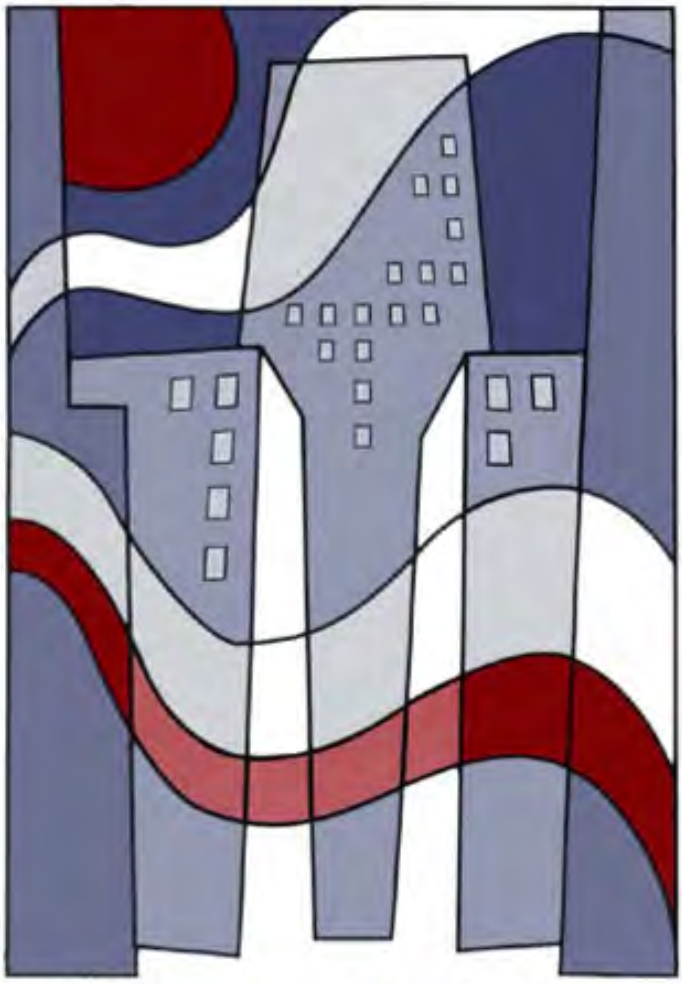
SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

2000 ANNUAL MEETING

The Doctor-Patient Relationship



APA2000
chicago

MAY 13 - 18, 2000 ■ CHICAGO, ILLINOIS

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
153rd Annual Meeting of the APA,
Chicago, IL, May 13-18, 2000
President's Theme: The Doctor-Patient Relationship

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

Allan Tasman, M.D.
APA President

Steven M. Mirin, M.D.
Medical Director

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

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

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to 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 13-18, 2000, Chicago, IL

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 by *sending the APA a copy of your state medical society CME certificate*. The APA will issue a CME certificate valid for the same period of time. The state medical societies currently having CME requirements comparable to those of the APA are Arizona, California, Florida, Kansas, New Jersey, Oregon, Pennsylvania, and Vermont.

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

You 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 Geriatric 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-THIRD
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

Chicago, IL

May 13-18, 2000

Published by

AMERICAN PSYCHIATRIC ASSOCIATION
1400 K Street, N.W.
Washington, D.C. 20005
May 2000

$25.00

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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 Wright-Brown and Gwynne Jackson in the Office to Coordinate Annual Meetings.

Pedro Ruiz, 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.

2000 ANNUAL MEETING
TOPIC AREAS FOR THE SCIENTIFIC PROGRAM

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2. Alcohol and Drug-Related Disorders
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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, Subspeciality Areas or Special Interests, Treatments and Other Issues. Under each overall Topic, you will find subtopics listed in alphabetical order with the formats (type of session) listed alphabetically underneath. Within each format you will find the title of the individual session listed by number. The listing will also show the page number the session appears on. You should refer to the page number in this *Program Book* to obtain further details about the session.

TOPIC INDEX

DISORDERS

PRACTICE AREAS

SUBSPECIALITY AREAS OR SPECIAL INTERESTS

TREATMENTS

OTHER ISSUES

Allan Tasman, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

The Doctor-Patient Relationship

The relationship with our patients provides the context for all our therapeutic interventions. The last century has been marked by tremendous advances in our understanding of the importance of this unique relationship to the process of treatment and recovery from illness. The expansion of our knowledge from clinical research, combined with clinical wisdom, has enhanced our ability to foster the skills necessary to observe, understand, and maintain a therapeutic partnership with our patients.

The central importance of this therapeutic relationship is obvious to clinicians and patients. In recent years, however, restrictive managed care practices, and government and industry interference with the privacy of communication with patients and the confidentiality of medical records, have impinged on the sanctity of our relationships with patients. Changes in medical and psychiatric education also have understandably focused more curriculum time on technological and scientific advances, but at the expense of attention to our role as healers.

The beginning of the new millennium is an extraordinary time to refocus our attention on the timeless importance of our relationship with our patients. This is essential to assure that the future practice of psychiatry integrates the best of our humanistic traditions with the latest scientific advances. We are dedicated to enhancing all aspects of the doctor-patient relationship: in psychiatric and medical eduation, research, treatment, ethics, the expanding importance of the patients' rights and patients' advocacy movement, and our use of public education and government relations to enhance and preserve this central and essential aspect of our therapeutic role.

This is an era of tremendous opportunity within psychiatry, even with the present constraints on non-discriminatory access to the highest quality psychiatric care. While the nature of psychiatric practice has been shifting, there remain new opportunities in nearly every aspect of psychiatric practice. In adition, emerging areas of practice, such as behavioral medicine, offer tremendous opportunities to advance patient care in the coming decades. The 1999 White House Conference on Mental Health and the 1999 release of the first Report of the Surgeon General on Mental Health are clear indicators that there is increased public awareness of the importance of good mental health to good general health. This is an opportune time to increase our public education and advocacy efforts to further decrease the stigmatization and unfair discrimination directed toward those with psychiatric illness, their families, and their caregivers.

The advances in electronic communication and information technology of the last decade also pose important opportunities and challenges for psychiatrists as we contemplate the future of our profession in the information age. We know that the way such technology will influence psychiatry will continue to unfold, but it is already clear that control of such technology will likely become one of the most critical society decisions of the information age.

We have an unparalleled set of challenges and opportunities as information technology and psychiatry intersect, and there is tremendous excitement as we explore meaningful ways of using present computer-based technology in our research, education, and clinical missions. But we must remain vigilant about the uses of this potent technology. Our profession of psychiatry, placed in the role of arbiter of sanity and reality, both by virtue of our training and by societal sanction, must face the challenge of preserving the human and humane aspects of care within an increasingly mechanistic world. This task will become of more and more central importance as our world undergoes the continuous changes brought about by the further evolution of the information age.

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MONDAY, MAY 15, 2000

SCIENTIFIC AND CLINICAL REPORT SESSION 1—TREATMENT ISSUES WITH SSRIS

No. 2
SSRI-ASSOCIATED SEXUAL DYSFUNCTION: NEW DATA FROM PROSPECTIVE TRIALS

David Michelson, M.D., *Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center/DC 2423, Indianapolis, IN 46285;* Mark E. Schmidt, M.D., Robert Johnston, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should have a greater understanding of changes in sexual functioning associated with fluoxetine administration as well as the value of pharmacologic intervention.

SUMMARY:

Objective: Sexual dysfunction associated with the administration of SSRIs and other antidepressants has been a focus of considerable interest, but few controlled studies assessing its epidemiology, phenomenology, and physiology have been reported. Most assessments of interventions are limited to anecdotal reports, and reliable long-term data have not been available. We undertook a series of studies to better assess both SSRI-associated sexual dysfunction and putative interventions.

Methods: We recently completed a systematic, prospective assessment of sexual function during acute and long-term fluoxetine administration as part of a large, randomized clinical trial. We also conducted two randomized, placebo-controlled trials assessing the efficacy of multiple putative interventions (including mirtazapine, yohimbine, amantadine, buspirone, and olanzapine) for patients who experience new-onset sexual dysfunction during fluoxetine treatment.

Results: The results of these trials suggest that when sexual dysfunction occurs or worsens after the initiation of treatment it is a relatively acute effect occurring in approximately 14%–19% of patients and may be specific for orgasm. A greater percentage of patients report gains in sexual function, most likely secondary to the resolution of depressive symptoms. During a six-month continuation period, new-onset sexual dysfunction was strongly associated with the return of depressive symptoms, but not treatment assignment. Results of the intervention trials will be discussed.

Conclusion: Changes in sexual function associated with fluoxetine administration are complex and can include either worsening or improvement. The efficacy of interventions will be discussed.

This research was funded by Eli Lilly and Company, Indianapolis, Indiana 46285.

REFERENCES:

1. Rosen RC, Lane RM, Menza M: Effects of SSRIs on sexual function: a critical review. J Clin Psychopharmacol 1999;19:67.
2. Laumann EO, Paik A, Rosen RC: Sexual dysfunction in the United States: prevalence and predictors. JAMA. 1999;281(6):537–44.

No. 3
SEXUAL DYSFUNCTION DURING SSRI CONTINUATION TREATMENT

Christina M. Dording, M.D., *Department of Psychiatry, Massachusetts General Hospital, WACC 812 15 Parkman Street, Boston, MA 02114;* Kathryn A. Bottonari, B.A., Andrea C. Hutchins, B.A., Jonathan E. Alpert, M.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

To gain an increased understanding of the frequency, nature, and course of sexual dysfunction during SSRI continuation treatment.

SUMMARY:

Objective: Sexual dysfunction is a common side effect of antidepressants during both the acute and long-term phases of treatment, although very little is known about its frequency and course in particular during continuation treatment. This study examines these issues.

Methods: We studied 127 consecutive remitted depressives (69 women and 58 men; mean age: 40 ± 10) who had been randomly assigned to 28-week treatment with either fluoxetine, 40 mg/d alone or fluoxetine 40 mg/d in combination with cognitive therapy. These patients, who had initially been diagnosed with MDD with the SCID-P and had reported a HAM-D-17 ≥ 16 at baseline, had responded (i.e. their HAM-D-17 score was ≤ 7) to eight weeks of open treatment with fluoxetine, 20 mg/d prior to being randomized. As part of the study, the emergence and the course of spontaneously reported symptoms of sexual dysfunction were prospectively ascertained by the study physicians during this phase where the dose of fluoxetine was raised from 20 mg/day to 40 mg/day.

Results: Of the 127 patients enrolled, 65% completed the 28 weeks of treatment and 24 (19%) patients (nine women and 15 men, mean age 44 ± 8) reported the emergence of any symptom of sexual dysfunction during the fluoxetine continuation treatment at a higher dose. The common reported symptoms were anorgasmia (54%), decreased libido (50%), impotence (17%), and delayed ejaculation (13%). The mean time to onset of sexual dysfunction was 13 ± 10 weeks, and its mean duration was 16 ± 10 weeks. In six (25%) of the 24 patients, the sexual dysfunction resolved spontaneously.

Conclusion: Sexual dysfunction can emerge relatively late in the course of continuation treatment with the SSRI fluoxetine when the dose is increased from 20 mg/day to 40 mg/day and it affects approximately 20% of the patients, although it appears to remit spontaneously in a significant proportion of patients.

REFERENCES:

1. Rosen RJ et al: Effects of SSRI on sexual function: a critical review. J of Clin Psychopharmacology 1999;19:67–85.
2. Lane RM: A critical review of SSRI-related sexual dysfunction; incidence, possible aetiology and implications for management. J Psychopharmacology 1997;11:72–82.

No. 4
A PILOT STUDY OF THE EFFECTIVENESS OF NEFAZODONE IN DEPRESSED OUTPATIENTS WITH OR WITHOUT A HISTORY OF SSRI TREATMENT FAILURE

David Mischoulon, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street/WAC 812, Boston, MA 02114;* Gudrun Opitz, B.S., Karen E. Kelly, B.A., Maurizio Fava, M.D., Jerrold F. Rosenbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the risks and benefits involved when prescribing nefazodone to patients who have recently been treated with an SSRI.

SUMMARY:

Objective: To compare the tolerability and efficacy of nefazodone in patients who have recently discontinued a serotonin reuptake

inhibitor (SSRI) with patients who have not taken any antidepressant for at least six months.

Methods: Twenty-six patients, aged 18–75, diagnosed with major depression by clinical interview and Hamilton D-6 were recruited. Thirteen patients had discontinued an SSRI within one to four weeks due to lack of effectiveness and/or side effects. Thirteen patients had not been on any antidepressant for the previous six months. Patients were initially administered nefazodone 50mg po b.i.d. and doses were increased as tolerated to a maximum of 600mg/day. Patients were followed for 12 weeks and were assessed for response and side effects.

Results: Both groups improved significantly on nefazodone; however, there was no statistically significant difference between the degree of improvement of the two samples. Response (defined as at least a 50% decrease in HAM-D-6 score) rates were 80% for completers on prior SSRI and 67% for antidepressant-naïve completers. Response rates overall were 31% for both groups. Association between prior use of SSRIs and drop-out rates due to side effects or nonresponse was not statistically significant.

Conclusion: Despite anecdotal observations that SSRI discontinuers may have poorer outcomes on nefazodone, this study suggests that psychiatrists may safely prescribe nefazodone to patients who are discontinuing SSRIs due to lack of efficacy or side effects.

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

REFERENCES:

1. Thase ME, Zajecka J, Kornstein SG, et al: Nefazodone Treatment of Patients with Poor Responses to SSRIs. Presented at ACNP 37th annual meeting, Las Croabas, PR, Dec 14–18, 1998.
2. Owen JR, Nemeroff CB: New antidepressants and the cytochrome P450 system: focus on venlafaxine, nefazodone, and mirtazapine. Depress Anxiety 1998;7 Suppl 1:24–32.

SCIENTIFIC AND CLINICAL REPORT SESSION 2—ISSUES IN ADOLESCENT PSYCHIATRY

No. 5
TWO-YEAR STABILITY OF PERSONALITY DISORDER DIMENSIONS IN 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 the potential significance of dimensional versus categorical stability of psychiatric diagnoses, the two-year stability patterns of personality disorders in adolescents and the ways in which these patterns may inform us about the nature of personality pathology in adolescents.

SUMMARY:

Objective: The authors examined the stability of DSM-III-R personality disorder dimensions in a clinical sample of adolescents.

Method: Sixty adolescent inpatients were reliably assessed with the Personality Disorder Examination (PDE) soon after admission to the Yale Psychiatric Institute and were independently reassessed with the same diagnostic instrument two years after discharge. PDE symptom ratings were summed to create dimensional scores for each personality disorder. Baseline and follow-up dimensional scores were compared by strength of association (Pearson's r coefficient) and by magnitude of the difference (Student's paired t-test).

Results: Dimensional scores at the two assessment points were significantly correlated for histrionic, narcissistic, dependent, obsessive-compulsive, and passive-aggressive personality disorders. Compared with baseline, dimensional scores for most personality disorders were significantly lower at follow-up—and none was significantly higher.

Conclusions: Diagnostic stability is a key defining feature of personality disorders. We observed low-to-moderate stability for dimensional measures of personality dysfunction in adolescents, suggesting that previous reports of modest personality disorder stability in this age group cannot be attributed solely to limitations of the categorical approach to such pathology. Alternatively, our findings may be viewed as consistent with reports in the adult literature that personality disorders may improve over time, and that adolescents can benefit from treatment.

REFERENCES:

1. Mattanah JJF, Becker DF, Levy KN, et al: Diagnostic stability in adolescents followed-up 2 years after hospitalization. Am J Psychiatry 1995;152:889–894.
2. Widiger TA: Categorical versus dimensional classification: implications from and for research. J Pers Disord 1992;6:287–300.

No. 6
ASKING THE RIGHT QUESTIONS TO FIND TEENAGE KILLERS

Kenneth G. Busch, M.D., *Private Practice, 600 N. McClurg Center, Suite 1611A, Chicago, IL 60611-3025;* Robert J. Zagar, Ph.D., Jack Arbit, Ph.D., John R. Hughes, M.D., Judge Julia Quinn-Dempsey, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify teenage killers using brief questions: 101 teen killers will be compared with 101 nonviolent delinquents and 101 children as control.

SUMMARY:

Objective: To use the questions to find juvenile killers.

Method: Three groups of 101 each (a) adolescent murderers; (b) nonviolent delinquents; and (c) controls, matched by age, gender, race, and socioeconomic status were examined for criminally violent relatives, physical abuse, gang membership, alcohol and drug abuse, weapons, arrests, neurologic disorders, truancy, and school problems. Bayesian probabilities, odds, logistic regression, and discriminant analyses were used.

Results: Murderers with only one parent, violent relatives, physical abuse, gang membership, and alcohol or drug abuse had double the chance of killing. Adding weapons, arrests, neurologic disease, truancy, and school problems quadruples the chances. With each risk, odds increase. True positive hit rate for killers was 100%, while false positive hit rate of identifying nonviolent delinquents as killers was 95%.

Conclusions: Murderers had the most risks, while nonviolent delinquents more, and children as controls the least. Early- and late-onset killers were compared. Early-onset killers had lower intelligence. It is easier to identify early onset (multiple offenses before murder) because of prior arrest, jailing, and conviction before the killing. Killers with and without weapons were contrasted. Weapons were only one risk. A developmental, neurologic, economic, and psychosocial vulnerability model is proposed.

Funding: Juvenile Division Circuit Court of Cook County, summer research assistant; Edith Schiller Neurology Fund, Northwestern Memorial Hospital, data entry; total less than $10,000.

REFERENCES:

1. Farrington DP: Predicting individual crime rates. In M. Tomry (ed.) Crime and Justice, An Annual Review of Research. Chicago, University of Chicago Press, 1987.
2. Farrington DP: Predictors, causes, and correlates of male youth violence. In M. Tomry and M.H. Moore (eds.) Youth Violence, Crime and Justice. An Annual Review of Research. Chicago, University of Chicago Press, 1998.

No. 7
GENDER DIFFERENCES: YOUTH VIOLENCE EXPOSURE/RISK

Dwain C. Fehon, Psy.D., *Department of Psychiatry, Yale Psychiatric Institute, 184 Liberty Street, New Haven, CT 06519;* Carlos M. Grilo, Ph.D., Deborah Lipschitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to recognize potential important gender differences in violence exposure and violence risk among psychiatrically hospitalized adolescents.

SUMMARY:

Objective: To examine gender differences in violence exposure and violence risk among psychiatrically hospitalized adolescents.

Method: Eighty-nine inpatients aged 12–18 (mean 15.5 years) were administered a battery of psychometrically well-established psychological self-report instruments. Violence exposure was assessed using the Child's Exposure to Violence Checklist (CEVC).

Results: Boys were significantly ($p < .01$) more likely to be a victim of physical assault, and girls were significantly ($p < .001$) more likely to be a victim of sexual assault. Sexual assault victims reported significantly ($p < .001$) more symptoms of depression, suicidality, and PTSD than inpatients without sexual assault histories. Sexual assault victimization was significantly associated with physical assault victimization for girls ($p \leq .001$) and sexual assault perpetration for boys ($p \leq .01$). Physical assault victims reported significantly ($p \leq .001$) more symptoms of PTSD, dissociation, substance abuse, suicidality, and violence potential than inpatients without physical assault histories. Physical assault victimization was significantly associated with physical assault perpetration for girls and boys ($p \leq .001$). There were no gender differences with respect to violence potential or actual violence perpetration.

Conclusions: While psychiatrically hospitalized girls and boys may commonly fall victim to differing forms of violence, both genders are at equal risk for actual violence perpetration. Adolescent inpatient programs should integrate methods of coping with violence and trauma to help break the cycle of violence.

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SCIENTIFIC AND CLINICAL REPORT SESSION 3—PSYCHODYNAMIC ISSUES

No. 8
ROLE OF THE MOTHER IN PSYCHOANALYTIC THEORIES OF BPD

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the important role of the mother in psychoanalytic psychotherapy of borderline personality disorder.

SUMMARY:

Psychoanalytic child observation research has underscored the vital contribution of the mother's interaction during the first three years to the healthy development of the self ego and object relations. This conclusion has been supported by results of neurobiological studies that indicate that the wiring of the neurons is experience-dependent; specifically, attuned interaction on the part of the mother during crucial stages of development (10 to 12 months and 14 to 16 months) is essential to the child's capacity to self-regulate affect and socio-emotional relationships, demonstrating that the mother's role is as vital neurologically as it is psychologically.

In 1975, my clinical research indicated that the mother's difficulty in supporting the child's emerging self during the first three years was one of the major etiologic factors in the borderline personality disorder (along with genetic endowment and separation stresses). A psychoanalytic psychotherapy based on this theory was researched and found to be successful in adolescents and adults. Despite the cumulative weight of these findings, many psychoanalytic theoreticians continue to minimize the intrapsychic consequences of the interaction with the mother and their theories, and therapeutic approaches suffer accordingly: they remain in the neighborhood of the problem rather than at the exact address.

This paper contrasts the development, self, and object-relations points of view with the views of Kernberg, Kohut, Adler, Gunderson, Meissner, and others to demonstrate how failure to focus on the central role of the mother limits the effectiveness of psychoanalytic psychotherapy.

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2. Kernberg OF: Treatment of patients with borderline personality organization. International Journal of Psychoanalysis, 1968;49:600–619.

No. 9
TERMINATION OF PSYCHOTHERAPY: RESIDENTS' PERSPECTIVE

Vinay Kapoor, M.D., *Department of Psychiatry, UT-HSC-HOUSTON, 1300 Moursund Street, Houston, TX 77030;* Anu Motorin M.D., Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have greater awareness and sensitivity of issues around psychotherapy termination as well as an improved understanding in the anticipation, recognition, and management of these issues as a part of psychotherapy training in residency.

SUMMARY:

As a part of residency training, psychiatry residents are required to develop competency and proficiency in long-term psychotherapy. Despite agreement that planned termination as opposed to premature ending of the patient-therapist relationship is a desirable goal, due to time-limited curriculums and resident rotations premature termination will occur in training settings, with the patients having to accept therapist initiated terminations as fait accompli. Unfortunately, termination of long-term psychotherapy in the setting of residency rotations and its impact on the doctor-patient relationship has been a neglected area. Patients and resident therapists may respond to such

terminations in a variety of adaptive and maladaptive ways, thereby having an unanticipated impact on the therapeutic process. The authors present two clinical vignettes to demonstrate the effects of planned versus unplanned termination on the patient-therapist relationship highlighting issues of loss and abandonment, "the transfer syndrome," and recognition and management of transference and countertransference. The authors conclude that increased awareness and sensitivity around issues of termination should be a part of psychotherapy training during residency.

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No. 10
DOCTOR-PATIENT POST-TERMINATION ISSUES

Carl P. Malmquist, M.D., *University of Minnesota, 909 Social Science Building, Minneapolis, MN 55455;* Malkah T. Notman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the confusion existing in post-termination relationships at the present time; to assess difficulties when attempting to rely on the concept of transference to assess relationships involving romantic, financial, or social transactions.

SUMMARY:

The doctor-patient relationship once treatment has ended is a subject of continuing debate. The *objective* of this paper is to discuss questions that arise under the rubric of boundary issues. The *methodology* relies on cases and issues that have arisen in courts involving the mental health professions and from broad-based legislation. The *result* is a confusion for psychiatrists in post-termination relationships from courts attempting to rely on clinical explanations based on transference models as the basis for legal decisions about former patients. Transactions have encompassed romantic, financial, or social contacts.

The *conclusion* is that matters are made more complicated when a psychoanalytic concept, such as transference, is injected into the legal arena as the justification for legal decision making. One problem is the diverse meanings attached to the term transference, even among those who utilize the concept in their clinical work. A second problem is the indiscriminate application of the idea to post-termination situations in a period when a multitude of therapeutic approaches are being used. Third, apart from the question of the validity of the construct of transference itself, many practitioners do not utilize it as part of their treatment model. The result is a confused set of applications in courtrooms as well as many adverse personal and social outcomes for the main participants.

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1. Gabbard GO: The early history of boundary violations in psychoanalysis. J Am Psychoanal Assoc 1995;1115–1136.
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SCIENTIFIC AND CLINICAL REPORT SESSION 4—DOCTOR-PATIENT RELATIONSHIPS

No. 11
ASSESSING THE IMPACT OF RESEARCH ON PATIENTS

Randall D. Marshall, M.D., Anxiety Disorders, *NY State Psychiatric Institute, 1051 Riverside Drive Unit 69, New York, NY 10032;* Robert L. Spitzer, M.D., Susan C. Vaughan, M.D., Lisa A. Mellman, M.D., Roger A. MacKinnon, M.D., Steven P. Roose, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize important issues in the ethics of psychiatric research and the contribution that empirical research might make to such discussions.

SUMMARY:

Objective: Recent public controversy has drawn renewed attention to the ethics of psychiatric research. Unfortunately, there is a paucity of data on the experience of being a research subject that might inform such debates. This pilot study was designed to assess the subjective experience of being a research participant and was conducted in a feasibility study of outcome in long-term psychodynamic psychotherapy and psychoanalysis (N = 23).

Method: A questionnaire that systematically assessed positive and negative reactions to three typical research methodologies (self-report questionnaires, structured diagnostic interviews, and tape recording of sessions) was administered to patients and therapists. Therapist ratings and patient ratings were compared using t-tests.

Results: Patients reported questionnaires and interviews were slightly to moderately helpful in promoting self-realization and facilitating therapy, and not at all to slightly intrusive and disruptive. Adjustment to audiotaping of sessions was rapid (within two sessions). Therapists significantly underestimated ($p < .0001$) the positive benefit subjects reported from research participation. Nearly all subjects reporting willingness to participate in a study again.

Conclusions: This study examined methodologies typical to psychiatric research. Thus, objections to clinical research as currently practiced, particularly in dynamic psychotherapy, on the grounds that patients experience research procedures as significantly intrusive and disruptive appear unfounded.

Funding: Dorgan Fund, NYSPI.

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No. 12
CHARACTERISTICS OF PRE-IMPAIRED MALE PHYSICIANS

Roy W. Menninger, M.D., *Menninger Foundation, P.O. Box 829, Topeka, KS 66606*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand better the underlying character structure of many

"pre-impaired," stressed physicians; to employ this understanding in the development of a treatment plan for such physicians.

SUMMARY:

Attention given to physicians identified as impaired by virtue of drug or alcohol addiction or disabling psychiatric illness has obscured recognition of those physicians, particularly male, who continue to function adequately even as they struggle with significant psychological and characterological problems—physicians who might be termed "pre-impaired." These physicians are commonly depressed, partially decompensated compulsive personalities, or have socially disruptive narcissistic characters or combinations of both.

This paper will examine these two patterns of character organization with special attention to the problems both, to varying degrees, have with affect and intimacy. With some frequency, physicians with either pattern show marked emotional impoverishment and a striking limitation in or absence of much awareness of internal affective signals. As a result, they are quite unable to identify or describe their own feelings and, seemingly blind to affective signals from others, are experienced as "insensitive." This affective limitation is commonly coupled with an aversion to emotional intimacy, especially in the marital situation. The relationship of these disabling characteristics to the frequently cited image of the conscientious physician as a workaholic perfectionist is discussed, and treatment strategies for addressing the characterological nature of these limitations are suggested.

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2. Vaillant GE, Sobowale NC, McArthur C: Some psychologic vulnerabilities in physicians. NEJM 1972;287:372–375.

No. 13
PATIENTS' VIEW OF THE DOCTOR-PATIENT RELATIONSHIP

Irene Jakab, M.D., *Manic Depression, Mclean Branch, 74 Lawton St, Brookline, MA 02146-250*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, Doctors should be able to become aware of the importance of their relationship to patients and thus provide better care and assure wider patient compliance with treatment. They will be better able to build good relationship with patients to help resolve disagreement over treatment or unsatisfactory results instead of leading to malpractice suits.

SUMMARY:

Subjects: Fifty-five outpatient subjects, members of MDDA, suffering from mood disorders: 27 females, 28 males, ages 30 to 71, median age 48.

Method: On questionnaire about various doctor/patient interactions, subjects rated the importance of and doctor's performance on 36 items. Narrative responses described best and worst patient/doctor experience, ideal doctor, unacceptable physician behavior, and the influence of extraneous factors (HMO regulations, health insurance) on patient/doctor relationships.

Results: Overall, subjects found interactions important (81% highly important, 16% moderately important, 4% not important.) Subjects rated doctor performance good (64% very good, 24% moderately good, 11% not good.) Females rated importance higher (Chi square 46.1 $p < 0.00$, $df = 2$.) and doctor performance higher (Chi square 29.4, $p < 0.000$, $df = 2$) than males. Older subjects rated doctor performance higher than younger subjects did (Chi square 115.6, $p < 0.00$, $df = 6$.) Items rated high in both importance and doctor performance were: "Is caring physician", "Treats patients with respect and dignity", "Explains advice", "Listens carefully and patiently", "Explains findings and diagnosis".

Conclusions: Physicians are generally seen as caring, informative, respectful. Key issues are intimidation by doctors and attention to medication side effects. Females are especially concerned with the intimidation issue, males with discussion of treatment alternatives.

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SCIENTIFIC AND CLINICAL REPORT SESSION 5—CROSS-CULTURAL AND GENDER ISSUES

No. 14
GENDER DIFFERENCES IN VIOLENCE

Menahem Krakowski, M.D., *Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962;* Pal Czobor, Ph.D., Tovit Krakowski, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the different patterns of assaultive behaviors in men and women and understand the different clinical correlates that underlie these behaviors.

SUMMARY:

Objective: To examine gender differences in violence in schizophrenic, schizoaffective, and bipolar patients and to identify symptoms underlying these differences.

Method: Out of 2,019 newly admitted patients, 217 were physically assaultive. Psychiatric symptoms were assessed with the Brief Psychiatric Rating Scale (BPRS) and ward behaviors with the Nurses' Observation Scale for Inpatient Evaluation. Patients were followed for four weeks, and all assaults/agitation were recorded. Patients then received a psychiatric/neurological assessment.

Results: Proportionately to the hospital gender distribution, as many women as men were assaultive. Within this violent population, the women presented with more frequent physical assaults over an initial 10-day period ($F = 5.23$, $df = 216$, $p < .05$) and more frequent verbal assaults ($F = 7.02$, $df = 216$, $p < .01$) and agitation ($F = 7.40$, $df = 216$, $p < .01$) throughout the study. These differences remained significant with diagnosis as a covariant. There were no gender differences in BPRS or neurological impairment, but women were more irritable ($F = 6.9$, $df = 1,211$, $p < .01$) and had more difficulties observing ward regulations ($F = 6.84$, $df = 1,211$, $p < .01$). A higher number of men had a history of community physical assaults ($X^2 = 10.4$, $df = 1$, $p < .001$). These were associated with substance abuse and antisocial features.

Conclusions: Inpatient physical assaults among women are as common as among men; they are strongly associated with agitation and irritability. Community violence is more frequent in men.

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2. Eronnen M: Mental disorders and homicidal behavior in female subjects. American Journal of Psychiatry 1995;152:1216–1218.

No. 15
SCREENING OF MAJOR DEPRESSION AMONG CHINESE PATIENTS IN A PRIMARY CARE SETTING

Albert Yeung, M.D., *Department of Psychiatry, Massachusetts General Hospital, Suite 401 50 Saniford St., Boston, MA 02114;* Shauna Howarth, B.A., Andrew A. Nierenberg, M.D., Raymond Chan, B.S., Jonathan E. Alpert, M.D., David Mishoulon, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the importance of depression screening among Chinese patients in primary care. Asians tend to de-emphasize mood symptoms, which makes diagnosis of depression difficult.

SUMMARY:

Objective: To screen for major depression among Chinese patients in primary care.

Method: Chinese patients in the waiting area of a primary care clinic serving low-income Asian immigrants were asked to fill out the Beck Depression Inventory (BDI) (Chinese Version). Patients who scored above cut-off point (≥16) were interviewed by a psychiatrist with the SCID-III-R to confirm the diagnosis. Chief complaints of patients were also noted during interview.

Results: We approached 680 patients, and 410 (60%) filled out the BDI (60% female, 40% male; mean age 52.0 ± 17.2); 69 patients (16.8%) scored ≥16 on BDI. Using SCID-III-R as the standard, BDI was found to be a useful instrument for screening depression in this population; the sensitivity, specificity, positive predictive power, and negative predictive power are 0.91, 0.87, 0.87, and 0.91, respectively. The rate of depression among Chinese immigrants in primary care was extrapolated to be 14.6%; most of them had never been diagnosed or treated for depression. Though capable of reporting mood symptoms, chief complaints of depressed Chinese patients were predominantly somatic, making recognition of depression difficult.

Conclusion: Proactive screening of depression using the BDI is useful for recognition of depression among Chinese patients in primary care.

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2. Takeuchi DT, Chung RCY, Lin KM, et al.: Lifetime and twelve-month prevalence rates of major depressive episodes and dysthymia among Chinese Americans in Los Angeles. American Journal of Psychiatry 1998;155:1407–1414.

No. 16
SPIRITUALITY AND RESILIENCE TO TORTURE

Lynne M. Gaby, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue N.W., Washington, DC 20037;* James L. Griffith, M.D., Judy Okawa, Ph.D., Mellissa E. Griffith, M.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the therapeutic importance of torture-survivors' narratives of spiritual experience that may not be elicited by routine clinical assessments for post-traumatic stress disorder; to acquire cross-cultural interviewing skills for eliciting patients' use of spiritual beliefs and practices in coping with trauma.

SUMMARY:

Objective: To study how spiritual practices may have provided resilience against psychiatric sequelae of torture for refugees from Southeast Asian, African, and Middle Eastern countries.

Method: Nine torture survivors treated in an outpatient refugee program were interviewed (six survived political torture and three nonpolitical torture), representing Islamic, Sufi Catholic, and Orthodox Christian spiritual traditions. Severity of PTSD symptoms was assessed. A narrative account of the torture experience and any utilization of spiritual resources was elicited through a semistructured inquiry about use of religious metaphors and imagery, stories, beliefs, prayers, rituals and ceremonies, spiritual community, or such spiritual practices as meditation.

Results: Each participant identified specific dimensions of spirituality as having been vital for coping, although few of these accounts had been elicited during earlier clinical assessments. Prayer and beliefs were relied upon by all participants. Six viewed the occurrence of torture, either at the time or retrospectively, as somehow part of "God's plan" and felt comforted in this belief. Surprisingly, none of the nine described loss of religious faith due to the trauma, and four reported its strengthening. Whether contact with a spiritual community had been sustained through the torture best distinguished those with none-to-mild and moderate-to-severe PTSD symptoms.

Conclusions: This study suggests that those working with survivors of political torture and trauma should become aware of patients' utilization of spiritual resources. Stories not elicited by a typical PTSD assessment may nevertheless be regarded by patients as central to their survival of torture and important in their recovery. Subsequent studies need to compare patients such as these with others for whom spirituality may not have played an important role in coping in order to understand how spirituality is different from, or similar to, other factors that contribute to resilience.

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SCIENTIFIC AND CLINICAL REPORT SESSION 6—PSYCHIATRIC ISSUES IN MEDICALLY ILL PATIENTS

No. 17
BUSPIRONE IN PATIENTS WITH SCHIZOPHRENIA

Pinkhas Sirota, M.D., *Abarbanel Men Hlth Ctr 6A, 15 Keren Kayemet, Bay Yam 59100, Israel;* Bella Epstein, M.D., Rehuven Benatov, M.D., Michael Sousnotsky, M.D., Seth Kindler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to slow that buspirone may be of value when added to neuroleptics for patients with schizophrenia.

SUMMARY:

Background: Buspirone, an atypical anxiolytic agent, a $5HT_{1A}$ partial agonist, was identified as a possible antipsychotic agent since it demonstrates dopaminergic antagonism. Administration of buspirone to schizophrenic patients has produced inconsistent findings, but some schizophrenic patients showed an improvement of their psychosis. The aim of our study was to evaluate the coadministration of neuroleptics and buspirone to schizophrenic patients.

Method and subjects: Twenty schizophrenic inpatients participated in a six-week trial of buspirone 100mg/day added to a stable dose of conventional neuroleptics.

Results: At week 6, mean scores were significantly improved on the Positive and Negative Syndrome Scale, the Clinical Global Impression Scale, Hamilton Rating Scale for Anxiety, and the Simpson Angus Scale for Extrapyramidal Symptoms.

Conclusions: These results suggest that buspirone may be of value when added to neuroleptics for schizophrenic patients and indicate a need for further controlled, double-blind trials of this drug.

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1. Goff DC, Kamal KM, Broman AW, et al: An open trial of buspirone added to neuroleptics in schizophrenic patients. J Clin Psychopharmacol 1999;11:193–197.
2. Hyang HF, Jann MW, Wei FC, et al: Lack of pharmacokinetic interaction between buspirone and haloperidol in patients with schizophrenia. J Clin Pharmacol. 1996;36:963–69.

No. 18
MAGNESIUM AND VITAMIN C INFUSION IN FIBROMYALGIA

Mohammad Z. Hussain, M.D., *2727 2nd Avenue West, Prince Albert, SK S6V 5E5, Canada;* Zubaida A. Chaudhry, M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to determine the efficacy of magnesium sulphate and vitamin C infusion in the treatment of fibromyalgia with antidepressants.

SUMMARY:

Fibromyalgia is the third most common diagnosis in rheumatological practice, with a prevalence ranging from .66% to 11.2%. The etiology remains elusive, and diagnosis cannot be confirmed by laboratory tests. There are no specific treatments available. In psychiatric literature, fibromyalgia is viewed as somatoform disorder, a mood disorder that might have been superimposed on an immunological disturbance. Some studies have reported successful treatment with vitamin and mineral therapy to boost immunity. In this context, fibromyalgia may be best treated with a combination of various antidepressants and vitamin therapy.

Seventy subjects received open-label clinical treatment to determine the efficacy of weekly infusion of vitamin C 15 gm., thiamine 200 mg., peridoxine 200 mg., cyanocobalamin 2 mg., magnesium sulfate 1–2 gm. in normal saline. Subjects were diagnosed with fibromalgia by rheumatologists and met the criteria for this disorder. They have received treatment with antidepressants without relief. The subjects were rated on the 12-item, 0–6 score Fibromyalgia Rating Scale at one, two, and four-month intervals. There were 11 men and 59 women. The mean age was 42.5 (15–66), mean Fibromyalgia Rating Scale was 43.9 (28–58). Thirty-two received paroxetine and amoxapine combination; 18 received other antidepressants. Nine discontinued medication. One dropped out. Forty-five have scored less than 10, 15 between 10 and 20, and nine between 21 and 30.

Vitamin C and magnesium sulfate infusion with antidepressant has a stabilizing effect on fibromyalgia and augments effects of antidepressant.

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No. 19
PSYCHOEDUCATION IN ORAL CANCER

Mark R. Katz, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street/EN8-228, Toronto, ON M5G 2C4, Canada;* Jonathan Irish, M.D., Gerald Devins, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to identify educational information that can help relieve the burden of suffering for oral cancer patients undergoing surgery.

SUMMARY:

Objective: Oral cancer elicits considerable distress in both the pretreatment and post-treatment periods. This presentation details the development, validation, and pilot-testing of an innovative psychoeducational intervention for oral cancer patients.

Method: Preoperative and postoperative presentations by a health educator, summarized in an educational booklet and covering factual information about oral cancer and its treatment, effective coping skills, and communication issues were compared with standard care.

Results: Pilot data from 19 subjects (10 psychoeducation, nine standard care) indicate the intervention is feasible to study in a randomized controlled trial (RCT) and highly acceptable to subjects. At three-month follow-up, the intervention group showed a significant gain in oral cancer knowledge ($F = 6.652$, $df = 1$, $p = .02$), less body-image disturbance ($F = 6.035$, $df = 1$, $p = .014$) better social functioning ($F = 9.545$, $df = 1$, $p = .03$), and a trend toward reduced depressive distress, lower state and trait anxiety, and enhanced feeling of well-being.

Conclusion: The intervention will now be evaluated in a larger scale RCT with follow-up extended to six months. If shown to be successful, this program will provide a practical and efficient approach to reducing the considerable psychosocial burden of this disease. Funded by NCIC - Grant #7096

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SCIENTIFIC AND CLINICAL REPORT SESSION 7—THE IMPACT OF THE ENVIRONMENT ON MENTAL HEALTH

No. 20
SEASONAL VARIATION OF VIOLENCE AND LATITUDE

Gunnar Morken, M.D., *Department of Psychiatry, NTNU, Box 3008 Lade, 7043 Trondheim, Norway;* Olav M. Linaker, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand seasonal variation of violence and other forms of human behavior and correlations to changes in daylight and to latitude.

SUMMARY:

Objective: Seasonal variations of violence in Norway, situated between latitude 58°N and 72°N, have been studied.

Method: All police reports of violence from 1991 to 1997 were obtained for all of Norway, 4,450,000 inhabitants, and separately for seven cities at different latitudes.

Results: 82,537 episodes of violence were recorded. There was a significant variation between months ($\chi^2 = 343.08$, df = 11, $p < 0.0001$), with one significant peak in May-June and another significant peak in October-November, the daily frequency varying between 28.7 in March and 35.1 in June. The monthly frequency correlated with the absolute value of monthly change of day length for the previous month ($r_s = 0.778$, N = 12, $p < 0.01$). In the seven cities, the maximal monthly ratio of observed/expected episodes increased with latitude ($r = 0.783$, N = 7, $p < 0.05$). With increasing latitude, the months of largest increase in violence from one month to the next came later both in the spring ($r_s = 0.896$, N = 7, $p < 0.01$) and in the fall ($r_s = 0.945$, N = 7, $p < 0.01$).

Conclusions: There is a distinct pattern of seasonal variation in the frequencies of violence varying systematically with latitude. This pattern resembles the seasonal pattern of some forms of suicide, hospitalization for affective disorders, and mood and activity in the general population.

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2. Michael RP, Zumpe D: Sexual violence in the United States and the role of season. Am J Psychiatry 1983;140:883–886.

No. 21
MENTAL ILLNESS AND VIOLENCE: IS THE PUBLIC AT RISK?

Heather Stuart, Ph.D., *Dept of Epidemiology, Queen's University, Abramsky Hall 2nd Floor, Kingston, ON K7L 3N6, Canada*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to make a clear statement about the extent to which the general public is at risk of criminal violence from someone with a psychotic disorder, a non-substance-abuse disorder, or a substance abuse disorder.

SUMMARY:

Decreasing the stigma of mental illness is a major goal of the many organizations working for better treatment, more research, and improved tolerance for mental patients. Public misapprehension is based on the belief that the mentally ill are unpredictable, violent, and dangerous. Our goals were to identify the extent to which the public are at risk of criminal violence by the mentally ill and to estimate the proportion of criminal violence that theoretically could be reduced if specific mental illnesses were eliminated. A representative sample of 1151 remanded offenders who underwent a full, structured, diagnostic interview (giving one-month prevalence) were studied.

Half of the violent crimes were charged to offenders with a primary substance abuse disorder (alcohol or drugs). The proportion of all violent charges allegedly committed by offenders with a primary psychotic disorder was negligible, and the proportion of all violent crimes attributed to those with major mental illnesses (excluding primary substance abuse disorders) was small. Findings support the conclusions that public risk of criminal violence from someone with a psychotic or non-substance-related mental illness is small, and much greater risk is posed by individuals who abuse substances.

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No. 22
MENTAL HEALTH IMPACT OF HURRICANE MITCH

Robert Kohn, M.D., *Department of Psychiatry, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906;* Itzhak Levav, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should have an understanding of mental health implications of natural disasters, awareness of methodological issues related to research, understanding of mitigating factors that place people at risk for disasters.

SUMMARY:

Objectives: Hurricane Mitch devasted Honduras and other Central American countries on October 30, 1998 resulting in thousands of deaths, injured individuals, and extensive economic damage. We conducted a community survey 50–70 days after the disaster. The study aimed at identifying the differential psychopathological effects of the trauma with the purpose of providing a basis for immediate collective intervention.

Methods: Individuals 15 years and older from six residential areas in Tegucigalpa representing high, middle, and low income groups of high and low exposure were selected. A group of respondents in shelters was also investigated. The 800 individuals interviewed completed the PTSD section of the CIDI, a screen for major depressive disorder, alcohol abuse, violence, grief, and demoralization, as well as sociodemographic information and an inventory of traumatic events.

Results: High rates of major depression, PTSD, alcohol abuse, demoralization, and violence were found following the trauma. Analyses revealed an increased risk for psychopathology in the lowest SES group following the hurricane. This finding remained after controlling for emotional difficulties preceding the disaster.

Conclusion: The risk for psychiatric pathology following the disaster was markedly elevated in the highly exposed group. There is a need for continued monitoring of the mental health situation in Honduras.

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2. Canino G, Bravo M, Rubino-Stipec M, Woodbury M: The impact of disaster on mental health: prospective and retrospective analyses. International Journal of Mental Health 1990;19:51–69.

SCIENTIFIC AND CLINICAL REPORT SESSION 8—TREATMENT AND OUTCOME ISSUES IN SPECIAL POPULATIONS

No. 23
OUTCOME OF LIVER TRANSPLANTS FOR PATIENTS ON METHADONE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be aware of the potential for a positive outcome of liver transplantation in patients who are in methadone maintenance programs.

SUMMARY:

Much has been written about the screening process for liver transplantation for patients with alcohol-related liver disease. Furthermore, it is reported that up to 33 percent of alcohol-dependent patients resume alcohol use, once transplanted. However, there is little written about liver transplantation in patients who are in methadone maintenance programs. According to Levenson and Olbrisch, 84.8 percent of liver transplant programs surveyed would not transplant patients who use addictive drugs. It was not clear if methadone maintenance was considered separately. This paper examines five patients who were in methadone maintenance who received a liver transplant at our program. All had been in methadone maintenance for more than three years at the time of the transplant. At least one patient was rejected from another transplant program. The postoperative periods ranged from seven months to five years. All four patients were compliant with the transplantation protocol and no patient resumed use of opiates other than methadone. One patient died seven months after his transplant, while the other four are living and are considered to be doing well psychosocially.

In conclusion, based on these five patients, methadone maintenance should not be considered an absolute contraindication for liver transplantation.

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2. Surman OS, Purtilo R: Reevaluation of organ transplantation criteria: allocation of scarce resources to borderline candidates. Psychosomatics 1992;33:202–212.

No. 24
OUTCOMES ASSESSMENT IN A SCHIZOPHRENIA SERVICE

Thomas E. Smith, M.D., *Department of Psychiatry, Weill Cornell, 21 Bloomingdale Road, White Plains, NY 10605;* Kim Weiss, Ph.D., James W. Hull, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have a fuller understanding of the potential role of outcomes assessment in a vertically integrated schizophrenia clinic.

SUMMARY:

Objective: There continues to be a paucity of guidelines for outcomes assessment in treatment programs. We describe a two-year project in which outcomes-assessment activities were developed and implemented in a hospital-based treatment program for individuals with chronic psychotic disorders.

Method: The project had three phases: a) development of the assessment package; b) staff education and implementation of assessment activities; and c) data analysis and interpretation.

Results: Nearly 800 patients were admitted to inpatient and outpatient units of the program and assessed at regular intervals over the two-year period. Clinician compliance approached 90% as nearly 4,000 assessments were completed. Data were collected regarding symptoms, treatment alliance, treatment compliance, substance abuse, functional skills, and satisfaction with treatment. Many obstacles arose and were addressed over the implementation period, and preliminary reports were used to identify patterns of substance abuse and treatment compliance in our population.

Conclusion: Our outcomes-assessment program offered the potential to address interesting quality improvement and research questions, but also presented a multitude of challenges to the staff. As technologies improve and assessment activities become more standardized, their usefulness will be increasingly apparent.

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No. 25
UNDERSTANDING MENTAL AND GENERAL MEDICAL DISABILITY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the prevalence and impact of mental disability in the U.S. and understand the similarities and differences between disability due to mental, general medical, and combined conditions.

SUMMARY:

Objective: To characterize the prevalence, characteristics, and impact of mental and general medical disabilities in the U.S.

Method: The 1994–5 National Health Interview Survey of Disability is the largest U.S. disability survey ever conducted. Analyses for the current study compared cohorts who attributed disability, which was operationally defined as limitation or inability to participate in a major life activity, to physical, mental, or combined conditions.

Results: Of 106,573 adults age 18–55, 1.2% reported functional disability due to a mental condition, 4.7% due to a general medical condition, and 1.2% due to combined mental and general medical conditions. Disabilities attributed to a mental condition were predominantly associated with social and cognitive difficulties, those attributed to general medical conditions with physical limitations, and combined disabilities with deficits spanning multiple domains of function. One-fifth to one-third of respondents with a mental disability reported economic, social, and job-based barriers to work, including employer discrimination.

Conclusion: An estimated three million Americans, or one-third of those with disabilities, report that a mental condition contributes to their disability. Mental and general medical conditions are each associated with unique patterns of functional impairment. Social factors, economic issues, and job discrimination may further exacerbate the functional impairments resulting from the clinical syndromes themselves.

Supported by a grant from American Psychiatric Association; Van Ameringen Foundation

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SCIENTIFIC AND CLINICAL REPORT SESSION 9—DEPRESSION AND THE HEART

No. 26
IS DEPRESSION A RISK FOR CORONARY ARTERY DISEASE ONSET? A META-ANALYSIS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the quality and quantity of evidence for depression's role as a major risk factor for the onset of coronary artery disease.

SUMMARY:

Objective: To perform a meta-analysis of all methodologically good studies that examine whether depression contributes to the later development of coronary artery disease (CAD).

Method: We searched Medline and PsychInfo (1966–98), cross references, and informal searches for all controlled community studies of depression symptoms in samples free of heart disease at baseline. We included only follow-up studies of four years or more that controlled for other CAD risk factors and reported relative risks of baseline depression for the development of CAD. For the meta-analysis, we used a random effects model for combining individual risk ratio estimates.

Results: Eight studies met our inclusion criteria, (including one unpublished study). Seven studies reported depression associated with an independent risk for CAD greater than 1; five reported significantly increased risk. Relative risks ranged from .94–4.5. The weighted average relative risk of depression for later CAD was 1.66 (95% CI 1.25–2.03).

Conclusions: Depression's relative risk for the later development of CAD is similar to that conferred by obesity, but less than the risk conferred by smoking (standard incidence ratio = 2.5). Future studies should examine the importance of severity and duration of depressive symptoms on the risk for the onset of CAD.

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1. Glassman AH, Shapiro PA: Depression and the course of coronary artery disease. Am J Psychiatry 1998;155:4–11.
2. Musselman DL, Evans DL, Nemeroff CB: The relationship of depression to cardiovascular disease: epidemiology, biology, and treatment. Arch Gen Psychiatry 1998;55:580–592.

No. 27
DEPRESSION IN ELDERLY PATIENTS WITH CONGESTIVE HEART FAILURE: SIX-MONTH FOLLOW-UP

George Fulop, M.D., DMA, *Merck Medical College, 100 Parsons Pond Drive, Franklin Lakes, NJ 07417;* James J. Strain, M.D., Glen Stettin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the frequency and course of depression among elderly patients with CHF in the six months following hospital discharge.

SUMMARY:

Objective: Up to 25% of elderly medical inpatients are depressed, yet less than 1% receive treatment. We examined the course of depression and its treatment and hypothesized that 50% of the elderly with congestive heart failure (CHF) who are depressed at hospital discharge will be depressed four and 28 weeks after discharge.

Method: Elderly inpatients (age 65 or older) with CHF were evaluated for the presence or absence of depression (major affective disorder) using the Structured Clinical Interview for DSM (SCID) at hospital discharge, and four and 28 weeks post-discharge, at the Mount Sinai-NYU Health System, N.Y. The 203 consenting subjects evaluated were 53.2% female, and 47.3% white, 31% black, and 20.7% Hispanic. The mean (±SD) age was 76.8 ± 7.8 years, range 65–98.

Results: At discharge 44/203 (21.7%) subjects were depressed. At four and 28 weeks follow-up, 166 (81.7%) and 113 (55.6%) subjects completed evaluations, and 34 (20%) and 22 (19%) subjects were depressed, respectively. Among subjects depressed at discharge, 55.5% and 41.7% were depressed at four and 28 weeks post-hospitalization (Chi-square = 23, $p < 001$, Chi-square = 15.1, $p < .001$), respectively. Among subjects not depressed at discharge, 10.8% and 9.0% were depressed at four and 28 weeks follow-up, respectively.

Conclusion: In a six-month follow-up period, 42% to 55% of CHF patients depressed at discharge evaluation remained depressed, and 9% to 11% of the nondepressed elderly experienced a new onset of depression, suggesting the importance of screening for depression at both hospital discharge and throughout the six months post-hospitalization. More research is needed to characterize the depressed elderly who require treatment versus those who will improve without intervention.

Supported by NIMH Services Research and Clinical Epidemiology Branch, R01MH50091-03 (Drs. Fulop and Strain)

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2. Cole MG, Bellavance F, Mansour A: Prognosis of depression in elderly community and primary care populations: a systematic review and meta-analysis. Am J Psychiatry 1999;156:1182–1189.

No. 28
DEPRESSION, HOSTILITY, GENDER, AND MYOCARDIAL INFARCTION

Michael W. Kaufmann, M.D., *Department of Psychiatry, Fairground Medical Center, 400 N. 17th Street, Suite 207, Allentown, PA 18104-5052;* Elliot J. Sussman, M.D., James Reed, Ph.D., John Fitzgibbons, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the impact of clinical depression on patients who have experienced a myocardial infarction on survival, understand the complex relationship between myocardial infarction, depression, hostility, and mortality, and become aware of the possible public health implication of early recognition and treatment of depression in patients suffering from a myocardial infarction.

SUMMARY:

Objective: The purpose of this study was to examine gender differences in the independent impact of major depression and hostility on mortality of patients with a myocardial infarction at six months and 12 months after discharge from a university-affiliated medical center.

Method: 217 male patients and 114 female patients were prospectively evaluated for depression using a modified version of the National Institute of Mental Health Diagnostic Interview Schedule for major depressive episode. The Cook Medley Hostility Scale data were analyzed using chi square procedures for nominal and categorical data, and students T-test for continuous data types.

Results: Depression was a significant predictor of mortality at 12 months ($p = 0.04$) but not at six months ($p = 0.08$). Hostility was not found to be a predictor of mortality at six months or 12 months. Neither of these findings were associated with gender differences.

Conclusion: Major depression in female and male patients hospitalized following a myocardial infarction is a significant univariable predictor of mortality at 12 months, although it is not a statistically significant predictor after adjusting for other variables. Hostility is not a predictor of mortality. Prospective studies are needed to understand the effect of aggressive treatment of depression on post-myocardial infarction survival.

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2. Barefoot J, Helms M, Mark D, Blumenthal J, et al: Depression and long-term mortality risk in patients with coronary artery disease. AM J Cardiol 1996;78:613–617.

TUESDAY, MAY 16, 2000

SCIENTIFIC AND CLINICAL REPORT SESSION 10—ECONOMIC ISSUES IN PATIENT CARE

No. 29
EVALUATING PAYER TYPE EFFECTS ON ADOLESCENT CARE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that payer types may influence access, length, and outcome of treatment; to learn how these elements of care were measured and understand our results and conclusions. The participant should gain knowledge of how to conduct such an investigation within his or her own program after hearing this presentation.

SUMMARY:

All psychiatric admissions to an acute-care, adolescent, partial hospitalization program from July 1993 through June 1994 were evaluated to determine insurance coverage/payer effects on 1) access to care, 2) length of treatment, and 3) outcome. Three payer types were identified: HMO, commercial, and publicly funded health insurance plans. Seventy-four patients' medical records were analyzed in a chart review to determine the effect these different insurance plans had on patient care.

No significant differences were found between payer types regarding access to treatment or length of stay. There were significant overall group effects on all indices of outcome attained after average treatment stays of about 20 days. Outcome effects were evenly distributed within the three payer types, with some trends favoring publicly funded patients.

The overall effectiveness of partial hospitalization treatment within our sample was consistently demonstrated. This treatment effect was equally distributed across all three groups with a slight trend favoring medical assistance patients on some measures. Our results are compared with those of published studies, and future impacts of payer type on quality of care are considered.

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1. Dalton R, Moseley T, McDermott B: Psychiatric findings among child psychiatric inpatients grouped by public and private payment. Psychiatric Services 1997;48:689–693.
2. Wells KB, Manning WG, Valdez RB: The effects of a prepaid group practice on mental health outcomes. Health Services Research 1990;25:615–625.

No. 30 WITHDRAWN

No. 31
CARE COORDINATION REDUCES INPATIENT COSTS

Laurence P. Karper, M.D., *Department of Psychiatry, LeHigh Valley Hospital, 400 N 17th St Ste 207, Allentown, PA 18104;* Michael W. Kaufmann, M.D., Elliot J. Sussman, M.D., Donna Stevens, OTR/L, Gail Stern, M.S.N., D. James Ezrow, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the elements that contribute to efficiency and lower costs for psychiatric inpatient treatment and recognize the processes that can lead to improved coordination of care.

SUMMARY:

Objective: 1) To study inpatient utilization strategies to reduce costs of psychiatric treatment and 2) to characterize the effects of care coordination to optimize treatment and outcomes on a general hospital adult psychiatric unit.

Method: One-year review of data from inpatient stays in a general hospital adult psychiatric inpatient unit. Variables include length of stay; number of CT scans, MRI studies, and EEG's; cost per discharge; physician practice style; quality-of-life measurement (MOS 20); and patient satisfaction (Press Ganey report).

Results: Completed fiscal year results revealed significant reductions in length of stay (8.4 to 6.8 days, $p < 0.0001$), number of CT and MRI studies (210 to 64, $p = 0.001$), number of EEG's (86 to 18, $p = 0.001$), and cost per discharge ($1,619 to $1,278). Measures of quality-of-life and patient satisfaction were maintained. MOS psychiatric component increased 34% after discharge, and likelihood of recommending hospital increased from 84 to 86 on patient satisfaction measure.

Conclusion: Care management coordination and oversight provide an effective means to reduce the cost of care. Unnecessary testing and delays in discharges were addressed when physician, nursing, and social work staff developed processes to streamline care and sharpen the focus on treatment outcomes to facilitate discharge planning.

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2. Vaughn K, Webster DC, Orahood S, Young BC: Brief inpatient psychiatric treatment: finding solutions. Issues Ment Health Nurs 1995;16:519–31.

SCIENTIFIC AND CLINICAL REPORT SESSION 11—NOVEL ISSUES IN THE TREATMENT OF MOOD DISORDERS

No. 32
COMBINED TREATMENT FOR MAJOR DEPRESSION: DOES IT SAVE HOSPITAL DAYS?

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to update acute treatment and combined treatment issues in major depression; to identify valuable guidelines for cost-effective provision of psychodynamic psychotherapy in major depression.

SUMMARY:

Objective: The purpose of this study was to determine whether provision of additional psychodynamic psychotherapy (PP) saves hospital days in psychiatric patients assigned to effective antidepressant medication (ADM) with severe major depression (MD).

Significance: While major depression accounts for a significant proportion of the expenditures associated with hospitalization and loss of days of work for medical illness (Murray and Lopez, 1996), innovative combined treatment may contribute to decrease these costs (Lazar and Gabbard, 1997).

Methods: Seventy-four consecutive patients referred to acute outpatient treatment in a general psychiatry service for severe depression were randomly assigned to clomipramine protocol (CI) plus PP and CL plus intensive aspecific care. Reliable prospective assessment of outcome and costs was obtained at 10 weeks, discharge, and one-year follow-up.

Results: Those patients with additional PP had fewer days in inpatient treatment at discharge ($p > 0.05$) and at one-year follow-up ($p < 0.01$). Assignment to combined treatment was associated with significant savings on direct costs (despite increased initial expenditure for PP provision) as well as on indirect costs for sick leave.

Comment: Provision of additional PP is cost-effective in MD patients assigned to acute treatment with effective ADM and severe symptoms. Psychotherapy deserves better insurance coverage in selected subgroups of MD patients.

REFERENCES:

1. Lazar SG, Gabbard GO: The cost-effectiveness of psychotherapy. J Psychother Pract Res, 1997;6:307–14.
2. Murray CJL. Lopez AD: The global burden of disease. World Health Organization, Cambridge, MA Harvard University Press, 1996, p. 43.

No. 33
A DOUBLED-BLIND, RANDOMIZED 12-WEEK COMPARISON OF NORTRIPTYLINE AND PAROXETINE IN THE TREATMENT OF LATE-LIFE DEPRESSION

Benoit H. Mulsant, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Bruce G. Pollock, M.D., Robert Nebes, Ph.D., Mark D. Miller, M.D., Robert A. Sweet, M.D., Sati Mazumdar, Ph.D., Charles F. Reynolds III, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to optimize an antidepressant trial in older depressed patients.

SUMMARY:

Objective: Some studies have suggested that selective serotonin reuptake inhibitors may be less efficacious than tricyclic antidepressants in the treatment of severe depression in older patients. The objective of this study was to compare the 12-week outcome of treatment with nortriptyline and paroxetine in older patients with a major depressive episode.

Method: A double-blind, randomized comparison of nortriptyline and paroxetine was conducted in 113 older (mean age: 75 ± 8 years) psychiatric inpatients and outpatients who presented with a major depressive episode. Dropout and response rates were compared in patients who began or who completed treatment. Rates of response of inpatients and patients with melancholic depression were also compared.

Results: Over 12 weeks, the dropout rate due to side effects was significantly higher with nortriptyline than with paroxetine (40% vs. 18%). There were no significant differences between the rates of response to nortriptyline or paroxetine (intent-to-treat analysis: 62% vs. 58%; completer analysis: 77% vs. 83%). Analyses restricted to inpatients or to patients with melancholic depression yielded similar results.

Conclusion: Paroxetine appears to have similar efficacy but better tolerability than nortriptyline in the acute (12-week) treatment of older depressed patients, including hospitalized patients and those with melancholic features.

Supported in part by USPHS grants MH-52247, MH-43832, MH-01509, MH-00295 from the National Institute of Mental Health. Paroxetine tablets were provided by SmithKline Beecham Pharmaceuticals.

REFERENCES:

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2. Mulsant BH, Pollock BG, Rosen J: Newer antidepressants and antipsychotics in geriatric psychiatry. Annals of Long-Term Care, 1997;5:240–248.

No. 34
FISH CONSUMPTION AND DEPRESSIVE SYMPTOMS IN THE POPULATION

Antti Tanskanen, M.D., *Department of Psychiatry, University of Kuopio, PO Box 1777, 70211 Kuopio, Finland;* Joseph R. Hibbeln, M.D., Jaakko Tuomilehto, M.D., Antti Uutela, Ph.D., Johannes Lehtonen, M.D., Heimo Viinamaki, M.D., Erkki Vartiainen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the importance of the associations between fish consumption, omega-3 polyunsaturated fatty acids, and depression.

SUMMARY:

Objective: Fish contains high concentrations of omega-3 polyunsaturated fatty acids (PUFAs). Several studies have reported depletions of omega-3 PUFAs among depressed patients. A cross-national comparison revealed a 50-fold difference in annual prevalence of major depression with higher prevalence rates predicted by lower fish consumption. We examined the association between fish consumption and depressive symptoms in a single population.

Method: A large survey of psychosocial risk factors among Finnish adults was carried out in 1992. A random sample (N = 3,403) of men and women aged 25–64 was drawn from the national population register. Depressive symptoms were estimated with the 21-item Beck Depression Inventory. A frequency question with six options was used to assess fish consumption.

Results: After adjustment for gender, age, marital status, education, employment status, alcohol intake, smoking, coffee drinking, body-mass index, serum cholesterol, and physical activity, the odds ratio of having mild to severe depressive symptoms was 31% (OR = 1.31, 95% CI's: 1.10–1.56, p = 0.0021) higher among infrequent (<once a week) fish consumers compared with frequent (at least once a week) users.

Conclusions: Since fish is the major source of omega-3 PUFAs in the human diet, the infrequent use of fish could lead to low intake of omega-3 fats increasing the risk of depression.

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1. Hibbeln JR, Salem N Jr: Dietary polyunsaturated fatty acids and depression: when cholesterol does not satisfy. Am J Clin Nutr 1995;62:1–9.
2. Hibbeln JR: Fish consumption and major depression. Lancet 1998;351:1213.

SCIENTIFIC AND CLINICAL REPORT SESSION 12—CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY

No. 35
NOVEL ANTIPSYCHOTIC IN ADHD WITH CONDUCT DISORDER

Mohammad Z. Hussain, M.D., *2727 2nd Avenue West, Prince Albert, SK S6V 5E5, Canada;* Zubaida A. Chaudhry, M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to improve treatment response of those ADHD and conduct disorder patients who only partially respond to psychostimulants.

SUMMARY:

Attention deficit hyperactivity disorder and conduct disorder coexist in 30%–50% of children and are among the most common disorders of childhood and adolescence. Psychostimulants significantly reduce symptoms in 60%–70% of this group. A fair number of children respond partially or have to reduce the dosage due to side effects. The novel neuroleptics olanzapine and risperidone were investigated in the treatment of partial responders.

Fifty children who met the criteria for ADHD and conduct disorder in accordance with the DSM-IV were included in the study. Subjects continued to receive their previous dose of psychostimulant. In addition, they received olanzapine 1,25-5 mg daily or risperidone 0.25-1 mg daily. Six of the patients receiving risperidone and five receiving olanzapine discontinued within two weeks due to side effects or parental perception of ineffectiveness.

Children were rated on Conners Parent's, teacher rating, and Global Improvement Scale at monthly intervals. They all showed significant reduction in target symptoms and managed better in school, home, and socially.

It was safe to use risperidone and olanzapine in combination with psychostimulants. Both were well tolerated and equally effective. Combination reduced the symptoms of ADHD and conduct disorder and enhanced psychosocial functioning.

REFERENCES:

1. Kuhne M, Schachar MD, Tannock R: The impact of comorbid oppositional or conduct problems on attention deficit hyperactivity disorder. American Academy of Child and Adolescent Psychiatry 1997;36:1715–1725.
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No. 36
COMPLIANCE WITH ANTISEIZURE MEDICATION IN ADOLESCENT PSYCHIATRIC PATIENTS

David L. Pogge, Ph.D., *Department of Psychology, Four Winds Hospital, 800 Cross River Road, Katonah, NY 10536;* Milissa Singer, B.S., Susan R. Borgaro, Ph.D., Douglas Wayland-Smith, M.A., Michele L. Zaccario, M.A., John M. Stokes, Ph.D., Philip D. Harvey, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate an increased understanding of current prescribing trends for antiseizure medication and postdischarge compliance rates.

SUMMARY:

Objective: Recent research has indicated that bipolar disorder is relatively common in adolescent psychiatric patients, and a number of clinical reports have suggested that antiseizure medications may be effective in the treatment of this condition. Use of antiseizure medications appears to range beyond bipolar disorder in many inpatient settings, although there are few data about effectiveness, side effects, and compliance with treatment.

Methods: Randomly selected adolescent psychiatric inpatients were seen at discharge and 30 and 120 days post discharge and examined for treatment compliance as well as other clinical factors. Of 94 cases, 27 (29%) received clinical chart diagnoses of bipolar disorder, 20 (21%) had conduct disorder diagnoses, and 47 (50%) had diagnoses of major depression.

Results: Ninety-six percent of the patients with bipolar disorder were treated with antiseizure medication as were 75% of the cases with conduct disorder and 49% of the patients with depression. SSRI antidepressants were prescribed to 47% of the patients with depression, making antiseizure medication the most common medication used, regardless of diagnosis. When compliance was examined, rates of compliance at 30 days with antiseizure medications ranged from a low of 40% (conduct disorder) to a high of 56% (bipolar disorder). In contrast, the lowest rate of compliance with SSRI antidepressants was 86% (depression).

Conclusion: These data suggest that antiseizure medications are widely used across diagnoses, without major evidence from randomized studies supporting their efficacy. In addition, medications with demonstrated efficacy for the treatment of depression were in less common use. Compliance with antiseizure medication was quite low relative to SSRI antidepressants. These data suggest that clinicians should be concerned about that enthusiasm for the use of antiseizure medication may be reducing the use of medications with demonstrated efficacy.

Funding Source: Four Winds GGFoundation

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2. Geller B, Luby J: Child and adolescent bipolar disorder: a review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry 1997;36:1168–1176.

No. 37
TRENDS IN PSYCHOTROPIC MEDICATION USE AMONG YOUTH

Elizabeth L. McGarvey, Ed.D., *Department of Psychiatry, University of Virginia, Univ. of VA Health Systems, Charlottesville, VA 22908;* Randolph J. Canterbury, M.D., Cheryl Koopman, Ph.D., Dennis Waite, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that psychotropic medication use among youths who were committed to a state juvenile correctional facility has significantly increased over a six-year period; to recognize significant differences among youths grouped by demographic and other variables and history of psychotropic medication use.

SUMMARY:

Objective: This study examined trends in the history of specific psychotropic medication use among males and females, minority and nonminority youths who were incarcerated in a southern state's juvenile correctional facilities between 1993 and 1998.

Method: Upon entry to the state's juvenile correctional facilities, all youths received a comprehensive medical examination, psychosocial and education assessments from psychologists, physicians and, when necessary, psychiatrists. Data were entered into a Client Profile Database, which had 413 data elements and 175 calculated variables. Six years of data, or about 1,500 youth per year, were available for analysis.

Results: Over the six-year period, there was a statistically significant linear increase ($p < .001$) in the percentage of youths committed to the system with a history of use of antianxiety medications (from 3% in 1993 to 6% in 1998); antipsychotics (4% in 1993 to 5% in 1998); antidepressants (11% in 1993 to 27% in 1998), and methylphenidate (10% in 1993 to 25% in 1998). History of psychiatric hospitalizations among youths, by contract, had not significantly increased.

Conclusions: These results indicate a dramatic increase in the use of psychotropic medications over six years. Over a 100% increase was found in the use of antidepressants and methylphenidate. The impact of these findings needs to be evaluated.

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SCIENTIFIC AND CLINICAL REPORT SESSION 13—TREATMENTS AND OUTCOMES IN ANXIETY DISORDERS

No. 38
FUNCTION AND WELL-BEING OF PRIMARY CARE PATIENTS WITH ANXIETY

Risa Weisberg, Ph.D., *Department of Psychiatry, Brown University, Box G-BH, Providence, RI 02912;* Martin B. Keller, M.D., Jennifer Allsworth, A.B., Regina T. Dolan, Ph.D., Larry Culpepper, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the impact of anxiety disorders on the functioning and well-being of patients and to recognize the relative severity of impairment associated with these disorders.

SUMMARY:

Objective: Functioning and well-being is examined in primary care patients with anxiety disorders and compared with those of individuals with other chronic conditions.

Method: Data for this study come from the Primary Care Anxiety Project (PCAP), a naturalistic, longitudinal study of anxiety disorders in patients seeking treatment at general medical facilities. Functioning and well-being of 308 subjects with one or more anxiety disorder was measured using the Rand 36-Item Health Survey. Scores were compared with those of subjects from the Medical Outcomes Study (MOS) who had general medical and psychiatric conditions including hypertension, osteoarthritis, diabetes, and depression, and with subjects from a general population sample.

Results: Patients with anxiety disorders reported functioning that was significantly worse than that of the general population, falling at or below the 25th percentile of scores for this sample. In comparison with chronic medical conditions, anxiety disorders were associated with worse energy, social functioning, and emotional health. Overall, patients with anxiety disorders reported functioning and well-being that were generally comparable to those of individuals with depression. Individuals from PCAP with anxiety disorders and comorbid major depression reported impairment that was significantly more severe than that of individuals with anxiety alone or with the depression sample from the MOS.

Conclusion: Findings suggest that anxiety disorders are associated with poor functioning and well-being. Particularly severe impairment is seen in primary care patients with comorbid anxiety and depression.

Research funded through an unrestricted educational grant from Pfizer Pharmaceuticals.

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No. 39
USE OF ALTERNATIVE THERAPIES AMONG PATIENTS WITH ANXIETY DISORDERS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to recognize the prevalence of the use of alternative therapies and the importance of discussing the use of alternative therapies with their patients.

SUMMARY:

Objective: The purpose of this study was to survey the use of alternative therapies by patients with anxiety disorders and attempt to better understand patients' beliefs and attitudes about the use of these therapies.

Method: A survey of the use of alternative therapies as well as measures of patients' attitudes and beliefs were administered to 200 patients at an anxiety disorders clinic.

Results: Data are reported for patients with a primary diagnosis of panic disorder (71), obsessive-compulsive disorder (64), social phobia (42). Seventy-five percent of patients reported past or current use of an average of 9.21 (9.03) alternative therapies, most often

nutritional supplements and botanical medicines. Patients reported that they believed that alternative therapies have a chemical effect on the body and are safer than conventional treatments. Seventy percent of patients reported that they had not discussed the use of alternative therapies with their psychiatrist.

Conclusion: Patients who present with anxiety disorders often turn to alternative therapies, including those with potential side effects and interactions with psychotropic medications. Implications for clinical practice are discussed.

REFERENCES:

1. Ernst EE, Rand JI, Stevinson C: Complementary therapies for depression. Archives of General Psychiatry 1998;55:1026–1032.
2. Wong AH, Smith M, Boon HS: Herbal remedies in psychiatric practice. Archives of General Psychiatry 1998;55:475–479.

No. 40
OUTCOME IN ANXIETY DISORDERS

Oscar R. Carrion, M.D., *Phobia Club, Piedras 469 5to Piso Dpto 9, 1070 Capital Fede 00014, Argentina;* Gustavo Bustamante, Ph.D., Hans Spatz, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize good and bad signs of prognosis in the treatment of anxiety disorders.

SUMMARY:

Objective: To find out predictors of outcome in anxiety disorders treatment.

Methods: All patients met the diagnosis criteria of DSM-IV for anxiety disorders. A Minnesota Multiphasic Personality Inventory (M.M.P.I), computerized EEG, a blood sample determining platelet serotonin, total phenyl-acetic acid in plasma (A.F.A.T.S) and benzyl-amine-oxidase or plasmatic MAO immediately processed, was evaluated. After two years of follow-up, we divided the sample (N = 163) into two groups (success N = 125, and failure N = 38)

Conclusion: Neither age nor sex showed any significant difference of outcome. Poor educational level and single or divorced marital status showed a little higher rate of failure. There were not any significant differences between groups of biochemical markers. Alternate MU rhythm and 14/6 rhythm in EEG as a sign of fear, the high rate of fear in M.M.P.I clinical subscales, the M.M.P.I. profile 2772, 1331, 6886 and 1881, the diagnosis of panic disorder with and without agoraphobia are signs of good prognosis. Desynchronized EEG, low rate of fear, or high rate of negative to treatment in M.M.P.I. subscales, M.M.P.I profile 7887, comorbidity with personality disorders of Axis II or with conversion disorder (300.11) are signs of bad prognosis.

REFERENCES:

1. Noyes R, Reich J, Christiansen J, Suelzer M: Outcome of panic disorder: relationship to diagnostic subtypes and comorbidity. Archives of General Psychiatry 1991;48:809–818.
2. Carrion OR, Bustamante G, Spatz H: Relationships among DSM-IV diagnosis, M.M.P.I. scales, biochemical markers and computerized EEG in patients with anxiety disorders. XI World Congress of Psychiatry F.C 12-2 Abstract Vol. II, Hamburg, August 1999. p. 19.

SCIENTIFIC AND CLINICAL REPORT SESSION 14—IMPACT OF THE DOCTOR-PATIENT RELATIONSHIP ON MEDICAL TREATMENT

No. 41
ATTACHMENT THEORY AND ADHERENCE TO MEDICAL TREATMENT

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to 1) recognize the four main types of attachment, 2) understand the role of attachment theory in the doctor-patient relationship, and 3) understand how dismissing attachment is associated with poor adherence to medical treatment, particularly in the setting of poor doctor-patient communication.

SUMMARY:

Objective: This study explores patient and provider factors underlying lack of adherence to diabetes treatment, using the model of attachment theory.

Methods: Instruments assessing attachment, treatment adherence, depression, diabetes severity, patient-provider communication, and demographics were administered to 367 type 1 and 2 diabetics in an HMO primary care setting. Glucose control, medical comorbidity, and adherence to medications and clinic appointments were determined from automated data. We used analysis of covariance to determine if attachment style and quality of patient-provider communication was associated with adherence to treatment.

Results: Patients with *dismissing* attachment had significantly worse glucose control (HbA1c) than patients with *preoccupied* or *secure* attachment. An interaction between attachment and communication quality was significantly associated with HbA1c [$F(3,292) = 2.741$, $p = .044$]. There was a clinically significant difference in HbA1c among dismissing patients who rated their patient-provider communication as poor compared with those rating communication as good [8.50% ± 1.55% vs. 7.49% ± 1.33%; $F(1,76) = 4.321$, $p = .041$]. In patients on oral hypoglycemics, adherence to medications and glucose monitoring was significantly worse in this interaction group.

Conclusions: Dismissing attachment in the setting of poor patient-provider communication is associated with poorer treatment adherence in patients with diabetes.

Funding: Bayer Institute of Health Care Communication and the Group Health/Kaiser Permanente Community Foundation.

REFERENCES:

1. Mickelson KD, Kessler RC, Shaver PR: Adult attachment in a nationally representative sample. Journal of Personality and Social Psychology 1997;73:1092–1106.
2. Sherbourne CD, Hays RD, Ordway L, et al: Antecedents to medical recommendations: results from the Medical Outcomes Study. Journal of Behavioral Medicine 1992;15:447–468.

No. 42
A PILOT STUDY OF HERBAL REMEDY USE BY PSYCHIATRIC PATIENTS

Cornelia W. Lange, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker N.E., Albuquerque, NM 87131–5236;* Joel

Yager, M.D., Virgil Etsitty, M.D., Robert Rhyne, M.D., Lewis Erwin, M.D., Betty Skipper, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this report the participant should be more familiar with the nature of herbal usage among psychiatric patients. Participants will be able to return to clinics and conduct a similar study utilizing research methodology outlined in the report.

SUMMARY:

Objective: To assess the prevalence of herbal remedy use by psychiatric outpatients.

Method: Two samples of psychiatric outpatients were drawn from a university mental health general outpatient clinic (MHC) and a VA primary care psychiatry clinic. Participants represented a consecutive sample as was permitted by logistical constraints.

Results: Of 80 MHC patients, 56 (69%) used herbal medications compared with 16 (19%) of 83 VA patients who used herbal medications. Patients in both samples tended not to disclose their herbal usage to their physicians. Most commonly used herbs were St. John's Wort, ginseng, ginkgo biloba, echinacea, and chamomile. No statistical difference in herbal usage existed between Hispanic and white non-Hispanic respondents.

Conclusions: A sizable minority of psychiatric outpatients take herbal remedies not prescribed by physicians. Rates and types of remedies utilized differ by institution. VA patients attributed their relatively low level of use to the fact that these remedies were not covered by VA payment sources. Psychiatric outpatients should be assessed for their use of herbal remedies, since several of the more popular remedies may potentially have deleterious side effects and untoward interactions with psychiatrically prescribed medications.

Funding: University of New Mexico Psychiatry Department

REFERENCES:

1. Yager J, Seigfreid SL, DiMatteo TL: Use of alternative remedies by psychiatric patients: illustrative vignettes and a discussion of the issues. Am J Psychiatry 1999;156:1432–1438.
2. Wong AHC, Smith M, Boon HS: Herbal remedies in psychiatric practice. Arch Gen Psychiatry 1998;55:1033–1044.

No. 43
WHAT CAN BE LEARNED FROM THE PLACEBO EFFECT?

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EDUCATIONAL OBJECTIVE:

Upon conclusion of this presentation, the participant will have an understanding of what the placebo effect tells us about the physician-patient relationship.

SUMMARY:

In focusing on the physician-patient relationship, there is a dearth of quantitative information about the potency and problems associated with that relationship—except for the placebo effect. The placebo effect provides data as to the enormous strength of that relationship. The placebo response suggests that the physician-patient relationship can attain results equal to that of medications or psychotherapy 20% to 60% of the time depending on the illness being addressed. Furthermore, studies of placebo effect clearly demonstrate that the physician-patient relationship can achieve positive results regardless of age, gender, ethnic background, social class, intelligence, and personality type.

This paper will review the findings of placebos in research settings, the factors that contribute to the physician-patient relationship leading to patient improvement, the factors that contribute to the relationship producing a negative result. These findings should influence public policies so that medicine's oldest treatment and the crucible of health care, the physician-patient relationship, will remain fully available to the care and treatment of patients.

REFERENCES:

1. Brown WA: Harnessing the placebo effect. Hospital Practice 1998, 33:107–116.
2. Shapiro AK, Shapiro E: The Powerful Placebo: From Ancient Priest to Modern Physician. 1997. Baltimore, Johns Hopkins Press, 1997.

SCIENTIFIC AND CLINICAL REPORT SESSION 15—MANAGED CARE ISSUES

No. 44
BENEFITS MANAGERS' VIEWS ON MENTAL HEALTH

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EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, participants should understand employee benefits' managers' opinions about mental health and should recognize the need for public educational programs about behavioral health care.

SUMMARY:

Objective: Employee benefits managers arrange behavioral health insurance coverage for the majority of people in the United States, but little is known about these individuals. This study surveyed benefits managers to learn their opinions about behavioral health care.

Methods: Subjects were 77 people (61% female, 93% white, average age 47, average of 13 years in the human resources field) identified from several databases. Most (55%) of the subjects worked in companies with fewer than 500 employees although several (18%) were employed by firms with over 5,000 workers.

Results: The majority (87%) of managers agreed that mental health problems should be covered just like physical health problems. However, the managers described their mental health benefits as being much more restricted than those for physical health care (3.0 versus 2.4 on a five point scale; $p < .001$). The managers felt that their company received less value per dollar expended on mental health treatment than physical health care (2.4 versus 3.3 on a five point scale; $p < .001$). Managers pointed out that employees often (2.9) ask for improved physical health benefits but rarely do so for mental health (3.9) or alcohol and drug (4.1) benefits ($p < .001$).

Conclusions: Employee benefits managers may in principle support parity for behavioral and physical health care. However, these decision makers view behavioral health services as delivering less value than physical health care services and rarely receive requests from their employees for better behavioral health benefits. Educating benefits managers and employees about the value of behavioral health services may be worthwhile.

Supported by National Institute of Mental Health grant number R03 MH56363.

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1. Buck JA, Teich JL, Umland B, Stein M: Behavioral health benefits in employer-sponsored health plans. Health Affairs 1999;18:67–78.

2. Buck JA, Umland B: Covering mental health and substance abuse services. Health Affairs 1997;16:120–126.

No. 45
THE IMPACT OF MANAGED CARE

Mark Freeman, M.P.A., *Franklin County ADAMH Board, 447 East Broad Street, Columbus, OH 43215;* Mina Chang, Ph.D., Dean Kauffman, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should appreciate the potential limitations of capitation payment mechanisms in a public mental health care system.

SUMMARY:

Changes in treatment costs and outcomes were examined one year after the introduction of capitation payments for a group of severely mentally ill (SMI) patients served by six community mental health centers in Franklin County, Ohio.

Method: Data from 350 patients participating in a pilot case rate project were compared with 350 retrospectively matched patients remaining in fee-for-service programs. Regression analyses were used to examine outcome and cost differences attributable to the pilot program. Treatment outcome variables include level of functioning, Brief Psychiatric Rating Scale scores, employment status, independent living, and substance abuse.

Results: Treatment outcomes were significantly worse for patients participating in the case rate pilot project. Treatment costs were not significantly different between the two groups.

Conclusions: This study raises concerns about the desirability of capitation or capitation-like financing mechanisms for publicly funded SMI patients and questions the causal linkage between these mechanisms and cost savings. However, unique features of Franklin County's pilot case rate program need to be considered when interpreting the results of this study.

REFERENCES:

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2. Dickey B, Normand ST, Norton EC, et al: Managing the care of schizophrenia: lessons from a 4-year Massachusetts Medicaid study. Arch Gen Psychiatry 1996;53:945–952.

No. 46
RISK MANAGEMENT IN SHARED TREATMENT

Eugene L. Lowenkopf, M.D., *150 East 77th Street, New York, NY 10021-1922;* Abe M. Rychik, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to 1) understand the various legal issues relating to physician liability in shared treatment and managed care circumstances; 2) deal more knowledgeably with potential malpractice liability in these cases; 3) practice risk management more effectively in supervision and consultation.

SUMMARY:

Psychiatrists are finding themselves working in shared treatment scenarios, especially in this era of managed care. The role may be as medication "back-up" for other disciplines or in a variety of consultative, supervisory, or administrative relationships. In these situations, when a patient is injured, who is liable? Malpractice claims are clear when they relate to diagnosis and treatment of patients directly under one's care but are complicated in managed care and other shared settings. Administrators, directors, supervisors, and clinicians who work in group settings supervising other nonphysicians share information and responsibilities. How can one protect oneself in this environment? Traditional legal principles, statutory analysis, and guidelines are examined for clarification and practical risk management.

REFERENCES:

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

SCIENTIFIC AND CLINICAL REPORT SESSION 16—SOCIETAL ISSUES IN MENTAL ILLNESS

No. 47
MAJOR DEPRESSION AND MOTHER'S MARITAL TRANSITION

Terrance J. Wade, Ph.D., *Department of Psychiatry, University of Cincinnati, PO Box 670840, Cincinnati, OH 45267–0840;* John Cairney, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to better understand the relationship between marital transition and major depression among a high-risk population of mothers.

SUMMARY:

Objective: This analysis employs a national panel study to examine the relationship between marital transition and depression among mothers within the framework of selection and causation processes.

Method: The data come from the two-wave, longitudinal National Population Health Survey (NPHS) by Statistics Canada collected in 1994 and again in 1996. This analysis focuses on women between 20 and 65 years of age with children living at home (N = 2158).

Results: Compared with mothers who remain married, mothers who make the transition into single-parenthood had a significantly higher rate of major depression at Time 1, which increased but not significantly at Time 2. Rates of depression among single-parent mothers who made the transition into a marital relationship did not decrease significantly between waves nor did the rate differ significantly from stable single-parent mothers at Time 1 or Time 2. Finally, for mothers moving from marriage to single-parenthood, it appears that change in income adequacy accounts for part of the increase in their rate of major depression at Time 2.

Conclusion: These findings indicate that selection processes are operating among mothers experiencing a marital disruption and that movement into marriage is not a protective factor.

REFERENCES:

1. Weissman MM, Leaf PS, Bruce ML: Single-parent women. Social Psychiatry 1987;22:29–36.
2. Menaghan EG, Liederman MA: Changes in depression following divorce: a panel study. Journal of Marriage and the Family 1986;48:319–328.

No. 48
OUTPATIENT COMMITMENT IN NEW YORK: FROM PILOT PROJECT TO STATE LAW

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the clinical and legal theories underlying court-ordered outpatient treatment for the mentally ill, Bellevue's implementation of New York State's pilot program, and the events lending to the passage of "Kendra's Law" in August 1999.

SUMMARY:

Homelessness, incarceration, and repeated psychiatric hospitalizations may result when severely mentally ill individuals become noncompliant with treatment. Outpatient commitment is a legal intervention that has been developed to compel patients to accept psychiatric treatment in the community and thereby prevent adverse outcomes. Research has suggested that court-ordered outpatient treatment is effective in reducing rates and duration of psychiatric hospitalization and dangerousness in the community. It has, however, been the subject of much controversy because of concerns about patients' rights, provider liability, and adequate funding of services.

This report will describe the operation of the Bellevue Outpatient Commitment Pilot Program, which started in 1995. It will review the results of the independent research evaluation conducted by Policy Research Associates. It will also discuss the December 1998 public hearing at which the future of outpatient commitment in New York was debated and the recommendations that emerged from the pilot experience. This report will also discuss two highly publicized New York City subway pushings, which focused enormous public attention on issues of psychosis, dangerousness, and outpatient commitment. The political process that ultimately led to the passage of a state "assisted outpatient treatment" law will be reviewed.

REFERENCES:

1. Lidz CW: Coercion in psychiatric care: what have we learned from research? J Am Acad Psychiatry Law 1999 26, 631–7.
2. Sterrett D, Miller RD, Bloom J, et al: Report of the Task Force on Involuntary Outpatient Commitment. Washington, DC, American Psychiatric Association, 1987.

No. 49
SIX-MONTH FOLLOW-UP OF THE NAIROBI EMBASSY BOMBING

Pius A. Kigamwa, M.D., *Department of Psychiatry, University of Nairobi, PO Box 19676, Nairobi, Kenya;* Dr. Margaret Makanyengo, Josephine Omondi, M.D., Victoria Wells, M.D., Lawson R. Wulsin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the frequency of PTSD in a sample of injured Kenyans during the six months following the Nairobi embassy bombing of 1998.

SUMMARY:

Objectives: 1) To assess the frequency of post-traumatic stress disorder (PTSD) in a sample of Kenyan citizens during the six months following exposure to the 1998 bombing of the U.S. Embassy in Nairobi. 2) To examine the feasibility of intercontinental collaborative epidemiologic research.

Methods: By e-mail correspondence the authors completed study design and selection of instruments. A convenience sample of injured survivors of the bombing seeking care at Kenyatta National Hospital were evaluated with a modified version of the Mississippi PTSD Scale. The Nairobi authors collected and transferred the data electronically to Cincinnati where the analyses were done. Results, interpretations, and reports were iteratively exchanged.

Results: The sample (N = 103) was 63% male, 98% Christian, and had a mean age of 35 years. Ninety percent had at least some secondary education. Over half (57%) received some form of counseling. Fifty-six (54.4%) met criteria for PTSD.

Conclusions: U.S. and African investigators can collaborate efficiently on epidemiologic study design and analyses. This injured clinical sample reported rates of PTSD (54.4%) substantially higher than the 34.3% reported by a nonclinical sample of survivors of the Oklahoma City bombing during a similar follow-up period.

REFERENCES:

1. North CS, Nixon SJ, Shariat S, et al: Psychiatric disorders among survivors of the Oklahoma City bombing. JAMA 1999;282:755–762.

SCIENTIFIC AND CLINICAL REPORT SESSION 17—SPECIAL ISSUES IN MOOD DISORDERS

No. 50
QUALITY OF LIFE AFTER COGNITIVE-BEHAVIOR THERAPY

Gerhard Lenz, M.D., *Department of Psychiatry, University of Vienna, Wahringergurtel 18–20, Vienna 1090, Austria;* Ulrike Demal, MAG

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize how quality of life is perceived by patients suffering from depression and anxiety disorder who participated in an intensive inpatient CBT program for six weeks, and how quality of life changed at six weeks follow-up after the end of treatment.

SUMMARY:

Objective: Investigation of changes in quality of life after inpatient cognitive behavior therapy.

Method: 37 patients with DSM-III-R major depression and/or anxiety disorder who had been poor responders or nonresponders to pharmacotherapy participated in an intensive inpatient cognitive behavior therapy program for six weeks. They were interviewed before treatment and six weeks after the end of treatment; in addition to other measures, quality of life was assessed with the Berlin Quality of Life Profile.

Results: Substantial reduction in subjective quality of life, objective functioning, and environmental assets was found at baseline. At follow-up according to CGI 13.5% of the patients were very much improved, 45.9% much improved; in 26.3% only slight improvement, and in 16.2% no improvement was reported. Quality of life changed for the better in areas like work and education, leisure, living situation, social relations, psychological well-being, and a global rating of satisfaction with life, but not in marital relations, health in general, and finances.

Conclusion: There is growing evidence of substantial impairment in subjective quality of life, objective functioning, and environmental circumstances in patients with anxiety disorders. In depression one major problem is that satisfaction judgments are clearly influenced by actual mood state. Our follow-up of patients with inpatient CBT added to ongoing medication treatment indicates that patients' QOL changed for the better in some areas six weeks after the end of treatment.

REFERENCES:

1. Katschnig H, Freeman H, Sartorius N: Quality of life in mental disorders. Chichester, England, Wiley, 1992.
2. Lenz G, Demal U: Psychotherapy and quality of life, In: Katschnig et al (Eds). Quality of life in mental disorders. Chichester, England, Wiley, 1997, pp 227–239.

No. 51
SECULAR TREND OF VIOLENT METHODS IN SUICIDE VICTIMS

Zoltan Rihmer, M.D., *National Institute for Psychiatry, Huvosvolgyi Unit 116, Budapest 1021, Hungary;* Wolfgang Rutz, M.D., Hans Pihlgren, M.D., Gergely H. Kiss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that there is an increasing secular trend of violent methods in persons with repeated suicide behavior: nonviolent attempters frequently switch their method to violent, but persons with previous violent attempt(s) rarely die by nonviolent suicide.

SUMMARY:

Objective: The aim of this study was to investigate the stability of suicide methods (violent vs. nonviolent) in suicide victims with previous suicide attempt.

Method: The authors investigated the method of suicide (violent vs. nonviolent) in 115 Gotlandian suicide victims (89 males and 26 females) who died between 1981 and 1992. Seventy-seven (67%, 63 males and 14 females) died by violent method, and 33 (29%) (21 males and 12 females) had at least one previous suicide attempt (Rihmer et al. 1995).

Results: While the proportion of persons with previous violent attempt was 9/33 (27%), the rate of violent method for the fatal suicide was 18/33 (55%). All but one of the nine victims with previous violent attempts died by violent methods, but only 14 out of the 24 victims with previous nonviolent attempts died by nonviolent method.

Conclusions: The results show an increasing trend of violent methods in persons with repeated suicidal behavior and suggest that nonviolent attempters frequently switch their suicide method to violent, but persons with previous violent attempt(s) rarely die by nonviolent suicide. Our findings are in agreement with the results of Isomatsa and Lönnqvist (1998) showing that suicide victims commonly switch their suicide method from nonlethal to lethal.

REFERENCES:

1. Rihmer Z, Rutz W, Pihlgren H: Depression and suicide on Gotland: an intensive study of all suicides before and after a depression-training programme for general practitioners. J Affect Disord 1995;35:147–152.
2. Isometsa ET, Lönnqvist JK: Suicide attempters preceding completed suicide. Br J Psychiatry, 1998;173:531–535.

No. 52
AN OPEN STUDY OF OLANZAPINE AND FLUOXETINE FOR PSYCHOTIC DEPRESSION: INTERIM ANALYSES

John D. Matthews, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street WAC 812, Boston, MA 02114;* Laura M. Polania, B.A., Meridith A. Rankin, Robert W. Irvin, M.D., Jerrold F. Rosenbaum, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

The participant will learn about the efficacy of the atypical antipsychotic agent, olanzapine, in combination with the selective serotonin reuptake inhibitor, fluoxetine, in the treatment of psychotic depression.

SUMMARY:

Although atypical antipsychotic agents are commonly used in the treatment of psychotic depression, there are no published prospective studies on their use in this condition. The aim of this study was to assess, by interim analysis, the efficacy of the atypical antipsychotic agent olanzapine in combination with the SSRI fluoxetine.

Methods: We enrolled 13 [eight (62%) women and five (38%) men; mean age: 46.2 ± 16.7] patients with major depressive disorder with psychotic features into an open trial of olanzapine 5–20mg/day plus fluoxetine 20–80mg/day. Patients were assessed at each visit with the HAM-D-17 and both the psychotic module and the mood module of the SCIDI/P. Responses were defined as: 1) absence of psychotic symptoms with ongoing depression (Psychosis Response); 2) 50% or greater reduction in HAM-D-17 scores with ongoing psychotic symptoms (Depression Response), and 3) absence of psychotic symptoms with 50% or greater reduction in HAM-D-17 scores (Psychotic Depression Response). We are reporting the results of the first eight weeks of treatment.

Results: Of the 13 enrolled patients, 93% met criteria for melancholic features; 23% had delusions alone; 15% had hallucinations alone; and 62% reported both delusions and hallucinations. In addition, 69% showed a Psychotic Depression Response, 0% showed a Depression Response alone, and 8% had a Psychosis Response alone. While 100% of the five patients with hallucinations or delusions alone showed a Psychotic Depression Response, only 50% of the eight patients with both hallucinations and delusions responded. Finally, 23% of patients dropped out due to side effects.

Conclusion: The combination of olanzapine and fluoxetine appears to be a promising, safe, and effective treatment for psychotic depression. Double-blind studies are needed to confirm this impression.

REFERENCES:

1. Rothschild AJ, Bates KS, Boehringer KL, Syed A. Olanzapine response in psychotic depression. Journal of Clinical Psychiatry 1999;60:116–8.
2. Dubovsky SL: Challenges in conceptualizing psychotic mood disorders. Bull Menninger Clin 1994;58:197–214.

SCIENTIFIC AND CLINICAL REPORT SESSION 18—ALCOHOL AND DRUG RELATED DISORDERS

No. 53
IMPULSIVITY, SEROTONIN, AND ADOLESCENT ALCOHOL ABUSE

Paul H. Soloff, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213;* Kevin G. Lynch, Ph.D., Howard B. Moss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the relationship of impulsivity and aggressivity to early adolescent alcohol use disorder.

SUMMARY:

Objective: Alcoholism in some adults is associated with impulsive-aggressive and antisocial personality traits and evidence of diminished central serotonergic function, which may define a vulnerability to the disorder. We studied adolescents with alcohol use disorders to examine the relationships between impulsivity, aggressivity, conduct

disorder, and responsiveness to serotonergic challenge with d,l fenfluramine (FEN) early in the course of alcohol abuse.

Method: 36 adolescents between the ages of 16 and 21 were assessed for DSM-III-R alcohol use disorders (ALC) and other Axis I disorders using the SCID-PSUD, K-SADS, and conduct disorder interviews. Impulsivity and aggressivity were assessed by the Barratt Impulsiveness Scale, Brown-Goodwin Lifetime History of Aggression, Buss-Durkee Hostility Inventory, Eysenck Impulsiveness Questionnaire, Youth Self Report, and Multidimensional Personality Questionnaire aggression subscales. Prolactin response to FEN was measured as peak response (minus baseline) and area-under-the-curve, following a standardized protocol.

Results: 18 ALC+ adolescents (12 male, six female) scored significantly higher on all measures of impulsivity and aggressivity compared with 18 ALC- controls (12 male, six female). There were no significant differences between ALC+ and ALC– groups in prolactin response to FEN, or between ALC+ adolescents with or without comorbid conduct disorder.

Conclusion: Adolescents with early alcohol use disorders are characterized by impulsivity and aggressivity compared with healthy peers, but do not demonstrate the diminished prolactin response to FEN characteristic of adult alcoholics with impulsive aggression.
Supported by NIAAA grant P50 AA08746.

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2. Moss HB, Yao JK, Panzak GL: Serotonergic responsivity and behavioral dimensions in antisocial personality disorder with substance abuse. Biol Psychiatry 1990;28:325–338.

No. 54
DWI PREVENTION: THE PSYCHIATRIST'S ROLE

Bryce Templeton, M.D., *Dept of Psychiatry, Eastern Pennsylvania Psychiatric Institute, 3200 Henry Ave, Philadelphia, PA 19129-1137;* Richard P. Amar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify at least three methods whereby a psychiatrist can reduce the risk of alcohol-impaired vehicular crashes and the resulting death and disability.

SUMMARY:

Objective: To improve the role of psychiatrists in reducing alcohol-impaired vehicular crashes and the resulting death and disability.

Method: A review was conducted of the following: (1) the epidemiology of alcohol-impaired driving; (2) methods of available intervention; and (3) apparent system failures. An analysis was undertaken to determine how psychiatric clinicians could play a more effective role in this process.

Results: Despite considerable progress over the past two decades, alcohol-impaired driving is responsible for over 15,000 deaths and many serious injuries each year. Many alcohol-abusing individuals continue to drive with suspended licenses. Hospitalized injured drivers are rarely referred for treatment of their alcohol abuse. Two promising approaches include vehicle impoundment and court-mandated, breathalyzer-based, ignition interlock devices; five studies have shown that interlocks reduce DWI recidivism.

Conclusions: Psychiatrists could play a more effective role in reducing resulting death and disability in a number of ways including the following: supporting legislation for lower blood-alcohol limits, vehicle impoundment programs, and ignition interlock programs; recommending to alcohol-impaired patients and their families that the impaired patients voluntarily employ ignition interlocks; and arranging for local inpatient trauma units to refer injured, alcohol-impaired drivers for treatment of their alcoholism.

Funding: in part by MCP-Hahnemann School of Medicine.

REFERENCES:

1. Coben JH, Larkin GI: Effectiveness of ignition interlock devices in reducing drunk driving recidivism. Am J Prev Med 1999;16:81–87.
2. Danielsson PE, et al: Reasons why trauma surgeons fail to screen for alcohol problems. Arch Surg 1999;134:564–8.

No. 55
SELF-HELP STRATEGIES AMONG SUBSTANCE ABUSERS

Joseph J. Westermeyer, M.D., *Department of Psychiatry, University of Minnesota-VAMC, 1 Veterans, Suite 116A, Minneapolis, MN 55417;* Sarah Myott, B.S., Rembrant Aarts, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify seven self-help behavioral strategies against addiction, relate self-help goals (e.g., cutting down vs. sobriety) to self-help strategies, and appreciate frequency, demographic associations, and clinical correlates of self-help for addiction.

SUMMARY:

Objective: To determine self-help efforts among addicted patients and the association between self-help and demographic and clinical characteristics.

Design: Retrospective report, current demographic and clinical characteristics, and analysis of associations with self-help.

Setting: Two university centers with alcohol-drug programs.

Subjects: 642 patients with substance abuse.

Methods: A research associate (RA) interviewed patients regarding seven types of self-help involving specific, mutually exclusive behaviors. The patient, RA, and addiction psychiatrist provided demographic, familial, and clinical information.

Results: Most patients (78%) had tried self-help, with a mean of 2.7 methods per patient. Methods involving the substance or joining a self-help group were more frequent than methods involving life change. Certain patterns of self-help tended to occur together. Some self-help approaches occurred primarily in association with other methods rather than alone. More self-help was associated with higher socioeconomic class, more relatives with substance abuse, greater severity of substance abuse, and more substance abuse treatment.

Conclusions: Self-help tends to occur more often after exposure to addicted relatives or addiction treatment. Clinicians and public adult education should promulgate self-help methods in the general population.

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1. Granfield R, Cloud W: The elephant that no one sees: natural recovery among middle-class addicts. Journal Drug Issues. 1996;26:45–61.
2. Sobell L, Cunningham J, Sobell M: Recovery from alcohol problems with and without treatment. American Journal Public Health. 1996;86:966–972.

WEDNESDAY, MAY 17, 2000

SCIENTIFIC AND CLINICAL REPORT SESSION 19—EATING DISORDERS

No. 56
LEPTIN DYNAMICS IN BULIMIA NERVOSA

Palmiero Monteleone, M.D., *Department of Psychiatry, University of Naples Sun, Largo Madonna Delle Grazie, Naples 80138, Italy;* Alfonso Tortorella, M.D., Michele Fabrazzo, M.D., Antonello Di Lieto, M.D., Mario Maj, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to acknowledge the importance of leptin in the pathophysiology of bulimia nervosa.

SUMMARY:

Objective: In healthy humans, restriction of food intake and overeating have profound effects on leptin production. Bulimia nervosa (BN) is characterized by recurrent binge episodes and prolonged starvation. We investigated the dynamics of leptin response to acute changes in the caloric intake in bulimic patients.

Method: Ten drug-free women meeting DSM-IV criteria for BN and eight age-matched, healthy females underwent blood sample collection during a 24-hour fasting and subsequent 24-hour refeeding with normal diet.

Results: In BN women, plasma leptin concentrations were significantly lower than in healthy controls. Moreover, in patients, acute fasting induced a 10% decrease in leptin levels, which was significantly lower than the 52% decline observed in controls. Normal refeeding was associated with a prompt rise in plasma leptin in both patients and controls.

Conclusions: These findings show, for the first time, that in BN women leptin production is reduced, its response to acute starvation is impaired, and its response to normal refeeding is preserved. The extent to which these changes contribute to the maintenance of the altered eating behavior as well as to the pathogenesis of some metabolic and hormonal alterations of BN remains to be determined.

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1. Boden G, Chen X, Mozzoli M, Ryan I: Effect of fasting on serum leptin in normal human subjects. J Clin Endocrinol Metab 1996;81:3419–3423.
2. Kolacyneld JW, Considine RV, Ohannesian J, et al: Responses of leptin to short-term fasting and refeeding in humans. Diabetes 1996;45:1511–1515.

No. 57
A COMPARISON OF INPATIENT AND DAY TREATMENT FOR ANOREXIA NERVOSA

Allan S. Kaplan, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street EN8-231, Toronto, ON M5G 2C4, Canada;* Marion P. Olmsted, Ph.D., Jacqueline Carter, D.Phil., D. Blake Woodside, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the characteristics of patients with serious anorexia nervosa who can be effectively treated in a specialized inpatient versus day hospital setting, and recognize the clinical and economic advantages/disadvantages of each type of intervention.

SUMMARY:

Objective: There is much interest in the clinical and cost-effectiveness of intensive in-hospital treatments for anorexia nervosa (AN). The purpose of this study is to compare the cost and clinical efficacy of treatment for AN in the inpatient (IP) and day hospital (DH) components of the eating disorder program at the Toronto General Hospital in order to identify the characteristics of patients who can be effectively treated in each type of program.

Method: This eating disorder program is a large multidisciplinary program that includes, in addition to outpatient services, two intensive treatment interventions: a 10-bed inpatient service and a 12-person four-day-a-week day hospital. Both intensive services provide psychological support through group treatments and nutritional rehabilitation through supervised meals. Over approximately two years, 57 AN patients in the IP and 42 in the DH completed at least four weeks of treatment and were assessed at pre and post treatment on a variety of demographic and clinical variables.

Results: The mean age of AN patients treated in both programs was the same (IP 27, DH 26 years). As expected, at admission IP patients were thinner than those in the DH (mean BMI IP, 14.5 vs. DH, 16.6; $p < .01$) and had a longer treatment duration (IP 12.4 weeks vs. DH 10.6 weeks; $p < .05$). The mean rate of weight gain per week was greater in the IP compared with the DH program (IP 0.9 kg/wk vs. DH 0.6 kg/wk; $p < .01$). However, it is noteworthy that the percentage of patients who are weight restored (BMI ≥ 20) at the end of treatment is roughly the same for both IP and DH. Excluding M.D. costs, the approximate personnel cost per patient for IP treatment is $20,000 Canadian compared with $6000 Canadian per patient for DH treatment.

Conclusion: These data suggest that patients seriously ill with AN can be treated effectively in either an IP or DH setting. As expected, DH treatment is significantly more cost-effective. However, there remains a group of very emaciated patients with AN who do require initial full hospitalization, but who likely could, following stabilization, step down to a partial hospitalization program. This model has recently been instituted at the Toronto General program, and further results of its efficacy will be presented.

REFERENCES:

1. Kaplan AS, Olmsted MP: Partial hospitalization. In: Handbook of Treatment of Eating Disorders. Edited by Garner DM, Garfinkel PE, Guilford Press, New York, 1997, pp 354–360.
2. Kaye W, Kaplan AS, Zucker ML: Treating Eating Disorders in a Managed Care Environment. Psychiatric Clinics of North America 1996, pp. 793–810.

No. 58
SELF-LOATHING AS A RISK FACTOR FOR EATING DISORDERS

Alayne Yates, M.D., *Department of Psychiatry, University of Hawaii, 1319 Punahou Street, Suite 636, Honolulu, HI 96826;* Jeanne Edman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to better distinguish individuals at risk for eating disorder (ED) from persons with normative weight concerns, and understand the concept of self-loathing and its relationship to neurotic perfectionism.

SUMMARY:

Objective: Study attempts to distinguish individuals at risk for eating disorder (ED) from persons with normative weight concerns and athletes with ED from those who are extremely thin and follow a "healthy" diet.

Method: The study employs the Exercise Orientation Questionnaire (EOQ), a reliable and valid 27-item instrument to assess exer-

cise attitudes and behaviors. EOQ subscales assess self-control, exercise orientation, self-loathing, weight reduction, identity, and competition. The study compares clinical (ED + obese) and nonclinical groups including 99 elite runners, 80 ED patients, 74 obese patients, and 214 controls from a previous study.

Results: Multivariate analysis of variance showed that ED and athlete groups had higher mean total EOQ and exercise intensity scores than all other groups. Self-loathing factor clearly distinguished clinical from nonclinical groups. Self-control, weight reduction, and identity factors did not differentiate ED from nonclinical groups.

Conclusion: The self-loathing factor may represent the character trait "neurotic perfectionism" described in ED and compulsive exercise. Self-loathing differentiates clinical from nonclinical groups and is the first instrument based on exercise attitudes and behaviors that detects risk for ED.

REFERENCES:

1. Yates A, Edman J, Crago M, Crowell D, Zimmerman R: Measurement of exercise orientation in normal subjects: gender and age differences. Personality Individ Differences 1999;27:199–209.
2. Yates A, Crago M, Allender J, Shisslak C: Overcommittment to sport: is there a relationship to the eating disorders? J Clin Sports Med 1994;4:39–46.

SCIENTIFIC AND CLINICAL REPORT SESSION 20—DIAGNOSIS AND TREATMENT OF BIPOLAR ILLNESS: PART 1

No. 59
UNIPOLAR MANIA: A SEPARATE DIAGNOSTIC ENTITY?

Vishal K. Adma, M.D., *Department of Psychiatry, Univ. of Kansas Medical Center, 3901 Rainbow Blvd. Kansas City, KS 66160;* Ekkehard Othmer, M.D., Cherilyn Desouza, M.D., Elizabeth C. Penick, Ph.D., Elizabeth J. Nickel, M.A., Sanjay M. Vaswani, M.D., William F. Gabrielli, Jr., M.D.

SUMMARY:

Objective: Unipolar mania refers to the presence of one or more manic episodes in the absence of major depression. Unipolar mania is not specifically recognized as a separate diagnosis in DSM-IV but is recognized in the ICD-9-CM. We examined the clinical validity of unipolar mania as a possible diagnostic entity distinct from bipolar mania.

Method: During a five-year period, we studied 1458 admissions to an outpatient psychiatric clinic with structured interviews, rating scales, and self-report measures. Three hundred nineteen patients (22% of the total) met lifetime inclusive DSM-III criteria for at least one manic episode. Forty-four of these, or 14 percent of those who fulfilled criteria for mania, failed to meet criteria for major depression. We compared unipolar manic patients with bipolar manic patients on multiple clinical dimensions.

Results: Unipolar and bipolar mania patients did not differ according to age, race, marital status, or education. Proportionally more of the patients with unipolar mania were male. Although the two groups did not differ in a review of childhood problems, onset of mania was six years earlier in bipolar mania (22 vs. 28 years). Bipolar manics reported higher levels of symptom severity, greater social impairment, and more comorbid schizophrenia, somatization, and anxiety disorder. Bipolar manics also reported more mania and depression among first-degree relatives. Approximately one-half of each group had been hospitalized psychiatrically. Mood stabilizers were more often prescribed to unipolar than bipolar manic patients (37% vs. 20%); otherwise, treatment utilization was the same in the two groups.

Conclusions: Our data offer support for unipolar mania as a distinct clinical syndrome.

REFERENCES:

1. Numberger J, Roose SP, Dunner DL, Fleve RR: Unipolar mania: a distinct clinical entity? American Journal of Psychiatry 1979;136:1420–1423.
2. Shulman KI, Tohen M: Unipolar mania reconsidered: evidence from an elderly cohort. British Journal of Psychiatry 1994;164:547–549.

No. 60
RAPID CYCLING: TESTING FOUR DEFINITIONS

Mario Maj, M.D., *Department of Psychiatry, Naples University, Largo Madonna Delle Grazie, Naples 80138, Italy*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the clinical implications of four alternative definitions of rapid cycling.

SUMMARY:

Objective: The study evaluated the reliability and validity of four definitions of rapid cycling.

Method: Two trained psychiatrists independently assessed 210 bipolar patients using the SADS. They checked whether each patient fulfilled four definitions of rapid cycling: one consistent with DSM-IV criteria, one waiving duration criteria for effective episodes, one waiving these criteria and requiring at least one switch from mania to depression or vice versa during the reference year, and one waiving duration criteria and requiring at least eight weeks of fully symptomatic affective illness during the reference year. Patients who fulfilled each definition according to both psychiatrists were compared with those not fulfilling any definition (nonrapid cyclers) with respect to demographic and clinical variables.

Results: Kappa values for the four definitions of rapid cycling were 0.93, 0.73, 0.75, and 0.80, respectively. Only the groups fulfilling the second and third definition included significantly more females and bipolar II patients, compared with nonrapid cyclers. Those groups had the lowest frequency of a favorable lithium prophylaxis outcome and the highest stability of rapid cycling pattern on follow-up.

Conclusion: The DSM-IV definition, although very reliable, includes only part of the spectrum of rapid cycling, and the conditions that are excluded are very typical in terms of key validators and relatively stable over time.

REFERENCES:

1. Maj M, Magliano L, Pirozzi R, et al: Validity of rapid cycling as a course specifier for bipolar disorder. Am J Psychiatry 1994;151:1015–1019.
2. Bowden CL: Rapid-cycling bipolar disorder: how to define it, how to treat it. J Bipolar Disorder 1998;2:14–18.

No. 61
COMPLIANCE IN BIPOLAR ILLNESS

Michael Z. Sobel, M.D., *Department of Psychiatry, NYU School of Medicine, 251 East 32nd Street, Apt 8D, New York, NY 10016;* Eric D. Peselow, M.D., Ronald R. Fieve, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand clinical factors, demographics, personality traits, and attitudes that lead bipolar patients to discontinue long-term main-

tenance therapy and to understand how the above variables affect outcomes.

SUMMARY:

Objective: The utility of lithium in the prophylaxis of bipolar illness has been well established. However, lithium has many burdensome side effects including the long-term problem of renal toxicity. As a result of this, many patients discontinue lithium. Since the consequences of noncompliance can be very devastating, the purpose of this paper is examine a variety of characteristics that may be predictive of noncompliance.

Method: We evaluated 78 patients with bipolar illness who were stabilized on lithium for six to 24 months who subsequently dropped out of treatment, discontinuing their medication. These patients were examined with respect to demographic characteristics, clinical symptoms, personality traits, and attitudes toward their illness and the taking of medication (the latter via a survey following discontinuation). These patients were matched against a cohort of 103 patients who continued on maintenance medication and who were examined with the same variables.

Results: The patients who dropped out of treatment tended to have more of a belief that they were well and no longer needed medication compared to the control group. They also felt more stigmatized by the illness and the need for medication. Patients who dropped out of treatment tended to have been ill for shorter periods of time and had fewer lifetime affective episodes. Patients who dropped out of treatment had slightly higher cluster B personality traits than the control group.

Conclusion: Implications of these findings (interpersonal chaos, family disruption, financial crises) and the reversal of noncompliance through experience with the illness and education will be discussed.

REFERENCES:

1. Jamison KR, Akiskal HS: Medication compliance in patients with bipolar disorder. Psychiatric Clinics of North America 1983;6:27–38.
2. Post RM: Issues in the long-term management of bipolar affective illness. Psychiatric Annals 1993;154:396–399.

SCIENTIFIC AND CLINICAL REPORT SESSION 21—ADHD AND SAVANT SYNDROME

No. 62
LONG-TERM TREATMENT OF ADHD WITH OROS METHYLPHENIDATE

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the long-term effectiveness of OROS® methylphenidate for ADHD; to identify side effects reported with long-term OROS® methylphenidate treatment

SUMMARY:

Objective: To evaluate long-term safety and effectiveness of OROS® methylphenidate hydrochloride (MPH), a new once-a-day, 12-hour, controlled-release formulation of methylphenidate, in ADHD children.

Methods: After participation in blinded trials evaluating the short-term effectiveness of OROS® (MPH) and Ritalin® t.i.d. in ADHD for one month, 410 patients aged 6–13 received once-daily OROS® (MPH) treatment for up to eight months. Treatment effectiveness was assessed in multiple settings by multiple raters using standardized tests.

Results: Treatment effectiveness with OROS® (MPH) was sustained over the treatment period. Mean Iowa Conners I/O subscale scores were comparable to those seen for previous OROS® (MPH) (5.67 vs. 5.88) and Ritalin® (5.44 vs. 5.91) treatments. Patients previously treated with placebo showed a significant improvement in scores with OROS® (MPH) treatment (10.12 to 5.98). OROS® (MPH) was well tolerated, with a safety profile similar to that for shorter treatment durations of OROS® (MPH). Adverse events most frequently reported (headache, insomnia, appetite suppression) are well-known effects of methylphenidate in children.

Conclusions: Once-daily OROS® (MPH) treatment was well tolerated and effective in treating ADHD over the long term. No new safety issues arose with OROS® (MPH).

Study funding: ALZA Corporation, Crescendo Pharmaceuticals Corporation.

REFERENCES:

1. Wilens TE, Biederman J: The stimulants. In: The Psychiatric Clinics of North America. Edited by Shafferd. Philadelphia, WB Saunders, 1992; pp. 191–222.
2. Spencer T, Biederman J, Wilens T, et al: Pharmacotherapy of ADHD across the lifecycle. J Am Acad Child Adolesc Psychiatry 1996;35:409–432.

No. 63
ADHD AND DEPRESSIVE SUBTYPES AMONG ADULTS WITH MAJOR DEPRESSION

Jonathan E. Alpert, M.D., *Department of Psychiatry, Massachusetts General Hospital, WAC-815, 15 Parkman Street, Boston, MA 02114;* Karen E. Kelly, B.A., Amy Farabaugh, M.A., Shamsah B. Sonawalla, M.D., Andrew A. Nierenberg, M.D., David Mischoulon, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the prevalence of ADHD comorbidity among adults with major depression and the association of ADHD with particular depressive subtypes.

SUMMARY:

Objective: Although ADHD is frequently comorbid with major depressive disorder (MDD), very little is known about the prevalence of ADHD across particular subtypes of depression.

Methods: We assessed symptoms of ADHD as defined by DSM-III-R among 348 adults with MDD aged 18–64 (55% female) consecutively enrolled in an antidepressant treatment trial who were also evaluated for depressive subtypes. The SCID-P was administered to all subjects at baseline. In addition, subjects were evaluated for the presence of melancholia by DSM-III-R criteria, atypical depression as defined by the Columbia Atypical Depression Diagnostic Scale, Anger Attacks (''hostile/irritable depression''), comorbid anxiety disorders (''anxious depression''), early age of onset (<18 years), and comorbid dysthymia (''double depression'').

Results: 90 depressed subjects (48% female) met full or subsyndromal lifetime criteria for ADHD, representing 26% of the total sample. ADHD was more common in subjects with atypical depression and comorbid dysthymia than among subjects without those subtypes; (32% vs 22%; $p < .04$; 35% vs 23%; $p < 03$, respectively). There was also a trend for patients with anger attacks to show a higher prevalence of ADHD than those without ($p = .054$). However, there was no difference in ADHD prevalence between depressed subjects with and without melancholia, comorbid anxiety disorders, and an early age of onset.

Conclusion: Within a sample of adults presenting for treatment of major depression, the prevalence of ADHD is likely to be relatively high, and the strength of association between ADHD and MDD may differ across depressive subtypes. Evaluation for ADHD comorbidity appears to be particularly crucial among adult patients with atypical, double, and hostile/irritable depression.

REFERENCES:

1. Alpert JE, Maddocks A, Nierenberg AA, et al: Attention deficit hyperactivity disorder in childood among adults with major depression. Psychiatry Research 1996;62:213–219.
2. Fava M, Uebelacker LA, Alpert JE, et al: Major depressive subtypes and treatment response. Biological Psychiatry 1997;42:568–576.

No. 64
SAVANT SYNDROME: GENIUS AMONG US, GENIUS WITHIN US?

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify etiologic considerations, clinical features, incidence, male:female ratios, typical skills and characteristic memory functioning in savant syndrome as it occurs in autistic disorder or other forms of developmental disability; to discuss implications for better understanding brain function overall.

SUMMARY:

Thirty-six years ago at the 1964 APA Annual Meeting a discussant concluded "the importance of the idiot savant lies in our inability to explain him." Interest in the fascinating condition of savant syndrome has accelerated markedly since the movie "Rain Man" made autistic savant a household word. This paper is an update on what we do now know about savant syndrome and summarizes our progress to date in explaining him, or her, as an update to my 1988 review article with new cases, new research findings, imaging studies, and new implications for understanding brain function, particularly memory. Adding research interest are five newly reported cases by Miller of elderly persons with frontotemporal dementia who acquired new savant-like artistic skills as the dementia unfolded. While emergence of new savant skills (acquired savantism) following CNS injury or disease in early life has been reported earlier, the uncovering of such new skills in older adults with dementia raises interesting new questions about buried potential in all of us. The imaging and other findings in these older adults mirror those findings to date in younger savants. We are making progress in explaining savant syndrome, and this paper summarizes where we are in that journey a century after Down first described this intriguing condition.

REFERENCES:

1. Treffert DA: The idiot savant: a review of the syndrome. American Journal of Psychiatry 1988;145:563–572.
2. Miller BL, Cummings J, Mishkin F, et al: Emergence of artistic talent in frontotemporal dementia. Neurology 1998;51:978–982.

SCIENTIFIC AND CLINICAL REPORT SESSION 22—DIAGNOSTIC ISSUES AND PERSONALITY DISORDERS

No. 65
A 25-YEAR FOLLOW-UP OF BPD: PRELIMINARY FINDINGS

Joel F. Paris, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote St. Catherine Road, Montreal, PQ H3T 1E4, Canada;* Hallie Zweig-Frank, Ph.D.

SUMMARY:

Objective: To study the long-term outcome of borderline personality disorder.

Methods: In an ongoing research project, 50 patients diagnosed with BPD (out of 100 followed in 1986) were examined after a mean follow-up interval of 27 years. Assessment includes rediagnosis by the Diagnostic Interview for Borderlines, revised, the SCID, and global outcome scores (GAF).

Results: Only four patients (8%) still met criteria for BPD; nine met criteria for a mood disorder, while only two still had active substance abuse. The mean global outcome score for the cohort was 63.3 (± 13.0). Patients could be divided into three groups: fully recovered (n = 19), clearly improved (n = 21), and unimproved (n = 10). The suicide rate for the project as a whole has now reached 11%.

Conclusions: More patients have recovered from BPD after 25 years than at a 15-year follow-up.

REFERENCES:

1. Paris J, Brown R, Nowlis D: Long-term follow-up of borderline patients in a general hospital. Comp Psych 1987;28:530–535.
2. McGlashan TH: Implications of outcome research for the treatment of borderline personality disorder. In: Borderline Personality Disorder: Etiology and Treatment, edited by Paris J. Washington, DC, American Psychiatric Press, 1993, pp 235–260.

No. 66
DSM-IV PERSONALITY DISORDER CRITERIA: DIAGNOSTIC EFFICIENCY

Carlos M. Grilo, Ph.D., *Department of Psychiatry, Yale Psychiatric Institute, PO Box 208038/184 Liberty St., New Haven, CT 06519;* Thomas H. McGlashan, M.D., Leslie C. Morey, Ph.D., Andrew E. Skodol II, M.D., M. Tracie Shea, Ph.D., John G. Gunderson, M.D., Mary C. Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize clinical and research issues specific to the diagnosis of personality disorders.

SUMMARY:

Objective: To evaluate the performance of DSM-IV Axis II personality disorder (PD) criteria sets.

Method: The Collaborative Longitudinal Personality Study (CLPS) reliably assessed 668 adults with the semistructured Diagnostic Interview for Personality Disorders—DSM-IV Version (DIPD-IV). Within-category cohesiveness (internal consistency) of the criteria was evaluated by Cronbach's alpha and median intercriterion correlations (MIC). Between-category criterion overlap was evaluated by examining intercategory median intercriterion correlations between (ICMIC) all pairs of PD. Diagnostic efficiency statistics (sensitivity, specificity, positive and negative predictive power) for the four primary CLPS PD study groups (schizotypal, borderline, avoidant, and obsessive-compulsive) were calculated.

Results: Cronbach's alpha, ranged from .47 to .87 (median = .71); seven of the 10 DSM-IV diagnoses had alphas greater than .70. Between-category criterion overlap was evaluated by examining "intercategory" median intercriterion correlations between all pairs of disorders (ICMIC). ICMIC values (median = .08) were substantially lower than MIC values (median = .23) for the PD diagnoses. Diagnostic efficiency statistics will be presented for the four CLPS PD groups.

Conclusions: The findings suggest that the PD criteria sets have some convergent validity (as indicated by acceptable alphas) and that the PD criteria have discriminant validity as well—criteria for PDs correlate better with each other than with the criteria for other

PDs. Diagnostic efficacy findings can inform future revisons of the DSM.

REFERENCES:

1. Becker DF, Grilo CM, Morey LC, et al: Applicability of personality disorder criteria to hospitalized adolescents: evaluation of internal consistency and criterion overlap. J Am Acad Child Adolesc Psychiatry 1999;38:200–205.
2. Morey LC: Personality disorders in DSM-III and DSM-III-R: convergence, coverage, and internal consistency. Am J Psychiatry 1988;145:573–577.

No. 67
STABILITY OF PERSONALITY DISORDER DIAGNOSES IN REMITTED DEPRESSED OUTPATIENTS

Amy Farabaugh, M.A., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-812, Boston, MA 02114;* Gabrielle I. Siegel, B.A., Joel Pava, Ph.D., Jonathan E. Alpert, M.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

The participant will become familiar with the stability of personality disorder diagnoses among patients whose depression has gone into remission.

SUMMARY:

The aim of this study was to assess the stability of personality disorder diagnoses in remitted depressed patients.

Method: 129 outpatients (71 women; mean age: 40.16 ± 10.17 years), who were treatment responders in an eight-week open trial of fluoxetine 20 mg/day and were enrolled in a 26-week continuation clinical trial comparing the efficacy of fluoxetine and cognitive behavioral therapy (CBT). Personality disorders were assessed using the Structured Clinical Interview for DSM-III-R Axis II Disorders (SCID) before and after antidepressant continuation treatment with fluoxetine.

Results: At baseline, 61 remitted depressive outpatients (47%) had at least one personality disorder. Thirty-three outpatients had one personality disorder, 10 outpatients had two personality disorders, and 18 outpatients had three or more personality disorders. With regards to clusters, 19 (15%) had at least one Cluster A diagnosis, 17 (13%) had at least one Cluster B diagnosis, and 50 (39%) had at least one Cluster C diagnosis. Seventy-five outpatients, who completed 26 weeks of treatment for remitted depression, were reassessed with the SCID-II. Thirty (40%) met criteria for at least one comorbid personality disorder. There was no significant (McNemar Test; $p < .05$) reduction in the proportion of patients meeting criteria for any personality disorder or for any cluster.

Conclusion: A relative stability of personality disorder diagnoses in remitted depressed patients was suggested by our study.

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SCIENTIFIC AND CLINICAL REPORT SESSION 23—NICOTINE DEPENDENCE

No. 68
SHORT-TERM NICOTINE PATCH USE: IS IT EFFECTIVE?

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the advantages and disadvantages of short-term nicotine patch use for smoking cessation and to use this information to guide treatment decisions.

SUMMARY:

Objective: This study was designed to investigate the effectiveness of a short-term course of nicotine patches for smoking cessation.

Method: All persons who presented to a smoking cessation clinic and agreed to participate were screened. Those meeting eligibility criteria were randomly assigned to receive either four (experimental) or 10 (standard) weeks of tapering-dose nicotine patches. Expired carbon monoxide was monitored as was self-report of smoking. Subjects who had no evidence of smoking after 16 weeks were defined as having "successfully quit".

Results: Of the 375 subjects who entered the study, 147 completed the study, 72 in the experimental group and 75 in the standard group. The groups were similar demographically. Among those who completed the study, 40% in the experimental group quit while 24% in the standard group quit. This difference was statistically significant ($p = .034$).

Conclusion: Subjects who received a short course of nicotine patches were more likely to quit smoking than those who received a longer course. This suggests that short-term nicotine patch use can be useful in smoking cessation.

Funding Source: The Chief, Navy Bureau of Medicine and Surgery, Washington, DC, Clinical Investigation Program sponsored this study (CIP #P93-HH00000-033:N).

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No. 69
CORRELATES OF CIGARETTE SMOKING IN SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the high prevalence and clinical characteristics of cigarette smoking in patients with schizophrenia; to recognize that patients with schizophrenia have often made numerous unsuccessful attempts to quit smoking and may have a desire to quit even when hospitalized on smoke-free units.

SUMMARY:

When admitted to smoke-free psychiatric units, patients with schizophrenia who smoke may experience severe symptoms of nicotine withdrawal.

Objectives: The purpose of the present study was to examine the clinical correlates of cigarette smoking and nicotine withdrawal in this patient population.

Method: The authors studied 21 patients (all smokers) who were admitted to the inpatient psychiatric unit of a general hospital in mid-Michigan with the diagnosis of schizophrenia. A psychiatrist examined the patients, confirmed the DSM-IV psychiatric diagnosis of schizophrenia, and completed the Positive and Negative Syndrome Scale (PANSS). The patients completed a smoking questionnaire and the Fagerstrom Nicotine Tolerance Questionnaire.

Results: The majority of patients had made several previous attempts to quit smoking. Nine of the 21 patients (42%) expressed a desire to quit smoking. The mean total PANSS score was 102. The total PANSS score did not correlate with desire to quit, the severity of withdrawal symptoms, or the Fagerstrom Index. However, the PANSS negative symptom subscore correlated with the Fagerstrom Index ($r = 0.56$; $p < 0.05$).

Conclusion: Many patients hospitalized with schizophrenia desire to quit smoking. They may smoke to counteract negative symptoms such as anhedonia, alogia, and avolition. Possible clinical and therapeutic implications of this finding will be presented.

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No. 70
DETOXIFICATION FROM NICOTINE DEPENDENCE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be informed of the effect of inhaled nitrous oxide on cigarette smoking.

SUMMARY:

Objective: An open trial to determine the effectiveness of nitrous oxide (N_2O) in reducing cigarette smoking in subjects with nicotine dependence.

Method: Seven subjects were administered analgesic doses of N_2O after refraining from smoking overnight. N_2O was administered by an anesthesiologist using a facial mask. The dose was titrated upward until subjects reported the absence of craving or until a dose of 3L/minute was reached. Subjects kept daily diaries recording the number of cigarettes during the three days before and after N_2O administration. Urine samples were obtained for cotinine levels.

Results: Daily average cigarette consumption decreased from 17.1 (sd = 7.6) before N_2O to 2.6 (sd = 3.42) following the procedure ($t = 9.04$, $df = 6$, $P < 0.0001$). All seven subjects reported decreased cigarette consumption, and five (71%) reported they had discontinued smoking entirely. Reductions in cigarettes smoked were highly correlated with decreases in cotinine levels (spearman $r = 0.94$, $p < 0.0051$). Three-month follow-up interviews revealed four of the seven subjects had remained abstinent (57%).

Conclusion: An open trial of a single exposure to N_2O was associated with decreased smoking in smokers who volunteered for the experiment. The results suggest N_2O might be a useful discontinuation strategy for transitioning patients into longer-term treatment.

Funding source: department of psychiatry of Weill Cornell Medical School.

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SCIENTIFIC AND CLINICAL REPORT SESSION 24—NEW ISSUES IN SUBSTANCE ABUSE

No. 71
CHILDHOOD PHYSICAL ABUSE: EFFECTS ON ADDICTION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to know demographic characteristics of substance abuse patients who are apt to have experienced physical abuse in childhood, identify morbid effects of childhood physical abuse on course and severity of substance abuse, and acquire awareness regarding morbidity and treatment patterns associated with childhood physical abuse.

SUMMARY:

Objective: To assess the morbidity of substance related disorder (SRD) in relation to childhood physical abuse (CPA).

Design: Current and retrospective data, comparison of CPA with non-CPA.

Setting: Two university medical centers with alcohol-drug programs.

Subjects: 642 patients, of whom 195 (30%) experienced CPA and 447 (70%) did not.

Methods: A research assistant obtained demographic data, family history of substance abuse, problems related to substance abuse, and treatment of substance abuse, SRD severity measures also included one patient-rated scale, one interviewer-rated scale, and two psychiatrist-rated measures.

Results: Patients with CPA were more apt to be women, have lower socioeconomic status, and have more familial substance abuse. Their substance abuse was more severe on five out of six indices of severity. On measures of lifetime treatment for substance abuse, patients with CPA showed more lifetime treatment on three out of four measures.

Conclusions: Physical abuse during childhood resulted in greater severity of substance abuse and a more morbid course of substance abuse later in adulthood. Although female gender and lower SES were both associated with CPA, the relationships were separate (i.e., women did not have lower SES).

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1. Windle M, Windle RC, Scheidt DM, Miller GB: Physical and sexual abuse and associated mental disorders among alcohol inpatients. American Journal Psychiatry. 1995;152:1322–1328.

2. Mulder RT, Beautrais AL, Joyce PR, Fergusson DM: Relationship between dissociation, childhood sexual abuse, childhood physical abuse, and mental illness in a general population. American Journal Psychiatry. 1998;155:806–811.

No. 72
BIOMARKERS TO EVALUATE TREATMENT FOR ALCOHOLISM

John P. Allen, Ph.D., *Treatment Research Br., NIAAA, Willco Bldg., 6000 Executive Blvd. Suite 505, Bethesda, MD 20892-7003;* Raye Z. Litten, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to learn how to appropriately use lab tests to assess relapse status of alcoholic patients.

SUMMARY:

Objective: To summarize findings of controlled studies on use of biochemical markers as aids to recognition of relapse to drinking by alcoholics in treatment.

Method: Review of eight controlled research investigation on biomarkers of alcohol relapse.

Results: 1) All eight studies demonstrated that carbohydrate deficient transferrin (CDT) and gamma glutamyl transpeptidase (GGT) elevate following relapse of alcoholics in treatment; 2) CDT appears to have a shorter latency and a more acute rise following relapse; 3) Elevation in CDT typically precedes verbal acknowledgment of relapse by the patient by up to 40 days on average; 4) GGT is preferable to CDT as a relapse marker in women; and 5) The two tests should be used in combination.

Conclusions: Consideration of status on biochemical markers improves clinical judgment of progress of alcoholics in treatment and can suggest the need for modifying the nature or intensity of the intervention.

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No. 73
HIGH- VERSUS LOW-STRUCTURE INDIVIDUAL COUNSELING FOR SUBSTANCE ABUSE: A CONTROLLED COMPARISON

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that equal numbers of patients do well when treated by high and low structure counseling styles and that we are unable to predict which patients will do better in which styles.

SUMMARY:

Objective: Although controlled clinical trials have provided more support for behavior therapies, less-structured approaches continue to be widely used. Thus, our main objectives were to compare the effectiveness of a high-structure, behaviorally oriented (HSB) with a low-structure, facilitative (LSF) treatment style and to determine whether drug use severity or demographic characteristics were associated with doing better in HSB or LSF.

Method: A difficulty in comparing these treatment styles directly in clinical trials has been the problem of manualizing low-structure approaches. We did develop LSF and HSB manuals and adherence rating scales, however, and found that counselors could learn and deliver them in a consistent and distinct manner. Using a counterbalanced design to control for potential counselor effects, 80 volunteer substance-dependent patients were randomly assigned to HSF and LSF and treated in once-weekly individual counseling.

Results: Significant symptom reduction occurred for patients treated in both HSB and LSF. However, no significant differences between HSB and LSF were found in degree of symptom reduction, treatment retention, negative urines, counselor assessments, and patient benefit ratings. Neither drug severity nor demographic variables were associated with doing better in HSB or LSF.

Conclusion: Patients improved when treated by either HSB or LSF. We are proceeding to explore whether particular coping and/or motivational variables will predict which patients will do better when treated in high- or low-structure therapy.

Funding Source: NIDA Grant #501 DA8527

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SCIENTIFIC AND CLINICAL REPORT SESSION 25—ACQUIRED IMMUNE DEFICIENCY SYNDROME AND HUMAN IMMUNODEFICIENCY VIRUS: RELATED DISORDERS

No. 74
GROUP THERAPY, DEPRESSION, AND CD4 IN AN HIV-POSITIVE PERSON

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize significance of depression in treating persons with HIV infection; to recognize possible mechanisms linking depression and CD4 cell count in HIV+ persons.

SUMMARY:

Objective: Preliminary analysis of the effectiveness of group therapy in our study indicates that this intervention is linked to a significant improvement in immunity in the first year after randomization.

Method: These results are based on the coded medical records of 25 persons who participated in this study. These results are based on the analysis of the follow-up slopes, using an intention-to-treat analysis. Baseline immunity, viral load, and whether or not the person was on HAART therapy were statistically controlled.

Results: Using slope analysis across all available follow-ups for each participant, we found that individuals in the group therapy condition showed a significant increase on CD4 cell count ($p < .01$) and on the CD4/CD8 ratio ($p < .05$). The mean expected CD4 cell

count at 12 months showed a mean increase of 20% in CD4 cell count in the group therapy condition compared with an increase of 1% in the educational control condition. Furthermore, the increase in CD4 cell count is related to a decrease in depression ($r = -.27$).

Conclusion: These results extend previous research by demonstrating a longitudinal change in immunity that is associated with the effect of group therapy in reducing depression in HIV-positive persons.

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No. 75
PSYCHIATRIC SERVICE UTILIZATION BY HIV-POSITIVE PATIENTS

John M. Budin, M.D., *Department of Psychiatry, Montefiore Medical Center, 390 West End Avenue, Suite 1-H, New York, NY 10024;* Sarah Boslaugh, Ph.D., Mark Winiarski, Ph.D., Emily Beckett

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize patterns of psychiatric utilization for HIV+ persons of color; recognize aspects of integrated and culturally responsive care that affects such utilization; recognize strategies that increase utilization of psychiatric services by HIV+ persons of color.

SUMMARY:

Objective: This study describes utilization of psychiatric services by HIV+ persons of color in a primary care setting.

Methods: HIV+ patients in a primary care clinic in the Bronx, New York, were referred to an on-site, culturally responsive, mental health program.

Results: Of the 91 patients referred for psychiatric services (71.4% Latino/a, 25.3% African American, 2.2% Caucasian, 1.1% Asian), 78 (85.7%) saw the psychiatrist at least once. Fifty-eight patients (74.7%) were "brief utilizers" (five visits or fewer) while the remaining 20 (25.6%) were "chronic utilizers" (six visits or more) but accounted for 66.5% of the total clinical time. The 63 patients (80.8%) who received psychotropic medication were significantly more likely ($p < .011$, $x^2 = 6.404$) to be "chronic utilizers" of psychiatric care.

Conclusions: HIV+ persons of color use psychiatric services at high rates in our culturally responsive mental health program. We suspect that two distinct groups of patients are receiving psychiatric care: the great majority, who see the psychiatrist for fewer visits, and the remaining minority, who see the psychiatrist on a more chronic basis and thereby utilize a disproportionate amount of the clinical services.

Funding Source: Ryan White CARE Act Title V. Special Projects of National Significance BRH 970178-02-0.

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No. 76
PSYCHIATRIC DISORDERS IN INJECTING DRUG USERS INFECTED WITH HIV

Andre Malbergier, M.D., *Department of Psychiatry, University of Sao Paulo, Grea-Ipqp-R Ovidio Pires Campos S/N, Sao Paulo, SP 05403-010, Brazil*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the specific characteristics of psychiatric disorders diagnosis in cocaine-injecting drug users infected and noninfected with HIV. Public health policy makers should consider the need for the presence of psychiatry in the AIDS treatment setting, based on the high prevalence of psychiatric illnesses in this sample.

SUMMARY:

Objective: In Brazil, the most-used injection drug is cocaine, and the generalization of study results on heroin users for the cocaine-injecting drug users (IDU) population is questionable. This research intends to study the prevalence of psychiatric disorders (depression, anxiety, suicide attempts, cognitive deficits) in HIV-infected IDUs compared with noninfected IDUs.

Method: IDUs entering treatment for drug dependence in São Paulo, Brazil were selected in two groups according to the HIV status (HIV-positive and HIV-negative). Thirty patients were assigned to each group. After at least 15 days of drug abstinence, the patients were given a structured interview (CIDI-WHO-ADAMHA) to assess psychiatric disorders. The disorders were classified as "lifetime", "history" (if present in any period of the patients' life but not in the month before the interview), "current" (if present in the month before the interview).

Results: The results revealed that the cocaine-dependence diagnosis was more frequent in HIV-infected patients than in the noninfected. Being HIV-positive was not associated with higher prevalence of depression. Anxiety disorders were more frequent in HIV-negative patients. The frequency of suicide attempts was equal in the two groups.

Conclusions: Being HIV-positive was not associated with higher prevalence of psychiatric disorders in this sample.

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SCIENTIFIC AND CLINICAL REPORT SESSION 26—ISSUES IN SLEEP AND OUTCOME RESEARCH

No. 77
OPEN INFRASTRUCTURE FOR OUTCOME RESEARCH

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the merits and limitations of open vs. closed information infrastructures for outcome research; to describe the compo-

nents of an information infrastructure that is both publicly sharable and preserves the patients' confidentiality.

SUMMARY:

Objective: The collection of quantitative outcome measures for ordinary clinical services will more likely take place when the human and fiscal costs of data collection, management, and analysis are lowered. A shared, public infrastructure that allows the pooling of expertise, assessment instruments, data management, training, quality assurance, and reporting tools is a way to reduce the cost of conducting outcome assessments.

Method: We describe the goals, overall design, and Year-1 progress of the Open Infrastructure for Outcomes (OIO) project. We used the public Internet, open source software, and a user-extensible architecture to create an environment for the sharing of expertise, assessment instruments, data management, and data analysis services.

Results: We have completed the development of an Internet-accessible server, object-relational database system, object-application server, and other software components. We have completed the design of the patient-tracking module and a novel architecture for the protection of patient confidentiality. We are beginning the validation of the core components in ongoing clinical studies. We will release OIO for public testing and adaptation in 2000.

Conclusion: An open and public infrastructure is essential for the sharing of outcome research tools and resources. The OIO is a step towards the realization of that goal. (WWW.TxOutcome.org)

REFERENCES:

1. Ho A: Patient-Controlled Electronic Medical Records, 1998 American Psychiatric Association Institute on Psychiatric Services, Los Angeles, October 1998
2. Ho A: A Secret Splitting Method for the Protection of Confidentiality in Computer Records, 13th International Federation of Information Processing (IFIP) WG 11.3 Working Conference on Database Security, Seattle, Washington, July, 1999.

No. 78
DRUG TREATMENT OF CHRONIC INSOMNIA: CASE STUDIES

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participants will recognize the potential value of careful long-term medicinal treatment of chronic insomnia and the need for controlled long-term drug trials.

SUMMARY:

Introduction: While 90% of adults complain of chronic insomnia, often associated with considerable morbidity, medicinal treatment is approved only for short-term use. Few clinical data are available on the long-term use of hypnotic medication for chronic insomnia.

Method: An examination of the clinical experience at the Bethesda Hospital Sleep Clinic in Cincinnati in treating 1) 150 sleep-laboratory-diagnosed clinic insomniacs with medications e.g. benzodiazepines and sedative antidepressants (group A), (2) 105 chronic insomniacs with behavioral techniques (group B), and (3) 72 psychiatrically ill patients with insomnia with a combination of medication and behavioral techniques (group C). Group A was treated for one to 90 months, group B for one to 12 months, and group C for two months.

Results: 61.3% of the medication-treated insomniacs were improved at the last clinical contact as were 62% of the behaviorally treated and 60.5% of the psychiatric patients treated with a combined approach. At follow-up two years later, 36% of group A were still improved. Six to 70 months after last clinical contact 39% of group B were still improved, but 78% of these patients were also on hypnotic medication. Group C at six months had 72.6% improved, but 74% of those improved were also on hypnotic medication. Troublesome side effects, mounting drug doses, and significant drug interactions were minimal or absent.

Impression: In clinical case series, long-term medicinal treatment of chronic insomnia is effective. Combining medication with systematic behavioral techniques increases effectiveness. Controlled studies of long-term drug therapy for insomnia is necessary and remains to be done.

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1. Kramer M, Bailey S, Sepate M: Long-term medicinal treatment of insomnia: a followup study. Sleep Research 1995;24:266.
2. Dashevsky B, Kramer M: Behavioral treatment of chronic insomnia in psychiatrically ill patients. J. Clin Psychiatry 1998;59:693–699.

No. 79
THE CONTEXTUALIZING IMAGE: THE CENTER OF THE DREAM

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be familiar with the concept of the contextualizing image—a powerful image in the dream that pictures the underlying emotion of the dreamer. They should be aware of a number of sources of data supporting the idea that the contextualizing image is the nucleus, or center, of the dream.

SUMMARY:

The contextualizing image (CI) is a central, powerful image in a dream that appears to picture (contextualize) the emotional state of the dreamer. In the paradigmatic case, people after a variety of trauma dream, "I was overwhelmed by a tidal wave." This does not describe their actual experience, but pictures the underlying emotion of terror or helplessness. Though seen most easily when there is one powerful emotion, we believe that the CI is the central feature of all dreams.

Objective: To present four different studies characterizing CIs.

Methods and Results: A system for scoring CIs in dream reports was developed, which shows good inter-rater reliability (r's ranging from .70 to .90). CIs are rated from "0" (no CI) to "3" (most powerful CI). *Study 1* examined 160 written dreams and daydreams of 40 normal students. CI scores were significantly higher (about twice as high) for dreams as for daydreams. *Study 2* compared reports obtained in similar fashion from REM sleep, non-REM sleep, sleep onset, and waking periods: a total of 563 reports from 14 students. CI scores were significantly higher in REM than NREM sleep reports, NREM scored significantly higher than sleep onset or waking. *Study 3* compared "most recent dreams" of 286 students with dreams series collected from 10 persons who had undergone recent trauma. Overall CI scores were significantly higher after trauma. The mean CI in each trauma victim was higher than the student mean. In *Study 4* comparisons were made within the same group of 286 students. CI scores were found to be significantly higher in students who had reported either physical or sexual abuse on a questionnaire compared with students who had not.

Conclusions: CIs in dreams can be scored reliably. The scores are higher in dreams than in daydreams, higher in REM sleep reports than in other reports, and higher in dreams after trauma. This supports the idea that CIs are central to dreams. They are more prominent in dreams than in other material, and they are especially prominent when powerful emotions are present.

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1. Hartmann E: Outline for a theory on the nature and functions of dreaming. Dreaming, 1996;6:147–170.
2. Hartmann E: Dreams and Nightmares: The New Theory on the Origin and Meaning of Dreams. New York, Plenum Press, 1998.

SCIENTIFIC AND CLINICAL REPORT SESSION 27—PANIC DISORDER

No. 80
MEDICATION DISCONTINUATION IN PANIC DISORDER

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the appropriateness of medication discontinuation for panic-free patients and to see if there are predictors for these patients that delay relapse.

SUMMARY:

Objective: Though various pharmacological and cognitive-behavioral treatments are effective in short-term treatment of panic attacks, use of long-term medication for panic disorder remains unstudied. Also important is the relapse rate for panic disorder after medication discontinuation.

Method: To date we have followed 58 patients who after 12 weeks of initial pharmacotherapy (antidepressants or anxiolytics + antidepressants) recovered with a complete cessation of full-blown panic attacks were followed over a succeeding 12–48 month period (average 36 months) on the medication to which they had responded. At this point, based on the mutual consent of the patient and M.D., the patients were gradually discontinued from medication. They were then followed until one of three outcomes—termination well (all patients continuously well until July 31, 1999 the endpoint of this preliminary analysis), dropout, or relapse with relapse being defined as having a breakthrough full-blown attack. For all these patients at baseline and at three-month intervals, the patient was rated with the Hamilton Anxiety Scale, Panic Inventory, Montgomery-Asberg Depression Scale, and CGI rating for anticipatory anxiety, phobic avoidance, spontaneous panic attacks, functional impairment, and overall severity of illness.

Results: 35/58 patients (60.4%) discontinued from medication relapsed with a full-blown attack within one year of discontinuation. Phobic avoidance and initial degree and severity of anticipatory anxiety correlated negatively with length of time free of a full-blown attack. It did appear that patients who received CBT treatment in addition to pharmacotherapy had better outcomes. Patients who required anxiolytics + antidepressants during prophylaxis fared less well.

Conclusion: There was significant relapse of panic disorder following medication discontinuation.

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2. Mavissakalian MR, Perel JM, deGroot C: Imipramine treatment of panic disorder with agoraphobia: the second time around. Journal of Psychiatric Research 1993;27:61–68.

No. 81
BURDEN OF SIDE EFFECTS OF IMIPRAMINE TREATMENT OF PANIC DISORDER

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the patterns of change in side effects and to gauge the side-effect burden of extended imipramine treatment in panic disorder.

SUMMARY:

Objective: The aim of the study was to investigate in detail the side-effect burden of imipramine treatment in 110 patients with panic disorder with agoraphobia who started a fixed-targeted, weight-adjusted dose of 2.25 mg/kg/day; 59 of them adhered to this regimen and showed marked and stable response.

Method: Hierarchical linear modeling, which has several advantages over repeated measures of analysis of variances for studying change over time, was used on data collected at the single-blind, placebo baseline assessment and at weeks 1, 2, 4, 6, and 8 of acute treatment and weeks 16 and 24 of extended treatment. Deviations from the general pattern were explored by considering only severe side effects or only treatment completers to better gauge the clinical significance of the findings.

Results: Of 15 complaints systematically elicited using a side-effects inventory, only dry mouth, sweating, and constipation continued to be a substantial burden at the end of six months of treatment. On most other items, the initial increase was followed by a decrease to lower than baseline at the end of treatment. In the case of nausea, vomiting, increased energy, headache, and sexual disorders, the complaints were at their worst before treatment started and improved over the course of treatment. Sustained heart rate elevation between 10–15 beats per minute, but no significant effects on blood pressure or weight was found.

Discussion: The results will be placed in the context of the available comparative studies with SSRIs in panic disorder.

This study is being funding by NIMH.

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2. Baldwin DS, Birtwistle J: The side-effect burden associated with drug treatment of panic disorder. J Clin Psychiatry 1998;59(suppl 8):39–44.

No. 82
BRAIN ELECTRICAL MICROSTATES IN PANIC DISORDER

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the role of a reduced efficiency of right hemisphere cognitive modalities in the pathogenesis of panic disorder.

SUMMARY:

Objective: Brain electrical microstates (spatial configurations of momentary maps of scalp-recorded brain electrical activity) were

studied in subjects with panic disorder to investigate neural activation patterns associated with cognitive processes.

Method: Fourteen drug-free patients with DSM-IV panic disorder (PD) and 14 matched, healthy subjects participated in the investigation. Brain electrical activity was recorded during a target detection task. Stimuli were tachistoscopically presented to the center of a screen (central condition) and to either hemifield (lateral condition). The positive and negative centroids of the electrical field were calculated for each microstate. Results for the fourth microstate, corresponding to the P300 component of the event-related potentials, are reported.

Results: In the central condition, subjects with PD, compared with controls, showed a rightward shift of the negative and a leftward shift of the positive centroid. The latter abnormality was associated with a worse memory for recurring spatial sequences. In the lateral condition, a significant hemifield effect for the positive centroid was found in the control group, but not in PD subjects. Moreover, in the latter group, the altered topography of the fourth microstate was associated with the number of panic attacks.

Conclusions: The observed topographic abnormalities reflect a reduced efficiency of the right hemisphere cognitive modalities in PD subjects.

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1. Koenig T, Lehmann D: Microstates in language-related brain potentials maps show noun-verb differences. Brain and Language 1996;53:169–182.

THURSDAY, MAY 18, 2000

SCIENTIFIC AND CLINICAL REPORT SESSION 28—DIFFICULT ISSUES IN FORENSIC PSYCHIATRY

No. 83
DETECTION OF MALINGERING WITH THE REY AUDITORY VERBAL LEARNING TEST (RAVLT)

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that assessment of malingering requires objective evaluation methods. The time given to malingering assessment should accord with the forensic examinee population (likely base rate) and indicia of malingering from the use of screening instruments, which also provide clinical data useful for the evaluation of degree of impairment.

SUMMARY:

Detection of potential malingering is a critical component of any forensic psychiatric evaluation. A number of highly regarded objective measures are now commercially available for the evaluation of malingering that clinicians may use confidently. The difficulty with these measures is that they expend valuable time in administration and address only the issue of potential malingering; they contribute little more to understanding the examinee's condition. The protocols of 53 forensic examinees were reviewed in which the Test of Memory Malingering (TOMM) and the Rey Auditory Verbal Learning Test (RAVLT) had been administered. Trials 1 and 2 on the TOMM were used to indicate malingering status. Discriminant function analysis (DFA) was used to predict malingering using RAVLT scores and clinical measures such as medication noncompliance, unreported illicit drug use, and inconsistency in clinical data.

The DFA was successful in classifying more than 90% of the cases using the RAVLT recognition and delayed-recall trials. This illustrates the utility of the RAVLT as a good indicator of likely malingering status. The advantage of using this measure is that meaningful memory and concentration data are still obtained concerning nonmalingerers. Where malingering is indicated, subsequent use of time-consuming specific measures can be justified.

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2. Gutierrez, JM, Gur RC: Detection of malingering using forced-choice techniques, in Detection of Malingering During Head Injury Litigation, edited by Reynolds CR, New York, Plenum Press, 1998, pp. 88–89.

No. 84
CULTURE, ENGLISH PROFICIENCY, AND TRIAL OUTCOME

S. Peter Kim, M.D., *Department of Psychiatry, University of Hawaii Medical School, 1319 Punahou Street 6th floor, Honolulu HI 96826*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should have increased his/her knowledge and understandings of the effects of linguistic and cultural factors of plaintiffs/defendants who have immigrated from Asian countries on their trial outcomes.

SUMMARY:

Objective: The study aims at studying the correlations between degree of acculturation and English proficiency of litigants and their trial outcomes.

Methods: The transcripts of pretrial depositions and court proceedings of consecutive private referrals (N = 14) and randomly selected cases from public defenders' offices (N = 9) over an 18-month period (SS = 23) were studied. English language proficiency was measured by average-per-minute errors (APME) in three areas: sentence/syntax, semantics/pragmatics, pronunciation/enunciation. Country of origin, education level, and number of years in the U.S. were used as referential variables of acculturation degree.

Results: (1) In both the civil cases (CV) group and the criminal cases (CR) group, APME scores are significantly and inversely correlated with trial outcomes ($p < 0.01$ in CV group; $p < 0.001$ in CR group). The high APME scores are correlated significantly with negative trial outcomes (conviction or defeat). (2) In the CR group, subject's age (younger) and trial outcomes (negative) were significantly correlated ($p < 0.05$). (3) Total years of formal education and length of stay in U.S. are significantly correlated in trial outcomes (the longer the positive) in the CR group ($p < 0.05$) but not in the CV group.

Conclusion: English language proficiency is significantly correlated with trial outcomes in both civil and criminal cases, along with some effects of degree of acculturation.

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1. Roy JD: The difficulties of limited-English-proficient individuals in the legal setting. Annals of New York Academy of Sciences 1990;606:73–83.
2. Milroy L: Comprehension and context: successful communication and communication breakdown, in Applied Sociolinguistics, Edited by Trudgill P., New York, Academic Press, 1984, p 8.

No. 85
RESIDENTIAL TREATMENT UNIT: A TWO-YEAR STUDY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate understanding of the RTU concept, recognize the specific problems involved with the practice of psychiatry in a correctional setting, and understand the impact of providing correctional mental health services and the parameters proposed for assessing the outcomes.

SUMMARY:

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

Method: The current study is based on a two-year experience of treating mentally ill offenders in a residential treatment unit (RTU) at Grafton Correctional Institution. Through the analysis of a two-year caseload, the study defines the term RTU and the admission criteria, discusses the referral process, the incidence and prevalence of affections treated since the opening of the unit in 1997 and compares them with the data available for the general population in the prison system and "on the street." Also treatments are compared and specific correctional-psychiatry problems are identified.

Conclusions: The findings support the validity of the RTU concept. The main diagnoses were treatment-resistant schizophrenia, severe mood disorders, and severe personality disorders. An eclectic, multidisciplinary treatment approach is suggested, and the interaction with the correctional staff is discussed.

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2. Wettstein R: Treatment of Offenders with Mental Health Disorders. New York, NY, Guilford Press, 1998.

SCIENTIFIC AND CLINICAL REPORT SESSION 29—DIAGNOSIS AND TREATMENT OF BIPOLAR ILLNESS: PART 2

No. 86
BIPOLAR DEPRESSIVE MIXED STATE: DELINEATION OF A NEGLECTED CONDITION

Giulio Perugi, M.D., *Institute of Psychiatry, Via Roma 67, Pisa 56100, Italy;* Donato Madaro, M.D., Franco Frare, M.D., Barbara Vitale, M.D., Cristina Toni, M.D., Giuseppe Ruffolo, M.D., Hagop S. Akiskal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to acquire information on diagnosis, clinical features, and treatment implications of an understudied subtype of bipolar mixed states that is characterized by full syndromal depression and less-than-syndromal mania.

SUMMARY:

Objective: DSM-IV requires the presence of the criteria for both manic and depressive episodes for diagnosis of bipolar mixed state (MS). In order to delineate a mixed depressive state, which consists of full syndromal depression and less-than-syndromal mania, we proposed more-inclusive criteria for mixed states, based on the concepts of Kraepelin and the Vienna School.

Method: The study population comprised 191 bipolar I inpatients. Diagnosis of MS was made on the basis of the presence of a sustained emotional instability and/or perplexity in which depressive and manic symptoms in the areas of mood, thought, perceptions, or motility are simultaneously present in a fluctuating manner. Moreover, the presence of heightened emotional resonance, anger-hostility, impulse discontrol, or marked sleep or sexual-drive disturbances is required. Eighty-six patients met both ours and DSM-III-R criteria for MS; 32 patients identified by our criteria as mixed state met the DSM-III-R criteria for major depression (D-MS); 36 patients only met the DSM-III-R criteria for major depression (MD).

Results: Depression was the most frequent first episode in MS and MD, and mixed state in D-MS group. The MD group showed a higher mean total number of recurrences than the D-MS and MS. The mean number of past depressive and manic episodes was higher in MD, while mixed state in D-MS and MS. Incongruous psychotic features were more common in the D-MS and MS. Interepisodic remission was significantly lower in D-MS, while rapid cycling was significantly more common in MD compared with the other two groups. The DSM-III-R symptomatological profile of the D-MS subgroup consisted of agitated, mostly psychotic depression with pressured speech and flight of ideas.

Conclusion: Our results support the existence of a subgroup of bipolar mixed states with predominantly depressive features, with important clinical and therapeutic implications.

REFERENCES:

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No. 87
FROM CELL TO PATIENT: ARE THERE COMMON EFFECTS ON MEMBRANE CURRENTS BY ANTICONVULSANTS EFFICACIOUS IN TREATING BIPOLAR RAPID CYCLING?

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have a better understanding of potential links from ion channel modulation to efficacy of a drug in rapid-cycling bipolar disorder. These links will be emphasized by combining our results of the research of mechanisms of action and clinical efficacy of lamotrigine.

SUMMARY:

Objective: Recent studies suggest that the anticonvulsants carbamazepine and valproate may be more efficacious than lithium in treating bipolar rapid cycling. These antiepileptic drugs share common actions on the level of ion channels, namely, activation of a fast transient potassium outward current, and inhibition of voltage gated sodium and calcium channels. Calcium antagonism may be a particularly decisive mechanism for controlling rapid cycling, as the

calcium antagonists nimodipine seems to be an efficacious treatment, too. This supplies a rationale to test potential mood stabilizers for their ion flux modulating properties.

Methods and results: Our electrophysiological in vitro recordings from rat and guinea pig hippocampi demonstrate a similar profile of actions on ion channels for lamotrigine. These findings will be discussed in the light of recent clinical findings on the efficacy of lamotrigine in rapid-cycling bipolar disorder.

Conclusion: It appears that there is a pattern of action on different ion channels that may contribute to efficacy in rapid-cycling bipolar disorder.

Funding source: The Vada & Theodore Stanley Foundation

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2. Walden J, Schärer L, Schlösser S, Grunze H: A naturalistic follow up of patients with bipolar rapid cycling treated with lithium or lamotrigine for mood stabilization. J. Clin. Psychiatry 1999, submitted.

No. 88
ANTICONVULSANT PROPHYLAXIS IN A NATURALISTIC CLINICAL SETTING

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to examine the prophylactic efficacy of depakote and carbamazepine in a naturalistic sample of bipolar patients comparing it with double-blind studies in the literature and with no treatment.

SUMMARY:

Objective: The utility of lithium in the prophylaxis of bipolar illness has been well established. However, lithium has many burdensome side effects including the long-term problem of renal toxicity. Over the last decade, anticonvulsants have been utilized in the acute and long-term treatment of bipolar illness as an alternative to lithium, and it is the purpose of this paper to examine the prophylactic efficacy of depakote and carbamazepine for bipolar disorders in a naturalistic clinical setting.

Method: To date we have followed 54 patients on depakote and 43 patients on carbamazepine who after six months stability of mood were then followed until one of three outcomes—termination well all patients continuously well until Aug 31, 1998 the endpoint of this preliminary analysis), dropout or relapse with relapse being defined as having a breakthrough manic or depressive episode as defined by DSM-IV, requiring either hospitalization or additional or other pharmacotherapy.

Results: Overall 28 of 54 patients on depakote (51.9%) and 19 of 43 on carbamazepine (44.2%) suffered a known affective relapse over a subsequent four-year course. The rates of relapse for manic or depressive relapse was equal for either agent. More patients dropped out on carbamazepine-13/43 (30.2%) vs. 7/54 on depakote (13.0%). Attempts to stabilize 20 of the patients who failed on either mood stabilizer with a manic episode with lithium + anticonvulsant (depakote or carbamazepine) led to a better prophylactic effect.

Conclusion: Depakote and carbamazepine had comparable efficacy in the long-term treatment of bipolar illness. Comparisons between the naturalistic studies in the literature and double-blind studies will be discussed as will possible reasons for these differences.

REFERENCES:

1. Prien RF Gelenberg AJ: Alternatives to lithium for preventive treatment of bipolar disorders. American Journal of Psychiatry 1989;146:840–848.
2. Goldberg JF. Harrow M, Grossman LS: Course and outcome in bipolar affective disorders: a longitudinal follow-up study. American Journal of Psychiatry 1995;152:379–384.

SCIENTIFIC AND CLINICAL REPORT SESSION 30—TREATMENT ISSUES AND MOOD DISORDERS

No. 89
DOUBLE-BLIND STUDY OF HIGH-DOSE FLUOXETINE VERSUS LITHIUM OR DESIPRAMINE AUGMENTATION OF FLUOXETINE IN PARTIAL AND NONRESPONDERS TO FLUOXETINE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will become familiar with strategies commonly used in the treatment of depressed patients refractory to treatment with fluoxetine.

SUMMARY:

Introduction: In a previous study among 41 depressed patients who had not responded to fluoxetine 20 mg/day, 53% of patients treated with high-dose fluoxetine (40–60 mg/day) responded (i.e., their HAM-D-17 score was ≤7) vs. 29% and 25% of patients treated with fluoxetine plus lithium (300–600 mg/day) or fluoxetine plus desipramine (25–50 mg/day), respectively. We wanted to assess whether these findings could be replicated in a larger sample of depressed outpatients.

Methods: We prospectively identified 99 outpatients with major depressive disorder (50 men and 49 women; mean age: 41.6 ± 10.7) who were either partial (n = 48) or nonresponders (n = 51) to eight weeks of treatment with fluoxetine 20 mg/day. These patients were then randomized to four weeks of double-blind treatment with high-dose fluoxetine (40–60 mg/day), fluoxetine plus lithium (300–600 mg/day), or fluoxetine plus desipramine (25–50 mg/day).

Results: In the overall group of patients (n = 99), there was no significant difference in response rates across the three treatment groups (high-dose fluoxetine: 38%; fluoxetine plus desipramine: 34%; fluoxetine plus lithium: 27%). Drop-out rates were also comparable, ranging from 9% (high-dose fluoxetine) to 16% (fluoxetine plus desipramine). There were also no significant differences in response rates across the three treatment groups among partial responders (high-dose fluoxetine: 47%; fluoxetine plus desipramine: 44%; fluoxetine plus lithium: 35%) and nonresponders (high-dose fluoxetine: 32%; fluoxetine plus desipramine: 25%; fluoxetine plus lithium: 19%). At the end of the study, the mean lithium level was 0.45 ± 0.27 meq/l (range: 0.1 to 1.1 meq/l) among lithium-treated patients and the mean desipramine level was 124.6 ± 93.9 ng/ml (range: 25 to 418 ng/ml). There was no significant relationship between lithium or desipramine blood levels and degree of improvement (as measured by the change in HAM-D-17 score).

Conclusion: We found no significant differences in efficacy among these three treatment strategies among patients who have failed to respond to eight weeks of treatment with fluoxetine 20 mg/day. However, the response rates among nonresponders were rather low for all treatment groups, while among partial responders the response

rates were closer to 50%, at least for the high-dose fluoxetine and fluoxetine plus desipramine groups.

REFERENCES:

1. Fava M, Rosenbaum JF, McGrath PJ, et al: A double-blind, controlled study of lithium and tricyclic augmentation of fluoxetine in treatment resistant depression. American Journal of Psychiatry 1994;151:1372–1374.
2. Nelson JC: Augmentation strategies with serotonergic-noradrenergic combinations. J Clin Psychiatry 1998;59(suppl 5):65–69.

No. 90
CHOLESTEROL LEVELS IN MAJOR DEPRESSIVE DISORDER AND RESPONSE TO FLUOXETINE TREATMENT

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that elevated serum cholesterol levels may be associated with a nonresponse to antidepressant treatment.

SUMMARY:

Objective: Previous studies have suggested that patients with major depressive disorder (MDD) may have significant differences in cholesterol levels compared with healthy controls. The purpose of this study was to examine the relationship between levels of serum cholesterol and response to fluoxetine treatment among outpatients with major depression.

Methods: We evaluated 279 drug-free depressed outpatients (144 women; mean age: 40.3 ± 10.1 years) meeting DSM-III-R criteria for major depressive disorder. Non-fasting serum cholesterol levels were assessed for all patients before they started an eight-week open treatment with fluoxetine 20 mg/day. We defined response at least 50% decrease in HAM-D-17 scores at endpoint (week 8) and a HAM-D-17 score of 7 lower at endpoint. Cholesterol levels were classified as either "elevated" (≥ 200 mg/dl, based on the laboratory's reference normal values) or "non-elevated" (< 200 mg/dl).

Results: Among the 279 patients, 154 (55%) were classified as having elevated cholesterol levels. Depressed patients with elevated cholesterol levels did not differ in gender ratio but were significantly ($p < .0001$) older (mean age: 42.6 ± 9.1) than depressed patients with nonelevated cholesterol levels (mean age: 37.5 ± 10.7). After adjusting for age and gender, depressed patients with elevated cholesterol levels were significantly more likely to be nonresponders to fluoxetine treatment than depressed patients with nonelevated cholesterol levels ($t = -2.8$; $p = 0.006$).

Conclusion: Elevated serum cholesterol levels appear to be associated with poorer response to fluoxetine treatment. Further studies are needed to confirm our findings.

REFERENCES:

1. Fava M, Abraham M, Pava J, et al: Cardiovascular risk factors in depression: the role of anxiety and anger. Psychosomatics 1996;37:31–37.
2. Olusi SO, Fido AA: Serum lipid concentrations in patients with major depressive disorder. Biological Psychiatry 1996;40: 1128–31.

No. 91
SSRIs AND TIME OF ONSET OF ANTIDEPRESSANT ACTION

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EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to understand the differences and similarities in the time to onset of antidepressant action of fluoxetine, paroxetine, and sertraline.

SUMMARY:

Background: Whether or not fluoxetine, paroxetine, and sertraline with distinct half-lives have similar times to onset of antidepressant effect has yet to be determined.

Methods: A multicenter, double-blind trial of fluoxetine, paroxetine, and sertraline was conducted to assess differences in discontinuation symptoms in responders who had their antidepressant discontinued suddenly. We performed a secondary analysis from the acute phase to determine time to onset of response. Survival analysis was used to determine time to onset as defined as a 30% decrease in HAM-D scores without any further increase for responders (50% decrease in HAM-D) exclusively. Log-rank tests were used to compare the survival curves for each SSRI, and Cox proportional hazards was used to assess the covariates of time to onset of response.

Results: 92 patients were randomized to fluoxetine, 96 patients to paroxetine, and 96 to sertraline. The proportion of responders were 62%, 67%, and 73% respectively. Log-rank test for differences for time to onset of response between the three survival curves of responders only resulted in $p = 0.76$.

Conclusions: These data suggest no statistically significant differences in the onset of response for responders to either fluoxetine, paroxetine, or sertraline. We found no relationship between time to onset and half-life of SSRIs or their major metabolites. Further analysis will be presented for covariates of response.

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1. Laska EM, Siegel C: Characterizing onset in psychopharmacological clinical trials. Psychopharmacology Bulletin 1995;31:29–35.
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SCIENTIFIC AND CLINICAL REPORT SESSION 31—DIAGNOSTIC AND OUTCOME ISSUES IN DEPRESSION

No. 92
MELANCHOLIA AND AXIS II COMORBIDITY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will learn whether patients who exhibit melancholic features during an episode of major depressive disorder are less likely to have comorbid personality disorders than patients without melancholic features.

SUMMARY:

Objective: While the DSM-III-R classification of melancholic depression included as one of the criteria the absence of personality disorder features, the DSM-IV removed this criterion from the definition of this depressive subtype. However, a recent study by Parker et al. (1998) showed that disordered personality function was less likely to occur among patients with DSM-IV melancholic features compared with nonmelancholic depressed patients. We therefore wanted to assess whether the actual rates of comorbid personality disorders differed between DSM-IV melancholic and nonmelancholic depression.

Methods: We evaluated 253 consecutive depressed outpatients [137 women (54%); mean age: 39.01 ± 10.4 years] with DSM-III-R major depressive disorder. Major depressive disorder was diagnosed with the use of the SCID-P, and enrolled patients were required to have a HAM-D-17 score ≥ 16. The presence of the melancholic subtype of major depression was determined with the use of a DSM-IV checklist.

Results: Of the 98 (39%) patients who met criteria for melancholic depression and the 155 (61%) who did not, there were no significant differences in age, gender, or rates of personality disorder diagnoses. Finally, we observed no significant difference in rates of individual personality disorder clusters between melancholic and nonmelancholic depressed patients.

Conclusion: Our findings support the current classification of melancholic depression, in that it appears that this subtype does not confer any protection against the presence of comorbid personality disorders.

REFERENCES:

1. Amsterdam JD: Selective serotonin reuptake inhibitor efficacy in severe and melancholic depression. Journal of Psychopharmacology 1998;12 Supp. B: 99–111.
2. Parker G, Roussos J, Austin M-P, et al: Disordered personality style: higher rates in non-melancholic compared to melancholic depression. Journal of Affective Disorders 1998;47:131–140.

No. 93
CLINICAL AND DEMOGRAPHIC DIFFERENCES OF NEUROTIC VERSUS NONNEUROTIC DEPRESSIVES

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EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant will be able to understand how neuroticism plays a role in the clinical manifestations of depression.

SUMMARY:

Background: Neuroticism has been clinically defined as a constellation of symptoms and characteristics that develops early in life, predates the onset of depression, and includes frequent worrying, labile mood, somatic reactions to stress, overly strong emotional reactions, and difficulty recovering from such reactions (Eysenck and Eysenck 1994). While all of these characteristics are commonly found in patients diagnosed with major depression, there is evidence that such patients represent a subtype of affective disorders known as neurotic depression.

Objective: The purpose of this study was to compare neurotic and nonneurotic patients meeting criteria for major depression on several demographic and clinical variables.

Method: 47 outpatients, diagnosed with the SCID-I/P as meeting criteria for major depression, were administered the Eysenck Personality Questionnaire—Revised (EPQ-R). Subjects were divided into two groups: those scoring one or more SD above the mean (neurotics, n = 22, mean = 19.91) and those scoring one SD above the mean or below (nonneurotics, n = 25, mean = 16.32) on the Neuroticism Subscale of the EPQ-R.

Results: Results indicate that neurotics have significantly higher HAM-D (17-item) scores than nonneurotics (t = 3.237, p = .0023). Neurotics and nonneurotics did not differ on other variables including: gender, marital status, educational level, living circumstances, previous episodes of depression, and employment status.

Discussion: These data suggest a relationship between severity of depression and neuroticism and raise the possibility that neurotic traits may contribute to more severe forms of depression. We are planning to obtain follow-up information on all 47 patients and to investigate possible differences in treatment outcome between neurotic and nonneurotic depressives.

REFERENCES:

1. Boyce P, Parker G: Neuroticism as a predictor of outcome in depression. J Nervous and Mental Disease 1985;173:685–688.
2. Tsuang DW, Winokur G: Testing the validity of the neurotic depression concept. J Nervous Mental Dis 1992;180:446–450.

No. 94
GLOBAL ASSESSMENT FUNCTION AND LENGTH OF STAY AS PREDICTORS OF OUTCOME IN DEPRESSION

John W. Goethe, M.D., *Clinical Research, Institute of Living, 400 Washington Street, Hartford, CT 06106-3309* Stephen B. Woolley, M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss the distinction between symptom-related criteria and functional-status-related criteria for discharge of depressed patients; to discuss the evidence for the predictive power of initial patient assessment and LOS for depressed inpatients.

SUMMARY:

Objective: To examine the associations of LOS and admission GAF with symptoms and functional status post discharge among patients with major depressive disorder (MDD).

Method: Longitudinal analysis of demographic, GAF, LOS, and BASIS-32 results from 3,000 inpatients diagnosed with MDD using graphic, bivariate, and regression techniques.

Results: Low GAF scores were associated with high LOS (p = .002). GAF scores ≤30 were associated with increased risk of "moderate" post-discharge difficulty "managing day-to-day life" (p < .001; 93% increased risk) but no difference in risk for difficulty with "suicidal feelings or behavior." For these same two outcome measures, LOS ≥ 12 days was associated with a 47% increased risk in "managing" and a 20% decreased risk in suicide (both p ≤ .001).

Conclusion: These data do not support the recent emphasis on the importance of functional status as a primary consideration in decisions about discharge readiness. These results suggest there are different and complex associations between admission GAF (a scale mixing symptom severity and functional status) and LOS as predictors of post-discharge patient self-management difficulties (a functional status measure) and difficulties with suicide (a symptom measure).

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SCIENTIFIC AND CLINICAL REPORT SESSION 32—ANXIETY: SYMPTOM OR DISORDER?

No. 95
AUGMENTATION WITH NORADRENERGIC AGENTS FOR TREATMENT-RESISTANT DEPRESSION IN PATIENTS WITH OCD

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to recognize that many patients with OCD and comorbid MDD do not experience improvement in depressive symptoms with SSRI treatment and appreciate the potential role of augmentation of SSRIs with noradrenergic antidepressant agents in the treatment of these patients.

SUMMARY:

Objective: Obsessive-compulsive disorder (OCD) often coexists with major depressive disorder (MDD). Serotonin reuptake inhibitor (SRI) medications are the treatment of choice for both OCD and MDD. The presence of depressive symptoms in OCD is usually considered to be an incidental result of the chronic effcts of OCD. We report on a series of 10 patients with OCD and comorbid depression whose response to SRI agents was inconsistent with such a model. Serotonergic treatment was augmented with noradrenergic agents. Treatment response and theoretical implications of the efficacy of this strategy are discussed.

Method: Ten patients with OCD and comorbid MDD who experienced a worsening or exacerbation of depressive symptoms following an adequate trial of SRI therapy were treated using a combination of SRIs and agents with effects on noradrenergic reuptake. Response to treatment was based on clinician ratings of severity of OCD and MDD (CGI-S).

Results: Following augmentation, nine of the 10 patients had a significant improvement/resolution of their MDD with little further change in the severity of their OCD.

Conclusion: The results of this case series suggest a possible subgroup of OCD patients whoses MDD is neurobiologically different from that of patients whose depression is secondary to their OCD.

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No. 96
DREAMS IN PTSD: A REVIEW

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have knowledge 1) of the phenomenology of dreaming in trauma victims, 2) that the core of the sleep disturbance in PTSD is in psychological dreaming and nonREM sleep early in the night, 3) that the avoidance of dream recall may contribute to improved adaptation and 4) of the limited scientific nature of the dream studies in PTSD.

SUMMARY:

Objective: To review the publications on the dreams of trauma victims to establish their content and to explore their possible adaptive significance.

Method: A Medline search from 1960 to 1997 of the dreams of trauma victims yielded 95 titles. The 42 articles with 44 studies that had dream content were reviewed for scientific adequacy along 53 parameters, and their content was summarized.

Results: The nature of the trauma and the time since it occurred affect the frequency and content of the disturbing dream. The content of the disturbing dream is not necessarily stereotyped, and different dream types have been described. The dream is not REM bound and occurs early in the night as do increased awakenings, motoric activity, sweating, elevated arousal threshold, and startle response suggesting an alteration in non-REM sleep mechanisms. The dream is not necessarily focused on the past and can continue after the trauma or reoccur years later. The trauma can be linked to childhood traumas and a genetic predisposition for re-experiencing traumas has been reported. The content of the dream can change across time, and in veterans the military content of dreams is variable. The dreams in PTSD are not affect laden and may be hard to recall, with the lowest recall rates occurring in the better adjusted trauma victims. Unfortunately, only 23% of the studies reported statistically significant results, which limits the inferences that can be drawn.

Conclusion: A disturbance in the psychological aspects of dreaming and possibly of non-REM sleep early in the night may be the central sleep disturbance in PTSD. The avoidance of dream recall by trauma victims years after the trauma may contribute to better daytime adaptation.

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2. Ross R, Ball W, Sullivan K, Caroff S: Sleep disturbances as the hallmark of post traumatic stress disorder. Am J Psychiat 1989;146:697–707.

No. 97
GENDER DIFFERENCES: DRUG ABUSE AND RELATED ANXIETY

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EDUCATIONAL OBJECTIVE:

This presentation demonstrates that females are most susceptible to the anxious effect of illegal drugs, and that this effect may persist after the finish of drug usage.

SUMMARY:

Objective: We investigated the prevalence and gender difference of anxious symptoms, illegal drug consumption, and drug-provoked anxious symptoms in Hungary.

Method: We used a self-report questionnaire. Sixteen symptoms of panic disorder (DSM-IV) were listed in three different relations with drug use (before, during and after), and there were questions about drug consumption, age, gender, and qualification.

Results: Of the 1298 adults, significantly more females mentioned a repeated occurrence of at least one anxious symptom (female: 61%, male: 49%), and the average symptom score was 2.61 in females and 2.40 in males. There were differences in the most fre-

quent symptoms (females: dizziness: 36.7%, nausea: 34.7%, males: sweating: 25.7%, palpitation: 24.5%). Significantly more males had ever used illegal drug (males: 35.6%, females: 17.4%). While the order of frequently used drugs was the same (marijuana, amphetamines, LSD, and Ecstasy), significantly more men used cocaine and heroin. Drug usage significantly improves the probability of feeling palpitations trembling, paresthesias, and fear of dying, especially in females. The drug-provoked anxious symptoms persisted in 7.8% of drug users after finishing its usage.

Conclusion: The connection between drug usage and anxious symptoms is strong, especially in females. Drug abuse may provoke anxiety disorders, which may persist after the drug is stopped.

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2. Luie AK, Lannon RA, Rutzik EA, et al: Clinical features of cocaine induced panic. Biol. Psychiatry 1996;40:938–940.

SCIENTIFIC AND CLINICAL REPORT SESSION 33—HORMONES AND PSYCHIATRY

No. 98
TREATMENT OF MAJOR DEPRESSION IN PERIMENOPAUSAL WOMEN: RESULTS FROM A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL OF 17B-ESTRADIOL

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the impact of estradiol treatment on perimenopausal depressed women and consider their potential antidepressant benefits.

SUMMARY:

Background: Recent studies describe improvement of mood symptoms following treatment with estrogen.

Objective: To demonstrate the efficacy of 17β estradiol for the treatment of major depression in endocrinologically confirmed perimenopausal women.

Methods: Fifty women were recruited from a menopause clinic and a psychiatric clinical program specializing in reproductive psychiatry. Women meeting the following entry criteria were included: (1) age 40–55 (2) diagnosis of major depressive disorder (DSM-IV), (3) FSH > 25 IU/L, and (4) irregular periods during the pervious 12 months. Subjects were randomized to transdermal patches containing 100μg of 17β-estradiol (n = 25) or placebo (n = 25) for 12 weeks. This was followed by a four-week washout period and crossover phase (eight weeks). Assessments were made at baseline, 4, 8, 12, 16, 20, and 24 weeks and included measures of both mood and somatic symptoms. Depressive symptoms were assessed by the Montgomery Asberg Depression Rating Scale (MADRS). Menopausal symptoms were assessed by Blatt-Kupperman Menopausal Index (BKMI). Response to treatment was defined as (≥ 50% reduction of baseline MADRS scores) and full remission (MADRS scores <8).

