of maternal depression on neuroendocrine function during pregnancy and obstetrical outcome will be presented. These data represent a significant contribution to a comprehensive risk-benefit assessment.

No. 42B
ROLE OF HORMONAL THERAPIES FOR DEPRESSED PERIMENOPAUSAL WOMEN

Catherine A. Roca, M.D., *10/3N242 10 Center Drive, MSC 1277, Bethesda, MD 20892*

SUMMARY:

Depressed mood is common in perimenopausal women. Middle-aged women presenting with affective instability should be evaluated for perimenopause-related depression, a hormonally mediated mood disorder likely to respond to estrogen replacement. Estrogen replacement is first-line therapy for mild mood disturbance in perimenopausal women. However, the role of estrogen replacement in treating major depression in perimenopausal women is controversial. Peri menopause-related mood disturbance must be distinguished from major depression so that appropriate therapeutic strategies are implemented.

The etiology of depression in perimenopausal women remains controversial. Estrogen withdrawal may cause depressive symptoms through a direct CNS effect or indirectly as a consequence of hot flushes. Hot flushes occur in up to 75% of perimenopausal women, and nocturnal hot flushes (night sweats) interrupt sleep. Because estrogen replacement suppresses hot flushes, thereby improving sleep, it is difficult to discern the role of hot flushes in mood disturbance in perimenopausal women.

This presentation will review clinical features of the perimenopause and discuss characteristics that distinguish perimenopause-related mood disturbance from major depression. Evidence supporting a causative role of estrogen withdrawal and vasomotor symptoms in perimenopausal mood disturbance will be reviewed. Therapeutic benefits of estrogen replacement for mood disturbance and the effects of progestins on mood in perimenopausal women will be addressed.

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INDUSTRY-SUPPORTED SYMPOSIUM 43—DEPRESSION: GENDER, AGE, AND SPECIAL POPULATIONS, PART 1
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

To recognize the complexity in diagnostic presentations and treatment decisions regarding depression in children and adolescents, the elderly, women, those with comorbid medical disorders, and those with varied ethnic backgrounds.

No. 43A
MOOD DISORDERS IN THE CHILD AND ADOLESCENT

Graham J. Emslie, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75235-7200*

SUMMARY:

Mood disorders are a leading cause of morbidity and mortality in the pediatric age group and are the strongest predicators of suicide risk, poor academic performance, substance abuse, and difficulties in interpersonal relationships. It is estimated that the prevalence in children and adolescents is approximately 6% for major depressive disorder (MDD) and 1% for bipolar disorder (BPD). Although the criteria for the disorders are the same for children and adolescents as for adults, some challenges exist in ascertaining the diagnosis, as children often have difficulty expressing or recalling information about their disorder. Information must be elicited from several sources, including the child, parents, teachers, etc. In addition, comorbid disorders are common in this population, further confounding the diagnostic process. Therefore, underdiagnosis or misdiagnosis remain a significant public health problem.

Once a diagnosis of MDD or BPD is made, the decision as to what treatment to administer is determined. Treatment in this population is multimodal, including the child, parents, and school, and may include psychotherapy or psychopharmacology. This presentation will focus on the challenges of assessing and treating mood disorders in children and adolescents, including common symptoms, general management issues, antidepressant treatment for depression, and preliminary data on mood stabilizers for bipolar disorder.

No. 43B
ETHNIC AND GENDER ISSUES IN THE TREATMENT OF DEPRESSION

David L. Dunner, M.D., *4225 Roosevelt Way NE, #306C, Seattle, WA 98105-6099*

SUMMARY:

This presentation will review the impact of gender and ethnicity on the diagnosis and treatment of depression. It has long been observed that the prevalence of depression is about twice that in women as in men. Hazard rates for women peak during the childbearing years. Suicide attempts are more frequent in depressed women than depressed men, but suicide is more frequent among men, and in particular elderly men.

Complicating clinical practice are recent reports that women have a better antidepressant response to SSRIs than men. However, the response of depressed women who are postmenopausal to antidepressant pharmacotherapy may be enhanced by concomitant treatment with hormone replacement therapy.

Issues regarding treatment of depression in women, such as risk of treatment with SSRIs during pregnancy, use of antidepressants during lactation, and treatment of premenstrual dysphoric disorder will be discussed.

Additionally, we will explore issues of determining ethnicity, cross-cultural issues in the diagnosis and treatment of depression, and the selection of pharmacotherapy and psychotherapy in relation to ethnic background.

No. 43C
THE ELDERLY PATIENT: A DELICATE BALANCE

Alan P. Siegal, M.D., *60 Washington Avenue, Suite 203, Hamden, CT 06518*

SUMMARY:

The diagnosis of late-life depression must be given particular attention. The NIMH Consensus Development Conference (1991) concluded that the consequences of unrecognized and untreated depression in the elderly include increased health services utilization, longer hospital stays, poor treatment compliance, and increased morbidity and morality from medical illness and suicide. The prevalence of major depressive disorder may be lower in the elderly than in nonelderly adults, which suggests that aging *per se* is not an etiological factor in depression. The onset of primary major depressive disorder past the age of 50 is uncommon and often related to a specific medical etiology. A particularly careful medical evaluation is often needed in these patients.

The efficacy of various treatments for depression in the elderly is, by and large, equal to that found in adults in general. The differences in dealing with the elderly are the particular practical problems that they and the treatments confront. These problems require more strategic planning and somewhat different tactics (e.g., particular care in minimizing side effects and maximizing tolerability). In general, major depressive disorder in late life is a treatable illness. The evidence for the specific efficacy of medication is strongly based on randomized, placebo-controlled trials. The evidence for the efficacy of psychotherapy alone as a treatment for less severely ill, nonpsychotic outpatients is beginning to accumulate, though this area remains understudied.

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INDUSTRY-SUPPORTED SYMPOSIUM 43—DEPRESSION: GENDER, AGE, AND SPECIAL POPULATIONS, PART 2
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

To recognize the complexity in diagnostic presentations and treatment decisions regarding depression in children and adolescents, the

elderly, women, those with comorbid medical disorders, and those with varied ethnic backgrounds.

No. 43A
DEPRESSION AND THE TREATMENT-RESISTANT PATIENT

Richard C. Shelton, M.D., *1500 21st Avenue South, #2200, Nashville, TN 37212*

SUMMARY:

One of the most common problems facing psychiatrists today is treatment resistant depression. The positive side of this problem is that increasing numbers of patients are being identified and adequately treated in primary care settings. The negative side is that with the unusual efficacy of antidepressant pharmacotherapy (about 70 percent of people respond), the increased caseload results in an increases flow of patients who have not responded to first-choice treatment. Thus, the topic of treatment resistance is an important one for psychiatric practitioners.

This talk will emphasize the "Four Ds of Hollister" Diagnosis, Drug and Duration, and Different treatment. The approach will be to emphasize the clinical specificity of the newer treatments and will develop a rational approach to the assessment and treatment of these difficult patients.

No. 43B
THE DEPRESSED PATIENT WITH COMORBID ILLNESS

Wayne J. Katon, M.D., *1959 NE Pacific, Box 356560 Seattle, WA 98195*

SUMMARY:

Depression is often present in patients with other illnesses. Compared with the general population, the prevalence of depression is higher in patients with stroke, diabetes, myocardial infarction (MI), and cancer. Further, one in four patients in hospital medical units has clinically significant depressive symptoms. The diagnosis and treatment of depression is complicated by these comorbid medical disorders. Symptoms of depression are often mistakenly attributed to physical disease, or that physical disease is erroneously considered "good reason" for depression. Depression can influence the outcome of comorbid conditions. Depression in post-stroke patients can impede rehabilitation and impair intellectual functioning; in patients with diabetes it can lead to poorer glucose control; in post-MI patients it can slow return to functioning and is associated with a five-fold increased risk of mortality. Improvements in depression have been associated with improvements in uncontrolled pain and quality of life in women with advanced cancer. Systematic reviews of randomized trials show the effectiveness of antidepressants in the treatment of patients with a diagnosis of depression and a specific physical disorder. These data will be presented.

REFERENCES:

1. House A, et al. Br J Psych 1991; 158:83–92

INDUSTRY-SUPPORTED SYMPOSIUM 44—PLASTICITY AS EFFICACY? NEUROTROPHIC EFFECTS OF MOOD STABILIZERS
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

To understand new scientific techniques being applied to the study of major neuropsychiatric diagnoses and the effects of mood stabilizers on specific molecular and cellular targets; to review current uses of mood stabilizers in psychiatry, and reconceptualize the pathogenesis and treatment of several neuropsychiatric disorders, including manic-depressive illness and Alzheimer's disease.

No. 44A
NEUROTROPHIC AND NEUROPROTECTIVE EFFECTS OF MOOD STABILIZERS

Husseini K. Manji, M.D., *4201 Saint Antoine Drive, UHC 9B-29, Detroit, MI 48201*

SUMMARY:

Recent studies demonstrating adult human neurogenesis have highlighted the degree of neuroplasticity that can persist into senescence and generated considerable excitement about the possibility of attenuating and perhaps even reversing disease-associated neuronal atrophy and death. Intriguingly, the mood stabilizing agents lithium and valproate have recently been demonstrated to robustly increase the expression of a completely unexpected target—the major neuroprotective protein bcl-2. Consistent with these effects, both lithium and valporate exert robust neuroprotective effects in a variety of paradigms. Valproate also robustly activates the ERK MAP kinase pathway, 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, these results suggest that a reconceptualization about the pathogenesis and optimal long-term treatment of recurrent mood disorders is warranted. Optimal long-term treatment for these severe illnesses may only be achieved by the early use of agents with neurotrophic/neuroprotective effects, irrespective of the primary, symptomatic treatment.

No. 44B
CLINICAL AND NEUROIMAGING EVIDENCE OF ILLNESS PROGRESSION IN BIPOLAR DISORDER

Terence A. Ketter, M.D., *401 Quarry Road, Room 2124, Stanford, CA 94305-5723*

SUMMARY:

Manic-depressive illness has long been recognized as common, severe, and life threatening. In addition, evidence is accumulating that it can be progressive, with episodes going from reactive to spontaneous, increasing in frequency and severity, and becoming resistant to treatment. Brain imaging studies suggest cerebral concomitants to these clinical phenomena. Structural changes include increased cortical sulcal prominence, lateral and third ventricular enlargement, subgenual cingulate and cerebellar atrophy, and increased subcortical hyperintensities. In functional imaging studies, corticolimbic dysregulation is seen during depression, with absolutely decreased cortical and relatively increased anterior paralimbic glucose metabolism. Although some changes reverse with recovery, in treatment-resistant patients relative increases in cerebellar metabolism persist during remission. Even non-treatment-resistant patients may show decreased dorsolateral prefrontal neuronal viability. Recent preclinical evidence suggests that mood stabilizers have neuroprotective and neurotrophic properties at the intracellular level. We recently found that euthymic patients on the GABAergic anticonvulsant(s) divalproex ± gabapentin had cerebral GABA 60% higher than healthy controls. This may represent an increase in the ratio of

neuronal inhibition to excitation (GABA to glutamate), which in turn could offer attenuation of glutamatergic excitotoxic damage, providing clinical evidence of neuroprotection at the neurotransmitter level. Hence, convergent evidence is accumulating that bipolar disorders may involve deterioration, which may be attenuated by mood stabilizers, at the intracellular, neuronal, neurotransmitter, enuroanatomic, and clinical levels.

No. 44C
IMPLICATIONS FOR THE TREATMENT OF ALZHEIMER'S DISEASE

Pierre N. Tariot, M.D., *435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

The use of mood stabilizers in dementia was originally advocated on the basis of extrapolation from reports of reduced agitation, aggression, and impulsivity across a range of other neuropsychiatric disorders. Since 1994, we have conducted research into the efficacy and tolerability of mood stabilizers, including carbamazepine and divalproex sodium, for patients with dementia. Using a video case study, this session will first summarize data from prior studies of these agents, then present new data from two placebo-controlled trials of divalproex indicating probable symptomatic antiagitation efficacy. The focus will then shift to the intriguing and rapidly emerging evidence addressing the special relevance of lithium and valproate as possible neuroprotective treatment for Alzheimer's disease. Their effect on the enzyme GSK3 is especially relevant since this plays a key role in the emergence of neurofibrillary tangles in Alzheimer's disease. The design of a multicenter study addressing this neuroprotective hypothesis in Alzheimer's disease will be presented. It is quite possible that we have a class of agents that, via one set of mechanisms, may confer symptomatic benefit, and via separate pathways may confer unexpected neuroprotective benefit in this devastating illness. This offers a fascinating case study of possible future therapeutic developments in Alzheimer's disease.

No. 44D
PTSD, SUBSTANCE USE DISORDERS, AND PERSONALITY DISORDERS: COMMONALTIES IN MECHANISMS AND TREATMENT

Hugh Myrick, M.D., *IOP 4 North, 67 President Street, P.O. 250861, Charleston, SC 29425*

SUMMARY:

Substance abuse, PTSD, and certain personality disorders, as well as other disorders show partially overlapping phenomenology, comor bidities, and response to therapy, especially to mood stabilizers. In this talk, key clinical characteristics of these disorders as well as the essential findings regarding response to therapy will be highlighted. The provocative notion that these new advances in understanding the mechanisms of treatment effect also permit a reconceptualization of the pathophysiology of these disorders will be explored. Specifically, data concerning protective effects of anticonvulsant use during alcohol withdrawal will be presented, as will pilot data on the use of anticonvulsant agents in the treatment of personality disorders and PTSD. Commonalities in response to neuroprotective and neurotrophic therapy may account for "symptomatic" effects that are observed as well as illuminate underlying commonalities in pathophysiology.

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INDUSTRY-SUPPORTED SYMPOSIUM 45—BIPOLAR SPECTRUM DISORDERS: U.S. AND EUROPEAN PERSPECTIVES
Supported by the International Academy for Biomedical and Drug Research

EDUCATIONAL OBJECTIVES:

To present the psychiatric clinician with new data on the longitudinal symptomatic structure of bipolar disorders as they occur throughout the lifecycle. Participants' diagnostic acumen will be enhanced by understanding the dynamic and fluctuating nature of bipolar disorders, which validates the concept of the bipolar spectrum. The clinician will learn that it is the course of the illness, over time, which is not only a central characteristic of the illness, but which also provides the clearest evidence of the bipolar spectrum.

No. 45A
LONGITUDINAL STUDIES OF BIPOLAR DISORDERS: IS THERE A SPECTRUM?

Lewis L. Judd, M.D., *9500 Gilman Drive, La Jolla, CA 92093-0603*

SUMMARY:

Prior studies of bipolar disorders (BPD) have focused exclusively on the diagnosis, treatment, resolution, and recurrence of syndromal episodes of mania and depression. Throughout the years, however, anecdotal clinical observations have indicated that bipolar disorders are much more varied and complex than previously thought. This has given rise to the concept of a bipolar spectrum of disorders, which although still controversial, has proven to be very useful to clinicians and researchers in understanding and treating this illness. Definitive new data will be presented on a series of prospective studies we have conducted on the weekly symptomatic naturalistic course of a large cohort of bipolar disorder patients. These unique and interesting data support the validity of the bipolar spectrum and also present a detailed, accurate description of the bipolar spectrum as it unfolds over the patient's lifetime. It appears that bipolar disorders, similar to unipolar disorders, are a single clinical illness that presents over time as fluctuating levels of symptom severity involving both manic and depressive features.

No. 45B
BIPOLAR SPECTRUM: CLINICAL AND FAMILIAL VALIDATION

Hagop S. Akiskal, M.D., *9500 Gilman Drive (La Jolla), San Diego, CA 92093-0603*

SUMMARY:

Kraepelin had envisaged a broad concept of manic-depressive illness that included recurrent depressions. The unipolar-bipolar dichotomy restricted the territory of manic-depressive illness to strictly

defined bipolar disorder with mania (bipolar I). Research over the past three decades has shown that bipolarity extends into the severe psychotic domain, as well as into the interface between bipolarity and unipolarity. At the severe end of the spectrum familial-genetic and course parameters support the extension of bipolar disorder into schizo-bipolar. At the "softer end" of the spectrum, bipolar II, III, and IV have been described. These conditions are distinguished from bipolar I by the fact that excited periods are nonpsychotic and brief and sometimes adaptive (hypomania), or occasioned by pharmacotherapy, or constitute temperamental characteristics along cyclothymic and hyperthymic lines. The clinical and familial data in support for extending the bipolar spectrum have come from U.S. and European centers and epidemiologic studies. The broadened clinical spectrum does not necessarily imply genetic homogeneity; indirect evidence supports underlying polygenic or oligogenic inheritance. Finally, the broad spectrum has important therapeutic and public health significance in terms of early intervention and extending the benefit of mood stabilizers to conditions that might otherwise be diagnosed "unipolar" or "impulse control disorders."