Results: Response to treatment with estradiol was statistically significant compared with placebo ($F = 7.28$, $p = 0.010$). Time to response was also statistically significant ($F = 82.52$, $p < 0.001$). Recrudescence of menopausal somatic symptoms was noted in patients treated with estradiol during the crossover phase, though antidepressant benefit appeared to be sustained. Remission of depression was observed in 64.0% of patients receiving active treatment compared with only 28.0% of placebo group ($\chi^2 = 6.52$, $p = 0.011$).

Conclusions: Major depression in perimenopausal women may be effectively treated with estradiol. The antidepressant effect of estradiol seems to be independent of the secondary effect of improving perimenopausal physical symptoms.

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2. Joffe H, Cohen LS: Estrogen, serotonin and mood disturbance: where is the therapeutic bridge? Biological Psychiatry 1998;44:798–811.

No. 99
CORTISOL AND ACUTE STRESS IN WOMEN WITH PTSD

Cheryl Koopman, Ph.D., *Department of Psychiatry, Stanford University, MC 5718, Stanford, CA 94305;* Catherine Classen, Ph.D., Sandra E. Sephton, Ph.D., Cheryl Gore-Felton, Ph.D., Lisa Butler, Ph.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize patterns of cortisol dysregulation among persons with PTSD; to identify acute stress symptoms that are likely to be related to cortisol dysregulation among persons with PTSD.

SUMMARY:

Objective: This study examined in a sample of women with PTSD the relationships between acute stress disorder (ASD) symptoms in response to a recent stressful life event and changes in salivary cortisol after an acute stress task.

Method: Participants were 44 women sexual abuse survivors with PTSD seeking treatment. The stress task was the woman describing her childhood sexual abuse experience. All women completed the Stanford Acute Stress Reaction Questionnaire (SASRQ) which assessed their ASD symptoms in response to the most disturbing event that occurred in the previous month in each woman's life. Salivary cortisol was assayed prior, immediately following, and one hour following the stress task.

Results: A decline in salivary cortisol from pre-stress task to one-hour post-task was significantly associated with a greater total acute symptom score on the SASRQ ($r = .32$, $p < .05$), indicating that women whose cortisol declined immediately after a stressful task reported the greatest ASD symptoms. In particular, symptoms of acute dissociation and social/occupational impairment were associated with a greater decline in cortisol from pre-stress task to one hour post-task ($r > .30$, $p < .05$).

Conclusion: These findings extend previous research by showing that ASD symptoms, particularly dissociative symptoms and impairment in response to recent life stress, are associated with cortisol dysregulation among women with PTSD.

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2. Resnick H., et al: Effect of previous trauma on acute plasma cortisol level following rape. American Journal of Psychiatry 1995;152:1675–1677.

No. 100
NEUROACTIVE STEROIDS IN CHRONIC FATIGUE SYNDROME

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the chronic fatigue syndrome and appreciate that there are biochemical alterations suggestive of an alteration in adrenocortical metabolism, which may be related to the clinical presentation.

SUMMARY:

Hans Selye showed more than 50 years ago that some progesterone metabolites, when given in supraphysiological doses, are very powerful anesthetics. Although it was known that these are present in blood and tissues, they have rarely been measured for technical reasons, and their physiological role, if any, is unknown. Recently some of them have been shown to bind to the $GABA_A$ receptor. Progesterone, five of its neuroactive metabolites, and pregnenolone (the precursor of progesterone) were measured by radioimmunoassay after high-performance liquid chromatography in patients referred to a chronic fatigue syndrome (CFS) clinic. Thirty women were considered to meet the criteria required for CFS, half of whom were significantly depressed. When mean levels determined in the follicular phase were compared with those of age-matched control women, all of the metabolites were elevated. CFS women with mild or no depression had significantly increased levels of 5α-dihydroprogesterone ($p = 0.01$) and 36,5α-tetrahydroprogesterone ($p = 0.0006$). Those with moderate to severe depression had increased levels of 3β,5β-tetrahydroprogesterone ($p = 0.0001$), 3β,5α-tetrahydroprogesterone ($p = 0.001$) and 3α,5α-tetrahydroprogesterone ($p = 0.05$); that for 5α-dihydroprogesterone was borderline ($p = 0.068$). Levels of progesterone and pregnenolone did not differ significantly. These steroids are derived from the adrenal cortex and peripherally.

We conclude that in CFS there may be an alteration in metabolism such that cortisol levels are lowered while those of some neuroactive progesterone metabolites are elevated. These changes may be related to symptoms of fatigue and depression in CFS.

This study was supported by NARSAD (National Alliance for Research in Schizophrenia and Depression).

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SCIENTIFIC AND CLINICAL REPORT SESSION 34—COMORBIDITY IN MOOD DISORDERS

No. 101
PSYCHIATRIC COMORBIDITY IN PATIENTS PRESENTING FOR IN-VITRO FERTILIZATION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to diagnose comorbid depressive and anxiety disorders in patients presenting for in-vitro fertilization.

SUMMARY:

Objectives: Studies assessing psychological distress in patients presenting for in-vitro fertilization (IVF) have reported high levels of anxiety and depression in these patients. The purpose of this study was to examine psychiatric comorbidity in patients presenting for in-vitro fertilization (IVF).

Methods: We evaluated 60 outpatients (30 consecutive couples) presenting for IVF at an assisted reproduction center in Bombay. All couples were interviewed individually initially and then together, using a semistructured interview technique. Psychiatric diagnoses were made using the DSM-IV criteria. Scales administered to all patients included Hamilton Depression Rating Scale (HAM-D-17), Hamilton Anxiety Rating Scale (HAM-A), Brief Psychiatric Rating Scale (BPRS) and Self-Rating Symptom Scale (SRSS). Data were analyzed using the Statistical Package for Social Sciences (SPSS), and statistical tests included analysis of variance, chi-square, t-tests and discriminant analysis.

Results: Mean age of the study patients was 32.3 ± 5.2 years. There were 30 men and 30 women. Forty percent of the study group met DSM-IV criteria for an Axis I 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, and 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. Being a Hindu female could accurately predict a high depression score in 78.3% of the cases.

Conclusion: Our study underscores the high prevalence of psychiatric comorbidity in patients presenting for IVF and the need for preliminary psychiatric evaluation and intervention in this population.

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2. Merari D, Feldberg D, Elizur A et al: Psychological and hormonal changes in the course of in-vitro fertilization. Journal of Assisted Reproduction and Genetics. 1992;9:161–9.

No. 102
PSYCHOTHERAPY OF PSYCHOSIS

Jon E. Gudeman, M.D., *Medical College of WI Milwaukee City, 9455 Watertown Plank Road, Milwaukee, WI 53226-7217;*

EDUCATIONAL OBJECTIVES:

The diagnostic interview is an opportunity not only to make a phenomenologic cross-sectional diagnosis and determine biologic treatment, it is also an opportunity to explore the psychodynamic aspects of the illness. This talk will illustrate the psychological impasse in psychosis, discuss the theoretical structure, and review technical aspects in treatment.

SUMMARY:

As new psychopharmacologic agents and managed care are central in the treatment of psychosis, intensive individual psychotherapy for

people with severe illness is relegated to a secondary role. This report will reinvent an approach to psychotherapy from the vantage point of the precipitant and subsequent decompensation. The presenter recognizes the importance of the biologic basis of psychosis.

Psychosis is seen as a psychologic defense against pain. Whether biologically or psychologically induced, it manifests not only as biologic decompensation but with psychologic defenses of denial, distortion, avoidance, and projection. Defenses keep the person with illness at a distance. The job of the therapist is to help the patient acknowledge the pain in his/her life, begin to put this in perspective so that simultaneous with medical intervention the person is helped. Techniques include triangulation, grieving the loss, experiencing the pain of the current situation, gaining contact with one's own body, and the beginning of an alliance.

How the therapist approaches the psychotic patient not only as an educator of illness but also as an empathic listener will be outlined. This approach draws heavily on the work of psychotherapists of psychosis such as Reich, Sullivan, Will, and Semrad.

REFERENCES:

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2. Havens L: Participant Observation, Jason Aronson, New York, 1976.

No. 103
FAMILIAL AGGREGATION OF EATING AND MOOD DISORDERS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand newer methods to analyze familial aggregation of two disorders and the results of these methods applied to two studies of eating and mood disorders.

SUMMARY:

Objective: Family studies have suggested that eating disorders and mood disorders may coaggregate within families. Previous studies, however, have been limited by use of univariate modeling techniques and have failed to account for the correlation of observations within families. The objectives of this paper are to provide an improved analysis of the familial aggregation of eating and mood disorders, and illustrate multivariate logistic regression models for familial aggregation of two disorders.

Method: Pooled data from two previously published family studies were analyzed using multivariate proband predictive and family predictive models. These models represent extensions of previous univariate models.

Results: For both models, their application yielded a significant familial aggregation of mood disorders, a significant familial coaggregation of eating and mood disorders, and a magnitude of the coaggregation of eating and mood disorders similar to that of the aggregation of mood disorders. Similar results were obtained with alternative models, including a traditional univariate proband predictive model.

Conclusion: In comparison with traditional univariate models, the multivariate models provide greater flexibility, precision in estimates of aggregation effects, and generality in the interpretation of aggregation effects.

Funding Source: NIMH grant T32 MH-017119 (Dr. Hudson)

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SCIENTIFIC AND CLINICAL REPORT SESSION 35—TREATMENT ISSUES IN SCHIZOPHRENIA

No. 104
RECOVERY FROM SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to familiarize audiences with a possible definition of recovery from schizophrenia and clinical and neurocognitive correlates of recovery.

SUMMARY:

Schizophrenia is considered a chronic condition, yet research has shown quite a heterogeneous course and potential for recovery. Research has been hampered by lack of consensus on how to define recovery. Our aim was to determine if we could locate rigorously diagnosed schizophrenia patients who met our definition of recovery and learn about clinical and neurocognitive correlates of recovery. Our definition entails two years of freedom from positive and negative symptoms, good social and work functioning, and good familial relations. We identified 22 former patients who met our criteria. Sixty percent of this sample reported that they had recovered from schizophrenia (with no definition of "recovery" given to them). Those who felt that they had recovered noted an absence of psychotic symptoms and their ability to work productively as indicators that they had recovered. Among the subjects who stated that they felt they had not recovered, 60% said they would consider themselves recovered if they were able to function without taking antipsychotic medication. For a subsample of patients, findings indicated that recovered patients approached the normal range on several dimensions of neurocognitive functioning that are usually impaired among individuals with schizophrenia. Identifying factors associated with recovery may be useful in understanding the course of schizophrenia.

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No. 105
ANTIPSYCHOTIC ADHERENCE AMONG OUTPATIENTS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that poor antipsychotic adherence is not inevitable, to understand that improved medication administration processes may improve antipsychotic medication adherence, and to recognize that medication class alone (conventional versus atypical) is a poor predictor of adherence despite the improved tolerability of atypical agents.

SUMMARY:

Objective: Our objective in this study was to report and analyze the differences in baseline medication adherence for patients receiving antipsychotics under conditions of routine outpatient care for an eight month period in 1998–9.

Methods: Persistence was defined as a patient's documented pick-up of a prescribed pharmacy refill and was taken as a proxy for medication adherence. Complete refill records for a national retail pharmacy chain were analyzed for more than 26,000 patients on atypical and conventional antipsychotics. We tracked the percentage of patients who continued to take their prescribed antipsychotic over an eight-month period.

Results: At eight months, 77.2% of patients started on clozapine persisted with antipsychotic therapy compared with 52.2% of patients started on a conventional agents and 46.8% of patients started on atypical agents.

Conclusions: The high rates of medication adherence for patients on clozapine suggest that poor medication adherence in major mental illness is not inevitable. Among factors that may have promoted improved adherence on clozapine are medication administration processes that insured more frequent patient provider contact and increased provider accountability for patients discontinuing their medication. Moreover, this analysis revealed that antipsychotic class alone (atypical versus conventional agent) was a poor predictor of medication adherence.

Funding Source: Adheris Inc, Woburn, MA 01801

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No. 106
ADJUNCTIVE VALPROATE IN SCHIZOPHRENIA

Leslie L. Citrome, M.D., *Clinical Research, Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962;* Jerome Levine, M.D., Baerbel Allingham, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the extent of utilization of mood stabilizers, particularly valproate, in patients hospitalized with a diagnosis of schizophrenia.

SUMMARY:

Objective: To describe the utilization of the adjunctive use of valproate and other mood stabilizers (lithium, carbamazepine, and gabapentin) in schizophrenia.

Method: A database containing patient information and drug prescription information for every inpatient within the adult civil facilities of the New York State Office of Mental Health was queried for the time period 1994 to 1998 inclusive.

Results: In 1994, 2,201 out of 8,405 inpatients with schizophrenia received a mood stabilizer (26.2%), with lithium most commonly prescribed (13.2%), followed by valproate (12.3%). In 1998, 2,134 out of 4,922 inpatients with schizophrenia received a mood stabilizer (43.4%), with valproate most commonly prescribed (35.0%), followed by lithium (11.3%). This is in addition to any antipsychotic that was coprescribed. Patients received valproate for approximately two-thirds of their hospital stay, at a mean dose of 1520 mg/day. In 1998, gabapentin was prescribed slightly more often than carbamazepine (3.7% vs. 3.5%).

Conclusion: From 1994 to 1998 adjunctive valproate use in schizophrenia almost tripled. Valproate has become the most commonly prescribed mood stabilizer in this population, despite the relative lack of evidence in the literature of efficacy for this use. There is an urgent need for controlled clinical trials for the adjunctive use of mood stabilizers, in particular valproate, in patients with schizophrenia.

REFERENCES:

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SCIENTIFIC AND CLINICAL REPORT SESSION 36—COURSE OF ILLNESS IN SCHIZOPHRENIA

No. 107
NEUROCOGNITION AND RECOVERY IN SCHIZOPHRENIA

Thomas E. Smith, M.D., *Department of Psychiatry, Weill Cornell, 21 Bloomingdale Road, White Plains, NY 10605;* James W. Hull, Ph.D., Jonathan Huppert, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should have a fuller understanding of the role of neurocognitive deficits in determining functional capacities in schizophrenia.

SUMMARY:

Objective: Reports suggest that neurocognitive deficits are associated with functional capacity in schizophrenia. Many studies, however, used retrospective designs and did not account for the influences of symptoms. We completed a prospective study of social behavior skills in individuals with schizophrenia who were recovering from acute exacerbations.

Method: Thirty-six subjects were recruited upon discharge from an inpatient unit. All were assessed for symptoms, neurocognitive deficits, and social behavior at three-month intervals up to one year. The neurocognitive battery included tests of vigilance, memory, and executive functioning, and social functioning was assessed using Wyke's Social Behavior Scale (SBS).

Results: SBS scores improved by 10% over one year. Mixed effects regression models revealed that negative and disorganized symptoms predicted SBS scores, as did short-term and working memory deficits. Patients with working memory scores below the median at baseline did not improve their social behavior over the one-year follow-up period, whereas those without this deficit showed greater than 20% improvements in social behavior.

Conclusion: Both symptoms and cognitive deficits influence the development of functional capacities in individuals recovering from

relapse. Working memory deficits in particular are strong predictors of acquisition of these skills, and rehabilitation interventions should be designed to take into account these deficits.

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No. 108
ANTISOCIAL COMORBIDITY AND HOMELESSNESS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to assess the risk of homelessness in patients with cormorbid antisocial personality disorder and plan preventive interventions for those at greatest risk.

SUMMARY:

Objective: Does comorbid antisocial personality disorder increase the risk of homelessness among the urban poor *with* and *without* schizophrenia? We explored this question in two samples of indigent urban adults; people with schizophrenia, and people with no psychotic disorder. Previous studies have lacked the carefully defined diagnostic groups and adequate non-homeless controls to make such a comparison possible.

Method: Data were drawn from two parallel case-control studies of risk factors for homelessness: (1) 400 men and women with DSM-III-R (SCID) schizophrenia or schizoaffective disorder *(funded by NIMH),* and (2) 400 men and women with no psychiatric hospitalization history and no psychotic disorder *(funded by NIDA).* Literally homeless cases were selected from crisis shelters. Never-homeless controls with schizophrenia were attending mental health treatment programs; those without psychotic disorder were applicants for public assistance. Both samples were stratified by gender. Assessment of antisocial personality disorder was carried out with the SCID-II.

Results: Antisocial personality disorder distinguished the homeless from the never homeless only among men and women with schizophrenia (adjusted LRT for men = 17.99, $p < .001$; adjusted LRT for women = 7.03, $p < .05$). Lifetime substance use disorders were widespread in all groups studied.

Conclusions: Antisocial personality is mediated by psychopathology in contributing to the risk of homelessness. Clinicians should be aware that antisocial personality disorder among men and women with schizophrenia might place them at greater risk of homelessness, signaling the need for interventions to prevent homelessness.

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No. 109
ANHEDONIA IN SCHIZOPHRENIA: LONGITUDINAL ANALYSES

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to interpret more accurately implications for patients with different mental disorders who present with physical anhedonia. Differences in correlates of anhedonia across diagnosis suggest that different interventions may or may not be effective with different diagnostic groups.

SUMMARY:

Goal: To investigate the relationship between physical anhedonia, symptoms, and adaptive functioning across time and across diagnostic groups.

Method: 160 patients (67 schizophrenia spectrum, 31 other psychotic, 62 depressed) completed structured assessments, including the Physical Anhedonia scale and measures of symptoms and functioning at 2.5, 4.5, 7.5, and 10 years following index hospitalization.

Results: 1) Schizophrenia spectrum subjects showed more persistent scores on measures of physical anhedonia across the 10-year follow-up period than did other diagnostic groups. 2) Physical anhedonia was not consistently correlated with symptoms in the schizophrenia spectrum sample, but was in the other two diagnostic groups. 3) Physical anhedonia was significantly related to functioning impairments in schizophrenia spectrum and depressed subjects ($p < .05$), but this relationship did not hold for the other psychotic subjects.

Significance: The results indicate that physical anhedonia has different correlates in different patient groups. Consistent with prior studies, physical anhedonia appears to be related to symptoms in nonschizophrenic subjects, but may be more trait-like in schizophrenia spectrum subjects. Notably, physical anhedonia was particularly associated with impairments in adaptive functioning in the schizophrenia spectrum and depressed groups, but not in the other psychotic group. Reasons for this difference remain to be evaluated.

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SYMPOSIUM 1—INTERNATIONAL ASPECTS OF ETHICS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to recognize the common and divergent ethical principles and priorities that exist worldwide and understand their applicability to the Madrid Declaration of 1996.

No. 1A
LAW AND MEDICAL ETHICS: AN INTERNATIONAL PERSPECTIVE

Alan A. Stone, M.D., *Hauser Hall, Room 400, Harvard University Law School, 1575 Massachusetts Avenue, Cambridge, MA 02138-2996*

SUMMARY:

Medical ethics is in a state of transition around the world. Crucial to this process is the growing impact of law and universal notions of human rights applied to the doctor-patient relationship. Where state laws vary, one can expect medical ethics to differ. The most dramatic example is the practice of euthanasia and assisted suicide in Holland. However, medical ethics is also changing from within as the traditional principles are increasingly modified by ethicists both inside and outside of medicine. A central axiom both in legal and ethical change is the emphasis on the patient's individual autonomy as the central concern of the doctor-patient relationship. The right to abortion, the right to refuse treatment, and the right to assisted suicide are all derived from the axiom of autonomy.

No. 1B
DOCTOR-PATIENT RELATIONSHIP IN TRADITIONAL SOCIETIES

Ahmed M.F. Okasha, M.D., *Neuropsychiatry, Ain Shams University, 3 Shawarby Street, Kasr Elmil Cairo 00094, Egypt*

SUMMARY:

The doctor-patient relationship may differ greatly depending on the method of health services delivery and the involvement of the third party, and the cultural matrix of the society.

In many traditional societies, the doctor-patient relationship is still healthy. Individual autonomy is not empowering and the family role is the decisive factor. Attributing health and disease to God's will, puts the doctor in a very defensive role. Suing for malpractice is rarely encountered as all complications are attributed to God's will. The external locus of control, belonging to certain religious or philosophical beliefs, and the absence of managed care make the doctor-patient relationship very warm, and effective and give the doctor a higher rank of respect, dignity, and obedience. The patient and doctor have a mutual belief that the outcome of any illness is through God's will; the doctor is an agent so he should not be blamed. The usual statement is "Do your best for healing your patient, but God has the final decision." The physician in traditional societies embarks on treatment out of dedication and a desire to heal and not under the fear of being sued, which may hamper implementing life saving treatment in Western societies.

A full explanation of the impact of culture and ethics in doctor-patient relationship in traditional societies as compared with Western societies will be presented.

No. 1C
MENTAL HEALTH: CONFLICT AND CRISES IN LATIN AMERICA

Julio E. Arboleda-Florez, M.D., *Department of Psychiatry, Queens University, Hotel Dieu Hospital 166 Brock Street, Kingston, ON K7L 3N6, Canada*

SUMMARY:

Latin America, a vast land extending from the Rio Grande to the Patagonian and with a population of about 500 million people, is home to a variety of cultures, races, and ethnic groups, from the aboriginal groups who were the first settlers, to the Europeans, and the African descendants. Other groups have joined the Latin American mosaic over the past decades. The inhabitants of Latin America speak many languages, but the most important are Spanish and Portuguese. The most important religion in the region is Catholic, but many Latin Americans practice several Protestant Christian denominations, and others are Muslims. This social heterogeneity in the demographic composition of the countries may be the most important characteristic of Latin America. Yet, within the differences in background, many common characteristics can be discerned in the cultural landscape south of the Rio Grande that have ramifications on important aspects of the mental health of the "Latins" and the way in which they conceptualize health, illness, treatment system, and the ethics of health care. This presentation will discuss these characteristics, will find common themes, and will review the cultural, demographic, ethical, and political forces that are shaping mental health systems in the region.

No. 1D
CULTURE AND THE ETHICS OF MANAGED CARE IN THE UNITED STATES

Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Medicine, 1670 Clairmont Road, Decatur, GA 30033*

SUMMARY:

Defined as the paradigmatic example of an open society in contemporary times, the North American continent in general, and the United States, in particular, represent a natural laboratory for the complex interactions between culture and ethics. After reviewing the main psychocultural features of contemporary American life, this presentation explores its historical and ethical bases as an introduction to the examination of the ethical perspectives on psychiatric managed care, considered not only as a powerful factor in the economy, quality, and efficiency of patical care, but also as a fundamental challenge to the medical profession itself. Against the seemingly contradictory background of a society guided by compassion and solidarity but also by individualism and competitiveness, a society that believes in the value of hard work but also in the hedonistic complacencies of wealth, a society profoundly religious but also multidimensionally sensuous, one whose historical advancement was based on the exploration of endlessly open frontiers but whose citizens feverishly defended their right to privacy, the development and organization of health care has mirrored such set of conflicting cultural values. The ethical challenges generated by contemporary managed care encompasses several levels: double agentry, fidelity, confidentiality, informed consent, honesty, and vulnerability. These areas are examined in detail. It is concluded that a vigilant profession must be, in the end, the best guarantee for the people whom it serves.

Thus, cultural principles and ethical norms would have converged for the genuine healing of society as a whole.

No. 1E
ETHICS, CULTURE, AND PSYCHIATRY FROM A SCANDINAVIAN PERSPECTIVE

Marianne C. Kastrup, M.D., *RCT, Brondebyosterves 13, PO BOX 2107, Copenhagen DK-1014, Denmark*

SUMMARY:

Scandinavian countries have common features with respect to political systems, culture, language, religion, and health services. Ethical guidelines are provided by the medical associations and education on medical ethics is a part of the medical curricula. Research ethical committees review all biomedical research and ethical councils provide expert knowledge to the governments. Ethical committees are established within all medical associations and usually with a psychiatric expert among their members.

Ideals to be strived for in the field of psychiatry are respect for the dignity, integrity, and autonomy for the mentally ill, protection of others against violations by the mentally ill, and security against abuse of psychiatry. Particular focus will be paid to the issues of medical confidentiality, patient autonomy, and access to psychiatric records.

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SYMPOSIUM 2—RELIGION AS A WEDGE BETWEEN DOCTOR AND PATIENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, clinicians will be able to identify religious beliefs that interfere with the treatment of women who are victims of domestic violence, and to help the patient clarify distortions of religious doctrine that perpetrators use to perpetuate the abusive relationship.

No. 2A
DOMESTIC VIOLENCE: PSYCHIATRY VERSUS RELIGION

Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 836 West Wellington Avenue, Chicago, IL 60657*

SUMMARY:

The treatment of women in the context of domestic violence poses challenges not well addressed by classical psychotherapeutic paradigms. Past and current abuse distort emotions, thought, and real-life possibilities. As the psychiatrist works with the patient to improve her self-esteem, identify inner conflicts, and make choices about her future, the abuser, who is bound by no professional constraints and who has many more hours of access to the patient, works actively to frighten and control her. The abusive situation damages the patient's (and her children's) mental health and threatens her (their) very existence, thereby demanding more active intervention on the part of the psychiatrist than the usual psychotherapy. Religious issues may further complicate the situation. Some religions, especially in their more orthodox forms, preach that endurance of suffering is a virtue, that women must submit to their husbands, and that the marriage bond is never to be broken. These tenets can be misused by an abusive partner as an excuse for his behavior and a requirement that the patient remain in the abusive situation. This paper presents such a case, one in which the husband attempted to disrupt the therapeutic relationship by declaring the psychiatrist an evil tool of Satan.

No. 2B
DOMESTIC VIOLENCE AND MENTAL HEALTH: EXPANDING THE CONCEPTUAL FRAME

Carole L, Warshaw, M.D., *Internal Medicine, Cook County Hospital, 3428 North Janssen, Chicago, IL 60657*

SUMMARY:

Despite the tremendous impact that ongoing abuse can have on women's emotional well-being, mental health providers are rarely trained to address the social factors that entrap victims in abusive relationships. This can result in falsely interpreting survival strategies as psychiatric problems, overlooking the advocacy needs (shelter, legal assistance, safety planning) of victims of domestic violence, and not understanding the risks a psychiatric diagnosis can pose for custody battles with an abusive spouse. This paper will address a number of these critical issues in addition to providing an overview of the prevalence and mental health impact of domestic violence. It will also review practical guidelines for clinicians working with women abused by an intimate partner. Finally, it will present a framework for responding to the mental health concerns of battered women from both a social and psychological perspective, and briefly address community and cultural perspectives on healing and social change.

No. 2C
RELIGION, ETHICS, AND PSYCHIATRIC RESPONSIBILITIES

Martha B. Holstein, Ph.D., *Department of Research, Park Ridge Center, 211 East Ontario Suite 800, Chicago, IL 60611-3215*

SUMMARY:

Ethics is often obscured in psychiatric practice or merely touched upon by professional codes. In the case this symposium will address the ethical issues are substantial. Taking a religiously pluralistic society as the context, this presentation will ask: What are the psychiatrist's ethical responsibilities to his/her patient when religious positions promote a victimization and oppression (as she reports them), thereby blocking effective psychiatric intervention? What are the psychiatrist's responsibilities in helping the patient claim moral agency without asking her to sacrifice her faith? What duties does the psychiatrist have to help the patient recover the moral virtue of courage as she moves toward becoming a moral agency and in helping grasp her many moral responsibilities and commitments? What are his/her duties toward the patient's need to formulate a newer and stronger sense of self? Ethics does not require external justification for determining that some action is the best "all things considered." Instead ethics can strive to help people occupy a com-

mon moral world. The psychiatrist starts an ethical analysis by ascertaining the "facts," uncovering the patient's core values, and helping her renegotiate moral understandings that allow her to live as comfortably as she can.

No. 2D
THE FORGOTTEN FACTOR IN MENTAL HEALTH

David B. Larson, M.D., *National Institute of Health Research, 6110 Executive Boulevard, #908, Rockville, MD 20852-4213;* Byron R. Johnson, Ph.D.

SUMMARY:

In the last decade, psychiatric research and training has experienced a renewed and increased interest in exploring a "forgotten factor" of psychiatric care—the clinical relevance and significance of the psychiatric patient's spiritual and religious involvement. Psychiatric training is beginning to pay greater attention to this "forgotten factor" while a greater number of increasingly better studies are being published. This presentation will first review some of these recent changes that have taken place in psychiatric training and research. Next, the presentation will highlight how frequently and how well patients utilize their spirituality or religious supports to cope with their psychiatric problems or illnesses. The presenter will note that, despite psychiatry's historical perspective of generally viewing religion as harmful, religion can play a clinically supportive role, an ineffective role, as well as a clinically harmful role. Lastly, this review will present the research concerning each of these roles religion can play as well as suggest how to apply these research findings in psychiatric assessment and care in this complex, clinical context.

No. 2E
THEOLOGY AND DOMESTIC ABUSE

Don S. Browning, Ph.D., *University of Chicago Divinity School, 5841 South Maryland, Chicago, IL 60637*

SUMMARY:

This paper will investigate the question of whether the western religious tradition teaches male domination and authority or condones domestic violence. Implications for psychiatric practice will also be reviewed.

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SYMPOSIUM 3—BIPOLAR ILLNESS AND ALCOHOL ABUSE: COURSE AND TREATMENT
National Institute on Alcohol Abuse and Alcoholism

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to further appreciate the prevalence rate of co-ocurring bipolar illness and alcoholism, the prospective course of the comorbidity, and potential treatment options.

No. 3A
BIPOLAR DISORDER AND COMORBID ALCOHOLISM

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML 0559, Cincinnati, OH 45267-0559*

SUMMARY:

Epidemiological data from community populations indicate that bipolar disorder co-occurs with alcoholism at rates that are significantly higher than those in the general population, and in some studies, higher than those in depressive disorders. Clinical studies similarly find high rates of comorbid alcoholism. These studies further indicate that comorbid alcoholism may adversely affect the presentation, course, and outcome of bipolar disorder. In this presentation, available epidemiologic and clinical data on the prevalence of alcoholism in bipolar disorder will be reviewed, with focus on new comorbidity data from over 300 patients from the Stanley Foundation Bipolar Network. Also, the potential complications of comorbid alcoholism on the presentation, outcome, and treatment of bipolar disorder will be discussed.

No. 3B
ALCOHOL AND AXIS II COMORBIDITY IN BIPOLAR PATIENTS

Lori L. Altshuler, M.D., *Department of Psychiatry, UCLA, 300 Medical Plaza #1544, Los Angeles, CA 90068;* JoAnne Kay, M.A., Joseph Ventura, Ph.D., Jim Mintz, Ph.D.

SUMMARY:

Objective: This study sought to determine the prevalence of comorbid personality disorder in euthymic bipolar I patients.

Method: Sixty-one outpatients were assessed using the Structured Clinical Interview for DSM-IV Personality Disorders (SCID II) and/or the Personality Diagnostic Questionnaire-Revised (PDQ-R).

Results: Thirty-eight percent of bipolar patients met criteria for an Axis II diagnosis based on the SCID II. Bipolar subjects with a history of comorbid alcohol use disorder were significantly more likely to have a SCID II diagnosis (52%) compared with those bipolar subjects without an alcohol use disorder history (24%). Cluster A diagnoses were significantly more common in the bipolar/alcohol use disorder group. The PDQ-R consistently over diagnosed Axis II disorders, finding 62% of the overall bipolar group to have an Axis II diagnosis.

Conclusions: Euthymic bipolar patients may have an increased rate of personality disorders, but much less so than previously reported in studies that did not take into account (1) current mood state, (2) comorbidity for an alcohol use disorder, and (3) instrument used for assessment of Axis II psychopathology.

No. 3C
COURSES OF CO-OCCURRING BIPOLAR AND ALCOHOL USE DISORDERS

Stephen M. Strakowski, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, Suite 7005, Cincinnati, OH 45267-0559;* Melissa P. Delbello, M.D., Wendilyn Wigh, M.S.W., A. Monique Brock, B.A., David E. Fleck, Ph.D.

SUMMARY:

Bipolar and alcohol use disorders co-occur far more commonly than expected, for unclear reasons. We proposed that these syndromes co-occur because: (1) bipolar disorder causes alcohol abuse (e.g., through self-medication), or (2) alcohol abuse causes bipolar disorder (e.g., through sensitization), or (3) alcohol use and bipolar disorders share a common risk factor (e.g., environmental stressors) (DelBello & Strakowski, in press). Prospective outcome studies provide one means to examine the relative contributions of these proposed mechanisms by identifying relationships between the courses of illness of both bipolar and alcohol use disorders. For example, during the 12 months following hospitalization for a first manic episode, 54% of the patients with a history of alcohol abuse experienced ongoing affective episodes in the absence of alcohol abuse, although alcohol abuse always occurred concurrently with an affective syndrome (Strakowski et al, 1998). In a new outcome study of first-episode mania, we observed that manic and mixed, but not depressed, episodes were commonly precipitated by increased alcohol abuse in bipolar patients with histories of alcohol dependence. In contrast, cases of patients increasing alcohol abuse in response to new affective episodes was uncommon. These data suggest that affective symptoms do not necessarily initiate drinking in patients with a history of alcohol abuse, but when alcohol abuse does occur, it may precipitate affective symptoms. Updated results will be presented at the time of the APA meeting.

This work has been supported by MH 54317 & MH58170.

No. 3D
ANTICONVULSANTS IN BIPOLAR ILLNESS WITH ALCOHOL COMORBIDITY

Mark A. Frye, M.D., *Department of Psychiatry, UCLA NPI&H, 300 UCLA Medical Plaza, #1154, Los Angeles, CA 90095;* Kirk D. Denicoff, M.D., Earlia-Smith Jackson, R.N., Elizabeth Vanderham, M.A., Gabriele S. Leverich, M.S.W., Robert M. Post, M.D.

SUMMARY:

Kindling and sensitization models have both been applied to the clinical observations of bipolar illness progression and increased alcohol withdrawal symptom severity associated with recurrent alcohol intoxication. Additionally, mania complicated by current or historical alcohol abuse has been associated with relative decreased lithium responsivity. Mood stabilizing anticonvulsants have been shown to have "anti-killing" properties and are clinically efficacious in the treatment of both bipolar disorder and alcohol withdrawal. This study was conducted to test the hypothesis that bipolar illness complicated by alcohol abuse comorbidity would represent a "compound liability" for kindling progression and would preferentially respond to anticonvulsant treatment.

In a controlled, double-blind prophylaxis study, 28 bipolar outpatients (14f/14m) were randomized to one year lithium or one year of carbamazepine (CBZ) in the first two years, and the combination in the third year. A CGI call of much or very much improved was used to define CBZ response. Blind to CBZ response, alcohol abuse history was assessed through SCID harvesting and/or review of the medical record. Fisher's exact test was utilized to analyze the relationship between CBZ response and presence or absence of alcohol abuse history.

A total of 8/28 patients (4/14, 29% female, 4/14 29% male) were CBZ responders. There was no significance of CBZ response between patients with or without a history of alcohol abuse ($n = 28$, $p = 0.09$). 4/8 (50%) male patients with a history of alcohol abuse responded to CBZ in comparison with 0/6 with no prior history ($p = 0.08$). One of two female patients (50%) with a history of alcohol abuse responded to CBZ in comparison with 3/12 (25%) with no prior history ($p = 0.5$).

This study suggests a trend preferential CBZ response in males with a history of alcohol abuse, but not in females. Although controlled data, the small sample size and unequal distribution of alcohol abuse histories limit this study. Further studies are encouraged.

No. 3E
ANTICONVULSANTS IN ALCOHOL WITHDRAWAL AND RELAPSE

Hugh L. Myrick, M.D., *Department of Psychiatry, MUSC, IOP 4 North, 67 President street PO Box 250861, Charleston, SC 29425*

SUMMARY:

This presentation will focus on the role of anticonvulsant agents in the treatment of alcohol withdrawal and relapse prevention. Mood stabilizing anticonvulsant agents 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 anticonvulsant agents carbamazepine, divalproex, and gabapentin will be discussed. While the acute phase of alcohol withdrawal 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 use disorders and psychiatric disorders and may respond to anticonvulsant agents. Studies investigating the use of anticonvulsants in the treatment of these dimensional aspects of functioning will be discussed.

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SYMPOSIUM 4—ESTROGEN-REPLACEMENT THERAPY IN MENOPAUSE-RELATED MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to recognize clinical, neuroendocrine, and cognitive indices of menopause-related mood disorders and update his/her knowledge of optimal treatment paradigms of these disorders.

No. 4A
ESTROGEN-REPLACEMENT THERAPY: COGNITION AND DEPRESSION IN POSTMENOPAUSAL WOMEN

Natalie L. Rasgon, M.D., *Department of Psychiatry, UCLA University, 300 UCLA Medical Plaza, #2200, Los Angeles, CA 90095;* Jennifer Dunkin, Ph.D., Lori L. Altshuler, M.D., Andrea Rapkin, M.D.

SUMMARY:

The development of late-life depression and antidepressant therapeutic response may involve postmenopausal estrogen deficiency. Existing data suggest that estrogen replacement therapy (ERT) after menopause enhances both mood and cognitive function. This presentation will discuss the preliminary results of the study of the effects of ERT on cognition and antidepressant response in postmenopausal women. The study involved 30 women ages 45–65 with or without (control group) major depression. Cognitive test battery was administered prior to and after the treatment phase. Depressed subjects received SSRI (Sertraline) in a standard antidepressant dose for ten weeks. Estrogen or placebo patches were administered simultaneously with an antidepressant treatment using the transdermal estradiol system. Effects of ERT were assessed in a double-blind design: (1) in postmenopausal depressed women on cognition and on Sertraline + ERT vs. Sertraline + placebo treatment outcomes; (2) in postmenopausal women without depression on cognitive responses to ERT vs. placebo. We observed beneficial effects of ERT on both mood and cognitive outcomes compared with placebo. Our data further support salutary effects of ERT in postmenopausal women.

No. 4B
MOOD DISORDERS IN PERIMENOPAUSE: THE ESTROGEN-SEROTONIN CONNECTION

Hadine Joffe, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Gonadal steroids have extensive neuromodulatory effects that may increase the risk of mood disorders in women. A growing body of evidence suggests that a subset of women are vulnerable to mood instability caused by physiologic changes in hormone levels. Declining levels of estrogen during the transition to menopause (perimenopause) may trigger depressive symptoms. However, estrogen withdrawal also causes hot flushes and night sweats in 75% of perimenopausal women. The disruption of sleep by night sweats may cause daytime mood changes. Because hot flushes and night sweats correlate strongly with depressive symptoms, it is therefore difficult to distinguish whether perimenopausal mood symptoms are a direct consequence of estrogen fluctuation or night sweat-induced sleep disturbance.

This presentation will review the mood symptoms that occur in perimenopausal women. The evidence supporting different etiologic models of depressive symptoms in perimenopausal women will be reviewed. Implications of estrogen-serotonin interactions in the central nervous system will be discussed. Therapeutic options for this reproductive-endocrine-associated mood disorder will be addressed.

No. 4C
ESTROGEN, DEPRESSION, AND THE PERIMENOPAUSE

Peter J. Schmidt, M.D., *Endocrinology, National Institute of Mental Health, 10 Center Dr., Building 10, Room 3N-238, Bethesda, MD 20892;* Catherine A. Roca, M.D., David R. Rubinow, M.D.

SUMMARY:

The relationship between declining ovarian function, estrogen withdrawal, and midlife-onset depression is the source of considerable controversy. We have employed several strategies to investigate the effects of the perimenopause, hypogonadism, and hormone replacement on mood and behavior. Two groups of subjects have been studied: women with depression occurring during the natural perimenopause and women with GnRH agonist-induced hypogonadism. Perimenopausal depressed women did not differ from nondepressed controls in the experience of adverse life events, hot flushes, or in basal measures of reproductive hormones. Estradiol replacement under double-blind, placebo-controlled conditions, significantly improved measures of both mood and verbal memory in depressed perimenopausal women. The efficacy of estradiol replacement on mood was independent of its salutary effects on hot flushes. In contrast, estradiol replacement in younger women with GnRH-agonist-induced hypogonadism was not associated with changes in cognitive function, nor did estradiol replacement improve libido in either perimenopausal depressed or younger hypogonadal women. Finally, we observed reductions in cognition-activated regional cerebral blood flow during GnRH-agonist-induced hypogonadism with the restoration of normal regional cerebral blood flow during estradiol replacement. Our data suggest that estradiol may be involved in the regulation of some aspects of mood, cognitive performance, and neural physiology, but the effects observed are dependent on a number of contextual variables including age.

No. 4D
ESTROGEN AND COGNITION IN OLDER WOMEN

Barbara B. Sherwin, Ph.D., *Department of Psychology, McGill University, 1205 Dr. Penfield Avenue, Montreal, P.Q., QC H3A 1B1, Canada*

SUMMARY:

There is now considerable evidence that estrogen modulates brain structure and function in areas known to subserve memory. During the past decade, numerous observational studies as well as prospective randomized investigations have been carried out to test whether estrogen maintains memory in postmenopausal women. Healthy 65-year-old estrogen users scored higher on tests of verbal memory compared with age-matched nonusers (Kampen & Sherwin, 1994). In prospective studies of premenopausal women who had their uterus and ovaries removed, those who received estrogen postoperatively also performed better than women who were given placebo (Sherwin, 1988; Sherwin & Phillips 1990; Phillips & Sherwin, 1992). When postmenopausal women were given a gonadotropin-releasing-hormone analog (GnRH-a), scores on memory decreased and were subsequently restored in women who randomly received the GnRH-a plus "add-back" estrogen but not in those who received "add-back" placebo. Healthy 72-year-old estrogen users also performed

better on some tests of memory than age-matched nonusers (Carlson & Sherwin, 1999). These studies demonstrated that estrogen replacement therapy helps to maintain verbal and, possibly, visual memory in postmenopausal women.

No. 4E
ON THE CUSP OF PERIMENOPAUSE: DEPRESSION IN OLDER PREMENOPAUSAL

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 115 Parkman Street, WAC 815, Boston, MA 02114*

SUMMARY:

The relationship between female reproductive endocrine function and mood remains to be delineated in various populations of women. The Harvard Study of Moods and Cycles is a community-based cohort study designed to describe the relationship between changes in reproductive endocrine function and risk for mood disturbance in women. This presentation will describe findings from initial screening of 4,161 women (age 36–44) with respect to demographic characteristics, depressive illness history, menstrual history, and current depressive symptoms as assessed with the Center for Epidemiologic Studies Depression Scale (CES-D).

Significant depressive symptoms (CES-D≥16) were noted in 22.4% of the sample. These data suggest an estimated prevalence of depression of 7.4% (assuming a 33% predictive validity) consistent with prevalence estimates of depression in other epidemiologic studies. Women who were (1) widowed, divorced, or separated and who (2) were in the upper tertile with respect to tobacco use were also noted to be at risk for depression as were those who endorsed more significant premenstrual symptoms. Undertreatment of depression was noted across the sample consistent with other community-based studies. With respect to reproductive endocrine function, considerable variability was noted in early follicular phase assays of hormones including estradiol and FSH. The significance of this variability, its relationship to current mood symptoms, and risk for developing mood disorder as women age will be reviewed.

No. 4F
PERIMENOPAUSE AS CONTEXT

David R. Rubinow, M.D., BEB, *National Institute of Mental Health, 10 Center Drive, Building 10, Room 3N-238, MSC 1276, Bethesda, MD 20892-1276*

SUMMARY:

The perimenopause represents the convergence of two physiologic processes, aging and reproductive endocrine change, both of which are directly linked to alterations in central nervous system function. The presenters in this symposium detail the consequences of the perimenopause and its treatment. This discussion will attempt to integrate the preceding presentations, with emphasis on the following two points: first, the neurobiologic mechanisms of action of ovarian steroids will be reviewed, with emphasis on the role of the steroid hormone receptor as a point of convergence of multiple cellular signaling pathways. This multiplicity of effector mechanisms provides a basis for understanding the diverse, widespread, and profound effects of changes in gonadal steroids on brain function. Second, the context dependency of steroid effects at a cellular and organismic level will be described as a model for explaining the different responses across individuals to the changes in gonadal steroid levels that occur during aging.

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1. Burt V, Altshuler L, Rasgon N: Depressive symptoms in the perimenopause: prevalence, assessment, and guidelines for treatment. Harvard Rev Psychiatry 1998;6:121–132
2. Joffe H, Cohen LS: Estrogen, serotonin, and mood disturbance: where is the therapeutic bridge? Biol Psychiatry 1998;44:798–811
3. Schmidt PJ, Roca CA, Bloch M, Rubinow DR: The perimenopause and affective disorders. Seminars in Reproductive Endocrinology 1997;15:91–100
4. Sherwin BB: Estrogen effects on cognition in menopausal women. Neurology 1997;48(suppl. 7):521–526
5. Harlow BL, Cohen LS, Otto MW, Spiegelman D, Cramer DW: Prevalence and predictors of depressive symptoms in older premenopausal women. Arch Gen Psychiatry 1999;56:418–424

SYMPOSIUM 5—PROFESSIONAL BOUNDARIES: TRAINING METHODS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) design a training program for residents, (2) develop a remedial boundaries training program for an impaired physician, (3) plan a clinic or hospital inservice on boundary issues, (4) identify at least three key boundary issues for medical practitioners

No. 5A
TEACHING BOUNDARIES TO RESIDENTS: A MODEL COURSE

Gregg E. Gorton, M.D., *Department of Psychiatry, Jefferson Medical, 1201 Chestnut Street Suite 1400C, Philadelphia, PA 19107;* Steven E. Samuel, Ph.D., Gail Zibin, Ph.D.

SUMMARY:

Following a 1991–92 survey of psychiatric residency directors, we designed and implemented a core course on sexual feelings and boundary management that we have taught to PGY III/IV residents at Thomas Jefferson University Hospital since 1993. This 12-hour seminar has both didactic and experiential components including presentations of case material, videotaped vignettes, role-playing, boundaries exercises, presentations by an offending therapist and an exploited patient, group discussion, and reading. Goals of the course are to increase factual knowledge, enhance self-awareness, increase comfort with the handling of sensitive transference and countertransference issues, improve technical skills, and foster a professional culture that encourages discussion and consultation about sexual feelings and boundary concerns in the treatment relationship. The history and design of the course will be discussed along with data collected over four years on pre/post knowledge and attitudes. Examples of some training tools, including exercises and videotapes will be demonstrated. There will also be discussion of how to integrate education about sexual boundaries into the full four years of training. Teaching methods and tools discussed will have applicability to shorter courses, workshops, and even supervision and consultation with members of the health care team. These may also be helpful to practitioners seeking to examine these issues in their own practices.

No. 5B
AN ADAPTABLE CURRICULUM ON BOUNDARY VIOLATIONS WITH PATIENTS

Gail E. Robinson, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada;* Donna E. Stewart, M.D.

SUMMARY:

Although health care professionals, licencing bodies, governments, and the community are paying increasing attention to the negative consequences of sexual misconduct and other boundary violations by health care professionals, education for professionals about this subject is rare and limited. The curriculum devised at the University of Toronto to teach faculty and students about these topics is now being widely used at other universities in Canada and by various professional bodies. The program includes a didactic portion and a workshop component. The didactic portion consists of discussions of the definitions, causes, and consequences of health care professional-patient sexual misconduct. By discussing brief case vignettes designed to illustrate salient points, the participants have an opportunity to consider their responses in actual clinical situations. The vignettes address such issues as language, touching, socializing, and post-termination relationships and are easily adjustable to address the particular concerns of different physician specialties or other health care providers. Evaluations of this teaching program have shown that a majority of the participants stated they were either practicing in a way congruent with the models discussed or would change their clinical practices in positive ways as a result of the program.

No. 5C
AFTER THE FALL: REMEDIAL BOUNDARIES TRAINING

Gary R. Schoener, Psy.D., *Walk-in Counseling Center, 2421 Chicago Avenue, South, Minneapolis, MN 55404*

SUMMARY:

An increasing number of state licensure boards and employers are requiring that physicians who have engaged in sexual contact with patients undergo rehabilitation before sanctions are lifted so that they can return to practice. This is a new and expanding area of practice in which assessment, rehabilitation, consultation, and supervision must be done in conjunction with the requirements of a disciplinary body. As we develop a greater understanding of sexual and related boundary violations, a number of models are evolving for diagnosing and rehabilitating the impaired professional. Whether from a cognative-behavioral perspective (e.g. Gene Abel), a psychodynamic (e.g. Glen Gabbard), or an addiction (e.g. Richard Irons & Jennifer Schneider), psychiatrists and other physicians are evolving models for remedial boundaries training or "coaching." This presenter will discuss examples drawn from several hundred cases, and discuss a variety of tools, exercises, and methods of doing boundaries training for the physician who has violated patient boundaries. As this new field evolves, there is a growing opportunity for psychiatrists in clinical, supervisory, training, and even forensic roles to assist other physicians with this challenge. Handouts will provide direction as to the components of an individualized boundaries retraining program, and also how materials can be ordered. Discussion will focus on when such training is likely to be of help.

REFERENCES:

1. Gorton GE, Samuel SE, Zebrowski S: A pilot course for residents on sexual feelings and boundary maintenance in treatment. Academic Psychiatry 1996;20:43–55
2. Robinson GE, Stewart DE: A curriculum on physician-patient sexual misconduct and teacher-student mistreatment—Part I: the content. Can Med Assoc J 1996;154(5):843–849
3. Robinson GE, Stewart DE: A curriculum on physician-patient sexual misconduct and teacher-student mistreatment-Part II: the teaching method. Can Med Assoc J 1996;154(7):1021–1025
4. Schoener GR: Preventive and remedial boundaries training for helping professionals and clergy: successful approaches and useful tools. Journal of Sex Education and Therapy (in press)

SYMPOSIUM 6—NEUROBIOLOGY OF BPD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium participants will have an integrated view of how environmental variables with a history of childhood trauma may contribute to prognosis in borderline personality disorder (BPD) subject, and the neuroendocrine findings associated with trauma and comorbid posttraumatic stress disorder. Participants will gain a multidimensional understanding of the core BPD trait of impulsive aggression from data presented on neurobiological challenge studies and metabolite assays, genetic, and functional neuroimaging.

No. 6A
PREDICTORS OF IMPROVEMENT FOR BORDERLINE PATIENTS

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

SUMMARY:

Objective: The purpose of this study was to assess the best multivariate predictors of two important outcomes for borderline personality disorder (BPD): remission of BPD and the attainment of good psychosocial functioning.

Method: A series of semistructured interviews and self-report measures were administered to 290 borderline patients and 72 axis II controls at baseline and to the 95% of the 350 surviving patients who were reinterviewed at two- and four-year follow-up.

Results: Of the 273 traced borderline patients, 34% experienced a remission of their borderline symptomatology and 58% attained good psychosocial functioning. Using lagged indicators in time-series, probit analyses, four domains were predictive of a failure to remit: severity of borderline psychopathology (level of dysphoric inner states, cognitive symptoms, and interpersonal symptoms), comorbid conditions (mood disorder and level of odd cluster psychopathology), negatively valenced psychosocial factors (physical/sexual assault as an adult and being a disability recipient), and temperamental neuroticism. Three other factors were predictive of a remission from BPD: temperamental agreeableness, parental competence during childhood, and supportive relationship with at least one parent as an adult. Using similar analytic methods, four factors were found to be negatively associated with the attainment of good psychosocial functioning: older age, level of dysphoric inner states, level of cognitive symptoms, and receiving disability payments. Six other factors were predictive of good psychosocial functioning: temperamental agreeableness, openness, childhood competence, parental competence during childhood, supportive relationship with one or both parents, and a supportive relationship with a spouse/partner. Neither childhood abuse or neglect, nor an adult diagnosis of PTSD were predictive of either outcome in these multivariate analyses.

Conclusions: Both symptomatic and psychosocial improvement for borderline patients seem to be best explained by a coping/resilience model of adult development.

No. 6B
HPA AXIS ACTIVITY IN BPD

Robert A. Grossman, M.D., *Department of Psychiatry, Mount Sinai Medical Center, Box 1230/1 Gustave Levy Place, New York, NY 10029;* Larry J. Siever, M.D., Richard Lee, M.D., Jeremy Silverman, Ph.D., Nelly Stamaria, M.A., James Schmeidler, Ph.D., Rachel Yehuda, Ph.D.

SUMMARY:

Historically, BPD has been viewed as a mood disorder variant (depressive or cyclothymic), but more recently been hypothesized to be a type of "complex posttraumatic stress disorder" arising out of childhood experiences of abuse. Interestingly, hypothalamic-pituitary-adrenal (HPA) axis studies have revealed a particular pattern of peripherally measured alterations in posttraumatic stress disorder (PTSD—the paradigm stress disorder) that is virtually opposite to findings in major depression. These clear neuroendocrine differences prompted us to study the HPA axis in BPD and other personality disordered subjects in order to ascertain their relationship to PTSD and the impact, if any, of a history of abuse. Thirty medically healthy and medication-free personality disordered subjects were divided into groups of +/– BPD, +/– trauma history, +/– comorbid PTSD. Plasma cortisol and lymphocyte glucocorticoid receptor density was measured at baseline and following a 0.5 mg dexamethasone challenge. The data suggest that BPD subjects without comorbid PTSD have a constellation of HPA axis findings that is different from both PTSD and depression.

No. 6C
BIOLOGICAL FACTORS IN IMPULSIVE AGGRESSION

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

SUMMARY:

Reduced central serotonin (5-HT) system function reflected by reduced concentrations of lumbar cerebrospinal fluid 5-hydroxyindolacetic acid or by altered hormonal responses to 5-HT challenge agents, has been associated with suicidal and impulsive aggressive behaviors in a variety of psychiatric patients, particularly those with personality disorders. This presentation will review previous and new data from a variety of neurochemical and pharmaco-challenge studies, in personality disordered patients, in which history of suicidal and/or impulsive aggressive behavior were used as independent variables. Among the variables that have been reported as correlating with suicidal and/or impulsive aggressive behavior are: (a) CSF 5-HIAA, (b) hormonal responses to 5-HT challenge, and (c) platelet 5-HT transporter/5-HT-2a receptors. In addition, data from family history study of individuals with recurrent, problematic, impulsive aggression as well as data from clinical trials using 5-HT uptake inhibitors (i.e., fluoxetine) as an anti-aggressive agent will also be presented.

No. 6D
GENETIC STUDIES OF IMPULSIVE AGGRESSION IN PERSONALITY DISORDERS

Antonia S. New, M.D., *Department of Psychiatry, Mount Sinai/ Bronx VAMC, Box 116A, 130 West Kingsbridge Road, Bronx, NY 10468;* Joel Gelernter, M.D., Vivian Mitropoulou, M.A., Larry J. Siever, M.D.

SUMMARY:

The etiology of personality disorders is undoubtedly multidetermined. A range of biologic measures from CSF 5-HIAA to prolactin response to fenfluramine have been found, which suggest that abnormal serotonergic function may be associated with impulsive aggression in patients with personality disorders. The personality disorder most commonly associated with impulsivity and aggression is borderline personality disorder (BPD).

As irritable aggression is partially heritable, it is logical to investigate whether genetic differences in determinants of serotonergic function, such as synthesis and receptor sensitivity, may contribute to different susceptibilities to impulsive aggression. Polymorphisms in human genes involved in serotonin functioning have been identified. Some of these are the serotonin transporter, the serotonin 1b receptor, and the tryptophan hydroxylase gene.

In our laboratory preliminary results suggest that differences in impulsive aggression and suicidal behavior are associated with different alleles in polymorphisms in these genes in patients with personality disorders. For example, an association has been found between the "G" allele of the serotonin 1b receptor gene and a history of suicide attempts in a sample of 89 Caucasian patients with personality disorder, and, in an already published manuscript, the "LL" genotype of the tryptophan hydroxylase gene has been associated with higher scores in the Buss-Durkee Hostility Inventory (New et al. 1998). Additional genetic data including other serotonin-related genes will be presented.

The implications of these findings will be discussed along with caveats related to genetic studies of complex behaviors.

No. 6E
IMAGING THE SEROTONIN SYSTEM IN PERSONALITY DISORDER PATIENTS

Larry J. Siever, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, 1 Gustave Levy Place/Box 1230, New York, NY 10029;* Antonia S. New, M.D., Monte S. Buchsbaum, M.D., Erin A. Hazlett, Ph.D., Marianne Goodman, M.D., Diedre A. Reynolds, M.D., Harold W. Koenigsberg, M.D.

SUMMARY:

Decreases in serotonergic activity have been associated with impulsive aggression in personality disordered patients and suicide attempts in personality disordered patients and depressed patients. The orbital frontal cortex appears to play a critical role in regulating aggression by inhibiting subcortical structures such as amygdala and cingulate involved in the evaluation of highly charged emotional stimuli. Lesions of orbital frontal cortex can lead to poor social judgment and poorly modulated aggressive behavior. These regions are heavily serotonergically innervated and their metabolic activity is increased by serotonergic agents. In one study, fenfluramine at a dose of 60 mg was administered to six impulsive aggressive patients and five normal controls. The impulsive aggressive personality disorder patients showed significantly reduced metabolic activity increases following fenfluramine in orbital frontal and cingulate cortex but not in other brain regions evaluated. Fenfluramine caused increases in metabolism in a variety of brain regions including orbital frontal cortex, cingulate cortex and medial frontal cortex, while these increases were not significant in the impulsive aggressive personality disorder patients. This study in conjunction with studies of depressed patients, particularly suicide attempters, showing reductions in metabolic activation of cortex by fenfluramine, suggest that serotonergic innervation of key cortical regions may modulate the expression of aggression. New studies using the direct serotonergic agonist metachlorophenylpiperazine (mCPP) and studies evaluating the metabolic response to treatment with fluoxetine as well as correlations with the genotypes of key candidate serotonergic-related candidate genes will be presented.

No. 6F
CHILDHOOD TRAUMA AND LOSS OF AFFECT REGULATION

Bessel A. Van Der Kolk, M.D., *Department of Psychiatry, Boston University School of Medicine, 227 Babcock Street, Brookline, MA 02446-3173*

SUMMARY:

In 1997, 3,195,000 children in the U.S. were reported to child protective services for caretaker abuse and/or neglect. Exposure to extreme stress in childhood has been shown to affect biological, emotional, cognitive, behavioral, and characterological functioning. Numerous studies have demonstrated a strong association between childhood trauma and the development of borderline personality disorder, self-mutilation, and substance abuse. In recent years several studies have started to elucidate how childhood trauma affects the biological systems that affect the maintenance of internal homeostasis. Independently, other investigators have been studying the psychobiology of BPD. This paper will review the various behavioral and biological abnormalities in traumatized children and integrate those findings with recent developments in the study of BPD.

REFERENCES:

1. Stone MH: The Fate of Borderline Patients. New York, Guilford Press, 1990
2. Yehuda R, Boisoneau D, Lowry MT, Giller EL: Dose-response changes in plasma cortisol and lymphocyte glucocorticoid receptors following dexamethasone administration in combat veterans with and without posttraumatic stress disorder. Arch Gen Psychiatry. 1995;52:583–593
3. Coccaro EF, Kavoussi RJ, Cooper TB, Hauger RL: Central serotonin and aggression: inverse relationship with prolactin response to d-fenfluramine, but not with CSF 5-HIAA concentration in human subjects. Am Journal Psychiatry 1997;154:1430–1435
4. New A, Gelemter J, Yovell Y, Trestman R, et al: Increases in irritable aggression associated with genotype at the tryptophan hydroxylase locus. Am J Med Genet 1998;81(1):13–17
5. van der Kolk BA, McFarlane AC, Weisaeth L: Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. New York, Guilford Press, 1996

SYMPOSIUM 7—TREATMENT-REFRACTORY SCHIZOPHRENIA: A NEW LOOK

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to discuss current criteria for treatment-refractory schizophrenia and develop a plan for appropriate treatment with an atypical antipsychotic, taking into account the patient's history of response to prior treatments, comorbid conditions, and recent information about optimization of clozapine use.

No. 7A
IMPLICATIONS OF DEFINITIONS FOR TREATMENT

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

SUMMARY:

The term treatment refractory has been used in schizophrenia to encompass a wide range of conditions. Patients who do not respond "briskly" to medication in an acute treatment setting within a few days or weeks have been called treatment refractory. At the other end of the continuum lie patients who do not respond well to a course of clozapine treatment—the acknowledged standard in the field. The term is rarely used to denote lack of responsiveness to psychosocial treatment or rehabilitation efforts.

This presentation will review some critical issues in determining whether a patient with schizophrenia is refractory to antipsychotic medication. What are the specific symptomatic criteria? Are the criteria met based on history or on prospective observation by the clinician? How long must patients meet such criteria before intervention is considered? How can we decide if medication noncompliance is a factor?

The major question for clinicians is what treatment alternatives should be considered for a given set of criteria? Three criteria sets will be described and treatment alternatives considered: refractory to older antipsychotic medication; refractory to one of the newer antipsychotic medications; refractory to clozapine.

No. 7B
OPTIMIZATION OF CLOZAPINE TREATMENT

Del D. Miller, M.D., *Department of Psychiatry, University of Iowa, #2880 JPP/200 Hawkins Drive, Iowa City, IA 52242*

SUMMARY:

Despite recent pharmacological advances in the treatment of schizophrenia such as the development of risperidone, olanzapine, and quetiapine, there remain a significant number of persons with schizophrenia who are refractory to treatment. Clozapine has been shown to be particularly effective in treating those persons with schizophrenia who are refractory to treatment with other antipsychotic medications. Controlled studies report that 40% to 50% of patients refractory to conventional antipsychotics will respond to treatment with clozapine. Nonetheless, many analyses find that clozapine is underutilized. Although not all patients with treatment-refractory schizophrenia will respond to clozapine, it is important that clozapine treatment be optimized before considering a patient clozapine refractory as there are no controlled trials and few guidelines in the literature regarding logical treatment of this population. This presentation will examine some of the factors that limit the use of clozapine and will present findings from newer studies that indicate how clinicians can optimize clozapine treatment. This will include recent data on dosing, use of clozapine plasma concentrations, and duration of treatment. There will also be a discussion of the management of clozapine side effects as it is clear that the appropriate handling of side effects facilitates a maximization of the benefits of clozapine treatment.

No. 7C
MEDICATION GUIDELINES AND ALGORITHMS

Alexander L. Miller, M.D., *Department of Psychiatry, University of TX Health Science Center, 7703 Floyd Curl Drive, San Antonio, TX 78284-7792;* John A. Chiles, M.D., M. Lynn Crismon, Pharm.D.

SUMMARY:

For a number of years medical practice has been increasingly influenced by guidelines and protocols. This trend is evident in psychiatry, with the recent publication of guidelines by various groups and organizations. This presentation will compare current guidelines for medication treatment of schizophrenia, focusing on the recommendations for patients who have failed at least two trials of antipsychotics.

The guidelines that will be reviewed will include those developed by the APA, the Expert Consensus method, the Texas Medication

Algorithm Project, the VA, the American Pharmaceutical Association, and the PORT project. Each differs in its proposed sequence of medications, in the specificity of its recommendations, in the methodology used to develop and change the guidelines, and in the number of alternatives available to the clinician. The evidence that supports each guideline's recommended course of treatment for patients with prior treatment failures will be critically examined. The evidence and rationales for monotherapy versus combination antipsychotic therapies will be reviewed.

The goal is that audience participants will understand the potentially helpful role of guidelines in the treatment of the patient with treatment-refractory schizophrenia and will be able to select the elements from current guidelines that are appropriate to incorporate into their practices.

No. 7D
THE ROLE OF SECOND-GENERATION ANTIPSYCHOTICS IN TREATMENT-REFRACTORY SCHIZOPHRENIA

Robert R. Conley, M.D., *Psychiatric Research Center, University of Maryland, PO Box 21247, Baltimore, MD 21228*

SUMMARY:

Treatment resistance in schizophrenia remains a public health problem. Clozapine has been shown to be effective in about one third of this population, but carries with it medical risks and weekly blood draws. A systematic approach to the evaluation and characterization of treatment resistance in schizophrenia has become increasingly important since the introduction of risperidone, olanzapine, and quetiapine. The need for accurate evaluation will increase with the introduction of the next generation of antipsychotic medications. Clinicians facing the decision of when to change from one antipsychotic to another must clearly understand the appropriate length of a trial and what target symptoms respond to antipsychotics in order to maximize the response in patients with treatment-resistant schizophrenia. There are now a number of studies published that evaluate the effectiveness of second-generation antipsychotics in treatment-refractory schizophrenia. In this presentation these studies will be presented and reviewed. The role of clozapine therapy in light of these data will be addressed. Treatment-resistant patients who fail on second-generation antipsychotics may benefit from a subsequent trial of clozapine.

No. 7E
MANAGING COMORBID MANIFESTATIONS OF SCHIZOPHRENIA

Peter F. Buckley, M.D., *Department of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue HPV5080, Cleveland, OH 44106*

SUMMARY:

With increasing focus on the potential of medication algorithms to provide a consistent and effective "road map" for treating persons with serious mental illness, the clinical characteristics and management of persons with severe schizophrenia who have comorbid conditions have become a growing concern. Patients with schizophrenia who also abuse drugs or alcohol and patients with persistent aggression are two noteworthy groups. There is accruing evidence for the efficacy of atypical antipsychotics in these patient groups. These data suggest comparable or superior outcome to conventional antipsychotics both with respect to symptoms of schizophrenia and comorbid behaviors. The relative efficacy of each atypical antipsychotic medication in these comorbid conditions is, however, less clear. Moreover, management approaches are complicated by concerns over access to atypical antipsychotics, therapeutic alliances, continuity of care, and planning for sustained community tenure. This presentation will focus on the management of persons with schizophrenia who have comorbid substance abuse and those with persistent aggression and on the emerging clinical profiles of novel antipsychotic medications for comorbidity in schizophrenia.

REFERENCES:

1. Van Kammen DP, Schooler NR: Are biochemical markers for treatment-resistant schizophrenia state dependent or traits? Clinical Neuropharmacology 1990;13(1):16–28
2. Miller DD: The clinical use of clozapine plasma concentrations in the management of treatment-refractory schizophrenia. Annals of Clinical Psychiatry 1996;8:99–109
3. Miller AL, Chiles JA, Chiles JK, et al: The Texas Medication Algorithm Project Schizophrenia Algorithms. J Clinical Psychiatry, in press (1999)
4. Conley RR, Taminga CA, Kelly DL, Richardson, CM: Treatment-resistant schizophrenic patients respond to clozapine after olanzapine non-response. Biological Psychiatry 1999 Jul 1;46(1):73–7
5. Buckley PF: Management of aggression in patients with schizophrenia. Schizophrenia Monitor 1998;8:19–22

SYMPOSIUM 8—BIPOLAR DEPRESSION: CLINICAL, BIOLOGICAL AND TREATMENT SPECIFICITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the biological and clinical specificity of bipolar depression, have a critical grasp of currently available treatment modalities, and be able to formulate a treatment plan taking properties of the illness and the patient's previous course into account.

No. 8A
BIOLOGICAL SPECIFICITY OF BIPOLAR DEPRESSION

Alan C. Swann, M.D., *Department of Psychiatry, UT Houston Medical School, 1300 Moursund Street, Room 270, Houston, TX 77030;* Terry Allen, Ph.D., Martin M. Katz, Ph.D.

SUMMARY:

Depressive episodes of bipolar and major depressive disorders were not distinguished until the 1950s. Clinically, bipolar depressive episodes have more psychomotor retardation and are more likely to have atypical features, but these characteristics overlap considerably and the diagnosis cannot be made without knowledge of the history. Bipolar depressions occur in the context of greater episode frequency, earlier onset, more comorbid substance abuse, and a more equal gender ratio. Bipolar depressions appear to have a stronger relationship to function of catecholamine systems. Fine motor performance is equally impaired in bipolar and unipolar depression, but in bipolar depression motor impairment is more strongly related to norepinephrine and to severity of depressed mood. Noradrenergic function is also more strongly related to effects of stress and prediction of response to antidepressant drugs in bipolar than in unipolar depression. Little is known about differential pharmacological sensitivities. The differing biological properties of unipolar and bipolar depression suggest that treatments that were originally intended for unipolar depression may not be optimal for bipolar depression. Bipolar and unipolar depressions could represent similar clinical syndromes with

different biological substrates, or originally similar physiologic entities that were modified by the effects of manic episodes.

No. 8B
CEREBRAL FUNCTION IN BIPOLAR DEPRESSION

Terence A. Ketter, M.D., *Department of Psychiatry, Stanford University School of Medicine, 401 Quarry Road, Room 2124, Stanford, CA 94305-5723;* Timothy A. Kimbrell, M.D., John T. Little, M.D., Mark S. George, M.D., Nadia Sachs, M.Eng., Mirene E. Winsberg, M.D., Po W. Wang, M.D., Robert M. Post, M.D.

SUMMARY:

Objective: To explore cerebral metabolism in bipolar depression in relation to illness chronicity and treatment refractoriness.

Methods: Cerebral metabolism was assessed using fluorine-18 deoxyglucose and positron emission tomography in 43 bipolar disorder inpatients at NIMH and 17 bipolar disorder outpatients at Stanford.

Results: In the NIMH cohort, treatment-refractory depressed bipolar disorder inpatients had absolute prefrontal and anterior paralimbic cortical hypometabolism and relative anterior paralimbic subcortical hypermetabolism. All bipolar disorder subgroups (depressed, mildly depressed, euthymic; bipolar I, bipolar II; rapid cycling, non-rapid cycling) compared with healthy controls had cerebello-posterior cortical relative hypermetabolism. Baseline left insula hypermetabolism was associated with carbamazepine response and hypometabolism with nimodipine response. The less chronically ill and less treatment-refractory depressed bipolar disorder outpatients at Stanford compared with controls had anterior paralimbic and cerebello-posterior cortical hypermetabolism. Metabolic decreases with sustained sadness compared with controls were blunted in patients who ultimately had antidepressant responses to divalproex and enhanced in nonresponders.

Conclusions: Illness chronicity and treatment refractoriness appear to influence patterns of cerebral metabolism in bipolar depression. Cerebello-posterior cortical hypermetabolism could be a trait marker. Further studies are needed to better understand the neurobiology of bipolar depression and assess possible baseline markers of treatment responses.

Supported by the Stanley Foundation Research Awards Program.

No. 8C
RECENT CLINICAL RESEARCH IN BIPOLAR DEPRESSION

Joseph R. Calabrese, M.D., *Department of Psychiatry, Case Western Reserve, 11400 Euclid Avenue, Suite 200. Cleveland, OH 44126*

SUMMARY:

The literature on the effectiveness of lithium and preliminary data on the efficacy of divalproex in rapid cycling (Calabrese et al, 1990) has prompted our group to begin a controlled trial comparing the efficacy of lithium monotherapy with divalproex monotherapy in the treatment of rapid-cycling bipolar disorder. This NIMH-funded trial is ongoing. Of the 137 evaluable patients with rapid cycling who have completed the open stabilization phase of this trial, 24% of the intent-to-treat sample and 51% of the completer sample experienced both marked antidepressant and antimanic effects from lithium and divalproex combination therapy. Forty-four patients were noncompliant and 32 were nonresponders (25 resistant depression and 7 resistant mania/hypomania). These data suggest that even the combination of lithium and divalproex does not produce enough improvement in most patients with rapid-cycling bipolar disorder and that more aggressive treatment strategies are needed. In addition, the observed profile of nonresponse suggests that much of the refractoriness to the combination of lithium and divalproex is attributable to resistant depression. These data are consistent with the earlier findings of Kukopulos et al (1980) who observed that patients with rapid cycling tend to experience depressions that are more severe and longer lasting than their hypomanias or manias. It is clear that an alternative pharmacotherapy is needed in the clinical management of bipolar depression. One such possibility includes lamotrigine, which has recently been shown to be superior to placebo in bipolar I depression and without inducing a switch into hypomania/mania at a rate exceeding that of placebo (Calabrese et al, 1999).

No. 8D
CLINICAL EVIDENCE ON ANTIDEPRESSANTS FOR BIPOLAR DISORDER

Trisha Suppes, M.D., *Department of Psychiatry, UT Southwestern Medical Center, 5959 Harry Hines Boulevard, Dallas, TX 75235*

SUMMARY:

Controversies still exist on the use of antidepressants for bipolar depression. These issues include the use of antidepressants generally, once used how long to continue, and potential impact on the long-term course of illness after their use. While answers on many of these issues may not yet be reached, available data from controlled studies and larger case series will be reviewed. Additionally, the therapeutic specificity of earlier agents versus newer agents will be discussed. The question of whether the newest antidepressants provide an improved option or are a minor improvement will be reviewed. New complementary medicine approaches to depression will be considered. Finally, the potential impact of the spread of treatment guidelines for bipolar disorder into clinical practice will be considered in light of the above controversies and issues.

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SYMPOSIUM 9—THE PRACTICAL MEDICAL MANAGEMENT OF HIV DISEASE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the current, complex HIV treatment regimens and the challenges they pose to patient adherence; identify specific drug-drug interactions and principles; understand the diagnosis and treatment of neuropsychiatric manifestations.

No. 9A
NEW ANTIRETROVIRAL TREATMENTS IN HIV DISEASE

Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130*

SUMMARY:

The availability of an increasing number of antiretroviral agents and the rapid development of new information has introduced and sustained extraordinary complexity regarding the treatment of HIV-infected persons. Potential benefits of such treatments include control or reduction of viral replication, delayed disease progression and prolongation of life, and potential maintenance or reconstruction of a normal immune system. While generating waves of hope and optimism, these treatments also carry significant risks, including the reduction of the quality of life because of toxicity, the potential for early viral resistance and the resulting decrease in treatment options, and the unknown long-term efficacy as well as toxicity of the combination therapies. These risks pose serious challenges in the treatment of HIV disease. To address the challenges presented by this epidemic, this session will provide information on recent advances in virologic detection and monitoring and explore guidelines and options for the treatment of HIV disease.

At the end of this session, participants should be able to delineate the challenges that psychiatrists must be aware of when treating HIV patients, identify new trends in viral detection and clinical measurements, and describe updated HIV treatment guidelines, options, and controversial unanswered questions.

No. 9B
TREATMENT APPROACHES TO HIV-RELATED NEUROCOGNITIVE DISORDERS

Mark H. Halman, M.D., *Department of Psychiatry, University Toronto, 77 Metcalfe Street, Toronto, ON M4X1S1, Canada*

SUMMARY:

Neurologic disease is the first manifestation of symptomatic HIV infection in roughly 10% to 20% of people, while 30% to 40% of patients with advanced HIV disease will have neurologic dysfunction during the course of their illness. The incidence of subclinical neurologic disease is even higher: 70% to 90% of autopsy studies of patients with advanced HIV disease have demonstrated pathologic abnormalities of the CNS. This research shows that HIV directly infects the brain, resulting in CNS 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 improved treatments and longer survival times, the incidence of HIV-related neuropsychiatric sequelae is expected to increase. The involvement of psychiatrists in treating HIV/AIDS patients is essential because of the prevalence of HIV-related neuropsychiatric complications, comorbidity, and the psychodynamic aspects of HIV 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 treatments.

By the end of this presentation participants should be able to identify the neuropsychiatric conditions that often exist with or because of HIV infection, and be able to list the general and specific effective psychopharmacologic treatment approaches.

No. 9C
COMPLICATIONS OF DRUG-DRUG INTERACTIONS AND SUBSTANCE USE

Karl Goodkin, M.D., *Department of Psychiatry, University of Miami School of Medicine, 1400 NW 10th Avenue, Room 806-A, Miami, FL 33136*

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.

By the end of this presentation participants should be able to identify general and specific drug-drug principles and interactions, acknowledge drug prescribing guidelines and patient discussion points, and recognize special issues and complications regarding patient substance use.

No. 9D
ADHERENCE STRATEGIES

Milton L. Wainberg, M.D., *New York Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Recent studies have found that patients who feel they are involved in their community and in their own care are more likely to take medications, keep appointments, and follow medical advice. However, patients who feel detached or depressed are more apt to disregard treatment. These findings are important in the continuous effort to identify reasons why some HIV patients become nonadherent. The consequences of nonadherence may be severe: resistance and cross-resistance can develop and potential benefits of treatment can be entirely lost. In light of these potential personal and public health consequences, psychiatrists have a vital role to play in assessing the medical and behavioral aspects that directly impact on treatment follow through. This session will present the issues involved in patient adherence to treatment, identify challenges that psychiatrists may face, and explore methods that clinicians can employ with patients.

By the end of this presentation participants should be able to identify factors that determine patient failure and adherence to treatment, be able to assess a patient's ability to adhere to complex treatment regimens, and be aware of strategies that psychiatrists can use to affirm or boost patient adherence to HIV treatment.

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SYMPOSIUM 10—TRAGEDY AND REMEDY: REMEMBERING LITTLETON ONE YEAR
APA Alliance and the APA Committee on Juvenile Justice Issues

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have increased knowledge of the complex clinical problems of serious juvenile offenders in the realm of policy making, programmatic planning, and funding decisions. The papers reflect the urgent need for psychiatric expertise in these matters.

No. 10A
NEW AND IMPROVED: CHICAGO'S JUVENILE COURT CLINIC

Bernardine Dohrn, J.D., *School of Law, Northwestern University, 357 E. Chicago Avenue, Chicago, IL 60611*

SUMMARY:

The chief judge of the Circuit Court of Cook County (Chicago) requested that the department of psychiatry, University of Chicago, and the Children and Family Justice Center, Northwestern University School of Law, study and make recommendations for the redesign of the juvenile court clinical information system in 1995. A multidisciplinary team of psychiatrists, psychologists, lawyers, and researchers investigated the acquisition and use of clinical information through the review of 1,500 case files, interviews with court personnel, fiscal examination, time studies, and assessments of court clinics across the nation. The recommendations forthcoming were for sweeping structural, substantive and procedural reforms for a court clinic based on the specific needs of youth and families of juvenile court.

The effective marshaling of responsive timely information requires the simultaneous education and inter-relationship of clinicians and legal staff, the establishment of professional standards, linkages with community resources with prior clinical involvement, and the development of services responsive to the needs of the juveniles. The presentation will discuss the proposed juvenile court-based clinic with four units: clinical coordination, education and resource, clinic administration, and program evaluation.

No. 10B
POINTS OF INTERVENTION WITH DELINQUENTS: TIMELY OR TOO LATE?

Wade C. Myers, M.D., *Department of Psychiatry, University of Florida, PO Box 100234/JHMHC, Gainesville, FL 32610-0256;* Kimberly M. Donat, M.S.W., Paul R.S. Burton, Jane Cheney, O.T., Paula D. Sanders, C.T.R.S., Linda Monaco, Ph.D.

SUMMARY:

Juvenile delinquency remains a national health concern. Nearly 2.9 million juveniles were arrested in 1997, accounting for 19% of all arrests. In Florida, referrals for juvenile crime increased 133% between 1984 and 1997. Juvenile crime is also expensive—the cost of incarcerating a juvenile offender for one year is approaching $40,000, a little more than Harvard College admission.

There is an expanding body of research on treatments for antisocial behavior by youth; outcomes overall have been modest at best to date. A multicomponent, multicontextual approach that intervenes at family, school, and peer levels, and allows flexibility in application appears to be the most promising strategy.

This paper will examine different points of intervention that can be made by psychiatrists in their work with juvenile offenders. Project Back-on-Track, a multimodal after-school diversion program for early career juvenile delinquents ages 8 through 17 years, will be discussed. Most youths referred to this four-week treatment program based in a child psychiatry outpatient clinic had committed violent offenses and had conduct disorders. At one-year follow-up, treatment through Project Back-on-Track was effective in reducing criminal recidivism and costs. Other points of intervention (e.g., interaction with juvenile and adult courts) with case examples to illustrate where help might have been forthcoming earlier to avoid incarceration will also be discussed.

No. 10C
THE ROLE OF POLICY MAKERS IN DELINQUENCY PREVENTION

Altha J. Stewart, M.D., *Detroit Wayne CMHA, 640 Temple, Detroit, MI 482*

SUMMARY:

Recent events have forced health care policy makers to carefully review their role in creating programs that address the often unique forms of intervention required to meet the needs of an increasingly diverse population. The incident at Littleton, Colorado, along with similar occurences over the past few years, has highlighted once again the importance of providing prevention, education, and outreach services, as well as quality treatment and intervention services.

Mental health professionals have a responsibility to assure that key decision and policy makers have the full benefit of the specialized training and skills we can provide as we seek to learn more about preventing such tragedies and identifying those individuals most at risk.

As we transform the current health care delivery system, clinicians and administrators will have to work closely with legislators and policy makers to maximize all available resources to decrease the occurence of such events. Strategies for working with legislators, communities, and families to accomplish this will be discussed.

No. 10D
IS THIS CHILD AT RISK FOR VIOLENCE? A SCHOOL ASSESSMENT

Louis J. Kraus, M.D., *Department of Psychiatry, Evanston NW Healthcare, 2650 Ridge Avenue, Evanston, IL 60201*

SUMMARY:

This presentation will focus on psychiatric consultation within the school system of children and teens identified at risk for violent behavior. Psychiatrists can make a major contribution to children's mental health through a close working relationship and interaction with school personnel. Consultants should understand that they are outsiders being asked to evaluate a child in the school system. The focus of their work needs to be the child's basic educational needs, diagnostic evaluation with particular attention to whether the youth is at risk for harm to self or others, and should include recommendations for mental health interventions.

The tragic school shootings in Colorado and elsewhere have received strong media attention and are responsible in part, for the increased anxiety of parents about their children attending school, leaving children fearful as well as teachers. This presentation will describe the type of child at risk within school systems with a particular emphasis on children who are depressed and socially isolated. Behavior disordered children will be discussed including a

differentiation of conduct-disordered children from other types of associated mental illness and how appropriate therapeutic intervention can be structured.

No. 10E
VIOLENCE AND THE CULTURE OF FEAR: THE LEGISLATIVE CHALLENGE

Herbert S. Sacks, M.D., *Child Study Center, Yale University, 260 Riverside Avenue, Westport, CT 06880-4804*

SUMMARY:

Sweeping juvenile crime legislation passed the House and Senate in the last session of Congress in the wake of the murderous violence in Littleton, Colorado. While the Senate bill provides juvenile justice funding for mental health services for the 66% of incarcerated youth and reduces children's access to guns, the House bill fails to address the mental health and substance abuse needs of children. The House bill would reverse core protections for the young, try more children as adults, and place them at risk in adult jails.

In September 1999 observers were not optimistic that the Senate-House conferees would accept the more compassionate Senate provisions supported by APA. In the political background, Governor Bush, a presidential aspirant, tripled the number of juveniles in Texas prisons, lowered the age for transfer to adult courts, and increased the maximum sentences for juveniles up to 40 years. Congressional legislators, to avoid charges of "being soft on crime," will push for a punitive bill despite recent Center for Disease Control data that teenagers are carrying fewer weapons and are committing 33% fewer homicides than they were seven years ago. If political posturing obscures scientific findings in the debate, legislation inimical to America's children may be passed.

REFERENCES:

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4. Glasser B: The Culture of Fear: Why Americans are Afraid of the Wrong Things. Basic Books, 1999

SYMPOSIUM 11—THE MANY FACES OF TRANSFERENCE IN EVERYDAY CLINICAL CARE: PART 1
American Academy of Psychoanalysis and the American Psychoanalytic Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the presentation, the participants will acquire an understanding of the conscious and unconscious effects of the doctor/patient relationship on the course of psychiatric and medical treatment.

No. 11A
WOMAN TO WOMAN: THE PSYCHOTHERAPEUTIC RELATIONSHIP

Jennifer I. Downey, M.D., *Department of Psychiatry, Columbia University College, 108 E. 91st Street #1A, New York, NY 10128*

SUMMARY:

This presentation focuses on some of the important ways in which the gender of patients and therapists influences the therapeutic relationship. The patients discussed will be women of all ages, heterosexual, lesbian, and bisexual, during different phases of treatment with a female psychotherapist. As a result of transference, the overt themes discussed at the beginning of therapy are given new meanings, and lead to behaviors that often seem to defy commonsense explanations. Exploring the patient's fantasies about the therapist illuminates underlying psychotherapeutic themes. The major transference areas selected for discussion are the maternal/paternal, and the exotic transferences. The many types of fantasies considered include the therapist's vocation, sexual orientation, relationship to her children, financial status, romantic life, family of origin, and religious convictions. Fantasies about the therapist, if left unexplored, may be acted out in self-destructive ways, and lead to resistance. Common pitfalls leading to difficulties in the therapeutic relationship will be outlined.

No. 11B
MAN TO MAN: THE PSYCHOTHERAPEUTIC RELATIONSHIP

Richard C. Friedman, M.D., *Department of Psychiatry, Weill Medical College, 225 Central Park West # 103, New York, NY 10024*

SUMMARY:

A sound therapeutic relationship provides the foundation for psychotherapeutic treatment. In this presentation, I discuss ways in which the meaning of the relationship is influenced by gender. The clinical situations outlined include heterosexual, bisexual, and gay man during diverse phases of the life cycle. Topics selected illustrate how mutual understanding of the meanings of the patient's fantasies about the therapist facilitates the therapeutic relationship. Pitfalls, resistances, and countertransference errors are also explored. Two major transference areas are focused on in relation to psychotherapeutic and psychopharmacological treatment compliance or treatment resistance—the maternal/paternal transference and the erotic transference. Clinical illustrations are provided.

No. 11C
BOUNDARY VIOLATIONS IN THE THERAPEUTIC RELATIONSHIP

Glen O. Gabbard, M.D., *Department of Psychiatry, Menninger Clinic, P O Box 829, Topeka, KS 66601-0829*

SUMMARY:

Sexual and homosexual boundary violations occur on a continuum involving misjudgments within the relationship. They are enactments that are the end result of a complex set of psychodynamic determinants. The majority of practitioners who commit serious boundary violations in practice fall into four overall categories: (1) psychoses, (2) predatory psychopathy and paraphillas, (3) lovesickness, and (4) masochistic surrender. Common psychodynamic themes occurring in instances of boundary violations will be discussed, and preventive measures will also be outlined.

No. 11D
THE DOCTOR AND THE SUICIDAL PATIENT

Joan Wheelis, M.D., *Two Brattle Center Ltd., 2 Brattle Square 4th Floor, Cambridge, MA 02138–3742*

SUMMARY:

This paper will examine the vicissitucles of an intensive psychotherapy with a young woman who suicided in the course of her treatment.

REFERENCES:

1. Friedman RC, Downey JI: Psychoanalysis and sexual fantasies, in On the Development of Sexual Attraction. Edited by Herdt G, McClintoch M. Chicago, University of Chicago Press, in press
2. Friedman RC, Downey JI (eds): Masculinity and Sexuality: Selected Topics in the Psychology of Men. Washington, D.C., American Psychiatric Publishing Group, 1999
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4. Mallberger JT: Calculated risks in the treatment of intractably suicidal patients. Psychiatry, 1994;57(8)

SYMPOSIUM 12—FRONTIERS IN ALCOHOLISM TREATMENT: PHARMACOLOGY
National Institute on Alcohol Abuse and Alcoholism

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the potential utility of pharmacotherapy in the treatment of alcohol dependence.

No. 12A
UPDATE ON ANTICONVULSANTS FOR ALCOHOL WITHDRAWAL

Robert J. Malcolm, Jr., M.D., *Department of Psychiatry, Medical Univ. of South Carolina/IOP, 67 President St. PO Box 250861, Charleston, SC 29425-0001;* Donald L. Myrick, M.D., Raymond F. Anton, M.D., James Roberts, Ph.D.

SUMMARY:

Anticonvulsants may be as effective as benzodiazepines for the treatment of alcohol withdrawal (AW) and have potential advantages in outpatient settings: lack of abuse potential and minimal interactions with alcohol. Carbamazepine appears to be as effective as lorazepam and oxazepam in ameliorating the symptoms of alcohol withdrawal. Carbamazepine appears to be superior to lorazepam in suppressing electrophysiologic measures of alcohol withdrawal.

An interim analysis of a controlled trial of carbamazepine vs. lorazepam indicated that carbamazepine was superior in preventing post-treatment withdrawal rebound, subjective sleep disturbances, a reduction of anxiety and depressive symptoms, and in reducing the number of drinks per drinking day in subjects who had previous detoxes. Divalproex may also suppress symptoms of AW based upon several open-label studies. Gabapentin also appears to reduce AW symptoms in preclinical and clinical trials, does not interact with other drugs, and lacks the uncommon but serious toxicities of carbamazepine and divalproex. Minimal alcohol use and a reduction of psychiatric symptoms during detox is advantageous for patients entering alcohol rehabilitation. Anticonvulsants may offer several advantages over benzodiazepines in safety and multiple dimensions of efficacy.

No. 12B
ACAMPROSATE TREATMENT OF ALCOHOL DEPENDENCE

Barbara J. Mason, Ph.D., *Department of Psychiatry, Univ. of Miami School of Medicine, 1400 NW 10th Ave, Ste307A(D-79), Miami, FL 3313*

SUMMARY:

Acamprosate (calcium acetylhomotaurinate), is a centrally active synthetic compound with a chemical structure similar to that of GABA that has been shown to reduce voluntary drinking in both animal models and in controlled clinical trials involving patients with alcohol dependence. Its predominant mechanism of action is thought to involve NMDA receptor modulation, with no anxiolytic, antidepressant, or pharmacodynamic effects other than on alcohol consumption. Acamprosate is available by prescription and has been widely studied in Europe, including 16 multicenter, randomized, placebo-controlled trials of three to 12 months duration, involving over 4,400 alcoholics across 11 countries. A meta-analysis of this large database confirmed the safety and significant efficacy of acamprosate relative to placebo for maintaining or prolonging abstinence. A recent European open-label, multinational six-month study of acamprosate in combination with a variety of behavioral treatments in nearly 1,300 patients with alcohol dependence confirmed the safety and efficacy findings of the double-blind studies. A 21-site, six-month, double-blind, multicenter study of acamprosate in 601 patients with alcohol dependence was recently completed in the U.S. to confirm the safety and efficacy of acamprosate in U.S. alcoholics. Efficacy and safety results from the U.S. study and the European database will be presented.

No. 12C
NALTREXONE: EFFECT OF THERAPY AND TREATMENT DURATION

Stephanie S. O'Malley, Ph.D., *Department of Psychiatry, Yale University Medical School, One Long Wharf Drive, Box 18, New Haven, CT 06511* Patrick G. O'Connor, M.D., Conor K. Farren, M.D., Kee Namkoong, M.D., Bruce J. Rounsaville, M.D.

SUMMARY:

This study was undertaken to evaluate the relative short-term effectiveness of naltrexone when provided with a medical model of counseling and with a specialty model of alcoholism treatment. The second objective was to examine the efficacy of long-term naltrexone in those who responded to initial therapy. A total of 197 alcohol-dependent patients were randomized to receive either primary care counseling or cognitive behavioral therapy for 10 weeks with naltrexone 50 mg daily. Treatment responders, who drank heavily on no more than two days in the last month of treatment, were randomized to naltrexone or placebo for six additional months. The percentage of responders to initial treatment was similar for the two models of care. Among responders treated with cognitive behavior therapy, a substantial proportion maintained their responder status during the following six months irrespective of whether they continued on naltrexone or received placebo. However, within the medical model counseling condition, those who continued on naltrexone were more likely to continue as responders. These results indicate that naltrexone treatment is effective in conjunction with medical model counseling, especially when long-term treatment is provided. Responders to cog-

nitive behavioral therapy and naltrexone, however, do not appear to require longterm naltrexone therapy.

Supported by NIH Grants KO2-AA00171 and RO1-AA0953.

No. 12D
NALTREXONE: EFFECTS OF TREATMENT DURATION

Joseph R. Volpicelli, M.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut St, Philadelphia, PA 19104;* John Monterosso, Ph.D., Helen M. Pettinati, Ph.D.

SUMMARY:

The aims of this study were to test whether naltrexone is effective using a medication management approach that incorporates compliance enhancement techniques (BRENDA nodal) and to compare the safety and effectiveness of nine months of naltrexone versus three months of naltrexone (100 mg/day). One hundred eighty-four alcohol-dependent subjects were randomly assigned to either nine-months of naltrexone, nine months of placebo, or three months of naltrexone followed by six months of placebo. All subjects were treated by a nurse practitioner for 30-minute BRENDA sessions. During the first three months of the trial, the naltrexone arouse had fewer days of heavy drinking (5 or more drinks) $p < 0.05$. During months 4 through 9, the naltrexone group that crossed over increased alcohol drinking, while the group maintained on naltrexone did not (time by group interaction p(.05). During the three-month follow-up period, the group that had received naltrexone for nine-months continued to report fewer days of heavy drinking than either the placebo group $p < 0.05$ or the group that received naltrexone for just three months. These results show that naltrexone can provide clinically significant benefits when used in a primary care setting and maintenance on naltrexone for nine months improve treatment outcome.

No. 12E
MATCHING SSRI TREATMENT TO SPECIFIC GROUPS OF ALCOHOLICS

Henry R. Kranzler, M.D., *Department of Psychiatry, Univ. of CT Health Center, 263 Farmington Avenue, Farmington, CT 06030-2103;* Helen M. Pettinati, Ph.D.

SUMMARY:

Initial reports that selective serotonin reuptake inhibitors (SSRIs) reduce alcohol consumption in heavy drinkers generated considerable interest in the use of these medications for alcoholism treatment. Subsequently, however, studies of these medications in alcoholics have shown them to produce either modest effects or no advantage over placebo. Recently, a cluster-analytic subtyping procedure using measures of premorbid risk and alcoholism severity has provided a basis for understanding these variable findings. A study of the efficacy of fluoxetine in 101 alcohol-dependent subjects who were not selected for comorbid psychopathology provided initial evidence of the utility of this approach. Although fluoxetine treatment was not significantly different from placebo in its effects on alcohol consumption, when subjects were grouped into low risk/severity (Type A: $n = 60$) and high risk/severity (Type B: $n = 35$) groups, a significant interaction with treatment ($p = .03$) was observed. Interestingly, Type B subjects treated with fluoxetine had poorer drinking-related outcomes than those receiving placebo. Subsequently, a placebo-controlled study of sertraline in 100 alcohol-dependent subjects showed a significant interaction of medication with alcoholic subtype ($p < .01$). In this case, there was both an advantage for placebo in Type B subjects ($n = 54$) and an advantage for sertraline in Type A alcoholics ($n = 46$). Together, the results of these studies underscore the importance of matching subgroups of alcoholics to SSRI treatment.

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SYMPOSIUM 13—PROFESSIONAL ADVOCACY: PERSONAL LEADERSHIP ODYSSEYS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) understand that advocating for the profession entails a strong personal commitment, (2) describe the leadership skills necessary to move professional agenda, (3) recognize relationship building and political acumen in advocacy.

No. 13A
LEADERSHIP IN ORGANIZED PSYCHIATRY

Rodrigo A. Muñoz, M.D., *University of CA at San Diego, 3130 5th Avenue, San Diego, CA 92103*

SUMMARY:

The last decade of the 20th century and the first of the 21st century will test the ability of the APA to lead its members, and other physicians, to successful advocacy for the profession. Leadership competencies are now more critical than ever as health care faces tremendous economic and social changes. Skills to understand medicine in the context of change require psychiatrists to expand their thinking to include solid business acumen. Organized psychiatry has the opportunity to champion issues that strongly support patients, the community, and the profession in general; techniques to move this forward must be underscored by the practical application of creative visions. This presentation will describe useful leadership skills that have been tried and been found successful in other professions and can be applied to psychiatry. Specific cases will be offered that will provide an understanding of strategic vision, which ultimately became successful, and can be used by organized psychiatry for its own purpose.

No. 13B
PROFESSIONAL ADVOCACY: PROMOTING PRIVACY AND CONFIDENTIALITY

Richard K. Harding, M.D., *Department of Psychiatry, 2 Richland Medical Park, Suite 508, Columbia, SC 29203*

SUMMARY:

One of the bedrock issues of importance to medicine and especially psychiatry is confidentiality. This presentation will provide an intimate glimpse of the only psychiatrist on a national governmental

committee looking at privacy and confidentiality of the medical records. The ability to work effectively with both other medical colleagues and with those outside of medicine who have other interests in medical records will be discussed. The major areas of controversy relating to the rights of individuals versus the rights of public health and research was one of the most contentious. The controversy of accepting blanket consumer (patient) release versus contemporaneous informed consent for release of medical information is another topic. The special nature of the psychiatric relationship will be discussed in the context of the overall medical record and how, as the only psychiatrist involved, issues pertinent to psychiatry alone needed to be advocated for. While engaged in the work of the national committee, the author continued in his governance roles within APA and a description of walking a fine line as a member of the national committee as opposed to speaking for the APA required exquisite attention. As the privacy and confidentiality battle will undoubtedly be solved in some way by the time of this symposium, the author will describe ongoing attempts through the connections made to influence the debate.

No. 13C
ADVOCACY IN ORGANIZED MEDICINE

Daniel B. Borenstein, M.D., *Department of Psychiatry, University of California, 151 North Canyon View Dr, Los Angeles. CA 90049-2721*

SUMMARY:

This presentation will describe Dr. Borenstein's personal odyssey from membership to leadership within organized medicine. It begins with joining the Los Angeles and California Medical Associations at the same time he became a member of the American Psychiatric Association. Dr. Borenstein always believed that it was important for psychiatrists to remain a part of the medical community. Since he is in solo practice, his initial involvement with other medical doctors occurred in hospital settings.

Through Dr. Borenstein's participation in state legislative activities via his APA district branch, he became increasingly aware of the similarities in psychiatric and general medical issues. Subsequently, when he became president of his district branch, he communicated with leaders in the medical community in efforts to ensure that psychiatric issues were included in their agendas. These contacts led to his interest in and membership on local and state medical association committees and his subsequent election to leadership positions in these organizations, including president of a medical district of the L.A. Medical Association, LACMA councilor, CMA Trustee, and membership in the AMA House of Delegates. Similar opportunities are available for members who wish to become more involved in organized medicine. Working together will benefit our patients and our profession.

No. 13D
ADVOCATING FOR THE PROFESSION: MENTORSHIP

Miles F. Shore, M.D., *Harvard University, 76 John F. Kennedy Street, Cambridge, MA 02138*

SUMMARY:

Most physicians can name mentors who helped them advance their careers by precept and example. But, when the same physician becomes a leader, he or she often seems to have great difficulty in finding equivalent leadership mentors. It may be partly because there are many more clinical mentors available to physicians than physician leader mentors. It may also be because career development for graduate physicians is not institutionalized in most health care organizations. That is assumed to be the responsibility of the individual, not the organization. The situation is very different in business organizations in which career development of subordinates is an explicit task of supervisors. Consequently, it is not unusual for a CEO of a large or small company to find some retired CEO, a board member, or an organizational consultant with whom he or she can meet regularly to discuss leadership skills and performance. Mentorship requirements include wisdom, experience, tact, freedom from personal interest in the outcome other than improvement of the mentee, and most of all, the capacity to tell the truth, no matter how painful.

No. 13E
PROFESSIONAL LEADERSHIP IN ETHICS

Jeremy A. Lazarus, M.D., *Department of Psychiatry, Univ. of CO, Health Sciences Center., 8095 East Prentice Avenue, Englewood, CO 80111*

SUMMARY:

No field brings more respect and more controversy than medical ethics. When medical leaders try to establish ethical policy, they run into conflicts of views, conflicts of morals, and conflicts in decision making. Following ethical similarly fraught with difficulty. The presenter will describe his personal experiences both as a member and then chair of a state ethics committee followed by terms as a member and chair of the APA Ethics Committee. A description of attempts at integration with the rest of organized medicine through the AMA and the state medical society will also be presented. The difficulties in integrating the teaching of psychiatric ethics in residency training will also be discussed. Case vignettes of struggles and successes in overcoming hurdles along the way will enlighten the discussion. The response of governance of the various organizations and also the personal experiences in enforcing ethical codes will help to fill in the details of a 25-year experience in trying to provide leadership in medical and psychiatric ethics.

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SYMPOSIUM 14—SOCIAL PSYCHIATRY: 21ST CENTURY PERSPECTIVES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize some of the critical social aspects of psychiatry that influence the use of our biopsychosocial model.

No. 14A
HARRY STACK SULLIVAN AND THE 21ST CENTURY

Steven S. Sharfstein, M.D., *Sheppard Pratt, 6501 N. Charles Street, Baltimore, MD 21204*

SUMMARY:

Harry Stack Sullivan, a founder of social psychiatry, was one of the most important innovators in the 20th century. He was a synthesizer, bringing together the new science of psychoanalysis with the emerging fields of sociology and anthropology, to form what has been called interpersonal or social psychiatry. The roots of the community mental health movement in the latter half of the 20th century are found in Dr. Sullivan's works and writings. He departed from Freud in conceiving humans as primarily social beings emphasizing a contemporary context for understanding behavior rather than early psychosexual development. He departed from Kraeplin to view the whole person in his or her social context rather than through descriptive categories of pathology. With regard to even the most regressed psychotic patient, he opined, "We are all more basically human than otherwise." His treatment focus was on strengths and abilities that could be used to compensate for biopsychosocial dysfunction. This paper will review some of Sullivan's basic concepts of anxiety, insecurity, and avoidance in relation to treatment opportunities in community-based settings of care. The ideas of Sullivan will persist well into the 21st century.

No. 14B
SOCIAL VIOLENCE: PSYCHIATRIC AND SOCIOLOGICAL ASPECTS

Gerald J. Sarwer-Foner, M.D., *Department of Psychiatry, Wayne State Univ Med School, 3320 Bloomfield Shores Drive, West Bloomfield, MI 48323*

SUMMARY:

Intrapsychic developmental factors for violence will be discussed; these include dehumanizing rejection, with non-gratification of basic needs, violent physical abuse, and degrading scapegoating. Hate and rage, unmodified by loving identification with others, allow violence to erupt. This is a common pattern in individual criminal acts—street thugs; viscous, explosive killers; serial killers.

Sociological factors, such as our conscious and unconscious view of ourselves in relationship to others, our "we-identity" (Norbert Elias) as a group or nation, play major roles in what becomes personal views of permissable violence in people, without the first type of etiological factors operating (i.e., intrapsychic developmental factors outlined above). Here the very ability to have good control, planning, and self-justifying rationalizations of a control of themselves nature, as part of a subculture in a society; or are *the* major aspects of that society's "we-identity".

There will be discussion of the roles of these factors in the forming of a personal "We" identity, and how that conflicts with the "we-identity" of the society of subgroup.

No. 14C
SOCIAL PSYCHIATRY, FAMILY FUNCTION, AND THE MILLENNIUM

John J. Schwab, M.D., *Dept of Psychiatry, University of Louisville School Medicine, 550 South Jackson Street Louisville, KY 40202;* Helen Gray, M.D., Florence Prentice, Ph.D.

SUMMARY:

During the 20th century, the American family completed the transition from "institution to companionship" and made many changes in traditional family functions. To increase understanding of family functioning at this time when so-called "family dysfunction" is blamed for many of the social and medical ills affecting society, we have developed the General Living Systems (GLS) Assessment. Results will be presented on its use with a random sample of 19 community families, eight clinic families with a young person in treatment, and eight neighborhood control families.

The GLS Family Functioning Assessment evaluates family functioning, problems, and severity in relation to actions of specified subsystems. Levels of families' subsystem functioning are compared with members scores on the Family Environment Scale, the Diagnostic Interview Schedules for Adults (DIS) and children (DISC) and the Child Behavior Checklist (CBCL). Of the 19 families in the community sample, eight were rated on the GLS Assessment as high functioning, six as midieval functioning, and five as low functioning. Among the high functioning families, only two (25%) contained at least one family member who was symptomatic. In contrast to four (87%) of the mid-level and four (80%) of the five low functioning families. Further results will be presented and the discussion will focus on family functioning as an independent variable, not tautologically confounded with symptomatology. The GLS family functioning assessment is neutral, and especially usefully with varying ethnic groups—important considerations for social psychiatry and family research—in this postmodern era at the beginning of the Millennium.

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2. Elias N: The Civilizing Process. Oxford, Blackwell, 1996
3. Miller LG, Miller JL: The family as a system, in Hofling: The Family, Evaluation and Treatment. Edited by Hofling. New York, Brunner Mazel. Inc., 1980

SYMPOSIUM 15—DOCTOR INFLUENCE ON HASTENED DEATH IN WOMEN AND MEN WORLDWIDE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have an understanding of the differential susceptibility of men and women to the clinician's influence on health care decisions with specific regard to requests for hastened death.

No. 15A
PHYSICAL HEALTH FACTORS IN COMPLETED SUICIDE

Yeates Conwell, M.D., *Department of Psychiatry, University of Rochester, 300 Crittenden Boulevard, Rochester, NY 14642;* Paul R. Duberstein, Ph.D., Larry Seidlitz, Ph.D., Andrea Digiorgio, M.A., Christopher Cox, Ph.D., Eric D. Caine, M.D., Nicholas Forbes, M.D.

SUMMARY:

Both physician-assisted death and completed suicide commonly occur in the context of physical illness and functional impairment. Examination of the role played by physical health factors in completed suicide may aid in the understanding of factors influencing other forms of end-of-life decision making. The objectives of this paper are to examine (1) whether physical health status and functional impairment distinguish completed suicides age 50 years (SCs) and over from demographically matched controls (NCs), (2) whether the influence of health and function variables is mediated by depression,

and (3) whether men and women differ with regard to the relationships between physical health factors, depression, and suicide.

Data are derived from an ongoing case-control study of completed suicide using the psychological autopsy method. Preliminary univariate analyses compared 49 SCs with 42 NCs. In addition to significantly greater odds of psychiatric illness and depressive symptoms, SCs had significantly more physical illness burden, pain, physically-based functional impairment, and overall functional impairment than NCs. For this presentation analyses will be conducted with larger case and control samples, using multivariate logistic regression to examine the influence of depressive symptoms and gender on the relationships between health variables and suicide outcome. The applicability of these results to physician-assisted death will then be considered.

No. 15B
DEMORALIZATION AND BURDEN IN DARWIN'S EUTHANASIA SERIES

David W. Kissane, M.D., *University of Melbourne, 104 Studley Park Road, Kew Melbourne Victoria 3101, Australia;* Annett Street, Ph.D.

SUMMARY:

A subgroup of palliative care patients desire death, but do not meet diagnostic criteria for major depressive disorder. The core clinical feature they demonstrate is hopelessness. Their cognitions include pessimism, fatalism, all-or-nothing thinking, and loss of purpose or meaning in their lives. Social isolation is common. Adjustment disorder, dysthymia, or "not otherwise specified DSM" mood categories are not as meaningful to our physician colleagues as demoralization syndrome. Cognitive-behavior therapy is an appropriate psychotherapeutic treatment. Patients from the euthanasia series derived from the Northern Territory, Australia, will be used to illustrate demoralization syndrome.

Concern about being a burden is another reason leading to physician-assisted suicide or euthanasia requests. Care issues trouble busy, committed families with both parents employed full time while caring for a dying grandparent. A number of ethical issues emerge when engaged in family therapy with such families struggling with the issue of burden. Another case from the Darwin euthanasia series will be discussed to illustrate this problem.

No. 15C
GENDER, THE DOCTOR-PATIENT RELATIONSHIP, AND HASTENED DEATH

Silvia S. Canetto, Ph.D., *Department of Psychology, Colorado State University, Fort Collins, CO 80523*

SUMMARY:

Published reports from Oregon (United States), Australia, and the Netherlands (where a greater range of physician's involvement in hastened death has been permitted), indicate that women represent half or more of the cases of death involving assistance from physicians (ranging from assisted suicide to euthanasia). These data are remarkable because in these countries, women represent a minority of suicide cases. The focus of this paper is on gender dynamics in the patient-doctor relationship. It examines how gender may influence the decision-making process about desirable outcomes for seriously ill persons when the issues considered include perceptions of quality of life; availability, and sense of entitlement to resources; costs; and rationality and practicality; when authority, knowledge, and power differences between patient and physician are significant; and when one of the possible solutions is the patient's hastened death.

No. 15D
PATIENT GENDER, DOCTOR INVOLVEMENT, AND DECISIONS ON DYING

Kalman J. Kaplan, Ph.D., *Department of Psychology, Wayne State University, 71 W. Warren, Detroit, MI 48202;* Martin Harrow, Ph.D., Mark E. Schneiderhan, Pharm.D.

SUMMARY:

This paper examines the role of gender in end of life decisions. Comparison of gender ratios across different physician-assisted death samples (The Netherlands, Australia, American physician survey data, Oregon and Michigan) indicates the following trend: The proportion of women to men choosing physician aid in dying generally increases as the death situation becomes more structured and the physician more involved (Unweighted proportion means (F%–M%) across samples: Unaided suicides 19%–81%; unstructured physician-assisted suicide (PAS) (lethal prescription/self-administered) 30%–70%; structured PAS (lethal injection and/or inhalation/physician-administered/self-activated) 67%–33%; euthanasia (physician-activated) 53%–47%. However this may be true only for women who subscribe to stereotypic sex roles. For men, in contrast, receiving aid in making a suicide is not perceived as stereotypically masculine (i.e., self-reliant) as compared with doing it oneself (receiving a self-activated but physician-administered lethal injection/inhalation) as compared with an unstructured unaided suicide. As such, more stereotypically feminine women may choose PAS rather than to make an unaided suicide. More stereotypically masculine men may choose to make an unaided suicide rather than PAS. Implications are drawn for understanding of the interaction of gender and doctor-patient relationship on end of life decisions.

No. 15E
GENDER, HELP-SEEKING, AND EUTHANASIA

Joseph A. Flaherty, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, MC 913, Chicago, IL 60612;* Judy Richman, Ph.D.

SUMMARY:

There is a reasonable body of literature relating to gender differences in help-seeking behavior, medical decision making, and ultimate use of and response to health services. Women have traditionally used more overall health services than men have, even when controlling for greater need for obstetrical care. Previous explanatory hypotheses, such as women have more time, have proven incorrect as it has been shown that working women actually use more health services than non-working controls. There is evidence supporting the hypothesis that women have greater knowledge of illness and health care than men do. More recently there has been evidence that while women receive more health care, they may not receive access to the types of specialty care that men to. For example, women are less likely to be referred to cardiology or for catheterization even when presenting with similar symptoms as men and that they are less likely to receive coronary bypass surgery than men are even when controlling for risk levels. Likewise, in the mental health area, women present more frequently with symptoms, which may be partly explained by their greater willingness to admit symptoms some may see as weakness. However, once a women seeks help for mental symptoms she is less likely than a man to be referred to a mental health specialist and more likely to receive pharmacotherapy from her primary care provider. While one must be cautious in generalizing from this literature, it is not implausible to suggest that the health care industry in general have either not taken women's complaints as seriously as their male counterparts. Therefore, when health care considers broadening its scope of activities to include physician-assisted suicide, we need to be vigilant and collect data to examine

potential gender differences in the way women and men are treated when requesting euthanasia, and carefully consider who is initiating the request and how physicians respond to each request. Literature will be presented on gender differences in health care in the U.S. and Europe as a prelude to the presentation of gender differences in physician-assisted suicide in the U.S.

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SYMPOSIUM 16—WORLD VIEWS AND THE DOCTOR-PATIENT RELATIONSHIP

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (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. 16A
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 discoveries. The author will draw upon the philosophical and autobiographical writings of Freud as well as on personal interviews with Anna Freud.

No. 16B
CLINICAL MODELS AND A SPIRITUAL WORLD VIEW: A RAPPROCHEMENT

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 this complementarity between the clinical/scientific and spiritual/religious perspectives. It will be proposed that a psychiatrist can practice clinical science that is congruent 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, which 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. 16C
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 02115-6195*

SUMMARY:

One of the most powerful ways a clinician can reduce a patient's suffering is by helping him or her to put it into perspective. Using case examples, this paper explores the therapeutic implications of patients' differing world views.

Individuals with a spiritual world view may draw more 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 patients' 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 them in light of painful experience.

No. 16D
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. 16E
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:

What is the relationship between a patient's religious faith or philosophical position and the diagnosis and treatment of psychiatric disorders? How can clinicians "obtain information on the religious or ideological orientation and beliefs of their patients so that they may properly attend to them in the course of treatment?" (APA Guidelines).

This presentation will consider specific issues that impinge on the border between the psychological and the spiritual/religious/ethical. Issues such as guilt, forgiveness, suffering, sexuality, and death will be addressed from the clinical perspective and from the perspective of the "religious" and "scientific" world views.

This presentation will describe the clinical evaluation of the patient's degree of adherence to either a scientific or a religious world view. The clinician can gain valuable information about world view through assessing patients' concept of God, their use of prayer and ritual, and their level of involvement in a community of like-minded others.

Finally, this presentation will summarize how the doctor-patient relationship is strengthened, diagnostic thoroughness is enhanced, and compliance in treatment is increased when the psychiatrist understands the patient's religious or scientific world view.

REFERENCES:

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2. Sheehan W, Knoll J: Psychiatric patients' belief in general health factors and sin as causes of illness. Am J Psychiatry 1980;147:112–113
3. Cassel EJ: The nature of suffering and the goals of medicine. New Engl J Med 1982;306:639–645
4. Beck AT, Brown G, Berchick RJ, et al: Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. Am J Psychiatry 1990;147:190–195
5. APA Official Actions: Guidelines regarding possible conflict between psychiatrists' religious commitments and psychiatric practice. Am J Psychiatry 1990;147:542

SYMPOSIUM 17—BUPRENORPHINE TREATMENT: RESEARCH AND PRACTICE
American Academy of Addiction Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) describe the principal clinical and research efforts currently under way for application of buprenorphine treatment to heroin addiction, and (2) understand the role of the federal government in developing studies on buprenorphine and establishing guidelines for its use.

No. 17A
OVERVIEW OF RESEARCH OPTIONS

Thomas R. Kosten, M.D., *Dept of Psychiatry (116A), Yale University, 950 Campbell Avenue, West Haven, CT 06516*

SUMMARY:

Buprenorphine remains an investigational medication for treating opioid dependence. For detoxification it can be combined with clonidine and naltrexone to complete the process within as little as eight hours after as brief a stabilization on buprenorphine of 72 hours. The typical detoxification doses of buprenorphine are one to 4 mg sublingual daily, but for more sustained outpatient maintenance the doses needed range from 8 mg to 16 mg daily using a liquid formulation. Bioavailability data suggest that a sublingual tablet may require a 50% higher dose for equivalence, and that dosing can be as infrequent as every fourth day with doses as high as 40 mg. Outcome with these outpatient buprenorphine maintenance programs is equivalent to methadone maintenance for treatment retention and urine toxicologies. Finally, comparisons of outpatient treatment in primary care medical settings to methadone type settings using buprenorphine find equivalent or better outcomes for primary care settings encouraging new approaches to treatment availability.

No. 17B
BUPRENORPHINE/NALOXONE OFFICE-BASED TREATMENT OF OPIATE DEPENDENCE

Paul P. Casadonte, M.D., *Department of Psychiatry, New York VAMC-NYU, 423 East 23rd Street, #116-A, New York, NY 10011*

SUMMARY:

Buprenorphine is a mu opiate partial agonist that is currently under active investigation as a treatment for opiate dependence. Results from numerous studies have supported its therapeutic utility. Buprenorphine produces morphine-like subjective effects and cross-tolerance to other oplates similar to that produced by methadone and LAAM. Buprenorphine may exhibit an enhanced safety profile compared with full opiate agonists. A combination product containing both buprenorphine and the opiate antagonist naloxone is expected to be undesirable for parenteral abuse by opiate-dependent individuals. However, when administered sublingually, it is expected to be safe and efficacious for both detoxification and maintenance treatment of opiate-dependent individuals. Currently, there are clinical and legislative initiatives to extend the availability of buprenorphine and

the buprenorphine/naloxone combination tablet beyond the traditional methadone clinic to the primary care setting. Buprenorphine is currently a Schedule V analgesic, which should allow for its administration in and dispensing from a physician's office as a result of its safety and low intravenous abuse liability. This presentation will overview the feasability of office-based treatment with buprenorphine, and induction, stabilization, and maintenance treatment as well as outpatient heroin detoxification procedures. It will also present clinical experience from the ongoing NIDA/VA multicenter trial of private office based treatment of heroin dependence with buprenorphine/naloxone.

No. 17C
NATIONAL INSTITUTE ON DRUG ABUSE'S MEDICATION DEVELOPMENT PERSPECTIVE

Frank J. Vocci, Ph.D., MDD, NIDA, *6001 Executive Blvd., Rm. 4123, Bethesda, MD 20892-9551*

SUMMARY:

The history of the development of buprenorphine (Bup) as a treatment for opiate dependence exemplifies translational research from the preclinical laboratory to the clinical pharmacology lab to initial and confirmatory clinical studies. Bup was recognized as having possibly unique pharmacological activity in animal testing studies of its dependence potential. Initial clinical pharmacology studies of Bup's therapeutic potential were performed by Jasinski and colleagues at the NIDA Addiction Research Center (ARC) more than 20 years ago. The first Phase II clinical trial of Bup was performed at the ARC's research clinic and demonstrated the efficacy of an 8 mg sublingual liquid dose of Bup in comparison with methadone. A subsequent multicenter study of four doses of sublingual Bup liquid in methadone maintenance clinics at Veterans Administration Medical Centers (VAMCs) demonstrated a dose-related reduction in opiate use and decreased craving. A formulation change from a liquid to a solid dosage form and the addition of naloxone to a second Bup dosage form necessitated another clinical study for the demonstration of efficacy of the new Bup products. This study was performed in 12 outpatient clinics at VAMCs and demonstrated the superiority of both Bup dosage forms to placebo. MDD is currently sponsoring a multicenter clinical trial of Bup/naloxone (Bup/nx) in a variety of clinical treatment settings. The study will evaluate induction regimens and the safety of Bup/nx in opiate-dependent adolescents. The results of this study may also be used to modify the development of practice guidelines and potential federal regulations.

No. 17D
REGULATION OF CLINICAL PRACTICE

H. Westley Clark, M.D., CSAT, DHHS/SAMHSA, *5515 Security Lane, Rockville, MD 20852*

SUMMARY:

The use of "narcotic" medications for the treatment of opiate abuse is subject to a system of federal and state clinical practice regulations. These regulations stem from federal law, which requires that treatment with opioid medications is provided in accordance with standards. The system was established to provide a framework for physicians to treat narcotic addicts with narcotics drugs, and requires that federal oversears determine compliance with medication dispensed for unsupervised use. Federally enforced treatment regulations, in place for over 25 years, recognize two potent opioid agonist treatment medications—methadone and LAAM, and require services including counseling and rehabilitation.

Buprenorphine, a partial agonist, has been researched for use as a new medication in the treatment of narcotic addiction and is currently under review. The pharmacology of partial agonist medications distinguishes them from full agonists, warranting the consideration of a different regulatory paradigm. Clinical data on the effectiveness, safety, and abuse potential will determine the necessary and appropriate standards for using partial agonist treatment medications for narcotic addiction. These data and analyses will form the basis for determining which standards can be addressed by treatment guidelines and what needs to be in clinical regulation. The object will be to balance availability of treatment medications with measures that assure their effective use and reduce the risk of abuse and diversion.

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SYMPOSIUM 18—THERAPEUTIC ALLIANCE: EVALUATION, TREATMENT AND OUTCOME

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the importance of the therapeutic alliance in psychiatric evaluation and treatment. Originating from psychotherapy research, the study of therapeutic alliance contributes to improving the doctor-patient relationship in evaluation, medication management, and therapy, and may improve treatment retention and outcome.

No. 18A
THE BUILDING OF THERAPEUTIC ALLIANCE: AN EMPIRICAL STUDY

Jean-Nicolas Despland, M.D., *Universitaire De Psychiatrie, D'etude Des Psychotherapies, 1 Rue Tunnel, Lausanne CH-1005, Switzerland;* Yves DeRoten, Ph.D., M. Stigler, M.D., E. Martinez, M.P.S., S. Solai, M.P.S.

SUMMARY:

Introduction: Early alliance being a more powerful prognosticator of outcome than late alliance and mostly associated with a mutual emotional involvement process, its empirical study is crucial in order to improve the patient-doctor relationship.

Objective: This study investigates early alliance building process from two points of view: patient psychodynamics and therapist interventions.

Method: A sample of 20 patients was studied. Brief Psychodynamic Investigation (Gilliéron 1988), Alliance (Haq 2, Luborsky 1994), clinical data (SCL-90, SAS), defense profile (DMRS, Perry 1986), core conflictual relationship thema (CCRT, Crits-Christoph et al 1988) and intervention profile (PIRS, Bond et al 1997) have been

established. Patients with low, growing, and high alliance profile are compared.

Results: Early alliance building process occurs very early during investigation, mainly during the first interview. Defense, conflicts, and interventions alone have very little impact on alliance building. The adjustment of the type of interventions (supportive versus exploratory) at the patient defensive functioning level and the adequacy of interpretations (defined as an accurate, exhaustive, and confronting intervention) have more impact on alliance.

Conclusion: These results confirm that early alliance building is a specific phenomenon that depends more on the psychotherapist's work than on patients' characteristics. Impact of the results on psychotherapy training must also be considered.

No. 18B
ALLIANCE, ADHERENCE, AND OUTCOME IN PHARMACOTHERAPY

Arthur Dworetz, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote Ste-Catherine Rd, Montreal, QC H3T1E4, Canada*

SUMMARY:

Multiple studies have shown that therapeutic alliance predicts outcome in psychotherapy, and that many factors, including treatment relationship, influence medication adherence. A few studies have begun to examine the role of alliance in pharmacotherapy. This paper, a literature review, examined these empirical data, their research methodologies, and related theory to begin to understand the relationship between alliance, adherence, and outcome and develop more focused measures for studying their connections. Adherence, the major findings show, is influenced by patient, treater, their relationship, illness, medication, and family. Health attitudes and beliefs of patient and treater can also affect adherence. Studies in alliance in pharmacotherapy utilized instruments modified from those used in psychotherapy studies. They indicate that alliance correlates with both adherence and outcome, that patients with stronger alliances may require less medication, that the time necessary to develop an alliance that will influence outcome may vary with diagnosis, but there can be large individual variation in these interactions. In conclusion, while positive alliance likely increases medication adherence, it also has an independent benefit. Since adherence can be considered a behavioral aspect of alliance, factors that influence adherence should be accounted for in future studies of the role of alliance in pharmacotherapy.

No. 18C
THE THERAPEUTIC ALLIANCE ACROSS TIME AND TREATMENTS

J. Christopher Perry, M.D., *Erikson Institute, The Austen Riggs Center, 25 Main Street, Stockbridge, MA 02162;* Barbara Zheutlin, M.S., Leveen Lapitsky, M.S., Eric M. Plakun, M.D.

SUMMARY:

Objective: There is a general consensus that a positive therapeutic alliance early on in therapy predicts a good outcome. More recent evidence indicates that the pattern of change in the early alliance may be a better predictor in some cases than the overall level of the alliance itself, especially among those with disturbed relationship patterns. However, among patients with treatment-resistant disorders, multiple therapies both concurrently and over time may confound observations from a single treatment. This presentation examines whether the pattern of change in alliance across time and across multiple therapies-clinicians also predicts outcome.

Method: A sample of adults, entering residential treatment at the Austen Riggs Center for treatment-resistant disorders, was gathered. Periodic follow-along interviews while at the center and afterward assessed patients' alliances and perceptions of treatment in both medication and psychotherapeutic treatments.

Results: Among the first 40 patients followed for three or more years, the mean pattern of the alliance over time fell into five patterns: continuing low, deteriorating, vascillating, improving, and continuing high. The presence of the last three patterns was associated with the best outcomes. Patients endorsing a greater number of techniques of a specific type of therapy (e.g. dynamic, CBT), had better alliances.

Conclusion: The quality of the alliance is important across treatments over time and is associated with perception of a specific treatment being offered, not simply the perception of support. Patients who have better alliances across time and treatments tended to improve more.

No. 18D
PSYCHOTHERAPEUTIC INTERVENTIONS AND THE ALLIANCE

Michael P. Bond, M.D., *Department of Psychiatry, McGill University, 4333 Cote Ste Catherine, Montreal, PQ H3T IE4, Canada;* Elisabeth Banon, M.D., Marcella Grenier, Ph.D.

SUMMARY:

The goal of this study was to examine the relationship between clearly defined therapist interventions and the therapeutic alliance with personality-disordered patients. Transcripts of one psychotherapy session for each of 10 subjects taking part in a long-term psychotherapy research project were rated for therapist interventions and therapeutic alliance to determine if specific interventions were followed by enhanced or diminished therapeutic work. Transference interpretations were followed by a deterioration in the therapeutic alliance when the alliance was weak, but by enhanced work when the alliance was solid. In patients with both strong and weak alliances, defense interpretations and supportive interventions enhanced therapeutic work without increasing defensiveness. Supportive interventions seemed to prepare the way for exploration and to repair ruptured alliances.

No. 18E
PATIENT AND THERAPIST CONTRIBUTIONS TO THE ALLIANCE

Mary Beth Connolly, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3535 Market St., Room 6419, Philadelphia, PA 19104-3309;* Paul Crits-Christoph, Ph.D., Clara De LaCruz, B.A.

SUMMARY:

The therapeutic alliance has been one of the most robust predictors of psychotherapy outcome. One question that has not been thoroughly addressed by the theoretical and research literatures is whether patient pretreatment characteristics influence the development of the therapeutic alliance. We examined whether patient pretreatment demographics, symptom levels, and expectations regarding treatment were predictive of the therapeutic alliance at sessions 2 and 10. The sample consisted of 93 patients who participated in one of eight open trials evaluating the efficacy of either supportive-expressive psychotherapy or cognitive therapy. Both expectations of improvement and interpersonal distress predicted the development of the alliance in therapy, indicating that the therapeutic alliance is in part attributable to what the patient brings to treatment. A second research question concerns the therapist's contribution to the development of the therapeutic alliance. We designed a training study to evaluate whether therapists can be trained to enhance their alliances. New therapists first treated

depressed patients in treatment-as-usual before undergoing a year-long training program in alliance-enhancing psychotherapy. Following training, therapists treated three additional depressed patients. This study will allow us to evaluate whether the alliance can be enhanced through therapist training.

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SYMPOSIUM 19—DEVELOPMENTS IN THE USE OF SECLUSION AND RESTRAINT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe the major recent developments in the use of seclusion and restraint in the United States.

No. 19A
THE EXPERIENCES OF A JCAHO SURVEYOR

Thomas B. Stage, M.D., *11410 Hollow Timber Way, Reston, VA 20194-1906*

SUMMARY:

There have been dramatic reductions in the use of seclusion and restraint since the JCAHO introduced new more stringent standards in 1996. These new standards were recommended by a committee of consumers, advocates, and clinicians. Primarily the periods of evaluation for adults were shortened, and the periods of evaluation for adolescents and children were shortened even more. Substandards were added stating that "organization leaders support limited, justified use," "creating a culture emphasizing prevention" "and encouraging alternatives." Additional substandards addressed staff education, integration into performance improvement activities, and human resource implications of reduced use. For the first time, adverse findings were scored under the human rights and leadership standards. In the past they were primarily only scored for professional staff. These citings have apparently invigorated hospital and governing body leadership to address adequate staff education and adequate staffing in areas where restraint and seclusion are used. Even more strict standards have been proposed by the Health Care Financing Administration and Congressional committees are considering new legislation about seclusion and restraint. New demands on psychiatrists are imminent.

No. 19B
REDUCING SECLUSION AND RESTRAINT BY A CQI PROCESS

Lloyd I. Sederer, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

A statewide benchmarking report some years ago compared 11 psychiatric hospitals for their use of restraints and seclusion. While McLean Hospital had the lowest rate of placing patients in restraint and seclusion, the duration of episodes exceeded the norm. A physician and nurse co-led CQI team examined the process of restraint and seclusion (R/S), hypothesized why duration was not normative (or below), and designed and implemented a set of CQI interventions. Dramatic reductions of both incidence and duration of R/S were achieved promptly and sustained over several years. The success of this CQI process resulted in CQI team members lecturing on their efforts at a regional department of mental health conference.

In this presentation, this CQI process will be fully detailed.

No. 19C
EXPERIENCE IN REDUCING THE USE OF SECLUSION AND RESTRAINT

Lynn C. DeLacy, M.S., *Department of Nursing, Northern VA Mental Health, 3302 Gallows Road, Falls Church VA 22042*

SUMMARY:

As public psychiatric hospital beds are decreased, the often dangerous behaviors of the remaining inpatients would seem to place clinicians on a collision course with national level policy makers. Managing potential for inpatient violence within a society that is ready to litigate for both injuries and restrictive interventions has become a daily challenge for clinicians and administrators alike.

This portion of the symposium will review one public psychiatric hospital's successful reduction of seclusion and restraint hours by 98% over a two-year period. Factors that supported the original reduction as well as lessons learned while sustaining the reduction for an additional three years will be reviewed. Administrative and clinical leadership challenges at both the organizational and treatment team level will be discussed with a special emphasis on integrating the interdisciplinary treatment team response to potential for violence.

No. 19D
DEVELOPMENT IN THE USE OF SECLUSION AND RESTRAINT: THE EXPERIENCE OF A STATE SYSTEM

Dale P. Svendsen, M.D., *Medical Director, Ohio Department of Mental Health, 30 East Broad Street, 8th Floor, Columbus, OH 43215*

SUMMARY:

In the 1990s, the use of seclusion and the use of restraint has declined in Ohio's state psychiatric hospitals. Using a retrospective analysis, this study will examine interventions that seem to have influenced changes in the use of seclusion and restraint.

In a statewide analysis, we will review what effect, if any, standards from accrediting agencies (e.g., JCAHO, Medicare), policies, benchmarking, or administrative rules from the Ohio Department of Mental Health had on the overall use of seclusion and or restraint.

In Ohio, state hospitals develop local policies and procedures that are individualized but must meet or exceed the state administrative rule. Local hospital policies and approaches for seclusion and/or restraint will be reviewed and correlated with the hospital's seclusion and restraint data. Adverse effects from the use (e.g., deaths and debriefing data) and possible adverse effects from not utilizing seclusion and/or restraint (e.g., assaults) will also be reviewed. We will review and correlate seclusion and restraint data with intervention approaches used prior to instituting seclusion and/or restraint, utilization of emergency medications, debriefing approaches, and training requirements for staff.

No. 19E
WHAT'S BEHIND LOWER SECLUSION AND RESTRAINT IN THE VA?

William W. Van Stone, M.D., *2620 Woodley Place, NW, Washington, DC 20008*

SUMMARY:

A significant and unexpected decrease in the use of seclusion and restraint on VA psychiatric hospital units and VA nursing homes has occurred over the past eight years. This has been accompanied by a 45% decrease in the number of psychiatric beds (measured as average daily census) since 1992 (from 14,161 to 7,785 in 1998), a commensurate decrease in length of stay and a major effort nationally to move the Veterans Health Administration (VHA) from a hospital-based system to that of primary care, multiple clinics, intensive case management, and community residential services. The decrease is more pronounced where facilities have been modernized, where there are smaller units, the introduction of four- to eight-bed intensive psychiatric care units, and there is an increasing emphasis on a continuum of care from inpatient to a variety of community-based programs. Interestingly, the age of veterans hospitalized on psychiatric services has not been a major factor. Anecdotally, lead nurses attribute the decline in seclusion and/or restraint to the use of newer antipsychotic medications, a major national emphasis on less use of restraints of all kinds, nursing staff better trained and motivated in finding earlier methods of de-escalating disturbed patients, and a decrease in "hopelessness" where long-term wards begin to offer an option to what is perceived as indefinite care.

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SYMPOSIUM 20—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. 20A
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. 20B
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. 20C
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 manifestation in 20% of cases. Early recognition is critical to a gratifying 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. 20D
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 shown 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. 20E
PSYCHIATRIC MANAGEMENT IN MULTIPLE SCLEROSIS

Randolph B. Schiffer, M.D., *Department of Neuropsychiatry, Texas Tech 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. 20F
NEUROPSYCHIATRIC ASPECTS OF AIDS

Francisco Fernandez, M.D., *Department of Psychiatry, Loyola University, 2160 South First Ave/Bldg. 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 of infected persons.

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SYMPOSIUM 21—EATING DISORDERS: A CLINICAL RESEARCH UPDATE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify the particular challenges in treating patients with anorexia nervosa, bulimia nervosa, and binge eating disorder. Recent findings from several clinical research trials will be reviewed.

No. 21A
INPATIENT TREATMENT OF ANOREXIA NERVOSA

Evelyn Attia, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 105 Riverside Drive, New York NY 10032-2603;* Laurel Mayer, M.D.

SUMMARY:

Inpatient treatment for anorexia nervosa has been greatly impacted by the pressures placed by third-party payers and managed care. Hospital stays are dramatically shorter than they were even a few years ago, yet clinical recommendations that patients with anorexia nervosa normalize their weight remain unchanged with increasing data to suggest that relapse rates are higher for this illness if patients are discharged from hospital programs while still underweight.

This paper will review our clinical experience on an inpatient clinical research unit where patients were asked to increase the rate of recommended weight gain and move more rapidly to eating solid food. Overall, patients tolerated the changes and were able to successfully and safely increase their rate of weight gain by approximately 50%. Length of hospital stay decreased substantially, consistent with the more rapid rate of refeeding. Patients asked to gain at the more rapid rate demonstrated no significant difference in their willingness to complete the treatment program, nor in the degree of improvement seen on Beck Depression Inventory or Body Shape Questionnaire scores, compared with a group whose treatment required a slower rate of weight gain. Long-term results of psychological measures remain unknown.

The study suggests that inpatient hospital treatment for anorexia nervosa may be able to be successful with a moderately shortened length of stay.

No. 21B
PARTIAL HOSPITALIZATION AND WEIGHT GAIN IN ANOREXIA NERVOSA

Angela S. Guarda, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N. Wolfe Street Meyer 101, Baltimore, MD 21287-7101;* Leslie J. Heinberg, Ph.D.

SUMMARY:

Treatment programs for anorexia nervosa are under intense pressure by managed care to shorten inpatient lengths of stay and preferentially treat patients in partial hospitalization programs. Despite initial enthusiasm for partial hospitalization, weight gain has proved more difficult to achieve in this less monitored setting. Inpatient behavioral specialty programs achieve average weight gains of 2–3 lb./week as compared with reported rates of 0.5–1.5 lb./week in partial hospitalization programs. Given the current health care climate and increasing evidence supporting weight normalization and interruption of dieting behaviors as necessary, if not sufficient, for recovery from anorexia nervosa, it is crucial to identify factors that improve partial hospital rates of weight gain.

This paper will describe a clinical partial hospitalization program for anorexia nervosa capable of achieving average weight gains of over 2 lb./week. Factors likely to contribute to the program's efficacy include (1) a step-down, seamless inpatient-partial hospitalization model of care, (2) flexibility in rapidly titrating percent of supervised meals to progress with weight gain, (3) behavioral focus on practicing healthy eating behaviors.

Although inpatient treatment of anorexia nervosa remains more effective in achieving rapid weight gain, these data illustrate how a partial hospital program can achieve effective rates of gain in this population.

No. 21C
PSYCHOTHERAPY AND MEDICATION IN THE TREATMENT OF BULIMIA

B. Timothy Walsh, M.D., *NY State Psychiatric Institute, 1051 Riverside drive Unit #98, New York, NY 10032-2603*

SUMMARY:

Introduction: In the last two decades, compelling evidence has emerged that specific forms of psychological treatment, especially cognitive-behavior therapy (CBT), and medication, specifically antidepressants, are useful in the treatment of bulimia nervosa. This presentation will review these data, and present information from new studies comparing the short- and long-term outcome of CBT to interpersonal therapy (IPT), and examining the utility of medication for patients who fail to respond satisfactorily to psychological treatment.

Methods: Published data regarding the utility of psychotherapy and medication for bulimia will be summarized. Data from a recently completed multi-center (Stanford and Columbia) trial comparing CBT and IPT will also be presented.

Results: The outcome of CBT was clearly superior to that of IPT at the conclusion of treatment. However, at eight to 12-month follow-up, differences in outcome diminished. Compared with placebo, antidepressant medication (fluoxetine) was of significant benefit for patients who did not respond to CBT or IPT, or who relapsed following the end of treatment.

Conclusions: The available data support the choice of CBT as a first-line treatment for bulimia nervosa. Antidepressant medication is also a useful intervention, even for patients who fail to respond adequately to good psychological treatment.

No. 21D
EATING DISORDERS IN CHILDREN AND ADOLESCENTS

Lisa A. Kotler, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive Unit #74, New York, NY 10032;* B. Timothy Walsh, M.D., Michael J. Devlin, M.D.

SUMMARY:

Eating disorders in children and adolescents are serious conditions that can impede physical, emotional, and behavioral growth, and are an increasingly recognized problem in these age groups. Anorexia nervosa and bulimia nervosa are expressed differently in children and adolescents than in adults. Consequently, diagnostic procedures and multidisciplinary treatments need to be tailored to the unique developmental needs of children and adolescents with eating disorders. A variety of treatment approaches, including cognitive-behavioral therapy, interpersonal therapy, and antidepressant medications have been used clinically in children and adolescents with eating disorders, but few treatment studies of this population exist in the literature.

We are conducting an open clinical trial of fluoxetine and supportive psychotherapy for the treatment of adolescents with bulimia nervosa. The study is still in progress, but preliminary results suggest that these treatment interventions, which have been shown to be effective in adults, may be effective in reducing binge episodes and purging behavior in adolescents with bulimia nervosa. Data will be presented on symptoms of bulimia nervosa, comorbid depression, and anxiety as well as the tolerability of fluoxetine in these patients. In addition, we will address the unique challenges of conducting psychopharmacologic treatment trials in this adolescent population.

No. 21E
TREATMENT OF OBESE PATIENTS WITH BINGE EATING DISORDER

Michael J. Devlin, M.D., *Clinical Psychopharmacology, NY State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032-2603;* Juli A. Goldfein, Ph.D., Pamela Raizman, Ph.D.

SUMMARY:

Binge eating disorder among the obese is a serious and increasingly recognized problem. A significant minority of patients presenting for obesity treatment report the regular occurrence of large uncontrolled eating binges. The eating behavior of these patients is demonstrably different from that of their equally obese non-binge eating counterparts, and they display greater body image dissatisfaction and more associated psychopathology than obese non-binge eaters. A variety of treatment approaches, including adaptations of cognitive-behavioral therapy (CBT) for bulimia nervosa and antidepressant medications have been studied in this group.

We are conducting a clinical trial of the effectiveness of two supplemental treatments—fluoxetine and individual CBT—given in addition to a standard group behavioral treatment program for eating and weight control. Although the study is still underway, preliminary results suggest that the treatment interventions are effective in reducing binge eating, enhancing self-acceptance, and ameliorating psychological distress. Results from the pilot cohort will be reviewed and treatment interventions and response will be illustrated with case material. Obese patients with binge eating disorder can, in many cases, be successfully treated with psychotherapy and/or medication interventions based on successful treatment programs for other eating disorders.

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SYMPOSIUM 22—CULTURAL COMPETENCE AT SAMHSA, CMHS, AND STATE LEVELS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able (1) to understand about cultural competence standards and performance measures for systems of care developed through the Substance Abuse and Mental Health Services Administration Center for Mental Health Services; (2) to understand cultural competence implementation in California.

No. 22A
CENTER FOR MENTAL HEALTH SERVICES AND WESTERN INTERSTATE COMMISSION FOR HIGHER EDUCATION: CULTURAL COMPETENCE STANDARDS

Andres J. Pumariega, M.D., *Department of Psychiatry, East Tennessee State Univ., 107 Hillrise Hall/PO Box 70567, Johnson City, TN 37614*

SUMMARY:

As managed behavioral health transformed mental health care delivery, it presented opportunities and challenges for organizations serving culturally diverse populations. The principles of consumer-oriented and outcome-driven systems of care espoused under managed care increase the opportunity of tailoring services for diverse populations and integrating principles of cultural competence. On the other hand, providers and consumers of color have suffered under for-profit managed behavioral health due to underfunding of services, reduction in support services needed by poor and multiproblem consumers, and de-credentialing of providers of color, who provide most culturally competent services.

The National Latino Behavioral Health Workgroup, a national panel of experts, developed national standards for cultural competence for managed behavioral health services for Latinos, sponsored by the Western Interstate Commission for Higher Education and the Substance Abuse and Mental Health Administration (SAMHSA). These standards became the basis of the Cultural Competence Standards for Four Underserved Racial/Ethnic Populations, recently released by the Center for Mental Health Services of SAMHSA. This presentation will focus on the principles underlying these standards as well as the key clinical and systems standards that are critical in managed mental health systems of care caring for populations of color.

No. 22B
PERFORMANCE MEASURES OF CULTURAL COMPETENCE

Carole E. Siegel, Ph.D., *Department of Psychiatry, Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962*

SUMMARY:

The panelist will report on a project to develop performance indicators for cultural competence within the context of emerging behavioral health care environments, "The Development of Cultural Competence Measures for Managed Behavioral Health Care Programs." The project was jointly conducted by the New York State Office of Mental Health and the Center for the Study of Issues in Public Mental Health and funded by SAMHSA, Center for Mental Health Services. Content analysis of a dozen existing federal and state

reports on the topic revealed several areas in which measures of cultural competency are desirable: needs assessment, Information exchange, mental health services. Human resources, policies and procedures, and outcomes. Indicators of cultural competence were defined for each of these domains to apply at the point of face-to-face interaction between individual clinicians and consumers, in the physical and social environment of the provider agency and in the network of providers that form mental health and managed behavioral health care systems. Expert panels and consumer focus groups were used both to select, expand, and validate the measures. Checklists of desired features, consumer surveys, and management information systems that are adapted to include elements reflecting cultural competence are needed to obtain the data to evaluate performance measures as they indicate progress toward cultural competence.

No. 22C
CULTURAL COMPETENCE IMPLEMENTATION IN CALIFORNIA: A STATEWIDE VIEW

Rachel G. Guerrero, M.S.W., *Department of Mental Health, CA Department of Mental Health, 1600 9th Street Room # 150, Sacramento, CA 95814*

SUMMARY:

The California State Department of Mental Health (DMH), in October of 1997 issued statewide Cultural Competency Plan Requirements (CCPR) as an addendum to the previously issued Phase II Consolidation of Medi-Cal Specialty Mental Health Services Plan Requirements. California is the only state in the nation that has required each of its 58 county-based mental health plans (MHP's) to submit cultural competency plans to DMH. DMH intent in issuing these standards and requirements was to assist MHPs in creating a more responsive and accessible system for Medi-Cal beneficiaries for the delivery of quality and cost-effective specialty mental health services. This presentation will present the process DMH developed to implement statewide cultural and linguistic plan requirements. The key components of the plan including the population, organizational, and service provider assessments and the standards included in the plan document will be presented. The safeguards put in place to review compliance of the plans once they were submitted and general lessons learned will also be provided. This presentation will demonstrate how a state system can and should take a leadership role in moving cultural and linguistic competency forward.

No. 22D
INTEGRATING CULTURAL COMPETENCE STANDARDS AT THE COUNTRY LEVEL

Josie Romero-Torralba, L.C.S.W., *JTR and Associates, 955 Hoxett Street, Gilroy, CA 95020*

SUMMARY:

This presentation discusses how California counties created and integrated cultural competence plans into their county mental health managed care plans for the Medi-Cal population as required by the State of California Department of Mental Health by July 1998. Two counties that have been studied intensively will exemplify how development of such plans created opportunities for innovating best practices to improve quality of care for underserved populations in daily operations. Identifying and reframing challenges to the existing system of care by cultural competence is critically important. The role of administration and supervisors in implementing cultural competence plans at county and agency levels will be highlighted.

No. 22E
ANALYSIS OF ACCESS: 15 CALIFORNIA COUNTIES

Courtenay M. Harding, Ph.D., *Department of Mental Health, WICHE, P.O. Box 9752, Boulder, CO 80301;* A. Marie Sanchez, B.S.W.

SUMMARY:

WICHE/CMHS National Core Standards for Cultural Competence were used to compare the "Access" Standard (with its 13 guidelines, three performance indicators and three outcome/benchmarks) to those submitted to the California Department of Mental Health by counties for their implementation Plans for Phase II Consolidation of Medi-Cal Specialty Mental Health Services. Five urban, five suburban, and five rural counties out of 58 possible counties were selected by specific criteria for comparison. Findings included: (1) differences from the comparison on Access, (2) differences between the targeted counties, (3) differences related to the racial/ethnic composition of the counties, (4) technical assistance needs for full implementation, and (5) current "best practices." A long-range strategic plan was developed recognizing the impact of changes in systems of care (i.e., evolving financing and care systems, credentialing and certification issues, professional training, as well as contracting rules and regulations). Twelve specific action plans were identified to push the cultural competence agenda forward.

No. 22F
CALIFORNIA CULTURAL COMPETENCE PLAN: LONG-TERM-CARE SERVICES

Robbin L. Huff-Musgrove, Ph.D., *Staff Development Center, Patton State Hospital, 3102 East Highland Ave., Patton, CA 92369*

SUMMARY:

The cultural and ethnic landscape of the United States is changing rapidly. The state of California is a leader in this demographic shift. Currently, whites constitute 52% of the state's population while 48% of the population are ethnic/racial minorities. Demographers estimate that by the year 2000, 55% of the state will consist of racial and ethnic minorities. As a result of this shift from minority to majority, there has been a corresponding change in the ethnic composition of those utilizing public mental health services. The utilization of long-term care services. (i.e., state hospitals) by ethnic/racial minorities is significant. Fifty-two percent of California's state hospital population are ethnic/racial minorities. In response to these demographic changes the California State Department of Mental Health convened a committee, in November of 1998, of representatives from its five long-term care service facilities to develop Cultural Competence Plan Requirements for Long-Term Care Services. This presentation will reveal the developmental model utilized to address the cultural and linguistic needs of the patient population in long-term care services, as well as the key components of the plan requirements and standards: policy, administration, practitioner, and consumer. Additionally, plans for implementation and compliance will be discussed.

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SYMPOSIUM 23—UPDATE OF TREATMENT OF STIMULANT ABUSE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize stimulant abuse in patients, diagnose its common psychiatric comorbidities, and treat it effectively using both psychosocial and pharmacological modalities.

No. 23A
RECOVERY-ORIENTED PSYCHOSOCIAL TREATMENT

Douglas M. Ziedonis, M.D., *Department of Psychiatry, UMDNJ-RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854;* Ilana Pinsky, Ph.D., Jonathan Krejci, Ph.D., Edward Mann, A.A.S., Victoria Lipinski, M.S.W., Frank Baffige, M.A., Brenda Rambo, B.A.

SUMMARY:

Psychosocial treatments are very important in the overall treatment of individuals with stimulant abuse. This presentation will focus on clinical advances in behavioral therapy and community-based self-help approaches-including motivational enhancement therapy, relapse prevention, psychoeducation, 12-Step facilitation, and community reinforcement. Clinical examples will be presented, focusing on clinical strategies and treatment-matching approaches and highlighting psychotherapy research findings that support the efficacy of these approaches. Stimulant dependence gives rise to unique clinical issues during the course of individual, family, and group therapy. Strategies to better engage the low-motivation patient into treatment and the skills necessary for short-term and long-term sobriety will be discussed. The progressive stages of recovery will also be reviewed, including different models such as the neurobehavioral model, the developmental model of recovery, and the Pavillon Stages of Recovery. The recommended psychotherapeutic approach varies according to the stage of recovery. Polysubstance abuse, dual diagnosis, and other compulsive activities are often complicating factors that require adaptations in the treatment.

No. 23B
PSYCHOTHERAPY AND COUNSELING APPROACHES TO COCAINE ABUSE TREATMENT

David R. Gastfriend, M.D., *Department of Psychiatry, Harvard Medical School, 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, multi-site 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. Preliminary results from the MGH/Harvard ASAM Criteria Validity Study of patient placement criteria suggest that matching patients to level of care based on their clinical and psychosocial characteristics (including attitude toward treatment) may improve 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. 23C
PHARMACOLOGICAL TREATMENT OF STIMULANT ABUSE

David A. Gorelick, M.D., *Clinical Pharmacology, 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 have not yet been 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. 23D
PSYCHIATRIC COMORBIDITY IN STIMULANT ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, 317 East 17th Street, 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 non-substance-related (NSR) mental disorders in this group is not straightforward. Yet, it is important to accurately elucidate the present diagnoses in order to provide the most specific and effective treatments. New approaches to behavioral treatment of stimulant abusers with differing NSR psychiatric diagnoses such as schizophrenia, mood disorders, and PTSD will be presented, with information on how traditional addiction approaches have been effectively modified for the mentally ill. In addition, novel pharmacotherapeutic strategies that have been developed for stimulant abusers with differing comorbidity will be reviewed.

No. 23E
UPDATE ON TREATING METHAMPHETAMINE ABUSE

Steven L. Batki, M.D., *Department of Psychiatry, Univ. of CA at San Francisco, 1001 Potrero Avenue, Rm. 7M12, San Francisco, CA 94110*

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 behaviors, and methamphetamine users have some of the highest HIV seroprevalence rates among drug users. Relatively little work to date has been done to find medical treatments of methamphetamine abuse and there are no established, effective pharmacotherapies, although a number of medications are theoretically plausible to utilize. Medication trials are underway. 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 24—ADMINISTRATIVE RELATIONS IN PSYCHIATRIC LEADERSHIP

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) recognize how the relationship between the psychiatrist administrator and the chief nonmedical administrator will influence the psychiatrist's role in the behavioral health system, (2) identify factors influencing the development of this relationship across various management settings, (3) understand both the positive and negative forces influence the development of constructive and collaborative partnerships in administration.

No. 24A
DIVIDE AND COOPERATE: THE MEDICAL DIRECTOR AND THE CEO

Clifton R. Tennison, Jr., M.D., *Helen Ross McNobb, 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 (Station 1991, Langsley 1983) concerns suggest a division of labor between the business and the provision of health care. Several surveys (AACP 1984 & 1985, NCPA 1989) clarified the demedicalization of community mental health and predicted similar dissatisfaction in today's managed behavioral health organizations if roles are not clearly defined. Practical suggestions for this relationship (Tennison 1989, 1998) coupled with analysis of clinicians' roles as administrators (Levinson 1967) can help organizations create adaptive, functional role descriptions. Many of the community psychiatrists' struggles have been related to issue of leadership (Urbaitis 1989, Mnetz 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 co-leadership role with his CEO has 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. 24B
SLEEP AT NIGHT: THE TRAVELS OF A MANAGED CARE PHYSICIAN

Jerome V. Vaccaro, M.D., *PacifiCare, 5900 Sepulveda Boulevard #400, Van Nuys, CA 91411*

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 non-medical 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 non-psychiatrist CMHC administrators; the battles of the 1950s–

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 debate values, ethics, and goals in managed care. He will present a theoretical framework for his approach and then use three case examples to illustrate a process by which we can improve managed behavioral health care.

No. 24C
PUBLIC SYSTEM CLINICIAN-ADMINISTRATOR RELATIONSHIPS

Christopher G. Fichtner, M.D., *State of Illinois, Department of Mental Health, 100 West Randolph Suite 6-400, Chicago, IL 60601;* Daniel J. Luchins, M.D.

SUMMARY:

Psychiatrists hold a variety of positions as medical administrators within public systems of care and play various roles that balance differently the demands of management and clinical practice. Clinical executive leadership spans a broad spectrum of activities ranging from organizational/political at one end to case-specific clinical decision-making at the other. In between are such activities as clinical program and systems development, policymaking, clinical supervision, case review, and professional development and mentorship. These roles shape, and are importantly shaped by, relationships with non-physician administrators. An understanding of the systems-based context of these roles and relationships is essential to the development of working collaborations between clinicians and non-clinicians in administrative, managerial, and leadership roles. Such an understanding is facilitated by recognition and appreciation of the various interests, demands, and other influences that converge on individual leaders and managers in their administrative and clinical roles within systems. Strategies for framing working relationships within these systemic contexts include assuming a group-as-a-whole perspective, appreciating organizational psychodynamics including projective identification, and using images and metaphor to help characterize organizational functioning and culture. Such approaches facilitate reflection upon, and understanding of, clinician-administrator leadership relations in the context of public systems wherein multiple competing agendas may be evident.

No. 24D
AVOIDING THE PITFALLS: WHEN IT DOESN'T WORK

Gordon H. Clark, Jr., M.D., *Integrated Behavior Health, 1 Forest Avenue, Portland, ME 04101*

SUMMARY:

This presenter will provide three examples from his own career of "When It Doesn't Work." He will share how these experiences affected him and how he responded. He will offer some additional suggestion 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. 24E
I HAD A DREAM: MAKING IT WORK

Kathleen A. Daly, M.D., *Edelman Westside MHC, 11080 W. Olympic Blvd, 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 (non-medical 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 medical staff may seem an inherent feature of the medical director role, but ironically is not 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, their 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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TUESDAY, MAY 16, 2000

SYMPOSIUM 25—DSM-V PERSONALITY DISORDERS: TOWARDS AN EMPIRICALLY-BASED DIMENSIONAL CLASSIFICATION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand four alternative proposals for an empirically based dimensional classification of personality disorders for consideration in DSM-V.

No. 25A
A STEPWISE PSYCHOBIOLOGICAL CLASSIFICATION

C. Robert Cloninger, M.D., *Department of Psychiatry, Washington University Medical School, 4940 Children's Place, Saint Louis, MO 63110*

SUMMARY:

The clinical diagnosis of personality disorders has been handicapped by complexity of the criteria for separate disorders and the overlap among categories and clusters of personality disorders. 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 clinicians. This allows clinicians to determine whether someone has any personality disorder before subtyping. This initial screening greatly increases the efficiency of personality diagnosis by reducing the number of concepts and questions that a clinician needs to consider. 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.

No. 25B
A TWO-COMPONENT STRUCTURE FOR CLASSIFYING PERSONALITY DISORDER

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 10560 Blundell Road, Richmond, BC V6Y 121, Canada;* Kerry L. Jang, Ph.D.

SUMMARY:

The evidence suggests that personality disorder represents extremes of normal personality variation. An extreme score on a personality dimension, however, does not necessarily constitute personality disorder. This suggests that it is necessary to define personality disorder and establish criteria for the diagnosis independently of extreme variation. A two-component structure for personality classification will be proposed that separates the diagnosis of personality disorder from the assessment of clinically relevant personality traits.

The definition of personality disorder will be based on an analysis of the functions of normal personality. The condition is defined as a tripartite failure involving the failure to develop adaptive solutions to evolutionary life tasks of establishing a coherent self, the capacity for intimacy and attachment, and the capacity for adaptive societal behavior. Clinically relevant dimensions for describing personality will be presented based on the phenotypic and genetic structure of personality disorder traits. The results of multivariate genetic analyses of data from nearly 900 twin pairs will be used to establish the basic or lower-order traits. Further analyses suggest that these traits may be organized into three higher-order clusters: emotional dysregulation, dissocial behavior, and inhibitedness. The relationship between this model and accounts of normal personality structure such as the fivefactor approach will be examined.

No. 25C
FIVE-FACTOR MODEL OF PERSONALITY DISORDERS

Thomas A. Widiger, Ph.D., *Department of Psychology, University of Kentucky, 115 Kastle Hall, Lexington, KY 40506-0044*

SUMMARY:

A substantial amount of research has now indicated that the DSM-IV personality disorders are constellations of maladaptive variants of commonly occurring personality traits. The five-factor model of personality is to date the most comprehensive and empirically supported dimensional model of personality functioning. It consists of the five broad domains of neuroticism (or negative affectivity), introversion versus extraversion, openness versus closedness (or unconventionality), antagonism versus agreeableness, and conscientiousness (or constraint), within which there are 30 more specific facets of functioning (e.g., gullibility vs. suspiciousness, self-consciousness vs. glib charm, and sacrificial vs. exploitative). Not surprisingly, the DSM-IV personality disorders are readily understood from the perspective of the five-factor model, and a substantial amount of research has now documented this close relationship. This paper summarizes the empirical research described above, as well as indicating additional advantages available to the clinician provided by a five-factor model of personality disorders.

No. 25D
EMPIRICAL PROTOTYPES BASED ON CLINICAL OBSERVATION

Drew Westen, Ph.D., *Cambridge Hospital, 1493 Cambridge Street, Cambrige, MA 02139;* Jonathan Shedler, Ph.D.

SUMMARY:

The approach that has guided efforts at revising Axis II over the last 20 years has used empirical procedures to hone categories and criteria initially derived from clinical observation. The research reported here takes the inverse approach, which we believe better capitalizes on the strengths of both empirical methods and clinical observation: applying empirical procedures such as factor and cluster analysis to discover the latent structure of data (which may not be obvious to the naked eye) provided by expert clinical observers (experienced clinicians). We collected data on a sample of 701 patients with a range of personality pathology from mild to severe, using a psychometrically sound Q-sort instrument resembling an MMPI (except that the data are provided by clinicians rather than by self-report). Cluster analyses produced a series of clinically meaningful prototypes, many resembling current Axis II categories but others making distinctions not currently made (e.g., between two types of patients currently diagnosed with borderline personality disorder who are psychologically distinct). These prototypes can be treated both dimensionally and categorically, and have predictable correlates, notably genetic and developmental history variables. The prototypes that emerged are both empirically derived and clinically meaningful, because they are derived from quantified clinical observation.

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SYMPOSIUM 26—THE DOCTOR-PATIENT RELATIONSHIP IN THE AMERICAS
Inter-American Council of Psychiatric Organizations

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant will understand the opportunities and difficulties that psychiatrists confront treating patients from different cultures.

No. 26A
PRACTICE OF PSYCHOPHARMACOLOGY AND THE DOCTOR-PATIENT RELATIONSHIP

Antonio Pacheco, M.D., *Central University of Venezuela, P.O. Box 17344, Caracas. 1010 A, Venezuela;* Gabriela Iglesias, M.D., Ruben J. Hernandez-Serrano, M.D.

SUMMARY:

During the last decades, drug prescription has been the predominant vehicle for therapeutic action, and continues to be the most widely used treatment. This action identifies the physician and acts as an emotional support for him and for his patients.

The use of drugs as a therapeutic agent is accompanied by some risks among which side effects, interactions, and toxicity have been studied and commented on consistently. The practice of psychopharmacology is additionally complicated by cultural factors including myths and false beliefs. All these factors play a very important role in the doctor-patient relationship.

A good relationship is essential in any medical treatment and in particular in psychiatric interventions. The failure to achieve this goal is responsible for the lack of efficiency in many therapeutic trials.

In this paper we present the results of a survey of the opinions of professionals about the impact of psychopharmacological practice in the doctor-patient relationship. These professionals included 217 psychiatrists, psychologists, and general paracticioners. The study is part of a multicenter program organized by the Latin American Union Against Depression.

No. 26B
INFLUENCE OF CULTURE IN PATIENT-PSYCHIATRIST RELATIONSHIP

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Casilla 17-16-127 CEQ, Quito, Ecuador*

SUMMARY:

In all relationships there is a system of symbols conveying ideas that make possible interpersonal communication and disclosure an what is and what is imagined to be. In the patient-psychiatrist relationship in a general hospital setting these cultural symbol systems are evident in the interpretation of body signals.

Our experience in renal transplant patients will be presented with a theoretical interpretation of the symptomatic expression differences found in recipients and donors of kidneys. The cultural relative belief systems will be analyzed for their implications for prevention of posttransplant maladaptive reaction.

Donors in our study show a highest pain reaction when compared with recipients who show highest anxiety reaction.

No. 26C
CULTURAL ISSUES IN THE DOCTOR-PATIENT RELATIONSHIP

Miguel R. Jorge, M.D., *Department of Psychiatry, Federal Univ. of Sao Paulo, R Antonio Relicio 85, Sao Paulo 04530-060, Brazil*

SUMMARY:

In order to be successful when treating a patient from a different social or cultural background, the physician needs to take in consideration some particular aspects. The doctor's perspective on the patient's illness may not be the same as his or her patients' or patient's family beliefs and understanding of the nature, causes, and context of the illness experienced. Their attitudes and expectations toward clinical care are also essential to be considered when planning and conducting treatment.

No. 26D
PHYSICAL OR MENTAL CHRONIC ILLNESS: CHARACTERISTICS OF THE DOCTOR-PATIENT RELATIONSHIP

Rodolfo D. Fahrer, M.D., *University of Buenos Aires, J. Salguero 2436, 8 Piso, Buenos Aires 1425, Argentina;* Amelia E. Musacchio, M.D.

SUMMARY:

There is evidence that emotionally disturbed chronic patients such as cancer, hemodialysis, AIDS, Parkinson, Alzheimer, multiple sclerosis, diabetes, can be helped to cope with their problems. There is an increasing emphasis on the fact that quality of life must be taken into account for the design and evaluation of treatment programs for chronically ill patients. Psychodynamic processes of the doctor-patient relationship must be appropriately managed to encourage the therapeutic alliance. Psychiatric comorbidity is closely linked with substantial impairment of health. There is a complex interaction between the patients and their families. Patients with a wider social network or one that can afford better emotional support will be better able to cope depending on their own feelings about the disease. The familial environment of chronically ill patients participates throughout the different stages of the disease, as well as in the regressive mechanism resulting from the patient's illness and treatment. Efficient treatment of patients as a biopsychosocial unit benefits and improves their quality of life, that of relatives and families who must accompany and care for them and, ultimately, the community will also benefit itself, ensuring their protection.

No. 26E
LANGUAGE AND DOCTOR-PATIENT RELATIONS IN PSYCHIATRY

Roberto E. Chaskel, M.D., *Department of Psychiatry, University Nueva Granada, Apartado Aereo 4124, Bogota, Colombia;* Sharon C. Harvey, M.D., Enrique Camarena, M.D., Nichole Steiner, M.S.

SUMMARY:

Language is a major component in mental health treatment and as such becomes an important issue when different people merge due to immigration. The authors will share their experience from the West Indies, Mexico, and the Caribbean where migration has created new problems and challenges for local psychiatrists.

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SYMPOSIUM 27—QUALITY INDICATORS IN PSYCHIATRY
APA Council on Quality Improvement

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand performance measurements; the definition of quality indicator, measure, and standard; and the dimensions of care (access, quality, perception of care, outcomes) being developed by the APA Committee on Quality Indicators.

No. 27A
CLINICALLY-BASED QUALITY INDICATORS

John M. Oldham, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York, NY 10032*

SUMMARY:

The American Psychiatric Association Task Force on Quality Indicators submitted its Final Report to the Board of Trustees in March 1999, and it was approved. Subsequently, a standing committee, the Committee on Quality Indicators, was established, within the newly-established Council on Quality Improvement. Working closely with the Steering Committee on Practice Guidelines, the APA Office of Quality Improvement and Psychiatric Services, and other councils and components, the committee has begun its work to develop a strategy to field-test the sample quality indicators already developed, utilizing Practice Research Network data along with other available datasets. A "high confidence" set of indicators will then be selected from those that are field-tested, for priority utilization by organized systems of care and by reviewing and accrediting organizations. The evolving work of the Committee on Quality Indicators to collect data on existing quality indicators and to develop additional indicators linked, when possible, to the practice guidelines, will be presented.

No. 27B
QUALITY INDICATORS AND PRACTICE GUIDELINES

John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, Rochester, NY 14608*

SUMMARY:

Practice guidelines have become increasingly important in the practice of medicine. Thousands of guidelines have been developed by professional associations, government agencies, payers, and provider groups. The American Psychiatric Association has approved and published 10 practice guidelines (two of which have recently been revised). At present major focus of guideline efforts throughout medicine is the effective dissemination of the guidelines. Research has demonstrated that publishing the guidelines is insufficient in changing physician behavior. Monitoring the use of guidelines will become increasingly important for quality improvement efforts as well as meeting the challenge of increased accountability. In order to measure the conformance to guidelines, indicators that are systematically derived from guidelines are essential. This presentation will explore issues and methods in deriving indicators from evidence-based guidelines.

No. 27C
CONFORMANCE WITH QUALITY INDICATORS IN ROUTINE PRACTICE

Joyce C. West, Ph.D., *Quality Improvement, American Psychiatric Assoc., 1400 K Street, N.W., Washington, DC 20005;* Deborah A. Zarin, M.D., Phillip S. Wang, M.D., Christine Rose, M.S., Steven Marcus, Ph.D.

SUMMARY:

Objectives: (1) Identify patient, psychiatrist, health plan, and setting factors associated with conformance with key evidence-based practice guideline treatment recommendations; and (2) distinguish clinically appropriate from clinically inappropriate reasons for nonconformance.

Methods: Nationally representative data from the APA Practice Research Network's 1997 Study of Psychiatric Patients and Treatments on 1,228 adult patients of psychiatrists. Logistic regression was used to assess the relationship between guideline conformance with key treatment recommendations and patient, psychiatrist, health plan, and setting characteristics.

Results: Analyses have been conducted for all three disorders assessing overall rates of conformance with specific recommendations and factors associated with conformance. For example, for patients with bipolar disorder, conformance with the psychopharmacologic and psychiatric management recommendations ranged from 71% to 93%. A total of 93% of the bipolar patients received psychiatric management; 81% of the patients with BP Type I not in remission were currently receiving a mood stabilizer; and 71% of the patients who were currently receiving an antidepressant were also receiving a mood stabilizer. Clinical data provided insight regarding potential reasons for nonconformance with the specific recommendations studied and will be presented.

Conclusions: Findings have implications for designing and targeting quality improvement initiatives and developing and using evidence-based practice guidelines and guideline-based quality of care indicators.

Funding provided by the MacArthur Foundation, NIMH, and CMHS.

No. 27D
QUALITY MEASUREMENT IN A CLINICAL FACILITY

Lloyd I. Sederer, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Changes in the health care delivery system have made assessing the effectiveness of medical treatment a clinical imperative. Assessing outcome in clinical practice offers a wide range of applications, including quality improvement, meeting regulatory and accreditation standards, fostering patient and family trust, and meeting payer demands for evidence of effectiveness, community relations, and marketing of clinical services.

This presentation will detail the quality assessment and quality improvement approach used at McLean Hospital. Four domains of

assessment will be described and demonstrated: (1) clinical outcomes, (2) patient satisfaction, (3) readmissions, and (4) high-risk events. I will explain the instruments and measurements used and demonstrate their application in both inpatient and ambulatory settings.

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SYMPOSIUM 28—THE PSYCHIATRIC HOSPITAL IN THE 21st CENTURY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) appreciate the forces impacting on the psychiatric hospital, (2) identify business and clinical strategies employed by America's leading hospital systems, and (3) position themselves to survive and prosper in their era of cost containment and accountability.

No. 28A
WHAT WORKS BEST FOR WHOM AND AT THE LOWEST COST?

Efram Bleiberg, M.D., *The Menninger Foundation, PO Box 829, Topeka, KS 66601*

SUMMARY:

The vacuum that care providers created by ignoring the demand of payers to control the escalation of health care costs was filled with the development of managed care. Today, 80% of behavioral health care in the United States is provided through some form of managed care. While payers continue to demand reduced costs, payers as well as governmental and other regulatory agencies are increasingly insisting on demonstrated performance (particularly outcomes), reflecting widespread concern about abuses by a system that is fundamentally designed to manage cost rather than genuinely improve the effectiveness and efficiency of care (Schreter, Sharfsten, and Schreter, 1997). These pressures are only bound to intensify as managed behavioral health plans face market pressures to reduce premiums, coupled with enormous difficulties in financing debt service, integrating multiple and disparate systems (two companies, Magellan and Value Options have, through acquisitions, grown to manage the behavioral health care of 100,000,000 people), and public resistance to further reductions in amount and level of care—including legislative mandates for parity and resistance to cost-shifting to the public system or the "dumping" of patients.

Providers have responded to this trend by seeking to regain greater control over the delivery of care. In some locations, care providers have formed delivery systems willing to assume financial risk which, with few exceptions, have been financially unsuccessful. When successful, they have found themselves replicating the very practices they previously deplore.

The premise of this presentation is that the convergence of market pressures and clinical advances in the field converge to offer the opportunity to create—in partnership with health care systems, employees, or managed behavioral health plans—systems of care designed to make decisions about the care of patients based on the conscientious, explicit, and judicious use of current best evidence.

This presentation argues that: (1) the current reimbursement system creates powerful structural obstacles against defining what are the most effective and cost-effective patterns of care for particular psychiatric problems and individuals with specific constellations of strengths and weaknesses, and (2) a system designed to capture outcomes in a naturalistic fashion—as opposed to randomized controlled studies—offers the best approach to create clinically and ethically-driven yet financially competitive systems capable of defining which set of procedures are effective in producing what kind of functional results, when applied to what kind of patient with what kind of problem as practiced by what sort of clinician (Barrnett, et al, 1992).

No. 28B
PARTNERS, PSYCHIATRY, AND THE MENTAL HEALTH SYSTEM

Gary L. Gottlieb, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street Building 37 OE, Boston, MA 02114*

SUMMARY:

Partners HealthCare System was formed in 1994 as the not-for-profit parent of the merger of Massachusetts General Hospital (MGH) and Brigham & Women's Hospital (BWH). Early in 1996, it became evident to the Partners board that behavioral health required special attention to ensure system mission and financial viability: the system's large, freestanding psychiatric hospital, McLean, was suffering mounting financial losses; psychiatric services were increasingly carved out of the system full-risk agreements, borne through the primary care network established in the merger; and the fate of behavioral neuroscience research and the system's training programs were imperiled. Partners created an ad hoc committee of its board to provide governance to the evolution of the first system-wide product line: psychiatry and mental health. Over the course of the ensuing two years, a single bottom line was developed and the first Partners-wide department was created with a new professor and chair recruited. The system now includes psychiatric services at McLean, MGH, BWH, three community hospitals, seven community health centers, and the behavioral health needs of a 1,000 physician primary care network. The implementation of a strategic plan developed in mid-1999 focused on integration of clinical services including urgent care and front end functions and reengineering of ambulatory services, the cross-site integration of research activities, and enhancement and sustaining financial support for training programs will be presented.

No. 28C
ACADEMIC CHALLENGES IN THE PSYCHIATRIC HOSPITAL IN THE 21st CENTURY

Sheldon I. Miller, M.D., *Department of Psychiatry, Northwest Memorial Hospital, 303 East Superior, Room 561, Chicago, IL 60611-3015*

SUMMARY:

The structure and programming for the NUMS department of psychiatry has evolved over the past 10 years with multiple changes in the delivery system responding to the changing market in Chicago. Point-of-service contracts with negotiated bed and physician fees

are the drivers in the market rather than capitation and HMOs. Our initial organization anticipated capitation and built fully integrated vertical and horizontal systems to respond to what became a managed fee-for-service environment. Efforts to achieve low cost per case on the inpatient service using partial hospital aftercare were not rewarded by insurers who focused on per diam costs and close management, thereby nullifying efforts to use the most cost efficient services. Thus, initial enthusiasm for a continuum was somewhat dampened by the lack of interest and willingness to pay for the spectrum on the part of the managed care companies. The services continue to be offered but the hope for the support has not materialized to the degree anticipated. All of this will be discussed in the context of an academic medical center with a guiding principal of providing excellence in resident and medical student education as well as an environment in which clinical research thrives.

No. 28D
THE MONTEFIORE AND UNIVERSITY BEHAVIORAL ASSOCIATES' EXPERIENCE

Bruce J. Schwartz, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467*

SUMMARY:

Adaptation to the current health care environment has required the addition of a business orientation to the traditional academic missions of clinical care, education, and research. The transformation was initiated as a proactive response in which the faculty were involved as the earliest participants. The process was and needed to be driven by the chairman, who committed his prestige and aggressive advocacy, a necessary intervention as hospital administrators were not readily accepting of a departmental business enterprise. The reconfiguration of the department led to the development of infrastructure components such as a management services organization and an integrated provider association. Business principles and strategies for network providers, both affiliated and nonaffiliated, were implemented that were compatible with good patient care, medical ethics, and collegial relationships, not models developed by managed care organizations, which emphasize profits over quality and take decision making away from physicians. Innovative reimbursement strategies and principles of medical management needed to be developed, piloted, and modified. The provision of psychiatric services to patients in the general medical system has also differentiated our market and service delivery strategy. Present and future approaches and strategies will be outlined in the presentation.

No. 28E
THE REINVENTION OF SHEPPARD PRATT

Steven S. Sharfstein, M.D., *Sheppard Pratt, 6501 N. Charles Street, Baltimore, MD 21204*

SUMMARY:

For over 100 years, the Sheppard and Enoch Pratt Hospital was a national leader for inpatient psychiatric care. Renowned clinicians such as Harry Stack Sullivan, Louis Hill, Lawrence Kubie, and Clarence Schulz, put Sheppard Pratt in the forefront of hospital treatment for severe mental illness and the training of generations of psychiatrists. Intensive psychotherapy was pioneered at Sheppard Pratt for patients who remained for many months. The 100-acre campus, in fact, contained a rose garden.

Beginning a decade ago when the average length of stay was 70 days, marketplace-driven change invaded the tranquil campus and challenged its survival. Length of stay decreased dramatically and beds were closed. Sheppard Pratt changed by: embracing the concept of health system, reorganizing the hospital infrastructure into service lines, pressing forward with a continuum of care for a variety of subspecialty populations, expanding in new clinical arenas, retraining the clinical staff to understand and work with private managed care payers and the public sector, renegotiating contracts with salaried clinicians to focus on a productivity model, emphasizing new ideas of "customer service" into the doctor/patient relationship, and partnering with general hospitals, university departments of psychiatry, public community mental health centers, psychosocial rehabilitation programs and housing programs, employers, and government.

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SYMPOSIUM 29—THE COMING OF AGE OF THE BIPOLAR SPECTRUM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize a broad bipolar spectrum with varied clinical and mixed presentations, as well as the need for a science-based art in combining various somatic and psychological approaches.

No. 29A
BIPOLARITY AT 2000: PROGRESS BEYOND CLASSIC MANIA

Hagop S. Akiskal, M.D., *Department of Psychiatry, University of California at San Diego, 3350 Lajolla Village Dr. 116A, San Diego, CA 92161*

SUMMARY:

The definitions of bipolar subtypes in DSM-IV and ICD-10 do not do justice to the rich phenomenology of bipolarity encountered in contemporary practice. This paper reviews the evidence that beyond classic bipolar disorder (categorized as BP I), there exists a broad territory of soft bipolarity extending into the domain of major depressive disorders. Of these, only bipolar II with hypomania of at least four days has been granted official status in DSM-IV. However, there exists an even more prevalent group of major depressives with hypomanic periods lasting one to two days. Then there are major depressives arising from a cyclothymic temperament. Another common category of patients experience hypomania upon pharmacological challenge only. Finally there exist major depressives arising from a stable level of over-cheerful, over-confident, and over-energetic disposition (hyperthymic temperament). Evidence will be presented that from a familial standpoint that all of the foregoing categories have a significant excess of bipolar disorders compared with strict unipolar patients. Indeed, recent evidence from European and U.S. studies suggest that as many as 50% of major depressives belong to a broad bipolar spectrum. These can be categorized in a proposed spectrum of II/2, II, II1/2, III, III1/2, and IV.

No. 29B
AGITATED DEPRESSION AS A MIXED STATE

Athanasio Koukopoulos, M.D., *Centro Lucio Bini, 42, Via Crescenzio, Roma 00193, Italy*

SUMMARY:

The extensive use of antidepressant drugs in the treatment of all forms of depression makes the question of the real nature of agitated depression a crucial issue because many patients have adverse outcomes, including increased agitation, increased insomnia, increased risk of suicide, and sometimes the onset of psychotic symptoms. Agitated depression is no longer considered a mixed state in the DSM system. After a review of the literature on melancholia agitata as a mixed state and on the introduction of the concept of mixed states, this paper will examine the psychopathology of agitated depression. The main symptoms are depressive mood with marked anxiety, restlessness, and often delusions; in other cases, psychic agitation and racing or crowded thoughts prevail. This condition, a form of mixed depression (as contrasted with mixed mania) is similar to what Kraepelin had considered excited depression. Their clinical recognition is important because these cases require ECT, antipsychotics, or mood stabilizers.

No. 29C
ARE IMPULSE CONTROL DISORDERS BIPOLAR?

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML 0559, Cincinnati, OH 45267-0559*

SUMMARY:

In this presentation, data suggesting that impulse control disorders (ICDs) are related to bipolar disorder will be reviewed. These data will include evidence of (1) phenomenologic similarities, including harmful, dangerous, or pleasurable behaviors; impulsivity and similar affective symptoms and dysregulation; (2) high comorbidity with one another and similar comorbidity with other psychiatric disorders; (3) elevated familial rates of mood disorder in both conditions; (4) possible shared abnormalities in central serotonergic and noradrenergic neurotransmission; and (5) response of both conditions to mood stabilizers and antidepressants. However, data will also be presented showing how ICDs and bipolar disorder differ in some important respects—particularly how ICDs may be more closely related to obsessive-compulsive disorder (OCD) than is bipolar disorder. To explain a possible relationship among ICDs, bipolar disorder, and OCD, it will be hypothesized that impulsivity and bipolarity (or mania) may be related to one another, that compulsivity and unipolarity (or depression) are similarly related, and that each state may represent opposing poles of a bidimensional continuum. The clinical and theoretical implications of such a compulsivity/unipolarity versus bipolarity/impulsivity continuum will also be discussed.

No. 29D
ANTICONVULSANT AUGMENTATION IN BORDERLINE PERSONALITY-II AND BORDERLINE PERSONALITY-III

Olavo D. Pinto, M.D., *Department of Psychiatry, University of California, San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0603*

SUMMARY:

Anticonvulsants are being increasingly used in both private and public psychiatry to augment antidepressants in the treatment of a variety of bipolar conditions. This literature is largely made of case reports as opposed to the literature on lithium augmentation. In this study of 32 patients with bipolar conditions that extend between bipolar II and bipolar OS by DSM-IV criteria, patients with inadequate response to antidepressants and/or antidepressants plus lithium were augmented with divalproex in doses ranging from 500-2000mg. At intake, patients were assessed with a specially designed questionnaire on cyclothymic and hyperthymic temperaments as validators of soft bipolarity. GAF scores constituted the main outcome measure in this open study: the scores of the patients at entry were in the 40s and 50s, and within three months two out of three had achieved a robust response with scores in the 70s and 80s. This is a type of study that illustrates how clinicians in their own psychiatric practice can generate data of importance for clinical management involving patients that are rarely investigated by researchers. Such studies can thus serve as stimulus for more controlled investigations, or they enrich the knowledge obtained from double-blind studies on superselected populations.

No. 29E
ADVANCES IN TREATMENTS FOR BIPOLAR DISORDER

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

SUMMARY:

The past decade has seen unprecedented developments in the treatment of bipolar disorder. Both the best evidence for lithium's effectiveness and the strongest evidence for lithium's limited range efficacy have been published in this decade. Methodologically strong studies have confirmed a quarter century's worth of largely open trials of the efficacy of valproate for mania. These studies, and the shift to divalproex-based treatment of mania, have spawned systematic research programs for a range of other drugs, principally ones also effective in epilepsy, e.g., lamotrigine, topiramate, gabapentin; or psychosis, e.g., olanzapine, risperidone. Better symptom characterization has been essential, both for diagnostic subtyping and assessing the most sensitive and specific indicators of drug efficacy. Divalproex, and for some patients carbamazepine, have extended the spectrum of subtypes and the dimensions of behavior beyond those alleviated by lithium. Nevertheless, major domains of the illness remain inadequately treated, especially rapid cycling, psychotic symptomatology, and subthreshold depression. These treatments needs have particularly contributed to studies with lamotrigine, topiramate, olanzapine, and risperidone for various components of bipolar disorder.

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SYMPOSIUM 30—EVOLUTION OF CARE: SCHIZOPHRENIA AND SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the need for integrated treatment, understand the non-linearity of recovery in dual-diagnosis patients, and treat patients with increased attention to motivational state and the utility of outreach.

No. 30A
INTEGRATING SERVICE FOR SUBSTANCE ABUSE AND SCHIZOPHRENIA

David J. Hellerstein, M.D., *Department of Psychiatry, Beth Israel Medical Center, 1st Ave & 16th Street, Pos 2-B, New York, NY 10003-2992*

SUMMARY:

Overview: Psychiatric and substance abuse services are typically provided separately to patients with comorbid mental illness and substance abuse. Yet, studies have clearly demonstrated that each disorder negatively effects the outcome of the other. We studied the effects of service integration on treatment retention (TR), rehospitalization (RH), substance use (SU), and psychiatric symptom severity (PS) in 63 patients with RDC schizophrenia and DSM-III-R psychoactive substance use disorders. .

Method: We compared manualized integrated psychiatric and substance abuse services (COPAD) with equally-intense nonintegrated treatment in a randomized clinical trial. To evaluate TR, we used Fisher's Exact tests; for RH, Kaplan-Meier plots & Cox proportional hazards regression; and for SU and PS (ASI composite scores), Generalized Estimating Equations (GEE).

Results: The early dropout after randomization was 39.7% (N = 25 attending ≤1 outpatient session). For "starters" (≥2 sessions), 87% of COPAD patients were retained in treatment at eight months versus 53.3% of control patients ($p = .03$, $\phi = .37$), a moderate effect size. Between groups comparisons were obscured by high attrition among controls. A significant main effect for RH was found for Engagement Status, favoring starters ($h = 4.1$; $p < .0001$). Treatment-exposed subjects improved in PS over time; GEE yielded no main Group effects. COPAD subjects showed trends toward less alcohol ($z = -1.93$, $p < .10$) and drug problems ($z = -1.72$, $p < .10$) at eight months vs. controls.