No. 45C
MOLECULAR GENETIC EVIDENCE FOR THE BIPOLAR SPECTRUM

Julien Mendlewicz, M.D., *808 Route De Lennik, Brussels, Belgium 1070*

SUMMARY:

Advances in understanding of the etiological mechanisms involved in bipolar related disorders (BPAD) provide interesting yet diverse hypotheses and promising models. Most recent studies indicate that several chromosonal regions may be involved in the etiology of BPAD. These include genes on chromosomes 12, 18, 21, 4, 5, 11, and X. In a large multicenter European study (European Community Biomed 2 Grant No. BMH4-97-2307), we investigated the role of DRD2 (11q22.2–22.3) and GABRA3 (Xq28) polymorphisms in affective disorders (AD). A significant association has been found between BPAD (n = 362) and controls (n = 362) for genotype distribution, in particular for the genotypes 3-5 and 5-5. Moreover, the allelic distribution underlines that allele 5 is significantly more frequent in bipolar patients than controls. Association was found with allele 1 of a dinucleotide repeat (CA)n polymorphism of GABRA3 in BPAD (n = 254), especially when these subjects had a family history of AD. Regarding the group of unipolar patients (UPAD), no association has been shown. Our results allow us to conclude that the mutation in the DRD2 and GABRA3 may be susceptibility factors for BPAD. The other explanation is that these polymorphisms could be in linkage disequilibrium with other polymorphisms involved in the pathogenesis of BPAD.

Findings on the genetics of some behavioral traits may be relevant to bipolar spectrum disorders. Association between novelty seeking and the locus for DRD4 has been observed. The possible role of a polymorphism in the serotonin transporter gene (5HTTLMR) has been associated with neuroticism and harm avoidance. In light of these results, such personality dimensions and their genetic determinants are being investigated in bipolar disorders.

Other studies have reported the presence of anticipation in BPAD and UPAD. This mode of transmission correlates with the presence of specific mutations (Trinucleotide Repeat Sequences). Large multicenter and multidisciplinary programs are currently underway in Europe and in the U.S. exploring novel geriatric factors involved in bipolar spectrum disorders.

No. 45D
TREATMENT ADVANCES IN BIPOLAR SPECTRUM DISORDERS: MOOD STABILIZERS

Susan L. McElroy, M.D., *231 Bethesda Avenue, Cincinnati, OH 45267-0559*

SUMMARY:

The knowledge base regarding the medical treatment of bipolar spectrum disorders with mood stabilizers is rapidly expanding. In this presentation, we first review research supporting the efficacy of the established mood-stabilizing agents lithium, valproate, and carbamazepine in the established bipolar spectrum disorders, bipolar II disorder, and cyclothymia. We then review studies suggesting the effectiveness of these agents in potential forms of bipolar spectrum disorder, such as impulse control disorders, borderline personality disorder, and migraine headache. Next, we review available research of an important class of drugs—the new antiepileptics—that are emerging as potential mood stabilizers in the treatment of conventional and potential bipolar spectrum disorders. These agents include lamotrigine, topiramate, gabapentin, and zonisamide. We conclude that agents with mood-stabilizing properties are important treatments for bipolar spectrum disorders.

No. 45E
TREATMENT ADVANCES IN BIPOLAR SPECTRUM DISORDERS: ATYPICAL ANTIPSYCHOTICS

Guy M. Goodwin, M.D., *Headington, United Kingdom OX3 7JX*

SUMMARY:

Classical antipsychotics have long occupied a central place in the management of bipolar affective disorder. Indeed, there is good evidence that chlorpromazine is superior to lithium in acute treatment of mania. Antipsychotics remain the treatment of choice for acute mania in most European countries and, prior to the introduction of lithium, were commonly used for the long-term treatment of bipolar patients as well. Surveys still consistently show long-term use of antipsychotics, usually in combination with either lithium or an anticonvulsant drug, in 20%–30% of cases of bipolar disorder. Despite this, North American guidelines have de-emphasized the role of antipsychotics in bipolar treatment.

The availability of atypical antipsychotic drugs with improved side-effect profiles has prompted re-examination of the case for antipsychotics in bipolar disorder. For example, olanzapine is efficacious in acute mania, comparable with valproate (divalproex) and lithium under similar conditions. These trials have been conducted over short intervals and are characterized by high rates of drop out. They form a poor basis for generalizing to continuation or long-term maintenance treatment. The true role for atypicals singly or in combination with other drugs poses a continuing challenge for the management of the bipolar spectrum.

REFERENCES:

1. Winokur G, Coryell W, Keller M, et al: A prospective follow-up of patients with bipolar and primary unipolar affective disorder. Arch Gen Psychiatry 1993; 50:457–465
2. Bipolarity: Beyond Classic Mania, edited by Akiskal HS. Psychiatric Clinics of North America. September, 1999
3. Mendlewicz J, Souery D, Rivelli SK: Short-term and long-term treatment for bipolar patients: beyond the guidelines. Journal of Affective Disorders 1999; 55:79–85
4. Manj HK, Bowden CL, Belmaker RH (eds.): Bipolar Medications: Mechanisms of Action. Washington, DC, American Psychiatric Press, 2000

5. Prien RF, Caffey EM Jr, Klett CJ: Comparison of lithium carbonate and chlorpromazine in the treatment of mania. Arch Gen Psychiatry 1972; 26:146–153

INDUSTRY-SUPPORTED SYMPOSIUM 46—ADVANCES IN ADHD: NAVIGATING COMORBIDITY
Supported by Alza Corporation

EDUCATIONAL OBJECTIVES:

To demonstrate knowledge regarding the complexity of ADHD patients and their presenting symptomatology. Participants will be able to apply this broader conceptualization to the clinical application of informed diagnosing and treating.

No. 46A
OVERVIEW OF COMORBID CONDITIONS IN ADHD

Joseph Biederman, M.D., *15 Parkman Street, WACC-725, Boston, MA 02114*

SUMMARY:

Background: Previous cross-sectional data showed that ADHD children and adolescents are at increased risk for comorbid conduct, mood and anxiety disorders, as well as impairments in cognitive, social, family, and school functioning. However longitudinal data were needed to confirm these initial impressions.

Methods: Using DSM-III-R structured diagnostic interviews and blind raters, we re-examined psychiatric diagnoses at one-year and four-year follow-ups in ADHD and control children. In addition, subjects were evaluated for cognitive, achievement, social, school, and family functioning.

Results: Significant differences were revealed between ADHD and control children in rates of behavioral, mood, and anxiety disorders, with these disorders increasing markedly time over. In addition, ADHD children had significantly more impaired cognitive, familial, school, and psychosocial functioning than controls. Baseline diagnosis of conduct disorder predicted conduct disorder and substance use disorders at follow-up, major depression at baseline predicted major depression and bipolar disorder at follow-up, and anxiety disorders at baseline predicted anxiety disorders at follow-up.

Conclusions: ADHD children are at high risk for developing a wide range of impairments affecting multiple domains of psychopathology, cognition, interpersonal, school, and family functioning. These findings support the value of considering psychiatric comorbidity in both clinical assessment and pharmacotherapy of ADHD children.

No. 46B
PATTERNS OF COMORBIDITY IN ADHD: ARTIFACT OR REALITY?

Stephen V. Faraone, Ph.D., *750 Washington Street, Suite 255, South Easton, MA 02375*

SUMMARY:

One of the most well-replicated findings in the area of ADHD is its extensive comorbidity with other disorders. Comorbidity raises fundamental questions about validity. When a patient has two disorders, are both valid? Is one secondary to the others? What are the implications for clinical work and for how researchers select subjects? This presentation adresses these questions by reviewing data from several research strategies that address the issue of comorbidity and diagnostic error: 1.) symptom-overlap studies, 2.) follow-up studies, 3.) multiple sampling strategies, and 4.) the study of family members.

When these methods are combined into a programmatic research project, they provide converging evidence for the validity of comorbid conditions. Symptom-overlap studies examine comorbidity by subtracting overlapping symptoms between diagnosis. Follow-up studies benefit from the fact that if comorbid conditions are transient or not clinically meaningful, they should not be evident or not be recalled at follow up. Multiple sampling strategies increase confidence in comorbid diagnoses by including studies of both adults and children and by sampling from populations of each comorbid disorder. Family-study strategies capitalize on the fact that many psychiatric disorders run in families. Diagnoses in relatives can clarify a typical or comorbid presentation in patients.

No. 46C
DEPRESSIVE DISORDERS AND ADHD

Thomas J. Spencer, M.D., *15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Prospective studies of ADHD youth are demonstrating that up to one-third of these youth are at risk for the development of depression. Similarly, studies in ADHD adults indicate a clear over-representation of depression in ADHD. Conversely, studies of depressed children, adolescents, and adults indicate higher than expected rates of ADHD with associated impairment. Treatment of co-occuring depression within ADHD appears necessary for optimal ADHD outcome as well as overall quality of life. In this presentation, the nature of the association between ADHD and depression will be described. Treatment strategies and interactions with commonly used agents (i.e., serotonin reuptake inhibitors and stimulants) will be reviewed.

No. 46D
BIPOLAR DISORDER AND ADHD: AN OVERLOOKED COMORBIDITY

Janet Wozniak, M.D., *15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Objective: This presentation provides a discussion of a subset of children with ADHD who also present with the severe mood disturbance of juvenile bipolar disorder (BPD), outlining clinical presentation, patterns of comorbidity and treatment approaches to help clarify current diagnostic controversies. As treatments for ADHD may exacerbate BPD, the differential diagnosis is of great clinical concern.

Method: The presenter summarizes recent research in the field of juvenile bipolar disorder and provides clinical guidance for diagnosing and treating the condition, as well as guidelines on how to differentiate the combined condition of bipolar disorder plus ADHD from uncomplicated ADHD. Data from across the lifecycle will be presented to address this comorbid condition.

Results: Data from several studies will be summarized, and focus will be placed on the clinical applications of these studies, which provide a basis for practical guidelines for diagnosing and managing difficult cases of comorbid bipolar disorder and ADHD in children. Data from studies of children and adolescents evaluated for the presence of bipolar disorder as well as from studies starting with ADHD children will be presented. Treatment data that stress the need for combined pharmacotherapy will be discussed.

Conclusion: Diagnosing and treating bipolar disorder in children and adolescents with ADHD may be difficult to do, but initial guide-

lines can provide clinicians with useful information resulting in thoughtful treatment strategies.

No. 46E
ADHD AND THE SUBSTANCE USE DISORDERS

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

SUMMARY:

The co-occurrence of ADHD and the 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 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 have a different course in the development of their SUD. Likewise, ADHD adults have a longer duration of SUD compared with their non-ADHD peers.

Recent research has demonstrated that the pharmacotherapy of ADHD prevents SUD. The treatment of adolescents and adults with ADHD and various SUD remains unclear. In this talk, a systematic, data-oriented presentation of this important overlap will be presented. Intervention strategies including both psychotherapy and pharmacotherapy of individuals with ADHD and SUD will be presented.

REFERENCES:

1. Biederman J, Faraone SV, Lapey K: Comorbidity of diagnosis in attention-deficit hyperactivity disorder. Child and Adolescent Psychiatric Clinics of North America 1992; 1:335–360
2. Biederman J, Faraone SV, Keenan K, et al: Further evidence for family-genetic risk factors in attention deficit disorder: patterns of comorbidity in probands and relatives in psychiatrically and pediatrically referred samples. Arch Gen Psychiatry 49:728–738
3. Spencer T, Bierderman J, Wozniak J, Wilens T: Attention deficit hyperactivity and affective disorders in childhood: continuum comorbidity or confusion. Current Opinion in Psychiatry 2000; Accepted for publication
4. Wozniak J, Biederman J, Kiely K, et al: Mania-like symptoms suggestive of childhood-onset bipolar disorder in clinically referred children. Journal of the American Academy of Child and Adolescent Psychiatry 1995; 34:867–876
5. Biederman J, Wilens TE, Mick E, et al: Protective effects of ADHD pharmacotherapy on subsequent substance abuse: a longitudinal study. Pediatrics 1999; 104:20

INDUSTRY-SUPPORTED SYMPOSIUM 47—EXCESSIVE DAYTIME SLEEPINESS: EVALUATION AND MANAGEMENT IN PSYCHIATRY
Supported by Cephalon Inc.

EDUCATIONAL OBJECTIVES:

To identify the differential diagnosis of excessive daytime sleepiness in psychiatric patients; recognize the appropriate means of testing such hypotheses, and understand the principal treatments available for excessive daytime sleepiness.

No. 47A
NEURAL SUBSTRATES OF AROUSAL AND SLEEP: NEW VISTAS

Robert W. McCarley, M.D., *940 Belmont Street, Brockton, MA 02301*

SUMMARY:

Arousal and wakefulness are mediated by neurotransmitter systems in both brainstem and the basal forebrain. In the brainstem, arousal systems utilizing acetylcholine, norepinephrine, serotonin, and excitatory amino acids as neurotransmitters project to thalamus, where they depolarize thalamocortical neurons, thereby lessening the occurrence of slow-wave activity and spindles and favoring EEG activation. In the basal forebrain, arousal systems utilizing acetylcholine, GABA, and other neurotransmitters principally project directly to cerebral cortex, where they enhance wakefulness and EEG arousal.

Recent data point to the neuromodulator adenosine as the mediator of the sleepiness that occurs following prolonged wakefulness (homeostatic sleep): increased levels of extracellular adenosine occurring as a result of increased metabolic and synaptic activity during wakefulness inhibit the basal forebrain wakefulness system, as well has having direct actions on cortex. Knockout mice for the newly discovered neurotransmitter orexin exhibit a phenotype strikingly similar to human narcolepsy patients, as well as canarc-1 mutant dogs. While many features of human narcolepsy appear to result from REM sleep dysregulation, new experimental results using microdialysis perfusion in animals demonstrate that orexin, found to be deficient in many human narcoleptics, regulates wakefulness via a direct excitatory action on the basal forebrain wakefulness system. Finally, the possibility that orexin may act as a circadian neuromodulator of wakefulness and sleep will be discussed.

No. 47B
EVALUATION AND MEASUREMENT OF DAYTIME SLEEPINESS

Mary A. Carskadon, Ph.D., *300 Duncan Drive, Providence, RI 02906*

SUMMARY:

The evaluation of daytime sleepiness encompasses approaches that range from behavioral observation to physiological monitoring. A careful assessment of the complaint is important for diagnosis and assessment of therapeutic response, as well as for the patient's safety when sleepy behavior creates risk for accident and injury. Evaluation approaches can be classified in the following categories: introspection of internal state, self-report of behaviors, observer's report of behaviors, reports of adverse events, and measures of physiological parameters. Historically, measurement of sleepiness used relatively nonspecific mood and "fatigue" scales. For example, the POMS has a subscale that characterizes feelings of fatigue. The Activation-Deactivation Checklist was one of the first measures that had a focus on waking alertness assessment. The first well-documented introspective measure of sleepiness was the Stanford Sleepiness Scale, a 7-point Likert rating scale. Other introspective measures, including visual analog scales are currently used. A number of questionnaire assessing behaviors related to daytime sleepiness have been developed, typified by the Epworth Sleepiness Scale. Observers' reports are best gathered from a patient's spouse, partner, or parents of children or adolescents. Adverse events may best be used to mark the risk level to which the patient is exposed. Physiological assessments purport to provide insight into brain state through such measures as pupil diameter, EEG evoked response, type and amount of daytime sleep, or speed of falling asleep under conditions that favor sleep or involve resisting sleep. The latter measures are typically used in sleep disorders clinics.

No. 47C
DISORDERS OF EXCESSIVE DAYTIME SOMNOLENCE: DIAGNOSIS AND MANAGEMENT

Karl Doghramji, M.D., *1015 Walnut Street, Suite 319, Philadelphia, PA 19107*

SUMMARY:

Excessive daytime somnolence is commonly encountered in psychiatric settings. This paper will focus on the primary sleep disorders that can be responsible for this complaint. These include chronic and cumulative sleep deprivation, sleep apnea syndrome, narcolepsy, periodic limb movement disorder, frequent changes in work shift, and jet lag, among others.

Cumulative sleep deprivation is thought to represent a major risk to public safety and has been implicated as a key factor behind many catastrophes such as the grounding of the Exxon Valdez, the explosion of the Challenger space shuttle, and the meltdown of the Three Mile Island nuclear power plant. It is also responsible for impairments in productivity and contributes to mood impairment. Sleep apnea syndrome and narcolepsy not only impair daytime alertness, but also result in alterations in mood, perception, and cognition. They can, therefore, be mistaken for other disorders, and their identification can be challenging. The core symptoms of these disorders will be reviewed. Diagnostic tests that are used to establish the diagnosis, and the characteristic findings of these tests, will be explained. Finally, techniques of management will be reviewed.