Discussion: This controlled study provides evidence that patients with addiction and schizophrenia connect better with integrated treatment services, which can lead to better outcome in a variety of domains. A replication and other confirmatory studies will be discussed in presenting integrated treatment as the mode of choice for such patients.

Supported by NIMH MH 46327 and NIDA DA 09431.

No. 30B
EFFECTS OF ASSERTIVE OUTREACH IN THE DUALLY DIAGNOSED PATIENT

Christian R. Miner, Ph.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th St, 5F, New York, NY 10003;* Richard N. Rosenthal, M.D., David J. Hellerstein, M.D.

SUMMARY:

Overview: Patients with schizophrenia and comorbid substance use disorders (SUD) have been described as difficult to treat and to retain in treatment. After a brief review of recent studies of Assertive Community Treatment, we will present a randomized trial with 78 volunteers with comorbid SCID/DSM-IV schizophrenia and SUD. We compared a manualized control treatment of integrated psychiatric and substance abuse outpatient services (COPAD) with the same integrated treatment plus Targeted Assertive Outreach (COPAD+TAO).

Method: We used Generalized Estimating Equations to evaluate outcomes at 0, 4, 8, and 12 months: hospital days/trimester; quality of life (WQLI); substance use severity (ASI SUS); and psychiatric symptom severity (SANS, SAPS).

Results: Subjects in both treatments had significantly decreased inpatient days ($Z = -3.38$, $p < .005$) and SUS ($Z = -3.04$, $p < .005$) while reporting improved quality of life ($Z = 2.03$, $p < .05$) from 0–12 months, with no significant between-groups effects. Both groups showed decreased positive symptom severity 0–12 mos. ($Z = -6.13$, $p < .001$), with a significant between-treatments difference on the SAPS ($Z = -2.68$, $p < .005$), sustained when antipsychotic medication effects or atypicality were controlled for, in favor of COPAD+TAO subjects. A significant Treatment × Time interaction for the SANS showed differentially decreased negative symptom severity for COPAD+TAO subjects by 12 months.

Conclusion: TAO contributes significantly and substantially to psychiatric outcome over and above the important positive effects of integrated psychiatric and substance abuse treatment upon substance use severity, rehospitalization, and quality of life. Hypothesized effects of TAO on treatment compliance and symptom reduction will be discussed.

Supp.: NIDA DA 09431.

No. 30C
DUAL RECOVERY THERAPY AND MOTIVATION

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854;* Ilana Pinsky, Ph.D., Jonathan Krejci, Ph.D., Brenda Rambo, B.A., Phyllis Reilly, M.A., Ann Hummel, B.A.

SUMMARY:

Clinical experience and research studies suggest that blending mental health and substance abuse treatment improves outcomes for individuals with co-occurring schizophrenia and substance abuse. Using the Stages of Change model, this presentation will focus on the importance of assessing the patient's motivational level to stop using each specific substance and to continue medication treatment for schizophrenia. Results from assessing motivation to stop using specific substances 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. Dual Recovery Therapy techniques will be presented, including findings from a NIDA-funded study that supported therapy development for treating co-occurring cocaine addiction and schizophrenia. "Recovery" is a powerful concept for individuals who are dually diagnosed and includes the role of spirituality in individual's lives and dual-diagnosis treatment. This presentation will also include a brief overview of assessing and treating nicotine dependence among this population. In conclusion, the presentation (and handout) will summarize a Dual-Diagnosis Training Program for community mental health centers that outlines key dual-diagnosis training issues for mental health staff.

No. 30D
ALLIANCE AND ENGAGEMENT IN SUBSTANCE-ABUSING SCHIZOPHRENIA PATIENTS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street - 9F, New York, NY 10003;* Christian R. Miner, Ph.D., Sena Philomena, M.A., David J. Hellerstein, M.D., J. Christopher Muran, Ph.D.

SUMMARY:

Overview: Treatment engagement in patients with substance abuse and schizophrenia is a major clinical issue, yet research has rarely explored the therapeutic alliance in this population. We examined patients' therapeutic alliance over time in a sub-study of a randomized trial comparing twice-weekly manualized outpatient group therapy (COPAD; Control) with group therapy plus Targeted Assertive Outreach visits (COPAD+TAO).

Method: Patients (N = 35) and therapists in two experimental and two control treatment groups, completed the Group Climate Questionnaire [GCQ] (MacKenzie, 1983) following each group session for 30 sessions. Individual subject Engagement subscale scores were computed and the means for each session were computed by Group. A GEE model tested whether patients' Engagement scores vary by treatment condition, using time-in-treatment as a covariate. Patient-therapist agreement on GCQ subscales was examined by cross-correlating between Therapist Means and Patient Means treated as time series.

Results: There were no significant correlations between staff attendance and patient GCQ scores, suggesting they are unrelated. Group distinction affects Engagement, but seniority in treatment does not. TAO patients' mean Engagement scores exceed controls' by 3.33 subscale points ($z = 2.26$, $p < .01$). Cross-correlations between pooled therapists' and patients' GCQ Conflict subscale scores were significant for COPAD+TAO groups ($r = .51$, $p < .01$; $r = .36$, $p < .05$), but not for control groups ($r = .09$, $p = ns$; $r = .15$, $p < ns$).

Discussion: TAO enhances the treatment alliance in group psychotherapy, a salient factor of which may be improved interpersonal tracking of conflict by patients and therapists. As integration of services increases treatment retention, the differential effects and implications of TAO will be discussed.

Support: NIDA DA 09431.

No. 30E
SKILLS TRAINING FOR SUBSTANCE ABUSING PATIENTS

Andrew L. Shaner, M.D., *Department of Psychiatry, Veterans Affairs Medical Center., 11301 Wilshire Boulevard, Los Angeles, CA 90073;* Lisa J. Roberts, M.A., Thad Eckman, Ph.D.

SUMMARY:

Objective: Most schizophrenic substance abusers either do not tolerate or are not helped by standard treatments for substance abuse. We adapted cognitive-behavioral drug relapse prevention strategies originally developed for non-mentally ill substance abusers by using a skills training method originally developed to teach social and independent living skills to schizophrenics.

Method: The intervention consists of three components: (1) Basic Training (eight psycho-educational sessions), (2) Skills Training (27 sessions to teach nine relapse prevention skills), and (3) Practice Sessions (35 sessions paired with the other two kinds of groups during which patients apply newly learned knowledge and skills to real-life situations). A total of 56 patients with DSM-IV schizophrenia or schizoaffective disorder and co-occurring substance dependence participated in a feasibility study. Thirty-four completed treatment and participated in a follow-up assessment three months after study completion.

Results: Subjects acquired and maintained a wide range of drug relapse prevention concepts and skills. Days abstinent from drugs and alcohol increased significantly as did days taking antipsychotic medications

Conclusions: If subsequent research demonstrates that participants actually use these skills, then this manual-driven therapy may play an important role in the treatment of substance abuse among schizophrenic patients.

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SYMPOSIUM 31—PSYCHOSOCIAL REHABILITATION ADVANCES FOR THE SEVERELY AND PERSISTENTLY MENTALLY ILL

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have learned about recent advances in psychosocial rehabilitation and the negative impact that public sector managed care has had on those, its role in psychiatric care in several settings, the components of an Ohio recovery program, and key aspects of an APA committee report on this topic.

No. 31A
IMPACT OF PUBLIC SECTOR MANAGED CARE ON PSYCHOSOCIAL REHABILITATION

Clifton R. Tennison, Jr., M.D., *Helen Ross McNabb, 1520 Cherokee Trail, Knoxville, TN 37920-2205*

SUMMARY:

The proliferation of restrictive, underfunded, and poorly managed public sector managed care schemes over the past five years threaten our capacity to offer psychotherapy, prevention, and rehabilitation programs. An example of a poorly planned system, TennCare Partners, the mental health carve-out for Tennessee's Medicaid waiver initiative, has by design or mismanagement destroyed most of the psychosocial efforts in the state. Falling below one's own standard of care and watching the deterioration of rehabilitative programming, interagency collaborations, and the essential safety net are not only demoralizing but also dangerous, resulting in increased recidivism, homelessness, incarceration, crisis, suicide, and homicide. These sentinel events are far outpaced by the numbers of patients who would have achieved varying levels of improved family, social, occupational, and self-care functioning had the programs not been

cut. Aggressive and creative diversification is required in order to obtain non-Medicaid funding to create necessary wrap-around services for severe, persistently mentally ill adults and seriously emotionally disordered children and adolescents. Such programs may include forensic and adult corrections services, independent drop-in center and vocational skills development programs, school- and juvenile–court-based programs, primary prevention and primary care interface programs, enhanced collaborations with alcohol and drug treatment programs, and closer affiliations with training programs.

No. 31B
INTEGRATING PSYCHIATRIC REHABILITATION AND PSYCHIATRIC CARE

Selby C. Jacobs, M.D., *Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519;*

SUMMARY:

Psychosocial rehabilitation has grown enormously since the 1970s. Psychiatrists have made essential contributions to this growth, yet a gulf exists between the treatment models of psychiatrists and the recovery models of psychosocial rehabilitation specialists. With growing evidence for the effectiveness of rehabilitative interventions in the face of potential neglect of rehabilitative tasks for seriously ill persons under managed care, it is timely to reconsider the role of psychosocial rehabilitation in psychiatric care. Revisiting this question provides a renewed opportunity to narrow the gap between the two arenas of treatment for symptoms and rehabilitation for disabilities. This presentation considers the evidence for rehabilitative interventions, the complementary relationship of rehabilitation to treatment, the need and strategies for integration, and roles for psychiatrists and other professionals in comprehensive care of the seriously ill. Psychiatrists' roles might include education for themselves and others about psychosocial rehabilitation, incorporation of rehabilitation into comprehensive plans of care, services research on the efficacy of rehabilitative interventions, advocacy of psychosocial rehabilitation to purchasers and care managers, and alliances with rehabilitation colleagues for these purposes. We illustrate with examples from an urban community mental health center and its affiliated, community-based rehabilitation agencies serving disadvantaged persons with serious illness and disabilities.

No. 31C
PSYCHOSOCIAL REHABILITATION: EMERGING BEST PRACTICES IN RECOVERY

Dale P. Svendsen, M.D., *Medical Director, Ohio Department of Mental Health, 30 East Broad Street, 8th Floor, Columbus, OH 43215*

SUMMARY:

Recovery is a consumer-led personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. It is based on the philosophy that people with severe mental illness live in the community and participate in a lifestyle of their choice. Consumers, families, clinicians, and administrators in Ohio identified nine essential components needed in order for a community to provide effective services and support. These are:

1. Clinical care
2. Family support
3. Peer support and relationships
4. Work/meaningful activity
5. Power and control
6. Stigma
7. Community involvement
8. Access to resources
9. Education

Stakeholder workgroups also identified developmental steps in the recovery process. These steps are dependent/unaware, independent/unaware, independent/aware, and interdependent/aware. These emerging best practices in recovery guide clinicians, families, consumers, and the system of care. We will share the guidelines using examples form hospitals and community.

No. 31D
REPORT FROM THE AMERICAN PSYCHIATRIC ASSOCIATION'S PSYCHOSOCIAL REHABILITATION COMMITTEE

Troy L. Thompson II, M.D., *Department of Psychiatry, Jefferson Medical College, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107;*

SUMMARY:

As chair of the APA Committee on Psychosocial Rehabilitation, I will review key aspects of that group's report, including six principles that should guide the future development of psychosocial rehabilitation. The committee also made recommendations related to eight issues at the interface of psychosocial rehabilitation and psychiatry care. The rationale and obstacles to implementation (and possible solutions) and key references for each issue will be discussed. The recommendations focus on:

1. Improving the relationships of psychiatry to others who work in psychosocial rehabilitation,
2. Psychiatry's support of psychosocial rehabilitation technologies proven to be efficacious,
3. How clinical psychiatrists can further utilize psychosocial rehabilitation most effectively,
4. Improving the awareness/knowledge of psychiatric administrators about psychosocial rehabilitation,
5. How academic psychiatry programs might best address education about rehabilitation,
6. Enhancing psychosocial rehabilitation's acceptance and roles in managed care environments,
7. Incorporating psychosocial rehabilitation on public and private psychiatry inpatient units, and
8. Treatment guidelines on appropriate utilization of psychosocial rehabilitation in patient care in multiple clinical settings.

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SYMPOSIUM 32—EATING DISORDERS 2000: CAUSES, PATTERNS, AND OUTCOMES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe new developments in eating disorders regarding:

(1) genetic and other susceptibility factors; (2) patterns of PTSD in bulimia nervosa patients; (3) changing epidemiology of hospitalized eating disorder patients; (4) the impact of eating disorders on bone growth and calcium, and on pregnancies and neonates; and (5) long-term follow-up of gastric bypass surgery in obese binge eaters.

No. 32A
SUSCEPTIBILITY FACTORS IN EATING DISORDERS

Walter H. Kaye, M.D., *Eating Disorders, Western Psychiatric, E-724, 3811 O'Hara Street, Pittsburgh, PA 15213;* Lisa Lilefeld, Ph.D., Katherine A. Halmi, M.D., *Price Foundation Study Group*

SUMMARY:

Considerable studies have linked anorexia nervosa (AN) to a cluster of personality and temperamental traits, specifically obsessionality, perfectionism, anxiety, and harm avoidance. An international, multi-site study funded by the Price Foundation has collected 237 affected relative pairs to correlate these potential traits with genetic factors that may contribute to the pathogenesis of AN. These symptoms were assessed with the Multidimensional Perfectionism Scale (MPS), Temperament and Character Inventory (TCI), Speilberger State-Trait Anxiety Scale (SPAI), and Yale-Brown Obsessive Compulsive Scale (Y-BOCS).

Data from 103 AN-restrictor-types and 145 AN-binge-purge-types showed that perfectionism and harm avoidance scores were significantly elevated compared with healthy subjects and were independent of weight or state of the illness. Obsessions and compulsions were present in 64% the restrictor-types and 80% of the binge-purge-types. A factor analysis revealed that the most influential factor was one of trait anxiety, harm avoidance, perfectionism, obsessionality, and diminished self-directedness, although the precise nature of this factor differed across sites.

In summary, this large sample set confirms that people with AN have elevated obsessionality, perfectionism, and harm avoidance symptoms that are independent of state of the illness. These factors may be traits that contribute to the expression of AN.

No. 32B
PREDICTIONS OF SIMPLE AND COMPLEX PTSD IN BULIMIA NERVOSA

Marcia E. Rorty, Ph.D., *Private Practice, 3070 Sparr Boulevard., Glendale, CA 91208-1843;* Stephen A. Wonderlich, Ph.D., Joel Yager, M.D., Ross D. Crosby, Ph.D., Catherine Haudek, B.A.

SUMMARY:

We examined childhood predictors of "simple" and "complex" PTSD in adult women with bulimia nervosa (BN) and subclinical BN (bulimia-spectrum eating disorder NOS).

Participants were approximately 20 adult women gathered by newspaper advertisement. The great majority had been ill for well over five years and had received multiple forms of treatment for the eating disorder. We administered self-report questionnaires regarding childhood experiences with adversity and attachment, including the Childhood Trauma Questionnaire and the Parental Bonding Instrument. For the diagnosis of "simple" PTSD, we used the SCID IV (researcher version), and for "complex" PTSD or DES NOS we used the Structured Interview for Disorders of Extreme Stress (SIDES). We administered the latter even in the absence of a diagnosis of simple PTSD, using both categorical and dimensional ratings.

In this presentation, we will present trauma and attachment variables that best predicted simple and complex PTSD in this group. Participants often showed significant symptoms of complex or chronic PTSD in the absence of simple PTSD. The stressors cited as traumatic in complex PTSD were more commonly related to severe relational problems in the family of origin than to the distinct Type A stressors required for diagnosis of simple PTSD.

No. 32C
INPATIENTS WITH EATING DISORDERS: CHANGING EPIDEMIOLOGY

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell Medical College, 21 Bloomingdale Road, White Plains, NY 10605-1504;* Claire Wiseman, Ph.D., Suzanne Sunday, Ph.D., Fern Klapper, Ph.D.

SUMMARY:

Background: Managed care decreased the length of stay for hospitalized eating disorder patients and this has been devastating. This paper compares epidemiological statistics of eating disorder inpatients in a specialty unit from 1984 to 1998.

Method: The records of all eating disorder admissions to the eating disorder unit at Cornell-Westchester from 1984 to 1998 were scrutinized for epidemiological information.

Results: There was an increase of eating disorder patient admissions from 20 in 1984 to 51 in 1989. Readmissions were one in 1984, 0 in 1985–1988, and two in 1989. From 1990 to 1998 admissions increased from 57 per year to 182 per year. Readmissions increased from two in 1990 (3.5% of admissions) to 50 in 1998 (27.5% of admissions).

Males account for 3% of admissions per year in the 1980s and 16% in the 1990s. Readmissions during the 1990s for males was 52.9% and for females 16%.

Mean age of admission increased from 18.8 in 1984 to 25.3 in 1998; greatest number of admissions consistently occurred between ages of 19–30. There was a significant increase in patients >30 and a small increase in those under 13 years.

EDNOS diagnoses were 3.7% of diagnoses in the 1980s and 20% in the 1990s. The anorexia nervosa-restricting stayed consistently between 20% to 35% of admissions. Bulimia nervosa and anorexia nervosa-binge/purge vacillated each year.

Mean length of stay decreased from 149.5 days in 1984 to 23.7 in 1998.

Conclusion: Undoubtedly the increasing influence of managed care companies has had an effect on the eating disorder inpatient readmission rate.

No. 32D
THE IMPACT OF EATING DISORDERS ON BABIES AND BONES

David B. Herzog, M.D., *Eating Disorders Unit, Massachusetts General Hospital, 15 Parkman Street, EDU 725-ACC, Boston, MA 02114;* Steven K. Grinspoon, M.D., Mark A. Blais, Psy.D., Debra L. Franko, Ph.D., Pamela K. Keel, Ph.D., Sherrie E. Selwyn, B.A., Andrea T. Flores, M.Ed., Anne Kubanski, M.D.

SUMMARY:

Eating disorders are associated with many severe medical complications. We are studying two of these phenomena: (1) the impact of eating disorders on pregnancy, delivery, and the neonate, and (2) anorexia-related osteopenia. The MGH Longitudinal Study of Anorexia and Bulimia Nervosa, now in its 12th year, has interviewed 246 women bi-annually and analyzed data on 106 pregnancies and 64 live births that have occurred prospectively. To date, our results indicate that eating disordered women who are symptomatic at the time of conception experience more medical complications during pregnancy and delivery than nonsymptomatic women. Furthermore, preliminary results suggest that infants born to bulimic women who are symptomatic at the time of conception are at greater risk for

birth defects. As for osteopenia, we are studying the efficacy of Insulin-like Growth Factor (IGF-1) in the stimulation of bone formation in women with anorexia nervosa. Studies indicate that over half of women with anorexia nervosa have significant bone loss of more than two standard deviations below the mean, placing them at significantly increased risk for bone fracture. It is theorized that IGF-1 deficiency (associated with nutrition) is the critical factor that accounts for the severe bone loss seen in anorexic women. At year three of this five-year study, 40 subjects have received serial bone density testing, nutritional and metabolic analyses, and treatment for bone loss. New data regarding medical complications from both studies will be presented and clinical implications will be discussed.

No. 32E
OUTCOME OF GASTRIC BYPASS FOR BEDRIDDEN AND NONBEDRIDDEN OBESE

James E. Mitchell, M.D., *Department of Psychiatry, Neuropsychiatric Research Institute, 700 First Avenue South, P.O. Box 1415, Fargo, ND 58107;* Stephan A. Wonderlich, Ph.D., Blake Gosnell, Ph.D., Ross D. Crosby, Ph.D.

SUMMARY:

This paper will present data on the long-term (mean 13.5 year) follow-up of 100 individuals who underwent gastric bypass for obesity. The original sample included 20 men and 80 women. The age range at the time of surgery was 17-62 years with a mean of 40. Subjects were interviewed in person or by phone using a semi-structured instrument designed for this purpose as well as several additional rating scales and questionnaires. The impact of presurgery binge eating and binge eating disorder as well as binge eating during the period of follow-up will be reviewed. One of the most interesting findings of the study was that the majority of the subjects reported regular involuntary vomiting, usually on a daily basis, over the period of follow-up. Overall, most subjects were quite satisfied that they had undergone the procedure.

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SYMPOSIUM 33—DOMESTIC VIOLENCE AND HEALTH INTERVENTIONS
U.S. Department of Justice's Office for Victims of Crime, APA Task Force on Violence, and APA Committee on Family Violence and Sex Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to have increased understanding of therapeutic mental health interventions for targets, perpetrators, and witnesses of domestic/intimate partner violence.

No. 33A
DOMESTIC VIOLENCE: AN OVERVIEW

Sandra J. Kaplan, M.D., *Department of Psychiatry, North Shore University Hospital, 400 Community Drive, Manhasset, NY 11030*

SUMMARY:

An overview of the prevalence and costs of domestic violence will be presented. Recent advances in psychiatric interventions available for families with domestic violence will be mentioned. Findings relating to mental health and behavioral problems, including substance abuse will be highlighted. The importance of the work of the remaining symposium presenters will be presented.

Issues of access to health care for these families and the importance of the Office of Victims of Crime of the U.S. Department of Justice in the area of this access will be discussed.

No. 33B
DOMESTIC VIOLENCE: LEGAL TRENDS

Diane Geraghty, J.D., *The Law Program, Loyola University, 1 East Pearson Street, Chicago, IL 60611*

SUMMARY:

This presentation will review recent legal trends throughout the United States that pertain to domestic violence. New legislation impacts on police procedures during investigation of and the implementation of victim and child witness protections. Mandatory arrest and services referrals procedures by police will be reviewed. Child custody judicial review in many states now must include domestic violence as a consideration. Mechanisms for and types of orders of protection will also be presented. The relationship of emotional maltreatment relating to domestic violence and consequent child maltreatment reporting responsibilities will be emphasized.

An emphasis will be made on the legal responsibilities of mental health clinicians as well as the legal rights of child witnesses and targets of domestic violence.

No. 33C
MEETING THE MENTAL HEALTH NEEDS OF BATTERED WOMEN: CRITICAL REVIEW OF TREATMENT INTERVENTIONS

Carole L. Warshaw, M.D., *Primary Care, Cook County Hospital, 1900 West Polk Street, Room 930, Chicago, IL 60612*

SUMMARY:

Increasing recognition of the impact of abuse and violence against women has led to the emergence of a number of treatment approaches. Although few have been tested empirically. There is growing consensus within the trauma field about the types of interventions that are most helpful to survivors of abuse. Published studies have focused on interventions following single-event sexual assaults. These are generally aimed at reducing the severity of or preventing PTSD and to some extent, depression and anxiety. There is even less research on which treatment modalities will be most helpful for individual women. Few, if any, outcome studies have been completed involving treatment for women sexually abused as children or women abused by intimate partners. Most reports are descriptive, feature nonstandardized approaches to care, or demonstrate relatively modest positive results. The dearth of studies in this area is not surprising given that treatment for the chronic effects of abuse is often multimodal and long-term. This session will review what is known

about effective interventions for survivors of intimate partner abuse and describe promising interventions emerging from the field.

No. 33D
MENTAL HEALTH TREATMENT OF THE DOMESTIC VIOLENCE BATTERER

Donald G. Dutton, Ph.D., *Department of Psychology, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 1Y4, Canada*

SUMMARY:

This presentation will review the efficacy of treatments for domestic violence perpetrators (batterers). The pioneering 21-year research effort of the Assaultive Husbands Program, in the department of psychology at the University of British Columbia, will be presented. This study reports on the efficacy of treatment and the characteristics of men who batter. Recommendations will be made regarding the needed roles of psychiatrists in the development and study of mental health interventions to prevent and rehabilitate perpetrators of domestic violence.

No. 33E
COLLABORATIVE APPROACHES TO CHILDREN EXPOSED TO VIOLENCE: THE EXPERIENCE OF A POLICE/MENTAL HEALTH PARTNERSHIP

Miriam Berkman, M.S.W., *Yale Child Studies Center, 230 South Frontage Road, New Haven, CT 06520*

SUMMARY:

Children who chronically witness domestic violence are at heightened risk for a range of developmental difficulties, disturbances of attention and relating, poor school performance, substance abuse, depression, and involvement in violence and other delinquent behaviors. Often, children who experience violence within their families do not receive any clinical service until symptoms are serious and well entrenched. Police come in frequent contact with these children in the context of their roles as first responders to scenes of violence, but police lack the training and resources to respond to child witnesses' psychological distress. Many professional groups are involved in responding to domestic violence, including law enforcement, mental health, school, child welfare, and judicial personnel, however, no single professional discipline can be successful when their efforts take place in isolation. The Child Development-Community Policing Program, developed in New Haven, Conn., brings together police officers, child mental health clinicians, domestic violence advocates, and others to create and implement coordinated approaches to intervention, which address issues of physical safety and psychological response. This presentation will describe the elements of the New Haven CD-CP's Domestic Violence Intervention Project and will describe the experience of the project's first two years of operation, including illustration with representative case material.

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SYMPOSIUM 34—NEW TRENDS IN EMERGENCY PSYCHIATRY IN NORTH AMERICA AND EUROPE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have increased knowledge of the future of the psychiatric emergency system in Europe and North America; how to face the important clinical, ethical and organizational challenges; how emergency psychiatrists with the increasing number of psychiatric emergencies if there is no simultaneous provisional adjustments; and how can the work of the psychiatric emergency system be organized if the psychosocial network downstream is not developed accordingly.

No. 34A
EMERGENCY PSYCHIATRY IN THE U.S.: FACING THE MANAGED CARE REVOLUTION

James R. Hillard, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 237 Bethesda Avenue, Cincinnati, OH 45275*

SUMMARY:

The role of emergency psychiatry in the United States has evolved as a function of the changes that have occurred in the field of community psychiatry over the past decades.

Managed care has had a profound impact on the composition of the psychiatric emergency department (PES) and on the specific functions performed for patients.

The PES in Cincinnati processes approximately 10,000 patient visits per year. The service is staffed with social workers, psychiatrists, and nurses. All patients are triaged by a registered nurse. Triage evaluation includes physical screening. Following the nursing evaluation, patients are seen by a social worker and finally by the psychiatrist on site who acts as medical reviewer of the case.

Summary data over the years show that 70% of patients coming into the PES return to outpatient status and 30% are hospitalized.

We observed different limiting factors: to match perceived needs and available resources, the unpredictability of violent behavior, the increasing number of patients who are brought against their will.

For the near future, the United States is poised to expand its collective commitment to managed care.

As long as there is managed care, be it directed at the chronically mentally ill or any other psychiatric patient population, the PES will play a crucial role as pre-screener, gate-keeper, and rapid intervention facility. A PES is indispensable to a functioning managed care system.

The trend will presumably be toward dispersion in geographic terms and more mobile crisis units rather than centralized fixed base operation. The PES will increasingly need to be conceptualized as one facet in a fully integrated array of services to a defined population.

No. 34B
THE CHALLENGES OF EMERGENCY PSYCHIATRY IN EUROPE

Michel De Clercq, M.D., *Department of Psychiatry, Saint Luc Hospital, Hipprocrate Avenue, 70 B.P. 2760, Brussels 7200, Belgium*

SUMMARY:

In the face of the explosion in the number of psychiatric emergencies in the major cities of Europe, the emergency services of general hospitals have developed and set up psychiatric teams to deal with this phenomenon.

In emergency services, the emphasis is often put on psychiatric assessment and on the need to direct the patient through the proper channels. In many cases, the psychiatric assessment does not serve to determine the intervention to be applied but rather to determine whether the patients should be sent.

The institutional structures are often inadequate: no specialized office to talk with the patient, no short-term hospitalization beds, young interns, junior psychiatrists, and nurses with no training.

In emergency psychiatry, the patient requests emergency help but, in most cases, it is the family, the friends, the police, or the social service who take this step.

Patients express a series of complaints and ask to be relieved of their problem and to be cured. They are often unable to express a genuine request for individual or family psychotherapy, for specific psychiatric care, or hospitalization.

We often observe in Europe this misunderstanding between the request—or absence of request—for psychiatric care and the care actually on offer.

What are the major objectives of our interventions in the face of psychiatric emergencies in Europe?

1. Analyzing the entire crisis system,
2. Developing a response that compels the psychiatric staff to come down to the level of the patient instead of obliging the patient to adjust to the modus operandi of the world of psychiatric care,
3. Addressing the problem and not simply the patient's disorder,
4. Negotiating a therapeutic alliance with the patient or his familiars and ensuring compliance with the treatment,
5. Using the resources of the patient and the context,
6. Crisis interventions to enable the most severely affected patients to use the resources of psychiatry, and
7. Minimal "institutional" resources:
   - specialized team composed by psychiatrists, psychiatric nurses, psychologists, and social workers,
   - short-term hospitalization beds,
   - isolation rooms.

No. 34C
CANADIAN VERSUS AMERICAN PSYCHIATRIC EMERGENCY SERVICES

Suzanne Lamarre, M.D., *Department of Psychiatry, Saint Mary's Hospital, 3830 Lacombe Avenue, Montreal, QC H3T 7M5, Canada;* Andreanne Elie, M.D.

SUMMARY:

The Canadian authors have identified two respective constraints when comparing American with Canadian psychiatric emergency services (PES) in two cities, Boston and Montreal: the cost-effective one for the American city, the territorial one for the Canadian city.

In fact, the authors have observed that psychiatric practitioners working in PES of the Boston area need to verify the patient's health insurance company at the first encounter, as for the psychiatrists working in the Montreal area, they need to verify the patient's psychiatric sector. In both cities, clinical needs have to be dealt inside those respective practical limits.

The authors will discuss the different types of practice that have emerged within those two constraints when dealing with the following particular aspects:

- number of hours spent by the clinician to direct the patient where he belongs,
- delay for the patient's psychiatric assessment in PES and in OPD,
- psychiatrist's evaluation including medical and/or dynamic aspects,
- development of hospital or community based practice,
- priority given to the administrative or the clinical aspects when there is no consensus, and
- prevention of mental illnesses as the main responsibility of public health, emergency psychiatry, or insurance groups.

No. 34D
INNOVATING ACUTE TREATMENT: A SWISS PILOT PROJECT

Antonio Andreoli, M.D., *Department of Psychiatry, University of Geneva, Rue Micheli Du Crest, Geneve 74 7277, Switzerland;*

SUMMARY:

Objective: To review previous research aimed to evaluate an innovative treatment programs for acute mental disorders.

Significance: Acute mental disorders are an important area of contemporary psychiatry, with significant relevance to treatment progress and increased efficiency. Better acute care may result in shorter duration of psychiatric hospitalization, earlier detection of severe disorders, shorter time to adequate effective treatment, and reliable long-term treatment assignment, i.e., in more efficient management of a given mental health system.

Methods: To fulfill these aims, we developed a comprehensive program for acute mental disorders in a Geneva urban catchment area. Phase 1 was aimed at implementing a comprehensive acute care delivery project integrating a specific acute treatment program at each level of the mental health system (psychiatric hospital, general hospital, ambulatory services). Phase 2 and 3 were, respectively, a naturalistic evaluation of feasibility and outcome and a controlled evaluation of effectiveness and costs.

Results: Comprehensive, specialized acute care was more effective and less expensive compared with both standard hospitalization and ordinary ambulatory care. Furthermore, provision of additional psychotherapy within acute treatment appeared to be cost-effective in those patients with major depression.

Comment: These studies confirmed that acute mental disorders are a significant area for treatment innovation and research, suggesting that despite elevated initial costs provision of intensive acute treatment programs may be cost-effective in these patients.

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SYMPOSIUM 35—ANTIPSYCHOTIC MEDICATIONS AND SEXUALITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) critically evaluate available information on antipsychotics and sexual dysfunction, (2) understand the pathomechanisms of antipsychotics to sexual dysfunction, (3) recognize that sexual dysfunction in persons with schizophrenia is multifactorial.

No. 35A
REVIEW OF PATHOMECHANISMS OF SEXUAL DYSFUNCTION SECONDARY TO ANTIPSYCHOTIC AND ANTIDEPRESSANT MEDICATIONS

R. Taylor Segraves, M.D., *Department of Psychiatry, Case Western Reserve Univ., 2500 Metro Health Drive, Cleveland, OH 44109-1998*

SUMMARY:

A variety of mechanisms have been proposed for antipsychotic and antidepressant-induced sexual side effects. Major hypotheses concerning the effect of antidepressants on sexual function include inhibition of nitric oxide synthase, direct effect of increasing serotonergic activity on the descending inhibitory serotonergic spinal pathways from the medulla, modulating effect of serotonergic activity on mesolimbic dopaminergic pathways, and modulating effect of serotonergic activity on adrenergic activity. Theories concerning effects of antipsychotic drugs on sexual function include adrenergic blockade, anticholinergic side effects, dopamine blockade, and increased prolactin levels. Hypotheses often have been formulated after observing that an antidote reverses a drug-induced sexual dysfunction, assuming that the action of the antidote provides information concerning the pathomechanism of the psychiatric agent. Another source of hypotheses have been derived from differential effects of various agents on sexual function. All hypotheses have to be evaluated with the knowledge that there are few prospective controlled studies of the efficacy of antidotes and that there are only a small number of studies using proper methodology comparing the frequency of sexual side effects between different agents.

No. 35B
SEXUALITY AND THE COST OF COMPLIANCE FOR CONSUMERS

Francine Chisholm, B.A., *MB Schizophrenia, 5211-3093 Pembina Highway, Winnipeg, MB R3T 4R6, Canada*

SUMMARY:

There are many variables that influence the sexual health of persons with schizopohrenia, but research indicates that antipsychotic medication may produce undesireable side effects on sexual functioning. There is a paucity of research on the subjective experience of sexual dysfunction for persons with schizophrenia and how these difficulties are mediated in their lives. Preliminary research indicates that these side effects are not only undesireable but distressing and may affect compliance with treatment. Focus group data with women with schizophrenia suggest that sexuality is an area of concern for this group. Among these women, compliance frequently involved compromised sexual functioning as one trade-off for clinical stability. This compromise was seen to impact engagement in relationships, ongoing sexual relationships, and the sense of femininity for many of the participants. These issues may have similar relevance for males. Sexual health is an important consideration in the rehabilitation of persons living with schizophrenia.

No. 35C
SEXUAL PROBLEMS IN A WOMEN'S CLINIC FOR SCHIZOPHRENIA

Mary V. Seeman, M.D., *Department of Psychiatry, University of Toronto, 250 College Street, Toronto, ON M5T 1R8, Canada*

SUMMARY:

Objective: To illustrate the range of sexual problems volunteered during four years of assessments in a women's clinic for schizophrenia.

Method: Chart review and tabulation of 320 referrals to a specialized comprehensive treatment service for women with schizophrenia.

Results: Loss of libido was the most pervasive sexual complaint. Guilt about past abortions was the second most frequently voiced complaint. The third was sexual infatuation with an unattainable, sometimes imaginary male. Spontaneous arousal and orgasm, visual and tactile hallucinations of sexual acts, auditory hallucinations of sexual insults, pseudocyesis, denial of pregnancy and childbirth, delusion of childbirth, sexual victimization, and sexual "addiction" were other, not infrequent, complaints.

Conclusions: Women with schizophrenia, often after years of illness and treatment, retain their interest in sex and in sexual aspects of interpersonal relating. These interests can be reassuring or problematic for individual women.

No. 35D
DEVELOPMENT OF A SCALE TO ASSESS SEXUAL FUNCTIONING

Ruth A. Dickson, M.D., *Department of Psychiatry, University of Calgary, Carnat Centre PLC, 3500 26th Avenue NE, Calgary, AB T1Y 6J4, Canada;* William M. Glazer, M.D., Joan M.C. Hillson, Ph.D.

SUMMARY:

Development of instruments to assess and quantify medication-induced sexual dysfunction in persons with schizophrenia has lagged assessment of other dimensions of outcome, for example, psychopathology and movement disorders, contributing to a lack of data on antipsychotic-induced sexual side effects. There is no detailed, standardized scale that is widely accepted for assessing drug-induced sexual dysfunction in patients with schizophrenia and related psychotic disorders. The authors report on the development of a theoretically-driven, self-report, computer-administered questionnaire designed to assess sexual functioning, and the effects of antipsychotic medications on sexual functioning, in patients treated with antipsychotic drugs. This questionnaire also includes the patient's perceptions of the impact of drugs on his/her sexuality. Results obtained using this scale will be reviewed and compared with results from other studies.

No. 35E
SEXUAL DYSFUNCTIONS IN PATIENTS ON ANTIPSYCHOTICS

Rikus Knegtering, *Department of Psychiatry, University Hospital, Hanzepleini, Groningen 9700 RB, Netherlands;* Maroo Boks, M.D., Durk Wiersma, Ph.D., Carl Blijd, M.D., Richard Bruggeman, M.D., Robert Bosch Van Oer, Ph.D.

SUMMARY:

How often do patients using antipsychotics experience sexual side effects? What are possible mechanisms? What is the clinical relevance? The author will present two completed studies described below and ongoing research investigating the relationship of sexual dysfunction to antipsychotic treatment. In the first study, 90 patients using antipsychotics for six weeks completed a questionnaire that assessed libido, orgasm, ejaculation, menstruation, and galactorrhea. The percentages of patients reporting sexual dysfunction differed significantly between group by medication prescribed, traditional neuroleptics vs. risperidone vs. olanzapine.

In the second study, 41 patients in an open trial were randomized to either risperidone or olanzapine. Only 10% of the patients spontaneously reported sexual dysfunction. In response to a questionnaire, 31% reported sexual dysfunction. This differed significantly between the groups: 50% with risperidone, and 11% with olanzapine (Chi-square = 4, 47, df = 1, p = 0,032).

Sexual dysfunctions are rarely reported spontaneously, but are very common side effects in patients using antipsychotics. The frequency of these side effects differ between antipsychotics. Mechanisms and clinical relevance will be discussed in relation to gender differences.

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2. Finn SE, Bailey JM, Schultz RT, Faber: Subjective utility ratings of neuroleptics in treating schizophrenia. Psychological Medicine 1990; 20:843–848
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4. Aizenberg D, Zemishlany Z, Dorfman-Etrog P, Weizman A: Sexual dysfunction in male schizophrenic patients. J Clin Psychiatry 1995; 56:137–141
5. Knegtering H, Blijd C, Boks M: Sexual dysfunction and prolactin levels in patients using classical antipsychotics, risperidone or olanzapine. Schizophrenia Research, Special Issue 1999; 35(1–3)355

SYMPOSIUM 36—RECOVERED MEMORY: LAW, SCIENCE, AND THE CLINICIAN

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have increased knowledge of the current scientific evidence about recovered memory, the reasons for disagreement, changing legal standards for scientific evidence based on recent Supreme Court decisions, acceptable clinical practices in light of these controversies, the positions of lawyers and experts who play leading roles in recovered memory litigation.

No. 36A
MEMORY DISTORTION: DATA, THEORY, AND APPLICATION

Daniel L. Schacter, Ph.D., *Department of Psychology, Harvard University, 33 Kirkland Street, Cambridge, MA 02138*

SUMMARY:

The controversy concerning recovered and false memory of childhood trauma has led to a surge of research concerning the mechanisms involved in traumatic remembering, and has also stimulated new research concerning memory distortion. This presentation will review recent experimental studies that explore the nature and basis of false memories—remembering events that never happened. Cognitive psychologists have developed paradigms for producing powerful false recall and recognition effects in the laboratory. Evidence from such paradigms will be presented, with a particular focus on the mechanisms involved in reducing susceptibility to false recollections. Application of paradigms and ideas from basic research to the recovered memories controversy will also be considered. Data from recent studies examining susceptibility to memory distortions in individuals reporting recovered or repressed memories will be presented.

No. 36B
RECOVERED MEMORIES: A MULTIDISCIPLINARY ANALYSIS

Christopher Barden, Ph.D., *1093 East Duffer Lane, North Salt Lake, UT 84054*

SUMMARY:

The presenter is an attorney/psychologist/researcher who has litigated dozens of "recovered memory" malpractice lawsuits and many "recovered memory" Frye/Daubert hearings. Based on his litigation experience and his work as a psychotherapist, researcher, expert witness (in law and psychology), teacher, consultant, and service on the Minnesota State Board of Psychology, Dr. Barden will discuss the methodological, scientific, ethical, and clinical errors that produced a deluge of "recovered memory" malpractice lawsuits in the 1990s.

Common clinical and ethical errors of recovered memory therapists will be discussed with examples from unidentified but actual litigated cases. Boundary violations, the misuse of hypnotic processes, failures of informed consent, the use of false information, failures of assessment, billing fraud, the unauthorized use of experimental treatments, and failures to properly consult with colleagues will be discussed.

Errors of methodology, logic, and ethics in recovered memory research will be discussed. Research on the effects of trauma will be briefly reviewed from child development, anthropological, sociological, legal, and psychiatric perspectives. Future directions for productive research into dissociative processes will be suggested.

Suggestions for ending the recovered memory crisis will also be offered.

No. 36C
JUSTICE AND PSEUDOSCIENCE IN THE MEMORY WARS

Alan W. Scheflin, L.L.M., *School of Law, Santa Clara University, 500 El Camino Real, Santa Clara, CA 95053;*

SUMMARY:

For two decades, courts have received the opinions of experts regarding how memory functions. Sadly, a great deal of this testimony has been pseudoscience.

In the first decade, courts were led to believe that hypnosis, guided imagery, and other similar retrieval techniques inevitably contami-

nated memory. As a response, courts prohibited the introduction into evidence of testimony based on the use of these techniques.

In the second decade, courts were told by experts that repressed memory does not exist, that all memories first recovered in therapy are necessarily false, that it is easy to implant false memories of horrific events that never happened, that simple suggestions can lead to automaton-like responses, that retractors are always telling the truth, and that multiple personality disorder (dissociative identity disorder) is always iatrogenic. These opinions violate what the science says about each of these issues.

When justice is based on pseudoscience, only true victims suffer. It is the responsibility of professionals and their associations (1) to testify consistent with the prevailing knowledge base and with the prevailing standard of care and (2) to distinguish in their testimony matters of science and matters of opinion.

No. 36D
STANDARD PRACTICES WITH RECOVERED MEMORIES

Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N Wolfe Street, Meyer 4-113, Baltimore, MD 21287*

SUMMARY:

The proposition that memories of serious recurrent physical and sexual abuse in childhood, adolescence, or early adulthood can be "repressed" or "dissociated" only to be "recovered" years later, most commonly during psychotherapy, has led to controversy and confusion over matters of clinical practice in psychiatry. Some of the "recovered" memories are false on their face as in "alien abduction" and "satanic cults." The opinions that forgotten traumatic incidents can be either the source of particular later life mental disorders or regularly and accurately recalled have never been convincingly demonstrated. This presentation will review standards of practice, long established and uncontroversial, that should be employed by diagnosticians and therapists faced with patients who claim to have a "recovered" memory of early life abuse. The diagnostic issues revolve around matters of actual versus pseudo memories and turn on issues of observation, confirmation, and suggestibility. The therapeutic issues revolve around assessment and reassessment, openness to consideration of warnings given by patients and families, and prudence over publicly charging purported assailants. The regular application of these diagnostic and therapeutic practices can resolve this distressing controversy in psychiatry.

No. 36E
RECOVERY AND MEMORY

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford, CA 94305-5544;* Catherine Classen, Ph.D., Kirsten Nevill-Manning, Cheryl Koopman, Ph.D.

SUMMARY:

Traumatic stress is a discontinuity in personal experience, constituting a threat to life, health, and personal safety. Evidence will be reviewed that trauma affects memory processing, including intrusive recollection, such as flashbacks and nightmares, as well as difficulty accessing memory, including suppression, avoidance, and dissociative amnesia. Data from studies involving victims of earthquakes, firestorms, shootings, witnessing an execution, combat, and childhood physical and sexual abuse will be reviewed. These studies provide evidence that a substantial minority of subjects show difficulty in controlling access to traumatic memories, and that those who do are more likely than others to develop post-traumatic stress disorder symptoms. As a result of these data, the DSM-IV contains a new diagnostic category, acute stress disorder, which has prominent dissociative symptoms, along with intrusion, avoidance, and hyperarousal symptoms, in recognition of the frequency and predictive importance of acute reactions to trauma. Components of effective psychotherapy for individuals who have been exposed to trauma will be reviewed, involving exposure and re-experiencing of traumatic memoires, uses of hypnosis, grief work, transference, and other treatment components in the working through of traumatic experience. Concerns regarding suggestive influences upon patients by therapists and families will be discussed. Dissociative amnesia is a distortion of memory and can be thought of as the other side of the coin of suggestive influence on recollection. Interim data from an NIMH-sponsored randomized trial comparing trauma-focused versus present-focused group therapy for sexual abuse survivors will be presented. Preliminary results (N = 50) indicate that compared with a waiting-list control condition, treatment of either type results in significant reductions in dissociative and other trauma-related symptoms, and more assertiveness and less anger in interpersonal relationships.

REFERENCES:

1. Schacter DL: The seven sins of memory: insights from psychology and cognitive neuroscience. American Psychologist 1999; 54:182–203
2. Pope HG Jr, Oliva PS, Hudson JI: The scientific status of research on repressed memories, in Modern Scientific Evidence: The Law and Science of Expert Testimony. Edited by Faigman DL, Kaye DH, Saks MJ, Sanders J. St. Paul, MN, West Group, 1999, pp 115–155
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4. McHugh PR: Witches, multiple personalities, and other psychiatric artifacts. Nature Medicine 1995; 1(2):110–114
5. Butler LD Duran, et al: Hypnotizability and traumatic experience: a diathesis-stress model of dissociative symptomatology. American Journal of Psychiatry 1996; 153(7):42–63

SYMPOSIUM 37—THE PSYCHOTHERAPY OF PRESCRIBING

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize the importance of the doctor-patient relationship in medication management; (2) understand the multiple etiologies related to adherence or nonadherence to medication regimens; (3) be able to discuss the issues of transference and countertransference in the therapeutic relationship between patient and psychopharmacologist; 4) understand the psychotherapeutic themes in medication management.

No. 37A
OVERVIEW: PRESCRIPTIONS OF MEDICATIONS AND DOCTOR-PATIENT RELATIONSHIP

Michael D. Jibson, M.D., *Department of Psychiatry, University of Michigan Medical Center, 1500 E Medical Center Dr, Ann Arbor, MI 48109-0016*

SUMMARY:

Much of how we practice psychiatry has changed in the last 25 years with the continued emergence of biological psychiatry,

molecular biology, and managed care. As psychiatry changes, we must not lose sight of the fact that the doctor-patient relationship and the study of that relationship is one of the foundations of psychiatry. This presentation presents an overview as to how the doctor-patient is fundamental to the practice of psychiatry and crucial to the effective medication management of patients with psychiatric illness. Even when the sole defined role of the psychiatrist is medication management, the quality and extent of the doctor-patient relationship cannot be ignored. This paper puts forth tenets and provides examples as to how the doctor-patient relationship can affect the course of illness, the patient's compliance with medication regimens, and the overall outcome of the treatment. The doctor-patient relationship forms the framework of a cooperative and collaborative effort between prescribing psychiatrist and patient, and such collaboration can only enhance the self-esteem of the patient. To appreciate the nature of the relationship, the prescribing psychiatrist needs to be aware of and be able to tolerate both his/her as well as the patient's feelings and be invested in understanding how the patient relates to others. Thirty years ago, Lawrence Kubie described a distinction between practicing psychiatry and being a psychiatrist. Through clinical examples, this presentation will emphasize that distinction and will set forth how one can develop into and remain a psychiatrist such as described by Kubie even when relegated to the narrow role of writing prescriptions for psychotropic medications.

No. 37B
FACTORS AFFECTING ADHERENCE TO A PHARMACOTHERAPEUTIC TREATMENT

James M. Ellison, M.D., *Harvard Pilgrim Healthcare, 20 Wall Street, Burlington, MA 01803;* Kenneth R. Silk, M.D., Jonathan M. Metzl, M.D., Michael D. Jibson, M.D.

SUMMARY:

Adherence (a term preferred to compliance) to a pharmacotherapy regimen is frequently poor but can be improved by attention to the following four factors: (1) the patient's level of distress, (2) the therapeutic effects and side effects of the medication regimen, (3) the accessibility of treatment, and (4) the quality of the therapeutic relationship. Composite case vignettes illustrate these principles.

In order to accept pharmacotherapy, a patient must have an appropriate level of distress. When the patient's defense mechanisms (particularly denial and externalization) directly interfere with recognition and ownership of the target symptoms, adherence will be more problematic. Medications have both desired and undesired effects, and the undesired effects are considered a major contributor to treatment nonadherence. A patient is likely to tolerate considerable side effects when the primary effects of the medication are desired and observed. Accessibility of treatment is a more significant factor than many prescribing clinicians realize. If a patient's life is chaotic and disorganized, it may be unrealistic to expect adherence to a medication regimen. The discontinuity of care in the current health care system and the increasing cost of pharmaceuticals further contribute to nonadherence. Families who stigmatize an individual for taking medication also become a powerful barrier to adherence.

The treatment relationship with a prescribing clinician detracts from or supports treatment adherence. The relationship consists of a treatment alliance (working relationship) and a transference relationship that may profoundly affect a patient's attitudes toward being medicated. Furthermore, the patient may have strong feelings toward particular medications or medications in general. Finally, adherence is enhanced or undermined by the way in which a collaborating psychotherapist relates to the pharmacotherapy and pharmacotherapist. For each of these factors that undermine treatment adherence, a range of suggestions for improving adherence is offered.

No. 37C
UNDERSTANDING THE SYMBOLIC VALUE OF MEDICATIONS

Jonathan M. Metzl, M.D., *Department of Psychiatry, University of Michigan, 1150 E. Medical Center Drive, Ann Arbor, MI 48109;* Kenneth R. Silk, M.D., James M. Ellison, M.D., Michael D. Jibson, M.D.

SUMMARY:

This presentation will examine the importance of considering the symbolic value of medications in the clinical encounter. The discussion will combine clinical theory, case vignettes, and examples from works of American fiction. The first part of the presentation will describe the ways medications are frequently presented in medical training in a fixed and denotative manner. In pharmacology courses, for example, students are responsible for memorizing the smallest details of a medication's profile, ranging from its half-life to its mechanism of action to its clinical indications. These facts are to be memorized and then reproduced on fill-in-the-bubble, multiple-choice examinations. In the process students learn to master "the latest, most authoritative drug information possible" to quote the Physician's Desk Reference. Little attention, if any, is paid to the complexities that can arise when these treatments are considered as symbols rather than as hard-and-fast facts. There is, of course, a great deal of validity in such an approach. However, the second part of the presentation will focus on evidence that a consideration of the symbolic functions of a medication can be as important to understanding its clinical efficacy as memorizing its membrane stabilizing properties or its hypothesized elimination half-life. When approached as theoretical symbols rather than as physiological absolutes, medications can be understood to carry messages that are both highly connotative and often culturally specific. These can range from the unspoken psychological messages of nurturance at play when doctors prescribe medications for patients to the larger social and commodified messages these medications stealthily invoke. In such interactions the "information" presented in the PDR is complicated by the many social roles medications often play—often before they are ever prescribed. This latter form of information is exceedingly important to the training of clinicians and to the understanding of issues such as compliance and efficacy.

REFERENCES:

1. Kubie LS: The retreat from patients: an unanticipated penalty of the full-time system. Arch Gen Psychiatry 1971; 24:98–106
2. Silk KR: Collaborative treatment for patients with personality disorders, in Psychopharmacology and Psychotherapy: A Collaborative Approach. Edited by Riba MB, Balon R. Washington, DC., American Psychiatric Press, 1999
3. Chen A: Noncompliance in community psychiatry: a review of clinical interventions. Hosp Comm Psych 1991; 42:282–7
4. Metzl JM: Signifying Medications in Thom Jone's "Superman, My Son." Teaching Literature and Medicine (the MLA Approaches to Teaching Series). New York, MLA Press, in press (publication November, 1999)
5. Blackwell B: The physician who prescribes, in Treatment Compliance and the Therapeutic Alliance. New York, Harwood, 1997

SYMPOSIUM 38—THE MANY FACES OF TRANSFERENCE IN EVERYDAY CLINICAL CARE: PART 2
American Academy of Psychoanalysis and the American Psychoanalytic Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the presentation, the participants will acquire an understanding of the conscious and unconscious effects of the doctor/patient relationship on the course of psychiatric and medical treatment.

No. 38A
THE THERAPEUTIC RELATIONSHIP: CULTURAL INFLUENCES ON BOUNDARIES

Silvia W. Olarte, M.D., *Department of Psychiatry, New York Medical College, 37 East 83rd Street, Apt 1, New York, NY 10028*

SUMMARY:

Boundaries within the therapeutic relationship are the well-defined parameters within which the interpersonal relationship between patient and therapist takes place. Most of these specific parameters are clearly specified from the beginning of treatment. Some of those parameters are: the frequency and duration of sessions, the time of the appointments, the customary fee for the sessions, the mode of payment, and the coverage system in case the therapist is not available. Within these clear and well defined demarcations an interpersonal relationship develops, which not only mimics past conflictual and nonconflictual intimate relationships, but also reflects the rich and varied well that represents the therapist's and the patient's cultural backgrounds. The interplay between cultural norms and the fostered distortion of the therapeutic relationship by the analytic method can be very difficult to differentiate. The consequence can be misleading of interpersonal queves with the consequent inappropriate interpretation, which can increase the resistance to treatment or foster boundaries violations. Clinical vignettes as they apply to patients of different cultural backgrounds will be presented. Treatment approaches to address both increased resistance and miscommunication that can foster boundaries violations will be addressed.

No. 38B
IMPACT OF THE CHANGING SOCIAL CONTEXT ON THE DOCTOR-PATIENT

Edward R. Shapiro, M.D., *Admissions, Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge, MA 01262*

SUMMARY:

This paper will explore the effect of impinging social changes on the doctor-patient relationship. Managed care, regulatory agencies, pressures on confidentiality, the technological and biological revolution in health care, and society's altered stance toward dependency have all transformed the dyadic setting for care. Though the larger context has always affected the doctor-patient relationship, the post-World War II era had affirmed society's supportive response to dependency. In the current era, with increasing recognition of limited resources, society's response to dependency has changed. This transformation has affected all dependency-bearing institutions, including social welfare, the family, religion, education, and health care. Developing third-party institutions have undercut both the doctor's authority to treat and the patient's authority to seek treatment. This has evoked disorganization and disarray in both roles. I will explore some of the implications of these changes.

No. 38C
THE ACTIVE ENGAGEMENT OF PATIENTS IN SUPPORTIVE RELATIONSHIPS

Milton Viederman, M.D., *Department of Psychiatry, Cornell Medical College, 525 East 68th St, New York, NY 10021-4873*

SUMMARY:

This presentation will illustrate the use of psychodynamic principles in the development of supportive relationships during consultations with physically ill patients or those in crisis. Emphasis will be placed on a concept, "meaning as an intervening variable," which focuses attention on the special meaning of a patient's dysphoric response to a particular experience, this to be understood as a product of early life experience. An intervention called the Psychodynamic Life Narrative, used to alleviate anxiety and depression in crisis situations, will be described. Techniques used to facilitate the formation of a therapeutic bond between patient and physician to alleviate distress will be discussed. Anecdotes will illustrate these processes.

No. 38D
HOW PSYCHODYNAMIC THERAPISTS MODIFY BEHAVIOR

Saul Tuttman, M.D., *Department of Psychiatry, Albert Einstein, 170 East 77th St, New York, NY 10021-1912*

SUMMARY:

As part of the American Psychiatric Association's May 2000 annual meeting, this session of the American Academy of Psychoanalysis consists of a symposium involving psychodynamic formulations regarding patient-therapist interaction and how that process can become therapeutic. My presentation offers concrete examples from the clinical practice of an experienced training analyst who continually deals with transference, countertransference, and resistance, which inevitably occurs in both patients and therapists in the course of working together. A genuine interaction between the two provides an opportunity to develop a working therapeutic alliance. In this context it becomes more likely that conflicts, pathology, maladaptive patterns, and symptoms can be identified, understood, and modified.

Specific examples will be offered that stimulate insights and empathic perceptions. The role of family history, meaningful identifications with significant others in the patient's past history, and current life are examined. An opportunity to overcome repetition compulsions and "acting out" patterns is encouraged in the observing and experiential ego functions of the patient. The combined efforts of therapist and patient can often replace counterproductive "acting out" with constructive "working through."

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3. Viederman M: Psychodynamic life narrative: a psychotherapeutic intervention useful in crisis situations. Psychiatry 1983; 46:236–246
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SYMPOSIUM 39—NEUROSCIENCE OF ALCOHOLISM: TREATMENT IMPLICATIONS
National Institute on Alcohol Abuse and Alcoholism

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Attendees of this symposium will be presented state-of-the-art data on neural mechanisms of alcohol tolerance, dependence, and withdrawal. Implications for craving and medications to treat alcohol withdrawal and dependence will be highlighted. The clinican should obtain a solid foundation for evaluating new research findings and treatments for alcoholism.

No. 39A
EXTRACELLULAR AND INTRACELLULAR SIGNALS IN ALCOHOL DEPENDENCE

Boris Tabakoff, Ph.D., *University of Colorado Health Science Center, 4200 East 9th C236, Denver, CO 80262*

SUMMARY:

Receptor-gated ion channels and G protein-coupled receptors modulate neuronal excitability through changes in ion permeability and intracellular second messengers. Ethanol, at concentrations that produce intoxication, significantly affects the function of the NMDA subtype of glutamate receptors and the function of receptor-coupled adenylyl cyclase (AC). The action of ethanol at both of these signalling complexes involves protein kinase C (PKC) and chronic ethanol ingestion produces a neuroadaptive alteration in the function of the NMDA receptor and AC. An upregulation of NMDA receptor number and function is evident in brains of animals made physically dependent on ethanol. The upregulation of the NMDA receptor is related to the CNS hyperexcitability seen during ethanol withdrawal; to the induction of ethanol-withdrawal-induced brain damage; and to decreased release of dopamine in the nucleus accumbens (withdrawal anhedonia). Recently developed medications targeting the NMDA receptor and glutamate release have a preclinical profile indicating good efficacy for controlling withdrawal hyperexcitability, withdrawal-induced brain damage, and reducing withdrawal anxiety. The function of G_5 protein-coupled AC systems are related to an animal's sensitivity to ethanol and initiate a cascade of events leading to activation of transcription factors (e.g., CREB), which control gene expression and neuroadaptive events. It is of interest that 5′ upstream regions of certain NMDA receptor subunit genes contain CREs, which bind and respond to CREB.

Support by NIAAA and the Banbury Fund.

No. 39B
ARE THERE GENES FOR ALCOHOLISM? NEUROBIOLOGY OF ALCOHOL REWARD AND DEPENDENCE

George F. Koob, Ph.D., *Neuropharmacology, The Scripps Research Institute, 10550 North Torrey Pines Road, CVN 7, La Jolla, CA 92037;*

SUMMARY:

Multiple sources of reinforcement subsume motivational basis for excessive drinking in alcoholism. The neurochemical and neurocircuitry substrates for these sources of reinforcement are being elucidated. The positive reinforcing effects of alcohol as measured by alcohol self-administration in nondependent rats appear to involve multiple neurotransmitter systems within the brain reward circuitry, including dopaminergic, opioid peptidergic, GABAergic, serotoninergic, and glutamatergic systems. The reward circuitry implicated in these acute reinforcing effects include sites within a basal forebrain macrostructure called the extended amygdala, particularly, the nucleus accumbens and central nucleus of the amygdala. The negative reinforcement associated with alcoholism involves development of alcohol dependence and produces elevated ethanol intake. Ethanol dependence is also associated with disruptions in reward function as reflected in elevated thresholds for intracranial self-stimulation, and decreases in the function of the same neurochemical systems associated with the acute reinforcing effects of ethanol. In addition, ethanol dependence produces an activation of the brain stress neurotransmitter, corticotropin releasing factor (CRF). Animals with a history of alcohol dependence, and subsequently detoxified retain increased ethanol intake and show enhanced sensitivity to CRF antagonists, suggesting a residual allostatic load that may be mediated by activation of brain stress systems. Results suggest that decreases in primary reward function and increases in secondary anti-reward function in basal forebrain circuits may be the basis for the excessive drinking of alcoholism.

No. 39C
NEUROBIOLOGY OF ALCOHOL DEPENDENCE AND WITHDRAWAL

Howard C. Becker, Ph.D., *Department of Psychiatry, Medical University of South Carolina, Center of Drug Alcohol Program, IOP 4N, Charleston, SC 29425*

SUMMARY:

One of the serious consequences of chronic excessive alcohol consumption is the development of dependence and experience with associated withdrawal. This presentation will provide a general overview of factors that influence the withdrawal response, neuroadaptive mechanisms that underlie expression of withdrawal symptoms, and current treatment approaches for management of alcohol detoxification. Numerous animal model systems have been employed to study various aspects of alcohol withdrawal, including physical and psychological symptoms, underlying neurobiological mechanisms, and long-term consequences such as relapse and cognitive deficits associated with alcohol-induced brain damage. Special emphasis will focus on the kindling hypothesis of alcohol withdrawal. A growing body of preclinical and clinical evidence has demonstrated sensitization of withdrawal symptoms following repeated withdrawal experience. Chronic alcohol exposure produces alterations in many neurochemical systems resulting in an imbalance in brain function. Behavioral, neurochemical, and molecular studies have indicated that some of these neuroadaptive perturbations may progressively intensify with successive withdrawal episodes, leading to persistent brain dysfunction and exacerbated withdrawal symptoms. Other clinical ramifications of withdrawal sensitization include potential impact on relapse as well as neurotoxicity and cognitive impairment. These consequences of multiple withdrawal experience have important treatment implications. Recent research on pharmacotherapy for multiple alcohol withdrawals will be discussed.

No. 39D
NEUROBEHAVIORAL ASPECTS OF ALCOHOL CRAVING AND RELAPSE

Raymond F. Anton, M.D., *Institute of Psychiatry, Medical University of South Carolina, 67 President Street, P.O. Box 250861, Charleston, SC 29425*

SUMMARY:

Knowledge of the neuroscientific basis of addiction in general and alcoholism, in particular, has been accelerating. New data and models provide a greater understanding of alcohol-induced phenomenon such as alcohol withdrawal, craving, and relapse drinking. Additionally, information on the neurocellular and neurosystem effects of alcohol is leading to new pharmacological treatments of alcohol withdrawal and dependence.

The goal of this presentation is to provide treatment professionals with a neurobehavioral model of alcoholism. This model attempts to integrate basic and clinical neuroscience with phenomenona of alcohol dependence such as craving and relapse drinking. Emphasis will be placed on the neuronal reward pathway, its neurotransmitter connections, and its long-term adaptation. Connections between environmentally and internally induced craving states and the role of psychiatric conditions, such as various anxiety and mood disorders, in the generation and maintenance of "alcohol craving" in the addicted individual will be made. The overlap of obsessive-compulsive states and aspects of alcohol craving will be mentioned. New brain imaging data will be shown to highlight brain activity differences between alcoholics and social drinkers when exposed to alcohol cues (taste and pictures). Finally, implications of these neuroscience findings for the pharmacotherapy of alcoholism will be highlighted.

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1. Koob GF, Roberts AJ: Neurocircuitry targets in reward and dependence, in Principles of Addiction Medicine, 2nd edition. Edited by Graham AW, Schultz TK. ASAM 1998, pp 72–83
2. Becker HC: Alcohol withdrawal: neuroadaptation and sensitization. CNS Spectrums 1999; 4(1):38–65
3. Anton RF: Neurobehavioural basis for the pharmacotherapy of alcoholism: current and future directions. Alcohol and Alcoholism 1996; 31:43–53

SYMPOSIUM 40—REHABILITATION AS A DYNAMIC PROCESS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) describe rehabilitation as a dynamic, ongoing process using various modalities, (2) recommend policies for continuity of care and use of increasingly effective coping mechanisms, (3) prescribe rehabilitation modalities according to the shifting needs of the patient.

No. 40A
THE WORLD PSYCHIATRIC ASSOCIATION'S CONSENSUS STATEMENT ON PSYCHOSOCIAL REHABILITATION

Robert Cancro, M.D., *Department of Psychiatry, Nathan Kline Institute, 140 Old Orangeburg Rd, Orangeburg, NY 10962;* Zebulon C. Taintor, M.D.

SUMMARY:

The World Psychiatric Association (WPA) has generated position statements on a number of topics that seemed at risk in a for-profit managed care environment. Psychiatric rehabilitation, while a growing and vigorous field, nonetheless is in danger of being seen as a nothing more than off-the-shelf skills that could be provided briefly according to a set of reductionist guidelines. The Section on Rehabilitation of the WPA has developed a consensus statement based on expert opinions of a variety of psychiatrists and other professionals who treat chronic mental illness in different countries. What has emerged is a view of rehabilitation as a dynamic process that meets the shifting needs of patients as they and their illnesses evolve and change in response to treatment. The consensus emphasizes that change occurs in the context of the doctor-patient relationship and the relationship of the patient to the treatment team. Pros and cons of various definitions of rehabilitation and recovery will be reviewed. However, it is clear from the papers in this symposium that any definition must include attention to policy and continuity of care. Chronic mental illness requires years of continuous treatment for progress from primitive defenses to coping skills, otherwise "progress" is illusory.

No. 40B
PROGRAM RETENTION PREVENTS RELAPSE BETTER THAN PROGRAM TYPE

Martin Gittelman, Ph.D., *Center for Advanced Study, 140 East 94th St, New York, NY 10025*

SUMMARY:

This review of all previously published studies of the interaction of psychosocial interventions and rehabilitation programs shows that psychosocial interventions increase medication efficacy (including what studies have been published on the new antipsychotics) by about 40% in terms of preventing relapse as defined by rehospitalization or emergency room visits. Program retention is by far the best predictor of decreased relapse. Continuity of care is more important than program type. This is particularly true in the United States where more different types of programs have been generated than anywhere else in the world. However, this has resulted in fragmentation that has added to system discontinuity from other sources, such as different levels of government arguing over which is responsible for housing, income support, etc. For-profit managed care, with its emphasis on minimal services and short-term outcomes, can be predicted to bring about more relapses in the long run.

No. 40C
PROGRESS IN DEINSTITUTIONALIZATION IN JAPAN

Naotaka Shinfuku, M.D., *International Health, Kobe University School of Medicine, Kusinoki-Cho, 7 Chome, Chuo-Ku, Kobe 650, Japan*

SUMMARY:

The author served for 14 years as Western Pacific WHO regional mental health advisor. He contrasts the Japanese and South Korean cultures vis-a-vis other countries. There has been both a strong push from some segments of Japanese society to reform the mental health system and considerable resistance from a strongly entrenched private sector. The result has been new legislation aimed at reducing hospital stays, averting hospitalization, reducing stigma, and promoting continuity of care. Now the legislation is being implemented, with improvement in statistics and some progress in reducing stigma. Rehabilitation is very difficult with the current level of stigma, but family and recipient associations are becoming increasingly active.

No. 40D
SECTOR TREATMENT IN GERMANY

Michael Stark, M.D., *Department of Psychiatry, University of Hamburg Medical School, Martinstr 45, Hamburg 20246, Germany*

SUMMARY:

As a German sector head I shall describe from first-hand experience the current situation in the country, which varies from state to state. Inpatient and outpatient care are separately controlled. Psychiatric beds are being added to general hospitals, along with day care and other rehabilitation programs. The general plan is to reduce the large hospitals, which is being carried out slowly, so far without the sort of problems that have been reported elsewhere. The system assumes responsibility for care providers being paid, and supposedly all payment disputes are settled without involving the treatment team or the patient. Claims are not denied. However, recent budgetary pressures have reduced the payments to some physicians. There are unemployed physicians exerting a deflationary pressure on medical earnings. A lack of information systems results in overutilization being undetected, and the imposition of budgetary caps late in the fiscal year when the funds run out of money. Thus, while the German system has many apparent strengths, it represents only a partial implementation of the French sector system and will have to be reformed again to provide a single team responsible for the patient wherever he or she is in the sector. Rehabilitation is somewhat fragmentary as a result of the discontinuity.

No. 40E
PRESSURES ON SECTORIZATION IN FRANCE

Jacques M. Dubuis, M.D., *Hospital Du Vinatier, 95 Boulevard Pinel, Bron 69677, France*

SUMMARY:

This description of the French sectorization system, from a sector chief in Lyons, describes how the system evolved with the doctors from the hospitals following their patients into the community with deinstitutionalization. Treatment is provided by the psychiatrist-headed sector team. The team is responsible wherever the patient is and makes all the decisions about disposition: hospital, home, residential treatment, etc. There is no screening as the patient moves from one setting to another. Paperwork is minimal. Decisions are carried out rapidly and all involved know the team will be supportive. There are no disputes among levels of government about responsibility for entitlements, provision of services, etc., since the national government is responsible. Thus, a patient may move from one part of France to another easily, but generally people stay in one place and receive continuity of care from the team. This provides considerable opportunity for rehabilitation, since the patient moves from regressing, through the levels of defenses, and into coping in the community and back again as the illness waxes and wanes. The pressures on the system are budgetary of course, but mostly related to its success in that less ill patients try to get services.

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SYMPOSIUM 41—MERGERS AND INTEGRATION OF VA MENTAL HEALTH SERVICES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will learn about the driving forces behind mergers of mental health services in the Department of Veterans Affairs and the steps needed to undertake such mergers; and about three models of such integrations and the pros and cons of such mergers.

No. 41A
CONSOLIDATION OF PSYCHIATRIC SERVICES AT THE VA CHICAGO HEALTH CARE SYSTEM

Surinder S. Nand, M.D., *Chief Psychiatry Service, MP 116A, VA Chicago Health Care Systems, 820 S Damen, Chicago, IL 60612;* Laurent S. Lehmann, M.D., Boris M. Astrachan, M.D., Christine LaGana, Ph.D., Richard A. McCormick, Ph.D.

SUMMARY:

Over the past decade health care facilities have been engaged in a dance of merging and restructuring. VA medical centers have undergone their own process of restructuring and reorganizing. While a good deal has been written about health care restructuring, far less is available on the restructuring of mental health services. Within the VA the merger and integration of mental health services has taken many forms. In this symposium three such efforts at integration will be discussed.

1. Psychiatric Services within two facilities consolidated under unified leadership.
2. The formation of a mental health service line with mental health services integrated Under one director.
3. The formation of a mental health service line at the VISN level with the mental health manager responsible for all mental health operations within the Veterans Integrated Service Network.

This symposium focuses on the driving forces behind three such mergers, the steps undertaken for successful mergers, pros and cons of such consolidation and the impact on delivery of patient care.

No. 41B
VA MARYLAND HEALTH CARE SYSTEM: AN INTEGRATED CONTINUUM OF MENTAL HEALTH CARE

Christine LaGana, Ph.D., *Department of Psychology, VA Maryland Health Care, 10 North Greene Street, Baltimore, MD 21201;* Laurent S. Lehmann, M.D., Boris M. Astrachan, M.D., Surinder S. Nand, M.D., Richard A. McCormick, Ph.D.

SUMMARY:

Throughout the nation, VA mental health services are being reorganized. VA Maryland Health Care System (VAMHCS) has formed a mental health service line integrated under one director. This presentation will discuss the challenges involved in developing a multi-divisional health system consisting of three divisions: two community-based outpatient clinics and a freestanding, 120-bed nursing home located within a 47-mile radius. These three divisions were originally independent facilities under separate management structures. VAMHCS has approximately 400 staff from various disciplines, 1,200 beds, 9000 admissions and 500,000 outpatient visits per year and is affiliated with the University of Maryland School of Medicine.

The Mental Health Clinic Center (MHCC) is the largest of six clinical centers within the VAMHCS, with a $25 million budget. The MHCC is organized into five sub-product lines: general (inpatient) mental health; community (outpatient) mental health; geriatric mental health, substance abuse; and special programs. There are two psychology internship programs, and a psychiatric residency program. In addition, training is provided for students of social work, nursing, occupational therapy, physician assistants, and other allied health professions. A MHCC research section conducts funded and unfunded research. The MHCC also provides coordination and oversight of three employee assistance programs (EAP). This presentation focuses on the innovative model of mental health delivery at VAMHCS.

No. 41C
VISN MENTAL HEALTH SERVICE LINE

Richard A. McCormick, Ph.D., *Department of Psychology, Louis Stokes DVA, 10000 Brecksville Road, Brecksville, OH 44141*

SUMMARY:

The Veterans Health Administration has been restructuring and re-engineering the delivery of health care for the past several years. Mental health administrators within the VA health care system are faced with major challenges as they design efficient systems of care to reduce costs. This presentation describes the merger of psychiatric services at two separate VA medical centers, affiliated with two separate departments of psychiatry and medical schools under a unified leadership. It focuses on how this merger has been accomplished at the VA Chicago Health Care System in VISN 12. Issues of access, continuum and coordination of care, and quality of care will be addressed. The impact of this merger on teaching and training of students and residents will be covered.

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SYMPOSIUM 42—MINORITY VETERANS: OBSTACLES TO MENTAL HEALTH CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify barriers to mental health services that need to be addressed to improve the utilization of services among minority veterans.

No. 42A
A CODING SCHEME FOR BARRIERS TO PSYCHIATRIC CARE

Judith M. Garrard, Ph.D., *University of Minnesota, School of Public Health, 420 Delaware St. SE (Box 729), Minneapolis, MN 55455*

SUMMARY:

The goal of this project was to determine barriers to psychiatric care for American Indian (AI) and Hispanic American (HA) veterans in VAMCs. Subjects and settings consisted of 50 AI and HA staff members at two VAMCs (Albuquerque and Minneapolis). Method consisted of open-ended, audio-taped, confidential interviews. Results consisted of over 100 barriers identified by two researchers after listening to tapes of the interviews. For ease in coding responses, these were reduced to 25 barrier items that were all-inclusive and mutually exclusive. These 25 barrier items were in turn classified into seven general areas: VA system, VA staff, veterans themselves, veterans' communities, VA system-to-veteran barriers, VA system-to-staff barriers, VA system-to-community barriers. Reliability of the items varied, but was sufficiently high overall to proceed with coding all interviews. In conclusion, it was possible to identify 25 barriers to psychiatric care that were psychometrically sound. Moreover, they fell within several categories that might later lend themselves to interventions aimed either at particular groups (e.g., veterans, VA staff, veterans' communities) or to particular systems or interactions (e.g., VA system and its interactions with its own staff, with veterans, and with veterans' communities).

No. 42B
VETERANS ADMINISTRATION MINORITY STAFF IDENTIFIES OBSTACLES TO MENTAL HEALTH SERVICES

Jose M. Canive, M.D., *Department of Psychiatry, VAMC-University of New Mexico, 1501 San Pedro Drive (116A), Albuquerque, NM 87108;* Eligio Padilla, Ph.D.

SUMMARY:

Minority veterans are underrepresented in the VAMC patient population, yet little is known about barriers to accessing services. The goal of the study was to identify factors that auger or impede utilization of mental health services among American Indian (AI) and Hispanic American (HA) as perceived by AI/HA VA workers at two VAMCs. In each setting, we obtained 10 AI workers and 10 HA workers, for a total of 40 informants. In addition, we sampled another 10 AI and HA persons who worked in a variety of settings, mostly in outreach clinics. All interviews were confidential and audio-taped. Reported individual barriers ranged from 22% to 92% of a total 25 possible barrier items, with each worker reporting an average of 15.5 barrier items. Barriers were not clearly in any one locus. For example, the most commonly reported item was that AI/HA veterans had difficulty talking about personal matters with mental health providers. The second most common item involved the VA system being difficult to access. Significant differences were found on five out of the eight subscale scores, with more Minneapolis AI/HA staff reporting specific barriers to care. Comparing clinicians and non-clinicians, more clinician staff reported barriers on three out of eight subscales. As compared with men, women reported more barriers on one subscale.

No. 42C
VETERANS ADMINISTRATION MENTAL HEALTH WORKERS AND BARRIERS TO CARE

Joseph J. Westermeyer, M.D., *Department of Psychiatry, University of Minnesota, VAMC, 1 Veterans Drive, 116A, Minneapolis, MN 55417*

SUMMARY:

The goal of the study was to identify barriers to psychiatric care for American Indian (AI) and Hispanic American (HA) veterans, as

observed by VA mental health staff. Subjects and setting included 100 staff, 50 from Albuquerque and 50 from Minneapolis.

Method consisted of an open-ended, taped, confidential interview; responses were coded into 25 barrier items (in seven different categories).

Results revealed that barrier identification varied widely, with 70% of staff reporting the most widely recognized barrier and only 11% reporting the least recognized barrier. Younger staff members reported more barriers than did older staff members. Ethnicity and gender of the staff members did not affect the number of barriers reported. As compared with administrative and support staff, clinical staff reported more barriers related to the relationship between the VA system and AI/HA communities and barriers with the AI/HA communities themselves. Staff members in Minneapolis (with fewer AI/HA staff members) reported many more barriers than staff members in Albuquerque (with more AI/HA staff).

In conclusion, younger staff and clinical staff were more apt to perceive barriers to care. The proportion of ethnic staff members was inversely proportional to the number of identified barriers.

No. 42D
PSYCHIATRIC CARE BARRIERS: 2000 VETERAN REPORTS

Ross D. Crosby, Ph.D., *Neuropsychiatric Research Institute, 700 First Avenue South, Fargo, ND 58107;* Sean Nugent, Paul D. Thuras, Ph.D.

SUMMARY:

The goal of the project was to identify barriers to psychiatric care that were related to particular psychiatric diagnoses among AI and HA veterans, to design interventions for reaching patient populations. Subjects and settings included 1,000 AI and 1,000 HA veterans, half of each group from Minnesota and half from New Mexico; snowball sampling in the AI and HA communities was employed. Method of data collection included (1) an open-ended interview regarding barriers to care, (2) a 24-item barriers questionnaire, and (3) a diagnostic screening instrument (the Quick Diagnostic Interview Schedule).

Results showed that major depressive disorder, alcohol abuse/dependence, and posstraumatic stress disorder were the most common Axis 1 psychiatric diagnoses (each occurring in over 20% of the respective groups, with considerable comorbidity among the diagnoses). Barriers to care differed among the diagnostic groups.

In conclusion, interventions to overcome barriers to psychiatric care must be tailored to the specific clinical condition (i.e., particular diagnoses and/or comorbid disorders). For example, family and community entrees for case detection are important for facilitating care of alcoholism and PTSD in AI/HA veterans. However, these entrees are less important for depressed AI/HA veterans, who are apt to be aliented or withdrawn from their families and communities.

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SYMPOSIUM 43—THE TREATMENT OF PSYCHIATRICALLY ILL HIV-INFECTED

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the complex medical issues that may lead to brain dysfunction; identify the criteria for diagnosing mood, anxiety, pain, and psychotic disorders; recognize various treatment strategies and interventions for the psychiatrically ill HIV patient.

No. 43A
MOOD DISORDERS

Stephen J. Fernando, 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.

This session will present the clinical manifestations for depression and mania, define the differential diagnosis for mood disorders, and describe the pharmacologic and nonpharmacologic interventions for treating the HIV patient.

Educational objectives: By the end of this presentation participants are expected to: (1) be able to identify clinical manifestations for major depression and mania, (2) define the diagnostic criteria for mood disorders, and (3) identify pharmacologic and non-pharmacologic treatment options.

No. 43B
PSYCHOTIC DISORDERS

Francine Cournos, M.D., *Department of Psychiatry, Columbia University, 5355 Henry Hudson Parkway #9F, Bronx, NY 10471-2839*

SUMMARY:

Psychosis is associated with HIV infection in four different ways: as preexisting primary psychiatric disorder that is associated with HIV-related risk behavior; as a complication of substance use disorders, which are themselves strongly associated with HIV infection; as a neuropsychiatric manifestation of HIV disease; and 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 extrapyramidal side effects associated with the use of standard neuroleptics in advanced HIV disease.

Educational Objectives: By the end of this session participants are expected to be able to: (1) recognize the causes and treatment of psychosis in HIV infected individuals, (2) identify drug-drug interactions between antipsychotic medications and HIV treatments, and (3) understand the side effects associated with neuroleptic medications in HIV disease.

No. 43C
ANXIETY DISORDERS

J. Stephen McDaniel, M.D., *Department of Psychiatry, Emory University, 341 Ponce de Leon Avenue, Atlanta, GA 30308*

SUMMARY:

Anxiety disorders represent a broad spectrum of syndromes that can manifest in HIV-positive individuals throughout the course of their infection. While there is a general trend for increased prevalence of anxiety disorders as HIV disease progresses, clinicians need to be familiar with the full spectrum of these disorders, as they may complicate both the medical and psychiatric presentation of HIV infection. Because many anxiety disorders manifest with autonomic and somatic symptoms, their identification may be difficult in medically ill HIV-positive individuals. Treatment for anxiety in the setting of HIV infection must take into account the full ranges of medications these patients may be taking as well as their compromised medical status. This session will address the epidemiology of anxiety disorders in HIV infection, the symptoms that may be attributed to anxiety disorders, and the effective anxiety treatments to be used with HIV infected individuals.

Educational Objectives: By the end of this session, participants are expected to: (1) be able to describe the epidemiology of anxiety disorders in HIVAIDS, (2) describe the constellation of symptoms that may be attributed to anxiety disorders, and (3) define the components of diagnostic evaluation and pharmacologic treatment of anxiety within the context of HIV and AIDS.

No. 43D
PAIN DISORDERS

William Breitbart, M.D., *Department of Psychiatry, Memorial Sloan Kettering, 1275 York Avenue, Box 421, New York, NY 10021-6007*

SUMMARY:

Pain in individuals with HIV infection or AIDS is highly prevalent, diverse, and varied in syndromal presentation; associated with significant psychological and functional morbidity; and alarmingly undertreated. Pain management must become more integrated into the total care of patients with HIV disease. Psychiatrists working with HIV-infected patients must become aware of the basic aspects of pain assessment and management in HIV/AIDS, so that they may better distinguish between psychiatric symptoms due to inadequate control of pain and other distinct neuropsychiatric disorders complicating HIV disease, including substance abuse.

This session will explore the prevalence and types of pain associated with HIV disease, address factors involved in the under-treatment of HIV-related pain, and identify principles of pain management and specific pharmacologic treatment options, particularly in patient populations with a history of substance abuse.

Educational Objectives: At the end of this session, participants are expected to: (1) be able to describe the prevalence and types of pain commonly encountered in patients with HIV disease, (2) be able to evaluate the nature and extent of the under-treatment of pain in AIDS and the barriers to adequate treatment, and (3) be able to identify the principles of pain management and the pharmacologic approaches that can be utilized.

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4. Breitbart W, Rosenfeld B, Passik S, et al: A comparison of pain report and adequacy of analgesic therapy in ambulatory AIDS patients with and without a history of substance abuse. Pain 1997; 72:235–243

SYMPOSIUM 44—POLITICAL VIOLENCE IN THE NEW MILLENNIUM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to better understand the psychological roots and consequences of political violence. The effects, both individually and collectively of violence will be considered, as well as the role of war crimes tribunals in healing, and the rise of right-wing extremism and violence.

No. 44A
MILLENNIAL HOPES AND THE PSYCHOLOGY OF MASS VIOLENCE

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

SUMMARY:

What can we look forward to in the new millennium? The fact that the 20th century was the most violent and bloody in history has tempered our millennial hopes. For most of the last half of the century, the ideological conflict of the cold war, with its nuclear "balance of terror," provided an organizing principle for international relations. The greatest danger of the use of nuclear weapons now seems related to the outbreak of ethno-nationalistic conflict. The intensity of feeling in ethno-nationalistic conflict and its closeness to core definitions of the self raise concern that participants might be less deterrable and use less restraint than did the superpowers. The phenomenon of ethno-national enmity is multidetermined and complex, deriving from the interaction of psychological, economic, social, and cultural forces. Symptoms persist because they meet needs for individuals. Social, cultural, and political institutions, including war, persist because they meet needs for groups of people. This paper explores some of the ways in which individual psychology and larger scale ethnic and national behavior interact, the role of violence in such interaction—and addresses the question of whether and how new understandings may help to favorably influence the course of future events.

No. 44B
WHEN HISTORY IS A NIGHTMARE

Stevan M. Weine, M.D., *Department of Psychiatry, University of Illinois, 1601 West Taylor, Room 423 South, Chicago, IL 60612*

SUMMARY:

At the end of the 20th century, we did not let genocide stand unaddressed . . . but then what? As psychiatrists, we aim to treat trauma memory disorders, but how can we also contribute to the problems of collective memories that play such a critical role in the genesis of political violence? A war crimes tribunal or a truth commission are recognized methods, but what of other means to enter into the many ways that memories participate in the social life of survivor communities. How do you harness survivors' testimonies as a step toward a stable and lasting peace? How do you help post-war communities to link remembrances with reconciliation? It is especially important to help those persons and organizations who are already involved in receiving, sharing, interpreting, and communicating survivors' memories, including religious leaders, health professionals, legal professionals, academics, educators, journalists, writers, and artists. Contrary to the claims about unchangeable ancient ethnic hatreds, there are several accomplishable aims with respect to memory: One, is to improve the technical interdisciplinary skills of understanding and intervening regarding memories of suffering; two, is to develop community based working projects that produce and share narratives that link remembrances with reconciliation; three, is to develop an interdisciplinary collaborative dialogue on memories of trauma, suffering, and reconciliation. By working with existing organizations, the result should be to strengthen the secular, religious, intellectual, and professional ways of dealing with survivors memories. This presentation will consider these matters through a comparative exploration of post-war Bosnia-Herzegovina and Kosovo.

No. 44C
JUSTICE AND RIGHTEOUSNESS AFTER GENOCIDE

Kenneth B. Dekleva, M.D., *Department of Psychiatry, University of Texas, Southwestern Medical School, P.O. Box 381759, Duncanville, TX 75138*

SUMMARY:

From 1991–1999, the peoples of Croatia, Bosnia-Hercegovina, and Kosovo experienced wars of genocidal proportions. The International Criminal Tribunal for the Former Yugoslavia has since indicted multiple perpetrators on charges of genocide, crimes against humanity, and war crimes. By way of comparison, nations in Latin America, Africa, and Eastern Europe have utilized "truth commissions" in fostering justice for victims of human rights violations, guided by the assumption that public narratives of suffering can bind the wounds of hatred and violence.

But genocide singularly demands justice that transcends the narrative and judicial structures noted above. Justice and reconciliation can best occur when lasting symbols are created that allow victims to transcend their victimization and reclaim the task of collective healing. The examples of Jasenovac, Vukovar, and Srebrenica can illustrate—as *symbols* of genocide—the above principles.

No. 44D
VIRTUAL GROUP DYNAMICS AND THE PROPAGATION OF HATRED

Jerrold M. Post, M.D., *Political Psychology, George Washington University, 2013 G Street, NW, Suite 202A, Washington, DC 20052*

SUMMARY:

The shooting rampage by Buford Furrow in the L.A. Jewish Community Center, which resulted in the wounding of three young children and two adults, was motivated by his hatred of Jews and designed "to send a wake-up call." Acting as a lone wolf, Furrow may been acting to initiate himself in the Phineas Priesthood by committing a violent act against a minority member. Increasingly, we are seeing acts of violence by a new generation of racial warrior who believe in acting alone. Yet they are deeply immersed in a virtual community of belief in which neo-Nazi and racist themes are circulated on the Internet, reinforcing the need for defensive aggression against what they believe is the plot by "the spawn of the devil" in league with the "mud people" to take over and destroy the white majority. What is particularly dangerous is that the previously disparate strands of racism, anti-Semitism, and anti-government "survivalism" are brought together under the banner of a pseudo-Christian ideology, Christian Identity.

A newly emerging phenomenon, computer-mediated communication, may assist in the intensification of the hatred. Emerging understanding of virtual group dynamics suggest that individuals who are shy in person can "flame" with anger on the net and that there is often a competition for extreme statements and bold actions. With close to 400 web sites of hate groups on the net, it may well be that the community of hatred fostered by the Internet contributes to moving otherwise isolated and alienated individuals along the path from hatred to violent action.

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SYMPOSIUM 45—THE FIRST INTERVIEW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have a better understanding of how the first interview, enhanced by new technology, enhances the doctor-patient relationship.

No. 45A
COMPUTERIZED PSYCHOLOGICAL TESTING: EXPANDING PSYCHIATRISTS' CLINICAL AND FISCAL POTENTIALS

Maurice Rappaport, M.D., *1185 McKendrie Street, San Jose, CA 95126-1406*

SUMMARY:

This presentation will consist of providing information on how psychiatrists can strengthen their practices professionally and financially. Strengths and weaknesses of computerized psychological testing will be highlighted. Examples of new and standard tests will be described. Also, an explanation will be offered on how computerized psychological testing can be used cost effectively to enhance benefits not only to patients but to those in business and industry who request evaluation of valued employees both on-line and in management.

No. 45B
EVALUATION OF THE ILL PHYSICIAN

Michael Myers, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada*

SUMMARY:

When physicians become symptomatic, it is not easy for them to go for help. In this paper, I will discuss imperatives in the evaluation of physicians: establishing rapport—being welcoming, compassionate, respectful, thorough, and direct; clarifying the context i.e., is the physician consulting you privately or are you being asked to do an evaluation for a third party?; appreciating how terrified and ashamed many physicians feel sitting opposite a psychiatrist; being as rigorous at history taking and mental status examination as with non-physicians; watching boundaries and avoiding conflict-of-interest dilemmas; treating psychiatrist-patients no differently than other physician-patients; assessing suicide risk with vigilance—asking about means (insulin, barbiturates, fentanyl, KCl) and being aware that many suicidal physicians deny the seriousness of their desperation; taking a careful substance abuse history, looking for genetic and familial history of alcoholism, mood disorders, and suicide; explaining diagnosis and treatment plans as with any patient; obtaining collaborative information from family (especially interviewing the wives of male physicians for details of their functioning at home), assessing the marriage or other intimate relationship, getting second opinions from psychiatric subspecialists when indicated; respecting and being prepared to answer questions about confidentiality, and monitoring transference and countertransference issues.

No. 45C
COMPUTERIZED PSYCHIATRIC DIAGNOSTIC INTERVIEW FOR DSM-IV

Mark Zetin, M.D., *P.O. Box 879, Orange, CA 92856;* Tasha Glenn, Ph.D.

SUMMARY:

A computerized psychiatric diagnostic interview is useful to the clinician if it provides reliable data for differential diagnosis, is comprehensive in scope, and is inexpensive in terms of staff time and equipment requirements. PsychDiagnoser is a rules-based expert system designed to simulate a semi-structured clinical interview. It was developed on a locked inpatient unit; the current version was tested in the author's outpatient private practice. The interview gathers information on Axis I & II differential diagnosis, III-V data, danger to self and others, drug response, family and developmental history, and treatment goals. Sixty patients were diagnosed by the computer interview, with 96% completing Axis I and II, and 58% completing the entire interview. Mean ± SD completion time was 70 ± 36 min. Sensitivity and specificity were calculated relative to the diagnostic impressions of a Board-certified psychiatrist for the most common diagnoses and found satisfactory for major depression (90%, 86%), bipolar disorder (92%, 72%), substance abuse (86%, 83%), and borderline personality (100%, 84%). The program detected comorbidities of mood disorders with substance abuse or anxiety disorders well.

The program was well accepted by patients. A short version covering only Axis I and dangerousness was developed for ER and primary care use.

REFERENCES:

1. Lezan MD: Neuropsychological Assessment, 3rd Edition. New York, Oxford University Press, 1995
2. Myers MF: Treatment of the mentally ill physician. Position Paper of the Canadian Psychiatric Association. Can J Psychiatry 1997; 42:Insert
3. Zetin M, Glenn T: Development of a computerized psychiatric diagnostic interview for use by mental health and primary care clinicians. CyberPsychology & Behavior 1999; 2:3

SYMPOSIUM 46—MOOD AND MENOPAUSE: TREATING WOMEN IN MIDLIFE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) identify psychodynamic issues of perimenopausal women, (2) understand neuroendocrine and physiologic changes that occur during the perimenopause, (3) know a conceptual framework for the relationship of mood disorders to menopause, (4) know rational approaches to psychotropic treatment during the perimenopause, (5) recognize the health risks and benefits of hormone replacement therapy.

No. 46A
PSYCHOTHERAPY DURING THE PERIMENOPAUSE

Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 836 West Wellington Avenue, Chicago, IL 60657*

No. 46B
GENDER-BASED BIOLOGY AND PUBLIC POLICY

Florence Haseltine, M.D., *National Institute of Health, 610 Executive Bldg Rm 8B-07, Bethesda, MD 20892*

No. 46C
MOOD AND MENOPAUSE: CLINICAL ISSUES IN TREATING MIDLIFE WOMEN

Diana L. Dell, M.D., *Duke Medical Center, 1460 Gray Bluff Trail, Chapel Hill, NC 27514*

SUMMARY:

Psychiatrists are increasingly aware that physiologic changes in the perimenopausal period can create a biologically vulnerable time for recurrent mood symptoms in susceptible individuals. They are also aware that differentiating climacteric symptoms from mood symptoms can be difficult.

This presentation will assist participants in differentiating perimenopausal symptoms from mood symptoms. It will assist participants in understanding the hormonal regimens that are commonly used to treat symptoms in perimenopausal and menopausal patients, many of which have mood side effects. Alternative therapies for the treatment of perimenopausal symptoms will also be addressed.

No. 46D
PSYCHOTROPIC MEDICATIONS IN THE PERIMENOPAUSE AND MENOPAUSE

Margaret F. Jensvold, M.D., *Center for Life Strategies, 4312 Montgomery Avenue, Bethesda, MD 20814*

SUMMARY:

Women frequently present to physicians in the perimenopause and postmenopause for treatment of a variety of psychological symptoms. The question often arises whether psychotropic medication, hormonal therapy, or both are indicated or will be most helpful to the patient. This presentation will review common psychological symptoms of perimenopause and menopause. Aspects of psychiatric disorders (major depression, bipolar disorder, schizophrenia, and Alzheimer's disease), including their presentation in peri- and postmenopause, and evidence regarding potential roles of exogenous estrogen as primary or adjunctive therapy, will be discussed. Evidence of a menopausal effect upon tolerance of antidepressant medication will be presented. Psychotropic medications, exogenous hormones, and endogenous sex steroid changes in the perimenopause and menopause may create drug-drug interactions, which are potentially clinically significant, at least for some patients. A clinically significant case example of nefazodone-HRT interaction is presented. With 40 million postmenopausal women in the U.S. today, expected to increase by 20 million in the next 10 years, appropriate use of psychotropic agents in the perimenopause and menopause is increasingly important.

No. 46E
PROMOTING INFORMED DECISION-MAKING ABOUT HORMONE REPLACEMENT

Lori A. Bastian, M.D., *Department of Medicine, Duke Durham VAMC, 508 Fulton Street, Room 152, Durham, NC 27705*

SUMMARY:

It has been proposed that the topics of menopause and hormone replacement therapy (HRT) best illustrate the gap between women's informational needs and expectations and what is actually provided by physicians. The decision about whether to take HRT is one of the most important health-related decisions that mid-life women will make. HRT is important from a public health perspective because of the potential to reduce the risk of onset or, if not the risk, the age of onset of many chronic diseases, such as osteoporosis, heart disease, Alzheimer's disease, ovarian cancer, and colon cancer. On the other hand, the risks established in observational studies to be associated with estrogen include an increased risk of breast cancer, endometrial cancer (if unopposed), and thromboembolic disease. The challenge for the physician is to communicate all of these benefits and risks so that women can make an informed decision about HRT. The presence of depressive symptoms may impact upon a woman's ability to make an informed decision about HRT. This presentation will include a discussion of the risks and benefits of HRT as well as attitudes, knowledge, and symptoms associated with decision making about HRT.

REFERENCES:

1. Taylor M: Alternatives to conventional hormone replacement therapy. Comprehensive Therapy 1997; 23:514–532
2. Jensvold MF: Psychopharmacology, in A Clinician's Guide To Menopause. Edited by Stewart DE, Robinson GE. Washington, DC, American Psychiatric Press, 1997
3. Bastian LA, Couchman GM, Rimer BK, McBride CM, Siegler IC: Promoting informed decision making: hormone replacement therapy, in Cancer Policy. Edited by Bennett CL. Norwell MA, Kluwer Academic Press, 1998, pp. 129–147

SYMPOSIUM 47—ELECTRONIC RECORDS: THE END OF CONFIDENTIALITY?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand current issues relating to the expanding role of electronic records in psychiatry, especially with respect to confidentiality, from a policy, technological, and practical perspective

No. 47A
COMPUTERIZED PSYCHIATRIC RECORDS TODAY: CAN THEY BE PROTECTED?

David P. Olson, M.D., *Department of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

The computerization of the psychiatric record has the potential to dramatically improve the quality of care we provide to our patients. Examples of benefits of these electronic patient records include better coordination of care between physically separated providers, simultaneous access to patient records, linkages to drug interaction databases with automated alerts, outcome tracking, and access to standards of care such as practice guidelines.

Electronic psychiatric record systems, when inadequately protected, also potentiate breaches of confidentiality on a scale that dwarfs potential abuses of the traditional paper record. In an unprotected system, thousands of patient records could be searched and copied in a matter of seconds or minutes from a remote site via the Internet.

How do we ensure the protection of this highly sensitive data while preserving the advantages of an electronic record? Psychiatry needs to advocate for the incorporation of existing security technology into all electronic medical record storage and communication systems. Encryption, partitioned data, secure communication standards, virtual private networks, firewalls, access policies, and audit trails all play a role in the construction of a secure psychiatric information system. These technologies are in use by banks to securely move billions of dollars electronically every day around the globe.

No. 47B
ELECTRONIC PATIENT RECORDS: THE ETHICAL CHALLENGES

Ronald J. Draper, M.D., *Department of Psychiatry, Saint John of God, Stillorgan, Dublin, Ireland (northern)*

SUMMARY:

The electronic storage, processing, and transfer of personal health information has already begun to replace traditional paper records in many centers and is coming into more generalized use. Medicine has more complex data sets than commerce for which data protection laws exist and do not easily translate. Mental health, in particular, requires a record that is holistic in content and longitudinal in format. Sensitive data from many sources must be integrated to support high-quality decision making, creating many legal and ethical challenges, which became apparent when the Irish Province of the Hospitaller Order of St. John began the development of a computerized patient record (CPR) to solve problems of record availability and accessibility. A task force representing each service and clinical discipline,

addressed all relevant European and national legislation, with input from the Data Protection Commissioner, and held an international conference to validate the conclusions. A series of principles and policies to regulate information management has been developed. Recent European directives apply not only to CPRs, but extend the ethical and legal provisions to manual records and telecommunication systems. The new environment will threaten some clinicians but afford others a unique opportunity to forge new ethical and consensual therapeutic relationships.

No. 47C
WILL THE HIPAA CHALLENGE HAVE BEEN OVERCOME BY THE AMERICAN PSYCHIATRIC ASSOCIATION IN 2000?

Francoise Gilbert, J.D., *Gray Cary Ware Freidenrich, 400 Hamilton Avenue, Palo Alto, CA 94301-1825*

SUMMARY:

The anticipated HIPAA laws and regulations directly affect the creation, handling, maintenance, and processing of computerized psychiatric records. Every practitioner should be apprised of their goal and content, as well as the requirements that they impose on health care practitioners.

After providing an overview of the legal issues relating to computerized psychiatric records, this presentation will describe the current federal and state laws, and will provide a practical, simple, easy-to-understand, overview and commentary of the proposed—or perhaps then-enacted—federal legislation and regulations that apply the directives in the HIPAA.

No. 47D
ENCRYPTION: WHAT IT IS AND HOW TO USE IT

Robert C. Hsiung, M.D., *Department of Psychiatry, University of Chicago, 5737 South University Avenue, Chicago, IL 60637*

SUMMARY:

Providers and consumers increasingly are using electronic mail to communicate. Paradoxically, this is taking place despite widespread awareness of hackers and other threats to the integrity of computer systems. The security of both stored and transmitted electronic information can be greatly increased—though still not guaranteed—by encrypting it.

Two types of encryption are especially applicable to psychiatric practice. "Symmetric key" encryption (for example, of a computer file) uses the same password (the "key") to encrypt and decrypt the information. A single password is sufficient because the same person is doing both the encrypting and the decrypting. "Asymmetric key" encryption (for example of an e-mail message) uses one key to encrypt the information and another to decrypt it. Two keys are necessary because one person is doing the encrypting and another the decrypting. In either case, once encrypted, the confidentiality of the information is secured.

A particular software package, Pretty Good Privacy, ⟨http://web.mit.edu/network/pgp.html⟩, has become popular and is highly recommended. It is available free of charge in both Macintosh and Windows formats. It encrypts both computer files and e-mail messages and manages both passwords and keys. Its use is relatively easy and is demonstrated "live."

No. 47E
RESPONSIBLE MANAGEMENT OF CONSUMER INFORMATION

Mary Graham, *NMHA, 1021 Prince Street, Alexandria, VA 22314*

SUMMARY:

This presenter will discuss the special challenges that psychiatrists face in managing consumer information responsibly. A major focus will be on the ethical dilemmas created by advances in technology (e.g., facsimile, electronic transmissions, telemedicine, and audio and video files).

She will also describe some of the key threats to confidentiality posed by the increasing intrusiveness of managed care practices, including strategies to effectively address these problems. Special emphasis will be placed on psychotherapy session notes, "releases," and especially sensitive situations, including medical emergencies, child abuse and neglect, and custody disputes. There will also be discussion of the special considerations of working with consumers who are minors, have HIV/AIDS, have substance abuse problems, or are declared legally incompetent.

Finally, the presenter will conclude with a discussion of the key privacy rights consumers have and should have. This discussion will cover the current gaps in laws and regulations, as well as the impact that breaches of confidentiality have on consumer behavior, including failure to access care, misinforming or providing incomplete information to the psychiatrist, failing to form a trusting relationship with the psychiatrist, and foregoing treatment altogether.

REFERENCES:

1. For the Record: Protecting Electronic Health Information, National Research Council, Washington, D.C., National Academy Press, 1997
2. Cryptography's Role in Securing the Information Society. National Research Council, National Academy Press, Washington, D.C., 1996
3. Draper R, Rigby M, (eds): Towards an Ethical Protocol for Mental Health Informatics, Synopsis of an International Conference, Dublin 12 June 1997. Hospitaller Order of St. John of God, 1997, ISBN 0 9507065 1 5
4. American Psychiatric Association resource document on computerized records: a guide to security. Journal of the American Academy of Psychiatry & the Law 1997; 25(4):561–4
5. Best and Worst Practices in Private Sector Managed Mental Healthcare, Graham, 1999

SYMPOSIUM 48—SUBSTANCE ABUSE: CUTTING-EDGE TREATMENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should know the best methods, both pharmacologic and behavioral, for treating the major abused substances—nicotine, heroin, cocaine, alcohol, and marijuana. In addition, treatment of comorbid conditions will be covered.

No. 48A
ADVANCES IN SMOKING CESSATION

Alexander H. Glassman, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Most smokers who successfully stop, do so on their own. However, as the population of smokers is reduced, those who remain are increasingly hard-core. As a result, the need for treatment is increasing; however, a number of treatments do aid this hard-core population. The first was nicotine gum. It was apparent that although effective by itself, behavioral support improved its success rates. It was also apparent that the gum was troublesome and that a patch preparation would be more user-friendly.

Numerous patch preparations are now available and have been more widely studied than any other cessation treatment. Again, while a patch itself will aid cessation, it is more effective when combined with a behavioral program. Newer nicotine preparations have become available. However, there is little evidence that they are more effective than a patch and they have found only limited acceptance.

The most significant recent change has been the introduction of non-nicotine preparations. The best studied, the antidepressant bupropion, has proven to have robust effects on cessation. Although the older TCAs may also aid cessation, it appears the SSRIs do not. Combining presently available treatments also improves the smoker's chances of success.

No. 48B
TREATMENT OF HEROIN DEPENDENCE

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York, NY 10032*

SUMMARY:

The increased purity and decreased price of heroin, along with an increased number of addicts, has 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. 48C
TREATMENT OF COCAINE DEPENDENCE

Marian W. Fischman, Ph.D., *Department of Psychiatry, Columbia University Med. School, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Cocaine abuse and dependence remain severe public health problems, with treatment difficult and few controlled trials reporting success. A combination of pharmacological and behavioral interventions will likely be required for these patients to achieve and maintain abstinence. Antidepressants, with desipramine the most studied, have 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 D1 agonist and a dopamine D1 antagonist have been tested, with promising results for one of them. Other foci have included NMDA antagonists, the partial opioid agonist buprenorphine, and anti-convulsants 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. 48D
TREATMENT OF ALCOHOL AND MARIJUANA DEPENDENCE

David M. McDowell, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Marijuana, the most commonly used illicit substance in the United States, and alcohol, the most commonly used legal intoxicant, produce substantial morbidity and, in the case of alcohol, mortality. This presentation will review both current treatment of these problems and new approaches. Contrary to public perception, heavy and chronic use of marijuana carries with it substantial morbidity and risk of dependence and withdrawal. Pharmacological interventions for marijuana dependence have included mood stabilizers and medications focused on withdrawal symptoms. The results of such studies will be presented as well as promising other agents. Medications discussed include bupropion, valproic acid, and naltrexone. Psychosocial interventions such as motivational enhancement will also be discussed.

A substantial amount of work has been done to study the treatment of alcohol dependence. Agents with demonstrated efficacy for alcohol dependence include disulfiram and naltrexone. Acamprosate, approved in some European countries, is being studied here and these studies plus other agents will also be described. In addition, psychosocial interventions, such as relapse prevention therapy, network therapy, and brief office interventions have shown promise. The combination of pharmacology, psychological therapy, and self-help groups will be discussed.

No. 48E
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, post-traumatic stress disorder, generalized anxiety and panic disorder, attention-deficit hyperactivity disorder, and schizophrenia/schizoaffective illness. Although there are established pharmacologic and nonpharmacologic approaches for each of these psychiatric conditions in non-substance abusing patients, the efficacy of these approaches in substance-abusing patients is not well established. Several questions will be addressed in this presentation: (1) What are the appropriate pharmacologic treatment approaches for specific dually-disordered patients? (2) Should medications with abuse potential be avoided? (3) Is substance use reduced if the psychiatric comorbid condition is treated? (4) What are some possible modifications of

currently available nonpharmacologic strategies that might be used for various dually diagnosed groups? Although there are no definite answers, clinical guidelines will be offered.

REFERENCES:

1. Covey LS, Sullivan M, Johnston JA, Glassman AH, et al: Advances in non-nicotine pharmacotherapy for smoking cessation. Drugs, 1999, In press
2. Kleber HD: Opioids: detoxification, in The American Psychiatric Press Textbook of Substance Abuse Treatment, 2nd Edition. Edited by Galanter M, Kleber HD. Washington, D.C., American Psychiatric Press 1999, pp 251–269
3. Fischman MW, Haney M: Neurobiology of stimulants, in The American Psychiatric Press Textbook of Substance Abuse Treatment, 2nd Edition. Edited by Galanter Kleber HD. Washington, D.C., American Psychiatric Press, 1999, pp 21–31
4. Haney M, Ward AS, Comer SD, Foltin RW, et al: Abstinence symptoms following smoked marijuana in humans. Psychopharmacology 1999a; 141:395–404
5. Levin FR, Evans SM, Kleber HD: Treatment of substance abusers with adult ADHD: practical guidelines for treatment. Psychiatric Services 50:1001–1003

SYMPOSIUM 49—CLINICAL CHALLENGES TO THE PSYCHIATRIST OF FAITH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to appreciate the need to understand the patient's world view, how it frames clinical diagnostic and therapeutic issues, and the manner in which faith or belief colors psychiatric illness and the relationship between the clinician and the patient.

No. 49A
CLINICAL EXPLORATION OF THE PATIENT'S WORLD VIEW

Irving S. Wiesner, M.D., *Swarthmore Medical Center, Yale Avenue and Chester Road, Swarthmore, PA 19081*

SUMMARY:

Whether a patient has adhered to a particular faith tradition or ideological framework from their youth, has rejected the world view of their upbringing, or changed beliefs gradually over the course of their lives, belief remains a foundational psychological function.

Within this framework, patients interpret their world, determine their responses to that world, and set their goals, dealing with such issues as suffering, guilt, forgiveness, and death. These boundary issues between the psychological and the spiritual/religious or ideological must be dealt with in the course of psychiatric evaluation and treatment.

Using the APA guidelines relating to religious/spiritual commitments as a starting point, a general theoretical and clinical approach will be presented as an introduction to the several panel members who will discuss these issues in the context of the Hindu, Jewish, Catholic, and Protestant faith traditions.

The emphasis will be in helping the practicing clinician "obtain information on the religious or ideological orientation and beliefs of their patients so that they may properly attend to them in the course of treatment," (APA guidelines) as well as avoid conflicts or deal with them when they arise.

No. 49B
CHALLENGES TO THE PSYCHIATRIST OF HINDU FAITH

Nalini V. Juthani, M.D., *17 Pheasant Run, Scarsdale, NY 10583-3100*

SUMMARY:

Patients from Hindu faith may present with somatic symptoms, crying, depressed mood, vegetative signs of depression, anxiety, etc. They may also present with a need to conduct rituals in an obsessive-compulsive manner. Patients from Hindu faith may explain that their suffering is as a result of an undesirable Karma in the past. The patient may consult a Guru who may offer some rituals that would nullify the sins from bad karma, and may feel forgiven, which may remove the guilt and the suffering. These rituals could be prayers, fasting, chanting, idol worship, etc. Forgiveness can be offered by the priest after completion of rituals. Patients may initiate these rituals on their own and without the intervention of a Guru as well.

A healthy person from Hindu faith will use the law of Karma as an educative force and sublimate unacceptable desires to positive actions. An immature or pathological user of faith will become obsessed with getting rid of suffering and anxiety by conducting rituals in a compulsive manner. Such rituals interfere in their daily functioning.

When a psychiatrist does not understand patient's belief system or agree with it, he/she should explore the underlying reasons on which the belief system may be based. An exploratory, nonjudgmental accepting mode leads to open dialogue and understanding. The psychiatrist can point out the patient's anxiety, fear, and obsessions without knocking their religious beliefs. Listening empathically and accepting the patient provides support. The psychiatrist may consult family and other elders of patient's faith for clarification and self-education. The psychiatrist must recognize that every patient is at a different stage of spiritual development. Many spiritual issues may have psychological underpinnings, e.g., a constantly angry person may perceive God as punitive and sadistic. Addressing psychological issues may free the patient to move to a higher level of spirituality.

No. 49C
VALUE CONFLICTS FOR OBSERVANT JEWISH PSYCHIATRISTS

Abba E. Borowich, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 30 East 76th Street Suite 5A, New York, NY 10021*

SUMMARY:

For many years, a myth existed that psychotherapy was value-free. The only value admitted to was the value of improving the patient's mental health. That myth is long dead.

Patients and psychiatrists each bring their values to the therapeutic context. Among the values that affect treatment for each person, religion plays an important role-especially for the religiously-observant participant.

This presentation will focus on some of the more common dilemmas that the observant Jewish psychiatrist will face in his/her practice. These problems affect not only the patient but also the therapist.

Among the issues to be discussed will be: (1) the contemplation of inter-faith marriage, (2) refusing to divulge prior major psychopathology to a future spouse, (3) the religious leader with deviant behavior, (4) the victim who questions Divine justice, and (5) a rational request for assisted suicide.

Traditional Jewish sources will be discussed as well as the author's attempt to synthesize the values of Jewish tradition and psychiatric practice.

No. 49D
A CATHOLIC SYNTHESIS OF FAITH AND REASON

Judith Moss Hughes, M.D., *45 Flagg Street, Worcester, MA 01602-1450*

SUMMARY:

The psychiatric patient whose religion is Roman Catholic has an understanding of human personhood that includes the following: (1) the person, male and female, is created at conception in the image of the Triune God, unlike any animal; (2) each person is composed of a unity of a material body and a spiritual soul; (3) the universal vocation of the person is to transcend the self and freely love in action; (4) a baptized person has received the Holy Spirit and belongs to the Church, which is the Body of Christ; and (5) the balanced bio/psycho/social/moral/spiritual life is based on the Ten Commandments, the wisdom of Holy Scripture, the life of Jesus Christ, the gifts and the fruits of the Holy Spirit, prayer, grace, the Sacraments, and the magisterial teachings of the Tradition of the Church. The psychiatrist whose religion is Roman Catholic has the above understanding of human personhood and, in addition, has the following concept of the practice of medicine: (1) medicine is both an art and a science; it is for healing and preserving life, not for killing; (2) healing comes from God, who works through doctors, but healing is not limited to medicine: it can occur as a result of prayer and participation in the Sacraments of the Church; (3) body and soul are inseparable; whatever is done to one affects the other; (4) psychiatric medicine must not endorse biological reductionism nor psychological reductionism; (5) psychotherapy and the Sacrament of Reconciliation differ in crucial aspects; (6) science, philosophy, and faith can work together to discover the truth and establish health and harmony where there is disorder; and (7) human freedom is essential in the formation of religious belief, the choice of philosophical outlook and political ideology, and in the pursuit of a virtuous action.

No. 49E
CHRISTIAN FAITH AND PRACTICE: A DELICATE BALANCE

Mark E. Servis, M.D., *Department of Psychiatry, UC Davis Medical Center, 2230 Stockton Boulevard, Sacramento, CA 95817*

SUMMARY:

The psychiatrist with Christian religious beliefs is presented with several challenges in integrating spiritual beliefs and perspectives with clinical practice. Christian theology offers elaborate and cogent ideas about guilt, forgiveness, and other aspects of psychic life that differ from traditional psychiatric and psychodynamic perspectives. A Christian understanding of pain and suffering for either the patient or practioner may suggest a different treatment approach from usual practice. Patients with Christian beliefs that present to a psychiatrist of Christian faith may insist on understanding and addressing their clinical problems from a spiritual perspective only. A delicate balance is called for between using the religious perspectives of patients and of the treating psychiatrist to inform assessment and treatment, and ignoring the spiritual perspective on a patient's problem. Clinical examples help to delineate some of the conflicts and collaborations that are possible between a Christian perspective and a traditional psychiatric perspective in clinical practice. A careful delineation of the ethical issues involved in negotiating the spiritual dimension of clinical practice is required. Though difficult and dangerous if misused, we need to incorporate our understanding of our patients' spiritual and religious experience in etiology, diagnosis, prognosis, and treatment.

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2. Juthani NV: Understanding & treating Hindu patients, in Handbook of Religion & Mental Health, Ch. 19, Academic Press
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SYMPOSIUM 50—HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE
APA Committee of Early Career Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant 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 market place, and (3) learn to balance the functions of manager, technician, and entrepreneur in a small business.

No. 50A
BALANCING MULTIPLE ROLES IN PRIVATE PRACTICE

William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618;* Ann S. Maloney, M.D., Barry W. Wall, M.D., Keith W. Young, M.D.

SUMMARY:

Dr. Callahan will discuss balancing the functions of psychiatrist, technician, manager, and entrepreneur. Tips about office location and the specifics of setting up your office space will be discussed. Having an attorney review your office contract and avoiding ways to be 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, keeping your financial expectations realistic, and distinguishing your practice from others.

At the conclusion of this presentation, participants will be able to: (1) learn factors important to setting up your new office that will enhance your professionalism, (2) develop the skills to avoid the biggest risks for failure in private practice, and (3) learn how to function effectively as a manager, including when to ask for advice.

No. 50B
PERSONAL FACTORS LEADING TO A SUCCESSFUL PRIVATE PRACTICE

Ann S. Maloney, M.D., *123 East 37th Street, New York, NY 10016-3030;* William E. Callahan, Jr., M.D., Barry W. Wall, M.D., Keith W. Young, M.D.

SUMMARY:

Dr. Maloney will discuss personal and individual factors that can lead to, or detract from, success. Ways to assess your own personality style and to consider your own needs and desires will be discussed. The essential elements of being in practice, such as ensuring your own therapy, obtaining supervision, and enjoying the work, will be covered. Financial uncertainty, potential isolation, and the increased responsibility of private practice will also be discussed.

At the conclusion of this presentation, participants will be able to: (1) examine your own personality style to assess your strengths and weaknesses, (2) prioritize your own needs and desires in setting up your practice, and (3) identify potential deterrents to starting your practice.

No. 50C
STREAMLINING OVERHEAD IN PRIVATE PRACTICE

Barry W. Wall, M.D., *184 Waterman Street, Providence, RI 02906;* William E. Callahan, Jr., M.D., Ann S. Maloney, M.D., Keith W. Young, M.D.

SUMMARY:

Dr Wall will discuss streamlining your practice to limit overhead and maximize quality. Tips about minimizing personal and office expenses, including the use of staff, will be discussed. Billing, setting fees, scheduling appointments, and appropriately utilizing telephone calls will be detailed. Other issues for professional success will be covered, including malpractice insurance, use of computer programs, and collecting unpaid bills.

At the conclusion of this presentation, participants will: (1) know the importance of minimizing personal expenses when setting up private practice; (2) develop the skills to bill, set fees, schedule appointments, and effectively make telephone calls; and (3) understand the importance of financial discipline to professional success.

No. 50D
MARKETING YOUR UNIQUE PRIVATE PRACTICE

Keith W. Young, M.D., *10780 Santa Monica Blvd #250, Los Angeles, CA 90025-4749;* William E. Callahan, Jr., M.D., Ann S. Maloney, M.D., Barry W. Wall, M.D.

SUMMARY:

Dr. Young will discuss making your practice unique and marketing yourself with no budget. The importance of public speaking and maintaining visibility through nonprofit boards or volunteer work will be identified. Personal tips about your mannerisms, dress, style of speech, and timeliness, and how this impacts other people's perceptions, will also be covered. Making yourself more available and flexible than providers in managed care settings will be discussed as well.

At the conclusion of this presentation, participants will be able to: (1) understand the importance of identifying yourself to a particular market or group, (2) understand ways to persistently foster name recognition, and (3) understand the importance of public speaking to develop your private practice.

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2. Storr A: The Art of Psychotherapy. 2nd edition. New York, Routledge. 1990, pp 168–190. ISBN 0-412-90302-5
3. Logsdon L: Establishing A Psychiatric Private Practice. Washington DC, American Psychiatric Press, Inc., 1985
4. Practice Management for Early Career Psychiatrists. APA Office of Healthcare Systems and Financing, 1998

SYMPOSIUM 51—APPLYING VIRTUAL ENVIRONMENTS IN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should know (1) the basics of what virtual reality and virtual environments are, (2) how they are used for clinical treatment and research into psychiatric disorders, and (3) what the future applications and potential of these technologies might be.

No. 51A
AN INTRODUCTION TO VIRTUAL ENVIRONMENTS

Milton Huang, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48104-6462*

SUMMARY:

Virtual environment (VE) technology has undergone a transition in the past few years that has taken it out of the realm of expensive toy and into that of functional technology. Recently, in the field of neuropsychology, the considerable potential of VEs has been recognized for the scientific study, neuropsychological assessment, and cognitive rehabilitation of cognitive and functional abilities in persons with acquired brain injury, neurological disorders, and learning and developmental disabilities. This presentation will provide a general introduction to neuropsychological assessment and cognitive rehabilitation, and present a rationale for the use of VEs in these areas. I will review the work that has been done in these areas and provide a description of the advantages for the use of VEs, as well as some of the cost/benefit issues that need to be considered for its application.

No. 51B
VIRTUAL ENVIRONMENT FOR NEUROPSYCHIATRIC ASSESSMENT AND REHABILITATION

Albert A. Rizzo, Ph.D., *Department of Gerontology, University of Southern California, 3715 McClintock Avenue MC0191, Los Angeles, CA 90089*

SUMMARY:

Virtual environment (VE) technology has undergone a transition in the past few years that has taken it out of the realm of expensive toy and into that of functional technology. Recently, in the field of neuropsychology, the considerable potential of VEs has been recognized for the scientific study, neuropsychological assessment, and cognitive rehabilitation of cognitive and functional abilities in persons with acquired brain injury, neurological disorders, and learning and developmental disabilities. This presentation will provide a general introduction to neuropsychological assessment and cognitive rehabilitation, and present a rationale for the use of VEs in these areas. I will review the work that has been done in these areas and provide a description of the advantages for the use of VEs, as well as some of the cost/benefit issues that need to be considered for its application.

No. 51C
VIRTUAL HUMANS: THE FUTURE OCCUPANTS OF VIRTUAL REALITY

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

As virtual realities and their potential use in psychiatry are explored, very little is ever mentioned concerning virtual humans. What are virtual humans? How will they be created? How will they represent psychopathology, and how will they be utilized to deal with psychopathological conditions? In this presentation, virtual humans will be defined. How they can be created using motion capture technologies will be presented. How virtual humans might be utilized to expand our understanding of psychiatric disorders and possibly be used to treat them will also be covered.

No. 51D
A VIRTUAL FUTURE FOR PSYCHIATRY

Mark Wiederhold, *SAIC, 1200 Prospect, Suite 400, La Jolla, CA 92037*

SUMMARY:

Virtual environment (VE) technology is exciting with enormous potential, yet significantly underused. This presentation reviews where virtual technologies are in clinical psychiatry and psychiatric research. We review the different barriers that have slowed its use including technical, financial, social, and political obstructions. Early expectations of virtual reality were biased by inflated dreams and hype. The expense and expertise required for using these complex computer systems dulled such initial hopes. Constantly advancing technology has allowed a shift away from focusing on the splash and the technology itself. Clinically, we are seeing the development of applications that are more focused on issues of practicality or commercial success. In research, it is becoming a down-to-earth tool for exploring psychological responses that would not otherwise be measured. Perceptions are changing slowly, and this talk will conclude with projections of how these trends will change and where the future of virtual environments lies.

REFERENCES:

1. Glantz K, Durlach NI, Aviles WA: Virtual reality (VR) and psychotherapy: opportunities and challenges. Presence: Teleoperators and Virtual Environments (1997); 6(1):87–105
2. Rizzo AA, Buckwalter JG, Neumann U, Kesselman C, Thiebaux M: Basic issues in the application of virtual reality for the assessment and rehabilitation of cognitive impairments and functional disabilities. CyberPsychology and Behavior 1998; 1(1)59–78
3. Alessi NE, Huang MP: The potential relevance of attachment theory in assessing relatedness with virtual humans, in Virtual Environments in Clinical Psychology and Neuroscience. Edited by Riva G, Wiederhold BK, Molinari E. Amsterdam: IOS Press, 1998, pp 180–187
4. Huang MP, Alessi NE: Current limitations in the application of virtual reality to mental health research, in Virtual Environments in Clinical Psychology and Neuroscience. Edited by Riva G, Wiederhold BK, Molinari E. Amsterdam, IOS Press, 1998, pp 63–66

SYMPOSIUM 52—ARAB PERSPECTIVE ON PSYCHOTIC DISORDERS
Arab American Psychiatric Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand Arab cultural aspects in symptom presentation in psychotic disorders, the impact of emotional expression on treatment outcome, and the prevelance of post partum psychiatric morbidity and its risk factors in the Arab world.

No. 52A
ARAB PERSPECTIVE ON PSYCHOSIS

Nasser F. Loza, M.B., *The Behman Hospital, El Marsad Street, Helwan Cairo, Egypt;* Ahmed Eldosoky, Sherif Atalla, M.R.C., Mohamed Fakhr-Flisiam, Khaled Nabil, Mona Botros, Elizabeth Coker, M.S.

SUMMARY:

The Arab world established psychiatric services for psychotic patients centuries ago. They acknowledged psychosis and had made trials to treat patients suffering from psychosis.

In the past decade there has been a significant change on the emphasis of religious beliefs. There are a number of research projects that dealt with religious experience among psychotic patients. These articles came to the conclusion that there is an increase in the number of patients presenting with religious symptoms and reflects an increase in the emphasis on religion over the past decades. In the west there is a decline in the number of patients presenting with psychotic symptoms since there is a decreased emphasis on religion.

Also, there is a change in the concept of using ECT in the treatment of psychosis in the Arab world where prognosis is better and different from that in the West.

Also, the research team at Behman Hospital looked at the prevalence of first-rank Schneiderian symptoms among a sample of 42 patients suffering from schizophrenia according to DSM-IV. This study was a replication of a similar study conducted in Kuwait by F. El Islam et. al. (1985).

In terms of management, the very same neuroleptic medications are used, although the dose is smaller among the Arabs. The social network is different, where the family takes the upper hand in community care of seriously mentally ill people.

No. 52B
TRANSCULTURAL ASPECTS OF EXPRESSED EMOTIONS IN RELAPSE OF PSYCHOTICS

Ahmed M.F. Okasha, M.D., *Neuropsychiatry, Ain Shams University, 3 Shawarby Street, Kasr Elain Cairo 00094, Egypt*

SUMMARY:

Expressed emotion (EE) is one of the most thoroughly investigated concepts in the psychosocial construct of psychiatry. Studies in different cultures showed that high EE is associated with high rates of relapse in schizophrenia and bipolar disorders. EE is expressed and measured through critical comments, overprotection, inner hostility, and warmth and positive remarks.

What is the boundary between normal concern and overinvolvement in relation to each family member? This has a cultural variation. Egyptian studies in schizophrenia and bipolar disorders found that for a relapse to occur, the cut-off point for criticism is 7 as compared with USA and UK where it ranges between 2 and 4 points. A detailed

discussion about the implications of EE in relapse of psychosis in the West as compared with traditional societies will be evaluated. Evaluation of the reasons for better outcome of psychosis in developing than developed countries will be clarified.

No. 52C
PREVALENCE OF EARLY POSTPARTUM PSYCHIATRIC MORBIDITY IN DUBAI: A TREATMENT PERSPECTIVE

Mohammed Abou-Saleh, M.D., *Addictive Behaviors, St. George's Hospital, Cranmer Terrace, London SW170RE, England;* Rafia O.S. Ghubash, Ph.D.

SUMMARY:

There have been numerous studies of the prevalence of postpartum psychiatric illness and its putative risk factors in Western Europe and North America, but very few studies have been undertaken in developing countries, including the Arab world. A total of 95 women admitted to the New Dubai Hospital in Dubai, United Arab Emirates, for childbirth were studied. All subjects were assessed in the postpartum period using clinical and sociocultural instruments, namely the Self-Reporting Questionnaire (SRQ) on day 2 and the Edinburgh Postnatal Depression Scale (EPDS) on day 7 after delivery. The prevalence of psychiatric morbidity was 24% according to the SRQ and 18% according to the EPDS. A number of psychosocial factors emerged as putative risk factors for postpartum psychiatric disturbance, including depressive illness. It is concluded that the prevalence of postpartum psychiatric morbidity and its risk factors in this Arab culture are similar to the results obtained in numerous previous studies conducted in industrialized countries. These findings have implications for the early detection and care of women at risk for postpartum psychiatric illness.

No. 52D
STRUCTURED CLINICAL INTERVIEW IN PSYCHOTIC DISORDERS: ARAB

Adel Sadek, M.D., *Department of Psychiatry, AIN Shams University, PO Box 22 Deir, El Malak, Cairo 11657, Egypt*

SUMMARY:

Studies at Ain Shams University are how being carried out to evaluate the use of a structured clinical interview in psychotic patients in Egypt.

Applied interview on Egyptian samples are showing cultural differences as far as symptom interpretation by physicians. It is expected that the way we ask the question will differ resulting in a need to restructure the item to adjust to the Egyptian sample. In the sample of children it is expected that presentation of psychosis will be different due to different family structures and interactions. Some questions were found not to be valid for Egyptian children.

REFERENCES:

1. Okasha, et al: Expressed emotion, perceived criticism and relapse in depression: a replication in an Egyptian community. American Journal of Psychiatry 1994; 151:7
2. Abou-Saleh MT, Ghubash R: The prevalence of early postpartem psychiatric morbidity in Dubai, a treatment perspective.

SYMPOSIUM 53—ONE PSYCHIATRY, TWO CULTURES AND SCORES OF TREATMENT GUIDELINES: VIVE LA DIFFERENCE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the history of the development of treatment guidelines in medicine and psychiatry, recognize the difference between the approaches to the assessment of adults and treatment of patients suffering from schizophrenia in France and the U.S. and to use the best portions of both nations' guidelines.

No. 53A
DEVELOPMENT OF TREATMENT GUIDELINES IN THE U.S.

John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, Rochester, NY 14601*

SUMMARY:

Over the last two decades there has been an explosion in the development of practice guidelines in the United States. The rapid growth of guidelines has been fueled by the explosion of information, variation in clinical practice, increased accountability, and potential cost savings in the delivery of health services. Guidelines are being developed by the federal government, state governments, professional associations, health care systems, and payers. The Institute of Medicine and the American Medical Association have defined criteria for "good" guidelines. The American Medical Association has established a practice guideline partnership with major specialty organizations identifying criteria for clinical guidelines. Significant issues concerning increased liability with the use of guidelines has also been raised. This presentation will review these major developments in the field of practice guidelines as well as outline the American Psychiatric Association's process for developing and disseminating guidelines.

No. 53B
INTERVIEW AND CLINICAL ASSESSMENT IN FRANCE

Jean-Jacques Laboutiere, M.D., *3 Avenue Banderon De Sennece, Macon 71000, France*

SUMMARY:

Psychiatry is a medical discipline. It refers to specific clinics and thinks in terms of pathologies. It could even be said that the notion of diagnostics in French psychiatry is somehow more rigid than it is in the United States for diagnostics are now always related to the structure of personality.

On the other hand, French psychiatry remains deeply bounded to every-patient singularity. Clinics can be fully utilized only if the patient can freely utter his own insight, which presupposes a necessarily singular relationship between him and the psychiatrist, a genuine interest for who is this patient and not only for what is this pathology. Furthermore, following a still very strong humanist tradition, psychiatric care tries as far as possible to set every patient free from the personal pain from which he is suffering because of his pathology rather than normalistic behaviors or reduce symptoms.

The place of clinical assessment in practice is best in this perspective, yet not a contradiction. Its role is indeed to comfort a diagnostic but only in the purpose to guide the therapeutic response, which must

remain free and adapted in every case. This will of a personalized therapeutic response puts the question of the assessment of its quality. Guidelines already elaborated by consensus conferences appear to be an acceptable solution for French psychiatrists.

No. 53C
PRACTICE GUIDELINES FOR THE PSYCHIATRIC EVALUATION OF ADULTS

Ronald A. Shellow, M.D., *2980 McFarlane Road, Ste 202, Miami, FL 33133-6030*

SUMMARY:

The project of writing the guideline for the psychiatric evaluation of adults began as two guidelines: one for inpatients and one for outpatients. It became apparent that the evaluation process for all patients was similar, and so a single set of guidelines was developed for adult patients. Most APA guidelines have been based primarily on evidence-based material. There are very few blinded studies dealing with evaluation of psychiatric patients. This guideline, therefore, is mainly based on concensus of experts. Some issues, such as forensic evaluations, were specific and left for other studies. Over a thousand comments were received from interested parties; many were incorporated into the final publication. The central aspect of evaluation is face-to-face examination of the patient. Psychoanalytically oriented psychiatrists questioned whether psychiatrists should do physical examinations of their patients. The guideline states that the psychiatrist is responsible for a physical examination as part of the process, no matter who does it.

No. 53D
CONSENSUS CONFERENCE AND GUIDELINES IN PARIS

Vivione Kovess, *75708, MGEN, 3 Square Max Aymans, Paris 75748, France;* Jean-Charles Pascal, M.D.

SUMMARY:

A national agency, ANAES (ANDEM), was created in France in order to realize quality evaluation and guidelines. Psychiatric topics were brought up and until now three consensus conferences have been finalized: on schizophrenia long-term treatment, depression in childhood, and treatment of opiate addiction. In addition, guidelines were elaborated through revision expert addiction on the following diverse themes:

- hypnotic and anxiolytic prescription (1995)
- neuroleptic prescription and chronic psychosis follow up (1995)
- antidepressant drugs (1996)
- autism (1994)
- hospitalization of suicidal adolescents (1998)
- electroconvulsivetherapy (1998)
- study of isolation procedure in psychiatry (1998)

At the same time mandatory quality evaluation procedures were set up for each health deliver structure including psychiatric, and continuing medical education was reformed.

This presentation will discuss the limits of these methodologies and the difficulties encountered when guidelines have to be implemented in diverse clinical settings.

No. 53E
THE 1999 EXPERT CONSENSUS GUIDELINES FOR THE TREATMENT OF SCHIZOPHRENIA

Allen J. Frances, M.D., *200 East 82nd Street, New York, NY 10028*

SUMMARY:

We will present the results of the 1999 Expert Consensus Guidelines for the Treatment of Schizophrenia. These were derived from surveys of 50 leading experts on psychopharmacology treatments and 50 leading experts on psychosocial treatments. Results will be compared with a previous survey conducted in 1996. We will also briefly discuss how the schizophrenia guidelines are being implemented in clinical practice, particularly as part of the Texas Medication Algorithm Project, and in the several other states that have been influenced by them. We will also compare the expert consensus guidelines with those developed by the American Psychiatric Association and by the National Institute of Mental Health.

No. 53F
TREATMENT OF SCHIZOPHRENIA: THE FRENCH CONSENSUS STATEMENT

Francois C. Petitjean, M.D., *SM 24, Hospital Saints Anne, 1 Rue Cabanis, Paris 75674, France;* Charles Gury, M.D.

SUMMARY:

The first consensus conference to be held in France on a psychiatric subject was organized in January 1994 by the Fédération Française de Psychiatrie.

The theme was long-term treatment of schizophrenia. Recommendations were issued concerning such aspects as pharmacological treatments: type and duration, psycho-educative interventions with families, and psychosocial rehabilitation.

Various studies carried out since the publication of these recommendations show a limited impact on therapeutic usages. Neuroleptic polypharmacy however, is gradually declining despite French prescribing habits thus far.

Thanks to contributions from experts of various disciplines, this first conference marked the beginning of a new approach to the treatment of patients with schizophrenia.

This presentation will outline the various recommendations of the consensus conference and will give an outlook on recent developments observed in France in this field.

REFERENCES:

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2. Fogel BS, Shellow RA: Practice Guidelines for Psychiatric Evaluation of Adults. American Psychiatric Association, 1995
3. McEvoy J, Frances A: The Expert Consensus Guidelines for the Treatment of Schizophrenia. Journal of Clinical Psychiatry, Supplement, February, 1999
4. Dalery J. D'Amato T: La schizophrénie. Recherches actuelles et perspectives. Masson ed. Paris, 2ed révisée 1999, p 285

SYMPOSIUM 54—PSYCHOPHARMACOLOGICAL APPROACHES TO THE ATHLETIC AND EXERCISE POPULATION
International Society for Sport Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand the unique physiology of the competitive athlete and serious exerciser, have a better understanding of which psychopharmacological agents to use for which disorder in this population, while taking into account the specific side effects most important to this patient group.

No. 54A
PHARMACOLOGIC MANAGEMENT OF ANXIETY AND MOOD DISORDERS IN THE ATHLETE

Antonia L. Baum, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue NW, Washington, DC 20037*

SUMMARY:

There is a dearth of information on the use of anxiolytics and antidepressants in the athlete. This is in part attributable to the lack of recognition of these disorders in an athletic population. Some data have been collected on the prescribing practices of psychiatrists who treat athletes, both professional and recreational. These data inform us that the overriding emphasis is on the use of "clean drugs" with minimal side effects for this special population, for whom the body is a finely tuned instrument.

Mood stabilizers also have a place in the psychopharmacologic management of atheletes. Misconceptions about lithium and alternative drugs will be discussed.

The widespread use of performance enhancing drugs has created an ethical dilemma. Some drugs that might play a legitimate role in the treatment of mood or anxiety disorders have become hanned substances in athletic competition. This is an area in need of reexamination.

Further exploration is also necessary of the effects of psychotropic drugs on athletic performance. This will assist us in new drug development and optimal prescribing practices, which may translate to the general population.

No. 54B
DIAGNOSIS AND PSYCHIATRIC TREATMENT OF ATHLETES

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford, CA 94305-5490;* Jessica L. Horstall, M.S.

SUMMARY:

Although enormous amounts of time and money have been spent on enhancing performance for college and professional athletes, their psychiatric needs have been minimally addressed. This paper reviews the literature and summarizes the authors' experience with this population. There is a dearth of evidence underlying intervention guidelines with Axis I and II disorders. Accordingly, the authors describe relevant diagnostic issues and delineate treatment principles for both male and female athletes including: (1) making an accurate diagnosis, (2) setting realistic goals, (3) delivering psychoeducation, (4) involving the family/significant others, and (5) delivering appropriate treatment (the most difficult task). We focus on the use of psychotropics when the athlete has a psychosis, bipolar disorder, and/or explosive behavior on or off the court. The overall objectives are to enhance individual talent and improve the quality of life by appropriately treating the illness/problem to maximize individual and/or team performance.

No. 54C
EATING DISORDERS AND ADHD IN ATHLETES: PSYCHOPHARMACOLOGIC MANAGEMENT ISSUES

Robert W. Burton, M.D., *Department of Psychiatry, Northwestern University, 405 North Wabash Avenue, #4605, Chicago, IL 60611*

SUMMARY:

Athletes and people who exercise strenuously are at increased risk of developing eating disorders, and male athletes are at greater relative risk than females. Research has revealed that athletes engage in a variety of disordered eating behaviors, including but not limited to the syndromes of anorexia nervosa and bulimia nervosa. A sport-related syndrome, anorexia athletica, has been proposed and will be presented for discussion.

The first-line medications for the treatment of eating disorders are the selective serotonin reuptake inhibitors. In athletes, the side effects of concern are sedation and the potential for dehydration when training or competing. Depending on the sport, agitation may be extremely detrimental to athletic performance, as well.

Individuals with attention deficit hyperactivity disorder may also be overrepresented among athletes due to self-selection. People with ADHD may be drawn to sports as a means of coping with excess physical energy. They may experience success in them, too, which promotes further involvement.

Unfortunately, the first-line medications for ADHD, the psychostimulants, are likely to be substances that are banned by the governing bodies of competitive sports. This likelihood makes the management of ADHD in the sports setting challenging, to say the least. Strategies for dealing with these difficulties will be discussed.

REFERENCES:

1. Baum AL: Psychopharmacoloy in Athletes in Sport Psychiatry. Daniel Begel and Robert Burton. WW Norton, New York, 1999
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3. Norman TC, Mathews W, Yohe CD: A case study on the effects of strenuous exercise on serum lithium levels. Nebraska Medical Journal 1987; 72:224–225
4. Begel D: An overview of sport psychiatry. Am J Psychiatry 1992; 149:606–614
5. Burton RW: Mental illness in athletes, in Sport Psychiatry: Theory and Practice. Edited by Begel D, Burton RW. New York, W.W. Norton, 1999, pp 57–75
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WEDNESDAY, MAY 17, 2000

SYMPOSIUM 55—TOWARD INTEGRATION IN INTERNATIONAL CLASSIFICATION
The World Psychiatric Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize recent developments in international classification of mental disorders (ICD-10, DSM-IV, CCMD-3, GC-3, GL-1), and to identify new perspectives toward integration in international classification.

No. 55A
WORLD HEALTH ORGANIZATION'S PERSPECTIVES ON INTERNATIONAL CLASSIFICATION

Bedirhan Ustun, M.D., *World Health Organization, 20 Avenue Appia, CH-1211 Geneva, Switzerland;* Shekhar Saxena, M.D.

SUMMARY:

The World Health Organization is responsible for developing and maintaining international health-related classifications to assist in

individual health care needs as well as for public health reporting and planning. Toward these aims, WHO has developed a family of international classifications that include the two prominent members, the ICD and ICIDH. While ICD has been very useful for diseases and disorders, WHO's attempt in recent years has been to go beyond these to health-related functioning, disability, and quality of life as attributes and indicators of health. The newly developed International Classification of Functioning and Disability (ICIDH-2) captures functioning at body, person, and society levels. Field trials of the Beta-2 draft are going on and finalization in the year 2001 is planned. Classification and assessment of quality of life is also being developed systematically to add to the information available about health status of individuals and populations. National classifications and linked instruments need to be fully compatible with the international ones. Hence, WHO is ready to work with APA on compatibility of DSM with ICD and ICIDH-2.

No. 55B
APA/DSM PERSPECTIVES ON INTERNATIONAL CLASSIFICATION

Michael B. First, M.D., *NY State Psychiatric Institute, 722 West 168th Street, New York, NY 10032-2603*

SUMMARY:

With the publication of ICD-10 in 1992 and DSM-IV in 1994, the international research and clinical community has been faced with a choice of two classification systems which, while closely compatible, are not identical. This presentation begins by briefly reviewing the historical relationship between the DSMs and the ICDs. Most of the differences between the two classifications stem from their divergent goals, applications, and functional constraints. For example, since the primary goal of the ICD is to provide a comprehensive classification in a wide variety of international settings, inclusion of categories in the ICD is based mostly on widespread international usage. In contrast, new diagnostic categories are included in the DSM only if there are data supporting their validity. Given the ongoing and continuing differences in underlying objectives, it is anticipated that the two systems will continue to coexist in parallel for future revisions. Although collaborative meetings between the developers of ICD-10 and DSM-IV served to minimize differences between the two classifications, a number of differences continue. The presentation concludes with a brief summary of an analysis of these differences and presents suggestions to facilitate coordination in future revision processes.

No. 55C
CHINESE PERSPECTIVE ON INTERNATIONAL CLASSIFICATION

Yuan-Fang Chen, M.D., *Shandong Medical Center, Department of Psychiatry, 49 Wen Hua Dong Road, Jinan 250014, China*

SUMMARY:

Since 1996, the Chinese Classification & Diagnostic Criteria of Mental Disorders, Third Edition (CCMD-3) task force has been carrying out a national field trial. In CCMD-3, Chinese psychiatrists continuously seek either to be in accordance with ICD-10 and DSM-IV more closely, or to sustain a nosology with Chinese cultural characteristics. Therefore, broad similarities between the ICD-10, DSM-IV, and CCMD-3 are obvious. In CCMD-3, there still are some differences. For example, the particular additions (e.g., traveling psychosis, qigong-induced mental disorders, etc), retention (e.g., unipolar mania, neurosis, hysteria, homosexuality, etc). Some disorders are used more common in forensic conditions (e.g., pathological somnolent, pathological intoxication, etc). However, if the national classifications can enhance international communication, the CCMD-3 should usefully contrast with the ICD-10, and DSM-4 as it moves toward an international nosology.

No. 55D
WORLD PSYCHIATRIC ASSOCIATION AND INTERNATIONAL COOPERATION ON PSYCHIATRIC CLASSIFICATION

Juan E. Mezzich, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, Fifth Avenue & 100th Street, Box 1093, New York, NY 10029;* Ahmed M.F. Okasha, M.D., Sing Lee, M.D., Petr Smolik, M.D.

SUMMARY:

The World Psychiatric Association (WPA) has a rich track of participation in international efforts on psychiatric diagnosis and classification. The WPA Section on Classification, Diagnostic Assessment, and Nomenclature has cooperated over many years with the World Health Organization (WHO) as illustrated by its 1985–87 consultation with national psychiatric societies for the development of the mental disorders chapter of ICD-10. Additionally, section leaders have collaborated with various WPA member societies in the preparation of psychiatric classifications variously related to ICD-10 such as APA's DSM-IV; the Chinese Classification of Mental Disorders, Third Edition (CCMD-3); the Third Cuban Glossary of Psychiatry (GC-3); and the emerging Latin American Glossary.

WPA has further contributed to the field through educational programs such as the ICD-10 Training Kit and the International Guidelines for Diagnostic Assessment. More recently, WPA collaborated with WHO on the conduction of an International Survey of Psychiatrists on the Use of ICD-10, which documented the need for greater efforts at the dissemination of and training on ICD-10, and identified recommendations for future updates and revisions of the international classification.

On the basis of this experience and working connections with WHO and with national and regional psychiatric associations, WPA is ready to participate in the development of a veritably universal and culturally informed international classification aimed at serving effectively clinical care and public health needs across the world.

No. 55E
LATIN AMERICAN VIEWS ON INTERNATIONAL CLASSIFICATION

Carlos Berganza, M.D., *San Carlos University, Department of Psychiatry, AVE Reforma 13–70, Zona 9 No. 11-B, Guatemala, 01009;* Angel A. Otero, M.D., Miguel R. Jorge, M.D.

SUMMARY:

Latin American psychiatry has a long tradition of involvement with developments in the international classifications of psychiatric disorders. This concern has been best represented by the pioneering efforts of Cuban psychiatry with the development of the Cuban Glossaries, a series of local adaptations of the latest three editions of the International Classification of Mental Disorders. Aware of problems of reliability in psychiatric diagnosis, Latin American psychiatrists embraced with enthusiasm various international efforts at systematization in psychiatric classification, epitomized by the development of DSM-III, DSM-IV, and ICD-10. Illustratively, a survey of over 500 psychiatrists in Latin America, carried out in 1994, indicated that a large majority was inclined to use standardized diagnoses in their practices.

The Cuban Glossary of Psychiatry represents a multidisciplinary effort by Cuban psychiatry to adapt the International Classification of Psychiatric Disorders to Cuban reality. Already in its third edition,

this national annotation presents important features such as being fully multiaxial and paying especial attention to patterns in the expression of psychopathology in the Cuban population.

The Latin American Glossary of Psychiatry is a project built on the experience gained by the Cubans, and attempts to reconcile the need for a universal language in psychiatric diagnosis (and its emphasis on reliability), with the need to attend to the particularities of local realities and needs in Latin America. Psychiatrists and behavioral scientists from a number of countries in Latin America are constructing this regional annotation. Important sections include reviews of Latin American culture, Latin American psychiatry, comprehensive diagnostic formulations, major classes of disorders and the particularities of their presentation in Latin America, as well as regional culture-bound syndromes. In this presentation, we review the main characteristics of these two glossaries and their prospects toward a more integrated and culturally suitable international classification.

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SYMPOSIUM 56—MANAGEMENT OF SCHIZOPHRENIA WITH COMORBID CONDITIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants should be able to recognize and manage clinically significant comorbid conditions in schizophrenia. This symposium will familiarize participants with the new approaches in assessment and treatment of these complex and treatment-refractory schizophrenia.

No. 56A
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 treatment of depression in schizophrenia from the standpoint of making a differential diagnosis of the depression-like syndrome. These differential diagnoses include 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 disappointment reactions; demoralization syndrome; the "negative symptom" syndrome; depression as an intrinsic component of decompensation either on a biological or psychological basis; "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; schizoaffective disorder; and the possibility of a coexisting affective diathesis. Treatment strategies considered in relationship to these various situations include reducing or otherwise adjusting neuroleptic dosage; changing antipsychotic agents, including the possible use of so-called atypical antipsychotics; the rational use of adjunctive tricyclic, SSRI, and MAOI antidepressant medications; the potential role of benzodiazepines, lithium, antiseizure medications, and ECT; and the importance of psychosocial approaches. An orderly path for considering diagnosis and treatment will be presented.

No. 56B
MANAGEMENT OF OBSESSIVE-COMPULSIVE SCHIZOPHRENIA

Michael Y. Hwang, M.D., *Department of Psychiatry, FDR VAMC, PO Box 100, Montrose, NY 10548;* Miklos F. Losonczy, M.D., Merton Lee, B.S., James Crichton, M.A.

SUMMARY:

While obsessive-compulsive (OC) schizophrenia has long been recognized, its clinical and pathophysiological implications remain obscure. Prior to DSM-III-R, diagnostic convention precluded simultaneously diagnosing schizophrenia and obsessive-compulsive disorder (OCD), and as a result OC schizophrenia was believed to occur only rarely. Recent epidemiological studies (e.g., the ECA study) and clinical reports, however, indicate greater comorbidity and worse prognosis in OC schizophrenia.

Recent advances suggest a common biological basis for OC phenomena found in a diverse neuropsychiatric disorders (e.g., Tourette's syndrome, autism, delusional disorder). The OC schizophrenia may be conceptualized categorically, e.g., as reflecting comorbidity, or dimensionally, e.g., as representing one of many phenomenological syndromes in schizophrenia. This presentation will examine existing clinical, epidemiological, and neurobiological evidence in proposing novel approaches for clinical management and future research. The presenters will briefly review recent clinical and neurobiological reports and discuss the diagnostic, assessment, and treatment issues.

No. 56C
COGNITIVE-FUNCTIONAL REHABILITATION IN OLDER PATIENTS

Dilip V. Jeste, M.D., *Department of Psychiatry, VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161;* Eric Granholm, Ph.D., John Mc Quaid, Ph.D., Barton W. Palmer, Ph.D., Robert K. Heaton, Ph.D., Thomas L. Patterson, Ph.D.

SUMMARY:

Conventional neuroleptics improve positive symptoms of schizophrenia, but have only marginal impact on negative symptoms and cognitive impairment. The newer atypical antipsychotics are superior to the older drugs, but their effects on negative symptoms and cognitive deficits are limited. In older patients with schizophrenia, cognitive/functional impairment is more prominent than positive symptoms. Relatively little research has been done in the past on the

assessment and treatment of cognitive/functional impairment in this population. In our Intervention Research Center, we have developed instruments to assess cognitive and functional deficits as well as management strategies for the same. We have developed relatively brief batteries for evaluating cognitive status along with scales to measure everyday functioning based on direct observation of performance (UCSD Performance-based Skills Assessment, or UPSA). We have also tested the effectiveness of a combination of cognitive/behavior therapy and social skills training for older patients with schizophrenia and found this to add to the effects of pharmacotherapy in terms of daily functioning and quality of well-being. The promising results from our preliminary studies suggest that pharmacotherapy should be combined with behavioral and psychotherapeutic management for optimal treatment of older patients with schizophrenia.

No. 56D
SCHIZOPHRENIA AND COMORBID SUBSTANCE ABUSE

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854;* David A. Smelson, Psy.D., Jonathan Krejci, Ph.D., Jill Williams, M.D., Julie Grofsik, R.N., Ilana Pinsky, Ph.D., Phyllis Reilly, M.A.

SUMMARY:

Most individuals with schizophrenia use alcohol, nicotine, or other drugs. Substance use disorders are common and the combination presents special challenges for diagnosis and treatment. This comorbidity may reflect self-medication, as well as a biological susceptibility to both disorders. Dual-diagnosis treatment is more effective when traditional substance abuse and mental health treatment approaches are integrated and address differences in severity of both illnesses. The presentation will discuss critical treatment matching factors, including motivation. Strategies to better engage the low-motivation patient into treatment will be reviewed, including how to modify traditional motivational enhancement therapy, 12-Step, and relapse prevention. The progressive stages of dual recovery will be reviewed, including different models. The recommended psychotherapeutic approach varies according to the stage of recovery. Polysubstance abuse, dual diagnosis, and other compulsive activities are often complicating factors that require adaptations in the treatment. Pharmacotherapy strategies will be also be reviewed, including the psychiatric and addiction medications.

No. 56E
SCHIZOPHRENIA AND PERSISTENT AGGRESSIVE BEHAVIOR

Leslie L. Citrome, M.D., *Clinical Research, Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962;* 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 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.

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SYMPOSIUM 57—NEW RESEARCH ON DELUSIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have an overview of innovative American and British research on delusions, emphasizing the value of viewing delusions as multidimensional constructs, with delusionality measured on a continuum.

No. 57A
THE CONTINUUM BETWEEN OBSESSIONS AND DELUSIONS IN OCD AND BDD

Jane L. Eisen, M.D., *Butler Hospital, Brown University, 345 Blackstone Boulevard, Providence, RI 02906;* Katharine A. Phillips, M.D., Steven A. Rasmussen, M.D.

SUMMARY:

The relationship between obsessions and delusions has important nosologic and clinical implications in psychiatry. Although obsessions and delusions are clearly defined and differentiated in DSM-IV, recent investigations have suggested that the boundary between obsessions and delusions may not be dichotomous, but rather, obsessions and delusions may exist on a continuum of insight. Interest in the interface between obsessions and delusions is also reflected by the term "schizo-obsessive subtype," which has been used to describe several distinct groups of patients including patients with the delusional variant of obsessive compulsive disorder (OCD) as well as patients with both OCD and schizophrenia. We will present findings concerning the frequency of the delusional variants of OCD and body dysmorphic disorder (BDD) using the Brown Assessment of Beliefs Scale (BABS), a semi-structured, reliable, and valid rating scale designed to assess delusionality regardless of diagnosis. These

findings suggest that, while the delusional variant of OCD is extremely rare, delusional BDD is more frequent. We will describe the results of two studies that have assessed the relationship between degree of delusionality and response to serotonin reuptake inhibitors in patients with OCD or BDD. These preliminary data suggest that patients with the delusional variant of BDD and OCD patients with poor insight may respond well to SRIs alone. The implications of these findings as well as the relationship between obsessions and delusions in patients with schizophrenia will be discussed.

No. 57B
ARE DELUSIONS ON A CONTINUUM?

Emmanuelle Peters, Ph.D., *Department of Psychology, Institute of Psychiatry, Decrespigny Park, London SE58AF, United Kingdom;* Samantha Day, R.S.C., Philip A. Garety, Ph.D.

SUMMARY:

Work into schizotypy suggests that symptoms of schizophrenia, such as delusional beliefs, are at the extreme end of a continuum, which ranges from healthy functioning, through eccentricity, to florid psychosis. Garety & Hemsley (1994) have also highlighted delusions as multidimensional phenomena rather than all-or-nothing events. The PDI (Peters et al. Delusions Inventory) is a questionnaire measuring delusional ideation in the normal population that incorporates dimensions of distress, preoccupation, and conviction. The psychometrics of the PDI will be briefly presented. A number of studies comparing "normal," New Religious Movements (NRMs), and deluded people on the PDI will be reported. The overall findings support the notion that there is a continuity of function between normality and psychosis, with considerable overlap in the range of scores obtained in the three groups. Secondly, the results support the multidimensionality of delusions, with the groups being more clearly differentiated by their scores on the distress and preoccupation dimensions. These data call into question our existing diagnostic criteria for delusions, which emphasize unduly the content or "bizarreness" of beliefs to classify them as pathological. This pattern suggests that form may be more important than content: it is not *what* you believe, it is *how* you believe it.

No. 57C
DELUSIONS: MORE FLUID THAN FIXED

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue, North, Worcester, MA 01655*

SUMMARY:

At least since the influential work of Karl Jaspers, delusions have been viewed as fixed thoughts, relatively insusceptible to alteration by confrontation with reality or other circumstances. Clinicians working with more acute populations, however, see more plasticity in their patients' delusions than this traditional description would suggest. This presentation examines the changes seen in delusions over time in a sample of delusional patients drawn from the MacArthur Violence Risk Assessment Study. A total of 1,136 acutely hospitalized psychiatric patients were evaluated soon after admission, then reinterviewed five times during the subsequent one year after hospital discharge. Delusional thinking was assessed with the MacArthur Maudsley Delusions Assessment Scale, a multidimensional measure of delusions. Three hundred twenty-eight subjects were delusional at baseline, with 466 delusional at some point during the study. The follow-up interviews revealed substantial flux in the presence or absence of delusions as well as the nature of the dominant delusion and the quality of the patients' delusions, even when the content remained unchanged. These data reinforce the view of delusions as more dynamic than previously envisioned, with implications for new approaches to their treatment.

No. 57D
DIMENSIONS OF DELUSIONS: A 15-YEAR FOLLOW-UP

Martin Harrow, Ph.D., *Department of Psychiatry, University of Illinois, 1601 West Taylor Street, M/C 912, Chicago, IL 60612;* Ellen S. Herbener, Ph.D., Anne V. Shanklin, B.A., Thomas H. Jobe, M.D., Francine Rattenbury, Ph.D., Kalman J. Kaplan, Ph.D.

SUMMARY:

Goal: There are large gaps in our understanding of psychotic symptoms. The present research (1) attempts to advance knowledge of psychosis by studying the influence of three different dimensions of delusions on functioning and adjustment over time in schizophrenia, and (2) investigates whether, for nonschizophrenic patients, the occurrence of delusions represents a one-time aberration or is a trait-like feature which recurs over time.

Method: As part of the Chicago Followup Study, 211 patients, including 58 schizophrenics and 61 schizoaffective and psychotic affective disorders were assessed five times over 15 years for psychosis, affective symptoms, psychosocial functioning, and medication treatment. In addition, major dimensions of psychosis were studied including extent of patients' belief conviction about their delusions, self-monitoring ability, and extent of emotional commitment to their delusions.

Results: (1) A large percent of initially psychotic affective disorders showed subsequent psychotic episodes years later. (2) Patients with poor self-monitoring concerning their delusions were more asocial ($p < .05$). (3) Schizophrenic and affectively disordered patients with high emotional commitment to their delusions were significantly more likely to be rehospitalized ($p < .05$).

Significance: Analysis of separate dimensions of delusions over time, especially the extent of emotional commitment to one's delusions, indicates that these dimensions are related to poorer post-hospital functioning and adjustment, with many of these relationships cutting across diagnostic groups. Delusions tend to recur for both schizophrenia and affective disorders with initial psychosis. Affective disorders showed a trait-like vulnerability to recurrent delusions over the 15-year period.

No. 57E
SOCIAL COGNITION AND PARANOID DELUSIONS

Richard P. Bentall, Ph.D., *Department of Psychology, University of Manchester, Oxford Road, Manchester M139PL, United Kingdom*

SUMMARY:

Paranoid delusions are associated with an abnormal attributional style, in which negative events are excessively attributed to external, global, and stable causes. Bentall et al. (1994) have argued that these attributions serve the function of minimizing discrepancies between self-representations and self-ideals. However, the origins of this defensive style have not been adequately explained. Recent studies conducted to address this question will be described, including:

(1) A pilot functional magnetic resonance study, in which defensive attributions in normal people were associated with activation of specific brain regions.

(2) A cognitive study in which predictions about the response time required to generate attributions were tested. It was found that, in both patients and normal individuals, the time to generate internal attributions was related to the accessibility of relevant self-representations, suggesting a close link between the attributional system and the self system.

(3) A study in which self-discrepancies and reports of relationships with the family of origin of paranoid were assessed in remitted paranoid and normal participants. The main findings were that both currently ill and remitted paranoid patients reported adverse relationships with their parents, which extended back until early childhood.

The implications of these findings for cognitive-behavioral interventions will be discussed.

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SYMPOSIUM 58—PRODROMAL INTERVENTION TO FIRST-EPISODE PSYCHOSIS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the signs of being at high risk for psychosis and become familiar with ways of assessing and handling people in a prodromal phase.

No. 58A
EARLY DETECTION AND INTERVENTION: RATIONALE

Thomas H. McGlashan, M.D., *Yale Psychiatric Institute, 184 Liberty Street, New Haven, CT 06519;* Jan O. Johannessen, 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 premorbid, prodromal, and onset 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 can be retained or reversed despite deficit processes. This includes the putative attenuation of the severity of schizophrenia throughout the 20th century, retrospective and prospective linkage of earlier neuroleptic treatment and better long-term outcome, and data from programs designed to intervene in the prodromal phase of the disorder. While the evidence to date does not demonstrate that early intervention with known treatments can change the natural history of schizophrenia, it is suggestive enough (for both biological and psychosocial treatments) to support active clinical investigation. Focusing on the prodromal phase of schizophrenia also offers the possibility of identifying at-risk patients before onset and of designing clinical trials of treatment with a preventive aim.

No. 58B
DESCRIPTION AND ASSESSMENT OF PRODROMAL STATES

Tandy J. Miller, Ph.D., *Yale Psychiatric Institute, 184 Liberty Street, New Haven, CT 06519;* Scott W. Woods, M.D., Larry Davidson, Ph.D., Ralph E. Hoffman, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

New strategies are being tested for intervening before onset in schizophrenia, but a prerequisite is the ability to diagnose and rate the severity of the prodrome in people who are at risk for psychosis. Existing diagnostic and severity instruments have limitations that will be discussed.

Methods: Using historical descriptions of prodromal states, our group recently developed the SIPS (Structured Interview for Prodromal States) and the SOPS (Scale of Prodromal Symptoms). The SOPS was developed to provide more breadth and detail within the lower, pre-psychotic ranges of severity than earlier measures and consists of positive, negative, disorganized, and general symptom items.

Results: During the recently completed SOPS scale development phase, SOPS interviews were conducted by two or more raters in 20 untreated subjects undergoing evaluation for suspected prodromal states. The positive item anchors were finalized first, and during the course of the 20 interviews, anchors for the other items were developed. The inter-rater ICC for the positive symptom subscale was .79, with $p < .003$. For test-retest reliability, $N = 15$ prodromal positive subjects were rated by the same rater at two consecutive visits. The ICC for the total score was .83, $p < .002$. For internal consistency, Cronbach's alpha was calculated on all 19 items at visit 1 and was .85. Correlations between SOPS total scores and other measures of psychosis and functioning demonstrate preliminary evidence of convergent validity, while lower correlations between the SOPS and the Young Mania Rating Scale suggest evidence for discrimination validity. Patients who converted to psychosis had slightly higher scores at baseline and patients who remitted had lower scores.

Discussion: Preliminary data suggest that the presence and severity of prodromal states can be measured with adequate reliability. Illustrative cases will be described qualitatively.

No. 58C
HELP-SEEKING IN FAMILIES OF INDIVIDUALS PRODROMAL TO PSYCHOSIS

Larry Davidson, Ph.D., *Department of Psychiatry, Yale University, CMHC 25 Park Street, New Haven, CT 06519;* Cheryl Corcoran, M.D., Connie Nikou, Psy.D., Tandy J. Miller, Ph.D., Scott W. Woods, M.D., Ralph E. Hoffman, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

Purpose: One of the major challenges encountered in efforts to intervene early in psychosis is the identification of individuals at the earliest stages of the disease. One of the primary contexts for early identification is the family. This presentation will report the preliminary findings of a study of help-seeking behaviors in families of individuals identified as at risk for psychosis with those who have had a first episode.

Methods include both quantitative measures of family burden, social support, efficacy, stigma, and coping, and qualitative, narrative interviews of family experiences with their loved ones, all conducted with a family member.

Results include consistent themes in family narratives leading up to onset and first diagnosis of psychosis that may impede help-seeking behavior. Families perceive a change in their child and describe an initial sense of alienation, but they attribute this at first to adolescence. They grapple with possible explanations for their child's behavior such as Agent Orange, x-rays, vodoo, and "hanging out with the wrong crowd," until the evidence accumulates to a sufficient degree to bring about a turning point. When the desperation and helplessness become unbearable, families then turn to others for help, seeking assistance first from clergy, family friends, or primary care providers prior to psychiatric professionals.

Implications of these findings for identification and early intervention efforts are outlined.

No. 58D
NEUROPSYCHOLOGICAL MARKERS OF SUSCEPTIBILITY

Keith A. Hawkins, Psy.D., *Department of Psychiatry, Yale University, CMHC Room 530 34 Park Street, New Haven, CT 06519;* Ralph E. Hoffman, M.D., A. Jocelyn Ritchie, Ph.D.

SUMMARY:

The neuropsychological deficiencies associated with schizophrenia are relatively independent of positive symptoms and acute states, are apparent early in the illness, and are found in attenuated form in relatives. Impaired attention and other neurobehavioral deficits are found in samples of children at risk for schizophrenia, where they appear to be related to a genetic liability to schizophrenia (rather than affective disorders). Children not at risk on familial grounds who later develop the illness have also been reported to display neuropsychological deficits. Neuropsychological deficits are largely non-overlapping with prodromal clinical signs, suggesting that these two realms of vulnerability may prove to be additive predictors of later illness. As a group, Yale PRIME subjects at baseline exhibit neuropsychological weaknesses, that lie between those reported by Goldberg et al 1990 for the affected siblings in a sample of monozygotic twins discordant for schizophrenia and their well siblings. Given that the PRIME sample likely includes both true prodromal subjects and others who will not develop schizophrenia (and who could be disproportionately responsible for better performances), these data lend support to the idea that, among subjects showing prodromal clinical signs, neuropsychological features could facilitate the identification of true prodromal states. Consistent with this, the earliest converters have tended to display the greatest deficiencies at study entry. Areas of weakness have included smell identification, IQ, and difficulties mastering an object alternation task.

No. 58E
NOVEL EARLY INTERVENTIONS FOR PRODROMAL STATES

Scott W. Woods, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven, CT 06519;* Bruce E. Wexler, M.D., Tandy J. Miller, Ph.D., Keith A. Hawkins, Psy.D., Walid Abi-Saab, M.D., Larry Davidson, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

The promise of early detection and intervention offers the possibility to change schizophrenia from a condition that is generally chronically disabling to one that leads to recovery. In order to realize this promise fully, novel early intervention strategies need to be developed and tested.

Methods: Our group is currently piloting novel intervention strategies for persons at risk for schizophrenia. Eligible subjects will be randomized to one of three conditions: the glutamate antagonizing medication lamotrigine, placebo administered in double-blind fashion, or neurocognitive enhancement training (NET).

Results: A pilot early first-episode subject has thus far participated in NET for five sessions. At baseline he showed a specific deficit in language-related working memory. Scores on this test have improved from 61% to 83% with the NET. Further results will be presented.

Discussion: Candidate early intervention/prevention strategies should be selected from among those that target current theories about the mechanisms of disease progression in the prodromal phase of schizophrenia, as well as from interventions known to be effective in established cases of schizophrenia. The most effective treatment to prevent disease progression could potentially be one that has little effect once illness has reached chronicity.

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SYMPOSIUM 59—PSYCHIATRIC ASPECTS OF OBESITY: UPDATE 2000

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to demonstrate an understanding of (1) the unique challenges in treating children and adolescents with obesity, (2) the effects of psychotropic medications on weight, (3) recent advances in the treatment of binge eating disorder, (4) eating behavior differences.

No. 59A
REVIEW OF CHILD AND ADOLESCENT OBESITY

Lisa A. Kotler, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive Unit #74, New York, NY 10032*

SUMMARY:

More than one out of 10 children and adolescents in the United States are obese and one out of four are at serious risk of becoming obese by adulthood. While recognized by health professionals as a major health problem, obesity is difficult to treat, and thus rarely receives the attention given to other more easily treated childhood disorders. In addition, children and adolescents with obesity present a unique opportunity in this field as they have the potential for linear growth and thus present the possibility of weight maintenance rather than weight loss, which is necessary in adults with obesity. They

also present the challenge of working with a patient, his or her parents, and an entire family system.

Unlike in adults, there are no universally accepted criteria for the definitions of childhood and adult obesity. However, the rising prevalence and increasingly recognized risk of morbidity make it important for the mental health professional to be well informed about recent developments in the field of childhood and adolescent obesity. This paper will highlight recent research in the areas of prevalence and health consequences of childhood and adolescent obesity, review current treatments available for obesity, and propose a potential collaborating role for the mental health professional in its treatment. It will also review the experience of a child psychiatrist participating in a multidisciplinary obesity treatment clinic in an innercity academic medical center.

No. 59B
NOVEL ANTIPSYCHOTIC MEDICATIONS AND WEIGHT GAIN

Michael J. Devlin, M.D., *Clinical Psychopharmacology, NY State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032-2603;* Merrill Simpson, Ph.D., B. Timothy Walsh, M.D.

SUMMARY:

While novel antipsychotic medications have several advantages compared with typical antipsychotics, weight gain is a particularly problematic side effect. Weight gain is often associated with medical risks and is a frequent cause of nonadherence to treatment recommendations. Relatively little is yet known about the mechanism by which these medications lead to weight gain or the relative potency of particular medications in promoting weight gain.

This presentation will review current knowledge concerning the relative risks of weight gain with various antipsychotic medications and the physiological alterations that lead to weight gain. We will also review the results of a retrospective chart review of patients treated with novel antipsychotic medications on an inpatient unit. Patients in this study were treated with a novel antipsychotic medication following either a medication-free period or a period of treatment with a typical antipsychotic. This allows us to compare the rate of weight change, under controlled inpatient conditions, on novel antipsychotic vs. typical antipsychotic and novel antipsychotic vs. no medication. Finally, we will discuss pilot studies of eating behavior in patients with schizophrenia at baseline and following treatment with novel antipsychotic medications. Implications for treatment and prevention of weight gain in these patients will be discussed.

No. 59C
TREATMENT FOR OBESE PATIENTS WITH BINGE EATING DISORDER

Denise E. Wilfley, Ph.D., *Department of Psychology, SDSU-UCSD, 6363 Alvarado Court, Suite 100, San Diego, CA 92120*

SUMMARY:

As many as 30% of obese individuals seeking weight loss treatment suffer from binge eating disorder (BED). Obesity is associated with substantial health risk, with or without concomitant BED. However, obese individuals with BED endure additional complications, including recurrent binge eating with its attendant psychological distress, more chaotic eating habits, greater concern about body shape and weight, and higher rates of psychiatric comorbidity. There are two currently accepted approaches to treat BED: specialty treatments that target the eating disorder and behavioral weight loss interventions that target obesity. Specialty treatments that target binge eating have consistently documented short- and long-term success with reducing binge eating and associated psychopathology in controlled trials, but specialty treatments only minimally impact weight. Behavioral weight loss interventions produce clinically significant short-term weight loss and reductions in binge eating among obese BED individuals, but the long-term impact on binge eating, weight, and other eating disorder psychopathology remains unclear. This presentation will review the state-of-the-science in treatment research for BED, with a focus on the implications of this research for clinical practice.

No. 59D
EATING BEHAVIOR IN OBESE BINGE AND NONBINGE EATERS

B. Timothy Walsh, M.D., *NY State Psychiatric Institute, 1051 Riverside Drive, Unit #98, New York, NY 10032-2603;* Janet L. Guss, B.A., Harry R. Kissileff, Ph.D., Michael J. Devlin, M.D.

SUMMARY:

Binge eating, i.e., the episodic uncontrolled consumption of large amounts of food, is the most thoroughly described abnormal eating pattern among the obese. Obese patients with binge eating disorder (BED) are known to eat larger amounts, both in binge and non-binge meals, than equally overweight non-binge eaters. However, the association between degree of obesity and amount consumed by patients with BED has not been systematically studied.

We studied five groups of patients: morbidly obese (body mass index [BMI] >38 kg/m^2) and moderately obese (BMI 28–32 kg/m^2) women with BED, morbidly and moderately obese women without BED, and normal weight controls. Each subject consumed one binge and one non-binge meal. Subjects with BED consumed more than subjects without BED in both meals. Intake in the binge meal, but not the non-binge meal, was significantly correlated with BMI among subjects with BED. In contrast, the amount consumed by subjects without BED did not differ among different weight groups in either meal. These findings confirm that there are disturbances in satiety mechanisms in patients with BED and suggest that these disturbances are more severe in morbidly obese patients. Mechanisms that may account for the observed differences between BED and non-BED subjects will be explored.

No. 59E
PSYCHIATRIC ASPECTS OF OBESITY SURGERY

L.K. George Hsu, M.D., *Department of Psychiatry, New England Medical Center, 750 Washington St. N.E. MC #100, Boston, MA 02111-1526*

SUMMARY:

Severe obesity, defined as body mass index ≥ 40 kg/m^2 and estimated to affect about two million Americans, is associated with increased health and functional impairment and higher mortality. Conventional weight loss treatments are usually ineffective. Surgical treatments consisting of gastric banding or bypass are effective in causing weight loss, although some weight regain is common after one year. Factors associated with weight loss and weight regain after surgical treatments have not been well studied, but disturbances in eating behaviors, changes in energy metabolism, and individual psychosocial characteristics have been implicated. This presentation will review data on the outcome of obesity surgery; studies conducted to determine the mechanisms underlying weight loss and regain; and preliminary data on a longitudinal study that examines changes in eating attitudes and behaviors, energy metabolism and psychosocial functioning after gastric bypass. Issues such as whether symptom substitution occurs after weight loss and whether outcome can be improved by better subject selection will be discussed.

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SYMPOSIUM 60—INTERACTIONS BETWEEN PERSONALITY AND MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusions of this symposium, the participant should be able to identify personality traits, dysfunctions, and disorders that are relevant for the comprehension, the diagnosis, and the treatment of the main mood disorders.

No. 60A
PERSONALITY TRAITS AFFECTING MOOD DISORDER OUTCOME

Michael H. Stone, M.D., *Department of Psychiatry, Columbia College, 225 Central Park West, #114, New York, NY 10024-6027*

SUMMARY:

There is diversity of opinion regarding the impact of personality disorder upon the treatment response and long-term course of depression. Some suggest that premorbid personality traits predict treatment response (Heerlein). Others conclude that personality disorder does not predict depressive relapse (Paykel), or that Cluster A comorbidity adversely affected the course of depression, while Cluster B comorbidity interacted reciprocally with depression each aggravating the other (Daniel Klein). As to suicide, comorbidity of major depression heightened the risk in borderline [BPD] patients (Isometsä AJP '96; Stone '90).

The present pilot study concerns 22 patients with major depression. 14 were comorbid for BPD; 8 for other PDs (schizotypal-2, obs.-compulsive-2; dependent-1; avoidant-1; depressive/self-defeating-2). Patients were evaluated via a 20-item trait-scale focusing on spirituality-vs.-narcissism (Stone 2000), emphasizing trait-pairs viz.: humility vs false pride; resignation vs. bitterness; serene vs tormented; self-transcendent vs. constricted, etc. Scored on a 7-point scale, the BPD patients averaged 69.4 (28–119); those with other PDs, 99.3 (71–128). A cut-off of 80 correctly identified 10/14 of BPDs and 6/8 of the others. The three BPDs with the lowest scores (28, 28, 31) consisted of a completed suicide and two with antisocial traits. The depressives with low "spirituality" had a more unfavorable treatment course, and appeared more at risk for suicidal acts.

No. 60B
HYPERTHYMIC AND CYCLOTHYMIC DEPRESSIONS

Hagop S. Akiskal, M.D., *Department of Psychiatry, VA Medical Center, 3350 LaJolla Village Dr. # 116A, San Diego, CA 92161*

SUMMARY:

Current evidence indicates that a broad spectrum of bipolar disorders exists in both the community and clinical populations. Rather than mania, hypomania is a defining characteristic of many of these "soft" expressions of bipolarity. In addition, work conducted by the author and his collaborators in Memphis, Pisa, Paris, and San Diego indicates that major depressions arising from a cyclothymic temperamental base also belong to the bipolar spectrum. Furthermore, a stable level of hypomanic traits known as hyperthymic temperament also imparts a bipolar feature to major depressions. The evidence for these contentions comes from family studies that demonstrate that cyclothymic and hyperthymic depressions have basically the same rates of familial bipolarity as bipolar II. In addition, age at onset and course characteristics, as well as certain clinical features argue for considering these depressions as being different from more ordinary unipolars, which tend to have anxious temperaments. These considerations suggest that the interface of unipolar and bipolar disorders constitutes a fertile soil for soft bipolar expression, which considerably expands the spectrum of bipolarity and to some extent shrinks the unipolar universe.

No. 60C
PERSONALITY AND TREATMENT RESPONSE IN MAJOR DEPRESSION

Andres Heerlein, M.D., *Department of Psychiatry, University of Chile, AV. La Paz 1003, Santiago, Chile;* Paul Richter, Ph.D., Guillermo Gabler, M.D., Cristian Chaparro, M.D.

SUMMARY:

Introduction: For decades, researchers have debated whether major depression is one homogenous disorder differing only in degrees of severity or a more complicated illness that can be defined by specific subtypes. Subtyping a nosological entity facilitates prediction regarding course and prognosis of the underlying disorder. Premorbid personality traits have been found to be strong predictors of treatment response in different psychiatric disorders.

Method: A total of 51 outpatients of the Clinics of the Universidad de Chile with DSM-IV criteria for a major depressive episode and no other comorbid entity were included in this six-week prospective study. Personality traits were assessed with a clinical checklist at the first interview and the BIAQ. All patients received combined treatment with SSRIs and IPT. Treatment response was assessed after six weeks according to CGI and HAM-D.

Results: Stability, self-esteem, perfectionism, extraversion, calmness, rigidity, and lack of fantasy are predictors of a good treatment response, while premorbid neuroticism, impulsivity, negativism, depressiviness, anxiety, dependency, hostility, infantilism, and irritability are predictors of a bad treatment response.

Conclusions: Premorbid personality traits are strong predictors of treatment response in major depression, suggesting the possibility of a nosological differentiation of two main subtypes of depressive patients.

No. 60D
PERFECTIONISM, NORMAL ORIENTATION AND RIGIDITY IN DEPRESSIVE PATIENTS: CONSEQUENCES FOR COURSE AND THERAPY RESPONSE

Christoph Mundt, M.D., *Department of Psychiatry, Psychiatric University Hospital., Voss-Str 4, Heidelberg 69115, Germany;* Matthias Backenstrass, Ph.D., Klaus Kronmueller, M.D., Peter Fiedler, Ph.D.

SUMMARY:

Conscientiousness and rigidity along with perfectionism and norm orientation have been found to be salient personality features in major depression in patients by several studies. These features are main components of the "typus melancholicus" (t.m.) intermorbid personality of depressives. In a series of clinical studies the Heidelberg our group found the following results concerning the "typus melancholicus" personality: the prevalence among clinical samples with severe unipolar major depression is about 50% for salient t.m. features and 25% with marginal t.m. features. Factorial analysis of 264 patient-assessments revealed four factors of t.m., with dependency being the most powerful one, followed by ambiguity intolerance, perfectionism, and norm orientation. The two-year course shows better outcome for the t.m. personalities, as in one additional study. This and some other findings suggest that t.m. is not a premorbid causative factor of depression, but rather a coping attitude. Positive response to cognitive behavior therapy (CBT) is not related to t.m. features specifically. However, improvement of negative mood regulation under CBT is predicted by autonomy and frustration tolerance, whereas maintenance of dysfunctional attitudes is predicted by neuroticism, schizoidia, and sociotropy; the latter one also correlating to nonresponse of subjective and objective depressive symptoms.

No. 60E
DEPRESSION AND PERSONALITY DISORDERS OVER TIME

Daniel N. Klein, Ph.D., *Department of Psychology, Suny Stony Brook, Stony Brook, NY 11794-2500;* Joseph E. Schwartz, Ph.D.

SUMMARY:

While there are high rates of personality disorders in patients with depressive disorders, little is known about the relationship between these two groups of conditions over time. We examined the longitudinal relationship between depression and personality disorders in a prospective longitudinal study.

Subjects were 97 outpatients with DSM-III-R dysthymic disorder. The patients were evaluated three times, at 30-month intervals, over the course of five years using semi-structured diagnostic interviews and rating scales for Axis I and II conditions. Structural equation modeling techniques were employed to compare three general models: (1) other than being correlated at baseline, levels of depression and personality disorder are not associated over time; (2) there are contemporaneous (or cross-sectional) associations between level of depression and personality disorder; and (3) there are sequential (or cross-lagged) relationships between level of depression and personality disorder. In addition, given the existence of contemporaneous or sequential relationships over time, we tested the direction of the effects.

The contemporaneous effects model provided the best fit to the data for cluster A, B, and C personality disorders. For clusters A and C, the effects were unidirectional, with level of personality disorder influencing level of depression, but not vice versa. For cluster B, there were reciprocal effects between levels of personality disorder and depression.

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SYMPOSIUM 61—ADVANCES IN ETIOLOGY, DIAGNOSIS, TREATMENT AND OUTCOME IN MAJOR DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have knowledge regarding new findings in the etiology, diagnosis, treatment, and outcome of major depression so as to better manage the clinical care of the depressed patient.

No. 61A
ACUTE PHARMACOLOGICAL TREATMENT OF DEPRESSION

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

The optimization of treatment adherence in depression is typically based on efforts aimed at enhancing education (about illness and medications' side effects), communication, and collaboration between clinicians and patients. In addition, the choice of well-tolerated antidepressants is a major contributing factor to improved compliance, since side effects may impact adversely quality of life and response. Newer antidepressants appear to have an improved side-effect profile compared with the older drugs such as TCAs and MAOIs. On the other hand, it is important to consider that rates of specific adverse events may vary across classes of newer agents and across agents within the same class. The success of the pharmacological treatment also depends on its adequacy of dose and duration. Although most patients require six to 12 weeks to exhibit full response, minimal improvement after four to five weeks of treatment tends to lead to a very small chance of response. Other important steps toward optimization of treatment outcome consist of ensuring adequacy of follow-up and of proactively detecting and managing side effects that emerge during antidepressant treatment. Finally, since 31% to 49% of patients are partial or nonresponders to antidepressant treatment, clinicians have been using a variety of treatment strategies, including switching, augmentation, and combination, with some success. However, there is a great need for systematic studies in this area to allow the development of rational algorithms.

No. 61B
BIOLOGICAL BASIS FOR MAJOR DEPRESSIVE ILLNESS

Norman Sussman, M.D., *Department of Psychiatry, NYU School of Medicine, 1501 East 58th St. Suite 204, New York, NY 10155*

SUMMARY:

Over the past 40 years, many hypotheses regarding the biological mechanisms of mood disorders have been proposed. In part these mechanisms developed from observations on the clinical effects of drugs and somatic therapies in humans as well as drug-induced behavioral changes in animals.