No. 47D
EXCESSIVE DAYTIME SLEEPINESS IN THE PSYCHIATRIC PATIENT

John W. Winkelman, M.D., *1400 Center Street, Suite 109, Newton Center, MA 02459*

SUMMARY:

Daytime sleepiness and fatigue are commonly encountered by the psychiatrist. Although frequently nonspecific, careful evaluation of these symptoms may assist with differential diagnosis and eventual therapeutic strategies. Successful treatment may not only improve quality of life, but, as hypersomnia has been demonstrated to be a predictor of future depressive illness, it may afford an opportunity for prevention.

This presentation will describe a data-based differential diagnosis for the psychiatric patient with excessive daytime sleepiness. The first goal of such an assessment is to distinguish fatigue, which is present in many systemic and psychiatric illnesses, from true daytime sleepiness. Genuine daytime sleepiness derives from three potential etiologies: shortened sleep time, sleep disruption, or excessive sleep drive. This presentation will review what is known about the relative propensities of psychiatric illnesses to alter sleep phase or disrupt sleep, either through the intrinsic psychiatric disease, as a result of specific sleep disorders (e.g., sleep apnea, leg movements of sleep) or via the mediating roles of substances or medications. We will then examine the direct influence of anxiolytic, antidepressant, anticonvulsant, and antipsychotic medications on daytime alertness. Finally, we will examine the role of psychostimulants as treatments for daytime sleepiness in the psychiatric patient.

REFERENCES:

1. Porkka-Heiskanen T, Strecker RE, Thakkar M, et al: Adenosine: a mediator of the sleep-inducing effects of prolonged wakefulness. Science 1997; 276:1265–1268
2. Roth T, Roehrs TA, Carskadon MA, Dement WC: Daytime sleepiness and alertness. In Principles and Practice of Sleep Medicine (2nd edition), Philadelphia, Saunders, 1994, pp 40–49
3. Sleep Disorders Medicine: Basic Science, Technical Considerations and Clinical Aspects, Second Edition edited by Chokroverty S. Boston, Butterworth-Heineman, 1999
4. Breslau N, Roth T, Rosenthal L, Andreski P: Sleep disturbance and psychiatric disorders: a longitudinal epidemiological study of young adults. Biol Psychiatry 1996; 39:411–418

INDUSTRY-SUPPORTED SYMPOSIUM 48—AN EVIDENCE-BASED-MEDICINE APPROACH TO PEDIATRIC PSYCHIATRY
Supported by Ortho-McNeil Pharmaceutical

EDUCATIONAL OBJECTIVES:

At the end of this symposium the participant will be familiar with recent well-designed, placebo-controlled studies using atypical antipsychotics for pediatric psychiatric conditions including conduct disorder, juvenile bipolar disorder, schizophrenia, and Tourette's syndrome and their implications for overall treatment guidelines.

No. 48A
LONG-TERM EFFICACY IN CONDUCT DISORDER: EVIDENCE FROM MAINTENANCE TRIALS

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

SUMMARY:

Conduct disorder is one of the most commonly diagnosed disorders seen in outpatient psychiatric clinics. It is frequently seen comorbidly with ADHD or learning disorders. Treatment involves both pharmacologic and behavioral therapies. In the past, the typical pharmacologic treatment has involved conventional antipsychotics, which are associated with extrapyramidal side effects (EPS). The atypical antipsychotics (clozapine, risperidone, olanzapine, and quetiapine) have demonstrated reduced or absent risk for EPS. Open-label clinical studies have shown promise for use of these atypical compounds in a wide range of neuropsychiatric disorders in young patients.

Risperidone, an atypical antipsychotic with a high serotonergic to dopaminergic binding ratio in the central nervous system (CNS), has shown promise in double-blind, placebo-controlled studies for conduct disorder as well as bipolar spectrum disorders. This presentation will showcase data from three double-blind pilot studies of risperidone. One of these studies was a randomized 10-week study of 20 juvenile outpatients (ages 5–15 years), who met DSM-IV criteria for conduct disorder. Half of the youths were randomly assigned to the risperidone group, while the other patients were given placebo. Subjects who received risperidone were significantly less aggressive during the last four weeks of the study. Two other international studies have shown similar results and will also be presented. The main side effects of sedation, increased appetite, insomnia, and irritability in general were mild and transient.

No. 48B
EFFECTS OF RISPERIDONE ON THE BEHAVIOR OF CHILDREN WITH SUBAVERAGE IQS AND CONDUCT DISORDER OR OPPOSITIONAL DEFIANT DISORDER

Michael G. Aman, Ph.D., *1581 Dodd Drive, Room 175, Columbus, OH 43210-1296*; Robert L. Findling, M.D.; Albert T. Derivan, M.D.; Ursula Merriman, M.S.

SUMMARY:

Case reports and small studies of developmental disabilities suggest that atypical antipsychotics are helpful in reducing aggression and self injury. This double-blind, parallel-groups study compared placebo and risperidone treatment for six weeks. Sixty-three children were randomly assigned to receive placebo and 55 to receive risperidone. Participants were permitted to continue treatment with constant doses of psychostimulants, antihistamines, and chloral hydrate, but no other psychotropic medicines. The mean daily dose of risperidone was 1.23 mg. The principal outcome measure, parent ratings on the Conduct Problem subscale of the NCBRF, showed statistically significant improvement at week 1 and throughout the six weeks. Significant improvement was observed on the NCBRF Prosocial subscales and on four of the six Problem Behavior subscales (including Conduct Problem). Significant improvements were observed with risperidone on related acting-out subscales of the ABC and BPI and on the VAS of the most troublesome symptom, as related by parents. Clinician CGI ratings indicated highly significant improvements with risperidone, and cognitive measures showed no changes due to medication. Most commonly reported adverse events were drowsiness, headache, vomiting, and dyspepsia. These findings suggest that when significant hostility occurs in conjunction with below-average IQ, judicious trials of risperidone may be helpful.

No. 48C
A PLACEBO-CONTROLLED TRIAL OF RISPERIDONE IN TOURETTE'S DISORDER: PRELIMINARY RESULTS

Lawrence D. Scahill, M.D., *230 South Frontage Road, New Haven, CT 06520*

SUMMARY:

Objective: Evaluate the efficacy and safety of risperidone for the treatment of tics in Tourette syndrome (TS).

Methods: Eight-week, randomized, double-blind, placebo-controlled trial. Primary outcome measure was the Total Tic score of the Yale Global Tic Severity Scale (YGTSS). Each subject was followed by two clinicians: one who evaluated side effects and adjusted dose; one who evaluated therapeutic response.

Results: A total of 33 medication-free subjects (29 males, four females) ranging in age from 8 to 62 years (mean = 18.7 ± 16.14) participated. Of these, 26 subjects were less than 18 years of age (mean = 11.1 ± 2.20). There was no difference between groups in the YGTSS Total Tic score at baseline (25.8 ± 5.2 for risperidone versus 27.9 ± 8.35 for placebo). After eight weeks of treatment ranging from 1.5 to 3 mg per day in two divided doses, the 16 risperidone subjects showed a 32% reduction in tics from baseline (25.8) compared with 9% reduction in the 17 placebo-treated subjects ($F[1,31] = 9.03$; $p = .005$). For the 12 pediatric subjects randomized to risperidone, there was a 36% reduction in the Total Tic score compared with an 11% drop in the 14 placebo-treated subjects ($F[1,24] = 11.47$; $p = .002$). No extrapyramidal symptoms were observed. Social anxiety emerged in two children on risperidone, but resolved with dose reduction. Additional analyses, including cardiovascular effects, weight gain, and secondary outcome measures are currently underway.

Conclusion: Risperidone appears to be safe and effective for short-term treatment of tics in children or adults with TS. Longer-term studies are needed to evaluate the durability of treatment effects.

No. 48D
COMPARATIVE USE OF OLANZAPINE AND RISPERIDONE IN PSYCHOTIC YOUTH

Linmarie Sikich, M.D., *CB 7160, Chapel Hill, NC 27599-7160*; Joseph P. Horrigan, M.D.; Jeffrey A. Lieberman, M.D.; L. Jarrett Barnhill, Jr., M.D.; Brian B. Sheitman, M.D.; Helen E. Courvoisie, M.D.

SUMMARY:

This presentation will examine the use of olanzapine and risperidone in psychotic youths. Results from an ongoing, double-blind trial comparing these two atypical agents and haloperidol will be presented. Treatment duration in the double-blind trial may be as long as five months. Subjects are between 8 and 19 years old and have active positive symptoms occurring in the context of either affective or schizophrenia spectrum illnesses. Subjects who have completed the double-blind study are openly followed for up to 30 months. Findings from a systematic review of 60 pediatric patients with a broad range of psychiatric diagnoses treated openly with antipsychotics in the UNC Developmental Neuropharmacology Clinic will also be presented. The majority of these subjects were treated with risperidone or olanzapine. Over half were treated with both agents, allowing intrasubject comparisons. Several also had trials of molindone, which has led to little or no weight gain in adults. The average length of antipsychotic treatment in the case series was 24 months.

The efficacy, side-effect profile, and long-term tolerability of risperidone and olanzapine in youths will be compared. Approaches to individualizing treatment given the potential differences between these two atypical agents will be discussed.

REFERENCES:

1. Findling RL, McNamara NK, et al: A double-blind pilot study of risperidone in the treatment of conduct disorder. Am Acad Child Adolesc Psychiatry 2000; 39:509–516
2. Aman MG, Madrid A: Atypical antipsychotics in persons with developmental disabilities. Mental Retardation and Development Disabilities Research Reviews 1999; 5:253–263
3. Leckman JF, Riddle MA, Hardin MT: The Yale Global Tic Severity Scale: initial testing of a clinician-rated scale of tic severity. J Amer Acad Child Adoles Psychiatry 1989; 28:566–573
4. Sikich L, Sheitman BB, Bashford RA, et al: A double-blind comparison of haloperidol, olanzapine and risperidone in psychotic youth: interim results. In preparation

LECTURES

LECTURE 1
APA/APPL MANFRED S. GUTTMACHER AWARD
STALKERS AND THEIR VICTIMS

Professor Paul E. Mullen, *Victorian Institute of Forensic Mental Health, PO Box 266, Rosanna Victoria, 3084 AUSTRALIA;* Dr. Michelle Pathe, *Community Operations, 213-219, Victorian Institute of Forensic Mental Health, Brunswick Road, Brunswick Victoria, 3056 AUSTRALIA;* Rosemary Purcell, *Victorian Institute of Forensic Mental Health, PO Box 266, Rosanna Victoria, 3084 AUSTRALIA*

SUMMARY:

Stalking, as a distinct form of harassment, was first recognized, named and criminalised a decade ago. It is now regarded as a significant social problem throughout the Western world. Stalking can create distress and disturbance in the victims and, on occasion, lays waste not only to their lives but those of their pursuers. This presentation will examine the nature and prevalence of stalking separating those brief, albeit distressing, outbursts of harassment from pursuits continuing over months or years. Data will be presented from community and clinic populations of the impact on the mental and social health of victims. Psychiatrists will increasingly be called upon to both assist victims and manage perpetrators. A multiaxial classification of stalkers will be presented based on their psychopathology, their choice of victim and a typology. The typology derives from an analysis of both what initiates and what sustains the behavior. We currently recognize broadly five types of stalkers: the rejected, the intimacy seekers, the incompetent suitors, the resentful and the predatory. This classification assists in both guiding management and in evaluating the likely future course of the stalking.

REFERENCE:

1. Mullen PE, Pathe M, Purcell R: Stalkers and Their Victims, Cambridge University Press, Cambridge, 2000.

LECTURE 2
APA'S MARMOR AWARD
GENES, SYNAPSES, AND LONG-TERM MEMORY

Eric R. Kandel, M.D., *Columbia University, 722 West 168th Street, New York, NY 10032-2603*

SUMMARY:

One of the most fascinating problems confronting biology concerns the neurobiology of mental processes. The recent increase in the technical and conceptual strength of both psychology and biology has allowed scientists to confront the boundary between these two disciplines, in the attempt to unify them. In my talk, I would like to illustrate how one can combine molecular biology and cognitive psychology in the study of one mental process by using as specific examples various simple forms of memory storage.

I will focus specifically on one component of memory storage, the conversion of short to long-term memory. It has become well established that there are at least two temporally distinct phases of memory storage: there is a short-term memory lasting minutes and a long-term memory lasting days or longer. These two phases of memory storage differ not only in their time course, but also in their molecular mechanisms: long-term memory differ from short-term memory in requiring the synthesis of new protein. Recent studies in Aplysia, Drosophila and mice, have revealed that these temporally and mechanistically distinct phases in behavioral memory are reflected in temporally and mechanistically distinct phases of synaptic plasticity in the very cells that participate in storing that memory. These findings in turn suggest the interesting possibility that the distinction between short and long-term memory evident at the behavioral level results from this fundamental distinction at the cellular level. As a result, this behavioral distinction can now begin to be analyzed by molecular studies focused at single cells and their connections.

In examining the molecular mechanism that contribute to long-term synaptic plasticity on the cellular level, I plan to divide my talk into two parts: First, I will briefly outline some of the recent studies in Aplysia, Drosophila, and mice that have led to the conclusion that the requirement for protein synthesis which characterizes long-term memory is reflected, on the cellular level, in the activation of a cascade of genes and that this cascade leads to the growth of new synaptic connections. I will then go on to consider in more detail studies which have examined the cell biological consequences for individual synapses of having a long-term memory process that require gene transcription and synaptic growth.

REFERENCE:

1. Albright TD, Jessell TM, Kandel ER, Posner MI: Neural Science: A Century of Progress and the Mysteries that Remain, Neuron (Supplement) 25(S2): 1–55, 2000.

LECTURE 3
APA'S OSKAR PFISTER AWARD
EXISTENTIAL PSYCHOTHERAPY AND RELIGIOUS CONSOLATION: CONVERGENCE AND DIVERGENCE

Irvin D. Yalom, M.D., *957 Matadero Avenue, Palo Alto, CA 94306*

SUMMARY:

Religious consolation and existential therapy have a complex strained relationship. In a sense, they are cousins with the same ancestors, concern, and a common mission of ministering to human despair. Yet their belief systems and basic practical approaches are antipodal.

Both traditions seek to minister to anxiety emanating from concerns rooted in the human condition. Especially germane to the psychotherapy venture are four ultimate concerns: death, meaninglessness, freedom, and isolation. I shall discuss each of these concerns and explore differences and similarities between an existential psychotherapeutic and a religious consolatory approach. The relevant writings of three of the ancestors of existential psychotherapy—Freud, Nietzsche, and Schopenhauer—will be reviewed.

REFERENCE:

1. Freud S: The Future of an Illusion.

LECTURE 4
BEYOND DSM IV: FROM APPEARANCES TO ESSENCES

Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N Wolfe Street, Baltimore, MD 21287*

SUMMARY:

Psychiatry has three major problems to resolve in taking its place as a medical discipline: The mind/brain problem, the factionalization of the discipline, and a classification system based on appearances. A structure for psychiatry linking the clinical presentations to distinct natures of disorders will be brought forth in this lecture explaining how with different groups of disorders issues of evaluation, research and treatment differ. Psychiatric conditions can be divided into those that rest on brain diseases, those that rest on psychological dimensions, those that are goal-directed behaviors and those that are responses to life encounters. How this thinking about a structure of psychiatry has been employed to develop the clinical, education, and research directions of Johns Hopkins of Psychiatry will be reviewed.

REFERENCE:

1. McHugh P, Slavney P: The Perspectives of Psychiatry (Second Edition), Johns Hopkins University Press, Baltimore, MD.

LECTURE 5
WHY PLAY ON ONLY THREE STRINGS, WHEN YOU CAN PLAY ON THE WHOLE VIOLIN? THE IMPORTANCE OF PSYCHOTHERAPY EDUCATION APA/NIMH VESTERMARK PSYCHIATRY EDUCATOR AWARD

Jerald Kay, M.D., *Department of Psychiatry, Wright State University, PO Box 927, Dayton OH 45401*

SUMMARY:

Psychotherapy instruction in residency training programs has been increasingly limited. For practitioners, despite the absence of scientific evidence, managed care organizations have pressed many psychiatrists to embrace a split treatment model wherein the psychiatrist is relegated to managing a patient's medication and psychotherapy is often provided by a nonphysician mental health professional. Both of these trends are unfortunate because when psychiatrists provide integrated treatment of pharmacotherapy and psychotherapy, it distinguishes them from other mental health disciplines. Moreover, this practice offers hope in reducing ideological tension in the field and moving us toward a more comprehensive and neuroscientifically integrated approach to psychiatric treatment.