The purpose of this paper is to discuss the various biological theories of depression including neurotransmitter theory (norepinephrine, serotonin, dopamine), receptor theory, issues concerning

second messengers, membrane and cation hypothesis, biological rhythms and sleep physiology, neuroendocrine findings, as well as immunological and genetic theories. The interaction of many of these theories (neurotransmitters interacting with neuroendocrine, and circadian rhythms) will be discussed. In addition, how antidepressant medications affect the pathophysiology of the above hypotheses (for example down-regulation of post-synaptic receptors) will be discussed. Changes in the above mechanisms upon clinical recovery where applicable will be discussed.

No. 61C
PSYCHOTHERAPIES FOR DEPRESSION

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical College, 525 East 68th Street, Room 1322, New York, NY 10021*

SUMMARY:

Depressive disorders rank among the most highly prevalent psychiatric disorders. They are significantly debilitating in the distress they cause as well as in their impairment of social and vocational functioning. Pharmacotherapy provides one efficacious avenue of treatment. Specific psychotherapies, in particular interpersonal psychotherapy (IPT) and cognitive-behavioral therapy (CBT), have also demonstrated acute efficacy in a series of randomized controlled studies. IPT has also been shown to have prophylactic efficacy as a maintenance treatment in two studies. Recent studies are now extending the testing of these therapies to chronic depression as well. This presentation will review key recent studies on the psychotherapy of mood disorders.

No. 61D
ANTIDEPRESSANT PROPHYLAXIS IN A NATURALISTIC CLINICAL SETTING

Wieslawa Tomaszewska, M.D., *Department of Psychiatry, Cabrini Medical Center, 312 East 30th Street, New York, NY 10010;* Eric D. Peselow, M.D., Ronald R. Fieve, M.D.

SUMMARY:

The utility of antidepressants in the long-term treatment of depression has been established in doubleblind studies. One of the problems with the double-blind studies is their generalizability to clinical practice. For instance double-blind studies involving lithium show a 70% success rate over one to two years but in naturalistic clinics studies have shown only a 40% response to lithium. Naturalistic studies regarding efficacy of antidepressants have been very scarce.

A total of 663 patients who were treated for depression and recovered from depression—322 on tricyclics, 80 on MAOIs, 261 patients on SSRIs, and 57 patients on no treatment were followed from their seventh month of euthymic mood until one of three outcomes—termination well (remaining well until Oct. 1, 1998), dropout, and relapse. Patients were followed over a six-month to 12-year period (average followup time was 4.8 years). Probabilities of remaining free of a subsequent depressive episode for each drug class were assessed via a survival analysis.

Overall 39% of the depressed sample had a known depressive episode despite receiving medication as compared with 81% on no treatment. The probability of remaining free of a depressive episode while on antidepressants was 86% at one year, 62% at two years, and 39% at five years. There was no difference between the three classes of antidepressants with respect to relapse rate.

In conclusion, in this naturalistic setting, long-term treatment with antidepressants while more efficacious than no preventive treatment still yields high rates of relapse. Where available correlations between initial clinical symptoms, personality traits, and cognitive distortion and long-term course will be presented.

No. 61E
RECENT ADVANCES IN SCREENING FOR DEPRESSIVE DISORDERS

Waguih W. Ishak, M.D., *Department of Psychiatry, NYU School of Medicine, 550 First Avenue, #16-X, New York, NY 10016;* Eric D. Peselow, M.D., Benjamin J. Sadock, M.D., Michael Z. Sobel, M.D.

SUMMARY:

Screening for depressive symptoms is gaining more importance as more information is becoming available on prevalence, morbidity, and mortality and delays in treatment initiation. In the Epidemiologic Catchment Area (ECA) study, the one-year prevalence of unipolar major depression in adults was found to be 5.0%. In the National Comorbidity Study the one-year prevalence of major depression is 10.3%. Moreover, 55% of individuals with a depressive disorder have not had treatment for the disorder in the previous 12 months, according to ECA study. Possible reasons include under-recognition of depression on the part of health professionals and patients, and problems with cost/access to mental health care and stigma. Online Internet-based screening for depression might help in addressing some of the above factors. The Online Depression Screening Test (ODST) located at www.med.nyu.edu/Psych/screens/depres.html enables users at the privacy of their own locale, to take a user-friendly, DSM-IV-derived 10-questions test, to detect the presence of depressive symptoms and guide the user to information on depression and referral resources. Preliminary studies of ODST showed high correlation with standard depression measures such as HAM-D and BDI in depressed patients.

This presentation will highlight the crucial role of screening for depression in addition to the use of technological advances such as the Internet in addressing delays in seeking treatment and providing information for patients and families.

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SYMPOSIUM 62—ENHANCING THE PHYSICIAN-PATIENT RELATIONSHIP

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to describe the many ways in which the status of the physician-patient relationship can be enhanced.

No. 62A
EDUCATION AND THE PHYSICIAN-PATIENT RELATIONSHIP

Carolyn B. Robinowitz, M.D., Dean, *School of Medicine, Georgetown University, 3900 Reservoir Road, N.W., Washington, DC 20007-2197*

SUMMARY:

Clinicians and psychiatrists in particular, have recognized the importance of the physician-patient relationship, its role in improving patient compliance, satisfaction and outcome. Increasing complexities of medical care demand a strong physician patient relationship. Unfortunately, forces ranging from legislators to insurers and other third parties have stepped between the physician and the patient, making it difficult for the physician to function in the patients best interest, influencing not only the patients perception of care, but actual outcome.

Many medical schools have expanded formal curricula to include specific courses on this relationship. Content includes didactic material, as well as experiential hands-on practical sessions. Simulated patients portray the symptoms of specific illnesses, patients; response to illness, as well as underlying personality organization. The focus on professionalism has emphasized ethics, to address dilemmas brought by the changes in health care.

Students, trainees, and physicians experience a "hidden curriculum." This term represents the informal but frequent modeling (how patients are actually treated; conversations away from the bedside, e.g., nursing station or operating room; and what behaviors seem really to be valued). It also includes the impact of economics, interference with the physician patient relationship and other constraints on actual care.

This presentation will describe approaches to teaching, supporting and enhancing professionalism and the physician patient relationship, including components of successful programs and their impact on patient care, as well as provide recommendations for future work.

No. 62B
FROM THE PERSPECTIVE OF THE PSYCHIATRIC CLINICIAN

John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, 3rd floor, Rochester, NY 14608*

SUMMARY:

Psychiatric guidelines have become increasingly important in the practice of medicine. The APA has published 10 practice guidelines (and two revisions) over the past six years and four more guidelines are in the development phase. A key concept which has evolved in the APA guidelines is "psychiatric management." This includes a number of general and specific interventions which are crucial to good patient care. A key part of psychiatric management is the physician/patient relationship. Psychiatric management will be described in detail both in general and for two specific disorders. The historical development of the physician/patient relationship will be described, and implications for practice in the 21st Century will be reviewed.

No. 62C
MEDICAL ETHIC'S ENHANCEMENT OF THE PHYSICIAN-PATIENT RELATIONSHIP

Roger Peele, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue 8th floor, Washington, DC 20037-2396*

SUMMARY:

Medical ethics has and will remain a major foundation to enhance the physician-patient relationship through bringing competence, compassion, respect, honesty, confidentiality, and informed consent to that relationship. To the degree that financial incentives in health care may encourage superficiality in the care and treatment of the psychiatrically ill, medical ethics is one of the major resources that the practicing psychiatrist can draw upon to counter these forces. It is important that the American Medical Association and American Psychiatric Association continue to more clearly define ethical standards to provide the utmost protection of the physician-patient relationship.

No. 62D
DOCTOR AND PATIENT IN THE PUBLIC EYE

Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 836 West Wellington Avenue, Chicago, IL 60657*

SUMMARY:

The media have the power to influence the public's perception of doctors, and thereby the relationship between individual doctors and patients. When television 'doctors' like Marcus Welby seem to spend whole days and weeks caring for a single patient, unrealistic expectations are raised. When exposes or sensationalized fictional programs depict physicians as greedy, careless, incompetent, or heartless, potential patients may be frightened off and current patients may become suspicious. In psychiatry, centuries of stigma further burden the doctor-patient relationship.

The proliferation of medical information, accurate and inaccurate, in print and electronic media, further complicates the situation. The provision of information about diagnosis, prognosis, and treatment has always been a cornerstone of the doctor-patient relationship. At the same time, the media offer unparalleled opportunities for physicians to inform the public and to convey a positive image. Individual psychiatrists must utilize the media as well as face-to-face opportunities such as talks in schools and other community institutions. But probably nothing affects our image as powerfully as the collective impressions from the relationships between individual doctors and individual patients.

No. 62E
GOVERNMENT RELATIONS AND THE PHYSICIAN-PATIENT RELATIONSHIP

Jeremy A. Lazarus, M.D., *Department of Psychiatry, Univ. of CO, Health Sciences Center., 8095 East Prentice Avenue, Englewood, CO 80111*

SUMMARY:

The physician patient relationship has been described and honored for centuries through ethical traditions and clinical mentoring. Changes in health care financing and the increasing use of managed care techniques have led to profound changes in the manner in which doctors interact with patients. The force of the economic pressures seems to have surpassed attempts by physicians to protect the sanctity of the relationship. In response organized medicine along with patient advocacy groups and other coalitions have been proposing tighter regulation of the managed care and healthcare industry. In addition, protections of patient rights to see the doctor of their choice as well as other patient protective legislation have been debated in recent federal and state laws. This talk will outline the history of these events and the success and failures from a legislative perspective on protection and strengthening of the physician patient relationship. An update on laws currently being processed and those already passed will be discussed.

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SYMPOSIUM 63—NMS AND CATATONIA: ONE SYNDROME OR TWO?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to answer the question whether NMS is a subtype of catatonia or a separate clinical entity, and be able to apply the treatment implications of each view.

No. 63A
NMS AS MALIGNANT CATATONIA

Teresa A. Rummans, M.D., *Adult Psychiatry Desk West 11, Mayo Clinic, 200 1st Street SW, Rochester, MN 55905-0001*

SUMMARY:

Catatonia is a syndrome that spans medical, neurologic, and psychiatric disease. Malignant catatonia (previously referred to as neuroleptic malignant syndrome, near lethal or lethal catatonia) exists on one end of the catatonic spectrum. At this end, characteristic catatonic symptoms can develop including motor signs, psychosocial withdrawal and/or excitement, and bizarre repetitious behaviors. Additionally, autonomic instability or hyperthermia occurs.

Unfortunately, the recognition of this syndrome has been hindered by the separation of this condition into multiple syndromes rather than appreciating it for what it is/single clinical syndrome associated with a variety of precipitants. Subtyping could further characterize the syndrome by possible causes. The subtypes would include psychiatric, medical/neurologic, drug-related, or idiopathic.

Effective treatment of malignant catatonia depends on awareness and early recognition. Interventions include those described in the literature for NMS (one form of malignant catatonia). Initially, this includes supportive care (i.e., adequate hydration), removal of the pharmacological agents thought to aggravate or cause the condition, and the evaluation for medical or neurologic factors contributing to the overall picture. More aggressive interventions include a variety of other pharmacological agents and electroconvulsive therapy.

No. 63B
MALIGNANT CATATONIA

Stephan C. Mann, M.D., *Department of Psychiatry, University of Pennsylvania, VA Medical Ctr.-116A Univ. Ave., Philadelphia, PA 19104* Stanley N. Caroff, M.D., E. Cabrina Campbell, M.D., Henry R. Bleier, M.D., Gregory L. Fricchione, M.D., Paul E. Keck, Jr., M.D.

SUMMARY:

Malignant catatonia (MC), a life-threatening neuropsychiatric disorder characterized by catatonic excitement or stupor, hyperthermia, altered consciousness, and autonomic dysfunction was widely reported both in this country and abroad during the preneuroleptic era. Although the incidence of MC may have declined, coincident with the introduction of modern psychopharmacologic agents, it continues to occur, now reported primarily in the foreign literature. Lack of recognition probably accounts for the scarcity of recent American reports on MC. Both historical and modern findings indicate that MC is a syndrome rather than a specific disease. While MC is more commonly recognized as an outgrowth of various psychiatric disorders, it may also develop in association with a wide array of general medical conditions or be substance-induced. From this perspective, neuroleptic malignant syndrome (NMS) may be conceptualized as a toxic or iatrogenic form of MC. Antipsychotics have been shown to aggravate or complicate MC episodes and should be discontinued whenever MC is suspected. Existing data indicate that electroconvulsive therapy (ECT) is an effective and practical treatment for MC occurring as an outgrowth of a psychiatric condition. ECT has also been effective in NMS. The authors will provide a logical framework for recognizing, diagnosing and treating MC.

No. 63C
IDENTIFICATION AND TREATMENT OF NMS

Patricia I. Rosebush, M.D., *Department of Psychiatry, McMaster University, 1200 Main Street West Room HSC-3G15, Hamilton, ONT L8N 3Z5, Canada;* Michael F. Mazurek, M.D.

SUMMARY:

Purpose: We have prospectively diagnosed and studied 43 episodes of neuroleptic malignant syndrome (NMS) in 39 patients (18M, 21F; × age: 45.8 years). The majority of cases involved the use of typical neuroleptics (40) while 3 were associated with atypical agents (risperidone = 2; olanzepine = 1). We determined the clinical and biochemical profile as well as treatment response and outcome in these patients.

Methodology: All patients were examined thoroughly and followed throughout the course of their illness. Detailed clinical and biochemical profiles were obtained in every case including EEGs, measurement of muscle enzymes, platelet count, urinalysis, and calcium, zinc, iron, and magnesium levels.

Results: Clinical profile: Delirium = 100%; fever = 98%; rigidity = 95%; mutism = 94%; diaphoresis = 91%; tremulousness = 78%; incontinence = 61%; diffuse slowing on EEG = 100%. Biochemical profile: Low serum iron = 95%; ↑ CPK = 91%; ↑ LDH = 91%; ↑ AST = 85%; ↑ ALT = 60%; ↓ calcium = 56%; ↓ magnesium = 63%; myoglobinuria = 68%.

Treatment response: (1) Dantrolene and bromocriptine afford no advantage, (2) in view of evidence that NMS may be an acute phase response, prostaglandin inhibitors may be efficacious, (3) in light of the clinical overlap with catatonia, benzodiazepines may be very effective agents.

No. 63D
IDENTIFYING CATATONIA IN CASES OF NMS

Georgios Petrides, M.D., *Department of Psychiatric Research, LIJ-Hillside Medical Center, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

The development of a rating scale for catatonia at SUNY at Stony Brook in 1996 allowed us to examine the catatonia syndrome in patients meeting criteria for the neuroleptic malignant syndrome (NMS). In a prospective study of all adult psychiatric admissions to University Hospital in a six-month period, 15 (8%) met criteria for catatonia, defined by the presence of two or more signs. Three patients (20%) also met research diagnostic criteria for NMS.

We identified 16 patients who met the DSM-IV diagnostic criteria for NMS in a retrospective study of patients admitted to UH in a three-year period who exhibited elevated serum CPK. Eleven patients met more stringent research criteria for NMS. Of the 16 patients, 15 met the criteria for catatonia after the onset of NMS signs. One patient exhibited catatonia before the onset of NMS. The severity of catatonia ratings correlated with the severity of NMS signs.

We reviewed the treatment of NMS in these patients and all 16 received and responded to benzodiazepines.

These studies support the view that NMS and catatonia represent the same psychopathology.

No. 63E
NMS AS A TYPE OF CATATONIA: TREATMENT IMPLICATIONS

Max Fink, M.D., *Department of Psychiatry, Suny at Stony Brook, P.O. Box 457, St. James, NY 11780-0457*

SUMMARY:

Catatonia is a psychopathological syndrome, once thought to be a specific subtype of schizophrenia, that is now identified in a wide range of mentally ill patients, including those with affective, psychotic, systemic, and toxic illnesses. The syndrome is best identified using rating scales and defined examinations, accepting its presence when two or more motor signs are present for longer than 24 hours.

The first patients treated with convulsive therapy in 1934 were suffering from catatonic schizophrenia. Since then, extensive reports find ECT very effective in relieving the catatonia syndrome. In the 1930s, barbiturates were shown to relieve half the instances of catatonia. At present, the benzodiazepines, diazepam and lorazepam, are seen as effective as the barbiturates.

The treatment regimen for catatonia today is a short trial of high dose benzodiazepines (equivalent to lorazepam to 15 mg/day). If this fails, ECT *en bloc* for two to three days is effective. More extensive trials are occasionally required.

If NMS is viewed as a variant of catatonia, these treatments are recommended as effective alternatives to dopamine agonists and dantrolene.

No. 63F
CATATONIA AND NMS: ONE ENTITY OR TWO?

Denise A.C. White, M.D., *Department of Psychiatry, Groote Schuur Hospital, Observatory 7925 Cape, South Africa*

SUMMARY:

The issue of the neuroleptic malignant syndrome (NMS) and Catatonia as separate or single diagnostic entities is unresolved and there is divided opinion among investigators. Certain writers argue that the disorders are separate clinical syndromes and this view has been reinforced by the DSM-IV diagnostic criteria for NMS, which states that catatonia is in fact an exclusionary criterion for the diagnosis of NMS.

There is evidence to support the opposing view: NMS and catatonia in its severe form share a similar clinical profile and interventions such as benzodiazepines and/or ECT are recommended for the treatment of both syndromes, which suggest a common pathophysiology.

Our experience supports the single entity hypothesis following the observation that in 17 consecutive cases of so-called NMS, a catatonic syndrome preceded neuroleptic administration. Following neuroleptic exposure, the catatonic state intensified and extrapyramidal rigidity emerged. These findings suggest therefore that NMS is an intensified form of a pre-existing catatonic syndrome with the additional feature of neuroleptic-induced extrapyramidal rigidity.

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2. Mann SC, Caroff SN, Bleier HR, et al.: Lethal Catatonia. Am J Psychiatry 1986; 143:1374–1381
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6. Fink M: Neuroleptic malignant syndrome and catatonia: One entity or two? Biol Psychiatry 1996; 39:1–4.
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SYMPOSIUM 64—STRESS AND COPING IN PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to better understand why patients with personality disorders experience many stressors and cope poorly with them.

No. 64A
LIFE EVENTS IN FOUR TYPES OF PERSONALITY DISORDER

Andrew E. Skodol II, M.D., *Personality, NYS Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* John G. Gunderson, M.D., M. Tracie Shea, Ph.D., Thomas H. McGlashan, M.D., Ingrid R. Dyck, Ph.D., Robert L. Stout, Ph.D., Mary C. Zanarini, Ed.D.

SUMMARY:

Objective: The purpose of this study was to examine the incidence and types of stressful life events experienced by patients with personality disorders in the year prior to seeking treatment.

Method: 571 patients with one or more of four specific DSM-IV personality disorders (STPD, BPD, AVPD, or OCPD) and 97 comparison subjects with major depressive disorder (MDD) and no PD received semistructured interviews assessing the occurrence of negative (i.e., undesirable or loss) life events. Qualitative data about the circumstances leading up to and following the events were rated for the degree of control (fatefulness) the subject had over the occurrence of the event and the impact the event had on the subject's life.

Results: Subjects with BPD had more life events (X = 6.0) than did subjects with other PDs or the MDD controls. Fateful events, i.e., those presumed to be outside of the subjects control, were relatively uncommon. Subjects with STPD or BPD had more presumed fateful events than subjects with AVPD or OCPD, but these differences disappeared when interviewers rated the effect the subject's behavior had on the occurrence of certain events.

Conclusions: Patients with personality disorders experience many stressful life events, but also appear to be involved in their occurrence.

No. 64B
DEFENSIVE FUNCTIONING OF BORDERLINE PATIENTS

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

SUMMARY:

Objective: This study assessed the defensive functioning of 290 criteria-defined borderline patients and compared it to that of 72 patients with other forms of axis II psychopathology.

Method: The Defense Style Questionnaire, a 78-item self-report measure with demonstrated construct validity and internal consistency, was administered to 362 axis II inpatients diagnosed using semistructured interviews of proven reliability.

Results: Borderline patients had significantly higher scores than axis II controls on eight immature defenses (acting out, hypochondriasis, passive aggression, projection, inhibition, regression, somatization, and withdrawal), two image distorting or borderline defenses (projective identification and splitting), and one neurotic-level defense (undoing). In contrast, Axis II controls had significantly a higher score than borderline patients on one mature defense (suppression). When all significant defenses were considered together in a logistic regression, three were found to be significant predictors of a borderline diagnosis: acting out, hypochondriasis, and undoing. This model has both good sensitivity (.95) and positive predictive power (.86).

Conclusions: The results of this study suggest that the defensive profile of borderline patients is distinct from that of patients with other forms of Axis II pathology. They also suggest that the defensive triad of acting out, hypochondriasis, and undoing may serve as a useful clinical marker for the borderline diagnosis.

No. 64C
CHANGE IN DEFENSIVE FUNCTIONING AND LIFE STRESS

J. Christopher Perry, M.D., *Erikson Institute, The Austin Riggs Center, 25 Main Street, Stockbridge, MA 02162;* Stephen Beck, M.Psy., Barbara Zheutlin, M.S., Leveen Lapitsky, M.S., Eric M. Plakun, M.D.

SUMMARY:

Objective. Defenses are automatic mediators of the individual's response to stress. Clinical observation has noted that individuals, such as those with severe personality disorders, display low defensive functioning at the same time as they perceive high levels of stress in their life. This study examines the relationship between defenses and stress over time in a sample demonstrating improvement in defensive functioning over time with treatment.

Method. A sample of adults, entering residential treatment at the Austen Riggs Center for treatment-resistant disorders, was gathered. Periodic follow-along interviews while at the Center and afterward assessed patients' life events and self-ratings of their stressfulness. Assessment of defenses was also done using the Defense Mechanism Rating Scales applied to interview data.

Results. Among the first 40 patients followed for three or more years, defensive functioning improved by 0.6 effect sizes. Perceived stressfulness was correlated over time and decreased in many individuals as defensive functioning improved.

Conclusion. Among patients with treatment-resistant disorders, defensive functioning with an initial predominance of lower level defenses improves significantly over time. Perceived stressfulness of actually occurring life events tends to diminish among some improved individuals suggesting a relationship between more adaptive defensive functioning and diminishing subjective stress.

No. 64D
ADOLESCENT PD AND MALADAPTIVE TRANSITION TO ADULTHOOD

Patricia Cohen, Ph.D., *Department of Epidemiology, NYS Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Stephanie Kasen, Ph.D., Hunian Chen, M.D., Jeffrey G. Johnson, Ph.D., Andrew E. Skodol II, M.D., John M. Oldham, M.D.

SUMMARY:

Recent evidence based on general population samples suggests that personality disorders in adolescents may be as persistent and maladaptive as they are at older ages. Nevertheless, many questions remain about the specificity of effects of different PDs, about the mechanisms of their impact on development, and about the independence of the effects of PD from the effects of childhood risk factors for these disorders. These questions are addressed in a study of 200 youth from a random sample, studied prospectively from childhood, who provided narratives about their development in the transition years from adolescence (age 17) to age 27. Investigator-based ratings were made on each youth's monthly progress from a childlike state toward an adult status in terms of occupation, residence, financial independence, romantic commitment, and family formation. Analyses focus on aspects of these ratings, including mean level, increases in adult function over time, and variability in the level and quality of functioning. Findings suggest moderate specificity of the impact of different PDs on this transition, and of the independence of such effects from the risks common to PD and transitional difficulties.

REFERENCES:

1. Perry JC, Lavori PW, Pagano CJ, Hoke L, O'Connell ME: Life events and recurrent depression in borderline and antisocial personality disorders. J Personality Disord 6:394–407, 1992
2. Bond M, Paris J, Zweig-Frank H: Defense styles and borderline personality disorder. Journal of Personality Disorders 1994; 8:28–31
3. Perry JC: A prospective study of life stress, defenses, psychotic symptoms and depression in borderline and antisocial personality disorders and bipolar type II affective disorder. J Personality Disorders 1988; 2:49–59
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SYMPOSIUM 65—THE DOCTOR AND PATIENTS' HUMAN RIGHTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant should be able to recognize the forms and venues of human rights abuses toward people who suffer from mental illnesses, both in the US and internationally. The participant should also be able to demonstrate methods to avoid and eliminate such abuses.

No. 65A
DUAL LOYALTY AND THE PROTECTION OF HUMAN RIGHTS

Leonard Rubenstein, J.D., *Physicians for Human Rights, 100 Lolston Street, Boston, MA 02116*

SUMMARY:

The problem of dual loyalty—simultaneous obligations, express or implied, to the patient and to a third party, frequently the state—

remains a continuing challenge for health professionals, psychiatrists among them. The conduct of a health professional with a sense of obligation to the state as well as to the patient can be especially troubling in situations where serving the interests of the state infringes the human rights of patients. The recently-released report of South Africa's Truth and Reconciliation Commission, documenting the complicity of health professionals in the apartheid regime, provides a particularly potent illustration of the problem. The report urges the adoption of effective standards of conduct in situations of potential dual loyalty that protect human rights as well as institutional arrangements and educational programs to ameliorate the problem.

Psychiatrists have faced these problems in the United States and abroad, where they are asked to play roles on behalf of the state as well as on behalf of the patient.

Presenter will discuss problem of dual loyalty and the search for standards of ethics applicable to the medical profession and proposed solutions, relying on experience in South Africa and the United States.

No. 65B
PATIENTS' HUMAN RIGHTS: INTERNATIONAL PERSPECTIVE

Eric Rosenthal, J.D., *Mental Disability Rights International., 4801 Massachusetts Avenue NW, Washington, DC 20016*

SUMMARY:

I will discuss the rights of people with mental illness under international human rights law and its implications for the doctor-patient relationship in mental health systems around the world. The presentation will contrast the legal obligations of mental health workers with those of the government. I will focus particularly on the right to community integration and the right to treatment in the least restrictive environment. While governments bear the primary responsibility of planning and financing appropriate community services, the failure of governments to do so creates barriers to effective doctor-patient collaboration.

The presentation will describe some of the strategies that practitioners and professional organizations have taken within Central and Eastern Europe to promote mental health system reform. I will propose ways that individual practitioners and professional organizations in the United States can contribute to the growing world-wide movement for disability rights and mental health system reform. My presentation will draw on the findings of Mental Disability Rights International (MDRI), an advocacy organization that has been working with service providers and activists in Central and Eastern Europe and Latin America to promote rights enforcement and community integration.

No. 65C
WORLD ASSOCIATION FOR PSYCHOSOCIAL REHABILITATION ADVOCACY WORK FOR HUMAN RIGHTS

Humberto L. Martinez, M.D., *WAPR Comm on Human Rights, 781 E. 142 Street, Bronx, NY 10454*

SUMMARY:

Background information on the World Association for Psychosocial Rehabilitation (WAPR) will be provided. The work that WAPR has done at the United Nations will be described. This includes the preliminary contribution to the development of the United Nations Resolution 46/119. It is the most detailed and comprehensive statement about the rights of the mentally ill. A description of other activities the WAPR does in the United Nations, in the USA, and abroad will be presented.

The importance of safeguarding the self determination of all individuals with the protection of human rights will be highlighted. Why the psychiatrist plays a pivotal role in self determination will be addressed. Examples of human rights violations will be provided both in the USA as well as abroad.

The presenter will discuss different aspects of the patient and doctor relationship: (1) education of the patient and his family about their rights, (2) confidentiality, (3) informed consent, (4) the importance of safeguarding the patient's self determination, (5) the human rights aspect, as well as the importance of access to information for further developing the patient/doctor relationship into an equal partnership, will be addressed.

No. 65D
NATIONAL ALLIANCE FOR THE MENTALLY Ill PERSPECTIVE AND PATIENTS' HUMAN RIGHTS

Laurie M. Flynn, Executive Director, *National Alliance of the Mentally Ill, 200 N Glebe Road, Suite 1015, Arlington, VA 22203*

SUMMARY:

As both the executive director of the National Alliance for the Mentally Ill (NAMI) and a member of the White House National Bioethics Advisory Commission, I will discuss issues of significance and NAMI advocacy approaches to three public policy issues—protection of human subjects in research, Institutional Review Board (IRB) composition and training, and general bioethics issues as they impact persons with serious mental illness. NAMI's 210,000 members include both families and consumers directly impacted by severe mental illness and I hope to provide insight into their motivation and desires.

REFERENCES:

1. Truth and Reconciliation Commission of South Africa Report, The Health Sector, Vol. IV, chapter 5 (1998)
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4. About Meeting Rights and Education Standards for Behavioral Health Care Joint Commission on Accreditation of Healthcare Organizations 1998
5. UN Resolution 46/119. The Protection of Persons with Mental Illness and the Improvement of Mental Health Care. 17 December 1991
6. The *PACT* Model of Community-Based Treatment for Persons with Severe Mental Illness: A Manual for *PACT* Start-Up. NAMI, 1999

SYMPOSIUM 66—PSYCHIATRY AND CULTURALLY DIVERSE POPULATIONS
American Association of Community Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have explored challenges from the perspective of daily psychiatric practice and integrated some of the new knowledge and concepts which allow the field of psychiatry to be more cross-culturally relevant and effective as we enter into the new millennium.

No. 66A
CULTURAL COMPETENCE: FRAMEWORK FOR WORKING ACROSS CULTURES

Andres J. Pumariega, M.D., *Department of Psychiatry, East Tennessee State Univ., 107 Hillrise Hall/PO Box 70567, Johnson City, TN 37614*

SUMMARY:

The cultural competence model in mental health services was first outlined by Cross, Bazron, Dennis, and Isaacs (1989). It proposes the development of community-based systems of care which can address the mental health needs of culturally diverse populations through changes in policies and practices by institutions. The model also calls for the development of provider cultural competence through the acquisition of knowledge, skills, and attitudes to enable clinicians to serve peoples which are culturally different from themselves. This presentation will outline the principles of cultural competence as well as its application in institutional change as well as provider competencies. The latter address the development of self-awareness of personal attitudes about cultural diversity, clinical issues which arise in serving culturally diverse patients, and techniques in addressing alliance building, clinical assessment and interviewing, family dynamics, and psychopharmacology with culturally diverse patients. Cultural competence standards developed by the Center for Mental Health Services based on these principles and applications will be briefly reviewed, including its implications for systems of care and practitioners.

No. 66B
DEPRESSION IN AFRICAN AMERICANS

Annelle Primm, M.D., *Department of Psychiatry, Johns Hopkins, 600 N. Wolfe Street, Meyer 144, Baltimore, MD 21287-7180*

SUMMARY:

African Americans experience depressive disorders at rates similar to that of other racial groups, but are less likely to ever seek help especially mental health settings and have higher rates of attrition from follow-up visits. There is considerable evidence that African Americans with depressive disorders are frequently misdiagnosed and are less likely to be offered antidepressant medication. African American patients' perceptions of mental illness-associated stigma, life experiences as the cause of depression, mistrust of health care professionals, and concerns about the effects of psychotropic medications, have been identified as potentially important barriers to mental health care. This presentation will examine how patient cultural factors, health care provider biases, and health care system biases influence the treatment of depression in African Americans. In addition, it will offer strategies for introducing culturally competent practices to improve care for depression among African Americans.

No. 66C
ANXIETY AND SOMATIZATION IN HISPANICS

Jose M. Canive, M.D., *Department of Psychiatry, VAMC-U New Mexico, 1501 San Pedro Drive (116A), Albuquerque, NM 87108*

SUMMARY:

Hispanics will become the largest minority population in the United States within the next 10 to 20 years. Already, significant population centers in the United States are predominantly Hispanic both in numbers as well as influence. However, Hispanics continue to underutilize mental health services in spite of data which suggest at least an equal need for such services. Lack of access to bilingual and bicultural services as well attitudes and beliefs which impact on Hispanics' views on mental illness contribute to this disparity. A significant mode of expression of emotional distress and psychopathology in Hispanics are symptoms of anxiety and somatization. These symptoms can be not only in traditional anxiety disorders, but also co-morbidly seen in a number of diagnostic entities, such as depression, as well as in culture-bound syndromes. This presentation will review studies of the epidemiology of anxiety and somatization amongst Hispanics, their clinical presentation and significance in different conditions, and approaches to effective treatment in Hispanics.

No. 66D
ETHNOPSYCHOPHARMACOLOGY: SELECTING MEDICATIONS ACROSS CULTURES

Michael W. Smith, M.D., *Department of Psychiatry, Harbor-UCLA REI, 1124 West Carson Street/B4 S, Torrance, CA 90502;* Keh-Ming Lin, M.D., Ricardo P. Mendoza, M.D.

SUMMARY:

Ethnic differences in pharmacological response have long been recognized. New research methodologies in the field of pharmacogenetics have begun to provide us with important insights concerning the biological mechanisms that underlie this differential response. The emerging data has highlighted the central role of genetic factors in the metabolism, and perhaps plasma protein binding, of many of the psychotropic agents used today. Ethnic differences in these genetic factors may explain in large measure why ethnic minority patients respond differently than Caucasians when given psychotropic medications. However, it is clear that, as is the case for psychiatry in general, when considering psychopharmacological response in particular, the role of the environment on these genetic factors must be understood. In this presentation, the role that genetic and biological factors play in determining cultural competent psychiatric treatment will be reviewed.

No. 66E
CULTURAL COMPETENCE GUIDELINES: NATIONAL AND LOCAL

Russell F. Lim, M.D., *Psychiatry, Univ. of California, Davis, 601 W North Market Blvd, Suite 100, Sacramento, CA 95834*

SUMMARY:

The increasing cultural diversity of the United States, as shown by U.S. Census data, requires that clinicians understand how cultural differences affect diagnosis and treatment. From 1980 to 1990, the number of Asians in the United States increased by 100%, Hispanics by 53%, American Indians by 45% and African Americans by 14%, while Caucasians increased only by 7%. In addition, ACGME (Accreditation Council for Graduate Medical Education) requirements for psychiatric residents now include a familiarity with cultural assessment. Finally, the DSM-IV (Diagnostic and Statistical Manual, 4th Edition) has added new emphasis to the influence of culture on diagnosis by including an outline for cultural formulation and a glossary of culture bound syndromes.

Culturally diverse individuals have special needs and require special skills and knowledge to treat them appropriately and effectively. Cultural competence mandates at the national level will be discussed, including the role of professional organizations such as the American Psychiatric Association (APA). The California State Cultural Competence Plan will be presented as a specific example of cultural competence at the state level. Finally, an example of a county level cultural competence plan (Sacramento County, California) will be presented to demonstrate a practical application of mandated cultural competence plans.

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2. Cross T, Bazron B, Dennis K. & Isaacs M. Culturally Competent Systems of Care for Children with SED Wash DC: Georgetown Univ. Child Development Ctr & CASSP
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4. Cooper-Patrick L, Powe NR, Jenckes MW, Gonzales JJ, Levine DM, Ford DE: Identification of patient attitudes and preferences regarding treatment of depression. Journal of General Internal Medicine 1997; 12:431–438
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7. Cross TL, Bazron BJ, Dennis KW, Isaacs MR: Towards a Culturally Competent System of Care. Washington, DC, CASSP Technical Assistance Center, 1989 Cultural Competence Strategic Framework Task Force: New York State Cultural And Linguistic Competency Standards, New York State Office of Mental Health, 1997

SYMPOSIUM 67—ARE THERE GENES FOR ALCOHOLISM?
National Institute on Alcohol Abuse and Alcoholism

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be well informed of the latest research findings regarding the genetic susceptibility for alcohol dependence and be able to cogently inform patients and family members in relation to issues of genetic susceptibility for alcoholism.

No. 67A
A SEARCH FOR GENES FOR THE LOW RESPONSE TO ALCOHOL

Marc A. Schuckit, M.D., *Department of Psychiatry, VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161*

SUMMARY:

This presentation offers the most recent results from both case-control, association studies, and genetic linkage analyses searching for genes related to the low pressure to alcohol. This phenomenon, with an estimated heritability of 0.4, is seen in an estimated 40% of the sons and daughters of alcoholics, and explains a significant proportion of the ability of the family history of alcohol dependence to predict alcoholism in offspring. The data to be reviewed include cross-sectional and longitudinal studies of children of alcoholics, current candidate gene analyses focusing in on genetic material related to serotonin and to GABA, and sibling-pair analyses using data from an indirect measure of the response to alcohol, the Self-Report of the Reaction to Ethanol (SRE) measure.

No. 67B
THE RELATIONSHIP BETWEEN ALCOHOLISM AND DEPRESSION: A MOLECULAR ANALYSIS

John I. Nurnberger, Jr., M.D., *Department of Psychiatry, Indiana University, 791 Union Drive, Indianapolis, IN 46202;* Tatiana Foroud, Ph.D., Victor Hesselbrock, Ph.D., Leah Flury, Ph.D., Bernice Porjesz, Ph.D., Eric Meyer, M.A., Theodore A. Reich, M.D.

SUMMARY:

In the Collaborative Study of the Genetics of Alcoholism, alcoholic subjects have an increase in depressive syndrome (depression that may occur in conjunction with increased drinking). The increase in depressive syndrome tends to run in families.

This information was used to construct two alternate phenotypes to test for linkage. "Alcoholism and Depression" (AAD) was defined as the presence of alcoholism plus depressive syndrome. "Alcoholism or Depression" (AOD) was defined as either alcoholism or depressive syndrome. The total number of affected sib pairs was 284 for alcoholism and depression (199 independent) and 1383 for alcoholism or depression (694).

These definitions of affected status were analyzed in conjunction with the data from a genomic scan using ASPEX. The AOD phenotype showed a LOD score of 4.7 on chromosome 1, peaking at about 120 cM, as calculated using SIB-IBD including all possible pairs. Allele sharing in this area was 57% in the total sample of 1383 sibpairs. This compares with a comparable LOD score of 2.9 for alcoholism (58% sharing). It may be observed that the peak on chromosome 1 includes an area of interest noted in the NIMH Genetics Initiative Bipolar dataset (Rice et al. 1997).

No. 67C
GENETIC CONCOMITANCE OF ALCOHOL ABUSE AND DEPENDENCE

Jack H. Mendelson, M.D., *Alcohol Drug Abuse Res., McLean Hospital, 115 Mill Street, Belmont, MA 02478-1041*

SUMMARY:

The investigation of single major genes plus the involvement of multiple genes is an important initial step for the determination of a genetic basis of alcoholism. Subtle multiple gene factors may concurrently influence alcohol risk. Among such genetic factors are those that influence fluidity of membranes in multiple organs including the central nervous system. These genetic factors may be more or less prevalent in specific populations such as Native Americans. Genetic factors that may enhance risk for affective disorders may also contribute to risk for alcohol dependence. Some populations that have high risk for alcohol dependence also have a high incidence of concurrent bipolar depression. A genetically determined physiologic response for alcohol effects upon behavioral responsivity may be an important factor for predicting the future development of alcoholism. Processes including biologic mechanisms of innate tolerance for alcohol and how these processes affect subsequent acquire tolerance for alcoholism will be discussed. New biomedical procedures including magnetic resonance imaging and magnetic resonance spectroscopy may facilitate an improved understanding of potential genetic factors that increase risk for the development of alcohol abuse and alcohol dependence.

No. 67D
THE DETECTION OF SUSCEPTIBILITY GENES FOR ALCOHOLISM

Theodore A. Reich, M.D., *Department of Psychiatry, WA Univ. School of Medicine, 4940 Children's Place, Saint Louis, MO 63110*

SUMMARY:

COGA is a six-center, multigenerational, study to identify genes that increase or decrease (protective) susceptibility to develop alcohol dependence. A large sample of families, densely affected with alcohol dependence have been ascertained and interviewed using a comprehensive lifetime diagnostic schedule. Resting electroencephalograms and auditory and visual evoked potentials have also been measured since these variables are genetically correlated with alcohol dependence. Using a split sample design to minimize type 1 error, genetic linkage and candidate gene studies have been conducted to identify chromosomal regions segregating susceptibility genes for alcohol dependence and related phenotypes. Two criteria are used to identify and confirm genetic linkage. These are (1) evidence for linkage at the same chromosomal region in each of the split samples, and (2) evidence for linkage at the same chromosomal region with several phenotypes. Using these criteria, genes for alcohol susceptibility are likely to be present on chromosomes 1 and 2. Evidence for genes that reduce susceptibility (protective) is found on chromosome 4. Candidate loci in these regions are under study as causal factors in alcohol dependence.

REFERENCES:

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2. Reich T, Edenberg HJ, Goate A, Williams JT, et al: Genome-wide search for genes affecting the risk for alcohol dependence. Am J Med Genet (Neuropsychiatric Genetics) 1998; 81:207–215
3. Chiu TK, Mendelson JH, Woods BT, Teoh SK, et al: In vivo proton magnetic resonance spectroscopy detection of human alcohol tolerance. Magnetic Resonance in Medicine 1994; 32:511–516
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SYMPOSIUM 68—CLINICAL TOPICS IN POSTPARTUM MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, the participant should have an increased understanding of the recognition and management of mood disorders occurring during the puerperfum.

No. 68A
DETECTING POSTPARTUM DEPRESSION IN A COMMUNITY CLINIC

Kimberly A. Yonkers, M.D., *Department of Psychiatry, Yale University School of Medicine, 200 College Street, Suite 206, New Haven, CT 06519*

SUMMARY:

Introduction: Major depressive disorder (MDD) occurring during the postpartum period constitutes a significant clinical problem; however, there is a dearth of data on minority women afflicted with this condition.

Objective: To estimate rates of depressive symptoms and MDD during the puerperium in a large cohort of African-American and Hispanic women; to determine whether the onset and persistence of depressive symptoms or MDD could be predicted based upon readily available medical and demographic information.

Study Design: Women at four inner-city clinics were assessed at two (T1), 3 (T2), and four weeks (T3) postpartum using demographic and medical history questionnaires, the inventory for Depressive Symptomatology—Self Report [IDS-SR], and the Edinburgh Postnatal Depression Scale [EPDS]. The SCID was administered to women who scored above threshold at T2.

Results: A total of 802 of 890 women approached agreed to participate; 75.8% were Hispanic, while 19.8% were African American. At T1, 37% of the cohort scored above threshold for EPDS or IDS-SR. At T2, 295 of 299 were evaluated and 28% continued to experience depressive symptoms. In the 71 women with continued depressive symptoms at T3, 61% were positive for MDD. However, only 28 women had a postpartum onset; the point-prevalence rate for postpartum MDD was 10%. The risk of depressive symptoms was increased by approximately 30% if the mother had other children. Higher educational levels and residence with a spouse rather than extended family decreased the risk for depressive symptoms. Higher scores on the EPDS at screening predicted the syndrome of MDD at one month.

No. 68B
PAROXETINE IN THE TREATMENT OF POSTPARTUM DEPRESSION

A. Chris Heath, M.D., *Department of Psychiatry, UT Southwestern Medical University, 5959 Harry Hines Blvd., MC 9101, Dallas, TX 75235;* Kimberly A. Yonkers, M.D., A. John Rush, M.D.

SUMMARY:

Introduction: Depression during the postpartum period afflicts approximately 10% of women. To date, only two randomized, controlled studies have been published that specifically evaluate treatment for women who develop major depressive disorder (MDD) during the postpartum period.

Objective: To evaluate the efficacy of paroxetine in the treatment of postpartum MDD.

Study Design: This is a multicenter, double-blind, parallel, placebo-controlled study of women with an onset of MDD within three months of parfurition. Women were assigned to either flexible dose treatment with paroxetine (10–50 mg daily) or placebo (one to five capsules daily) for 12 weeks. Trained staff, blinded to both study design and condition, collected depressive symptom and severity ratings.

Results: A total of 28 women from two sites participated in this interim analysis. Women on active treatment remained in the study for eight weeks, while women on placebo remained in the study for nine weeks. Data from an interim analysis of scores on the Hamilton Rating Scale for Depression and Clinical Global Impression Scale will be presented.

No. 68C
ASSESSING THE SAFETY OF SSRIs DURING BREAST FEEDING

C. Neill Epperson, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven, CT 06519;* Erica Weiss, M.D., Deborah Ward-O'Brien, M.S.N., Katheryn Czarkowski, M.A., Peter Jatlow, M.D., George M. Anderson, Ph.D.

SUMMARY:

The treatment of postpartum depression, which occurs in 10% of childbearing women, is often complicated by a woman's desire to breast-feed. There is a relative dearth of information regarding the safety of various antidepressants, including the selective serotonin reuptake inhibitors (SSRIs), in breast-feeding. Although plasma SSRI levels in infants exposed through breast milk are reported to be low,

it is not known whether 5-HT transport in the infant is affected. The human platelet and neuronal 5-HT transporters are identical, and animal studies indicate that reuptake inhibitors cause similar central and peripheral blockade. We have measured whole blood 5-HT in 14 mothers and their nursing infants prior to and during sertraline (SER) treatment of postpartum depression. Maternal and infant whole blood 5-HT levels were determined before and after six to 12 weeks of maternal treatment with SER at doses of 50 mg/d to 200 mg/d. Frequency of breastfeeding ranged from seven to eight times per day to only one to two times per day. Infant plasma SER and DMS levels, which were measured at the time of post-exposure sampling, were <2.5 ng/ml and <5.0 ng/ml, respectively in all cases excepting one. As expected, marked declines in platelet 5-HT were observed in the mothers (to 10.8 ± 2.5% of baseline), while little or no change was seen in the infants. The data indicate that platelet 5-HT levels and, hence, platelet transport were not substantially reduced in the nursing infants.

Funding Sources: NARSAD, NIMH, Pfizer Inc.

No. 68D
COURSE AND TREATMENT OF BIPOLAR ILLNESS DURING PREGNANCY AND THE POSTPARTUM PERIOD

Adele C. Viguera, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street/WAC 815, Boston, MA 02114*

SUMMARY:

While the postpartum period has typically been considered a period of risk for relapse of bipolar disorder, systematic data regarding the course of bipolar disorder during pregnancy is essentially unknown. The management of bipolar women who plan to conceive or who are pregnant poses significant challenges for clinicians who care for these patients. Recent data suggest that pregnancy is not protective and the risk for relapse after lithium discontinuation is similar in pregnant and nonpregnant women with 50 percent relapsing within six months. This presentation reviews the major clinical dilemmas in managing pregnant bipolar patients as well as recent data on the course of bipolar disorder during pregnancy and the postpartum period. Treatment guidelines for the management of bipolar illness during pregnancy and the postpartum period will also be presented.

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SYMPOSIUM 69—OCD UPDATE: EUROPEAN AND AMERICAN COLLABORATIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The aim of this symposium is to present and discuss the latest developments deriving from collaborative studies between European and American investigators.

No. 69A
THE OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place/Box 1230, New York, NY 10029;* Concetta M. DeCaria, Ph.D., Suzanne Yoon, M.D., Charles Cartwright, M.D., Sherie Novotny, M.D., Carol Bienstock, B.A., Jared Finkell, B.A.

SUMMARY:

The obsessive-compulsive disorders spectrum concept has grown in recent years because of the common clinical features, such as obsessive thinking and compulsive rituals, biological markers, presumed etiology, and treatment response, that these disorders may share with obsessive-compulsive disorder (OCD). This concept has important implications in regard to diagnosis, nosology, neurobiology, and treatment of a wide group of diverse disorders affecting up to 10% of the population. New insights in central nervous system (CNS) mechanisms that drive the repetitive behaviors of the obsessive-compulsive spectrum disorders have heightened interest in the spectrum in researchers, clinicians, and those involved in drug development.

An important approach in neuropsychiatry centers on employing a dimensional classification of psychopathology. Psychiatric phenomena often fall on a continuum. A dimensional approach allows for the classification of patients who fall at the border of classical entities or who are otherwise atypical. Diagnostic categories are considered along a spectrum if there is considerable overlap in symptoms and in etiology, as demonstrated by familial linkage, biological markers, and pharmacological dissection. Categorical and dimensional approaches to the OCD spectrum could have significant implications for diagnosis, nosology, neurobiology, and treatment of a wide group of disorders affecting a sizable percentage of the population.

No. 69B
EPIDEMIOLOGY AND TREATMENT OF OCD AND SCHIZOPHRENIA

Joseph Zohar, M.D., *Department of Psychiatry, Chaim Sheba Medical Center, Tel-Hashomer 52621, Israel;* Yehuda Sasson, M.D., Vital Iaz, M.D., Miriam Chopra, M.A.

SUMMARY:

Perhaps one reason that comorbidity of schizophrenia and obsessive-compulsive disorder (OCD) has only achieved limited recognition is that prior to the DSM-III-R (1987) schizophrenia was one of the exclusion criteria for diagnosing OCD. The possibility for comorbidity has subsequently led to heightened interest and to surprising findings. The range of comorbidity of the two disorders in three studies carried out since 1988 (Karno et al. 1988, Berman et al. 1996, and Zohar et al. 1999) was 12%, 25%, and 15%, respectively. Moreover, the prognosis of patients with a diagnosis of both disorders was found to be associated with a global decline in functioning in one study (Fenton and McGlashan, 1986) and with lower capacity for age-appropriate functioning as judged by their clinicians in another study (Berman et al. 1995). This increased prevalence of OCD in schizophrenia compared with that in the general population (2%) has raised intriguing questions regarding the association between the two disorders.

Adapting the symptomatic approach, several groups attempted to administer a combination of antipsychotic and antiobsessive medications in this subset of patients. Preliminary results obtained from these studies suggest added beneficial effects for this approach. Further epidemiological and genetic studies examining the prevalence of schizophrenia in OCD, and vice versa, with special focus

on the "schizo-obsessive" subset, could further illuminate the relationship between these two disorders.

No. 69C
THE ROLE OF SECOND MESSENGERS IN OCD

Donatella Marazziti, M.D., *Department of Psychiatry, University of Pisa, Viaroma 67, Pisa 56100, Italy;* Silvio Presta, M.D., Irene Masala, Ph.D., Eric Hollander, M.D., Alessandra Rossi, Ph.D., Giovanni B. Cassano, M.D.

SUMMARY:

Objective: Different observations have shown a reduced functionality of the serotonin (5-HT) transporter in obsessive-compulsive disorder (OCD) that might be due to a disturbance of its regulation at intracellular level. Protein kinase C (PKC) has been reported to provoke a decrease in the number of the 5-HT transporter proteins. Therefore, we investigated whether OCD patients differed from control subjects in the effect of PKC upon the 5-HT transporter, after stimulation of this enzyme with 4-beta-12-tetradecanoylphorbol 13-acetate (β-TPA).

Methods: Fifteen patients affected by OCD, according to DSM-IV criteria, were compared with a similar group of healthy subjects.

Results: At baseline, OCD patients showed a significant decrease in the maximal velocity (V_{max}) of 5-HT uptake, as compared with control subjects, with no change in the Michaelis-Menten constant (K_m). The activation of PKC with β-TPA provoked a significant decrease in V_{max} values in both groups, but the effect was significantly more robust in OCD patients.

Conclusions: These findings could indicate the presence of hyperactivity of PKC in OCD that could be the result of increased activity of the phosphatidylinositol pathway.

No. 69D
LONG-TERM TREATMENT OF OCD

Luigi Ravizza, M.D., *Department of Neuroscience, Psychiatric Unit, Via Cherasco 11, Torino, IT 10126, Italy;* Giuseppe Maina, M.D., Umberto Albert, M.D., Filippo Bogetto, M.D.

SUMMARY:

We performed a three-year, open-label, follow-up study on 148 OCD patients who were responders to a previous six-month treatment with CMI, FLX, and FLV. Patients who continued taking drug (either half or full doses) had significantly less relapses as compared with patients who discontinued the treatment after the acute phase. Regarding dosages to be used in the long-term treatment, in our follow-up study, continuation treatments with full doses were compared to continuation with half doses over a three-year period: no statistically significant differences in efficacy were found between full and half doses. Other studies have provided further support for this conclusion. The chance of using lower doses for the prevention of recurrence of OCD appears of great importance as it implies clear advantages for tolerability, cost and compliance. With regard to the optimal length of the continuation therapy, recommandations for a duration of at least two to three years after the acute phase emerge from several studies; however, the studies that have provided the basis for these recommandations were designed to demonstrate the need for continuation therapies, not its optimal duration. Studies that have prospectively examined several different lengths of continuation under controlled conditions have not yet been attempted. Most of the available data based on long term follow-up, instead, indicate that discontinuation of medication leads to recurrence of symptomatology in most patients. A question, however, that has received little attention is whether the reinstitution of the treatment in patients who relapsed after drug discontinuation is associated with the same degree of response. We performed an open-label study on the reinstitution of treatment in 81 OCD patients who had responded to six months' treatment with CMI, FLX, FLV or PAR and relapsed after drug discontinuation. All patients were treated again with the same drug at the same daily dose than before. The cumulative proportion of responders to the reinstitution treatment was significantly lower (mean rate: 83.9% at six months), although the analysis of responders' rates to each of the four drugs failed to reveal, probably due to the small sample size, a statistical difference between the acute and the reistitution phase. No statistically significant differences were found among CMI (response rate: 83.3%), FLX (response rate: 86.4%), FLV (response rate: 85.71%) and PAR (response rate: 80.0%).

No. 69E
ADVANCES IN THE TREATMENT OF RESISTANT OCD

Stefano Pallanti, Ph.D., *Institute for Neuroscience, Viale Ugo Bassi 1, Florence 50137, Italy;* Leonardo Quercioli, M.D., Lorrin M. Koran, M.D., Floyd R. Sallee, M.D.

SUMMARY:

Objective: The search for effective and safe strategies for conventionally treated resistant obsessive-compulsive disorder (OCD) cases, is a major issue for the clinical practice. We describe our experience in treating resistant OCD patients using specific pharmacological augmentation protocols.

Method: Four trials performed in four different samples are described: (1) An open trial of five patients treated with gradual-dosing intravenous clomipramine (2) A randomized, open-label trial of 16 patients randomly assigned to citalopram alone or citalopram plus clomipramine. (3) A double-blind study on 27 patients assigned to oral or intravenous pulse-loading of clomipramine. (4) Two case reports of olanzapine augmentation.

Results: Intravenous clomipramine produced an improvement of 25% (Y-BOCS) after four weeks in all patients. Response onset was faster in the clomipramine pulse-loading group. Citalopram plus clomipramine group experienced a significantly larger improvement than the citalopram alone group after 90-days. In two resistant cases, the augmentation of sertraline and fluvoxamine with olanzapine decreased noticeably OC symptoms.

Conclusion: These protocols appeared effective and safe in several cases of resistant OCD patients and suggest useful possibilities to extent the current guidelines.

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SYMPOSIUM 70—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 six model residency programs have implemented curricula on religious/spiritual issues.

No. 70A
THE RELIGION AND SPIRITUALITY IN PSYCHIATRY CURRICULUM AT SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE

Gary E. Myers, Ph.D., *Department of Psychiatry, South Illinois School of Medicine., 913 N. Rutledge Street, Springfield, IL 6279-49603;* Karen E. Broquet, M.D.

SUMMARY:

The "Religion and Spirituality in Psychiatric Practice" curriculum offered by the departments of psychiatry and medical humanities trains psychiatric residents to integrate religious and spiritual issues into treatment. The learning objective for each year of the three-year curriculum addresses one of three probable causes for why psychiatrists are generally reluctant to include the religious/spiritual issues of patients into treatment. These causes are: (1) difficulty constructing an intellectually satisfying way to relate religion and psychiatry, (2) limited understanding of the psychological and social significance of religion/spirituality, and (3) limited training in clinical skills necessary to include patients' religious/spiritual issues into treatment.

Consequently the participants will be able to: (1) evaluate the sources of conflict and misunderstanding between religion/spirituality and psychiatry; (2) identify the dynamic function of religion/spirituality in personality, family, and culture; and (3) develop skills that include taking religious histories, making religious/spiritual assessments, and working with transference and countertransference issues related to the patients' or residents' religious belief or unbelief.

Training methods include monthly lecture/discussion, an online discussion group, dialogue with clergy, movie discussions, case presentations, supervision, and simulated patient interviews. Evaluation includes student/faculty feedback, yearly clinical exams, and pre- and post-testing.

No. 70B
THE GEORGETOWN CURRICULUM ON RELIGION, SPIRITUALITY AND PSYCHIATRY

Thomas Zaubler, M.D., *Department of Psychiatry, Georgetown University, 3800 Reservoir Road, Washington, DC 20007;* Aileen P. Oandasan, M.D.

SUMMARY:

With the support of the John Templeton Spirituality and Medicine Award, the department of psychiatry at Georgetown University offers residents a course, Religion, Spirituality and Mental Health. The course is integrated throughout all four years of psychiatry residency training and includes lectures, clinical encounters, and experiential learning opportunities. The timing of the sessions in the course will complement the core clinical work required of our residents. During the first year of residency training, the course introduces basic concepts and definitions of religion, spirituality, and spiritual experiences and the interface between these and psychiatry. The second year includes sessions focusing on a range of major religious faiths and how each faith views mental illness and health. During the third year, when our residents are exposed to patients with a combination of medical and psychiatric problems, the course introduces residents to the role of faith and spirituality in the medically ill and provides residents an opportunity to collaborate with the hospital's pastoral care counseling service. Issues in death, dying and bereavement, as well as issues surrounding religion and spirituality in psychotherapy are covered in the third year as well. The sessions during the fourth year will cover a range of topics including spirituality in the human life cycle, pathologic religiosity, and the spirituality of the physician.

No. 70C
THE CLEVELAND CLINIC CURRICULUM ON SPIRITUALITY, CULTURE, AND PSYCHIATRY

David S. Rue, M.D., *Department of Psychiatry, Cleveland Clinic Desk P57, 9500 Euclid Ave, Cleveland, OH 44195-0001*

SUMMARY:

The Spirituality, Culture, and Psychiatry curriculum at the Cleveland Clinic Foundation is unique in that it is a combined program for both child and adult residents. It provides the "forgotten" dimension of spirituality to psychiatric education at the foundation. The curriculum consists of lecturers/seminars, clinical training, and an elective with chaplains.

Lectures include six departmental grand rounds on culture, spirituality, and religion; one half-day workshop on diversity for all residents, and 12 one-hour lectures for all child fellows and PGY II-IV adult residents. Lecture topics are: mental health research on religion and spirituality, beliefs and practices of the world's major religious traditions, relevant religious/spiritual definitions and concepts, assessing patients' religious and spiritual practices, transference and counter-transference issues, religion/spirituality and mental health in childhood and adolescence, religion, mental health, marriage and divorce, religious and spiritual development in late life, and values and ethics in the treatment of religious patients.

Residents on clinical services have case-based discussions on how religion/spirituality may interplay in the lives of the patients. Case conferences, in collaboration with liaison chaplains, are conducted to highlight symptom expression, culturally sensitive interviewing, and spiritually syntonic treatment.

A one-month elective rotation with senior chaplains is offered to PGY-IV residents. The resident "shadows" the chaplain at the teaching hospital, with an opportunity to attend to the terminally ill, culturally diverse patients, and seriously ill pediatric patients.

No. 70D
THE CURRICULUM ON RELIGION, SPIRITUALITY, AND PSYCHIATRY AT EAST TENNESSEE STATE UNIVERSITY

Brent R. Coyle, M.D., *Department of Psychiatry, East TN State University, PO Box 70567, Johnson City, TN 37614*

SUMMARY:

This presentation describes the required and elective activities in training for "Spiritually Sensitive Psychiatry (SSP)." This program involves residents at all levels of training. Beginning residents are educated on overall cultural and spiritual competence in practice. Second-year residents receive a broad overview of the burgeoning literature in this highly relevant clinical issue. During more advanced stages of training, the program makes liberal use of standardized patients for careful training in expectedly difficult patient interac-

tions. An overview will also be provided for the popular elective activities for residents and students of all levels of training in a "SSP Journal and Writing Club."

No. 70E
UNIVERSITY OF PENNSYLVANIA CHILD AND ADOLESCENT PSYCHIATRY CURRICULUM ON RELIGION

Mary L. Dell, M.D., *Department of Neuropsychiatry, NIMH, 10 Center Drive, MSC1255, B-10, Rm 4N208, Bethesda, Maryland 20892*

SUMMARY:

This curriculum spans the entire two years of the child and adolescent psychiatry fellowship. Knowledge objectives focus on world faith traditions, including but not limited to basic theological principles and practices, and beliefs, attitudes, and practices regarding medicine, diet, health care provisions, sexuality, reproduction, chronic illness, death and dying, alternative medical practices, burial rituals, and various issues in classical bioethics.

The first year is dedicated to surveying major faith traditions. Religious leaders in the Philadelphia area are invited to serve as guest faculty and address aspects of child and family life inherent to particular traditions. Half-day visits to Philadelphia area Hebrew, Catholic, Protestant, and Islamic schools serve as practical extensions of didactic and discussion sessions. The second year focuses on specific topics in childhood, adolescence, and family religion/spirituality. Trainees learn about religious/spiritual assessment, religious/spiritual aspects of normal development, psychopathology, abuse, psychotherapy, marriage and parenting, sexuality, pediatric medicine, and death and dying. Strong emphasis is placed on understanding the roles of religious professionals and communities.

The course is required for all trainees (ten total). The first year includes a minimum of 45 hours and the second year a minimum of 36 hours. Many didactics are shared with trainees from other mental health disciplines and medical students.

No. 70F
SPIRITUALITY AND EDUCATION: A PRIMER FOR CHILD AND ADOLESCENT PSYCHIATRIC CONSULTANTS AND THE WRIGHT STATE UNIVERSITY CURRICULUM

David M. Rube, M.D., *Dept of Psychiatry, School of Medicine, Wright State University, One Children's Plaza, Dayton, OH 45401-0927*

SUMMARY:

Spiritual needs of children, adolescents, and their families are crucial in assessing, diagnosing, and treating any child, adolescent, and family. The course that I designed is matched to the mission of Wright State University, School of Medicine, a community-based medical school, in assessing, diagnosing, and treating any child, adolescent, and family. Working in conjunction with religious schools will allow the course participants firsthand experience in developing the expertise necessary to work through religious and spiritual issues with their patients.

The didactic portion of the curriculum will cover topics dealing with spirituality in children in both medical and school settings. The faculty will include hospital chaplains and religious school principals and administrators. Topics include spirituality in children, the spiritual needs of families with medically ill children, and fundamentals of Catholicism, Judaism, Christianity, and Islam and their respective educational philosophies.

The experiential portion of the curriculum will include visits to a children's hospital and its pastoral department. Class participants will visit the schools that are represented by the faculty, assessing firsthand how spirituality, religiosity, mental health, and academic issues are dealt with in a religious school setting. They will observe how various belief systems and how religious individuals and families react to the suggestion of a mental health referral, and the role of stigma in mental health referrals in a religious population.

No. 70G
TEACHING PSYCHIATRIC RESIDENTS ABOUT THE ROLE OF SPIRITUALITY IN PRACTICE

Nancy K. Morrison, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker, NE, Albuquerque, NM 87131-0001*

SUMMARY:

At the University of New Mexico Department of Psychiatry a three tiered curriculum in spirituality and psychiatry will be integrated into the current didactic training of residents. Issues of spirituality will be introduced at the level of training that correlates with the residents' professional development. First year residents will receive three lectures regarding the American public's attitude toward religion, the impact of piritual/religious values and practice on medical outcomes and other related topics. In addition they will observe an interview regarding spirituality done by a psychiatrist and one done by a chaplian. A course entitled "Spirituality in America" will be incorporated into the second year course on cultural psychiatry. Ministers, rabbis, shamans and healers from different traditions will introduce the residents to different approaches to spirituality and healing. The third and fourth year residents will share a course entitled "Interfacing issues shared by psychiatry and spiritual traditions." Such topics as guilt, shame, forgiveness, mercy, and compassion will be addressed from the two disciplines. Facilitators will be both psychiatrists and spiritual leaders.

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SYMPOSIUM 71—CLINICAL FEATURES OF OCD: FAMILY STUDY PERSPECTIVE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the importance of homogeneous subtypes of OCD

and the possibility that there is a spectrum of psychopathology that is related to OCD and is transmitted in the relatives of cases.

No. 71A
FAMILIAL NATURE OF OCD

Gerald Nestadt, M.D., *Department of Psychiatry, Johns Hopkins, 600 N Wolfe Street/Meyer 4-181, Baltimore, MD 21287;* Jack F. Samuels, Ph.D., Oscar J. Bienvenu III, M.D., Mark A. Riddle, M.D., Marco A. Grados, M.D., Rudolf Hoehn-Saric, M.D., Kung-Yee Liang, Ph.D.

SUMMARY:

Objective: The current study was conducted to determine if OCD is familial and to investigate possible familial subtypes.

Methods: Eighty case probands were identified in five specialty OCD clinics, and 73 control probands were identified by random-digit dialing. These probands and their first-degree relatives (343 case and 300 control relatives) were evaluated, blinded by group, by PhD psychologists or psychiatrists using semi-structured instruments, and final diagnoses were assigned by a blinded consensus procedure.

Results: The lifetime prevalence of OCD is significantly higher in case relatives. Case relatives have higher rates of both obsessions and compulsions; however, this finding is more robust for obsessions. Age at onset is strongly related to familiality; no case was detected in relatives of probands whose age at onset of symptoms was greater than 18. Probands with tics or obsessive-compulsive personality disorder were not more likely to have relatives with OCD.

Conclusions: OCD is familial. Obsessions are more specific than compulsions. Age at onset of OCD is valuable in characterizing a familial subtype.

No. 71B
OCD, ANXIETY AND AFFECTIVE DISORDERS

Mark A. Riddle, M.D., *Department of Psychiatry, Johns Hopkins University, 600 N Wolfe Street/CMSC 346, Baltimore, MD 21287;* Gerald Nestadt, M.D., Jack F. Samuels, Ph.D., Oscar J. Bienvenu III, M.D., Marco A. Grados, M.D., Rudolf Hoehn-Saric, M.D., Bernadette Cullen, M.D.

SUMMARY:

Objective: This study investigates the relationship of anxiety, affective, and substance use disorders to obsessive-compulsive disorder in a blind, controlled family study.

Methods: Eighty case and 73 control probands and 343 case and 300 control first-degree relatives participated. Subjects were examined by PhD psychologists or psychiatrists using the SADS-LA. Two experienced psychiatrists independently reviewed all materials, and final diagnoses were made according to DSM-IV criteria, by consensus procedure.

Results: All anxiety and affective disorders investigated were significantly more common in case compared with control probands except bipolar disorder. Substance dependence disorders were not more common. Generalized anxiety disorder (GAD), panic disorder, agoraphobia, separation anxiety disorder (SAD), and recurrent major depression were more common in case relatives. These disorders occurred more frequently if the relative was diagnosed with OCD. Only GAD was significantly more frequent in case relatives without OCD. As with case probands, relatives with OCD were more often diagnosed with additional disorders such as brief depressive disorder and social phobia.

Conclusions: GAD and OCD have a common familial etiology. The other anxiety and affective disorders emerge as a consequence of the OCD; they either share an underlying pathological process or are a direct consequence of the condition.

No. 71C
A FAMILY STUDY OF OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS

Oscar J. Bienvenu III, M.D., *Department of Psychiatry, Johns Hopkins University, 600 N Wolfe Street, Meyer 4-181, Baltimore, MD 21287;* Gerald Nestadt, M.D., Jack F. Samuels, Ph.D., Mark A. Riddle, M.D., Marco A. Grados, M.D., Bernadette Cullen, M.D., Rudolf Hoehn-Saric, M.D.

SUMMARY:

Objective: This study investigates the relationship of obsessive-compulsive disorder (OCD) to purported obsessive-compulsive spectrum disorders (body dysmorphic disorder, hypochondriasis, anorexia nervosa, bulimia nervosa, nail biting, trichotillomania, kleptomania, pathological gambling, and pyromania) using a blinded, controlled family study methodology.

Methods: Eighty case and 73 control probands, as well as 343 case and 300 control first-degree relatives were examined by psychiatrists or Ph.D. psychologists using the Schedules for Affective Disorders and Schizophrenia, Lifetime Anxiety version. Two experienced psychiatrists independently reviewed all diagnostic information, and final consensus diagnoses were made using DSM-IV criteria.

Results: Body dysmorphic disorder (BDD) and hypochondriasis occurred significantly more frequently in case than control probands. In addition, BDD occurred more frequently in case relatives than control relatives, whether or not case probands also had BDD. However, BDD only occurred significantly more frequently in case relatives who also had OCD. There was some evidence for familial links between OCD and most other "spectrum" disorders; however, small numbers limit inferential power.

Conclusions: Either OCD and BDD share a common pathological process, or BDD is somehow a consequence of OCD. Future studies of this issue should use larger numbers of families.

No. 71D
OCD AND TICS

Marco A. Grados, M.D., *Department of Psychiatry, Johns Hopkins University, 600 N. Wolfe St. CMSC 346, Baltimore, MD 21287;* Gerald Nestadt, M.D., Jack F. Samuels, Ph.D., Oscar J. Bienvenu III, M.D., Mark A. Riddle, M.D., Rudolf Hoehn-Saric, M.D., Kung-Yee Liang, Ph.D.

SUMMARY:

Tourette's syndrome (TS), the presence of vocal and/or motor tics for at least 12 months, is a recognized neurodevelopmental disorder that reflects a dysfunction in striatal brain function. TS and obsessive-compulsive disorder (OCD) have a bidirectional overlap from familial-genetic, phenomenological, comorbidity, and natural history perspectives.

In a family study of TS, the rates of TS, chronic tics, and OCD in the total sample of biologic relatives of TS probands were significantly greater than in the relatives of controls. Thus, OCD may be part of a "TS spectrum."

The relationship of tics and OCD in 796 probands and family members in a family study of OCD is explored. There were significantly more lifetime single or multiple motor or vocal tics in OCD case probands than in control probands ($p = 0.007$). The same was true for OCD case relatives vs. control relatives ($p = 0.026$). There was a trend toward greater tic frequency in males ($p = 0.100$) when relatives were considered. Although the mean age of onset of OCD symptoms was similar for relatives with tic-related OCD and non-

tic-related OCD, the age of onset had a much narrower range in tic-related OCD relatives.

No. 71E
PERSONALITY AND PERSONALITY DISORDERS IN OCD

Jack F. Samuels, Ph.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, M 4-181, Baltimore, MD 21287;* Gerald Nestadt, M.D., Oscar J. Bienvenu III, M.D., Mark A. Riddle, M.D., Bernadette Cullen, M.D., Rudolf Hoehn-Saric, M.D.

SUMMARY:

Objective: To compare personality disorders and normal personality dimensions in persons with and without obsessive-compulsive disorder (OCD).

Methods: As part of the Hopkins OCD Family Study, we assessed personality disorders (using the SIDP) and normal personality features (using the NEO) in 72 OCD case and 72 control probands.

Results: The prevalence of avoidant (15% vs 1.4%) and obsessive-compulsive personality disorders (32% vs 6%) was significantly higher in the case probands. The case probands also scored significantly higher on neuroticism and lower on extraversion.

Conclusions: Individuals with OCD have specific personality profiles that are different from individuals without OCD.

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SYMPOSIUM 72—LONG-TERM CONSEQUENCES OF CHILDHOOD SEXUAL ABUSE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify various deleterious consequences of being a survivor of childhood sexual abuse and their clinical implications.

No. 72A
DYSFUNCTIONAL SEXUAL BEHAVIOR AND SEXUAL ABUSE

John N. Briere, Ph.D., *Department of Psychiatry, USC School of Medicine, 1937 Hospital Place, Los Angeles, CA 90033;* Diana Elliott, Ph.D.

SUMMARY:

This study examined the extent of self-reported dysfunctional sexual behavior (DSB) in 927 males and females from the general population who had or had not been sexually abused in childhood. Dependent variables were the ten individual items of the Dysfunctional Sexual Behavior Scale of the Trauma Symptom Inventory (Briere, 1995). MANOVA indicated that younger subjects were more likely to endorse DSB ($p = .001$), as were those with sexual abuse histories ($p < .001$), and there was a trend for males to endorse more DSB than females ($p = .071$). There was an interaction between subject sex, age, and sexual abuse history ($p = .002$). Childhood physical abuse, however, was not related to DSB. Posthoc ANOVAs indicated that younger subjects endorsed all 10 DSB items more than older subjects, and sexually abused subjects were considerably more likely to endorse all 10 items than nonabused subjects. Posthoc analysis of the interaction indicated that anonymous sex was especially likely for younger males with sexual abuse histories, whereas sexual fantasies of being dominated or overpowered and of having sex with someone who was "bad for you" were most common among younger females with sexual abuse histories.

No. 72B
SEXUAL REVICTIMIZATION IN SURVIVORS OF CHILD SEX ABUSE

Catherine Classen, Ph.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5544;* Cheryl Koopman, Ph.D., Kirsten Nevill-Manning, Nigel Field, Ph.D., Lisa Butler, Ph.D., David Spiegel, M.D.

SUMMARY:

Objective: (1) To examine the relationship between sexual revictimization and interpersonal problems in adult survivors of childhood sexual abuse diagnosed with PTSD, and (2) to provide preliminary treatment outcome data comparing the effectiveness of trauma-focused and present-focused group therapy in reducing sexual revictimization.

Method: Fifty-two treatment-seeking women participated in this study. Participants completed the Sexual Experiences Survey to assess sexual revictimization within the last six months and the Inventory of Interpersonal Problems. Participants were randomly assigned to one of three conditions: (1) a trauma-focused group psychotherapy, (2) a present-focused group psychotherapy, and (3) a waiting list no-treatment control condition.

Results: Revictimized participants reported overall greater interpersonal problems compared with nonrevictimized participants. Revictimized participants had significantly higher scores on "hard to be assertive," "too responsible," socially avoidant, nonassertive, overly nurturant, and intrusive subscales. Among those individuals who had been sexually revictimized in the previous six months, at post-treatment only 38% of the women who were in the treatment group were revictimized compared with 67% of women in the wait-list condition.

Conclusion: Further research with a larger sample of women is needed to confirm these findings and to test for differential effects of trauma-focused group therapy and present-focused group therapy.

No. 72C
SUBSTANCE-ABUSING WOMEN AND SEXUAL ABUSE

Rita K. Teusch, Ph.D., *129 Mount Auburn Street, Cambridge, MA 02138*

SUMMARY:

Objective: (1) To describe how alcohol and drug addiction frequently become a long-term sequelae of childhood sexual abuse, (2) to outline the physical and psychological functions that substances often serve for the sexually abused woman, and (3) to demonstrate how attitudes and feelings about the addiction tend to mirror those

of the unresolved trauma, complicating recovery from both the addiction and the sexual abuse.

Method: A review of the literature and clinical experience are used to highlight these points, as well as the short- and longer-term treatment goals and typical therapeutic challenges.

Results: This review shows that women with histories of sexual abuse frequently use alcohol and drugs to reestablish emotional control or to numb the physiological sequelae of their trauma. An important part of their recovery process is then to become fully aware of the function alcohol and drugs have served for them before they can begin to work on alternative coping strategies.

Conclusion: The preferred treatment approach is one that integrates substance abuse treatment and recovery work from sexual traumatization. Feeling secure and understanding the functions that substance abuse have served for her will provide the basis for recovery from both sexual traumatization and substance abuse.

No. 72D
SEX ABUSE AND MEDICAL UTILIZATION: CLINICAL IMPLICATIONS

Bruce A. Arnow, Ph.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5722;* Stacey Hart, Ph.D.

SUMMARY:

Findings and clinical implications of the following study will be presented and discussed:

Objective: To examine the relationships between reported history of childhood sexual abuse (CSA), psychological distress, and medical utilization among women in an HMO setting.

Method: Participants were 206 female adults recruited from an HMO primary care clinic. Participants were: (1) CSA distressed, (2) distressed only, (3) CSA only, (4) controls. Medical utilization rates were generated from the HMO's computerized database.

Results: CSA distressed and distressed only groups both used significantly more nonpsychiatric outpatient visits than CSA only and control participants, but were not different from one another. CSA distressed participants used significantly more ER visits and were more likely to visit the ER for pain-related complaints than the other groups. Among CSA distressed participants, those meeting criteria for physical abuse used significantly more ER visits than those who did not.

Conclusions: Psychiatric distress is associated with higher outpatient medical utilization, independent of CSA history. History of CSA with concomitant distress is associated with significantly higher ER visits, particularly for those with physical abuse histories. History of CSA without distress is not associated with elevated rates of medical utilization.

No. 72E
TREATING SOMATIZATION RELATED TO CHILD ABUSE

Elizabeth S. Bowman, M.D., *Department of Psychiatry, Indiana University, 541 Clinical Drive, Room 291, Indianapolis, IN 46202*

SUMMARY:

Studies from Briquet onward show a robust association between somatoform disorders and childhood trauma, regardless of which group (somatoform or abused) is studied. This paper summarizes studies demonstrating the association of childhood abuse with somatization disorder, somatoform pelvic pain, and conversion seizures. From a case series, I will illustrate the association of conversion seizures with childhood trauma (67%), dissociation (>90%), PTSD (49%), and other somatoform symptoms (>82%). I will propose several pathways that may link childhood abuse with conversion seizures, including that of adult trauma causing arousal of dissociated experiences of childhood trauma. Recent studies of the neurobiology of traumatic memories (in PTSD) have found trauma memories are stored in the right frontal lobe in verbally unprocessed somatosensory forms, explaining why they may be poorly remembered but recur as somatoform symptoms. These findings may explain why verbal insight-oriented therapies that target the left tempo-parietal area are remarkably unhelpful with somatoform disorders. Using cases of conversion seizures, I will illustrate dynamic pathways linking child abuse, especially sexual abuse, with conversion seizures and outline how psychotherapeutic treatment of conversion seizures may be more successful if dissociated child abuse experiences are ascertained during evaluation and explicitly addressed in treatment.

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SYMPOSIUM 73—NEUROANATOMY AND NEUROENDOCRINOLOGY OF PTSD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session the participant will be able to gain a better understanding of the biological alterations in posttraumatic stress disorder and their relationship to symptoms.

No. 73A
ANALYZING BIOLOGIC CHANGES OVER THE COURSE OF CHRONIC PTSD

Rachel Yehuda, Ph.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 130 West Kingsbridge Road, Bronx, NY 10468;* Heidi S. Resnick, Ph.D., Julia A. Golier, M.D., A. McFarlane, Robert A. Grossman, M.D.

SUMMARY:

Data from individuals with acute and chronic PTSD will be presented in order to demonstrate, in a cross-sectional fashion, the longitudinal progression of hypothalamic-pituitary-adrenal (HPA) over the course of the lifetime in trauma survivors with and without PTSD. Several points will be emphasized. (1) Cortisol levels are significantly lower in trauma survivors with PTSD compared with those in trauma survivors without PTSD and nontraumatized comparison subjects. (2) Low cortisol levels in PTSD do not appear to represent a chronic adaptation to stress or symptoms since low corti-

sol levels are present in trauma survivors who develop PTSD within hours after exposure to a traumatic event. Indeed, cortisol levels are higher in the immediate aftermath of trauma in survivors who do not develop PTSD. (3) Low cortisol levels may have predated the trauma exposure and may be related to risk factors for PTSD. This is supported by the findings that low cortisol following rape was particularly associated with a prior history of rape, and that cortisol levels were low in a group at increased risk for the development of PTSD prior to traumatization. (4) Although cortisol levels are low in both young and old survivors with PTSD, regardless of the age at which the focal trauma occurred, there are important changes in the patterns of cortisol release associated with both age and duration of symptoms. The neuroendocrine changes are paralleled by alterations in cognitive performance. The developmental progression of HPA alterations and cognitive performance have implications for understanding structural brain alterations in PTSD.

No. 73B
HIPPOCAMPUS AND HPA IN ABUSE-RELATED PTSD

J. Douglas Bremner, M.D., *Department of Psychiatric Research, Yale University, 184 Liberty Street, New Haven, CT 06519;* Meena Narayan, M.D., Thomas H. McGlashan, M.D., George R. Heninger, M.D., Ann M. Rasmusson, M.D., Steven M. Southwick, M.D., Dennis S. Charney, M.D.

SUMMARY:

We reported smaller volume of the hippocampus, a brain area involved in learning and memory, and elevations in corticotropin releasing factor (CRF), in patients with posttraumatic stress disorder (PTSD). Animal studies suggest high levels of glucocorticoids released during stress are responsible for hippocampal damage and release of inhibition of corticotropin releasing factor (CRF) and the hypothalamic-pituitary-adrenal (HPA) axis. Low or unchanged levels of urinary cortisol in PTSD did not seem to fit, however, with this model of glucocorticoid-induced damage. In order to more comprehensively assess the hippocampal-HPA system we measured hippocampal volume, diurnal cortisol, and ACTH over 24 hours, and cortisol response to CRF and ACTH challenge in 33 women, including those with childhood sexual abuse and PTSD, with abuse without PTSD, and without abuse or PTSD. Abused PTSD women had lower diurnal levels of cortisol in the afternoon compared with abused non-PTSD women, and in the 3 p.m. to 4 p.m. time segment relative to non-abused non-PTSD. Abused PTSD women had lower cortisol levels following both CRF and ACTH challenge. Both abused women with and without PTSD had a blunted ACTH response to CRF challenge. The findings suggest long-term dysregulation involving increased central CRF activity with hypocortisolemia in the periphery in PTSD.

No. 73C
NEUROBIOLOGY OF PTSD IN AGING TRAUMA SURVIVORS

Julia A. Golier, M.D., *Department of Psychiatry, Bronx VA Medical Center, 130 Kingsbridge Road, Bronx, NY 10468;* Rachel Yehuda, Ph.D., Mony de Leon, Ed.D., Susan DeSanti, Ph.D., Antonio J. Convit, M.D.

SUMMARY:

It has been hypothesized that the smaller hippocampal volumes and associated memory impairment described in PTSD are due to glucocorticoid-mediated neurotoxicity. However, our group has consistently reported reduced cortisol levels in PTSD. We therefore have begun examining hippocampal-dependent memory function and MRI-based hippocampal volumes in tandem with neuroendocrine activity in aging trauma survivors to clarify the relationships between these measures. Elderly trauma survivors with PTSD (N = 25), trauma survivors without PTSD (N = 15), and an age-matched group of non-psychiatric subjects (N = 25) were compared on a measure of hippocampal-dependent memory function (paired associates test). The groups differed significantly on cued-recall, after correcting for educational attainment, in both the high associate and low associate conditions, with the PTSD group recalling fewer word pairs than the non-psychiatric group. The PTSD group also had lower salivary cortisol levels than the non-psychiatric group at several points in the diurnal cycle. To date we have obtained MRIs of the brain in 25 elderly trauma survivors; preliminary qualitative analysis suggests that hippocampal atrophy is present in the majority of these trauma survivors. Quantitative analysis is underway and will be completed by the time of presentation, which will allow us to assess the relationships between hippocampal volume, basal cortisol level, and memory impairment in elderly trauma survivors.

No. 73D
HIPPOCAMPUS IN TWINS DISCORDANT RECOMBAT AND PTSD

Mark W. Gilbertson, Ph.D., *VA Research Service, 228 Maple St. 2nd Floor, Manchester, NH 03103;* Martha E. Shenton, Ph.D., Natasha B. Lasko, Ph.D., Scott P. Orr, Ph.D., Roger K. Pitman, M.D.

SUMMARY:

The objective of this project is to advance our understanding of the origin of diminished hippocampal volume in PTSD by studying monozygotic twins discordant for combat exposure. By measuring hippocampal volume in unexposed twins of combat veterans who develop PTSD vs. those who do not, hippocampal reduction as a familial/genetic vulnerability marker can be examined. The comparison of hippocampal volume in combat-exposed PTSD veterans with their unexposed co-twins allows for an analysis of hippocampal reduction as environmentally (e.g., combat) acquired. Subjects are divided into two groups on the basis of whether the combat-exposed twin meets DSM-IV criteria for PTSD. Each subject undergoes magnetic resonance imaging (MRI) using a 1.5 Tesla GE Signa series scanner obtaining contiguous 1.5mm coronal slices for volumetric analysis. In addition to hippocampal volume, three comparison brain structures (amygdala, caudate nucleus, and superior frontal gyrus) serve as volumetric control sites in order to establish anatomic specificity. Given the well-established relationship between the hippocampus and memory functioning, cognitive memory performance data are also obtained.

To date, 16 twin pairs have been studied. At the time of the presentation, the results of 30 or more twin pairs will be available for presentation.

No. 73E
HYDROCORTISONE PET IMAGING IN PTSD

Robert A. Grossman, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, Box 1230/1 Gustave Levy Place, New York, NY 10029;* Rachel Yehuda, Ph.D., Nelly Sta-Maria, M.A., Richard Lee, M.D., Mony deLeon, Ph.D., Monte S. Buchsbaum, M.D.

SUMMARY:

Based on hypothalamic-pituitary-adrenal axis findings, it has been hypothesized that subjects with PTSD display a heightened sensitivity of central glucocorticoid receptors. This hypothesis can be explored through use of a double-blind hydrocortisone and placebo challenge followed by positron emission tomography imaging using radio-labeled deoxy-glucose (^{18}FDG). Glucocorticoid administration

results in translocation of cell membrane glucose transporters to inactive intracellular storage sites. Therefore, increased sensitivity of central glucocorticoid receptors should result in a greater decrease in hippocampal and amygdala metabolism (two brain regions richest in glucocorticoid receptors) following hydrocortisone in subjects with PTSD, as compared with subjects without PTSD. Further, high physiologic levels of glucocorticoids decrease declarative memory encoding, presumably—through interference with a type of synaptic plasticity—long-term potentiation. Our preliminary results have shown an increased inhibition of ^{18}FDG uptake and greater deficits in declarative memory function following a 17 mg I.V. hydrocortisone challenge in one subject with PTSD compared with a normal comparison subject. Data will be presented from a larger group, and will be discussed in terms of enhancing our understanding of the interface between neuroendocrinology and neuroanatomy of PTSD.

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SYMPOSIUM 74—VULNERABILITY TO PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium the participant should understand biochemical, genetic, family history, and behavioral pattern vulnerabilities that can contribute toward the development of a personality disorder.

No. 74A
BIOLOGICAL FACTORS IN VULNERABILITY TO PERSONALITY DISORDERS

Kenneth R. Silk, M.D., *Department of Psychiatry, University of Michigan, 1500 E Medical Center/Box 0704, Ann Arbor, MI 48109-0704*

SUMMARY:

Vulnerability to a personality disorder appears to be a combination of life experiences, parental style and responsivity, and biological vulnerability. Biological vulnerability implies a predisposition for specific biological mechanisms to become disordered when exposed, probably repeatedly, to sufficient stressors. These stressors may either be environmentally or biologically (physiologically) determined. When stressed sufficiently, these disordered biological mechanisms contribute in unique ways to how a person thinks, behaves, reacts, and feels; or clinically, how the person presents symptomatically with problems in cognition, affect regulation, impulsivity, anxiety, and responsivity and reactivity to interpersonal and environmental situations. Specific neuroendocrine substrates are thought to be related to specific psychopathological presentations (i.e., cognitive disturbances to dopaminergic systems; impulsivity to serotonergic systems). What appears unique in personality disorders is that no single neurobiological disturbance seems to be primarily operative. For example, patients with borderline personality may have vulnerabilities across multiple neurobiologic systems in that they appear to be environmentally hyperreactive (noradrenergic system), which leads to emotional instability and dysphoria and the need to act out impulsively (serotonin) to quell the dysphoria and lability. At the height of reactivity, these patients also appear to suffer cognitive distortions (dopamine), which facilitates dissociation, poor judgment, and subsequent impulsivity. Original biological vulnerability may arise from parental predispositions to impulsivity, anxiety, or depression. Psychopharmacologic treatment provides an opportunity to reregulate the disordered biological system, reduces stress, and give the patient a better chance to achieve successful coping mechanisms.

No. 74B
THE GENETIC ARCHITECTURE OF PERSONALITY DISORDER TRAITS

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancover, BC V6T 2A1, Canada;* Kerry L. Jang, Ph.D.

SUMMARY:

Behavior-genetic analyses point to the importance of genetic and environmental contributions to the etiology of personality disorder traits. This presentation reports on the genetic architecture underlying personality disorder based on data obtained from a general population volunteer sample of 693 twin pairs. All subjects completed the Dimensional Assessment of Personality Pathology (DAPP-DQ) along with other personality scales. The DAPP-DQ assesses 18 basic traits of personality disorder that provide a comprehensive description of the domain. Each scale is subdivided into several specific trait scales. In total, 69 specific traits define the 18 traits. Estimates of genetic and environmental influences on the scales indicated a substantial heritable component to all scales with specific environmental factors accounting for the remaining variance.

Multivariate genetic analyses identified four broad genetic factors underlying the 18 traits. These were labeled emotional dysregulation, dyssocial behavior, inhibition, and compulsivity. Further analyses indicated that when the effects of these higher order factors were removed from each of the 18 trait scales a substantial heritable component remained. Further analyses indicated that most of the 18 traits, scales, consisted of several specific and independent components of variance.

These results suggest that personality is inherited as a large number of specific genetic factors. These findings will be considered in terms of their implications for understanding the pathogenesis of personality disorder.

No. 74C
BORDERLINE PATHOLOGY: A CHILDHOOD PRECURSOR OF PERSONALITY

Joel F. Paris, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, PQ H3T 1E4, Canada;* Jaswant Guzder, M.D., Phyllis Zelkowitz, Ph.D., Ron Feldman, M.D.

SUMMARY:

Objective: This study was designed to determine whether children with borderline pathology (a probable precursor of personality disorders) demonstrate a specific pattern of risk factors.

Method: The subjects were 94 school-aged children in day treatment, divided into borderline (n = 41) and nonborderline (n = 53) groups using the Child Version of the Diagnostic Interview for Borderlines. All children were assessed using the Child Behavior Checklist, the K-SADS, a psychosocial questionnaire, and a neuropsychological battery. Parental pathology was assessed by the mini-SCID.

Results: Children with borderline pathology had higher rates of physical abuse, sexual abuse, severe neglect, as well as of family breakdown and parental criminality. In multivariate analyses, the discriminating factors were sexual abuse and parental criminality. The borderline children also showed problems with executive function, as measured by significantly abnormalities on two neuropsychological tests: the Wisconsin Card Sorting Test and the Continuous Performance Test.

Conclusions: Borderline pathology in childhood is associated with a unique pattern of biological and psychosocial risk factors.

No. 74D
FAMILY HISTORY AND VULNERABILITY TO PERSONALITY DISORDER

James H. Reich, M.D., *Department of Psychiatry, Harvard Medical School, 2255 North Point Street, #102, San Francisco, CA 94123*

SUMMARY:

This presentation will use the family history method to examine potential vulnerabilities to the personality disorders. The family history method gathers information about relatives to determine familial predispositions. The family history method is also useful in determining possible relationships between Axis I and Axis II disorders. These relationships may represent important vulnerabilities to the development of personality disorders. I will present evidence for the relationship between family history of generalized anxiety disorder and vulnerability to borderline personality disorder; the relationship of mixed anxiety/depression and familial personality vulnerability; and the relationship of personality disorders to the anxiety disorders. Theoretical and treatment implications of these findings will be discussed.

No. 74E
BEHAVIORAL SCHEMA AND PERSONALITY DYSFUNCTION

Marsha M. Linehan, Ph.D., *Department of Psychology, University of Washington, Guthrie Hall, Room 119/Box 351525, Seattle, WA 98195-1525*

SUMMARY:

This presentation examines the interaction of behavior and environment in the preservation and development of personality disorders from the Dialectic Behavior Therapy (DBT) perspective. DBT is a theoretical and therapeutic method of conceptualizing and treating some of the complex behavioral and environmental relationships found in personality disorders. Certain behaviors or "schemas of behavior" can reduce stress, but reinforce patterns of behavior that are not adaptive in the overall picture of a patient's life. Frequently, these behaviors are predisposed to by genetics and neurochemistry. Once a reinforcing pattern is established, the behaviors can be, to a greater or lesser extent, independent of the original causes. Repeated ingrained behavioral schema can become, in effect, part of a person's environment. These environmental-behavioral interactions are not static, but in a constant state of fluid evolution. This presentation will give examples of personality schematic dysfunction and how they may develop. It will also offer suggestions as to the DBT approach for preventing and treating these behaviors. The presentation will encompass both the theory and practice of DBT for ingrained maladaptive behavioral schema.

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SYMPOSIUM 75—TRAUMA AND THE DEVELOPMENT OF DISORDERED EATING

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the various ways in which different types of trauma influence eating behaviors across development.

No. 75A
BEHAVIOR THERAPY IN POSTTRAUMATIC FEEDING DISORDERS

Diane Benoit, M.D., *Dept of Psychiatry, The Hospital for Sick Children, 555 University Ave, Toronto, ON M5G 1X8, Canada*

SUMMARY:

Objective: To determine whether behavior therapy is more efficacious than nutritional therapy in obviating the need for tube feeding in infants with posttraumatic eating disorders (PTED). PTED are eating problems, often misdiagnosed as infantile anorexia or other eating disorders, that occur in children of all ages with food refusal and a history of distressing experiences involving the mouth, nose, throat, and esophagus (e.g., intubation, suctioning).

Method: Sixty-four 4- to 36-month-old infants with PTED, tube fed for at least one month, were randomly assigned to behavioral or nutritional interventions (32 per group). For seven consecutive weeks, subjects and their feeders attended a clinic with one of two therapists, followed by three follow-up visits. The nutritional intervention provided structured schedules and routines. The behavioral intervention provided the same nutritional intervention plus behavior therapy (flooding). The primary outcome measure was the proportion of successes defined as infants no longer requiring tube feeding at the third follow-up visit in each group (four and a half months after start of trial).

Results: A total of 15 of 32 (47%) subjects in the behavioral group versus none in the nutritional group were successes ($p < .001$).

Conclusion: Behavior therapy is more efficacious in eliminating the need for tube feeding in PTED than nutritional counseling.

Study funded by the Medical Research Council of Canada, the National Health Research and Development Program, and the Ontario Mental Health Foundation.

No. 75B
DISORDERED EATING IN CHILDREN WITH ALLEGED MALTREATMENT

Timothy D. Brewerton, M.D., *Department of Psychiatry, Medical University of SC, 67 President St/PO Box 250861, Charleston, SC 29425-0002;* Elizabeth Ralston, Ph.D., Michelle Dean, M.A., Lisa D. Hand, M.D.

SUMMARY:

Objective: Studies of community and representative samples of women suggest that victimization experiences, especially during childhood or adolescence, are significant risk factors for the development of disordered eating behaviors and attitudes. However, few studies have examined this directly in children.

Method: One hundred eleven children (94 girls, 17 boys) between 7–8 y/o who were referred for forensic evaluation of alleged maltreatment were asked to complete questionnaires, including the Kids' Eating Disorders Survey (KEDS), the Eating Disorders Inventory for Children (EDI-C), the Trauma Symptom Checklist for Children (TSC-C), the Child Depression Inventory (CDI), and the Adolescent Dissociative Experiences Scale (ADES) (age ≥ 11 y/o only). A parent or guardian completed the Child Dissociative Checklist (CDC) and the Child Behavior Checklist (CBCL). Our hypothesis was that eating disorder-related symptoms would be correlated with trauma-related symptoms.

Results: Mean age (±SD) of the sample at time of evaluation was 12.0 ± 2.3 yrs, and mean age of first abuse was 9.3 ± 2.6 yrs. Mean BMI was 21.9 ± 6.8. Forty percent (%) of the girls and 29% of the boys reported some type of "eating problem." In the girls alone the mean EDI-C scores were significantly correlated with the anxiety ($r = 0.50$, $p < 0.0001$), PTSD ($r = 0.53$, $p < 0.0001$), depression ($r = 0.47$, $p < 0.0001$), dissociation ($r = 0.43$, $p < 0.0001$), and sexual concerns ($r = 0.49$, $p < 0.0001$) subscale scores of the TSC-C ($p < 0.0001$), the mean TSC-C score ($r = 0.60$, $p < 0.0001$), the ADES score ($r = 0.35$, $p < 0.02$), the mean KEDS score ($r = 0.61$, $p < 0.0001$), and BMI ($r = 44$, $p < 0.001$) (but not with the CDI, CDC, or CBCL scores). The mean KEDS score was significantly correlated with the anxiety ($r = 0.28$, $p < 0.02$, PTSD ($r = 0.31$, $p < 0.008$), depression ($r = 0.33$, $p < 0.004$), and dissociation ($r = 0.23$, $p < 0.05$) subscale scores of the TSC-C ($p < 0.001$), the mean TSC-C score ($r = 0.29$, $p < 0.02$), the CDC score ($r = 0.39$, $p < 0.003$), and BMI ($r = 0.58$, $p < 0.0001$) (but not the ADES, the CDI, or the CBCL scores).

Conclusions: These findings contribute to the premise that childhood maltreatment is an important risk factor in the early development of disturbances in eating behaviors and attitudes in children.

No. 75C
SEXUAL ABUSE AND EATING DISTURBANCES IN CHILDREN

Stephen A. Wonderlich, Ph.D., *Department of Neuroscience, University of ND Medical School, 1919 North Elm Street, Fargo, ND 58102;* Ross D. Crosby, Ph.D., Jennifer Roberts, M.S., James E. Mitchell, M.D., Beth Haseltine, M.S., Kevin Thompson, Ph.D., Gail DeMuth, R.N.

SUMMARY:

Objective: The purpose of this study was to examine the relationship between a history of sexual abuse during childhood and eating disturbances in a sample of 10- to 15-year-old girls.

Method: Twenty girls who were evaluated at a local rape and abuse crisis center were compared with 20 non-abused control girls in terms of disturbances in eating, self-concept, mood disturbances, substance use, and impulsive behaviors.

Results: Sexually abused children showed a variety of disturbances that differentiated them from control children. First, sexually abused children showed higher levels of weight concern and dieting behavior, as well as purging behavior than control subjects. Additionally, sexually abused girls showed greater evidence of a negative self-concept with a particular perception of "feeling different than other girls." Sexually abused girls were also more likely to utilize alcohol, marijuana, and cigarettes and also engage in impulsive and self-destructive behaviors. Mediational analyses suggested that impulsivity was a stronger mediator of the relationship between sexual abuse and eating disturbance than was body image concern.

Conclusions: This study supports the existing empirical data, which indicate that sexual abuse is a risk factor for eating disturbance in children. Furthermore, sexually abused children tend to display a wide variety of deficits, and impulsivity may serve as a significant factor in the development of eating disorders in sexually abused children.

No. 75D
ATYPICAL DEPRESSION ASSOCIATED WITH EARLY PARENTAL STRAIN

Robert D. Levitan, M.D., *Department of Psychiatry, University of Toronto, 250 College Street, Toronto, ON M5T 1R8, Canada;* Tess Sheldon, M.S.C., Sagar V. Parikh, M.D., Elizabeth H.B. Lin, M.D., Paula N. Goering, Ph.D.

SUMMARY:

Background: In a large community sample of Ontario, we have recently described an association between early childhood physical and sexual abuse and atypical neurovegetative symptoms of depression. In the current study we examined whether another early developmental factor, i.e., parental strain, was independently associated with atypical symptoms in adulthood.

Methods: A total of 8,116 individuals aged 15 to 64 years were interviewed using the World Health Organization Composite International Diagnostic Interview (CIDI) and 653 subjects met criteria for major depression. For depressed subjects, a "parental strain" variable was derived based on the summed score across four items related to parental conflict, parental separation, death of a parent, and lack of a confiding relationship. We then compared these "parental strain" scores in unipolar depressive subgroups defined by typical and atypical neurovegetative symptom patterns (i.e. decreased appetite, weight loss, and insomnia, vs. increased appetite, weight gain, and hypersomnia, respectively). Manic subjects were excluded from the analysis.

Results: Early parental strain was associated with major depression with atypical neurovegetative features across both genders. In a subsequent analysis, a multiple regression model including both childhood trauma and parental strain as independent variables predicted atypical symptoms of depression at a highly significant level (model chi-square = 11.1, df = 3, $p = .01$). In this model, neither parental strain nor early trauma was a significant predictor of atypical symptoms on its own.

Conclusions: Early parental strain is associated with atypical symptoms of depression, including increased eating and weight gain, in adulthood. Taken together with our prior data, these results suggest that one must consider a number of early environmental factors in assessing possible links between early experience and later psychopathology.

No. 75E
TRAUMA AND NEUROBIOLOGICAL STATUS IN BULIMIA NERVOSA

Howard Steiger, Ph.D., *Eating Disorders, Douglas Hospital, 6875 LaSalle Boulevard, Montreal, PQ H4H 1R3, Canada;* Naomi

Koerner, B.A., Nmk Ying Kin Ng, Ph.D., Mimi Israel, M.D., Pascale Lehoux, M.A., Simon Young, Ph.D.

SUMMARY:

Objective: Bulimia nervosa (BN) has been linked to childhood abuse and to disturbances in central neurotransmitter/neuroendocrine mechanisms. This study examined implications of childhood abuse experiences for neurobiological status in women with and without BN.

Method: We had 27 women with BN and 22 normal-eater women provide blood samples for tests of (a) paroxetine binding in blood platelets, (b) hormonal responses to "challenge" with the serotonin (5-HT) agonist meta-Chlorophenylpiperazine (m-CPP), and (c) plasma cortisol. Structured interviews and/or self-report questionnaires were used to obtain measures of childhood traumata and of psychopathological features (e.g., impulsivity, posttraumatic stress symptoms, affective problems).

Results: BN participants were prone to blunting of prolactin responses following m-CPP, reduced density of platelet 5-HT reuptake sites, and decreased baseline cortisol. Experiences of trauma also coincided with a profile characterized by blunting of prolactin response after m-CPP (visible in control women) and lowering of baseline cortisol—and such effects seemed to exist independently of various psychopathological indices. Posttraumatic symptoms corresponded, in bulimics, to especially low baseline cortisol. Although weakly, severe trauma predicted elevated impulsivity, dissociation, and self destructiveness.

Conclusions: Our findings suggest that common neurobiological factors may mediate interconnections among childhood abuse, bulimic eating patterns, and certain psychopathological characteristics.

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1. Benoit D, Coolbear J: Post-traumatic feeding disorders in infancy: behaviors predicting outcome. Inf Ment Health J 1998; 19:409–421
2. Dansky BS, Brewerton TD, Kilpatrick DC, O'Neil PM: The National Women's Study: relationship of victimization and posttraumatic stress disorder to bulimia nervosa. International Journal of Eating Disorders 1997; 21:213–228
3. Wonderlich SA, Brewerton TD, Jocic Z, Dansky BS, Abbott DW: Relationship of childhood sexual abuse and eating disorders. J Am Acad Child Adolesc Psychiatry 1997; 36:1107–1115
4. Levitan RD, Parikh S, Lesage A, Hegadoren K, et al: Major depression in individuals with a history of childhood physical and/or sexual abuse: relationship to neurovegetative features, mania and gender. American Journal of Psychiatry 1998; 155:1746–1752
5. Levitan RD, Kaplan AS, Jofte RT, Levitt AJ, Brown GM: Hormonal and subjective responses to intravenous meta-chlorophenylpiperazine in bulimia nervosa. Archives of General Psychiatry 1999; 54(6):521–527
6. Wonderlich SA, Brewerton T, Jocic Z, Dansky BS, Abbott DW: Relationship of childhood sexual abuse and eating disorders. J Am Acad Child Adolesc Psychiatry 1997; 36(8):1107–1115

SYMPOSIUM 76—ADOLESCENTS AND THE MEDIA IN THE NEW MILLENIUM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand the effect of exposing teens to violence, sexuality, and drug use through television, the Internet, and other media, and its impact on attitudes and behavior. Our role as professionals will also be discussed.

No. 76A
ADOLESCENTS AND THE MEDIA: AN INTRODUCTION

Victor Strasburger, M.D., *Department of Pediatrics, University of New Mexico, ACC-3 University of New Mexico, Albuguerque, NM 87131*

SUMMARY:

Does the media cause teenagers to engage in violence, early sexual activity, and drug use, or do they simply "mirror" society as the entertainment industry suggests? This presentation will discuss state-of-the-art research on adolescents and the media, highlighting studies on violence, sexuality, and drug use. Illustrated clips from current media will be shown, and suggestions for practitioners about how to interact with parents, patients, and local schools regarding this issue will be presented.

No. 76B
VIETNAM AND LITTLETON: VIOLENT VIDEO GAMES AND MURDER SIMULATORS

David Grossman, *1422 S. Main, Jonesboro, AR 72401*

SUMMARY:

This paper will review WWII U.S. Army findings that the vast majority of riflemen in combat would not fire at exposed enemy soldiers. The primary limitation was found to be in training soldiers to fire at bullseye targets. The military now recognizes that, to enable a soldier to shoot at and kill humans, he/she must practice shooting at human figures in training. Thus, the military developed "killing simulators," intentionally nurturing firing in combat as an operantly conditioned response (in consultation with B.F. Skinner), which raised the firing rate among U.S. soldiers up to six-fold in Vietnam. Today this killing enabling mechanism is used world-wide in military and law enforcement communities. You need three things to kill: the weapon, the skill, and the will to kill. The military understands that these simulators can provide two out of three.

The violent video games that children are now playing have startling similarities to military and law enforcement killing simulators. The military and law enforcement communities use many video games as training devices. Violent video games have been associated with most of the recent schoolyard mass murders, creating a need to understand the degree to which these "murder simulators" may be enabling our kids to kill.

No. 76C
TEEN VIOLENCE AND THE INTERNET

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 E. Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

After Columbine, the interest paid to the Internet and the role it may have played in the tragedy was discussed at great length by the media. What is it about the Internet that it is seen as being both influential and yet potentially so dangerous? This presentation will provide an overview of the Internet and the areas that are thought to be the most toxic for our youth, including the review of hate, violence, and perversion sites. What can be done to contain the Internet? What federal and international initiatives have there been and are there to deal with the availability of potentially toxic material? Initiatives concerning Internet containment as well as our role as professionals will be discussed.

Objectives:

1. Review the Internet material that is most likely to be harmful to our youth.

2. Increase the knowledge of the participant about the national and international initiatives concerning Internet containment.

No. 76D
ADOLESCENT SEXUALITY, THE MEDIA, AND THE INTERNET

Donna M. Woods, M.D., *Department of Psychiatry, University of Michigan, 1500 E. Medical Center Dr., Ann Arbor, MI 48109-0390*

SUMMARY:

The presence of erotic material has been available to man for hundreds, if not thousands, of years. The Internet has changed the availability of this material drastically. Erotic or pornographic images that were relegated to "art houses" or specialty shops, many of which have been banned from cities around the world, have made themselves available again through the Internet. Pre-Internet, each year, teenagers viewed on television 15,000 sexual references, innuendoes, and jokes, of which less than 170 dealt with abstinence, birth control, sexually transmitted diseases, or pregnancy. However, television does not compare with the unrestricted access to sexually explicit material that is provided through the Internet. In March 1998, a survey found 100,000 commercial pornography sites on the Internet with an estimated 200 new sites available every day. This presentation will discuss the effect of sexually explicit material on teen's attitudes and behaviors and the potential effect of the Internet.

REFERENCES:

1. Strasburger VC, Donnerstein E: Children, adolescents, and the media: issues and solutions. Pediatrics 1999; 103(1):129–39
2. Grossman DA, DeGaetano G: Stop Teaching Our Kids to Kill: A Call to Action Against TV, Movie, and Video Game Violence. NY, NY, Random House (Crown Books), 1999
3. Huang MP, Alessi NE: Developing trends of the World Wide Web. Psychiatric Services 1999; 50(1):31–2, 41
4. Strasburger VC, Donnerstein E: Children, adolescents, and the media: issues and solutions. Pediatrics 1999; 103(1):129–39

SYMPOSIUM 77—NIAAA/NIDA/NIMH GRANTS AND CAREER DEVELOPMENT

EDUCATIONAL OBJECTIVE FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have information regarding NIH support mechanisms that can foster the training and career development of new investigators, and helpful advice on grant writing.

No. 77A
WELCOME AND INTRODUCTORY COMMENTS

Ernestine Vanderveen, Ph.D., *NIAAA, 6000 Executive Boulevard, Bethesda, MD 20892*

SUMMARY:

The NIH provides support for research in the causes, consequences, treatment, and prevention of mental illnesses and disorders associated with alcohol and other drug abuse. This symposium will provide participants with the opportunity to obtain information and gain understanding of extramural programs for obtaining research and research training support through grants awarded by NIAAA, NIDA, and NIMH. Presentations by senior staff members will include descriptions and discussions of key aspects of preparing and submitting applications, including steps involved in receipt, referral, and peer review procedures. The first presentation will describe and differentiate the various career development awards specifically designed for junior investigators who seek additional research experience and mentoring in a productive research environment. Next is a presentation that will outline and characterize National Research Service Award fellowships and training opportunities for graduate students and postdoctoral level scientists. The final presentation will focus on the peer review process and suggest appropriate ways to become a successful applicant. Discussion will include responses to questions generated by attendees. Information on how to utilize electronic systems to obtain information from NIH will be in handouts as well as summarized information on specific programs and staff to contact. The final phase will be interactive small group meetings with institute representatives.

No. 77B
CAREER DEVELOPMENT OPPORTUNITIES AT NIH

Walter L. Goldschmidts, Ph.D., *NIMH, 6001 Executive Boulevard, Bethesda, MD 20892*

SUMMARY:

NIAAA, NIDA, and NIMH provide opportunities for clinical and basic research scientists to pursue additional periods of supervised career development beyond postdoctoral training. Investigators in the initial stages of establishing research careers can utilize a variety of career development mechanisms to gain experience in new areas and/or additional experience in areas that would enhance their scientific careers. Each of the career mechanisms supported by the three participating institutes will be presented. Attendees will have the opportunity for further discussions with program staff during the latter part of the workshop.

No. 77C
NATIONAL RESEARCH SERVICE AWARD TRAINING PROGRAMS

Lucinda Miner, Ph.D., *NIDA, 6001 Executive Blvd, Bethesda, MD 20892*

SUMMARY:

The National Research Service Awards (NRSA) were created by Congress in 1974 to help ensure that highly trained scientists would be available in adequate numbers and in appropriate research areas to carry out the nation's biomedical and behavioral research agenda. An overview of the NRSA program at NIH will be presented with information about who is eligible for these awards and how to apply.

No. 77D
THE PEER REVIEW PROCESS AT NIH

Mark Green, Ph.D., *NIAAA, 6000 Executive Blvd #409, Bethesda, MD 20892*

SUMMARY:

The presentation will cover receipt, referral, and review of grant applications at NIH. Emphasis will be placed on things applicants can do at each of these points to interact with NIH staff who manage the peer review process.

REFERENCES:

1. Niederhuber JE: Writing a successful grant application. Journal of Surgical Research 1985; 39(4):277–84
2. Levey GS, Sherman CR, Gentile NO, Hough LJ, Dial TH, Jolly P: Postdoctoral research training of full-time faculty in academic

departments of medicine. Annals of Internal Medicine 1988; 109(5):414–8
3. Conway ME: The National Research Service Awards with emphasis on the mentor relationship. Nursing Research 1981; 30(6):376–8
4. Novello AC: The peer review process: how to prepare research grant applications to the NIH. Miner Electrolyte Metab 1985; 11(5):281–6

SYMPOSIUM 78—MEASURING CHANGE IN BORDERLINE PATIENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand and assess different levels at which patient change can be conceptualized and measured, including behavioral change, change in interpersonal relations, intrapsychic change, and change in patients' families; to compare the foci and instruments used to measure change in two contrasting treatments—a cognitive-behavioral one and a psychodynamic one.

No. 78A
EVALUATING SUICIDAL AND SELF-MUTILATING BEHAVIOR IN BPD

Barbara Stanley, Ph.D., *Department of Psychiatry, Columbia University, NYSPI Unit 42 1051 Riverside, New York, NY 10024*

SUMMARY:

Suicide and nonsuicidal self-injury (i.e., self-mutilation) are significant problems in individuals with borderline personality disorder (BPD). BPD carries a lifetime suicide rate of approximately 10%. About 80% of individuals hospitalized with BPD have a history of self-mutilation. Clearly, these behaviors are among the most important to focus on when treating patients with BPD.

Individuals with BPD tend to experience suicidal feelings differently than other suicidal patients. In BPD, suicidal feelings are typically more frequent, have a fast onset, and are often in reaction to seemingly minor interpersonal losses and stresses. Therefore, the seriousness of the intent is often underestimated and change in suicidality is difficult to assess.

The purpose of this presentation is to identify ways to evaluate suicidality and self-mutilating behavior and how to assess change in these behaviors. Standard measures that are useful to the clinician will be reviewed. In addition, we will distinguish the ways in which clinicians can differentiate between self-mutilatory behaviors and those with suicidal intent.

No. 78B
CHANGES IN ATTACHMENT, SYMPTOMS, AND PERSONALITY IN TRANSFERENCE FORCED PSYCHOTHERAPY

Diana Diamond, Ph.D., *Department of Psychiatry, New York Presbyterian, 21 Bloomingdale Road, White Plains, NY 10605;* Ken Levy, Ph.D., John F. Clarkin, M.D., Pamela A. Foelsch, Ph.D., Hilary Levine

SUMMARY:

Transference-Focused Psychotherapy (TFP) is based on an object relations model of severe personality disorders, and thus hypothesizes that different internal personality organizational structures exist and will be observed in patients' relationships with others, including the therapist. We have utilized several methods to measure patients' internal representations, including the Adult Attachment Interview (AAI), and the Inventory of Personality Organization. We will present preliminary findings on patients who have completed one year of treatment.

Attachment classification has been found to discriminate among subtypes of borderlines, and to predict differential responses to treatment. We have tracked the process and outcome of TFP by assessing change in attachment representations and reflective function on the AAI, given at the beginning of treatment and at one year. Clinical and research data will be presented, with particular emphasis to two patients. The attachment status of both patients changed from insecure to secure after one year. These findings suggest that the working through of the transference effects change in patients' representational world, allowing them to represent more coherently their relationship with early attachment figures.

To provide validation of the shifts in attachment status, we will present data on measures of change in symptomatology and in personality organization.

No. 78C
THERAPY PROCESS PREDICTS INTRAPSYCHIC STRUCTURAL CHANGE

Pamela A. Foelsch, Ph.D., *Department of Psychiatry, Cornell Medical, 21 Bloomingdale Road, White Plains, NY 10605;* Lina Normandin, Ph.D., John F. Clarkin, M.D., Frank E. Yeomans, M.D.

SUMMARY:

Structural change was assessed using the Transference & Countertransference Analysis (TCA, Foelsch & Normandin, 1997) method in five female patients diagnosed with borderline personality disorder (DSM-IV, American Psychiatric Association, 1994) and treated for one year with Transference-Focused Psychotherapy (TFP, Clarkin, Yeomans, & Kernberg, 1999) as part of an NIMH treatment development grant (Clark in: NIMH R21-MH53705-02). The TCA method was applied to videotapes of consecutive sessions early and late in the year of treatment. Measures at time one and time two show different levels of activation of structure. Differential levels of patient structural change at time two can be understood in the context of the therapist's way of responding to the patient. The relationship between the *therapist's* pattern of activity and the *patient's* pattern of activity predicted patient structural change, more than either pattern alone.

No. 78D
FAMILY FACTORS AND BPD

Perry D. Hoffman, Ph.D., *Department of Psychiatry, New York Presbyterian, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Although the role the family environment plays in the genesis of borderline personality disorder has been researched, no data exist identifying the role the current family environment plays in the course and effective treatment of the disorder. The absence of this critical information may severely limit the range of potential treatment strategies that are crucial to the recovery process.

This paper will present the first stage of a five-year research project funded by the National Institute of Mental Health to test the hypothesis that certain family patterns and attributes may influence patient outcome. Variables considered are: presence or absence of parental/spouse pathology, level of emotional involvement, perception of burden, level of patient validation, familial problem-solving, parental/spouse affective style, and knowledge about the disorder. Patient outcome will be defined by reduction in frequency and sever-

ity of suicidal behaviors; reduction in the number of rehospitalizations; decrease in behaviors that severely limit the quality of life, including (a) depression, (b) alienation in family relationships, (c) generalized hopelessness, (d) level of loneliness; and an increase in reasons for living.

REFERENCES:

1. Winchel R, Stanley M: Self-injurious behavior: a review of the behavior and biology of self-mutilation. Am J of Psychiatry 1991:148(3):306–317
2. Fonagy P, Steele M, Steele H, Leigh T, et al: Attachment, the reflective self and borderline states: the predictive specificity of the Adult Attachment Interview and pathological emotional development, in Attachment Theory: Social, Developmental and Clinical Perspectives. Edited by Goldberg S, Muir R, Kerr J. Hillside, NJ, Analytic Press, pp. 233–279
3. Normandin L, Bouchard MA: The effects of theoretical orientation and experience on rational, reactive, and reflective countertransference. Psychotherapy Research 3(2):77–94
4. Hooley JM, Hoffman PD: Expressed emotion and borderline personality disorder. American Journal of Psychiatry 156(10)

SYMPOSIUM 79—ELECTRONIC MEDICAL RECORDS AND THE DOCTOR-PATIENT RELATIONSHIP

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: The object of this symposium is to (1) review the factors that are making the electronic medical record a necessity in psychiatry, (2) acquaint participants with the potential impact of the electronic medical record on the doctor/patient relationship.

No. 79A
THE PATIENT-CONTROLLED ELECTRONIC MEDICAL RECORD

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 E. Medical Center Drive, Ann Arbor, MI 48109-0390*

SUMMARY:

The electronic medical record (EMR) raises a number of critical questions. One of the most central is that of who owns the clinical information contained within the medical record. For convenience sake, in the past, medical records were owned by the hospitals where patients were seen and cared for. This had enormous practicality because the medical record was, in fact, an entity that people did not want to lose. With the development of the electronic medical record, all medical information, laboratory values, x-rays, and text are digital. This information will be available ubiquitously. It can reside anywhere. This will make the issue of who owns the record more relevant and will change the balance from the hospital to the patient. What will be the benefits of patients controlling their own medical records? What will be the mechanism to do so? What will the impact be on the business of medicine and psychiatry? What will be the downfall, if any, of patients having control of their records? This presentation will cover these issues, as well as the shift that occurs as a consequence of the digitization of medical information from institutions to the patient.

No. 79B
THE ELECTRONIC RECORD: A PATIENT PERSPECTIVE

Sheila M. Marcus, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0722;* Kevin B. Kerber, M.D., Mary W. Roberts, M.D., Raymond J. Kloss, M.D., Heather Flynn, Ph.D.

SUMMARY:

Patients are now treated in complex, integrated health care systems, and the tension between their privacy and the health care system's need for information has become a central debate. Nowhere is the debate more contentious than in the field of psychiatry where the most intimate information is shared. Electronic medical records make broader dissemination of medical information possible, improving coordination of care between multiple providers, and simplifying tracking of patient outcomes, essential to improving quality of care. These improvements must, of course, be balanced with the confidentiality concerns of patients who worry about inappropriate access to their medical records and have concern that electronic information will impugn the integrity of the physician-patient relationship.

This presentation explores the dilemma of the psychiatric record from a systems perspective, explaining the implementation of an electronic system for psychiatric records in a large medical center. Key decision points in the implementation process will be elaborated and data from patients who have refused to participate will be presented. It is hoped that these data, and the strengths and shortcomings of the University of Michigan decision-making process regarding the electronic record will serve to inform other medical centers who embark on this difficult yet inevitable journey toward electronic information.

No. 79C
PRIVACY: COST CENTER OR PROFIT CENTER?

Richard K. Harding, M.D., *Department of Psychiatry, University of South Carolina, 3555 Harden Street #102, Columbia, SC 29203*

SUMMARY:

Health information and the construction of a national health information infrastructure to supply information to "users" are big business. Demand for evidence-based assessments of clinical practice, report cards, and an array of other applications will require a quantum leap in medicine's uses of high-speed processing of electronic medical data. With the doctor/patient relationship under pressure and billions invested to increase access to medical information, psychiatrists must push to reframe the political and economical debate, emphasizing the therapeutic and fiscal value of strong privacy protections in the paperless medical record.

REFERENCES:

1. Ridsdale L, Hudd S: What do patients want and not want to see about themselves on the computer screen; a qualitative study. Scandinavian Journal of Primary Health Care 1997; 15(4):180–3
2. Bluml BM, Crooks GM: Designing solutions for securing patient privacy—meeting the demands of health. J Am Pharm Assoc (Wash) 1999; 39(3):402–7
3. Harding RK: Testimony on medical records privacy before the subcommittee on financial institutions and consumer credit. U.S. House of Representative July 21, 1999
4. Div. of Gov't Relations, A.P.A., Washington

SYMPOSIUM 80—SPIRITUALITY, CULTURE, AND PSYCHIATRY: NAVAJO AND WESTERN PERSPECTIVES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand core concepts of Christian spirituality, including developmental stages, moral transformation, psychospiritual dynamics, and spiritual practices. Basics of Navajo spirituality and healing will be understood so participants will be able to recognize the impact of spirituality on patients from two cultural perspectives.

No. 80A
SPIRITUAL DIRECTION IN A COSMOPOLITAN SETTING

Shiella Fodchuk, M.A., Spiritual Director, *Christ Church, 1075 West Georgia St #2100, Vancouver, BC V6E3G2, Canada*

SUMMARY:

Persons practicing psychiatric medicine may at times work with mysteries of the psyche that seem to pertain to an order beyond that of the personal psyche and outside of the scope of psychiatry. It may be difficult at times to ascertain whether a person is moving toward health and integration, or into dangerous terrain. Some familiarity with the characteristics of spiritual growth and with the field of spiritual direction may provide another perspective on some issues that arise with psychiatric patients.

As they look at individuals holistically and see persons as spiritual beings, some psychiatrists may be interested in the salutary effects of a spiritual community versus isolation; in the healing possibilities of prayer; in the dynamics of the moral transformation of an individual; and finally, some may be interested in the deepest spiritual, even mystical life, the goals of which may seem incompatible with the goals of ego development and strengthening.

Spirituality focuses on the inner, deepest center of a person, the "spiritual core" that is open to experiencing transcendent reality. Spirituality explores the dynamics and goals of spiritual development, methods of prayer and meditation, various maps, and languages of spiritual growth.

No. 80B
DINE' (NAVAJO) SPIRITUALITY AND HEALING

Johnson Dennison, M.A., *Dine' College, President's Office, P.O. Box 125, Tsaile, AZ 86556*

SUMMARY:

Sa'ah Naaghai Bik'eh Hozhoo (Walking or being in the pattern of beauty that surrounds you.) is a central theme or core to Navajo philosophy, health, healing, and harmony. Concepts relating to this central theme will be explored along with holistic teachings of protection and blessings. Inseparable parts include:

- nitsahakees (thought: consciousness)
- nahat'a (actions and implementation of our thoughts and ideas)
- iina' (quality outcomes of thoughts and action; life; achievements)
- sihasin (having personal stability and satisfaction with personal achievements)

The practices of counseling, prayer, sand paintings, chanting, bathing, sweat lodges, and use of herbs will be discussed to explain how these are helpful in restoring an individual to harmony or producing ya'at'eehgo iina' (good life) Case discussions will ensue to cover examples of patients of anxiety, depression, and physical illnesses. A discussion on working with practitioners of Western medicine will follow.

No. 80C
DINE' PSYCHIATRIC PRACTICE: RELIGION AND SPIRITUALITY

Mary H. Roessel, M.D., *Northern Navajo Iina' Counsel, P.O. Box 3688, Shiprock, NM 87420*

SUMMARY:

The mixing of two religious/spiritual cultures with varying degrees of acculturation creates unique conflicts within individuals, between individuals, and within families. Understanding these conflicts and assisting patients deal with the situations as they arise is essential to providing comprehensive and effective psychiatric care.

Cultural formulations as described in the DSM-IV will be done and expanded upon as is essential in working with Dine' (Navajo) patients. Specific cases will be presented that focus on patients that are exclusively traditional, patients that combine both Christian and Navajo beliefs, and Navajo patients that espouse only Christian beliefs. Treating patients in conjunction with traditional Navajo medicine persons will also be described and discussed.

No. 80D
SPIRITUALITY AND CULTURE: ITS IMPACT IN PSYCHIATRIC PRACTICE

Edward J. Neidhardt, M.D., *Northern Navajo, Iina' Counsel, P O Box 3688, Shiprock, NM 87420*

SUMMARY:

Spirituality and prayer have been described as the forgotten dimension in medicine and psychiatry. As it is a major part of our patients' lives it is incumbent upon psychiatrists to have a basic understanding of religious and spiritual practices. A theoretical presentation will form a basis for conceptualizing spirituality in two diverse cultures and provide a structure for further clinical presentations. Excerpts from the three previous presentations by Fodchuk, Dennison, and Roessel will be used to exemplify theoretical constructs; further, specific clinical case material will be used to ground the theoretical discussions.

Religion and spirituality can be a cause of conflict and anxiety and also function to resolve conflict and relieve anxiety. These apparent opposing views will be explored from within a singular and a mixed cultural perspective. Psychiatrists can play a key role in supporting the patient's spiritual development as part of the therapeutic process. They can also, within certain cultural contexts, help the patient use their religious practices to transcend the limitations of therapy.

REFERENCES:

1. Fodchuk S: To come to light: an account of papture. Studia Mystica 1992; 15:4–21
2. Jensen N, Dennison J, Jim RL, Morgan F, et al: Navajo Psychology, Shiprock, NM, Northern Navajo Med. Center, 1997
3. Mehl-Madrona, Lewis E: Native American medicine in the treatment of chronic illness: developing an integrated program and evaluating its effectiveness. Alternative Therapies 1999; 5(1):36–44
4. Puchalski CM: Taking a spiritual history: FICA. Spirituality & Medicine Connection 1999; 3:1
5. Fowler JW: Stages of Faith. New York, NY Harper Collins, 1995

SYMPOSIUM 81—SOCIAL PHOBIA: A NEGLECTED DISORDER COMES OF AGE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be aware of the history of social phobia as a diagnosis, evidence that it is a discrete disorder, and recent issues around patient education and its approval as a drug indication.

No. 81A
SOCIAL ANXIETY DISORDER: FROM NEGLECT TO THE SPOTLIGHT

Michael R. Liebowitz, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Dr., New York, NY 10032-2603*

SUMMARY:

Fifteen years ago social anxiety disorder, or social phobia, as it was then better known, was a neglected anxiety disorder. Issac Marks had distinguished it from agoraphobia and the specific phobias, and a few farsighted behavior therapists had begun looking at exposure-based treatments. The APA had included it as a category in the 1980 DSM-III version, but without empirical support limited its boundaries mainly to performance anxiety. More generalized interpersonal anxiety and avoidance were classified under the newly created rubric of avoidant personality disorder. Psychopharmacologists did not consider social anxiety disorder to merit independent study or be susceptible to medication treatment, viewing it instead as part of agoraphobia, a personality disorder or as a severe variant of normal shyness.

The situation now is obviously very different. For one, social anxiety disorder is now recognized to have a generalized subtype characterized by severe anxiety and avoidance in many, and often, most interpersonal situations. This condition is now known to be prevalent, chronic, early in onset, and frequently highly disabling. The good news is that several types of treatment, both psychopharmacological and psychotherapeutic, have been found extremely helpful. In addition, we are fortunate to have highly reliable and sensitive assessment instruments and, at least to date, low placebo response rates, easy research subject recruitment, and low drop-out rates, all of which facilitate therapeutic research. One result is intense clinical research activity, which is even beginning to extend down to children and adolescents. This in turn is generating attention, interest, questions, encouragement, and, at times, concern, from media and the general public about what is going on and where it is heading. How social anxiety disorder moved from neglect to the spotlight is the subject of this presentation.

No. 81B
IS SOCIAL PHOBIA A DISCRETE DISORDER?

Franklin R. Schneier, M.D., *Department of Therapeutics, NY State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Since social phobia was formally recognized as a disorder by designation in DSM-III, a growing body of data has supported its consideration as a discrete condition. Other findings, however, suggest that social phobia might alternatively be considered to exist along a continuum of social anxiety and shyness that is present in the general population. This issue recently took on new importance as the FDA weighed whether to allow social phobia as a specific drug treatment indication.

This presentation will review evidence on the extent to which social phobia is a discrete disorder, including demographic features, twin and family studies, studies of phenomenology, course and cognitive features, assessment of comorbidity in epidemiologic samples, biological challenge, and brain imaging studies. The relationship of social phobia to associated traits, such as shyness, avoidant personality traits, and behavioral inhibition, will also be considered.

No. 81C
SOCIAL ANXIETY DISORDER: AN FDA PERSPECTIVE

Thomas P. Laughren, M.D., *HFD-120, Food & Drug Administration, 5600 Fishers Lane, Rockville, MD 20857-0001*

SUMMARY:

Over the past two decades, the focus in drug development in the area of anxiety disorders has shifted from seeking general anxiolytic claims to seeking claims targeting specific anxiety disorders, including panic disorder, obsessive-compulsive disorder, social anxiety disorder, posttraumatic stress disorder, and generalized anxiety disorder. FDA has similarly modified labeling for anxiolytic claims by shifting from language suggesting a general anxiolytic indication to indications linked specifically to the populations studied.

This talk will focus on the (1) regulatory issues addressed by FDA in approving the first claim for the treatment of social anxiety disorder, and (2) the regulatory requirements that must be satisfied in a development program for a drug intended for the treatment of this disorder. These issues include: (1) acceptance of social anxiety disorder as an independent entity, (2) recruitment of patients with this disorder, (3) comorbid psychiatric and other disorders, (4) response specificity for social anxiety disorder, (5) number of trials needed, (6) duration of trials needed, (7) long-term effectiveness, (8) optimal assessment instruments, (9) selecting primary outcomes, (10) exploration of dose/response for effectiveness, (11) basic study design requirements, (12) safety considerations, (13) requirements for studies in pediatric patients with this disorder and (14) labeling for social anxiety disorder.

No. 81D
SOCIAL PHOBIA: THE ADVOCACY PERSPECTIVE

Jerilyn Ross, M.A., *Ross Center for Anxiety, The Ross Center, 5225 Wisconsin Ave NW, STE 400, Washington, DC 20015*

SUMMARY:

The Anxiety Disorders Association of America (ADAA), whose members include clinicians, researchers, and patients, is the only national, nonprofit organization solely dedicated to improving the lives of people suffering from anxiety disorders. The most common of the anxiety disorders, social phobia, has been among the most neglected mental disorders, even though it is the third most common psychiatric illness in the United States, after depression and alcoholism. Despite its prevalence, severity, and treatability, less than 5% of those suffering from social phobia receive treatment.

To help reduce the ignorance and stigma surrounding this disorder, ADAA, the American Psychiatric Association, and Freedom from Fear formed a coalition and launched a national campaign to raise awareness and to educate health professionals, legislators, and the public about the causes, symptoms, and treatments for social phobia. The campaign, entitled, "Imagine Being Allergic to People," included a variety of mediums, such as placing billboard ads on busses.

This presentation will describe how the coalition, with the support of industry, reached millions of Americans with the message of help and hope. The discussion will highlight the challenges faced by the partnership, including responding to the media's perception that

the participating organizations helped the pharmaceutical industry "create" an illness for which there are marketable products.

No. 81E
MEDICATING SHYNESS: ENHANCEMENT OR TREATMENT?

Peter D. Kramer, M.D., *Department of Psychiatry, Brown University, 236 Hope Street, Providence, RI 02906-2212*

SUMMARY:

With the development of new medications with new indications and ranges of side effects, the more minor psychiatric conditions, formerly in the exclusive domain of psychotherapy, are increasingly being treated with medication. This practice has raised concern about the possibility of using medication to alter normal personality traits and normal psychological states, a topic discussed by philosophers under the heading "enhancement" and by psychiatrists as "cosmetic psychopharmacology." Whether the pharmacologic amelioration of social phobia, especially in its less severe manifestations, is standard medical treatment or enhancement has become a contentious issue, discussed at length in the lay press. This talk will consider the ethical implications of treatments for social phobia in light of current and past discussions of enhancement and then look more broadly at the implications of enhancement and progress in biological psychiatry for diagnosis and definition of illness.

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SYMPOSIUM 82—MUSIC THERAPY: INTEGRATIVE MEDICINE FOR THE NEW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) define music therapy, (2) identify illnesses that respond to music therapy, (3) describe outcome data regarding the efficacy of music therapy in the treatment of dementias and other psychiatric disorders, neurologic disorders, and cancer, and (4) explain the term *Mozart Effect.*

No. 82A
THE MOZART EFFECT: EDUCATION, MEDICINE, OR MYTHOLOGY?

Bryan C. Hunter, Ph.D., *Music Department, Nazareth College, 4245 East Avenue, Rochester, NY 14618*

SUMMARY:

In the past half decade an interesting public phenomenon regarding the education and health benefits of music has occurred, particularly focused on the music of Mozart. The phenomenon, which began as scientific inquiry, has rapidly evolved and given rise to what has nearly become a household phrase: The Mozart Effect.™ The trademark of the phrase itself is a clue to this phenomenon that is a unique confluence of scientific inquiry, music products industry funding, and marketing.

While the original scientific inquiry focused on the benefits of music on cognitive development in children, the now popularized phrase is being used in reference to virtually any educational, therapeutic, or spiritual benefit that music may offer to human beings. This paper will review the development of this phenomenon and the status of the original area of scientific inquiry regarding the impact of music on children's cognitive development. In addition, a clarification and overview of the now popular phrase will be presented.

No. 82B
MUSIC THERAPY IN THE TREATMENT OF ALZHEIMER'S-TYPE DEMENTIA

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. 82C
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:

Data from neurological research in the areas of sensorimotor control and cognition will be presented that 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. 82D
MUSIC THERAPY IN ONCOLOGY: PSYCHOSOCIAL CARE, AND PAIN MANAGEMENT

Deforia L. Lane, Ph.D., *Department of Oncology, 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 assessment, 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 experiential learning, and will offer guidelines for implementing music therapy in private practice and medical facilities.

No. 82E
THE USE OF VOCAL IMPROVISATION IN ANALYTICALLY ORIENTED MUSIC THERAPY

Diane S. Austin, M.A., *28 Willow Street, Brooklyn, NY 11201*

SUMMARY:

Analytically oriented music therapy is an approach to psychotherapy that integrates theories and concepts from depth psychology with the practice of music therapy. This model utilizes both musical and verbal expression in the service of the therapeutic process. Music (usually improvised by the client or the client and therapist) is used to explore the verbal content of the session and/or words are used to process the music.

This paper will focus on the use of vocal improvisation, a powerful method of accessing and expressing split-off or repressed feelings, memories, and associations. Techniques developed to create a safe musical container for vocal improvisation will be demonstrated and discussed. Case material will illustrate the use of vocal improvisation with an adult suffering from early childhood trauma.

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THURSDAY, MAY 18, 2000

SYMPOSIUM 83—THE CHALLENGES OF TREATING POSTPARTUM DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to provide more effective treatment for women with postpartum depression several issues are addressed: a) childhood sexual abuse, b) work discrimination and job stress by gender, c) sleep deprivation and cognition, d) seasonal variation in mood, and e) a model to facilitate the selection of management strategies.

No. 83A
SEXUAL ABUSE IN PREGNANT AND POSTPARTUM WOMEN

Shaila Misri, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Room 2B-250, Vancouver, BC V6Z 1Y6, Canada;* Ariel Cantin, R.N.

SUMMARY:

Although literature on sexual abuse in women is abundant, there is limited research available on sexual abuse in pregnant and postpartum women. Some studies report an increase in violence towards pregnant women. The postpartum period can often trigger traumatic memories of sexual abuse previously repressed. Emergence of these fearful, frightening feelings can further complicate postpartum depression in vulnerable women. This study looks at the correlation between postpartum depression and sexual abuse issues in childhood. Women referred to the reproductive mental health program for treatment of postpartum depression (PPD) were investigated for effect of sexual abuse on recovery from PPD. Recommendations on obtaining sexual abuse information and implications of treatment will be discussed.

No. 83B
WORK DISCRIMINATION BY GENDER AND POSTPARTUM DEPRESSION

Susanne I. Steinberg, M.D., *Department of Psychiatry, St. Mary's Hospital, 3830 Lacombe Avenue, Montreal, QC H3T 1M5, Canada;* Francois Bellavance, Ph.D., Karen Aboud, B.A., Fraida Weiskop, R.N.

SUMMARY:

The most significant recent development in employment law in Canada has been the passage of the human rights statutes. If human rights complaints are any indication, gender-based discrimination is widespread.

Objectives: To describe the rate and nature of work discrimination and job stress in 256 women, both index cases with Axis I disorders and controls, during pregnancy or postpartum and that of their partners.

Methods: Overall, 201 index cases (78.5%) and 55 controls (21.5%) completed the SCID and self-reports scales. Work histories of both partners were transcribed, and NUD-IST software was used for coding and theme extraction. Quantitative statistics were descriptive.

Results: 107 (42%) women were employed, of whom 91 were index cases (85%) and 16 were controls (15%); 35 are working part time (33%) and 72 full time (67%). No controls experienced work discrimination compared with 16% of the index cases ($p = 0.059$).

Work discrimination appears in many formats and can result in litigation. No work discrimination was documented among partners. Job stressors were common for both genders (men-65%; women-67%). Index cases and their partners were more likely to have experienced job stresses than were controls (women: index-73% vs controls-38%, p = 0.006; partners: index-69% vs controls-48%, p = 0.005).

Conclusions: 1) Job stress but not work discrimination is experienced by both genders. 2) Treatment implications for PPD of such employment history will be discussed.

No. 83C
THE EFFECTS OF CHILDBEARING ON SLEEP, MOOD, AND COGNITIVE FUNCTION

Michael W. O'Hara, Ph.D., *Department of Psychology, University of Iowa, 11 Seashore Hall, East, Iowa City, IA 52242*

SUMMARY:

From the second trimester of pregnancy and extending through the first two months after delivery, women experience many types of sleep disturbance, which may be associated with emotional disturbances. Mother's reports of fatigue have been associated with depression at two days and at two weeks postpartum. Sleep disruptions during the postpartum period may also affect the cognitive functioning of women. Many new mothers report feelings of confusion and forgetfulness during the early postpartum period. Objective investigations have provided equivocal results. This work will be reviewed in detail for this presentation as will the results of a study undertaken to examine the sleep, mood, and cognitive abilities of normal postpartum women and nonpostpartum controls over a three-week period (Swain et al., 1997).

Postpartum women reported more evening awakenings, more time awake after retiring, and more naps than controls, but overall sleep time was similar. New mothers experienced a higher level of dysphoric mood during the first week than did nonpostpartum controls; however, controlling for the effect of "time awake" at night eliminated the significant effect for dysphoric mood. Few differences were observed on the multiple assessments of cognitive function; however, performances of new mothers on memory and psychomotor tasks were likely to be influenced by sleep loss. Implications of this work will be discussed.

No. 83D
SEASONAL AND SLEEP CHANGES IN POSTPARTUM DEPRESSION

Jan Berle, M.D., *Department of Psychiatry, University of Bergen, Haukeland University Hospital, N-5021 Bergen, Norway;* Fred Holsten, M.D., Trond F. Aarre, M.D.

SUMMARY:

The prevalence of SAD is greater at higher latitudes, in younger people, and in women, particularly those of childbearing age.

Objective: To investigate the impact of sleep disturbances and seasonal variation on postpartum depression in Bergen, Norway where there is wintertime light deprivation (latitude 60N).

Method: 411 women were screened with a Norwegian version of the EPDS (Edinburgh Postnatal Depression Scale) at six and 12 weeks postpartum. Women with high scores on the EPDS and a random sample of controls were administered a diagnostic interview (MINI) and the MADRS. In total, 100 women were interviewed and videotaped to permit interrater reliability to be established, using DSM-IV criteria. All were given SPAQ (Seasonal Pattern Assessment Questionnaire) and asked to fill in a sleep diary.

Results: 72 women completed SPAQ and a one-week sleep diary. Eighteen of these met the DSM-IV criteria for major depression and 21 met the DSM-IV research criteria for minor depressive disorder; 34 were controls. Women with postpartum depression had higher seasonal scores on the SPAQ than healthy controls, averaging 10.05 in depressed subjects and 5.67 in controls; 44% of depressed women and only 15% of controls regarded seasonal changes as a problem. Depressed women with seasonal problems had more disturbed sleeping patterns.

Conclusions: A high rate of seasonal variation was seen amongst women in Norway having postpartum depression, a finding with possible treatment implications.

No. 83E
DECISION MAKING FOR TREATMENT OF DEPRESSION IN PREGNANCY

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve Univ., 11400 Euclid Avenue, Suite 280, Cleveland, OH 44106;* Alan J. Gelenberg, M.D., Henrietta L. Leonard, M.D., Deborah A. Zarin, M.D., Ellen Frank, Ph.D.

SUMMARY:

Objective: Women of childbearing age are at high risk for major depressive disorder. The goal of this study was to guide the clinician in the process of risk-benefit decision making for treating depression during pregnancy.

Method: A work group of members from the APA Committee on Research on Psychiatric Treatments defined the model.

Results: The model directs the physician to structure the problem through diagnostic formulation and identification of treatment options for the disorder. Likely outcomes, from exposure to various treatments are discussed. Outcomes related to depression and its dysregulation symptoms are reviewed. The patient is an active participant and provides her evaluation of the outcomes. Her ability to participate in this process provides evidence of competency to consent. The decision-making process is viewed as ongoing, with the need for incorporation of additional data as the pregnancy and treatment efforts unfold.

Conclusion: The conceptual model and information from recent prospective studies provide clinicians with welcome relief from decades of decision making using meager data.

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SYMPOSIUM 84—NMS 1960–2000: FORTY YEARS OF PROGRESS

Neuroleptic Malignant Syndrome Information Service

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize and diagnose NMS and related clinical syndromes. The participant should also be able to compare the relative efficacies of competing treatments and understand the changing trends in managing patients with these disorders.

No. 84A
ANALYSIS OF THE NORTH AMERICAN NMS INFORMATION SERVICE DATABASE

Stanley N. Caroff, M.D., *Department of Psychiatry, VAMC 116A, University Avenue, Philadelphia, PA 19104;* Stephan C. Mann, M.D., Paul E. Keck, Jr., M.D., Group NMSI Study

SUMMARY:

Objective: To examine cases reported to the Neuroleptic Malignant Syndrome Information Service (NMSIS) hotline relating to management of NMS in clinical practice.

Method: Data were obtained by telephone report and standardized case report forms on 51 cases during 1998–1999.

Results: Twenty-three cases met DSM-IV criteria for acute NMS, five had experienced previous episodes, and two involved NMS-like crises in patients with Parkinson's disease. While polypharmacy was common, 10 patients (43%) received atypical antipsychotics when NMS developed. Five patients experienced prolonged, residual catatonic symptoms after NMS, which responded to ECT in two cases. Twenty-one cases did not fulfill NMS criteria and included catatonia, parkinsonism, sepsis, delirious mania and heatstroke. Antipsychotics may have complicated neurologic function and thermoregulation in 14 non-NMS cases. NMS patients were more often rigid, akinetic, and mute, whereas non-NMS patients were more often delirious and agitated.

Conclusions: The NMSIS database reflects a concentration of complex cases and provides a unique window on the occurrence of extreme febrile encephalopathies of diverse etiologies. Further studies should address NMS due to atypical antipsychotics and during medication switching, the continuum of antipsychotic effects on neurovegetative functions culminating in NMS, and the best treatment strategies for NMS and post-NMS catatonia.

No. 84B
NOVEL ANTIPSYCHOTICS AND NMS: THE UNITED KINGDOM'S NMS DATABASE

Dora D. Kohen, M.D., *Department of Psychiatry, Homerton Hospital, Homerton Row East Wing, London E96SR, England*

SUMMARY:

Objective: Neuroleptic malignant syndrome (NMS) is a rare but potentially fatal disorder induced by antipsychotic drugs. While the role of classical antipsychotics in the emergence of NMS is well established, we sought to study cases of NMS induced by novel, atypical antipsychotics.

Method: The U.K. NMS database has been established to collect cases of NMS by referral to promote early diagnosis and management of the syndrome.

Results: Out of 49 cases that fulfilled DSM-IV criteria for NMS collected over the last four years, 17 (35%) were associated with the use of novel antipsychotics. Demographic variables, clinical and biochemical data, and drug doses and combinations recorded during and following NMS episodes, and during rechallenge, will be presented.

Conclusions: Increased awareness and changes in the practice of antipsychotic therapy may have decreased mortality from NMS. However, novel antipsychotics have been linked to NMS in the initial and rechallenge periods. Recently, cases of partial NMS with localized rigidity, lower temperatures, and mild changes in autonomic signs and level of consciousness have predominated. These partial NMS cases require further study and pose a dilemma in deciding on rechallenge with antipsychotics.

No. 84C
CATATONIA AND NMS: WHAT IS THE CONNECTION?

Andrew J. Francis, Jr., M.D., *Department of Psychiatry, SUNY Stony Brook, Health Sciences Center T-10, Stony Brook, NY 11794*

SUMMARY:

Objective: To examine the relationship of catatonia and NMS (neuroleptic malignant syndrome) using operational criteria.

Method: We used the Bush-Francis catatonia scale and both DSM-IV and Caroff-Mann criteria to compare 28 previously reported catatonia cases with 16 new retrospective NMS cases.

Results: Of 28 catatonia cases, three met NMS criteria. Two of these received lorazepam, and both catatonia and NMS promptly remitted. Another 10 cases failed NMS criteria but showed autonomic signs and elevated CPK, especially if febrile. Of 16 NMS cases, 15 met both Bush-Francis and DSM-IV motor criteria for catatonia. Severity scores for NMS correlated with number of catatonic signs. Benzodiazepines appeared to hasten recovery from NMS, with resolution of fever and rigidity in 36 ± 17 (SD) hrs.

Conclusions: NMS was present in three of 28 cases of catatonia, but subthreshold autonomic signs were also prevalent. Catatonia was present in 15 of 16 NMS cases and covaried in severity. Lorazepam appears beneficial for prompt recovery from NMS and catatonia. These data suggest a spectrum of illness: catatonia, catatonia with autonomic signs, catatonia with fever, and NMS. These subtypes may share pathophysiology and treatment response to lorazepam.

No. 84D
HYPOTHERMIA SYNDROMES IN PSYCHIATRY: ONE OR MANY?

Ronald J. Guerrera, M.D., *Department of Psychiatry, Brockton DVAMC, 940 Belmont Street 116A, Brockton, MA 02301*

SUMMARY:

Objective: To elucidate a possible common pathophysiologic process responsible for hyperthermia syndromes encountered in psychiatric practice, with the aim of identifying potentially more effective approaches to diagnosis and treatment.

Method: Comprehensive computerized searches of the MEDLINE database were conducted to ascertain relevant studies; these primary references were supplemented by citations contained within them.

Results: Dysregulated autonomic hyperactivity is a prominent and ubiquitous feature of lethal catatonia, acute cocaine toxicity, neuroleptic malignant syndrome, and scrotonin syndrome. The sympathetic nervous system (SNS) is intimately involved in all aspects of normal thermoregulation, including thermogenesis, and regulates muscle contractility by effects on intracellular calcium levels. Serotonorgic

inputs modulate SNS activity, and 5HT2 receptors increase intracellular calcium levels.

Conclusion: A hyperactive and dysregulated SNS is capable of producing the core clinical features that define these syndromes and render them nearly indistinguishable from one another. Specifically, elevated SNS activity increases thermogenesis and muscle tone by raising intracellular calcium levels; impairs heat dissipation through direct effects on end-organs; and can produce, directly and indirectly, mental status changes. Interaction between serotonergic and adrenergic systems, in addition to direct effects of serotonin on muscle function, suggests a possible biochemical basis for similarities and differences between the serotonin syndrome and other hyperthermia syndromes.

No. 84E
CENTRAL DOPAMINE HYPOACTIVITY AND THE PATHOGENESIS OF NMS

Stephan C. Mann, M.D., *Department of Psychiatry, University of Pennsylvania, VA Med Ctr.-116A Univ. Ave., Philadelphia, PA 19104;* Stanley N. Caroff, M.D., Gregory L. Fricchione, M.D., Paul E. Keck, Jr., M.D., E. Cabrina Campbell, M.D.

SUMMARY:

There is compelling clinical evidence implicating antipsychotic-drug-induced dopamine (DA) receptor blockade in the pathogenesis of neuroleptic malignant syndrome (NMS). All antipsychotics, including the atypical agents, have been reported to cause NMS, and despite diverse pharmacologic activities, all share the common property of D-2 DA receptor antagonism. Furthermore, antipsychotics with greater potency as D-2 receptor blockers are more frequently implicated in causing NMS. Additional evidence is provided by the occurrence of NMS-like conditions with nonneuroleptic DA antagonists, during treatment with DA depleting agents and during DA agonists withdrawal. Further evidence is provided by the efficacy of DA agonists in the treatment of NMS. Finally, the disruption of DA-mediated neurotransmission in nigrostriatal, mesolimbic, and mesocortical DA pathways, hypothalamic DA neurons, and peripheral DA receptors could account for nearly all the clinical manifestations of NMS. However, the DA receptor blockade hypothesis appears simplistic in that it fails to account for the rare occurrence and unpredictable onset of NMS episodes. It is proposed that going beyond D-2 dopamine receptor blockade, NMS is the product of preexisting central hypodopaminergia characterizing NMS-susceptible individuals coupled with downward adjustments in the DA system that occur in response to acute and repeated exposure to stress.

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SYMPOSIUM 85—THERAPEUTIC RELATIONSHIP AND PSYCHOTHERAPY EFFICACY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participants should be able to identify and understand the treatment principles for personality disorder patients who may do poorly in brief psychotherapy.

No. 85A
A COMPARATIVE ANALYSIS OF THERAPY OUTCOME AND FAILURE

Arnold Winston, M.D., *Department of Psychiatry, Beth Israel Medical Center, 1st Avenue & 16th Street, New York, NY 10003-2992;* J. Christopher Muran, Ph.D., Jeremy Safran, Ph.D., Lisa Wallner-Samstag, Ph.D., Elizabeth Bernbach, M.A.

SUMMARY:

The Brief Psychotherapy Research Program at Beth Israel Medical Center is currently investigating the treatment efficacy of three 30-session manualized treatments, with particular attention paid to treatment failure and drop-out (including what constitutes lasting change as determined by personality measures and follow-up assessment). The treatments include an ego-psychological-based psychodynamic model (DYN), a schema-focused cognitive-behavioral model (CBT), and an integrative model consistent with trends towards a relational perspective in contemporary psychoanalysis (REL). The integrative model was developed to address alliance ruptures and treatment impasses, with support by a grant from NIMH. This paper will present findings from a comparative outcome study that includes 85 outpatients: 23 in DYN, 36 in CBT, and 26 in REL. All patients were diagnosed with an Axis II Cluster C Personality Disorder or Personality Disorder NOS. Thirty-five percent of the patients dropped out before the 30th session. A sample of cases were checked for adherence. Analyses examined change on three domains: (1) patient ratings of symptomatology, (2) patient ratings of personality style, and (3) therapist ratings of symptomatology and functioning. Results indicated significant change from intake to termination and intake to follow-up, but no treatment differences. We also conducted analyses of the drop cases, including an intention-to-treat approach.

No. 85B
A COMPARATIVE ANALYSIS OF THE THERAPEUTIC ALLIANCE

J. Christopher Muran, Ph.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003;* Eyal Rozmarin, Ph.D., Bernard Gorman, Ph.D., Jeremy Safran, Ph.D., Lisa Wallner-Samstag, Ph.D., Arnold Winston, M.D.

SUMMARY:

This study examined patient and therapist repeated post-session reports of the therapeutic alliance (as measured by the Working Alliance Inventory) and their interpersonal transactions (as measured by a modified version of the Interpersonal Adjectives Scale) in three 30-session treatment conditions: a cognitive-behavioral (N = 19), psychodynamic (N = 15), and relational model (N = 22). The specific aim was to investigate the relationship of these ratings and the extent to which they are concordant (or discordant) with treatment efficacy. Outcome was determined by a composite index of standardized residual gain scores from patient- and therapist-rated target complaints and the Inventory of Interpersonal Problems, which were

averaged because they were highly intercorrelated. Results were based on a series of regression analyses of repeated measures with a generalized estimating equations approach and a multilevel linear modeling approach. We found that 1) patient ratings of the alliance were equally and significantly predictive of outcome in all three treatments, 2) therapist ratings were only predictive in the cognitive and relational conditions, and 3) the session-by-session correlations of these ratings were predictive of outcome in only the relational condition. Similar results were found from analyses of patient and therapist perceptions of their interpersonal tranactions on the modified IAS.

No. 85C
INTERPERSONAL AND ATTACHMENT PERSPECTIVES ON THE ALLIANCE AND OUTCOME

Lisa Wallner-Samstag, Ph.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue & 16th Street, New York, NY 10003;* J. Christopher Muran, Ph.D., Paul L. Wachtel, Ph.D., Arietta Slade, Ph.D., Jeremy Safran, Ph.D., Arnold Winston, M.D.

SUMMARY:

The focus of this study was interpersonal processes of difficult patient-therapist dyads and early identification of treatment failures in 30-session psychotherapy. Forty-eight dyads were equally divided into premature dropout (DO), poor outcome (PO), or good outcome (GO) conditions. Groups were compared on three measures of the relationship: 1) patient-and therapist-rated Working Alliance Inventory; 2) observer-rated Structural Analysis of Social Behavior; and 3) observer-rated Narrative Coherency adapted from the Adult Attachment Interview. Each measure significantly differentiated groups, and the DO condition was not consistently found to have the most difficult relationships, as hypothesized: DOs had the most problematic alliances and most incoherent session narratives, while POs demonstrated greatest hostile behavior between patients and therapists. PO patients also reported fewer early attachment losses/traumas at intake. Significant interrelations among measures were: 1) the greater the strength of patient-rated alliance, the greater the degree of Narrative Coherency; 2) the greater the alliance from patient and therapist ratings, the greater the degree of friendliness and the lesser the degree of hostility observed; and 3) the more coherent the narrative in sessions, the more friendly and less hostile the behavior within dyads.

No. 85D
THERAPEUTIC CLIMATE GROUP TREATMENTS FOR DUALLY DIAGNOSED

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, 317 East 17th Street, New York, NY 10003;* Christian R. Miner, Ph.D., David J. Hellerstein, M.D., J. Christopher Muran, Ph.D.

SUMMARY:

Although treatment engagement and retention in severely mentally ill patients with substance use disorders is a major clinical issue, research has rarely addressed the therapeutic alliance in this population. In a NIDA-funded study, we examined changes in patients' therapeutic alliance over time in an effort to identify "active ingredients" of the treatment process in a substudy of a randomized trial comparing twice-weekly outpatient group therapy (COPAD) with group therapy plus community outreach visits (COPAD+TAO). Patients (N = 35) in four ongoing treatment groups (two experimental, two control) completed the Group Climate Questionnaire (GCQ) following each group therapy session for 30 sessions. Individual Treatment Engagement subscale scores were computed and the means for each session were computed by Group. A simple generalized estimating equations model for repeated measures tested the hypothesis that, over time, patients' Engagement scores vary by Treatment Condition. Group members varied by seniority in the treatment protocol, so time-in-treatment served as a coveriate. Seniority in treatment did not affect Engagement, but the Group distinction did. With time-in-treatment held constant, patients who received Targeted Assertive Outreach demonstrated Engagement scores that, on average, exceeded those of control patients by subscale points.

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SYMPOSIUM 86—COMORBID DISEASE AND MORTALITY IN SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize factors associated with physical comorbidity and their relationship to mortality in schizophrenia, identify optimal strategies for their management, and improve long-term outcome in terms of physical as well as psychiatric well-being

No. 86A
PHYSICAL COMORBIDITY IN SCHIZOPHRENIA

Povl Munk-Jorgensen, Ph.D., *Department of Psychiatry, Psychiatric Hospital in Aarhus, 8240 Risskov, Denmark;* Henrik Ewald, Ph.D., Ole Mors, Ph.D., Prebenbo Mortensen, Ph.D.

SUMMARY:

Objective: From a clinical point of view results from studies on physical illnesses in patients with schizophrenia are diverging. Mortality studies show an increased SMR from most physical illnesses. Several clinical studies on comorbidity find an underrepresentation of somatic illness in patients with schizophrenia.

Method: Results from a nationwide case-register follow-up study of more than 20,000 schizophrenic patients in Denmark compared with 200,000 population-based controls are presented.

Results: The results show an overrepresentation of some physical illnesses, mainly infectious, and an underrepresentation of others, especially cancers. This is examplified by lung diseases.

Conclusion: One hypothesis might be that a certain group of physical illnesses is neglected by the patients—and maybe by the psychiatrists?

No. 86B
HIV AND SCHIZOPHRENIA

Francine Cournos, M.D., *Department of Psychiatry NYS Psychiatric Institute, 1051 Riverside Drive, #112, New York, NY 10032*

SUMMARY:

While HIV infection is not the most common comorbid medical condition associated with schizophrenia, it is one of the deadliest. In the United States AIDS has emerged as a leading cause of mortality among young people with psychotic disorders.

This presentation will review the factors that render people with schizophrenia vulnerable to acquiring HIV infection: unsafe sexual activity, alcohol and other drug use, the presence of other comorbid sexually transmitted infections, and social conditions related to institutionalization and the poverty associated with living on limited entitlement benefits. Strategies for prevention will be outlined: counseling approaches, harm reduction, and teaching safer sexual practices. Diagnostic and treatment implications will be described: offering routine voluntary HIV testing, enhancing access to medical care, differential diagnosis of mental status changes, the use of antipsychotic medication in the presence of HIV infection, drug-drug interactions between psychotropic and antiretroviral medications, and new strategies for adherence to complex regimens. Handouts illustrating these points will be available.

No. 86C
DIABETES AND SCHIZOPHRENIA

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Room 476, Baltimore, MD 21201;* Anthony F. Lehman, M.D., Alicia Lucksted, Ph.D., Janine C. Delahanty, M.A., Leticia T. Postrado, Ph.D., Richard Goldberg, Ph.D.

SUMMARY:

People with schizophrenia have significantly higher mortality rates than the general population and may be at increased risk for type II diabetes, among several medical conditions. Research suggests this higher risk is due to factors within schizophrenia itself, medication side effects, and poor overall physical health and health care. Recent reports of the impact of the new antipsychotic drugs on weight gain and the possible development of diabetes will be reviewed. As part of the Schizophrenia PORT study, 1991 Medicaid, Medicare, and more recent interview data were collected regarding the comorbidity of schizophrenia and diabetes: prevalence, quality of life, physical health, and services utilization and costs. Rates of diabetes far exceeded general population statistics. Self-reported physical health status was lowest among interviewees reporting that they have diabetes but are not receiving treatment (14% of sample) and highest among people without diabetes. Diabetes was clearly associated with greater use of health services and greater costs compared with people with schizophrenia but without diabetes. Diabetes risk and obstacles to self-care and health care access that are specific to having schizophrenia will be discussed.

No. 86D
WEIGHT GAIN AND ANTIPSYCHOTICS

Peter F. Buckley, M.D., *Department of Psychiatry, Case Western Reserve Univ., 11100 Euclid Avenue HPV5080, Cleveland, OH 44106*

SUMMARY:

The gap between knowledge from clinical trials and accumulating wisdom from clinical practice is pronounced for endocrine and metabolic effects, most notably for the relative propensity of novel antipsychotics to cause weight gain and to induce diabetes mellitus. Available evidence suggests that weight gain occurs as an adverse effect of all of the new antipsychotics, but that this effect differs between these agents. Additionally, the role of polypharmacy in aggravating neuroleptic-induced weight gain is not well.determined. Since many of the agents used in combination with neuroleptics (e.g., lithium, anticonvulsants) may themselves induce weight gain, this is an important consideration. We have examined the extent and pattern of weight gain among 130 patients receiving one of the new antipsychotics (clozapine, risperidone, olanzapine, quetiapine) in a long-stay facility.

No. 86E
MORTALITY AND POLYPHARMACY IN SCHIZOPHRENIA

John L. Waddington, D.Sc., *Clinical Pharmacology, Royal College for Surgeons, 123 St. Stephen's Green, Dublin 2, Ireland;* Hanafy A. Youssef, D.M., Anthony Kinsella, M.S.C.

SUMMARY:

Though increased mortality is one of the most consistent and accepted epidemiological findings in schizophrenia, a distressingly high rate of suicide appears unable to account fully for this burden, which remains poorly understood in terms of illness and medication factors. Investigation of mortality independent of suicide would help to clarify these issues. Our own studies involved a cohort of 88 inpatients satisfying Washington University criteria for schizophrenia that was characterized and followed prospectively over a 10-year period. Independent predictors of survival were sought among demographic, clinical, and treatment variables. Over the decade, 39 of the 88 patients (44%) died, with no known instances of suicide. Reduced survival was predicted by increasing age, male gender, edentulousness, and time since pre-terminal withdrawal of antipsychotics; additionally, two indices of polypharmacy predicted reduced survival: maximum number of antipsychotics given concurrently (relative risk 2.45, 95% CI 1.10–5.47; P = 0.03) and absence of cotreatment with an anticholinergic (relative risk 3.33, 95% CI 0.99–11.11; P = 0.05). Receiving more than one antipsychotic concurrently was associated with reduced survival in the face of little or no systematic evidence to justify the widespread use of antipsychotic polypharmacy. Conversely, it may be necessary to re-evaluate overcautious attitudes about the use of adjunctive anticholinergics.

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SYMPOSIUM 87—THE BODY SELF AND ITS DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to clarify the concept of the body self and how disturbances in this domain may be manifest in psychiatric and nonpsychiatric populations.

No. 87A
THE BODY SELF: AN OVERVIEW

Gary M. Rodin, M.D., *Department of Psychiatry, University Health Network, 200 Elizabeth Street EN8-222, Toronto, ON M5G 2C4, Canada*

SUMMARY:

The body self, i.e., the domain of self-experience related to the body, is the developmental foundation of the core self and remains fundamental to it through life. It is disturbed not only in somatizing disorders but also in a wide range of other psychiatric conditions. Further, secondary disorders of the self may arise in response to the physical changes of aging, injury, or major medical illness. In conditions such as anorexia nervosa and body dysmorphic disorder, the boundaries between normality and psychopathology are often blurred. Hypochondriasis, bodily preoccupation, and body dissatisfaction are also common patterns of distress in the general population. The emphasis on physical fitness and appearance in modern culture has increased these concerns in many individuals and triggered clinical disorders in a smaller subgroup. This effect is even more striking in high-risk groups such as competitive athletes and models. Psychiatrists and mental health professionals need to be able to distinguish between pathological and nonpathological bodily concerns in order to identify those in need of preventive interventions or treatment and to advise about the suitability of surgical and other procedures designed to improve physical appearance.

No. 87B
CULTURE AND THE BODY SELF

Melanie A. Katzman, Ph.D., *Department of Psychology, Cornell Medical Center, 10 East 78th Street Suite 4A, New York, NY 10021*

SUMMARY:

The detection of eating disorders globally provides a renewed challenge to our explanatory models of self starvation. Following a brief review of the cross-cultural data on the presentation and permutations of eating disorders over the last three decades, this talk will offer suggestions for future inquiry. It will be argued that the 1970s focused on eating disorders as a specific syndrome, while the 1980s began to attend to the culture specificity of the problem. The 1990s has witnessed a surge in both biological and cultural research as well as a recognition of the social construction of illness. Although they may appear to be divergent scientific methods, examination of molecular causes and treatments (the biological) may be successfully integrated into more molar methods of inquiry (the social and cultural).

Specific attention will be given to refining the often-cited influences of gender, weight, and culture on the development of eating disorders, arguing that current models take too restricted a view of bodily idioms of distress. The importance of examining the manner in which diagnoses are formulated and whom they serve will be addressed as will the role of cross-disciplinary collaboration in defining the care we offer and the training we receive.

No. 87C
BDD: NEW DATA ON AN OLD DISORDER

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, has until recently been an underrecognized and understudied disorder. Although BDD might be considered an epiphenomenon of today's appearance-focused society, this often-secret disorder has been reported around the world and consistently described for more than 100 years. Despite its long historical tradition and recent research advances, BDD remains underrecognized and underdiagnosed in clinical practice. BDD consists of time-consuming and distressing preoccupations with perceived appearance flaws, as well as compulsive behaviors such as mirror checking, excessive grooming, skin picking, and camouflaging. Insight is usually poor, and many patients are delusional. Unlike normal appearance concerns, BDD is associated with notably high levels of perceived stress, unusually poor quality of life, impaired social and occupational/academic functioning, and a high suicide-attempt rate. Most patients seek nonpsychiatric treatment (e.g., surgical or dermatologic), often with a poor outcome. In contrast, serotonin-reuptake inhibitors and cognitive-behavioral therapy appear often to be effective. This presentation will present recent data on BDD's prevalence, clinical features, and treatment response. Guidelines for diagnosing BDD will be provided, including how to differentiate BDD from normal appearance concerns.

No. 87D
MUSCLE DYSMORPHIA IN MALE WEIGHTLIFTERS

Roberto Olivardia, M.A., *Department of Psychology, McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Harrison G. Pope, M.D., James I. Hudson, M.D.

SUMMARY:

Background: Muscle dysmorphia is a form of body dysmorphic disorder in which individuals develop a pathological preoccupation with their muscularity.

Method: We interviewed 24 men with muscle dysmorphia and 30 comparison weightlifters, recruited from gymnasiums in the Boston area, using a battery of demographic, psychiatric, and physical measures.

Results: The men with muscle dysmorphia differed significantly from the comparison weightlifters on numerous measures, including body dissatisfaction, eating attitudes, prevalence of anabolic steroid use, and lifetime prevalence of DSM-IV mood, anxiety, and eating disorders. Men with muscle dysmorphia frequently described shame, embarrassment, and impairment of social and occupational functioning in association with their condition. By contrast, ordinary weightlifters displayed little pathology. Indeed, in an *a posteriori* analysis, the ordinary weightlifters proved closely comparable to a group of male college students recruited as a comparison group in an earlier study.

Conclusions: Muscle dysmorphia appears to be a valid diagnostic entity associated with striking and stereotypical features. Men with muscle dysmorphia differ sharply from ordinary weightlifters, most of whom display little psychopathology. Further research is justified to characterize the nosology and potential treatment of this syndrome.

No. 87E
BODY SELF-ESTEEM IN CANCER

Mark R. Katz, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street/EN8-228, Toronto, ON M5G 2C4, Canada;* Jonathan Irish, M.D., Gerald Devins, Ph.D., Gary M. Rodin, M.D., Patrick Gullane, M.D.

SUMMARY:

Cancer and its treatment can pose a significant threat to bodily vitality, functioning, and appearance. Body self-esteem, or the feelings of self-worth related to one's bodily appearance and functioning, may sometimes be impaired in cancer patients. Research findings in fact have been conflicting with regard to the impact of cancer and its treatment on body self-esteem. An overview of the empirical findings concerning body self-esteem and cancer will be presented, and data from a study of surgically treated head and neck cancer patients with facial disfigurement will be reported. Results indicate a significant minority of head and neck cancer patients reported body self-esteem disturbances six months or more after surgical treatment. The majority of patients reported preserved levels of body and other aspects of self-esteem. The prevalence of body self-esteem disturbance depended on the measurement technique used. Worsened body self-esteem was seen in women and subjects with greater degrees of disfigurement. These findings underscore the role of illness and disfigurement on body self-esteem but also point to individual strengths that preserve body self-esteem in the face of major illness and bodily alteration.

No. 87F
MOTIVATIONS FOR AND PSYCHOLOGICAL EFFECTS OF CHANGING THE BODY

Marcia K. Goin, M.D., *Department of Psychiatry, University of Southern CA, 1127 Wilshire Blvd, Suite 1115, Los Angeles, CA 90017-4085*

SUMMARY:

Questions and theories abound about why people are willing to submit to the surgical knife in order to change the size and/or shape of a body part. In fact there is no simple answer. The reasons lie in many domains including the effect of cultural norms (where beauty actually resides in the eye of the beheld not the beholder), the psychological meaning of a body part, and an individual's confused sense of identity or other psychiatric disorder. In order to increase the understanding of the vagaries of body-image distortion and peoples' pleasure and displeasure with their body, this presentation will draw from data obtained in the study of the psychological effect of face-lift operations, rhinoplasty, breast reduction, breast loss, and breast reconstruction

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SYMPOSIUM 88—HEALTH SERVICES USE IN SCHIZOPHRENIA: NEW DATA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have knowledge of: (1) age and gender differences in health services utilization in schizophrenia, (2) effects of assertive community treatment versus standard case management, (3) cost-effectiveness of atypical antipsychotics, and (4) appropriate use of nursing home services by elderly patients with schizophrenia.

No. 88A
OLDER VETERANS WITH SCHIZOPHRENIA: THREE-YEAR TREATMENT OUTCOMES

Frederic C. Blow, Ph.D., *Smitrec, Ann Arbor VA HSR&D, P.O. Box 130170, Ann Arbor, MI 48113;* Scott Roberts, Ph.D., Kristen Barry, Ph.D., Laurel A. Copeland, M.P.H.

SUMMARY:

Background: Treatment response in later-life schizophrenia is poorly understood and of serious concern.

Method: This study examined one-year and three-year service utilization and functional outcomes in 499 veterans with severe forms of schizophrenia. Participants were divided into three age groups: age 60 and over (n = 128); age 40–59 (n = 252); and age 20–39 (n = 119). Outcomes included global functioning, psychiatric symptomatology, instrumental activities of daily living (IADL), and days of hospitalization per year.

Results: Older patients became more impaired over time in terms of global functioning, while the other groups showed improvement. At three years, all three groups showed a significant decline in psychiatric symptomatology from baseline. The older group was the most impaired at all three time points in terms of IADL. All groups' days of hospitalization declined over time, although the older patients had higher utilization at baseline and three years.

Conclusion: Older veterans with schizophrenia were more impaired and benefitted less from specialized treatment than their younger counterparts. They did not show the gains of younger patients in terms of global functioning and continued to require more inpatient services and assistance with instrumental activities of daily living. Innovative programming for older veterans with schizophrenia may need to be developed to meet the needs of this growing and difficult population.

No. 88B
AGE-RELATED COMPARISON OF HEALTH RESOURCE UTILIZATION IN WOMEN ADMITTED TO AN ACUTE-CARE STATE PSYCHIATRIC FACILITY

Martha Sajatovic, M.D., *Department of Psychiatry, Case Western Reserve, 345 Timberidge Trail, Gates Mills, OH 44040;* Karl Donewirth, Dilara Sultana, M.D., Peter F. Buckley, M.D.

SUMMARY:

Despite the fact that there are an increasing number of elderly individuals with serious mental illness (SMI) such as schizophrenia, there has been little research on the manifestation of SMI in old age, and there is limited understanding of the mental health care needs of this population. For example, the literature on how aging affects women with schizophrenia in later life is extremely scanty. It has been suggested that estradiol functions as a dopamine antagonist and has a protective effect in schizophrenia. Some clinical investigators have reported that post-menopausal women are less responsive to neuroleptic medications and may have poorer outcome compared with younger women with schizophrenia. This is a comparative age-related analysis of health resource utilization of women admitted to an acute-care state psychiatric facility. A computer search of all women discharged from this large, urban, state facility over a one-year period was undertaken. Demographic and resource utilization data, including total hospital length of stay (LOS) and pharmacy utilization, were obtained from the electronic record. There were 564 women, mean age 37.5 ± 10.7. Mean LOS for the entire group was 16.1 ± 26.3 days with a mean of 15.0, ± 26.5 days for women under age 50 (N = 492) and a mean of 23.1 ± 23.7 days for women aged 50 or more (N = 72) (t = 2.5, df = 562, p = .01). Diagnosis of schizophrenia was seen in 58.3% of women aged 50 or older admitted to a state inpatient facility, while a smaller proportion of women (38.0%) under age 50 had a primary psychiatric diagnosis of schizophrenia (x^2 = 10.8, df = 1, p = .001). Our data suggest that older women hospitalized at an inpatient facility have greater hospital utilization compared with younger women. Further research is indicated on how aging in women with serious mental illness affects clinical outcomes and health resource utilization.

No. 88C
ACT VERSUS STANDARD CASE MANAGEMENT CLIENTS USE DIFFERENT SERVICES

Susan M. Essock, Ph.D., *Department of Psychiatry, Mt. Sinai Medical School, One Gustave Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

Patients who were high service users with serious mental disorders (N = 262) were randomly assigned to assertive community treatment (ACT) or to standard case management (SCM) at three study sites and followed for 18 months. ACT patients used a different array of services than did SCM patients (e.g., ACT patients used hospitals and nursing homes less and community-based services more than SCM patients). Therefore, the availability of a given service influences the use of other services, and this interaction needs to be taken into account when constructing payment systems (e.g., a provider of community services paid on a capitated fee would have no fiscal incentive to promote the formation of ACT teams). In addition to aligning payment incentives to be cost-effective, places on ACT teams should be limited to patients who are so severely ill as to have been recent and heavy users of hospital services. The amount and distribution of services used by ACT and SCM patients can vary widely by site, even within the same state. Hence, estimates of costs and relative distribution of services used vary greatly by site, even if the relative performance of the ACT and SCM interventions is consistent across sites.

No. 88D
ARE ATYPICAL ANTIPSYCHOTICS COST EFFECTIVE?

Jonathan P. Lacro, Pharm.D., *Department of Psychiatry, UCAL San Diego, VASDHCS, 3350 La Jolla Village Drive, San Diego, CA 92161;* Thomas L. Patterson, Ph.D., James B. Lohr, M.D., Steve Stolley, Pharm.D., Robert V. Ashley, B.A., Dilip V. Jeste, M.D.

SUMMARY:

In cost-effectiveness analysis, the effectiveness is measured in terms of clinical outcomes that are more natural than dollars. This presentation will focus on studies comparing outcomes with typical versus atypical antipsychotics in patients with schizophrenia. We will also discuss a new model of comparing cost-effectiveness of clozapine with that of haloperidol based on the published data. This model shows that the overall costs of care with clozapine and haloperidol are generally similar, although there are significant differences in outcomes related to psychopathology as well as adverse effects. Our own studies of over 300 middle-aged and older adults with schizophrenia and related psychotic disorders on either typical or atypical antipsychotics show that the newer atypical agents have a significantly lower risk of tardive dyskinesia, a trend for an improvement in health-related quality of well-being, and a reduction in psychiatric health care utilization. On the other hand, the impact of the atypical antipsychotics on cognition and adherence (compliance) remains unclear. Some age-related differences suggest a greater utility of the atypical agents in older than in younger adults. We will discuss the implications of our results for the use of these drugs in different age groups.

No. 88E
INAPPROPRIATE NURSING HOME USE BY ELDERLY WITH SCHIZOPHRENIA

Stephen J. Bartels, M.D., *Department of Psychiatry, NH-Dartmouth Res CT, 2 Whipple Place, Ste 202, Lebanon, NH 03766-1360;* Keith Miles, M.P.A., Kristin A. Levine, Ph.D.

SUMMARY:

Objective: The goal of this study is to identify clinical characteristics associated with appropriate treatment of elderly people with severe mental illnesses in nursing homes compared with those in the community.

Methods: Individuals with SMI over age 60 were randomly selected from outpatient and nursing home populations and assessed using standardized measures of symptoms and function. The study sample (n = 417) had a mean age 74 years and was 77% female, including 33% schizophrenia, 31% depression, 15% bipolar disorder, and 21% other. Of those in nursing homes (n = 182), 39% were determined to be more appropriate for community living, including almost half (49%) in nursing homes who had schizophrenia, compared with 17% with depression and 10% with bipolar disorder. Principal components analysis and logistic regression found three functional characteristics (self-care skills, social skills, and problem behaviors) and four symptoms (negative, positive, depressive symptoms, and cognitive impairment) discriminated between elderly appropriately living in nursing homes vs. community with 91% and 88% accuracy, respectively. Self-care skills and cognitive impairment were the most powerful individual predictor variables.

Conclusions: A substantial proportion of elderly people with schizophrenia in nursing homes are more appropriately served in less-intensive and less-costly community settings. Appropriate level of care can be accurately determined with a small number of functional or symptom variables.

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SYMPOSIUM 89—CLINICAL APPLICATIONS OF PSYCHIATRIC GENETICS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium participants should be able to use the results of psychiatric genetic research in their clinical practice and understand the ethical implications they will face when discussing genetic information with their patients.

No. 89A
CLINICAL APPLICATIONS OF GENETIC KNOWLEDGE: AN OVERVIEW

Stephen V. Faraone, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 750 Washington Street Suite 225, South Easton, MA 02375*

SUMMARY:

This presentation provides an overview of how psychiatric genetic data can be applied in clinical practice. We first discuss genetic counseling, which provides principles to help clinicians communicate genetic risks to patients and their families. The second application of psychiatric genetics seeks to improve diagnosis and treatment. In addition to genetic counseling, psychiatric genetic data have implications for the diagnosis and treatment of the mentally ill. In the future, as genes are discovered and their mechanisms of action understood, psychiatric genetics will have a tremendous impact on clinical practice. DNA tests will be available to aid genetic counselors and to diagnose disease. The delineation of subforms having different genetic and environmental contributions will allow clinicians to target treatments to specific causes. And, perhaps, the technology of gene therapy will allow physicians to prevent psychiatric disorders at the very earliest stages of life. We discuss these potential future developments but also show how current psychiatric genetic knowledge can facilitate diagnosis and treatment. In this regard we emphasize family-based diagnosis, fighting therapeutic nihilism, and facilitating treatment. We also discuss the implications of genetic knowledge for studies of primary prevention.

No. 89B
APPLICATIONS TO CLINICAL ISSUES IN SCHIZOPHRENIA

Ming T. Tsuang, M.D., *Department of Psychiatry, Harvard Medical School, MMHC 74 Fenwood Road, Boston, MA 02115*

SUMMARY:

We briefly review evidence for the genetic transmission of schizophrenia provided by family, twin adoption, and molecular genetic studies. We then focus on two areas of psychiatric genetic information needed by clinicians working with schizophrenic patients and their families: the spectrum of psychopathology and dysfunction in nonpsychotic relatives, and the potential for primary prevention of the disorder.

Clinicians frequently work with family members of schizophrenic patients with the goal of teaching them coping strategies and educating them about their relative's illness. But an informed approach to these families should consider the spectrum of problems that may affect family members, including negative symptoms and neuropsychological impairments. Although the prevention of schizophrenia is not currently possible, we will discuss how psychiatric genetic data are setting the foundation to make such studies possible. We will describe how current studies will eventually provide us with the ability to predict the onset of psychosis to make primary prevention research feasible. We also describe a pilot study demonstrating how interventions among relatives of schizophrenic patients can be used to formulate hypotheses about the design of primary prevention trials.

No. 89C
APPLICATIONS TO ANXIETY DISORDERS

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC-725, Boston, MA 02144*

SUMMARY:

This talk addresses a basic scientific and clinical question: Is it is possible to predict the development of anxiety disorders among children whose parents have panic disorder (PD)? This question is straightforward, yet the answer has broad implications. Although it is well established that children of parents with PD are at high risk for anxiety disorders, only some of these children will develop psychopathology. The identification of a predictor would facilitate primary prevention by delineating a group of young children at very high risk for anxiety disorders among those already at risk by having a PD parent. One predictor that holds much promise is "behavioral inhibition to the unfamiliar." Behavioral inhibition (BI), which is measured in a laboratory setting, reflects the consistent tendency to display fear and withdrawal in situations that are novel or unfamiliar. Since these responses are assumed to indicate low thresholds of limbic arousal or increased sympathetic outflow in response to challenge, they may indicate a predisposition to develop anxiety disorders that can be measured long before the disorders can be assessed with a standard psychiatric instrument. We discuss data suggesting that the onset of anxiety disorders can be predicted and discuss the implications for primary prevention.

No. 89D
PSYCHIATRIC GENETIC COUNSELING

Debby Wen Tsuang, M.D., *University of Washington, 1660 South Columbian Way, Seattle, WA 98198*

SUMMARY:

Through the diligent efforts of the National Institutes of Health and the biotechnology and pharmaceutical industries, more than 4,000 diseases are known to be genetic. Diagnostic tests are available for more than 450 genetic disorders. This new knowledge portends hope for many patients and their families as the tree of genetic knowledge bears the fruit of diagnostic and therapeutic applications. But new knowledge creates new confusions. As genetic tests become widely available, their use and interpretation will require basic knowledge of human genetic principles and how to communicate these to patients and their family members. Through genetic counseling we educate our patients about these principles, communicate risks for future disease onset, and correct many of the misconceptions that cause undue distress among people seeking counseling. Despite the need for psychiatric genetic counseling, these services are not routinely available at genetic counseling clinics, which focus mainly

on rare Mendelian conditions. This talk provides an overview of the methods used in psychiatric genetic counseling in a manner that will allow clinicians to incorporate such counseling into their clinical practice.

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2. Tsuang MT, Stone WS, Seidman LJ, et al: Treatment of nonpsychotic relatives of patients with schizophrenia: four case studies. Biological Psychiatry 1999; 41:1412–1418.
3. Rosenbaum JF, Biederman J, Bolduc-Murphy EA., et al: Behavioral inhibition in childhood: a risk factor for anxiety disorders. Harvard Review of Psychiatry 1993; 1:2–16.

SYMPOSIUM 90—DOCTOR-PATIENT RELATIONSHIP: PAST, PRESENT, AND FUTURE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize two consequences of the erosion of the doctor-patient covenant; (2) give one example each of the placebo effect's power and limitations; (3) list a positive and negative consequence of the Tarasoff decision; (4) identify two areas each of improvement and problem in the male physician-female patient dyad.