This lecture will discuss some aspects of the neurobiology of psychotherapy with particular emphasis on the process of neuronal plasticity in learning and memory. Significant studies of integrated treatment will be reviewed. It is shortsighted for our field to abandon psychotherapy as a core clinical skill. Interventions that are likely to strengthen psychotherapy education will be considered.

REFERENCE:

1. Kay J: Integrated Treatment for Psychiatric Disorders: Review of Psychiatry Series, Volume 20, Washington, DC, American Psychiatric Press Inc, 2001.

LECTURE 6
BIPOLAR DISORDER: USING AFFECTIVE NEUROSCIENCE TO BRIDGE THE GAP BETWEEN CHILDREN AND ADULTS

Ellen Leibenluft, MD., *PDN Branch, NIMH, Bldg 10, Rm 6N240, 10 Center Drive, MSC 1255, Bethesda, MD 20892*

SUMMARY:

The diagnosis of bipolar disorder is being assigned to young children with increasing frequency, and the phenomenon has sparked considerable controversy in the field. Was the diagnosis missed in the past; is it now being applied too liberally; or has the prevalence of bipolar disorder increased? Everyone agrees that a significant cohort of children with severe behavioral and emotional dysregulation exists, but how can we identify those children who are, or will become, bipolar?

Workers in the field have identified a number of important factors contributing to the current controversy. These include criterion overlap between diagnoses, "criterion drift," a dearth of longitudinal studies, and difficulties operationalizing such criteria as "euphoria" and "grandiosity" in young children. Obviously, research in these areas is needed.

In addition, the emerging field of affective neuroscience may provide new approaches to the study of the pathophysiology of bipolar disorder in both children and adults. For example, the controversy around the diagnosis of juvenile bipolar disorder demonstrates that high-arousal, negatively-valenced emotional states are common in distressed children, while the low-arousal, negatively-valenced states often seen in distressed adults are much less common in children. Future research could elucidate the mechanisms underlying these developmental differences, while also describing differences between patients with bipolar disorder and controls in their response to emotional stimuli.

REFERENCE:

1. Bhangoo R, Leibenluft E: Perspectives from Affective Neuroscience, in, Child and Early Adolescent Bipolar Disorder: Theory, Assessment, and Treatment. Geller B, DelBello M (eds), Guilford Press, in press.

LECTURE 8
APA'S WILLIAM C. MENNINGER MEMORIAL AWARD
A TRIP TO THE MOON AND BEYOND

Harrison H. Schmitt, *P.O. Box 90730, Albiquerque, NM 87100*

LECTURE 9
GENE THERAPY AND ITS POTENTIAL APPLICATIONS TO PSYCHIATRY

Robert Sapolsky, Ph.D., *Department of Biological Sciences, Stanford University, Gilbert Lab/MC 5020, Stanford, CA 94305-5020*

SUMMARY:

There is now sufficient understanding of the reductive bases of many diseases to prompt therapeutics at the genetic level. One version of this, gene therapy, involves the transfer into diseased tissue of either protective transgenes, or of antisense sequences meant to block the pathological consequences of the expression of some native gene. While there has been impressive advances in many realms of gene therapy, work in the central nervous system represents, in many ways, the most difficult frontier of the field. This is because of the heterogeneity of the brain, its inaccessibility, and the post-mitotic nature of most adult neurons (limiting gene therapy on such neurons to only a handful of techniques). In this lecture, I will: a) review the technical underpinnings of gene therapy in the nervous system. There will be a heavy emphasis on the use of neurotrophic viral vectors to deliver genes to post-mitotic neurons; b) review the progress that has been made in neuronal gene therapy to date. This will be oriented almost entirely around therapy for neurological insults; c) and review the promises and pitfalls of gene therapy as it might be applied to psychiatric disorders.

REFERENCE:

1. Sapolsky R, Steinberg G: Gene therapy for Acute Neurological Insults, Neurology 1999; 10: 19–22.

LECTURE 10
APA'S SOLOMON CARTER FULLER AWARD AUTHENTIC REPRESENTATION, BELONGING, AND THE NARRATIVE OF SELF-IDENTIFICATION

Ezra E.H. Griffith, M.D., *Department of Psychiatry, Yale University School of Medicine, 25 Park Street, Rm 626, New Haven, CT 06519-1109*

SUMMARY:

In this lecture, I will explore the process of self-identification in which minority professionals inevitably must engage. The clarification and ultimate establishment of the minority professional's identity cannot escape certain pragmatic influences. There is first social insistence on the notion that minority professionals must be aware

that they represent a minority community. In addition, there is further emphasis on the idea that such representation must be authentic.

I shall use the mechanism of narrative discourse to explore this process of self-identification. I will engage in narrative dialogues with individuals who have grown up in different loci of the diaspora. I shall examine certain aspects of the longitudinal trajectory of their life stories recognizing the cultural distinctiveness of their experiences. I will also note the context of enmeshed colonialism, racialism, and the pervasive presence of religion as powerful forces that impact on the experiences of the individual.

Such narrative accounts are important in the exploration of black and minority self-identification throughout the diaspora. They also contribute to a better understanding of how minority professionals decide about whether they belong to institutions of the dominant and minority groups.

REFERENCE:

1. Griffith EEH: Race and Excellence: My Dialogue with Chester Pierce, Iowa City, Iowa, University of Iowa Press, 1998.

LECTURE 11
APA'S SIMON BOLIVAR AWARD LECTURE INTERNATIONAL COOPERATION IN MENTAL HEALTH IN THE AMERICAS: AN AGENDA FOR THE NEW MILLENNIUM

F. Moises Gaviria, M.D., *Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC913, Chicago, IL 60612*

SUMMARY:

Healthcare historically has been one of the issues on which many nations have found common ground the eradication of tropical diseases, the fight against polio and smallpox, and the provision of emergency care in natural disasters have stood as a model of what international cooperation can and has accomplished.

Furthermore, one must be aware of the unique meaning of mental health in the context of Latin America and other third world regions. For the urban and rural poor, the malnourished, unemployed or underemployed and other marginalized sections of these societies mental health includes base needs such as nutrition and clean living conditions in which the human being can develop to potential both mentally and physically.

The stress of urbanization and unemployment in particular presents great obstacles to normal development in heavily populated areas.

The very basic consideration for human living go hand in hand with treatment for disorders like alcoholism, depression, chronic mental illness, etc., which fall under the rubric of mental health.

On the other hand, in the U.S. the growth of Hispanics as the largest minority group has helped to make foreign policy a domestic issue with issues such as the impact of Cuban immigrants on U.S. foreign policy.

The struggle to stem the flow of drugs or the debate of illegal immigration becomes not only local but national politics.

The convergence of foreign and domestic politics ensures that Hispanic issues will remain on the national agenda and heighten the need for greater regional leadership and cooperation. This situation demands a new vision, for American institutions, federal agencies and professional organizations including the APA and its' Hispanic committee. This lecture aspires to discuss the elements of such a vision.

REFERENCE:

1. Molina CW, Molina JA: Latino Health in the US: A Growing Challenge, APHA, 1994.

LECTURE 12
IMAGING BRAIN DYSFUNCTION IN SUBSTANCE ABUSE

Edythe London, Ph.D., *UCLA-NPI, 760 Westwood Plaza, C8-532, Box 60, Los Angeles, CA 90024*

SUMMARY:

Animal studies have advanced our understanding of the neurobiology of drug abuse. The results, however, are limited by the extent to which animal studies model human addiction. Noninvasive brain imaging offers new opportunities to push forward our understanding of addiction. Positron emission tomography (PET) and magnetic resonance imaging (MRI) provide information about the brain with molecular and anatomical detail. Brain imaging can also be paired with cognitive measures to test brain circuitry while the brain is at work.

Drug abusers have prefrontal deficits. MRI shows volumes of the prefrontal lobe in polydrug abusers than in controls. Abstinent cocaine abusers also show a relatively hypermetabolic condition in the orbitofrontal gyrus, reflecting drug craving. Indeed, studies on cue-induced cocaine craving show correlations between self-reported craving and activation of the orbitofrontal cortex as well as other limbic regions, including the amygdala. Prefrontal deficits in cognitive processing, measured in tests of executive functions paired with neuroimaging, again reveal prefrontal cortical deficits that may contribute to addiction. Regions implicated in pain pathways also show deficits in drug abusers. An issue for future studies is to what extent the persistent deficits in brain function pre-date drug abuse.

REFERENCE:

1. London ED, Ernst M, Grant S, Bonson K, Weinstein A: Orbitofrontal Cortex and Human Drug Abuse: Functional Imaging: Cerebral Cortex 2000; 10, 334–342.

LECTURE 13
WHAT DO WOMEN REALLY WANT?

Donna E. Stewart, M.D., *Women's Health, University of Toronto, 200 Elizabeth Street, M/L 2-004, Toronto, Ontario M5G 2N2 CANADA*

SUMMARY:

Over the last century psychiatrists have held interesting perspectives on the roles of women in society, as patients and as health care providers. Colorful examples from the literature as well as personal experience will be used to illustrate some of their views.

In the latter years of the 20th century, women began to reclaim ownership of their bodies, health, minds, and roles in society. Some of the ways organized psychiatry has dealt with these changes will be discussed. In conclusion, the speaker will try to answer the question posed in the title "What do women Really Want?".

REFERENCE:

1. Astbury Jill: Crazy for You: The Making of Women's Madness, Oxford University Press, Melbourne, Australia, 1996.

LECTURE 14
APA'S INTERNATIONAL AWARD AN EXAMPLE OF NEUROPSYCHOANALYTIC RESEARCH: THE RIGHT HEMISPHERE SYNDROME

Mark L. Solms, Ph.D., *Academics Department of Neurosurgery, Royal London Hospital, Whitechapel, London, E11BB UNITED KINGDOM*

SUMMARY:

This lecture introduces the new interdisciplinary field of neuropsychoanalysis, referring to some recent clinico-anatomical research. Dysfunction of the right cerebral hemisphere is associated with a group of striking neuropsychiatric symptoms: denial of illness, unawareness of the left side of space (including one's own body), and other abnormalities of spatial cognition and perception. Prevailing theories of right hemisphere function are based on neurobehavioral analyses of these symptoms. Psychoanalytic investigation of these same symptoms reveals unexpected complications incompatible with the existing theories. A new theory of right hemisphere functioning is described to reconcile the neurobehavioral and psychoanalytic data. The aim of this lecture is to demonstrate the value of integrating objective neuroscientific research methods with data derived from the psychoanalytic method concerning the subjective experience of neurological patients. This approach overcomes the limitations of traditional psychoanalytic and neurobehavioral methods by mutually correcting for viewpoint-dependent errors.

REFERENCE:

1. Solms M: A Psychoanalytic Contribution to Contemporary Neuroscience. in, Velmans, M., Ed., Investigating Phenomenal Consciousness: New Methodologies and Maps. Amsterdam/Philadelphia. John Benjamins Publishing Co., 2000.

LECTURE 15
HOW MATTER BECOMES IMAGINATION: FROM BRAIN DYNAMICS TO CONSCIOUSNESS

Gerald M. Edelman, M.D., *The Neurosciences Institute, 10640 John J. Hopkins Drive, San Diego, CA 92121*

SUMMARY:

Most approaches to understanding consciousness are generally concerned with the contributions of specific brain areas or groups of neurons. By contrast, in this talk, I consider what kinds of neural processes can account for key properties of conscious experience including its unity and its diversity.

To understand how these processes of brain dynamics give rise to consciousness requires a global brain theory. I shall therefore review a selectional theory called Neural Darwinism that rejects strict computer models of the brain and mind. This theory considers brain complexity to be integrated by a process called reentry. Applying measures of neural integration and complexity, together with an analysis of extensive neurological data, leads to a testable proposal - the dynamic core hypothesis - about the properties of the neural substrate of consciousness. This hypothesis is built on cortical mechanisms involving reentrant signaling. Supporting evidence from MEG studies of human subjects will be presented and possible implications for psychiatry will be considered.

REFERENCE:

1. Edelman GM, Tononi G: A Universe of Consciousness: How Matter Becomes Imagination, Basic Books, New York, 2000.

LECTURE 16
APA'S ADMINISTRATIVE PSYCHIATRY AWARD SURVIVING ORGANIZATIONAL CHANGE

Steven M. Mirin, M.D., *American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*

SUMMARY:

The last decade has been one of enormous change for both health care organizations and professional associations. Advances in technology and telecommunications, coupled with the need to respond to a rapidly changing health care environment, has challenged these organizations to review their strategic priorities and reconfigure their budgets to address current and future threats to their survival. At the same time, staff and volunteer leadership have had to learn how to work collaboratively to advance a common agenda, avoid internal divisiveness and effectively communicate with internal and external constituencies. This lecture will illustrate some of these challenges and the survival strategies that have worked for individuals and organizations coping with rapid organizational change.

REFERENCE:

1. Kotter, JP: Leading Change, Harvard Business School Press, Boston, MA, 1996.

LECTURE 17
APA'S ADOLF MEYER AWARD PSYCHIATRIC DIAGNOSIS: ARE WE PREPARED FOR A NEW MILLENNIUM?

Steven E. Hyman, M.D., *Parklawn Building, Room 17–99, National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD 20857*

SUMMARY:

During the century just past, it was hoped that psychiatric symptom clusters, family history, long-term outcome, biological markers, and perhaps even treatment response would coalesce into valid diagnostic entities. Despite the lack of biological markers or even adequate family history data, the intense need for improved communication both in practice and in research pushed various groups to proceed with diagnostic classifications based largely on symptom clusters. Arguably the most widely used classification, the Diagnostic and Statistical Manuals of the American Psychiatric Association, provided putatively atheoretical, operationalized diagnostic criteria based on clinical symptoms and signs. The strength of such efforts, including DSM III, IIIR, and IV lay in reliability rather than validity. Real problems with current classifications soon began to surface. For example, was the apparent plague of comorbidity real or an artefact of too much "splitting"? Another problem is that symptom clusters that define DSM-III diagnoses do not always segregate together in families - nor do shared familial risks always give rise to the same disorder. These and other problems with our current psychiatric diagnostic systems are easier to discern than are the solutions. This lecture will examine the nature of mental illness, and the ways in which modern genomics, genetics, and neuroscience may ultimately yield diagnoses that are not only reliable, but also valid.

REFERENCE:

1. Robins E, Guze SB: Establishment of Diagnostic Validity in Psychiatric Illness: Its Application to Schizophrenia, American Journal of Psychiatry, 126: 983–988, 1970.

LECTURE 18
CONSCIOUSNESS INTEGRATED AND DIFFERENTIATED

Giulio Tononi, M.D. *The Neurosciences Institute, 10640 John J. Hopkins Drive, San Diego, CA 92121*

SUMMARY:

A useful way of identifying the neural basis of consciousness is to consider the kinds of neural processes that could account for its most fundamental properties. Two fundamental properties of consciousness are integration or unity, and differentiation or complexity. Integration is evident in that each conscious state is experienced as a whole and cannot be subdivided into independent components. Differentiation is evidenced by our ability to access, in a fraction of a second, any one out of countless numbers or conscious states. To understand these properties of consciousness and their neural substrates, a novel theory is developed that accounts at the same time

for the integration and the differentiation of conscious experience. As encapsulated in the dynamic core hypothesis, consciousness does not arise as a property of brain cells as such, but rather as a consequence of dynamic interactions of a continually changing functional cluster of nerve cells in the thalamus and cerebral cortex. The formulation of this hypothesis involves new theoretical concepts and measures, which can be applied to brain imaging methods to yield new insights into the relationships between conscious and nonconscious processes.

REFERENCES:

1. Edelman GM, Tononi G: A Universe of Consciousness: How Matter Becomes Imagination, Basic Books, New York, 2000.

LECTURE 19
QUILLS: THE MARQUIS ON THE MARQUEE

Doug Wright, *420 Eighth Street, #3, Brooklyn, NY 11215*

SUMMARY:

Over the years, the notorious French philosopher, the Marquis de Sade, has been a potent Rorschach for artist; he's been appropriated by the surrealists, by the German playwright Peter Weiss and by authors as diverse as Yukio Mishima and Camille Paglia. In my lecture, I hope to trace my own journey with the most notorious malcontent in the history of Western literature, from the birth of my play *QUILLS* at the New York Theater Workshop in Manhattan's East Village, all the way to its big-screen incarnation, starring Geoffrey Rush, Kate Winslet, Joaquin Phoenix and Michael Caine. I will address key biographical moments in the life of the Divine Marquis, questions of poetic license in literary adaptation, and the research employed to recreate an early nineteenth century asylum onstage and on film. In addition, I plan to share anecdotal information about the movie's production.