No. 90A
DOCTOR-PATIENT RELATIONS IN NAZI GERMANY AND THE FATE OF PATIENTS

Irwin N. Hassenfeld, M.D., *Department of Psychiatry, 18 Wilshire Drive, Delmar, NY 12054*

SUMMARY:

In the decades prior to the Nazis coming to power, German psychiatry was acknowleged as scientifically the most advanced of any country in the world. During the period of the Weimar Republic, the government pioneered a universal health care delivery system. These reforms, while markedly reducing morbidity and mortality, resulted in patients losing their medical confidentiality and the right to consult the physician of their choice. Another unfortunate consequence was a shift in physician allegiance from individual patients to "the health of the nation". Weimar reforms were vehemently opposed by the powerful political right on the grounds that they were too expensive, benefitted the racially unfit, and were inspired by Marxists and "the international Jewish conspiracy". A review is undertaken of the impact on the physician-patient relationship of scientific, socioeconomic, and political developments in the 50 years leading up to the Third Reich, which set the stage for the atrocities visited upon psychiatric patients by academic physicians in the name of medical care and which were unprecedented in the history of medicine. The erosion of the doctor-patient covenant leading up to and during the Nazi regime may have made it possible for German psychiatrists to kill their patients.

No. 90B
TARASOFF AND THE PSYCHIATRIST-PATIENT RELATIONSHIP

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

Twenty-five years have passed since the California Supreme Court issued its first decision in the famous *Tarasoff* case, declaring that psychiatrists and mental health professionals had a duty to protect potential victims of their patients' violent acts. A great deal of concern was expressed at the time regarding the impact of this duty on the therapist/patient relationship. In particular, there was fear that patients would stop coming to psychotherapists or would withhold substantial amounts of information from psychotherapists, if they knew that therapists' concerns regarding their potential for violence might lead to disclosures to potential victims or the police. Some version of the *Tarasoff* duty is now the law in almost every jurisdiction, whether as a result of statute or court decision. There have been a fair number of follow-up studies attempting to document the effects of *Tarasoff* on the therapist/patient relationship. These studies suggest much less impact than had been feared. There is little evidence that patients avoid entering therapy as a result of the *Tarasoff* duty. Moreover, even when disclosure of patients' threats occurs, the evidence seems to suggest that negative impact on the therapeutic relationship can be minimized if the disclosure is handled in an appropriate fashion. The factors that have combined to minimize *Tarasoff*'s impact on the psychiatrist/patient relationship will be discussed.

No. 90C
THE PLACEBO EFFECT IN THE CONTEMPORARY DOCTOR-PATIENT RELATIONSHIP

Walter A. Brown, M.D., *Department of Psychiatry, Brown University, 108 Driftwood Drive, Tiverton, RI 02878*

SUMMARY:

Although conventional medicine has more to offer than ever before in diagnostic precision and treatment effectiveness, the public is increasingly turning to alternatives. What brings people in such droves and with such avidity to unproven alternative therapies? Among other things, alternative health care now offers to a greater extent than conventional care the healing ingredients of the treatment situation most precious to those who are ill: a thorough evaluation, healing rituals and symbols, a healer's optimism, commitment, encouragement and attention, and high expectations for improvement. These components of the traditional treatment situation—referred to sometimes disparagingly as "placebo"—are a powerful part of healing. They contribute to the benefit of all treatments, are the only benefit of many and, until recently, constituted an important part of conventional health care. But now they are in short supply. The phenomenal advances in scientific medicine over the last two decades mean that patients spend more time with machines and less with healers. Further erosion of the healing situation comes from managed care with its focus on cost-containment, triage, and physician time. Good patient care requires us to acknowledge that the components of treatment contributing to the "placebo effect" are an important part of healing.

No. 90D
MEN DOCTORS/WOMEN PATIENTS: PROBLEM OR POTENTIAL?

Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 836 West Wellington Avenue, Chicago, IL 60657*

SUMMARY:

Discussions of gender issues in the doctor-patient relationship have focused on sexual transferences and countertransferences, on boundary violations, on gender roles, and on power differentials. In the early days of psychotherapy, the male psychiatrist-female patient

dyad was taken for granted. In recent decades, feminist therapists have viewed this dyad as fundamentally flawed; males in positions of dominance, they argued, exacerbate the damage society causes to women. Reports of sexual relationships between male psychiatrists and female patients did nothing to improve this perception. The reality is more nuanced. Patients of either gender can be helped or hurt, understood or misunderstood, by psychiatrists of either gender. Cultural factors play a role. No therapy is value free. It takes real effort to become aware of one's unconscious assumptions and agendas and their effects on psychiatric treatment. What is the therapist's vision of the patient's best interests and potential and how does it compare with the patient's? Is the therapist lowering or raising expectations to help the patient achieve her potential or to satisfy the needs or reify the beliefs of the therapist? There are no final answers, but the real dangers lie in unexamined assumptions and in ignoring the gender issue altogether.

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2. Appelbaum PS: Almost a Revolution: Mental Health Law and the Limits of Change. New York, Oxford University Press, 1994.
3. Eisenberg DM, Davis RB, Ettner SL, et al: Trends in alternative medicine use in the United States, 1990–1997. JAMA, 1998; 280:1569–1575.
4. The Woman Patient. Edited by Notman MT, Nadelson CC. New York, Plenum, 1978.

SYMPOSIUM 91—MANAGED CARE AND THE PATIENT-DOCTOR RELATIONSHIP

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the complexity of change, which has impacted the doctor-patient relationship in a managed care system.

No. 91A
CONSUMER TECHNOLOGY AND ORGANIZED SYSTEMS OF CARE

Mary Jane England, M.D., *WA Business Group on Health, 777 North Capitol St, NW, #800, Washington, DC 20002-4239*

SUMMARY:

The doctor/patient relationship remains central to building trust for the purpose of improving and maintaining the patient's ability to function and grow in an increasingly complex world. With advanced technology and individuals assuming more of the cost for their own care, patients will begin to act less like users and more like consumers. In the future, psychiatrists will need to focus more on being in the service business and respond to the consumer movement.

To retain and enhance loyalty of their patients, all physicians will need to create the information systems and management infrastructure to integrate multiple aspects of treatment plans while protecting patients' confidentiality. Physicians will proactively reach out to patients to ensure that appropriate detection, prevention, and acute and chronic care are provided through broad networks and multiple caregivers. This is especially true for children and youth with serious emotional disturbance and adult patients with severe mental illness. The burgeoning use of the Internet, i.e., chat rooms and list serves, will need to be understood in the context of a trusting relationship between doctor and patient.

All of medicine will have to provide care and treat patients more cost-effectively and with better service by reducing variations, implementing best practices, and by building and adhering to national standards for all health care delivery while preserving trusting doctor/patient relationships.

No. 91B
THE CHANGING NATURE OF THE DOCTOR-PATIENT RELATIONSHIP

Alan A. Stone, M.D., *Hauser Hall, Room 400, Harvard University Law School, 1575 Massachusetts Avenue, Cambridge, MA 02138-2996*

SUMMARY:

The doctor-patient relationship is the basic building block of any health care system. Traditionally, law assumed that the doctor had fiduciary obligations to the patient based on a standard premise of common law, namely that they were unequal parties negotiating a contract. Generally, the law left it to medical ethics, standards of care, and the torts system to police the doctor-patient relationship. Under managed care, doctors have new obligations to health plans that limit the physician's capacity to fulfill his or her fiduciary obligations. Market forces driving the health care system have intensified this dilemma. The doctor's responsibility for covered lives sets a limit on fiduciary obligations. ERISA has allowed market forces to avoid malpractice liability and the restraints established by traditional standards of care. Congress is currently debating these issues, but there has been insufficient consideration of the doctor-patient relationship in the proposed reforms of managed care.

No. 91C
DEVELOPING A COMMUNITARIAN ETHIC

James Sabin, M.D., *Harvard Pilgrim Health Care, 126 Brookline Avenue Suite 203, Boston, MA 02215*

SUMMARY:

Hippocratic medical ethics and APA's own code of ethics have focused largely on the patient-doctor dyad. As all societies struggle with the challenge of providing the best possible care to individuals in the context of finite societal resources for health care, clinicians face the challenge of cultivating a clinically ethically admirable relationship with patients in the context of limits. This presentation will present an overview of U.S. efforts to define criteria for "ethical managed care" and international efforts to develop a more communitarian medical ethic.

No. 91D
THE AFRICAN-AMERICAN EXPERIENCE IN MANAGED CARE

Donna M. Norris, M.D., *Parents and Children Services, 654 Beacon Street, Boston, MA 02215;* Billy E. Jones, M.D.

SUMMARY:

The medical literature has recently focused on the impact of race on the quality of the patient-doctor relationship and the medical care provided when the patient is from a minority group. Within the United States, the general public, including African-American communities, is turning increasingly to alternatives to traditional medical care. This is of particular concern for patients who may need psychiatric services. The authors will present survey results concerning the experience of African-American psychiatrists with the managed care system and their perceptions regarding the care that was provided to their patients.

No. 91E
THE PATIENT-DOCTOR RELATIONSHIP: WHAT HAPPENED?

Leon Eisenberg, M.D., *Dept. of Social Science, Harvard Medical School, 641 Huntington Avenue, Boston, MA 02115*

SUMMARY:

Sound medical practice rests on a fundamental principle: a relationship of trust between patient, family, and physician. Developing that relationship takes time: time to listen, time to understand the sources of distress, time to make the diagnosis and sort out therapeutic alternatives, time to help the patient and family appraise the pros and cons of the treatment choices, and time to support the patient in sticking with the treatment or changing it if it isn't effective.

Time is the currency of medical care. Time is not measured simply by the duration of individual visits, but by the multiple visits needed to provide continuity. Chronic diseases such as diabetes, depression, and schizophrenia are not susceptible to quick technical fixes or sound bites of advice. The effective management of long-term illnesses requires that the patient adhere to long-term treatment regimens that are often onerous and complex. The key to adherence on the patient's part is understanding why these regimens are necessary and the benefits they bring. For the patient to believe that the doctor has presented the facts fully and fairly, he or she must have confidence in the physician's integrity. For that to be possible, the clinical decisions physicians make must be income-neutral and not subject to financial controls that discourage referral, tests, and hospitalization when they are necessary for good care.

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1. WBGH: Distinguishing Organized Systems of Care. Washington, D.C., 1995
2. England MJ: Capturing mental health cost offsets. Health Affairs 1999; 18:91
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6. Eisenberg L: Subject and object in the grammar of medicine. Penn Medicine 1992; 6:18–28

SYMPOSIUM 92—NEW DEVELOPMENTS IN INTERPERSONAL PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand recent research adaptations of IPT to diagnostic subgroups and the results of outcome studies.

No. 92A
OVERVIEW OF INTERPERSONAL PSYCHOTHERAPY

John C. Markowitz, M.D., *Department of Psychiatry, Cornell Univ. Medical College, 525 East 68th Street, Room 1322, New York, NY 10021*

SUMMARY:

This presentation will review the basic principles and interventions of interpersonal psychotherapy (IPT) for major depression. IPT focuses on the connection between life events and mood symptoms in a practical attempt to alleviate a psychiatric condition. Depressed patients tend to forget that their environment may play some role in how they are feeling. The strategy for major depression is to link the onset of an episode of major depression to a major life event such as the death of a significant other (complicated bereavement), a struggle in a key relationship (role dispute), an upsetting life event (role transition), or social isolation (interpersonal deficits). If the patient can alter this difficult interpersonal situation and his or her social role, this is not only good in itself but relieves the mood episode as well.

This fundamental IPT approach has been adapted in various ways to patients with different diagnoses. Bulimia and adolescent depression will be presented as brief examples.

No. 92B
TREATING DYSTHYMIA IN PRIMARY CARE: SERTRALINE VERSUS INTERPERSONAL PSYCHOTHERAPY

Meir Steiner, M.D., *Department of Psychiatry, McMaster University, 50 Charlton Ave E/St. Joseph's, Hamilton, ON L8N 4A6, Canada;* Gina Browne, Ph.D., Jacqueline Roberts, M.S.C., Amiram Gafni, Ph.D., Carolyn Byrne, M.H.S.C., Barbara Bell, M.D., Edward Dunn, Ph.D.

SUMMARY:

The purpose of this naturalistic, two-year randomized trial was to compare the effects and economic consequences of treating dysthymia with sertraline and/or interpersonal psychotherapy (IPT) in primary care. A total of 707 patients with dysthymia were randomized to: sertraline (S) (N = 229); S + IPT (N = 247); IPT (N = 231); 525 completed two years of follow-up and were assessed using the Montgomery Asberg Depression Rating Scales (MADRS) and the Browne Health Services Utilization Inventory.

At six months, one and two years treatment with S, or with S + IPT was more effective than IPT alone (intention-to-treat analysis: $p = 0.02$) as measured by a reduction of at least 40% on the MADRS. However, the IPT component of the S + IPT combination paid for itself by reducing the use of other health and social services.

The S and S + IPT groups were similar in the small proportion of subjects experiencing serious adverse events, but fewer participants in the S + IPT group discontinued the study due to side effects compared with the S alone group ($p = 0.003$).

Long-term treatment with sertraline is clearly indicated in dysthymia and augmenting it with IPT improves not only the quality of life and coping strategies of these patients but also reduces the use of health and social services.

No. 92C
MAINTENANCE INTERPERSONAL PSYCHOTHERAPY IN LATE-LIFE DEPRESSION

Charles F. Reynolds III, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

The Pittsburgh study of Maintenance Therapies in Late-Life Depression tested the hypotheses that monthly maintenance interpersonal psychotherapy (IPT-M) and nortriptyline, both singly and in combination, will be superior to placebo in preventing recurrence of major depressive episodes in the elderly, and that combined therapy (IPT-M plus NT) will be superior to either alone in prolonging

recovery and in maintaining wellness. In a sample of 107 elderly patients with recurrent unipolar depression, we observed higher rates of continued wellness over three years among patients randomized to IPT-M plus NT (80%, 20/25) than among those on NT and clinical management (NT: 57%, 16/28), IPT-M plus placebo (36%, 9/25), or placebo plus clinical management (10%, 3/29). The advantage of combined treatment over monotherapy was even greater in patients aged 70 and above. Thus, all active treatments were better than placebo, and combined treatment was better than monotherapy in maintaining wellness in the elderly. Pretreatment severity of depression correlated with continued recovery on maintenance IPT: the three-year recurrence/nonrecurrence status of patients on IPT-M plus placebo was correctly identified in 80% of cases (20/25) by pretreatment Hamilton scores of less than 20 (continued wellness) or 20 or greater (recurrence).

Monthly maintenance IPT offers significant benefit in preventing return of depression in the elderly, whether combined with antidepressant medication or as a monotherapy.

No. 92D
INTERPERSONAL PSYCHOTHERAPY FOR PERINATAL DEPRESSION

Scott P. Stuart, M.D., *Department of Psychiatry, University of Iowa, 2882 JPP, 200 Hawkins Drive, Iowa City, IA 52242;* Michael W. O'Hara, Ph.D.

SUMMARY:

Although the standard psychological therapies for depression such as interpersonal psychotherapy (IPT) have been found to be efficacious with women generally, few studies have evaluated their efficacy with perinatal depressed women. This presentation reports on the use of IPT with both antenatal and postpartum depressed women.

Our initial study involves 120 postpartum depressed women assigned to either 12 weeks of IPT or to a wait-list control group. Participants underwent assessments of depressive symptomatology and social functioning at pretreatment, post-treatment, and following the 4th and 8th week of therapy. Significantly fewer women in the IPT group met criteria for depression following treatment compared with controls. IPT subjects had significantly lower levels of depressive symptomatology compared with controls. Women in the IPT group also reported significantly better social adjustment. These results led to the investigation of IPT for depression during pregnancy. Data from our ongoing open trial strongly suggest that IPT is efficacious for this population as well. Preliminary results from this study will be reviewed.

No. 92E
INTERPERSONAL PSYCHOTHERAPY FOR SOCIAL PHOBIA

Joshua D. Lipsitz, Ph.D., *Department of Psychiatry, NYSPI Columbia University, 1051 Riverside Drive #69, New York, NY 10032*

SUMMARY:

Social phobia is a prevalent and debilitating anxiety disorder. Available treatments include medications such as phenelzine and the selective serotonin reuptake inhibitors and cognitive-behavior therapy. Interpersonal psychotherapy (IPT) was modified for treatment of social phobia, incorporating content and techniques relevant to this disorder. An overview of this modification will be presented along with clinical examples.

Nine patients meeting DSM-IV criteria for social phobia entered open treatment with IPT. All patients completed 14 individual weekly sessions. Assessments were made by an independent evaluator (IE), the patient, and the therapist at weeks 0, 7, and 14. Repeated measures analyses of variance demonstrated significant improvement on several measures of symptom severity. Changes approximated those of established treatments for social phobia. Seven of nine patients (78%) were classified as responders (much improved or very much improved) by the IE based on Clinical Global Impression.

Results suggest that IPT may have promise for treatment of social phobia. A randomized controlled trial comparing IPT with supportive psychotherapy is underway.

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SYMPOSIUM 93—UPDATE ON THE ETIOLOGY, TREATMENT, DIAGNOSIS, AND COMORBIDITY OF PANIC DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have knowledge of recent advances in the etiology, diagnosis, treatment, and comorbidity of panic disorder in order to aid the clinician in the management of panic disorder patients.

No. 93A
PANIC DISORDER ACROSS THE LIFE SPAN

R. Bruce Lydiard, M.D., *Department of Psychiatry, Medical University of SC, 67 President St./PO Box 250861, Charleston, SC 29425*

SUMMARY:

Panic disorder (PD) can affect individuals from childhood to old age. While most individuals develop PD during the second to fourth decades of life, onset of PD can occur across the life span. This presentation will highlight the approach to patients who do not respond to initial treatment efforts. Special considerations for treatment in the very young and very old will be discussed. Factors such as dose, duration of treatment, identification of the undertreated component, comorbid psychiatric/medical disorders, and environmental, psychosocial and developmental factors will be discussed. These can be used in a differential diagnostic assessment of incomplete or nonresponse to initial and long-term treatment of PD. Remaining gaps and directions for future research will be reviewed.

No. 93B
RECENT ADVANCES IN THE BIOLOGY OF PANIC DISORDER

Donald F. Klein, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032-2603*

SUMMARY:

Over the past 20 years, biological perspectives on the pathogenesis of panic disorder have rapidly evolved. It is the purpose of this paper to review the evidence implicating neurochemical, neurophysiological, and functional neuroanatomical abnormalities in the pathogenesis of panic disorder. In particular we will review evidence for noradrenergic and serotonergic abnormalities as well as lactate and CO_2 metabolism in panic. We will also examine GABA dysfunction, CCK, and HPA axis dysfunction in panic disorder. Neurophysiology findings in panic that will be discussed include startle studies, EEG findings and the relationship of panic to changes in cardiovascular physiology. Neuroimaging findings will also be discussed. The clinical relevance of these findings will be discussed as well as implications and changes in these parameters with successful treatment. Finally and most important, future research issues regarding mechanism of action and its relevance to clinical treatment will be discussed.

No. 93C
PANIC DISORDER IN A CLINICAL SETTING: ISSUES OF COMORBIDITY

Eric D. Peselow, M.D., *Department of Psychiatry, NYU School of Medicine, 32 Bassett Avenue, Brooklyn, NY 11234;* Mary T. Guardino, B.A., Wieslawa Tomaszewska, M.D., R. Sandlin Lowe III, M.D.

SUMMARY:

The purpose of this report is to evaluate the frequency of DSM-IV personality disorders, generalized anxiety disorder (GAD), agoraphobia, obsessive-compulsive disorder (OCD), social and specific phobia, and depression in patients with panic disorder.

To date we have evaluated 140 patients with panic disorder who were diagnosed using a modified symptom checklist adapted from the SCID during the acute stage of the illness and following clinical recovery (defined as being free from a full-blown panic attack for at least one month) 12-16 weeks later. To assess personality disorders, the SIDP for DSM-IV was used both during the acute phase of the illness and upon clinical recovery. From the SIDP we assessed both dimensional personality traits and categorical diagnosis. In addition, using the modified SCID at baseline, we also determined whether the patients met DSM-IV criteria for GAD, agoraphobia, social and specific phobia, OCD, or depression. Our results note that at baseline 72/140 patients (51%) met criteria for at least one DSM-IV personality disorder, with the two most frequent being avoidant (35%) and dependent (31%). However, upon clinical recovery, only 46/140 patients (33%) met criteria for at least one DSM-IV personality disorder, and the frequency of meeting criteria for a DSM-IV personality disorder as well as the dimensional trait score with respect to the Cluster A and Cluster C traits decreased significantly when the panic attacks ceased. Panic patients with a greater comorbidity of other anxiety disorders tended to retain the personality disorder diagnosis. Overall comorbidity of panic disorder compared with depression, OCD, GAD, social phobia, specific phobia, and agorophobia was 48%, 37%, 33%, 28%, 18% and 37%, respectively. Only 31% of the sample had a diagnosis of panic disorder alone. Our findings suggest that panic disorder does not occur singly, but comorbid factors must be considered with respect to treatment.

No. 93D
COGNITIVE-BEHAVIORAL THERAPY FOR PANIC DISORDER

Mark Sisti, Ph.D., *Long Island Centers for Cognitive Therapy, 317 Marine Avenue, Brooklyn, NY 11209*

SUMMARY:

Over the past 10 years, cognitive-behavioral treatments (CBT) have been increasingly used to treat panic disorder. Indeed the greater understanding of the core fears of anxiety disorders—fears of anxious and somatic sensations and their perceived consequence—have led to well-targeted treatment interventions.

It is the purpose of this paper to describe a cognitive behavioral model for treating panic disorder. We will review the data concerning CBT in the short-term and long-term treatment of panic disorder. We will discuss treatment considerations such as the need to eliminate catastrophic misinterpretations, conditioned fears of bodily sensations, avoidance, and compensatory safety techniques and ways to combat these problems.. We will discuss predictors of response to CBT as well as the interactive effect of medication plus CBT for the short-term and long-term treatment of panic disorder. We will show how CBT boosts the effects of pharmacological treatment for individuals who fail to have a full response to pharmacotherapy alone, as well as helping patients discontinue their antipanic medication while maintaining clinical benefits. Finally, we will attempt to show the psychopharmacologist and general clinician how various elements of CBT can be added to the standard pharmacologic and supportive treatment for panic disorder.

No. 93E
PANIC DISORDER: A FIRST-PERSON ACCOUNT

Mary T. Guardino, B.A., *Freedom from Fear, 308 Seaview Avenue, Staten Island, NY 10305*

SUMMARY:

Panic disorder, agoraphobia, and major depression plagued my life for more than 25 years. These illnesses affected all capacities of my functioning causing life to be an ongoing struggle to survive daily. It reached a point that simple activities such as riding a bus or visiting family were impossible tasks. What was even more devastating was living in a world where there was no explanation for what was happening to me. Appropriate diagnosis and treatment of my illness controlled my symptoms and eventually, even without medication, they did not return.

Anxiety and depressive illnesses are major worldwide health concerns. These illnesses are common, chronic, and devastating to sufferers as well as their families and friends. This presentation will highlight my personal battle with anxiety and depressive illness and the experiences of thousands of sufferers whom I have met as an advocate in the mental illness advocacy network.

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SYMPOSIUM 94—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, post-traumatic 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 merits of these therapeutic interventions.

No. 94A
THE DIFFICULT-TO-TREAT BIPOLAR PATIENT

Frederick K. Goodwin, M.D., *Department of Psychiatry, George Washington University, 2300 Eye Street NW Roff Hall Room 514, Washington, DC 20037*

SUMMARY:

Bipolar disorder often is a refractory illness. Treatment resistance is 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 the disorder refractory or not, is complex and requires careful attention to the therapeutic alliance.

No. 94B
TREATMENT-RESISTANT SCHIZOPHRENIA

Ronald W. Pies, M.D., *Department of Psychiatry, Tufts University Medical, P.O. Box 332, Bedford, MA 01730*

SUMMARY:

Despite the evident benefits of neuroleptics, about 40% of neuroleptic-treated patients continue to show moderate to severe psychotic symptoms, and 8% show no improvement or become worse. Between 5% and 25% of schizophrenia patients can be considered unresponsive to standard neuroleptics. However, these figures do not take into consideration several important measures of treatment outcome including social function, cognitive function, work function, rehospitalization, and suicide risk. When these issues are considered, the incidence of treatment resistance is undoubtedly higher. Depending on operational criteria and patient characteristics, some 30%-50% of patients with symptoms of schizophrenia do not respond to conventional neuroleptics. Standard agents have minimal long-term effects on negative symptoms, neurocognitive symptoms, and mood symptoms of schizophrenia. Clozapine—arguably the "gold standard" of efficacy among the atypical agents—is effective in about 40% of neuroleptic-refractory patients. Rates of response in well-defined refractory populations have not yet been determined for the other atypical agents, though clinical data look promising for risperidone and olanzapine. In this presentation, we will discuss the various reasons for treatment-resistance in schizophrenia, including inherent biological factors (metabolic, pharmacodynamic, absorptive, neurodevelopmental; medication-related issues; duration of trial; adequacy of dose; adequacy of plasma antipsychotic level; patient compliance factors; comorbidity; and inappropriate use of psychosocial intervention. The management of these problems will also be discussed.

No. 94C
THE DIFFICULT-TO-TREAT PTSD PATIENT

Randall D. Marshall, M.D., *Anxiety Disorders, NY State Psychiatric Institute, 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 post-traumatic 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. 94D
THE DIFFICULT-TO-TREAT EATING DISORDERED PATIENT

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell 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 among the general public, medical, and psychiatric communities of being impossible to treat.

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 that 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 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.

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SYMPOSIUM 95—TREATMENT OF SUBSTANCE USE DISORDERS IN ROUTINE CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, participants will be able to identify the characteristics of the routine treatment of substance use disorders and learn about the use of new and effective tools for their treatment.

No. 95A
ADDICTION AND CO-OCCURING PSYCHIATRIC DISORDERS

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854;* Jill Williams, M.D., David A. Smelson, Psy.D., Maureen Kaune, M.D., John A. Williams, M.D., Brenda Rambo, B.A., Ilana Pinsky, Ph.D.

SUMMARY:

Co-occurring psychiatric disorders are common among individuals with a substance use disorder. These dually diagnosed individuals often have a poor prognosis and poor response to traditional treatments. Treatment of the co-occurring disorders requires an integrated approach to diagnosis and treatment. Specific treatment matching for the dually diagnosed is a necessity since the treatment of the dually diagnosed varies according to the combination of disorders, the severity of the different disorders, and the patient's motivation to address each problem. This presentation will review diagnostic issues and new and innovative pharmacotherapy and psychotherapy approaches for the dually diagnosed. The treatment of the dually diagnosed varies according to the treatment setting (substance abuse, mental health, or primary care settings). This presentation will review recent research findings in this population, including innovative therapy approaches that have been developed for specific dual-diagnosis subtypes through the National Institute on Drug Abuse's behavioral therapy development grants. The presentation will include a discussion on developing a training program for psychiatrists and other staff on screening, evaluating, and treating the dually diagnosed.

No. 95B
USE OF ASAM CRITERIA FOR SUD PATIENT PLACEMENT

David R. Gastfriend, M.D., *Department of Psychiatry, Harvard Medical School, 15 Parkman Street/WACC-812, Boston, MA 02114*

SUMMARY:

Clinical experience suggests that treatment intensity should match need. One glove should not fit all, particularly the cheapest glove. What is the scientific evidence for this assumption? Comprehensive patient placement criteria are evolving that have adequate reliability, feasibility, and resolution. An independent panel of the U.S. Center for Substance AbuseTreatment found sufficient face validity to recommend that states proceed with implementation and evaluation of criteria such as the ASAM Criteria. A high degree of concordance of decisions between MCOs and the ASAM Criteria has been reported. Support for the concurrent validity comes from the ASAM Validity Study at the Massachusetts General Hospital. Early evidence is also emerging for outcome validity of the ASAM Criteria. In a V.A. hospital, naturalistic ASAM matching was associated with less Boston Target Cities Project suggesting that the Central Intake model, using a coarse implementation of the ASAM Criteria, was associated with improved treatment subsequent service utilization than mismatching. Standardization through the use of criteria seems likely to facilitate improved care and efficiency of addictions treatment.

No. 95C
SUBSTANCE USE DISORDERS IN ROUTINE PSYCHIATRIC PRACTICE

Ivan D. Montoya, M.D., *Office of Research, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005;* Dace Svikis, Ph.D., Diane Herbeck, M.A., Terri L. Tanielian, M.A., Steven Marcus, Ph.D., Harold Alan Pincus, M.D.

SUMMARY:

Objective: To examine the demographic and practice characteristics of psychiatrists who treat patients with substance use disorders (SUD) in their routine clinical practice.

Methods: A nationally representative sample of 887 psychiatrists who are members of the Practice Research Network of the American Psychiatric Institute for Research and Education received a self-administered questionnaire to collect aggregated information about their clinical practice in the last typical work week. Comparisons were made between psychiatrists who reported patients with SUD in their caseload versus those who did not.

Results: 756 (85.2%) psychiatrists reported to have SUD patients in their caseload. Psychiatrists who saw SUD patients were significantly ($p < 0.05$) more likely to be males (73.1% vs 64.7%), younger than 38 years of age (18.2% vs. 8.0%), have higher mean number of patients per week (50.3 vs. 30.0), mean hours spent in direct patient care (30.9 vs 21.4), percent of patients treated as inpatients (19.0% vs. 6.9%), and patients aged 15 to 64 (78.1% vs. 70.8%). This group was also significantly more likely to see patients in public settings, under managed care health plans, to have income from salary, the main source of payment from Medicaid or other government/public program, and the higher average of patients with psychotic disorders.

Conclusion: The results show that there are important demographic and practice differences between psychiatrists who treat and those who do not treat SUD patients. These findings may help clinicians, administrators, and policymakers target specific areas regarding training, reimbursement mechanisms, and allocation of resources for SUD treatment.

No. 95D
TREATMENT FOR PREGNANT AND POSTPARTUM DRUG-DEPENDENT WOMEN

Dace Svikis, Ph.D., *Virginia Commomwealth Univ., P.O. Box 980109, Richmond, VA 23298*

SUMMARY:

Pregnant drug-dependent women present for treatment with a myriad of medical, psychosocial, and psychiatric comorbidities. Historically, such women fared poorly in standard care settings, and studies have shown they require comprehensive, interdisciplinary care

(Svikis and Huggins, 1996). The Center for Addiction and Pregnancy (CAP) in Baltimore, Md., was created through funding from the Alcohol and Drug Abuse Administration of the State of Maryland (Jansson et al., 1996). Since 1991, the program has provided substance abuse, psychiatric, OB/Gyn, and pediatric care to hundreds of high-risk women and their children. Program evaluation has been ongoing, with a focus on both clinical and economic efficacy. In a recent study, outcome data for 100 women who delivered while in CAP treatment were compared with a sample of 46 controls not entering drug treatment. Women enrolled in CAP showed better clinical outcomes at delivery, with less drug use and higher infant estimated gestational age, birthweight, and Apgar scores. Infants of CAP-treated women were also less likely to require admission to neonatal intensive care units (NICUs), and length of NICU stay was significantly reduced. When costs of drug treatment were summed with NICU care costs, mother-infant pairs admitted to CAP evidenced a nearly $5,000 net cost reduction as compared with NICU costs alone for untreated mother-infant pairs. The presentation will review methodological difficulties encountered in the conduct of such research and the cost-benefit ratio for studying such issues within clinical practice.

No. 95E
MATCHING PATIENTS TO SUBSTANCE USE TREATMENTS

Thomas McLelland, Ph.D., *University of Pennsylvania, Univ. & Woodland Ave Bldg. 7, Philadelphia, PA 19104*

SUMMARY:

It is possible and practical to increase treatment effectiveness by "matching" types of patients to particular kinds of programs or treatments? What are the system barriers to "matching?"

Data and Methods: Data from a prospective study of patient-treatment matching involving two treatment settings and four accredited, private programs treating 460 employed alcohol and cocaine dependent patients referred from a large EAP.

Stage I: Patients were evaluated by the EAP using a standard clinical interview and referred in the normal manner to one of the four programs. All patients were followed weekly by independent researchers monitoring the nature and number of the services received. Patients were re-contacted (94%) six months after treatment discharge and re-evaluated. These data were used to develop a model of patient-program and treatment service matching for the second stage of the study.

Stage II: Used the stage-one decision tree to randomly assign 387 new patients to "matched" programs and services profiles. "Matched" patients were compared against controls treated at the same programs in the standard manner but not given the "matched" services. Outcome measures were drug and alcohol use, employment, crime, use of medical and social services.

Results and Conclusions: It was impossible to actually match patients to the programs due to insurance constraints, managed care, geography, and patient resistance. However, matching treatment services to patient problems at the program level was quite successful. "Matched" patients received the same total services as control patients but were less likely to drop out early. Six-month outcome comparisons showed that matched patients had 15%–25% better outcomes than control patients treated in the same programs by the same staff under standard conditions.

No. 95F
CHILD WELFARE REFERRAL TO SUBSTANCE ABUSE TREATMENT

Kathleen M. Carroll, Ph.D., *Department of Psychiatry, Yale University, New Haven, CT 06520;* Bryce Libby, Joseph P. Sheehan

SUMMARY:

Efforts to identify and treat substance-abusing parents are an important means of preventing a number of problems in their children. Unfortunately, there have been major gaps between the child welfare and the substance abuse treatment systems, and it has been difficult to encourage substance-abusing parents identified through the child welfare system to enter treatment. We conducted a randomized controlled trial of the effectiveness of motivational interviewing, a brief approach with a comparatively high level of empirical support in research settings, as a strategy to encourage treatment entry. The study took place in a community treatment program (CTP) that had no prior involvement in clinical research. Several design features were included to emphasize the external validity of the study and its generalizability to nonresearch community settings: participating clinicians were all drawn from the staff of the CTP, the assessment battery was drawn from measures already in place, staff training was brief (one day), and participant inclusion/exclusion criteria were nonrestrictive. Sixty-one individuals were randomized and received either a standard or a motivational evaluation. Primary outcomes (rates of participants who initiated substance abuse treatment and satisfaction) will be presented as will experiences with conducting randomized trials of empirically validated treatments in community settings.

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SYMPOSIUM 96—FRONTIERS IN CLINICAL ALCOHOLISM TREATMENT/ BEHAVIOR THERAPIES
National Institute on Alcohol Abuse and Alcoholism

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will be knowledgeable about new methods and refinements of existing techniques for treating alcohol dependence.

No. 96A
ENHANCING MOTIVATION FOR CHANGE IN ALCOHOLISM TREATMENT

Carlo C. Diclemente, Ph.D., *Department of Psychology, UMBC, 1000 Hilltop Circle, Baltimore, MD 21250*

SUMMARY:

Significant differences in levels of motivation influence treatment seeking, treatment compliance and completion as well as successful long-term changes in drinking. Alcohol-abusing and alcohol-dependent individuals can be classified in terms of their engagement in the process of behavior change into different stages of change based on their readiness to change their drinking. These stages range from not currently considering change (precontemplation) through intermediate decision making and planning stages (contemplation and preparation) to taking action to change their drinking (action) that then can be sustained over time (maintenance). Most treatment programs are action oriented but clients seeking treatment at these programs are not always ready for action. This presentation will offer an examination of motivation in the context of treatment and successful recovery from substance abuse. Findings from Project MATCH about motivational readiness to change related to predicting drinking outcomes and matching with types of treatments will be discussed. In addition, the research related to motivational enhancement therapy (MET) will be presented. Finally, the presentation will focus on the role of motivation in alcoholism treatment and how treatment providers are in the process of incorporating motivational approaches into the course of treatment and designing programs to address the less-motivated as well as the more-motivated patients.

No. 96B
COGNITIVE-BEHAVIORAL THERAPY: STATUS AND NEW DIRECTIONS

Gerard J. Conners, Ph.D., *Research Institute on Addiction, 1021 Main Street, Buffalo, NY 14203*

SUMMARY:

Cognitive-behavioral therapy (CBT) has emerged as one of the most widely applicable and beneficial forms of treatment for persons with alcohol use disorders. The primary goal of CBT is to help patients master skills that will assist them in achieving and maintaining abstinence from alcohol. CBT includes a range of specific techniques that employ psychological and especially learning-based principles to change drinking behavior. CBT views drinking as functionally related to major problems in the patient's life and posits that addressing this broad spectrum of problems will prove more effective than focusing on drinking alone. Thus, an emphasis is placed on overcoming skill deficits and increasing the person's ability to cope with high-risk situations that commonly precipitate relapse.

In this presentation, the basic assumptions of CBT first will be outlined. This will be followed by a presentation of core tasks of treatment from a cognitive-behavioral perspective, including the development of a therapeutic relationship, behavioral assessment, and skills training. A prototypic CBT treatment package will be described, based on the CBT intervention used in Project MATCH. The application of specific clinical strategies, along with their associated empirical support, will be described. These include coping with cravings and urges to drink, problem solving, drink refusal skills, and coping with lapses. The presentation will close with a discussion of current and emerging applications of CBT in the treatment of alcohol use disorders.

No. 96C
COUPLES THERAPY FOR ALCOHOLISM AND DRUG ABUSE

Timothy J. O'Farrell, Ph.D., *Department of Psychiatry, Harvard Medical School, 940 Belmont Street, VAMC-116B1, Brockton, MA 02401;* William Fals-Stewart, Ph.D.

SUMMARY:

Behavioral couples therapy (BCT) sees the alcoholic or drug-abusing patient together with the spouse to build support for abstinence, increase relationship cohesion, and improve communication skills, because these relationship factors are conducive to substance abuse recovery. Research on BCT shows that BCT for alcoholics and drug abusers produces better abstinence rates and fewer marital separations over a two-year follow-up period than individually based treatment. Outcomes after BCT show substantial and significant reductions in domestic violence and very favorable cost-benefit and cost-effectiveness results. This presentation will describe the clinical interventions used in BCT, the results of studies showing clinical outcomes of better abstinence rates and improved relationship adjustment, and our most recent work showing reduced domestic violence and favorable cost outcomes.

REFERENCES:

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3. Kadden R, Carroll K, Donovan D, et al: Cognitive-Behavioral Coping Skills Therapy Manual (Project MATCH Monograph Series No. 3), Rockville, Md, National Institute on Alcohol Abuse and Alcoholism, 1992
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SYMPOSIUM 97—DEPERSONALIZATION DISORDER: AN OVERVIEW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize and diagnose depersonalization disorder and to identify phenomenological and neurobiological correlates

No. 97A
FEELING UNREAL: INTRODUCTION TO DEPERSONALIZATION DISORDER

Daphne Simeon, M.D., *Department of Psychiatry, Mount Sinai Medical Center, One Gustave Levy Pl., Box 1230, New York, NY 10029* Orna Guralnik, Psy.D., Eric Hollander, M.D., James Schmeidler, Ph.D.

SUMMARY:

Depersonalization disorder has been the subject of limited study. This presentation introduces its phenomenology, comorbidity, traumatic antecedents, neurobiology, and treatment response. Eighty adult subjects with DSM-III-R/DSM-IV depersonalization disorder were consecutively recruited into several research protocols. The illness tends to have an early onset and chronic course, usually continuous but sometimes episodic. Marked distress and interper-

sonal impairment are typical. Comorbid unipolar mood disorders and anxiety disorders are common, but none emerges as specifically related to depersonalization. A wide range of personality disorders is manifested by the majority of subjects. Depersonalized subjects report significantly more childhood and lifetime trauma compared with healthy volunteers. Although little is known about the neurobiology of depersonalization, it can be symptomatically evoked by challenge with tetrahydrocannabinol or with the partial serotonin agonist m-CPP. Depersonalization disorder subjects tend to have a blunted growth hormone response to yohimbine compared with healthy volunteers. PET imaging reveals abnormalities in glucose metabolism in the sensory cortex, visual, somatosensory, and auditory. Depersonalization is commonly described as refractory to treatment, but systematic data on psychopharmacological or psychotherapeutic interventions are sparse. Retrospective treatment histories and small prospective trials suggest that serotonin reuptake inhibitors may be of benefit, and a controlled study is in progress.

No. 97B
AUTONOMIC RESPONSE IN DEPERSONALIZATION DISORDER

Mauricio Sierra, M.D., *Institute of Psychiatry, Denmark Hill, London SE58AZ, England;* Carl Senior, B.S.C., Jefferey Dalton, Mary L. Phillips, M.D., Alyson Bond, M.D., Anthony S. David, M.D.

SUMMARY:

In this study we tested a model that predicts a reduced autonomic response to emotional stimuli in patients with depersonalization disorder.

The skin conductance response (SCR) of 15 patients with chronic, DSM-IV depersonalization disorder, and 14 age- and sex-matched normal controls was recorded in response to nonspecific elicitors of SCR (unexpected clap and taking a sigh); and 15 randomized pictures with different emotional valence: five neutral, five pleasant, five unpleasant.

SCR to the unpleasant pictures was significantly reduced in the depersonalized patients. The same trend was observed to the neutral and pleasant pictures but the difference was not statistically significant. There was no difference in SCRs to both of the nonspecific elicitors. However, the latency of response to the startling clap was significantly shorter for the patients with depersonalization.

Our findings support the view that in depersonalization autonomic response to unpleasant stimuli is reduced. The fact that patients with depersonalization had an earlier onset of response to a startling noise suggests that patients with depersonalization are in a heightened state of alertness and that the reduced response to aversive stimuli is due to a selective inhibitory mechanism on emotional processing.

No. 97C
FEELING UNREAL: THE NEUROPSYCHOLOGY OF DEPERSONALIZATION

Orna Guralnik, Psy.D., *Department of Psychiatry, Mt. Sinai Medical School, 1 Gustave Levy Place Box 1228, New York, NY 10029;* Beth E. Sirof, M.A., Margaret E. Knutelska, M.A., Daphne Simeon, M.D.

SUMMARY:

Depersonalization disorder is characterized by a detachment from one's sense of self and surroundings leading to considerable distress and impairment yet intact reality testing. Depersonalized individuals often report difficulties in perception, concentration, and memory; however, there have been no investigations of their cognitive profile. In this study, 15 subjects with depersonalization disorder were compared with 15 matched normal controls on a comprehensive neuropsychological battery assessing cognitive functions.

Results: Depersonalized subjects showed a distinct cognitive profile in which they performed significantly worse than controls on certain measures of attention, short-term visual and verbal memory, and spatial reasoning, within the context of comparable intellectual abilities. It is proposed that depersonalization involves alterations in the attentional and perceptual systems, specifically in the ability to effortfully control the focus of attention. These early encoding deficits are hypothesized to have a deleterious effect on the short-term memory system, manifesting as deficits in the ability to take in new information but not in ability to conceptualize and manipulate already encoded information. Further studies investigating both perceptual and attentional functioning are underway and preliminary results will be reported.

No. 97D
DEPERSONALIZATION: THINKING WITHOUT FEELING

Mary L. Phillips, M.D., *Department of Psychology, Institute of Psychiatry, 1 Denmark Hill, London SE58AZ, England;* Nicholas Medford, M.D., Michael J. Brammer, Ph.D., Carl Senior, B.S.C., Mauricio Sierra, M.D., Edward T. Bullmore, M.D., Anthony S. David, M.D.

SUMMARY:

A prominent symptom of depersonalization is the experience of emotional detachment from the environment. We report the first functional magnetic resonance imaging (fMRI) study of brain activation in response to emotive scenes in depersonalized patients (n = 6), psychiatric controls (10 patients with obsessive-compulsive disorder), and six normal volunteers. All subjects were scanned while viewing standardized pictures of aversive and neutral scenes (complexity-matched). After scanning they rated the pictures in terms of emotional content.

Viewing aversive scenes produced the expected activation in occipital and inferior temporal cortex (visual processing regions) in OCD patients and normal volunteers, as well as activation in the insula, a region implicated in disgust perception. OCD patients activated visual processing regions more extensively than controls. Depersonalized patients failed to activate these regions normally and showed increased activation in inferior frontal lobe; insula activation occurred only during presentation of neutral scenes. These patients rated aversive pictures as much less emotive on three dimensions, compared with controls. The phenomena of depersonalization, including a lack of subjective experience of emotions, can now be understood in terms of a lack of brain activation in emotion-sensitive regions combined with increased activation in regions associated with interpretation and control of emotions.

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SYMPOSIUM 98—URBAN MENTAL HEALTH: INTERNATIONAL PERSPECTIVE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium the participant should be familiar with the most relevant mental health issues related to urbanization and urban environments.

No. 98A
URBANIZATION AND MENTAL HEALTH: AN OVERVIEW OF ISSUES, RESEARCH, AND DIRECTIONS

Anthony J. Marsella, Ph.D., *Department of Psychology, University of Hawaii, Gartley Hall Room 110, Honolulu, HI 96822*

SUMMARY:

This presentation will review the international research and clinical literature on the relationship of urbanization and mental health. Following a review of the historical interest in the topic, attention will be called to the multidisciplinary and multisectoral nature of the topic and its associated definitional, conceptual, and methodological issues and challenges. Selected research on urban-rural differences in mental health will be reviewed. Numerous environmental and social processes have been posited and investigated as the sources of psychopathology in urban settings. However, there is little consensus on the causal relationship between urbanization and mental health. The research literature suggests that rural and urban milieus can have both pernicious and salutary consequences, and that more research is needed to specify critical contextual parameters and subpopulation characteristics. The presentation will offer suggestions for improving future research efforts through the use of more complex theoretical models, measurement indices, and data analytic procedures.

No. 98B
MEGA CITIES AND MENTAL HEALTH

Giovanni Caracci, M.D., *Department of Psychiatry, Cabrini Medical Center, 227 East 19th Street, New York, NY 10003*

SUMMARY:

A mega city is defined as a city with more than 10 million inhabitants. In 1950 New York was the only mega city. By 2015 there will be 26 mega cities in the world, most of them in developing countries, especially in Asia where there will be 18 mega cities by 2015. While it took New York almost a century to grow to 8 million people it will take some cities like Sao Paulo and Lagos less than 15 years to grow by the same number. Such rapid growth rate is creating problems with the environment and infrastructure that greatly affect urban dwellers' mental health. High rates of unemployment, poverty, and environmental degradation are accompanied among others by violence, substance abuse, depression, and suicide. Overwhelmed mental health services are unable to provide adequate care. This presentation will focus on the crisis of mental health in mega cities supported by data obtained from a survey on mental health issues in urban areas conducted by the World Psychiatric Association section on urban mental health. In addition it will indicate the role American psychiatry in addressing some of the issues, especially in developing countries.

No. 98C
URBANIZATION AND MENTAL HEALTH: A CASE STUDY IN KOBE

Shinfuku Naotaka, M.D., *Department of Psychiatry, Kobe University, Chuo-Ku Kusunokicho 7-5-1, Kobe City 650-0017, Japan*

SUMMARY:

Kobe is the seventh largest city in Japan with a population of 1.5 million. As other large cities in Japan, Kobe has common mental health problems related to Japan's overall demographic changes. They are an increase of geriatric population, decrease of the number of children per family, and tendency towards the nuclear family. These changes result in the lack of human resources and spaces to take care of people with disability. Kobe has other problems resulting from the major disaster brought about by the Hanshin Awaji Earthquake in January 1995. The earthquake that hit Kobe city and surrounding urban areas killed more than 6400 and made more than 230,000 people homeless. The elderly and handicapped were the most affected by the disaster. The writer will present common and specific mental health problems in Kobe.

No. 98D
RINGS OF POVERTY: THE CITY AROUND THE CITY

Roberto E. Chaskel, M.D., *Dept. of Psychiatry, University M. Nueva Granada, Apartado Aereo 4124, Bogota, Colombia*

SUMMARY:

Due to internal warfare in Colombia, 600,000 inhabitants have surrounded the city of Bogota creating a new city around the old city of 6 million inhabitants. This has brought a migration where the incidence of anxiety, depression, and PTSD is larger than management of the situation. The author will show how the situation is being handled and how it affects the rest of the population.

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2. Harpham T: Urbanization and mental health in developing countries: a research role for social scientists, public health professionals and social psychiatrists. Soc Sci Med 1994; 39:233–245
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4. Ward D, Zanna M, Cooper J: The non-verbal mediation of self-fulfilling prophesies in interracial interaction. Journal of Experimental Social Psychology 1974; 10:109–120

SYMPOSIUM 99—PSYCHODYNAMIC EDUCATION: SHOULD WE? CAN WE? DO WE?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to place current psychotherapy education within the broad context of the evolving clinical field of psychiatry, learn discrete areas of clinical competency that can be acquired through the establishment of a psychotherapy program, learn the principles of teaching, supervising, and evaluating psychotherapy skills.

No. 99A
CURRENT ISSUES IN PSYCHOTHERAPY EDUCATION

Elizabeth Auchincloss, M.D., *Department of Psychiatry, NY Hospital Cornell-Payne Whitney, 525 East 68th Street, New York, NY 10021*

SUMMARY:

The transformation of American psychiatry, with its increasing emphasis on biomedical approaches, brings into question the scope and depth of psychotherapy competency that will be required of psychiatrists in the near future. In the face of these profound changes within our field, there has been relatively little evolution in the teaching of psychotherapy in psychiatry residency training programs. If psychiatry is to continue to lay claim to broad-based expertise in the care of patients, including sophistication in the area of the doctor-patient relationship and management of diverse psychological issues, then it is imperative for our field to achieve a consensus about what is essential for all psychiatrists to learn within the broad domain of psychotherapy education.

This presentation will briefly outline the context in which to consider psychotherapy education, including scope of practice, administrative and collaborative roles, the increasing insistence on empiricism, and realistic possibilities within the four-year time frame of residency education. Specific areas of psychotherapy education that can be integrated within this evolving model of psychiatry will then be articulated. This will include both core knowledge and skills that can span the several major models of psychotherapy in existence today, as well as specific aspects of psychotherapy that pertain to discrete "schools" (e.g., psychodynamic, cognitive-behavioral, interpersonal, and systems). New trends in psychotherapy education will then be presented, including important pedagogical principles and practical suggestions.

No. 99B
MISSOURI PSYCHOTHERAPY MODULES

Bernard D. Beitman, M.D., *Department of Psychiatry, University of Missouri, 3 Hospital Drive, Columbia, MO 65201*

SUMMARY:

The Missouri Psychotherapy Training Modules present a uniform introduction to psychotherapy that offers the basic, generic concepts common to the major schools in a time-efficient manner. The program is being used in more than 20 psychiatric residency programs in the United States as well as in Spain, Canada, and Australia. It contains six modules—verbal response modes and intentions, working alliance, inducing patterns, change, resistance, and transference and countertransference. During the pretraining, trainees obtain two third-session audiotapes, which are rated for therapist intentions and patient responses to those intentions, as well as measures of the strength of the working alliance by both patient and therapist and four outcome domains. After the program, the same steps are taken and differences between pre- and post-training are measured. In addition, trainees complete the Counselor's Self-Estimate Inventory, which is a well-researched measure of trainee self-confidence as a psychotherapist. Data from these and several other measures carried out throughout the program will be presented.

No. 99C
WHY INCLUDE INDIVIDUAL SUPERVISION IN PSYCHOTHERAPY EDUCATION?

James W. Lomax II, M.D., *Department of Psychiatry, Baylor University, College of Medicine, One Baylor Plaza, MS350, Houston, TX 77030*

SUMMARY:

This paper will delineate the specific elements of individual supervision that warrant its continued presence as an educational format in psychotherapy education. The historical development of individual supervision, specific supervisory interventions, and products of this educational format will be elaborated. Videotape material illustrating the concepts presented will allow audience participation and facilitate group discussion.

No. 99D
PUTTING PSYCHIATRY TO THE TEST: MEASURING THERAPY SKILLS

Linda S. Mullen, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive Unit 103, New York, NY 10032;* Ronald O. Rieder, M.D.

SUMMARY:

Training in psychodynamic psychotherapy remains a core requirement of psychiatric residency training programs, yet no standard measures of competency exist to document residents' knowledge, attainment of skills, and capabilities in this area. Recently, the Residency Review Committee (RRC) proposed credentialing in different forms of psychotherapy as part of the core requirements for psychiatric residency training. Currently, however, there are no systematic methods of evaluation that allow for uniform compliance with this requirement across programs.

To address this issue, we developed a written test of psychodynamic psychotherapy knowledge and skills, which consists of multiple-choice questions related to real psychodynamic-psychotherapy clinical vignettes. The test has been piloted in a group of more than 200 PGY II, III, and IV residents in nine training programs around the country and more than 50 faculty members. Data from this project address test validity and reliability and the feasibility of testing psychotherapy skills in a standardized fashion. Additionally, they provide a distribution of proficiency of residents at each level of training, both within individual programs and across a group of programs with varying teaching and practice patterns. This study may allow for recommendations regarding psychotherapy curricula and time devoted to didactic teaching, supervision, and clinical practice of psychodynamic psychotherapy in residency programs.

REFERENCES:

1. Beitman BD, Yue D: A new psychotherapy training program: description and preliminary results. Academic Psychiatry 1999; 23:95–102
2. Watkins CE: Handbook of Psychotherapy Supervision, New York, John Wiley and Sons, 1997
3. Liston E, et al: Assessment of psychotherapy skills: the problem of interrater reliability. Amer J Psychiatry 1981; 138:1069–1074

SYMPOSIUM 100—IMPACT OF OLDER AGE ON HIV

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will appreciate the impact of age on neuropsychological impairment, cognitive-motor disorder prevalence, and related changes in function in HIV. Depression/anxiety associations are also presented.

No. 100A
AGE, COGNITIVE MOTOR IMPAIRMENT AND DISORDER, AND FUNCTIONAL STATUS

Karl Goodkin, M.D., *Department of Psychiatry, Univ of Miami School of Med, 1400 NW 10th Avenue, Rm 803-A, Miami, FL 33136;* Frances L. Wilkie, Ph.D., Mary Tyll, Ph.D., Wen Li Zheng, M.B.A., Imad Khamis, Ph.D., Joshua Cohen, B.S.

SUMMARY:

Objective: To assess the relationship of age with cognitive-motor disorder and impairment in HIV-1+ individuals compared with HIV-1-individuals.

Methods: The relationship of age to performance on the Mini-Mental Status Examination, the Figural Visual Scanning Task, and the diagnosis of minor cognitive-motor disorder were examined in the sample. The Sickness Impact Profile was used as measure of functional status.

Results: Age was significantly related to total time to complete the Figural Visual Scanning task ($p < .002$) in 122 HIV-1+ homosexual men predominantly pre-AIDS, controlling for CDC clinical stage, CD4 cell count, and education level. Further, this score was associated with significant decrement in overall functional status in daily life activities ($p < .009$). Age was also associated with this performance on this task in a group of HIV-1+ women predominantly pre-AIDS ($N = 65$; $p < .01$). In contrast to the men, in HIV-1+ women the score on this test was not significantly associated with changes in overall functional status. Neither the HIV-1+ men nor women studied showed significant effects of age with MMSE score or with the diagnosis of MCMD.

Conclusions: HIV-1+ men and women both showed relationships of age to performance on the figural visual scanning ask, a measure of information-processing speed, but may differ in the functional status implications of these performance decrements. To uncover the relationship of age to overall mental status and to the diagnosis of MCMD, it may be necessary to study a large sample of HIV+ individuals older than age 50 and at a later disease stage.

No. 100B
THE EFFECTS OF AGE ON COGNITION IN HIV INFECTION

Frances L. Wilkie, Ph.D., *Department of Psychiatry, Univ. of Miami School of Medicine, 1400 NW 10th Avenue #803-A, Miami, FL 33136;* Karl Goodkin, M.D., Hose Van Zullen, Ph.D., Mary Tyll, Ph.D., Diedrik Hoag, Ph.D.

SUMMARY:

Objective: The major neurological complication of HIV infection is cognitive impairment, which can range in severity from a subclinical cognitive inefficiency to a severe dementing illness. Most of the current knowledge of HIV-associated cognitive impairment has been based on studies of young adults. Preliminary findings are presented on the effects of age on cognition and functional status in HIV infection.

Method: The effects of age on cognition and functional status were examined in three separate HIV-positive and HIV-negative cohorts. The cognitive battery was designed to measure the following domains: 1) information processing speed, 2) memory, 3) attention, 4) language processes, 5) visuoconstructive/visuospatial, 6) abstraction/executive functions, and 7) motor abilities, which are processes affected by HIV infection. The Sickness Impact Scale (SIP) assessed functional status.

Results: Our preliminary findings suggest that increasing age (50–79 yrs, $n = 14$) may exacerbate the adverse effects of HIV infection (early and late symptomatic stages) on cognition (i.e., information processing speed, memory, abstraction, and verbal fluency) relative to HIV-positive young adults (20–39 yrs, $n = 112$) and HIV-negative young ($n = 79$) and older ($n = 20$) control subjects. In a separate cohort ($n = 185$, aged 20–67), relative to their counterparts younger than age 49, there was a trend for subjects over age 50 to report a greater decrease in alertness and more confusion on the Sickness Impact Scale, independent of CDC clinical stage, CD4 cell count, serostatus, and education. In a separate cohort followed longitudinally, even mild to moderate cognitive impairment is a significant risk factor for mortality in 119 HIV-infected adults (age 21–58), independent of baseline CDC clinical stage, CD4 cell count, hemoglobin level, antiretroviral and prophylactic medication use, and sociodemographics. Hence, cognitive impairment should be identified early in older adults for maximization of both functional status and survival.

Conclusion: These findings suggest that age may serve as a cofactor, exerting a deleterious, synergistic effect on cognition beyond that associated with HIV infection or aging alone.

No. 100C
PSYCHOLOGICAL SYMPTOMS AMONG OLDER MEN LIVING WITH HIV AND AIDS

Timothy G. Heckman, Ph.D., *Department of Psychiatry, Medical College of Wisconsin, 8701 Plank Road, Watertown WI 53226;* Arlene Kochman, M.S.W., Kathleen Sikkema, Ph.D., Seth Kalichman, Ph.D., James Masten, M.S.W.

SUMMARY:

Objectives: While health science research has recently devoted greater attention to the mental health needs of HIV-infected older adults, these studies have ignored potential race differences by combining African-American and white participants into one large and racially homogeneous sample. The current study compared patterns of stressor burden, ways of coping, and emotional distress among older African-American and white men living with HIV/AIDS.

Method: Self-administered surveys were completed by 72 HIV-infected middle-aged and older men living in New York City and Milwaukee (mean age = 53.4 years).

Results: African-American and white men experienced comparable levels of stressor burden associated with AIDS-related discrimination, AIDS-related bereavement, financial dilemmas, relationship difficulties, and domestic problems. However, in responses to these stressors, African-American men more frequently engaged in positive reappraisal and were more likely to resolve that things would be different in the future. Compared with their African-American counterparts, HIV-infected older white men reported elevated levels of depression, anxiety, interpersonal hostility, and somatization. In addition, African-American men received more support from family members but were less likely to disclose their HIV serostatus to close friends.

Conclusions: As AIDS becomes more common among older adults, mental health interventions will be increasingly needed for this population. Older white men living with HIV disease appear to be in relatively greater need of tailored mental health support services.

No. 100D
OLDER CAREGIVERS OF HIV-AFFECTED KIN: IMPACT ON AFFECT AND CARE

Nathan L. Linsk, Ph.D., *Social Work, University of Chicago, 808 S. Wood St. MIC 779, Chicago, IL 60612;* Sally J. Mason, Ph.D.

SUMMARY:

Seventeen older adults were interviewed about caring for children who were HIV-infected or affected because they had an absent or

deceased with HIV/AIDS and compared with 11 non-affected or non-disclosing families providing non-HIV-related relative care. Caregivers mean age was 48.5 years, range of 25–77 years; 85.7% black. CESD Mood Scale scores ranged from 0–54 (60 possible, greater numbers = more depression). Mean was 16.4., median 12. Slightly more disclosers were severely depressed (24% versus 18.2%); however, both groups had 36% with scores over 20 and more than half had low scores of 0–15.

Most frequent services used in the past year were financial assistance, information/referral, and legal services. Regarding mental health services, 17.2% of disclosers and 18.2% of the non-disclosers used counseling. Slightly more used support groups; 29.4% of disclosers and 18.2% of the non-disclosers. Use of psychiatry or psychotropic drugs was not specifically reported.

The findings suggest older caregivers are at risk for depression; however, they infrequently take advantage of mental health and social services that may address these concerns. Providers need to be sensitive to possible caregiving of older adults and determine the presence of depression and need for appropriate treatment.

REFERENCES:

1. McArthur JC, Hoover DR, Bacellar H, et al: Dementia in AIDS patients: incidence and risk factors. Neurology 1993; 43:2245–2252.
2. Wilkie FL, Goodkin K, Eisdorfer C, et al: Mild cognitive impairment and risk of mortality in HIV-1 infection. Journal of Neuropsychiatry and Clinical Neurosciences 1998; 10:125–132.
3. Heckman TG., Somlai AM., Sikkema KJ., et al: Psychosocial predictors of life satisfaction among persons living with HIV/AIDS. Journal of the Association of Nurses in AIDS; Care 8:6–15.
4. Linsk N, Poindexter CC: Social support needs of older minority HIV-affected caregivers. Abstracts of: Role of Families in Preventing and Adapting to HIV/AIDS. Baltimore, Md, July 23–25, 1997, Poster #38, p.63.

SYMPOSIUM 101—COMPLEMENTARY MEDICINES AND THE PSYCHIATRIST

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this workshop, the participant will be able to describe the principles, supporting research, psychiatric applications, risks, drug interactions, and legal issues for the three most popular alternative medicine modalities of acupuncture, homeopathy, and herbal remedies.

No. 101A
HOMEOPATHY FOR THE DIFFICULT-TO-TREAT PSYCHIATRIC PATIENT

Edward B. Gogek, M.D., *818 West Gurley, Prescott, AZ 86305*

SUMMARY:

In 1990, one out of five medical doctors in the U.S. was a homeopath. This presentation will summarize the principles of homeopathy and how homeopathy can be used in psychiatric patients and in combination with allopathic approaches. The principles of homeopathy include "like cures like," utilization of the minimum dose, addressing the whole person, and the doctrine of signatures. Approaches to selecting remedies will be discussed as will a review of relevant research. Clinical examples will be presented.

No. 101B
WHAT THE PSYCHIATRIST NEEDS TO KNOW ABOUT HERBS

Hyla R. Cass, M.D., *Department of Psychiatry, UCLA, 1608 Michael Lane, Pacific Palisades, CA 90272*

SUMMARY:

Herbs are an integral part of Chinese, Ayurvedic, and Native-American healing systems. They are popular in Europe and the U.S. With recent changes in the Dietary Supplement Health Education Act, herbs are more available with fewer restrictions on their use. Hence it is important that psychiatrists as well as other physicians are knowledgeable about the herbal remedies patients are using and how these remedies affect our patients and interact with prescribed medications.

This presentation will include approaches for treatment of several common symptoms such as anxiety, depression, and cognitive decline. Management of side effects and issues of toxicities will be discussed. Interactions between herbal treatments and synthetic drugs will be addressed in addition to the effects on the P450 liver enzyme system. Examples of combining allopathic and herbal remedies will be presented. Regulatory and legal issues will be highlighted.

No. 101C
ACUPUNCTURE AND PSYCHIATRY

John M. Ackerman, M.D., *Cottage Hospital, 2417 Castillo Street, Santa Barbara, CA 93105-4301*

SUMMARY:

Acupuncture has been practiced in China for centuries. It is commonly practiced in France today. In North America, widespread public and professional awareness of acupuncture occured after James Reston's description on the front page of the New York Times of his experience with acupuncture in his emergency appendectomy in China.

This presentation will discuss the techniques, applications, and research involving acupuncture. A clinical pilot study in Waco, Texas, showed a decrease in rehospitalization rates for severely mentally ill patients who received acupuncture. Acupuncture has also produced positive results in pain relief and drug detox. There are preliminary promising findings concerning the efficacy of acupuncture in the treatment of depression.

REFERENCES:

1. Linde K, Clausius N, Ramirez G, et al: Are the clinical effects of homeopathy placebo effects? a meta-analysis of placebo-controlled trials. Lancet. 1997; 350:834–843.
2. Wong AHC, Smith M, Boon HS: Herbal remedies in psychiatric practice. Arch Consulting Psychiatry. 1998; 55:1033–1044.
3. Hans JS: Electroacupuncture: an alternative to antidepressants for treating affective diseases? Intern J Neuroscience. 1986; 29:79–92.

SYMPOSIUM 102 VIOLENT PATIENTS: ASSESSMENT, MANAGEMENT AND TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to expand awareness and understanding about the relationship of violence and mental illness; the assessment and management of

the violent patient, including psychopharmacological treatments; the obligations of the practitioner to warn and protect third parties; and the response to adolescent violence and violence in the workplace.

No. 102A
VIOLENCE AND MENTAL ILLNESS: AN OVERVIEW

W. Walter Menninger, M.D., *Menninger Clinic, 5800 SW 6th Street, Topeka, KS 66606*

SUMMARY:

Violence is a significant problem in psychiatry—40% of psychiatrists and 48% of psychiatric reisdents report being assaulted by a patient. Over the past decade, studies report a prevalence of violent behavior ranging from 6%–40% in mentally ill patients requiring hospitalization, with a median prevalence of 15% prior to hospitalization, and 25% being violent on mental hospital wards.

NIMH Epidemiological Catchment Area study data noted prevalence of violence in persons meeting the criteria for a DSM-III Axis I diagnosis to be 11%–13%, more than five times the rate among persons not diagnosable. More recent community sampling found no significant difference between the prevalence of violence in patients with a major mental disorder without symptoms of substance abuse (4.7%) and violence by others living in the same neighborhoods without either symptoms of major mental disorder or substance abuse (3.3%). Violence is most likely to occur in young, lower-class males with a diagnosis of substance abuse and a major mental disorder.

In psychiatric settings, four social variables predict much of the violence: history of violence, coercion, length of hospitalization, and a bipolar diagnosis. Commonly, mentally ill persons are violent over issues of power and control, similar to persons who are not mentally ill.

No. 102B
ASSESSMENT AND MANAGEMENT OF THE VIOLENT PATIENT

Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago, IL 60617-2746*

SUMMARY:

Staff attitudes and affects will be discussed as impediments or strengths in appropriately assessing and managing the violent patient. The need to explore staff's prior experience with violence will be discussed. This need will be highlighted by a survey of social service providers that revealed 3% reported being physically assaulted and 7% reported being robbed in the past year. Further, 9% reported being raped, 11% reported being shot at with 3% of those being hit, and 3% reported having been stabbed. Regarding witnessing violence, 25% reported seeing someone get shot, 25% reported seeing someone stabbed, 11% reported seeing someone killed. Finally, 55% reported knowing someone who was murdered, and 48% reported knowing someone who was raped. Only 3% reported ever being counseled. The difference types of violence will be highlighted as different types of violence will call for a difference staff response. The amount of time available to respond to violence determines the response, and, as such, time is the main principle for managing violence and differentiates violence into potential, urgent, and emergent situations. Each of these situations will be discussed and appropriate interventions will be given for each situation.

No. 102C
PSYCHOPHARMACOLOGICAL TREATMENTS FOR VIOLENCE

Stuart C. Yudofsky, M.D., *Dept of Psychiatry & Behavioral Science, Baylor College of Medicine, One Baylor Plaza, RM 115D, Houston, TX 77030*

SUMMARY:

Violent and aggressive behaviors are highly prevalent among psychiatric patients and people who suffer from organic brain disorders. Elliott reported that 94% of 286 patients with histories of recurrent uncontrolled rage attacks with little or no provocation had evidence of developmental or acquired brain deficits. Aggressive episodes related to organic brain disorders may range from verbal expressions to physical outbursts and severe injury. Each year in the United States more than 400,000 people suffer from brain injury secondary to trauma. Irritability and aggressiveness occur in up to 70% of people who suffer from traumatic brain damage. Irritability and aggressiveness, as opposed to physical deficits, are often the major source of disability to victims and of stress to their families. This lecture will focus on assessment and treatment of these difficult patients. Pharmacologic treatment of these aggressive disorders will be explored.

No. 102D
NEW DEVELOPMENTS IN THE DUTY TO PROTECT

James C. Beck, M.D., *Department of Psychiatry, Harvard Medical, 1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

The duty to protect continues to vex psychiatrists, particularly in the public sector where psychiatrists increasingly see patients who have been violent. Psychiatrists should know the current state of the law and its clinical implications. Review of the recent legal cases suggests two contrasting themes: The good news is that several state courts have rejected the duty to protect altogether. The bad news is that California courts have extended the duty to criminal cases, raising potentially serious problems for patient/therapist confidentiality in that state.

Lastly, I review the clinical implications of the legal duty, giving concrete suggestions on how to evaluate and manage potential violence and document effectively. These suggestions are designed to be clinically sound and to protect the clinician against potential liability if violence should occur.

No. 102E
JUVENILE VIOLENCE: CAUSES AND EFFECTS

Charles L. Scott, M.D., *Department of Psychiatry, UC Davis, 2230 Stockton Boulevard, Sacramento, CA 95817*

SUMMARY:

The peak in juvenile crime during the early 1990s combined with media attention to "kids who kill" has heightened concerns regarding violent youth. Juveniles account for nearly one of every five persons arrested for a violent crime. In 1997, the juvenile crime arrest rate dropped over 20% below the peak year of 1994. Despite this improvement, juvenile violence and crime remains significantly high when compared with previous decades. This presentation focuses on risk factors for juvenile violence that include demographics, history, family history, and exposure to violence. Particular attention will be given to risk assessment of weapon carrying, participation in gangs, and risk factors for school violence. DSM-IV diagnoses commonly associated with juvenile violence will be reviewed. More than 80% of incarcerated male and female juvenile offenders meet the criteria for conduct disorder. Other common associated diagnoses include attention deficit-hyperactivity disorder, major depression, and post-traumatic stress disorder. Categories of juvenile violence to include juvenile homicide and juvenile sexual offenders will be discussed. A description of various treatment interventions will also be highlighted to include pharmacotherapy, "boot camp," and multisystemic therapy (MST).

No. 102F
VIOLENCE IN THE WORKPLACE

Ronald Schouten, M.D., J.D., *Department of Psychiatry, Mass General Hospital, 60 Staniford Street, Boston, MA 02114*

SUMMARY:

This presentation will review demographic data on workplace violence and explore popular notions about violence in the workplace and the role of mental illness. There will be a specific focus on the role of psychiatrists and mental health professionals as consultants in this area.

REFERENCES:

1. Steadman HJ, Mulvey EP, Monahan J, et al. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry 1998; 55:393–401
2. Link BG, Stueve A: Commentary: new evidence on the violence risk posed by people with mental illness; on the importance of specifying the timing and targets of violence. Arch Gen Psychiatry 1998; 55:403–404
3. Tupin JP: The violent patient: a strategy for management and diagnosis. Hospital & Community Psychiatry 1983; 34:37–40
4. Yudofsky SC, Silver JM, Jackson M, et al: The Overt Aggression Scale: an operationalized rating scale for verbal and physical aggression. Amer J Psychiatry 1986; 143:35–39
5. Beck JC: Legal and ethical duties of the clinician treating the patient who is liable to be impulsively violent. Behavioral Science & Law 1998; 16:375–389
6. Scott CL: Juvenile violence, Psychiatric Clinics of North America 1999; 22:71–84
7. Brakel SJ: Legal liability and workplace violence. J. Am. Acad. Psychiatry Law 1998; 26:553–562

SYMPOSIUM 103—DEFINING PHENOTYPES IN THE GENETIC STUDY OF OCD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium the participant should be able to better appreciate the importance of defining specific phenotypes for genetic studies of OCD.

No. 103A
SYMPTOM SUBTYPES AND FAMILY HISTORY IN OCD

Margaret A. Richter, M.D., *Anxiety Clinic, Clarke Institute, 250 College Street, Room 1148, Toronto, ON M5T 1R8, Canada;* Laura J. Summerfeldt, Ph.D., Richard P. Swinson, M.D., James L. Kennedy, M.D.

SUMMARY:

Objective: Despite some consensus regarding the familial nature of obsessive-compulsive disorder (OCD), the empirical literature exhibits inconsistencies. Potential heterogeneity within OCD in the form of symptom subtypes (e.g., checking, washing, and symmetry manifestations) has been posited as one contributing factor. This study examined the relationship between primary symptom subtypes in probands and familial history of OC phenomena, the hypothesized OC spectrum of disorders (e.g., tic-related disorders), and anxiety disorders.

Method: Probands (n = 60) and selected first-degree relatives underwent structured interviews, with diagnoses made of clinical and subclinical target disorders.

Results: Rates of OC phenomena were highest in relatives of probands with symmetry symptoms, with the greatest difference seen in rates of subclinical OCD. A similar pattern was observed for several spectrum conditions. Symmetry symptoms in probands were associated with significantly elevated rates in relatives of tic-related disorders and behaviors and impulse-related grooming habits.

Conclusions: Symptom subtypes may reflect disparate etiologies and be one key to understanding both familial transmission of OCD and the relationship of this disorder to a range of nosologically distinct conditions. Symmetry symptoms in OC patients may represent alternate expression of a common genetic diathesis underlying the OC spectrum of disorders.

No. 103B
BEYOND TYPES: EXAMINING THE EVIDENCE FOR A DIMENSIONAL MODEL OF OCD

Laura J. Summerfeldt, Ph.D., *Anxiety Disorders, St. Joseph's, 50 Charlton Avenue East, Hamilton, ON L8N 4A6, Canada;* Margaret A. Richter, M.D., Martin M. Antony, Ph.D., Richard P. Swinson, M.D.

SUMMARY:

Objective: Despite growing consensus regarding heterogeneity within OCD, conventional classification on the basis of overt symptom subtypes has significant limitations. An alternative dimensional model of this disorder is presented here. Building upon earlier work by Rasmussen and Eisen, this posits the existence of two orthogonal core dimensions in OCD—"harm avoidance" and "incompleteness"—that cut across overt symptoms and in combination may underlie all manifestations of this disorder and be associated with different features, vulnerabilities, and causal factors. This quantifiable model may provide a key to several issues under debate in the OCD literature, such as OCD's link with the obsessive-compulsive spectrum and its continuity with obsessional personality characteristics.

Method: Individuals with OCD (n = 40) high in either incompleteness or harm avoidance were compared on several variables of clinical significance: 1) comorbidity with spectrum conditions (e.g., trichotillomania) versus anxiety disorders, 2) personality characteristics, and 3) cognitive characteristics.

Results: Predominance of the incompleteness dimension predicted greater prevalence of spectrum conditions, higher levels of obsessional personality traits (e.g., perfectionism), and such cognitive feature as indecisiveness.

Conclusions: Several characteristics commonly attributed to OCD in general are in fact primarily associated with its "incompleteness" aspect. Nosologic, clinical, and conceptual implications are discussed.

No. 103C
OCD PHENOTYPES: THE ROLE OF THE SENSORY PHENOMENA

Euripedes C. Miguel, M.D., *Department of Psychiatry, University of Sao Paulo, Rua Valenca 91, Sao Paulo, SP 05403-010, Brazil;* Maria C.R. Rosario-Campos, M.D., Roseli G. Shavitt, M.D., Ana G. Hounie, M.D., Marcos T. Mercadante, M.D.

SUMMARY:

Obsessive-compulsive disorder (OCD) is a common psychiatric disorder characterized by recurrent and intrusive thoughts or persistent ideas or images (obsessions) that are usually accompanied by intentional repetitive behaviors (compulsions) performed to relieve

either the obsessions or the anxiety caused by them. Although compulsions are frequently precipitated by obsessions, we will present data indicating that for a subgroup of OCD patients, compulsions are also performed in response to other intrusive events such as urges, tactile sensations, or a sense of incompleteness rather than obsessions. There are also patients who report the need to perform repetitive behaviors until they feel "just right" or complete. All these subjective experiences are not well defined in the literature and are frequently described under the label sensory phenomena. These subjective experiences may be helpful for the characterization of specific subgroups of OCD patients, particularly the OCD related to tics and/or Tourette syndrome, early onset OCD, and rheumatic fever.

This talk will focus on clinical and phenomenological approaches used to determine OCD subgroups. Considering that the etiology of OCD is still unknown and that several lines of research suggest that OCD is a heterogeneous disorder, the characterization of more precise clinical phenotypes will be crucial to finding more homogeneous forms of the disorder. Those will be more likely to be associated with specific genotypes and neurobiological substrates. This approach will eventually lead to more specific treatments.

No. 103D
ISSUES IN THE GENETICS OCD

Michele T. Pato, M.D., *The Buffalo General Hospital, 80 Goodrich Street, Buffalo, NY 14203;* Kim M. Schindler, B.S., Carlos N. Pato, M.D.

SUMMARY:

Most of the molecular genetic work to date in OCD has not shown significant or replicable findings despite compelling data from twin and family studies that would seem to indicate that there are familial or heritiable forms of OCD. These findings may be related to the fact that OCD may not truly represent a genetically homogeneous population of patients. Recent data looking at different phenotypes, as presented previously in this symposium, should lead us to wonder if some of the lack of significance is related to the study of a heterogeneous phenotype in the OCD samples that have been analyzed to date. Phenotypic strategies that have been used include analysis of age of onset, cluster analysis, factor analysis and segregation analysis. Analysis of age of onset has shown familial OCD to be twice as common in families of probands with onset before age 9 versus onset after age 10 (Pauls et al). Cluster analysis data comparing 16 OCD and 16 OCD + TS probands showed that 15 of 16 OCD + TS and seven of 16 OCD probands were assigned to one cluster. Other data will be reviewed and future directions will be discussed.

REFERENCES:

1. Summerfeldt LJ, Richter MA, Antony MM, Swinson RP: Symptom structure in obsessive-compulsive disorder: a confirmatory factor-analytic study. Behaviour Research and Therapy 1999; 37:297–311.
2. Rasmussen SA, Eisen J: The epidemiology and clinical features of obsessive compulsive disorder. Psychiatric Clinics of North America 1992; 15:742–758.
3. Miguel EC, Baer L, Coffey BJ, et al: Phenomenological differences, obsessive-compulsive of repetitive behaviors in obsessive-compulsive disorder and Tourette's syndrome. Brit J Psychiatry 1997; 170:140–145.
4. Pauls DL: Phenotypic variability in obsessive-compulsive disorder and its relationship to familial risk. CNS Spectrum 1999; 4:57–61.

SYMPOSIUM 104—OUTCOMES OF DEPRESSION IN EUROPE: THE ODIN PROJECT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: understand the methods used in the ODIN Project; recognize the variation in prevalence of depressive disorders within urban and rural communities in Europe; appreciate the importance of social and psychological risk factors from both cross-sectional and longitudinal perspectives; recognize the relative acceptability and efficacy of individual and group psychological interventions.

No. 104A
THE ODIN PROJECT: STUDY, DESIGN, AND INSTRUMENTS

Jose Luis Vazquez-Barquero, M.D., *Department of Psychiatry, Hospital Univ. Marq. De Valla, AV. Valdecilla S/N, Santander 39008, Spain*; Jose Luis Ayuso-Mateos, *Lourdes Lasa*

SUMMARY:

Five European centers with expertise in mental health research are participating in ODIN: based in Liverpool, Dublin, Oslo, Santander (Spain), and Turku (Finland). The centers are linked electronically, and the study teams meet regularly for training and strategic reviews. Nine urban and rural communities were studied, using a sampling frame of adults aged 18–64, identified via primary care databases or electoral registers. Operating a two-stage survey procedure, potential cases of depressive disorders were identified by the Beck Depression Inventory (BDI) using a cut-off score of >12. At second-stage interview, SCAN2 was used to assign caseness against DSM-IV and ICD-10 criteria, and validated instruments were deployed to measure social support and function, self-rated disability, cognitive status, the presence of personality disorders, and the provision and utilization of local health care services. A randomized controlled trial of two psychological interventions—individual Problem Solving Treatment and a group educational program (the Coping With Depression course)—provided by community mental health facilitators, was undertaken for respondents identified as cases of depressive disorder. Subjects were followed-up at six and 12 months to assess personal outcomes and health care utilization. Data have been logged, cleaned, and analyzed using SPSS-PC and STATA packages.

No. 104B
THE ODIN PROJECT: EPIDEMIOLOGY AND PREVALENCE

Ville Lehtinen, M.D., *Department of Mental Health, Stakes, Kunnalli. 20 Building 4, Turku FIN 20700, Finland*

SUMMARY:

Objective: To provide comparative data on the prevalence of depressive disorders in rural and urban settings.

Methods: A two-phase epidemiological survey, in nine urban and rural European communities, employing the Beck Depression Inventory and the Structured Clinical Assessment in Neuropsychiatry.

Results: 15,000 subjects were contacted. First phase response was 65%, with site variations from 51% to 90%. Second phase response was 72%. Weighted prevalence of depressive disorders among responders was estimated for each study site. There was wide variation amongst the five urban areas, from 2.8% to 21.8%: mean rates in Liverpool and Dublin were over six times higher, and in Oslo over

three times higher, than those in Santander. There was relatively little variation between the four rural areas, with weighted prevalence ranging from 6.7% in Wales to 9.0% in rural Norway. In Britain and Ireland, urban rates were some three times higher than in their rural communities, but in Norway and Finland, there was little difference between the urban and rural figures.

Conclusions: There appears to be considerable variation in levels of depression across Europe. Socioeconomic indices are sampled in each center, and different degrees of exposure to risk factors may explain some of the differences.

No. 104C
SOCIAL SUPPORT, LIFE EVENTS, AND PREVALENCE OF DEPRESSION

Steffen Dalgard, D.M., *Department of Comm. Medicine, University of Oslo, P.O. Box 4404 Torshov, Oslo N-0403, Norway*

SUMMARY:

Objectives: To assess the relationship between negative life events, social support, and depression in the different ODIN centres and to test the hypothesis that social support acts as a buffer against negative life events.

Methods: Data from BDI and SCAN were analyzed together with measures including the List of Threatening Experiences and Miller's Social Support questionnaire.

Results: In all centers there are significant associations between negative life events and depression, and between lack of social support and depression. In multivariate statistical analysis (ANOVA), there are strong main effects of social support and negative life events on depression, with a clear interaction between the two variables, particularly for new cases of depression. When comparing Santander, with the lowest mean BDI score, with the four other cities in the study, Santander has a significantly better score on social support, but the same level of negative life events.

Conclusion: Depression is strongly related to lack of social support and negative life events in the ODIN study. There is evidence of a buffering effect of social support, particularly for new cases of depression. Supporting interpersonal relationships seem to contribute to a lower prevalence of depression in Santander than in other urban centers.

No. 104D
IMPACT OF PERSONALITY ON DEPRESSION: RISK AND OUTCOME

Patricia R. Casey, M.D., *Department of Psychiatry, University of Coll. Dublin, Mater Hospital Eccles Street, Dublin 7, Ireland*

SUMMARY:

Objective: To examine the prevalence of personality disorder among ODIN subjects and to measure associations between personality, caseness, psychosocial factors, and depression outcomes.

Methods: The Personality Assessment Schedule was administered to subjects at six-month follow-up and analyzed with demographic, BDI, and SCAN data.

Results: The prevalence of personality disorder among the 343 subjects interviewed at six months varied from over 40% in Ireland and Spain to under 20% in Norway and Britain. The predominant diagnostic categories were avoidant, paranoid, and dependent. Personality disorders were more common in urban areas, among women, and among single and divorced people. It was most common among those with a diagnosis of dysthymia, and least commonly associated with adjustment disorders. Subjects with personality disorder were significantly more likely to have a higher BDI score at initial assessment and still be SCAN cases at six-month follow-up. Those with personality disorder did not experience more life events or poorer support for life events than those without. On multivariate analysis, personality disorder was independent of initial BDI score in determining six-month caseness.

Conclusions: Personality disorder appeared to be relatively common among ODIN subjects and to be an independent predictor of outcome at six-month follow-up.

No. 104E
TRIAL OF PSYCHOLOGICAL INTERVENTIONS IN THE COMMUNITY

Christopher F. Dowrick, M.D., *Department of Primary Care, University of Liverpool, Liverpool L69-3GB, England*

SUMMARY:

Objectives: To assess the acceptability and effectiveness of individual problem solving treatment (PST), and the Coping with Depression (CWD) course for people with depressive disorders in community settings.

Methods: ODIN subjects identified as SCAN cases were randomly allocated to PST, CWD, or a control group with no study intervention. Each intervention was offered by facilitators at five of the study sites, with quality control procedures. Follow-up was at six and 12 months.

Results: Of 444 eligible subjects, 128 were randomized to PST, 111 to CWD, with 205 controls, PST subjects were significantly more likely than CWD subjects to accept and complete their intervention. On an intention-to-treat basis, both PST and CWD subjects were less likely than controls to be cases at six months, but differences were significant only for PST. At 12 months, the proportion of PST subjects who were still cases was similar to controls (40% vs. 44%), while the proportion of CWD cases had increased to 55%. On multivariate analysis, PST, initial BDI score, and social support were independent predictors of outcome at six months.

Conclusions: PST appears to be a more effective intervention than CWD for people with depressive disorders in community settings.

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SYMPOSIUM 105—MOLECULES TO MIND: PSYCHIATRY AT THE MILLENNIUM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the latest advances in neuroscience at the millenium, to understand their impact on clinical care, and to better manage specific aspects of psychiatric treatment, including issues such as individualized psychopharmacology, the medical consequences of depression, and weight loss or gain either as a symptom or as a medication side effect.

No. 105A
DNA INFORMATION WILL INDIVIDUALIZE PATIENT CARE

James L. Kennedy, M.D., *Department of Psychiatry, Univ. of Toronto/Clarke Inst., 250 College Street (R-31), Toronto, ONT M5T 1R8, Canada;* Vincenzo S. Basile, B.S.C., Mario Masellis, B.S.C., Vural Ozdemir, Ph.D., Herbert Y. Meltzer, M.D., Jeffrey A. Lieberman, M.D., Fabio MacCiardi, M.D.

SUMMARY:

The variable response to medications across individuals is determined by a combination of genetic and environmental factors. The genetic factors may include variability in metabolism of the drug (pharmacokinetic) as well as receptor and second messenger systems (pharmacodynamic). As a model for psychiatric disorders, we have been studying the variation in schizophrenia patients' response to clozapine. The candidate genes for our work include the hepatic enzyme CYP1A2 as well as the genes for serotonin2 and dopamine D3 and D4 receptors. In addition to the remarkably variable third cytoplasmic loop polymorphism in DRD4, we typed other D4 markers in treatment-resistant patients with schizophrenia who had been treated with clozapine in a structured trial (total n = 220). Chi-square and ANOVA analyses were performed on alleles versus categorical and continuous (respectively) clinical measures.

The DRD4 intron I was significantly associated with change in BPRS ($p = .003$). In addition to these dopamine system gene results, the 5HT2A gene significantly predicted overall response to clozapine ($p = .01$). Tardive dyskinesia, as measured by AIMS at entry into the clozapine trial, was significantly correlated with D3 ($n = 112$, $F = 8.25$, $p < .0005$) incorporating age, sex, and ethnicity as covariates. We have also found an effect of CYP1A2 genotype on risk for TD ($N = 85$, $p = .0007$), after stratifying for smoking, which is an inducer of CYP1A2.

Our current hypothesis is that an algorithm of DNA measures in DRD4 and 5HT2 genes will be a clinically important predictor of response to clozapine and that tardive dyskinesia risk will be in part predicted by genetic variation at DRD3 and CYP1A2.

No. 105B
GENETIC SUSCEPTIBILITY TO PSYCHOSES

Wade H. Berrettini, M.D., *Department of Psychiatry, University of Pennsylvania, 415 Curie Blvd., Room 111, Philadelphia, PA 19104*

SUMMARY:

Several family studies of bipolar (BP) disorder and schizophrenia (SZ) suggest some overlap in vulnerability to certain diagnostic entities. First-degree relatives of BP individuals are at increased risk for schizoaffective (SA), recurrent UP (RUP), and BP disorders, while first-degree relatives of persons with SZ are at increased risk for SA, RUP and SZ. This overlap in risk from family studies appears to be genetic. The overlap in risk for RUP and SA diagnoses detected in genetic epidemiologic studies is also evident in molecular genetic linkage research. A confirmed 18p11.2 BP susceptibility locus has been detected in multiplex SZ families, and a confirmed 13q32 SZ susceptibility locus has been observed in a BP linkage study. Similar overlap has been observed for chromosome 10p12 and for 22q11-13 BP and SZ linkage studies. If the overlap was restricted to one locus, a false positive explanation would be tenable. However, since there is substantial evidence for shared genetic susceptibility at four loci (18p11.2, 13q32, 22q11-13 and 10p12), this false-positive hypothesis is improbable. These data suggest that the dichotomy between BP disorder and SZ, originally articulated by Kraepelin, may not be as complete as previously considered. A continuum model of psychosis, as articulated by Crow and others, may be more consistent with these genetic data.

No. 105C
WEIGHT DYSREGULATION: SYMPTOM AND SIDE EFFECT

Julio Licinio, M.D., *3554 Gonda (Goldschmied) Ctr, 695 Charles E. Young Dr, South, Box 951761, Los Angeles, CA 90095-1761;* Andre B. Negrao, M.D., Paolo Prolo, M.D., Ma-Li Wong, M.D.

SUMMARY:

The regulation of food intake and body weight is the result of a complex process that is regulated by a multitude of genetic, molecular, cellular, biochemical, hormonal, psychological, environmental, social, and cultural signals. Alterations in food intake and body weight are characteristic of several psychiatric disorders, such as anorexia nervosa, bulimia nervosa, binge eating disorder, and major depression. Moreover, weight gain can be a serious side effect of antidepressants, antipsychotics, and lithium. The degree of weight gain by psychotropic drugs can be of such magnitude as to affect compliance, leading patients not to take drugs that might otherwise effectively treat psychosis, depression, or bipolar disorder. Enormous progress on the elucidation of the central nervous system mediators of body weight regulation has been achieved in recent years. Peptides such as leptin, neuropeptide Y, insulin, melanin-concentrating hormone, the orexins, alpha-melanocyte-stimulating hormone, neurotensin, glucagon-like peptide, and corticotropin-releasing hormone (CRH) contribute to modulate food intake, energy expenditure, and body weight. The adipocyte hormone leptin decreases food intake and stimulates weight loss. Leptin is secreted in a pulsatile and circadian manner, and it contributes to regulate CRH secretion. We have shown that human plasma leptin concentrations are inverse to those of adrenocorticotropic hormone and cortisol. CRH is a key regulator of the response to stress and it has profound behavioral effects. Thus, leptin provides a link between the stress response, behavior, and nutritional status. Research on the role of leptin in psychiatric disorders and in the response to psychotropic drugs may lead to new avenues for treatment of body weight dysregulation in psychiatric patients. Our work has shown that because women require more leptin than men to maintain normal body weight, they may exhibit a relative resistance to the effects of leptin. This may explain the clinical finding that all disorders characterized by food intake and body weight dysregulation have a higher prevalence in women than in men.

No. 105D
STRESS, IMMUNITY, AND BEHAVIOR

Esther M. Sternberg, M.D., *CNE, Nat'l Inst. of Mental Health, 10 Center Dr., Bldg. 10, 2D-46, Bethesda, MD 20892-1284*

SUMMARY:

The field of neuroimmune interactions is a prime example of interdisciplinary research spanning immunology, neurobiology, neuroendocrinology, and behavioral sciences. It also exemplifies research from the molecular to the clinical domain. The greatest challenge of the field is conducting research that is at the same time precise, focused, and integrative. Several levels of interdisciplinary overlap will be highlighted. At the molecular level, neuro- and immune mediator molecules or their receptors may be members of the same superfamily or may regulate each other's expression or function. Most extensively studied are cytokine-neuropeptide/neurotransmitter interactions, including expression of cytokines within the central nervous system and production of neuropeptides by immune cells or at inflammatory sites. Advances relating cytokine-neurohormone interactions to mechanisms of apoptosis will ultimately shed light on the role of neuroimmune interactions in neuronal cell death and survival and immune cell selection, processes important in neuronal plasticity and immune specificity. At a systems level, advances have been made in cross-disciplinary application of modes of thinking. Incorporation of neurobiology's appreciation of anatomical organization, endocrinology's temporal dimension of neurohormonal secretion, and immunology's understanding of stimulus specificity all contribute to a more precise definition of how these complex systems interact at multiple levels. More precise understanding of effects of disruptions of these communications on disease susceptibility and expression will clarify how perturbations of one system, such as stimulation of the neuroendocrine stress response, might affect expression of disease in the other, such as behavioral, autoimmune/inflammatory, or infectious diseases.

No. 105E
LONG-TERM MEDICAL CONSEQUENCES OF DEPRESSION

Philip W. Gold, M.D., *Research, NIMH, Bldg. 10/RM 2D46, 10 Center Drive, Bethesda, MD 20892-1284*

SUMMARY:

Major depression is associated with substantial medical morbidity. Our group has shown that premenopausal women with past or current depression have decreased bone mineral density and are at increased risk for fractures. Additionally, studies from various groups have shown that patients with cardiovascular disease have a worse prognosis when they also suffer from depression. Thus, depression can be conceptualized as chronic and recurrent psychiatric disorder with substantial medical morbidity. The biochemical and endocrine features of depression negatively impact on bone metabolism and on cardiovascular function. Those features include dysregulation of hypothalamic-pituitary-adrenal function, growth hormone secretion, sympathetic nervous system activity, and glucose homeostasis. Body-fat distribution can also contribute to the adverse consequences of depression on cardiovascular function. Additionally, level of physical exercise and nutrition may be adversely affected by depression. The optimal assessment and treatment of the depressed patient should therefore include adequate evaluations of bone mineral density and cardiovascular function. It is particularly important that patients with major depression be optimally treated for diseases of bone and cardiovascular function. Moreover, patients with current or past depression should be educated about these issues and encouraged to decrease risk factors for osteoporosis and cardiovascular disease.

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SYMPOSIUM 106—PHARMACOTHERAPY OF IMPULSIVE PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be better informed about psychopharmacological stabilization and management of impulsivity in patients with personality disorders.

No. 106A
THE USE OF MOOD STABILIZERS IN THE TREATMENT OF IMPULSIVITY

Charles L. Bowden, M.D., *Department of Psychiatry, University of TX Health Science Ctr., 7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

SUMMARY:

Several lines of evidence support a beneficial role for mood stabilizers in the treatment of impulsivity. Valproate, carbamazepine, and more recently, lamotrigine have been reported effective in impulsive conditions, including cyclothymia and post-traumatic stress disorder. Although most studies are uncontrolled, controlled data exist for carbamazepine and valproate. Impulsivity is a primary dimension of bipolar disorder and is particularly benefited by mood stabilizers, with the strongest data being for valproate. Bipolar disorder is often comorbidly associated with impulse control disorders. Additionally, impulsivity is a key feature of several other disorders, e.g., emotionally intermittent explosive disorder, obsessive-compulsive disorder, for which mood stabilizers have been reported effective. Progress in this area has been impeded by current diagnostic criteria, which emphasize syndromes rather than dimensions of behavior, even when the dimensions reflect fundamental processes such as impulsivity, anxiety, and irritability. Similarly, behavioral rating scales scored by clinicians tend not to capture impulsivity well, which is best assessed in observation of instantaneous behaviors. Each of these lines of evidence will be presented, along with implications for future research on the subject.

No. 106B
MEDICATION MANAGEMENT OF IMPULSIVE SUBSTANCE ABUSE

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032*

SUMMARY:

Medication to control impulsive seeking after abuseable substances varies by the particular drug. Heroin dependence has the greatest range of available medications with agonists such as methadone and LAAM, partial agonists such as buprenorphine, and antago-

nists such as naltrexone. To manage alcoholism, the narcotic antagonist naltrexone may decrease the likelihood of a lapse becoming a relapse, while disulfuram may control use by producing a very aversive reaction when combined with alcohol. No medication is currently available for marijuana, although data with adolescents with intermittent explosive disorder have suggested that mood stabilizers such as valproic acid may be promising. Finally, for cocaine, the stimulant most associated with impulsive substance abuse, no good medication currently exists, in spite of more than 40 agents being tried. A number of new classes of drugs are being studied, but as yet none have been shown to be effective. All the medications mentioned above need to be given in the context of psychosocial support, relapse-prevention training, involvement in self-help groups, and family support. In addition, treatment of comorbid psychiatric disorders has been shown to be an important facet of successful treatment.

No. 106C
PHARMACOTHERAPY OF PATIENTS WITH IMPULSIVE PERSONALITY DISORDERS

Paul S. Links, M.D., *St. Michael's Hospital, 30 Bond Street, Room 2011 2DS, Toronto, ONT M5P 3H9, Canada*

SUMMARY:

A recent study of patients with borderline personality disorder (BPD) found that the initial level of impulsivity significantly predicted the course of the disorder over seven years follow-up. These findings suggest that the effective treatment of the impulsive characteristics of BPD may alter the long-term course of the disorder. This paper will review the evidence for pharmacotherapy of impulsive personality disorders and discuss the clinical implications. The treatments of impulsive personality disorders will be discussed regarding their acute and continuing management.

Substantial evidence supports the use of traditional neuroleptic medication for the acute management of impulsive-aggression based on their effectiveness, safety, and rapidity of action. Several recent studies suggest that novel antipsychotics such as olanzapine and clozapine may have a role in the management of impulsive personality disorders. The evidence for SSRIs in the continuing management of impulsive disorders will be reviewed. Mood stabilizers have demonstrated limited effectiveness for this patient population. Clinically, response to medication in impulsive personality disorders may be related to gender, may be lost over time, may lessen the risk of suicide, and may be augmented by other psychosocial approaches.

No. 106D
LONGITUDINAL PATTERNS OF MEDICATION UTILIZATION IN BPD

John M. Oldham, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York, NY 10032;* 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), a disabling condition common among treatment-seeking populations, is defined in DSM-IV by nine criteria, five or more of which must be present for the diagnosis to be made. When clinically prominent, several of these 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 regarding medication practice patterns in the treatment of BPD are, however, sparse. Controlled studies are beginning to be done, and those available in the literature are being 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 = 173) 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 or anxiolytics 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. Prospective data are being collected, and longitudinal medication usage patterns for the first year of the study will be presented.

No. 106E
COGNITIVE THERAPY TECHNIQUES TO ENHANCE MEDICATION COMPLIANCE

Judith S. Beck, Ph.D., *Cognitive Therapy & Research, The Beck Institute, 1 Belmont Avenue, Suite 700 GBS BLDG, Bala Cynwyd, PA 19004-1610*

SUMMARY:

Patients with an Axis II disorder often demonstrate poorer treatment compliance than patients with an Axis I disorder only (Andreoli, 1989). There is virtually no research, however, examining the efficacy of various psychotherapies in increasing medication compliance among personality disorder patients, though two studies did demonstrate that patients with other psychiatric disorders who were treated with cognitive therapy showed greater medication compliance than control groups (Cochron, 1984, Lecompte, 1996). And Anrntz (1999) concluded, following a review of the literature, that there are indications that personality disorder patients can be successfully treated with modified cognitive-behavioral methods.

In order to enhance medication compliance, the clinician seeks to identify the thoughts and beliefs and/or problems related to a particular Axis II patient's noncompliant behavior. Often patients have a combination of lack of information about their psychiatric disorder, distorted ideas about medication, and practical difficulties. Understanding the characteristic thoughts and beliefs for the various personality disorders enables the clinician to select and implement cognitive and behavioral strategies designed to respond to patients' dysfunctional ideas and to do problem-solving. Methods to conceptualize patients' noncompliance from a cognitive perspective and specific techniques to improve medication compliance will be described.

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TUESDAY, MAY 16, 2000

TELECOMMUNICATIONS SESSION 1—SEX, HATE AND VIOLENCE ON THE INTERNET

No. 1
PORNOGRAPHY ON THE WEB: WHAT'S THE BIG DEAL?

Donna M. Woods, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive., Ann Arbor, MI 48109-0390;*

EDUCATIONAL OBJECTIVES:

The objective of this presentation is to: (1) expose the audience to the availability of pornography on the Web, (2) discuss the potential impact that it may have on children and adolescents, and (3) to discuss, in brief, what can and can not be done concerning the presence of pornography.

SUMMARY:

Pornography has become much more widely available as a consequence of the Internet. Despite the availability of filtering systems and other types of technology, pornography can still be accessed by children and adolescents who desire to find it. Most disturbing is not the access, but the types of pornography which are available, that otherwise would not be available to children and adolescents except under rare circumstance.

Is this potentially destructive? Will this be damaging to our children, adolescents, and our culture? What should we be doing as practitioners and parents? What can be done legislatively? These are just a few of the significant questions that confront us.

No. 2
HATE GROUPS, ADOLESCENTS AND THE INTERNET

Keith Cheng, M.D., *Adolescent Psychiatry, Emanuel Hospital, 3001 North Gantenbein Avenue, Portland, OR 97227;*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify hate group Web sites and their marketing tactics toward youth, and discuss the impact this may have on their view of the world and others.

SUMMARY:

Few people have been able to ignore the explosive growth of the Internet and World Wide Web in the past five years. The Internet's unprecedented capacity as an international resource for commercial and personal use continues to grow daily as some 20 million homes and institutions currently have access. However, as more people become aware of the Internet's potential for disseminating information, hate groups—which are subject to scrutiny in other media formats (television, newspaper, radio)—have discovered the Web as well. According to the Simon Wiesenthal Center, there was one hate site on the Web in 1995; today there are over 1,400. Over 50 hate groups have developed their own Web sites, thriving on the Internet's lack of regulation and the opportunity for the anonymous dissemination of biased and untruthful information. Even more troubling is the fact that many of these sites have aspects designed specifically to appeal to young people. This presentation will feature a live demonstration of the accessibility of these sites and a review of their content. We will also address the impact this information may have on vulnerable youth, and discuss approaches clinicians may take with children and their parents.

No. 3
DOMESTIC VIOLENCE: A CME WEB COURSE

Marjorie S. Braude, M.D., *11973 San Vicente Boulevard, Suite 211, Los Angeles, CA 90049-5098;*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize common presentation of domestic violence in psychiatry, protect the safety of the victim and family, and treat the victim and family. This includes knowledge of safety planning, appropriate referrals, suicide and homicide risks, and legal and reporting requirements.

SUMMARY:

The presenter is the principal author and course director of an online interactive CME Web site course in domestic violence for psychiatrists and other health care professionals. This course was funded by the Department of Justice and administered through the American Medical Women's Association. The course has links to case histories, specific protocols, and audio and video clips of victims, which illustrate specific points in the course.

The eight units of the course cover the major subject areas necessary to give the psychiatrist a basic understanding of the major aspects of domestic and family violence. These include basic theory, definition and patterns of abuse, identification and documentation of abuse, psychiatric symptoms including suicidality, guidelines for treatment, safety planning, reporting requirements, useful referrals, legal remedies, and techniques for working with children and perpetrators. The speaker will select out and emphasize the portions most important for psychiatrists in the presentation.

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TELECOMMUNICATIONS SESSION 2—VARIETIES OF ELECTRONIC MEDICAL RECORDS

No. 4
CONTINUOUS MONITORING OF SYMPTOMS AND MEDICATIONS

Elliot D. Luby, M.D., *Department of Psychiatry, Mt. Sinai Hospital, 148000 West McNichols Road, Detroit, MI 48235;*

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

This easy-to-use program is designed to monitor patient progress by contrasting symptom level over time. Practitioners can record, in narrative, the mental status examination, diagnosis, physiological tests, and medications. Symptoms correspond to Axis I, II, and III of DSM-IV (Axis II is documented partially); they are recorded on a three-point scale as not at all, occasionally, and very often, so that at the subsequent session any change may be identified. Changes in diagnosis, tests, and medications are recorded in narrative.

Entries may be made first on paper, and then keyboarded by clerical staff, or entered directly into the computer after the session. At each following session, current symptoms are recorded and for each one, any change from the previous session is noted on the screen and written in a printable file as better, same, or worse. The data from each session are appended to the original file in readable form.

The program runs under Windows 95 or 98 and is contained in a self-installing diskette.

No. 5
THE UNIVERSITY OF MICHIGAN'S ELECTRONIC MEDICAL RECORD MODEL

Sheila Marcus, M.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Ann Arbor, MI 48109-0722;*

EDUCATIONAL OBJECTIVES:

The objective of this presentation is to discuss the electronic medical record that is currently being used at the University of Michigan, and to compare this model with others that are currently being used.

SUMMARY:

The University of Michigan's Department of Psychiatry has embarked on the implementation of an electronic medical record (EMR) over the last several months. The EMR allows information through dictations to be transcribed into text fields or so text can be entered directly by clinicians. Is this a computerized patient record? Is there a difference between a computerized patient record and the text based record which exists at the University of Michigan? The strengths of the utilization of this model will be discussed and will be compared in brief to other kinds of technologies which are available, and which represent the electronic medical record.

No. 6
PSYCHIATRIST-PROGRAMMED ELECTRONIC MEDICAL RECORDS

Daniel A. Deutschman, M.D., *Behavioral Health Center, South West General Hospital, 18051 Jefferson Park Road, Middleburg Heights, OH 44130;*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) demonstrate a relational Electronic Medical Record (EMR) developed by a practicing psychiatrist; (2) assess its impact on quality of care, productivity, and costs; (3) review important features; (4) perform a mock interview using the EMR.

SUMMARY:

In 1995, a practicing psychiatrist created a comprehensive Electronic Medical Record (EMR) for use in a busy inpatient/outpatient group practice. A total of 35,000 inpatient/outpatient visits have been recorded.

The presentation will demonstrate the EMR using a mock patient. Impact on quality of care, productivity, and costs will be discussed. Participants will have an opportunity to schedule appointments electronically and to enter data into rating scale modules that automatically score and import results into the patient's record.

Features of interest that will be discussed include: (1) click-list data entry, (2) data input form guiding the clinician, (3) DSM-IV criteria prompting, (4) treatment algorithms, (5) decision support for treatment-resistant patients, and (6) automatic prescriptions, lab request forms and billing reports. Additional considerations of interest are (1) hardware/software costs, (2) remote access of records when on call, and (3) more efficient documentation allows extra time for patient education. The EMR pays for itself in weeks via increased productivity and decreased clerical costs. Practicing psychiatrists can enhance the quality of their work and increase their productivity using EMR.

No. 7
CAPER SOFTWARE

Peter F. Fore, M.D., *Department of Psychiatry, VA Chicago HCS WS, P.O. Box 8195 MC116A 1, Chicago, IL 60680;* Richard Weaver, Ph.D., *VAMC Salt Lake City, 500 Foothill Boulevard MC127PS, Salt Lake City, UT 84148;*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, 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, Ph.D. 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 over 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.

REFERENCES:

1. Trzepacz PT, Baker RW: The psychiatric mental status examination. New York, Oxford University Press, 1993
2. American Psychiatric Association: Diagnostic and Statistical Manual for Mental Disorders, 4th edition. Washington, DC, American Psychiatric Press, 1994
3. J AM Pharm ASsoc (Wash) 1999 May May-June;39(3):402-7
4. Designing solutions for securing patient privacy—meeting the demands of health care in the 21st century
5. Health Prog. 1998 May-June;79(3)26–31 Schick IC

6. Protecting patients' privacy. Health information networks raise new questions.
7. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. Hosp Community Psychiatry 1993; 44:1091–1095
8. Hammer JS, et al: Operationalizing a bedside pen entry notebook clinical database system in consultation-liason psychiatry. General Hospital Psych 1995; 17:165–172
9. 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
10. Weaver RA, Christensen PW, Sells J, et al: Computerized treatment planning. Hospital and Community Psychiatry 1994; 45:825–827

WEDNESDAY, MAY 17, 2000

TELECOMMUNICATIONS SESSION 3—AN INTERNET-BASED SYSTEM FOR IMPROVING PSYCHOPHARMACOLOGY PRACTICE

No. 8
OVERVIEW OF THE SYSTEM

Robert D. Patterson, M.D., *Mental Health Center, 21 Blossom Street, Lexington, MA 02173-8103;*

EDUCATIONAL OBJECTIVE:

To provide an overview of the disease management system whose components will be described and feasibility of use will be demonstrated in the presentations.

SUMMARY:

The Harvard Psychopharmacology Algorithm Project is an Internet-based disease-management system for delivering evidence-based pharmacotherapy strategies to the point of service. Evidence considered includes published research and significant practice guidelines, algorithms, and expert opinion. At present, the program covers schizophrenia, depression (all types, from dysthymia to bipolar-related depressions), and anxiety disorders (panic, social phobia, PTSD, OCD, GAD) in patients with a history of chemical abuse.

This application is a virtual psychopharmacology consultant. It inquires (electronically) about the consultee's specific patient and, when enough information is supplied, offers detailed analysis and recommendations. The evidence supporting the order of the questions and the recommendations is provided and discussed in windows accompanying the questions. These also contain definitions, criteria, and diagnostic caveats.

Other features include: tactics for adequate trials of medications; a separate, attached program that identifies potential cytochrome-enzyme interactions in current or proposed treatment regimens; and an algorithmic approach for dealing with medication noncompliance.

Data collection tools are available at each decision point, enabling comparison of outcomes from patients treated with recommended strategies compared with other choices. Decision points are uniquely identified by a numbering system.

The presentation will demonstrate how psychopharmacology-management systems like this may be useful as performance-improvement engines.

No. 9
ANXIETY IN PATIENTS WITH CHEMICAL ABUSE/ DEPENDENCE

David N. Osser, M.D., *Taunton State, Harvard Medical School, 60 Hodges Avenue, Taunton, MA 02780;*

EDUCATIONAL OBJECTIVE:

To demonstrate Internet software that offers psychopharmacology consultation on patients who present with anxiety disorders and a history of chemical abuse or dependence, and to recognize the value of the Internet for training, improving the consistency and effectiveness of patient care, and outcome research.

SUMMARY:

This is an Internet expert system for advising psychiatrists on strategies to optimize the pharmacotherapy of anxiety disorders in patients with a history of chemical abuse or dependence.

Panic Disorder: The first-line recommendation is for an SSRI or nefazodone plus appropriate psychotherapy. Benzodiazepines are generally not recommended, either as monotherapy or adjunctively, but many exceptions are proposed. The routine second-line suggestion is a second SSRI/nefazodone but consider venlafaxine, mirtazapine, or a tricyclic (if not high suicide or seizure risk). The third-line emphasizes the last three options. Fourth-line would be valproate if persistent liver disease is not a problem, or various combination treatments.

Social Phobia, Generalized type: If there is comorbid depression, SSRIs or possibly nefazodone are first-line treatments. If not, cognitive behavioral therapy or SSRIs are suggested. Benzodiazepines are considered, as above. Second-line treatment would be another SSRI/nefazodone. Third-line would be augmentation with buspirone or a third SSRI/nefazodone, but consider clonazepam, gabapentin, venlafaxine, and certain others.

PTSD: Patients with comorbid depression are offered SSRIs or nefazodone first-line. Those without depression but with insomnia may receive a trial of a hypnotic (e.g., trazodone). After that, an antidepressant is proposed. If PTSD-related psychosis is present, an antipsychotic might be tried next, or another antidepressant trial given. Those still symptomatic with hyperarousal symptoms may be given clonidine, and those with impulsivity and aggression may receive mood stabilizers.

OCD: Two or three monotherapy trials with SSRIs, at higher doses if necessary, are proposed. Clomipramine may be less safe in this population. Among the augmentations, buspirone and antipsychotics have slight priority.

GAD: The first-line pharmacotherapy is buspirone, followed by antidepressants. Venlafaxine has particular support.

No. 10
ACUTE DEPRESSION IN BIPOLAR DISORDER

Anne E. Dantzler, M.D., *69 Gerry Road, Chestnut Hill, MA 02167-3139;*

EDUCATIONAL OBJECTIVE:

To demonstrate Internet software that offers psychopharmacology consultation on patients who present with acute depression in bipolar disorder, and to recognize the value of the Internet for training, improving the consistency and effectiveness of patient care, and for outcome research.

SUMMARY:

This presentation will discuss the flowcharts and recommendations for bipolar depression in the most recent version of the Algorithm for the Pharmacotherapy of Depression, an Internet-based expert system developed as part of the Harvard Psychopharmacology Algorithm Project.

After ruling out contributing medical factors, the first consideration is to determine if there is an urgent indication for ECT. The next question is whether psychotic symptoms are present, which would generally suggest the use of an antipsychotic in addition to whatever other medications will be chosen.

For Bipolar I depression, the next recommendations depend on what medication the patient is on at first. If the patient is taking lithium, it is optimized to 0.8 to 1.2 meq/L. If the patient is currently taking other mood stabilizers, these are adjusted to full therapeutic range to prevent cycling with the antidepressant(s) that will be subsequently added. If taking no mood stabilizer, lithium monotherapy is tried in mild cases, and lithium plus an antidepressant in cases of moderate or greater severity. SSRIs and bupropion are first-line, followed by venlafaxine and then consideration of tranylcypromine. For bipolar II depression: patients with no significant impairment from hypomanic episodes, who have not had antidepressant-induced hypomania in the past and who do not have a hyperthymic temperament are possible candidates for antidepressant monotherapy. Rapid-cycling bipolar I or II patients are first screened for predisposing factors. They are then given at least two mood stabilizers in combination before considering antidepressants, but alternatives to an antidepressant may include trying another mood stabilizer or atypical antipsychotics. ECT is strongly reconsidered. Refractory bipolar depression is carefully reassessed, and then options include ECT, augmentation strategies, and a variety of novel approaches.

No. 11
FEASIBILITY STUDY ON THE USE OF TWO ALGORITHMS AT TAUNTON STATE HOSPITAL

David N. Osser, M.D., *Taunton State, Harvard Medical School, 60 Hodges Avenue, Taunton, MA 02780;*

EDUCATIONAL OBJECTIVES:

To describe the development of a project to explore the implementation of an Internet-based computerized disease management system for the use of evidence-based pharmacotherapy in patients with depression and schizophrenia, and to present the initial patient outcome data

SUMMARY:

As part of a performance improvement project, psychiatrists on five units of the hospital consult the Internet algorithms for schizophrenia and depression when they are about to begin a new treatment for patients with these diagnoses. After reviewing the algorithm's reasoning (which is based to the extent possible on evidence-based medicine, using a broad definition of "evidence"), the psychiatrist determines if one of the algorithm's recommendations is appropriate or whether another treatment would be more appropriate. The psychiatrist prescribes only the treatment that he/she determines is the best choice for that patient. If the psychiatrist selects some other treatment than one of the algorithm's recommendations, the reasoning of the psychiatrist is documented. Outcomes are determined. Each member of the multidisciplinary team contributes to the assessment and outcome evaluation process. Outcome measures include the Current Assessment of Risk and Functioning–Revised, Allen Cognitive Levels, and three locally developed brief rating instruments that are filled out by the primary nurse, the patient (a self-assessment/satisfaction evaluation), and the social worker (based on the impressions of an involved family member, if any). The first three patients have been evaluated using these procedures. The goal is to have results on 30 patients for this presentation.

No. 12
THE USE OF ALGORITHEMS AT THE MENDOTA MENTAL HEALTH INSTITUTE

David V. Mays, M.D., *538 West Lakeside Street, Madison, WI 53715-1728;*

EDUCATIONAL OBJECTIVES:

To describe a project to explore the implementation of an Internet-based pharmacotherapy algorithms in patients with schizophrenia, at an institution and by individuals not in any way connected with the developers of the program, and to present the initial patient outcome data

SUMMARY:

As part of a performance improvement project, psychiatrists on units of the Mendota Mental Health Institute in Madison, Wisconsin consult the Internet algorithm for schizophrenia when they are about to begin a new treatment for patients with this diagnosis. The algorithm provides generic suggestions for what might be best for each patient, based on its consideration of evidence-based medicine combined with the best available expert opinion (e.g., from published practice guidelines, other algorithms, etc.). The physician evaluates the reasoning and supporting documentation behind the recommendations of the algorithm. He/she may decide to prescribe one of the first-line recommendations (there are usually more than one) if the reasoning they have just examined seems to apply to their patient. Or they can select any other medication, but if they do, they must provide their reasoning for why their choice would be better. The patient's outcome is determined using change scores on the Current Assessment of Risk and Functioning–Revised (CERF-R), obtained at baseline and at completion of the medication trial. The goal is to have results on 30 patients for this presentation.

No. 13
THE CYTOCHROME P450 DRUG INTERACTION PROGRAM

Jessica R. Oesterheld, M.D., *Child and Adolescent Psychiatry, University of South Dakota, Medicine, 1100 South Euclid Avenue, Sioux Falls, SD 57117;*

EDUCATIONAL OBJECTIVES:

To demonstrate the use and features of a computer program that provides consultation on the risk of cytochrome-related drug interactions from proposed combinations of medications, which can be employed as part of a disease management system for fostering provision of evidence-based psychopharmacology practice.

SUMMARY:

P450 cytochrome interactions are a particular challenge because there are so many drugs, metabolites, and enzymes involved. In addition, the literature is rapidly evolving. Printed lists are of limited usefulness; they must address substrate, inhibitor, and inducer status, strength of effects, and theoretical vs. clinically reported interactions. Such lists are error-prone and rapidly become out-of-date.

This program makes useful information for consultative purposes available in a practical manner. The user indicates the medications the patient is taking by picking from the program's list. The program then displays the cytochrome involvement of each of these drugs (and their metabolites) in one window, and the potential drug interactions among the picked drugs in another window. The intensity of enzyme effects is rated on a three-level scale. Notes associated with specific pairs provide comments and the evidence basis. Non-cytochrome-related interactions are also being added. There are more than 1,300 references in the program at this time. The program's database can be updated over the Web at any time.

No. 14
THE P450 PROGRAM IN THE HOSPITAL SETTING

Dean Najarian, R.Ph., *Taunton State Hospital, 60 Hodges Avenue Extension, Taunton, MA 02780;*

EDUCATIONAL OBJECTIVES:

To describe a study of the impact of the Cytochrome P450 Drug Interaction Program on prescribing decisions by psychiatrists at Taunton State Hospital.

SUMMARY:

As part of the algorithm disease-management project described earlier in this session, an assessment will be made of each proposed new medication order using the Cytochrome P450 Drug Interaction Program. When the order reaches the pharmacy, the pharmacist enters the present medications and the proposed new medication into the program and examines the displayed predicted interactions and their evidence basis. Physicians will be informed of any potential drug interactions and given a printout of the computer's analysis. The pharmacy department will record if, after receiving this information, the physician changes the medication order in any way (dose, type of medication). The frequency of prescribing changes in relation to the severity of the proposed interaction will be tracked.

REFERENCES:

1. Patterson RD: The Harvard psychopharmacology algorithm project. Psychiatric Annals 1999; 29:248–250
2. Shore MF: Algorithms and the quality of care. Psychiatric Annals 1999; 29:315–316
3. Osser DN, Renner JA, Jr., Bayog R: Algorithms for the pharmacotherapy of anxiety disorders in patients with chemical abuse and dependence. Psychiatric Annals 1999; 29:285–301
4. Dantzler A, Osser DN: Algorithms for the pharmacotherapy of acute depression in patients with bipolar disorder. Psychiatric Annals 1999; 29:270–284
5. Osser DN, Patterson RD: Algorithm for the pharmacotherapy of depression: Part One and Part Two. Directions in Psychiatry 1998; 18:303–336
6. Osser DN, Zarate CA, Jr. Consultant for the pharmacotherapy of schizophrenia. Psychiatric Annals 1999; 29(5):252–269
7. Oesterheld JR: A review of developmental aspects of cytochrome P450. Journal of Child and Adolescent Psychopharmacology 1998; 8:161–174
8. Oesterheld JR, Osser DN: Drug interactions in augmentation strategies for pharmacotherapy of obsessive-compulsive disorder. Journal of Practical Psychiatry and Behavioral Health 1999; 5:179–183
9. Poses RM: One size does not fit all: questions to answer before intervening to change physician behavior. The Joint Commission Journal on Quality Improvement 1999; 25:486–495
10. Matchar DB, Samsa GP: The role of evidence reports in evidence-based medicine: a mechanism for linking scientific evidence and practice improvement. The Joint Commission Journal on Quality Improvement 1999; 25:522–528

TELECOMMUNICATION SESSION 4—OFFICE OF THE FUTURE

EDUCATIONAL OBJECTIVES:

We will demonstrate how technology will enrich the practice of psychiatry and better enable us to realize both our individual professional, as well as APA organizational, goals.

SUMMARY:

The Office of the Future reflects APA awareness that understanding technology is an essential component of not only the practice of medicine, but of global citizenship. Recognizing the strengths and limitations of technology and participating in the creation of better tools is imperative.

Our understanding of these technologies are integral to our achievement of APA strategic goals. Our mastery of technology will:

- enrich our ability to take care of patients, with better access to them, to our colleagues, to new sources of information and analyses,
- improve our ability to communicate with our political and community leaders, and to effect humane and appropriate mental health policy,
- enhance our ability to educate, train, and learn for our lifetime,
- enable us to become knowledgeable and active citizens of the information age, who will not tolerate misuses of information systems, and who will assume leadership in assuring medical safety and privacy, and
- allow us to contribute to the explosion of new research related to biotechnology and our understanding of the human genome.

Members of the CIS will introduce various facets of the psychiatrist of the future, in conjunction with our main exhibit, Office of the Future, housed in the Exhibition Hall.

REFERENCES:

1. Zen Mind, Beginner's Mind, Shunryu Suzuki, Weatherhill: 1972
2. Being Digital, Nicholas Negroponte, Vintage Books: 1996

Component Workshop 1
CYTOCHROME P450 AND THE MANAGEMENT OF MEDICALLY ILL PATIENTS
APA Commission on AIDS

Chairperson: Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130*
Participants: Francine Cournos, M.D., Robert S. Stasko, M.D., Karl Goodkin, M.D., Stephen J. Ferrando, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the implications of psychopharmacologic treatments for patients with medical illness with regard to potential drug-drug interactions, especially those involving the cytochrome P450 system.

SUMMARY:

This workshop will examine the theoretical and practical issues of drug-drug interactions in psychiatric patients with medical illness, with particular attention to the cytochrome P450 system. Panelists will provide an overview of metabolic pathways by which medications are processed, review specific issues related to cytochrome series and psychiatric medications, and discuss the clinical impact of prescribing medications for the chronically mentally and medically ill. HIV disease will be used as a paradigm. Particular attention will be paid to protease inhibitors, antipsychotics, mood stabilizers, antidepressants, and, medications for wasting, hypogonadism, and sexual dysfunction. Clinical cases will be presented and discussion of individual clinical experiences will be encouraged.

REFERENCES:

1. Lin JH, et al: Inhibition and induction of cytochrome P450 and the clinical implications. Clin Pharmacokinet 1998; (5):361–90
2. Tseng AL, et al: Significant interactions with new antiretrovirals and psychotropic drugs. Ann Pharmacother 1999; (4):461–73

Component Workshop 2
THE DOCTOR AS PATIENT: BOTH SIDES OF TRANSFERENCE
APA/Glaxo Wellcome Fellows

Chairperson: Bradley W. Strong, M.D., *400 Brookline Ave #16E, Boston, MA 02215*
Participants: Carol A. Bernstein, M.D., Art C. Walaszek, M.D., Judith H. W. Crossett, M.D., Andrew B. Klafter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand more completely the current prevalence, attitudes, and barriers surrounding the issue of residents undertaking individual psychotherapy while in residency training.

SUMMARY:

This presentation explores the current state of psychotherapy experience among North American psychiatry residents. Eighteen residency programs are surveyed for the following data: (1) number of residents currently involved as patients in psychotherapy, (2) reasons for engaging in psychotherapy among resident trainees, (3) perceived support for individual psychotherapy within residencies, and (4) barriers to obtaining individual psychotherapy in residency. Data presentation and analysis will be followed by panel discussants, including Glaxo/Wellcome fellows and residency training faculty. Topics for discussion will include the following: (1) views on the theoretical and practical importance of receiving individual psychotherapy treatment during residency training, (2) the impact of recent changes in health care delivery systems on resident accessibility or openness to psychotherapy treatment (i.e. diagnostic criteria for reimbursement, fears about confidentiality violations, and license requirements for reporting mental conditions), (3) personal experience by panel discussants and audience regarding impact of personal psychotherapy treatment on their clinical work.

REFERENCES:

1. Dubovsky SL, Scully JH: Hazards of long-term psychotherapy during psychiatric residency. Psychiatry 1990; 53(2): 185–94
2. Weintraub D, Dixon L, Kholhepp E, Woolery J: Residents in personal psychotherapy; a cross-sectional perspective. Academic Psychiatry 1999; 23(1):14–19

Component Workshop 3
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 1
APA Committee of Early Career Psychiatrists and APA Assembly Committee of Early Career Psychiatrists

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Ann S. Maloney, M.D., *123 East 37th Street, New York, NY 10016-3030*
Participants: Barry W. Wall, M.D., Keith W. Young, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) develop his/her own individual strategy for launching a successful private practice, while maximizing strengths and interests, (2) learn techniques that will provide the necessary edge to succeed in a competitive marketplace, (3) learn to balance the functions of manager, technician, and entrepreneur in a small business.

SUMMARY:

Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. This symposium provides you with the tools to create your own successful private practice, while minimizing risk. Co-led by two early career psychiatrists with thriving practices, the symposium includes up-to-the-minute ideas about marketing, office location, individual issues, potential downfalls, and billing, as well as a segment by risk management experts. It concludes with small groups organized by geography to address regional differences. Time to network with other ECPs is included.

REFERENCES:

1. Garban LE: The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About it. Hyperbusiness, ISBN 0887307280, April 1995
2. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996

Component Workshop 4
OPEN ETHICS FORUM
APA Ethics Committee

Chairperson: David S. Wahl, M.D., *12600 West Colfax, C-430, Lakewood, CO 80215-3736*
Participants: Beverly J. Fauman, M.D., Robert M. Wettstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the importance and value of professional ethics and be

able to discuss, within the context of ethical principles, issues related to professional responsibility.

SUMMARY:

The APA Ethics Committee will present a forum for participants to address current ethical standards. Past and present members of the committee will make brief (3–5 minute) presentations on several issues of relevance to the members, other physicians, and professionals. Discussion will follow to create a new arena for member participation in the establishment, updating, and promulgation of the code of ethics. Participants will be encourage to raise issues concerning current ethical principles, as well as offer suggestions for new annotations to the current "Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry." We will also discuss issues unique to members-in-training, early career psychiatrist, international members, and underrepresented groups within the APA. This workshop can evolve into an annual gathering, with followup reports of actions taken in response to input from the membership.

REFERENCES:

1. Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 1998 edition. Washington, DC, APA
2. Opinions of the Ethics Committee on the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. 1995 wsuruib, Washington, DC APA, 20005

Component Workshop 5
BULLYING AND HARASSMENT: PATHS TO SCHOOL VIOLENCE
APA Committee on Psychiatry and Mental Health in the Schools

Chairperson: Lois T. Flaherty, M.D., *University of Pennsylvania, 770 Lantern Lane, Blue Bell, PA 19422-1612*
Participants: Eugenio M. Rothe, M.D., Trina B. Allen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the biological, psychological, and social factors involved in bullying behavior, diagnose psychiatric disorders in bullies and victims, and help schools develop effective intervention plans.

SUMMARY:

Bullying and harassment are part of the spectrum of violent behavior and are serious problems in schools. The perpetrators of recent multiple-victim school shootings were all described as isolated loners who were ostracized by other students, often having experienced harassment or bullying at school for several years. Consequences of being a victim of bullying include depression and suicide, as well as violent retaliation after prolonged suffering. Bullies themselves are at risk for becoming more violent later on. A "conspiracy of silence" often prevails in which other students who witness bullying do not report it, providing further license for the bully to continue. Bullying affects all social classes and schools.

Multiple-victim school shootings linked to bullying have made the need for effective approaches to this problem more urgent. Schools must be actively involved in addressing problems of bullying and harassment. Effective measures involve creating an emotional climate that encourages students to report bullying, a zero tolerance policy at the school, identification of high risk students, and psychiatric assessment and intervention for victims as well as perpetrators. This workshop will use clinical case examples and recent research findings to illuminate the role of the psychiatrist in addressing this problem.

REFERENCES:

1. Olweus D: Bullying in Schools: What We Know and What We Can Do. Cambridge, MA, Blackwell Publishers, Inc, 1993
2. Tatum D, Herbert G (Eds): Bullying: Home, School and Community. London, David Fullon Publishers; 1997

Component Workshop 6
SOLVING MANAGEMENT PROBLEMS IN VIVO
APA Committee on Psychiatric Administration and Management

Chairperson: Philip E. Veenhuis, M.D., *Department of Psychiatry, NC DMH/DD/SAS UNC, 325 North Salisbury Street, Raleigh, NC 27603*
Participants: W. Walter Menninger, M.D., Veena Garyali, M.D., Stuart B. Silver, M.D.

EDUCATIONAL OBJECTIVES:

At conclusion of this workshop the patient should be able to recognize how experienced administrators solve complex organizational problems.

SUMMARY:

This workshop will focus on administrative/managerial problems presented to the audience by four experienced psychiatrists/administrators with over 100 years of collective experience including a state department of mental health medical director, the CEO of a large private psychiatric system, a former commissioner of mental health, and a state forensics director. Audience participation will be encouraged. Audience will experience how seasoned psychiatrists administrator/managers work.

REFERENCES:

1. Tulhof Textbook of Psychiatric Administration
2. Freedman/Kaplan: Comprehensive Textbook of Psychiatry

Component Workshop 7
REDISCOVERING AUTHORITY IN AMERICAN LIFE
APA Alliance

Chairperson: Jacquelyn M. Le Blanc, *4700 Fort Sumner Drive, Bethesda, MD 20816-2467*
Participant: Sara C. Charles, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) Recognize instances in which natural authority functions well within human relationships, (2) Recognize some sequella of authority default, (3) Demonstrate some remedies for strengthening the appropriate functioning of authority within human relationships.

SUMMARY:

Most Americans are ambivalent about authority—in part, because they tend to confuse authority with authoritarianism. Since most of us need to exercise authority in order to achieve our goals and fulfill our responsibilities both in our personal and professional lives, this workshop will review related concepts and their applications. The derivation of the word authority, for example, flows from the Latin word "augere," which means "to create, to enlarge, to make able to grow." It is intrinsically relational and nourishes growth and maturity. It differs from authoritarianism which, instead of promoting freedom and growth, controls, confines, and involves the misuse of power. Some philosophers have suggested that we cannot live in a civil society without authority. A case can be made, however, that America currently suffers from an authority "default." A series of illustrative vignettes drawn from the doctor-patient relationship, family life, the educational system, and human relationships within other American institutions will be presented in order to stimulate discussion with the audience about whether or how natural authority functions in each instance. The discussion will include suggestions

for rediscovering authority in our everyday lives since the appropriate exercise of authority is closely associated with good mental health.

REFERENCES:

1. Kennedy E, Charles SC: Authority: The Most Misunderstood Idea in America. New York, NY, The Free Press, 1997
2. Simon YR: A General Theory of Authority. Notre Dame, IN, University of Notre Dame Press, 1980

Component Workshop 8
HOT ISSUES IN TELEPSYCHIATRY
APA Committee on Telemedical Services

Chairperson: David F. McMahon, M.D., *29 Puritan Lane, Swampscott, MA 01915*
Participants: Charles L. Zaylor, D.O., Ellen N. Rothchild, M.D., Stuart Gitlow, M.D., Zebulon C. Taintor, M.D., Donald M. Hilty, M.D., Scott I. Bienenfeld, M.D., Beverly N. Jones, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the varied applications of telepsychiatry, with an understanding of the advantages, limitations, and current issues being studied in this fast-developing field. Applications from geriatrics to rural and prison populations, plus a review of minimal technological requirements, will be discussed by leaders in the field as well as resident psychiatrists.

SUMMARY:

Telepsychiatry has come of age, offering a panoply of opportunities and the possibilities of misuse. As a follow-on to last year's successful program, which examined telepsychiatry from the point of view of patient and psychiatrist, this year's workshop features a highly interactive discussion with the audience and telepsychiatry experts involved with geriatric, rural, prison, Internet, global, and low-technology applications.

REFERENCES:

1. Telemedicine: A Guide to Assessing Telecommunications in Health Care. Marilyn J. Field, ed. Washington DC, National Academy Press, 1996, pp. 73–82
2. AMA Policy 225.962 Medical staff membership category for physicians providing telemedicine: http://www.ama-assn.org/mem-data/special/omss/omssadv/ policy.htm.

Component Workshop 9
RESIDENCY TRAINING: ADDICTIONS TREATMENT ADVANCES
APA Committee on Training and Education in Addiction Psychiatry

Chairperson: Richard S. Schottenfeld, M.D., *CMHC/SAS, 34 Park Street, New Haven, CT 06519*
Participants: Jonathan Rivto, M.D., William M. Greenberg, M.D., Peter R. Martin, M.D., Jeffrey A. Berman, M.D., Teresita Sanjurjo, M.D., Denise C. Bridgeford, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) identify the results of the major recent clinical trials evaluating psychosocial, behavioral, and pharmacologic treatments for alcohol, cocaine, opioid, and other substance use disorders; and (2) design addictions training opportunities for general psychiatry residents.

SUMMARY:

This workshop will provide an overview of recent advances in the treatment of substance use disorders and describe models for incorporating these advances in general psychiatry residency training programs. The proposed ACGME requirements for general psychiatry residency training programs will require a one-month full-time equivalent clinical rotation in additions. Recent treatment advances and the new ACGME requirements create an opportunity for improving addictions training in general psychiatry residency training programs. The first presentation will provide an overview of recent treatment advances and clinical trials evaluating promising new treatments for alcohol, cocaine, opioids, and other drug use disorders. Subsequent presentations by general and addiction psychiatry training directors and addiction psychiatry residents will describe model training programs that are currently being used to train general psychiatry residents in addictions. An extended discussion period will allow members of the audience to discuss their own training programs and other issues regarding implementation of addictions training programs for general psychiatry residents.

REFERENCES:

1. Swift R: Drug therapy for alcohol dependence. NEJM 1999; 340:1482–1490
2. Crits-Christoph P, Siqueland L, Blaine J, Frank A, et al: Psychosocial treatments for cocaine dependence. National Institute on Drug Abuse Collaborative Cocaine Treatment Study. Archives of General Psychiatry, 56(6):493–502, 1999 Jun.

Component Workshop 10
CAREER LESSONS FOR ASIAN-AMERICAN EARLY CAREER PSYCHIATRISTS
APA Committee of Asian-American Psychiatrists

Co-Chairpersons: Jacquelyn B. Chang, M.D., *341 Spruce Street, Suite C, San Francisco, CA 94118,* Edmond H. Pi, M.D., *Department of Psychiatry, Charles R. Drew University, 1720 E. 120th Street, #102, Los Angeles, CA 90059*
Participants: Jambur V. Ananth, M.D., Albert C. Gaw, M.D., Norma C. Panahon, M.D., Ming T. Tsuang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the career experiences of established Asian-American psychiatrists representing the Veteran's Administration, state mental health system, community mental health, academics, research, and private practice. They will gain a greater awareness of the importance of mentorship, role models, and networking, as well as the relevance of organized psychiatry to career development.

SUMMARY:

In the changing world of psychiatry, it is even more important for young early career psychiatrists to learn from more established ones. All too often, the experiences of mid- and late-career psychiatrists and the lessons learned from them are not discussed in large forums. This workshop will provide perspectives from psychiatrists working within the VA system, the state system, community mental health, academics, research, and private practice. It will examine choices made during career pathways and the resulting ramifications. The importance of mentorship, role models, and networking such as the APA National Minority Mentorship Network (NMMN) as tools for career development will be explored. The role of organized psychiatry will also be discussed. While focused on the Asian-American community of psychiatrists, the experience should be generalizable to other ethnic minority and other psychiatrists as well. Psychiatrists from all levels of experience, from members-in-training and early career psychiatrists, will learn from participating in this workshop.

REFERENCES:

1. Davis Lori L, Little Marc S, Thornton WL: The art and angst of the mentoring relationship. Academic Psychiatry 1997; 21:61–71
2. Lu F, Lee K, Prathikanti S: Minorities in academic psychiatry, in Handbook of Psychiatric Education and Faculty Development. Edited by Kay J, Silberman EK, Pesson L. Washington, D.C, American Psychiatric Association, 1999

Component Workshop 11
NEW TOOLS FOR ASSESSMENT AND DIAGNOSIS OF TODDLERS
APA Committee on Pre-School Children

Chairperson: Harry H. Wright, M.D., *Department of Neuropsychiatry, University of South Carolina, 3555 Harden St Extended, Suite #104, Columbia, SC 29203*
Participants: Helen L. Egger, M.D., Christopher Lucas, M.D., Margaret Briggs-Gowan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe and discuss the use of new measures for assessment and diagnosis of psychiatric disorders in infants and toddlers.

SUMMARY:

The presenters will describe and discuss three new measures for the assessment/diagnosis of psychiatric disorders in infants and toddlers. Workshop participants will be encouraged to ask questions and contribute to the discussion of the measures. The first presentation will describe the structure and uses of the PAPA, an interviewer-based structured parental interview for the assessment of psychopathology in children aged two to five years old. The interview includes symptoms in DC:0–3, DSM-IV, and ICD-10, as well as symptoms not included in any of the three systems. Psychiatric diagnoses are generated by algorithm after the interview. The discussion will include how the PAPA will facilitate standardized assessments of psychiatric symptoms in epidemiologic and clinical samples of preschool children, and thus contribute to the development of a reliable psychiatric nosology for preschool children.

The second presentation will present pilot data on the Young Child DISC, for use with the parents of children aged three to eight: It will discuss the problems in developing a diagnostic instrument when the nosology is uncertain in the age group. A new computer application that incorporates DISC symptoms questions and cartoon illustrations for use by children aged five to eight will also be demonstrated.

Utilizing data from a representative sample of approximately 1,300 12- to 36-month-old children the final presentation will examine the prevalence of parent-reported symptoms on the Infant-Toddler Social and Emotional Assessment. In particular, symptoms that map onto the DC:03 and DSM-IV diagnostic systems for infants and toddlers will be examined to determine how many children are reported to exhibit significant symptomatology within each diagnostic area. The limitations of parent-reported measures will be discussed.

REFERENCES:

1. Briggs-Gowan MJ, Carter AS: Preliminary acceptability and psychometrics of the infant-toddler social and emotional assessment (ITSEA): a new adult-reported questionnaire. Infant Mental Health Journal 1998; 19(4):422–445
2. Diagnostic Classification of Mental Health and Developmental Disorder of Infancy and Early Childhood-Zero to Three. Washington DC, 1994

Component Workshop 12
IS HOMOPHOBIA A MENTAL DISORDER?
APA Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Leslie G. Goransson, M.D., *1629 K Street, NW, Suite 302, Washington, DC 20006*
Participants: Howard C. Rubin, M.D., Ronald L. Cowan, M.D., Philip A. Bialer, M.D., Mark H. Townsend, M.D., Kenneth B. Ashley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the concept of homophobia, its terminology, origins, and relevant research.

SUMMARY:

Recently, the psychiatric community has been faced with a fascinating question: "Is racism a mental disorder?" This workshop will explore the parallel question, Is homophobia a mental disorder? Relevant research regarding antigay prejudice, its organs, manifestations, and measurement tools will be presented. Issues around antigay violence and domestic violence in the gay, lesbian, and bisexual community will be explored. Current research on homophobia in our medical schools will be presented. The audience will be encouraged to participate in a discussion of whether homophobic thinking represents a mental disorder and possible avenues of treatment. Speakers will present material for the first 45–50 minutes, to allow ample time for discussion.

REFERENCES:

1. Cabaj R, Stein T (eds): Textbook of Homosexuality and Mental Health. American Psychiatric Press, 1996
2. Ryan C, Futterman D: Lesbian & gay youth; Care and Counseling. Columbia University Press, 1998

Component Workshop 13
DOCUMENTATION REQUIREMENTS AND CODING UPDATE
APA Committee on Codes and Reimbursements and APA Committee on Resource-Based Relative Value Scale Study

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., Ronald A. Shellow, M.D., Melodie Morgan-Minott, M.D., Donald J. Scherl, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant will be knowledgeable about (1) the 1994–1995 Documentation Guidelines for E/M services, (2) the current revisions in those guidelines, and (3) the Commission on Psychotherapy's suggestions for documenting psychotherapy.

SUMMARY:

Existing guidelines for documenting evaluation and management codes published by the Health Care Financing Administration and the American Medical Association are in the process of revision. Revised guidelines are expected in mid-2000. The new guidelines will effect coding and billing for psychiatric inpatient, partial hospital, consultation, and nursing home professional services. Medical directors of third-party carriers are in the process of publishing local directives, which establish guidelines for the use and documentation of psychiatric service codes. The American Psychiatric Association's Commission on Psychotherapy has drafted guidelines for psychiatric service codes.

The goal of the workshop is to familiarize practitioners with these evolving guidelines in order to assist practitioners in establishing coding, documentation, and billing procedures that are accurate and efficient. Presentations and handouts will provide the detail of the various sets of guidelines and the basis for questions and answers.

REFERENCES:

1. CPT - 1999
2. CPT Advisor - July 1997
3. Schmidt CW: CPT Handbook for Psychiatrists, Second Edition. American Psychiatric Press, Inc., Washington, DC, 1998

Component Workshop 14
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 2
APA Committee of Early Career Psychiatrists and APA Assembly Committee of Early Career Psychiatrists

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Ann S. Maloney, M.D., *123 East 37th Street, New York, NY 10016-3030*
Participants: Barry W. Wall, M.D., Keith W. Young, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) develop his/her own 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 market place, (3) learn to balance the functions of manager, technician, and entrepreneur in a small business

SUMMARY:

Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. This symposium provides you with the tools to create your own successful private practice, while minimizing risk. Co-led by two early career psychiatrists with thriving practices, the symposium includes up-to-the-minute ideas about marketing, office location, individual issues, potential downfalls, and billing, as well as a segment by risk management experts. It concludes with small groups organized by geography to address regional differences. Time to network with other ECPs is included.

REFERENCES:

1. Gerber ME: The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About It. Harperbusiness, ISBN 0887307280, April 1995
2. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996

Component Workshop 15
OFFICE OF THE FUTURE
APA Committee on Information Systems

Co-Chairpersons: Bertram Warren, M.D., *86 North Martine Avenue, Fanwood, NJ 07023-1330,* Ronnie S. Stangler, M.D., *1425 Western Avenue, Suite. #101, Seattle, WA 98101-2036*
Participants: Norman E. Alessi, M.D., Joshua E. Freedman, M.D., Cheryl A. Chessick, M.D., John Luo, M.D.

EDUCATIONAL OBJECTIVES:

We will demonstrate how technology will enrich the practice of psychiatry and better enable us to realize both our individual professional, as well as APA organizational, goals.

SUMMARY:

Understanding technology is an essential component of the practice of medicine and integral to the achievement of APA's strategic goals. The mastery of technology will:

- enrich our ability to take care of patients, fostering better access to them, our colleagues, and new sources of information;
- improve our ability to communicate with political and community leaders and effect humane and appropriate mental health policy.

REFERENCES:

1. Negroponte N: Being Digital. Knopf, 1995
2. Suzuki S: Zen Mind, Beginner's Mind. Weatherhill, 1972
3. Viaud-Delmon I, Ivanenko YP, Berthoz A, Jouvent R: Sex, lies and virtual reality. Nature Neuroscience 1998; 1(1):15–6
4. Botella C, Banos RM, Perpina C, Villa H, Alcaniz M, Rey A: Virtual reality treatment of claustrophobia: a case report. Behaviour Research & Therapy 1998; 36(2):239–46
5. North MM, North SM, Coble JR: Virtual reality therapy for fear of flying (letter). American Journal of Psychiatry 1997; 154(1):130

Component Workshop 16
GENERATIONS OF MENTORING: FROM RECEIVING TO GIVING
APA Committee on Women

Co-Chairpersons: Deborah Spitz, M.D., *New England Medical Center, Box 1007/750 Washington Street, Boston, MA 02111-1526,* Samantha E. Meltzer-Brody, M.D., *301 Woodhaven Road, Chapel Hill, NC 27514-7511*
Participants: Marian I. Butterfield, M.D., Cheryl F. McCartney, M.D., Donna E. Stewart, M.D., Diana L. Dell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify the benefits of mentorship, understand how to initiate and maintain a mentoring relationship as both a mentor and a mentee, and discuss the issues of gender in the mentor/mentee relationship.

SUMMARY:

This workshop, sponsored by the APA Committee on Women, explores the experience of mentoring—how it feels to provide mentorship, how it is to be mentored, what works, and what doesn't. Several generations of mentors and mentees will discuss their experiences of mentoring, being mentored, and mentoring others in turn. A mentor and mentee paired through the Committee on Women's Mentoring Network will discuss the process of building a productive relationship. The workshop will explore issues of dependence, autonomy, competition, collaboration, reciprocity, and gender in the mentor/mentee relationship. Audience members with mentoring experiences will be encouraged to participate.

REFERENCES:

1. Skeff KM, Mutha S. Role models—guiding the future of medicine. New England Journal Medicine 1998; 339(27):2015–7
2. Palepu A, et al: Junior faculty members' mentoring relationships and their professional development in US medical schools. Academic Medicine 1998; 73(3):318–23

Component Workshop 17
ALCOHOL AND DRUG USE IN LATE LIFE: DIAGNOSIS AND TREATMENT
APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly and APA Council on Aging in Collaboration with the National Institute on Alcohol Abuse and Alcoholism

Chairperson: Mustafa M. Husain, M.D., *University TX Southwestern Medical School, 5323 Harry Hines Boulevard, Dallas, TX 75235*
Participants: Julian Offsay, M.D., Daniel Weintraub, M.D., Sharon S. Levine, M.D., Blaine S. Greenwald, M.D.

EDUCATIONAL OBJECTIVE:

Participants will learn about the nature of the Eton/Drug usage in the elderly population, a working knowledge of how to treat and what resources to employ, and the other comorbid medical problems encountered in this patient group.

SUMMARY:

Alcohol and drug dependence is underdiagnosed and often difficult to treat in the elderly population. This workshop will address the extent of the problem of alcoholism and drug dependence (especially prescribed drugs) in late life. The ways in which these problems affect health and quality of life will be reviewed. We will discuss how to accurately diagnose and effectively intervene, and will also review the challenges and obstacles encountered in the effort to provide optimum care. The presentation will review the available literature and comment on prevalence and incidence of substance use and abuse in this population. The physical and psychiatric manifestations of these disorders will be discussed. The comorbid medical problems and other health related complications of alcohol and drug abuse are common in the elderly. Effects on organ systems, patterns of personal care, psychological functioning, work patterns, and social/family relationships will be outlined. Issues of importance including lack of appropriate treatment facilities, ageism, true different treatment requirements of the elderly, funding deficits, family and patient denial, and obstacles to appropriate treatment will be discussed. The presentation will also review the international perspective of alcohol and substance use in late life and discuss models in different settings.

REFERENCES:

1. Thun et al: Alcohol consumption and mortality among middle-aged and elderly U.S. adults. BEJM 1997; 337(24):1705–14
2. King CJ, et al: Diagnosis and assessment of substance abuse in older adults: current strategies and issues. Addictive Behaviors 1994; 19(1):41–55

TUESDAY, MAY 16, 2000

Component Workshop 18
VICTIMS IN THE WORKPLACE: AWFUL TO OPTIMAL OUTCOMES
APA Committee on Psychiatry in the Workplace

Chairperson: Leonard T. Sperry, M.D., *University of Wisconsin, 1950 Kathlynn Court, Brookfield, WI 53045*
Participants: Ronald Schouten, M.D., J.D., Robert C. Larsen, M.D., Jeffrey P. Kahn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to better appreciate the role of case management in achieving optimal outcomes for cases involving psychological trauma in the workplace leading to disability. Case examples will be the central focus for the presentations and discussions. Appropriate recognition by the clinician will be contrasted with ineffective management and enabling behavior on the part of the practitioner. Workshop participants will be asked to consider not only the employee patient's symptoms but functional ability, workforce reentry, and maintenance of the work unit.

SUMMARY:

Overt aggression and acts of violence can have both physical and psychological sequelae for victims. A study of the California workforce estimates that approximately 13,000 employee assaults occur annually in that state alone.

This workshop will utilize case examples to demonstrate a range of traumatic exposures, clinical-organizational interventions, and functional capacity results. The importance of case management in addition to the direct provision of treatment services will be emphasized as a means of optimizing positive outcomes. The need to take an "occupational psychiatric" perspective so as to fully involve other professionals such as human resource personnel, legal representatives, vocational rehabilitation counselors, and insurers goes beyond the traditional doctor-patient relationship.

Workshop participants will be invited to discuss their impressions of clinical intervention as well as management techniques that allow for very different outcomes. This will follow the case presentations and a discussion by the moderator of the organizational dynamics relevant to each case and the management techniques that were or could have been utilized to achieve the goals of functional capacity restoration and continued operations of the work unit. A proactive role for the psychiatrist going beyond the provision of treatment alone will serve as a contrast to the more traditional dyadic doctor-patient container. Concepts that will be presented include early intervention, critical incident debriefing, workplace accommodation, and functional capacity.

REFERENCES:

1. Peek-Asa C, Howard J, Vargas L, Krauss JF: Incidence of non-fatal workplace assault injuries determined from employers' reports in California. JOEM 1997; 39:44–50
2. Larsen RC: Workers' compensation stress claims: workplace causes and prevention. Psychiatric Annals 1995; 25:234–237

Component Workshop 19
MENTAL ILLNESS IN PSYCHIATRISTS: TRAINING AND BEYOND
The National Alliance for the Mentally Ill

Co-Chairpersons: Michael Myers, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 500 South Preston, Suite 214, Louisville, KY 40292*
Participants: Elizabeth A. Baxter, M.D., Mark L. Dembert, M.D., Suzanne E. Vogel-Scibilia, M.D., Marian Fireman, M.D., Julie Wilcox, M.D., Frederick J. Frese III, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) face the challenge of psychiatric illness during residency or later, and (2) possess less internalized stigma toward colleagues with psychiatric illness.

SUMMARY:

In this workshop, the co-chairs (Drs. Myers and Dickstein) will make brief introductory remarks about the roles of the treating psychiatrist and the training director when residents become ill. Drs. Wilcox, Fireman, Baxter, Dembert, and Vogel-Scibilia will present first-person accounts of being treated for psychiatric illness before, during,

and/or after residency. Issues to be addressed are: confronting denial and facing one's illness, overcoming stigma and coming out, overcoming stigma and not coming out, what to tell and what not to tell on residency applications and in interviews, how to access first-rate and compassionate care, impact of one's illness on loved ones and on fellow residents, frequently asked questions about disability insurance, addressing career considerations after residency, responding to questions on applications for a medical license and hospital privileges, support groups for psychiatrists living with mental illness during and after residency, advanced directives regarding relapse, and tips for psychiatrists who look after other psychiatrists. Dr. Fred Frese, first vice-president of NAMI will sum up and impart advocacy strategies for us to take home and to our medical schools. Thirty minutes will be provided for audience participation.

REFERENCES:

1. Miles SH: A challenge to licensing boards: the stigma of mental illness. JAMA 1998: 280;865
2. Baxter EA: The turn of the tide. Psychiatric Services 1998;49:1297–1298

Component Workshop 20
MISUSE AND ABUSE OF PSYCHIATRY: CLINICAL ISSUES
APA Committee on Abuse of Psychiatry and Psychiatrists

Co-Chairpersons: Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Med, 1670 Clairmont Road, Decatur, GA 30033,* Jose E. De La Gandara, M.D., *2161 Palm Beach Laks Blvd #215, West Palm Beach, FL 33409-6611*
Participants: Abraham L. Halpern, M.D., Satyanarayana Chandragiri, M.D., Robert P. Cabaj, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the essential distinctions between misuse and abuse of psychiatry and psychiatrists, and their applicability in the clinical realm, and (2) understand the need to incorporate pertinent knowledge of misuse and abuse of psychiatry in professional training programs and educational efforts with the public and society at large.

SUMMARY:

While knowledge and attitudes of both the psychiatric profession and the public at large regarding misuse and abuse of our discipline and practitioners have increased and improved, there is still a clear need to clarify issues of relevance in the clinical arena. Examples of violations of essential principles of psychiatric practice and the values that guide the activity of psychiatrists within and outside the United States are presented within a variety of contexts and settings. The origin of these problems resides in both internal and external sources: the former have to do, for instance, with features of the mental health care delivery system or misunderstanding of the role of the psychiatrist as a diagnosing and treating agent; the latter are related to sociocultural characteristics of the host country or community, as well as to political or economic factors. This workshop addresses the issues by elaborating on working definitions of misuse and abuse of psychiatry and/or psychiatrists; the perspectives of residents and early career psychiatrists; the relationship between governments, mental health institutions, and psychiatric and religious organizations; and cases of mismanagement of adolescents with gender identity disorders. It is hoped that this presentation will foster clinical dialogues, and will also stimulate a more systematic teaching of these matters in established training programs as well as within community and lay organizations.

REFERENCES:

1. Principles, Guidelines and Guarantees for the Protection of Persons' Detained on Grounds of Mental III Health or Suffering from Mental Disorders. UN Publications, New York, 1997
2. Corrado RR, Tompkins E: A comparative model of the psychological effects on the victims of state and anti-state terrorism. Int J Law Psychiatry 1989; 12:281–293

Component Workshop 21
ABPN EXAMINERS AND ABPN EXAMINEES
APA Committee of Early Career Psychiatrists and APA Assembly Committee of Early Career Psychiatrists

Chairperson: Anand Pandya, M.D., *Columbia University, 215 East 24th Street, #322, New York, NY 10010-3804*
Participants: Paul P. Yeung, M.D., Rodrigo A. Munoz, M.D., Joseph I. Sison, M.D., Troy L. Thompson II, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the purpose of the ABPN exam; list five common pitfalls of examinees and how to avoid them; and use the above information to prepare for the ABPN exam.

SUMMARY:

The American Board of Psychiatry & Neurology examination is a right of passage that is now more important than ever. New economic forces have created tremendous pressure to pass the exam, since many managed care provider panels will not employ psychiatrists who are not board certified. These economic realities have brought into focus long-standing concerns about board pass rates, objectivity, and access for recently-graduated residents. This workshop will help any psychiatrist prepare for the examination by reviewing the board's history, current format, and some common pitfalls examinees make in both preparing for and taking the exam. It will also aid any psychiatrist—whether they have taken the exam or not—to better understand the purpose of this exam. We will hear the perspective of both examiners and examinees who will discuss their experiences with this exam and how best to prepare for it. The audience will be encouraged to share their experiences or their concerns about the examination.

REFERENCES:

1. Weiner J, et al: Letters to the Editor: ABPN Exam, Psychiatric News, May 7, 1999
2. Morrison JR, Munoz RA: Boarding Time: A Psychiatry Candidate's Guide to Part II of the ABPN Examination. Washington, D.C., American Psychiatric Press, 1995

Component Workshop 22
RACISM AND PSYCHOPATHOLOGY
APA Committee of Black Psychiatrists

Chairperson: Michelle O. Clark, M.D., *1810 H Street, Suite B5-324, Modesto, CA 95354*
Participants: Carl C. Bell, M.D., George L. Mallory, M.D., Nada L. Stotland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) describe the current diagnostic controversy with respect to whether racism is a mental illness, and (2) describe a treatment plan for correcting this behavioral disturbance.

SUMMARY:

Given recent hate crime rampages and strocities, it has been suggested that "extreme racism is a classifiable mental illness." Some prominent psychiatrists have objected, citing nosological grounds and questioning our ability to treat manifestations of racism. The faculty will lead a spirited discussion exploring this controversy, noting how good-willed people wanting to end the public health problem of racism may have conflicting strategies. Participants in this workshop will learn the rationale for proposing extreme racism as a mental illness, and a formulation directing treatment of this behavioral disturbance.

REFERENCES:

1. Pouissant AF: They Hate. They Kill. Are They Insane? The NY Times, August 26, 1999, p21
2. Bell CC: Racism: a symptom of the narcissistic personality disorder, Journal of the National Medical Association 1980; 27(7):661–665

Component Workshop 23
PAUL RICOEUR IN DIALOGUE WITH AMERICAN PSYCHIATRISTS
APA Committee on Religion and Psychiatry

Chairperson: Reverend Clark S. Aist, Ph.D., *Director of Chaplin's Service, St. Elizabeth's Hospital, 2700 Martin L. King Jr Avenue, SE, Washington, DC 20032*
Participants: Leigh C. Bishop, M.D., Paul Ricoeur, M.D., William J. Richardson, Ph.D., Peter Homans, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize three ethical and/or therapeutic implications for the practice of psychiatry that derive from a philosophical analysis of the structure of the "pathological" in human experience, (2) identify three ways in which the philosophy of Paul Ricoeur advances and extends the dialogue between religion spirituality and psychiatry.

SUMMARY:

Professor Paul Ricoeur, Oskar Pfister Award recipient for the year 2000 and one of the century's greatest thinkers, has written extensively on psychoanalysis, hermeneutics, theology, and aesthetics. His writings have significantly influenced the fields of theology and philosophy of the social sciences in Europe and America. In his Pfister lecture, Dr. Ricoeur will focus his philosophical insights on an analysis of the structural differences between the "normal" and the "pathological" in human experience and the ethical and therapeutic implications for the practice of psychiatry of understanding and respecting that difference.

The workshop will occur after the Pfister lecture and is intended to continue and extend the conversation with Professor Ricoeur concerning: (1) a critique of his analysis of the structure of the "pathological" and its therapeutic and ethical implications and (2) some of the ways his philosophical insights may facilitate and advance the dialogue between religion and psychiatry in the new millennium.

The workshop will begin with a five to seven minute presentation by four panelists on the topic above with a brief response by Professor Ricoeur. Panelists will include persons with notable expertise in philosophy, ethics, religion, and psychiatric practice. Following the panel presentation, Professor Ricoeur along with the panelists will respond to questions and comments from the audience.

REFERENCES:

1. Ricoeur P: Freud and Philosophy: An Essay on Interpretation. Tr. by Denis Savage. New Haven, CT, Yale University Press, 1970
2. Ricoeur P: Hermeneutics and the Human Sciences. Edited and translated by Thompson. Cambridge, Cambridge University Press, 1981
3. Ricoeur P: Critique and Conviction. New York, Columbia University Press, 1988

Component Workshop 24
LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED RESIDENTS: CHALLENGES IN TRAINING
APA Northern California Psychiatric Society's Committee on Lesbian, Gay, Bisexual and Transgender Issues

Chairperson: Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco, CA 94110*
Participants: Ellen Haller, M.D., Tamar D. Gershon, M.D., Elias Aboujaoude, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify needs of lesbian, gay, bisexual, and transgendered psychiatry residents and ways to improve the training experience for these residents.

SUMMARY:

This workshop will identify needs of lesbian, gay, bisexual, and transgendered (LGBT) psychiatry residents and discuss how training programs can foster a supportive and effective learning environment. Challenges LGBT psychiatry residents may face, such as isolation and stigmatization, will be presented. Issues arising in supervision and concerning disclosure will be addressed. The presenters will share their experiences as residents and faculty in two training programs, using clinical and personal vignettes. Audience members will be asked to discuss issues facing LGBT residents at their training programs and the varied responses of these programs. Strategies for residents and faculty to improve the residency training experience will be identified from this discussion.

REFERENCES:

1. Polansky JS, Karasic DH, Speier PL, Hastik KL, Haller E: Homophobia: therapeutic and training considerations for psychiatry. Journal of the Gay and Lesbian Medical Association 1997; 1(1):41–47
2. Townsend MH, Wallick MM, Combre KM: Gay and lesbian issues in residency training at US psychiatry programs. Academic Psychiatry 1993; 17:67–72

Component Workshop 25
ANALYZE THIS: PSYCHIATRY, CULTURE, AND THE MEDIA
APA/Center for Mental Health Services Minority Fellows and APA/AstraZeneca Minority Fellows

Co-Chairpersons: Varanise C. Booker, M.D., *University of Louisville, 14308 Willow Grove Circle, Louisville, KY 40245,* Tracy L. Benford, M.D., *2801 South King Drive #208, Chicago, IL 60616*
Participants: Rajendra A. Morey, M.D., Ramon Solhkhah, M.D., Jacquelyn D. McLemore, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants will have an increased awareness of the role of the media in creating and perpetuating stereotypes. The participants will also have a greater

appreciation of how cultural issues impact utilization of psychiatric services and treatment.

SUMMARY:

In the 25 years since the creation of the APA Minority Fellowship, the portrayal of psychiatrists in the media has undergone gradual, but important, cultural changes. In this workshop, we will explore the representation of psychiatrists in the media, and how these changing stereotypes have influenced public perception. We will also examine how the portrayal of psychiatrists in the media has impacted access and utilization of mental health services among different cultural populations. The psychodynamic and cultural dimensions of this topic will be explored through discussion and multimedia presentations. The audience will be encouraged to share their own experiences and to generate discussion on ways to further dismantle stereotypes and to enhance cultural awareness.

REFERENCES:

1. Clara A: The image of the psychiatrist in motion pictures. Acta Psychiatr Belg 1995; 95(1):7–15
2. Gabbard G, Gabbard K: Psychiatry and the Cinema 2nd ed. Washington, D.C., American Psychiatric Press, Inc., JAM, 1999

Component Workshop 26
SPLIT THERAPY AND THE PSYCHIATRIC RESIDENT
APA Committee of Residents and Fellows

Chairperson: Geoffrey M. Gabriel, M.D., *10111 Pierce Drive, Silver Spring, MD, 20901–2431*
Participants: Lori Simon, M.D., Kira D. Stein, M.D., Jessica G. Roberts, M.D., Jason M. Andrus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the resident will demonstrate a knowledge of both the positive aspects and the negative aspects of collaborative treatment psychiatric clinic. The resident will be able to recognize the following issues involved in collaborative treatment with nonmedical mental health care providers: (1) legal, (2) psychopharmacology, (3) supervision, (4) setting goals, and (5) the team approach; transference and countertransference issues.

SUMMARY:

The changing scope of psychiatric practice settings has had a significant impact on psychiatric residency training. The increase in split therapy, especially in the outpatient setting, often places the psychiatric resident in a collaborative situation with nonmedical mental health providers. This workshop is designed to provide the resident with an overview of the various aspects, including legal, supervision, medication backup, team approach, and misperceptions involved in collaborative treatment. Following an overview, including presentation of current literature, workshop participants will explore these issues through a series of case presentations illustrating the various core components of collaborative treatment. Participants will be encouraged to bring to the open discussion their own experiences in the arena of split therapy and residency training.

REFERENCE:

1. Riba ME, Goldberg RS, Tasman A: Medication backup in psychiatry residency programs. Academic Psychiatry 1993; 17:32–35
2. Tekell JL, Erickson SS, Matthews KL: Collaboration with the nonphysician therapist: a seminar for postgraduate psychiatry residents. Academic Psychiatry 1997; 21:155–164

Component Workshop 27
PATIENT AUTONOMY AND PATERNALISM ACROSS CULTURES
APA Council on International Psychiatry

Co-Chairpersons: Ramaswamy Viswanathan, M.D., *State University of New York, Box 127, 450 Clarkson Ave, Brooklyn, NY 11203–2012,* Jeffrey L. Geller, M.D., Department of Psychiatry, University of Mass Med. Center, 55 Lake Avenue North, Worcester, MA 01655
Participants: Silvia W. Olarte, M.D., Giovanni Caracci, M.D., Kristin J. O'Dell, M.D., Hicham M. Ibrahim, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should appreciate (1) variations in importance given to patient autonomy in different nations and cultures; (2) benfits and shortcomings of such variations, especially as they pertain to psychiatry; (3) adjustments in approach foreign-born physicians need to make in treating patients in the USA, and US-born physicians need to make in treating foreign-born patients.

SUMMARY:

There are important national and cultural differences that impinge on the nature of the doctor-patient relationship. In the United States personal autonomy and individuality are highly valued, whereas some other countries are more paternalistic. It is not uncommon in some cultures that vital health information about the patient is revealed by the physician to a family member, but not to the patient, and the family member or the physician, not the patient, makes health care decisions for the patient, sometimes not even consulting with the patient.

The panelists from African-Arabian, Asian, European, Latin American, and American backgrounds will discuss these aspects in their culture of origin. Through interactions with the audience, the panel will explore adaptive and maladaptive elements of paternalism in different cultures, and modifications clinicians and society need to make in this regard based on the cultural context of the patient. Specific issues such as educating patients about diagnosis, warning about medication side effects, informed consent, handling refusal of psychiatric medications, involuntary hospitalization, and handling conflicts between the patient and the family will be explored. It is hoped that members of the audience from different countries and cultures will substantially contribute to this discussion.

REFERENCE:

1. Griffith EEH, Gonzalez CA: Essentials of cultural psychiatry, in American Psychiatric Association Textbook of Psychiatry (2nd. ed.). Edited by Hales RE, Yudofsky SC, Talbott JA. Washington, DC, American Psychiatric Press, 1994, pp 1379–1401
2. Lu F, Lim R, Mezzich J: Issues in the assessment and diagnosis of culturally diverse individuals, in American Psychiatric Press Review of Psychiatry (vol. 14). Edited by Oldham J, Riba M. Washington, DC, American Psychiatric Press, 1995

Component Workshop 28
RISK-MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE
APA Psychiatrists' Purchasing Group, Inc. and APA Committee to Monitor APA's Relationship with the Professional Liability Insurance Program

Chairperson: Alan I. Levenson, M.D., *Psychiatrists' Purchasing Group, 75 North Calle Resplendor, Tucson, AZ 85716*
Participants: Ellen R. Fischbein, M.D., Martin G. Tracy, J.D., Jacqueline Melonas, J.D.

EDUCATIONAL OBJECTIVE:

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 suites and become aware of malpractice in terms of their own works 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 non-psychiatrists 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 polices 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.

REFERENCE:

1. Meyer DS, Simon RI: Split treatment: clarity between psychiatrists and psychotherapists, in, Psychatric Annals Part I. May, 1999
2. Guidelines for Prescribing Psychiatrists in Consultative, Collaborative, and Supervisory Relationship, by Sederer, L.; Ellison, J, & Keyes, C, in Psychiatric Services, 49(9):1197–1202. September, 1998

Component Workshop 29
FACING THE CHANGING REALITIES OF PHYSICIAN STRESS
APA Committee on Physician Health, Illness, and Impairment

Chairperson: Richard F. Limoges, M.D., *327 South Camac Street, Philadelphia, PA 19107*
Participants: Patti Tighe, M.D., Carmen T. Webb, M.D., Linda Logsdon, M.D., Michael H. Gendel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will be able to recognize, diagnose, and treat more effectively both the precursors and sequelae of stress in their physician patients. In addition, attention will be paid to gender differences both in the genesis of stress and in its resolution. The particular needs of medical students will be explored.

SUMMARY:

The causes and genesis of stress in medicine and among physicians are rapidly changing. Physicians well adapted to the stress of their practices of 10 to 15 years ago find themselves more challenged by new realities, and ineffective coping mechanisms. In addition, the stress organizational changes, gender differences, uncertainty of making a living, and the increasing disconnect between the needs of new medical students and the experiences of their teachers and mentors all take an enormous toll. This workshop will examine the bases of stress both in clinical practice and in personal life, recent research and approaches to physicians who are in difficulty, the differing tasks of men and women as women assume an ever greater portion of the clinical workload, and finally discuss what we can do to ease the stress of medical students, and what we can learn from them. Participants will be asked to share examples, both clinically and in their own experiences, and to discuss ways in which they have been able to recognize and address stress-making situations by changing elements of their lives.

REFERENCES:

1. Bowman MA, Allen DI: Stress and Women Physicians. Springer-Verlag, New York NY, 1990
2. Callan JP (ed): The Physician; A Professional Under Stress. Norwalk, CT, Appleton-Century-Crofts, 1983

Component Workshop 30
LATIN AMERICA: SOCIAL AND POLITICAL TURMOIL AND PTSD
APA Committee of Hispanic Psychiatrists

Chairperson: Oscar E. Perez, M.D., *1400 N. El Paso, El Paso, TX 79902*
Participants: Maria C. Bayon, M.D., Alejandra Ruiz Lopez, M.D., Marta B. Rondon, M.D., Renato D. Alarcon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the effect of officially unrecognized social and political turmoil in the mental health of the populations addressed by the speakers and extrapolate this knowledge to other populations at risk.

SUMMARY:

Posttraumatic stress disorder is easier to diagnose when the trauma is evident such as in war or environmental disasters. Its diagnosis becomes more complicated when the trauma is chronic and becomes a way of life for the given society. If the need for political denial is added to the trauma, the mental health consequence is felt not only on the patient/victim but also on the mental health professional who works with this population.

Social and political unrest if common in Latin America is different for each of the countries that encompass the central and southern portion of this continent. Professionals working with PTSD victims in Colombia, Peru, and Argentina will present their experience and frame it within the particular sociocultural frame for each country.

The National Committee on Hispanic Psychiatrists under the auspices of the Council on Professional Values and Human Dignity, has invited colleges from Argentina, Colombia, and Peru, who work with patients suffering from Posttraumatic stress disorder to share with us their clinical experience.

REFERENCE:

1. Herman JL: Trauma and Recovery. Basic Books, Division of Harper Collins Publishers, 1992

WEDNESDAY, MAY 17, 2000

Component Workshop 31
SEXUAL HARASSMENT: A MILLENNIUM UPDATE
APA New Jersey Psychiatric Association

Chairperson: Rita R. Newman, M.D., *Department of Psychiatry, St. Barnabas Medical Center, 1046 South Orange Avenue, Short Hills, NJ 07078-3131*
Participants: Annette J. Hollander, M.D., Arlene G. Sherer, M.D., Louise F. Fitzgerald, Ph.D., Penny N. Kahan, Esq., Naomi J. Weinshenker, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize: (1) the clinical manifestations of sexual harassment,

(2) the patterns of presentation for psychiatric evaluation and treatment, (3) the psychiatrist's role as a treating physician versus the psychiatrist's role as an expert witness, and (4) the place of the judicial system in the management of cases and that command legal action.

SUMMARY:

This workshop will provide clinicians with an understanding of sexual harassment issues as they present in the year 2000. Psychiatrists and psychologists are often asked either to serve as expert witnesses or to treat individuals who allege sexual harassment in a work or academic setting. The panel will clarify clinical features found most consistently in much victims and will show how early subtle sexual harassment or discrimination sequences at work impact upon individuals. The importance of relating present complaints to prior experiences at work will be examined, as well as the need to identify affective features and memory traces in victims of harassment or discrimination.

Management of these issues systematically and appropriately in a therapeutic and legal framework will be delineated. Landmark cases and legal trends will be reviewed, as well as the significance of large out-of-court settlements, e.g. The Ford Motor Company vs. U.S. Equal Opportunity Commission agreement on September 7, 1999, for $8 million in damages for hostile work environment.

The panel includes psychiatrists, a psychologist, and an attorney with direct experience dealing with individuals who claim sexual harassment. The panel invites participation from the audience, who will be able to share their experiences.

REFERENCE:

1. Jesvold MF: Workplace sexual harassment: the users of and misuse and abuse of psychiatry, Psychiatric Annuals: Issue on Women and Therapy, December 1992
2. Shrier D (ed): Sexual Harassment in the Workplace and Academia—Psychiatric Issues. American Psychiatric Press, Inc., 1995

Component Workshop 32
RESIDENCY TRAINING IN PUBLIC SERVICE LEADERSHIP
APA Committee on Graduate Education

Co-Chairpersons: James W. Lomax II, M.D., *Department of Psychiatry, Baylor University, One Baylor Plaza, Ste 619D, Houston, TX 77030,* Deborah Hales, M.D., *222 West 39th Avenue, San Mateo, CA 94403*
Participants: Carol A. Bernstein, M.D., Jacquelin D. McLemore, M.D., Jacqueline C. McGregor, M.D., Kimberly A. Busi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: collaboratively develop programs in their home communities that (a) provide opportunities for the development of leadership skills in psychiatry residents, (b) meet community needs through structured volunteer activities that utilize psychiatric skills and (c) enhance the image of psychiatry in minority and underserved areas.

SUMMARY:

Faculty and residents from three geographically distinct programs will present initiatives that enhance the development of leadership skills by psychiatry residents. Each program utilizes volunteer activities in which psychiatric knowledge and skills are particularly useful and also provides improved services to minority and underserved patient populations. The principles involved in establishing these initiatives will be elucidated. An exchange with the audience will take place to allow workshop participants to establish collaborative, mutually beneficial, relationships in their local areas.

REFERENCES:

1. Battaglia J, Coverdale J, Bushong C: Evaluation of a Mental Illness Awareness Week program in public schools. America Journal of Psychiatry 1990; 147:324–329
2. Coverdale J, Battaglia J, Bushong C: A residents' program for educating adolescents about mental health issues, Academic Psychiatry 1991; 15:160–164

Component Workshop 33
INTERNATIONAL MEDICAL GRADUATES: CAREER CHOICES
APA Committee of International Medical Graduates

Chairperson: Jambur V. Ananth, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson St. Bldg 1 St, Torrance, CA 90509*
Participants: Rodrigo A. Munoz, M.D., Mantosh J. Dewan, M.D., Syed M. Husain, M.D., Hagop S. Akiskal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: understand the various career choices available, advantages of each choice, and learn to be successful in their career choices by listening to the experiences of the speakers.

SUMMARY:

International medical graduates (IMG) constitute about 45% of the psychiatric residents in training and 25% of the APA membership. Being from a variety of cultural backgrounds, they often have problems in career development in the United States. These include appreciation of the availability of the various career choices, the relative importance of these choices, and the knowledge required to pursue these goals. Unless guided, a student's career develop into wasted talent, emotional turmoil, and discontent. This workshop will provide career development strategies based on personal experience. Dr. Mantosh Dewan will speak on how to succeed in administration, Dr. Hagop Akiskal will discuss how to survive in research and obtain grants, Dr. Arshad Hussain will discuss how child psychiatry is a challenging academic area, and Dr. Rodrigo Muñoz will discuss how to build a private practice empire. These authors will illustrate their points by drawing from personal experiences and provide practical guidelines to residents and useful suggestions to early career psychiatrists. Hopefully, audience participation will enrich the presentation.

REFERENCES:

1. Goldbloom DS, et al: Rediscovering general psychiatry: creation of an academic division. Can J Psychiatry 1997; 42(1):58–62
2. Cutler J: Choosing a career in psychiatry. Am J Psychiatry 1996; 153(10):1372–1373

Component Workshop 34
HOW MEDICAL RECORDS PRIVACY PROPOSALS WILL CHANGE MEDICINE
Joint Commission on Government Relations

Co-Chairpersons: Robert Gellman, J.D., *Privacy and Information Policy Consultant, 431 5th Street, SE, Washington, DC 20003,* Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester, MA 01655*

EDUCATIONAL OBJECTIVES:

Participants should possess an understanding of how the proposed Clinton medical privacy regulations and the major congressional privacy proposals would impact on the delivery of effective medical and particularly psychiatric care.

SUMMARY:

The privacy workshop is designed to allow participants to understand the implications of the major medical privacy proposals before the Congress, as well as the Clinton Administration's privacy proposal. Aspects that will be considered are the proposals' impact on quality of care, the impact on psychiatrists' practice, as well as broader public policy questions. An important part of the program will be the role of the media and public opinion in shaping the debate and the opportunities psychiatrists have to influence the debate.

REFERENCES:

1. U.S. Supreme Court decision, *Jalfee v. Redmond,* 518 U.S. 1 1996
2. Clinton Administration Confidentiality of Medical Records Proposed Rule: Standards for Privacy of Individually Identifiable Health Information; Proposed Rule, Federal Register, November 3, 1999, page 59918

Component Workshop 35
MANDATORY OUTPATIENT TREATMENT: IS IT WORTHWHILE?
APA Council on Psychiatry and Law

Chairperson: Renee L. Binder, M.D., *Department of Psychiatry, Langley Porter Institute, 401 Parnassus Avenue, Box F, San Francisco, CA 94143*
Participants: Howard W. Telson, M.D., Marvin S. Swartz, M.D., Joan B. Gerbasi, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to the conclusion of the workshop, the participant should be able to understand clinical and legal issues related to mandatory outpatient treatment and why it may be helpful when used appropriately in combination with adequately funded intensive outpatient services.

SUMMARY:

There is legislation or proposed legislation concerning mandatory outpatient treatment (MOT) in many states. The use of MOT is controversial because of issues related to the balancing of civil liberties and protections for patients and society. First, Dr. Telson, who is the director of the Bellevue Outpatient Commitment Pilot Program, will review his experiences in New York and how this pilot program has helped and/or been problematic for patients and clinicians. Next, Dr. Swartz, who has evaluated the effects of outpatient commitment in North Carolina, will summarize the results of his outcome studies including the impact of commitment on recidivism and violence. Finally, we will present a resource document developed by the APA Council on Psychiatry and the Law with our recommendations concerning the application of MOT. There will be an opportunity for an active interchange between panel members and the audience about controversial issues.

REFERENCES:

1. Telson H, Glickstein R, Trujillo M: Report of the Bellevue Hospital Center Outpatient Commitment Pilot Program, 1999
2. Swartz MS, Swanson JW, et al.: Can involuntary outpatient commitment reduce, hospital recidivism? Findings from a randomized trial of severely mentally ill individuals. Am J Psychiatry, 1999, in press

Component Workshop 36
CERTIFICATION IN PSYCHIATRIC ADMINISTRATION
APA Council on Medical Education and Career Development

Co-Chairpersons: William H. Reid, M.D., *P.O. Box 4015, Horseshoe Bay, TX 78657,* Carmel A. Foley, M.D., *20 Tain Drive, Great Neck, NY 11021*
Participants: Gary E. Miller, M.D., W. Walter Menninger, M.D., Philip E. Veenhuis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be aware of the benefits of APA's certification in Administration and Management, general topics important to certification, and application requirements.

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.

Component Workshop 37
CAREER CHOICES IN PSYCHIATRY
APA Assembly Committee of Area Member-in-Training Representatives

Chairperson: Kimberly L. Valentine, M.D., *University of Pennsylvania, 3600 Market Street, 8th Floor, Philadelphia, PA 19104*
Participants: Patrice A. Harris, M.D., Anna Holmgren, M.D., Robert M. Weinrieb, M.D., Gregory J. Brown, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize (1) several pros and cons on a career in addictions, forensic, C&A, and consultation-liason psychiatry, (2) three questions to ask themselves when deciding about a specialty, (3) how choosing a fellowship in one of these areas could impact their career.

SUMMARY:

At the dawn of the twenty-first century, more specialty training programs will be available to psychiatry trainees than in previous years. Residents must ask themselves: Should I specialize? How do I decide? How would doing a specialty fellowship change the course of my career? This workshop will (1) help residents learn more about four specialty areas in psychiatry—forensics, child and adolescent, consultation and liason, and addictions; (2) help them formulate questions about deciding on a specialty; and (3) give them suggestions about what they can do now to help decide. After a brief introduction, several early career psychiatris 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. 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, Maryland, Williams and Wilkins, 1998

2. Dorwart R: A national study of psychiatrists' professional activities. Am J Psychiatry 1992; 49:1499–1505

Component Workshop 38
TEACHING PSYCHIATRY IN AN AMBULATORY SETTING
APA Committee on Medical Student Education

Co-Chairpersons: Michael J. Vergare, M.D., *Thomas Jefferson University, 833 Chestnut East, Suite 1001, Philadelphia, PA 19107-4414,* Carl B. Greiner, M.D., *985582 Webber Medical Center, Omaha, NE 68198-5582*
Participants: Steven P. Wengel, M.D., H. Jonathan Polan, M.D., Linda F. Pessar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) identify educational challenges in ambulatory settings, (2) describe administrative requirements to have a successful outpatient teaching model, (3) identify ethical models for involvement of volunteer faculty in ambulatory settings, and (4) identify ethical involvement of voluntary faculty in ambulatory teaching

SUMMARY:

The workshop will focus on the application of an ambulatory teaching model in psychiatry. Successful models exist in pediatrics, internal medicine and its subspecialties, and other primary care settings. However, even where successful models exist, there are substantial problems with additional faculty time, faculty funding, site equivalency, and more complicated administration. Educators are attempting to find an adequate successor to the Oslerian model of inpatient teaching. The workshop will provide practical steps for improving the design of ambulatory teaching.

The panel members all have extensive experience with medical student education. Dr. Vergare, workshop chair, has both a longstanding administrative perspective and is an educationally minded departmental chair. Dr. Greiner, co-chair, has been involved with faculty budgeting in education and ethical issues in teaching; his major focus will be on allocation of teaching resources. Dr. Wengel has developed an active teaching service at federal, state, and private ambulatory settings. He will describe a very successful Nebraska model for pediatric ambulatory care. Dr. Polan will describe psychiatry ambulatory services in a New York teaching hospital. Dr. Pessar has reviewed the current literature in ambulatory care in other fields. The participants will have the opportunity to have both a didactic overview and involvement in small group discussion.