REFERENCE:

1. Wright D: Quills, Dramatists Play Service, Inc; New York, NY, 1996.

LECTURE 20
THE SCIENCE OF PSYCHOTHERAPY: LEGACY OF PSYCHOANALYSIS

Leo Rangell, M.D., *456 North Carmelina Avenue, Los Angeles, CA 90049-2704*

SUMMARY:

The influence of psychoanalysis on psychiatry in the 20th century has been as profound as any scientific development affecting the theoretical armamentarium of the healing professions. The decade of the brain needs to be integrated and seen in perspective with the century of psychoanalysis for a rational and comprehensive application of basic research across the spectrum of disciplines embracing behavior and mental functioning.

Psychoanalysis informs the psychiatrist in the theory of both understanding and therapy. The recognition of unconscious conflicts and their compromises resulting in a range of external behavioral phenomena, from dreams to symptoms to character traits, has transformed the understanding of human life. Focusing on anxiety as the center of neurosis as well as of conflict resolution in normal behavior, is operative in attitudes and interventions by therapists of every persuasion.

Scientific psychoanalytic psychotherapy emerges as the main enduring legacy of the science of psychoanalysis. For analyst, psychiatrist or physician, it will take its place, in its many forms and appropriate variations, within the armamentarium of every practitioner. Each will be addressing an interpretation stemming from his particular expertise to the receptive and worried ego of the patient, with the goal to enhance rational choices, action and behavior.

REFERENCE:

1. Rangell, L: The Future of Psychoanalysis: The Scientific Crossroads; Psychoanal Q, 57, 1988; 313–340.

LECTURE 21
PSYCHIATRY FOR THE MEDICALLY ILL: WHAT IS IT? WHAT WAS IT? WHAT HAS IT DONE?

Donald Kornfeld, M.D., *Columbia Presbyterian Hospital, 622 West 168th Street, MB 427, New York, NY 10032-3702*

SUMMARY:

Psychiatry for the medically ill is the proposed new designation for what has been known as consultation/liaison psychiatry. Why is there need to change the name of this era of subspecialization at this time? What has been its history? What has been its contribution to the practice of medicine? What has it contributed to psychiatry? What does the future hold for these psychiatrists with this, "area of added (special) qualifications?"

REFERENCE:

1. Kornfeld DS: Consultation: Liaison Psychiatry and the Practice of Medicine, Psychosomatics, 37: 216–218, 1996.

LECTURE 22
GUT SENSATION: SEROTONIN AND BRAIN-BOWEL CROSSTALK

Michael Gershon, Ph.D., *Anatomy and Cell Biology, Columbia University, 630 W. 168th Street, PS-12-513, New York, NY 10032*

SUMMARY:

The bowel has a unique ability to display neuronally mediated behaviors independently of input from the brain or spinal cord. This ability is made possible by the presence within the gut of the enteric nervous system (ENS), which contains primary afferent (sensory) neurons and complex microcircuits that allow it to function autonomously. Despite its potential independence, the ENS also communicates bidirectionally with the CNS, although far more nerves carry information to the brain from the ENS than relay signals in the opposite direction. Modern studies suggest that vagal stimulation, which activates ascending nerves from the bowel, is useful in treating depression and epilepsy. Critical to ENS function is the detection of conditions in the intestinal lumen; nevertheless, no nerves enter this space. Transduction of liminal information, therefore, occurs an apithelial barrier and is mediated by the secretion of molecules such as serotonin into by the wall of the bowel mucosal epithelial cells. Serotonin is secreted by enterochromaffin (EC) cells, which contain about 95% of the body's serotonin. Different subtypes of serotonin receptor are responsible for exciting intrinsic primary afferent neurons of the submucosal plexus (5-HT_{1P}) and the extrinsic primary afferent neurons that realy information to the brain. As a result, 5-HT3 antagonists can relieve wymptoms of enteric distress (nausea, urgency, bloating) without paralyzing the bowel. Serotonin is inactivated in the mucosa by reuptake, mediated by a specific transporter, SERT, which is also expressed in the brain. Knockout of SERT or its inhibition with SSRIs is associated with affects on intestinal motility, secretion, and sensation, but is partially offset by the activities of non-selective organic cation transporters and the dopamine transporter (DAT). These non-selective transporters and DAT enable animals to survive without SERT, but they do not maintain normal intestinal function. SERT deficient mice thus excrete heavier stools than normal with an abnormally high content of water. SERT deficient mice and mimic conditions prevalent in patients treated with

SSRIs, other antidepressants, or cocaine. The animals may also model some of the properties of the irritable bowel syndrome (IBS).

REFERENCE:

Gershon, M.D: The Enteric Nervous System: A Second Brain. Hosp Pract (Off Ed) 34:31-2,35-8, 41-2 passim, 1999.

LECTURE 23
WHY WE WILL SPEND MOST OF OUR TIME IN VIRTUAL REALITY IN THE 21ST CENTURY

Ray Kurzweil, *Kurzweil Technologies, Inc., 15 Walnut Street, Wellesley Hills, MA 02481*

SUMMARY:

In considering the genesis of Moore's Law, I put 49 famous computing devices over the past century on an exponential graph. From this exercise, it became apparent that the acceleration of computing power did not start with integrated circuits, but has continued through multiple paradigm shifts (electromechanical calculators, relays, vacuum tubes, transistors, and finally integrated circuits). Moore's Law was not the first, but the fifth paradigm, to provide exponential growth in computing. The next paradigm, which will involve computing in three dimensions rather than the two manifested in today's flat chips, will lead to computing at the molecular, and ultimately the subatomic level. We can be confident that the acceleration of computing will survive the well anticipated demise of Moore's Law.

There are comparable exponential trends underlying a wide variety of other technologies: communications (both wired and wireless), brain scanning speeds and resolutions, genome scanning, and miniaturization (we are currently shrinking technology at a rate of 5.6 per linear dimension per decade). Even the rate of technological progress is speeding up, now doubling each decade. The mathematical models I've developed over the past couple of decades to describe these trends, which I call the law of accelerating returns, has proven predictive of the developments we've seen during the 1990s. From these models, I believe we can be confident of continued exponential growth in these and other technologies for the foreseeable future.

By 2009, computers will disappear. Displays will be written directly onto our retinas by devices in our eyeglasses and contact lenses. In addition to virtual high resolution displays, these intimate displays will provide full immersion visual virtual reality. We will have ubiquitous very high bandwidth wireless connection to the Internet at all times. "Going to a website" will mean entering a virtual reality environment - at least for the visual and auditory sense - where we will meet other real people. There will be simulated people as well, but the virtual personalities will not be up to human standards, at least not by 2009. The electronics for all of this will be so small that it will be invisibly embedded in our glasses and clothing.

REFERENCE:

1. Kurzweil R: The Age of Spiritual Machines; Viking, 1999.

MEDIA SESSIONS

SUNDAY, MAY 6, 2001

1. THE JOY LUCK CLUB

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand the role of resilience in coping with trauma and loss; and understand cultural aspects of the lives of Chinese women born both in China and in the U.S.

PROGRAM DESCRIPTION:

The Joy Luck Club is the story of transmission of resilience from Asian-born mothers to their American-born daughters. This feature film speaks not only to courage in the face of war, arranged marriages, infidelity, infanticide, and abandonment of babies, but also to the epiphany of achieving an "I-Thou" level of intimacy between mother and daughter. While rooted in Chinese life circumstances and customs, the film explores universal themes of resilience in the face of trauma and the reconciliation of mothers and daughters through hope and love.

REFERENCE:

1. Lee E: Working with Asian Americans. Guilford Press, New York, 1997.

2. THE CONFORMIST

PROGRAM DESCRIPTION:

The Conformist, directed by Bernardo Bertolucci, is set in Italy in the 1930s and stars Jean-Louis Trintignant and Stefanie Sandrelli. Trintignant portrays Marcello Clerici, an ambitious professor who proclaims himself a fascist as Mussolini comes into power. A blind friend arranges an assignment for him with the secret police. Clerici soon marries Giulia, played by actress Stefania Sandrelli, and receives his assignment, to assassinate the head of an antifascist resistance group, during their honeymoon in Paris. Assailed by doubts, Clerici's desperate attempt to find acceptance leads him to commit murder.

MONDAY, MAY 7, 2001

3. BOYS DON'T CRY

PROGRAM DESCRIPTION:

Boys Don't Cry, directed by Kimberly Pierce, is a compelling and absorbing story of a girl named Teena Brandon who decides to become a boy named Brandon Teena. Moving to a small town, she, now he, falls in with a crowd of rough pool players and their girl friends. Brandon begins dating and falls in love with Lana, a girl about her age. They live in a violent world of alcohol, drugs and thugs, who at first accept Brandon, but eventually discover her secret, with tragic consequences.

4. OUT OF MY MIND

PROGRAM DESCRIPTION:

Out of My Mind is an intimate portrait of twenty-three year old John Cadigan, who became seriously mentally ill while he was an art student in college. Soon after his first psychotic break, John asked his sister, the filmmaker and his primary caretaker, to document his story. Filmed over three years, the sibling narrates the story of John's painful deterioration, a rare look through a family member's eyes of the early stages of schizophrenia. John struggles day to day with a stream of paranoid and violent thoughts. Obtaining an accurate diagnosis, medical benefits and housing were a few of the barriers in an arduous search for help. Despite multiple hospitalizations John tries to lead as normal a life as possible, relying on the love and support of his family.

5. A JOURNEY BACK: COPING WITH A PARENT'S SUICIDE

PROGRAM DESCRIPTION:

When a parent commits suicide, he or she leaves behind a wake of pain and guilt for children and spouse. It may take years for the survivors to resolve their feelings. Louise Gallup, the filmmaker, was nine years old when her father shot himself. She and her brothers and sisters, now all highly successful adults, never spoke about the personal tragedy that engulfed their family. *A Journey Back* is a moving account of the filmmaker's coming to terms, 15 years later, with her father's suicide.

6. MEANS OF GRACE

PROGRAM DESCRIPTION:

Means of Grace is J. Clement's haunting and evocative documentary of one woman's struggle with mental illness. Clement's mother, Ann, a writer, was hospitalized for paranoid schizophrenia in the 1950s. She was one of more than a million American women at the time who were committed to mental hospitals, often treated with massive doses of tranquilizers or electric shock treatments. Told through Ann's journals, diaries and fiction, interwoven with medical records, home movies, archival footage, and dramatizations, the film raises provocative questions about social control, the nuclear family, women's roles, definitions of madness, and our treatment of the mentally ill.

7. STOLEN LIVES

PROGRAM DESCRIPTION:

Every year in the United States and Canada huge sums of money are generated by the sexual exploitation of more than 300,000 children under the age of 18. *Stolen Lives* takes a hard look at this world through the eyes of the teenaged boys and girls in the fast-growing business of child prostitution. Many die before they can leave the industry. The stories of a few survivors, diverse, poignant, courageous, and compelling, expose the painful reality of this modern form of slavery. Interviews with their pimps and johns make clear the economics and power fueling this growing crisis.

8. A CENTURY OF SATCHMO

PROGRAM DESCRIPTION:

Complete with archival sights and sounds of the early 20th century musical scene in New Orleans, *A Century of Satchmo* is a special presentation on the city's native son trumpeter Louis Armstrong. The lecturers will examine the special contextual features of New Orleans at the time of Armstrong's development, the sources of his instrumental and vocal styles, his relationships with Joe Oliver, Lil Hardin, Sidney Bechet, Bessie Smith and other musicians, and his emergence as one of the dominant musical personalities of the 20th century. The presentation will also feature excerpts from oral history,

audio recordings and other original materials illustrating the life and times of Louis Armstrong.

9. THE ART OF BEING HUMAN

PROGRAM DESCRIPTION:

The Art of Being Human is an inspirational portrait of artist Frederick Franck, author of "The Zen of Seeing." Born on the border of Holland and Belgium, Franck saw the horrors of modern warfare first hand. Living now in upstate New York, he has dedicated his life, through painting, sculpture and books, to encouraging the intolerance of violence and the discovery of humanity in us all.

10. FACES OF THE HAND

PROGRAM DESCRIPTION:

There is nothing more intriguing than what is hidden behind the obvious. The miraculous workings of the human hand, eloquent, silent, restless, creative, sometimes violent, and often taken for granted, have shaped human history. *Faces of the Hand* takes you on a visual journey through different cultures and a range of human experiences focusing on hands at work, communicating, creating art and music, expressing sensuality, being used as weapons for defense or aggression, healing and worshipping. The film is an odyssey from cave art thirty millennia ago to the computer controlled robotic hands of today.

11. GIRL, INTERRUPTED: THE FILM AND THE BOOK

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have witnessed a cinematic portrayal of BPD and psychiatric hospitalization as treatment.

PROGRAM DESCRIPTION:

The memoir, *Girl, Interrupted,* was published in 1993, 26 years after Susanna Kaysen's 1967 hospitalization for treatment of borderline personality disorder. It describes her experience at a time when long-term inpatient treatment was common in psychiatry. The book won critical acclaim and became a national bestseller. This 1999 feature film, starring Winona Ryder and Angelina Jolie, is a flawed and banal version of Kaysen's memoir, but is typical of cinematic portrayals of mental disorders and those who try to treat them.

REFERENCE:

1. Gabbard G: The Psychiatrist in Film. American Psychiatric Press, 1999.

12. KING GIMP

PROGRAM DESCRIPTION:

King Gimp follows the life of Daniel Keplinger for 13 years as he moves from a special elementary school to mainstream life in Baltimore. In his battle with cerebral palsy, Daniel is confined to a wheelchair and is unable to communicate easily with words; however, his emotional life explodes on canvas when he discovers that he is a talented painter. This exhilarating documentary tells the story of a young man, afflicted with a devastating condition, who unveils his humanity through art.

13. SOOP ON WHEELS

PROGRAM DESCRIPTION:

Everett Soop, a member of the Blackfoot tribe, lives on the Blood Indian Reserve in southern Alberta. Muscular dystrophy has confined him to a wheelchair, but has not broken his spirit. Soop is an outspoken journalist and political cartoonist, a crusader for Native Canadian rights, and a man of acerbic wit who is self-educated in anthropology, the arts, and philosophy. In *Soop on Wheels,* the filmmaker captures the essence of a man with an impressive intellect and spirituality, challenged by disability and race, compounded by isolation from his own people who fear his illness, who survives and grows through humor, artistic talent, and spiritual values handed down from his ancestors.

14. THE REMARKABLE STORY OF JOHN/JOAN

PROGRAM DESCRIPTION:

Eight-month old John was the victim of a botched circumcision, which left him with almost no penis. When he was almost two, the family brought him to Dr. John Money at John Hopkins Hospital, who recommended that the boy's testicles be surgically removed. Dr. Money subscribed to a prevailing theory in the sixties that sexual identity derived from nurture rather than nature. Following Money's advice, the family renamed the boy Joan, dressed him in frilly clothing and treated him like a little girl. Beneath the curls and dresses, John/Joan was miserable in his female persona. His twin brother recalls that he was never "feminine." When John was an adolescent, he learned the truth about his gender at birth. In a first person interview, John, now in his thirties, describes his inner conflicts, his decision to have reconstructive surgery to restore male anatomy, and his subsequent life as a husband and father.

TUESDAY, MAY 8, 2001

15. INVISIBLE REVOLUTION

PROGRAM DESCRIPTION:

This disturbing documentary profiles a chilling subculture in American youth. For over a decade, the clash between racist and antiracist youth has been virtually invisible. But as ever-younger members are taking control of the white supremacy movement, antiracist skinheads, punk rockers, and mainstream kids, calling themselves the Antiracist Action (ARA), have burst onto the scene. The two antithetical groups are often indistinguishable as they engage in conflict. This hard-hitting film, with strong language and extreme expressions of racism, will awaken audiences to a frightening adolescent phenomenon.

16. METHAMPHETAMINE: FROM THE STREETS OF SAN DIEGO

PROGRAM DESCRIPTION:

Lurking behind San Diego's image of swaying palm trees and beautiful beaches is a pervasive methamphetamine subculture that knows no social boundaries. School-age children, affluent women, and working class San Diegans alike have lost control of their lives to the intoxicating effects of methamphetamines. This disturbing investigative documentary explores the reasons why San Diego has

become the center of methamphetamine production and distribution in America. The film traces the history of the drug, examines its effects on users, and demonstrates how it has been a factor in some of the nation's most bizarre and violent crimes, contributing to the overflow of meth-related cases in the courts, jails, and hospital emergency rooms.