REFERENCES:

1. Skeff KM, Bowen, JL, Irby DM: Protecting time for teaching in the ambulatory care setting. Acad Med 1997; 72(8):694–697
2. O'Sullivan PS, Weinberg E, Boll AG, Nelson TR: Students' educational activities during clerkship. Acad Med 1997; 72(4):308–13

Component Workshop 39
USING COMPUTERS TO GUIDE CLINICAL PRACTICE
APA Steering Committee on Practice Guidelines

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of NM School of Med, 2400 Tucker, NE, Albuquerque, NM 87131*
Participants: Kenneth Z. Altshuler, M.D., John S. McIntyre, M.D., Ian A. Cook, M.D., Amarendra Das, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe and discuss current and future developments regarding the use of computer-based systems for facilitating the use of practice guidelines and clinical decision making.

SUMMARY:

This workshop will present information on the use of computer-based technology to help physicians learn about and use practice guidelines in patient care. Panelists will discuss the use of computers in facilitating guideline use in other medical specialties and demonstrate a prototype of the computer-based, guideline-driven medical records and electronic intelligence being developed for the Texas Medication Algorithm Project (Comp-TMAP).

Panelists will also forecast future directions for personal digital assistants (PDAs), PCs, LANs, and web-based technologies. Attendees will be asked to share their positive and negative experiences with electronic, computer-based learning, and medical records systems, and help envision "user-friendly" formats for future guideline dissemination.

REFERENCES:

1. Owens DK: Use of medical informatics to implement and develop clinical practice guidelines. Western Journal of Medicine 1998; 168(3):166–75
2. Lobach DF, Hammond WE: Computerized decision support based on a clinical practice guideline improves compliance with care standards. American Journal of Medicine 1997; 102(1):89–98

Component Workshop 40
INNOVATIONS IN VETERANS AFFAIRS RESEARCH MIRECCS2
APA Consortium on Organized Service Systems

Co-Chairpersons: Laurent S. Lehmann, M.D., *Mental Hlth & Behav Scien, (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: Larry J. Siever, M.D., Greer Sullivan, M.D., Jerome A. Yesavage, M.D., Thomas B. Horvath, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants should be able to describe the goals and areas of study of VA's three newest Mental Illness Research Education and Clinical Centers ranging from neurobiological studies in schizophrenia to services delivery studies on pharmacotherapy in ethnically diverse populations.

SUMMARY:

This presentation describes the second group of VA's innovative Mental Illness Research Education and Clinical Centers (MIRECCs), each of which is dedicated to a range of scientific endeavors from basic science to services delivery research. Dr. Guggenheim and I will serve as co-chairs, introducing the presenters. Each presenter and the discussant, Dr. Tom Horvath, a guiding force in MIRECC development, will speak for 15 minutes, with time for questions after each presentation and a final question period. New York, New Jersey MIRECC Director Dr. Larry Siever will discuss service utilization by longterm patients placed in the community and pharmacologic cognitive augmentation strategies. Dr. Greer Sullivan, whose MIRECC spans four states including Arkansas and Mississippi, will describe studies optimizing pharmacotherapy in rural and ethnically diverse populations. Northern California MIRECC Director Dr. Jerome Yesavage will discuss pharmacological studies in dementia and neuroimaging in PTSD.

VA and non-VA psychiatric clinicians, researchers, and trainees.

REFERENCES:

1. Friedman JI, Temporini, H, Davis KL: Pharmacologic strategies for augmenting cognitive performance in schizophrenia. Journal of Biological Psychiatry 1999; 45:1–16
2. Glazer WM, Johnstone BM: Pharmacoeconomic evaluation of antipsychotic therapy for schizophrenia. J Clinical Psychiatry 1997; 58 (suppl) 50–54

Component Workshop 41
THE MEDIA AND DISASTERS AND OTHER TRAUMATIC EVENTS
APA Joint Commission on Public Affairs and APA Committee on Psychiatric Dimensions of Disasters

Co-Chairpersons: Michael Blumenfield, M.D., *Department of Psychiatry, New York Medical College, Room N314, Behavioral Health Center, Valhalla, NY 10595,* Robert J. Ursano, M.D., *3900 Cleveland Street, Kensington, MD 20895*
Participants: Barry Kaufman, Helen Chickering

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants will be able to better understand how media professionals can interact with the victims of disasters and also be traumatized themselves.

SUMMARY:

Print and electronic reporters are ubiquitous at mass causality events as well as any other newsworthy traumatic events. They interact with injured victims and their families and sometimes convey news such as death notification to next of kin. Through the power of the press, they may create mass hysteria and panic or may quell rumors and spread reassurance. The need of the press to get the story at almost any means may be in conflict with the best interest of acutely grieving persons. Reporters are frequently working at scenes of death and destruction, which are out of the usual human experience. They can be impacted similarly to other secondary victims such as fire, police, and EMTs. While such work may be found exhilarating to some reporters it may also lead to posttraumatic stress symptoms, depression, alcohol and drug problems, marriage breakups, and early career burnout.

The panel, which will consist of the chair of the APA Committee on Disasters, chair of the APA Joint Commission on Public Affairs, and two experienced NBC reporters. They will make presentations and then interact with the audience. This is a joint submission from the two above mentioned components in collaboration with the National Association of Medical Communicators.

REFERENCES:

1. Deppa J: The Media & Disasters. N.Y.U. University Press, 1994
2. Raphael B: When Disaster Strikes: How Individuals and Communites Cope with Disasters. Basic Books, 1986

Component Workshop 42
IS IT A CRIME TO BE HOMELESS? IDEAS FOR CHANGE
APA Committee on Poverty, Homelessness and Psychiatric Disorders

Chairperson: Hunter L. McQuistion, M.D., *Project Renewal Inc, 200 Varick St, New York, NY 10014-4810*
Participants: Paulette M. Gillig, M.D., Gene Pettit

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should gain recognition of the complex causes underlying the involvement of the mentally ill homeless with criminal justice. While fostering individual rights and responsive psychiatric care, the participant should also understand how to implement communication between mental health services add law enforcement.

SUMMARY:

Mentally ill homeless people have frequently experienced contact with law enforcement agencies. Their entry into the criminal justice system in disproportionate numbers has recently recieved wide publicity.

The underpinnings of criminalization are complex. Broad social forces have the victimization of an already severely marginalized group of citizens. As a result, law enforcement agencies have been moved into unfamiliar roles. Mental health have also been unprepared to deal with police.

After discussing social systemic causes of criminalization, this workshop will examine some creative solutions to diminish the involvement of mentally ill homeless persons in criminal justice. We will bring together a panel composed of law enforcement personnel, mental health providers, and mental health consumers to describe model programs and discuss solutions. We will particularly emphasize police training, mental health outreach, and educating mental health workers about law enforcement issues. The panel will ask our colleagues in the audience to participate by sharing experiences from the field and offering examples of collaboration with police and mental health agencies toward humanizing interactions with people who are mentally ill and homeless.

REFERENCES:

1. Gillig PM, Dumaine M, Stammer JW, et al: What do police officers really want from the mental health system? Hospital and Community Psychiatry 1990; 663–65
2. Barr H: Prisons and Jails: Hospitals of Last Resort. Correctional Association of New York and the Urban Justice Center, 1999

THURSDAY, MAY 18, 2000

Component Workshop 43
ANTIHOMOSEXUAL BIAS IN CLINICAL SETTINGS
APA New York County District Branch's Committee on Gay and Lesbian Issues

Co-Chairpersons: Kenneth B. Ashley, M.D., *NYU Medical Center, 85 East 10th Street, #1F, New York, NY 10003-5407,* John A. Gosling, M.D., *158 8th Avenue, Suite #2, New York, NY 10011*
Participants: David J. Pine, M.D., Julie K. Schulman, M.D., Steven T. Wozniak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize anti-homosexual bias in a variety of clinical settings and understand its negative therapeutic impact on the treatment of patients.

SUMMARY:

The issue of anti-homosexual bias in psychiatry will be presented and discussed from several perspectives. Each presenter will address a different aspect of anti-homosexual bias in the clinical setting: how it presents in the patient, the therapist, as it arises in the treatment of couples, and when it becomes an issue in training. After the presentations there will be ample time for the audience to comment on the material presented and discuss their experiences with anti-homosexual bias with the panel and other audience members.

REFERENCES:

1. Cabaj R, Stein TS (eds): The Textbook of Homosexuality and Mental Health. Washington, D.C., American Psychiatric Press, Inc. 1996
2. Drescher J: Psychoanalytic Therapy & the Gay Man, Hillsdale, NJ, The Analytic Press, 1998

Component Workshop 44
SPIRITUALITY AND RELIGION IN SUBSTANCE ABUSE TREATMENT
APA Committee on Treatment Services for Addicted Patients

Chairperson: Marianne T. Guschwan, M.D., *155 E. 31st Street, Suite 25-L, New York, NY 10016*
Participants: Victor Sierra, M.D., Susan Vex, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to: (1) recognize the importance of spirituality in patients' lives, (2) learn about the influence of spirituality in the development of 12-step programs, and (3) understand the impact of religion in substance abuse treatment.

SUMMARY:

The three presenters will discuss various aspects of spirituality and religion in substance abuse treatment. Marianne Guschwan, M.D., will present survey data focusing on attitudes toward spirituality and 12-step groups of patients in a therapeutic community. Victor Sierra will discuss Christian rehabilitation programs and what influence the religious aspect of these programs has on patients' beliefs and their treatment. Susan Vex, M.A., will discuss survey data regarding spirituality, Jews, and 12-step programs. The audience will be encouraged to ask questions and offer opinions throughout the workshop. Participants are encouraged to discuss their experiences with issues of spirituality and religion in substance abuse treatment.

REFERENCES:

1. Guschwan M, Galanter M, Dermatis H, Bunt G: Orientation Toward Spirituality Among Residents of a Therapeutic Community. Submitted for publication, 1999
2. Miller WR: Researching the spiritual dimensions of alcohol and other drug problems. Addiction 1998; 93(7):979–990

Component Workshop 45
UPDATE ON THE PRACTICE GUIDELINE ON BORDERLINE PERSONALITY DISORDER
APA Steering Committee on Practice Guidelines

Co-Chairpersons: John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, Rochester, NY 14608,* John M. Oldham, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York, NY 10032*
Participants: Deborah A. Zarin, M.D., Katharine A. Phillips, M.D., Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

The objective of this workshop is to provide an update concerning the overall progress of the APA practice guidelines effort and obtain feedback/answer questions on a wide variety of issues relating to the project in general and the development of the borderline personality disorder guideline.

SUMMARY:

The APA practice guidelines project has moved forward using an evidence-based process designed to result in documents that are both scientifically sound and clinically useful to practicing psychiatrists. The 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. Persons attending the session are invited to comment on the broad array of issues relating to practice guidelines including guideline content, overall development procedures, dissemination and evaluation strategies, future guideline topics, and implications for the field.

REFERENCES:

1. Zarin DA, Pincus HA, McIntyre JS: Editorial on practice guidelines. Am J Psychiatry 1993; 150:2
2. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Panic Disorder. Am J Psychiatry 1998; 155:5

Component Workshop 46
DOCUMENTING PSYCHOTHERAPY: PRINCIPLES AND DILEMMAS
APA Commission on Psychotherapy by Psychiatrists and APA Committee on Confidentiality

Chairperson: Norman A. Clemens, M.D., *Department of Psychiatry, Case Western Reserve University, 1611 South Green Road, Suite 301, Cleveland, OH 44121-4128*
Participants: Paul S. Appelbaum, M.D., Barry J. Landau, M.D., Sheila H. Gray, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to make knowledgeable decisions about documenting psychotherapy sessions so as to meet clinical responsibilities and administrative needs without sacrificing privacy and the special privilege of confidentiality.

SUMMARY:

The United States Supreme Court recognized an absolute privilege of communications in psychotherapy in its landmark decision in Jaffee v. Redmond (1996), noting that psychotherapy, which benefits individuals and society, could not occur without full confidentiality. At the same time there is growing pressure from insurance companies, Medicare, public health authorities, health care researchers, professional liability insurance risk managers, and law enforcement agencies for unprecedented access to medical records and/or detailed record-keeping on psychiatric services, including psychotherapy. These conflicting demands create a confusing and potentially dangerous situation for the psychotherapist. This workshop aims to explore the issues and provide practical assistance to participants in dealing with the dilemma.

Barry Landau, M.D., will discuss the ethical principles and operational importance of confidentiality in documentation. Paul Appelbaum, M.D., will present the medical-legal aspects of confidentiality and documentation. Norman Clemens, M.D., will present the APA's resource document on Documentation of Psychotherapy by Psychiatrists, with particular reference to documentation for Medicare. Sheila Hafter Gray, M.D., will discuss the presentations, adding highlights from the American Psychoanalytic Association's practice bulletin on Charting Psychoanalysis.

The audience will participate through the discussion of sample chart notes and the issues they raise.

REFERENCES:

1. Commission on Psychotherapy by Psychiatrists of the American Psychiatric Association: Documentation of Psychotherapy by Psychiatrists, Journal of Psychotherapy Practice and Research, in press, 1999
2. Appelbaum P, Gutheil T: Clinical Handbook of Psychiatry and the Law, 2nd Ed., Williams and Wilkins, 1991

Component Workshop 47
PRIVATE PRACTICE: CHANGE AND OPPORTUNITY
APA Committee on Private Practice

Chairperson: Michael C. Hughes, M.D., *University of Miami Medical School, Bayview Plaza, 3225 Aviation Ave #303, Miami, FL 33133- 4529*
Participants: Peter D. Kramer, M.D., Richard A. Shadoan, M.D., Daniel B. Borenstein, M.D., Theodore Hovaguimian, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should recognize major developments in our psychiatric capabilities and how they interact with changes in health care financing; demonstrate possibilities and limitations for current private practice of the psychotherapies, the pharmacotherapies, and the melding of treatment approaches; understand the basic ethical principles, clinical practices, and values that underlie private practice and the doctor-patient relationship.

SUMMARY:

Despite the maelstrom of change in medicine and psychiatry, the psychiatric private practitioner—51% of American psychiatrists—sees more patients than ever before, albeit for fewer visits, with burgeoning capabilities to diagnose and successfully treat a wide range of mental afflictions. Furthermore, most of us are happy and thriving in our work. This workshop surveys major scientific developments in our profession as well as trends in health care financing, but emphasizes constructive adaptations, opportunities, and the state-of-the-art for psychiatric private practice. Peter Kramer, M.D., former chair of the Committee on Private Practice and chronicler of our profession, presents an overview, emphasizing the interplay of psychotherapy and medication. Richard Shadoan, M.D., COPP member, explicates changes in his practice, seeing more and different kinds of patients, less often, with a wider range of treatment approaches, but with greater success. Daniel Borenstein, M.D., APA President-Elect, discusses change and stability for the various psychotherapies and the current status of psychodynamic psychotherapy. Theodore Hovaguimian, M.D., chair of the Section on Private Practice for the World Psychiatric Association, presents international approaches, emphasizing scientific, economic, social, and ethical values. Michael Hughes, M.D., chair of the COPP, introduces the program and moderates the interactive format with contributions from the COPP, audience and panel. The inextricable interweaving of the doctor-patient relationship with private practice is emphasized.

REFERENCES:

1. Kramer PD: Listening to Prozac. New York, Penguin Books, 1994
2. Borenstein DB: Does managed care permit appropriate use of psychotherapy? Psychiatric Services 1996; 47:971–974
3. Hughes MC: Private Practice and Managed Care: The American Experience, in Manage Or Perish: The Challenge of Managed Health Care in Europe. Edited by Guiman J. Sartorius N. New York, Plenum Publishing, in press

Component Workshop 48
PSYCHIATRIC SCOPE OF PRACTICE AND ITS IMPLICATIONS
APA Committee on Workforce Issues

Chairperson: Nyapati R. Rao, M.D., *Department of Psychiatry, Brookdale Hospital, One Brookdale Plaza, Brooklyn, NY 11212*
Participants: Larry R. Faulkner, M.D., Gloria Pitts, D.O., James H. Scully, Jr., M.D., Mary Kay Smith, M.D., Eva M. Szigethy, M.D., Allan Tasman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to understand the scope of the present day psychiatry practice and its implications for psychiatry workforce projection.

SUMMARY:

Our understanding of brain function and the etiology, diagnosis, and treatment of psychiatric illness has expanded rapidly in recent years. The advances in the field have occurred against the backdrop of deep inroads made by managed care in the practice of psychiatry, which in turn has engendered a debate in the field about the number of psychiatrists the nation needs. The managed care industry has estimated that four psychiatrists per 100,000 population is sufficient for delivery of mental health services as contrasted with 14 psychiatrists per 100,0000 population that currently exists. If there are too many psychiatrists, the profession will suffer from possible underemployment and unemployment. If there are too few psychiatrists, the public will suffer as a result of curtailed access. Hence, the profession has to advocate for an optimal number of psychiatrists based on objective assessments of demand, volume, and quality of clinical work. In that context, it is important to understand the scope of present-day psychiatric practice.

Accordingly, the APA Committee on Workforce Issues will conduct a survey of 3,000 randomly chosen psychiatrists, all residency training directors and chairs of departments of psychiatry regarding the scope of present-day practice. The survey instrument consists of 76 knowledge and skill items, and the respondents will be asked to rate on a four-point Likert scale how important they feel each item is in the repertoire of a general psychiatrist. The results of this survey will be presented at the workshop and the implications of its findings will be discussed by the members of the Workforce Committee.

REFERENCES:

1. Zarin, Pincus, Peterson, et al: Characterizing psychiatry with findings from the 1996 National Survey of Psychiatric Practice. Am J Psychiatry 1998; 155:397–404
2. Langsley DG, Yager J: Definition of a psychiatrist, Am J Psychiatry 1988; 145:468–473

Component Workshop 49
THE HEALING WAYS OF THE ANISHINAABE OJIBWE PEOPLE
APA Committee of American Indian, Alaska Native and Native Hawaiian Psychiatrists

Co-Chairpersons: Robert C. Palmer, M.D., *4501 Orcutt Road, San Luis Obispo, CA 93401*, Blackwolf Jones, M.S., *PO Box 28291, Green Bay, WI 54324*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should have new acquired skills from a culture that practices prevention by teaching its life principles. Participants' relationships with patients and each other will be enlivened and enriched by the traditional use of natural materials and practices.

SUMMARY:

The purpose of this workshop is to interactively teach Ojibwe healing traditions. Participants will learn to use the ancient healing methods of the Mishomis (grandfather stone), medicine wheel, medicine bundle, prayer stick, and fear bundle. The purpose of these methods is to help resolve fear, anger, shame, and pain. Questions will be answered after each healing method. The Ojibwe life principles of Mishkowsin (inner strength), Aindahing (inner heart), Bimadisiwin (full life), and Namaji (pride, honor, dignity, and respect) will be taught. These guiding principles foster healthy emotional and moral development by deflecting focus from "me" to "we." Many children are raised in an environment of violence and disrespect, Ojibwe teachings illustrate how what we do to each other we do to ourselves. Ultimately, psychiatrists will be encouraged to view themselves not only as physicians but as "elders" practicing and teaching more caring and respectful ways.

REFERENCES:

1. Jones B, Jones G.: Listen to the Drum. Salt Lake City, Utah, Commune-a-Key Publishing, 1995
2. Jones B, Jones G: Earth Dance Drum. Salt Lake City, Utah, Commune-a-Key Publishing, 1996

Component Workshop 50
DOCTORS AND INMATES: PSYCHIATRIC CHALLENGE AND OPPORTUNITY
APA Consortium on Special Delivery Settings

Co-Chairpersons: Charles A. Meyer, Jr., M.D., *Medical College of Georgia, 818 Aumond Place East, Augusta, GA 30909-32200,* Cassandra F. Newkirk, M.D., *519 Bloomfield Avenue, 4-S, Caldwell, NJ 07006*
Participants: Henry C. Weinstein, M.D., Edward A. Harrison

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) list positive and negative factors impacting on development of effective doctor-inmate treatment relationships in jails and prisons, and (2) identify and utilize national level medical accreditation standards and APA psychiatric service guidelines for jails and prisons to develop programs that promote doctor-inmate therapeutic working alliance in correctional facilities.

SUMMARY:

A panel of nationally recognized correctional health care clinicians and the president of the national organization that accredits medical programs in jails and prisons will present opening remarks focusing on major areas that impact on development of doctor-inmate treatment relationships and therapeutic alliances in correctional settings. Both positive and hampering factors will be identified. Areas covered will include women's issues, clinical concerns about dual diagnosis of mental illness and substance abuse, inmate PTSD secondary to abuse, STDs, and pregnancy and parenting. APA and National Commission on Correctional Health Care (NCCHC) guidelines and standards will be presented as a means of fostering effective doctor-inmate treatment alliances. The importance of good communications and mutual understanding and respect between psychiatric treatment staff and security and correctional personnel will be noted. The positive impact of effective treatment—security relationships on the doctor-inmate therapeutic alliance will be presented and discussed. Innovative ideas to be discussed include: (1) the value of organizing correctional psychiatrists for mutual support and benefit and (2) use of the Internet as a resource for information. Participants will be challenged to realize that correctional psychiatry is an opportunity—a unique combination of circumstances, time, and place for significant psychiatric action.

REFERENCES:

1. Standards on Health Services in Prisons, Chicago, IL, National Commission on Correctional Health Care, 1997
2. Psychiatric Services in Jails and Prisons, 2nd Edition, Washington, DC, American Psychiatric Press, 1999

Component Workshop 51
INNOVATIVE THERAPEUTICS IN CONSULTATION-LIAISON PSYCHIATRY
APA Committee on Consultation-Liaison Psychiatry and Primary Care Education

Co-Chairpersons: Francisco Fernandez, M.D., *Department of Psychiatry, Loyola University, 2160 S First Ave/Bldg. 54, #154, Maywood, IL 60153,* James L. Griffith, M.D., *Department of Psychiatry, George Wash University Medical Center, 2150 Pennsylvania Avenue, NW, Washington, DC 20037*
Participant: Edwin H. Cassem, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) describe some of the common problems encountered in psychiatric consultation to the medically and surgically ill; (2) outline the general principles of medical management in critically ill, agitated, and delirious patients with intravenous psychotropic agents; (3) manage severe depression in complex patients using psychomotor stimulants and intravenous psychotropic agents.

SUMMARY:

Finding effective therapeutic strategies for psychiatric complications in the medically ill is one of the most difficult endeavors for psychiatric consultants in medical and surgical settings. Unlike all other patient populations, these patients pose a unique set of problems. Diagnosing psychiatric disturbances in the medically ill is a challenge. Many medically and surgically ill patients present signs and symptoms that don't fit any specific category in DSM-IV. Standard pharmacotherapeutic strategies may be ineffective or yield limited results. Issues relating to route of administration of psychotropic agents in patients who have limited access or are unable to take oral medications make treatment decisions difficult. Creating a psychotherapeutic context for patients in various settings (intensive care units, and semi-private rooms) who have a myriad of problems from abuse to explosive metastatic disease is often intimidating. Brief presentations addressing these issues will be followed by interactive discussion of clinical vignettes from both the presenters and the audience.

REFERENCES:

1. Olson D, et al: The intravenous use of amitriptyline in depressed medically ill patients: two case reports and review of literature. Medicine and Psychiatry 1998; 80–85
2. Fernandez F, et al: Effects of methylphenidate in HIV-related depression: a comparative trial with desipramine. Int'l. J. Psychiatry in Medicine, 1995; 25(1):53–67
3. Cassem NH, Hurray GB: Delirious Patients, in Mass Gen Hosp Handbook of Gen Hosp Psychiatry, 4th Edition. Mosby, Bonstant. Edited by Cassem NH, Stern TA, et al., 1997

Component Workshop 52
FEARING AND WELCOMING THE NEW MILLENNIUM
APA Committee on History and Library

Chairperson: Richard J. Thurrell, M.D., *17 Beach Street, Madison, WI 53705-4405*
Participants: Marc Galanter, M.D., George T. Harding IV, M.D., James G. Donat, Ph.D., Ronald L. Numbers, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss historical and present day aspects of "millennial madness," be more sharply aware that extreme-seeming religious beliefs are not diagnostic of mental illness in the absence of established diagnostic criteria, and realize the potential impact, historical and current, of charismatic leaders on the mentally vulnerable.

SUMMARY:

Throughout history humans have wondered not only about the origins of the earth, but also about its possible end. Even while scientists accumulated relevant data, myths and religiously based accounts have flourished and continue to do so. Millennial turning points have invited not only positive images of bright new tomorrows, but also expectations of dramatic termination of the material world. Charismatic leaders have led groups of compliant believers to disappointing or even tragic end-points in anticipations of an apocalyptic millennial event. The millennialist believer and other followers of charismatic leaders have achieved a range of images in the public eye. In earlier decades of this century one form of millennialist was mocked as the wild-eyed street person, dressed in tatters, shouting, "repent, for the kingdom of heaven is at hand." Indeed, historical studies have shown that a fringe of troubled and sometimes severely mentally disturbed individuals has been attracted to extreme, charismatically led religious splinter groups that await a cataclysmic millenial event. The presenter panel and the workshop audience will discuss historical and modern millennial groups and their seeming affinity to mentally troubled persons.

REFERENCES:

1. Numbers RL: The Disappointed: Millerism and Millenarianism in the Nineteenth Century. Bloomington, Indiana University Press, 1987
2. Rush B: Medical Inquiries and Observations Upon the Diseases of the Mind. 1812

Component Workshop 53
TEACHER/LEARNER: BOUNDARIES IN MEDICAL EDUCATION
APA Rhode Island Psychiatric Society

Co-Chairperson: Patricia R. Recupero, M.D., *Department of Psychiatry, Brown University/Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906,* Alison M. Heru, M.D., *Department of Psychiatry, Brown University/Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*
Participant: Marilyn Price, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will be familiar with the problems of boundaries in teacher-learner relationships, the warning signs of boundary violations, and the legal consequences for boundary violations.

SUMMARY:

The issue of boundaries in doctor/patient relationships has been a focus in psychiatry for many years, and the issue has now become a recognized problem in most fields of medicine. Some research has suggested that trainees who have been involved in intense personal relationships with supervisors are more likely to become involved inappropriately with patients in professional life.

This workshop will focus on the issues of boundaries in the teacher/learner relationship in medical school and residency. The issues of boundaries will be discussed in both the clinical context and as an aspect of sexual harassment law. The results of a new study of medical school sexual harassment will be reviewed. The study examined the attitudes, responses, reporting practices, and expectations associated with perceived sexual harassment. The new Teacher/Learner Exploitation Index will be presented. The index explores such issues as self-revelation, personal favors and gifts, sexual fantasies, and sexual relationships between teacher and learner. The data collected from both studies and a teaching tape will be used to guide discussion on the limits of boundaries in professional education where mentorship issues often pose conflicts of boundaries.

REFERENCES:

1. Gutheil TG, Gabbard GO: Misuses of misunderstandings of boundary theory in clinical and regulatory settings. Am J Psychiatry 1998; 155:409–414
2. Epstein RS, Simon RI: The exploitation index: an early warning indicator of boundary violations in psychotherapy. Bulletin of the Menninger Clinic 1990; 54:450–465

MONDAY, MAY 15, 2000

Issue Workshop 1
CRIMINAL RESPONSIBILITY AND ALCOHOL INTOXICATION

Chairperson: Norman S. Miller, M.D., *Department of Psychiatry, Michigan State University, A227 East Fee Hall, East Lansing, MI 48824-1316*
Participant: Anthony R. Derrico, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the relationship between criminal responsibility and alcohol intoxication and the role of alcoholic blackouts and diminished capacity as a legal defense.

SUMMARY:

Legal responsibility in alcohol-related offenses poses a challenge for the clinician and legal system. The workshop will highlight the complexity of the connection between alcohol intoxication and responsibility for crime. The audience will participate in a discussion of a multidisciplinary approach with perspectives from psychiatry, medicine, law and criminology. Legal and clinical cases will be offered to illustrate major points.

Violent behaviors and alcohol-related behaviors are commonly associated in clinical and legal cases. The forensic psychiatrist is asked to assess and opine on the capacity or mens rea for a particular crime committed under the influence of alcohol or by someone with alcohol dependence. An affirmative defense such as "diminished capacity" may result in a lesser charge or a finding of not guilty. Research and legal decisions will be presented to illustrate various aspects of the law regarding diminished capacity defense.

The alcoholic blackout is a special case of the diminished capacity defense. It is defined as a temporary inability to form long-term memory as the result of a blood alcohol level. Recent clinical literature and legal cases regarding alcoholic blackout studies will be presented for audience discussion.

REFERENCES:

1. Paglia A, Room R: Alcohol and aggression: general population view about causation and responsibility, Journal of Substance Abuse 1998; 10:199–216.
2. Sweeney DF: Alcoholic blockouts: legal implications; Journal of Substance Abuse 1990; 7:155–159.

Issue Workshop 2

VOLUNTARY DISCLOSURE OF GENETIC FACTS

Chairperson: Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester, MA 01655*
Participants: Lauren S. Wakschlag, Ph.D., Yehoshua Eichenstein, Sander L. Gilman, Ph.D., Elliott S. Gershon, M.D.

EDUCATIONAL OBJECTIVES:

In this session, attendees will understand the ethics of personal disclosure and the dynamics of genetic self-concept. Awareness will be increased of the potential for family conflict and community stigma around inherited disorders of behavior and development. Attendees will also learn of methods for reducing this stigma in the community.

SUMMARY:

This workshop is focused on ethics and psychodynamics of voluntary disclosure between individuals, such as prospective spouses, and not on issues such as insurer or employer access to genetic information. The very-Orthodox Jewish community, with its combination of medical sophistication and its practice of arranged marriages, offers a preview of issues of disclosure that will become commonplace as the number and types of genetic tests proliferate. These issues include stigma, self-concept, and ethical responsibilities toward family members and prospective family members. Lauren Wakschlag, Ph.D., assistant professor of psychiatry at U. of Chicago (UC), is an Orthodox parent of two children with a recessive genetic development disorder. She will discuss the pain of children's disability and the pain of stigma and ostracism from the community. She will also present a model program in the Chicago Jewish community, Keshet, that integrates children with developmental disabilities and their families into the mainstream of Jewish life. Rabbi Yehoshua Eichenstein counsels families and is active in an independent Orthodox genetic program, Dor Yesharim, which tests for Tay-Sachs and other diseases. Its unique approach serves as a model for how marriage decisions can be informed by genetic tests while avoiding stigmatization of individuals. Prof. Sander Gilman of UC will discuss ethical considerations and family conflicts. Prof. Elliot Gershon of UC will review genetics of common mental disorders and present its clinical implications. The workshop chair, Prof. Paul Appelbaum of U. Mass., will introduce and lead a panel discussion with the audience.

REFERENCES:

1. The Council on Ethical and Judicial Affairs, American Medical Association: Multiplex genetic testing. Hastings Cent Rep 1998; Jul-Aug:15–21.
2. Burgess MM, Laberge CM, Knoppers BM: 14. Ethics and genetics in medicine. CMAJ 1998; 158:1309–1313.

Issue Workshop 3

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: A GUIDE PARTICULARLY FOR RESIDENTS TO UNDERSTAND THE REQUIREMENTS TO SIT FOR THE ABPN EXAMINATION

The American Board of Psychiatry and Neurology, Inc.

Chairperson: Stephen C. Scheiber, M.D., *Amer Brd of Psych & Neuro, 500 Lake Cook Road, Suite 335, Deerfield, IL 60015-5249*
Participants: Glenn C. Davis, M.D., Michael H. Ebert, M.D., Larry R. Faulkner, M.D., Pedro Ruiz, M.D., John E. Schowalter, M.D., James H. Scully, Jr., M.D., Elizabeth B. Weller, M.D., Daniel K. Winstead, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to assist resident, young career psychiatrist, and other members in learning the policies and procedures of the ABPN for certification, recertification, and subspecialization.

SUMMARY:

An overview of the policies and procedures of the American Board of Psychiatry and Neurology will be presented followed by a dialogue about the necessary conditions for admission to the certification examination, the examination process, and the current status of recertification and subspecialization. Material will focus on resident members and young career psychiatrists. Resident and young career psychiatrists will be encouraged to ask questions about certification, recertification, and subspecialization in addition to the specifics of the Part I and Part II written and oral examinations for certification. Participants will be urged to discuss child and adolescent psychiatry, addiction psychiatry, forensic psychiatry, geriatric psychiatry, clinical neurophysiology, and pain management.

REFERENCES:

1. Shore J, Scheiber SC: Certification, Recertification and Lifetime Learning. Washington, D.C., APPI Press, 1994.
2. American Board of Medical Specialties: Recertification for Medical Specialists, Evanston, IL, ABMS, 1987.

Issue Workshop 4

SUBJECTIVITY: CRUCIAL KEY TO THE THERAPEUTIC ALLIANCE

Co-Chairpersons: Alwyn Scott, Sc.D., *Mathematics, University of Arizona, 1503 East University, Tucson, AZ 85721,* Vincenzo R. Sanguineti, M.D., *1015 Chestnut St, Suite 825, Philadelphia, PA 19107-5567*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should 1) better understand the structure of the subjective experience and the sources of contributing data; 2) grasp the unique character of each individual mental state; 3) use such information to gain deeper understanding and empathy in relating to patients.

SUMMARY:

This highly interactive workshop will consist of three segments:

Segment #1 (approx. 30'): 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 (approx. 30'): The faculty will discuss the hierarchy of systems that participate in the emergence of mind out of brain

and the sources of data contributing to thought formation. Visual schemata will aid the audience in joining in such a search.

Segment #3 (approx. 30'): 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.

REFERENCES:

1. Scott AC: Stairway to the Mind: The Controversial New Science of Consciousness. New York, Springer-Verlag, 1995.
2. Sanguineti VS: Landscapes in My Mind: the Origins and Structures of the Subjective Experience. CT, I.U.P., 1999.

Issue Workshop 5
PERSONALITY DISORDER PROBLEMS IN THE WORKPLACE
Association for Research in Personality Disorders and International Society for Study of Personality Disorders

Chairperson: James H. Reich, M.D., *Department of Psychiatry, Harvard Medical School, 2255 North Point Street, #102, San Francisco, CA 94123*
Participants: Elsa F. Ronningstam, Ph.D., Cesare Maffei, M.D., Per Vaglum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participant will: 1) better able to identify some of the different ways that personality disorders can manifest themselves in the workplace, 2) understand the underlying psychopathology and natural course of these common presentations, and 3) have an improved knowledge of what interventions (if any) are possible.

SUMMARY:

Personality disorders have long been associated with low levels of occupational achievement and with antisocial or aggressive behaviors. In reality, many people with personality disorders will develop high levels of marketable skills, which allow them to enter the work marketplace, often in responsible or important positions. Unlike the stereotypes of these workers being antisocial and aggressive, different disorders may manifest themselves in different ways. Although antisocial traits and aggressive impulsive outbursts are one form of personality presentation, problems can also be caused by avoidant, dependent, and narcissistic traits or disorders as well. These disorders often go unrecognized as pathology by managers and coworkers until significant workplace difficulties develop. This can lead to suboptimal management of people with important work skills for an organization. This workshop will present background and vignettes of different types of workplace presentation of personality disorders. These will include avoidant/dependent, narcissistic, and borderline presentations as well as problems found in graduate student education. Ample time will be allowed for discussion of cases with the audience and to discuss issues or cases raised by the audience.

REFERENCES:

1. Reich J: Morbidity of dependent personality disorder. Journal of Nervous and Mental Disease 1996; 184:22–26.
2. Ronningstam E: Disorders of Narcissism—Diagnostic, Clinical and Empirical Implications. Washington, D.C., American Psychiatric Press, 1997.

Issue Workshop 6
BLAMING THE PATIENT: BLIND SPOT FOR DOCTOR AND PATIENT

Chairperson: David R. Coursin, M.D., *6-D Hills Ave, Concord, NH 03301*
Participant: Douglas B. Coursin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to 1) identify "blaming the patient" from a perspective that is, itself, less blaming, 2) identify basic concepts of contemporary evolutionary theory, 3) apply them to an understanding of social behaviors that generate stigmatization of mental illness, 4) critically examine a grass-roots plan addressing stigmatization in our communities.

SUMMARY:

"Blaming the patient" is a dynamic placing clinicians and patients at risk. We will examine its evolutionary origins, yielding insights into the maleficence it creates in all medical specialties and the stigmatization it generates toward the mentally ill.

The presentation of a patient's case of neuroborreliosis demonstrates this dynamic complicating the doctor-patient relationship. It compromises accurate self-assessment by the patient and puts blinders of suspicion on clinicians addressing her prominent symptoms without convincing findings.

Initial exercises engage group participation through the use of the Wason Card-Sorting Task to demonstrate adaptive problem-solving, the byproduct of which is the cognitive blind-spot where "blaming the Patient" hides. Later exercises will critique a plan to combat this face of stigma by organizing a nationwide coalition of psychiatrists, lawyers, legal aid agencies, law students, and psychiatric residents. The plan aims to identify and coordinate local psychiatric resources willing to provide live psychiatric testimony in cases of working people seeking compensation for mental illness. This is one of the places where stigmatization occurs right under our noses every day. Fair hearing in such cases is too often denied by "blaming the patient" and insuring availability of live psychiatric testimony is an untapped opportunity for our profession.

REFERENCES:

1. Fallon BA: Lyme disease: a neuropsychiatric illness, Am J Psychiatry 1994; 151:1571–1583.
2. Barkow JH, Cosmides L, Tooby J: The Adapted Mind: Evolutionary Psychology and the Generation of Culture. New York, Oxford University Press, 1992.

Issue Workshop 7
THE INTERFACE OF ESTROGEN AND NEUROTRANSMITTERS

Chairperson: Patricia L. Paddison, M.D., *CWH-C8, Virginia Mason Medical Center, PO Box 900, Seattle, WA 98111*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss the effects of estrogen on the neurotransmitters and apply this knowledge to help treat women successfully with appropriate psychopharmacological and/or hormonal interventions. Special attention to adolescence, the premenstrual period, pregnancy and postpartum, and the perimenopause will be paid.

SUMMARY:

Estrogen has been described as working as a serotonin agonist, a norepinephrine agonist, and an acetylcholine agonist. It also seems to down regulate dopa-2 receptors. A brief review of the literature and implications in the hormonal life cycle of women will be discussed. Specifically, the impact of estrogen on women at adolescence, premenstrually, in pregnancy and the postpartum, and the perimenopausal years will be discussed. The workshop invites discussion in this unique area to facilitate knowledge of and clinical experience with estrogen and the neurotransmitters and clinical implications.

REFERENCES:

1. Stahl S: Basic psychopharmacology of antidepressants, Part 2: estrogen as an adjunct to antidepressant treatment. J Clin Psyc 1998; 59:(4):15–24.
2. Seeman M: Psychopathology in women and men: focus on female hormones. Am J Psyc 1997; 154:12.

Issue Workshop 8
CHILD CUSTODY EVALUATIONS: DILEMMAS AND SOLUTIONS

Chairperson: Phyllis E. Amabile, M.D., *4200 W Peterson Ave Ste 103, Chicago, IL 60646*
Participants: Alan J. Ravitz, M.D., Alan Childs, Psy.D., Rachelle Hasson Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to recognize and effectively address several complex ethical, legal, diagnosis and reimbursement-related difficulties that can arise when conducting child custody evaluations.

SUMMARY:

Due in part to a dramatic increase in the divorce rate in recent years, the courts are more frequently relying upon our professional expertise in making difficult child custody and visitation determinations. Drs. Amabile, Ravitz, Miller, and Childs, who have each conducted hundreds of custody evaluations and have had extensive experience testifying as expert witnesses, will present the workshop. Each speaker will present a brief vignette based upon actual case experiences, illustrating a difficulty encountered and a solution attempted (not always with success). Questions to be discussed will include the following: 1) Can an expert maintain neutrality with the unique pressures that come to bear when retained by one party? 2) Can children comprehend the limits of confidentiality? Do parents retaliate against them once we publish their comments? Do they feel responsible for our decisions? 3) How can we ensure payment for our professional services when we have been called to testify as a "hostile witness"? This workshop will be highly interactive. The audience will be invited to comment and "problem solve" with the presenters and will be invited to present case material of their own.

REFERENCES:

1. AACAP Official Action: Practice Parameters for Child Custody Evaluation. J. Am. Acad. Child Adolesc. Psychiatry 1997; 36:10 Supplement, 57S–68S.
2. Schetky DH, Benedek EP: Clinical Handbook of Child Psychiatry & the Law. Baltimore, Williams & Wilkins, 1992.

Issue Workshop 9
A NONALGORITHMIC APPROACH TO INSOMNIA TREATMENT

Co-Chairpersons: Robert W. Bloom, M.D., *3633 W Lake Avenue #404, Glenview, IL 60025-5801,* Jane V. Dyonzak, Ph.D., *3633 West Lake Avenue, Suite 404, Glenview, IL 60025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the large variety of often overlapping factors involved in the development of insomnia; to analyze the dynamic of insomnia treatment within the context of the doctor-patient relationship; and to appreciate the integration of diverse treatment options for the patient.

SUMMARY:

In this era of outcome studies and cost containment, treatment algorithms are becoming more and more popular. In endeavoring to establish an algorithm for the evaluation and treatment of insomnia, the presenters, based on their 20 years of experience in this area, have concluded that algorithms regarding insomnia are of limited applicability. Algorithms will always be useful in ruling out the medical, neurologic, and psychiatric contributants, but an adequate understanding of the patient with severe insomnia must also include an appreciation of his or her lifestyle and emotional milieu. Algorithms for the diagnosis of insomnia are valuable, but the most successful treatment of insomnia must occur within the context of the unfolding evolution of the doctor-patient relationship.

For five years, the presenters have collaborated on the development of an algorithm for the evaluation and diagnosis of insomnia as well as a nonalgorithmic treatment approach. Their work will be introduced in slide and lecture format, focusing on the factors involved in the development of insomnia and a comprehensive approach to interviewing the patient with insomnia. The majority of this workshop, however, will be devoted to enhancement of treatment outcomes via integration of the doctor-patient relationship with treatment planning. Group participation will be encouraged through case examples provided by both the workshop presenters and the audience.

REFERENCES:

1. Kupfer DJ, Reynold CF: Management of insomnia. The New England Journal of Medicine, 1997; 336:341–346.
2. Lacks D, Morin CM: Recent advances in the assessment and treatment of insomnia. Journal of Consulting and Clinical Psychology, 1992; 60:586–594.

Issue Workshop 10
COMPLEMENTARY AND ALTERNATIVE MEDICINE

Chairperson: Daniel A. Monti, M.D., *Department of Psychiatry, Jefferson Medical College, 1020 Sansom St. Ste 1652 Thomp, Philadelphia, PA 19107*
Participants: Howard L. Field, M.D., Marie Stoner, M.Ed., Richard G. Petty, M.D., Bernardo A. Merizalde, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate a basic understanding of four systems of complementary and alternative medicine and how they are incorporated into general psychiatric practice.

SUMMARY:

Recent surveys of the U.S. population suggest that more than one out of three Americans use some form of alternative medical treatment. Such unconventional therapies are categorized under the rubric of complementary and alternative medicine (CAM). Some understanding of CAM practices is important for mental health care providers because 1) patients most often use CAM therapies for chronic psychiatric illnesses such as pain disorders, anxiety, and depression, 2) many of those patients do not tell their physicians of their use of CAM therapies, and 3) an increasing number of health care providers are incorporating aspects of CAM in their clinical services. The workshop will focus on four CAM health care systems, homeopathy, acupuncture, herbal medicine, and mind-body medicine. The panel will consist of three psychiatrists and one psychologist, each of whom has training and expertise in one of these CAM systems. There will be a brief overview on how each of the CAM modalities is integrated into a psychiatric practice, followed by two clinical cases that will be presented for discussion. This will allow the audience to observe how illness is approached from the perspective of each CAM paradigm. Participation and questions from the audience will be encouraged.

REFERENCES:

1. Eisenberg DM, Kessler RC, Foster C, et al: Unconventional medicine in the United States: prevalence, costs, and patterns of use. N Engl J Med, 1993; 328:246–252.
2. Elder N, Gillcrist A, Minz R: Use of alternative health care by family practice patients. Arch Fam Med, 1997; 6:181–184.

Issue Workshop 11
POEMS ON PSYCHIATRY

Chairperson: Charles R. Joy, M.D., *4406 Sunnydale Blvd, Erie, PA 16509-1651*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to appreciate the extent to which poetry can succinctly express insights related to the practice or psychiatry, recognize powerful emotional details related to identifications with poems on psychiatry, express personal experiences of practicing psychiatry in a highly refined fashion through the use of poetic technique.

SUMMARY:

The dynamic energies, interpersonal relationships, and 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. In this workshop participants will have the opportunity to appreciate such original poetry, discuss in detail their associations to the poems, and then begin to create their own poems in a highly structured writing exercise.

The chair of the workshop has extensive experience writing and reading original poetry inspired by the practice of psychiatry. Selections will include "Something Different", which won First Place at the APA Arts Association Exhibit in 1991 and "What If Lashkia", which appeared in The Pharos in 1999. Themes will include the price of empathy, the risks of intervention, the persistence of borderline psychopathology, the characteristics of assessment (including for wraparound services), the doctor-patient relationship, 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 CC: At The Preschool. Mediphora 1998; 11:60.

Issue Workshop 12
MOVEMENT, RHYTHM, AND AFFECTIVE STATES

Chairperson: Marion E. Wolf, M.D., *Department of Psychiatry, VA Medical Center, 3001 Green Bay Road, North Chicago, IL 60064*
Participants: Helen J. Conran, M.D., Susan Imus, M.A., Gina Demos, A.D.T.R., Gail A. Bradshaw, M.A., Yael Barkai, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the value of dance/movement therapy in the enhancement of traditional psychiatric treatments among the elderly with dementia, children with autism, patients with chronic intractable pain, and individuals with post-traumatic stress disorder.

SUMMARY:

The treatment of certain psychiatric populations can be enhanced by nonverbal complementary interventions such as dance/movement therapy (D/MT), which transcend the barriers for the expression of emotional content and cognitive deficits. In this workshop we shall discuss the value of D/MT in the humane and comprehensive treatment approach to children with autism, individuals with post-traumatic stress disorder, patients with chronic intractable pain, and the geriatric population. The beneficial impact of creative art therapies interventions in the geriatric sector is widely recognized and they constitute reimbursable services under Medicare (Medicare Manual, HCFA-Pub. 13-3). D/MT has been shown to be helpful in the management of elderly individuals, even those with advanced stages of dementia, offering them the opportunity for meaningful contact with others, a decrease in anxiety, and positive changes in mood. Children with autism also respond well to D/MT, and youngsters can learn to begin to communicate with their therapists and family members. D/MT also appears to be effective in the overall management of patients with chronic intractable pain as well as in individuals with chronic severe post-traumatic stress disorder. In both these populations, the complexities of their psychological defenses are often resistant to traditional verbal psychotherapy. In this workshop, we shall address the integration of nonverbal and verbal communications as well as the enhancement of conventional psychiatric treatments with complementary interventions such as dance/movement therapy. Participants will be encouraged to share their experiences with the group; the format of the workshop will include an integration of both didactic and experiential modalities. Be ready to move and be moved.

REFERENCES:

1. Ernst E, Randl JL, Stevenson C: Complementary therapies for depression an overview. Archives of General Psychiatry 1998; 55:1026–1032.
2. Embry CK: Psychotherapeutic interventions in chronic posttraumatic stress disorder. In Posttraumatic Stress Disorder: Etiology, Phenomenology, and Treatment. Wolf ME, Mosnaim AD, editors. American Psychiatric Press, Washington, DC, 1990, pp 226–236.

Issue Workshop 13
HOW TO DETECT DECEPTION

Chairperson: Alan R. Hirsch, M.D., *Smell & Taste Treatment Rsch, 845 N Michigan Ave, Ste 990W, Chicago, IL 60611-2201*
Participants: Carl M. Wahlstrom, Jr., M.D., David E. Hartman, Ph.D., Peter M. Fink, M.D., Charles J. Wolf, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able 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 through 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. Clinical Assessment of Melingering and Deception. Edited by Rogers R. New York, Guilford, 1988.
2. Resnick PJ: Detection of malingered mental illness. Behavioral Sciences and the Law, 1984; 2:21–38.

Issue Workshop 14
TEACHING BEHAVIORAL SCIENCES TO FAMILY DOCTORS

Chairperson: Jonathan S. Davine, M.D., *2757 King Street East, Hamilton, ON L8G 5E4, Canada*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to describe a longitudinal method of teaching behavioral sciences to family medicine residents; to describe 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 duration of the two-year residency. During this time, a psychiatric consultant is present on site in the family medicine unit. The training is problem based, usually within small groups, and utilizes examples from cases residents are seeing in their practice.

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

There will be question-and-answer periods with the audience after the presentation of each of these two models. Participants will be encouraged to share their experiences in this educational area.

REFERENCES:

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

Issue Workshop 15
A PRIMER ON THE NEW RRC ESSENTIALS FOR PSYCHIATRY

Co-Chairpersons: Daniel K. Winstead, M.D., *Dept of Psych & Neurology, Tulane University Medical Ctr, 1430 Tulane Ave # SL23, New Orleans, LA 70112-2699,* Carol A. Bernstein, M.D., *Department of Psychiatry, NY University Medical Center, 550 First Avenue, NB 20N11, New York, NY 10016*
Participants: Eva M. Szigethy, M.D., David G. Bienenfeld, M.D., Larry D. Sulton, Ph.D., Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the new RRC requirements and the key elements necessary for accreditation.

SUMMARY:

The ACGME has recently approved revisions to the Program Requirements for Residency Education in Psychiatry. This workshop will provide residents, training directors, and academic faculty with an opportunity to review and clarify these new guidelines. Dr. Winstead will briefly present the major changes to the document. Dr. Bernstein will then focus on those issues of most concern to training directors. Dr. Szigethy will comment from a resident's perspective. Dr. Ruiz will address issues related to cultural diversity and the need for cultural competency. Dr. Sulton (executive director, RRC-Psychiatry) will be available for guidance and technical interpretations. A model system for assessing and recording competencies will be presented by Dr. Bienenfeld. The floor will then be open for questions and comments. Half of the allotted time will be used for discussion.

REFERENCES:

1. Program Requirements for Residency Education in Psychiatry, ACGME, 1999.
2. American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, Washington DC, APA, 1989.

Issue Workshop 16
IMPLEMENTING THE RECOVERY PARADIGM AND BEST PRACTICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Chairperson: Dale P. Svendsen, M.D., *Medical Director, Ohio Department of Mntl Hlth, 30 East Broad Street, 8th Flr, Columbus, OH 43215*
Participants: Wilma Townsend, Lawrence P. Ackerman, B.A., Peter F. Buckley, M.D., Rodrigo A. Munoz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to appreciate the potential of the recovery paradigm, particularly (as exemplified by "Awakenings") the synergy with best practices pharmacotherapy; understand APA's commitment to these approaches; and be equipped with the essentials to implement a recovery approach.

SUMMARY:

The burgeoning interest in the psychopharmacology of schizophrenia may overshadow other powerful and potentially complementary approaches to patient care. The recovery paradigm, which espouses

client-centered (and directed) care along a multiaxial and graded rehabilitation framework, is a model gaining momentum in public mental health systems. In collaboration with the psychosocial rehabilitation program at Boston University, Ohio has endorsed and inculcated this recovery approach into its public services and is examining the potential synergy between the recovery paradigm and best practices pharmacotherapy. Such developments reflect a broader commitment by the American Psychiatric Association as exemplified by Dr. Munoz's clinical initiatives. This interactive workshop, drawing on the experience of the presenters (a consumer, clinician, and administrator), will delineate the specific practices and principles of the recovery model and its implementation within a system of care. This workshop will emphasize active questioning, discussion, and exchange of ideas between the presenters and audience. Didactic lecturing will be minimized by the use of handouts and audiovisuals.

REFERENCES:

1. Anthony WA: Recovery from mental illness: the guiding vision of the mental health system in the 1990s. Psychosoc Rehab J 1993; 16:11–23.
2. Frese FJ: Advocacy, recovery, and the challenges of consumerism for schizophrenia. Psych Clin N America 1998; 21:233–249.

Issue Workshop 17
THE WORLD WIDE WEB: SAFETY NET OR TRAP?

Co-Chairpersons: Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medial School, 96 Larchwood Drive, Cambridge, MA 02138-4639,* Robert C. Hsiung, M.D., *Department of Psychiatry, University of Chicago, 5737 South University Avenue, Chicago, IL 60637*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to provide guidance to patients who turn to the Internet for information and to demonstrate how to design a Web site to increase educational benefits and to decrease clinical, ethical, and legal risks.

SUMMARY:

The more managed care and other forces limit access to traditional mental health information and services, the more patients will turn to the Internet for them. At the same time, however, myriad Web sites promulgate misinformation and promote quack remedies. This workshop focuses on how, faced with this dilemma, Web sites can be effectively incorporated into the clinical process. One aspect of this is working with patients who go online to try to educate themselves. They can be advised to approach Web sites with a healthy skepticism and some common sense. They can be counseled to ask basic but important questions: Who is providing the information? On what is it based? Is it biased? Is it current? Psychiatrists can also develop Web sites themselves. If the structure and content of their sites are well thought out, they can increase the benefit and decrease the risk to patients. The Web sites of the presenters illustrate how they provide not only information and services, but also descriptions of what is and is not provided and appropriate disclosures and disclaimers. Workshop participants are encouraged to volunteer their own sites for analysis and discussion as well.

REFERENCES:

1. Silberg WM, Lundberg GD, Musacchio RA: Assessing, controlling, and assuring the quality of medical information on the Internet: caveat lector et viewor—let the reader and viewer beware. JAMA 1997; 277:1244–5.
2. Wyatt JC: Commentary: measuring quality and impact of the World Wide Web. BMJ 1997; 314:1879–81.

Issue Workshop 18
EXECUTIVE SKILLS: ASSESSMENT, COACHING, AND THEORY
Association of Organizational and Occupational Psychiatry

Chairperson: Howard E. Book, M.D., *2900 Yonge Street, Suite 101, Toronto, ON M4N 3N8, Canada*
Participants: Jeffrey P. Kahn, M.D., Stewart Gabel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to list the factors that enhance a candidate's "fit" for a specific role as a executive in an organization; list ways in which the consultant, as a "coach," might facilitate the executive's achieving enhanced leadership skills; and become familiar with the theoretical underpinnings of a developmental process of executive (leadership) functioning.

SUMMARY:

This highly interactive workshop begins with a brief presentation (Dr. Kahn) that focuses on a candidate applying for a specific executive position within an organization and offers a developmental assessment of that candidate. The presenter next facilitates a discussion centering on factors that emerge from his presentation that enhance or inhibit a "fit" between the candidate and the executive role for which he/she is applying.

The second brief presentation (Dr. Book) focuses on how the consultant, as "coach," might aid the executive's enhancing his/her leadership/managerial skills, as well as involving participants in a discussion on differences between coaching and therapy, how one deals with unconscious material as a coach, and other themes that may emerge.

The final presentation (Dr. Gabel) offers an overview of the developmental process inherent in becoming an executive and encourages a discussion of principles that illuminate phases in the development of executive skills.

Dr. Book will then facilitate a 15-minute summary of themes and issues that emerged from this workshop.

REFERENCES:

1. Kernberg O: Ideology, conflict and leadership in groups and organizations, New Haven, Yale University Press, 1998.
2. Kilburg RR: Toward a conceptual understanding and definition of executive coaching. Consulting Psychology Journal: Practice and Research 1996; 48:134–144.

Issue Workshop 19
SWORDS INTO PLOUGHSHARES: THE IMPORTANCE OF DIALOG

Chairperson: Sasha L. Ferguson, *11 Prospect Street, Maynard, MA 01754*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to make greater use of dialog within the therapeutic relationship as a means of mitigating the harmful consequences of power imbalance.

SUMMARY:

This workshop explores the question of trust—examining actions that facilitate its growth, and actions that in contrast, act to erode the bedrock upon which therapeutic efficacy is based. We will discuss three scenarios taken from clinical reports. We will examine the

question of what the therapist or other psychiatric caregivers might have done otherwise in each situation, and we will examine the ways in which the behavior of caregivers may itself have acted to bring about distrust or lead to the escalation of hostilities on the part of the patient. Alternatives will be presented, and we will steer clear of the temptation to "blame the patient." While it is true that a compromised state of mind can render the task extremely problematic; nevertheless, giving in to this way of looking at things leaves one at a loss as to how to improve the situation—for it is really only the therapist's own behavior that the therapist can control. The workshop presenter and facilitator, "Sasha," is one of Dr. Kenneth Minkoff's "most challenging" patients—in all of the best senses of the word. Their work together is something that both are proud of, especially for its extensive use of dialog, in the technical sense of confrontation and negotiation.

REFERENCES:

1. Miller JB, Stiver IP: The Healing Connection: How Women Form Relationships in Therapy and in Life. Boston, MA, Beacon Press, 1997.
2. Levi BH: Respecting Patient Autonomy. Urbana, IL, University of Illinois Press, 1999.

Issue Workshop 20
OSKAR PFISTER'S IMPACT ON PSYCHIATRY AFTER 2000

Chairperson: Hansjuergen W. Kienast, M.D., *3207 North Knoxville Avenue, Peoria, IL 61604*
Participants: Reverend Clark S. Aist, Ph.D., David A. Powell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the lasting influence of this universal man on our potential as healers and to carry its power into the next century for practical use.

SUMMARY:

Although the Oskar Pfister Award Lecture has been given at APA annual meetings since 1984, few members know just who Pfister was and why his name should be thus perpetuated. Some know of the Freud-Pfister published discussions or may recall that he was a Swiss pastor and lay analyst, but are unaware of his trail-blazing influence on psychotherapy and pedagogy. Few have any concept of his vital role as a caring, healing counsellor who was also a notable philosopher, prolific author, talented pianist, hardy mountaineer, and warm-hearted friend to Freud, Albert Schweitzer, or even to me as his student. I propose to present the whole man, who lived from 1873–1956. Today I am the only APA member who knew him, walked and talked with him, and learned the depth and breadth of his endeavors, which extended even to the religious life of the Navajo Indians. At the three-day symposium in Zurich for his centennial in 1973 I gave the concluding lecture. His widow later entrusted to me the treasure of his memoirs, letters, books, and articles. In the millennial year, I wish to clarify just who Oskar Pfister was and what his continuing legacy is for all of us.

REFERENCES:

1. Meng H, Freud E: The Letters of Sigmund Freud and Oskar Pfister. New York, Basic Books, 1963.
2. Die Bedeutung der Tiefenseelsorge Oskar Pfisters. Wege zum Menschen 1973; 25:479–493.

Issue Workshop 21
MEDICAL STUDENT EDUCATION: CHALLENGE OR DILEMMA?

Co-Chairpersons: David A. Baron, D.O., *Temple University, 3401 North Broad Street, Jones Hall 8th Floor. Philadelphia, PA 19437,* Ellen Sholevar, M.D., *3401 North Broad Street, Philadelphia, PA 19140*
Participants: Thomas Hardie, Ed.D., Paul Jay Fink, M.D., Howard B. Moss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to assess the challenges facing the delivery of psychiatry/behavioral science education and identify the role of psychiatry/behavioral health in attracting students to psychiatric residencies.

SUMMARY:

Behavioral health/psychiatry courses have been poorly rated by medical students. This contributes to problems in recruitment of psychiatric residency. Further, poor acceptance of the knowledge in these courses has broad impact for medical practice in general. Medical patients often fail to have their psychopathology detected, treated, or referred. This workshop will draw on an expert panel of educators and the experiences of the learners to identify potential solutions to the challenge of educating medical students and integrating humanism in this unique area.

Another important issue is recruitment of psychiatric residents. The workshop will explore the experiences of the panel and participants to improve recruitment of medical students. The format of the workshop is interactive with most of the time spent in facilitated problem solving and discussion groups. Improvement of behavioral health/psychiatry courses should result in improved recruitment of quality students to residencies. Other expected benefits are the acceptance and application of psychiatric principles by nonpsychiatrists improving patient care and appropriate referrals.

The results of the work will be reported on a Web site to share the knowledge generated with participants and others.

REFERENCES:

1. Walton H, Gelder M. Core curriculum in psychiatry for medical students. Med. Education 1999; 33:204–211.
2. Nierenberg DW: The challenge of "teaching" large groups of learners: strategies to increase active participation and learning. Int J Psychiatry Med 1998; 28:115–22.

TUESDAY, MAY 16, 2000

Issue Workshop 22
CAREER STRATEGIES Y2K: STAY GENERATIVE AND STIMULATED

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of NM, School of Medicine, 2400 Tucker, NE, Albuquerque, NM 87131*
Participants: Jerald Kay, M.D., Carol C. Nadelson, M.D., Carolyn B. Robinowitz, M.D., Zebulon C. Taintor, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to describe strategies used by psychiatrists to maintain generative and stimulating careers by 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 pummeled by changes that challenge the nature of traditional physician-patient relationships, reduce physician autonomy and resources, and increase administrative burdens. These changes are increasing physician distress in many fields of medicine, including psychiatry, and contribute to a crescendo of complaints about professional burnout. The panelists have successfully negotiated midcareer 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, they have mentored and supervised 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 utilized by the presenters and their professional acquaintances and focus on careers in private practice, public sector, and academic settings as well as particular issues related to women's careers and thinking about retirement and cutting back. Participants will be engaged in further discussion and exploration of these issues.

REFERENCES:

1. Career Pathways in Psychiatry: Transition in Changing Times. edited by Lazarus A. 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 23
PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chairperson: Steven E. Pflanz, M.D., *FE Warren AFB, USAF, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to examine contemporary films with mental health content and understand how the images portrayed in these films influence the public perception of psychiatry and mental illness.

SUMMARY:

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Perhaps unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments, and the profession of psychiatry. In particular, the far-reaching appeal of films with success at the box office gives them a unique opportunity to shape the attitudes of Americans. Often, psychiatrists and mental health professionals pay more attention to films that achieve critical acclaim for their artistic merits. The value of these films is undeniable. However, to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the facilitator will discuss briefly the portrayal of psychiatry in contemporary films during the 1990s, focusing on "The Prince of Tides," "Basic Instinct," "As Good as It Gets," "Good Will Hunting," and "Analyze This." Each of these films achieved both critical acclaim and box office success and was viewed by many Americans. To generate discussion, short film clips from these movies will be shown. 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 24
STRATEGIES TO BETTER IMPLEMENT THE WORLD PSYCHIATRIC ASSOCIATION EDUCATIONAL PROGRAMS
The World Psychiatric Association

Chairperson: Roger M. Montenegro, M.D., *World Psychiatric Association, Juncal 2425 8B, Buenos Aires 1425, Argentina Participants:* Pedro Ruiz, M.D., Sam Tyano, M.D., Srinivasa Murthy, M.D., Constantin Soldatos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand how to use the WPA educational programs to train psychiatrists and other physicians, as well as mental health workers and the community. The participants will discuss strategies to make the implementation of such programs practice based, modular, flexible, and locally adapted.

SUMMARY:

This workshop will deal with the implementation of the World Psychiatric Association (WPA) educational programs all over the world. Through its 112 WPA member societies, 18 zone representatives, and 250 members of the WPA Educational Liaisons Network, the WPA expects to offer educational opportunities to as many colleagues as possible, in all five continents.

The WPA invites its member societies and other institutions to organize educational activities in which the WPA educational programs are used. These programs have been developed by teams of experts, and they deal with subjects of interest for mental health care workers. To widen its offering, the WPA is constantly developing new programs.

The implementation of the programs involves the use of the educational materials, making the necessary cultural and local adaptations; the evaluation made by the participants of the activities; and feedback information provided by the organizers of the activities, which enable the WPA to improve its educational output.

The WPA educational programs will be briefly described, and then the audience will discuss how to improve the implementation of such programs, taking into account that such implementation should be modular, flexible, and practice based.

REFERENCES:

1. Reports of the WPA Secretary for Education to the WPA General Assembly, Hamburg, Germany, August 1999.

Issue Workshop 25
DEVELOPING A STATEWIDE PSYCHIATRIC DISASTER PLAN

Chairperson: Sheila G. Jowsey, M.D., *Dept. of Psychiatry, Mayo Clinic, 200 1st St SW, Rochester, MN 55905-0001 Participants:* David R. Johnson, M.D., Alan Q. Radke, M.D., Steve M. Kubas, M.D., Suzanne T. Witterholt, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to better understand the psychiatrists' role in disaster mental health provision, to recognize important steps to be undertaken in forming a statewide psychiatric disaster plan, and 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 forged 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 community resources. Topics presented include an overview of the psychiatrists' role in a disaster scenario, steps taken to form the committee and tasks to be completed, developing relationships with local Red Cross personnel and obtaining required certification, and steps toward generating interest in and educating psychiatrists about disaster preparedness. Information will be provided regarding relevant psychiatric literature, newsletter submissions, providing CME educational offerings, and obtaining educational videotapes distributed through APA Division of Public Affairs. 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. Shaley 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. Cambridge University Press, London, 1994.
2. Posttraumatic Stress Disorder: Acute and Long-term Responses to Trauma and Disaster. edited by Follerton C, Ursano RJ. Washington, DC, American Psychiatric Press, 1997.

Issue Workshop 26
USING TREATMENT OUTCOMES IN RESIDENCY TRAINING

Co-Chairpersons: Winston Brown, M.D., *Centers for Mental Health Care Research, 5800 W 10th, Suite 605, Little Rock, AR 72204,* James A. Clardy, M.D., *23 Masters Place, Maumelle, AR 72113*
Participant: R. Greg Wooten, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the basic components of an outcomes management system (OMS) and the use of OMS data for clinical quality improvement. Participants will understand the use of an OMS in a resident clinic and the value of system data for resident education in both disease management and service delivery.

SUMMARY:

In 1997, the University of Arkansas for Medical Sciences' department of psychiatry implemented a treatment outcomes assessment system in its two major outpatient training sites. Monitoring outcomes for the treatment of major depression, the system has enrolled nearly 500 cases, the majority treated by psychiatry residents.

Although intended as a clinical, quality-improvement tool, the outcomes management system (OMS) data provoked lively debate among residents, faculty, clinic medical directors, and health-services researchers. To discuss the OMS results, residents must consider not only basic diagnostics and pharmacology but also components of care, patient compliance, and patient definitions of recovery.

Recognizing the educational potential for training adaptable residents and the ACGME proposed program requirements revisions, the OMS has been made a formal part of the residency training program for Fall 1999. Residents will analyze two years of OMS data for their clinics and based on their analysis, implement improvements in their treatment of major depression to be tracked for effectiveness over the following year.

The workshop will present this educational use of treatment outcomes data and the added value for trainees practicing contemporary medicine. The OMS aggregate data reports from the resident clinics will be distributed to workshop participants for a hands-on learning experience. Discussions will be encouraged with emphasis on implementation of such systems and their integration into residency training programs.

REFERENCES:

1. Bowen JL: Adapting residency training: training adaptable residents. Western Journal of Medicine 1998; 168:371–7
2. Hillard RI, Tallett SE: The use of an objective structured clinical examination with postgraduate residents in pediatrics. Arch Pediatr Adolesc Med 1998; 152:715.

Issue Workshop 27
SPLIT TREATMENT: CLINICAL, LEGAL, AND ETHICAL ISSUES

Co-Chairpersons: Robert I. Simon, M.D., *7921 Glenbrook Road # D, Bethesda, MD 20814-2441,* Donald J. Meyer, M.D., *124 Mount Auburn St Suite 440, Cambridge, MA 02138*
Participants: Steven Behnke, Ph.D., James Ellison, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will become familiar with 1) the clinical, legal and ethical responsibilities in split treatment that psychiatrist and psychotherapist have for their patient and to each other, 2) the special concerns that apply to split treatment within managed care, and 3) the special concerns that apply to split treatment in training settings.

SUMMARY:

Split treatment is a clinical term in general psychiatry that customarily refers to a psychiatrist's prescribing of psychoactive medication while the remainder of the therapy is conducted by another, usually nonphysician, psychotherapist. Neither the nature of mental illness nor the stages of its treatment are easily separated into medical and nonmedical components. As a result, clarity of certain roles and responsibilities for each mental health clinician in split treatment must be created de novo between the clinicians involved, based on their training and experience, on the nature of the patient, and on the setting of the treatment. Workshop presenters will discuss clinical, legal, and ethical responsibilities in doing split treatment. Workshop presenters will then use clinical examples to illustrate how both clinicians can collaborate to clarify: 1) the duties each clinician has to the patient; 2) the relative autonomy of each clinician; and 3) the dependence or interdependence of the two clinicians. Workshop participants will be encouraged to present clinical vignettes that in turn will be used to foster a discussion highlighting differences of doing split treatment within managed care, in private practice, and with trainee clinicians.

REFERENCES:

1. Meyer DJ, Simon SI: Split treatment: clarity between psychiatrists and psychotherapists. Part I. Psychiatric Annals 1999; 29:241–245 Part II. Psychiatric Annals 1999; 29:327–332

2. Sederer LI, Ellison J, Keyes C: Guidelines for prescribing psychiatrists in consultative, collaborative and supervisory relationships. Psychiatric Services 1998; 49:1197–1202

Issue Workshop 28
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:

At the conclusion of this workshop, the participant should be able (1) to identify the need to diagnose couples involved in an abusive relationship, (2) identify a model that will differentiate an abusive fight from a fair fight, (3) identify control tactics used by an abuser to maintain power and control over a victim, (4) be able to counsel an abused woman on the need to seek therapeutic and legal help to break the cycle of abuse, (5) 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 the 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 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 Schechter S: When Love Goes Wrong. New York, Harper Perennial, 1992.

Issue Workshop 29
PSYCHIATRIC IMPLICATIONS OF WEAPONS OF MASS DESTRUCTION

Chairperson: Dickson Diamond, M.D., *FBI, 935 Pennsylvania Ave. NW, Room 10190, Washington, DC 20535*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to have an increased awareness from a psychiatric perspective of how to recognize, diagnose, triage, and treat casualties of weapons of mass destruction (WMD); understand the psychiatrist's role as consultant within the medical, mental health, and law enforcement community, from providing accurate medical information to hands-on crisis and consequence management.

SUMMARY:

The threat of a terrorist using biological, chemical, or radiological agents within the U.S. is of growing concern. Not only will psychiatrists be called upon to provide care to the victims, but will act in the capacity of expert consultants to the medical, mental health, and law enforcement agencies within their communities. It is expected that the greatest number of casualties will be psychogenic in nature. This was evidenced by the sarin release in Tokyo, in which only one-fifth of the 5,000 victims who presented to area hospitals were actually exposed to the chemical. Psychiatrists will play an important role in responding to an attack involving weapons of mass destruction (WMD), assisting in minimizing mass panic, and managing psychogenic cases. This workshop creates an interactive forum whereby the role of the psychiatrist can be further clarified. Information presented in this workshop has been generated from the National Domestic Preparedness Office (NDPO), an interdisciplinary federal agency created by the U.S. Department of Justice, to enhance preparedness for a domestic attack using WMD. The audience will be the victims of a simulated biological attack to illustrate the psychiatric implications that would ensue in an actual event.

REFERENCES:

1. Holloway H, et al.: The threat of biological weapons: prophylaxis and mitigation of psychological and social consequences. JAMA 1997; 278:425–427.
2. Grabenstein JD, et al.: The pharmacist's response to biological or chemical terrorism: developing a preparedness plan. Hospital Pharmacy 1998; 33:1423–1431.

Issue Workshop 30
TELEPSYCHIATRY SERVICES: FROM DESIGN TO GLOBAL IMPLICATIONS
Psychiatric Society of Informatics

Co-Chairpersons: Harry Karlinsky, M.D., University of British Columbia, *7511 Manning Court, Richmond, BC V7A 4J3, Canada,* Douglas A. Urness, M.D., *Box 1000, Ponoka, Alberta T4J IR8, Canada*
Participants: Norman E. Alessi, M.D., Rhonda G. Vought, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the key steps to implementing and managing a suitable telepsychiatry program at their setting, and recognize the global implications of telepsychiatry.

SUMMARY:

The most recent survey conducted by the Association of American Telemedicine Service Providers identified 44 telepsychiatry programs in North America. With sites receiving services located primarily in underserviced and rural communities, common goals across programs tend to include increasing access to psychiatric services, improving quality of care, containing the costs of service delivery, and provide distance education. As costs of the relevant technology decline, an increasing number of telepsychiatry programs will undoubtedly be established. Utilizing the experience of five existing telepsychiatry programs across North America, this workshop will identify all steps related to developing and managing a sustainable telepsychiatry program, ranging from the initial clinical needs assessment through service and technical design to implementation, evaluation, and ongoing program management. Further, with the advances occurring in the development of TCP/IP based networks, it is inevitable that psychiatry and other forms of medicine will become global. The cultural implications, language barriers, and reimbursement mechanisms for these ubiquitous global services will be discussed. Throughout the workshop, audience participation will be encouraged, with substantial opportunity for questions and comments. Participants from non-North American settings will be particularly encour-

aged to comment upon the potential international impact of exported telepsychiatry services.

REFERENCES:

1. Daer L, Elford R, Cukor P: Telepsychiatry at forty: what have we learned. Harvard Rev. Psychiatry 1997; 5:7–17.
2. Stevens A, Dodge N, Goldbloom D, et al: Pilot study of televideo psychiatric assessment in an underserviced community. Am J Psychiatry 1999; 156:783–785.

Issue Workshop 31
DOCTOR-PATIENT RELATIONSHIP IN CHEKHOV'S WRITING

Chairperson: Lesley R. Dickson, M.D., *New York University, 305 East 24th St, Apt. 10W, New York, NY 10010*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the influence of medicine on Chekhov's writing, appreciate the physician's role in 19th century Russia, and to recognize the value of Chekhov's short stories in teaching medical students and residents.

SUMMARY:

Anton Chekhov, the author of more than 400 short stories and four major plays, was also a physician in late 19th century Russia. His medical training and clinical experience are evident in his writings and shed light on the doctor-patient relationship of his time. His writing also benefits from his medical training in its keen observation of human behavior and empathic understanding of motivation. Chekhov suffered from tuberculosis, and his transition from humorist to serious dramatist can be charted as his illness took its toll.

This workshop will consist of an overview of Chekhov's development as a writer in tandem with his career development and the course of his illness. Readings from short stories such as "Peasants," "An Unpleasantness," "Enemies," "Typhus," "The Princess," and "Ward Six" and plays such as "Uncle Vanya" will then be used to demonstrate aspects of the doctor-patient relationship and the psychology of the lives Chekhov portrays so vividly. Audience members will do the readings, and each reading will be followed by a discussion of its revelations. The stories will also be analyzed for their usefulness in teaching skills such as keen observation, empathy, self-awareness, and appreciation of developmental difficulties.

REFERENCES:

1. Chekhov A: Early Short Stories, 1883–1888 and Later Short Stories, 1888–1903. Edited by Shelby Foote, translated by Constance Garnett. New York, The Modern Library, 1999.
2. Tucker WM: Teaching psychiatry through literature: the short story as case history. Academic Psychiatry 1994; 18:211–219.

Issue Workshop 32
A CHAIR'S LIFE: ETHIOPIA, TAIWAN, GENEVA, ATLANTA, AND LOS ANGELES

Co-Chairpersons: Milton H. Miller, M.D., *Department of Psychiatry, Harbor UCLA Medical Hospital, 1000 W Carson St, Torrance, CA 90509,* Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*
Participants: Fikre Workneh, M.D., Eng-Kung Yeh, M.D., Norman Sartorius, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop the participant should have an expanded appreciation of the responsibilities, satisfactions, and challenges associated with leadership roles in psychiatric departments worldwide. The words "I will be the chairperson of this department" prove life-changing for those who speak them and those who agree.

SUMMARY:

Participants in this panel are four academic chairs of departments of psychiatry and a former WHO director. They come from four continents. Their collective tenure in office totals more than 100 years. Despite vast differences in the socioeconomic and educational circumstances in their nations, there has proven to be considerable overlap in the personal and professional obligations undertaken when each accepted appointment as a chair of psychiatry. Panelists will address the following topics, and participants will question each speaker and speakers will question each other after each topic: my hopes and plans when I accepted my appointment, coping with my medical dean and my government, what I learned in relationships with students, colleagues, coprofessionals, patients, family members, and family groups, two seminal moments in my own career, relevant numbers: budgets, patients served, outcome differences over the years, advice I will offer to my successor.

REFERENCES:

1. Desjarlais R., Eisenberg L., Good BJ, Kleinman A: World Mental Health: Problems and Priorities in Low-Income Countries. New York, Oxford University Press, 1995.
2. Miller MH: Psychiatry: A Personal View. New York, Charles Scribner's Sons, 1982.

Issue Workshop 33
ACADEMIC/CORRECTIONS MODELS OF MENTAL HEALTH CARE

Co-Chairpersons: Robert L. Trestman, M.D., U Conn. Health Center, *263 Farmington Avenue, Farmington, CT 06030-1410,* Kenneth L. Appelbaum, M.D., *365 Plantation Street, Worcester, MA 01545-1571*
Participants: Brett S. Rayford, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the dimensions and issues involved in the development of academic collaborations with public and private partnerships in the delivery of mental health services to inmates in the correctional environment.

SUMMARY:

Academic partnerships between departments of psychiatry and state departments of corrections are developing in a range of contexts. Multiple issues and needs are driving these collaborations including: increased numbers of mentally ill inmates; improving ability to treat serious mental illness; changes in mandatory sentencing laws; and increased criminalization and sentences for substance abuse. We will present the experiences of the departments of psychiatry of the University of Connecticut Health Center and The University of Massachusetts in their initial experiences in mental health delivery in correctional environments. Participation of audience members will include open discussions about a) distinction between both care provision and the mental health mission in the correctional environment versus other public settings; b) custody/mental health collaboration: pitfalls and possibilities: how arguments of "mad versus bad" get played out; c) linkages with other state agencies for joint programming and aftercare; and d) distinctions of public-public (Connecticut) and public-private (Massachusetts) collaboration models.

REFERENCES:

1. Jemelka RP, Rahman S, Trupin EW: Prison mental health: an overview. In Mental Illness in America's Prisons. edited by Stead-

man HJ, Cocozza JJ. Seattle, WA, National Coalition for the Mentally Ill in the Criminal Justic System, 1993, pp. 9–23.
2. Metzner JL: An introduction to correctional psychiatry: parts I, II, III. 25/26. J Am Acad Psychiatry & Law 1998; 375:107.

Issue Workshop 34
POETRY AND MEDICINE

Co-Chairpersons: Janis B. Petzel, M.D., *Psychiatry Department, University of Nebraska Medical Center, Omaha, NE 68198-5582,* Chelsea L. Chesen, M.D., *University of Arizona, P O Box 245002 Tucson, AZ 85724*
Participants: Kimberly W. Larsen, M.D., Robert Coleman, Ph.D., David R. Kopacz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the ways in which writing and poetry can help students negotiate the medical socialization process and to discuss the ways poetry can be used to enhance the doctor-patient relationship.

SUMMARY:

One-third of U.S. medical schools incorporate poetry and literature into their curricula in an effort to foster and promote humane, empathic characteristics in physicians. This workshop will explore the art of poetry as it relates to the art and science of medicine. Presentation of original works by physician-poets will stimulate group discussion centering on the value of creative writing to the individual physician. The goals for this workshop are 1) to explore the ways in which writing helps individuals negotiate the "medical socialization" process in medical school, residency, and beyond; 2) to discuss the ways in which poetry and creative writing contribute to two models of understanding illness, "conceptual knowledge," which is inherent in the medical model, and "narrative knowledge" in the biopsychosocial model; 3) to discuss the ways poetry can be used to enhance the doctor-patient relationship, especially in psychiatry; and 4) to use the presentation of original poems by physician-writers to inspire interactive discussion with workshop participants. In conclusion, the workshop will provide a dynamic forum for sharing ways in which poetry writing enhances our professional lives, helping us nurture our humanistic qualities as physicians and better connect with our patients.

REFERENCES:

1. Connelly J: Being in the present moment: developing the capacity for mindfulness in medicine. Acad Med 1999; 74:420–424.
2. Poirier S, et al: Songs of innocence and experience: student's poems about their medical education. Acad Med 1998; 73:473–478.

Issue Workshop 35
BEETHOVEN AND HIS CREATIVE EVOLUTION

Chairperson: Richard Kogan, M.D., *30 East 81st Street, #9E, New York, NY 10028*
Participant: Arnold M. Cooper, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the forces that influenced Beethoven's artistic development and to understand some fundamental concepts about creativity.

SUMMARY:

No composer exerts a more powerful hold on the imagination than Ludwig van Beethoven, and no one has surpassed his extraordinary ability to express dramatic conflict and resolution. But the full measure of Beethoven's creative genius was slow to emerge. As a young composer, he fully embraced the styles and conventions of his contemporaries. Eventually, however, his quest to discover a personal voice led him to drastically redefine classical style. Beethoven reshaped pre-existing musical language in order to express the full range of human experience—anxiety and aggression as well as triumph and transcendence.

Psychiatrist and concert pianist Dr. Richard Kogan (first prize, Chopin Competition and Concert Artists Guild Award) will perform the "Appasionata" sonata as well as other musical examples that illuminate Beethoven's artistic development. He and Dr. Cooper will analyze the historical, psychological, and biographical forces that influenced his stylistic progression. They will speculate on the impact of deafness on his creative evolution.

The presenters will discuss the concepts of creativity and genius with the audience. The final 30 minutes will be reserved for question and answer.

REFERENCES:

1. Solomon M: Beethoven.
2. Thayer AW: Life of Beethoven.

Issue Workshop 36
DIAGNOSIS AND TREATMENT OF HEPATITIS-C IN MENTAL HEALTH SETTINGS

Chairperson: Peter Hauser, M.D., *Department of Psychiatry, Baltimore VAMC, 10 North Greene Street, Baltimore, MD 21201*
Participants: Fred C. Osher, M.D., Jaswinder S. Khosla, M.D., Richard Goldberg, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the relationship between hepatitis C and psychiatric illness, and to understand the risk factors, diagnosis, and treatment of hepatitis C as well as recognize the CNS side effects of interferon therapy.

SUMMARY:

Hepatitis C (HCV) is the most frequent cause of chronic viral hepatitis in the Western world and is estimated to affect between 3 million and 4 million Americans. Although it is well-known that HCV infection is common among people with intravenous substance abuse (SA) disorders, recent studies suggest that patients with severe mental illness (SMI) are also disproportionately affected, and prevalence rates as high as 20% to 25% have been reported. Furthermore, recent advances in the treatment of HCV have not translated into benefits for SMI patients, as the CNS side effects of interferon alpha (IFN-α) therapy, particularly depression, have resulted in patients with psychiatric illness being excluded from receiving potentially life-saving medication. Also, few studies have addressed the management and treatment of the CNS side effects of IFN-α therapy in nonpsychiatrically ill patients.

This workshop will address the various issues of HCV diagnosis and treatment that confront psychiatrists and mental health professionals. Presenters will give an overview of HCV and associated risk behaviors, the relationship of HCV to SA and SMI, management of IFN-α therapy in patients with a psychiatric illness, treatment of IFN-α-induced CNS side effects, and the utility of educational programs about HCV for patients and professionals. The discussion will encourage audience participation by sharing clinical experiences and focusing on the role of psychiatrists and mental health professionals in the prevention and management of HCV in patients with psychiatric illness. Members of the audience will be asked to complete pre- and post-workshop questionnaires about HCV.

REFERENCES:

1. McHutchison JG, Gordon SC, Schiff ER, et al.: Interferon alpha-2b alone or in combination with ribavirin as initial treatment for chronic hepatitis C. New England Journal of Medicine 1998; 339:1485–92.
2. Valentine AD, Meyers CA, Kling MA, et al.: Mood and cognitive side effects of interferon alpha therapy. Seminars in Oncology 1998; 25(suppl.1):39–47.

Issue Workshop 37
TRAUMA SURVIVORS: HETEROGENEITY OF PSYCHIATRIC MANIFESTATIONS

Chairperson: Andrei Novac, M.D., *Department of Psychiatry, University of California-Irvine, 400 Newport Center Dr, Suite 309, Newport Beach, CA 92660-7604*
Participants: Rita R. Newman, M.D., Rachel Yehuda, Ph.D., Jean P. Goodwin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants should: 1) become familiar with a more integrated biopsychosocial model of traumatic stress, 2) become familiar with the latest concept in the field of trauma: intergenerational aspects of trauma, cumulative effects, impact of trauma on biorhythms, 3) understand the heterogeneity of clinical manifestations after exposure to traumatic stress.

SUMMARY:

The beginning of a new century has stimulated renewed interest in the integrated biopsychosocial reexamination of traumatic stress and its psychopathological consequences. Researchers and clinicians alike have been further puzzled by a persistent trend of humans to victimize each other. A large body of recent literature has identified specific markers of trauma that are present in victims of traumatic stress who do not develop PTSD, but instead exhibit other behavioral manifestations (i.e., "in lieu" psychopathology). Such "soft" trauma-generated behaviors (e.g., "dehumanization" and "depersonification") are believed to be at the basis of human-to-human revictimization. The biological basis of these manifestations will be examined.

The panel of this workshop are members of the Intergenerational Aspects of Trauma interest group of the International Society of Traumatic Stress Studies. Their experience is drawn from a wide range of clinical populations: Vietnam veterans, Holocaust survivors and their families, victims of civilian assault, and victims of work-related trauma. Newer concepts in the field of traumatic stress (e.g., intergenerational transmission of trauma, acquired vulnerability, and social reenactment) will be revisited. Clinical examples will be discussed with the participation of the audience.

REFERENCES:

1. Goodwin J, Attias R: Splintered Reflections. Images of the Body in Trauma. New York, Basic Books, 1999.
2. Novac A: Traumatic disorders—contemporary directions. Western Journal of Medicine, 1998; 169:40 -41.

Issue Workshop 38
THE REAL SPICE GIRLS: BLACK FEMINISM THROUGH SONG

Chairperson: Yvonne B. Ferguson, M.D., *Sansum Medical Clinic, PO Box 1239, Santa Barbara, CA 93102*
Participant: Esmond H. Edwards

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the historical connection between song lyrics and the African-American female's self-assertion and feminist pride.

SUMMARY:

From the female Blues Era of "Ma" Rainey, Bessie Smith, and Billy Holiday through contemporary rhythm and blues and now the hip-hop generation, black women have bared their souls through music. Daring to depart from the traditional roles allowed their white counterparts, vintage female vocal artists spoke of subjects considered taboo for women—sexual relationships with men, exacting revenge for infidelity, or their own dalliances. Rising from impoverished southern rural backgrounds, post-Civil War blues artists were among the highest-paid blacks, a condition that afforded them a degree of independence most women did not enjoy. Their celebrity was no inoculation against vulnerability to abuse, addictions, and exploitation, yet in many respects their bold directness was a forerunner of black feminist ideology, which would be built upon by artists such as Nina Simone and Lauryn Hill. This workshop will expose the audience visually and auditorally to clips of female-written and -performed lyrics and set them in a historical context to trace the evolution of the modern black female psyche. A psychiatrist and jazz producer will intersect their fields with the audience's thoughts about the power of the sung word through Q & A and discussion.

REFERENCES:

1. Giddings P: When and Where I Enter: The Impact of Black Women on Race and Sex in America. New York, W. Morrow, 1984, pp75–117.
2. Davis A: Blues Legacies and Black Feminism. New York: Vintage Books, 1999.

Issue Workshop 39
RESIDENCY TRAINING: INTERNATIONAL PERSPECTIVES

Co-Chairpersons: Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Dr/Box 0704, Ann Arbor, MI 48109-0704,* Allan Tasman, M.D., *Department of Psychiatry, University of Louisville, 500 S Preston St/Building A Room 210, Louisville, KY 40292-0001*
Participants: Mauel Beneyto, M.D., Anne Lindhardt, M.D., Fritz Hohagen, Roeloff ten Doesschate, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able 1) to recognize some of the differences and similarities between psychiatric residency training in the United States and in several European countries (Germany; Denmark; Spain); 2) discuss some of the issues in measuring competencies and proficiencies of residents; 3) understand ways to collaborate on important topics such as psychotherapy training.

SUMMARY:

The purpose of this workshop is to help familiarize participants with the manner of residency training in the United States as it compares with that in several European countries. There are some very important differences and similarities in the way we have come to view goals and objectives of residency training and the clinical experiences and types of supervision that are used. Each of the workshop leaders, internationally recognized authorities in their respective countries and in the European Board of Psychiatry, will be asked to speak on several specific areas of training, especially measuring competencies and proficiencies, psychotherapy training supervision, etc. The audience will be asked to comment on such educational programs and compare what the successful areas might be and that are transferable. With the help of the audience, we will try to focus on ways to set up a process to continue to collaborate and learn from one another. We hope that this might be the beginning of future opportunities to share training experiences and information.

REFERENCES:

1. Weerasekera P: Postgraduate psychotherapy training: incorporating findings from the empirical literature into curriculum development. Academic Psychiatry 1997, 21:122–132.
2. Winer JA, Klamen DL: Psychotherapy supervision: a current method. Academic Psychiatry 1997, 21:141–147.

Issue Workshop 40
PROBLEMATIC EXCESSIVE SEXUAL BEHAVIOR

Co-Chairpersons: Reid Finlayson, M.D., *The Homeward Health Center, 150 Delhi Street, Guelph, ON NIE 6K9, Canada,* John R. Sealy, M.D., *23700 Caminodelsol, M200, Torrance, CA 90505*
Participants: Patrick J. Carnes, Ph.D., Richard R. Irons, M.D., Jennifer P. Schneider, M.D., Stephen S. Brockway, M.D., James C. Montgomery, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be aware of the differences and similarities between various models used to understand and treat problematic excessive sexual behaviors. Faculty will examine the role of addictive disorders in the causation of professional sexual exploitation.

SUMMARY:

Although the debate about sexual addiction and compulsion has been fueled by the sexual behavior of public figures, it also behooves us as health care professionals to be aware of the sexual misconduct that occurs between us and our patients. Using case examples of professional sexual misconduct, this workshop will focus on diagnosis, research, and model development for the understanding of problematic sexual behaviors. The role of addictive disorders in professional sexual misconduct will be examined. An eclectic overview of treatment approaches, including important family issues, will be discussed, along with implications for addiction medicine/psychiatry. Audience participation will be encouraged and a 20-minute period will be held for audience discussion. All participants will be supplied with copies of additional pertinent articles, resource materials, and lecture notes.

REFERENCES:

1. Irons RR, Schneider JP: The Wounded Healer: Addiction-Sensitive Approach to the Sexually Exploitative Professional. Fort Lee, NJ, Jason-Aronson Inc., 1999.
2. Irons RR, Schneider JP: Addictive Sexual Disorders. Chapter in Miller NS, editor: Principles and Practice of Addictions in Psychiatry. Philadelphia, PA, W.H. Saunders Co., 1997, 441–447

Issue Workshop 41
MANAGEMENT OF DIFFICULT SCHIZOPHRENIA

Co-Chairpersons: Michael Y. Hwang, M.D., *Department of Psychiatry, FDR VAMC, PO Box 100, Montrose, NY 10548,* Samuel G. Siris, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*
Participants: Douglas M. Ziedonis, M.D., Jeffrey P. Kahn, M.D., Naveed Iqbal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be familiar with the current state of knowledge regarding some of the challenging clinical conditions in schizophrenia and be better able to treat patients with these conditions.

SUMMARY:

Schizophrenic spectrum disorder has been known to encompass diverse clinical phenomena. Recent psychiatric research has demonstrated varying neurobiological abnormalities in schizophrenic illness. This clinical and biological diversity in schizophrenia continues to challenge clinicians in terms of assessment and treatment. Recent epidemiological and clinical evidence suggests that schizophrenics with comorbid conditions such as depression, OCD, substance abuse, and impulsive-aggressive behaviors may account for considerable part of schizophrenic heterogeneity and require specific pharmacological and behavioral treatment interventions. The proposed workshop will review recent research findings and discuss the clinical management of the following clinical conditions: Dr. Siris will review the various depressive phenomena in schizophrenia and discuss their management. Dr. Hwang will discuss the diagnostic and treatment issues in obsessive-compulsive phenomena in schizophrenia. Dr. Ziedonis will present recent findings and discuss the current management of substance abuse in schizophrenia. Dr. Kahn will review the clinical and treatment issues of panic symptoms in schizophrenia. Dr. Iqbal will discuss the clinical and neurobiological considerations of high-risk suicidal schizophrenia. At the end of the presentation, participants will be encouraged to share their clinical experience.

REFERENCES:

1. Hwang MY, Opler LA (Guest Editors): Treatment and assessment of schizophrenic comorbidities. Psychiatric Annals 1994; 24:9.
2. Hwang MY, Bermanzohn PC: Management of Schizophrenics with Comorbid Conditions, Clinical Monograph Series, APPI, Washington, DC, 1999, (in press)

Issue Workshop 42
WHEN CAN INCOMPETENT PERSONS BE RESEARCH SUBJECTS?

Chairperson: Herbert S. Peyser, M.D., *110 E 87th Street, Apt IF, New York, NY 10128-4102*
Participants: John M. Oldham, M.D., Barry B. Perlman, M.D., Seth P. Stein, J.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to evaluate, support, advocate for, set up and/or participate in research involving decisionally incapable persons where such research would allow for fully adequate use of the latest research methods and tools and at the same time carry the least risk to the subjects and be up to the highest ethical standards.

SUMMARY:

There is a trend toward increasingly vigorous questioning of guidelines governing the use of vulnerable populations, particularly decisionally incapable persons, in clinical psychiatric research. This has resulted in a controversial National Bioethics Advisory Commission (NBAC) report and a suit in New York State. The NYS Department of Health created a commission to develop new guidelines and sought input from the NYS Medical Society. That society's Psychiatry and Bioethics Committees and its Executive Council responded with several concerns, the main one being opposition to research that carried "no direct benefit" but had "more than minimal risk" for decisionally incapable (although nonobjecting) persons. The NYS commission introduced a category of "minor increase over minimal risk" (PET scans, etc.). The medical society, just as NBAC, opposed this category. The NYS Psychiatric Association, attempting mediation, suggested creating a "super IRB" (similar to an NBAC recommendation) to evaluate data about the procedures and categorically approve those found not to be harmful, categorizing them as functionally, even if not theoretically, within the "minimal risk" category.

Representatives from the research community opposed this proposal. Both sides of the issue will be discussed and active member participation invited in an attempt to work out a practical solution.

REFERENCES:

1. Oldham JM, Haimowitz S, Delano SJ: Protection of persons with mental disorders from research risk: a response to the report of the National Bioethics Advisory Commission. Arch Gen Psychiatry 1999; 56:688–693.
2. Childress JF, Shapiro HT: Almost persuaded: reactions to Oldham et al. Arch Gen Psychiatry 1999; 56:697–698.

Issue Workshop 43
BALINT GROUPS: PSYCHOLOGICAL LEARNING FOR PHYSICIANS

Chairperson: Roy W. Menninger, M.D., *Menninger Foundation, P.O. Box 829, Topeka, KS 66606*
Participant: Susan E. Farmer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the usefulness and appropriateness of the Balint Group Method as an effective teaching strategy for physicians and to acquire sufficient knowledge of the methodology to begin teaching groups of residents or practitioners.

SUMMARY:

The group discussion method pioneered by Michael Balint was originally developed to teach general practitioners about psychological issues in their patients, as reflected in the vicissitudes of the doctor-patient relationship. Drawing on unrehearsed descriptions of encounters with their patients, participating physicians were helped to recognize how psychological issues were often disguised in complicated medical complaints, and how these issues affected the doctor-patient relationship, the physician's diagnostic assessment, and subsequent treatment decisions. Because the method is solidly based in the practice experiences of the participants, it remains powerfully relevant to their work and thus retains their investment in the learning experience while it exposes them to psychological perspectives in tolerable doses.

Recent experience has demonstrated that this same process can be used to help first-year residents grapple with the difficult process of establishing their identity as physicians and facilitate further development as their training program unfolds.

This workshop will describe the structure and process of the Balint group and explore the usefulness of this teaching strategy in residency training for family practice and psychiatry. The presentation will use examples of the ways physicians' attitudes and patterns of practice were positively affected by a better understanding of the patient. Workshop participants will be invited to share their experiences with similar group teaching experiences.

REFERENCES:

1. Balint M: The Doctor, His Patient and the Ilness. New York, International Universities Press, 1957.
2. Brock CD, Johnson AH: Balint group observations: the white knight and other heroic physician roles. Family Medicine 1999; 31:404–408.

Issue Workshop 44
SHARED CARE: THE CANADIAN PSYCHIATRIC ASSOCIATION AND THE COLLEGE OF FAMILY PHYSICIANS

Co-Chairpersons: Nick S. Kates, M.B., *Department of Psychiatry, McMaster University, 40 Forest Avenue, Hamilton, ON L8N 1X1, Canada,* Marilyn Craven, M.D., *Department of Psychiatry, McMaster University, 40 Forest Avenue, Hamilton, ONT L8N 1X1, Canada*
Participants: Richard Handfield-Jones, Roger C. Bland, M.D., Ken LeClair, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand models of collaboration between psychiatrists and family physicians and how the Canadian Psychiatric Association and the College of Family Physicians of Canada have facilitated collaboration between the two disciplines.

SUMMARY:

Following the successful publication of their document on shared care in October 1997, the Canadian Psychiatric Association and the College of Family Physicians of Canada established a joint working group to oversee the implementation of the report recommendations. The working group has developed a three-stage strategy: 1) collecting relevant information on current projects and obstacles and building a network of interested colleagues, 2) disseminating this information in a variety of formats, and 3) facilitating collaborative projects. It has also developed strategies for working with academic departments, funding sources, health care planners, and for developing a national common research agenda. This workshop presents a summary of the work and findings of the working group, including studies of resident training, and discusses possible projects for strengthening collaboration between the two disciplines. The workshop will be interactive throughout, with participants being encouraged to discuss projects with which they have been involved and issues of interest.

REFERENCES:

1. Kates N, et al: Shared Mental Health Care in Canada: Supplement to Canadian Journal of Psychiatry and the Canadian Family Physician, October 1997.
2. Kates N, Craven M, Crustolo A, et al: Integrating mental health services into primary care. Gen. Hosp. Psych 1997; 19:324–337.

WEDNESDAY, MAY 17, 2000

Issue Workshop 45
SPIRITUAL/RELIGIOUS ASSESSMENT IN CLINICAL WORK

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110* Christina M. Puchalski, M.D., *National Institute of Health Research, 6110 Executive Boulevard, 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 cases 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 problems, and the use of religious/spiritual consultations and interventions such as with chaplains.

REFERENCES:

1. Peteet JR: Approaching spiritual problems in psychotherapy. J. Psychotherapy Practice and Research 1994; 3:237–245.
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 46
BODY IMAGE IN ADOLESCENCE: CONTEXT AND CURRICULA

Chairperson: Patricia R. Recupero, M.D., *Department of Psychiatry, Brown University/Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*
Participants: Katharine A. Phillips, M.D., Alison M. Heru, M.D., Anne T. Ryan, Ed.D., E. Kathleen Farrell, Ed.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will be aware of the complex body image issues that face early adolescents and the relationships between body image and pathological disorders and school disruptions.

SUMMARY:

Early adolescence is a difficult time in which concerns about body image become important to many children. Specifically, concerns about the rate of physical maturation, real or imagined concerns about appearance, and eating disorders develop in parallel. These issues are intensely felt by the adolescent and are compounded by the teasing and bullying of other students. Media, advertising, and sports all foster the image of the perfect body. Students must grapple with the many changes occurring in their body habitus as well as intense hazing from their peers.

This workshop will consider many of the consequences of body image. Dr. Recupero will review the demographics of the problem and the implications for school disruptions by harassment and violence. Dr. Phillips will discuss body image concerns and body dysmorphic disorder in adolescents. Dr. Heru will review the dynamics of victimization and its impact on the development of males. Dr. Ryan and Dr. Farrell will discuss a curriculum that they developed for use in the middle school. The components of the curriculum related to body image and eating disorders will be presented with outcomes data. Participants will discuss the components and development of a multisystem, educationally based approach to these issues.

REFERENCES:

1. Albertini RS, Phillips KA: 33 cases of body dysmorphic disorder in children and adolescents. J Am Acad Child Adolesc Psychiatry 1999; 38:453–459.
2. Hawkins JD, et al: Preventing adolescent health-risk behaviors by strengthening protection during childhood. Arch Pediatr Adolesc Med 1999; 153:226–234.

Issue Workshop 47
SEVERE PTSD AND THE DOCTOR-PATIENT RELATIONSHIP

Chairperson: Gordon D. Strauss, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 500 S Preston Street, Room 209-Bldg A, Louisville, KY 40202-1702*
Participant: Michelle A. Fiorella, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to list the aspects of combat-related posttraumatic stress disorder, which make it difficult to form a therapeutic relationship; to discuss why and how the doctor-patient relationship is a key mechanism for change in the treatment of patients with severe PTSD combined with Axis II psychopathology.

SUMMARY:

For many experienced clinicians treating Vietnam veterans who suffer from severe combat-related PTSD and have pronounced Axis II pathology is an overwhelming challenge. For psychiatric residents and others new to the field such patients often seem impossibly difficult for multiple reasons: their pervasive lack of trust, their anger and hostility toward medical and other forms of authority, and the seemingly intractable nature of their symptoms.

In fact these patients *are* difficult to treat. However, it is precisely among these exquisitely challenging patients that one often can see the profound effects of the doctor-patient relationship. This workshop will examine two cases: both are Vietnam veterans with PTSD and, in addition to considerable character pathology, both have severe, life-threatening medical conditions. A psychiatric resident (now a PGY-3) has treated both for the past two years. She will present her work with these patients with emphasis on the challenges they posed—medical, logistical, countertransferential—to forging and maintaining a psychotherapeutic doctor-patient relationship. Her long-term case supervisor will discuss the factors that contributed to her success in creating a relationship with each patient in which unexpected change took place. In addition to verbal and video presentations of the cases and discussion, the audience will be encouraged to interact with the presenters in several ways: by offering their own analyses of these two cases, by sharing their experiences in forming doctor-patient relationships with difficult patients, and by considering the role of the doctor-patient relationship in contemporary psychiatry.

REFERENCES:

1. Nicholi, AM Jr.: The therapist-patient relationship, in The Harvard Guide to Psychiatry 3rd Edition, Edited by AM Nicholi Jr. Cambridge, MA; Harvard University Press, 1999.
2. Foa EB, Meadows EA: Psychosocial treatments for posttraumatic stress disorder: a critical review. Annual Review of Psychology 1997; 48:449–480.

Issue Workshop 48
GROUP PSYCHOTHERAPY OF ADOLESCENT DRUG ABUSERS

Chairperson: David W. Brook, M.D., *Community Medical, Mt. Sinai School of Medicine, One Gustave Levy Place/Box 1044A, New York, NY 10029*
Participants: Paul Kymissis, M.D., Mary A. Pressman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the developmental, neurobiological, and psychosocial bases for the use of a variety of group psychotherapeutic approaches in the treatment of adolescent substance abusers; to treat adolescent substance abusers using a variety of group psychotherapeutic techniques.

SUMMARY:

Group psychotherapeutic approaches form a major method of treatment for adolescent substance abusers and for those at risk for substance abuse. Theoretical and technical issues will be presented that are relevant to both the evaluation and treatment of these adolescents.

Group approaches discussed will include multiple-family therapy groups, cognitive-behavioral groups, modified psychodynamic group therapy, relapse-prevention groups, behavioral-educational groups, harm-reduction groups, psychodynamic groups, self-help groups, and

others. A developmental approach will be used to look at risk and protective factors and their relationship to group treatment approaches. Issues involving comorbidity will be addressed as will the uses of group approaches in a variety of settings, including inpatient, outpatient, and partial hospitalization. The presenters will use specific clinical examples and material from group sessions as illustrations.

Active audience participation will be encouraged. Participants will be asked to present specific clinical examples or problems for discussion. This issue workshop is cosponsored by the American Group Psychotherapy Association.

REFERENCES:

1. Edited by Kymissis P, Halperin D: Group Therapy with Children and Adolescents. Washington, D.C., American Psychiatric Press, 1998.
2. Edited by Brooks DW, Spitz HI. Group Psychotherapy of Substance Abuse. Washington, D.C., American Psychiatric Press, in press.

Issue Workshop 49
A VERTICALLY INTEGRATED CONSULTATION-LIAISON TEACHING MODEL
Academy of Psychosomatic Medicine

Co-Chairpersons: Stephen M. Saravay, M.D., *Long Island Jewish Medical Center, 270-05 76th Avenue, New Hyde park, NY 11577-2701* Maurice D. Steinberg, M.D., *Department of Psychiatry, Long Island Jewish Medical Center, 276-05 76 Avenue, New Hyde Park, NY 11040*
Participants: Joseph S. Weiner, M.D., Diana M. Hughes, M.D., David Straker

EDUCATIONAL OBJECTIVES:

As a result of this workshop, participants will be aware of the teaching benefits for trainees (C-L fellows, psychiatry residents, and medical students as well as medical house staff) of a vertically integrated C-L teaching program. Participants will also learn the centrality of the role of a C-L fellowship program in this approach.

SUMMARY:

Unlike most medical teaching models, psychiatry training programs do not easily lend themselves to a vertical model. On a medical floor, attendings teach senior residents, both teach interns, and all have a hand in teaching medical students during their clinical clerkship assignments. Although inpatient psychiatric units may approximate this model, such experiences do not account for a major portion of psychiatry residency training. C-L training offers another opportunity to employ an integrated, vertical teaching model in a psychiatry training program and may also include medical house staff. Key to such a model is a well-established C-L fellowship program.

Using the C-L program at the Long Island Jewish Medical Center as an example, the workshop will explore the key components of a vertically integrated model, emphasizing the key roles of the C-L fellows. Presentations will briefly describe the components from the point of view of the attending, the fellow, the PGY-3 and PGY-4 psychiatry residents, the medical student, and the medical house staff. Presenters will include psychiatry and medical attendings, a member of the house staff, and a medical student. Participatory discussion will be encouraged during the presentation. The opinions of the audience will be sought regarding their experiences and the crucial role of a viable C-L fellowship in creating a vertically integrated teaching program in C-L psychiatry.

REFERENCES:

1. Gordon JH, Walerstein SJ, Pollack S: The advanced clinical skills program in medical interviewing: a block curriculum for residents in medicine. Int'l J of Psychiatry in Medicine 1996; 26:411–429.
2. Steinberg MD, Cole SA, Saravay SM: Consultation-liaison psychiatry fellowship in primary care. Int'l of Psychiatry in Medicine 1996; 26:135–143.

Issue Workshop 50
THE MANDATED PATIENT, PART 2: CONTROVERSIES AND EFFICACY

Co-Chairpersons: Susan Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504* Harvey Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504*
Participants: Michael M. Scimeca, M.D., David W. Preven, M.D., Sheldon Travin, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participants will be able to elucidate the various elements that need to be considered in framing mandatory treatment statutes as well as the controversies regarding their efficacy.

SUMMARY:

Legally mandated treatment on an inpatient basis has been part of the framework of psychiatry for a long time. Mandated outpatient treatment on the other hand is a relatively new and unevenly applied modality across the United States. This workshop will first explore the various and differing elements present in various state statutes to tease out those that appear crucial. There will then be discussions of special situations, e.g., treatment of substance abusers and those with histories of violence. The audience will be asked to compare how their own practice locales apply or do not apply these principles and how this appears to affect efficacy of treatment. Evolving mandates such as the newly enacted "Kendra's Law" in New York will be explored. This will include the effect of provider comfort with these mandates prescribed by law. The workshop will explore if practitioners see mandated treatment as a newfound opportunity or a burden.

REFERENCES:

1. Torrey EF, et al.: A national survey of the use of outpatient commitment. Psychiatric Services 1995; 46:778–784.
2. Husted JR, et al: Circle commitment viewed from three perspectives: professional, family, and police. Bulletin of the American Academy of Psychiatry and Law 1995; 23:533–564.

Issue Workshop 51
CLINICAL AND FORENSIC ISSUES IN SEXUAL HARASSMENT

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline, MA 02445*
Participants: Carl P. Malmquist, M.D., Elissa P. Benedek, M.D., Linda M. Jorgenson, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be familiar with the legal criteria for sexual harassment and the clinical manifestations that have been associated with this. They will also become aware of the areas of potential ambiguity.

SUMMARY:

Forensic evaluation of sexual harassment complaints is an area where complex personal and clinical data often must be reduced to black-and-white terms. The evidence involved in complaints of this type is sometimes subjective and can rely heavily on personal interpretations of words and actions.

As a legal issue, sexual harassment now receives considerable attention. It is, however, surrounded by confusion and ambiguity in a psychiatric setting. The potential for complications arises from the relationship, if any, of the harassment complaint to earlier experiences of trauma and abuse and the extent to which prior experiences affect the magnitude and importance of current events.

This workshop will explore the psychiatric and forensic issues involved in evaluating sexual harassment complaints by examining a series of actual cases and through the presentation of a detailed case on videotape. The audience will be invited to participate by bringing their own forensic and clinical cases as well as by discussion.

REFERENCES:

1. Roberts BS, Vann RA: Sexual harassment in the workplace: a primer. Akron Law Review 1996; No. 269.
2. Charney DA, Russell RC: An overview of sexual harassment. Am J Psychiatry 1994; 151:1.

Issue Workshop 52
CARE MANAGEMENT FOR CHRONIC ADDICTIVE DISORDERS
National Institute on Alcohol Abuse and Alcoholism

Chairperson: Mark L. Willenbring, M.D., *Department of Psychiatry, VA Medical Center, I Veterans Drive, Minneapolis, MN 55417*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will understand the principles of care management, how care management differs from rehabilitation, and when it is indicated. Through the use of case example, skills practice, and active discussion, participants will be able to apply the principles of care management in their own practices.

SUMMARY:

Physicians are often confronted with patients who either refuse referral to addiction treatment, are unable to participate in it due to other disabilities, or do not respond to treatments. Management of these patients has not previously been systematized, so most physicians are unclear as to how to proceed. At its worst, this leads to mutual dissatisfaction and frustration for both patients and physicians. The VA recently developed a new practice guideline for managing substance use disorders. In this guideline, care management is an alternative pathway when rehabilitation treatment is not possible or is ineffective. Care management uses principles similar to those used to treat other chronic illnesses. Ability to specify goals short of complete abstinence is essential. Treatment of complications, inducing remission, limiting relapses, and slowing deterioration are considered important, even when abstinence is not permanently achieved. Installation of hope and motivational support are important components. In this workshop, we will go through the care management guideline and explore its implementation with case examples. There will also be an opportunity to practice care-management interviewing and intervention skills. At the end of the workshop, participants should have the skill to apply these principles in their own practices.

REFERENCES:

1. VA Draft Guideline for the Management of Persons with Substance Use Disorders. Department of Veterans Affairs. Internet: http://12.0.190.99/subsuse
2. McLellan AT, Woody GE, Metzger D, et al: Evaluating the effectiveness of treatments for substance use disorders: reasonable expectations, appropriate comparisons. Milbank Q 1996; 74:51–85.

Issue Workshop 53
VOYAGES OF THE STARSHIP EMPATHY: TO BOLDLY GO...

Co-Chairpersons: Christine A. Barney, M.D., *Department in Psychiatry, Dartmouth Medical School, 6 S Park St, Lebanon, NH 03766-1300* Sandra L. Waugh, V.M.D., *Windsor Animal Hospital, 2326 us Route 5, North, Windsor, VT 05089*
Participant: Katherine I. Benziger, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify lead function, understand how lead function influences communication style, understand how the lead functions of therapist and client interact, understand how this interaction helps or hinders therapy, and use metaphors to enhance communication.

SUMMARY:

Warp speed to a successful therapeutic alliance! Beam on board to experience how differing cognitive and perceptual styles between therapist and client can either torpedo or engage connection and growth. Dr. Benziger will present breakthrough information on cortical specialization of both data gathering and processing as distributed between four discrete areas of the cortex: the posterior convexities and frontal lobes of both right and left hemispheres. While all of us can develop competency in using any of the brain's four core modes, each of us has an innate preference for only one of them. Our differing preferences lead to significant natural differences in how we think, experience, and communicate, as well as in what we value. Drs. Barney and Waugh will present demonstrations of how this functional specialization can affect the outcome of therapy. Video simulations of therapist-client interactions will illustrate how the preferences of therapist and client can either offer opportunities for hope or lead to misunderstanding, miscommunication, and dangerous disconnection. Participants will then be given the opportunity to role play a difficult client or a connected therapist, with either Dr. Barney or Waugh, or the leaders will role play a suggested interaction.

REFERENCES:

1. Aron EA: The Highly Sensitive Person: How to Thrive When the World Overwhelms You. Secaucus, NJ, Carol Publishing Group, 1996.
2. Benziger KI, Sohn A: The Art of Using Your Whole Brain. Rockwell, TX, KBA Publishing, 1995.

Issue Workshop 54
VIDEO CASE STUDIES OF COUPLES IN TREATMENT

Chairperson: Ian E. Alger, M.D., *500 East 77th Street, #132, New York, NY 10162*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify critical stages of couples therapy, and develop an increased awareness and understanding of his/her style as a couples' therapist.

SUMMARY:

Participants will have the opportunity to role play clinical examples of couples treatment with the leader and through the use of video playback and thereby identify issues of impasse and stress during different stages of couples treatment, including engagement, problem identification, change facilitation, and termination. Workshop partic-

ipants will have the the opportunity to compare their own clinical experiences relating to problems of dual-career couples, sexuality and intimacy, and issues involving children, as well as extended family members and peer and friendship networks.

REFERENCES:

1. Alger I: Marital therapy with dual-career couples. Psychiatric Annals 1991; 21:8.
2. Feld B: Gender: a critical issue in a couples group. Group, 1973; Vol. 17.

Issue Workshop 55
MANAGED CARE IMPACT IN PUBLIC SECTOR PSYCHIATRY

Co-Chairpersons: Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030* Robert W. Guynn, M.D., *Department of Psychiatry, 1300 Moursund Street, Suite 206, Houston, TX 77030*
Participants: David R. Small, M.B.A., Roy V. Varner, M.D., Patricia M. Averill, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the principles of managed care, assess the impact of managed care in the psychiatric public sector, and implement solutions to the managed care dilemma.

SUMMARY:

A main attraction of managed care is its promise of containment and/or reduction of health care costs. A central strategy in managed care is utilization management. Utilization management has produced some reduction of costs in managed care psychiatric systems. This reduction has primarily resulted from a decrease in inpatient care. Many states opted for the transformation of their tax-supported, public health/mental health services into privately oriented managed care systems. However, this decision has led to much concern about the quality of psychiatric care provided in these systems, particularly in the Medicaid program. Because of these concerns, we implemented an evaluation system at the Harris County Psychiatric Center. The center, a 250-bed hospital operated by the University of Texas Science Center at Houston, provides most of the public psychiatric inpatient services in Houston. Our study hypothesized that a decrease in length of stay in inpatient services would lead to an increase in the readmission rates, and thus to poor-quality care. In this workshop, we will present the results of our study, discuss their impact in the quality of psychiatric care, and advance potential solutions for this dilemma in the field of psychiatry.

REFERENCES:

1. Ruiz P, Venegas-Samuels K, Alarcon RD: The economics of pain: mental health care costs among minorities. Psychiatric Clinics of North America 1995; 18:659–670.
2. Ware JE, Bayliss MS, Rogers WH, et al.: Differences in 4-year health outcomes for elderly and poor, chronically ill patients treated in HMO and fee-for-service systems. Journal of the American Medical Association, 276:1039–1047.

Issue Workshop 56
THE DOCTOR AS PATIENT

Co-Chairpersons: R. Andrew Schultz-Ross, M.D., ALEF ANI *75-5995 Kuakini Highway #601, Kailua-Kona, HI 96813*
Aleen Grabow, M.D., *197 Dixon St # 1, Madison, WI 53704*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the role of traumatic stress (if it has occurred) in professional training and its impact on professional life. The participant may be able to begin the process of healing and know more about working with others who have experienced traumatic stress via the use of narrative.

SUMMARY:

Verbal, emotional, and workload-related abuse of medical trainees may be more common than is acknowledged; it is an accepted part of some medical training programs. If abuse is common and underreported, then there is likely to be psychiatric manifestations of such trauma in many physicians. Indeed, post-traumatic stress disorder (PTSD) or a minor variant has been noted to occur among physicians not exposed to war or disaster experiences; these conditions may be under-recognized and undertreated. In exploring the psychological aspects of PTSD among physicians exposed to medical training stress, the presenters have found that storytelling (and hearing) of the experiences of the physicians appears to have a helpful effect. Some report that such narratives lift the veil of denial that may surround abuse of trainees.

After an introductory discussion of abuse in medical training, the participants will be invited to engage in a narrative discussion of the situations they have witnessed and experienced. The discussion will not be psychotherapy but an opportunity to recall experiences in a safe manner, allowing physicians to become aware of the way it may impact their work and that of other doctors.

REFERENCES:

1. Schuckert MK: The relationship between verbal abuse of medical students and their confidence in their clinical abilities. Academic Medicine 1998; 73:907–909.
2. Ross D: Looking Into the Eyes of a Killer: A Psychiatrist's Journey Through the Murderer's World. New York, Plenum Press (Perseus Books), 1998.

Issue Workshop 57
CHILDREN OF PSYCHIATRISTS: WORKSHOP III

Co-Chairpersons: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 500 South Preston Suite 214, Louisville, KY 40292*
Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Dr/Box 0704, Ann Arbor, MI 48109-0704*
Participants: Marina Gilman, Daniel Weintraub, M.D., David Spiegel, M.D., Roy R. Grinker Jr., M.D., Barri Katz Stryer, M.D., Kenneth H. Talan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to be more aware and informed about the unique and common experiences, attitudes, and issues children of psychiatrists may experience directly and indirectly across their early developmental years and through all stages of adulthood.

SUMMARY:

This third Children of Psychiatrists Workshop is in response to the larger attendance and continuing interest by attendees and those who have thus far been unable to attend the first two.

For the year 2000, workshop participants will each speak for 12 minutes about their unique experiences in order to inform attendees about the unique positives and negatives their own children and/or patients whose parents are psychiatrists may experience and need to work through.

Many young career psychiatrists and residents are concerned about how to parent effectively and happily as they continue in their professional roles and responsibilities. Such issues as boundaries between personal and professional lives as well as increased knowledge about child-development stages, role modeling of communication skills,

emotional expression, satisfaction from and balance of personal and professional issues and lives. Adequate time has been scheduled for audience and presenter discussion.

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 58
CLINICAL CHALLENGES IN CORRECTIONAL PSYCHIATRY

Chairperson: Lee H. Rome, M.D., *Bureau of Forensic Mental Health, 3511 Bemis Road, Ypsilanti, MI 48197*
Participants: James E. Dillon, M.D., Jeffrey L. Metzner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to gain increased understanding of the general nature, evaluation issues, and management strategies of several difficult clinical problems confronting correctional psychiatrists, including self mutilation, malingering, and evaluating/managing behaviorally disordered prisoners in administrative segregation.

SUMMARY:

Due to the unique mission, culture, and security environment of correctional facilities, the practice of psychiatry in a prison setting is inherently challenging, even when dealing with commonly occurring and typically presenting mental disorders, such as major depression. More difficult yet are several clinical issues that are particularly related to the prison system, including self-mutilation, malingering, and the evaluation and management of mentally ill prisoners in administrative segregation. Often bedeviling and confounding, even for experienced clinicians, these special problems are often associated with serious complications including over- or under-treatment, splitting of staff (clinical and/or custody), disruption of programs, high medical-legal risk potential, and inordinate expenditure of money and time.

Brief overviews of scientific literature, evaluation issues, and management strategies regarding prisoner self injury, malingering, and identification/management of mentally ill prisoners in segregation will be presented by the panelists. In addition, case vignettes illustrating the complex nature of such clinical problems will be offered by the panelists and solicited from the workshop participants. Helpful mitigation approaches that emphasize an integrated effort of all staff will be explored. A substantial amount of time will be reserved for participants to ask questions and to share their experiences.

REFERENCES:

1. Roth LH: Correctional psychiatry, in Forensic Psychiatry and Psychology. Edited by Curran, McGerry, Shaw. Philadelphia, F.A. Davis Co., 1986.
2. Wettstein RM: Treatment of Offenders with Mental Disorders. New York, Guilford, 1998.

Issue Workshop 59
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 OBJECTIVE:

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 fails 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 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 an interactive discussion with workshop participants, who will be encouraged to present their own cases for group discussion.

REFERENCES:

1. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure and clinical application. American Journal of Psychiatry 1987; 144:543–550.
2. McLaughlin J: Clinical and theoretical aspects of enactment. Journal of the American Psychoanalytic Association 1991; 39:595–614.

Issue Workshop 60
AN INTERPERSONAL NEUROBIOLOGY OF PSYCHOTHERAPY

Chairperson: Daniel J. Siegel, M.D., *11980 San Vicente Boulevard #809, Los Angeles, CA 90049*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to demonstrate a knowledge of how mental processes are shaped by the transaction of neurophysiological function and interpersonal experiences; to identify the research-established elements of attachment relationships that are influential in the development of mental processes such as memory, narrative, and self-regulation.

SUMMARY:

This workshop will provide an interdisciplinary view of the mind and how it develops at the interface of neurophysiological processes and interpersonal experiences. This "interpersonal neurobiology" of the developing mind offers insights into how the doctor-patient relationship serves as the primary mechanism for promoting psychological change and mental well-being within the process of psychotherapy. Participants will be actively engaged in discussions throughout the workshop by means of examples from clinical practice and everyday life. By reviewing recent findings from a number of independent academic disciplines, such as those studying attachment, memory, narrative, emotion and its regulation, complexity theory, and neurobiology, a synthetic perspective emerges of how mental processes emerge from the structure and function of the brain, which in turn are directly shaped by interpersonal experiences. As recently published in *The Developing Mind,* this multidisciplinary view offers psychiatrists and mental health practitioners a scientifically grounded

foundation from which to understand how human relationships directly shape the development of the mind throughout the lifespan. Psychiatrists may find this approach especially useful in deepening their understanding of the importance of the therapeutic relationship in helping patients learn more adaptive mechanisms to cope with ongoing internal and external challenges to their mental health and emotional well-being.

REFERENCES:

1. Siegel DJ: The Developing Mind: Toward a Neurobiology of Interpersonal Experience. New York, Guilford Press, 1999.
2. Schore AN: Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development. Mahwah, NJ, Erlbaum, 1994.

Issue Workshop 61
GIVING CARE TO THE CAREGIVER

Chairperson: William F. Haning III, M.D., *University Hawaii Medical School, 1356 Lusitana Street 4th floor, Honolulu, HI 96813*
Participant: Chad Y. Koyanagi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to judge the adequacy of his/her boundaries in treating the peer-patient; recognize the most common defenses employed by the peer-patient and class them by severity of pathology; and have inventoried the reliable resources in his/her management of existing peer-patients.

SUMMARY:

Complications of giving care to physicians begin at the linguistic level ("Doctor?" "Doctor!") and can pervade administrative and therapeutic technical levels. The circumstances are further complicated in a small community by peer relationships and by social ties. If the domain of treatment is sufficiently narrow that there are few specialist in a given area (e.g., addiction psychiatry), a "small community" may be as large as a city of several hundred thousands.

Workshop participants will be given several scenarios, with a combination of videotape and role-playing illustrations, and then encouraged to answer questions that are commonly encountered and equally commonly dodged in the management of peer-patients. Examples include: 1) How many hats *can* you wear at once? 2) What are you willing to settle for in boundaries if the peer-patient can't go to another provider? 3) What are the most common transference and countertransference issues, and the most difficult? 4) What constitutes effective supervision? 5) What is the therapeutic place of self-disclosure?

REFERENCES:

1. AMA Council on Ethical and Judicial Affairs: Code of Medical Ethics. Chicago, AMA, 1997.
2. Coombs RH: Drug-Impaired Professionals. Cambridge MA, Harvard University Press, 1997.

Issue Workshop 62
HOW INTUITION CAN BE USED TO ENHANCE PATIENT CARE

Chairperson: Judith C. Orloff, M.D., *2080 Centry Park E #1811, Los Angeles, CA 90067*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize and access different types of intuition, define the intuitive/therapeutic role of dreams in diagnosis/treatment, recognize intuitive signals the body sends, use intuition as a potent adjunct to usual diagnostic tools, and recognize the difference between a genuine intuition and fear.

SUMMARY:

We are keepers of an innate intuitive intelligence so powerful that it can tell us how to heal and prevent illness. The future of medicine lies in reincorporating intuition and spirituality—vital sources of wisdom into patient care. In this workshop Dr. Orloff will present case histories of patients who have benefited from developing their intuition. She will outline specific techniques that can be put into direct action by health professionals. Participants will learn the technique of remote viewing to make medical diagnosis, recognize healing dreams, listen to the body's signals, get an overview of how the body's subtle energy system impacts health and discover the positive uses of intuitive empathy to foster breakthroughs with patients. The purpose of this workshop is to open a dialogue about intuition and spirituality—pros, cons, resistances, and practical applications in hospital and private practice settings. The workshop is lively and interactive using question-answer/discussion format.

REFERENCES:

1. Dossey L: Reinventing Medicine. San Francisco, Harper, 1999.
2. Orloff J: Dr. Judith Orloff's Guide To Intuitive Healing. Times Books, 2000.
3. Schultz M: Awakening Intuition. Harmony Books, 1999.

Issue Workshop 63
PARTNERING WITH PARENTS: TREATING PRESCHOOLERS

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, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should understand some of the ways in which the behavioral health needs of very young children can be addressed. Attendees should better appreciate the importance of establishing a working partnership with parents and the need for monitoring treatment response and outcome.

SUMMARY:

Addressing the behavioral health needs of very young children requires an expansion of the doctor-patient relationship. Because parents are the child's first leaders, strengthening their ability to do this effectively is a basic goal of treatment. The best way to do this is for the treatment team to build a partnership with the parents. The panel members presenting this workshop work with young children in the therapeutic nursery setting. They represent two different theoretical orientations, i.e., psychodynamic and cognitive-behavioral, but they agree that the process of establishing a partnership between the treatment team and the parents is essential. They will discuss their experiences trying to foster this process, and they will present some of the techniques used to help parents learn to work with young children successfully. Methods of monitoring treatment response and outcomes will also be described. Attendee participation will be facilitated through the use of videotaped vignettes that illustrate some of the issues raised by the panel.

REFERENCES:

1. McDonough S: Promoting positive early parent-infant relationships through interaction guidance. Child and Adolescent Psychiatric Clinics of North America 1995; 4:661–672.

2. Mayes L.: Addressing mental health needs of infants and young children. Child and Adolescent Psychiatric Clinics of North America 1999; 8:209–224.

Issue Workshop 64
STRATEGIES FOR RESIDENCY TRAINING IN MANAGED CARE

Chairperson: Emily Harris, M.D., *Department of Psychiatry, University of CA Davis Medical Center, 2230 Stockton Blvd, Sacramento, CA 95817-2201*
Participants: Mark E. Servis, M.D., John Luo, M.D., Terence Witham, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to identify at least three factors impacting teaching and education that differentiate an outpatient managed care service from a traditional outpatient teaching services and to describe at lease three teaching strategies to support residents learning in an outpatient managed care setting that may be applicable in their own setting.

SUMMARY:

As academic centers respond to the changing economics of medical education and practice, the clinical settings that support our teaching mission are transformed. In our setting, the university health system expanded its primary care base and became a provider of managed care services. The department of psychiatry took a lead role in developing and now manages the carveout mental health services for managed care patients in the health system. As part of this transition, the department's outpatient teaching service has become fully integrated into a comprehensive system of managed mental health care where the trainees are the largest single pool of outpatient providers. Integration of residency education into this new setting prompted the rethinking and reorganization of the outpatient curriculum. A training director, clinic chief, supervisor, and resident will provide an overview of the teaching strategies we have implemented to respond to the changes in the trainees' educational needs. The impact of the system change, i.e., the shift to managed care, on residency education and the consolidation of clinical skills is considered in a developmental framework. Workshop participants will be encouraged to contribute examples from their own experience.

REFERENCES:

1. Gomez AG, Grimm CT, Yee EFT, Skootsky SA: Preparing residents for managed care practice using an experience-based curriculum, Acad Med 1997; 72:959–965.
2. The Medical Education Committee Group for Advancement of Psychiatry: Health care reform and postgraduate medical education: challenges and solutions, Academic Psychiatry 1999; 23:1–8.

Issue Workshop 65
ADDICTION PSYCHIATRISTS, HMOS, AND PATIENT RELATIONSHIPS

Chairperson: Richard J. Frances, M.D., *Silver Hill Hospital, 208 Valley Road, New Canaan, CT 06840*
Participants: Sheila B. Blume, M.D., Robert B. Millman, M.D., Sheldon I. Miller, M.D., Frances R. Levin, M.D., Solursch Lionel, M.D.

EDUCATIONAL OBJECTIVES:

People who participate in this workshop should learn more about how the doctor/patient relationship in addiction psychiatry is being affected by third party payers and should be better informed about how best to handle the delicate process of getting approval for care.

SUMMARY:

This is the 33rd yearly meeting of an open forum on addiction treatment workshop that was first developed by John Ewing with a distinguished panel. The economics of health care have interposed third party payers as an important element in the addiction doctor/patient relationship that needs to be handled well by all in order to maximize effectiveness of addiction treatment. In this situation issues such as truth, lies, best-treatment practices, greed, and concern for the patient can lead to conflicts that need to be resolved constantly in daily practice.

We will discuss transference and countertransference issues and mistakes that can occur when working with addicted patients—especially with the relatively new injection of the conflict of dealing with third party payers and relationship the patient and psychiatrist has with third party payers. The workshop will also address the importance of having patients with substance use disorders receive psychiatric evaluation and involvement in their care. The issue of ERISA protection for insurance companies, medical-legal liability of psychiatrists working for insurance carriers, and physician care practices will all be discussed. We expect that this issue will generate heated discussion among the panellets and participants. The format is five-minute talks from the panel followed by an open discussion with questions that can broaden to any issue in addiction psychiatry that participants wish to address.

REFERENCES:

1. Addiction Treatment: Avoiding Pitfalls. Dallas, Texas, Group for Advancement of Psychiatry, 1998.
2. Clinical Textbook of Addictive Disorders (second edition). New York, Gullford Press, 1998.

Issue Workshop 66
INTEGRATING MIND AND BODY IN THE UNDERGRADUATE CURRICULUM

Co-Chairpersons: Barbara A. Schindler, M.D., *Department of Psychiatry, MCP Hospital, 3300 Henry Avenue APH Room 339, Philadelphia, PA 19129* Dilip Ramchandani, M.D., *3401 North Broad Street, Philadelphia, PA 19140*
Participant: Bryce Templeton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to assess the current status of their undergraduate curriculum, identify areas to improve integration, describe several integrated models, and identify strategies for overcoming resistance to curricular change.

SUMMARY:

As medical schools shift from traditional discipline-based courses to increased integration of basic and clinical science in year 1 and 2 and expand opportunities to learn basic science in the clinical context, strategies need to be developed to ensure adequate coverage and achievement of psychiatric educational objectives. To date, most undergraduate curricula include independent behavior science, clinical skills, and psychopathology courses with minimal correlation to other basic or clinical science material presented. Increasing opportunities now exists for psychiatric educators to participate in collaborative teaching in the first two years of medical school with other basic and clinical science disciplines and to present traditional educational objects and incorporate newer objectives from the expanding data on the role of behavior and psychopathology in the pathogenesis and treatment of illness.

This workshop will present innovative models of integrated curricula, organizing principles for those innovations, methods of integrating behavioral science objectives, and methods to address resistances to curricular changes. Participants will be invited to discuss their experiences with these and other models and strategies for

facilitating and implementing curricular change and will have an opportunity to reorganize a segment of curriculum to better meet the needs of their medical students.

REFERENCES:

1. Okasha A: The future of medical education and teaching: a psychiatric perspective, Am J Psychiatry 1977; 154 (6 Suppl):77–85.
2. Klamen DL, Sandlow L: Restructuring the role of psychiatry in medical education, Academic Medicine 1996; 71:1030–1.

Issue Workshop 67
LEADERSHIP IN ORGANIZATIONAL TRANSITIONS

Chairperson: Stewart Gabel, M.D., *Department of Psychiatry, Childrens Hospital, 1056 East 19th Avenue, Denver, CO 80218*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss specific objectives of leaders during their management of rapid organizational change, discuss leadership directed processes to facilitate successful organizational change, and discuss specific situations such as grief and mourning and resistance to change that may impede necessary organizational transitions.

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 in 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. This workshop further develops the concepts of the same workshop held at the 1999 Annual Meeting.

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, and ambivalence. Administration and Policy in Mental Health 1998; 26:3–19.

Issue Workshop 68
IMGS IN PSYCHIATRY: CHALLENGES AND OPPORTUNITIES

Co-Chairpersons: Anu Matorin, M.D., *UT-HSC-Houston, 1300 Moursund, Houston, TX 77030* Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*
Participants: Richard Balon, M.D., Vinay Kapoor, M.D., Pedro Ruiz, M.D., Tarek A. Okasha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have increased awareness of the challenges and opportunities facing IMGs as they integrate further into mainstream psychiatry in the U.S. The workshop also provides a forum for exchange of ideas and discussion on future perspectives related to this topic.

SUMMARY:

International medical graduates (IMGs) constitute 25% of the membership in APA and approximately 40% of psychiatry residents in training. Their contribution in providing psychiatric services in underserved areas has helped to mitigate the problem of serious maldistribution of psychiatrists in the U.S. Though many times referred to as a monolithic group, IMGs represent a diverse population in terms of language, culture, race, and ethnicity. However, IMGs face unique challenges in the process of adapting to the mainstream psychiatric workforce. In spite of their impact in public sector and rural psychiatry, they are not proportionately represented in private practice or academic arenas. The presentation will focus on issues such as the role and participation of IMGs in local, regional, and national professional organizations and their adaptation to the current health care environment. The workshop will also address the concerns of IMGs in psychiatry residency training as they relate to promoting fellowship training, academic careers, and providing mentorship support. This workshop will provide a forum for exchange of ideas with the hope that this discussion will increase awareness of the challenges and opportunities facing IMGs currently and in the future.

REFERENCES:

1. Blanco C, Carvalho C, Olfson M, et al: Practice patterns of international and U.S. medical graduate psychiatrists. American Journal Psychiatry 1999; 156:445–450.
2. Whitcomb ME, Miller RS: Comparison of IMG-dependent and non-IMG dependent residencies in the National Resident Matching Program. JAMA 1996; 276:700–703.

Issue Workshop 69
PROVING IT'S ALL WORTH IT

Chairperson: Leila B. Laitman, M.D., *CMHS, Visiting Nurses Services, 1601 Bronxdale Avenue, Bronx, NY 10462*
Participants: Linda Sacco, C.S.W., Rebecca Morales, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand issues involved in doing mental health service and psychotherapy efficacy research in the field and applied settings and be more willing to undertake outcome evaluation projects.

SUMMARY:

Mental health service and psychotherapy efficacy research findings under laboratory and controlled conditions have been difficult to duplicate in the field or in applied settings. This is probably because, until recently, there has been little effort even to examine the issue. An attitude that evaluation has to be done "scientifically" or it should not be done at all seems to prevail. There is an aura of mystery surrounding mental health services akin to the "black box" phenomenon. We know it works but we can't explain why. Evaluators and funders would like to know, however, whether or not consumers are different at the end of receiving services than when they began and/or how they compare with some other groups on the same measures.

The Community Mental Health Services Division of the Visiting Nurse Service of New York encompasses 22 mental health outreach programs located in four boroughs of New York City. Attempts have been made to look at outcome and efficacy of interventions in this setting. This workshop will look at two projects as examples: 1) measuring the effect of psychotherapy in increasing resistant patients' acceptance of referrals to outpatient mental health in an in-home

geriatric mental health program and 2) measuring efficacy of mobile crisis intervention via consumer / referent / funder satisfaction. In these projects, there was always tension between using methods that were feasible in field settings and drawing valid conclusions. The focus of this workshop will not be on reporting results but rather discussing problems that were encountered in implementing the outcome evaluation process and how they were dealt with. It is hoped that the audience will participate by discussing attempts they have made to evaluate outcome in their own programs.

REFERENCES:

1. Speer D: Mental Health Outcome Evaluation, San Diego, Academic Press, 1998.
2. Hargreaves W, Shumway M, HuT, Cuffel B: Cost-Outcome Methods for Mental Health. San Diego, Academic Press, 1998.

Issue Workshop 70
COLLABORATION IN ACADEMIA: TALES FROM THE TRENCHES

Chairperson: Deborah Spitz, M.D., *New England Medical Center, Box 1007/750 Washington Street, Boston, MA 02111-1526*
Participants: David A. Goldberg, M.D., Debra L. Klamen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify impediments to collaboration in academia and facilitate collaborative planning and projects, within departments and between departments and in medical student and resident education.

SUMMARY:

Collaboration is a new imperative in academia. As budgets for teaching, clinical work, and research shrink, individual faculty members—or individual departments—may be unable to carry on alone those responsibilities they shouldered in the past. Development of new curricula may require collaboration among departments at different, perhaps competing, institutions. Psychiatry is increasingly interdisciplinary, so that at both the medical student and resident levels, courses require cooperation among faculty in the neurosciences, medicine or family practice, geriatrics, and various radiological subspecialties, among others. Within departments, faculty have little time to talk about how to integrate their piece of clinical supervision or classroom teaching into the entire training program. This workshop will present three examples of collaboration. We will discuss the development of an interdisciplinary medical student curriculum, the connection among departmental faculty in a residency training program, and the involvement of individual supervisors in new training initiatives. We will address the problems in developing collaborations, such as turf issues, and the successful resolution of some of those problems. Audience participation, with examples of successful and unsuccessful collaborative efforts, will be encouraged.

REFERENCES:

1. Kouzes J, Pesner B: The Leadership Challenge. San Francisco, Jossey Bass Publishers, 1995.
2. Goodstain L, Nolan T, Pfeiffer JW. Applied Strategic Planning. New York, McGraw-Hill, Inc., 1993.

Issue Workshop 71
PSYCHOSOCIAL ADJUSTMENT OF ELDERLY ASIAN AMERICANS

Chairperson: Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, Southern Illinois University, Choate Mental Health Center, Anna, IL 62906*
Participants: Albert C. Gaw, M.D., Suk Choo Chang, M.D., Norma C. Panahon, M.D., S. Arshad Husain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to recognize major problems confronting elderly Asian Americans of major ethnic groups and learn of recognized and potential solutions.

SUMMARY:

Asians started immigrating to the United States in the 19th century; however, the vast majority of the immigrants arrived in the last four decades. There are over 10 million Asian Americans, and their number is expected to double in the next 25 years. As a result, the number of elderly Asian Americans is increasing as well. There are two groups of elderly Asian Americans: the immigrants who arrived young and the parents of immigrants who moved permanently late in life. The first group who arrived young had time to acculturate and developed reasonable strategies to function independently in this society. The second group, who arrived late in their life to a second homeland, are at a distinct disadvantage and face enormous stressors including value conflicts, lack of appropriate support system, dependence, and ambiguity of roles and identity. Perceived and real differences in customs, food habits, faith, and religion add to the problems. The faculty represent the major ethnic groups such as Chinese, Filipino, Indian, Korean, and Pakistani Asian Americans. While often the problems are similar, each group has evolved strategies to reduce the stressors and decrease morbidity. This workshop will provide a forum for sharing ideas and developing workable solutions that can benefit all elderly Asian Americans.

REFERENCES:

1. Norman A: Triple Jeopardy: Growing Old in Second Homeland. Policy Study in Aging No 3. Center for Policy on Aging, London, 1985.
2. Ananth J, Ananth K: Growing old in America, in, East Indian Immigrants to the United States: Life Cycle Issues and Adjustment. Indo-American Psychiatric Association, 1995.

THURSDAY, MAY 18, 2000

Issue Workshop 72
FORESTS, TREES, AND THERAPY: PSYCHIATRY'S PASTORAL ROLE

Chairperson: Rabbi Terry Bard, Ph.D., *Harvard Medical Center, BIDMC, 330 Brookline Avenue, Boston, MA 02215*

EDUCATIONAL OBJECTIVE:

At this workshop's conclusion, participants should be able to recognize the potential importance of a patient's spiritual and/or religious context, to evaluate its role in the patient's presenting problems, to diagnose the healthiness of this context, to develop a treatment plan incorporating these components, and to assess any changes over time.

SUMMARY:

Utilizing both case study and interactive models, this workshop will utilize the personal anecdotes and professional experiences from both the audience and the presenter to identify spiritual and/or religious dimensions of their lives and their patients' histories (approximately 20 minutes). Special attention will be given to understanding the healthy and, possibly, dysfunctional components of this context and the possible use of a supplementary differential diagnostic schemata to develop methods by which this spiritual/religious axis might be incorporated into the diagnostic assessment and the ensuing treatment planning. Particular attention will be given to transference/countertransference concerns relating to religious/spiritual material. Potential models for conjoint therapy will be offered (approximately 30 minutes). Finally, participants will discuss how to develop methodologies for longitudinal follow-up care and assessment, some of which might create interesting bridges between the physician and the community in which he or she practices (approximately 30 minutes).

REFERENCES:

1. Meissner WW: Psychoanalysis and Religious Experience. New Haven, Yale University Press, 1984
2. Sidneos P: Short Term Dynamic Psychotherapy Evaluation and Technique. New York, Plenum Medical Book Co., 1983

Issue Workshop 73
HIDDEN ABUSE: EXPLOITATION OF THE IMPAIRED ELDERLY

Chairperson: Michael J. Tueth, M.D., *Department of Psychiatry, University of Florida, PO Box 100256/College of Medicine, Gainesville, FL 32610*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate a knowledge base of financial abuse of the impaired elderly, (2) recognize the method of predatory exploitation, and (3) understand the role of the psychiatrist in legal areas of elder abuse.

SUMMARY:

This workshop consists of a literature review and the practice experience of a geriatric clinician and assistant to the Florida State Attorney. The main purpose of the presentation is to inform the audience about this hidden type of elder abuse. Areas that will be emphasized include history, epidemiological data, clinical features, as well as reporting and legal aspects. Psychological abuse of the impaired elderly virtually always accompanies exploitation. Commonly employed psychological tactics include intimidation, threats, insults, and deception in order to establish power and control over the impaired elderly person.

The most egregious form of financial abuse involves predatory exploitation of impaired elders by sociopathic individuals who are often caregivers. The method of operation of this select type of abuser consists of identifying the victim, establishing trust and confidence, isolation, securing access to funds and material possessions, and applying psychological abuse until assets are transferred. Elderly victims are often financially and emotionally devastated and rarely report the crime due to shame and guilt.

Community surveys report the prevalence of financial abuse to be 1% to 2% of the elderly population. Risk factors for victims and abusers will be identified. Also, state statutes information and appropriate interaction of the psychiatrist with legal authorities will be provided. Points of emphasis include the following: (1) financial abuse of the elderly accounts for up to 50% of the elder abuse cases, (2) abusers are usually sociopathic individuals and often caregivers, (3) there are recognized signs for identifying financial abuse of the elderly, and (4) the psychiatrist has a responsibility to identify victims and the expertise to assist with the investigation.

Approximately 40 minutes will be designated for audience participation. This involvement will consist of questions and answers, comments, and discussion of actual Florida cases.

REFERENCES:

1. Goldstein MZ: Maltreatment of elderly persons. Psychiatr Serv 1995; 46:1219–25
2. Wilber KH, Reynolds SL: Introducing a framework for defining financial abuse of the elderly. J Elder Abuse Neglect 1996; 8:61–80

Issue Workshop 74
PREVENTING INCARCERATION OF MENTALLY ILL ADULTS

Chairperson: J. Steven Lamberti, M.D., *University of Rochester, Department of Psychiatry, 1650 Elmwood Avenue, Rochester, NY 14620*
Participant: Robert L. Weisman, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify risk factors for incarceration of persons with severe mental illness, discuss current models for prevention of jail and hospital recidivism, and describe the structure and operation of Project Link.

SUMMARY:

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

This workshop will discuss risk factors for incarceration among the severely mentally ill, current models of prevention, and the structure and operation of Project Link. The importance of assertive outreach, cultural competence, and service integration will be emphasized. Results of a recent program evaluation of Project Link will be presented. Audience participation will be encouraged through the use of discussion questions and clinical vignettes.

REFERENCES:

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

Issue Workshop 75
PRINCIPLES OF EFFECTIVE STATE LEGISLATIVE LIAISON

Co-Chairpersons: Stephen M. Soltys, M.D., *SC Department of Mental Health, PO Box 485, Columbia, SC 29202,* Geoffrey J. Mason, M.P.A., *PO Box 485, Columbia, SC 29201*
Participants: Mark Binkley, J.D., David Rusin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to utilize the information presented to develop effective coalitions,

to learn to work with legislators, and utilize critical events to develop public policy issues.

SUMMARY:

Successful efforts by mental health advocates to influence the development of public policy at the state level are dependent on understanding exactly what factors need to be addressed in order to get action. In this workshop, the director of a state department of mental health and a state legislative affairs director will discuss how to effectively get action on public policy issues.

Topics will include developing a coalition of stakeholder groups, finding the common interests they have in a particular issue, and forming a common vision for action. The need to establish good working relationships with legislators, their staff, and agency heads will be stressed and ideas for how to form those relationships will be shared. The key role that critical incidents (events that grab the public's attention) play in public policy formation will be emphasized and strategies will be shared for how to utilize these windows of opportunity to increase public awareness about mental health issues. Didactic information supplemented with examples from both presenters' experiences with state government will be utilized to stimulate discussion. Participants will be encouraged to share experiences from their own states for discussion.

REFERENCES:

1. Wittenberg E, Wittenberg E: How to Win in Washington. Blackwell Press, 1994
2. Yankelovich D: Coming to Public Judgment: Making Democracy Work in a Complex World. Syracuse University Press, 1991

Issue Workshop 76
TERMINATION ISSUES IN A PSYCHOPHARMACOLOGY CLINIC

Chairperson: Toby D. Goldsmith, M.D., *College of Medicine, University of Florida, PO Box 100256, Gainesville, FL 32610–0256*
Participants: Marcia J. Kaplan, M.D., Hima B. Donepudi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to plan for the termination of a non-psychotherapy-based psychiatric practice, recognize patients who are more at risk for a difficult termination, prepare clinician for his or her own emotional issues surrounding the termination, and transition new psychiatrist into the role of caregiver to the patients.

SUMMARY:

The psychiatric and psychoanalytic literature is replete with investigations of termination issues in psychotherapeutic relationships. The disruption of a psychotherapeutic relationship due to the move of the therapist has been reviewed but there is little attention paid to the termination of relationships between patient and psychopharmacologist. With the increased prevalence of insurance panels that change each enrollment period, and with increasing mobility of our society, this sort of termination is common and largely unstudied. Termination also occurs annually in residency training programs and the impact it has upon patients in biological psychiatry clinics is minimized.

This workshop will review, retrospectively, cases terminated in the past year with most patients now followed by two other psychiatrists. The dropout rates will be assessed and the emotional needs of both patient and clinician will be discussed. The workshop faculty will include the psychiatrist who terminated with approximately 200 patient, the psychiatrist who took over with most of these cases, and the clinic's medical director. The experience of audience members will be sought and discussion encouraged.

REFERENCES:

1. Robb M, Cameron PM: Supervision of Termination in Psychotherapy. Can J Psychiatry 1998; 43:397–402
2. Firestein SK: Termination of psychoanalysis of adults: a review of the literature. J Am Psychoanal Assoc 1974; 22(4):873–94

Issue Workshop 77
21ST CENTURY AND COMMUNITY PSYCHIATRY

Chairperson: Kenneth S. Thompson, M.D., *Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*
Participants: Joel S. Feiner, M.D., Charles W. Huffine, Jr., M.D., H. Steven Moffic, M.D., Wesley E. Sowers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to (1) appreciate the shared history and common roots of social and community psychiatry (2) learn about professional efforts to advance the knowledge base and practice in these fields, (3) be engaged in a dialogue with leaders in the field to consider the future of the field.

SUMMARY:

Fifty years ago social and community psychiatry was an emergent force in the profession and in society as part of the community mental health movement. Organizations, such as the Group for the Advancement of Psychiatry and the American Orthopsychiatric Association (AOA) led the way. Some years later, after the rise and fall of the movement, the American Association for Social Psychiatry (AASP) and, later still, the American Association of Community Psychiatrists (AACP) joined the struggle. Now, as we enter a new millennium, leaving an industrial society for one unyet fully named, psychiatry is increasingly perceived as a biological/genetic science subject to market forces. What are the prospects for a social and community psychiatry in this context? In this workshop, leaders of the AASP, the AACP, and the AOA will discuss the work of their organizations and prospects for collaboration. Topics to be considered will include training psychiatrists in social and community psychiatry, its interdisciplinary nature, the social and community forces impacting on psychiatry and the contribution of psychiatry to understanding and responding to these forces, and current issues in practicing as a social and community psychiatrist. Participants will be encouraged to engage in an active dialogue to consider the future.

REFERENCES:

1. Breakey WR (ed): Integrated Mental Health Services: Modern Community Psychiatry. New York, Oxford University Press, 1996
2. Goldberg D, Thornicroft G (eds): Mental Health In Our Future Cities. East Sussex, Psychology Press Ltd, 1998

Issue Workshop 78
HOW TO MAKE AN EFFECTIVE PSYCHIATRIC PRESENTATION

Chairperson: Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able 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 (1) read while lecturing; (2) display their esoteric vocabulary; or (3) 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. Videotapes 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 and receive feedback from workshop participants.

This is a revision of a popular workshop given at the last APA annual meeting.

REFERENCES:

1. Sachdeva AK: Use of effective questioning to enhance the cognitive abilities of students. J Cancer Educ 1996; 11:17–24.
2. Bloom BS (ed): Taxonomy of Educational Objectives: The Classification of Educational Goals. Handbook I: Cognitive Domain, New York, Longman, 1984.

Issue Workshop 79
CHILD-ADOLESCENT SUBSTANCE USE DISORDERS
National Institute on Alcohol Abuse and Alcoholism

Co-Chairperson: Catherine A. Nageotte, M.D., *Northwestern University, 222 E. Superrior Street, Fourth Floor, Chicago, IL 60611,* Kevin M. Murphy, L.C.S.W., *2835 N. Heffield, Suite 211, Chicago, IL 60657*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand the scope of child-adolescent substance use disorders, (2) recognize the developmental phase of substance use disorder, and (3) identify effective intervention strategies for children and adolescents within multiple systems (family, school, health care, etc.)

SUMMARY:

1. The presenters will start with a slide presentation defining the scope (epidemiology, systems involved) of child-adolescent psychoactive substance use disorders (CAPSUDs), the developmental course of these disorders, a literature review of efficacious interventions, ineffective interventions, and currently unanswered questions about effective intervention. A comprehensive syllabus will be provided with reference citations. (15 minutes)

2. Audience questions will be addressed after this presentation (10 minutes)

3. Break. (10 minutes)

4. Presenters will ask each participant to introduce her/himself and state the one thing they would like to better understand or learn before the end of this session. Presenters will ask audience members to volunteer to describe a situation in which they were faced with specific CAPSUDs prevention or intervention. Alternately, presenter(s) will present their own cases and ask audience members to tell how they'd intervene at critical decision points. Presenters will provide hard copies of case material devoid of any identifying information for audience to use in and after the session. Presenter/audience member interaction and audience member/audience member interactions will largely occur in discussing intervention strategies during these case presentations. Presenters will also be available for questions during break and after the session. (45 minutes)

REFERENCES:

1. Johnston LD, O'Malley PM, Bachman JB: National survey results on drug use from the Monitoring the Future study, 1975–1997. Volume I: Secondary school students (NIH Publication NO. 98-4345.) Rockville, MD: National Institute on Drug Abuse, 1998.
2. Nageotte CA, Amato J: Treatment of Addiction in Adolescent Populations. Philadelphia, PA, W. B. Saunders, 1997

Issue Workshop 80
GUERILLA INTERVIEWING: A GUIDE TO ASSESSMENT

Chairperson: Gary A. Chaimowitz, M.D., *McMaster University, Box 585, Hamilton, ON L8N 3K7, Canada*
Participant: Jodi S. Lofchy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to present a new model of psychiatric assessment that is appropriate for both emergency room psychiatry and consultations to other clinicians. This outcome driven model will improve and focus assessment skills of participants.

SUMMARY:

The psychiatric interview is a dynamic process that can be adapted to fit the patient and setting. In the acute-care setting, such as the emergency room, brief focused interviewing is optimal. Time is of the essence and with a need to make decisions regarding disposition and management quickly. The classical open-ended interviewing approach would be inappropriate here. Often information is limited as a result of the severity of the patient's illness and the clinician must make decisions based on data from various sources. Immediate goals in the acute care setting include making a provisional diagnosis and effecting a safe management plan. In effect, outcomes often drive the interview; in the emergency room the clinician is constantly assessing the need for admission against discharge, with or without follow-up in the hospital or community. The interviewing approach can be structured to rapidly achieve these goals and assist with the decision making process.

Participants in this session will be introduced to a model of brief focused interviewing. Through the use of clinical vignettes, video presentation, and a game approach to history taking, they will have the opportunity to adapt the standard psychiatric interview to quickly assess the acutely ill patient.

REFERENCES:

1. Kaplan HI, Sadock BJ: Pocket Handbook of Emergency Psychiatric Medicine. Baltimore, Williams & Wilkins, 1993
2. Shea SC: Psychiatric Interviewing: the Art of Understanding, Philadelphia, W. B. Saunders Company, 1988

Issue Workshop 81
PTSD AND MEMORY: THE DEBATE GOES INTERNATIONAL

Chairperson: Landy F. Sparr, M.D., *Department of Psychiatry, Oregon Health Sciences Univ., PO Box 1034/ PVAMC P-7-MHDC, Portland, OR 97006*
Participants: J. Douglas Bremner, M.D., Charles A. Morgan III, M.D., Luka Misetic, J.D., James K. Boehnlein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that vigorous new research has reshaped thinking

about trauma and memory, and that these insights have both national and international forensic, as well as clinical, implications.

SUMMARY:

PTSD is the only psychiatric disorder that has the diagnostic requirement of exposure to a traumatic stressor. From the outset, therefore, clinicians and investigators focused on the primacy of the traumatic experience in PTSD patients' symptoms. Because a victim's description of the stressor usually depends on subjective recall, determinants of memory have received increasing scientific scrutiny. Evidence from a variety of studies has shown a relationship between exposure to traumatic stress and deficits in explicit memory function. Since victims of trauma often, either willingly or unwillingly, must enter the legal arena, it is hardly surprising that considerable importance is often attached to their recollections. In the summer of 1998, the controversial nature of these issues boiled over at the International War Crimes Tribunal for the Former Yugoslavia in The Hague, Netherlands, where a Bosnian-Croat soldier was being tried for aiding and abetting the rape of a Muslim woman. The trial turned on the woman's memory of her traumatic experiences (which were not in question) and her memory of who was there. The defendant's lawyer suggested that the troubled victim was manipulated into erroneously naming his client culpable and that her memory had been adversely affected by her trauma. The prosecution disagreed, saying that adding a PTSD label to a victim does not change the facts and that memories of such experiences are commonly hyperaccessible. Expert witnesses knowledgeable about biological correlates of memory function testified. Although research has shown that stress has long-term effects on brain regions such as the hippocampus that are involved in memory, the precise clinical expression of these findings is uncertain. The scientific parameters of this debate, which recently has been gaining momentum, and this time was staged at the world's most visible criminal court, will be presented at this workshop. Expert panelists, some of whom were at The Hague and represent both sides of the issue, will give brief presentations but will also focus on the comments and experiences of those in the audience.

REFERENCES:

1. Bremner JD, Mamar CR (eds): Trauma, Memory, and Dissociation. Washington, DC, American Psychiatric Press, 1998
2. Prosecutor v. Anto Furundzija Judgment. Case #: IT-95-17/-T. December 10, 1998. International Criminal Tribunal for the Former Yugoslavia

Issue Workshop 82
CULTURAL ISSUES IN THE DOCTOR-PATIENT RELATIONSHIP

Co-Chairpersons: Jon M. Streltzer, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813-2427,* Richard J. Castillo, Ph.D., *96-043 Alaike, Pearl City, HI 96782*
Participants: Robert T. Carter, Ph.D., Hoyle Leigh, M.D., J. David Kinzie, M.D.

EDUCATIONAL OBJECTIVES:

AT the conclusion of this workshop, the participant should be able to recognize the various ways culture/ethnicity may influence the doctor-patient relationship, understand the types of values that may differ between doctor and patient, and learn techniques to minimize the disadvantages and maximize the advantages of a cultural gap.

SUMMARY:

Culture influences the experiences, perceptions, and communications of both the doctor and the patient. Taking such influences into account may be critical to the establishment of rapport and to the success of psychotherapy, particularly when the doctor and patient come from different cultural groups. A "cultural gap" between doctor and patient may involve such factors as socioeconomic status, majority-minority racial/ethnic affiliation, and country of origin. Cultural differences may involve value systems that include very different attitudes toward such issues as work and productivity, deference to authority, openness, privacy, religion, and autonomy versus dependence. The pros and cons of matching the ethnic/cultural background between therapist and patient will be discussed. The participants in this workshop have all published extensively in the areas of culture and/or the doctor/patient relationship. They represent several racial/ethnic groups including black, white, Hispanic, and Asian. Professional backgrounds include psychiatry, psychology, consultation-liaison, and medical anthropology. Thus, the issues will be presented from varying perspectives. Case examples will be used to stimulate discussion among the presenters and the audience. The audience will be encouraged to present their own cases and perspectives for general discussion.

REFERENCES:

1. Castillo RJ: Culture and Mental Illness: A Client-Centered Approach. Pacific Grove, CA, Brooks/Cole, 1997
2. Tseng WS, Streltzer J (eds): Culture and Psychopathology: A Guide to Clinical Assessment. New York, Brunner/Mazel, 1997

Issue Workshop 83
APPLYING NARRATIVE THERAPY IN PSYCHIATRIC PRACTICE

Co-Chairpersons: Shoshana R. Sokoloff, M.D., *51 Blossoom Lane, Amherst, MA 01002-3003,* SuEllen I. Hamkins, M.D., *63 Paradise Road, North Hampton, MA 01063*

EDUCATIONAL OBJECTIVES:

In this workshop, participants will learn the theory and practice of narrative psychotherapy and its application to psychiatric practice. They will gain specific skills, such as using externalizing language, interviewing the problem, displaying transparency, promoting a more collaborative doctor-patient relationship, and eliciting a history of strengths.

SUMMARY:

Narrative psychotherapy is an innovative treatment paradigm that draws on the idea of people's lives as stories and seeks to help people experience their life stories in ways that are meaningful. Drawing from schools of individual and family psychotherapy and post-modern anthropology, narrative practices seek to create a collaborative doctor-patient relationship in which the psychiatrist allies with the patient against the problem, and develops the story of the patient's skill in resisting the problem in a treatment characterized by respect, playfulness, and creativity. Effective in psychotherapy, diagnostic and psychopharmacologic consultation, narrative practices invigorate both patients and psychiatrists.

This interactive workshop will introduce the theory and practice of narrative therapy and its application to psychiatric practice in a case-based format. Participants will have the opportunity to observe, discuss, and practice techniques including using externalizing language, eliciting the history of resistance to a problem, interviewing a problem, and using transparency in clinical practice.

Workshop participants will learn innovative and creative approaches rooted in narrative psychotherapy to help patients develop strength-based life story narratives. These approaches make the doctor-patient relationship more collaborative and render everyday adult and child psychiatric and psychopharmacological practice more engaging and more effective.

REFERENCES:

1. Freedman J, Combs G: Narrative Therapy: The Social Contruction of Preferred Realities. New York, Norton and Company, 1996
2. Freeman J, Epston D, Lobovits D: Playful Approaches to Serious Problems: Narrative Therapy With Children and Their Families. New York, Norton and Company, 1997

Issue Workshop 84
DOCTOR-PATIENT RELATIONSHIP AND MALPRACTICE SUITS

Co-Chairpersons: Sara C. Charles, M.D., *University of Illinois, Department of Psychiatry, 912 South Wood Street, MC913, Chicago, IL 60612,* Miguel A. Leibovich, M.D., *Harvard Medical School, 83 Cambridge Parkway, #609W, Cambridge, MA 02142*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to: (1) identify aspects of the doctor-patient relationship that may invite or complicate litigation, and (2) recognize signs within the doctor-patient relationship that suggest a negative rather than positive adaptation to the stresses of litigation.

SUMMARY:

It is well established that litigation is a stressful life event for physicians and may generate the development of physical or psychological symptoms and a change in practice behaviors, as well as stimulate a wide range of attitudinal changes. In a 1985 survey, for example, over 90% of the physicians indicated that one effect of being sued for malpractice was a change in the way they relate to patients. This workshop will examine the continuing impact of actual and potential litigation on physicians, many of whom work in managed care settings and all of whom are increasingly subject to fraud and abuse regulations. Is litigation still a concern or has it become so commonplace that its effects are well integrated into the doctor-patient relationship? How do trust, confidentiality, and clinical judgment fare in the current climate? Do physicians tend to do "too much or too little" for patients given the legal risks involved? After short presentations on pertinent research and clinical data, vignettes will be presented to focus on interactions with patients that may contribute to or mitigate against litigation. The audience will be able to participate actively by raising issues and bringing their own experiences.

REFERENCES:

1. Charles SC: The doctor-patient relationship and medical malpractice litigation. Bulletin of the Menninger Clinic 1993; 57(2):195–207
2. Billings JA, Stoeckie JD: The Clinical Encounter. St. Louis, MO, Mosby Publications, 1999

Issue Workshop 85
AVOIDING LEGAL RISKS IN PSYCHOPHARMACOLOGY

Chairperson: David W. Preven, M.D., *Weiler Hospital, 1825 Fastchester Road, Bronx, NY 10461*
Participants: Amy B. Rowan, M.D., Martin G. Tracy, J.D., Vernon M. Neppe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the increased forensic risks in clinical psychiatry through the use of "sophisticated" psychopharmacology, i.e., high doses, augmentation, use of non-FDA-approved drugs, and drugs used for non-FDA-approved indications.

SUMMARY:

Psychiatrists regularly use drugs that do not have FDA approved indications, e.g., clonazepam for anxiety, as well as higher doses than the FDA approved, e.g., tranylcypromine, 70–80 mg. Clinical necessity also prompts psychiatrists to try combinations not demonstrated to be effective by double-blind research, e.g., stimulants and SSRIs. Moreover, refractory patients often require drugs demonstrated to be effective in other countries, but not FDA approved, e.g., moclobemide.

This workshop will clarify which of the above expose the clinician to risk and how to lower that risk. Related questions to be answered include:

(a) What role does the Internet have in determining standard of care?

(b) What guidelines can child and adolescent psychopharmacologists use, given the paucity of research in those age groups?

This workshop is a follow-up of a well-received program offered two years ago. New information in these issues stimulated this update. Input will include a risk management expert, experienced psychopharmacologists, and contributions from the audience.

REFERENCES:

1. Frances AJ, et al: The Expert Consensus Guidelines for Treating Depression in Bipolar Disorder. J Clin Psychiatry 1998; 59 Suppl 4:73–9
2. Leonard HL (ed): The Brown University Child and Adolescent Psychopharmacology Update. Manissess Communications Group, Inc. 1(August): 1–8, 1999

Issue Workshop 86
THE PHYSICIAN-PATIENT RELATIONSHIP: NOT JUST MEDICATION

Chairperson: Eugene J. Fierman, M.D., *Faulkner Hospital, 1153 Centre Street, Suite 5970, Boston, MA 02130-3446*
Participants: Gregory G. Harris, M.D., Ann L. Potter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to conceptualize a model of practice for psychiatrists as "front door" medical specialists, which emphasizes active initial involvement and long-term follow-up and prevention, in lieu of the traditional model of "meds vs. therapy."

SUMMARY:

Despite medical and psychiatric morbidity and mortality greater than heart disease and diabetes, evaluation and treatment of major mental illness in many clinical settings (especially under managed care systems) is primarily performed by non-psychiatrists. All too often, psychiatrists have been relegated to the ("backup") role of prescriber of psychotropic medication, usually in brief "medication checks." We advocate putting psychiatrists in a more central role and encouraging them (both within the field and by managed care) to be actively involved in prevention, triage, acute management, treatment planning, and comprehensive follow-up over the lifetime of a person with mental illness. For psychiatrists, this model obviates the question of "meds vs. therapy," and shifts the focus to flexible treatment planning and engaging with patients who desire more access to psychiatrists. While some patients may engage in traditional psychotherapy, a large majority may be better served by the psychiatrist as the sole clinician. We will encourage active audience participation to discuss parity, use of psychodynamic and biological knowledge, managed care and professional lifestyle, and relations with non-psychiatrist providers.

REFERENCES:

1. Edwards J, Maude D, et al: Prolonged recovery in first episode psychosis. Br J Psychiatry 1998; 172 (33):107–16
2. Hays RD, Wells KB, et al: Functioning and well-being outcomes of patients with depression compared with chronic general medical illnesses. Arch Gen Psychiatry 1995; 52 (1):11–9

Issue Workshop 87
INTENSIVE OUTPATIENT PROGRAMS

Chairperson: Anand Pandya, M.D., *Columbia University, 215 East 24th Street, #322, New York, NY 10010-3804*
Participant: Mary Spelman Sciutto, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand where Intensive Outpatient Programs may fit in different care systems, recognize patients that are best treated by this modality, and identify adaptations that can help in the development of small outpatient programs.

SUMMARY:

Intensive Outpatient Programs (IOPs) can be defined as mental health programs that provide a minimum of nine hours per week structured services and are less restrictive than partial programs but significantly more intense than routine outpatient care. Such programs were originally designed for addictive disorders but are now being used for general psychiatric disorders.

First, we will discuss the historical and economic trends that have created a recent boom in IOPs. Second, we will describe the results of a survey of such programs in the New York area, reviewing what diagnostic and demographic groups are treated at IOPs. Audience members will be encouraged to describe their experience with this modality and their perceptions of its strengths and weaknesses.

Third, we will focus on one particular IOP. We will identify several challenges that occurred when developing such a program. These include the development of a referral base, the identification of appropriate dispositions for aftercare, and the negotiation of managed care contracts. We will discuss one set of solutions including decisions concerning affiliation, physical location, and innovative staffing patterns. We will invite the audience to describe their own approaches to these problems in analogous settings.

REFERENCES:

1. VBH Clinical Manual, 1995, pp B-9 B-11
2. Gottheil E, et al: Intensive outpatient treatment: methods and outcomes. Journal of Addictive Diseases 16: xv–xix

Issue Workshop 88
STALKING AND CYBERSTALKING: A RISK ASSESSMENT

Co-Chairpersons: John M. Deirmenjian, M.D., *101 Terraza Santa Elena, La Habra, CA 90631,* Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand a new classification of stalking and cyberstalking, methods of intervention, and approaches to prevention.

SUMMARY:

Stalking is defined as the willful, malicious, and repeated following and harrassing of another person that threatens his or her safety. While stalking is an age-old behavior, it has received significant attention by criminal justice and mental health professionals within the last decade. Since 1990, all 50 states have enacted anti-stalking laws. In addition, the Internet has created a new medium for stalking behavior, known as cyberstalking. Mullen and colleagues developed a new classification of stalking behavior into five categories: rejected, intimacy seekers, incompetent, resentful, and predatory. The five categories of stalking also apply to cyberstalkers. This workshop will address the characteristics of stalkers and present a risk assessment of stalking behavior. Methods of intervention for each type of stalker, such as involving law enforcement or obtaining restraining orders, will be discussed. Methods of prevention will also be addressed.

REFERENCES:

1. Mullen PE, Pathe M, Purcell R, Stuart GW: Study of stalkers. American Journal of Psychiatry 1999; 156:1244–1249
2. Deirmenjian, JM: Stalking in cyberspace. J Am Acad Psychiatry Law 1999; 27:407–413

Issue Workshop 89
AIM FOR THE RIGHT TARGET: FOCUS ON MOTIVATION

Chairperson: Mary C. Cole, M.S.W., *Durham Veterans Hospital, 508 Fulton, Durham, NC 27705*
Participants: Theresa A. Yuschok, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants should be able to assess the stage of change readiness, level of conviction, confidence and readiness; identify motivational interviewing techniques appropriate for each level of readiness; and develop an initial approach for client intervention with addicted clients.

SUMMARY:

What motivates clients to change and in what ways? How do clinicians determine interventions most appropriate to the client's stage of change? What therapeutic approach enhances our abilities to gain fuller understanding of the concerns that are presented by clients and maximizes our therapeutic alliance?

Proschaka and DiClemente outline five stages of change readiness: precontemplation, contemplation, determination, action, and maintenance. Keller and White discuss additional components of conviction, confidence and readiness. Miller and Rollnick utilize these concepts in the application of motivational interviewing with a strong emphasis on the use of reflective listening to enhance change. Clients struggling with addiction disorders often present initially in precomtemplation (not interested in change) or contemplation (ambivalence about change).

Participants in this workshop will engage interactively to identify change readiness as well as degree of confidence, conviction, and readiness. Utilizing a case presentation for an addicted client, participants will then formulate an initial treatment approach based on use of reflective listening skills and interventions appropriate for each stage of change readiness, with strongest emphasis on ambivalence for change.

REFERENCES:

1. Miller WR, Rollnick S: Motivational Interviewing, Preparing People to Change Addictive Behavior. New York, NY, The Guilford Press, 1991

2. Keller VF, White MK: Choices and changes: a new model for influencing patient health behavior. J of Communications on Medicine 1997; 4(6), 33–36

Issue Workshop 90
SPIRITUAL ISSUES IN END-OF-LIFE CARE

Co-Chairpersons: Christina M. Puchalski, M.D., *National Institute of Health Research, 6110 Executive Boulevard, Rockville, MD 20852,* William Breitbart, M.D., *Department of Psychiatry, Memorial Sloan Kettering, 1275 York Avenue, Box 421, New York, NY 10021-6007*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the role of spirituality in end-of-life care, (2) recognize the role of meaning in coping with cancer, particularly in advanced disease, (3) recognize the role of meaning and faith in symptom control in dying patients and in patients with cancer.

SUMMARY:

There are numerous problems in end-of-life care ranging from poor symptom control to unwanted treatment. A major area of difficulty has been in communicating with patients about their issues regarding their illness and their dying. Some of the key issues patients have are spiritual: what gives them meaning and what helps them cope with suffering. This workshop will consist of three parts. The first part will be an overview of the role of spirituality in end-of-life care with a discussion of research data and patient cases and also ways health care practitioners can address these issues in their patients and themselves. The second part will focus on meaning and cancer with the discussion of:

- Meaning-centered psychotherapy based on Victor Frankl's logotherapy.
- An eight-session meaning-centered group of psychotherapy interventions for cancer patients.
- A review of how issues of meaning and faith impact symptoms in cancer patients.

The third part of the workshop will involve a brief experiential exercise on "death awareness" designed to help workshop participants to sensitize trainees, staff, and colleagues to issues of death, dying and meaning.

REFERENCES:

1. Park CL, Folkman S: Meaning in the context of stress and coping. Review of General Psychology 1997; 1:155–144.
2. Puchalski CM: Grief: Making Sense of Loss, Primary Care of Older Adults: An Interdisciplinary Approach. St. Louis, MO, Mosby, September 1999 (In press)

Issue Workshop 91
COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Chairperson: Judith S. Beck, Ph.D., *Cognitive Therapy & Research, The Beck Institute, 1 Belmont Avenue, Suite 700, Bala Cynwyd, PA 19004*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) conceptualize personality disorder patients according to the cognitive model, (2) recognize therapeutic alliance issues in treatment of personality disorders, (3) set goals and plan treatment for patients with characterological disturbance, (4) combine pharmacotherapy and cognitive therapy for personality disorder patients, and (5) 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. Roleplays will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout and a final segment will instruct interested participants in the steps they can take to learn about this empirically validated approach for a difficult patient population.

REFERENCES:

1. Beck AT, Freeman A, et al: Cognitive Therapy of Personality Disorders. New York, Guilford, 1990
2. Beck JS: Cognitive approaches to personality disorders, in Dickstein, LJ, Riba, MB, Oldham, JM. (Eds.) American Psychiatric Press Review of Psychiatry, Vol. 16, Washington, D.C.: American Psychiatric Press, 1997

Issue Workshop 92
NEUROANATOMY AND NEUROPHYSICS OF THE UNCONSCIOUS

Co-Chairperson: Vincenzo R. Sanguineti, M.D., *1015 Chestnut St, Suite 825, Philadelphia, PA 19107-5567,* Stuart R. Hameroff, M.D., *University of Arizona, 1501 Campbell Street, Tucson, AZ 24511*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) achieve familiarity with the fundamental designs, the laws, and the experimental evidence to the quantal aspect 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 consist of three segments:
I.

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 the third segment.

b) Psychiatry has of late been primarily involved with neurobiology and with the stochastic operations of neuronal emsembles. The most significant and documented breakthroughs will be outlined. Faculty and participants will discuss these findings as they may pertain to sites and laws governing unconscious operations.

II. 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

III. The faculty will then join the audience in exploring the "fitting" between these findings and the characteristics of the unconscious as outlines in the first segment.

REFERENCES:

1. Beck F: Synaptic Transmission, Quantum State Selection, and Consciousness, in: Toward a Science of Consciousness: The Second Tucson Discussion and Debates. MIT Press, Cambridge, Mass, 1998: 619–634
2. 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. MIT Press, Cambridge, Mass, 1998: 635–644

RESEARCH ADVANCES IN PSYCHIATRY

RESEARCH ADVANCES IN PSYCHIATRY: AN UPDATE FOR THE CLINICIAN

Chairperson: Herbert Pardes, M.D.
Co-Chairperson: Pedro Ruiz, M.D.
Participants: Marc A. Schuckit, M.D., Jeffrey A. Lieberman, M.D., Charles B. Nemeroff, M.D., Carol A. Tamminga, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will become familiar with new advances in research, especially those covered at the 2000 Annual Meeting. In addition, participants will learn about new research in alcoholism, depression on cardiovascular disease, and schizophrenia.

SUMMARY:

Disseminating information in a timely fashion about advances in new research is critical to the practice of clinicians. This session will not only highlight the topics that are being covered at the 2000 Annual Meeting, but will attempt to give participants some notion of the national priorities in research.

REFERENCE:

1. Riba MB, Oldham JM (eds): Review of Psychiatry Volume 18, Washington, DC, American Psychiatric Press, Inc., 1999.

CLINICAL CASE CONFERENCES

MONDAY, MAY 15, 2000

1. A CHILD WITH MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS

Robert L. Hendren, D.O., *Department of Psychiatry, UMDNJ/Robert Wood Johnson, 671 Hoes Lane/UBHC/F12/Room C231, Piscataway, NJ 08855-1392*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be able to discuss the differential diagnosis of unexplained physical symptoms; develop a treatment plan for working with Somatization Disorder in children; and share the difficulties in working with children with unexplained physical symptoms and identify ways to have a successful outcome.

SUMMARY:

The case of an eight-year old child with multiple unexplained physical symptoms and multiple negative medical work-ups will be presented. The development of the symptoms, the work-ups performed, and the developmental and family history will be described. A potential differential diagnosis will be presented that includes Somatization Disorder, Conversion Disorder, Munchausen's Syndrome and Depressive Disorder as well as the possibility that a physical disorder has been identified.

Dr. Herzog will discuss key aspects of this case including the differential diagnosis and the recommended treatment plan.

Several key discussion points will be identified to engage the audience in an interactive case conference.

REFERENCES:

1. Brown LK, Fritz GK, Herzog DB (1997) Psychosomatic Disorders, in *Textbook of Child and Adolescent Psychiatry,* JM Wiener (Ed.) Washington DC, American Psychiatric Press, Inc., pp. 621–633.
2. Herzog DB, Harper G (1981) Unexplained Disability: Diagnostic Dilemmas and Principles of Management. Clin Pediatr (Phil) 22:29–33.

TUESDAY, MAY 16, 2000

2. AFFECT DYSREGULATION: CLINICAL ISSUES AND PSYCHOTHERAPY

Roslyn Seligman, M.D., *Department of Psychiatry, University of Cincinnati, 231 Bethesda/PO Box 670559, Cincinnati, OH 45267,* Brenda C. Solomon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be able to discuss the psychotherapeutic challenges of one case that mimics chronic bipolar affective disorder (BAD), but appears to be another; provide clinical vignettes and therapeutic interventions to illustrate a way of understanding and explaining affect dysregulation that leads to a diagnosis other than BAD; and show that understanding and explaining this patient's course of illness from a self-psychology perspective led to more significant improvement in his affect disregulation than that obtained using mood stabilizers and antipsychotic agents.

SUMMARY:

Manic depression is a major public health problem affecting approximately one percent of the U.S. population. If there is no definitive history of mania or current mania, making an accurate diagnosis can be challenging. Other conditions such as self or personality disorders can mimic the affect dysregulation of manic depression and can lead to over/misdiagnosis and therapeutic failure. In this conference, the presenter will introduce the case of a 33-year-old man with a 27-year history of increasing difficulty and age-related changes in diagnosis. The patient manifested an episodic course and became dysfunctional with failures in school, work and family. He also displayed addictive behaviors including drugs and gambling. The diagnosis of manic depression, ADD and anxiety disorder and their accompanying pharmacological treatments did not improve the patient's functioning or alleviate his chronicity. Recent psychotherapy has yielded slow, but definite improvement. The psychotherapy is one informed by an understanding of both disorders of the self and attachment disorders. The patient's course under different periods of diagnostic understanding and subsequent treatments affords us the opportunity to show how a self psychology informed psychotherapy can lead to a better outcome in some syndromes that mimic manic depression.

REFERENCES:

1. Kohut H: *The Restoration of the Self.* New York International Universities Press, 1977.
2. Ornstein Paul H. and Ornstein, Anna: Assertiveness, Anger, Rage, and Destructive Aggression: A Perspective from the Treatment Process in *Rage, Power, and Aggression,* Glick Robert A and Roose P. (eds.) New Haven and London: Yale University Press, 1993.
3. Goldberg, Anrold: *Being of Two Minds.* Hillsdale: The Analytic Press, 1999.

WEDNESDAY, MAY 17, 2000

3. AN ELDERLY PATIENT WITH MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS

William E. Reichman, M.D., *Department of Psychiatry, UMDNJ-RWJ Medical School, 667 Hoes Lane, Piscataway, NJ 08856,* Sandra Swantek, M.D., Lawrence Lazarus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant will understand how biological and psychological factors contribute to medically unexplained physical symptoms in elderly patients and how this process informs the most thoughtful approaches to treatment.

SUMMARY:

The clinical presentation of an elderly woman with intractable abdominal pain for which no medical cause could be found will be reviewed. A detailed account of the emergence of her symptoms and the aggressive medical and surgical approaches employed to identify possible causes will be offered. Additionally, discussion will focus on the myriad attempts that were made to treat the patient's symptoms by a host of medial and psychiatric providers. Importantly, the case review will focus on the potential biological and subsequently, uncovered, psychological factors that may have contributed to the patient's syndrome. Finally, there will be an in depth review of the recent literature that describes contemporary approaches to diagnosing and treating medically unexplained symptoms in the elderly.

REFERENCES:

1. Wessely S, Nimnuan C and Sharpe M. Functional Somatic Syndromes: One or Many? Lancet 1999; 354:936–39.
2. Russo J, Katon W, Sullivan M, Clark M, Buckwald D. Severity of Somatization and Its Relationship to Psychiatric Disorders and Personality. Psychosomatics 1994; 35:546–56.

THURSDAY, MAY 18, 2000

4. WOMEN AND ADDICTION: ENHANCING MOTIVATION FOR CHANGE

Tedra L. Anderson-Brown, M.D., *Butner Alcohol & Treatment Center, 1003 12th Street, Butner, NC 27509,* Tanya R. Cheevers, M.D., Mary C. Cole, M.S.W., David M. McDowell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant will be able to review and discuss clinical assessment and treatment strategies to motivate change in a woman with an addictive disorder and complex psychosocial issues. Strategies for pharmacotherapy will also be discussed.

SUMMARY:

The purpose of this clinical case conference is to present and discuss a woman who offered a complex array of diagnostic questions and clinical treatment issues. Numerous issues arise in working with women with addictive disorders including physical health, mental health, and psychosocial problems.

This case presentation will be chaired by Dr. Tedra Anderson-Brown who will present general principles in working with woman with addictive disorders as well as the numerous psychosocial issues that arise. Dr. Tanya Cheevers will present a case of a woman with an addictive disorder and a complicated narrative and comorbidities. Cathy Cole, LSW will review motivational interviewing techniques and apply these principles to the case as developed by Rollnick and Miller. Dr. David Miller will review the pharmacotherapy approaches to women with addictive disorders through the case wxample. The expert panel will encourage audience participation and a discussion of the issues that are raised in the treatment of a woman with addictive disorders.