17. DRINKING APART: FAMILIES UNDER THE INFLUENCE

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should better understand the influence of drugs and alcohol on family life and observe the role of family therapy.

PROGRAM DESCRIPTION:

At some time in their lives millions of Americans have wrestled with a drug or alcohol problem, usually without the aid of counseling. At the Ackerman Institute for the Family, teams of counselors help many to regain their freedom from drug and alcohol dependence. This film tracks the progress of a husband and wife, a mother and teenage daughter, and a young couple over a three-year period as they fight their way to recovery. The documentary carries us to the Ackerman Addicts Rehabilitation Center in New York City, the Cassadage Job Corps Center in upstate New York, and even into the subjects' homes, providing candid insight into substance use disorders and their treatment.

REFERENCE:

1. Steinglass P: The Alcoholic Family. Basic Books.

18. THE PERSONALS: IMPROVISATIONS ON ROMANCE IN THE GOLDEN YEARS

PROGRAM DESCRIPTION:

This video offers an extraordinary look at the emotional lives of elderly Americans. *The Personals* follows a group of senior citizens as they rehearse and present an original play at a community theater on Manhattan's Lower East Side. Drawn from the comedy and drama of their own lives, the play is structured around their quest for dates through the personal ads. On stage, the seniors perform their roles with energy and laughter. Off stage, their lives are often lonely and silent.

19. BRINGING THE CIRCLE TOGETHER

PROGRAM DESCRIPTION:

This video celebrates the cross-cultural, but disappearing reverence for the elderly as wise teachers of the young. In *Bringing the Circle Together,* four men from various walks of life and professions share their wisdom with us. Their candid thoughts on old age, death, money, work and the most essential qualities of life are sage.

20. A ONE AND A TWO

PROGRAM DESCRIPTION:

This is a portrait of Angelo, a widower after 37 years of marriage, as he begins to build a new life. During the process of "starting over," he discovers afternoon ballroom dancing, a new passion that is becoming a senior phenomenon. Set against his adventures on the dance floor in search of female companionship is his down-to-earth description of the adjustments he has had to make. He had depended on his wife for so much in life, preparing his meals, balancing his checkbook, selecting his clothes, and now he must deal with loneliness, retirement, finances, courtship and fathering all by himself.

21. AS TIME GOES BY

PROGRAM DESCRIPTION:

The simple acts of touching another human being, of expressing and receiving affection, of sharing companionship and love, are universal cravings. If the thought of parents or grandparents as sexual beings engenders disbelief or discomfort, then this new documentary reminds us that sexuality is lifelong. *As Time Goes By* depicts a community of vital, elderly people who openly share their thoughts on love, sex, and aging, challenging any notion that intimacy and affection wither with time.

22. THE MIRROR LIED

PROGRAM DESCRIPTION:

How does a young African-American woman deal with the ideals of feminine beauty imposed by white society? *The Mirror Lied* shows the struggle of the filmmaker's 15-year-old sister, Jantre, in accepting her appearance. Although she spends an hour each day trying to tame her unruly hair, Jantre never feels attractive. She envies white girls with "hair that blows in the wind." When Jantre asks for a wig for her birthday, her mother accuses her of not accepting her blackness. The daughter, who points out that her mother, in fact, wears "woven hair", challenges that notion. In a bold statement of defiance of her classmates' standards, Jantre goes to school with her hair in its natural fullness. She finds it a liberating experience.

23. STRUGGLE FOR IDENTITY

PROGRAM DESCRIPTION:

This short documentary profiles families who find themselves unprepared for the cultural clashes and identity conflicts which commonly arise in altruistically motivated, but perhaps too hastily arranged interracial adoptions or foster care.

24. FAT CHANCE

PROGRAM DESCRIPTION:

Fat Chance is the funny and sensitive story of Rick Zakowich, who started a diet to lose half his body weight and found all of himself along the way. Rick's journey toward a new identity is along a path he could not have anticipated, where values, assumptions, and perspectives are turned inside out.

25. MR. DEATH

PROGRAM DESCRIPTION:

Mr. Death tells the story of Fred A. Leuchter, Jr., an engineer who decided to become the "Florence Nightingale of death row." His mission was to design and repair gas chambers, electric chairs, and lethal injection systems. But Leuchter became infamous for his work with anti-Holocaust writer Ernst Zundel, who commissioned Leuchter to conduct a forensic investigation into the use of poison gas in World War II Nazi concentration camps. Leuchter's controversial findings lead him to hypothesize that the Holocaust never happened. He fully expected his involvement with Zundel to be the crowning achievement of his career; instead, it ruined him.

26. THE ITALIAN GARDENS OF SOUTH BROOKLYN

PROGRAM DESCRIPTION:

Italian Gardens of South Brooklyn is an infectiously enjoyable and inventive documentary that illustrates how a mixture of "old-world values and new-world horse sense" invigorates the traditional Italian-American community of South Brooklyn. This short documentary is infused with a strong respect for family, friends, and neighborhood.

27. DELTA JEWS

PROGRAM DESCRIPTION:

Through the eyes of those who remain, *Delta Jews* traces the history of a southern Jewish community and its relationship to both black and white Christian neighbors. Often adopting characteristic speech patterns and social attitudes of their neighbors, Jewish families maintained their traditions, even if it required importing rabbis and traveling miles for services. These families developed an active social network to reinforce their identity and keep the younger generation "in the fold."

28. A WOK IN PROGRESS

PROGRAM DESCRIPTION:

The third film of Paul Kwan's odyssey interweaves a love of food with cultural and psychic survival. In *A Wok in Progress,* Paul triumphs over his demons with a sense of whimsy, lyricism, and, of course, his enjoyment of food and family. This film is a joyous romp through memory, a touch of personal philosophy, and a distillation of sensory perceptions surrounding food and its preparation. Identity and a sense of well being are recreated in the kitchen. The film is a celebration of the powers of recovery.

29. THE MATRIX

PROGRAM DESCRIPTION:

The Matrix is a sci-fi thriller directed by Larry and Andy Wachowski starring Keanu Reeves and Laurence Fishburne. Reeve's character believes that he is living a normal life in the 1990s, but discovers that he and the rest of humanity are living a delusion fed to them by their computer captors of the future. Reeves' character breaks free and joins an underground group of computer hackers, led by Fishburne's character, eventually rising up in revolution against their machine masters.

30. SANKOFA

PROGRAM DESCRIPTION:

Sankofa is an Akan word that means "one must return to the past in order to move forward." In *Sankofa* the video, Mona, a contemporary model, is possessed by spirits lingering in the Cape Coast Castle in Ghana. She travels to the past where as a house servant called Shola, she is constantly abused by the slave master. Nunu, an African-born field hand, and Shango, Shola's West Indian lover, continuously rebel against the slave system. For Nunu this means direct conflict with her son, a mulatto benefiting from the system as a head slave. Inspired by Nunu's and Shango's determination to defy the system, Shola finally takes her fate into her own hands.

WEDNESDAY, MAY 9, 2001

31. NO FEARS...NO TEARS: THIRTEEN YEARS LATER

PROGRAM DESCRIPTION:

Thirteen years ago the award-winning documentary *No Fears, No Tears* profiled eight children in treatment for cancer with painful medical procedures and therapeutic support from clinical psychologist, Dr. Leora Kuttner. In *No Fears, No Tears: Thirteen Years Later,* Dr. Kuttner reconnects with some of these patients in an attempt to understand how dealing with pain and fear as a child may impart long term benefits. Now young adults, these cancer survivors vividly recall their painful childhood experiences, revealing the process by which children actively help themselves through crises, enhancing their appreciation of life.

32. IN GRANDMA'S HANDS

PROGRAM DESCRIPTION:

This intimate and gently probing documentary profiles three, diverse urban families in which grandparents are raising their grandchildren as a result of their adult children's drug addiction. In America today some four million children are being raised by their grandparents. In candid, reflective interviews, the grandparents comment on the challenges of raising young children at a time in their lives when they expected to be enjoying a quiet retirement.

33. TWITCH AND SHOUT

PROGRAM DESCRIPTION:

Twitch and Shout provides an intimate journey into the startling world of Tourette's Disorder told through the eyes of a photojournalist with the disease. This film is an emotionally absorbing, sometimes unsettling, and ultimately uplifting film about people who must contend with a society that often sees them as crazy, bad, or with a body and mind that won't do as they're told.

34. GRACE

PROGRAM DESCRIPTION:

This documentary traces the life of Grace Kirkland over her seven-year decline as a result of progressive dementia. Early on, Grace has difficulty with short-term memory. Nonetheless, her enthusiasm for life shines through her. Four years later, Grace is no longer able to speak, pacing aimlessly through her home. At the film's end Grace is no longer able to walk or feed herself. The documentary is a tribute to the selfless dedication of Grace's husband to her total care.

35. CHOICES AND CHALLENGE: CARING FOR AGGRESSIVE ADULTS

PROGRAM DESCRIPTION:

Choice and Challenge is a training video developed during a yearlong project sponsored by the American Psychiatric Nurses Association. Aggression is perhaps the most troubling, and often least understood behavioral problem of the elderly in hospital and nursing home settings. The program provides practical solutions to a variety

of real-life problems experiences by older adults and their care providers.

36. SOMETHING SHOULD BE DONE ABOUT GRANDMA RUTHIE

PROGRAM DESCRIPTION:

Something Should Be Done About Grandma Ruthie is a moving and unsettling portrait of the filmmaker's family as they struggle to deal with her 85-year-old grandmother's deteriorating mental condition due to Alzheimer's Disease. Though still physically healthy, Ruth Hammer no longer can be relied on to bathe and feed herself, or even to remember where she is. Her children live out of town, and a series of compassionate caregivers find themselves unable to deal with her growing disorientation. Ruthie refuses to leave her long time home, and the family must confront the necessity of medicating her against her will and eventually forcing her to move to a long-term care facility.

37. THROUGH MADNESS

PROGRAM DESCRIPTION:

This penetrating documentary demystifies psychotic illnesses, such as schizophrenia and manic depression, as it humanizes those who suffer from these diseases. *Through Madness* documents the lives of three people who describe their bout with psychosis: Eileen, a once promising actress, who now lives in a halfway house and has a severe form of schizophrenia; Lionel, a former NFL football star who had been diagnosed with paranoid schizophrenia; and Joe, a troubled adolescent with delusions and hallucinations, who has been diagnosed with manic depression.

38. BETWEEN THE LINES

PROGRAM DESCRIPTION:

Between the Lines is a visually lyrical experimental documentary about women who cut themselves. The film explores the gray areas in women's relationships to their bodies in the context of deliberately self-inflicted injury. The women in this film negotiate the fine line between self-destructive behavior and self-preserving coping mechanisms.

39. FIGHTING GRANDPA

PROGRAM DESCRIPTION:

Korean-American filmmaker Grek Pak creates a touching meditation on the human heart. He tells the story of his immigrant grandmother's 70-year struggle with her husband. Forced to give up her dreams of becoming a nurse, left with four children for ten years alone in Korea while her husband studied in America, and finally brought to Hawaii to endure new hardships created in part by her husband's parsimonious ways, Grandma had every right to be bitter. But, when Grandpa dies, Grandma's stoicism gives way to a piercing grief, which surprises and confounds her family.

40. MEN LIKE MY FATHER, FAMILIES LIKE MY OWN

PROGRAM DESCRIPTION:

This is a sensitive portrait of men who had each lost a dearly loved wife at an early age, through illness or sudden act of fate. We learn how they fare bringing up their children, housekeeping, dealing with their emotions, and sometimes finding new love. The filmmaker's mother had died when he was young, and his father had never been able to speak of their loss. It was this silence that ultimately propelled him to make the film and explore the effect of loss on young families. During the course of filming, father and son grew closer and the filmmaker is given his parents' precious wedding album.

41. WHAT DO I TELL MY CHILDREN?

PROGRAM DESCRIPTION:

In *What Do I Tell My Children,* narrated by Joanne Woodward, children and parents share their stories and feelings about the loss of a loved one, while professionals in the field offer advice about coping and grief.

42. GENERATIONS OF VIOLENCE

PROGRAM DESCRIPTION:

This documentary is a compelling portrait of the legacy of multigenerational family violence, showing abused children growing up to become abusive parents. We meet both the victims and the perpetrators of family violence and hear their personal experiences. The film also presents strategies for breaking this chain of destructiveness.

43. COLORS STRAIGHT UP

PROGRAM DESCRIPTION:

In the ghetto of South Central Los Angeles, where Latino and African-American kids struggle against a myriad of destructive influences, there is an option for a better life. Troubled teens discover their talents and self-dignity through "Colors United," a performing arts group created for inner city youth. This uplifting and emotional documentary offers powerful insights into the thoughts and feelings of these "at risk" children.

44. COME BACK JACK

PROGRAM DESCRIPTION:

Persistent ear infections, misguided medical treatments, and other mysterious physiological factors sent Jack's mind spinning. His brilliant blue eyes grown glassy, Jack became a captive in his own world, his intellectual and emotional development halted at age two. Terrified by the prospect of losing their youngest son, Jack's parents began searching for answers. *Come Back Jack* chronicles the ups and downs of Jack's therapeutic journey, which leads to the Language and Cognitive Development Center in Lynnfield, Massachusetts. There, with the guidance of a team of special educators, Jack begins to emerge from his internal chaos, embracing life and the people who love him.

45. AUTISM: A WORLD APART

PROGRAM DESCRIPTION:

Autism's cause is unknown. There is no cure, and it strikes each victim differently. In *Autism: A World Apart,* three families show us what the textbooks cannot, namely, living with autism.

46. A DYSLEXIC FAMILY DIARY

PROGRAM DESCRIPTION:

This film chronicles a mother's 18-year struggle to provide an education for her bright, dyslexic son, Ben. Ben was on the verge

of suicide by the end of the sixth grade. In approaching the school board for help, Dorothy Tod, the filmmaker/mother, is challenged by her husband, a lawyer and former school board member, with a very different perspective on their son's needs. In a surprising twist, Dorothy discovers that she, too, has dyslexia.

47. THE TALENTED MR. RIPLEY

PROGRAM DESCRIPTION:

To be young and carefree amid the blue waters and idyllic landscape of sun-drenched Italy in the late 1950s is the life that Tom Ripley, played by Matt Damon, craves, and the life that Dickie Greenleaf, played by Jude Law, leads. Dickie's father, a wealthy ship builder, asks Tom to bring his errant playboy son back home to America. Dickie and his beautiful expatriate girlfriend, Marge Sherwood, played by Gwyneth Platrow, never suspect the dangerous extremes to which Ripley will go to make their lifestyle his own. *The Talented Mr. Ripley* was directed by Academy Award winner Anthony Minghella.

48. 2001: A SPACE ODYSSEY

PROGRAM DESCRIPTION:

Ushering in a new era of cinematic special effects, Stanley Kubrick's grand space fantasy unfolds almost like an avant-garde film, telling its largely nonverbal story through balletic, hypnotic imagery. *2001: A Space Odyssey* uses the metaphor of a mysterious monolith to advance human development in various eras. Kubrick's breathtakingly evolutionary leaps of logic and almost abstract visual expression convey his meditations on the godlike potential within the apelike human species. Emotionally remote, with characters seeming less human than the computer onboard the spacecraft, *2001* brought about a quantum jump in the aspirations of the sci-fi genre.

THURSDAY, MAY 10, 2001

49. HOW TO LIVE TO BE 100

PROGRAM DESCRIPTION:

Not only are people living longer and healthier lives, but centenarians are no longer a rarity. This video presents the latest research on the elderly in the U.S., China, and Denmark. Every decade, the number of centenarians double. Once people reach 80, the mortality rate seems to reach a plateau. Why do some people survive past 80? James Vopel of the Max Planck Institute in Germany, and a senior scientist at Duke University, leads a team of researchers exploring lifestyle, hereditary and nutritional factors that may be linked to longevity. This fascinating video also challenges stereotypes about the extreme elderly.

50. THE ANDRE SHOW

PROGRAM DESCRIPTION:

When filmmaker Beverly Peterson was invited into the lives of Andre, an HIV-positive child, and his mother, Vilma, it was the beginning of an extraordinary friendship that eventually reshaped the lives of everyone around them. As she became friends with the family, Peterson and her husband Farrell became more and more involved, inviting Andre to stay with them while Vilma was in the hospital or in drug rehabilitation programs. When Vilma realized that she did not have long to live, she asked the Petersons to adopt Andre and, after considerable struggle, they agreed. *The Andre Show* is a poignant documentary of the Peterson's journey from ambivalence and conflict to increasing trust and resolution.

51. AT DEATH'S DOOR

PROGRAM DESCRIPTION:

A young mother is told the devastating news that her three-year-old daughter has leukemia, A young husband receives a shocking phone call that his 53-year-old father has stomach cancer. A 68-year-old woman's gnawing fears are confirmed: her husband has Lou Gehrig's disease. Through these vignettes, *At Death's Door* explores the emotional experience of dealing with the terminal illness of a loved one and the potential for the patient and his family to live fully in the time remaining.

52. LOOKING FOR COMMON GROUND

PROGRAM DESCRIPTION:

When Massachusetts enacted an antidiscrimination law establishing the rights of gay and lesbian high school students, the citizens of Westhampton were embroiled in controversy. Parents, students, school committee members, and local citizens were polarized. *Looking for Common Ground* gives voice to the gay and lesbian students who talk about their struggle for acceptance. There is articulate and passionate testimony from both sides in the controversy, during interviews and in community meetings. Among the issues raised are the locus of responsibility for educating minors, community values versus the rights of the individual, and nature versus nurture in determining sexual orientation.

53. SUMMER IN MY VEINS

PROGRAM DESCRIPTION:

It would be wrong to classify this remarkable film as simply a "coming out" film. It is also a look at family dynamics, the nuances of another culture, and a most unusual "road" movie. Harvard graduate Nish Saran, a gay Indian filmmaker, travels across America with his family visiting from India. He was recently tested for HIV after an unsafe encounter with an HIV-positive man. As he will not know the outcome for several weeks, the threat of terminal illness shadows the trip. Nish plans to reveal his gayness to his mother during this journey, but finds it difficult to say the words, as his unsuspecting mother and sisters are enjoying the vacation. When Nish finally comes out to his mother, her reaction is powerful and moving.

MEDICAL UPDATES

1. CAN STEM CELLS FROM BONE MARROW SERVE AS A FOUNTAIN OF YOUTH FOR THE BRAIN?

Darwin J. Prockop, M.D., *Department of Medicine, Center for Gene Therapy, SL-99, 1430 Tulane Avenue, New Orleans, LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be aware of the amazing possibility that adult stem cells from bone marrow may provide a way of rejuvenating the brain.

SUMMARY:

A stem cell is a unique cell that can divide to produce both another stem cell and a second cell that differentiates into more specialized cells. We all have several stem cell systems. Without them, we would rapidly lose our blood cells, skin, intestinal tract and several other tissues. The paraventricular stem cell system from which the brain develops during embryonic life continues to function at a low level throughout adult life. There are now may research efforts to invigorate this stem cell system. Our laboratory and others are using a kind of stem cell from bone marrow referred to as marrow stromal cells (MSCs) that are relatively easy to isolate from a patient, genetically engineer, and then use for therapy of the same patient. After systemic infusion, the cells appear in many tissues and differentiate into the appropriate cells such as osteoblasts in bone, chondrocytes in cartilage and myotubes in muscle. Encouraging results have been obtained using MSCs to treat children with severe brittle bone disease (osteogenesis imperfecta). After MSCs are infused in the CNS, they differentiate into astrocytes, oligodendrocytes and neurons. The cells have been effective in animal models for Parkinson's Disease, a demyelinating disease, and spinal cord injury. We cannot at this stage rule out the possibility that MSCs can be used repeatedly to replenish cells of a patient's own central nervous system throughout life. Modifying behavior is more problematic but also cannot be ruled out. Supported in part by grants from the NIH (AR47796 and AR44210), the Oberkotter Foundation and the Louisiana Gene Therapy Research Consortium.

REFERENCE:

1. Prockop DJ: Marrow stromal cells as stem cells for nonhematopoietic tissues, Science, 276:71–74, 1997.

2. BREAST CANCER PREVENTION: AN EXAMPLE OF TRANSLATIONAL RESEARCH

Roy S. Weiner, M.D., *Director, Tulane Cancer Center, Tulane University School of Medicine, 1430 Tulane Avenue, SL 68, New Orleans, LA 70112-2699.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with the direction cancer research is taking with respect to translating biological observations to specific treatments and prevention; understand how hormonal regulation of growth can be exploited for therapy and prevention; be knowledgeable of the concepts of Selective Estrogen Receptor Modulators, Gene Expression Modulators, and Signal Transduction Modulators as new approaches to molecular intervention; and be aware of the choices that women must make today, including balancing quality of life with reducing medical risk.

SUMMARY:

Breast cancer will be diagnosed in 180,000 American women in 2001. It is the most common cancer in women, but is surpassed by lung cancer as the most common cause of cancer death. Nevertheless, 45,000 American women will die of breast cancer this year. The age-specific incidence of breast cancer rises sharply at age 40 and remains high through the eighth decade. The impact of breast cancer can be devastating to the patient and impact negatively on the patient's entire family. While a minority of cases seem to result from a genetic predisposition, the specific etiology in most cases is unknown. However, the pathobiology, in most cases, is known. Estrogen is an important growth promoter in 2/3 of cases of breast cancer. Blocking the association of estrogen with its receptor has been shown to induce cell death and tumor regression in patients. It has been shown in animals that estrogen blockers can abort chemical induced carcinogenesis. Recently, an estrogen receptor modulator, Tamoxifen, has been shown to prevent breast cancer in a population of women at risk. A second clinical trial, currently ongoing, is testing Tamoxifen against Raloxifine (another SERM) to determine the relative effectiveness and safety of the two compounds. This study involves 22,000 women, all of whom will be faced with the choice of taking an "anti-estrogen" that may reduce their risk of breast cancer by as much as 50%, while precipitating menopausal symptoms; doing nothing; or taking estrogen to allay the symptoms of menopause, possibly protect against cardiovascular disease, and preserve bone mineralization. Our advances in cancer treatment and prevention are significant, but imperfect. The effect of these and other advances will present new challenges to our colleagues who assist in the management of psychosocial consequences.

REFERENCES:

1. Fisher B, Constantino JP, Wickerham DL, Redmond CK, Kavanah M, Cronin WM et al: Tamoxifen for Prevention of Breast Cancer: Report of the National Surgical Adjuvant Breast and Bowel Project P-1 Study; J Nat Canc Inst, 1998; 90 (18): 1371–1388.
2. Hatcher MB et al: Perceived Cancer Risk Influences Mastectomy Decision; Brit Med J, 322: 76–79, 2001.

3. WILL MEDICALIZING OBESITY TREATMENT IMPROVE OUTCOMES?

Donna H. Ryan, M.D., *Pennington Biomedical Research Center, 6400 Perkins Road, Baton Rouge, Louisiana 70808-4124.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to assess risk using BMI, waist circumference and metabolic profile as a guide to selecting appropriate treatment for obesity; recognize barriers to successfully implementing obesity treatment in the physician office; and acknowledge the role of the Primary Care Physician in managing obesity as well as the specialist physician in dealing with complicated cases.

SUMMARY:

Physicians face a daunting task in trying to manage patients in their weight control efforts. A positive attitude with a view to the long term is essential to managing this chronic incurable disease, obesity. Setting an achievable goal (10% reduction) and a slow, steady course are most likely avenues to long term success. There is a growing acceptance of medications to aid in weight loss and weight loss efforts for patients who are at health risk from overweight. They are generally restricted to patients whose BMI > 30 (or >27 with a comorbid condition). The general pattern with medication use is that weight loss occurs for the first six months of use and weight maintenance continues as long as the medication is in use. There are two medications that have been approved by the FDA for long term use (sibutramine and orlistat) and they should be a part of every physician's toolbox in treating obesity.

Will moving obesity treatment into physician offices result in improved outcomes? While progress has advanced rapidly in basic obesity research, we are at the forefront of incorporating those advances into medical practices. Physicians can be successful motivators for obesity prevention and treatment. What is needed for this success are behavioral intervention skills, knowledge of the current treatments and most importantly, a caring and accepting attitude for the obese patient. This presentation focuses on the practical aspects of obesity assessment and treatment with applications for the primary care and specialist physician.

REFERENCES:

1. Grundy SM, Blackburn G, Higgins M, Lauer R, Perri MG, Ryan D: Roundtable consensus statement: Physical Activity in the Prevention and Treatment of Obesity and Its Comorbidities, Medicine and Science in Sports and Exercise 31 (11-Supplement): S502–S508, 1999.
2. Ryan DH: Recent Progress in Obesity Pharmacotherapy. Current Opinion in Gastroenterology (Review), 16(2):166–172, 2000.

4. BRINGING THE SPACE STATION TO THE CLINICAL BEDSIDE: NEXT GENERATION BIOPRODUCTS AND DRUG TESTING MODALITIES DEVELOPED USING STUDIES IN SPACE.

Timothy Hammond, M.B., *Tulane University School of Medicine, Section of Nephrology, SL 45, 1430 Tulane Avenue, New Orleans, LA 70112-2699.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to understand the problems of dedifferentiation of cells in culture, and how that limits current in vitro testing of drug metabolism and drug interactions; to summarize the techniques of suspension cell culture as they relate to drug metabolism; to understand the nature and use of state-of-the-art gene array technology in the analysis of suspension culture; to understand the role space science has played, by providing a dynamic range for suspension culture not obtainable in gravity limited ground-based studies; and to understand the approach to studies in space, and how they translate in academic and commercial settings to clinical products using renal cell bioproducts and metabolism as an example.

SUMMARY:

Most if not all differentiated cells derived from diverse tissue sources lose their specialized features and dedifferentiate when grown under traditional 2-dimensional cell culture conditions. Suspension culture is the most popular means to prevent this problem, and maintain the specialized features of cells. There is a great deal of information available on the optimization of suspension culture by utilizing the information available on the optimization of suspension culture by utilizing the engineering principles of fluid physics to minimize shear and turbelence. Engineering optimization of suspension culture was largely undertaken by NASA engineers to model culture conditions in space flight, but may find its greatest utility in the carryover to commercial ground-based applications. Suspension culture continues to be useful for production of many bioproducts, from antibodies to hormones.

In this review we will use concrete examples of tests for drug interactions derived from renal and hepatic cell culture through cartilage implants an drug design by crystallization of proteins in space to demonstrate the passage of information from space based studies to the clinical bedside. Although the emphasis will be on the potential of new therapeutic strategies, the steps in the planning, execution and analysis of space shuttle and international space station experiments will be reviewed. This analysis includes demonstration of the use and interpretation of state-of-the-art gene array microarray technologies.

REFERENCES:

1. Westaby, S, Katsumata, T, Houel, R, Evans R, Pigott, D, Frazier, OH, Jarvik R: Jarvik 2000 Heart: Potential for Bridge to Myocyte Recovery, Circulation, 1998.
2. Macris, M, Parnis, S, Frazier, OH, Fuqua, J, Jarvik, R: Developmental of an Implantable Ventricular Assist System, The Society of Thoracic Surgeons, 1997.
3. Jarvik, R, Westaby S, Katsumata T, Pigott D, Evans R: VAD Power Delivery: A Percutaneous Approach to Avoid Infection, The Society of Thoracic Surgeons, 1998.

PRESIDENTIAL SYMPOSIUM

THE ROYAL ROAD REVISITED: DREAMS IN THE 21ST CENTURY

Chairperson: Daniel B. Borenstein, M.D.
Co-Chairperson: Michelle Riba, M.D.
Participants: Harold P. Blum, M.D., Morton F. Reiser, M.D., Eve Caligor, M.D., and Mark L. Solms, Ph.D.

A. HAROLD P. BLUM, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand that the dream is compatible with neuroscience formulations and that the dream is organized around an unconscious wish or wishes subject to censorship and distortion.

SUMMARY:

During this past century of psychoanalysis and into the new millennium there have been continuing challenges to psychoanalytic dream theory. In particular, the wishful meaning of dreams subject to the distortion and disguise of censorship is questioned or dismissed. This paper reconsiders and reaffirms the basic characteristic of most dreams as hallucinatory wish fulfillments. The recalled manifest dream, analagous to the daydream, represents the relatively forbidden unconscious wish or wishes in a form that is more or less acceptable to the awakened dreamer. Dream psychology is differentiated from the neurophysiology of dreaming, and is a different, but compatible domain of theory.

REFERENCES:

1. Freud S: The Interpretation of Dream (1900) Standard Edition, Volumes 4 and 5. London: Hogarth Press, 1953.
2. Blum, H: The Writing and Interpretation Dreams (2000) Psychoanalytic Psychology, 17:651–666.

B. MORTON F. REISER, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the logical problems of relating the psychological content of dreams with the psychophysiology of the dreaming brain and to acquaint them with a contemporary preliminary psychobiologic concept of dream process based upon psychoanalytic and neurobiologic research.

SUMMARY:

This paper offers selective reviews of cogent sectors of research: first, of recent (1953–1999) research on the neurobiology and clinical psychophysiology of dreaming sleep: second of experimental cognitive neuroscientific studies of perception, emotion and memory and putative interrelationships among them in generating dream imagery; and third of psychoanalytic studies (1900–1999) on related aspects of dreams and dream process. Exploration for interrelationships between information from these three areas entails discussion of the "Mind/Brain Problem." These considerations illuminate some of the logical and interpretive dilemmas that enter into debates about Freud's theory of the dream. Finally the paper proposes a preliminary psychobiologic concept of dream process and discusses—in the light of the foregoing considerations—the importance of collaborative research for developing a realistic perspective concerning the proper place of the dream in contemporary psychiatry.

REFERENCES:

1. Hobson JA: The New Neuropsychology of Sleep: Implications for Psychoanalysis, in Neuropsychoanalysis 1(2)157–225, 1999. Edited by Allen Braun and Morton Reiser.
2. Reiser MF: Memory in Mind and Brain: What Deram Imagery Reveals, New Haven Paperbound Yale University Press, 1994.

C. EVE CALIGOR, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be aware of the clinical approaches to dreams across the spectrum of psychodynamically-oriented treatments.

SUMMARY:

While Freud developed his technique of dream analysis within the framework of psychoanalytic treatment, today psychodynamically oriented psychiatrists work with dreams in a variety of clinical settings that span the supportive-expressive spectrum. How to use dream material in a particular treatment can only be understood within the framework of the goals, strategies and tactics of the particular treatment involved. This presentation will provide an overview of how one can use dream material in psychodynamically oriented supportive psychotherapy, transference-focused psychotherapy, psychoanalytic psychotherapy and psychoanalysis. Special attention will be paid to the role of the manifest dream, the context within which the dreamer dreams the dream, the day residue and the patient's associations to the dream as they inform the therapist's processing of the patient's presentation of the dream. Illustrative clinical material will be presented.

REFERENCES:

1. Mendelsohm R: The Manifest Dream and Its Use in Therapy, Northvale, 1990.
2. Ogden T: Reconsidering Three Aspects of Psychoanalytic Technique, Int J Psychoanalysis 77:883–899, 1996.

D. MARK SOLMS, PH.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to review recent findings on the neurological organization of dreaming derived from various neuroscientific methods and to highlight converging lines of evidence as well as construct a consensual model of the dreaming brain.

SUMMARY:

This presentation will review recent findings on the brain mechanisms of dreaming, derived form various neuroscientific methods. It will highlight converging lines of evidence and attempt to construct a consensual model of the dreaming brain. The status of psychoanalytic dream theory in the light of these findings will also be discussed.

REFERENCES:

1. Solms, M: The Neuropsychology of Dream (1997), Mahwah, NJ, Lawrence Erlbaum Associates.
2. Solms, M: Dreaming and REM Sleep Are Controlled by Different Brain Mechanisms (2000) Behavioral and Brain Sciences, 23:000.

RESEARCH ADVANCES IN MEDICINE

BRAIN SCIENCE: FROM IMPLANTS TO IMAGING

Chairperson: Michelle L. Kramer, M.D.
Participants: Carol A. Tamminga, M.D., Larry A. Carver, M.D., Christine E. Marx, M.D., Bryan Payne, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be familiar with new advances in brain research and the clinical implications of this research.

SUMMARY:

The last decade has led to significant research advances in the neuroscience and understanding of the brain. For psychiatrists, the implications of molecular and neuroimaging research advances are particularly compelling. This four part research advances in medicine session will bring together outstanding scientists who study the brain from different perspectives. These researchers will discuss their research and the clinical implications of these findings. First, Dr. Carol Tamminga, Professor of Psychiatry at the University of Maryland School of Medicine and Deputy Director of the Maryland Psychiatric Research Center will lead a review of advances in brain neuroimaging research and findings in schizophrenia. Dr. Larry Carver, Associate Professor of Psychiatry and Neuroscience and Co-Director of the Brain Tissue Bank at Louisiana State University (LSU) School of Medicine will discuss molecular research in schizophrenia and his work in dopamine receptors. Dr. Christine Marx, an assistant professor at the University of North Carolina will review recent advances in neurosteroid research and discuss the relevance of neurosteroids to psychiatric disorders and pharmacologic treatment strategies. Finally, Dr. Bryan Payne, Assistant Professor of Neurosurgery at LSU, will discuss clinical research advances in brain implant devices for the treatment of Parkinson's disease.