REFERENCES:

1. Rollnick, S., Miller, W. Motivational Interviewing—Preparing People to Change Addictive Behavior, Guilford Press, 1991.
2. Comfort, M, Zanis DA, Whitely MJ, Kelly-Tyler A, Kaltenbach KA, Assessing the Needs of Substance Abusing Women: Psychometric Data on the Psychosocial History, J Substance Abuse Treat; 17(1–2(:79–83, Jul-Sept, 1999.

MONDAY, MAY 15, 2000

CONTINUOUS CLINICAL CASE CONFERENCE PART I AND II: PATIENTS WITH MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS: PSYCHIATRY AND FAMILY MEDICINE AS PHYSICIAN PARTNERS

Arthur J. Barsky III, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115-6195,* Frank de Gruy, M.D., Susan McDaniel, M.D., Tom G. Campbell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this two-day presentation, the participant will be familiar with the diagnosis and treatment of depressed patients with prominent somatic features and the various models of collaborative care that psychiatrists and family physicians can employ to treat somatizing and depressed patients.

SUMMARY:

Day one of this presentation will be devoted to an extended discussion of several illustrative cases of somatized depression encountered in family practice and primary care medicine. The diagnosis, treatment and long-term management will be discussed from the perspective of the family physician, the consulting psychiatrist and the perspective of family dynamics and the family context.

The second day will consist of a workshop about the collaborative treatment of somatizing and depressed patients by psychiatrists and family physicians. Using specific case examples of particularly challenging psychiatric patients in medical practice, various models of collaborative care will be presented, and the obstacles, barriers, solutions and the advantages of each discussed.

REFERENCES:

1. Katon W, Kleinman A, Rosen G: Depression and Somatization: A Review. Part I Am J Med 1982; 72:127–135; Part II Am J Med 1982; 72:241–247.
2. Rodin G, Voshart K: Depression in the Medically Ill: An Overview. Am J Psychiatry 1986; 143:696–705.

DEBATE

SEXUAL REORIENTATION THERAPIES FOR HOMOSEXUALITY WORK AND ARE ETHICAL

Moderators: Robert L. Spitzer, M.D. and Richard C. Friedman, M.D.
Affirmative: Warren Throckmorton, Ph.D. and Gerald Zuriff, Ph.D.
Negative: Marshall Forstein, M.D. and Armond Cerbone, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be updated on the adequacy and limitations of the empirical and clinical evidence indicating that the various components of sexual orientation (fantasy, behavior, identity) are flexible and can be changed with a sexual reorientation therapy; the underlying assumptions of different sexual reorientation therapies; clinical assessment of the underlying motivations of some homosexuals for sexual reorientation and the possible untoward (and/or positive) effects of such therapy. Finally, the ethical justification of providing sexual reorientation therapy will be discussed.

SUMMARY:

Affirmative:

Critics of sexual reorientation therapy (SRT) claim that SRT is ineffective, harmful, and unethical. However, anecdotal evidence and a review of the literature, including psychoanalytic, behavioral, cognitive, group, and religious approaches, show that for many clients, change in sexual orientation is possible, especially with strong motivation and social support. These approaches agree on the need for increasing assertiveness, decreasing anxiety over heterosexual relationships, and the development of heterosexual social skills. This literature fails to specify what elements, if any, of SRT are harmful. Furthermore, given our ignorance about the longitudinal stability of sexual orientation, claims about the unalterability of sexual orientation lack empirical support. APA opposes only treatments that assume homosexuality per se is a mental disorder or that assume a priori that the patient should change homosexual orientation, but SRT does not necessarily entail these assumptions. A mental disorder is not a prerequisite for psychotherapy. Cosmetic surgery, abortion, and psychotherapy to improve normal performance are examples of ethically acceptable treatments for non-pathological conditions. Likewise, clients may wish to change their sexual orientation for rational, non-neurotic, and voluntary reasons. Clients who wish to explore SRT should be given that option and be informed of professional disagreements over SRT. Neither gay-affirmative nor SRT should be assumed a priori to be the preferred approach. Clinicians should not impose their own values by deciding for clients which aspects of their personalities should take precedence. To deny SRT to clients who authentically wish for change is to denigrate their values.

Negative:

Proponents of sexual orientation change therapy continue to try to make ethical the intention on the part of therapists to try to change their patient's sexual orientation. Aside from the absence of scientific evidence that sexual orientation can be changed by therapy, all proponents of such change therapy start with the prior assumption that sexual orientation which is not heterosexual is by definition problematic and inherently inferior. In this society, growing up with any feelings toward the same sex can create conflicting feelings and beliefs. Given the history of the mental health professions, attitudes towards homosexuality and the prevailing Judeo-Christian prohibitions, scientific discussions about changing sexual orientation cannot be separated from the political and theoretical issues, nor the social context. Without the assumption of pathology, there is no ethical or scientific basis to consider a role for psychotherapists in changing sexual orientation. Therapy may be helpful to people looking to explore the nature of their beliefs and conflicts about their sexual orientation. But it is one thing for patients to ask therapists to discuss these conflicts and choices about their behavior, and quite another for therapists to hold out a claim, even advertise, to be able to change sexual orientation. For any therapist to harbor and convey even subtle beliefs that heterosexuality is preferable is ethically problematic. Since most of those proponents of sexual orientation change therapy appear to be heterosexual, the ethics of a therapist in a position of social power over someone who is a figurative and often literal outlaw must be examined.

REFERENCES:

1. Ferrara P: More Than a Theory: Medical Savings at Work. Policy Analysis 22, CATO Institute, March, 1995.
2. Tanner M: Medical Savings Accounts: Answering the Critics. Policy Analysis 228, CATO Institute, March, 1995.
3. U.S. General Accounting Office Report to Congressional Committees: Medical Savings Accounts: Results from Surveys of Insurance, December 1998.
4. Bunce KC: The Basics of Medical Savings Accounts. Association Management 50(2):85-90, 1998.

FORUMS

MONDAY, MAY 15, 2000

1. PSYCHIATRIC PERSPECTIVES ON VIOLENCE

Chairpersons: Carl C. Bell, M.D.
Participants: Paul Jay Fink, M.D., Arthur Z. Berg, M.D., Sandra L. Bloom, M.D., Bradley R. Johnson, M.D., Sandra J. Kaplan, M.D., Richard P. Kluft, M.D., John R. Lion, M.D., Joe P. Tupin, M.D., J. David Kinzie, M.D., Linda Roll

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to outline the principles for managing violent patients; list five techniques to ensure practitioner safety; list five principles involved in treating the traumatized patient; list five principles in assessing perpetrators of violence; list five principles in treating victims and perpetrators of sexual violence, discuss biological variables involved in the etiology of violence; list seven principles necessary to prevent violence in youth; and understand assessment and treatment issues involved in the treatment of family violence (child abuse, domestic violence, and elder abuse).

SUMMARY:

The American Psychiatric Association's Task Force on Violence will present its report during this session. The topics will cover a wide range of issues including the biology of violence, assessing the violent patient and clinician safety, prevention of violence, assessing perpetrators of violence, treatment of the traumatized patient, issues of family violence (child abuse, domestic violence, and elder abuse), and treatment of victims and perpetrators of sexual violence.

REFERENCES:

1. Bell, CC. (ed.) *Psychiatric Perspectives on Violence.* San Francisco: Jossey-Bass, in press.
2. *Violent Behavior and Mental Illness.* Washington, DC: Psychiatric Services, 1997.

2. ETHNIC ISSUES IN ALCOHOL RESEARCH

Chairperson: William B. Lawson, M.D.
Participants: Bankole A. Johnson, M.D., Ting-Kai Li, M.D., Paul Spicer, M.D. and Deborah Deas, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will be more aware of the complex interplay between biology and cultural in determining alcoholism; and will become knowledgeable about the effectiveness of various treatment programs in different populations.

SUMMARY:

Recent research in alcohol use and abuse has shown significant ethnic variation. Cultural and biological factors probably interact to determine drinking patterns, and the physical consequences of alcohol dependence. Specific enzymatic makers have been found that may have a protective effect against dependence for some ethnic groups while others are particularly vulnerable and may be more likely to suffer the deleterious effects of alcohol exposure. Treatment response to both psychosocial programs and pharmacotherapy may show ethnic variation. These presenters will provide a forum for discussion of the complex interplay between biology and culture in determining alcohol use, consequences, and treatment across different populations.

REFERENCES:

1. Committee on Cultural Psychiatry. Alcoholism in the United States: Racial and Ethnic Considerations. Washington, DC, American Psychiatric Association Press.
2. Kinzie JD, Leung PK, Boehnlein, J. et al: Psychiatric Epidemiology of an Indian Village: A 19 Year Replication Study, J Nerv Mental Dis 1992; 180:33–39.

3. SCHOOL VIOLENCE AND ITS AFTERMATH

Chairperson: Mohammad Shafii, M.D.
Participants: Harriet Hall, Ph.D., Robert S. Pynoos, M.D., Michael Breen, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be familiar with acts of violence in the United States as compared with those in other developed nations; become cognizant of the tragic aftermath of school violence and the physical and psychiatric morbidities which follow; become aware of the development of time-limited cognitive-behavior group therapy programs for youth which might help the victims of physical and psychological trauma following acts of violence; become aware of the legal responsibilities and liabilities regarding the duty to warn and protect (ramification of the *Tarasoff* case) from a plaintiff lawyer's perspective and be able to respond proactively rather than reactively.

SUMMARY:

In the United States, acts of violence have been decreasing in adults but increasing in children and adolescents, particularly in schools. Acts of violence include vandalism, physical and sexual assault, rape, bodily injury, and homicide. Between 8–10% of U.S. high-school students carry guns to school every day. In a typical middle-sized city, 30–50 cases of school violence are reported daily, half of which involved guns.

The chance of a student dying a violent death in an American high school is five times higher than in other developed, industrialized countries. In Japan, for instance, with half the population of the U.S., the annual death rate by guns for all ages is 170 persons or less per year. The spread of endemic school violence from urban centers to suburban and smaller white communities has brought this major public health problem to national attention.

Educators and health and mental health professionals need to take a more proactive role in understanding, dealing with and preventing school violence. Not only have many youth, teachers, and parents been killed or physically maimed, but thousands are suffering and will continue to suffer for years to come from the physical and psychological traumas of school violence.

In this forum, Harriet Hall, Ph.D, Chief Executive Officer of the community mental health center in Denver, who has had direct clinical experience with the aftermath of Columbine High School massacre, will discuss this national tragedy and its physical and mental health consequences. Robert Pynoos, M.D., Professor of Psychiatry, Director, Trauma Psychiatry Program, UCLA School of Medicine, will describe an effective school-based cognitive psychotherapy program for adolescents who sustained or witnessed violent injuries. Michael Breen, J.D., Bowling Green, KY, the plaintiff's lawyer for the victims of school violence in Paducah, KY, will discuss the *Tarasoff* case and its ramifications for the clinician regarding the duty to warn and protect. Each presentation will be limited to 20–25 minutes and there will be ample opportunities for audience participation.

REFERENCES:

1. Garbarino, J: Lost Boys: Why Our Sons Turn Violence and How We Can Save Them. New York, The Free Press, 1999.

2. Shafii M, Shafii SL: School Violence: Contributing Factors, Management, and Prevention. Washington, DC, American Psychiatric Press, in press.

TUESDAY, MAY 16, 2000

4. BEYOND JUST WATCHING HATE CRIMES: IN THE 21st CENTURY

Chairperson: Leah J. Dickstein, M.D.
Participants: Carl C. Bell, M.D., Silvia W. Olarte, M.D., and Robert P. Cabaj, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be more informed of the multiple groups that are victimized by hate crimes and of the different ways to actively intervene to stop hate crimes.

SUMMARY:

The forum, "Beyond Just Watching Hate Crimes In the 21st Century," will give attendees the information they need to become more proactive as mental health professionals in working with the media. Our national experts will share their in-depth knowledge of and recommendations about effective interventions we all can use to intervene appropriately in the multiple forms of hate crimes everywhere. Carl Bell, M.D., will describe his efforts regarding racial hate crimes and hate crimes toward inner city populations, especially the youth; Robert Cabaj, M.D., will focus on hate crimes toward gays, lesbians, bisexuals and transsexuals at work and in communities at large; Silvia Olarte, M.D., will discuss hate crimes toward recent immigrant populations; Leah Dickstein, M.D., will highlight hate crimes focused on many religious groups and toward women and men at all life stages and in all life areas. Sufficient time will be held for questions and discussion.

REFERENCES:

1. Simkin, Ruth J., M.D., *Not All Your Patients are Straight,* CMAJ, 159(4):370–375, August 25, 1998.
2. Kressel, Neil Jeffrey, *Mass Hate: the global rise of genocide and terror.* New York, Plenum Press, 1996.

5. SEX, DRUGS (NOT ROCK AND ROLL) NATIONAL AND INTERNATIONAL POLITICS: PUBLIC VERSUS PRIVATE MORALITY

Chairperson: David M. McDowell, M.D.
Participants: Herbert D. Kleber, M.D., Nada L. Stotland, M.D., Andrew Solomon, and Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an increased understanding of the controversies surrounding public versus private morality issues; and will be able to articulate their own professional and personal attitudes toward specific controversies.

SUMMARY:

As the information age matures the boundary between what is publicly acknowledged, and what is completely privileged becomes increasingly blurred. What questions do reporters have to ask presidential candidates? What questions do candidates have a right to refuse to answer? What right does an employer have to know about sensitive issues in a potential employees life, either past or current? What are the boundaries between what is public and private? What should they be? This forum will bring together leading experts, both in psychiatry and in other professions to discuss this topic from both a theoretical and practical viewpoint. Some specific topics that will be explored are: Current and Past Drug use, Family history, Past Psychiatric history and treatment, Sexual Identity, and Past Sexual Activity. The creators of the US constitution, wrote Justice Lois D. Brandeis, conferred on American citizens "the right to be let alone—the most comprehensive of rights and the right most valued by civilized men." Yet we live in a world in which interconnectedness is increasingly apparent, and necessary, but where it may be used for either good or ill. What are the boundaries?

REFERENCES:

1. Schlesinger, Arthur Jr. He Won't Tell. Should We Care?" Op Ed New York Times Sunday January 9, 2000.
2. Bok, Sissela Lying: Moral Choice In Public and Private Life. Random House Books 1978.

6. MATERNITY LEAVE DURING PSYCHIATRY RESIDENCY TRAINING

Chairperson: Samantha Meltzer-Brody, M.D.
Participants: Carol C. Nadelson, M.D., Michelle L. Kramer, M.D., Lindsey George, M.D., Helen L. Egger, M.D., and Carol A. Bernstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss the current policy and practice of maternity leave in psychiatry residency training programs, identify issues related to maternity leave and childbearing during medical training and explore areas for future improvement.

SUMMARY:

Most women in medicine want to combine a family life and a career. Many women are having children during medical training which has resulted in increased demands for longer maternity leaves, greater training flexibility and child care opportunities. One major issue facing women physicians has been determining the most desirable time for pregnancy during their medical education and career. Two recent studies examining the issues related to pregnancy and child rearing for women physicians were conducted. The workshop will review the results of these studies, and discuss the current practice and policy of maternity leave in psychiatry residency training programs. Although the length of maternity leave has increased over the last several decades, many changes remain necessary in the training of physicians and the practice of medicine that place greater emphasis on the importance of caring for one's own family as a physician.

REFERENCES:

1. Potee RA, Gerber AJ, Ickovics JR: Medicine and motherhood:shifting trends among female physicians from 1922–1999. Acad Med 1999; 74(8):911–9.
2. Sinal S, Weavil P, Camp MG: Survey of women physicians on issues relating to pregnancy during a medical career. J Med Educ 1988; 63(7):531–8.

WEDNESDAY, MAY 17, 2000

7. ALCOHOL AND INTERPERSONAL VIOLENCE: PUBLIC HEALTH AND CRIMINAL JUSTICE ISSUES

Chairperson: Linda A. Teplin, Ph.D.
Participants: Raul Caetano, M.D., Jacquelyn C. Campbell, Ph.D., and Susan E. Martin, Ph.D.,

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to present the latest NIAAA-funded research on the relationship between drinking and crime.

SUMMARY:

Public health professionals have long been concerned about the relationship between alcohol use and crime. Studies consistently find that between 42% and 53% of homicide victims had been drinking. Data for other violent crimes are less accurate. However, studies of detained populations and the general population confirm that drinking is a common ingredient of crime, especially interpersonal violence. This forum presents recent research in four areas: (1) Dr. Susan Martin will review recent findings on the alcohol-crime relationship and recommend prevention strategies; (2) Dr. Linda Teplin will present data on alcohol abuse/dependence and psychiatric comorbidity from three studies of detained populations: adult males, adult females and delinquent youth; (3) Dr. Raul Caetano will present data on intimate partner violence in the general population and highlight socioeconomic and racial/ethnic differences; (4) Dr. Jacquelyn Campbell will present data showing the frequency and patterns of drinking from a study of women killed by their husbands or partners.

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2. Pernanen, K. Alcohol in Human Violence. New York: Guilford Press, 1991.

8. THE PHARMACEUTICAL INDUSTRY AND THE APA: CONTROVERSIES AND APPROACHES

Chairperson: Stephen M. Goldfinger, M.D.
Participants: Jacqueline M. Feldman, M.D., Charles R. Goldman, M.D., Carol C. Nadelson, M.D., Michelle Riba, M.D., Pedro Ruiz, M.D., James H. Scully, Jr, M.D., James W. Thompson, M.D., Daniel K. Winstead, M.D., and Ian E. Alger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to describe the current policies and activities of the APA and the ACCME; members will have shared their thoughts about important future directions for the APA; and discussions on how best to shape and oversee this industry/organizational boundary will have taken place.

SUMMARY:

The interface between the pharmaceutical industry and medical/professional organizations has become an area of increasing scrutiny and controversy. From scholarly publications to tabloid media, attention is being focused on the nature, content, oversight, and potential abuse of industry involvement in research, academic departments, and medical societies. In response to leadership and member concerns about these issues, in 1999 the APA established the Committee on Commercial Support.

This newly formed component is charged with developing policies and procedures to ensure that the interface between the APA and commercial/industry supported activities reflect the highest ethical and educational standards. Direct tasks of the group include monitoring the content of industry-supported presentations at the Annual Meetings, developing guidelines and policies for improving the quality and balance of these presentations, and establishing sanctions for members and organizations in violation of APA policy. Although many policies involve interpretation of the guidelines of the ACCME, others are newly developed by APA, which is now a leader for policymaking in this arena.

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1. Friedberg M. Saffran B. Stinson TJ et al: Evaluation of Conflict of Interest in Economic Analyses of New Drugs Used in Oncology; JAMA. 1999; 282:1453–1457.
2. ACCME's Essential Areas, Elements, and Decision-Making Criteria Accreditation Council for Continuing Medical Education, pp 7–10, July 1999.

THURSDAY, MAY 18, 2000

9. SUBSTANCE ABUSE: AN INTERNATIONAL PERSPECTIVE

Chairperson: Rodrigo A. Munoz, M.D.
Co-Chairperson: Pedro Ruiz, M.D.
Participants: Ismael Rolden, M.D., and Ivan Montoya, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have received facts and new information about medical strategies and government policy regarding problems in the cultivation and distribution of addictive drugs in the Americas.

SUMMARY:

Psychiatrists work in North and South America will review information coming from research at national or international levels regarding the health, financial and political effects of chemical dependence. The problem has evolved in such a way that today there is no country that is exempt from problems due to the cultivation, refinement, distribution and consumption of addictive drugs. Solutions require a better understanding of the circumstances attending the cultivation, processing and distribution of Cocaine and Heroin. The consumption of these drugs continues to be an international problem that would require intense cooperation among psychiatrists, government officials and international policy makers.

It has been argued that "treatment and prevention get the short end of the stick in Congress", while other interventions have not been proven to be successful.

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2. Sex, Drugs, Gambling, and Chocolate. Horvath, A. T. Impact Publishers, Inc., San Luis Obispo, California, 1998.
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INDUSTRY-SUPPORTED SYMPOSIUM 1—MIND AND BODY IN THE PATIENT WITH DEPRESSION: CLINICAL IMPLICATIONS OF THE INTERRELATIONSHIP BETWEEN PSYCHIATRIC, CEREBROVASCULAR AND CARDIOVASCULAR DISEASE

Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the hypothesized association between dysfunction of prefrontal systems and vascular depression; appreciate the importance of identifying and treating post-stroke emotional and behavioral disorders as a means of enhancing recovery; recognize the association between depression and increased risk of cardiovascular morbidity and mortality and the implications for the clinical management of patients with cardiovascular disease; and consider a rational approach to the use of antidepressants in patients with comorbid vascular disease.

No. 1A
PREFRONTAL DYSFUNCTION IN GERIATRIC PATIENTS

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Although late-onset depression is heterogeneous in nature, there may be a sub-population of geriatric patients with depressive disorders that are etiologically related, characterized by underlying cerebrovascular disease or risk factors. This "vascular depression" hypothesis is supported by the frequent comorbidity of depression with diabetes, hypertension, coronary artery disease, stroke, and vascular dementia. Additionally, imaging studies have shown that elderly patients with depression have white matter hyperintensities (WMHs) more frequently than nondepressed elderly patients, that WMHs are most frequent in elderly depressed patients with vascular disease, and that WMHs of elderly patients with depression are most prominent in subcortical and frontal areas. Similarly, cerebrovascular lesions have been shown to occur frequently in subcortical areas or perforating artery areas supplying the basal ganglia, which are connected to the frontal lobe through the cortico-striato-pallido-thalamo-cortical (CSPTC) pathways. Thus, disruption of prefrontal systems or CSPTC pathways by a single lesion or an accumulation of lesions may be a central mechanism in late-onset depression.

Patients with vascular depression appear to have symptoms consistent with damage to CSPTC pathways. For example, patients with late-onset depression and vascular risk factors have greater cognitive impairment and disability than those with nonvascular depression. Additionally, patients with vascular depression appear to have more psychomotor retardation, greater lack of insight, and less agitation and guilt than elderly patients with early-onset depression without vascular risk factors.

This presentation will review the evidence suggesting that neural dysfunction of the prefrontal cortex is a common feature of late-onset depression.

No. 1B
NEUROPSYCHIATRIC CONSEQUENCES 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:

Mood disorder is a common consequence of cerebrovascular disease although the prevalence of depression varies with the setting. It is highest among hospitalized patients and lowest in community samples. The overall frequency of major and minor depression is approximately 20% each. The duration of untreated major depressive disorder is approximately eight to nine months, although a minority of cases may continue for three years or more. Major depression following stroke is associated with a greater degree of cognitive impairment than stroke without depression and with delayed recovery in activities of daily living at two-year follow-up. In addition, patients with major or minor depression following stroke have 3.5 times greater likelihood of dying within the first 10 years following acute stroke than nondepressed patients. Randomized, double-blind treatment studies have demonstrated that post-stroke depression may be effectively treated with the tricyclic antidepressant nortriptyline or the serotonin reuptake inhibitor citalopram. A recent study comparing nortriptyline with fluoxetine in the treatment of post-stroke depression, however, demonstrated that nortriptyline is superior to both fluoxetine and placebo in the treatment of post-stroke depression in a 12-week treatment period. Neither fluoxetine nor nortriptyline led to significantly greater improvement in physical or cognitive recovery than placebo. These findings suggest that although depression can lead to adverse consequences in both physical and cognitive recovery, antidepressant treatment may be more effective on mood than physical or cognitive recovery. Only selective groups have been shown to have greater recovery in cognitive function and activities of daily living when treated with antidepressants or after spontaneous mood improvement.

No. 1C
CARDIOVASCULAR DISEASE AND DEPRESSION: CAUSE, EFFECT OR CONUNDRUM?

Francois Lesperance, M.D., *Montreal Heart Institute, 5000 Belanger Street East, Montreal, QC H1T 1C8, Canada*

SUMMARY:

Depression and coronary artery disease frequently co-occur, but whether there is a causal relationship remains unclear. Depression-related increases in cardiovascular risk have been documented in initially healthy samples and in patients with existing cardiovascular disease. The degree of risk associated with depression is as great as that associated with more traditional risk factors, and largely independent of them. For example, measures of depression have been associated with relative risks between 1.5 and 2 for fatal IHD or MI over periods ranging from six to 27 years in community samples of initially healthy individuals. The depression-related risk of cardiac mortality up to 18 months in post-MI patients is even higher, with relative risks in the range from 3 to 6 after control for measures of disease severity. Depression can influence behavioral risks like smoking, exercise, and compliance with recommended medications. Biologically plausible mechanisms have also been suggested including chronic disturbances in autonomic balance and platelet aggregation. Although the strength of the evidence suggests that it is a promising area of research, to date there have been no studies of the impact of treatment of depression on cardiovascular outcomes. This presentation will review the epidemiological and pathophysiological evidence linking depression and cardiovascular

disease, consider the possibility that at least part of this relationship may be due to vascular depression, and suggest avenues for future research.

No. 1D
ANTIDEPRESSANT PHARMACOTHERAPY IN THE ELDERLY AND OLD-OLD

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

SUMMARY:

Late-life depression is a prevalent and serious condition that is associated with increased morbidity and mortality. Although depressive symptoms are common among the elderly, depression is not a normal part of aging and must not be regarded as such. Compared with younger adults who typically present with depressed mood, the older depressed patient is more likely to present with symptoms including somatic complaints, irritability, insomnia, fatigue, and anxiety. The frequent comorbidity of depression with medical illness and/or cognitive dysfunction can further confound diagnosis and treatment.

The goals of treatment are to achieve remission of symptoms, to restore functioning, and to prevent relapse or recurrent episodes. Special care should be given during initiation of pharmacologic treatment, as older patients may be more susceptible to adverse events, both because of age-related changes in metabolism and drug clearance, as well as polypharmacy necessitated by comorbid illnesses. Tricyclic antidepressants (TCAs) no longer are considered first-line treatment for late-life depression, because they are associated with troublesome adverse effects and potential toxicity in patients with underlying cardiac disease. As a class, the selective serotonin reuptake inhibitors (SSRIs) have a more favorable adverse event profile, lacking the anticholinergic, cardiovascular, and sedative side effects associated with TCAs. Importantly, they do not appear to impair cognitive function. Unfortunately, there have been relatively few well-controlled studies of antidepressant treatment in the elderly, and, until recently, almost no data in patients with concomitant illnesses or in those 75 years of age and older-the so-called "old old". This presentation will review the differential diagnosis of latelife depression and discuss recent findings from clinical trials of antidepressant pharmacotherapy in the elderly and "old old".

No. 1E
PSYCHOPHARMACOLOGY IN THE CONTEXT OF COMORBID VASCULAR ILLNESS: APPLYING KNOWLEDGE OF DRUG METABOLISM TO OPTIMIZE DRUG THERAPY

David J. Greenblatt, M.D., *Department of Pharmacology, Tufts University, 136 Harrison Avenue, Boston, MA 02111*

SUMMARY:

The coincidence of cardiovascular disease and depression may require concurrent treatment with medications for both disorders. The availability of the selective serotonin reuptake inhibitor (SSRI) and related mixed-mechanism antidepressants over the last 15 years has broadened the pharmacologic options available for treatment of depression. However, the possibilities for pharmacokinetic and metabolic drug interactions have also increased, since many of the newer antidepressants are inhibitors of the Cytochrome P450 metabolic enzymes. Interactions via this mechanism may be of importance for treatment of cardiovascular disorders. Fluoxetine (and its metabolite norfluoxetine) and paroxetine are strong inhibitors of P450-2D6, responsible for metabolism of metoprolol and (in part) propranolol. Nefazodone and to a lesser extent fluvoxamine and norfluoxetine are inhibitors of P450-3A, mediating metabolism of most calcium antagonists and quinidine. Fluvoxamine is a strong P450-1A2 inhibitor, the cytochrome that mediates theophylline metabolism. The antidepressants citalopram, sertraline, and venlafaxine are relatively weak or negligible cytochrome inhibitors. Knowledge of potential cytochrome inhibitory effects will be of value in selecting an antidepressant agent for individuals with concurrent cardiovascular disease.

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INDUSTRY-SUPPORTED SYMPOSIUM 2—SEXUAL DYSFUNCTION: EPIDEMIOLOGY, ETIOLOGY, DIAGNOSIS AND MANAGEMENT
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) understand the extent and mechanisms of sexual dysfunction, (2) diagnose and accurately assess sexual dysfunction over time, and (3) manage treatment-emergent sexual dysfunction.

No. 2A
EPIDEMIOLOGY, CLASSIFICATION AND ASSESSMENT OF SEXUAL DYSFUNCTION

Anita L.H. Clayton, M.D., *Department of Psychiatry, University of Virginia, 2955 Ivy Road Northridge #210, Charlottesville, VA 22903*

SUMMARY:

Sexual functioning is an important public health issue. As such, it is important to examine the context of sexual functioning specific to the phases of the sexual response cycle, including lifelong psychosexual adjustment, primary sexual disorders, illness effects, medication effects, and interpersonal interactions. Sexual function appears to be largely mediated by sex steroids and the neurotransmitters, dopamine and serotonin. Thirty percent of men and 40% of women report primary sexual disorders. Many illnesses may impair sexual functioning, including psychiatric illness such as depression, with 70% to 80% of patients with major depressive disorder experiencing decreased libido. Impairment of sexual functioning is also associated with substance abuse, inadequate levels of sex steroids (i.e. menopause), and numerous medications (i.e. antihypertensives, antidepressants).

Because most patients do not spontaneously report sexual dysfunction, direct inquiry initiated by the physician is important. Assessment of sexual functioning must be gender- and phase-specific (desire, arousal, orgasm, and resolution), and should be performed at initial assessment to determine premorbid psychosexual adjustment and illness effects, and throughout treatment to document medication effects. Several tools are available for the assessment of sexual functioning. With timely and targeted assessments guiding appropriate interventions, the best possible outcomes can be achieved.

No. 2B
PREVALENCE AND ASSESSMENT OF ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

Antidepressant-induced sexual dysfunction (AISD) has emerged as an important clinical side effect since the advent of SSRIs and the newer generation of antidepressants. Each of the major classes of antidepressants is associated with variable rates of sexual dysfunction, but early data contained in package inserts were derived from spontaneous reports of side effects. These rates are probably gross underestimates of the true incidence of AISD since studies used, by default, a "don't ask, don't tell" methodology. In head-to-head studies that use established rating scales to measure sexual functioning before and after treatment, it appears that bupropion, nefazodone, and mirtazapine are associated with the least AISD, while the SSRIs (fluoxetine, sertraline, paroxetine, and citalopram) and venlafaxine are associated with substantial rates of AISD. TCAs and MAOIs have a long history of AISD but the rates are less clear because of methodological limitations. This presentation will review the prevalence and assessment of sexual dysfunction across antidepressants.

No. 2C
MANAGEMENT OF ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION

H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 2600 Marble Avenue, NE, Albuquerque, NM 87131*

SUMMARY:

Considerable attention to antidepressant treatment-emergent sexual dysfunction has recently emerged. This long under-recognized and under-reported side effect reportedly occurs in 45% to 60% of patients prescribed SSRIs. The renewed interest is in part due to advances in understanding the biological basis of sexual functioning, awareness that troublesome side effects compromise patient compliance necessary for continuation treatment, and competition in a $6 billion antidepressant market. Management of this iatrogenic condition centered on largely tautological literature reviews as to etiology, with limited evidence from primarily open-label/non-controlled studies, and offering only marginally effective treatment recommendations. The development of new agents based on advances into mechanisms of signal transduction and novel neurotransmitters suggests that effective treatment of this troublesome problem can significantly impact outcome and reduce the morbidity and mortality of the common disorders for which SSRI antidepressants are prescribed, but too commonly discontinued. Reports of SSRI antidepressant-induced sexual dysfunction prevalence vary according to multiple factors; i.e., when and how measured, agent, dose, treatment response, comorbid conditions, pre-existing SD, phase of sexual function, gender, age, and concurrent medications. Generally inconsistent approaches with serotonin antagonists, dopaminergic agonists, cholinergic agonists, 5-HT/adrenergic autoreceptor antagonists, stimulants, drug holidays, writing for tolerance, dose reduction, and herbals are reviewed. Augmentation and/or substitution by non-SSRI antidepressant agents is currently receiving much attention. The available data and implications of AD switching will also be critically reviewed. Finally, sildenafil, recently introduced for treatment of male erectile dysfunction, will be examined in terms of its potential use in the management of SSRI antidepressant-induced sexual dysfunction.

No. 2D
HORMONAL ASPECTS OF SEXUAL FUNCTION IN WOMEN: IMPROVEMENT WITH HORMONE REPLACEMENT THERAPY

Julia K. Warnock, M.D., *Department of Psychiatry, University of Oklahoma, 2808 South Sheridan, Suite 200, Tulsa, OK 74129-1014;* J. Clark Bundren, M.D., David W. Morris, M.A.

SUMMARY:

Menopause, surgical or naturally occurring, with reduced or deficient ovarian functioning has a major impact on morbidity and mortality in mid to late life. HRT typically includes an estrogen dose capable of protecting against osteoporosis, providing relief of hot flushes, and improvement in genitourinary symptoms such as vaginal dryness and dyspareunia. HRT research has recently focused on the role of androgens in maintaining women's health and emotional well being.

The administration of physiological levels of androgen replacement therapy as an adjunct to estrogen replacement to improve sexual desire in women with a deficiency in testosterone was investigated. The Sexual Energy Scale (SES), a simple, objective means of assessing the patient's lost familiar experience of sexual desire, was used to measure the patient's improvement with androgen replacement therapy. Three cases of women who had undergone a total abdominal hysterectomy with bilateral oophorectomy with complaints consistent with female hypoactive sexual desire disorder and free testosterone levels of <2.0 pg/ml are presented. The data suggest that physiologic androgen replacement using oral methyltestosterone in doses of 0.25 mg to 1.25 mg per day is helpful in increasing sexual desire for some women. Physiologic androgen replacement has a role in the treatment of women with hypoactive sexual desire disorder.

No. 2E
SEXUAL DYSFUNCTION IN MEN: DIAGNOSIS AND TREATMENT OF PATIENTS WITH DEPRESSION AND OTHER PSYCHIATRIC DISORDERS

Matthew A. Menza, M.D., *Department of Psychiatry, Robert Wood Johnson Medical School, 675 Hoes Lane, Piscataway, NJ 08854;* Raymond Rosen, Ph.D.

SUMMARY:

Data from the Massachusetts male aging study, a large population-based survey, suggest that erectile dysfunction (ED) is a prevalent condition, affecting 20 to 30 million men in the U.S. ED is also the most prevalent sexual disorder in males seeking treatment in sexual dysfunction clinics in the U.S. and abroad. There are strong data to suggest that ED increases in frequency and severity with age, medical illnesses, and lifestyle factors. Furthermore, there is a strong link between erectile dysfunction and depressive symptoms: depressed men are twice as likely to report symptoms of moderate to severe ED compared with non-depressed men. Numerous studies have also documented an increased rate of ED in men taking psychotropic medications. The traditional division of ED into organic and psychogenic appears to be undermined by data suggesting that most men have some combination of these factors. This leads to a treatment approach that takes both issues into account. The standard office medical workup for ED will be discussed. Common treatment approaches including herbal medications and oral erectogenics will be reviewed. Recent data suggesting that men with depressive symptoms and ED respond well to sildenafil, both in terms of ED and in depressive symptoms, will be reviewed.

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INDUSTRY-SUPPORTED SYMPOSIUM 3—REPRODUCTIVE PSYCHIATRY: AN UPDATE ON WOMEN'S HEALTH

Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, the audience will be updated on psychiatric issues related to PMDD, pregnancy, postpartum, and menopause. Current research, clinical implications, and future directions will be emphasized.

No. 3A
PREMENSTRUAL DYSPHORIC DISORDER: NEW RESEARCH

Meir Steiner, M.D., *Department of Psychiatry, McMaster University, 50 Charlton Avenue East, St. Joseph's, Hamilton, ON L8N 4A6, Canada*

SUMMARY:

The recent inclusion of research diagnostic criteria for premenstrual dysphoric disorder (PMDD) in the DSM-IV recognizes the fact that some women in their reproductive years have extremely distressing emotional and behavioral symptoms premenstrually.

As many as 75% of women experience some symptoms of premenstrual syndrome. However, only 3% to 8% of women in this age group meet criteria for PMDD. These women report premenstrual symptoms that seriously interfere with their lifestyle and relationships. The etiology of PMDD is largely unknown, but the serotonergic system, which is in close reciprocal relationship with the gonadal hormones, has been identified as the most plausible target for interventions. Thus, the serotonin reuptake inhibitors (SSRIs) are emerging as the most effective treatment option for this population.

Results from several randomized, placebo-controlled trials in women with PMDD, with predominantly psychological symptoms of irritability, tension, dysphoria, and lability of mood, have clearly demonstrated that the SSRIs have excellent efficacy and minimal side effects. More recently, several preliminary studies have indicated that intermittent (premenstrually only) treatment with SSRIs is equally effective in these women and, thus, may offer an attractive treatment option for a disorder that is itself intermittent.

No. 3B
MOOD DISORDERS IN PREGNANCY AND LACTATION: TREATMENT ISSUES

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University Medical School, 1639 Pierce Drive, Suite 4003, Atlanta, GA 30322;* James R. Strader, Jr., B.S., Amy L. Hostetter, B.A.

SUMMARY:

The impact of pregnancy on the natural course and treatment of mood and anxiety disorders remains obscure. Yet the literature is saturated with review articles and case reports typically emphasizing the risk/benefit assessment for medication use in pregnancy or lactation. Considering the potential impact of untreated mental illness on obstetrical outcome, infant well being, and the burgeoning database on the relative safety of antidepressants during the reproductive years, the actual management of women during pregnancy is seldom discussed beyond the risk/benefit assessment, such as daily dose, fetal exposure, and the impact of other medications. Equally important is the relationship between these illnesses and their treatment during the often abrupt transition to the postpartum period with respect to

medication adjustments, frequency of follow up visits, and treatment planning. Clearly, the data in breast feeding indicate a relatively lower infant exposure compared with placental passage. The interpretation of infant serum measures will be provided with practical guidelines for infant monitoring. The adverse impact of maternal depression on infants warrants the rapid identification and the most effective treatment model. Our group employs a multifaceted approach with >70% achieving wellness (Ham D <7) by eight weeks of treatment. The model and the symptomatic and biological predictors of treatment response in women with PPD will be discussed.

No. 3C
THE USE OF SSRIS IN PREGNANT AND LACTATING WOMEN

Shaila Misri, M.D., *Reproductive Psychiatric Program, St. Paul's Hospital, 1081 Burrand Street, Room 250, Vancouver, BC V6Z 1Y6, Canada*

SUMMARY:

For many women suffering from severe mood and anxiety disorders during pregnancy and lactation, treatment with the appropriate antidepressant medications remains a viable, but challenging option in which the benefits and risks of treatment must be carefully weighed. The selective serotonin reuptake inhibitor (SSRI) antidepressants are presently used by an increasing number of women who are of childbearing age for treatment of anxiety and depressive illnesses. Recent investigations of the fetal safety in relation to SSRI exposure during pregnancy and lactation reveal no specific increase in major malformations. However, current studies give limited information on the effects of early versus late exposure of these medicines on the developing fetus. Further, the biobehavioral impact of the SSRIs on the growing infant requires exploration. In this presentation, a comprehensive review of the current literature on the effects of SSRI exposure in the pregnant woman and her nursing infant is presented. Further, a summary of a peer-reviewed study conducted at the University of British Columbia entitled "Psychological, Behavioural, and Pharmacological Effects of Maternal Psychotropic Drug Use During and After Pregnancy," is described.

No. 3D
MOOD, HORMONES AND MENOPAUSE

Catherine A. Roca, M.D., *BEB, National Institute of Mental Health, Building 10-3N242, 10 Center Drive, MSC 1277, Bethesda, MD 20892;* Peter J. Schmidt, M.D., David R. Rubinow, M.D.

SUMMARY:

Epidemiologic studies demonstrate that the majority of women do not experience depression during the perimenopause. However, evidence suggests that for a subgroup of women, the perimenopause *is* a time of increased risk for developing major or minor depression. While a number of factors may contribute to the etiology of perimenopause-related depression, a growing body of evidence supports the relevance of estrogen (or the withdrawal of estrogen) in the etiology of this disorder. We have examined the role of estrogen in mood regulation in several ways. First, we demonstrated that estradiol under double-blind, placebo-controlled conditions, improved measures of mood in depressed perimenopausal women with and without hot flushes. Then, in an effort to identify potential mechanisms underlying estrogen's beneficial effects on mood, we showed that the serotonin receptor antagonist metergoline (but not placebo) reversed the efficacy of estradiol, suggesting that the beneficial effects of estradiol are mediated by the serotonin system. These data suggest a means by which estradiol may serve as a primary or adjunctive therapy in the treatment of depression during the perimenopause.

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INDUSTRY-SUPPORTED SYMPOSIUM 4— THE MANY FACES OF PSYCHOSIS
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should (1) be familiar with the genetic underpinnings of psychosis including factors contributing to different phenotypic expressions, and (2) be familiar with the phenomenology, diagnostic issues and management of psychosis associated with mood disorders, schizophrenia, and dementia.

No. 4A
THE GENETIC EPIDEMIOLOGY OF PSYCHOSIS

Kenneth S. Kendler, M.D., *Department of Psychiatry, Virginia Commonwealth University, P.O. Box 980126, Richmond, VA 23298-0126*

SUMMARY:

Of the psychotic disorders, we know most about the genetics of schizophrenia, which is a highly familial disorder. Most or all of the tendency for schizophrenia to "run" in families results from genetic factors shared among relatives. The spectrum of disorders that aggregate in families of individuals with schizophrenia includes schizophrenia-like personality disorders as well as non-schizophrenia, non-affective psychotic disorders such as schizoaffective disorder, schizophreniform disorder, and psychosis NOS. In support of a broad familial predisposition to "psychosis," affectively ill relatives of schizophrenic probands appear to be more likely to develop affective psychosis than are affectively ill relatives of controls. Despite much effort to localize schizophrenia susceptibility loci on the human genome, no unequivocally replicated linkages have been found to date, although several regions (e.g., 6p, 8p, 10p, 22q) are under active investigation. Of the four replicated linkage regions in the Irish Study of High-Density Schizophrenia Families, three of them maximize with a broad definition of the schizophrenia spectrum that include both non-schizophrenic, non-affective psychoses and psychotic affective illness. We review the evidence in published

reports of overlap of linkage regions between bipolar illness and schizophrenia and the current support, from a genetic perspective, for unitary models of psychosis.

No. 4B
PSYCHOSIS ASSOCIATED WITH SCHIZOPHRENIA

Prakash S. Masand, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Psychosis is considered sine qua non of schizophrenia even though negative symptoms and cognitive deficits are equally common. Contrary to popular belief among many clinicians, no single psychotic symptom or sign, including first-rank Schneiderian symptoms, are pathognomonic of schizophrenia. The phenomenological similarities and differences of psychosis in schizophrenia with that in mood disorders, dementia, seizure disorders, and delirium, among others, will be addressed. Pharmacological interventions including conventional and novel antipsychotics, mood stabilizers, antidepressants, benzodiazepines, glycine, ampakines, and other novel agents will be discussed, including the risk/benefit ratio of these different interventions.

No. 4C
PSYCHOSIS ASSOCIATED WITH MAJOR DEPRESSION

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

SUMMARY:

The possibility that psychotic depression is a distinct subtype of depression was first suggested by the observation that psychotic patients were less likely to respond to tricyclic antidepressants than were nonpsychotic patients. Subsequently, studies showed that recurrent episodes of depression were much more likely to be psychotic in the psychotic subgroup. Additionally, studies demonstrated that the illness ran true-to-form in families. Both of these findings supported the contention of the distinct nature of psychotic depression. Studies of other variables, including hypersecretion of cortisol, have also shown abnormalities in this group. Initial treatment studies suggested the advantage of the combination of an antipsychotic with an antidepressant over either drug alone, although these early studies were conducted with conventional neuroleptics and the tricyclic antidepressants. In recent years, treatments with atypical antipsychotics and SSRIs have been reported. The current state-of-the-art with respect to treatment will be reviewed.

No. 4D
PSYCHOSIS ASSOCIATED WITH BIPOLAR AND SCHIZOAFFECTIVE DISORDERS

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-812, Boston, MA 02114*

SUMMARY:

Bipolar and schizoaffective disorders are challenging to diagnose and treat. Both have been frequently mistaken with schizophrenia in the past, and sometimes remain confused with unipolar depression today. We will discuss some of the controversy around the validity of schizoaffective disorder as a diagnosis, review the presentation of psychosis in bipolar disorder, and discuss the efficacy of atypical antipsychotic agents in those two conditions.

No. 4E
PSYCHOSIS ASSOCIATED WITH DEMENTIA

George T. Grossberg, M.D., *Department of Psychiatry, St. Louis University, 1221 South Grand Boulevard, #213A, St. Louis, MO 63104-1016*

SUMMARY:

Alzheimer's disease (AD) accounts for up to 75% of progressive dementias and affects nearly four million patients in the United States. It has been estimated that 30% to 40% of patients with AD develop psychotic symptoms, with delusions and visual hallucinations being most commonly described. Psychotic symptoms in AD often trigger agitation and other behavioral disturbances that are a source of excessive disability in AD. Behavioral disturbances in AD are also the number one reason for nursing home admission. The evaluation, differential diagnosis, as well as nonpharmacologic and pharmacologic approaches to psychosis in dementing illnesses are discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 5—NOREPINEPHRINE AND DEPRESSION IN THE ELDERLY
Supported by Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize depression in the elderly, understand the role of norepinephrine in symptoms of anhedonia and decreased drive, be familiar with dosing of noradrenergic antidepressants.

No. 5A
EPIDEMIOLOGY AND CLINICAL PRESENTATION OF DEPRESSION IN THE ELDERLY

Soo Borson, M.D., *Department of Psychiatry, University of Washington School of Medicine, 1959 NE Pacific Street, Box 356560, Seattle, WA 98195*

SUMMARY:

Rates of depression in the elderly are integrally linked to the prevalence of age-related chronic medical diseases, and to losses and chronic stressors such as bereavement or caring for a demented spouse. Each of these etiological factors elevates risk for depression five-fold or more over rates for older adults enjoying a healthy and secure retirement. The critical need for effective detection of elderly persons at risk for depression or already ill remains unmet. At least half of all older depressives are unrecognized by health care providers; particularly vulnerable to failed detection are men in the early post-retirement years when suicide rates begin to accelerate, the very old, and persons with chronic, low-intensity symptoms. Clinical presentations more common in older than younger adults include severe, psychotic, and melancholic major depressions; depressions with brain dysfunction due to cardiovascular, respiratory, and primary neurodegenerative diseases; and chronic depressions causing insidious and progressive social disengagement, deconditioning, and disability easily mistaken for impacts of comorbid medical illness. In each, specific clinical features can be heuristically related to the impact of aging and disease on the central noradrenergic system, and therapeutic approaches designed to enhance noradrenergic mechanisms may have a unique place in geriatric therapy.

No. 5B
THE IMPORTANCE OF THE PREFRONTAL NORADRENERGIC SYSTEMS IN DEPRESSION, ALZHEIMER'S DISEASE AND PSYCHOSIS

Kenneth L. Davis, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029;* Joseph I. Friedman, M.D., Vahram Haroutunian, Ph.D.

SUMMARY:

The role of noradrenergic neurotransmission in normal cognitive functions has been extensively investigated; however, the involvement of noradrenergic functions in the cognitive impairment associated with schizophrenia and Alzheimer's disease has not been as intensively considered. The limited ability of atypical antipsychotics to treat the cognitive impairment of schizophrenia and of cholinominetics to treat the cognitive impairment of Alzheimer's disease may be related to the influence of a multiplicity of neurotransmitter abnormalities, including noradrenergic dysfunction, which these treatments do not address. Basic scientific and clinical evidence from studies in schizophrenia and Alzheimer's disease support the practice of using noradrenergic drugs in combinations with antipsychotics and cholinesterase inhibitors, respectively, to enhance the treatment of the cognitive impairment in these diseases. Evidence is also accumulating that the alpha-2A agonists may be a particularly rational choice of medications for cognitively impaired individuals with these diseases.

No. 5C
SIGNIFICANCE OF ANERGIA AND ANHEDONIA AS SYMPTOMS OF DEPRESSION: BIOLOGICAL AND PHARMACOLOGICAL PERSPECTIVES

Bruce G. Pollock, M.D., *Geriatric Psychopharmacology, Western Psychiatric Institute & Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Losses of energy, motivation, and capacity to experience pleasure are significant features of geriatric depression. In a recent study, our group at the Western Psychiatric Institute in Pittsburgh, found 95 of 117 depressed patients (mean age 72.7 ± 7.6 years) to be suffering from severe anergia. Depressive anergia and anhedonia in elders may be exacerbated by concomitant sensory impairments, other medical disorders (e.g., thyroid dysfunction, dementia, Parkinson's disease, malaise of chronic illness), as well as by a wide variety of medications (e.g., antipsychotics, selective serotonin reuptake inhibitors [SSRIs], beta blockers). Major forebrain regions, including the extended amygdala and ventral striatopallidium, are recognized as crucial to motivation, while the ascending dorsal noradrenergic bundle of the locus ceruleus has been implicated in cognitive processes such as selective attention. Dopamine (DA) modulates the regulation of arousal, motivation, and locomotor response. Norepinephrine has long been believed to play a vital role in sustaining drive. Uncontrolled studies of dopamine agonists suggest benefit in a motivational symptoms accompanying geriatric depression and dementia, while SSRIs may inhibit DA release potentially exacerbating parkinsonian and apathetic symptoms. Conversely, selective norepinephrine reuptake inhibitors (selective NRIs) may either directly improve executive function and focused attention through enhancing frontal lobe function or indirectly facilitate DA release, improving drive, social function, and the speed of cognitive processing.

No. 5D
EFFICACY AND SAFETY OF NORADRENERGIC ANTIDEPRESSANTS IN THE ELDERLY

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Administration, Stanford, CA 94305-5717*

SUMMARY:

There is a growing controversy regarding the relative efficacy of noradrenergic and serotonergic antidepressants in geriatric patients with major depression. Roose, et al reported in a study of post-cardiac depressives that significantly greater antidepressant effects were observed with treatment with nortriptyline, a noradrenergic tricyclic antidepressant, than with fluoxetine, a serotonergic antidepressant. In contrast, paroxetine (a serotonergic antidepressant) and nortriptyline were reported to have equal efficacy in a similar group of patients. Recent observations that paroxetine may exert effects on blocking norepinephrine (NE) reuptake suggest enhancing NE in brain may be particularly important in geriatric depression. Data will be presented from a recent trial of 300 geriatric patients in which venlafaxine, (a mixed NE/serotonin reuptake blocker) fluoxetine, and placebo were compared. Studies on reboxetine, a selective NE reuptake blocker, in older patients with major depression will also be reviewed. The role noradrenergic antidepressants may play in geriatric psychiatry will be discussed.

No. 5E
TREATMENT OPTIONS FOR MEDICAL AND PSYCHIATRIC COMORBIDITY WITH DEPRESSION

Dwight L. Evans, M.D., *Chairman of Psychiatry, University of Pennsylvania, 305 Blockley, 423 Guardian Drive, Philadelphia, PA 19104*

SUMMARY:

Depression is common in the medically ill. The prevalence of major depression and subsyndromal depressive conditions in patients with active medical problems far exceeds that of the general population. Rates of depression increase with the acuteness of medical care, ranging from a low of 9% in general outpatient environments to 30% or more in hospitalized patients. Despite its common occurrence,

depression is often overlooked in medically ill patients. The classic signs and symptoms of depression (eg, dysphoria, demoralization) are frequently overshadowed by vague nonspecific somatic complaints that are too often ascribed to medical illnesses or side effects of medications. This presentation will review options for the treatment of depression comorbid with medical and psychiatric diagnoses. Antidepressant medications can alleviate depression and improve the quality of life for medically ill patients, but data in support of specific antidepressants are scare. Several of the newer antidepressants that are well tolerated, have low potential for drug-drug interactions, and few safety concerns, are particularly promising for this population of patients who as a group are more susceptible to side effects. Medications other than antidepressants (eg, hormone replacements) may prove to be effective for relieving depressive symptoms. Other options include psychosocial interventions, which are both a safe and effective treatment for depression in the medically ill. The most successful psychosocial therapies are the ones that are integrated into comprehensive medical/psychological programs for patients with specific medical diseases (eg, cardiac risk reduction and rehabilitation, cancer treatment, HIV programs).

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INDUSTRY-SUPPORTED SYMPOSIUM 6— DOPAMINE: BEYOND SCHIZOPHRENIA, TOOLS FOR TREATMENT
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Beyond schizophrenia and Parkinson's disease, dopamine neurons play a major role in systems that regulate reward, motivation, and prefrontal cortical aspects of cognition. Symposium participants will recognize how these dopamine-dependent systems influence addiction, attention hyperactivity disorder, and major depression and are potential targets for treatment.

No. 6A
THE MESO-LIMBIC DOPAMINE SYSTEM IN MOTIVATION AND REWARD

Roy A. Wise, Ph.D., *Intramural Research, National Institute of Drug Abuse, 5500 Nathan Shock Drive, Baltimore, MD 21224*

SUMMARY:

The discovery that electrical stimulation of the brain region can be powerfully rewarding sparked the attempt to characterize brain circuitry of reward and motivation. Initial studies implicated the monoamines, and monoamine-selective drugs indicated that brain dopamine but not norepinephrine or serotonin was critical for the rewarding and inducing actions of the stimulation. Selective dopamine antagonists were found to attenuate the habit forming actions of the psychomotor stimulants, amphetamine, and cocaine and were also found to attenuate the habit forming effects of food and water for deprived animals. In the last decade it has been shown that amphetamine, cocaine, heroin, morphine, nicotine, alcohol, phencyclidine, and cannabis all activate the mesolimbic dopamine system and that behavioral indices of drug craving and drug satiety can be predicted on the rise and fall of dopamine levels in nucleus accumbens. Two caveats: First, dopamine is not the whole story. Most addictive drugs act on inputs and outputs of the dopamine system and some, like caffeine, may act on quite different circuitry altogether. Second, the fact that "knockout" mice lacking dopamine transporters still self-administer cocaine challenges early views of the necessary role of the dopamine transporter in cocaine reward.

No. 6B
SMOKING, SMOKING CESSATION AND ANTIDEPRESSANTS

Alexander H. Glassman, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

In 1988, we first reported an association between major depression and cigarette smoking, and smoking cessation failure. Those associations have been replicated by multiple investigators. We subsequently reported that smokers with a history of depression who succeeded in cessation were at risk for new episodes of depression. This has serious ramifications for depressed patients who smoke. New episodes occur not only in the immediate withdrawal period, but for months after cessation.

Although this is bad news for patients with a history of depression, it led directly to the development of antidepressants as aids in smoking cessation. Five studies show a robust effect with bupropion. This has been apparent in both patients with and without a history of major depression. There is evidence that the tricyclic nortriptyline is also useful. Interestingly however, no study has shown that this effect extends to the SSRIs. This raises the question of why bupropion and nortriptyline should effect cessation while SSRIs do not. TCAs and bupropion share effects on norepinephrine and dopamine, although their relative potencies are somewhat different. If either of these transmitters is responsible is speculation, but the data are clear that all antidepressants are not the same.

No. 6C
DOPAMINE IN THE TREATMENT OF DEPRESSION

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

Chronic treatment with numerous antidepressant drugs produces several changes in dopaminergic neurotransmission, in particular a sensitization of behavioral responses to agonists acting at dopamine D2/D3 receptors within the nucleus accumbens. In addition, antidepressant-like effects in animal models of depression have been reported with drugs that act directly on the dopaminergic system. A number of open trials have suggested the efficacy in depression of dopamine-active drugs such as bromocriptine, pramipexole, and

tolcapone. In addition, bromocriptine was found to be as effective as imipramine or amitryptiline in three double-blind trials, while piribedil and pramipexole were found to be superior to placebo in two other trials. Another dopamine-active drug, bupropion, has well-established antidepressant properties and is marketed as an antidepressant in the U.S., while dopamine neurotransmission is known to be significantly affected by monoamine oxidase inhibitors, also marketed antidepressants. Dopamine-active drugs are also commonly used as adjuncts to antidepressant medications in the management of partial response, non-response, relapse, and drug-induced sexual dysfunction. In particular, open trials with bupropion, pramipexole, and pergolide, and anecdotal reports with amantadine have suggested the usefulness of this strategy in refractory depression. Several reports on the usefulness of psychostimulant augmentation of all classes of antidepressants certainly support the view that the efficacy of antidepressants can be boosted through the use of dopamine-active drugs. Double-blind, controlled trials in these types of depressed populations are clearly needed to confirm the impression that these agents may play an important role in the optimization of treatment outcome in depression.

No. 6D
DIRECT AND INDIRECT MODULATION OF CORTICAL CIRCUITS INVOLVED IN COGNITION

Patricia Goldman-Rakic, Ph.D., *Department of Neurobiology, Yale University, 333 Cedar Street, SHM C303, New Haven, CT 06520-8001*

SUMMARY:

The cerebral cortex, particularly the cortex of the frontal lobe, is a major target of the brain stem dopamine system. Interference with the dopamine innervation of the prefrontal areas, either by experimental depletion with neurotoxins, local dopamine receptor antagonists, or due to endogenous conditions such as age, drug use, or disease, have all been shown to produce significant impairment in cognitive functions. Basic studies of the anatomy, physiology, and pharmacology of the primate prefrontal cortex with respect to the working memory system are providing insight into the cellular and circuit mechanisms by which dopamine exerts an influence on cortical function under normal and abnormal conditions. *In vivo* studies in primates and *in vitro* studies both in primates and smaller mammals have provided compelling evidence that dopamine has both direct and indirect actions on specific cortical neurons. The direct action occurs via D1/D5 receptors located on the distal dendrites and spines of pyramidal neurons to directly modulate excitatory transmission at synapses established by sensory afferents. Indirect actions occur via dopamine stimulation of local circuit inhibitory interneurons, which result in polysynaptic modulation of pyramidal cell activity. The basic cellular and circuit mechanisms elucidated with respect to cognitive operations of the prefrontal cortex are likely to generalize to other cortical areas and function.

Supported by NIH grants MH44866 & MH38546.

No. 6E
DOPAMINE IN THE ETIOLOGY AND TREATMENT OF ADHD

F. Xavier Castellanos, M.D., *Child Psychiatry, National Institute of Mental Health, 10 Center Drive, Room 3B-19, Bethesda, MD 20892-1251*

SUMMARY:

Converging, albeit indirect, lines of evidence indicate an involvement of dopamine in attention-deficit/hyperactivity disorder (ADHD). Anatomic as well as functional neuroimaging studies implicate prefrontal-striatal circuits that are regulated by mid-brain monoamines, particularly dopamine. The principal neuropsychological deficits in ADHD reflect impaired executive function, which is exquisitely regulated by dopamine and other monoamines. The most robust pharmacologic treatments for ADHD indirectly enhance synaptic dopamine levels and drug response is significantly related to baseline dopamine metabolite levels in cerebrospinal fluid. Finally, a number of research groups have found modest but consistent evidence for associations between ADHD and two dopaminergic genes, the dopamine transporter, and the dopamine 4 receptor. However, ADHD is probably not a simple dopamine deficiency state, but rather likely reflects dysregulation of mesocortical and nigralstriatal dopamine circuits and of frontal efferents to midbrain catecholaminergic nuclei. Improvements in our understanding of the pathophysiology of ADHD are needed to guide the development of better interventions in this most common psychiatric disorder of childhood.

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INDUSTRY-SUPPORTED SYMPOSIUM 7—SCHIZOPHRENIA: FROM SOCIAL ISOLATION TO SOCIAL REINTEGRATION
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify the importance of early identification and treatment in the successful treatment of schizophrenia, implement a comprehensive strategy for the treatment of schizophrenia that strives to engage patient and family in social reintegration, and understand the relationship of psychosis, mood, and cognition and how treatment by medications as well as behavioral and psychotherapeutic approaches improve patient response in these areas.

No. 7A
IMPACT OF EARLY IDENTIFICATION AND TREATMENT ON FIRST-EPISODE SCHIZOPHRENIA

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, University of North Carolina School of Medicine, 7025 Neuroscience's Hospital, CB716, Chapel Hill, NC 27599*

SUMMARY:

Because schizophrenia is a chronic and deteriorating illness that has its onset when people are beginning adulthood and then leaves them persistently symptomatic and functionally disabled, it is important to identify and intervene as early in the course as possible. However, several factors complicate this task. First, the illness often begins with a prodromal stage, which is characterized by nonspecific, subtle symptoms that are often only recognizable as harbingers of the illness retrospectively. Second, persons in the first episode of psychosis usually lack insight and awareness about their symptoms and don't believe that they have an illness or need treatment. Consequently, they don't seek treatment and remain symptomatic in the community for unnecessarily long periods of time before receiving professional help. Third, once treated patients feel that they are recovered and lack an understanding of the chronic and recurrent nature of the illness. In addition, they often object to the side effects of treatment or even the idea of taking medication. This leads them to discontinue treatment and eventually relapse, which can lead to a cycle of exacerbations and remissions that result in deterioration and chronic disability.

Recent scientific advances have furthered our understanding of the pathogenesis of schizophrenia and its underlying pathophysiology. This suggests that early intervention and the prevention of relapses can reduce the morbidity of the illness and improve outcome. Moreover, new therapeutic agents and strategies have been developed that offer the prospect of more effective and safe treatment that is comprehensive and geared to managing patients in all of the phases and over the course of the illness. This presentation will review these recent findings and describe the treatment strategies to be used in treating the early stages of schizophrenia. Findings from new studies of the use of atypical antipsychotic drugs as first-line treatments that demonstrate their comparative efficacy and safety will also be presented.

No. 7B
COGNITIVE DEFICITS AND EVERYDAY FUNCTIONING

Richard S.E. Keefe, Ph.D., *Department of Psychiatry, Duke University, Box 3270, Durham, NC 27710*

SUMMARY:

The pattern of cognitive deficits in patients with schizophrenia indicates that almost all domains of cognitive functioning are impaired, and many domains are severely impaired. Cognitive dysfunction appears to be a central feature of schizophrenia, as it is related to many of the other dimensions of illness, especially negative symptoms and adaptive dysfunction. In fact, cognitive deficits are the single best predictor of outcome in patients with schizophrenia.

Until recently, there has been no effective treatment for cognitive dysfunction in patients with schizophrenia. Conventional antipsychotic drugs are limited in the breadth of their therapeutic effects. While they can improve the positive symptoms of the illness, these drugs have less impact on negative symptoms and almost no impact on cognitive dysfunction.

The study of the effect of novel antipsychotic medications has tremendously important implications for the treatment of schizophrenia. The initial studies of the impact of clozapine and risperidone were frequently methodologically limited, yet a cognitive enhancing effect of these novel antipsychotics can be discerned. Most importantly, improvement in cognitive function with novel antipsychotics appears to be strongly associated with improvement in other important dimensions of illness in schizophrenia, including the quality of a patient's life.

No. 7C
ATYPICAL ANTIPSYCHOTIC AGENTS: EXPANDING THE GOALS OF THERAPY TO IMPROVE OUTCOMES

Richard G. Petty, M.D., *Department of Psychiatry, University of Pennsylvania Health System, 250 King of Prussia Road, Radnor, PA 19087-5286*

SUMMARY:

Since the earliest days of the introduction of effective antipsychotic medicines in the early 1950s, it has been clear that these agents could revolutionize the lives of patients and their families. However, it soon became clear that these improvements only occurred in a proportion of patients; were limited to the control of positive symptoms, pathological excitement, and behavioral dyscontrol; and were being bought at the expense of an array of serious side effects, including extrapyramidal movement disorders, tardive dyskinesia, depression, cognitive impairment, and neuroendocrine disturbances. Until the advent of clozapine, and subsequently of other novel antipsychotic agents, it was thought that these were inevitable consequences of therapy, which seriously impaired the utility of these agents and made them unacceptable to many patients, with consequent lack of compliance with all the ensuing problems that would follow.

The newer agents represent a revolution in the pharmacological management of the psychoses, and for the first time allow clinicians to focus not just on positive symptoms and behavioral problems, but also to actively treat negative symptoms, cognitive impairments, and depression, while protecting patients from deleterious side effects. However, it is already becoming clear that even within this class of medicines, there are significant difference in efficacy and side effects. We shall examine the data concerning the increased efficacy of the newer agents on different symptom complexes, their different side-effect profiles, and how this has already been translated into improved patient compliance, quality of life, and ability to work.

No. 7D
IMPROVING OUTCOMES: REINTEGRATION IN DISADVANTAGED POPULATIONS

Ralph Aquila, M.D., *Department of Psychiatry, St. Luke's Roosevelt Hospital, New York, NY 10025*

SUMMARY:

Taking medication for any chronic illness has been shown to be difficult, especially when the benefits do not clearly outweigh the risks. Side effects, such as EPS, from traditional antipsychotics, have been shown to be a major culprit of noncompliance. What is less clear is the long-term issue of compliance with antipsychotics when side effects are not overtly present. The issue of longterm benefit may play an important role. Outcome measures such as quality of life and goal attainment may be the key to increased compliance.

The therapeutic alliance has been helpful for many issues of noncompliance, but has shown to be lacking for others. The traditional doctor-patient relationship may be insufficient in certain situations. The introduction of the rehabilitation alliance may be helpful where the therapeutic alliance is not. For the past few years in conjunction with the clubhouse model, we have seen a greater compliance with medications by integrating the use of atypical antipsychotics with this particular rehab modality. The basis of the rehab alliance consists of having the patient/member as a co-team leader, a Fountain House worker, or another member, and the psychiatrist present in the meetings starting from the member's goals.

No. 7E
QUALITY OF LIFE AND ECONOMIC OUTCOMES IN TREATMENT

Martin R.J. Knapp, Ph.D., *Department of Health Services, Institute of Psychiatry, DeCrespigny Park, London SE5 8AF, England*

SUMMARY:

Schizophrenia is a costly illness, with potentially high economic impacts on patients, families, health service systems, and the wider society. Those high costs partly explain the widespread and growing interest in the economic consequences of different treatments for the illness. Another factor in this interest has been the development of more effective treatments, particularly atypical antipsychotic drugs. However, the atypical agents generally have higher acquisition costs (prices) than the drugs they are targeted to replace. These higher prices raise a number of fundamental and pressing questions. Are the newer, more expensive treatments cost-effective? Do they generate health and other outcomes that justify their higher prices? And might their wider resource implications actually prove to be cost *reducing*? These questions are being posed with increasing regularity in all health care systems as clinicians and funding bodies seek to deliver effective but affordable treatments to patients.

The paper will summarize the latest evidence on the quality of life and economic outcomes of the treatment of schizophrenia with atypical antipsychotic drugs, located within a structure that ensures that all relevant evidence is taken into account. The published and other emerging evidence broadly support the view that atypical antipsychotic treatment can have important comparative benefits in terms of quality of life, cost, and cost-effectiveness.

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INDUSTRY-SUPPORTED SYMPOSIUM 8— ADVANCES IN WOMEN'S MENTAL HEALTH: A DECADE OF PROGRESS
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Participants in the symposium will learn about the differential effects of gonadal steroid on CNS neuromodulation and critical clinical issues regarding course and treatment of illness during pregnancy, the puerperium, and perimenopause.

No. 8A
EFFECTS OF GONADAL STEROIDS ON BRAIN AND BEHAVIOR

David R. Rubinow, M.D., *BEB, National Institute of Mental Health, Building 10, Room 3N-238; MSC 1276, Bethesda, MD 20892-1276;* Peter J. Schmidt, M.D.

SUMMARY:

Gonadal steroids function as major neuroregulators and presumably underlie gender-related differences (sexual dimorphisms) in brain structure and function. In animals, gonadal steroids modulate neurotransmitter receptor ontogeny, distribution, and activity as well as create capacities for behaviors in adulthood. Further, recent studies have identified groups of persons who are differentially susceptible to mood destabilization by gonadal steroids. For example, estrogen administration precipitates depression in women with menstrual cycle-related mood disorders, has no effect on mood in women lacking a history of menstrual cycle-related mood disorders, and displays antidepressant efficacy in women with perimenopausal depression. Similarly, the beneficial effects of estrogen on verbal memory are far more apparent in perimenopausal women than in young women with experimentally-induced hypogonadism. Thus, while gonadal steroids create a context that shapes development, their activational/neuromodulatory effects are highly context dependent. These observations, culled from a variety of hormone manipulation studies in both male and female rats and humans (which will be described in this presentation), suggest that increased attention to the role of gonadal steroids in modulating human behavior will help elucidate a critical question in psychiatric research: Why do different individuals respond differently to what is ostensibly the same stimulus?

No. 8B
SSRIS IN THE TREATMENT OF PMDD: A CRITICAL REVIEW

Adele C. Viguera, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston, MA 02114*

SUMMARY:

Epidemiological data suggest that as many as 75% of women with regular menstrual cycles experience some symptoms of premenstrual syndrome (PMS). Premenstrual dysphoric disorder (PMDD), on the other hand, is less common and affects 3% to 8% of women in the general population. For these patients, premenstrual symptoms seriously interfere with occupational and social functioning. While the precise pathophysiology of PMDD is unclear, several studies have demonstrated serotonergic dysregulation in patients suffering from PMDD. Over the last five years, a growing literature has supported the efficacy of serotonin reuptake inhibitors (SSRIs) as a particularly effective treatment for patients with PMDD. This presentation will review data derived from the accumulated clinical trial literature on SSRI use for PMDD response to treatment evidenced

by remission of symptoms including irritability, tension, dysphoria, and lability of mood, as well as somatic symptoms across the class of compounds as well as dosing strategies (intermittent vs. continuous). Dosing strategies and recommendations regarding length of therapy will also be reviewed.

No. 8C
COURSE AND TREATMENT OF MOOD DISORDERS DURING PREGNANCY AND THE POSTPARTUM PERIOD

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 115 Parkman Street, WAC 815, Boston, MA 02114*

SUMMARY:

Pregnancy is frequently considered a time of well being for women, providing "protection" against emotional disturbance. A growing literature suggests that at least some women continue to manifest symptoms of depression during pregnancy and that those who discontinue antidepressants may be at particular risk for relapse. Women with histories of affective disorders also appear to be at risk for postpartum worsening of mood. Identification of women at risk for new onset or relapse of depression during pregnancy and the postpartum period allows for thoughtful treatment planning, which may include either pharmacologic and/or non-pharmacologic interventions as well as potential prophylactic strategies.

This presentation will review new data regarding risk for relapse of major depression and bipolar disorders following discontinuation of antidepressants and mood stabilizers, respectively. Risks associated with psychotropic use during pregnancy with particular focus on mood stabilizers and antidepressants will be reviewed. Data regarding teratogenic risk of agents used to treat major depressive disorder and bipolar illness will be presented. Treatment guidelines for psychotropic drug use during pregnancy, labor and delivery, and postpartum will be discussed.

No. 8D
PSYCHOPHARMACOLOGY DURING PREGNANCY AND LACTATION: DETERMINING INFANT EXPOSURE

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University Medical School, 1639 Pierce Drive, Suite 4003, Atlanta, GA 30322;* Lee S. Cohen, M.D., Amy L. Hostetter, B.A.

SUMMARY:

The cornerstone of treatment planning for psychiatric disorders during pregnancy and breast feeding is completion of the risk/benefit assessment. As such, the clinician and the patient must consider the risks of both the illness and the available treatment options. One facet of these considerations is what is known about fetal and neonatal exposure to medications. The literature on psychotropic medications, particularly antidepressants, during pregnancy and lactation has grown rapidly over the last five years. Data on the placental passage of antidepressants and excretion into human breast milk have confirmed that the SSRIs do not appear to accumulate in the fetal and neonatal circulation. Detailed investigations of the kinetics of medication excretion into breast milk suggests that nursing infants are exposed to less than 1/450th the maternal daily dose. These studies have also provided the first scientifically based guidelines for minimizing infant exposure and interpreting infant serum measures. The reproductive safety data and burgeoning studies on the SSRIs in breast feeding will be reviewed. These exposure data provide the initial phase for one aspect of the risk/benefit assessment.

No. 8E
MOOD DISORDERS IN PERIMENOPAUSE: THE ESTROGEN CONNECTION

Hadine Joffe, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

Gonadal steroids have extensive neuromodulatory effects that may increase the risk of mood disorders in women. A growing body of evidence suggests that a subset of women are vulnerable to mood instability caused by physiologic changes in hormone levels. Declining levels of estrogen during the transition to menopause (perimenopause) may trigger depressive symptoms. However, estrogen withdrawal also causes hot flushes and night sweats in 75% of perimenopausal women. The disruption of sleep by night sweats may cause daytime mood changes. Because hot flushes and night sweats correlate strongly with depressive symptoms, it is therefore difficult to distinguish whether perimenopausal mood symptoms are a direct consequence of estrogen fluctuation or night sweat-induced sleep disturbance.

This presentation will review the mood symptoms that occur in perimenopausal women. The evidence supporting different etiologic models of depressive symptoms in perimenopausal women will be reviewed. Therapeutic options for this reproductive-endocrine associated mood disorder will be addressed.

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INDUSTRY-SUPPORTED SYMPOSIUM 9— FROM NEUROBIOLOGY TO NOVEL TREATMENTS: APPLICATIONS IN ALZHEIMER'S DISEASE
Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recommend methods of screening and diagnosis of AD to primary care colleagues; understand the latest theories being explored; understand the role of inflammation, nicotine, neurotransmitters, NMDA receptor modulation; apply recent advances to emerging

therapeutic options; improve patient/family outcomes by utilizing pharmacologic and environmental interventions to manage the behavioral aspects.

No. 9A
MULTIDISCIPLINARY MANAGEMENT OF THE PATIENT WITH ALZHEIMER'S DISEASE: A CASE HISTORY

Murray A. Raskind, M.D., *Department of Psychiatry, VA Puget Sound Medical Center, 1660 South Columbian Way, 116A, Seattle, WA 98108*

SUMMARY:

As knowledge broadens concerning the high prevalence of Alzheimer's disease (AD) in later life and the availability of effective treatment modalities, health care disciplines must work closely together to increase effectiveness of early diagnosis and to optimize management. Two cases will be presented to illustrate first the typical clinical presentation of AD and then a more complex clinical presentation typical of dementia with Lewy bodies (DLB). The AD patient had the insidious onset of memory impairment and impaired executive function. These deficits progressed gradually over a period of years and broadened to include impaired language, praxis, and activities of daily living. Late in the disease course, disruptive agitation and psychotic symptoms become increasingly problematic. The DLB patient presented with episodic visual hallucinations, poor judgment, and slowed gait, with the subsequent development of progressive impairment of memory and other cognitive function. Multidisciplinary issues concerning diagnosis and long-term management of these two patients will provide a framework for other presentations in this symposium.

No. 9B
ETIOLOGY OF ALZHEIMER'S DISEASE: EVOLVING THEORIES

Paul R. Solomon, Ph.D., *Department of Psychology, Williams College, 33 Hoxsley Street, Williamstown, MA 01267*

SUMMARY:

The cause of AD is unknown, but a number of possible factors in the etiology and pathogenesis of this disease have been hypothesized. Treatments for Alzheimer's disease (AD) are based on these hypothesized factors. It is now well established that AD is characterized by deficits in the cholinergic system. Current symptomatic treatments for AD involve boosting synaptic acetylcholine by inhibiting acetylcholinesterase. Other neural transmitters are also depleted in AD and clinical trials are underway with compounds that may ameliorate these deficits. The neuropathology of AD is characterized by neuritic plaques and neurofibrillary tangles. It is unclear whether these pathological entitles cause the destruction of neurons in AD or are the by-product of neuronal damage caused by yet unidentified processes. Preclinical research is underway to block the production of these pathological entities. Biochemical factors including inflammation, free radicals, NGF deficits, and estrogen deficits may also contribute to the pathogenesis of AD and compounds are currently in clinical trials to address these factors. Genetic factors including APP mutations on chromosome 21 and mutations in the prasanelin 1 gene on chromosome 14 and the presenalin 2 gene on chromosome 1 cause AD in families with early onset autosomal dominant disease. Mutations in the Tau gene on chromosome 17 cause frontotemproal dementia. Certain alleles of the ApoE protein vary the risk of sporadic AD. Genetic manipulations may have the potential to alter the onset or course of AD.

No. 9C
EMERGING THERAPEUTIC OPTIONS IN ALZHEIMER'S DISEASE

Gary W. Small, M.D., *Department of Psychiatry, University of California at Los Angeles, Neuropsychiatic Institute, 760 Westwood Plaza, Los Angeles, CA 90024-8300*

SUMMARY:

Pharmacological and non-pharmacological treatments currently available for Alzheimer's disease may diminish symptoms and increase quality of life, but none of them can halt the dementing process. Most pharmacological agents, available or in development, target a specific symptom (e.g., agitation, depression, memory loss) and are derived from the known neurobiology of the disease (e.g., neurotransmitter deficit) or hypothesized anti-dementia approaches (e.g., anti-inflammation, anti-oxidation). The Food and Drug Administration has approved two reversible cholinesterase inhibitors, tacrine and donepezil, which improve memory and other aspects of cognition and may reduce behavioral symptoms in some patients. Another cholinesterase inhibitor in development, galantamine, also modulates nicotinic receptors. Additional promising cognitive enhancers or protectors under study include vitamin E, estrogen, and cyclooxygenase-2 (COX-2) inhibitors. Other developing anti-dementia treatments are designed to perform such functions as inhibition of beta-amyloid production or accumulation or interference with apolipoprotein E physiology. An Alzheimer vaccine has shown initial success in an animal model. Additional approaches may target other neurotransmitter systems (e.g., noradrenergic) or use drug combination strategies. Early detection using imaging and genetic technologies are now being coupled with treatment trials in order to initiate therapies in presymptomatic disease stages. This presentation will review a range of such emerging therapies.

No. 9D
THE ROLE OF THE PSYCHIATRIST IN OPTIMIZING OUTCOMES IN ALZHEIMER'S DISEASE: FACILITATING COOPERATION ACROSS SPECIALTIES

Elaine Peskind, M.D., *MIRECC, VA Puget Sound, 1660 South Columbian Way, Seattle, WA 98108*

SUMMARY:

In addition to the core cognitive symptoms of Alzheimer's disease (AD), this disorder is characterized by multiple behavioral problems including depression, disruptive agitation, and psychosis (delusions and/or hallucinations). In addition, family caregivers are at risk for depression and anxiety disorders during the long course of the illness. The psychiatrist plays a major role in the therapeutic management of AD by helping the primary provider (1) recognize and differentially diagnose behavioral problems, (2) develop a psychopharmacologic and behavioral treatment plan for treating behavioral problems, and (3) provide supportive psychotherapy and practical case suggestions to the caregiver(s) in the home or long-term care setting. For an increasing number of AD patients, the psychiatrist also assumes the primary provider role of diagnostic workup of dementia and prescribing a cholinesterase inhibitor and/or other agents (e.g., vitamin E) targeted at cognitive and functional deficits. Either as primary provider or consultant, the psychiatrist must be particularly knowledgeable about differentiating dementia from delirium, using psychotropic drugs effectively and safely in elderly persons, and optimizing behavioral and environmental approaches to symptom reduction.

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INDUSTRY-SUPPORTED SYMPOSIUM 10—IMAGES OF ANXIETY
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe the application of neuroimaging technology to clinical psychiatric practice and to recognize the controversies in the treatment of anxiety disorders.

No. 10A
ADVANCES IN NEUROIMAGING

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 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. Much of this work is now informed by anatomical and physiological findings from pre-clinical scientists studying the neural circuitry of fear and chronic stress. These advances can now be translated into studies of the human brain. Neuroimaging techniques are broadly divided into two facets: Structural and functional. Structural studies are now almost entirely done with magnetic resonance imaging. 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 posttraumatic stress disorder. Functional imaging measures cerebral blood flow, cerebral metabolism, various brain constituents and neuroreceptors, and uses SPECT, PET, magnetic resonance spectroscopy (MRS), and functional magnetic resonance imaging (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 panic disorder patients 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. 10B
IMAGES OF FEAR IN PANIC

Justine M. Kent, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 41, New York, NY 10032*

SUMMARY:

Neuroimaging techniques are shedding light on neuroanatomical and neurochemical hypotheses of both normal and pathological anxiety. Commonality and divergence of neurocircuitries likely account for the overlapping and diverging symptomatology of the anxiety disorders. Our current state of knowledge of the neural pathways subserving normal anxiety, gleaned from neuroimaging studies, will be presented as a framework for understanding areas of potential pathology in panic disorder and generalized anxiety disorder (GAD). The sum of resting baseline studies of cerebral blood flow and metabolism in panic disorder utilizing single photon emission tomography (SPET) and positron emission tomography (PET) support a possible baseline abnormality in limbic (particularly hippocampal and parahippocampal) regions. Provocation studies using various panic-inducing agents suggest decreased cortical blood flow, particularly in the frontal regions and increased blood flow in the insular cortex and claustrum/lateral putamen regions during heightened anxiety and panic. While there has been less imaging research in GAD, studies suggest the possibility of involvement of basal ganglia and limbic structures in this disorder. Imaging findings from panic disorder and GAD populations, along with data obtained from healthy subjects, suggest neuroanatomic frameworks in which to consider models of these anxiety disorders.

No. 10C
PTSD: A MIND'S-EYE VIEW

Murray B. Stein, M.D., *Department of Psychiatry, University of California at San Diego, 8950 Villa La Jolla Drive, Suite 2243, La Jolla, CA 92037*

SUMMARY:

Posttraumatic stress disorder (PTSD) is characterized by the symptom tetrad of reexperiencing (e.g., intrusive thoughts and images), behavioral avoidance, emotional numbing, and hyperarousal. It has been extensively studied from a neuroimaging perspective, using a variety of techniques. Results from these studies will be reviewed here.

Several quantitative MRI studies have demonstrated reductions in hippocampal volume of patients with PTSD, accompanied by varying degrees of neuropsychological impairment. Metabolic studies using PET have pointed to complex patients of neural circuit activation in some brain regions, accompanied by deactivation in

others, particularly during symptom provocation with either yohimbine or script-driven imagery.

Data from a new study of MR morphometry and neuropsychological function in female domestic violence victims will also be presented.

No. 10D
IMAGES OF SOCIAL ANXIETY DISORDER: A FIVE-YEAR VIDEO CASE STUDY

Daniel D. Christensen, M.D., *Neuropsychiatric Institute, University of Utah, 501 Chipeta Wey, Salt Lake City, UT 84108*

SUMMARY:

This presentation follows a patient over four and a half years of treatment for his social anxiety disorder. He initially presented at age 18 with a host of social fears and significant interference with his social, educational, and family lives. In addition, his life was becoming dysfunctional by virtue of his avoidance of social activities, dating, school, and his inability to talk if "two or more people are present." Treatment is initiated with paroxetine 20 mg. a day and cognitive-behavioral therapy. Serial video tapings illustrate his condition at presentation along with follow-ups at one month, three months, three years, and four and a half years.

No. 10E
SOCIAL ANXIETY DISORDER: THE SHY BRAIN

Franklin R. Schneier, M.D., *Department of Therapeutics, Unit 69, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Recent clinical trials in social anxiety disorder have considerably clarified the efficacy of a variety of treatment options, including SSRIs, monoamine oxidase inhibitors, benzodiazepines, and cognitive-behavioral therapies. This presentation will review recent therapeutic advances and their implications for clinical management of the patient with social anxiety disorder. Although the generalized subtype of social anxiety disorder has been shown to be highly familial and heritable, its neurobiological diarhesis has only recently begun to be explored via neuroimaging techniques. Imaging studies have suggested anatomical differences in basal ganglia structure, and differences in patterns of activation during social anxiety in specific cortical and subcortical regions. Recent neuroimaging findings of abnormalities in dopamine system function in social anxiety disorder, related personality traits and animal models of social anxiety also will be reviewed, along with preliminary data from ongoing studies of the dopamine and serotonin systems.

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INDUSTRY-SUPPORTED SYMPOSIUM 11—TREATMENT PRACTICE AND PROMISE FOR SCHIZOPHRENIA IN THE NEW MILLENNIUM
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant (1) will be familiar with the latest findings on how genetic and environmental factors affect the time of the first break episode and the course of schizophrenia, (2) will be updated on the comparative and optimal use of atypicals in schizophrenic patients, and (3) will be familiar with the glutamate model of schizophrenia and its implications for future treatment.

No. 11A
TOWARD THE PRIMARY PREVENTION OF SCHIZOPHRENIA

Ming T. Tsuang, M.D., *Department of Psychiatry, Harvard Medical School, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115*

SUMMARY:

There is an increased emphasis on identifying the early signs and symptoms of schizophrenia, largely because early detection and treatment (i.e., secondary prevention) are associated with relatively favorable clinical outcomes. This raises the issue of whether prevention of psychosis itself is possible. The achievement of this goal will require the identification of a premorbid state that could serve as the foundation for treatment strategies aimed ultimately at the prevention of schizophrenia. Evidence for such a state is emerging, in part because schizophrenia may result from a neurodevelopmental disorder that is associated with a variety of clinical, neurobiological, and neuropsychological features occurring well before the onset of psychosis. In this context, Meehl's term "schizotaxia" has been reformulated to describe this liability. The feasibility of schizotaxia as a concept on which to base prevention efforts will be outlined. Our pilot study to devise treatment protocols and administer them to schizotaxic adult subjects will be presented. The next step toward the prevention of schizophrenic psychosis will be discussed.

No. 11B
CHILDHOOD-ONSET SCHIZOPHRENIA

Christopher J. McDougle, M.D., *Department of Psychiatry, Indiana University, 702 Bamhill Drive, Room 3701, Indianapolis, IN 46202*

SUMMARY:

Childhood-onset schizophrenia is a rare but extraordinarily debilitating disorder. The etiology, pathophysiology, and behavioral presentation are presumably similar to those found in adults with schizo-

phrenia, with differences reflecting developmental factors. Pharmacotherapy has been based primarily on results from drug studies in adults, as very few controlled investigations are available in children and adolescents with schizophrenia. In double-blind controlled trials in this patient population, haloperidol and loxitane have been shown to be more effective than placebo. In another study, the atypical antipsychotic clozapine was found to be more effective than haloperidol in adolescents with schizophrenia. Open-label reports have suggested that the atypical antipsychotic agents risperidone, olanzapine, and possibly quetiapine, may also be effective in reducing the symptoms of childhood-onset schizophrenia. This presentation will briefly review the phenomenology, premorbid function, cognitive function, epidemiology, differential diagnosis, assessment, course, and prognosis of childhood-onset schizophrenia, along with results from studies of neurophysiology, neuroimaging, and pharmacotherapy.

No. 11C
THERAPEUTIC IMPLICATIONS OF THE GLUTAMATE MODEL OF SCHIZOPHRENIA

Donald C. Goff, M.D., *Department of Psychiatry, Harvard Medical School, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

Abnormalities in glutamate receptor density and subunit composition in postmortem schizophrenic brains, as well as experience with pharmacologic challenges with NMDA receptor antagonists, suggest that dysfunction of glutamatergic pathways may play a role in schizophrenia. Controlled clinical trials with agents acting at the glycine recognition site of the NMDA receptor (D-cycloserine, glycine, and D-serine) have demonstrated efficacy for negative symptoms. Ampakines, which activate the glutamatergic AMPA receptor, hold promise for treatment of cognitive deficits in schizophrenia. Finally, recent evidence indicates that certain atypical antipsychotics may differ from conventional agents in their effects upon glutamatergic receptors. Differing effects on NMDA receptors may account in part for enhanced efficacy of atypical agents for negative symptoms and, possibly, for decreased risk of tardive dyskinesia.

No. 11D
OPTIMAL USE OF ATYPICAL ANTIPSYCHOTICS

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

SUMMARY:

This presentation will examine the benefits and limitations of presently available conventional and novel antipsychotic medications. Through an evaluation of efficacy, tolerability, and cost, the conventional and novel antipsychotic medications will be compared and contrasted with the clinical implications fully developed. Further, the presentation will examine critical differences between and among the currently available novel antipsychotic medications: clozapine, olanzapine, risperidone, and quetiapine. The clinical significance of such differences will be evaluated. Critical side effects such as seizures, anticholinergic effects, agranulocytosis, sedation, serum prolactin levels, weight gain, and hypotension will be considered as clinically relevant issues for patients and health care providers.

No. 11E
LONG-TERM OUTCOME: STAYING THE COURSE

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

SUMMARY:

Most clinical trials of new antipsychotics are brief, but schizophrenia is a chronic illness. Sustained symptom relief, reduced side effects, relapse prevention, and improvement of clinical outcomes beyond symptom management are important to clinicians, patients, and their families. Long-term trials (e.g. Schooler et al 1997) allow estimates of the effects of older antipsychotic medications on long-term outcome. These studies indicate the powerful effects of these medications in prevention of relapse but only limited effects in improving social functioning and quality of life. There are a few long-term studies of newer antipsychotic medications. Comparisons of newer antipsychotics at least six months in length will be considered. Studies comparing risperidone and haloperidol, olanzapine and haloperidol (Tran et al, 1998), and risperidone and olanzapine (Tran et al 1999) will be reviewed and compared. We will discuss clinical recommendations based upon the available clinical trial data regarding indications, dosage, and strategies to improve compliance and minimize side effects. An important unanswered question for the new millennium is how to take advantage of the improvements in antipsychotic medications to engage patients in useful psychosocial treatments. Can we set our sights higher and strive for recovery in schizophrenia?

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INDUSTRY-SUPPORTED SYMPOSIUM 12—ADVANCES IN THE TREATMENT OF INSOMNIA
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to treat insomnia using a disorder-specific strategy designed to maximize efficacy and limit side effects.

No. 12A
PREVALENCE, PHENOMENOLOGY AND CONSEQUENCES OF INSOMNIA

Daniel J. Buysse, M.D., *Department of Psychiatry, Western Psychiatric Institute. & Clinic, 3811 O'Hara St., Room E-1127, Pittsburgh, PA 15213-2593*

SUMMARY:

"Insomnia" is used imprecisely to describe a symptom, a syndrome, or a disorder. By any definition, insomnia is a widely prevalent problem with consistent phenomenological features and adverse, consequences. The lifetime prevalence of insomnia *symptoms* is over 50%, with consistently higher rates among women, the elderly, and individuals with psychiatric and physical illness. The insomnia *syndrome* (including duration and severity criteria) has a one-year prevalence of 10% to 15%, and specific insomnia *disorders* (e.g., primary insomnia) have a one-year prevalence of 1% to 10%. The phenomenology of primary insomnia indicates that it is a 24-hour problem. Patients not only have more awakenings and shorter sleep at night, but also heightened arousal at night and during the day, as measured by daytime sleep propensity, EEG power density, whole-body metabolic rate, heart rate variability, and stress hormone and catecholamine production. Insomnia is associated with impaired quality of life and work performance disability, and increased health care utilization and costs. Insomnia is a consistent risk factor for the development of depressive, anxiety, and substance use disorders. Among patients with depression, insomnia is a risk factor for poor treatment response, recurrence, and suicide. It is currently unknown whether treatment mitigates these consequences of insomnia symptoms and disorders.

No. 12B
CIRCADIAN RHYTHM DISORDERS AND INSOMNIA: TREATMENT WITH MELATONIN, PHOTOTHERAPY AND CHRONOTHERAPY

Gary Richardson, M.D., *Sleep Medicine, Henry Ford Hospital, 2799 West Grand Boulevard, CFP-1, Detroit, MI 48202*

SUMMARY:

The timing of sleep within the 24-hour day is an essential aspect of its normal expression. Even if sleep is adequate in amount and composition, inability to obtain sleep within the desired hours of the day often results in a subjective complaint of insomnia. These "circadian rhythm sleep disorders" are diagnostically classified based on the nature of the incongruity between desired and actual sleep timing. By way of example, delayed sleep phase syndrome (DSPS) and advanced sleep phase syndrome (ASPS) represent opposite disparities between the time of which maximal physiological sleep tendency, and the subjectively desired sleep time. By contrast, shift-work sleep disorder and jet-lag are disorders in which sleep tendency fails to adjust to changes in the desired sleep time. Growing understanding of the role of the human circadian clock in the timing of sleep, and the environmental factors that regulate clock function, now permits a theoretical foundation for the pathophysiology and treatment of these disorders. In this discussion, we will review the circadian rhythm disorders, examine what is known and hypothesized about their pathophysiologic foundation, and evaluate the efficacy of three treatments—light, melatonin, and schedule manipulation (chronotherapy)—in addressing the complaint.

No. 12C
BEHAVIORAL INTERVENTION FOR CHRONIC INSOMNIA

Jack D. Edinger, Ph.D., *Psychiatry, VA and Duke Medical Center, 508 Fulton Street, Durham, NC 27705*

SUMMARY:

Insomnia characterized by persistent difficulty initiating, maintaining, or obtaining good quality sleep is a prevalent and significant health problem, which reduces quality of life, increases risk for psychiatric and medical disease, and increases health care utilization. Although many insomnia sufferers benefit from pharmacologic treatments to address underlying medical (e.g., painful arthritis, restless leg syndrome) or psychiatric (e.g., depression) causes of their sleep difficulties, a substantial proportion of those with insomnia complaints may benefit from nonpharmacologic, behavioral interventions to correct misconceptions and/or aberrant sleep habits, which serve to perpetuate their sleep difficulties. Following a brief discussion of the underlying rationale for behavioral interventions, the presenter will highlight those sleep-related misconceptions and sleep-disruptive practices that are common treatment *targets* among insomnia sufferers. In addition, the presenter will briefly describe common behavioral insomnia treatments including sleep education/sleep hygiene, relaxation training, stimulus control, and sleep restriction therapy. Also, the presenter will review recent meta-analytic studies that document the general efficacy of these treatments and that suggest the relative superiority of habit-focused treatments such as stimulus control. Subsequently, the presenter will consider the applicability and efficacy of new hybrid behavioral treatments with patients who present insomnia complaints. Considered in this discussion will be the results of recent NIH-funded clinical trials that have documented the efficacy of these newer hybrid treatments among insomnia sufferers. The presentation concludes by considering how the available behavioral treatments might be combined with short-term hypnotic use to optimize treatment outcome.

No. 12D
PHARMACOTHERAPY FOR INSOMNIA

W. Vaughn McCall, M.D., *Department of Psychiatry, Wake Forest University, Medical Center Boulevard, Winston-Salem, NC 27157*

SUMMARY:

Pharmacologic treatment of insomnia should be incorporated into a comprehensive insomnia treatment strategy that considers nonpharmacologic approaches. The duration of the insomnia is the most important factor in the treatment decision tree, with short-term insomnia often leading to symptomatic use of hypnotics, while long-term insomnia requires a disease-specific approach. Dopamine agonists are preferred for restless leg syndrome and periodic limb movement-associated insomnia. Sedating antidepressant medications such as tricyclics and trazodone may have a role in the treatment of depression-related insomnia, but their role in primary insomnia (unrelated to depression) is unclear. Despite these limitations, sedating antidepressants constitute an ever increasing share of prescription treatment for insomnia, thus constituting a concern for the public health. Symptomatic treatment of insomnia includes benzodiazepine receptor agonist hypnotics, and the choice of specific hypnotic should take into

consideration the pharmacokinetics of the agent. Generally speaking, rapid absorption and rapid elimination are desirable characteristics. Hypnotics with long durations of action cause anterograde memory impairment and daytime sleepiness, and may be a risk factor for falls and motor vehicle accidents. Although hypnotic medications are only approved for short-term use, this ignores the reality that hypnotics are sometimes prescribed for months and years at a time.

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2. Richardson GS, Malin HV: Circadian rhythm sleep disorders: pathophysiology and treatment. J Clin Neurophysiol 1996;13:17–31
3. Edinger JD, Wohlgemuth WK: The significance and management of persistent primary insomnia: the past present and future of behavioral insomnia therapies. Sleep Medicine Reviews 1999;3 (2) 101–18
4. Walsh JK, Schweitzer PK: Ten-year trends in the pharmacologic treatment of insomnia. Sleep 1999;22:371–375

INDUSTRY-SUPPORTED SYMPOSIUM 13—NOVEL TREATMENTS FOR DEPRESSION
Supported by Merck U.S. Health

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to outline the current status of managing depression, including the need for future treatment approaches; define the mechanism of action of SP antagonists in the treatment of depression and the clinical implications; discuss CRF antagonists and their potential role in the therapy of depression; review the concept of TMS and its use in the treatment of depression; and discuss the role of evidence-based psychotherapy in improving outcomes in patients with depression.

No. 13A
CURRENT STATUS OF MANAGING DEPRESSION: IS THERE A NEED FOR NEW TREATMENT STRATEGIES?

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Administration, Stanford, CA 94305-5717*

SUMMARY:

Recent years have witnessed considerable improvement in antidepressant therapy. The first-generation antidepressants—tricyclics and monoamine oxidase inhibitors—were effective in major depression but their side effects (e.g., anticholinergic) resulted in relatively high rates of discontinuance. Also, these agents were dangerous in overdoses or when taken with certain other medications. The selective serotonin reuptake inhibitors, introduced in 1988, have revolutionized the treatment of depression because they appear to be effective in a wide range of patients, are generally well tolerated, and are safe in overdoses. Since their introduction, several other antidepressants with alternative modes of action (e.g., mirtazapine, nefazodone, and venlafaxine) have been released. In spite of these advances, there are still limitations in our antidepressant armamentarium. These agents are not effective in many patients with major depression or dysthymia, so that in clinical trials there are relatively high percentages of patients (~40%) who do not respond to initial therapy. One explanation may be that depression represents a biologically heterogeneous group of disorders with a patient's individual biology not matching a drug's specific pharmacologic properties. Also, although the newer agents are generally better tolerated, they are not devoid of side effects. The pharmacologic mechanisms underlying various side effects are reviewed. Thus, despite the advancement to date in antidepressant therapy, we are still in need of antidepressants that work through other alternative mechanisms.

No. 13B
SUBSTANCE P ANTAGONISTS: MECHANISMS OF ACTION AND CLINICAL IMPLICATIONS

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, Room 623, New Haven, CT 06519*

SUMMARY:

There have been major advances in our understanding of the neurobiology of depression and the mechanism of action of antidepressant treatments. 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 with a particular emphasis on the role of substance P. Possible new approaches to the treatment of depression utilizing drugs with primary effects on substance P and other neuropeptides will be reviewed.

No. 13C
TRANSCRANIAL MAGNETIC STIMULATION: MAGNETS IN DEPRESSION

K. Ranga R. Krishnan, M.D., *Duke University Medical Center, Box 3950 DUMC, Durham, NC 27710*

SUMMARY

Transcranial magnetic stimulation (TMS) is a method by which small regional currents are induced in the brain. It has been used for diagnostic purposes in clinical neurology for the past several years. Its main advantage is that it can be used on conscious subjects and it produces minimal side effects. Initially, it was noticed that patients receiving the treatment often reported transient mood changes. This led to several brief, but somewhat ambiguous, experiments indicating its potential role as a treatment for affective disorders. In the mid-1980s, a series of studies reported significant benefits by stimulating the prefrontal cortex. Studies have demonstrated efficacy of both rapid- and slow-rate transcranial stimulation. Left dorsolateral prefrontal cortex stimulation was shown to be better than placebo treatment. More recent data suggest that this effect may be less clear in older depressed patients. Many issues regarding the utility of TMS remain to be clarified. The dosage, the location, the utility for maintenance, and its comparison with electroconvulsive therapy are still areas that require further study.

No. 13D
EVIDENCE-BASED PSYCHOTHERAPY: IMPROVING PATIENT OUTCOMES

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032-2603*

SUMMARY

The last decade has brought considerable improvement in the development, specification, and controlled clinical trial testing of time-limited psychotherapies for the treatment of depression. Effi-

cacy has been demonstrated for psychotherapy alone and in combination with medication for acute depression, and as maintenance treatment to prevent recurrence. There is evidence for efficacy of psychotherapy for the treatment of depression in HIV-positive patients, primary care patients, adolescents, and the elderly. Evidenced-based psychotherapy represents an additional way of improving patient outcome by dealing with the social and interpersonal problems that accompany a depressive episode. This talk will review the current efficacy data and new adaptations for one type of evidence-based psychotherapy—interpersonal psychotherapy—and will discuss the indications and contraindications for its use.

No. 13E
CORTICOTROPIN-RELEASING FACTOR ANTAGONISTS: PROMISING THERAPY FOR DEPRESSION

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4115, Atlanta, GA 30322*

SUMMARY

Because one of the most reproducible findings in all of psychiatric research is the increase in hypothalamic-pituitary-adrenal axis activity in depression, and since this increase is now generally acknowledged to be secondary to hypersecretion of CRF, it is plausible to scrutinize CRF receptor antagonists as a novel class of antidepressant agents. In addition to its contribution to this endocrinopathy of depression, CRF hypersecretion, particularly at extrahypothalamic central nervous system sites, is believed to also contribute to several of the cardinal symptoms of depression including decreased sleep, decreased libido, psychomotor alterations, and decreased appetite. Furthermore, several investigators have demonstrated increased cerebrospinal fluid concentration of CRF in drug-free depressed patients, and postmortem tissue studies have confirmed an increase in hypothalamic CRF and CRF mRNA expression in depressed patients. Two CRF receptor subtypes, CRF1 and CRF2, have thus far been identified. Several CRF receptor antagonists have recently been developed as putative novel antidepressants and anxiolytics. In several traditional, as well as novel, preclinical screening tests for antidepressants and anxiolytics, orally active CRF receptor antagonists exhibit clear activity. The pharmacologic profile of the lead compounds will be described, as well as potential problems with this therapeutic approach.

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3. Arborelius L, Owens MJ, Plotsky PM, Nemeroff CB: The role of corticotropin-releasing factor (CRF) in depression and anxiety disorders. J Endocrinol 1999;160:1–12
4. Figiel GS, Epstein C, McDonald WM, et al: The use of rapid-rate transcranial magnetic stimulation (rTMS) in refractory depressed patients. J Neuropsychiatry Clin Neurosci 1998;10(1):20–25
5. Reynolds CF III, Frank E, Perel JM, et al: Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. JAMA 1999;281:39–45
6. Weissman MM, Markowitz JC: Interpersonal psychotherapy. Current status. Arch Gen Psychiatry 1994;51:599–606

INDUSTRY-SUPPORTED SYMPOSIUM 14—INDIVIDUALIZING MANAGEMENT OF DEPRESSIVE DISORDERS
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The purpose of this symposium is (1) to provide a review of differences between short-term and long-term side effects of antidepressant drugs. (2) to offer information that with improve drug selection practices and enhance long-term compliance.

No. 14A
SEXUAL DYSFUNCTION ASSOCIATED WITH TREATMENT OF MAJOR DEPRESSION

Anita L.H. Clayton, M.D., *Department of Psychiatry, University of Virginia, 2955 Ivy Road Northridge #210, Charlottesville, VA 22903;* Elizabeth L. McGarvey, Ed.D., Gail Clavet, Ph.D.

SUMMARY:

Both depression and pharmacologic treatment of depression are associated with sexual dysfunction. Primary sexual disorders, depressive illness, medications/substances, and psychosocial issues all have effects on sexual functioning. Seventy percent to 80% of patients with major depressive disorder (MDD) experience decreased libido. Tricyclic antidepressants, monoamine oxidase inhibitors, and serotonin reuptake inhibitors adversely affect sexual functioning via several possible mechanisms.

Management of medication-induced sexual dysfunction is directed toward improving quality of life, and compliance with medication therapy for continued remission of depressive symptoms. Strategies include waiting for spontaneous remission, decreasing the antidepressant dose, prescribing drug holidays, switching to an antidepressant with minimal effects on sexual functioning (bupropion, mirtazepine, and nefazodone), and adding an antidote for sexual dysfunction. Substitution of an SSRI with bupropion sustained release is an effective alternative in at least 55% of patients, with a better outcome achieved with a gradual taper of the SSRI to avoid discontinuation syndrome. Available antidotes work via a variety of mechanisms including dopaminergic effects, alpha-adrenergic antagonism, serotonin receptor effects, increasing sex steroid levels (ie., testosterone), and enhancement of nitric oxide formation.

No. 14B
WEIGHT GAIN ASSOCIATED WITH LONG-TERM ANTIDEPRESSANT THERAPY

Norman Sussman, M.D., *Department of Psychiatry, New York University School of Medicine, 1501 East 58th Street, Suite 204, New York, NY 10155*

SUMMARY:

It is increasingly evident that the short-term effects of antidepressant drugs on body weight may be different than those seen during chronic therapy. SSRIs typically produce weight loss early in treatment, but this effect is transient. During ongoing therapy, some patients gain substantial weight. While most placebo-controlled studies do not show weight gain to be a frequent long-term side effect of SSRIs, anecdotal reports and non-placebo controlled studies do suggest that this is common. Mirtazapine causes significant weight gain early in treatment. This effect plateaus and patients may lose the added weight over time. Nefazodone appears to be weight neutral, while bupropion causes more weight loss than weight gain. The

clinical and methodological issues that are involved in understanding the weight effects of antidepressant drugs will be reviewed.

No. 14C
MANAGEMENT OF ANTIDEPRESSANT NONRESPONDERS

Jerrold F. Rosenbaum, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC 812, Boston, MA 02114*

SUMMARY:

The goal of antidepressant treatment is remission of depression, which implies full symptom reduction, relapse and recurrence prevention, and functional restoration. The majority of patients who merit antidepressant treatment fall short of this goal. For acute treatments, those who do not remit are either partial responders or nonresponders. The therapeutic strategies employed are different for these two groups. Recent surveys of practitioners reveal the approaches colleagues are most likely to take to address this clinical challenge. Although controlled data are also available to assess some clinical options, many preferred strategies are driven primarily by clinical consensus. Therapeutic options can generally be classified in the categories of optimization, augmentation, combination, or switching. Popular, novel, and promising strategies for antidepressant partial and non-responders will be presented.

No. 14D
LINKING ANTIDEPRESSANT THERAPY TO MEDICAL OUTCOMES

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University Medical Center, Trent Drive, Room 3547, Blue Zone, Durham, NC 27710*

SUMMARY:

Comorbidity of depression with medical illness is frequent, and depression has been reported to increase the risk for adverse medical outcomes in a variety of conditions including coronary disease, congestive heart failure, diabetes, stroke, AIDS, obstructive lung disease, and irritable bowel syndrome. Recent data also suggest that depression may be a risk factor for new onset cardiac disease, type 2 diabetes, and some forms of cancer, even after adjusting for other known risk factors for each of these conditions. A recent study of 7,518 women during a seven-year follow up found that higher number of depressive symptoms was a significant predictor of increased mortality (Whooley et al., 1998). Accumulating data also suggest that depression may be associated with alterations in platelet function, immune markers, heart rate variability, and glucose metabolism. These data raise several important questions: (1) Does treatment of depression reduce morbidity and recurrence of the comorbid medical conditions? (2) Can antidepressant therapy alter the incidence of medical conditions? (3) What are the mechanisms by which depression modulates the risk for medical outcomes? and (4) Does antidepressant therapy improve quality of life and longevity in medical patients? This presentation will review these data in relation to the changing paradigms that will be used to evaluate the effectiveness of antidepressant therapy in "real world" medical settings.

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4. Mischoulon D, Fava M, Rosenbaum JF: Strategies for augmentation of SSRI treatment: a survey of an academic psychopharmacology practice. Harvard Rev Psychiatry 1999;6:322–326
5. Whooley M, et al: Association between depressive symptoms and mortality in older women. Arch Int Med 1998;158:2129–2135
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INDUSTRY-SUPPORTED SYMPOSIUM 15—FAMILY VIOLENCE: VICTIMIZATION AND PERPETRATION
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the complexity of family violence, victimization, and perpetration. The participant will identify models of assessment and intervention for domestic violence and childhood violence. The participant will also learn integrated pharmacotherapy and psychotherapy with comorbid disorders, in community and inpatient settings.

No. 15A
DOMESTIC VIOLENCE: CONTEXT AND TREATMENT

Carole L. Warshaw, M.D., *Primary Care, Cook County Hospital, 1900 W Polk Street, Room 930, Chicago, IL 60612*

SUMMARY:

Despite increasing recognition over the past several years of domestic violence as a serious social and public health problem, mental health providers often have difficulty grappling with this issue, in part because of the theoretical shifts required to address it appropriately and in part because of the structural constraints imposed by mental health reimbursement policies. This presentation will provide an overview of the prevalence and impact of domestic violence as well as some of the key issues facing women as they attempt to heal from the psychological sequelae of abuse and violence. It will also provide a framework for understanding women's psychological responses to abuse within the larger contexts that generate them and for addressing the practical and theoretical challenges faced by clinicians in working with survivors of domestic violence.

No. 15B
BEYOND PTSD: ADAPTATION TO DOMESTIC TRAUMA

Bessel A. Van Der Kolk, M.D., *Department of Psychiatry, Boston University School. Of Medicine, 227 Babcock Street, Brookline, MA 02446-3173*

SUMMARY:

When the source of trauma is a person who is supposed to protect against danger, a complex set of psychological and biological sequelae ensues, which is far more complex than those captured in the DSM-IV definition of PTSD. The secrecy and inevitability of

continued exposure sets up adaptational reactions, which include identification with the aggressor, self-blame, shame, dissociation, somatization, and self-medication of chronic fear, anxiety, and hyperarousal with drugs and alcohol. Other self-soothing behaviors include self-injury and eating disorders. This presentation will review the assessment and treatment of the psychiatric sequelae of domestic traumatization.

No. 15C
CREATING SANCTUARY: TOWARD THE EVOLUTION OF SANE SOCIETIES

Sandra L. Bloom, M.D., *The Sanctuary Horsham Clinic, 13 Druim Moir Lane, Philadelphia, PA 19118*

SUMMARY:

Exposure to family violence plays a significant role in the development of many problems that result in inpatient psychiatric hospitalization. We call our systemic response to such violence "Creating Sanctuary"—the creation of nonviolent, health-promoting, socially responsible, and humane environments. This presentation will describe the treatment of victims of violence in two short-term, open inpatient psychiatric units using a trauma-based approach. This approach requires a cohesive treatment team, an agreed upon theoretical basis for treatment, a clearly staged model of intervention, and the establishment of attainable goals for patients. An integrated approach using many modalities of treatment can be of great utility, even if lengths of stay are brief, if treatment is highly managed and goal-directed, set within the context of an environment that emphasizes safety and affect management, psychoeducation, community involvement and personal responsibility. A shared value system and clearly defined stages of treatment, using our treatment model "S.A.G.E", make it possible for acute inpatient treatment to be integrated into an overall plan of recovery.

No. 15D
PTSD AND ADDICTIVE DISORDERS: CONCURRENT TREATMENT

Paula G. Panzer, M.D., *Department of Psychiatry, Columbia University, 500 West End Avenue, Suite. J, New York, NY 10024*

SUMMARY:

Alcohol and substance abuse disrupt women's lives in many ways. Drug seeking and other addictive behaviors take priority over relationships, parenting, self-care, and economic planning. Drug use in urban settings increases women's exposure to violence. They become victims, perpetrators, caretakers of victims, and mediators in disrupted families. There is now an abundance of evidence that violence across the life span occurs with remarkable frequency in women drug users. Furthermore, posttraumatic consequences and adaptations are often not addressed in female addicts, delaying the establishment of safety in recovery.

This presentation will review the emerging research literature on the concurrent treatment of addictive disorders and PTSD. Models involve cognitive-behavioral treatment, exposure therapy, modified 12-step treatment and routine treatment enhancement. Treatments are both individualized and through group modalities. A single clinical model will also be described, and treatment curriculum examples will be presented.

No. 15E
VIOLENT CHILDREN

Elissa P. Benedek, M.D., *Department of Psychiatry, University of Michigan, 2311 East Stadium, Suite 111, Ann Arbor, MI 48104*

SUMMARY:

A contemporary myth that is being shattered is that children and adolescents are not violent and that we need not assess them for potential for violence. The recent proliferation of school shootings has brought to public awareness the violent behavior of children at their place of work—the school. However, this is but a dramatic portrayal of the violence that children are capable of perpetrating and the least frequent form of violence children and adolescents experience in their daily lives. As clinicians we need to be more cognizant of the other more frequent forms of violence children and adolescents are capable of. We need to assess all children and adolescents we see for potential dangerousness. In addition, we need to assess them not only for the violence they may perpetuate but the violence that they have been subjected to or witnessed. Finally, the contemporary social environment of our youth, with exposure to violent modeling via television and the Internet, and its contribution to the increase of victims and victimization in our youth, is of critical import to evaluate and research.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 16—MANAGING PATIENTS WITH ACUTE PSYCHOSIS: AN INTERACTIVE PROGRAM
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to evaluate the acutely psychiatric patient and produce a comprehensive plan of action that addresses acute pharmacologic intervention. Medico-legal issues at activation and long-term treatment goals for the patient.

No. 16A
NEUROBIOLOGY OF AGGRESSIVE BEHAVIOR

Jean-Pierre Lindenmayer, M.D., *Department of Psychiatry, Manhattan Psychiatric Center Research, Unit M10A, Wards Island, New York, NY 10035*

SUMMARY:

Aggressive behavior is often a central component of the acute psychotic state. This presentation will review the neurobiological pathogenesis of aggressive behavior with particular emphasis on this aggression in acute psychotic states. Differences between impulsive, aggressive, and predatory behaviors and their corresponding measurements will also be reviewed. Dysfunction in both neuropsychiatric and central neurotransmitters systems can be associated with

aggressive behaviors. Specifically, a reduction in central serotonergic system function is hypothesized to lead to a reduction of behavioral restraint resulting in disinhibition of aggressive impulses. In contrast, central catecholaminergic, opiate, androgen, and adrenocorticotropin system dysfunction have been proposed to play a facilatory role. An attempt will be made to relate the most relevant central neurotransmitters dysfunction to aggressive behavior encountered in acute psychotic states.

No. 16B
INVOLUNTARY TREATMENT

Renee L. Binder, M.D., *Department of Psychiatry, Langley Porter Institute, 401 Pamassus Avenue, Box F, San Francisco, CA 94143*

SUMMARY:

Involuntary treatment of the mentally ill, including the use of medications, seclusion, restraint, and hospitalization, is justified by certain legal principles such as "police powers" and "parens patriae." However, United States Supreme Court decisions (e.g., Washington v. Harper) have established that individuals have a fundamental liberty interest in avoiding the administration of unwanted psychotropic medications, and constitutional law suggests that this liberty can be overcome only by the most compelling governmental issues. Moreover, state court decisions, such as the Riese decision in California, specify that medication cannot be given involuntarily except in emergencies or when patients lack the capacity to make treatment decisions. These legal decisions impact on clinical practice and the management of the acutely mentally ill patient. However, clinical decision making about involuntary treatment may lead to allegations of malpractice such as false imprisonment, breach of confidentiality, incorrect treatment/diagnosis, and failure to prevent suicide or homicide. Risk management strategies that apply to involuntary treatment such as consultation, knowledge of applicable statutes and laws, and documentation of the clinician's reasoning about risks and benefits, are reviewed here.

No. 16C
INITIAL PHARMACOLOGIC MANAGEMENT OF EPISODIC AGITATION

Michael H. Allen, M.D., *Associate Director of Psychiatry, Denver Health, 777 Bannock Street, Denver, CO 80204-4507*

SUMMARY:

The care of the agitated, acutely psychotic patient can be conceptualized as occurring in two phases: a brief period of initial management of behavioral disturbances followed by a much longer period of definitive treatment of the underlying condition. Historically, both initial management and definitive treatment were accomplished with conventional neuroleptics, first intramuscularly and then orally. Several rapid tranquilization strategies evolved to include benzodiazepines and/or lower doses of neuroleptics including droperidol. But while the wider practice environment has changed substantially with newer medications, shorter lengths of stay, and increased consumer participation, rapid tranquilization has remained static for a decade. In light of these changes, audience opinion will be compared with data from a survey of over 50 psychiatric emergency service directors and the evidence base for current rapid tranquilization strategies. The presentation will focus on minimizing adverse events during the nonspecific management phase and accomplishing a rapid transition to informed, voluntary treatment, placing this phase into the larger context of long-term outcome.

No. 16D
THE IMPACT OF THE SECOND-GENERATION ANTIPSYCHOTICS ON AGGRESSION AMONG PSYCHOTIC PATIENTS

K.N. Roy Chengappa, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Aggression and violence among subjects with psychoses brings attention (often negative) from caregivers, health providers, family members, and the media. While double-blind, random-assignment studies are sparse, there is increasing support for the notion that the second-generation antipsychotic agents impact on hostility and aggression in a positive manner. Most of these data derive from open, retrospective, prospective, and mirror-image studies. Most data exist for clozapine, but increasing data are now available regarding risperidone. Data are also becoming available indicating that quetiapine and, possibly, olanzapine may have similar effects. The decrease in seclusions, restraints, violence toward others and property, and self-mutilation is likely to have a salutary effect on morale of all concerned, as well as significant savings in costs related to these behaviors.

No. 16E
MAXIMIZING LONG-TERM COMPLIANCE AND FUNCTIONAL OUTCOME

Robert R. Conley, M.D., *Psychiatric Research Center, University of Maryland, P.O. Box 21247, Baltimore, MD 21228*

SUMMARY:

The purpose of this presentation is to examine rehospitalization rates of people receiving second-generation antipsychotics who had been discharged from state psychiatric hospitals in Maryland and also to examine factors that influence outcome. Rehospitalization status was monitored for all patients discharged from state psychiatric facilities on a regimen of second-generation antipsychotics. Patients were followed up with respect to readmission. Time to readmission was measured by the product-limit (Kaplan-Meier) formula. Risk factors associated with rehospitalization were examined. Reviews of other follow-up studies will also be presented. Recidivism rates for schizophrenic patients discharged on risperidone, olanzapine, or clozapine were not significantly different over a 24-month study period. All rates were superior to outcome on depot antipsychotics or the general readmission rate in the state system. No clinical or demographic variables were found to predict rehospitalization. This study demonstrates that the rehospitalization rates of patients taking the second-generation antipsychotics risperidone and clozapine are lower than those in previously published reports of conventional antipsychotic treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 17—CONTROVERSIES AT THE INTERFACE OF SLEEP AND PSYCHIATRY

Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The objective of this symposium is to teach by debate. At the conclusion of the symposium attendees should better understand the relationship of sleep disturbances to psychiatric disorders, and be more adequately prepared to take sleep needs into consideration when selecting treatment.

No. 17A
SLEEP DISTURBANCE IN MOOD AND ANXIETY DISORDER

Thomas A. Mellman, M.D., *Dartmouth-Hitchcock Psychiatric Association, One Medical Center Drive, Lebanon, NH 03756*

SUMMARY:

Sleep complaints are common with depression and anxiety and core aspects if their disorders occur in relation to sleep. For example, many depressed patients complain of awakening early in the morning without feeling refreshed and can experience their worst mood states during the morning. Mania features the perception of a diminished need for sleep. Panic attacks, which are the core symptom of panic disorder, sometimes emerge directly from sleep. In addition to featuring restless and disturbed sleep, a cardinal manifestation of posttraumatic stress disorder (PTSD) is re-experiencing nightmares.

Epidemiological data indicate that insomnia is associated with an increased risk for the subsequent onset of a mood or anxiety disorder. Sleep deprivation can transiently improve mood in depression while it typically exacerbates mania and panic disorder. We have recently found reports of dreams that are highly similar to a recent traumatic event to predict the continuation of PTSD symptoms.

It appears that sleep loss and disruption contribute directly to the pathogenesis and/or represent prodromal manifestations of certain psychiatric disorders. Longitudinal relationships of sleep disturbance and mood and anxiety disorders have implications for early case detection and possibly, prevention.

No. 17B
MOOD REGULATION: FUNCTION OF REM SLEEP AND DREAMING

Rosalind Cartwright, Ph.D., *Department of Psychology, Rush-Presbyterian, 1653 West Congress Parkway, Chicago, IL 60612*

SUMMARY:

Changes in waking mood, sleep variables, and dream affect in depressed volunteers were studied over an eight-month period to test whether REM sleep and dreaming act as modifying variables between pre-sleep depressed mood and morning mood, and whether overnight down regulation of negative mood is associated with remission. Twelve untreated volunteers were studied for two nights on four occasions with the first night being uninterrupted and the second night REM was interrupted to collect dream reports. Profile of Mood Scales was administered before and after each night, Beck Depression Inventory each month, and Hamilton Rating Scales on six occasions. Dream language was analyzed for positive and negative affect and for the direction of negative affect toward the self or toward others. Nine subjects remitted and three failed to remit. The remitters showed a consistent down regulation of overnight-depressed mood, while mood in the failure cares was unchanged. The REM interruption night served to increase REM pressure and intensify the dream affect until the fourth month when negative affect dreams were reduced and positive dreams increased. This was followed by normalization of Beck & Hamilton Scales. REM sleep and dreams contribute to a natural process of mood regulation in untreated depressed persons.

No. 17C
MEDICATIONS FOR SLEEP DISORDERS

Wallace B. Mendelson, M.D., *Sleep Research Lab, University of Chicago, MC3077, 5841 South Maryland Avenue, Chicago, IL 60637*

SUMMARY:

A number of changes in the pharmacologic treatment of insomnia have occurred in recent years. Overall, the use of pharmacologic approaches has declined, though the frequency of complaints of sleep disturbance has remained constant or increased somewhat. Certainly one striking feature has been the decline in use of hypnotic medications and the rapid increase in prescriptions for antidepressants for sleep disturbance. There has also been a substantial interest in alternative pharmacotherapies including melatonin. Insomaniacs also often self-medicate with ethanol, or employ over-the-counter hypnotics or antihistamine-analgesic combinations. We will review these approaches, and comment on their risk/benefit assessment. We will also consider the issue of combination use of pharmacologic and non-pharmacologic approaches in chronic insomnia.

No. 17D
DEFINING OPTIMAL SLEEP

Thomas Roth, Ph.D., *Sleep Disorders Center, Henry Ford Hospital, 2799 West Grand Boulevard., CFP3, Detroit, MI 48202*

SUMMARY:

The ultimate answer to the question of what defines optimal sleep awaits the elucidation of the functions of sleep. In lieu of that, this presentation will review the laboratory and epidemiological consequences of disturbed sleep, specifically, the consequences of partial sleep loss, fragmented sleep, selective sleep stage deprivation as well as the consequences of insomnia. The effects of sleep loss are most clearly evident in the performance of a variety of psychomotor and vigilance tasks. The relation between sleep loss and daytime impairment is linear. More recently, sleep loss has been shown to impact memory process as well as decision making. Studies on the consequences of sleep fragmentation parallel those of sleep deprivation. This parallel between sleep loss and sleep fragmentation demonstrates that total sleep time neither uniquely defines nor is predictive of the consequences on sub-optimal sleep. Also supporting this notion are the results of selective deprivation studies. Finally, insomnia has been associated with a variety of effects including increased absenteeism, functional impairment, increased accident rates, greater health care utilization, increased risk of first occurrences of depression, and decreased productivity. The specifics of what aspects of sleep predict those impairments has yet to be determined.

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INDUSTRY-SUPPORTED SYMPOSIUM 18—PHARMACOTHERAPY OF DEPRESSION: NEW STRATEGIES

Supported by Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The objective of this symposium is to help the clinician when faced with a patient with depression to select appropriate first and subsequent line treatments and to manage better side effects and improve adherence to treatment programs.

No. 18A
MECHANISM OF ACTION AND CLINICAL RESPONSE

Alan Frazer, Ph.D., *Pharmacology, University of Texas Health Sciences, 7703 Floyd Curl Drive, San Antonio, TX 78284-7764*

SUMMARY:

There are 21 drugs currently marketed in the United States for the treatment of depression. Based upon the acute pharmacologic actions of these drugs, they can be divided into four categories: (1) selective enhancers of noradrenergic transmission (e.g., desipramine, reboxetine), (2) selective enhancers of serotonergic transmission (e.g., fluoxetine, citalopram), (3) nonselective enhancers of both noradrenergic and serotonergic transmission (e.g., phenelzine, amitriptyline, mirtazapine), and (4) no known potent pharmacologic effects to enhance either noradrenergic or serotonergic function (e.g., bupropion, nefazodone). The third category is not homogeneous, as drugs may do this by inhibiting monoamine oxidase, by inhibiting the reuptake of both norepinephrine and serotonin, or being antagonists of alpha adrenoceptors. In nonselected depressed patients, it does not seem that there is differential efficacy among drugs with different mechanisms of action. Whether this is true for different subgroups of depressed patients (e.g., "severe," melancholic) is currently a topic of some controversy. By contrast, many of these drugs are quite different in their side-effect profiles, and this is usually the primary consideration in the selection of a particular drug. This presentation will review all of these issues.

No. 18B
ANXIETY AND DEPRESSION

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 32, New York, NY 10032*

SUMMARY:

It is now clear that depression and anxiety more commonly co-occur in any patient than exist as separate entities. This may in part be due to epidemiological chance, because both disorders are very prevalent in the general population. There is now evidence, however, that a number of neurobiological abnormalities may be common denominators for mixed anxiety and depression and explain their comorbidity. For example, there is evidence that depression and generalized anxiety disorder share a common genetic vulnerability. Early life stress produces permanent neurobiological changes. One of these is an increase in the activity of systems mediated by corticotropin releasing factor (CRF), which is also elevated in humans with several anxiety disorders and with depression. In turn, CRF both influences and is regulated by the serotonin (5-HT) and noradrenergic neurotransmitter systems. Medications that down regulate the activity of the brain's main noradrenergic center, the locus ceruleus, and that increase overall brain 5-HT activity appear to decrease fear-induced increases in CRF release. All antidepressants have in common these exact 5-HT and noradrenergic effects. Therefore, drugs that modulate either serotonergic (e.g., SSRIs, nefazodone) or noradrenergic (e.g., reboxetine) systems, or both (e.g., venlafaxine XR, mirtazapine), are the best treatments for most of the anxiety disorders, for depression, and for the very common comorbid situation. In the near future, drugs that directly block the CRF receptor may become important antianxiety and antidepressant medications as well.

No. 18C
SEXUAL DYSFUNCTION AND DEPRESSION

Robert M.A. Hirschfeld, M.D., *Psychiatric and Behavioral Science, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

There are several possible causes of sexual dysfunction in depressed patients. A core symptom of depression is anhedonia, including loss of libido. Therefore, determining a cause of sexual dysfunction in a depressed patient can be a difficult task, and the differential diagnosis must include a primary sexual dysfunction, sexual dysfunction associated with a general medical or psychiatric disorder, or sexual dysfunction associated with treatments for psychiatric disorders. Of particular clinical interest is sexual dysfunction associated with different classes of antidepressant drugs, such as tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), or venlafaxine. The pharmacological basis for antidepressant-induced sexual dysfunction is thought to be a stimulation of 5-HT_2 receptors. Antidepressant-induced sexual dysfunction most frequently presents as a reduction in libido or delayed orgasm, and may not pose a major burden on patients during acute treatment. However, in long-term treatment, patients are generally well, and anything that interferes with sexual function will be a greater problem and will contribute strongly to noncompliance. Different strategies are advised when managing sexual dysfunction in depressed patients treated with antidepressant drugs: (1) waiting for a spontaneous resolution of the problem, (2) reduction of antidepressant drugs, (3) drug holidays, (4) adjunctive pharmacotherapy, or (5) switching to another antidepressant. Perhaps the best way to avoid sexual dysfunction is to initiate treatment with an antidepressant with proven acute and long-term efficacy that is also devoid of sexual side effects (eg. mirtazapine, nefazodone, or bupropion).

No. 18D
SLEEP AND DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Sleep disturbances are a significant factor in depressive disorders. Sleep disturbances, including hypersomnia, early insomnia, and more classical difficulties such as early morning awakening and midnighttime awakenings, are common antecedents and almost cardinal features of depressive episodes. Primary sleep disorders (e.g., sleep apnea, narcolepsy, and nocturnal myoclonus) also may complicate the clinical picture. Sleep disturbances reflect more fundamental alterations in central nervous system function, and may influence the selection of, and response to, different classes of antidepressant therapies. This presentation will review the nature of sleep disturbances in depression and highlight its significance as both trait-like and state-dependent psychobiological correlates of depressive disorders. Treatment implications as a result of sleep disturbances will be considered in detail, including the impact they have on response to psychotherapy, differential response to several classes of antidepressant medication, and the use of behavioral sleep hygiene strategies. In sum, the skillful psychiatrist who is able to recognize the significance of sleep pathology is in better position to tailor the treatment plan appropriately to achieve optimum results.

No. 18E
COMPLIANCE AND TOLERABILITY

Steven P. Roose, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, Unit 98, New York, NY 10032*

SUMMARY:

Currently available antidepressants interact with several types of receptors, which may explain the occurrence of either wanted or unwanted effects of these drugs. These effects are different and distinctive and knowledge about them may help clinicians distinguish between the tolerability profiles of the various compounds. Given comparable efficacy, the tolerability profile is the critical determinant in selecting an antidepressant medication for a particular patient. In addition, tolerability is inseparably linked to patient compliance, both in acute and long-term treatment and, therefore, to the ultimate overall success of treatment. Refinements in the pharmacological profiles of newly introduced antidepressants have resulted in overall advantages in tolerability as compared with the tricyclics. Though compliance is associated with tolerability, a patient's willingness to engage in treatment (medication or psychotherapy) is multi-determined. Compliance may reflect a patient's attitude toward illness, pharmacotherapy, and doctors themselves. New data suggest that a certain pattern of defense mechanisms may predict treatment dropout. Therefore, attention to the patient, not just to the illness, may increase compliance and, thereby, treatment success.

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INDUSTRY-SUPPORTED SYMPOSIUM 19—BIPOLAR CHILDREN AND ADOLESCENTS: CONTROVERSIES IN DIAGNOSIS AND TREATMENT
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this program, the participants will be able to (1) understand the genetic etiology and deficits in neurocognitive functioning associated with bipolar disorder, (2) recognize the full spectrum of behavioral and symptomatic presentation of children and adolescents with bipolar disorder, and (3) implement appropriate innovative treatment strategies for severe presentations of bipolar disorder in children, utilizing proper evaluation techniques and treatment algorithms.

No. 19A
BIPOLAR SPECTRUM DISORDER: GENETIC HYPOTHESES

David A. Mrazek, M.D., *Department of Psychiatry, George Washington Medical Center., 2150 Pennsylvania Avenue, NW, Washington, DC 20037*

SUMMARY:

The familial basis of bipolar disorder has been recognized for more than a century. A series of family, twin, and adoption studies have established both the familial nature of the illness and many aspects of its mode of inheritance. Heritability based on twin studies has been estimated to be greater than 50% across a wide range of samples. Monozygotic concordance rates as high as 0.79 have been reported. A greater risk of maternal inheritance suggests a complex oligogenetic mode of inheritance that may include the possibility of either X-linked or mitochondrial transmission.

Defining the molecular genetic basis of the illness is an area of intense research efforts. Many candidate genes have been put forward. Despite early excitement about a locus on chromosome 11, no single allele has been linked to transmission. Defining the phenotype in a precise manner is a key objective. New methodologies such as the use of microarray analysis may lead to identifying specific genes that are involved in disease expression. Clinical research focused on the definition of appropriate family samples linked with the capacity to screen large numbers of candidate genes promises the potential for early identification of risk for the illness. Such information could dramatically enhance the capability of preventing the onset of symptoms in genetically atrisk individuals.

No. 19B
CONTROVERSIES IN MAKING THE DIAGNOSIS

Peter S. Jensen, M.D., *Child Psychiatry, Columbia University/New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032*

SUMMARY:

The last few years have witnessed a heightened interest in bipolar disorder in children and adolescents. Its differential diagnosis has generated substantial controversy, in part because of research reports of substantial overlaps of bipolar disorder with ADHD, as well as the suggestion that many supposed ADHD children have been misdiagnosed, and may instead warrant the diagnosis of bipolar disorder. Some reports have suggested that as many as 20% of ADHD children may meet diagnostic criteria for bipolar disorder. In contrast, other investigators have suggested that these putative

overlaps are spurious, and instead reflect the blind application of diagnostic criteria to children with heterogeneous syndromes and/or diagnostically complex and comorbid ADHD. In this presentation, we will review the research evidence recently compiled by the NIMH, pertaining to what is known fact about these overlaps. In addition, instruments that may assist in the differential diagnosis of the two conditions will be identified and discussed, and practical suggestions for clinicians who must discriminate difficult cases will be offered. Therapeutic strategies for complex cases will be outlined, and the research basis supporting these approaches will be critiqued. Lastly, recommendation; will be made for researchers concerning a "menu" of potential studies that might be conducted to establish a firm, basis for discriminating these two disorders.

No. 19C
CONTROVERSIES IN THE TREATMENT OF DIFFICULT BIPOLAR ADOLESCENTS

Karen D. Wagner, M.D., *Department of Psychiatry, University, of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77550-0188*

SUMMARY:

Bipolar disorder in children and adolescents is a serious disorder that disrupts social, academic, and family functioning. This disorder is often associated with comorbid conditions, a high recurrence rate, and a significant risk for suicide. Although mood stabilizers are often used to treat this disorder in children and adolescents, there are few controlled treatment studies. The current status of pharmacotherapy, including medication options, side effects, and treatment course for this disorder in youth will be reviewed. Medication strategies for treatment resistance will be discussed.

No. 19D
EVALUATION AND MANAGEMENT OF VIOLENT BEHAVIOR IN BIPOLAR ADOLESCENTS

Hans Steiner, M.D., *Division of Child Psychiatry, Stanford University, 401 Quarry Road, Room 1117, Stanford, CA 94305-5719*

SUMMARY:

As in most forms of psychopathology, aggression is a developmentally complex phenomenon, calling for exact typification and diversification of treatment approaches. Environmental manipulation, behavior modification, stimulants, mood stabilizers, and antikindling agents all are empirically shown to be effective treatment of subtypes of aggression. There will be discussion of different forms of aggression occurring in bipolar adolescents and the research-based typology, which is effective in delineating subtypes of aggression and their most appropriate treatment.

The empirical distinction between affective (defensive, reactive, impulsive) and predatory (planned, offensive, controlled) aggression in humans will be reviewed, and appropriate treatment approaches for each subtype will be outlined. The practitioner will be able to apply this typology to clinical cases and plan appropriately for the most effective treatment. Psychotherapeutic and psychopharmacological approaches will be discussed and their integration emphasized.

No. 19E
NEUROIMAGING AND NEUROPSYCHOLOGICAL TESTING

Robert L. Hendren, D.O., *Department of Psychiatry, University of Medicine and Dentistry New Jersey/Robert Wood Johnson, 671 Hoes Lane, UBHC F12, Room C231, Piscataway, NJ* 08855-1392

SUMMARY:

Bipolar disorder in children is difficult to diagnose and is often confused with depression and attention deficit/hyperactivity disorder. Objective sources of information such as neuroimaging and neuropsychological testing may have a role in improving diagnosis, prognosis, prediction, and treatment matching. This presentation reviews the published research using neuroimaging and/or neuropsychological testing to study bipolar disorder and related serious emotional disorders in youth. Results from a recently completed study supported by the Stanley Foundation using neuroimaging and neuropsychological testing to evaluate 60 8-to-12-year old children (20 bipolar disorder, 20 major depression, 20 matched controls) will be presenced, and the findings related to diagnostic subtypes and treatment response. Preliminary results suggest that children with depression are more likely to have reduced frontal and lateral ventricle volumes, and children with bipolar disorder are more likely to have frontal white matter intensities. Both groups demonstrate basal ganglia abnormalities, as do children with ADHD, although these are distinct when diagnosis is carefully determined. Neuropsychological testing reveals distinct differences between groups with depression, bipolar disorder, or ADHD. Further study will help determine the usefulness of this approach to diagnosis and treatment matching.

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INDUSTRY-SUPPORTED SYMPOSIUM 20—COMPLEXITIES OF TREATMENT OF BIPOLAR DISORDER
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) recognize risk factors for poor response to treatment in bipolar illness, and (2) develop a treatment plan for the complexities of bipolar disorder.

No. 20A
RECENT GENETIC FINDINGS IN BIPOLAR DISORDER

John I. Nurnberger, Jr., M.D., *Department of Psychiatry, Indiana University, 791 Union Drive, Indianapolis, IN 46202;* J. Raymond DePaulo, Jr., M.D., Theodore A. Reich, M.D., Mary Blehar, Ph.D., Tatiana Foroud, Ph.D., Elliott S. Gershon, M.D.

SUMMARY:

Bipolar affective disorder (BP) clearly aggregates within families. The genetics of BP is complex, however, and not consistent with single major locus inheritance; no specific genes have yet been

located and confirmed. A collaborative study involving four sites was supported as part of the NIMH Genetics Initiative. A structured interview (DIGS) was developed to provide a comprehensive phenotypic assessment of patients and relatives. Families included were required to have at least two affected subjects with bipolar I (BP) disorder or one with BPI and a second with schizoaffective disorder, bipolar type (SA/BP). Probands and relatives were interviewed and provided a blood sample for transformation and storage at a national data bank. We present results from 540 subjects selected from 97 families. This group included 282 affected sibling pairs, (BP & UP), as well as 412 affected relative pairs. A survey was completed with 319 markers. Analysis was carried out using SIBPAL and Genehunter Plus. A number of candidate areas are supported, especially areas on chromosomes 6, 10, and 16. A summary of results of linkage analysis on individual families from this dataset will also be presented.

No. 20B
DISTINCTIVE MIXED STATES OF BIPOLAR I, II AND BEYOND

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:

Official systems of classification such as DSM-IV and ICD-10 recognize mixed states only in the presence of syndromal depression during mania. Recent evidence indicates that even subthreshold levels of depression are relevant to bipolar mixed states. Furthermore, hypomanic intrusions into major depressive episodes have long been recognized as mixed states in the clinical literature. This presentation focuses on data obtained from the author's collaborative work with Italian and French investigators involving more than 300 patients in support for broadening the concept of mixed states. In particular, evidence for a new classification will be presented for distinctive mixed states. In BP I, mixed states seem to arise from a dysthymic temperamental background; when the temperament is congruent to mania (i.e., hyperthymic), the clinical picture is that of classical euphoric mania. In BP II, hypomanic intrusions into depression appear facilitated by antecedent cyclothymic instability leading to mood lability and impulsivity, especially in the sexual domain. There also exist major depressive episodes arising from a hyperthymic temperamental background, and where mixed features are manifested by flight of ideas and psychomotor excitement. Just like depressive mania, depressive episodes with hypomanic or hyperthymic admixtures respond best to anticonvulsant mood stabilizers, and perhaps to atypical neuroleptics.

No. 20C
ETHICS ISSUES IN BIPOLAR DISORDER

William B. Lawson, M.D., *Department of Psychiatry, Roudebush VAMC, 1481 West 10th Street (116A), Indianapolis, IN 46202;*

SUMMARY:

Bipolar disorder is often underdiagnosed or misdiagnosed in ethnic minorities leading to substantial undertreatment or mismanagement. Ethnic differences in symptom presentation and increased risk of substance abuse may account for some of the misdiagnosis. Ethnic differences in dosing, pharmacokinetics, and side effect profiles have been reported for many antimanic agents. African Americans appear to be less tolerant to lithium due to differences in the RBC/plasma ratio and less likely to be prescribed mood stabilizers. Overtreatment with typical neuroleptics is common, leading to poorer outcomes, inconsistent treatment compliance, and probably increased risk of abnormal involuntary movements. Newer treatments may offer substantial advantages in tolerability and side-effect profiles for many ethnic groups. Socioeconomic status, costs of newer treatments, access to services, and lack of information about bipolar disorder in diverse populations limit access to optimal treatment.

No. 20D
WOMEN WITH BIPOLAR ILLNESS: SPECIAL ISSUES

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Suite 280, Cleveland, OH 44106*

SUMMARY:

For women with bipolar disorder, pregnancy presents a challenge. Lithium, valproate, and carbamazepine treatment increase the risk for birth defects and other types of reproductive toxicity. The risk of teratogenicity must be balanced with the risk of uncontrolled maternal mood symptoms, which can also threaten the health of mother and fetus. A model to structure the decision-making process will be presented.

Similarly, breastfeeding while taking maintenance medication is a clinical concern. Lithium is considered contraindicated by the American Academy of Pediatrics, while carbamazepine and valproate are considered reasonable choices. Mother-infant serum level data and clinical observations will be presented to support this position.

Clinical management strategies and case examples will be used to illustrate the process by which pregnancy outcome can be optimized.

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INDUSTRY-SUPPORTED SYMPOSIUM 21—SCHIZOPHRENIA AND BIPOLAR DISORDERS: EVOLVING THERAPEUTIC CONCEPTS
American Society of Clinical Psychopharmacology: Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to assess and safely and effectively treat bipolar disorder and

schizophrenia both in their earliest phases as well as over many years of maintenance therapy.

No. 21A
CAN SCHIZOPHRENIA BE DIAGNOSED AND TREATED BEFORE IT'S SCHIZOPHRENIA

Barbara Comblatt, Ph.D., *Department of Psychiatry Research, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004;* Michael Obuchowski, Ph.D., Keith S. Ditkowsky, M.D., Julia A. Becker, M.D., Todd Lencz, Ph.D.

SUMMARY:

The schizophrenia prodrome begins with the first noticeable change in behavior and lasts until the onset of psychosis. Recent evidence suggests that treatment initiated during this stage of illness might stop progression to psychosis. The prodrome is currently characterized by a cluster of nonspecific (e.g., decline in school functioning; increasing social withdrawal) and schizophrenia-like (e.g., odd behaviors, unusual perceptions) symptoms and by a profile of neurocognitive abnormalities (e.g., deficits in attention).

The RAPP (Recognition and Prevention of Psychological Problems) Clinic of Hillside Hospital is a research/early intervention center focusing on adolescents in the prodromal stages of schizophrenia. A major goal of the RAPP Clinic is to establish an accurate screening battery so that treatment can be initiated as early as possible. Clinically, a broad range of intervention strategies are currently being evaluated, including pharmacological treatment; psychoeducation, and individual, family, and group therapies.

To date, over 50 patients have completed the RAPP Clinic research protocol and have received at least one year of treatment. Preliminary findings suggest that the early treatment strategies offered by the RAPP Clinic are having a considerable, beneficial impact on outcome, with the majority of patients either showing no further progression of illness or improving.

No. 21B
LONG-TERM MANAGEMENT OF SCHIZOPHRENIA: IMPROVED TREATMENTS, PROMISING OUTCOMES

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

Given the usual early age of onset and chronic course of schizophrenia, optimal long-term treatment is a critical goal in the management of this disease. Though considerable progress has been made in establishing the benefits of maintenance medication, a number of critical issues remain. Not all patients derive equivalent benefit in terms of symptom control, relapse prevention, or enhanced functioning. In addition, long-term treatment has been associated with significant adverse effects (tardive dyskinesia in the case of first-generation medications, and weight gain with second-generation medications). As in any chronic illness, facilitating compliance is always a challenge but this is particularly problematic during the early phases of a schizophrenic illness. Medication is a necessary, but not sufficient, component of long-term treatment and appropriate integration and phasing of psychosocial and vocational therapies is also critical. The extent to which the second-generation medications can improve overall outcome is an important focus of new research.

No. 21C
ACUTE BIPOLAR DISORDERS: STATE-OF-THE-ART TREATMENT

Lori L. Altshuler, M.D., *Department of Psychiatry, UCLA, 300 Medical Plaza, #1544, Los Angeles, CA 90095-7057*

SUMMARY:

This presentation will contain an overview of the treatment of acute episodes of bipolar disorder. Treatment goals, differential diagnosis, and the spectrum and precipitants of bipolar disorders will also be discussed. Several new anticonvulsants including lamotrigine, gabapentin, tiagabine, and topiramate, are currently undergoing trials as add-on treatment for mania. The literature will be reviewed and optimal clinical usage discussed. These new treatments will be compared with current treatment regimens. The available data on ideal treatment for bipolar depression will also be reviewed. The discussion will include guidelines for incorporating the new treatments into a patient's current regimen. Timing (when is it appropriate to use a new anticonvulsant), safety, and efficacy issues and suggested titration schedules will be reviewed.

No. 21D
LONG-TERM MANAGEMENT OF BIPOLAR DISORDERS

Alan J. Gelenberg, M.D., *Department of Psychiatry, University of Arizona Health Science Center, P.O. Box 245002, 1501 North Campbell, Tucson, AZ 85724-5002*

SUMMARY:

The first pharmaceutical approved by the FDA for maintenance (prophylactic) therapy of bipolar disorder was lithium. Lithium remains the only agent with this labelled indication and continues in use today. However, divalproex, approved for the treatment of acute mania, has overtaken lithium as a widely prescribed agent for bipolar disorder. More recent attention has focused on newer anticonvulsants and a series of adjunctive treatments, including such "natural" substances as omega-3 fatty acids. These days polypharmacy is the rule in treating patients with bipolar disorder. This presentation will review knowledge and opinion about maintenance treatments for patients with bipolar disorder.

No. 21E
MINIMIZING RISKS TO MAXIMIZE BENEFITS OF LONG-TERM TREATMENT

James W. Jefferson, M.D., *Healthcare Technology Systems, 7617 Mineral Point Road, Suite 300, Madison, WI 53717*

SUMMARY:

While the long-term benefit of pharmacotherapy for bipolar disorder and schizophrenia is well established, its success depends on the continued tolerability and safety of the treatment. Areas of concern with both mood stabilizers and atypical antipsychotics include adverse events that are neurologic (nontoxic cognitive impairment, movement disorders, and toxic syndromes), cardiologic (arrhythmias and hypotension), metabolic (weight gain and endocrinopathies), and reproductive. In addition, issues remain as to the long-term impact of lithium on the kidney and valproate on the ovary. Finally, even the most stable compliant patient can fall victim to the intricacies of drug interactions that can negate efficacy or induce toxicity. During this presentation, mood stabilizers and antipsychotics will be compared and contrasted with regard to their effects in these areas, and recommendations will be made with regard to preventing, minimizing, and treating both adverse reactions and drug interactions.

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INDUSTRY-SUPPORTED SYMPOSIUM 22—NEUROBIOLOGY OF DISEASE: FROM THE LAB TO THE CLINIC
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand advances in the field of functional brain imaging, apply the findings of functional brain imaging studies to clinical practice, design treatment regimens based on novel uses of antidepressants, and understand the neurobiological association between anxiety disorders and somatic symptoms.

No. 22A
RECENT ADVANCES IN THE NEUROBIOLOGY OF MOOD AND ANXIETY DISORDERS

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, Room 623, New Haven, CT 06519*

SUMMARY:

There have been major advances in our understanding of the neurobiology of depression and anxiety. The role of the monoamines serotonin and norepinephrine have 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 and anxiety will be reviewed.

No. 22B
NOVEL ACTIONS OF ANTIDEPRESSANTS

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4115, Atlanta, GA 30322;* Michael J. Owens, Ph.D., Paul M. Plotsky, Ph.D.

SUMMARY:

Although several studies have provided data concordant with the monoamine hypotheses of depression and its treatment, an impressive series of findings have led investigators to discard single neurotransmitter theories of both mechanism of action of antidepressants, and of the pathophysiology of depression. The former is the focus of this presentation. The central theme is that antidepressants, particularly after chronic administration, exert neurochemical effects other than those traditionally suggested to underlie their therapeutic utility. One such example is the similarities and differences among the selective serotonin reuptake inhibitor (SSRI) antidepressants. They all exhibit the shared property of potent serotonin reuptake blockers. However, paroxetine, but none of the others, is a relatively potent norepinephrine (NE) reuptake inhibitor, and sertraline is unique among the SSRIs as a dopamine reuptake inhibitor. The ability of paroxetine to inhibit NE reuptake has been demonstrated *in vitro* as well as *in vivo*. Because of the evidence that corticotropin-releasing factor (CRF)-containing neurons are hyperactive in depression, the effects of antidepressants on CRF neurons have been investigated. In a well validated animal model of depression, both paroxetine and reboxetine markedly reduced the elevated activity of CRF neurons. In other paradigms, fluoxetine and venlafaxine exhibit similar effects. Finally, the effects of antidepressants on signal transduction processes and neuronal gene expression will be reviewed.

No. 22C
USE OF FUNCTIONAL BRAIN IMAGING IN UNDERSTANDING MAJOR PSYCHIATRIC DISORDERS: PROFILES AND PROMISES

Clinton D. Kilts, Ph.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Functional brain imaging techniques such as positron emission tomography (PET) and functional magnetic resonance imaging (fMRI) have provided novel and powerful insights as to the anatomy of distributed neural processing that underlies complex behaviors. By spatially mapping hemodynamic and metabolic correlates of synaptic activity, these techniques have revolutionized our understanding of the functional anatomy of the healthy and psychiatrically ill human brain. Neuroreceptor PET imaging techniques complement these neurophysiological imaging strategies and provide relatively noninvasive, in vivo determinations of the roles of neuronal receptors and transporters in the pathophysiology and treatment of psychiatric disorders. In keeping with the theme of this symposium, specific examples of the use of PET and fMRI in defining the trait and state neural correlates of mood and anxiety disorders will be discussed. The neural substrates of cognitive impairments often associated with mood disorders, and an emerging view of the neural substrates of response associated with the treatment of anxiety disorders, will be presented. The emerging role of neuronal transporter PET imaging in predicting and defining treatment response will be discussed to demonstrate the promises of functional brain imaging techniques in understanding major psychiatric disorders.

No. 22D
PSYCHIATRIC SEQUELAE OF INTERFERON THERAPY AND ITS MANAGEMENT WITH ANTIDEPRESSANTS

Dominique L. Musselman, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322;* David H. Lawson, M.D., Charles B. Nemeroff, M.D., Andrew H. Miller, M.D.

SUMMARY:

A variety of illnesses, including viral infections and cancers, have been treated with interferon (IFN) alpha, a cytokine notorious for

inducing a depression-like syndrome. This depressive syndrome, also known as sickness behavior, includes symptoms of fatigue, anorexia, anhedonia, insomnia, and depressed mood. Animal studies have revealed that pretreatment with antidepressants may reduce such sickness behavior in rodents following administration of polysaccharide, a cytokine inducer. We wondered whether patients undergoing high-dose IFN alpha therapy for malignant melanoma exhibited major depression and whether pretreatment with an antidepressant might ameliorate their cytokine-induced sickness behavior. In a double-blind, placebo-controlled design, we pretreated these patients with the antidepressant paroxetine for two weeks before their initiation of treatment with INF-alpha therapy (daily intravenous 20 million/units/m2 of IFN alpha for four weeks followed by 10 million units/m2 subcutaneously three times per week for two months). Eighteen patients completed this three-month study. Seven of the nine (78%) placebo-treated patients fulfilled criteria for major depression, in comparison with only two of the nine (22%) patients treated with paroxetine ($p<0.05$). Paroxetine-treated patients also reported lower symptoms of IFN-alpha induced neurotoxicity symptoms and exhibited significantly decreased Hamilton Depression Rating Scale scores in comparison with the placebo-treated patients. Our data reveal that patients undergoing IFN-alpha therapy develop elevated rates of depression. Pretreatment with antidepressants may prevent and/or ameliorate the development of cytokine-induced depressive syndromes.

No. 22E
NEUROBIOLOGY OF THE GUT AND BRAIN: IMJPLICATIONS FOR MANAGEMENT OF IRRITABLE BOWEL SYNDROME

R. Bruce Lydiard, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, P.O. Box 250861, Charleston, SC 29425*

SUMMARY:

The literature on treatment-seeking patients indicates that there is a significant overlap between functional gastrointestinal disorders and psychiatric disorders. Anxiety and mood disorders are highly prevalent in patients with irritable bowel syndrome (IBS). Conversely, IBS is highly prevalent in patients with anxiety and mood disorders. More recent evidence indicates a similarly high association of IBS and psychiatric disorders, especially anxiety disorders, in community (e.g., nonpatient) samples. This suggests that there is a more fundamental association between IBS, anxiety, PTSD, and other psychiatric disorders. Important two-way links between the brain and the gut include several brain structures, which mediate normal gastrointestinal functioning. These same brain areas also appear to mediate both normal vegetative and also stress-induced and fear/arousal responses in both the brain and the GI system. These include the locus ceruleus (LC), amygdala, hypothalamis, periaquiductal grey, and others. Experimental distension of the colon causes increased LC firing. Corticotropin releasing factor (CRF) appears to play a role in this experimental stress-induced colonic motility. The enteric nervous system (ENS), often referred to as "the little brain," has a common embryonic origin with the CNS, distinct from other peripheral nerves. Given the substantial overlap in the neural systems modulating gut function and disorders of arousal, it is possible that common pathophysiology in the ENS and CNS might underlie the frequent co-existence of IBS, traumatic stress, panic, and other psychiatric disorders. The implications for using psychotropic medications in IBS will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 23—PHARMACOTHERAPY OF DEMENTIA: EXPANDING THE BOUNDARIES
Supported by Eisai Inc., Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, participants will be familiar with the pharmacotherapeutic treatments for managing cognitive disturbances, behavioral disturbances, and apathy in patients with dementia; primary prevention strategies for dementia including the use of vitamin E, cholinergic agents, and COX-2 inhibitors, amongst others.

No. 23A
CAN WE DELAY THE ONSET OF ALZHEIMER'S DISEASE?

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University Medical Center, Trent Drive, Room 3547, Blue Zone, Durham, NC 27710*

SUMMARY:

Strategies for preventing dementia that are translatable into clinical practice are an urgent, compelling need. However, their development has been restricted to some extent by limited knowledge of the cause of Alzheimer's disease (AD) and related dementias. Aberrant cleavage of amyloid precursor proteins, hyperphosphorylation of tau, increased oxidative stress, inflammatory reactions, neurotransmitter deficits, and impaired cortical metabolism are linked to AD. Once clinically detectable, disease progression is relatively rapid. Secondary oxidative, inflammatory, and other processes may drive the shift to a relatively malignant phase. More than 20 epidemiologic studies support a role for anti-inflammatory agents in AD. Vitamin E, cholinergics, COX-2 inhibitors, ginkgo biloba, and estrogen are the current agents being evaluated in prevention trials. Combination therapies have not been studied systematically for prevention. Since preclinical changes may occur more than 15 years before clinical diagnosis, prevention trials are focused on preventing development of symptomatic dementia in individuals at risk for dementia within the next three to five years. Trial entry criteria, outcome measures, and working criteria for identifying subjects at risk will be reviewed along with instruments for screening early dementia in routine practice.

No. 23B
PHARMACOTHERAPY OF COGNITION IN DEMENTIA

Trey Sunderland, M.D., *Department of Geriatric Psychiatry, National Institute of Mental Health, 9000 Rockville Pike, Bethesda, MD 20892*

SUMMARY:

Until recently, there were no approved treatments for cognitive decline associated with Alzheimer's disease (AD). Currently, many agents are being proposed for acute and chronic treatment of memory disturbances, e.g., cholinesterase inhibitors (ChEIs), hormone replacement therapy, nonsteroidal anti-inflammatory agents, antioxidants, and even gingko biloba. However, only the ChEIs donepezil and tacrine have received approval for the treatment of AD in the United States. Among the newer ChEIs in the United States, rivastigmine is pending final approval, and two other cholinesterase inhibitors, metrifonate and galantamine, are undergoing regulatory review. Striking similarities in the mean clinical responses across these agents have been reported at scientific meetings, whereas some differences have been reported in behavioral parameters. Although ChEIs are not preventative or disease slowing agents, they fill an important niche in the treatment of AD and will likely continue to be used as part of a multimodal treatment approach in the future.

No. 23C
PHARMACOTHERAPY OF DEPRESSION IN DEMENTIA

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Depressive symptomatology can be identified in almost half of demented patients. Depression associated with dementia is persistent and recurrent and most frequent in dementias affecting striatofrontal circuitry, including vascular dementia, dementia associated with Parkinson's disease, and Lewy body dementia, while frontotemporal dementia rarely is complicated by depression. The Apo E 3/4 genotype has been found to be associated with depression in Alzheimer's patients. These observations suggest that depression of dementia is linked to the pathophysiology of the underlying dementia.

Controlled studies suggest that depressed-demented patients may respond favorably to cyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs). Imipramine has been shown to reduce depressive symptomatology. Paroxetine was found equally effective to imipramine. Citalopram has been shown to be effective in both demented and non-demented elderly patients. These observations suggest that SSRIs may be useful in the treatment of depressed-demented patients and may be favored over cyclic antidepressants because of their favorable side-effect profile.

No. 23D
PHARMACOTHERAPY OF AGITATION IN DEMENTIA

Prakash S. Masand, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Nearly 90% of patients with dementia develop significant behavioral problems during the course of their illness. Agitated behaviors are among the most common behavioral disturbances in dementia and can be aggressive or non-aggressive and socially inappropriate. This presentation will discuss the neuroanatomic substrates, differential diagnosis, aggravating factors, and psychosocial underpinnings of agitation in dementia, which are critical to the successful management of the illness. Psychopharmacologic interventions, including novel antipsychotics, anticonvulsants, anxiolytics, antidepressants, estrogen and progestin therapies, dopaminergic agents, cholinesterase inhibitors, electroconvulsive therapy, and bright-light pulses are potential treatment options. The risk/benefit ratio of these different interventions will be addressed, as well as the practice of environmental manipulation and caregiver education.

No. 23E
PHARMACOTHERAPY OF APATHY IN DEMENTIA

Michael S. Mega, M.D., *Department of Psychiatry, UCLA School of Medicine, 710 Westwood Plaza, Los Angeles, CA 90095-1769*

SUMMARY:

Apathy is the most prevalent behavioral change in cortical and subcortical dementia. Apathy and depression are dissociable across degenerative disorders. The frontal-subcortical circuit of the anterior cingulate mediates the fundamental domains of motivation and attention and, when disrupted, produces varying degrees of apathy depending on the location of damage. Although apathy is common in Alzheimer's disease (AD), greater disruption of this circuit occurs in frontal system disorders such as progressive supranuclear palsy (PSP) and frontotemporal dementia (FTD). The effect cholinergic stimulation in AD has in treatment responders may be exerted via the anterior cingulate's impact on motivation and attention.

Using the Neuropsychiatric Inventory (NPI), apathy and depression were evaluated in patients with cortical degeneration (AD and FTD) and subcortical degeneration (PSP, Parkinson's disease, and Huntington's disease). Functional imaging studies correlated with the NPI reveal that the depressed, compared with the non-depressed, AD patients have significantly hypoperfused left dorsolateral and orbitofrontal regions, while apathy in AD is associated with anterior cingulate hypoperfusion. Cholinesterase inhibitor therapy in AD leads to a 30% improvement in apathy for 60% of patients treated, while the anterior cingulate is a principle site of activation with cholinergic stimulation in AD, as reflected by post-treatment minus pre-treatment minus pre-treatment FDG-PET.

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INDUSTRY-SUPPORTED SYMPOSIUM 24—NEW ANTIPSYCHOTICS: FROM PRACTICE TO THEORY
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding of the extent and limitations of controlled data on the new antipsychotics and how to prescribe cutting-edge treatment with them.

No. 24A
THE EFFICACY SPECTRUM FOR ATYPICALS IN CLINICAL PRACTICE

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford, CA 94305-5490*

SUMMARY:

The newer antipsychotics have drastically changed prescribing practices of clinicians. They have the advantage of a more benign side-effect profile with (at least) equal efficacy for the treatment of schizophrenia, and possibly better efficacy for negative symptoms and cognitive function.

Of interest, well over 60% of use of these drugs is for conditions other than schizophrenia. This paper critically reviews the literature concerning use of newer antipsychotics, both as a primary therapy and as part of combination therapy not only for schizophrenia and schizoeffective disorder, but also for bipolar disorder and major depressive disorder, psychotic disorders secondary to medical conditions, OCD, dementia, substance-induced psychotic disorders, and Tourette's syndrome. In addition, other off-label indications include PTSD, dissociative identity disorder and MPD, conduct disorder, borderline personality disorder, as well as residual delirium, dementia, and amnestic or other cognitive disorder, e.g., former cocaine addicts.

Controlled data supporting efficacy are available only for schizophrenia, and to a limited degree for schizoeffective and bipolar illnesses. Until controlled studies are available, clinical practice will be guided by case reports, word of mouth, and expert opinions. This presentation will present an overview of all of these types of information.

No. 24B
ADVERSE EXPERIENCES WITH NEWER ANTIPSYCHOTICS

Donna A. Wirshing, M.D., *Department of Research, West Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210-15, Los Angeles, CA 90073*

SUMMARY:

The widespread acceptance of newer antipsychotics has changed the experiences of clinicians that treat schizophrenia and other psychotic disorders. Whereas treatment with conventional antipsychotics required assessing and managing patients with extrapyramidal side effects (EPS), these neurological side effects are uncommon with all of the newer antipsychotics. Instead, the focus has shifted to other concerns. Clozapine, the first of the newer antipsychotics, requires blood monitoring, and also causes weight gain, sedation, seizures, hypotension, and other side effects. Other new drugs (including risperidone and olanzapine) can cause weight gain as well as sexual side effects in men. Quetiapine may be associated with a risk of cataracts. Olanzapine, quetiapine, and clozapine do not elevate prolactin above normal, suggesting they may have advantages for some women. Although industry-supported studies provide some information regarding adverse effects, the findings from these studies often fail to prepare the clinician adequately for prescribing these agents. This presentation will review the findings from double-blind studies, case reports, industry data, and the experiences of clinicians. It will emphasize differences in findings that emerge from controlled trials and clinical experiences. Strategies will be suggested for managing side effects on newer antipsychotics and for selecting agents for particular patients.

No. 24C
SUBJECTIVE RESPONSE TO ATYPICAL ANTIPSYCHOTIC MEDICATION

Stephen R. Marder, M.D., *Department of Psychiatry, West Los Angeles VA Medical Center, 11301 Wilshire Boulevard, Building 210-A, Los Angeles, CA 90073*

SUMMARY:

Objective: The subjective experiences of patients to conventional and atypical antipsychotic medications (APDs) have received little attention. Subjective response to medication may greatly influence treatment adherence and ultimate treatment outcome.

Methods: Thus far the subjective response of 85 patients participating in two double-blind treatment studies has been collected. One study contrasts haloperidol (HAL) with risperidone (RIS) in treatment-refractory schizophrenia. A second study compares HAL with RIS in stable outpatients over a two-year period in conjunction with psychosocial skills training. Two measures of subjective response, the Drug Attitude Inventory (DAI), and the Subjective Response Scale (SRS) were utilized.

Results: Both studies reflected that subjects had a more positive response to RIS compared with HAL as rated by the DAI. However, no differences were seen on the SRS. No relationships among the DAI, SRS, and EPS were found.

Conclusions: In conclusion, subjective response to both atypical and conventional APDs is an important facet of treatment of patients with psychotic disorders. We demonstrated a more favorable subjective response to RIS in two different clinical studies; with two different samples of schizophrenic subjects. This more favorable response may lead to greater treatment adherence and better overall outcome.

No. 24D
COMBINING NEW ANTIPSYCHOTICS WITH OTHER TREATMENTS

Heinz Katsching, M.D., *Department of Psychiatry, University of Vienna, Waehringer Guertel 18–20, Vienna A1090, Austria*

SUMMARY:

While clinical experience with clozapine in Europe as the first of the atypical antipsychotics goes back for over 20 years, its use in the United States has been largely restricted to second-line treatment. Only recently have the new antipsychotics been used as first-line treatment. The most remarkable observation is that not only compliance is better with the new neuroleptics once a patient is on treatment, but also that it is easier for the psychiatrist to convince a patient to accept neuroleptic treatment, since there is no need to stress the possible occurrence of extrapyramidal side effects. It is mainly these side effects that have created an "antidrug climate" in Europe—both because of their unpleasantness and their stigmatizing effects. This negative attitude is documented in population surveys and in publications by patients' self-help organizations. A second observation is that patients who are taking new antipsychotics start asking for psychosocial assistance in order to be able to lead more satisfying lives. The quality of life concept has become very popular in this respect and no psychiatrist can dare to offer neuroleptics as the only treatment. A review of recent studies and developments will be included.

No. 24E
THE MANAGEMENT OF TREATMENT-REFRACTORY SCHIZOPHRENIA: EXPERIENCES FROM THE FRONT LINE

Peter F. Buckley, M.D., *Department of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, HPV5080, Cleveland, OH 44106*

SUMMARY:

In tandem with the advent of atypical antipsychotic medications, there has been a reconceptualization and consequent broadening of the concept of treatment-refractory (TR) schizophrenia. This shift has advanced more complex outcome measures, which reach beyond symptomatic outcome as the immutable measure of TR, emerging treatment outcomes with atypical antipsychotics include their impact upon injurious behavior (both suicidality and persistent aggression) and comorbid substance abuse. The efficacy of current atypical antipsychotics should be viewed within this broader context. Also, efficacy should be clearly established in real-world clinical settings of community mental health centers and long-stay facilities where TR schizophrenia predominates and is associated with these comorbid manifestations. This shift to more inclusive effectiveness research is particularly relevant to TR schizophrenia since (1) there are insufficient comparative studies (either clinical trials or effectiveness trials) of atypicals in this patient subgroup; (2) issues of dosing and duration of trial remain unresolved, (3) clinicians are using more copharmacy in an effort to cross taper safely when switching medications and also to augment the response to atypical antipsychotics in TR schizophrenia. This presentation will illuminate these key aspects. Practical guidance on the pharmacologic management of TR schizophrenia will be given on the appropriate choice and dosing of atypical antipsychotics and on the current role of augmentation strategies.

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INDUSTRY-SUPPORTED SYMPOSIUM 25—RECURRENT DEPRESSION: CHALLENGES AND SOLUTIONS
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to manage chronic recurrent depression using different or a combination of pharmacologic and psychotherapeutic algorithms. A case-based discussion will illustrate clinical methods for treating patients with partial responses, loss of full remission, and comorbid psychiatric and general medical conditions.

No. 25A
MAXIMIZING ACUTE-PHASE TREATMENT

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

The acute phase of antidepressant treatment consists of the weeks or months spanning the initiation of therapy and the achievement of a stable response. Although a wide array of interventions have been shown to have acute phase efficacy, intent to treat response rates for any single intervention hover between 40% and 50%. This presentation will focus on strategies to maximize acute phase outcomes above this plateau of standard efficacy. Strategies to be addressed include selection and titration of the initial treatment trial, enhancing treatment adherence, switching and augmentation options, and combinations and sequences involving symptom-focused psychotherapies. A careful and systematic approach to each patient's treatment plan can maximize acute phase outcomes and minimize risks of nonresponse or subsequent relapse.

No. 25B
THE ROLE OF PSYCHOTHERAPY IN CHRONIC DEPRESSION

Jan Scott, M.D., *University of Glasgow, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G120XH, Scotland*

SUMMARY:

This presentation highlights the need to be aware of the influence of psychosocial factors on the course and outcome of chronic depressive disorders, and reviews the potentially important therapeutic role of psychological interventions. It identifies the evidence for the effectiveness of psychosocial approaches with this patient population, and specifically explores the use of cognitive therapy (CT) in chronic depression.

In Britain, a large-scale, randomized, controlled study (n=158) has been completed of medication plus clinical management versus medication plus 20 weeks of CT for patients with persistent depressive symptoms. At 20 weeks, significantly more CT than control cases (25% v 11%) met criteria for remission, and throughout follow up rates of persistent symptoms or major depressive relapse were significantly higher in the control group. Rates were 18% v 10% at 20 weeks, 40% v 24% at 44 weeks, and 47% v 29% at 68 weeks (Paykel, Scott, Teasdale et al, 1999). Furthermore, CT had specific effects on hopelessness, guilt, and social adjustment.

Patients with chronic depression present a challenge for any form of therapy. The overall results of research on psychological interventions indicate that these individuals have a somewhat more difficult treatment course than those with acute or less extreme symptoms. Most of the early outcome research of psychotherapy for chronic depression comprises open studies with small sample sizes. However, these studies are of comparable size and design to many studies of pharmacotherapy for this patient population, and the mean recovery rate (40%) was also similar (Price et al, 1986). The most recent MRC study highlights that a combination of CT with medication may offer specific health gains for such individuals.

No. 25C
MANAGING CHRONIC DEPRESSION

Lauren B. Marangell, M.D., *Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza, #110 D, Houston, TX 77030*

SUMMARY:

Major depressive disorder is a common illness with a lifetime prevalence of approximately 17%. Chronicity and recurrence are

typical characteristics of this disease and have a severe impact on the course and burden of illness. Studies have reported that at least 10% of patients continue to suffer from depression for five years after the onset of the first episode and 7% of the patients remain chronically depressed even after 10 years. Therapeutic goals are aimed at inducing a stable, fully asymptomatic state with restoration of psychosocial function, establishing a long-term state of wellness, and preventing new episodes.

Despite availability of several effective treatment modalities, depression is underdiagnosed and undertreated. Patients are at the greatest risk of relapse during the first six months after initially recovering from acute episodes; continuing therapy during this period is critical. Using the same effective dose in the continuation phase as during acute treatment is the optimal strategy. Maintenance therapy for several years or even for a lifetime with the same initial dose of antidepressant is imperative in patients to prevent recurrence. The efficacy and safety of most antidepressants in the acute-phase treatment has been well studied, but continuation and maintenance are less well investigated. Few studies have demonstrated the efficacy of continuation treatment in preventing relapses with tricyclics, selective serotonin reuptake inhibitors (SSRIs), and other antidepressants such as nefazodone or venlafaxine. Based on available data, the newer agents such as SSRIs, venlafaxine, or nefazodone are reasonable choices for long-term treatment of depression. Factors such as adverse-event profiles, drug-interaction potentials, convenience of use, and pharmacoeconomic issues influence the choice of an agent. Future directions in antidepressant therapy should focus on long-term treatment and maintenance of remission.

No. 25D
LONG-TERM PROPHYLACTIC STUDIES OF DEPRESSION: THE MESSAGE MEETS THE MEDIUM

Alan Wade, M.B., *Community Pharmacology Service, 11 Hume Street, Glasgow G811XL, England*

SUMMARY:

Depression is a recurrent illness, that is one of the most common causes of disability in younger age groups and which causes serious morbidity and increased mortality in the elderly. Recurrent episodes of depression happen with increasing frequency and severity as patients age. Between definite recurrences, patients may suffer low-grade symptoms which reduce their quality of life. Pharmacotherapy has been shown to reduce the rate of recurrences and yet both surveys and antidepressant sales information indicate that few patients receive this treatment.

The aim of prophylaxis is to reduce morbidity and mortality, prevent recurrence, and reduce subsyndromal symptoms. If a substantial proportion of eligible patients is to be treated, logistics dictate that the majority will be prescribed drug therapy and will be recognised and managed in primary care. To address this, guidelines have been drawn up by a number of expert groups covering the recognition, diagnosis, and treatment of these patients. Guidelines are strategies for improving the quality of care. They should be practical and helpful for the clinician and derived from evidence based medicine. I am of the opinion that these guidelines for depression have been oversimplistic and have effectively "dumbed-down" the diagnosis and management of what is a very complex clinical problem. Recurrent depression is a lifelong condition but the evidence of the benefit of truly long-term treatment—beyond three years—is missing. In general, leave the question of long-term treatment open-ended. Some form of pragmatic, concrete advice should be given and, more importantly, the collection of that long-term information should be started. The guidelines have not matched the clinical difficulties faced by these physicians and to date they have not been widely adopted in primary care. Additionally, primary care physicians are doubtful of the science behind the recommendations and, because thay are unable to place the benefit of treating depression into the hierarchy of other medical care, they have failed to persuade themselves or their patients of the benefits of treatment. Why should this be so? Is it a problem of presentation?

Virtually all long-term studies in depression express benefit on the basis of a Kaplan Meier plot. Similar plots can be found in other areas of medicine—recurrence of duodenal ulcer, benefit of treatment of hypertension or hypercholesterolaemia—but there is evidence that primary care physicians fail to understand the statistics behind these graphs and get no "feel" for the clinical implications.

NNT (number needed to treat), that is, the number of patients requiring treatment over a given period of time required to produce one beneficial outcome, is a simple concept which is easily understood. It gives a good concept of clinical benefit and possibly allows comparisons between different trials and across different disciplines of medicine. As with statistical concept, however, it is not without its pitfalls and care must be taken to ensure comparable at-risk populations when comparing studies and treatments. The NNT values derived from prophylaxis studies in depression compare extremely favourably with those from cardiology and other disciplines.

Information presented in this way may be more persuasive to our primary care colleagues than a further set of iversimplified guidelines, which appear unrelated to the patients they confront in practice and which fail to challenge either their intellect or their clinical acumen.

If we are to succeed in having more of our depressed patients adequately treated, it is important that we give realistic advice to our colleagues based on sound scientific infromation and presented in a meaningful way.

No. 25E
CHALLENGES IN DEPRESSION: A CASE-BASED PROBLEM-SOLVING PANEL

A. John Rush, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Suite 9086, Dallas, TX 75235-9070*

SUMMARY:

Dr. Rush will present several patient cases that will illustrate the substantive information provided by the prior panelists' presentations. The group (all presenters) will discuss each case with regard to issues including initial treatment selection; how to increase the remission rates with acute-phase treatment; longer-term continuation maintenance-phase treatment issues, including management of long-term side effects and symptomatic breakthrough; how and when to discontinue true treatment; and what to do if the first (or even second) treatment fails. Audience dialogue and questions will be entertained as well during this panel discussion.

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INDUSTRY-SUPPORTED SYMPOSIUM 26—VIOLENCE AND ITS PREVENTION: THE ROLE OF PSYCHIATRY
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should become familiar with the psychiatric disorders that are most commonly associated with a risk of violent behavior. The participant will also become familiar with the clinical treatment strategies aimed at managing aggressive behavior and reducing the risk for such behavior in psychiatric populations. The participant should also learn the relative risks and benefits of these therapeutic approaches to violent and aggressive psychiatric patients and how to deal with the issues that emerge in the context of treatment.

No. 26A
PERSONALITY DISORDERS AND IMPULSIVE AGGRESSION

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

SUMMARY:

Impulsive aggressive behavior appears to have genetic and other biological correlates including, but not limited to, central serotonergic system dysfunction. In accord with this psychobiogenetic data, interest in the efficacy of enhancing central serotonin system function as a strategy to reduce impulsive aggressive behavior in human subjects has increased. This presentation will review previous and new data from a variety of studies in human subjects that support the hypothesis that central serotonin system function is inversely related to impulsive aggression in personality-disordered subjects and that enhancement of central serotonin system function can reduce impulsive aggressive behavior in individuals with recurrent, problematic, impulsive aggression.

Specifically, we will present biological and psychopharmacologic data from an ongoing double-blind, placebo-controlled trial of fluoxetine in personality disordered subjects meeting Research Criteria for Intermittent Explosive Disorder. These data demonstrate: a) the antiaggressive efficacy of fluoxetine in these individuals and, b) the role of the central serotonergic system in aggression as well as in the antiaggressive response to fluoxetine treatment.

No. 26B
DEPRESSION AND ANGER ATTACKS

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

There is a significant association between violent behavior and depression in community samples, and major depressive disorder (MDD) is one of the most common psychiatric disorders in prison populations. For every 20% increase in depressive symptoms, the odds of being severely aggressive toward the spouse increase by 74%. In previous studies, we have found that outpatients with MDD are more likely to report having anger attacks than are healthy volunteers, with anger attacks being outbursts of rage accompanied by irritability, autonomic activation, and violent behavior. Approximately one-third of depressed outpatients report having anger attacks and they are significantly more likely to meet criteria for narcissistic, borderline, and antisocial personality disorders and for avoidant and dependent personality disorders than depressed patients without anger attacks. There is substantial evidence that pathological aggression is accompanied by a reduction in serotonergic activity.

We have conducted a fenfluramine challenge study that showed a significantly blunted prolactin response to fenfluramine among MDD patients with anger attacks compared with MDD patients without anger attacks, suggesting a relatively greater dysregulation in serotonergic neurotransmission in depression with anger attacks and the potential usefulness of selective serotonin reuptake inhibitors (SSRIs). This is consistent with the finding that SSRIs are more effective than placebo in managing aggression and irritability conditions such as Alzheimer's disease, PMDD, PTSD, autistic disorder, schizophrenia, and personality disorders. We have also found that 53%–71% of patients treated with antidepressants such as the SSRIs stop having anger attacks, and that depressed patients with anger attacks are as likely to respond to treatment with an SSRI as depressed patients without anger attacks. These data challenge the hypothesis that antidepressants would mobilize anger in depression and suggest the safety and efficacy of antidepressants in the treatment of anger attacks in depression.

No. 26C
IMPACT OF NEWER ANTIPSYCHOTIC AGENTS ON VIOLENCE IN PSYCHOSIS

K. N. Roy Chengappa, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Clozapine, the prototype of the atypical antipsychotic agents, has been shown to be effective not only for the psychoses associated with schizophrenia, schizoaffective disorder, and bipolar disorder, but it also appears to have efficacy against a spectrum of behaviors in subjects with these disorders, such as excessive water drinking, violence, aggression, substance abuse and suicidal behavior. Similar data regarding post-clozapine antipsychotic agents such as risperidone, olanzapine, and quetiapine have begun to emerge.

Most published studies demonstrating these benefits have employed a mirror-image design that compares specific time periods before clozapine treatment to a similar time period after treatment. Uniformly, these studies indicate positive results in favor of clozapine. Improvements in aggression and hostility are associated with improved functioning (for instance, movement to a less restrictive treatment setting—closed to an open ward, discharge from hospital, increased levels of hospital privileges, decreased need for the use of p.r.n. medications, decreased incidents, as well as hours spent in seclusion and restraint, etc.). Anecdotal reports indicate the benefits of clozapine in non-traditional diagnoses, for instance psychoses or psychoses-like phenomena associated with borderline personality disorder with severe and unremitting self-mutilation, traumatic brain injury, mental retardation, and dementia. In these non-traditional situations, the risks versus benefits of using clozapine must be considered very carefully in each subject, and a second opinion is warranted in such instances. Similar data have begun to emerge for risperidone,

olanzapine, and quetiapine, but the data are not as extensive as for clozapine.

Clearly, the reduction in violence and aggression are morale boosting for patients and their families, and for the treating professionals as well. Even though the cost of acquiring the second-generation antipsychotic agents is higher than the typical neuroleptic agents, this cost is quite readily offset by the reduction in the direct and indirect costs associated with behaviors such as violence, suicidal behavior, substance use, and rehospitalization. Finally, the reduction in aggression and violence has a salutary effect on morale and quality of life for patients with persistent mental illness, their families, and caregivers.

No. 26D
VIOLENT BEHAVIOR AND SUBSTANCE ABUSE: PREVENTIVE AND TREATMENT APPROACHES

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Box 250861, Charleston, SC 29425-0742*

SUMMARY:

In this presentation, the relationship between substance use disorders, aggression, and violence will be reviewed. The association between alcohol and drug use and violent crime will be explored using data from the forensic population. The role of alcohol and drug abuse in domestic violence, including spousal and child abuse, will be reviewed. Laboratory studies addressing the effect of drugs and alcohol on impulsivity and aggression will be reviewed. Finally, treatment considerations will be discussed. Data concerning pharmacotherapeutic strategies to reduce violence, including antidepressant, anticonvulsant, and hormonal therapies, will be discussed. Behavioral approaches to the treatment of impulsivity and aggression in substance users will also be explored.

No. 26E
A CYCLE OF TRAUMA: VIOLENCE AND PTSD

Kathryn M. Connor, M.D., *Department of Psychiatry, Duke University, Box 3812, Durham, NC 27710*

SUMMARY:

Violence is a worldwide public health problem, placing individuals who have witnessed or experienced a violent act at increased risk for developing posttraumatic stress disorder (PTSD). PTSD is a chronic and disabling condition characterized by the development of a constellation of symptoms following exposure to a traumatic event, including symptoms of intrusive recollections, avoidance and numbing, and autonomic arousal. Common sequelae of PTSD include increased aggression and violence. These behaviors may be directed toward oneself, in the form of suicidal acts or other self-destructive behaviors, or in violence towards others. Re-enactment and recreation of the victimization often leads to transmission of violence in the next generation, and a cycle of violence ensues. Furthermore, trauma victims with PTSD have higher rates of disability and psychiatric comorbidity, particularly depression and substance abuse, with impairment of health and quality of life. Findings from numerous studies of combat veterans and other victims of trauma support these observations. Psychological treatment interventions have been directed at anger management and temper control, as well as substance abuse issues. Pharmacotherapy can also be effective for both the core and secondary symptoms of PTSD and options include antidepressants, anxiolytics, anticonvulsants, and mood stabilizers.

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INDUSTRY-SUPPORTED SYMPOSIUM 27—NOVEL PRECIPITANTS OF ANXIETY
Supported by Solvay Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize how anxiety may present in special populations and be precipitated by developmental changes, non-combat trauma, repetitive thoughts, and social stressor situations. This information is helpful in enhancing the doctor-patient relationship and optimizing individual treatment strategies.

No. 27A
PRECIPITANTS OF ANXIETY IN RESPONSE TO NONCOMBAT TRAUMA

Phebe M. Tucker, M.D., *Department of Psychiatry, University of Oklahoma, 920 Stanton Young Boulevard, 5SP520, Oklahoma City, OK 73190;* Betty Pfefferbaum, M.D., Sara Jo Nixon, Ph.D.