REFERENCES:

1. CE Marx, GE Duncan, JH Gilmore, JA Lieberman, AL Morrow: Olanzapine Increases Allopregnanolone in Rat Cerebral Cortex, Biological Psychiatry 2000; 47(11):1000–1004.
2. NA Compagnone, SH Mellon: Neurosteroids: Biosynthesis and Function of These Novel Neuromodulators. Frontiers in Neuroendocrinology 21(1):1–56.

REVIEW OF PSYCHIATRY

SESSION I OF THE REVIEW OF PSYCHIATRY

TREATMENT OF RECURRENT DEPRESSION: A CALL TO ARMS

Chairperson: John F. Greden, M.D.

1. **Recurrent Depression and Mania: Their Overwhelming Burden**
   John F. Greden, M.D.
2. **Recurrent Depression in Women Through the Lifespan**
   Sheila Marcus, M.D.
3. **Chronic and Recurrent Depression: Pharmacotherapy and Psychotherapy Combinations**
   Robert Boland, M.D.
4. **Prevention of Recurrences in Bipolar Patients: The Best of the Old and the New**
   Charles L. Bowden, M.D.
5. **Clinical Prevention of Recurrent Depression: The Need for Paradigm Shifts**
   John F. Greden, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that one of the most important reasons for the burden of MDD is its recurrent pattern, describe strategies for identifying and treating higher-risk populations, recognize the potential of new treatment approaches, and recognize that major paradigm shifts are required if we are to effectively prevent recurrences.

SUMMARY:

Major Depressive Disorder (MDD) is recognized by the World Health Organization as among the world's most burdensome diseases. Reasons include: widespread prevalence (more than 340 million, 18 million in USA at any one time); earlier symptom onset than generally believed (peak onset, ages 15–19); severe underdiagnosis and undertreatment (fewer than 10% with MDD may receive optimal treatment); unavoidable stress-genetic vulnerabilities; but most importantly, frequent recurrences and minimal use of maintenance treatment. Brain hippocampal and amygdala degenerative changes have recently been observed on MRI scans following severe and frequent recurrences. If MDD's huge burden and neuronal degeneration are to be minimized, clinicians *must* reduce recurrences. That is the focus of this Symposium.

Emphasis will be placed upon five topics: 1) women, since they have the highest prevalence of MDD and experience the heaviest burden (Marcus); 2) combined pharmacotherapy and psychotherapy treatment for those with chronic and recurrent depression; recent data indicate such combinations are superior to either alone (Boland and Keller); 3) prevention of recurrences in bipolar patients incorporating the potpourri of new anticonvulsant mood stabilizers (e.g. lamotrigine) and other integrative treatment approaches recently shown to have benefit (Bowden); 4) potential applications of new somatic treatment strategies involving minimal brain stimulation since data are suggesting vagal nerve stimulation (VNS) and repetitive transcranial magnetic stimulation (rTMS) may join our treatment armamentarium (George); and 5) a "12-step" update of clinical recommendations for treating and preventing recurrent depression, emphasizing that nothing short of a "call to arms" will suffice.

REFERENCES:

1. Greden JF: Antidepressant Maintenance Medications. In, Pharmacotherapy for Mood, Anxiety, and Cognitive Disorders. Edited by U Halbreich and S Montgomery, Washington, D.C.: pp. 315–330, 2000.
2. Calabrese JR, Bowden CL, McElroy SL, et al: Spectrum of activity of lamotrigine in treatment-refractory bipolar disorder. American Journal of Psychiatry. 156(7):1019–23, 1999
3. George MS, Nahas Z, Molloy M, Speer AM, Oliver NC, Li X, et al: A controlled trial of daily left prefrontal cortex TMS for treating depression. Biol Psychiatry. 48:962–970, 2000.
4. Keller MB, McCullough JP, Klein DN, Arnow B, Dunner DL, Gelenberg AJ, et al: A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. New England Journal of Medicine, 342(20):1462–70, 2000

SESSION II OF THE REVIEW OF PSYCHIATRY

PTSD IN CHILDREN AND ADOLESCENTS

Chairperson: Spencer Eth, M.D.

6. **Evaluation and Assessment of PTSD in Children and Adolescents**
   Wilfred G. van Gorp, Ph.D.
7. **Forensic Aspects of PTSD in Children and Adolescents**
   James E. Rosenberg, M.D.
8. **PTSD in Children and Adolescents in the Juvenile Justice System**
   William Arroyo, M.D.
9. **Biological Treatment of PTSD in Children and Adolescents**
   Soraya Seedat, M.B.
10. **The Relationship Between Childhood Traumatic Experiences and PTSD in Adults**
    Rachel Yehuda, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should have an understanding of the salient developments in the research base and clinical practice of PTSD in children and adolescents.

SUMMARY:

In 1985 the American Psychiatric Press published Post-Traumatic Stress Disorder in Children, edited by Drs. Spencer Eth and Robert S. Pynoos, which arose from a landmark symposium presented during the 1984 Annual Meeting of the American Psychiatric Association. Its success rode a wave of interest in what was then a new concern for psychiatrists - the psychological impact of traumatic events in the lives of children. This Session reflects the maturation of the field of developmental psychotraumatology. Clinical practices in childhood trauma today are based on a wealth of research and case studies, found in many hundreds of publications in the scientific literature.

Dr. Wilfred van Gorp will present an overview of the evaluation of trauma in children and adolescents that surveys the variety of psychological instruments which have been shown to have value in diagnosing PTSD and rating its severity. Litigation has long been a catalyst in stimulating the study of traumatized children and adolescents. Further, many clinicians have been called to testify as expert witnesses regarding PTSD. Dr. James Rosenberg will discuss issues that are especially pertinent to the practice of forensic psychiatry, such as the reliability of traumatic memories in children. Dr. William Arroyo will examine the role of trauma in the lives of juvenile offenders, a population whose destructive impact represents a serious and growing problem in many cities in America.

The language and metaphor of psychoanalysis informed much of the early understanding of childhood trauma. Increasingly over the last decade, the construct chosen for understanding the traumatic process has been biological. Although the targeted application of this progress to specific biologically based therapies is premature,

psychopharmacologic agents are in widespread use in treating traumatized youth. Dr. Dan Stein will provide a comprehensive review of the important role of medication in clinical practice. The life course of child survivors of the Holocaust has been extensively studied, but the generalizability of these findings is unclear. Dr. Rachel Yehuda will offer an analysis of the literature and her own work on the natural history of children exposed to trauma, emphasizing the incidence and biological substrate of PTSD developing later in adulthood.

REFERENCES:

1. American Academy of Child and Adolescent Psychiatry: Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. J Am Acad Child Adolesc Psychiatry 37(10 supplement):4S–26S, 1998
2. Eth S, Pynoos RS (eds): Post-Traumatic Stress Disorder in Children. Washington DC, American Psychiatric Press, 1985
3. Perrin S, Smith P, Yule W: Practitioner review: the assessment and treatment of post-traumatic stress disorder in children and adolescents. J Child Psychol Psychiatry 41:277–289, 2000.
4. Pfefferbaum B: Posttraumatic stress disorder in children: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry 36:1503–1511, 1997.

SESSION III OF THE REVIEW OF PSYCHIATRY

INTEGRATED TREATMENT: AN OVERVIEW

Chairperson: Jerald Kay, M.D.

11. WITHDRAWN

12. Integrated Treatment Planning for BPD
John Oldham, M.D.

13. Integrated Treatment of Substance Abuse Disorders
Douglas Ziedonis, M.D.

14. A Cognitive Therapy Approach to Medication Compliance
Judith Beck, Ph.D.

15. The Challenges of Split Treatment
Michelle Riba, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will appreciate the extensive scientific support for integrated treatment—the use of psychotherapy and pharmacotherapy in the treatment of psychiatric disorders, understand the theoretical controversies surrounding integrated treatment employing psychodynamic psychotherapy and the need for a new and comprehensive neurobiologically based treatment model, become familiar with new approaches to the diagnosis and understanding of BPD and the role of psychotherapy in the treatment of this challenging disorder, understand the use of medications with three relevant forms of psychotherapy in the integrated treatment of substance abuse disorders, learn new methods and techniques of enhancing medication compliance through the use of cognitive therapy, and appreciate the challenges and rewards of participating in split treatment relationships.

SUMMARY:

Integrated or combined treatment is the simultaneous use of psychotherapy and pharmacotherapy in the treatment of patients with mental disorders. This approach is relevant to patients across a continuum of psychiatric disorders from the most chronic and disabling to those with more circumscribed and less disruptive symptomatology. Usually integrative treatment is provided by a psychiatrist, however managed behavioral health care with its emphasis on cost containment frequently favors a split or collaborative treatment model. Most often split treatment refers to the arrangement wherein the psychiatrist is responsible for medication management and the psychotherapy is provided by another non physician mental healalth professional. Given the ubiquity of integrated treatment it is only recently that the field has been attending to the major scientific and clinical questions about this treatment modality. This effort is much needed because, more than any other professional activity, integrated treatment defines the field of psychiatry and distinguishes it from other mental health disciplines and other medical specialties. This symposium will apprise the reader not only of the most recent research on this subject but discuss the clinical indications, challenges, and helpful approaches and interventions in providing this type of treatment.

REFERENCES:

1. Gabbard GO:Combined psychotherapy and pharmacotherapy, in Comprehensive Textbook of Psychiatry, seventh edition. Edited by Sadock BJ and Sadock VA. Philadelphia, Lippincott Williams and Wilkins, 2000, pp. 2225–2234.
2. Keller MB, McCullough JP, Klein DN et al:A comparison of nefazodone, the cognitive behavior-analysis system of psychotherapy, and their combination for the treatment of chronic depression. NEJM 342:1462–1470, 2000
3. Klerman GL, Weissman MM, Markowitz JC et al:Medication and psychotherapy in, Handbook of Psychotherapy and Behavior Change, vol 4 edited by AE Bergin, SL Garfield. New York, John Wiley and Sons, 1994, pp. 734–782.
4. Riba MB, Balon R:Psychopharmacology and Psychotherapy:A Collaborative Approach. Washington DC, American Psychiatric Press, 1999

SESSION IV OF THE REVIEW OF PSYCHIATRY

BRAIN IMAGING IN THE NEW MILLENIUM

Chairperson: John M. Morihisa, M.D.

16. Future Applications for fMRI in Psychiatry
Joseph H. Callicott III, M.D.

17. Imaging Human Cognition and Cognitive Disability in Mental Disorders
Cameron S. Carter, M.D.

18. Structural and Functional Imaging in Late-Life Depression
Harold A. Sackeim, Ph.D.

19. Neuroimaging Studies in Children: Implications for Research on Affect
Daniel S. Pine, M.D.

20. Neuroimaging Abnormalities in Primary Mood Disorder
Wayne C. Drevets, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand new research findings that will be presented in their theoretical context, begin to detect patterns of conceptual convergence in the brain imaging field, and be familiar with the new directions of technology and science.

SUMMARY:

This symposium brings together the research of five scientists who have investigated a spectrum of psycho pathology utilizing a variety of imaging approaches. Moreover, they each have brought to the scientific process a mastery of the technological issues melded with an abiding interest in the underlying theory that drives these research paradigms. As a result their research and their discussion of the field has a clarity and utility that is crucial to the explication of the highly complex issues that are the foundations of brain imaging.

The presentations will discuss psycho pathology ranging from major depression and late-life depression to schizophrenia, and in

so doing they will report some of the most recent findings in the field, review the relevant data in the literature, and place this research in a critical neuroscience context.

Although quite disparate clinical disorders are discussed, there are convergences in the neuropathological substrates highlighted. These convergences may point to useful disease pathways based more upon pathophysiological correlates that may complement nosology.

These scientists will also present data that will examine a broad range of patient populations from the pediatric to the geriatric. The diversity of investigations gives us an opportunity to begin to see patterns that weave throughout different technical approaches and a variety of psycho pathology.

What will be gained in the end is an enhanced understanding of the theory and practice of Brain Imaging in Psychiatry as well as an exciting glimpse of the future directions of both the technology and the science.

REFERENCES:

1. Pine DS, Cohen P, Gurley D, Brook J, Ma Y: The risk for early adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. Arch Gen Psychiatry 55:56–64, 1998.
2. Callicott, JH, Bertolino A, Eagan MF, Mattay VS, Langheim, FJP, Weinberger DR: A selective relationship between prefrontal N-acetylaspartate measures and negative symptoms in schizophrenia. Am J Psychiatry, 157:10, 2000.
3. Carter CS, Braver TS, Barch DM, Botvinick M, Noll D, Cohen JD: Anterior Cingulate Cortex, Error detection and the on line monitoring of performance. Science 280 (5364) 747–749, 1998.
4. Sackeim HA, Lisanby SH, Nobler MS, Van Heetum RI, DelLaPaz RL, Mensh B: MRI hyperintensities and the vascular origins of late life depression, in C Andrade (ed) Advances in Psychiatry, New York; Oxford University Press, 2000, 73–118.

SESSION V OF THE REVIEW OF PSYCHIATRY

PSYCHIATRY UPDATE: SOMATOFORM AND FACTITIOUS DISORDERS

Chairperson: Katharine A. Phillips, M.D.

21. BDD
Katharine Phillips, M.D.

22. A Critical Analysis of Factitious Disorder
Marc D. Feldman, M.D.

23. Somatization Disorder
Vincenzio Holder-Perkins, M.D.

24. Conversion Disorder
Jose Maldonado, M.D.

25. Hypochondriasis
Brian Fallon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an overview of the somatoform and factitious disorders, be familiar with the clinical features of these disorders and the current treatment approaches for these often difficult-to-treat disorders.

SUMMARY:

This session will provide a clinically focused overview of the somatoform disorders and factitious disorders—in particular, somatization disorder, conversion disorder, hypochondriasis, BDD, and the four subtypes of factitious disorder. These disorders, while often encountered by both psychiatrists and primary care clinicians, are often recognized in clinical practice and challenging to treat. This session will discuss these disorders' epidemiology and prevalence, comorbidity, and what is known about etiologic factors. Their clinical features will be reviewed, including diagnostic controversies and diagnostic approaches useful in a clinical setting. Current treatment strategies, both pharmacologic and psychosocial, will be discussed. Case material as well as recent research findings of relevance to clinical practice will be presented.

REFERENCES:

1. Phillips, KA: Body Dysmorphic Disorder. In: Gelder MG, Lopez-Ibor JJ, Andreasen NC, eds. New Oxford Textbook of Psychiatry. Oxford: Oxford University Press, in press.
2. Feldman, MD, Ford, CV: Factitious Disorders. In: Sadock BJ, Sadock VA, eds. Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 7th Edition. Baltimore: Lippincott, Williams & Wilkins, 1999.
3. Wessley S: Functional Somatic Syndromes: One or Many? Lancet 354:936–939, 1999.
4. Fallon BA: Pharmacologic Strategies of Hypochondriasis, in Hypochondriasis. Modern Perspectives on an Anxiety Malady. NY, Oxford University Press, 2001.

ROUNDTABLE

THE FUTURE OF BEHAVIORAL HEALTHCARE

Moderators: Robert Michels, M.D. and Robert K. Schreter, M.D.
Participants: Henry T. Harbin, M.D., Steven S. Sharfstein, M.D., Miles F. Shore, M.D., Howard H. Goldman, M.D., Richard Frank

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to predict emerging trends in the new healthcare marketplace; understand the forces shaping healthcare including the demand for quality and accountability, consumer power, economic pressures, public versus private employer needs, and policy and financing issues; and achieve their professional goals and advocate for their parents.

SUMMARY:

This roundtable discussion is designed to address the question, "Where is healthcare heading?" Demands for cost containment and accountability continue to dominate discussion but the techniques used to achieve these ends are no longer working. In fact, efforts at containing cost through restrictive benefit design, utilization review and capitation are being seen as more of the problem than as creative solutions.

Importantly, traditional managed care is no longer achieving its goals. Costs are no longer being contained and double digit inflation has returned to healthcare. For profit and not for profit systems are losing money. The consolidation strategy that shaped healthcare in the last five years of the 20th century has not yet delivered the anticipated economies of scale or improvement in quality and systems integration.

So what's next? To address this question, we have brought together an All Star Team representing different perspectives on healthcare.

REFERENCES:

1. Schreter RK: Trends in Managed Care; Psychiatric Services, 51 (12):1493-1495, 2000.
2. Hoge MA, Jacobs S, Thaker NM, Griffith ME: Ten Dimensions of Public Sector Managed Care, Psychiatric Services, 50 (1):51-55, 1999.

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