SUMMARY:

Civilians exposed to trauma, whether of human or natural origin, often suffer disabling anxiety and other emotional sequelae. Studies following Oklahoma City's 1995 terrorist bombing identified post-traumatic stress and depressive symptoms among residents directly exposed to the blast, medical examiners identifying bodies of fellow citizens, and families suffering traumatic bereavement. Physiologic reactivity to trauma reminders and persistent post-traumatic stress symptoms were found two to three years post-disaster in bereaved children and adults, with children being unable to accurately report measured physiologic reactivity. Among firefighters involved in rescue and recovery efforts, a positive attitude was associated with more experience, lack of previous job-related injuries, majority race, and perceived support from faith and management. A second disaster impacted Oklahoma City and surrounding areas in May 1999 as severe tornadoes killed more than 40 and destroyed more than 5,000 homes. Studies of child and adult survivors of the tornadoes characterized anxiety responses, with individuals exposed to both disasters (1995 and 1999) experiencing more symptomatology.

Diagnosing and treating PTSD presents special challenges to the treating doctor. Factors increasing the risk for PTSD, differences in neuroendocrine and brain functioning, and physiologic reactivity are

described. Individualized treatment plans may draw from diverse pharmacologic and psychosocial therapies and require care in maintaining a positive doctor-patient therapeutic alliance.

No. 27B
PRECIPITANTS OF ANXIETY IN CHILDREN AND ADOLESCENTS

Daniel S. Pine, M.D., *Department of Child Psychiatry, Columbia University, 1051 Riverside Drive, Unit 74, New York, NY 10032*

SUMMARY:

Objective: This presentation reviews recent studies on childhood precipitants of three anxiety disorders: social phobia, generalized anxiety, and separation anxiety disorders. The presentation focuses on relationships between childhood and adult anxiety disorders, examining the manner in which childhood precipitants broadly predispose to anxiety and to specific anxiety disorders in both children and adults.

Method: Data are reviewed from a series of longitudinal, family-based, and biological studies. These studies outline both commonalties and differences among the precipitants of distinct childhood anxiety disorders.

Results: Most chronic anxiety disorders of adults develop after a history of significant anxiety that begins early in childhood. There is evidence for both specific and nonspecific precipitants of individual anxiety disorders. Precipitants of childhood generalized anxiety disorder are similar to those for adult generalized anxiety disorder. Across ages, these precipitants relate to various other anxiety disorders and to major depression. Precipitants of childhood social phobia, as in adults, appear more specific for this condition. Finally, precipitants of separation anxiety disorder are similar to those for panic disorder, with both conditions showing relationships to respiratory factors.

Conclusions: Most adult anxiety disorders are preceded by childhood anxiety. Individual anxiety disorders exhibit unique associations with biological and phenomenological factors.

No. 27C
ANXIETY DISORDERS ACROSS CULTURES

Dan J. Stein, M.D., *Medical Research Center, Unit of Anxiety Disorders, University of Stellenbosch, P.O. Box 19063, Tygerberg 7505, South Africa*

SUMMARY:

Expanding interest in the anxiety disorders has been driven by advances in understanding of psychobiological mediating factors and treatment interventions. At the same time, however, advances in cross-cultural and social psychiatry may have fundamental implications for a comprehensive understanding of these conditions. These fields focus not only on psychopathology in non-Western cultures, but also emphasize the potentially significant contribution of anthropological theories and methods to the Western clinical setting. This presentation begins by considering different ways of approaching the intersection between culture and the anxiety disorders. We then consider different anxiety disorders from a "clinical anthropological" position. We propose that a number of anxiety disorders do in fact occur universally, but also consider ways in which their experience and expression may differ crucially.

No. 27D
REPETITIVE BEHAVIORS AND THE REGULATION OF ANXIETY

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, Box 1230, New York, NY 10029;* Concetta DeCaria, Ph.D., Suzanne Yoon, M.D., Charles Cartwright, M.D., Sherie L. Novotny, M.D., Carol Bienstock, B.A., Jared Finkell, B.A.

SUMMARY:

Obsessive compulsive disorder (OCD) is currently classified as an anxiety disorder, in part because the obsessive thoughts produce anxiety while the compulsive rituals are designed to reduce anxiety. However, repetitive behaviors are a symptom component that present in various forms across a broad range of neuropsychiatric disorders. While repetitive behaviors play an important role in the regulation of anxiety in some disorders, in other disorders they may serve a different purpose. For example, in OCD or disorders with obsessive preoccupation with body image, weight, or illness (i.e., body dysmorphic disorder), the repetitive behaviors serve to reduce anxiety. However, in impulsive (i.e., impulse control disorders), stereotypic (i.e., autism or Tourette's) or addictive disorders, repetitive behaviors may be associated with self-stimulation or arousal rather than anxiety reduction.

This presentation will clarify the role of repetitive behaviors in the regulation of anxiety vs. self-stimulation. It will highlight the phenomenology and neurobiology of repetitive behavior subtypes with and without anxiety. It will also describe the role of medication and psychosocial treatments in managing both the anxiety and the repetitive behaviors and in designing optimal individualized treatment strategies.

No. 27E
PRECIPITANTS OF ANXIETY IN SOCIAL SITUATIONS

Murray B. Stein, M.D., *Department of Psychiatry, University of California, San Diego, 8950 Villa La Jolla Drive, Suite 2243, La Jolla, CA 92037*

SUMMARY:

Social phobia (also known as social anxiety disorder) is distinguished by fear and/or avoidance of situations where scrutiny by others may occur. A core concern of persons with social phobia is that they will say or do something to bring negative attention to themselves, and that they will be found out as incompetent, foolish, or worthless. In its more severe forms, social phobia takes on characteristics of a "personality disorder," namely avoidant personality disorder, where the beliefs about one's own inadequacy are accentuated. Diagnosis of social phobia and hints for differentiating it from other anxiety disorders (e.g., panic disorder, agoraphobia) will be presented.

It turns out that social fears and avoidance are remarkably common in the general population. Public speaking fears are by far the most prevalent, but a variety of other social fears are seen at surprisingly high base rates in the general population. Data from a new epidemiologic survey of social phobia, focusing on impairment and illness interference attributable to social anxiety and avoidance, will be highlighted.

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INDUSTRY-SUPPORTED SYMPOSIUM 28—FROM PATIENTS TO PEOPLE: REDEFINING WELLNESS IN PSYCHOSIS Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize prodromal psychotic symptoms, formulate a treatment strategy that utilizes the unique advantages of the atypical antipsychotics across the spectrum of short-term and long-term management, and develop a treatment approach to switching from one drug to another.

No. 28A
EARLY INTERVENTION IN SCHIZOPHRENIA

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

A better appreciation of the nature and course of schizophrenia has led to an increasing focus on the early stages of this disorder. It has been known for a long time that some patients have clear premorbid manifestations of this illness, but in recent years a greater appreciation of more subtle premorbid signs has evolved. In addition, new strategies for the identification of prodromal states and the availability of safer medications has set the stage for research on early intervention aimed at preventing psychosis or reducing its duration and severity. However, even when psychosis has clearly developed, inordinate delays in appropriate treatment are the rule rather than the exception. The opportunity for earlier detection and early intervention must be addressed as a potential factor in improving long-term outcome.

No. 28B
ASSESSMENT AND TREATMENT OF ACUTE PSYCHOTIC AGITATION

Alan J. Mendelowitz, M.D., *Department of Psychiatry, Hillside Hospital, 7559 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

The management of an acute exacerbation of schizophrenia remains a clinical challenge. Acute exacerbations may involve the management of psychotic agitation. This psychiatric emergency must be addressed before the patient can be successfully initiated on his or her antipsychotic regimen. The need to control severe symptoms quickly must be balanced with a treatment algorithm that considers safety as well as effectiveness.

The management of acute psychotic agitation differs greatly among clinicians. The medical work up of acute psychotic agitation will be reviewed. The initial treatment strategies to control psychotic agitation will be discussed. The utilization of intramuscular agents in emergency settings will be examined including benzodiazepines such as lorazepam, standard antipsychotics such as haloperidol, and atypical antipsychotics such as ziprasidone.

The new generation of antipsychotic drugs has offered patients enhanced symptom efficacy with an improved tolerability and an improved EPS side-effect profile. This is vitally important in helping patients to remain compliant after they have improved. The potential of an intramuscular atypical antipsychotic in the management of acute psychotic agitation will be discussed.

No. 28C
BROADENING THE SPECTRUM OF ANTIPSYCHOTIC EFFICACY

Rajiv Tandon, M.D., *Department of Psychiatry, University of Michigan, Box 0120, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0210*

SUMMARY:

Until recently, clinicians and patients were relatively nihilistic in their expectations of treatment outcome in schizophrenia and other psychotic disorders; for the most part, we were reasonably satisfied if antipsychotic drug treatment suppressed psychotic symptoms and rendered patients manageable, with little expectation of substantially improving their quality of life or ability to function. Despite the clear recognition that the negative, cognitive, and depressive features of schizophrenia contributed principally to its poor outcome, there was a collective sense that there was little that we could do to ameliorate these symptoms. With the advent of the atypical antipsychotic drugs, clinicians and patients/families have become more optimistic about our ability to effectively treat these dimensions of psychotic illnesses. The implications of EPS reduction associated with atypical antipsychotic treatment touch virtually every domain of pathology in schizophrenia, including negative symptoms, cognitive dysfunction, and dysphoria. In clinical trials, the newer atypical antipsychotics have been found to be significantly more effective than the conventional neuroleptics in treating the negative, cognitive, and depressive aspects of psychoses; these observations have generally been confirmed by broader clinical experience. More effective treatment of these nonpsychotic aspects of schizophrenic illness by atypical antipsychotics has been accompanied by corresponding improvement in functional status and the quality of life. These issues will be reviewed in this presentation. While the class of atypical antipsychotics (clozapine, risperidone, olanzapine, quetiapine, and ziprasidone) share many of these clinical attributes, there are important differences between them as well, probably related to differences in their pharmacological profile. Recent findings with regard to these differences will be summarized and potential implications for clinical practice discussed.

No. 28D
RAISING STANDARDS AND SWITCHING MEDICATIONS

Peter J. Weiden, M.D., *Department of Psychiatry, SUNY 45C Brooklyn, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

SUMMARY:

Newer antipsychotics are rapidly replacing the older, conventional antipsychotics. Surveys of antipsychotic usage suggest that not only are more patients on newer antipsychotics, but many patients are switching between the newer agents as well. One survey found that 37% of patients taking one atypical switch to another within a year.

The most common switching question used to be "should I switch from a conventional antipsychotic to an atypical"? These days, the question has evolved to "I've tried one or more atypical medications—should I try another atypical?" As a result, patients and their physicians now have to contend with new questions concerning differential efficacy and unique side-effect profiles between the newer antipsychotics.

This talk will review the rapid changes over the last few years pertaining to the psychopharmacology of switching antipsychotic medications. The presentation will cover:

(1) The changing pharmacoepidemiology of antipsychotic treatment, with special attention to antipsychotic switching rates.
(2) How the newer medications are raising expectations, and in turn, how raised expectations affect switching decisions.
(3) The growing literature on switching studies, including studies on switching to currently available atypical antipsychotics, and new data on switching to the atypical antipsychotic ziprasidone, which is currently under development.

More than ever, physicians need to understand both the psychosocial and pharmacologic aspects of using newer medications, as well as the unique properties of each of the newer atypical antipsychotics.

No. 28E
ATYPICAL ANTIPSYCHOTICS: ENHANCING HEALTHY OUTCOMES

Daniel E. Casey, M.D., *Department of Psychiatry, Portland VA Medical Center, 3710 SW Veterans Hospital Road, Portland, OR 97201*

SUMMARY:

Until recently the traditional or typical neuroleptics have been the mainstay of treating acute and chronic psychosis. However, these drugs have limited efficacy, particularly in the domains of negative symptoms and affective disturbances. Also, a wide range of adverse effects imposed additional physical burdens on patients who were trying to overcome the impairments induced by psychosis. The new atypical antipsychotics have greatly improved the benefit/risk ratio by enhancing efficacy and substantially reducing the side-effect liabilities. Recent studies with the new agents have shown improvement in negative and depressive symptoms associated with acute psychosis as well as a decrease in suicide. In terms of adverse effects, most of the atypical drugs have eliminated the troublesome acute extrapyramidal syndromes so that akathisia, dystonia, and parkinsonism occur at rates that are not significantly different from placebo. New data also indicate that the vexing problem of tardive dyskinesia may be greatly reduced or eliminated by using the atypical agents. Similarly most atypical antipsychotics do not raise prolactin, leading to restoration of normal endocrine and sexual function. However, weight gain with some of the atypical drugs is of growing concern as this increases the risk of comorbid medical illnesses such as diabetes and cardiovascular diseases. Recent long-term studies support the concept of an enhanced benefit/risk ratio with lower relapse rates. This is due, at least in part, to improved compliance with better medicines. Overall the atypical antipsychotic medicines have greatly improved the chances for patients to more fully achieve their potential for healthy outcomes in everyday life and reduce the stigma of serious mental illness.

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INDUSTRY-SUPPORTED SYMPOSIUM 29—MANAGING PSYCHOSES ACROSS THE AGE SPECTRUM (PART 1)
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize characteristics of psychoses appropriate to patient age groups, develop optimal management strategies across the age spectrum, understand differential susceptibility to medication side effects for various age groups, recognize relevance of the broader efficacy and generally superior safety profiles of the atypical antipsychotics in treatment of psychotic disorders at different ages.

No. 29A
CHILD AND ADOLESCENT PSYCHOSIS

Robert L. Findling, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106*

SUMMARY:

Although children rarely suffer from psychoses, adolescent psychosis is relatively common. Since child-onset and adolescent-onset psychoses are associated with poor outcome, effective interventions for youths suffering from these conditions are needed. However, it has become increasingly clear that many youths who present with psychotic symptomatology do not meet criteria for schizophrenia. Therefore, an appreciation of the clinical presentation of pediatric schizophrenia is necessary prior to the initiation of pharmacotherapy.

The few clinical trials that have tested typical antipsychotics in pediatric patients with psychosis have generally suggested that these medications are associated with salutary effects for some, but not all, patients. These studies have also demonstrated that young patients may be particularly prone to extrapyramidal side effects. Over the past several years, investigators have begun to examine whether or not the atypical antipsychotics have a role in the treatment of youths suffering from psychotic disorders. Preliminary evidence suggests that clozapine, risperidone, olanzapine, and quetiapine may all have a role in the treatment of these young patients.

This presentation will review the clinical manifestations of child and adolescent psychosis. In addition, the clinical management of pediatric psychosis will be reviewed. Particular emphasis will be placed on the new research on pharmacotherapy.

No. 29B
ADOLESCENT PSYCHOSES AND THE FIRST EPISODE

Gabrielle L. Shapiro, M.D., *Department of Psychiatry, University of California, San Diego, 3030 Childrens Way, Suite 101, San Diego, CA 92123*

SUMMARY:

Although the effects of conventional and atypical antipsychotics in the treatment of psychotic disorders in young adults have been fairly well-characterized, their effects in adolescents with psychotic disorders have not been extensively studied. Schizophrenia often first presents itself to psychiatric attention in adolescence and young adulthood. Early and effective treatment in this stage of illness is extremely important to limit deterioration and social decline. There are distinctive aspects to the clinical presentation of psychotic disorders in adolescence and their differential diagnosis during the first episode of illness. Adolescence is clearly a unique phase of human

development, warranting special considerations in treatment. Patients are better responsive to antipsychotic treatment but also more susceptible to developing certain adverse effects to such treatment. While the class of atypical antipsychotics have substantially enhanced the effectiveness/tolerability ratio in comparison to conventional neuroleptics, it should be noted that there are important differences between different atypical antipsychotic agents that are pertinent in the treatment of the first episode of psychosis, particularly in adolescent patients. These issues will be discussed in this presentation, utilizing a series of case examples. Two case reports that describe the use of quetiapine in treating adolescent patients will be reviewed in detail; quetiapine therapy appeared to have substantial advantages over risperidone and conventional neuroleptics in these cases. The results of cumulative clinical experience thus far support assumptions about the clinical superiority of atypical antipsychotic agents over conventional neuroleptics in the treatment of psychotic disorders in adolescence and the first episode; they further indicate that there are important clinically pertinent differences between different atypical antipsychotic agents in this regard.

No. 29C
PSYCHOSES IN WOMEN: ACROSS THE AGE SPECTRUM

Diana O. Perkins, M.D., *Department of Psychiatry, University of North Carolina School of Medicine, CB 7160, Neurosciences Hospital, Chapel Hill, NC 27599*

SUMMARY:

The numerous epidemiological and clinical characteristics of schizophrenia and other psychotic disorders that differ in males and females will be reviewed in this presentation. In particular, while schizophrenia is equally common in males and females, females tend to have better premorbid function, a later age of onset, better response to antipsychotic medications, and better clinical and functional outcomes. Neuroanatomical findings in females with schizophrenia tend to be similar to findings in men, but less pronounced. Women are at increased risk of developing a new onset psychotic illness in late adulthood compared with men. In addition, women have a unique vulnerability to psychotic illness during the postpartum period.

Theoretical explanations for and the treatment implications of these gender differences will be discussed. Direct and indirect effects of estrogen are hypothesized to underlie these gender differences. Consistent with neurodevelopmental theories of schizophrenia, estrogens enhance neurotrophins involved in the modulation of neuronal axon and dendritic growth, and may affect vulnerability to prenatal stressors. Consistent with neuroprogressive theories of schizophrenia, estrogens regulate dopamine and serotonin receptors and also have neuroprotective antioxidant effects. A role for estrogen treatment of schizophrenia has been proposed and explored in open label trials.

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INDUSTRY-SUPPORTED SYMPOSIUM 29—MANAGING PSYCHOSES ACROSS THE AGE SPECTRUM (PART 2)
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize characteristics of psychoses appropriate to patient age groups, develop optimal management strategies across the age spectrum, understand differential susceptibility to medication side effects for various age groups, recognize relevance of the broader efficacy and generally superior safety profiles of the atypical antipsychotics in treatment of psychotic disorders at different ages.

No. 29A
PSYCHOSIS GENOTYPES AND PHENOTYPES: DIAGNOSIS AND TREATMENT

Henry A. Nasrallah, M.D., *Department of Psychiatry, University of Mississippi, 1500 East Woodrow Wilson Drive, 11M, Jackson, MS 39216*

SUMMARY:

Although the pathophysiology of psychosis remains unknown, many genetic and nongenetic etiological factors have been identified. Numerous genetic disorders such as albinism, G6PD deficiency, homocystinuria, Huntington's disease, and others may present with psychotic symptoms. There are also many induced forms (phenotypes) of psychosis which arise from a variety of acquired medical disorders. For example, many neurological lesions including head trauma, epilepsy, strokes, tumors, infections, etc. may present with schizophrenia-like psychosis. Psychotic symptoms may also be secondary to systemic medical disorders such as endocrinopathies, uremia, hepatic encephalopathy, hypercalcemia, autoimmune diseases, etc. There are also numerous drug-induced psychotic syndromes which may mimic primary psychotic disorders (i.e. schizophrenia or mania), most commonly caused by stimulants (amphetamine, cocaine) but also by phencyclidine, hallucinogens (LSD, mescaline, psilocybin) symphathomimetics (L-DOPA, ephedrine) and anticholinergic drugs. In addition, CNS depressants, glucocorticoids, heavy metals, disulfiram and even digitalis, have all been reported to cause psychosis. Finally, the stress of severe life-threatening events may precipitate psychosis in a subset of individuals, as evidenced by the fact that over a third of patients with post-traumatic stress disorder (PTSD) patients manifest psychotic symptoms.

Despite the heterogeneity in the pathogenesis of psychosis, the treatment is generally the same. Antipsychotic medications, particularly the neurologically safer novel antipsychotics, are the primary symptomatic treatment of psychosis. In schizophrenia, additional symptom clusters such as negative symptoms; cognitive deficits, mood, anxiety and aggressive symptoms can also be managed with the new generation antipsychotics, which have a broader efficacy profile on comorbid symptoms.

No. 29B
GERIATRIC PSYCHOSES

Dilip V. Jeste, M.D., *Department of Psychiatry, VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161*

SUMMARY:

The elderly comprise the most rapidly expanding segment of the population and consume a disproportionately large percentage of prescription medications. It comes as a surprise to realize also that as many as 23% of older people will experience a psychotic disorder at some point in their lives. The etiology of these include virtually every medical and neurologic disorder, from delirium through extrapyramidal disorders to the dementias; as well as virtually every psychiatric condition, from substance abuse to schizophrenia. The phenomenology is as complex and as varied as anything encountered in psychiatry. Both pharmacologic and non-pharmacologic treatments can be useful in controlling these symptoms. Clinical trials data, ranging from preliminary open label experiences to multicenter placebo controlled studies, show us the strengths and weaknesses of the older therapies and promise that the newer agents will not only be effective, but safer and better tolerated. It should be further noted that while the class of atypical antipsychotics shares many clinical properties, there are important clinical differences between them as well and that these differences are pertinent to their use in elderly patients. The talk will emphasize the data regarding efficacy, safety, and tolerability of antipsychotics in the elderly. The understanding in the application of these data are exemplars of the principles that govern sophisticated clinical practice in all of psychiatry.

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2. Maixner S, Mellow A, Tandon R: The efficacy, safety, and tolerability of antipsychotics in the elderly. J Clinical Psychiatry, 1999;60 (suppl 8):29–41
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INDUSTRY-SUPPORTED SYMPOSIUM 30—ANTIEPILEPTIC DRUGS IN PSYCHIATRIC DISORDERS (PART 1)
Supported by Parke-Davis

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to select the antiepileptic drugs that can be effective in the management of affective and anxiety disorders; know how to use antiepileptic drugs for detoxification from opiates, cocaine abuse, and benzodiazepine abuse; become familiar with psychotropic properties of antiepileptic drugs that are commonly used; and recognize the negative psychotropic properties of antiepileptic drugs.

No. 30A
ANTIEPILEPTIC DRUGS IN PSYCHIATRIC DISORDERS: AN OVERVIEW

Andres M. Kanner, M.D., *Department of Neurology, Rush Epilepsy Center, 1653 West Congress Parkway, Chicago, IL 60612*

SUMMARY:

Psychiatrists have been prescribing antiepileptic drugs (AED) considerably more over the past decade. Traditionally, AEDs have successfully been used as mood stabilizers in bipolar disorders, schizoffective disorder, and cyclothymia; nevertheless, they seem to be helpful in the treatment of many other mental problems such as major depression, anxiety disorders, schizophrenia, impulse control disorder, and intermittent explosive disorder. In addition, they tend to be beneficial in the management of patients with aggressive behavior, developmental disabilities, affective instability and impulsiveness. Further applications of AEDs have been seen in patients with personality disorders, substance abuse, psychiatric comorbidity in epileptic patients, and other neuropsychiatric conditions. This presentation shall provide a comprehensive overview of the classification, pharmacokinetics, pharmacodynamics, and psychiatric usages of the traditional and new AEDs, focusing on the practical aspects that may be helpful to the clinician.

No. 30B
ANTIEPILEPTIC DRUGS IN MOOD DISORDERS

Ovidio A. DeLeon, M.D., *Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC 913, Chicago, IL 60612-7327*

SUMMARY:

The antiepileptic drugs (AED) have moved into an important position as an alternative and adjunctive treatment of mood disorders. The mood stabilizers have proven their efficacy in bipolar disorder, either during manic or depressive episodes; their use as prophylactic agents have also been noted. Furthermore, their therapeutic efficacy appears to extend to cyclothymia, schizoaffective disorder, depression, suicide prevention, affective instability related to personality disorders, and other affective pictures. By employing the fundamental neurobiological basis of mood disorders and the amygdala kindling concept, this presentation will attempt to rationalize and integrate the use of traditional AEDs, such as mysoline, carbamazepine and valproate; new AEDs, such as Gabapentin, lamotrigine, clonazepam, topiramate, tiagabine, and vigabatrin will be discussed as well. Lastly, neuropeptides, such as thyrotropin releasing hormone will be mentioned as a novel and promising AED.

No. 30C
ANTIEPILEPTIC DRUGS IN ANXIETY DISORDERS

Thomas H. Jobe, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago, IL 60612*

SUMMARY:

There is a growing amount of information about the use and efficacy of antiepileptic drugs (AED) in anxiety disorders. Clonazepam has successfully been used in the treatment of several anxiety disorders. In addition, carbamazepine and valproic acid have shown to be beneficial in a wide domain of entities that includes panic disorder, social phobia, generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, and various anxiety symptoms related to other major psychopathologies. Recently, some publications have also reported the efficacy of novel agents such as gabapentin and vigabatrin, especially in social phobia. By incorporating the biological and neural mechanisms of anxiety and how they

relate to the pharmacodynamics of these drugs, this lecture will attempt to rationally discuss the advantages and disadvantages of AEDs as anxiolytic agents.

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3. Frye MA, Ketter TA, Kimbrell TA, et al: Gabapentin and lamotrigine monotherapy in mood disorder. Presented at the American Psychiatric Association Annual Meeting. Symposium 33C; May 17–22 1997; San Diego, CA
4. Bennett J, Goldman WT, Suppes T: Gabapentin for treatment of bipolar and schizoaffective disorders. J Clin Psychopharmacol 1997;17:141–2
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INDUSTRY-SUPPORTED SYMPOSIUM 30—ANTIEPILEPTIC DRUGS IN PSYCHIATRIC DISORDERS (PART 2) Supported by Parke-Davis

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to select the antiepileptic drugs that can be effective in the management of affective and anxiety disorder; know how to use certain antiepileptic drugs for the detoxification from opiates, cocaine abuse, and benzodiazepine abuse; become familiar with psychotropic properties of antiepileptic drugs that are commonly used; and recognize the negative psychotropic properties of antiepileptic drugs.

No. 30A
USE OF ANTIEPILEPTICS IN DRUG ABUSE DETOXIFICATION

Sylvia J. Dennison, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Fifth Floor, Chicago, IL 60612*

SUMMARY:

To recognize the role of antiepileptic drugs in the treatment of drug abuse Antiepileptic drugs (AED) such as phenytoin, carbamazepine, valproate, gabapentin, and vigabatrin have been reported as effective and safe therapeutic resources for the treatment of acute and chronic intoxication and withdrawal syndrome of cocaine, opiates, alcohol, benzodiazepines, and other drugs. Also, the role of AEDs as a preventative tool and as treatment of comorbid psychiatric conditions of drug abusers has been greatly explored. This presentation will review the available data on the use of AED as treatment for substance abuse disorders, integrating the biological basis of drug abuse as it relates to AED mechanisms. Consequently, clinical aspects will be taken into consideration. In order to attain the proper skills for handling AEDs as a therapeutic tool for the management of substance abuse disorders, such a broad approach should be undertaken.

No. 30B
NEGATIVE PSYCHOTROPIC EFFECTS OF ANTIEPILEPTIC DRUGS

F. Moises Gaviria, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, 4th Floor, Chicago, IL 60612*

SUMMARY:

Unfortunately, side effects from antiepileptic drugs (AED) are relatively common. Some central nervous system side effects, such as sedation and ataxia, are easily recognized and usually do not represent difficult management problems. More subtle side effects are seen in the areas of cognition, mood, and personality tend to be more problematic. Traditional AEDs, such as phenobarbital and phenytoin have been linked to depression, irritability and disruptive behavior. Felbamate, Ethosuximide, and the new Vigabatrin may also generate depression, as well as insomnia, agitation, and psychosis. Likewise, old AEDs tend to affect cognitive performance, while the new generation of AEDs, such as lamotrigine, gabapentin, and vigabatrin are proposed to have fewer cognitive effects. This presentation will review the behavioral and cognitive side effects of the AEDs, as well as therapeutic strategies employed to decrease them.

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INDUSTRY-SUPPORTED SYMPOSIUM 31—EVIDENCE-BASED MANAGEMENT OF REFRACTORY DEPRESSION (PART 1) Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to know the extent and limits of evidence for treatment of resistant depression.

No. 31A
TIMING AND NATURE OF INTERVENTIONS FOR NONRESPONDERS

Madhukar H. Trivedi, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, P.O. Box 1, #520, Dallas, TX 75235*

SUMMARY:

Advances in the treatment of depression have provided numerous alternatives for the pharmacotherapy of depressive disorders. Research attempts to predict the nature and timing of interventions that optimize response as well as remission have been only modestly successful. This dilemma, along with research suggesting that a sizable number of patients may respond even six to 10 weeks after modifications in treatment interventions, provides significant challenges in determining critical decision points used in clinical practice. Foremost among these is determining how long to treat a patient with any given treatment before trying a different treatment. Therefore, defining critical decision points during the acute phase of treatment and determining what information should be used to guide treatment decisions is important. This presentation will discuss the usefulness of changes in symptom severity in initial phases of treatment (weeks two, four, and six). It will also address the effectiveness of using symptom severity in a large public mental health care system. Additionally, factors that determine predictors of nonresponse and remission will be discussed. Finally, this presentation will highlight other types of information that may be used to plan treatment steps to achieve the goal of full remission.

No. 31B
OPTIMIZING ANTIDEPRESSANT DOSE WILL OPTIMIZE RESPONSE

James W. Jefferson, M.D., *Healthcare Technology Systems, 7617 Mineral Point Road, Suite 300, Madison, WI 53717*

SUMMARY:

In the (good?) old days, the underdosing of TCAs and MAOIs was generally accepted as a common cause of treatment failure. Even then, dosing issues were more complex than the number of milligrams prescribed; they also involved compliance, therapeutic windows, and differential rates of metabolism. At the same time, the side-effect profiles of these drugs necessitated low starting doses and gradual titrations that were often truncated prematurely.

The newer-generation antidepressants present a mixture of dosing issues that include so-called flat dose-response curves for some, the need to routinely titrate others, and some for which the dosing recommendations fall somewhere in between. Critical to the successful use of these drugs is being able to develop a balance between dose and duration of treatment so as not to unnecessarily prolong exposure to suboptimal doses while at the same time avoiding premature dose increases that might magnify side effects and cost without imparting additional benefit. In addition to elaborating on the abovementioned dosing issues, guidelines will be presented that should facilitate optimal dosing of the newer antidepressants.

No. 31C
THE ANTIDEPRESSANT POOP-OUT PHENOMENON: A REVIEW OF THE EVIDENCE WITH RECOMMENDATIONS FOR DIAGNOSIS AND TREATMENT

Isabel T. Lagomasino, M.D., *Department of Psychiatry, UCLA, 10920 Wilshire Boulevard, Suite 300, Los Angeles, CA 90024*

SUMMARY:

Among patients with remitted unipolar depression receiving maintenance antidepressant treatment, a reported 9%–57% suffer a relapse or recurrence, a phenomenon known as breakthrough depression, antidepressant tachyphylaxis, or antidepressant "poop-out." This presentation will review the available evidence, mostly from case studies and open-label trials, for the mechanisms, predictors, diagnosis, and treatment of breakthrough depression. Hypothesized mechanisms for the return of symptoms include patient noncompliance with medication, superimposition of a medical or another psychiatric illness, loss of placebo effects, and development of antidepressant tolerance. Potential predictors include number of prior depressive episodes, severity and duration of depressive symptoms, degree and duration of antidepressant response, and antidepressant dose and duration. Systematic algorithms for the diagnosis and treatment of breakthrough depression will be outlined. Assessments must be made for medication compliance, the presence of undiagnosed or untreated medical or comorbid psychiatric illnesses, and the adequacy of the current treatment. Treatment strategies include increasing the antidepressant dose; augmenting with lithium, thyroid hormone, buspirone, pindolol, or dopamine agonists; combining with other antidepressants; switching to another antidepressant in the same or in a different class; and using psychotherapy or electroconvulsive therapy.

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2. Hornig-Rohan M, Wolkowitz OM, Amsterdam JD: Novel strategies for treatment-resistant depression. Psychiatric Clinics of North America 1996;19:387–405
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INDUSTRY-SUPPORTED SYMPOSIUM 31—EVIDENCE-BASED MANAGEMENT OF REFRACTORY DEPRESSION (PART 2) Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to know the extent and limits of evidence for treatment of resistant depression.

No. 31A
JUVENILE DEPRESSION: DIAGNOSIS AND TREATMENT

Jefferson B. Prince, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-725, Boston, MA 02114-3117*

SUMMARY:

Despite the increased recognition of juvenile depression, psychiatrists are frequently unaware of the developmental presentation of the disorder and algorithms for treatment. An evaluation of the literature indicates that depression in youth is chronic, familial, highly comorbid, and presents with differing symptoms than in adults. A number of open trials but only a paucity of controlled trials have demonstrated efficacy of psychotherapy, pharmacotherapy, or the combination for this disorder. Within the pharmacological armamentarium, the safety and effectiveness of the serotonin reuptake inhibitors have been demonstrated in both open and controlled trials. Less-convincing evidence exists for the use of the atypical antidepressants. Controlled trials have failed to demonstrate the efficacy of tricyclic antidepressants for juvenile depression. Open data suggest that treatment of co-occuring conditions such as attention-deficit/hyperactivity disorder requires the combined use of stimulant and antidepressant agents. Clinically derived information suggests that treatment-refractory juvenile depression is a common occurrence requiring reevalua-

tion of comorbid disorders, switching to another antidepressant, and adjunctive therapies. Strategies for assessment and treatment of these often treatment-refractory youth will be presented.

No. 31B
DIVERGENCE OF PRACTICE FROM EVIDENCE FOR REFRACTORY DEPRESSION

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

The gap between actual practice and evidence-based medicine is particularly wide in the area of treatment-resistant depression. If clinicians rely too heavily on evidence from randomized clinical trials, then their practice could be construed as too conservative and out of date. If, alternatively, clinicians ignore the literature and evidence-based medicine, they risk practicing in a vacuum, providing treatments with possibly no benefits and unknown risks. In the absence of firm data, the art of clinical work is integrating and extrapolating from limited preclinical and clinical evidence and using good judgment to optimally balance benefits and risks. Clinical decision making for treatment-resistant depression is further complicated by a lack of studies that compare competing options at key decision points. For example, when patients are failing to respond to first-line antidepressant treatment, when should the clinician recommend switching versus augmenting antidepressants? What constitutes good clinical judgment for the management of treatment-resistant depression? The gap between practice and evidence and recommendations on how to best bridge the gap will be discussed.

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1. Nierenberg AA, Mulroy R: Declaration of treatment failures. In Mood Disorders. Systematic Medication Management edited by Rush A.J. Modern Problems in Pharmacopsychiatry 1997;25:17–33

INDUSTRY-SUPPORTED SYMPOSIUM 32—LENGTHENING THE FUSE: TREATMENT OF AGGRESSION (PART 1)
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the underlying mechanisms of aggression in the spectrum of psychiatric disorders, develop state of the art intervention and treatment strategies for various presentations of aggression, including violent manifestations, and utilize innovative pharmacotherapy to treat agitation and aggression in the elderly.

No. 32A
MECHANISMS OF AGGRESSION

Larry Young, Ph.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322–4990*

SUMMARY:

Aggressive behavior is essential for the survival of any species, being used to acquire territory, social status, mates, and for defense. However, inappropriate aggression can be detrimental. Therefore, neural mechanisms are in place to tightly regulate aggressive behavior. Animal and human studies of aggression are providing insights into the nature of these mechanisms. Molecular and pharmacologic studies indicate that the serotonin system plays an important inhibitory role in aggression. Selective serotonin-reuptake inhibitors decrease aggression in several animal models. In humans and nonhuman primates, deficits in serotonergic systems are correlated with impulsive as well as self-directed violence. Serotonin 5-HTβ receptor agonists decrease aggression in rodents and 5-HTβ knockout mice exhibit elevated levels of aggression. Genetic studies have found associations between polymorphisms in serotonergic genes and aggressive tendencies in humans. Other animal studies suggest that the neuropeptide vasopressin may potentiate aggression, and one clinical study reported that AVP in the CSF is correlated with history of aggression. Early-life experiences can modulate both aggressive behavior and the vasopressin-serotonin systems of adults. Clearly other neurotransmitter systems, such as nitric oxide, also play a role in regulating aggression. Understanding the neural mechanisms controlling aggression is essential for developing effective treatment strategies for inappropriate aggression and violence.

No. 32B
BIOLOGIES AND TREATMENT OF INTERMITTENT EXPLOSIVE DISORDER

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

SUMMARY:

Intermittent explosive disorder (IED) is a DSM-IV diagnosis that embodies a new, currently unappreciated, target area for clinical attention and treatment. Data over the past 20 years suggest that intermittent explosive behavior is heritable, specifically correlated with aspects of the brain neurochemistry, and responsive to treatment with specific psychopharmacologic agents and/or cognitive-behavior psychotherapy. In this presentation we will present data from four studies that support the validity of IED:

a.) phenomenological studies of research criteria for IED. b.) family history studies of IED, c.) biological studies of IED, and d.) treatment studies. In family history studies the morbid risk of IED was elevated in the first-degree relatives of IED-IV probands compared with the morbid risk of the same in first-degree relatives of non-IED control probands. IED subjects in the biological studies had reduced protectin responses to d-fenfluramine compared with non-IED subjects. In treatment studies, fluoxetine and divalproex sodium, individually, reduced overt aggression in IED subjects. Accordingly, IED appears to be a valid diagnostic entity worthy of further research and treatment intervention.

No. 32C
PSYCHOPATHOLOGY AND PHARMACOTHERAPY OF SEXUALLY AGGRESSIVE OFFENDERS

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML 0559, Cincinnati, OH 45267-0559*

SUMMARY:

Sexual aggression is an enormous public health problem. The perpetrators of sexual crimes (often called sex offenders), however, have been the subjects of strikingly little empirical psychiatric research. In this presentation, we will first review different types of sexual aggression and present data suggesting that approximately 2/3 of male sex offenders have paraphilias. We will then review data suggesting that sex offenders have high rates of mental disorders other than paraphilias, including mood disorders (especially bipolar disorder), Cluster B personality disorders, anxiety disorders, and

impulse-control disorders, and may respond to certain pharmacologic agents (e.g., antidepressants, antiandrogen drugs, mood stabilizers, and antipsychotics). We will also present data suggesting that the type of sexual aggression and associated psychiatric disorder(s) may be related to pharmacologic response, and that optimal pharmacologic treatment for a particular sexually aggressive person remains a highly individualized, often complex, determination. We will conclude by presenting a preliminary pharmacologic treatment algorithm for sexual aggression.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 32—LENGTHENING THE FUSE: TREATMENT OF AGGRESSION (PART 2) Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the underlying mechanisms of aggresion in the spectrum of psychiatric disorders, develop state of the art intervention and treatment strategies for various presentations of aggression, including violent manifestations and utilize innovative pharmacotherapy to treat agitation and aggression in the elderly.

No. 32A
IMPULSIVITY IN AGGRESSION: BPD AND AUTISM

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, Box 1230, New York, NY 10029;* Sherie L. Novotny, M.D., Andrea Allen, Ph.D., Charles Cartwright, M.D., Carol Bienstock, B.A.

SUMMARY:

Research suggests that impulsive aggression is a primary component of many psychiatric disorders, manifesting in a spectrum of behaviors from impulsive acting-out behaviors to violent outbursts. Although there are no DSM-IV criteria for an impulsive aggression diagnosis, we are working to delineate the role of specific medications in the treatment of borderline personality disorder and autism based on prominent symptom components. Current studies have focused on the role of SSRIs, MAOIs, atypical neuroleptics and mood stabilizers in the treatment of these patients.

Data suggest that divalproex sodium, lithium, and carbamazepine, either alone or used concomitantly with other medications, provide mood-stabilizing and anti-impulsive effects in impulsive aggressive patients. Large-scale double-blind studies are needed to provide direction in the optimal care of these hard-to-treat patients.

Data from double-blind, placebo-controlled studies in borderline personality disorder and autistic patients will be highlighted, and future directions discussed for the treatment of impulsive aggressive symptoms in these disabling disorders.

No. 32B
AGITATION AND AGGRESSION IN THE ELDERLY

Pierre N. Tariot, M.D., *Department of Psychiatry, Monroe Community Hospital, 435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

A rational approach to the treatment of agitated behaviors in dementia emphasizes careful evaluation of the patient, assessment of possible causes and aggravating factors, and diligent employment of nonpharmacologic approaches. After nonpharmacologic steps are exhausted, medications are usually considered. Developing a specific list of disturbed behaviors for each patient, and identifying a "psychobehavioral metaphor," or cluster of signs and symptoms analogous to a drug-responsive syndrome, guide the selection of the most relevant drug class. For instance, an agitated patient with features of psychosis would be treated with an antipsychotic, one with depressive features an antidepressant, one with manic features a thymoleptic, and so forth. If the "metaphor" is unclear in a patient, a physician is resigned to empirical trials of relevant agents—agents for which there are empirical efficacy data, that are well tolerated, and have the most desirable side-effect profile. The presentation will summarize basic findings from clinical trials and present details about recent findings. There are mounting data that suggest antipsychotic and nonantipsychotic therapies can play a useful role for the treatment of these disturbing behaviors, despite the current lack of consensus about syndromal definition. These new data offer a useful guidepost to the clinician treating these challenging patients.

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INDUSTRY-SUPPORTED SYMPOSIUM 33—NEW CLINICAL ADVANCES IN DEPRESSION (PART 1) Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to list the principal clinical symptoms of major depression and the biological basis for these symptoms, provide an overview of the biological etiology for clinical symptoms of acute depression, with a focus on sleep disturbance and sexual dysfunction, summarize the

clinical effects upon the symptoms of depression of each of the major antidepressant medications, list new research findings on the biology and course of chronic depression, and summarize the efficacy and benefits of combining psychotherapy with antidepressants in treating chronic depression.

No. 33A
THE TIME COURSE AND BIOLOGY OF MAJOR DEPRESSION: IMPACT ON THE CLINICAL MANIFESTATIONS OF THE DISORDER

Jerrold F. Rosenbaum, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Despite advances in therapeutics for major depression, efforts to understand the biologic underpinnings of the illness remain elusive. Symptoms of depression suggest that the dysregulation of depression influences multiple systems affecting cognition, vigilance, appetitive functions, circadian rhythms and other physiological functions. Indeed since depression is a heterogeneous illness in its onset, symptoms, and course, its pathophysiology is likely heterogeneous as well. Efforts to work back from antidepressant drug mechanism of action to neurobiology of disorder have been heuristic, but a comprehensive understanding of depression's biology may need to await advances in genomic research. That said, intriguing findings in neuroimaging, neurotrophic factors, stress, and novel therapeutics may open new windows on the brain circuitry and dysfunctions that generate the symptoms that comprise the clinical picture of major depression.

No. 33B
WHAT HAPPENS WHEN IN THE TREATMENT OF DEPRESSION: AN UPDATE ON THE CLINICAL EFFECTS OF THE NEWER ANTIDEPRESSANTS

John M. Zajecka, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison Street, # 955, Chicago, IL 60612*

SUMMARY:

The development of innovative antidepressants over the last decade demonstrates the evolution of refining our growing understanding of how these treatments impact the improvement of depressive symptoms and how they affect the development of potential side effects. Optimal recovery of any disorder for which an antidepressant is used should focus on maximizing efficacy and minimizing side effects. Common side effects associated with the newer antidepressants, including the pathophysiological basis of these side effects, relative to the theoretical mechanism of the new antidepressants, will be discussed. Appropriate clinical management of side effects, based upon these theories and the evolving literature on treating antidepressant side effects, will be discussed.

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1. Armitage R, Yonkers K, Cole D, Rush AJ: A multicenter, double-blind comparison of the effects of nefazodone and fluoxetine on sleep architecture and quality of sleep in depressed outpatients. J Clin Psychopharmacol 1997;17:161–8
2. Clayton PJ, Grove WM, Coryell W, et al: Follow-up and family study of anxious depression. Am J Psychiatry 1991;148:1512–7
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INDUSTRY-SUPPORTED SYMPOSIUM 33—NEW CLINICAL ADVANCES IN DEPRESSION (PART 2)
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to list the principal clinical symptoms of major depression and the biological basis for these symptoms, provide an overview of the biological etiology for clinical symptoms of acute depression, with a focus on sleep disturbance and sexual dysfunction, summarize the clinical effects upon the symptoms of depression of each of the major antidepressant medications, list new research findings on the biology and course of chronic depression, and summarize the efficacy and benefits of combining psychotherapy with antidepressants in treating chronic depression.

No. 33A
A CONCISE REVIEW OF WHAT WE DO KNOW AND WHAT WE DON'T KNOW ABOUT THE BIOLOGY AND COURSE OF CHRONIC DEPRESSION

David L. Dunner, M.D., *Center for Anxiety & Depression, 4225 Roosevelt Way NE, #306C, Seattle, WA 98105-6099*

SUMMARY:

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

No. 33B
NEW TREATMENT FINDINGS ON COMBINING PHARMACOTHERAPY AND PSYCHOTHERAPY FOR CHRONIC DEPRESSION

Martin B. Keller, M.D., *Department of Psychiatry, Butler Hospital, Brown University, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

This presentation will summarize a multicenter clinical trial involving 681 patients with longstanding, moderate-to-severe depression. The patients were randomized to one of three treatment groups. One group received a type of psychotherapy known as cognitive behavioral analysis system of psychotherapy (CBASP). Patients had

two sessions of psychotherapy weekly for the first six weeks with a total of 16 to 20 sessions over 12 weeks. A second randomized group received the antidepressant nefazodone alone, and the third group of patients received CBASP and nefazodone. The nefazodone dose averaged about 500 mg in both groups that received drug treatment.

About 75% of patients in each treatment group completed the 12-week acute phase of the trial. Among those who completed the acute phase, 85% of patients in the combination arm experienced remissions or satisfactory responses, compared with 55% in the nefazodone arm and 52% in the CBASP arm. Both nefazodone-treated groups had more rapid onset of antidepressant effect. All three groups had low rates of side effects. The one notable exception involved sleep disturbance, which was less of a problem with nefazodone therapy. Sexual dysfunction occurred in only 2.7% of nefazodone patients and 1.8% of the combination group. Nonresponders to psychotherapy or nefazodone alone were crossed over to the other form of treatment. Nonresponders in the combination arm were phased out of the study. Responders in the acute phase of the trial will remain in their respective treatment groups for a 16-week extension phase (results not available yet).

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1. Pages, KP, Dunner DL: Focus on dysthymic disorder in chronic depression, in Dunner DL, Rosenbaum JF, Eds. The Psychiatric Clinics of North American: Annual of Drug Therapy. Philadelphia, W. B. Saunders Co., 1997, pp. 91–97

INDUSTRY-SUPPORTED SYMPOSIUM 34—MANIC-DEPRESSIVE ILLNESS: AN UPDATE
Supported by Solvay Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should be able to evaluate more critically the often confusing negative and positive reports of genetic markers, have a better understanding of new mechanisms for the mood-stabilizing effects of lithium and valproate, and be better able to select and integrate appropriate acute and maintenance treatments for individual patients.

No. 34A
BIPOLAR DISORDER AND GENETICS: A CLINICIAN'S PERSPECTIVE

J. Raymond DePaulo, Jr., M.D., *Department of Psychiatry, Johns Hopkins University, 600 N Wolfe Street, Meyer 3-181, Baltimore, MD 21287*

SUMMARY:

Estimates of the heritability of bipolar (BP) disorder range from 50% to 100%. The heritability, the availability of families, and genetic markers have provided the rationale for linkage studies in BP disorder. Despite these resources, none of the genes involved in susceptibility to BP disorder have been isolated. Based on this, most observers are persuaded that BP disorder is a complex phenotype (i.e., not a simple dominant or recessive) and that single gene forms, if they exist, must be uncommon. Several genome-wide studies have failed to establish linkage of bipolar disorder at chromosomal loci. On the other hand, studies of candidate regions of particular chromosomes have produced statistically significant linkage results on chromosomes 4p, 12q, and 21q. However, even these regions of linkage are too broad to support standard cloning experiments. Evidence for linkage of BP disorder to other chromosomes, especially chromosome 18, varies in statistical strength, location of the linkage peak, and regarding a possible parent-of-origin effect. The strategies proposed to find genes for BP disorder, including larger family samples, association mapping, and refinement of the clinical phenotypes, will succeed as they are refined and as molecular tools and knowledge of the genome advances.

No. 34B
MOLECULAR MECHANISMS UNDERLYING MOOD STABILIZATION ON MDI

Husseini K. Manji, M.D., *Department of Psychiatry, Wayne State University, 4201 St. Antoine Drive, UHC 9B-29, Detroit, MI 48201*

SUMMARY:

It has become increasingly appreciated that the long-term treatment of manic-depressive illness (MDI) involves the strategic regulation of signaling pathways and gene expression in critical neuronal circuits. The chronic administration of the two structurally highly dissimilar agents, lithium and valproate regulate the PKC signaling pathway in a strikingly similar manner. Preliminary clinical studies using tamoxifen suggest that PKC inhibitors may represent a novel class of improved therapeutic agents for MDI. To identify genes which are long-term targets for mood stabilizing agents, mRNA RT-PCR differential display has been utilized. Lithium has been demonstrated to produce a marked increase in the expression of the neuroprotective protein bcl-2 in frontal cortex, hippocampus and striatum. Accompanying these effects, lithium not only robustly protects neurons from a variety of insults, but also increases neurogenesis in the dentate gyrus of adult rodents by 25%. Consistent with such neurotrophic effects, lithium also increases the levels of NAA (N-acetylaspaprtate, a marker of neuronal viability) in the brains of patients with MDI. These novel findings suggest that some of the long term beneficial effects of mood stabilizing agents may involve hitherto underappreciated neuroprotective effects, and may lead to the development of novel classes of compounds for MDI.

No. 34C
BRAIN ANATOMY AND FUNCTION IN BIPOLAR DISORDER

Harold A. Sackeim, Ph.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 126, New York, NY 10032*

SUMMARY:

This presentation will review the nature of brain structural and functional abnormalities in bipolar disorder. 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. In bipolar patients, the early age at manifestation and absence of association with cerebrovascular risk factors suggest a distinct pathoetiology. Bipolar patients often display enlarged ventricles, which may signal a nonspecific degenerative process. In euthymic bipolar patients, the frequency/duration of affective episodes is linked to neuropsychological deficits. Among euthymic unipolar patients, lifetime duration of depressive episodes is associated with reduced hippocampal volume and memory disturbance. Bipolar patients likely share this abnormality, as well as reduced frontal lobe volume, but this is not established. Functional imaging studies have found that major depression in bipolar and unipolar illness is associated with metabolic reductions in dorsolateral and medial prefrontal cortex and basal ganglia. The magnitude of prefrontal deficit covaries with symptom severity. When differences between bipolar and unipolar depressed

patients have been found, they generally reflect higher metabolic rates in bipolar depression. The limited information about mania suggests that this state is also accompanied by prefrontal deficits, suggesting a trait-level abnormality.

No. 34D
SUICIDE IN BIPOLAR DISORDERS

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1753 West Congress Parkway, Chicago, IL 60612*

SUMMARY:

This presentation will review the literature comparing rates of suicide in bipolar versus unipolar disorder, as well as various high-risk subtypes of bipolar disorder. Both chronic and acute risk factors for suicide in major affective disorders, including the added risk conferred by comorbid substance abuse, will be discussed. The question of whether the risk of suicide is a trait or state that crosses diagnostic boundaries that can be treated as a separate behavioral dimension, as opposed to the notion that successful management of the disorder is the basis of suicide prevention, will be discussed. Illustrative cases of completed suicide dramatizing these issues will be presented. Finally, evidence relating to the assessment and treatment of both acute and chronic suicide risk states will be discussed, including the use of anxiolytic medications, anticonvulsants, and lithium.

No. 34E
PHARMACOLOGICAL TREATMENT: CHALLENGES AND CONTROVERSIES

Frederick K. Goodwin, M.D., *Department of Psychiatry, George Washington University, 2300 I Street, NW, Ross Hall #514, Washington, DC 20037*

SUMMARY:

One a half century ago, the psychopharmacology revolution began with the discovery of the therapeutic benefits of lithium in manic-depressive (bipolar) illness. In the fast few years the pharmacologic options for bipolar disorders have rapidly expanded, even as the expression of the illness itself has changed. Thus, the clinician is faced with even more complex choices. This presentation will review what is known about the prophylactic efficacy of lithium, the anticonvulsants, the atypical neuroleptics and their combinations, in the management of manic-depressive illness.

There is a reasonable consensus that anticonvulsants (alone or in combination) are indicated in the presence of rapid cycles, mixed states, comorbid substance abuse, and a history of lithium failure. But absent these special (albeit common) circumstances, there is controversy. The only agent for which prophylactic efficacy has been established by randomized double-blind studies is lithium, and yet practice patterns suggest that for many, the anticonvulsant divalproex has apparently replaced lithium as their treatment of choice. Is this justified by the data? Do lithium and divalproex responders represent separable populations? Is there a differential effect on suicide prevention? Other questions to be addressed include: What is the role of atypical neurologistics alone or in combination? When and how should antidepressants be used? What about omega-3 fatty acids?

No. 34F
MANIC-DEPRESSIVE ILLNESS: AN UPDATE ON PSYCHOLOGICAL ISSUES

Kay R. Jamison, Ph.D., *Department of Psychiatry, Johns Hopkins University, 720 Rutland Avenue, Meyer 4-181, Baltimore, MD 21205*

SUMMARY:

Despite its indisputable biological roots, manic-depressive illness—as experienced by patients and as expressed to the world—is exquisitely psychological. It manifests itself as temperament and as fluctuations around that temperament. It reveals itself in thoughts, perceptions, language, behavior, and intellect. And it displays itself in interactions with family members, friends, colleagues, and society. Precise and quantitative psychological study of the illness, its cognition, speech patterns, perception, mood, psychomotor state, etc. has recently become especially important as brain imaging strategic are revealing more and more about its regional functional neuroanatomy.

Likewise, careful study of personality and of the interpersonal aspects of the illness has assumed new importance as effective medical can have made possible a recrudescence of psychotherapeutic approaches. Indeed, the recent growth of an impressive new literature in which psychotherapy plus medication is superior to medication alone challenges traditional notion that the principal benefits of psychotherapy are most likely to be seen among the less seriously ill. This presentation will review the evidence suggesting that the particular type of psychotherapy is important to outcomes in manic-depressive illness: specific cognitive, behavioral, and interpersonal strategies (including family and group approaches) underpin effective psychotherapy for this illness. On the other hand, analytic "recovering" may be counterproductive.

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1. Numberger JI, DePaulo JR, Gershon ES, et al: Genomic survey of the bipolar illness in the NIMH Genetics Initiative pedigrees-a preliminary report. American Journal of Medical Genetics 1997;74:227–237
2. Manji HK, Moore GJ, Chen G: Bipolar disorder: leads from the molecular and cellular mechanisms of action of mood stabilizers. British Journal of Psychiatry, In Press
3. Sackeim HA, Lisanby HH, Nobler MS, et al: MRI hyperintensities in major depression: the meaning of encephalomalacia. Advances in Psychiatry, edited by Andrade C. New York, Oxford University Press, in press
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6. Jamison KR, Goodwin FK: Manic-Depressive Illness. New York, Oxford Press, 1990

INDUSTRY-SUPPORTED SYMPOSIUM 35—NEUROTRANSMITTERS AND DEPRESSION: NEW POSSIBILITIES
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) demonstrate practical knowledge of biogenic amine theory and describe the research that supports and contradicts it; (2) identify and discuss the dynamic relationship between the principal endogenous chemicals currently under study in connection with depression and related brain states; (3) describe the affects of depleting serotonin, norepinephrine and dopamine on depressed and nondepressed human subjects; (4) treat patients with antidepressants monotherapeutically and in combination utilizing new strategies based on clinical symptoms and neurotransmitter mechanisms.

No. 35A
NEUROREGULATORS IN DEPRESSION

Jack D. Barchas, M.D., *Department of Psychiatry, Cornell University Medical College, 525 East 68th Street, Box 171, New York, NY 10021–4873*

SUMMARY:

A remarkable aspect of psychiatric research has been the impetus it has given to the study of neuroregulators (substances that act as neurotransmitters or modulators of neuronal function). Thanks to that new knowledge we now know of dozens, perhaps hundreds, of substances that have a critical role as neuroregulators, some of which may have a role in one or another form of mental disorder. As important as the substances themselves are the various forms of receptors and post-receptor mechanisms that permit direct intervention in mental disorders. There are strong reasons to study fundamental biological mechanisms from genetics to cell biology as well as developmental and behavioral processes and their interaction. The most exciting science of the coming century in psychiatry may involve the study of behavioral neurobiology and the reciprocal relationships between behavior and neuroregulator mechanisms as exemplified by depression. Such studies will provide new unified hypotheses for our field.

No. 35B
MOLECULAR ADAPTATIONS TO DRUGS USED FOR DEPRESSION

Chris J. Evans, Ph.D., *Department of Psychiatry, UCLA, 760 Westwood Plaza, Box 77, Los Angeles, CA 90095*

SUMMARY:

Historically, drugs targeting a number of neuromodulator and neurotransmitter systems have been used to treat melancholy. Early efforts embraced psychostimulant tonics such as cocaine that primarily modulate the dopamine system and at least temporarily alleviate depressive symptoms. Opiate drugs, such as buprenorphine, have also proven effective as clinical treatments for depression. Clearly a relationship exists between the reward pathways and depressive illness, and it comes as little surprise that there is a high rate of comorbidity of substance abuse and depression. Indeed, self-medication for depression and anxiety is cited as a primary causes for the abuse of many drugs. Recent medications for depressive illness target the reuptake transporters for serotonin (SSRIs) and norepinephrine (SNRIs), and a range of drugs has emerged providing a spectrum of serotonin to norepinephrine transporter targeting. In contrast to opiates and psychostimulants, the SSRIs and SNRIs do not function immediately to relieve depression, which implicates the requirement for adaptive or learned processes for drug efficacy. This presentation will review the molecular mechanisms of the primary actions of various drugs that have been used in the treatment of depression and will explore possible molecular and cellular adaptations to these drugs that may exacerbate or alleviate depressive symptoms.

No. 35C
DEPLETION OF NEUROTRANSMITTERS IN HUMANS

Pedro L. Delgado, M.D., *Department of Psychiatry, University of Arizona School of Medicine, 1501 North Campbell Avenue, Room 7303, Tucson, AZ 85724–2004;* Francisco A. Moreno, M.D.

SUMMARY:

The neurotransmitter depletion paradigm provides a direct method for investigating the role of monoamines in drug action and mental illness. The increase in the use of this paradigm is due to the relative ease and safety with which it can be accomplished. The synthesis of brain serotonin (5-HT) is dependent on plasma levels of the essential amino acid tryptophan (TRP), and 80% depletion of plasma TRP can be accomplished safely within a five-hour period in humans by a single oral administration of a 100 gm TRP-free amino acid mixture. Brain norepinephrine (NE) and dopamine can be rapidly reduced by oral administration of 1 gm t.i.d. of the tyrosine hydroxylase inhibitor alpha-methyl-para-tyrosine (AMPT) for two days.

The results of these studies show that patients having responded to and taking NE reuptake inhibitors are more vulnerable to catecholamine than TRP depletion and those having responded to and taking selective 5-HT reuptake inhibitors are more vulnerable to TRP than catecholamine depletion. Further, while TRP depletion causes depressive symptoms in out-of-episode, medication-free subjects with a history of a depression, healthy subjects with no personal or family history of mental illness are relatively unaffected. These data suggest that the neurobiological mechanisms underlying the therapeutic antidepressant responses to different drugs involve alterations in the functioning of several different neurotransmitters. The inability to induce clinical depression in healthy subjects or worsen depression in unmedicated symptomatic depressed patients suggests that dysfunction in neither the 5-HT nor NE systems may be the simple cause of depression. Antidepressant drugs may be enhancing neurotransmission in normal monoamine neurons and, through a time-dependent, as-of-yet undiscovered process, restoring normal activity to brain areas modulated by monoamine neurons.

No. 35D
THE TARGETED TREATMENT OF DEPRESSION

Richard J. Metzner, M.D., *Department of Psychiatry, UCLA, 11831 Mayfield Avenue, #1, Los Angeles, CA 90049*

SUMMARY:

There are currently no reliable methods for determining which antidepressant (AD) is most likely to benefit a depressed patient. However, it is reasonable to infer based on available data that: 1) serotonergic ADs may be more beneficial in anxious, angry, irritable, and impulsive (demodulated) states, 2) catecholaminergic ADs may be more effective in apathetic and fatigued (deactivated) states, 3) dual-mechanism ADs may be more efficacious in melancholic and other mixed states. To test such targeted treatment (TT) and improve results in practice, we have managed depressed private outpatients for the past decade by giving SSRIs to people in demodulated states, catecholaminergic ADs such as bupropion to those in deactivated states, and venlafaxine or dual-mechanism combinations such as fluoxetine and bupropion to patients in mixed states. In comparing the randomly selected charts of 100 recent TT cases with those of a similar non-TT group we treated in the 1980s, we found the percentage of patients globally improved in the TT group to be substantially higher (95% vs. 65%).

After discussing these preliminary findings and related studies, we will suggest an explanatory model linking TT with current neuroscientific research, propose further investigations, and offer prospective guidelines for the targeted treatment of depression.

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1. Barchas J, Altemus M: Biochemical hypotheses of mood and anxiety disorders, in Basic Neurochemistry edited by Siegel G, et al. Lippincott-Raven, 1999. pp. 1073–1093
2. Keith DE, Anton B, Murray SR, et al: Mu opioid receptor internalization: opiate drugs have differential effects on a conserved endocytic mechanism in vitro and in the mammalian brain. Mol. Pharm. 1998;53:377–384
3. Delgado PL, Charney DS, Price LH, et al: Serotonin function and the mechanism of antidepressant action: reversal of antide-

pressant induced remission by rapid depletion of plasma tryprophan. Arch Gen Psychiatry, 1990, 47:411–418
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5. Antidepressant Therapy at the Dawn of the Third Milennium, edited by Briley M, Montgomery S, London, Martin Dunitz 1998

INDUSTRY-SUPPORTED SYMPOSIUM 36—PSYCHIATRY IN UNCHARTED TERRITORY: ASSESSING AND TREATING PSYCHIATRIC CONDITIONS IN MEDICAL PATIENTS

Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have increased understanding of the nature and prevalence of psychiatric conditions that present in both general and specialty medical practice and the outcomes of a variety of treatment approaches for patients with such conditions.

No. 36A
BROKEN HEARTS: ISCHEMIC HEART DISEASE, DEPRESSION AND GENDER

Donna E. Stewart, M.D., *Women's Health, The Toronto Hospital, 200 Elizabeth Street, EN 1-222, Toronto, ONT M5G 2C4, Canada;* Susan E. Abbey, M.D., Zach Shnek, Jane Irvine, Paul Daly

SUMMARY:

Depression increases morbidity and mortality nearly four-fold in men following myocardial infarction. Although women are more likely than men to suffer from depression, die after their first myocardial infarction, be underdiagnosed, undertreated, and have a poorer quality of life, the role of depression in women with ischemic heart disease has not been studied. This study examined more than 250 men and women admitted to a Canadian coronary intensive care unit (CICU) with myocardial infarction or unstable angina who completed a questionnaire on demographics, symptoms, risk factors, and depression (BDI) in hospital and six months after discharge.

Forty percent of the patients were women. The average age was 62.7 years (SD ± 10.38), with no gender difference. Women reported significantly more symptoms than men in the month prior to and at the time of CICU admission ($p = 0.05$). Over 40% of patients waited more than three hours before seeking medical care. Women were more likely than men to have their symptoms occur without physical or emotional stress ($p = 0.02$) and to score in the depressed range on BDI (51.8% versus 40.7%) ($p = 0.05$). Ninety percent of patients who died in hospital scored over 10 on BDI. (Six month follow-up data are currently being analyzed.)

As heart disease is the leading cause of death in North American women, it is vital to identify early symptoms and treatable conditions such as depression that may affect outcomes Better education of women and their doctors is needed to improve the diagnosis and treatment of both ischemic heart disease and depression to improve the prognosis of these frequently comorbid conditions.

No. 36B
EFFECTIVE TREATMENT OF MINOR DEPRESSION IN PRIMARY CARE

Ellen Frank, Ph.D., *Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Psychiatrists are called upon increasingly to serve as consultants to other medical specialists. Among the most common conditions for which psychiatrists are called upon is minor depression presenting in the context of primary care. Knowledge of how treatments are likely to perform in this situation is critical to successful consultation.

We studied the relative efficacy of three treatments for mid-life and elderly primary care patients suffering from minor depression in a multisite randomized, controlled trial. In this 11-week trial patients were randomly assigned to paroxetine plus clinical management, placebo plus clinical management, or problem-solving treatment (Mynors-Wallis et al., 1996), a brief six-session psychotherapy. Patients in all three groups tended to improve; however, paroxetine was significantly superior to placebo in the overall analysis. Discussion will focus on which primary care patients with minor depression appear to benefit specifically from antidepressant treatment, and how the psychiatrist can best aid the primary care physician in providing such treatment.

No. 36C
EFFECTIVENESS OF AN SSRI AND PROBLEM-SOLVING THERAPY FOR PRIMARY CARE PATIENTS WITH DYSTHYMIA

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, P.O. Box 356560, Seattle, WA 98195;* Ellen Frank, Ph.D., James E. Barrett, M.D., John A. Williams, M.D., Thomas E. Oxman, M.D., Mark Sullivan, M.D., John Cornell, Ph.D.

SUMMARY:

Purpose: To evaluate the effectiveness of antidepressants and a manualized psychotherapy in primary care patients with dysthymia.

Design: An 11-week, multicenter, randomized, controlled trial comparing paroxetine, problem-solving therapy, and placebo. Primary care patients aged 18 and older were recruited from academic primary care practices in four cities. Patients were stratified separately by age cohorts 18 to 59 and 60 and above. Depressive symptoms were measured at multiple time points using the SCL-20 depression items, the Hamilton-Depression Scale, and the SF-36. Using an intent-to-treat approach outcomes were analyzed with a fixed effects random regression model.

Results: 211 patients with dysthymia were randomized to one of the three treatments. Patients treated with paroxetine were significantly more likely to recover over time based on the SCL-20 and SF-36 mental health factor than those treated with placebo ($p < .05$).

No. 36D
IMPROVING CARE FOR PANIC IN PRIMARY CARE

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, University of Washington, Harborview Medical Center, 325 Ninth Avenue, P.O. Box 359911, Seattle, WA 98104;* Deborah S. Cowley, M.D., Joan Russo, Ph.D., Wayne J. Katon, M.D.

SUMMARY:

Panic disorder, a prevalent, disabling, but highly treatable illness, is poorly recognized and inadequately treated in the primary care setting, resulting in high medical care utilization and increased costs. To address the absence of data on the application of efficacious panic disorder treatments in primary care, we examined the clinical

and cost-effectiveness of "expert pharmacotherapy" with the SSRI paroxetine, compared with usual care in 120 primary care panic disorder patients. Patients were randomized to receive either usual care by their doctor or a "collaborative care" intervention previously shown to improve both clinical and cost effectiveness in depressed primary care patients. The intervention consisted of pharmacotherapy with paroxetine, educational videotapes and pamphlets, two psychiatrist visits, and two phone calls over an initial eight-week period, and follow-up psychiatrist phone calls at three-month intervals over the next year. Measures of clinical status, functional disability, health-related quality of life, and medical service utilization were obtained at three, six, nine, and 12 months. Data focusing on the broadly defined clinical effectiveness of this intervention in the first three months of the study will be presented.

No. 36E
PRIMARY CARE TRAINING IMPROVES DEPRESSION OUTCOMES

Kathryn M. Rost, Ph.D., *Department of Psychiatry, University of Arkansas, 5800 West 10th Street, Little Rock, AR 72204;* Paul Nutting, M.D., Jeffrey Smith, B.S., James Werner, M.A.

SUMMARY:

Because the majority of primary care physicians practice in sites without onsite psychiatrists or mental health professionals, brief interventions that train primary care physicians and nurses to improve outcomes for major depression need to be tested. In a randomized block trial conducted in 12 community practices, we screened 11,006 patients to identify 479 patients (73.4% of eligibles) reporting five or more depression criteria. Intervention patients beginning a new treatment episode reported an 8.2 point (95% CI=0.2–16.1, p=0.04) improvement in depression symptoms, with most change occurring in patients who indicated before the intervention that antidepressant medication was an acceptable treatment. In this subgroup, the intervention improved symptoms by 16.2 points (95% CI=4.5 to 27.9, p=0.07), with 56.1% of enhanced care patients versus 21.7% of usual care patients reporting a 50% or greater symptom decrease (OR= 4.7, p=0.04), emotional functioning improved by 9.7 points (95% CI 2.2 to 16.7, p=0.07), and satisfaction with care increased (p= 0.02). Brief interventions with primary care physician-nurse teams can significantly improve depression outcomes for patients beginning a new treatment episode. Such interventions should target, patients who report antidepressant medication is an acceptable treatment. Systematic consultation with an offsite specialist is recommended for primary care patients who remain symptomatic after treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 37—DEFINING BIPOLAR DISORDER: A PUBLIC HEALTH CHALLENGE
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to implement strategies to properly diagnose bipolar disorder, including the Mood Disorder Questionnaire, develop cost-effective pathways for treating bipolar disorder using consensus guidelines and rapid stabilization with mood stabilizers, and utilize data to develop optimal treatment strategies for women and for children and adolescents with bipolar disorder who may have comorbid psychiatric disorders.

No. 37A
A NEW SCREENING TOOL FOR BIPOLAR DISORDER: THE MOOD DISORDER QUESTIONNAIRE

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry & Behavioral Sciences, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

Bipolar disorder is more prevalent than many are aware. Bipolar spectrum (including bipolar I, II, NOS, and cyclothymia) rates range from 2.6% to 7.8% of the adult population, leading Jules Angst to say, "the more we know, the larger the prevalence." Yet it is too often unrecognized, particularly in primary care settings. Patients usually present in outpatient settings in a depressed state, where the bipolarity is often missed. This misdiagnosis can lead to disastrous consequences. Unfortunately there have been no screening aids for bipolar disorder. The Mood Disorder Questionnaire (MDQ) is the first—it is a brief, simple, self-report inventory with nine questions for depression and 13 for mania. Results of a validation study in psychiatric outpatient clinics will be presented.

No. 37B
COST-EFFECTIVE PATHWAYS FOR BIPOLAR DISORDER

Gary S. Sachs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, #580, Boston, MA 02114*

SUMMARY:

Despite the complexity of bipolar illness and enormous individual variation between patients, there is an impressive consensus about reasonable steps in treating bipolar patients. The NIMH-sponsored Systematic Treatment Enhancement Program for Bipolar Disorder has incorporated this consensus into a pathway-based program for management of bipolar disorder. This program uses a multiphase treatment strategy and offers a "menu of reasonable choices" approach at operationally defined decision points. This presentation will review these concepts as applied to development of treatment pathways for bipolar depression, acute mania, and rapid cycling.

No. 37C
RAPID STABILIZATION OF MOOD AND PSYCHIATRIC SYMPTOMS IN MANIA

Paul E. Keck, Jr., M.D., *Department of Biological Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, P.O. Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

The rapid and safe reduction of manic symptoms is an important initial goal of the pharmacologic treatment of acute mania. For both humanitarian and economic reasons, interest in rapidly reducing symptoms of mania with pharmacologic loading strategies has increased over the past decade. Initial pilot studies of the safety and efficacy of lithium and divalproex sodium oral loading have recently been followed up by further, more rigorous studies. Data from these new studies will be presented with an emphasis on their clinical and pharmacoeconomic implications. In addition, the first studies examining the feasibility of carbamazepine loading will be presented.

No. 37D
PHARMACOLOGIC TREATMENT FOR WOMEN WITH BIPOLAR DISORDER

Lauren B. Marangell, M.D., *Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza, #110 D, Houston, TX 77030*

SUMMARY:

The high risk of relapse following medication discontinuation underscores the importance of long-term maintenance treatment for patients with bipolar disorder. However, the long-term treatment of women with bipolar disorder raises several difficult issues, including the use of medication during pregnancy and breast-feeding, possible endocrine effects, and interactions with contraceptives. Although avoiding medications during pregnancy is sometimes possible, the adverse impact of mania and depression on both the mother and developing fetus may produce an even greater risk for many women. The medications currently used to treat bipolar disorder have markedly different characteristics that are germane to these important issues. This presentation will discuss pharmacologic agents, including divalproex sodium, lithium, carbamazepine, and lamotrigine, emphasizing information clinically relevant to psychiatrists.

No. 37E
RECOGNITION AND MANAGEMENT OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Neal D. Ryan, M.D., *Department of Psychiatry, Western Psychiatric Institute & Clinic, 3811 O'Hara Street, Room ERC-720, Pittsburgh, PA 15213*

SUMMARY:

Diagnosing and treating bipolar disorder in children and adolescents is a challenging and important task for the clinician. First, we will review the symptomatology of bipolar disorder in youth and discuss strategies for its early recognition. Studies that solidify the molecular genetic basis and heritability of bipolar disorder will also be discussed. Because symptoms of bipolar disorder in children can overlap with symptoms of other psychiatric disorders, particularly ADHD, diagnosis can be difficult. We will review open and controlled treatment studies, including several that are only recently available. Aggressive treatment is critical because of the high morbidity and mortality of this disorder and the increased hazard for recurrence seen with additional episodes. To date, studies are encouraging on the use of mood stabilizers, but not definitive. We will provide data on dosing and side-effect issues important to the clinician treating children and adolescents with these compounds.

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INDUSTRY-SUPPORTED SYMPOSIUM 38—ADULT ADHD: RESEARCH FINDINGS AND CLINICAL PRACTICE
Supported by Shire Richwood

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium participants should be able to a) understand the evidence about the validity of adult ADHD, b) recognize its clinical manifestations in referred adults, and c) know what methods of pharmacotherapy are effective.

No. 38A
AGE-DEPENDENT DECLINE OF ADHD SYMPTOMS

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-725, Boston, MA 02114*

SUMMARY:

Objective: Although follow-up studies have documented the persistence of ADHD, the magnitude of this persistence has been inconsistent across studies. Since different ways of interpreting symptom decline could lead to different results, we examined patterns of symptom decline in ADHD using different definitions of persistence.

Method: Across five repeated measures, the mean number of symptoms of 128 ADHD subjects (aged 6-20 years) was estimated as a function of age with linear regression and the prevalence of syndromatic (< full syndrome), symptomatic (< subthreshold diagnosis), and functional (full recovery) remission was estimated as a function of age with logistic regression.

Results: Age was significantly associated with the decline of total ADHD symptoms and symptoms of hyperactivity, impulsivity, and inattention. Symptoms of inattention remitted at a lower rate than did symptoms of hyperactivity or impulsivity. The rate of remission varied considerably with the definition used (syndromatic remission > symptomatic remission > functional remission).

Conclusion: Patterns of remission of ADHD are highly sensitive to definitions of remission such that differences in reported remission rates reported may reflect the method of definition rather than the course of the disorder. These results also provide systematic support for the clinical observation that symptoms of hyperactivity and impulsivity tend to decline at a higher rate than those of inattention.

No. 38B
NEUROIMAGING IN PATIENTS WITH ADHD

Jean A. Frazier, M.D., *Department of Psychiatry, McLean Hospital, Belmont, MA 02178*

SUMMARY:

Objective: To present data from a functional magnetic resonance imaging (fMRI) study done in adults with ADHD (DSM-IV), using the Counting Stroop task.

Methods: An fMRI study (using the BOLD technique) was performed in eight unmedicated adults with ADHD with at least one first-degree relative with ADHD and eight matched controls. The Counting Stroop was used as the attentional/cognitive interference task.

Results: Both groups showed interference. The ADHD group's performance was significantly impaired compared to controls. The ADHD group, while performing the Counting Stroop, did not activate the anterior cingulate cognitive division (ACcd). Direct comparisons showed that ACcd activity was significantly higher in the control group. ADHD subjects did activate the prefrontal cortex, indicating that ACcd hypoactivity was not caused by globally poor neuronal responsiveness.

Conclusion: These data support a hypothesized specific dysfunction of the ACcd in ADHD. There are numerous reciprocal connections between the ACcd and the prefrontal cortex. The pathophysiology of ADHD may involve a dysfunctional interaction between the ACcd and fronto-striatal circuitry. Future network analysis of regional interactions should help answer the question surrounding the specificity of the ACcd dysfunction in ADHD.

No. 38C
GENETICS OF ADULT ADHD

Stephen V. Faraone, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 750 Washing Street, Suite 225, Southeaston, MA 02375*

SUMMARY:

Objective: To examine evidence for the genetic transmission of ADHD, it subtypes and its comorbid disorders (conduct disorder, major depression, bipolar disorder).

Method: Data from prior family, twin, and molecular genetic studies are reviewed. Meta-analysis is used to examine the consistency of reports across different laboratories. Data from a longitudinal family study of children with ADHD are used to illustrate the pattern of comorbidity in families.

Results: Family, twin, and molecular genetic studies show that genes influence susceptibility to ADHD and its comorbid conditions. There is considerable heterogeneity such that cases with comorbid conduct or bipolar disorders as well as persistent cases show the greatest genetic influence. Several studies have implicated the dopamine transporter and dopamine-4 receptor gene. Patterns of comorbid disorders in families suggest strategies for understanding the heterogeneity of ADHD. The DSM-IV subtypes do not "breed true" in families.

Conclusions: Genes influence the expression of ADHD and comorbid disorders. ADHD in combination with conduct or bipolar disorders may be genetically distinct from other forms of ADHD. Major depression may be a nonspecific manifestation of ADHD genotypes. Implications for research and clinical practice are discussed. The DSM-IV subtypes do not appear to represent distinct genetic conditions.

No. 38D
CHOLINERGIC MECHANISMS AND ADHD: TREATMENT IMPLICATIONS

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

SUMMARY:

A growing literature indicates important connections between attention deficit hyperactivity disorder (ADHD) and the cholinergic nervous system. An excess rate of cigarette smoking has been demonstrated in children, adolescents, and adults with ADHD. Nicotinic activation has been shown to improve attention, memory, and executive function. Moreover, recent reports have suggested the usefulness of cholinergic agents, such as the nicotine patch, for ADHD. To this end, we completed a controlled study of a novel nicotinic/cholinergic activating agent (ABT-418) in adults with ADHD.

We completed a double-blind, placebo-controlled, randomized, crossover trial, comparing a transdermal patch of ABT-418 (75 mg daily) with placebo in adults with ADHD. There were two three-week treatment periods separated by one week of washout. At the endpoint of each active arm (LOCF), a significantly higher proportionof subjects were considered improved while receiving ABT-418 than receiving placebo, and a significantly greater reduction in ADHD symptom checklist scores was found in the ABT-treated group. Of interest, symptoms reflective of attention, and subjects with less severe ADHD, responded more robustly to ABT-418. The results of this investigation indicate that ABT-418, a nicotinic analog, may be a useful agent in ADHD. The implications of current research on the cholinergic system in the treatment of ADHD will be discussed.

No. 38E
EFFICACY AND TOLERABILITY OF A MIXED AMPHETAMINE SALTS COMPOUND IN ADULTS WITH ADHD

Thomas J. Spencer, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114;* Joseph Biederman, M.D., Jeff Q. Bostic, M.D., Jefferson B. Prince, M.D., Kristine Gerard, M.D.

SUMMARY:

Objective: The assessment of a mixed amphetamine salts compound, adderall, in the treatment of adult ADHD.

Method: This was a randomized, double-blind, placebo-controlled, crossover study of adderall in 27 well-characterized adults with ADHD, attending to issues of psychiatric comorbidity.

Results: Treatment with adderall at an average oral dose of 54 mg administered in two daily doses, was highly effective and very well tolerated. Drug-specific improvement in ADHD symptoms was highly significant overall ($z=3.7$, $p=0.001$) and sufficiently robust to be detectable in a parallel groups comparison restricted to the first three weeks of the protocol ($z=2.9$, $p=.004$). Rates of improvement (Clinical Global Impression: very much or much improved) was robustly and significantly higher with adderall treatment than with placebo (70% vs. 7%; $\chi 2=13.8$, $p=0.001$).

Conclusions: This study showed that adderall was highly effective in the treatment of adults with ADHD and was very well tolerated. These promising results provide support for further studies of adderall employing robust dosage over an extended period of treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 39—COGNITION IN SCHIZOPHRENIA: MAXIMIZING RECOVERY
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the nature and severity of the cognitive dysfunction in schizophrenia, its functional significance, approaches to treatment with novel antipsychotic drugs, methods for rehabilitation, and relation to psychopathology.

No. 39A
COGNITIVE IMPAIRMENT AND OUTCOME IN SCHIZOPHRENIA

Herbert Y. Meltzer, M.D., *Department of Psychiatry, Vanderbilt University, 1601 23rd Avenue South, Suite 306, Nashville, TN 37212*

SUMMARY:

The outcome of schizophrenia treatment must be evaluated from a multidimensional perspective. Controlling positive symptoms is insufficient to achieve satisfactory work and social function or to reduce the familial and societal costs of schizophrenia sufficiently. Work, social function, and quality of life, as well as general medical well-being are other outcome measures that should be targeted, especially because newer treatment strategies make it more likely that good results can be achieved on these measures. A major reason for poor outcome in schizophrenia despite control of positive symptoms appears to be the pervasive deficits in all domains of cognition, including executive function, attention, working memory, verbal and spatial memory, and semantic memory, which are present from the first episode. These cognitive domains are independent of positive symptoms and weakly correlated with some types of negative symptoms. Some progression in cognitive impairment occurs throughout the course of illness in many patients. Treatment with the novel antipsychotic drugs can reverse this and improve some components of cognitive impairment, leading to better work and social outcome. The etiology of these cognitive deficits may involve a mixture of structural and functional changes in brain that can be ameliorated by the new antipsychotic drugs. Key neurotransmitters involved in the cognitive deficit in schizophrenia are likely to be dopamine, acetylcholine, glutamate, serotonin and GABA, which are the major targets of the new antipsychotic drugs.

No. 39B
COGNITION: THE LINK TO FUNCTIONAL OUTCOMES

Michael F. Green, Ph.D., *Department of Psychiatry, UCLA, 760 Westwood Plaza, C9-420, Los Angeles, CA 90024-1759*

SUMMARY:

Reflecting the surge of interest in this area of inquiry, the cumulative published literature on neurocognition and functional outcome in schizophrenia has doubled in the last few years. The data will be reviewed by counting the number of replicated findings through box scores and through formal meta-analysis. Meta-analyses revealed that the relationships between key neurocognitive constructs (secondary verbal memory, immediate memory, vigilance, and executive functions) and the outcome domains were highly significant (all p values <.0001). The effect sizes were in the medium range for the individual neurocognitive constructs. If composite indices are used instead of individual constructs, the relationships are much stronger (typically 20%–60% of the variance in functional outcome explained). It appears that certain neurocognitive capacities are necessary for adequate functional outcome of patients and that deficits in these areas may restrict the patient from adapting well. The mechanisms for these relationships are not understood, and the next step is to identify mediators that can account for these relationships. Social cognition and learning potential are two possible mediators that are related to basic neurocognition on the one hand and functional outcome on the other.

No. 39C
COGNITION-ENHANCING TREATMENTS IN SCHIZOPHRENIA

John W. Newcomer, M.D., *Department of Psychiatry, Washington University, 4940 Children's Place, Box 8134, St. Louis, MO 63110-1002*

SUMMARY:

An important predictor of functional outcome in patients with schizophrenia is cognitive impairment, especially in memory, attention, and executive function. While schizophrenia is associated with a variety of well-characterized cognitive deficits, these deficits have received relatively little attention as targets of pharmacological treatment. While there are no specific biological treatments for memory and attentional impairments for patients with schizophrenia, recent studies of agents that regulate memory and other elements of cognitive function in humans suggest a number of promising targets for cognition-enhancing treatments. Antipsychotic medications are used primarily to treat psychotic symptoms; however, older medications do affect cognitive functions, producing modest benefits for attention and some important adverse effects. Newer antipsychotic medications, while not originally developed as cognition-enhancing treatments, offer a number of cognitive advantages over the older medications. Studies of the cognitive effects of newer antipsychotic medications will be reviewed, emphasizing opportunities to reduce adverse cognitive events associated with older drugs and increasing evidence for treatment-induced improvements in various cognitive functions. The cognitive profiles of action of the newer agents will be reviewed. The future management of schizophrenia will target cognitive impairments, and cognition-enhancing medications will be an important component of future treatment. Supported by MH01045, and NARSAD.

No. 39D
COGNITIVE REHABILITATION FOR SCHIZOPHRENIA

Alan S. Bellak, Ph.D., *Department of Psychiatry, University of Maryland School of Medicine, 737 West Lombard Street, Baltimore, MD 21201*

SUMMARY:

It is well known that schizophrenia is characterized by marked functional impairment. As indicated in the prior presentations in this symposium, increasing evidence suggests that a significant factor in functional disability is cognitive impairment. Given that even the newer, atypical antipsychotics have only a modest impact on social role functioning and community adjustment, there has been considerable interest in psychosocial strategies to improve cognitive functioning and/or to decrease the effects of cognitive impairment on functional outcomes. This presentation will provide an overview of cognitive rehabilitation strategies. We will first describe general strategies that have been used to date, ranging from techniques that focus on single cognitive functions (e.g., memory) to broad-based rehabilitation programs. This will be followed by a brief review of the literature that highlights the most promising approaches. We will then describe and contrast two alternative models for rehabilitation that lead to very different strategies: an ameliorative model versus a compensatory model. We argue that the compensatory model is more in keeping with the neurodevelopmental nature of brain dysfunction in schizophrenia and is more likely to be effective. We will then illustrate the compensatory approach by describing an experimental intervention for treating substance abuse in schizophrenia patients.

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INDUSTRY-SUPPORTED SYMPOSIUM 40—WHY DO ANXIOUS PEOPLE BECOME DEPRESSED? THE ROLE OF STRESS SUPERSENSITIVITY (PART 1)

Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES:

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

No. 40A
EPIDEMIOLOGY OF COMORBID DEPRESSION AND ANXIETY

Scott W. Woods, M.D., *Department of Psychiatry, Yale University, 34 Park Street, Room B38, New Haven, CT 06519*

SUMMARY:

Anxiety disorders and major depression are frequently comorbid donditions. The National Comorbidity Survey suggested that when anxiety disorders and depression are comorbid, the more frequent longitudinal pattern is that the anxiety disorder develops first, followed by a forst episode of major depression years later.

both types of illness are familial, and evidence from twin studies suggests that the basis for familial aggregation is partly genetic transmission of illness in both depression and anxiety disorders. Panic disorder and obsessive compulsive disorder appear to be genetically distinct from major depression, while evidence suggests that generalized anxiety disorder and major depression may share a similar genetic diathesis coding for a common liability to anxiety and depression. Other evidence suggests that different environmental risk factors may specifically increase risk for anxiety and for depression and interact with genetic liability to produce either illness alone or both comorbidity.

No. 40B
THE HPA AXIS AND THE PATHOPHYSIOLOGY OF DEPRESSION

Dominique L. Musseiman, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Early untoward life stress, including child abuse and/or neglect is associated with an increase in the prevalence rate of depression in adulthood. Preclinical studies suggest CRF-containing neurons are rendered persistently supersensitive to stress after exposure to neonatal stress. Maternal separation, an animal model of early untoward life stress in rats, results in longlasting hyperactivity of the HPA axis. Additionally, there are increases in CRF mRNA expression in the PVN, central nucleus of the amygdala and bed nucleus of the stria terminalis, elevated CSF CRF concentrations, and behavioral alterations reminiscent of depression. Similar findings were also found in a bonnet macaque model of early stress. Treatment of adult rats exposed to neonatal maternal deprivation with a serotonin reuptake inhibitor reversed these measures of HPA axis hyperactivity and CRF neuronal hyperactivity.

Clinical studies of women with major depression who have suffered sexual abuse in childhood also document an enhanced response of the hypothalamic-pituitary-adrenal (HPA) axis to stress. The CRF and HPA axis alterations in patients with major depression, including those with early-life traumatic experiences, suggest that alterations of CRF neurons increase one's susceptibility to depression in adult life. The implications of these findings regarding therapeutic interventions will be discussed.

No. 40C
ANTIDEPRESSANTS: WHY ARE THEY ANXIOLYTIC ALSO?

Alan Frazer, Ph.D., *Department of Pharmacology, University of Texas Health Sciences, 7703 Floyd Curl Drive, San Antonio, TX 78284-7764*

SUMMARY:

Although there are numerous drugs classified as antidepressants, there is substantial evidence that they are also effective in various anxiety disorders. Indeed, it appears that most, if not all, classes of antidepressants have anxiolytic activity, e.g., tricyclic antidepressants such as imipramine, selective serotonin reuptake inhibitors such as fluvoxamine, and "atypical" drugs such as venlafaxine. Reasons for dual behavioral effects include: 1) In many patients, anxiety disorders and depressive illnesses coexist such that amelioration of one may produce improvement in the other; and 2) Pharmacologic actions that may improve such behavioral alterations separately. Some of these drugs have potent pharmacologic effects on both

serotonergic and noradrenergic neurons, whereas others exert more selective effects on serotonergic systems. Both the acute and longer-term effects of such agents on these monoamine systems will be reviewed, with emphasis on the complex regulatory effects these drugs produce, e.g., somatodendritic and terminal autoreceptor subsensitivity, transporter down-regulation, etc. How such effects may translate into behavioral improvement in both anxiety and depressive illnesses will be discussed from the perspective of the global or holistic behavioral and physiological functions of central noradrenergic and serotonergic neuronal systems.

INDUSTRY-SUPPORTED SYMPOSIUM 40—WHY DO ANXIOUS PEOPLE BECOME DEPRESSED? THE ROLE OF STRESS SUPERSENSITIVITY (PART 2)
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

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

No. 40A
NEURAL CIRCUITS UNDERLYING ANXIETY AND DEPRESSIVE DISORDERS

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

SUMMARY:

Recent neuroscientific advances provide insights into the neural circuits underlying the regulation of normal emotion as well as into mechanisms underlying anxiety and depression. Evidence demonstrates that the amygdala is important in responding to cued fears and is overactive in patients with depression and anxiety. The hippocampus is also involved with fearful responses, which are triggered by broad-based contextual factors. The bad nucleus of the stria terminalis may mediate sustained anxiety responses as those associated with generalized anxiety disorder. Studies in humans and monkeys demonstrate that prefrontal cortex is lateralized in relation to emotion. Activation of left prefrontal regions is associated with the expression of positive approach-like emotions, and right prefrontal activation is associated with negative emotions like anxiety and sadness. Additionally, studies demonstrate that benzodiazepines and antidepressants affect the balance of activity between left and right prefrontal regions and altered prefrontal cortical function occurs in patients with depression. Studies in primates suggest that excessive right prefrontal activity mediates anxiety/fearful temperament. Dorsolateral prefrontal cortex is interconnected with the hippocampus whereas orbitofrontal regions are linked to the amygdala. In general, prefrontal regions are thought to be important in regulating emotional responses. This may be very pertinent to anxiety and depression, as these disorders can be characterized as problems of emotion regulation.

No. 40B
EXPERIMENTAL MODELS OF ANXIETY AND DEPRESSION

Trevor Robbins, Ph.D., *Department of Experimental Psychiatry, Cambridge University, Downing Street, Cambridge C33 2EB, England*

SUMMARY:

Useful paradigms exist for differentiating various forms of anxiety, based on the distinction between Pavlovian and instrumental (i.e., avoidance) learning, which are also honored by different brain systems, including separate nuclei of the amygdaloid complex. Another dimension of importance is that of anxiety conditioned to discrete versus contextual conditioned cues. These basic processes can be used to explain naturalistic models of fear in primates (phobic anxiety in monkeys) and in unconditioned behavioral settings for rodents (open-field and elevated maze). The role of the monaminergic systems in modulating these forms of anxiety will be discussed, including experiments on the noradrenergic and serotoninergic systems that utilize in vivo microdialysis, as well as neurotoxic lesioning.

Similar though more controversial paradigms exist for depression, for example "learned helplessness:" the perceived loss of control over instrumental performance and goal-directed behavior. The achievements and inadequacies of this model will be discussed, particularly in relation to stress and the concept of "anhedonia." Some consideration will be given to the social dimension, particularly in a developmental perspective and its possible importance for models of affective disorder. Finally, possible improvements in our capacity to model affective disorders will be suggested, including a new look at cognitive and neuropsychological dimensions in the human disorders. The resulting challenge for therapeutic approaches will also be addressed.

No. 40C
MANAGEMENT OF COMPLEX ANXIETY AND DEPRESSION

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

SUMMARY:

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

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

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INDUSTRY-SUPPORTED SYMPOSIUM 41—CLINICAL CHALLENGES AND CHOICES IN THE TREATMENT OF ADD/ADHD (PART 1)
Supported by Shire Richwood

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to assess the design and clinical results of current and emerging therapies for ADD/ADHD, recognize the clinical symptoms of ADD/ADHD and describe the variances associated with the setting and domain, review the diagnostic criteria for ADD/ADHD, and evaluate current theories regarding the pathophysiology of ADD/ADHD.

No. 41A
BIOLOGICAL BASIS OF ADD/ADHD

James Swanson, Ph.D., *Child Development Center, University of California, Irvine, 19722 MacArthur Boulevard, Irvine, CA 92612*

SUMMARY:

Recently, the searches for biological bases of ADD/ADHD have focused on specific brain regions and chromosome locations. Multiple studies have reported abnormalities in well-defined neuroanatomical networks (cortico-striatal-thalamic-cortical loops) and well-studies genes (DRD4, the dopamine-4 receptor gene and DAT1, the dopamine transporter gene). These studies have documented smaller than average frontal and basal ganglia brain regions and altered frequencies and transmission rates for specific alleles of the DRD4 (the 7-repeat of a 48 bp VNTR) and DAT1 (the 10-repeat of a 40 bp VNTR) genes. These studies support dopamine theories of ADHD, which provide a plausible basis for the standard pharmacological treatments of ADHD/HKD with stimulant drugs (i.e., methylphenidate and amphetamine).

Based on these recent studies, two possible sites of action of the stimulant drugs will be proposed: a hyperactive dopamine transporter in the D2-rich subcortical regions of the corpus striatum and a subsensitive dopamine receptor in D4-rich cortical regions of the anterior cingulate gyrus. Possible presynaptic and postsynaptic effects of stimulants will be contrasted, which make opposite predictions about the effect of clinical doses on synaptic dopamine (i.e., net agonist versus antagonist effects). Implications for investigations of etiologies of ADD/ADHD and new treatments for this disorder will be discussed.

No. 41B
ADD/ADHD DIAGNOSTIC CRITERIA: A FRAMEWORK FOR DIAGNOSIS

Mark L. Wolraich, M.D., *Department of Pediatrics, Vanderbilt University, 2100 Pierce Avenue, Nashville, TN 37232-3573*

SUMMARY:

ADD/ADHD can present a considerable diagnostic dilemma to the pediatric clinician. Symptom overlap, comorbidity, incongruous information from informants, and the impact of developmental changes complicate the diagnosis and require a greater effort to establish the diagnosis. These factors can lead to underdiagnosis of cases of ADD/ADHD.

Obtaining information from multiple sources and, if possible, a multidisciplinary team approach is the most appropriate way to assess whether a child fulfills the DSM-IV criteria for the diagnosis of ADD/ADHD. There are no diagnostic tests that will absolutely confirm this disorder; therefore, clinicians must rely on the sum of the evidence provided through multisources testing paradigms. Several available diagnostic tools, including interviews, rating scales, and self-report instruments will be presented. The psychometric adequacy and clinical validity of these tools will be discussed in detail. Techniques for observation and administration of these tests in both naturalistic and analogue settings will be reviewed. Given the multifaceted nature of this common neurobehavioral disorder, collaborative assessment is encouraged.

No. 41C
INNOVATIONS IN THE DESIGN AND IMPLEMENTATION OF CLINICAL TRIALS FOR THE TREATMENT OF ADD/ADHD

William E. Pelham, Jr., Ph.D., *Department of Psychology, SUNY at Buffalo, 373 Park Hall, Buffalo, NY 14260-4110*

SUMMARY:

This presentation will focus on recent innovations for conducting clinical trials of novel or previously approved drugs for ADHD. A number of trials recently conducted often included unique procedures for analyzing time-course effects of new medications, as most new and modified preparations are designed to provide coverage over a longer portion of the day than standard preparations. These have included establishing laboratory-based classrooms in which children cycle through a brief (e.g., 30 min.) classroom setting numerous times throughout a day to track the onset and offset of the medication effect. Dependent measures in various trials have included teacher ratings, direct product measures of schoolwork, and objective observations of on-task, rule-following, and disruptive behavior. Other studies have established playgroups in which the time course of medications are tracked on the critical domain of peer relationships. Some trials have been conducted in summer camp settings in which classroom and playgroups are combined and standardized to examine main and time-course effects of medication. In addition to trials focusing on time course, novel trials have involved standardized and simple procedures for gathering teacher ratings and product measures in community school settings, as well as unique child-medication effects on parental affect and stress. Finally, one recent trial involved a balanced-placebo design in which expectancy was manipulated along with the pharmacological effect of medication. Illustrative results of these results will be discussed as will their implications for future studies of medication effects in children beyond the ADHD field.

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1. Arnold LE, et al: National Institute of Mental Health collaborative multimodal treatment study of children with ADHD (the MTA). Arch Gen Psychiatry. 1997;54:865–870

2. Barkley RA: ADHD and the Nature of Self-Control. New York, Guilford Press, 1997
3. Gaub M, Carlson CL: Gender differences in ADHD: a meta-analysis and critical review. J Am Acad Child Adolesc Psychiatry. 1997;36:1036–1045
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5. Swanson JM, Castellanos XF, Murias M, Kennedy J: Cognitive neuroscience of attention deficit hyperactivity disorder and hyperkinetic disorder. Curr Opin Neurobio 1998;8:263–271
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INDUSTRY SUPPORTED SYMPOSIUM 41—CLINICAL CHALLENGES AND CHOICES IN THE TREATMENT OF ADD/ADHD (PART 2)
Supported by Shire Richwood

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to assess the design and clinical results of current and emerging therapies for ADD/ADHD, recognize the clinical symptoms of ADD/ADHD and describe the variances associated with the setting and domain, review the diagnostic criteria for ADD/ADHD, and evaluate current theories regarding the pathophysiology of ADD/ADHD.

No. 41A
EMERGING TECHNOLOGIES FOR THE TREATMENT OF ADD/ADHD

James Swanson, Ph.D., *Child Development Center, University of California, Irvine, 19722 MacArthur Boulevard, Irvine, CA 92612*

SUMMARY:

Over 50 years, the stimulant drugs amphetamine and methylphenidate have been used to treat what is now known as attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD). The short duration of action of the immediate release forms of these medications requires multiple doses each day (every three to four hours) for effective treatment. There are many practical problems of this dosing regimen for efficacy, compliance, and privacy. Sustained-release forms of these drugs have been developed for once-a-day administration, but the available preparations are not considered as effective as b.i.d. or t.i.d. doses and are not widely accepted for clinical use.

Over the past few years, research at UC Irvine has focused on new delivery systems for the stimulants. The approach, based on a laboratory school protocol (LSP) to measure the pharmacokinetic (PK) and pharmacodynamic (PD) properties of stimulants, will be described. Applications to evaluate key concepts about the stimulants (e.g., Is a bolus of medication required?), to conduct proof of concept studies (e.g., Does acute tolerance develop?), and to perform efficacy trials (e.g., What drug profile works best in a controlled setting?) will be presented. The role of these PK/PD studies in drug development will be discussed.

No. 41B
EVIDENCE-BASED STIMULANT TREATMENTS FOR ADHD

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

SUMMARY:

Objective: To review the short- and long-term safety and efficacy of stimulants for the treatment of children with ADHD.

Method: Information was gathered from reviews and a Medline search on randomized controlled trials, stimulant treatments, ADHD children, human dopamine transporter occupancy by stimulants, tolerance, sensitization, and animal toxicology.

Results: A large body of single site, short-term, controlled efficacy data exists concentrated on the children of school age (6 to 12 years). A few prospective, long-term studies exist but have produced no conclusive evidence of harmful stimulant effects.

Conclusion: Current evidence indicates that stimulants show efficacy and safety in prospective, randomized trials lasting up to 24 months.

Educational Objective: At the conclusion of the presentation, the participant should be able to evaluate the evidence for efficacy and safety of the stimulants for children with ADHD.

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1. Arnold LE, et al: National Institute of Mental Health collaborative multimodal treatment study of children with ADHD (the MTA). Arch Gen Psychiatry. 1997;54:865–870
2. Barkley RA: ADHD and the Nature of Self-Control. New York, Guilford Press, 1997
3. Gaub M, Carlson CL: Gender differences in ADHD: a meta-analysis and critical review: J Am Acad Child Adolesc Psychiatry. 1997;36:1036–1045
4. Wolraich ML, Hannah JN, Pinnock TY, et al: Comparison of diagnositic criteria for attention-deficit hyperactivity disorder in a country-wide sample. J Am Acad Child Adolesc Psychiatry. 1996;35:319–324
5. Swanson JM, Gupta S, Guinta D, et al.: Acute tolerance to methylphenidate in the treatment of attention deficit hyperactivity disorder in children. Clin Pharmacol Ther 1999;66:1–11
6. Greenhill L: Childhood attention deficit hyperactivity disorder: pharmacological treatments. in: Treatments That Work, edited by Nathan PE, Gornan J, Philadelphia, Saunders, 1998, pp. 42–64

INDUSTRY-SUPPORTED SYMPOSIUM 42—THE MENTAL HEALTH OF WOMEN AND CHILDREN (PART 1)
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to apply criteria for diagnosing and treating children with obsessive compulsive disorder or social anxiety disorder: describe currently accepted treatment strategies for antidepressants in pregnant or breast-feeding women; recognize the impact of family violence on the mental health of women and children.

No. 42A
PREGNANCY AND BREASTFEEDING: WHAT PSYCHIATRISTS NEED TO KNOW

Lori L. Altshuler, M.D., *Department of Psychiatry, UCLA, 300 Medical Plaza, #1544, Los Angeles, CA 90095-7057*

SUMMARY:

Although pregnancy has typically been viewed as a time of emotional well-being, recent data do not substantiate this optimistic view for women with histories of mood disorders. The postpartum period is a time of particular vulnerability. A growing literature exists on the use of psychotropic agents during pregnancy and lactation, with some agents having safer profiles than others. This presentation will review 1) potential risks to mother and infant of untreated psychiatric illness during pregnancy and lactation, 2) risk factors associated with worsening of psychiatric illness during pregnancy and the postpartum period, and 3) strategies for the use of psychotropic medications during pregnancy and breastfeeding that maximize safety to the mother and developing child.

No. 42B
UPDATE ON OCD IN CHILDREN AND ADOLESCENTS

Henrietta L. Leonard, M.D., *Department of Psychiatry, Brown University, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903*

SUMMARY:

Selective serotonin reuptake inhibitors (SSRIs) or cognitive-behavioral therapy (CBT) has shown efficacy in adolescents with obsessive-compulsive disorder (OCD). The recent development of the AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents with OCD and the Expert Consensus Guidelines have provided an important addition to the field. Psychopharmacologic approaches will be emphasized in this presentation, including issues of choosing an agent, treating partial responders and nonresponders, and the need for long-term maintenance. Additionally, assessment and treatment of the subgroup of adolescents for whom OCD symptoms may be related to infections will be discussed, including the implications for novel treatment and prevention strategies.

No. 42C
MAJOR DEPRESSION IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *Department of Psychiatry, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77550-0188*

SUMMARY:

Major depression is a serious disorder in childhood that has adverse consequences on a child's social, emotional, and academic development. This disorder has a high recurrence rate, and there is a significant risk of suicide for depressed youth. Longitudinal studies have demonstrated continuity between depression in adolescence and its occurrence in adulthood. Therefore, early recognition and treatment of depression in youth is essential. Recent studies support the efficacy of selective serotonin reuptake inhibitors (SSRIs) and question the usefulness of tricyclic antidepressants (TCAs) in this age group. Investigation of newer antidepressants for childhood depression are underway. This presentation will focus on diagnostic issues, course, and current treatment for major depression in children and adolescents.

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1. Alkahuler LL, Cohen L, Szuba MP et al: Pharmacologic management of psychiatric illness during pregnancy: dilemmas and guidelines. Am J Psychiatry. 1996;153:592–606
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INDUSTRY-SUPPORTED SYMPOSIUM 42—THE MENTAL HEALTH OF WOMEN AND CHILDREN (PART 2)
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to apply criteria for diagnosing and treating children with obsessive compulsive disorder or social anxiety disorder: describe currently accepted treatment strategies for antidepressants in pregnant or breast-feeding women; recognize the impact of family violence on the mental health of women and children.

No. 42A
CONSIDERATIONS REGARDING THE COURSE OF SOCIAL ANXIETY DISORDER

Stanley P. Kutcher, M.D., *Department of Psychiatry, Dalhousie University, Lane Building, 5909 Jubilee Road, HSC, Room 408, Halifax, NS B3H 2E2, Canada*

SUMMARY:

Social anxiety disorder is a common psychiatric disturbance that often has its onset during the adolescent years. Untreated, it may to lead to significant long-term functional disability, a decreased quality of life, and alcoholism. Although a variety of pharmacologic and psychotherapeutic interventions have been successfully used with adults with social anxiety disorder, much less is known about interventions directed towards teenagers. Early effective treatments can be expected to lead to positive short-term and long-term outcomes. This presentation will review the literature on the treatment of SAD in adolescents and provide practical clinically relevant suggestions for interventions.

No. 42B
FAMILY VIOLENCE IN THE UNITED STATES

Bruce D. Perry, M.D., *Department of Psychiatry, Baylor College, One Baylor Plaza, Houston, TX 77030*

SUMMARY:

The home is the most violent place in America. More than 35% of murders involve family-on-family violence. Over 50% of child murders are at the hands of family members. More than 500,000 women are victims of severe domestic battery each year. There are more than 1 million children each year who are victims of violent physical or sexual abuse in the home. The neuropsychiatric sequelae of these experience are devastating. Conservative estimates suggest that over 50% of the victims of domestic violence and over 75% of the children witnessing this violence develop post-traumatic stress disorders. Growing up in this incubator of terror fuels the transgenerational cycle of violence as well as an intragenerational passage of aggressive behavior down a power continuum from the strongest to the weakest. Understanding the impact of this violence on the emotional, social, cognitive, and physiological development of children can help guide effective clinical and policy directions. The present paper will discuss family violence from a neurodevelopmental model that addresses issues related to vulnerability or resilience following exposure to familial violence. Clinical and policy implications will be discussed.

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1. Ashuler LL. Cohen L. Szuba MP. Burt VK, et al: Pharmacologic management of psychiatric illness during pregnancy: dilemmas and guidelines. Am J Psychiatry. 1996;153:592–606
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5. Perry BD: Incubated in terror: neurodevelopmental factors in the 'cycle of violence.' In: Children, Youth and Violence: The Search for Solutions edited by Osofsky J. New York, Guilford Press 1997, pp 124–148

INDUSTRY-SUPPORTED SYMPOSIUM 43—THE INTERFACE OF NEUROPSYCHIATRIC DISORDERS IN THE ELDERLY (PART 1)
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: apply concepts learned in the treatment of schizophrenia to the management of psychosis and other behavioral disturbances in Alzheimer's disease and Lewy body disease dementia, understand clinical considerations in the treatment psychosis and other behavioral disturbances in Alzheimer's disease and Lewy body disease dementia with conventional or atypical neuroleptic medications, and apply concepts learned in Alzheimer's disease to the assessment of cognition in older adults with schizophrenia.

No. 43A
DIAGNOSIS AND TREATMENT OF PSYCHOSIS AND OTHER BEHAVIORAL DISTURBANCES IN DEMENTIA I: A FOCUS ON CONVENTIONAL NEUROLEPTICS

Brian A. Lawlor, M.D., *Department of Psychiatry, St. James Hospital, James Street, Dublin 8, Ireland*

SUMMARY:

Although the use of neuroleptics is common in the treatment of behavioral and psychiatric symptoms in dementia, there are relatively few placebo-controlled studies to guide clinical practice. There is some evidence that indicates that the symptoms of hostility, aggression, psychomotor agitation, and psychosis (hallucinations and delusions), particularly when these symptoms are severe, respond best to conventional neuroleptics, but side effects—extrapyramidal, cardiovascular, anticholinergic, and cognitive—are frequent. There is little consensus on what constitutes appropriate duration of treatment for many of these symptoms, and there have been some suggestions that treatment with conventional neuroleptics could actually accelerate disease progression. Novel neuroleptics are now being used more widely in dementia patients and appear to be better tolerated than their conventional counterparts, with at least similar efficacy. Further studies will be necessary to clarify neuroleptic-responsive symptoms, appropriate duration of treatment, and the effect of conventional and novel neuroleptic treatment on the natural history of dementia.

No. 43B
DIAGNOSIS AND TREATMENT OF PSYCHOSIS AND OTHER BEHAVIORAL DISTURBANCES IN DEMENTIA II: A FOCUS ON ATYPICAL NEUROLEPTICS

Jacobo E. Mintzer, M.D., *National Institute of Mental Health, DSIR AGTPIRB, 6001 Executive Boulevard, R7160 MSC, Bethesda, MD 20892-9635*

SUMMARY:

In the late 1980s, the roles and limitations of conventional neuroleptics in the treatment of psychosis, aggression and other behavioral disturbances of dementia were well established. The availability in the early 1990s of atypical neuroleptics combining both dopaminergic and serotonergic activity brought new hope. Clinicians observed that schizophrenic patients benefited not only from an improvement in the side-effect profile these products provided, but also from a measurable improvement in efficacy when compared with conventional neuroleptics. Again, geriatric psychiatrists raise the question as to whether the clear advantages of these compounds in schizophrenic patients will also translate to benefits for demented patients presenting with psychosis and aggression.

Dr. Mintzer will discuss information providing a possible rationale for the use of atypical neuroleptics in the demented aggressive and psychotic patient. In addition, he will also present the most current product-by-product information available on the efficacy and side-effect profile of available atypical neuroleptics in these same patients.

No. 43C
DIAGNOSIS AND TREATMENT OF PSYCHOSIS IN DEMENTIA WITH LEWY BODIES

Ian G. McKeith, M.D., *Wolfson Research Center, Institute for Health of the Elderly, Newcastle General Hospital, Westgate Rd, Newcastle on Tyne, NE4 6BE, England*

SUMMARY:

Noncognitive symptoms, particularly visual hallucinations, are frequent in patients with dementia with Lewy bodies (DLB) and may dominate the clinical picture. The neurobiological basis for these symptoms appears to be an imbalance in cortical monoaminergic-cholinergic function. Because these psychotic symptoms are distressing and may precipitate requests for institutionalization, clinicians frequently attempt pharmacological management, usually with neuroleptic medication. Abnormal sensitivity of DLB patients to neuroleptic medication is associated with a two- to three-fold increase

in mortality risk, 50% of neuroleptic-treated patients being susceptible. The mechanism underlying neuroleptic sensitivity in DLB appears to be nigrostriatal dopaminergic depletion associated with a failure of adaptive up-regulation of postsynaptic striatal D2 receptors. Neuroleptic sensitivity reactions have been reported both with conventional and the newer atypical antipsychotic agents.

Activity of the cholinergic enzyme, choline acetyltransferase, is lower in the temporal and parietal neocortex of DLB patients than in Alzheimer's disease patients matched for global severity of dementia. DLB patients with, as opposed to without, hallucinations have significantly lower activity. Preliminary studies of cholinesterase inhibitors in DLB patients demonstrate significant reduction in psychosis and behavioral disturbance scores, the most responsive items being hallucinations, delusions, apathy, and anxiety. Cholinesterase inhibitors may prove to be the antipsychotic agents of choice in DLB and other dementia syndromes.

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1. Mintzer JE, Hoernig KS, Miraki DF: Treatment of agitation in patients with dementia. Clinics in Geriatric Medicine, 1998;14(1):147–170
2. Lawlor BA (ed.): Behavioral Complications in Alzheimer's Disease. American Psychiatric Press, Inc, Washington, DC, 1995
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4. Mohr E, Brouwers P, Clauss JJ, Purdon SE: Differential classification of dementia. Behavioral Neurology 1995;8:23–30

INDUSTRY-SUPPORTED SYMPOSIUM 43—THE INTERFACE OF NEUROPSYCHIATRIC DISORDERS IN THE ELDERLY (PART 2)
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to apply concepts learned in the treatment of schizophrenia to the management of psychosis and other behavioral disturbances in Alzheimer's disease and Lewy body disease dementia, understand clinical considerations in the treatment psychosis and other behavioral disturbances in Alzheimer's disease and Lewy body disease dementia with conventional or atypical neuroleptic medications, and apply concepts learned in Alzheimer's disease to the assessment of cognition in older adults with schizophrenia.

No. 43A
ASSESSMENT OF COGNITION IN SCHIZOPHRENIA: WHAT WE LEARN FROM ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

Richard C. Mohs, Ph.D., *VA Medical Center, Mt. Sinai School of Medicine, 130 West Kingsbridge Road, Bronx, NY 10468*

SUMMARY:

This presentation will review and present new data from studies investigating cognitive impairment in older patients with schizophrenia, how it compares with the cognitive impairment in Alzheimer's disease, and the development of cognitive deficits longitudinally. Cross-sectional data comparing the cognitive performance of people with schizophrenia aged 20–90 indicate that there is a loss of approximately two MMSE points per decade in these individuals. Cross-sectional comparison of matched groups of older schizophrenic patients, patients with Alzheimer's disease, and normal comparison subjects indicate that, compared with controls, AD patients have marked impairments particularly in memory and executive function with impairments in language and constructional ability developing only later. By contrast, schizophrenic patients manifest a more general cognitive deficit with less impairment in memory and relatively more impairment in visuospatial and language ability early in the course of their dementia. Longitudinal data from elderly schizophrenics indicate that, over eight years of follow-up, most show some measurable decline in cognition. Relationships with positive and negative symptoms and with functional deficits will also be described.

No. 43B
TREATMENT OF COGNITIVE DEFICITS IN SCHIZOPHRENIA WITH ANTIPSYCHOTIC DRUGS

Scot E. Purdon, Ph.D., *Department of Neuropsychology, Alberta Hospital-Edmonton, 1748 Fort Road. Building 9, Box 307, Edmonton, AL T5J 2J7, Canada*

SUMMARY:

The cognitive impairment in schizophrenia was previously deemed secondary to cerebral damage and therefore presumed nonresponsive to pharmacotherapy. Although the presence of cerebral dysfunction and cognitive impariment suggests similarities to subcortical and cortical dementia, there have been few direct comparisons of schizophrenia with these disorders. Three investigations will be described. The first showed volume reductions in schizophrenia on qCT in the frontal and temporal lobes, particularly the left side. The second showed similar profiles of severe impairment of learning and mild impairment of delayed recall in patients with schizophrenia, Huntington's, and Parkinson's disease that were distinct from the impairments in Alzheimer's disease. The third compared the effect of olanzapine, risperidone, and haloperidol on new learning and memory in schizophrenia and showed improvement with olanzapine that was not apparent for risperidone or haloperidol. Substantial cerebral volume reductions in schizophrenia in the frontal and temporal regions may be related to a profile of new learning impairment that is similar to that observed in subcortical dementia but dissimilar from that observed in Alzheimer's disease.

No. 43C
TRANSLATING ACADEMIA'S IMPACT ON THE FUTURE OF CLINICAL PRACTICE

Barry D. Lebowitz, Ph.D., *National Institute of Mental Health, 6001 Executive Boulevard, MSC 9635, Bethesda, MD 20892-9635*

SUMMARY:

This presentation addresses the question of why treatments do not work the same in clinical practice as they do in clinical trials. It is argued that studies done in accordance with a regulatory model do not readily generalize to actual practice because of restrictive inclusion and exclusion criteria, optimized treatment delivery, and narrowly defined outcomes. An expansion of research to a more public-health-oriented model is proposed. In a public-health model, exclusion criteria are minimal and based only on concerns for safety. Outcomes are broadly construed and settings are widely selected to represent a broad range of systems of care. Rather than supplanting traditional types of research, these public-health studies will provide new opportunities to influence clinical practice and optimize patient care. Examples are provided from several new NIMH-sponsored initiatives in bipolar illness, schizophrenia, Alzheimer's disease, and depression.

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1. Mintzer JE, Hoernig KS, Mirski DF: Treatment of agitation in patients with dementia. Clinics in Geriatric Medicine, 1998;14(1):147–170
2. Lawlor BA (ed.): Behavioral Complications in Alzheimer's Disease. American Psychiatric Press, Inc, Washington, DC, 1995
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INDUSTRY-SUPPORTED SYMPOSIUM 44—BREAKING THE CYCLE: NOVEL TREATMENTS IN BIPOLAR DISORDER (PART 1)

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to have a better understanding of the neuroreceptor systems involved in the various manifestations of bipolar disorder, be updated on the latest treatment options for bipolar disorder, particularly the use of anti convulsants and atypical antipsychotics, familiar with the practice of polypharmacy in bipolar disorder and how this can be individualized.

No. 44A
MAKING POLYPHARMACY WORK: HOMER'S TREATMENT PLAN

Gary S. Sachs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, #580, Boston, MA 02114*

SUMMARY:

Navigating through the multivariate options available to psychiatrists for the treatment of bipolar disorder can be a true odyssey. As research elucidates mechanisms and we begin to subcategorize bipolar disorder accordingly, there is an opportunity to tailor pharmacologic treatments to individual patient needs. Unfortunately, few bipolar patients respond adequately to any one medication. Most bipolar patients are managed best when polypharmacy is practiced skillfully. The psychotropic properties of atypical antipsychotics and third-generation anticonvulsants can be useful additions to the armamentarium of treatment regimens for bipolar patients. These agent can help meet the specific treatment objective in each separate phase of bipolar disease (acute, continuation, and maintenance) but are useless when the patient is noncompliant or abandons treatment. Therefore, it is necessary to approach treatment in a way that anticipates that patients may disregard treatment recommendation at precisely the times when they are most ill. This presentation will discuss the use of a multiphase treatment strategy that integrates standardized assessment and systematic treatment with a written collaborative-care treatment contract modeled on Homer's Odyssey. The overriding quest is to provide efficacious treatment options that have minimal adverse effects and lead to improved compliance.

No. 44B
TREATING DEPRESSION IN BIPOLAR DISORDER

Dwight L. Evans, M.D., *Chairman of Psychiatry, University of Pennsylvania, 305 Blockley, 423 Guardian Drive, Philadelphia, PA 19104*

SUMMARY:

Bipolar disorder is a potentially life-threatening medical disorder with significant morbidity and mortality. Studies have reported high rates of suicidal behavior with a mortality rate as high as 25% in untreated patients, and the depressed bipolar patient is particularly vulnerable to suicidality. Thus, the treatment of bipolar depression is critical to the successful treatment of individuals with bipolar disorder. However, treatment of bipolar depression has not been extensively studied and is based more on clinical case reports than systematic and controlled clinical research studies. Treatment approaches to the patient with bipolar depression will be presented. In particular, data regarding the efficacy of TCAs, MAOIs, SSRIs, lithium, anticonvulsants, and atypical antipsychotics will be presented. Special treatment considerations will be discussed including efficacy and safety of the available agents and the potential for antidepressant-induced switches into mania and cycle acceleration, including rapid cycling. Monotherapy and combination therapies will also be reviewed for subtypes of bipolar disease, including bipolar I and bipolar II disorders.

No. 44C
HOW USEFUL ARE THIRD-GENERATION ANTICONVULSANTS?

Patricia Suppes, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75235-9070*

SUMMARY:

The utility of the second-generation anticonvulsants valproate and carbamazepine is well established for patients with bipolar disorder, though many patients, despite adequate monotherapy treatment, need a combination of mood stabilizers for more complete remission of symptoms. The treatment armamentarium for management of bipolar disorder has expanded tremendously over the last five years to include atypical antipsychotics and, recently, the third-generation anticonvulsants lamotrigine, gabapentin, and topiramate. The potential use and role of topiramate and the atypical antipsychotics will be covered in other portions of this symposium. This presentation will focus on lamotrigine and gabapentin. The controlled clinical trials and case series for each of these medications will be reviewed. Special focus will be put on the antidepressant property of lamotrigine and the antianxiety and adjunctive use of gabapentin. Importantly, the potential of these newer medications for more specialized treatment roles and the different risk-benefit profiles will be considered. One issue currently being studied in controlled trials and larger treatment algorithm studies for bipolar disorder is the appropriate use of combination medications. Strategies for the integration and use of these newer medications in treatment planning for patients with bipolar disorder will be discussed.

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2. Marcotte D: Use of topiramate, a new antiepileptic as a mood stabilizer. J Affect Disord 1998;50:245–51
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5. Suppes T, Rush AJ, Kraemer H, Webb A: Treatment optimization for symptomatic patients with a history of mania using a treatment algorithm. J. Clin Psychiatry 1998;59:88–96

INDUSTRY-SUPPORTED SYMPOSIUM 44—BREAKING THE CYCLE: NOVEL TREATMENTS IN BIPOLAR DISORDER (PART 2)

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to have a better understanding of the neuroreceptor systems involved in the various manifestations of bipolar disorder, be updated on the latest treatment options for bipolar disorder, particularly the use of anticonvulsants and atypical antipsychotics, familiar with the practice of polypharmacy in bipolar disorder and how this can be individualized.

No. 44A
UPDATE ON THE USE OF TOPIRAMATE IN BIPOLAR DISORDER

Joseph R. Calabrese, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44126*

SUMMARY:

Recently there has been increasing interest in the potential role of the third-generation antiepileptic drugs (AEDs) such as gabapentin, lamotrigine and topiramate for the treatment of bipolar disorder. These drugs are distinguished by an increased ease of use, since screening, bloodwork, and therapeutic blood monitoring are not routinely required. The traditional AEDs valproate and carbamazepine have established acute antimanic efficacy for this condition and appear to exert their therapeutic effects through similar pharmacological mechanisms as the newer agents. For example, the structurally novel AED topiramate mirrors the pharmacological properties of valproate and carbamazepine (by including Na channel blockade and enhancing GABA neuroinhibition in addition to blocking glutamate kainate/AMPA receptors and modulating neuronal conductance channels).

Several early studies suggest that topiramate, lamotrigine, and gabapentin may have efficacy in controlling the manic and depressive episodes experienced by patients with bipolar disorder. Preliminary data from eight open-label studies using topiramate in bipolar disorder (n=177) suggest that this AED may possess mood-stabilizing properties (mania and depression).

Results from a recently completed, industry-sponsored, multicenter, double-blind, placebo-controlled study of the safety and efficacy of topiramate in the treatment of acute manic or mixed episodes will be presented. The primary outcome measure of this trial was improvement in bipolar I patients on the Young Mania Rating Scale (YMRS). Secondary outcome measures included the Brief Psychiatric Rating Scale, Montgomary-Asberg Depression Rating Scale, Clinical Global Impression, and Global Assessment Scale. The results of safety evaluations will also be addressed.

No. 44B
THE USE OF ATYPICAL ANTIPSYCHOTIC AGENTS IN BIPOLAR DISORDER

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-812, Boston, MA 02114*

SUMMARY:

Atypical antipsychotic agents can be effective in the treatment of bipolar disorder. Risperidone and olanzapine appear to have similar evidence in support of their efficacies, although they differ in side effects. These agents are probably more effective as adjuncts than in monotherapy.

REFERENCES:

1. Kalin NH: Management of the depressive component of bipolar disorder. Depression and Anxiety 1996–1997;4:190–198
2. Wehr TA. Goodwin FK: Can antidepressants cause mania and worsen the course of affective illness? Am J Psychiatry 1987;144:1403–1411
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INDUSTRY-SUPPORTED SYMPOSIUM 45—SEVEN HABITS OF HIGHLY EFFECTIVE PSYCHOPHARMACOLOGISTS

Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify the practice patterns for the most effective use of psychopharmacologic agents and apply molecular and pharmacologic principles to the selection and combination of psychotropic drugs.

No. 45A
TIPS ON HOW TO BEGIN WITH THE END IN MIND, SYNERGIZE AND SHARPEN THE SAW

Stephen M. Stahl, M.D., *Department of Psychiatry, University of California, San Diego, 8899 University Center Lane, #130, San Diego, CA 92122*

SUMMARY:

1.) Beginning with the end in mind: A highly effective psychopharmacologist will target complete remission for affective and anxiety disorders, not just a 50% reduction of symptoms (called a response). When treating psychotic disorders or dementias, however, one cannot aim this high because the drugs are not as effective.

2.) Synergize: If single pharmacological actions at serotonin or norepinephrine are not effective, it is best to put two independent mechanisms together in an attempt to get an output where the whole is greater than the sum of the parts, called synergy. Good psychopharmacology can thus be "bad mathematics" where 1 + 1 = 10 for efficacy of drug combinations.

3.) Sharpen the saw: The highly effective psychopharmacologist will find high-quality continuing medical education and have suffi-

cient background in order to detect commercial bias and be able to sort between information for information's sake (of academic value) and information that can be applied to changing diagnosing and prescribing behavior.

No. 45B
CLINICAL PEARLS ON HOW TO BECOME PROACTIVE, UNDERSTAND AND THEN BE UNDERSTOOD

David V. Sheehan, M.D., *Department of Psychiatry, University of South Florida, 3515 East Fletcher Avenue, Tampa, FL 33613-4706*

SUMMARY:

4.) Become proactive: Although generalized anxiety disorder often occurs in tandem with other anxiety and affective disorders, it is not always diagnosed in clinical practice. Frequently, attention is focused on the comorbid anxiety (e.g. panic disorder or social phobia) or major depressive disorder. When generalized anxiety disorder is diagnosed, it is often trivialized, and sufficient attention is not paid to extinguishing it once the comorbid condition is under control. Many patients who are treated for panic or major depressive disorders are left with residual symptoms of generalized anxiety. All too often, they accept that this is as good as it gets. We must actively encourage our patients to strive for the most complete symptom resolution possible. This requires persistence, patience, and a methodical approach with clearly defined endpoints. The highly effective psychopharmacologist understands this and extinguishes symptoms of GAD with the therapeutic options available today.

5.) Understand and be understood: If you don't take a good history, there is little chance of providing effective treatment. A good history with a clear clinical logic takes you more than halfway to a good result. The history-taking process helps ensure the patient's confidence. It also ensures compliance on the road towards a good outcome. Get a good history of illness episodes prior to the index episode and identify all comorbid conditions. Train your patients to become active partners in the long-term management of their illnesses. The well-informed psychopharmacologist learns from each patient just as the patients learn from them. The respectful posture that we are the students of the patient's life and illness is a critical building block of a good therapeutic alliance.

No. 45C
PRACTICAL PSYCHOPHARMACOLOGISTS: PUT FIRST THINGS FIRST AND THINK WIN-WIN

John M. Zajecka, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison Street, #955, Chicago, IL 60612*

SUMMARY:

6.) Put first things first: Many first reactions to psychotropic medications are side effects causing potential premature discontinuation from medication and the erroneous assumption that the medication is not effective. Practical psychopharmacologists know the difference between treatment intolerance and treatment resistance.

7.) Think win/win: Many trials of psychotropic medications are sabotaged by side effects. An effective psychopharmacologist will practice "bad mathematics" in this case; namely, to try to find one drug that cancels the side effects of another, leading to one plus one equals zero in terms of side effects.

REFERENCES:

1. Stahl SM: Essential Psychopharmacology, 2nd Edition, New York, Cambridge University Press, 2000
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INDUSTRY-SUPPORTED SYMPOSIUM 46—BEHAVIORAL DISTURBANCES IN DEMENTIA: CAUSES, TREATMENTS AND IMPACT

Supported by Elsai Inc., Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the complex etiology of dementia, its related behavioral disturbances, and its psychosocial impact on families and communities; understand diagnostic ceuroimaging techniques' be familiar with antipsychotic treatments.

No. 46A
NEUROIMAGING IN DEMENTIA EVALUATION AND RESEARCH

Gary W. Small, M.D., *Department of Psychiatry, UCLA Neuropsychiatic Institute, 760 Westwood Plaza, Los Angeles, CA 90024-8300*

SUMMARY:

Neuroimaging studies are not routinely used to assist in dementia diagnosis or differential diagnosis. Clinicians usually obtain structural studies (CT or MRI), which have only limited usefulness, often providing nonspecific information about cerebral atrophy or white matter disease and, rarely, uncovering treatable lesions. By contrast, functional imaging—particularly positron emission tomography (PET) because of the biological information it provides—can offer a positive diagnosis of early Alzheimer's disease (AD). Recent evidence indicates that PET provides greater diagnostic sensitivity and specificity than standard clinical methods for dementia assessment. The characteristic parietal and temporal deficits observed on a PET scan can be recognized years prior to clinical confirmation of AD. Demented patients with behavioral disturbances also show prominent frontal deficits. Current research focuses on functional imaging methods combined with genetic risk measures (apolipoprotein E-4; APOE-4) to assist in presymptomatic diagnosis. Our group has used PET measures of glucose metabolism during mental rest, functional MRI during memory-task performance ("cognitive stress test"), and in vivo PET imaging of neuritic plaques and neurofibrillary tangles with a radiolabeled small molecule probe. Promising initial results demonstrate functional changes in the brain that predict future cognitive decline in nondemented persons at genetic risk for AD. These methods are now being used in studies of antidementia treatments aimed at preventing or delaying cognitive decline.

No. 46B
TOOLS, TIPS, AND ATYPICALS

Pierre N. Tariot, M.D., *Department of Psychiatry, Monroe Community Hospital, 435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

Dementia is common and may indeed become the next century's pandemic. It is recognizable, diagnosable, treatable, but sadly underrecognized and undertreated. Simple tools are available to screen and characterize patients in the key domains of interest: examples of these will be reviewed. Among the most troubling manifestations is psychopathology, occurring in up to 90% of patients. John Bayley provided moving testimony about this in his recent account of his marriage to the British novelist Iris Murdoch, who suffered from Alzheimer's disease *(Elegy for Iris)*. While this psychopathology can seem confusing to the uninitiated, evidence has accrued allowing us to categorize the phenomenology into a relatively discrete number

of domains that can be anticipated and quantified and used to guide therapy. While we know more from experience than controlled studies that environmental and behavioral techniques can help, there is much information about the role of medications in managing these problems. Information from multiple clinical trials can now be reduced to treatment algorithms to help the busy clinician. With more awareness of these therapeutic challenges and opportunities, perhaps we can minimize the dreadful impact this illness has on our patients and their families.

No. 46C
PSYCHOSOCIAL IMPACT OF ALZHEIMER'S DISEASE ON THE FAMILY

Beth Smith-Boivin, M.S., *Mill View Adult Home, 89 Vanderwerken Avenue, Waterford, NY 12188*

SUMMARY:

Caring for someone with Alzheimer's disease (AD) is never an easy task. Yet, over 70% of the almost 5 million Americans with AD are cared for at home. Many of these families struggle with the physical, emotional, and financial demands of caregiving, which requires that they assume multiple roles. Family caregivers experience a wide range of physical and emotional effects ranging from anger and guilt to optimism and hope. While these feeling are all normal, the ability to deal with them varies from person to person. A family member's ability to deal with a caregiving situation also depends on their relationship to the person with AD, the history of that relationship, the role of other family members, and the amount of support/services and education available. Multiple caregivers can ease the burden; however, differences of opinion among them can occur, creating conflict or causing old issues to flare up. Providing information and support to family caregivers is a critical though difficult task for health care professionals, as families are often our best source of accurate patient information. Furthermore, as identified in the Mittelman study, the well-being of patients with AD is directly tied to the well-being of their caregivers. This presentation will highlight approaches to enhance the involvement of the health care professional to improve quality of life for both patient and caregiver.

No. 46D
ETIOLOGY OF BEHAVIORAL DISTURBANCES IN DEMENTIA

Murray A. Raskind, M.D., *Department of Psychiatry, VA Puget Sound Medical Center, 1660 South Columbian Way, 116A, Seattle, WA 98108*

SUMMARY:

Disruptive agitation and other noncognitive behavioral problems in Alzheimer's disease (AD) distress patients and caregivers and are common precipitants of nursing home placement. Although often influenced by interpersonal and environmental factors, it is becoming clear that neurobiologic disturbances in AD lower the threshold for expression of these behaviors. Multiple neurotransmitter system abnormalities appear to be involved. Complex noradrenergic/adrenergic changes result in increased behavioral responsiveness to noradrenergic/adrenergic stimulation in AD. Most typical and atypical antipsychotics are also alpha-1 adrenergic antagonists and that may explain their modest but clear efficacy for agitation in AD. Increased postsynaptic adrenergic responsiveness may also explain anecdotal reports that the beta-adrenergic antagonist propranolol reduces agitation in AD. The presynaptic serotonergic deficiency of AD may explain anecdotal reports that serotonin reuptake inhibitors reduce agitation in AD. Although interest in the presynaptic cholinergic deficit in AD has focused on its implications for cognitive dysfunction, controlled studies of cholinesterase inhibitors and selective M-1 muscarinic cholinergic agonists suggest that cholinergic enhancement may alleviate noncognitive behavioral problems. Optimal management of noncognitive behavioral problems in AD will need to address complex neurobiologic disturbances as well as environmental and interpersonal factors.

No. 46E
CAN WE HELP BEHAVIOR WITHOUT HURTING COGNITION?

Larry E. Tune, M.D., *Department of Psychiatry, Emory University, 1829 Clifton Road, NE, Atlanta, GA 30329*

SUMMARY:

Recent studies investigating the cognitive effects of antidepressants and antipsychotic medications have shown significant differences among drugs routinely prescribed for the management of behavioral symptoms in dementia. Among the antidepressants, some SSRIs have significant enhancing effects on cognitive measures (e.g., selective reminding). Many of the older-generation tricyclic antidepressants worsen performance on these measures. Similarly, some of the newer atypical antipsychotics, notably risperdone and olanzapine, have been shown, when compared with conventional antipsychotics, to enhance cognitive measures that include working memory and the MMSE. These data will be considered alone, with recommendations made for their use in behaviorally impaired demented patients. The choice of psychotropic interventions should be determined not only by their primary efficacy, but also because of differences in cognitive toxicity. Lastly, these medications will be considered in the context of "anticholinergic burden."

Most psychotropics are prescribed to elderly demented patients who receive many other medications with anticholinergic properties. Data will be presented from ongoing clinical studies of anticholinergic burden. These studies will emphasize the importance of avoiding cognitive toxicity when choosing psychotropic medications.

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2. Raskind MA, Peskind ER: Neurobiologic bases of noncognitive behavioral problems in Alzheimer's disease. Alzheimer Dis Assoc Disord 1994;8(Suppl 3):54–60
3. Small GW, Leiter F: Neuroimaging for diagnosis of dementia. Journal of Clinical Psychiatry 1998;59(suppl 11):4–7
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5. Mittleman M, Ferris S, Shulman E, et al: A family intervention to delay nursing home placement of patients with Alzheimer's disease, JAMA 1996;276:21

INDUSTRY-SUPPORTED SYMPOSIUM 47—SCHIZOPHRENIA: ACROSS THE LIFE CYCLE
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the factors that are critical to successful management of schizophenia throughout the unique phases of the illness. Discussions will include novel research on the developmental antecedents of schizophrenia as well as practical treatment options for the procthermal early and late stages of disease.

No. 47A
DEVELOPMENTAL ANTECEDENTS OF SCHIZOPHRENIA: SIGNPOSTS TO CAUSES AND PREVENTION

Peter B. Jones, Ph.D., *Division of Psychiatry, University of Nottingham, Porchester Road, Nottingham, NG3 6AA, England*

SUMMARY:

It has long been recognized that people who develop schizophrenia and other psychoses are different from their peers as children, long before these syndromes begin. Modern epidemiological techniques taking advantage of large general population samples, usually cohorts assembled for other reasons, are defining these developmental differences in detail. Domains now recognized as being abnormal in schizophrenia, such as language, cognition, motor systems, and social behavior, are shown to be already awry in the early years of life. This questions our nosological concepts of psychosis, suggesting a longitudinal or life-course dimension to the phenotype. It raises the possibility of evidence-based prediction, early identification and intervention, as well as posing questions about the mechanism of psychosis. From the point of view of causation, a variety of genetic and epigenetic factors must exert their effect in early life, some before birth. Evidence regarding the precise nature of these early causal components remains controversial. This controversy tests many disciplines, from epidemiology through neurobiology, and represents one of the greatest challenges in our understanding of psychosis.

No. 47B
TREATING THE EARLY STAGES OF SCHIZOPHRENIA

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, University of North Carolina School of Medicine, 7025 Neurosciences Hospital, CB716, Chapel Hill, NC 27599*

SUMMARY:

Schizophrenia is a chronic, deteriorating illness that has its onset at the beginning of adulthood and leaves patients persistently symptomatic and functionally disabled. It is important to identify and intervene as early in the course as possible. However, several factors complicate this task. First, the illness often begins with a prodromal stage characterized by nonspecific, subtle symptoms that are often only recognizable as harbingers of the illness retrospectively. Second, persons in the prodromal stage usually lack insight and awareness about their symptoms and don't believe they have an illness or need treatment. Consequently, they don't seek treatment and remain symptomatic in the community before receiving professional help. Third, once treated, patients often object to the side effects of treatment or even the idea of taking medication and then fail to comply, eventually relapsing. This can lead to a cycle of exacerbations and remissions that results in deterioration and chronic disability. Recent scientific advances have furthered our understanding of the pathogenesis of schizophrenia and its underlying pathophysiology. In addition, studies of its neurobiology have improved the ability to diagnose and determine the prognosis of patients developing schizophrenia. Finally, new therapeutic agents have been developed that offer the prospect of more effective and safe treatment geared to managing patients in all phases and over the course of the illness. This presentation will review these recent findings and describe the treatment strategies.

No. 47C
SCHIZOPHRENIA OF CHILDHOOD-ONSET SCHIZOPHRENIA: SOMETHING OLD AND SOMETHING NEW

Judith H.L. Rapoport, M.D., *Child Psychiatry Branch, National Institute of Mental Health, 10 Center Drive, MSC 1600, Bethesda, MD 20892-1600*

SUMMARY:

Childhood-onset schizophrenia (defined as an onset of psychosis by age 12) is a rare and severe form of the disorder that is clinically and neurobiologically continuous with the adult-onset disorder. There is growing evidence for more salient risk or etiologic factors, particularly genetic, in this possibly more homogeneous patient population. For the 49 patients with very-early-onset schizophrenia studied to date at the National Institute of Mental Health, there were more severe premorbid neurodevelopmental abnormalities, a higher rate of cytogenetic anomalies, and a seemingly higher rate of familial schizophrenia and spectrum disorders than later-onset cases. There was no evidence for increased obstetrical complications or environmental stress. These data, while preliminary, suggest that a very early age of onset of schizophrenia may be secondary to greater genetic vulnerability. Consequently, genetic studies of these patients may be particularly informative and provide important etiologic information.

No. 47D
THE EVOLUTION OF COGNITIVE IMPAIRMENT IN SCHIZOPHRENIA

Terry E. Goldberg, Ph.D., *Chief, Unit on Neuropsychology, National Institute of Mental Health, 10 Center Drive, Room 45235, Bethesda, MD 20892-1379*

SUMMARY:

Recent studies of cognitive impairment in schizophrenia demonstrate two developments paths. Using both clinically derived criteria and cluster analysis, we found that about 50% of a large series of consecutively admitted inpatients with schizophrenia deteriorated from near-normal levels of premorbid intellectual function and manifested selective deficits in attention/encoding, working memory, and episodic memory. A second group, consisting of about 25% of patients, displayed compromised premorbid intellectual function and manifested deficits in a wide range of cognitive domains. In general, cognitive impairment appears to remain relatively static over the long-term course of the illness.

To consider the cause of neurocognitive dysfunction, we administered a comprehensive test battery to 400 patients, siblings, and controls. Patients performed markedly worse than controls on all tests except WRAT reading. At-risk siblings had significantly worse scores relative to controls on WCST, WMS, CVLT, letter fluency, CPT, and Trails A and B. Sibs had rates of impairment ranging from 25% to 35% compared with 10% to 20% in controls on executive function, episodic memory, attention, and speed. Correlations between cognitive measures in all groups were weak, supporting the notion that these tests measure independent domains of cognitive function.

Last, in-depth analyses of certain mechanisms that might account for well-known cognitive abnormalities in schizophrenia, including working memory and formal thought disorder, will be provided. The implications that these findings have for the mode of action of neuroleptic medications at the cortical level will also be reviewed.

No. 47E
LATE-LIFE SCHIZOPHRENIA: COURSE AND TREATMENT

Dilip V. Jeste, M.D., *Department of Psychiatry, VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161*

SUMMARY:

Over the past decade, we have studied middle-aged and elderly patients meeting DSM-III-R or DSM-IV criteria for schizophrenia and several comparison groups. Longitudinal evaluations consisted of psychiatric, neurologic, neuropsychologic, and psychosocial (including health-related quality of well-being and everyday functioning) assessments. The outcome of the disorder in late life is not usually consistent with the Kraepelinian notion of dementia praecox. Our studies suggest that a large majority of elderly patients with schizophrenia live in the community and do not meet criteria for dementia, although many continue to be disabled in their everyday activities by negative symptoms and cognitive and functional impairment. Older patients with schizophrenia respond to conventional antipsychotic treatment but are at an increased risk for side effects particularly tardive dyskinesia. Newer atypical antipsychotics, such as clozapine, risperidone, olanzapine, and quetiapine, represent a significant advance over conventional ones. Although the risk of tardive dyskinesia is markedly lowered with these newer agents, side effects can manifest when used in higher dosages in the geriatric population. Specific recommendations will be made regarding appropriate dosing of these drugs, as well as the use of cognitive-behavior therapy and social-skills training.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 48—ADVANCES IN ADHD: FROM RESEARCH TO CLINICAL PRACTICE
Supported by Alza Corporation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the course and presentation of ADHD from childhood to adulthood, appreciate relevant gender differences in ADHD, understand the familial and genetic nature of ADHD and learn pharmacological strategies in the management of ADHD in children, adolescents, and adults.

No. 48A
GLOBAL FUNCTIONING IN BOYS WITH PERSISTENT ADHD

Eric Mick, Sc.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Objective: The goal of this study was to examine normalization of functioning among youths with persistent ADHD symptoms.

Research Design: Subjects were 85 referred boys with persistent DSM-III-R ADHD followed prospectively into mid-adolescence and 68 boys without ADHD. These subjects were assessed at baseline and follow up using measures from three domains of functioning: school, social, and emotional. For each of these domains, we defined ADHD boys as having normalized functioning if they attained scores above the 5th percentile of scores in the non-ADHD group.

Results: 20% of ADHD boys were functioning poorly in all three domains, 20% were functioning well in all three domains, and 60% had intermediate outcomes. Increased exposure to maternal psychopathology, larger family size, DSM-III-R psychiatric comorbidity, and symptoms of impulsivity were negatively associated with normalization of functioning among children with persistent ADHD.

Conclusion: Our results show that children with ADHD have a variable emotional, educational, and social adjustment despite syndromatic persistence. This suggests that normalization of functioning and syndromatic persistence of ADHD may be partially independent.

No. 48B
ADHD IN GIRLS: RESULTS FROM A FAMILY GENETIC STUDY

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-725, Boston, MA 02114*

SUMMARY:

Objective: The scientific literature about ADHD is almost exclusively based on male subjects. The aim of this study was to examine clinical correlates of ADHD in females using comprehensive assessments in multiple domains of functioning.

Methods: Subjects were 140 girls with ADHD and 122 non-ADHD comparison girls of the same age and social class identified from pediatric and psychiatric referral sources. Subjects were assessed with structured diagnostic interviews, psychometric tests assessing intellectual functioning and academic achievement, as well as standardized assessments of interpersonal, school, and family functioning.

Results: Compared with female controls, ADHD girls were more likely to have conduct, mood, and anxiety disorders; lower IQ and achievement scores; and more impairment on measures of social, school, and family functioning.

Conclusions: These results extend previous findings in boys indicating that ADHD in girls is characterized by prototypical core symptoms of the disorder, high levels of comorbid psychopathology, and dysfunction in multiple domains. These results not only support findings documenting phenotypic similarities between the genders but also stress the severity of the disorder in females.

No. 48C
GENETICS OF ADHD

Stephen V. Faraone, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 750 Washington Street, Suite 225, Southeaston, MA 02375*

SUMMARY:

Objective: To examine evidence for the genetic transmission of ADHD, its subtypes and its comorbid disorders (conduct disorder, major depression, bipolar disorder).

Method: Data from family, twin, and molecular genetic studies are reviewed. Meta-analysis is used to examine the consistency of reports across different laboratories. Data from a longitudinal family

study of children with ADHD are used to illustrate the pattern of comorbidity in families.

Results: Family, twin, and molecular genetic studies show that genes influence susceptibility to ADHD and its comorbid conditions. There is considerable heterogeneity such that cases with comorbid conduct or bipolar disorders as well as persistent cases show the greatest genetic influence. Several studies have implicated the dopamine transporter and dopamine-4 receptor gene. Patterns of comorbid disorders in families suggest strategies for understanding the heterogeneity of ADHD. The DSM-IV subtypes do not "breed true" in families.

Conclusions: Genes influence the expression of ADHD and comorbid disorders. ADHD in combination with conduct or bipolar disorder may be genetically distinct from other forms of ADHD. Major depression may be a nonspecific manifestation of ADHD genotypes. Implications for research and clinical practice are discussed. The DSM-IV subtypes do not appear to represent distinct genetic conditions.

No. 48D
PSYCHOPHARMACOLOGY OF PEDIATRIC ADHD

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

SUMMARY:

Although the origins of pediatric psychopharmacology began over 60 years ago, aside from the stimulants, there is only a small research-based literature. It is essential to apply a careful differential diagnostic assessment that assesses psychiatric, social, cognitive, educational, and medical/neurological factors that may contribute to the child's clinical presentation and, therefore, consider the use of pharmacotherapy as part of a broader treatment plan that encompasses all aspects of a child's life. In defining the role of pharmacotherapy in the treatment plan, realistic expectations of pharmacotherapeutic interventions, careful definition of target symptoms, and careful assessment of the potential risks and benefits of this type of intervention for psychiatrically disturbed children are major ingredients for a successful pharmacologic intervention. The lack of FDA approval for many of the medications, although a restriction on general use, does permit the careful introduction of innovative therapy. In this symposium, Dr. Spencer will give an overview of current clinical research and common practice in the assessment and treatment of childhood psychopathology.

No. 48E
PHARMACOTHERAPY OF ADULT ADHD

Thomas J. Spencer, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Attention deficit/hyperactivity disorder (ADHD) in adults is an increasingly recognized disorder associated with substantial impairment. As it is with juveniles, pharmacotherapy is one of the mainstays of treatment in ADHD in adults. Unlike the vast amount of data available on ADHD children, there are a limited number of medication studies in ADHD adults. To date, there are 10 studies of the psychostimulants and 19 studies of nonstimulant medications including antidepressants, antihypertensives, and amino acids for the treatment of ADHD in adults. The majority of controlled investigations were with the psychostimulants, with the nonstimulant agents studied generally under open conditions.

There tends to be a dose-related improvement in ADHD symptoms with the stimulant medications, with recent data suggesting the effectiveness of methylphenidate, pemoline, and amphetamine compounds. Similarly, the limited data would suggest the need for standard antidepressant dosing of the antidepressants bupropion and desipramine for ADHD efficacy. Agents with catecholaminergic activity have efficacy in ADHD, whereas those with predominantly serotonergic properties appear not to be effective for ADHD. Medications with cholinergic activity appear promising. The aggregrate literature supports that the stimulants are the most effective available agents for adults with ADHD and remain the treatment of choice. In cases of psychiatric comorbidity, residual symptoms, or adverse effects, a few studies suggest combined medication strategies. Pharmacotherapeutic strategies for the treatment of ADHD in adults based on recently derived data will be presented.

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2. Faraone S, Biederman J, Weiffenbach B, et al: The dopamine D4 gene 7-repeat allele is associated with attention deficit hyperactivity disorder in families ascertained through ADHD adults. Am J Psychiatry 1999;156:768–770
3. Spencer T, Biederman J, Wilens T, et al: Pharmacotherapy of ADHD across the lifecycle. J Am Acad Child Adolesc Psychiatry 1996;35:409–432
4. Wilens TE, Spencer TJ, Biederman J: Pharmacotherapy of ADHD in adults. CNS Drugs 1998;9:347–356

INDUSTRY-SUPPORTED SYMPOSIUM 49—THE ETHICS OF PSYCHIATRIC RESEARCH
Supported by Ortho-McNeil Pharmaceutical

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the recent controversies concerning the ethics of psychiatric research, including use of placebos, challenge studies, and the process of informed consent; to identify ethically acceptable mechanisms for addressing these issues.

No. 49A
PSYCHIATRIC RESEARCH ETHICS: CONCEPTS AND DATA

Laura W. Roberts, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker NE, Albuquerque, NM 87131*

SUMMARY:

The field of psychiatry has an opportunity to construct a more refined and enduring understanding of the ethical basis of mental illness research. The aim of this presentation is to help advance this understanding by: 1) tracing the evolution of the emerging ethic for biomedical experimentation, and 2) reviewing data and concepts related to compelling ethical questions faced in the study of mental disorders. Segments of original videotaped interviews with research participants diagnosed with schizophrenia, nonpsychotic psychiatric disorders, advanced HIV-related illness, cancer, and diabetes will be presented to illustrate key concepts. Empirical findings on informed consent, the ethical safeguards of institutional review, and surrogate decision-making, and the relationship between scientific and ethical imperatives will be outlined. The presenter will suggest that psychiatric researchers will increasingly be called upon to justify their scientific approaches and to seek ways of safeguarding the well-being of

people with mental illness who participate in experiments. Most importantly, psychiatric investigators will need to demonstrate their appreciation and respect for ethical dimensions of investigation with special populations. These efforts present challenges, but should not interfere with progress in neuropsychiatric science as long as investigators seek to guide the process of reflection and implementation.

No. 49B
THE USE OF PLACEBOS IN STUDIES OF DEPRESSION

B. Timothy Walsh, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 1051 Riverside Drive, Unit #98, New York, NY 10032-2603*

SUMMARY:

Introduction: In recent years, serious ethical concerns have been raised about the use of placebo controls in studies of new interventions for psychiatric disorders for which treatments of established efficacy already exist. This presentation will focus on the use of placebo in studies of outpatients with major depressive disorder.

Methods/Results: Placebo-controlled trials of antidepressant medication published between 1980 and 1997 were reviewed. The mean placebo response rate was 29.2 ± 11.5 (SD)% (range 6%–64%), and there was a significant positive correlation between the placebo response rate and the year of publication (r=0.4, p=.001). These data indicate that the rate of response of major depressive illness to placebo is quite variable and has changed significantly in the last 20 years.

Conclusions: From a scientific perspective, there appear to be valid reasons for the inclusion of a placebo group in trials of new antidepressant medications. However, the inclusion of such groups implies that treatment with agents of established efficacy will be delayed for some patients. Possible ways of grappling with this dilemma will be discussed.

No. 49C
THE CHALLENGE STUDY CONTROVERSY

William T. Carpenter, Jr., M.D., *Department of Psychiatry, Maryland Psychiatric Research Center, P.O. Box 21247, Baltimore, MD 21228;* Matthew Avila, Robert R. Conley, M.D.

SUMMARY:

Challenge studies yield data on pathophysiology by a transitory perturbation of symptoms. Application in psychiatry includes exploration of serotonin in depression, dopamine and glutamate in schizophrenia, and endorphins in panic.

Critics assert that adverse effects constitute unjustified harm, that subjects are recruited from vulnerable populations without valid informed consent, that scientific merit is low, and that intent to harm is unethical.

The ketamine challenge in schizophrenia subjects is central to the current ethics debate. Data from all schizophrenia subjects in ketamine challenge studies in the U.S. will be presented. Group data on 56 patients suggest that the psychosis reaction is modest, that anxiety is minimal, and that the experience is brief with no lasting adverse effects. Qualitative analysis of the "worse-case episodes" and follow-up data suggest no lasting adverse effect.

The authors conclude that scientific merit is high and risks are reasonable. Guidelines for the ethical conduct of challenge studies are suggested. The view that such studies should be subjected to unique restrictions is not supported by the data. The ethical conduct of challenge studies meets a social and moral obligation to the mentally ill citizen of the future through the creative acquisition of new knowledge.

No. 49D
COMPETENCE AND CONSENT IN RESEARCH

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

A competent informed consent is an absolute prerequisite to recruitment of human subjects for research. Because psychiatric disorders may affect cognitive and decision-making capacities, concern has been expressed regarding the competence of subjects in psychiatric research and the quality of the consent they provide. This has led, in turn, to calls for more careful screening of psychiatric research subjects. This presentation will provide a framework for conceptualizing subjects' decisional competence and will review the existing data on the extent of decisional incapacities and the disorders with which they are most likely to be associated. Data will be presented suggesting that even in the most severe disorders, impairments in decisional capacity may be remediated by efforts aimed at providing additional education to subjects. Finally, a graded approach to protection of subjects with the potential for impaired capacities will be outlined.

No. 49E
THE ETHICS OF PSYCHIATRIC RESEARCH

Suzanne E. Vogel-Scibilia, M.D., *Beaver County Psychiatric Services, 219 Third Street, Beaver, PA 15009-2301*

SUMMARY:

Dr. Suzanne Vogel-Scibilia will discuss the ethics of psychiatric research from the perspective of a psychiatrist who is also a consumer of psychiatric services. As both a clinician involved in psychiatric research trials and a subject of past research studies, she will discuss the controversy over when the expansion of clinical knowledge overrides the cost to human study subjects. She will present clinical vignettes to highlight areas of concern by the consumer/family-member community. Dr. Vogel-Scibilia will also offer 10 recommendations to address these concerns.

REFERENCES:

1. Roberts LW, Roberts B: Psychiatric research ethics: an overview of evolving guidelines and current ethical dilemmas in the study of mental illness. Biological Psychiatry 1999; (Special Issue), in press
2. Rothman KF, Michels RD: The continuing unethical use of placebo controls. N Engl J Med 1994;331:394–398
3. Carpenter WT, Jr.: The schizophrenia ketamine challenge study debate. Biological Psychiatry, in press
4. Berg JW, Appelbaum PS: Subjects' capacity to consent to neurobiological research. In Ethics in Psychiatric Research: Resource Manual for Human Subjects Protection, edited by Pincus HA, Lieberman JA, Ferris A. American Psychiatric Association, Washington DC, 1999
5. Vogel-Scibilia SE: The controversy over challenge and discontinuation studies: perspective from a consumer psychiatrist. Biological Psychiatry 1999; (in press)

LECTURES

SUNDAY, MAY 14, 2000

LECTURE 1
APA/APPL MANFRED S. GUTTMACHER AWARD FRONTIERS OF DECISIONMAKING COMPETENCE

Thomas Grisso, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester, MA 01655;* Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

Concepts developed for the MacArthur Treatment Competence Study of patients' decisionmaking capacities are being used to examine two other areas in which decision making raises legal and ethical questions: children's decisional capacities, and decisions about research participation. The law's presumptions about minors' decisionmaking capacities have been inconsistent, characterizing them as immature in some contexts (e.g., making treatment decisions) and adequate in others (e.g., waiving constitutional rights in criminal proceedings). Policy-relevant research on children's capacities also has presented a mixed message. Concepts that go beyond the MacArthur Treatment Competence Study's framework, as well as research underway that examines developmental differences between adolescents' and adults' decision making in legal contexts, may help to resolve these discrepancies. In the realm of consent to research, increased attention to the ethics of psychiatric research has highlighted the need for reliable means of assessing the decisionmaking capacity of potential research subjects. We have developed the MacArthur Competence Assessment Tool—Clinical Research (MacCAT-CR) to fill that need. Data will be presented demonstrating the use of this standardized framework for assessment in different subject populations, including patients with schizophrenia and major depression. Such tools may help insure the accountability of psychiatric researchers for the protection of subjects' rights.

REFERENCES:

1. Grisso, T., & Appelbaum, P.S.: Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals. New York: Oxford University Press, 1998.

MONDAY, MAY 15, 2000

LECTURE 2
SCHIZOPHRENIA AND THE THIRD AGE: OLD CONTROVERSIES, NEW INSIGHTS

Dilip V. Jeste, M.D., *Department of Psychiatry, VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161*

SUMMARY:

Kraepelin's concept of dementia praecox continues to define our notion of schizophrenia even today. While it has been useful for understanding the illness in youth and young adulthood (first and second age, respectively), it has led to potentially harmful myths about schizophrenia in the third (old) age. A dearth of research in this population has served to codify those myths. Our studies over the past 12 years involving several hundred community-dwelling patients with schizophrenia who are middle-aged or elderly paint quite a different picture than the one commonly visualized. We find that schizophrenia can have onset in the 40's, 50's, and 60's, and that this middle-age-onset illness is a distinct subtype of schizophrenia. Psychosis that manifests *de novo* after age 70 is, however, not schizophrenia and should be called schizophrenia-like psychosis. In terms of the course of earlier-onset schizophrenia into middle and old age, most patients do not manifest accelerated cognitive and symptomatic deterioration. Indeed, a minority of individuals demonstrate improvement in their functioning. The numbers of older people with schizophrenia will increase dramatically over the next several decades. We need to focus on ways of delaying the onset of schizophrenia and increasing the rate of remission of this disabling disorder.

REFERENCE:

1. Palmer BW, Heaton SC, and Jeste DV: Older patients with schizophrenia: Challenges in the coming decades. Psychiatric Services 50:1178–1183, 1999.

LECTURE 3
ALCOHOL RESEARCH: ACHIEVEMENTS AND PROMISE

Enoch Gordis, M.D., *The Willco Building, Suite 400, NIAAA, 6000 Executive Boulevard, Bethesda, MD 20892-7003*

LECTURE 4
APA'S ALEXANDRA SYMONDS AWARD SIX EASY LESSONS IN THE CARE OF WOMEN PATIENTS: USING WHAT YOU ALREADY KNOW TO IMPROVE YOUR PRACTICE

Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 836 West Wellington Avenue, Chicago, IL 60657*

SUMMARY:

Psychiatry is about patient care, and most psychiatric patients are women. Some psychiatric illnesses and treatments are generic, but others are gender-specific; women and men have different hormones, anatomies, physiologies, psychologies, roles, and life circumstances. If we ask the right questions, we can tailor our clinical assessments and treatments knowledgeably to those differences. The illness may occur only in women, as in premenstrual dysphoric disorder and postpartum depression. Episodes of psychiatric illness may be related to the anniversaries of reproductive losses. Signs, symptoms, and responses to medication can vary with hormonal status. Alcohol and substance abuse have gender-specific manifestations and consequences, such as the loss of custody of children, that further exacerbate symptoms and complicate care. Childhood abuse is more likely to have played a role in the genesis of presenting problems. Ongoing domestic violence may not be reported, but may interfere with treatment attendance, adherence, and symptom resolution. Doses of psychotropic medications may have to be adjusted to account for smaller body size, body composition, pregnancy, lactation, or drug-drug interactions with hormonal treatments. The psychiatrist who knows what to ask and how to respond can effect major improvements in outcomes and patient satisfaction.

REFERENCE:

1. Psychological Aspects of Women's Health Care: ed. By Nada Stotland and Donna Stewart. American Psychiatric Press, Washington, 1993, second edition in press.

LECTURE 5
THE NATURAL HISTORY OF BABIES

Meredith Small, Ph.D., *Department of Anthropology, Cornell University, Ithaca, NY 14853*

SUMMARY:

Humans infants are highly dependent on the adult members of their species. About four million years ago, our human ancestors began to walk on two legs, and this change in locomotion necessitated

an radical change in the architecture of the human pelvis, including the birth canal. Three million years later, when there was a push for large brain size, this pelvic reconfiguration caused a problem—infant head size had to remain relatively relative to the pelvic opening. As a result, human infants are born too early—some estimate three months too early—and they are neurologically unfinished, physically and emotionally dependent on others. In essence, the baby-parent relationship is an evolved system, a biologically entwined dyad. But people across cultures play out this system in myriad ways. In most cultures, the infant caretaking package includes carrying at all times, co-sleeping, and continuous breast feeding. These cultures also ascribe to a cultural ideology that believes in family and social integration. In the west, we believe that babies should be independent and self-reliant, and so we opt for a very different caretaking package—western babies spend much of their time alone, are expected to sleep alone, and are fed on some schedule. Thus cultural ideology, tradition and folklore are often at odds with an infant's biological expectations.

REFERENCE:

1. Small, MF: 1998 Our Babies, Ourselves; How Biology and Culture Shape the Way We Parent. Anchor Books/Doubleday.

LECTURE 6
APA'S ADOLF MEYER AWARD
PSYCHOBIOLOGY IN THE POST-GENOME ERA: A POTENTIAL MEYERIAN RENAISSANCE IN SCHIZOPHRENIA

Daniel Weinberger, M.D., *National Institutes of Health, 10 Center Drive, Room 4S235, Bethesda, MD 20892-1375*

SUMMARY:

Adolf Meyer viewed mental illness as a complex interaction of genetic predispositions, life long reaction patterns, and environmental events, that emerged from individual variations in biology, psychology, and sociology. In the post-genomic era of human biology and medicine, the psychobiological perspective of Adolf Meyer is likely to take on a new aura and guide our understanding of how genetic discoveries relate to psychiatric illness. These principles can be illustrated in studies of schizophrenia. Early enthusiasm for the possibility that a gene would be found for this illness have dimmed, as linkage studies demonstrate that a number of genetic variants, each of which may exist in relatively high frequency in the general population, contribute risk, but the risk does not explain manifest illness. Family studies have shown that a number of abnormalities found in ill patients, including neuropsychological and neurobiological, are also found in well family members. This suggests that it may be possible to define the biology of vulnerability, i.e. who is liable to react in predictable ways to the environment, and to characterize genetic factors ("alleles") that interact with and modify the vulnerable biology to account for individual variation in symptom choice, severity, treatment response, etc. For example, functional genetic variations in genes that regulate the response of the dopamine system to reinforcing environmental stimuli may not be causative of a disease, per se, but could dramatically impact on the quality of life of an individual with a disease like schizophrenia. These various principles and examples of how they appear to operate in the case of schizophrenia will be presented.

REFERENCE:

1. Weinberger DR: Schizophrenia: New Phenes and New Genes. Biol Psychiatry 46:3–7, 1999.

LECTURE 7
CELESTE ASCENDING

Kaylie Jones, *524 East 83rd Street, #3E, New York, NY 10028*

SUMMARY:

Ms. Jones will discuss the theme and structure of her new novel, "Celeste Ascending," and how the idea for the book came about. She will read pertinent sections to illustrate the theme and explore the psychological development of the protagonist, Celeste.

There is nothing like a life-altering event to set the wheels in motion for self-examination. This is also the time when denial is strongest. But as Celeste moves forward through the rites of passage leading up to her wedding day, her past keeps cropping up in unpleasant and unwanted days. She is running from her memories of her mother who died young and under suspicious circumstances, from a distant and emotionally inaccessible father, from an old lover she can't seem to forget, and from deep remorse.

What is denial? How does it manifest itself in our psyche? What human experience can force a person to break through his/her protective shields? It is Ms. Jones' belief that enlightenment has to be in some part spiritual, but that it can only come about after a series of events have prepared the person to accept the Moment of Truth. This is what she has tried to accomplish in "Celeste Ascending" and what she hopes to share with the audience in her readings from the novel.

REFERENCE:

1. Jones, K: Celeste Ascending; Harper Collins Publishers, April, 2000.

LECTURE 8
INTIMATE MACHINCES: FROM DIGITAL PETS TO DIGITAL PERSONAE

Sherry Turkle, M.D., *Building E51, Room 296C, MIT/STS Program, Massachusetts Institute of Technology, Cambridge, MA 02139*

SUMMARY:

This talk explores a new set of identity effects of the computer presence that are associated with several new directions in the development of computer technology.

Computational toys and digital "pets" affect how children sort through the question of what is alive and what is not, about what is special about being a person; recent work in building robots with emotional systems, and screen agents using principles of "affective computing" offer similar challenges to the world of adults.

Several questions emerge: first, how are we to conceptualize the nature of our attachments to interactive robots, affective computers, and digital pets, and second, how does interacting with these objects affect people's way of thinking about themselves, their sense of human identity, of what makes people special?

REFERENCE:

1. Turkle, S. *Life on the Screen:* Identity in the Age of the Internet; New York, 1995.

LECTURE 9
APA'S MARMOR AWARD
NOVEL NEUROTRANSMITTERS, DRUGS AND PSYCHIATRY

Solomon H. Snyder, M.D., *Department of Neuroscience, John Hopkins Medical School, 725 N. Wolfe Street, Baltimore, MD 21205-2105*

SUMMARY:

All the major drugs in Psychiatry and Neurology act via one or another neurotransmitter. Most act through a few of the biogenic

amines, though there exist 50-100 transmitters. Recently, gases such as nitric oxide and carbon monoxide have been established as transmitters of importance which don't obey the classic "rules" as to what constitutes a transmitter. A gas such as nitric oxide can't be stored in synaptic vesicles, nor released by exocytosis nor act at plasma membrane receptors. Recently, D-serine has been identified as a co-agonist with glutamate at the NMDA subtype of glutamate receptor. Besides being unprecedented as a D- rather than L-amino acid, D-serine is stored in glia rather than neurons, yet fulfills most criteria of a neurotransmitter.

It is likely that novel psychoactive drugs will emerge from these newer neurotransmitters. Mice with targeted gene deletion for neuronal nitric oxide synthase demonstrate extremely aggressive behavior and uncontrolled sexual impulses. This suggests that nitric oxide normally is part of an emotional inhibitory system so that modulatory drugs may be therapeutic. The enzyme serine racemase converts L-serine to D-serine so that inhibitors of the enzyme should diminish actions of D-serine and lessen neurotransmission at NMDA receptors. Drugs blocking NMDA receptors prevent stroke damage and also have behavioral influences. Serine racemase inhibitors may well provide a novel way of achieving similar benefits.

REFERENCE:

1. Snyder, S.H., Drugs for a New millennium. Philosophical Transactions of Royal Society, London B354:1985–1994, 1999.

LECTURE 10
APA'S WILLIAM C. MENNINGER MEMORIAL AWARD

Betrand Piccard, *Avenue de Florimont 20, Lausanne 1006 FRANCE*

TUESDAY, MAY 16, 2000

LECTURE 11
APA's GEORGE TARJAN AWARD
THE CONTRIBUTIONS OF THE INTERNATIONAL MEDICAL GRADUATES TO AMERICAN PSYCHIATRY

Jambur V. Ananth, M.D., *Department of Psychiatry, Harbor UCLA Medical Center, 1000 West Carson Street, Building 1, Torrance, CA 90509*

SUMMARY:

International Medical Graduates constitute 23 % of the American Medical manpower. 11677 of the 39098 psychiatrists were IMGs. In general, the IMGs came into the country, as they were needed to supplement the existing medical manpower. The worked in the jobs that the local graduates did not want and served in areas where the local graduates would not go. Clinically they have contributed by manning the public sector institutions and serving the undeserved. Currently many of the IMGs are in private practice not only in the cities but also in the remote corners of the United States thus increasing the breadth of psychiatry. Academically, they have contributed significantly to American Psychiatry. Tarjan and Rodrigo Munoz were former presidents of the American Psychiatric Institute. Many IMGs are currently the leaders in many important areas of psychiatry including schizophrenia and bipolar disorder. There are as of there are five chairs the department. In the American Psychiatric Association Journal over 25% of the articles are authored by the IMGs. Culturally they have enriched our value system and psychotherapeutic armamentarium and have assisted in helping patients. Therefore the IMGs are not just Takers but are also Givers.

REFERENCE:

1. Pasko T., Sxeidman B: Physician Characteristics and Distribution in the US. American Medical Association, 1999.

LECTURE 12
THINKING WHILE LISTENING

Robert Michels, M.D., *Department of Psychiatry, Cornell Medical College, 418 East 71st Street, New York, NY 10021*

SUMMARY:

Psychotherapy has been called the talking cure. Many supervisors and teachers emphasize that it might better be called the listening cure. However fundamental to listening is thinking—it is what the therapist thinks about while listening that makes psychotherapy different from simple friendship.

The psychotherapist thinks about what the patient has disclosed about past and present, the story of the problem and of the life that preceded and continues during it. The therapist thinks about what is said, and avoided, during the session. The therapist thinks about his or her own thoughts and feelings, both those that seem relevant to the therapy and those that don't. Finally, the therapist thinks about theories, the concepts that link the other thoughts together and that generate ideas about what the therapist will say when the listening cure shifts to become a talking cure.

REFERENCE:

1. Michels, R: Psychoanalysts' theories. In: Fonagy, P, Cooper, A.M. & Wallerstein, R. (Eds.): Psychoanalysis on the Move: The Work of Joseph Sandler. New York: Routledge, 187-200, 1999.

LECTURE 13
APA'S KUN-PO SOO AWARD MENTAL HEALTH PROBLEMS IN TAIWAN: ISSUES, DILEMMAS AND CHALLENGES

Eng-Kung Yeh, M.D., *Department of Psychiatry, Taipei Medical College, 309 Sung-Te Road, Taipei, 105 Taiwan*

SUMMARY:

Though the mental health program had gone through several stages of development, it had been an underdeveloped area as an integral part of the national health administration.

The year 1980 and the years following have marked an important turning point in evolution of nation-wide mental health program. A series of innovatory measures and actions taken by the central health authority have pushed the mental health program an epoch-making big step forward. The promulgation of mental health law, the first in the history of Taiwan, came into force on December 7, 1990. With rapidly growing awareness of the need nation-wide, the services that the nation can provide has been always far too short for the demand.

The National Health Insurance Administration, which has covered all range of care for mentally ill, has been forced to consider restructurization of payment from fee-for-service to case-capitated system after nearly 5 years of painful operation.

The issues, dilemmas, and the challenges that Taiwan mental health program has been facing or to face are to be discussed in socio-economic and cultural context.

REFERENCE:

1. Yeh EK: Development of Hospital-Community Psychiatry in Taiwan: The Past and the Perspectives. Chinese Psychiatry 6:47–59, 1992.

LECTURE 14
APA'S OSKAR PFISTER AWARD
THE DIFFERENCE BETWEEN THE NORMAL AND THE PATHOLOGICAL AS A SOURCE OF RESPECT: THERAPEUTIC AND ETHICAL IMPLICATIONS

Paul Ricoeur, M.D., *19 Henri Marrou, Chatney, Malabry, 92290 FRANCE*

SUMMARY:

"The respect due to persons with handicapping conditions, either physical or mental, is justified by the nature of the "pathological" in its relation to the "normal." The "normal" and the "pathological" represent two modalities of a person's relationship with his or her environment. As living beings, persons are in debate (or dialogue) with their environment, a debate to which they bring their own norms with which to judge situations and adjust to them. In illness, a person must adjust to a "narrowed" environment. This signifies an other structure, which has its own laws. It is this "catastrophic" riposte that makes the patient infinitely respectable. The implications of the respect due to the patient are both therapeutic and ethical. It is important in the exchange with healthy persons to provide access to the dimension of common humanity hidden in the difference."

REFERENCE:

1. Ricoeur, P: Freud and Philosophy: An Essay on Interpretation. Yale University Press, 1970.

LECTURE 15
APA'S PATIENT ADVOCACY AWARD

George McGovern, *Ambassador, United Nations Food and Agriculture Organization, American Embassy, FOBAG, PSC59, Box 31, APOAE 09624*

LECTURE 16
DEPRESSION IN THE MEDICALLY ILL

K. Ranga R. Krishnan, M.D., *Duke University Medical Center, Box 3950 DUMC, Durham, NC 27710*

SUMMARY:

Depression is a common problem in the medically ill population. It remains under-recognized and under treated. One of the major reasons for the under-recognition is the confusion of the depressive symptoms with the medical lists. One of the main reasons for under-treatment is the misunderstanding that since depression is due to the medical illness that the focus need not be on treating depression. In this lecture we will use the interplay between depression and cardiac disease to more closely understand the relationship between a medical disorder and depression. In the context of cardiac disease, depression alters, i.e., worsens the outcome, and increases morbidity and mortality. What is even more intriguing is the fact that depression increases the risk for an individual to develop cardiac disease. This has profound implications in our understanding, diagnosis, and management of depression. The mechanism by which depression increases the risk of cardiac disease is unknown. It may be due to a variety of factors including lifestyle changes, increased platelet aggregation and, possibly, poor maladaptive behaviors secondary to depression such as poor diet and smoking. The treatment in depression in the context of cardiac disease has not been well studied. There are two large scale studies ENRICHD is a study of cognitive therapy in post-myocardial infarction depression and, SADHART is a treatment of Sertraline in the context of post-MI depression. Data from these two studies should be forthcoming in the next year or so and, the results of these studies may have major implications in how we recognize and manage depressed patients in the post-myocardial infarction state. Current studies indicate that tricyclic antidepressants are more difficult to use and less safe than SSRIs in the context of patients with cardiac disease. It is possible that similar relationships exists between depression and other medical illness such as cancer. However, these relationships have not been as well explicated.

REFERENCE:

1. Krishnan KR, George LK, Pieper CF, Jian W, Arias R. Look A, O'Conner C: Depression and social support in elderly patients with cardiac disease. American Heart Journal 136(3):491–495, 1998.

LECTURE 17
DEPRESSION AMONG THE INDIGENT

Andrew Solomon, *18 West 10th Street, New York, NY 10011*

SUMMARY:

Depression cuts across class boundaries, but depression treatments do not. This means that most people who are poor and depressed stay poor and depressed; in fact, the longer they stay poor and depressed, the more poor and depressed they become. Poverty is depressing and depression is impoverishing, leading as it does to dysfunction and isolation. Poverty's humility is really just a passive relationship to fate, a condition that in people of greater ostensible empowerment would require immediate treatment. The poor depressed perceive themselves to be supremely helpless, so helpless that they neither seek nor embrace support. The rest of the world dissociates from the poor depressed, and they dissociate themselves: they lose that most human quality of free will. Our societal focus has been on altering horrible lives to alleviate depression, and that foal should never be discounted. Indigence is a good trigger for depression; relief of depression is a good trigger for recovery. It is equally feasible, however, to alter the depression to alleviate the horror. Only through aggressive interventions can the problem of depression among the indigent be addressed. In cases in which such interventions have been attempted, the scale of their success is stupefying.

REFERENCE:

1. Solomon, A: The Noonday Demon, Scribners, 2001.

WEDNESDAY, MAY 17, 2000

LECTURE 18
MUTANT ALLELES OF BRAIN GENES WITH MID TO LATE-LIFE PHENOTYPES

Kenneth Kosik, M.D. *Brigham and Women's Hospital, Harvard Institute of Medicine, 77 Avenue Louis Pasteur, Boston, MA 02115*

SUMMARY:

With the discovery of highly penetrant gene mutations capable of causing many late-onset neurodegenerative diseases, some patterns have now emerged. Many of these diseases have a rare genetic form and a more common sporadic form; Alzheimer's and Parkinson's diseases are examples. In general, the effect of these genes is to accelerate the age at onset relative to the sporadic form of the disease. The largest kindred in the world with familial Alzheimer's disease reside in Antioquia, Colombia. Approximately 4000 individuals comprise the genealogies of these families who harbor a misense mutation in presenilin 1. Affected individuals develop typical Alzheimer's disease with a mean age at onset of 45 years and a range that extends more than two decades around the mean. The wide variation in age at onset suggests the presence of a modifier gene in the population. SPECT imaging data on presymptomatic gene carriers suggests a disease signature may be present before the dementia can be clinically

detected. The presence of a mutant gene in an extended family raises difficult and often poignant questions. These questions are magnified among genetically isolated populations where superstitions about the disease readily gain credibility, where mate selection is limited and genetic counseling may not exist.

REFERENCE:

1. Kosik, KS: The Fortune Teller. The Sciences: July/Aug pp. 13–17, 1999.

LECTURE 19
THE GENE-ENVIRONMENT INTERACTION: SCHIZOPHRENIA AS AN ILLUSTRATIVE CASE

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive—Unit 32, New York, NY 10032*

SUMMARY:

Psychiatry is now in the forefront of the recognition that many human diseases—indeed, most human characteristics—represent the exquisite interplay of genetic predisposition and life events. Although the sequence of base pairs in the genome that we inherit is immutable, most genes are either never expressed in specific cells or only intermittently active. Environmental events are among the triggers that can activate latent genes and this process can occur at any time during life, including prenatally. In our remarkable progress in understanding the pathophysiology of schizophrenia, it has become increasingly evident that gene/environment interactions must play a key role. We have unmistakable evidence that schizophrenia is in part a heritable condition. The accumulation of family, twin, and adoption studies leaves us with no other reasonable conclusion. Despite many false starts and severe technical hurdles, modern molecular genetics should enable us to uncover some of the mutations involved in the not too distant future. Even complete genetic information, however, is unlikely to give us the whole picture of schizophrenia etiology. Scientists have long noted that schizophrenia is an illness present in the world population at a nearly constant rate of 1 per 100, even though it appears to confer absolutely no selective advantage. Concordance rates for schizophrenia among monozygotic twins hover around 50%, too low for a purely genetic illness. It is now widely suspected, therefore, that a variety of environmental events that occur during fetal life and affect embryonic brain development are probably involved in elevating the risk for later schizophrenia. Several candidate exposures are under vigorous investigation, including prenatal infection, maternal stress, obstetrical complications, and nutritional deprivation. The challenge is to orient these epidemiological findings with the evolving biology of human brain development in order to create a plausible model of schizophrenia risk. Meeting this challenge is now, for the first time, eminently possible.

REFERENCE:

1. Susser ES, Brown AS, Gorman JM: prenatal Exposures in Schizophrenia. American Psychiatric Press, Inc. 1999.

LECTURE 20
APA'S SOLOMON CARTER FULLER AWARD

Kweisi Mfume, *NAACP, 4805 Mt. Hope Drive, Baltimore, MD 21215*

LECTURE 21
APA'S SIMON BOLIVAR AWARD
THE SHAKY FOUNDATIONS OF MANAGED CARE

Rodrigo A. Munoz, M.D., *University of CA at San Diego, 3130 5th Avenue, San Diego, CA 92103*

SUMMARY:

The modern era of managed care began in the 1970s and produced new rules that eventually controlled most of medicine in subsequent decades. Cornerstones of managed care thinking were the ideas of Paul M. Ellwood, M.D., and Alain C. Enthoven, Ph.D.

In publications going back to the 1960s, Dr. Ellwood described the steps that should be taken to achieve "outcome management", which in turn was a basic principle of "health maintenance organizations" (HMOs). Doctor Ellwood saw these creations as a response to conditions that he identified as the "health crisis" that preceded HMO legislation.

Dr. Enthoven, who became a close ally of Dr. Ellwood, accused physicians of providing unnecessary care: "I believe that a great deal of flat of the curve medicine' is being practiced in the United States today—that is, application of health-care resources yielding no discernible or valuable health benefit" (1).

An immediate effect of the HMO movement was the progressive transfer of decision making in medical practice from physicians to HMOs, insurance companies and employers. As this transfer progressed, physicians found themselves unable to openly speak to their patients about the quality of their care ("gag rules"), unable to make proper referral for adequate specialized care, and even unable to make independent decisions about management of complex medical disorders.

The movement encouraged by the "outcome management" advocates created a nightmare that has advanced from the United States to many countries in America and other continents. While the movement's foundations can be seen today as weak and shaky, its financial incentives to HMOs, insurance companies and employers have given it a life of its own.

Simon Bolivar tried to rally all Americans to the defense of their rights. A good tribute to him is to show that the thinking of the fathers of "outcome management" had shaky foundations, and the future of the movement. It generated is extremely uncertain. This presentation will address answers proposed within the APA.

REFERENCES:

1. Enthoven, A.C. ShAttuck Lecture. New England Journal of Medicine. 318:1549–1556, 1988.

LECTURE 22
APA'S INTERNATIONAL AWARD
ANXIETY/AGRESSION-DRIVEN DEPRESSION: THE IMPORTANCE OF FUNCTIONALIZATION AND VERTICALIZATION OF PSYCHIATRIC DIAGNOSING

Herman M. van Praag, M.D., *Residentie Prinses Zu Wied, Kinnehin 5, 1901 ZP Castricum NETHERLANDS*

SUMMARY:

We have proposed the existence of a subgroup of depression characterized 1) psychopathologically, 2) biologically, and 3) psychopharmacologicaly. The data underlying this concept will be discussed.

The construct of anxiety/aggression-driven, 5-HT related depression is a product of two novel approaches in the diagnostic process of mental disordrs, which we have introduced, Functionalization and Verticalization. Functionalization and verticalization will refine psychiatric diagnosis and thus facilitate research into the relationships between abnormal neurobiological and psychological functions.

REFERENCES:

1. Van Praag HM: Over the mainstream: diagnostic requirements for biological psychiatric research. Psychiatry Research, 72:201-212, 1997.

THURSDAY, MAY 18,2000

LECTURE 23
APA'S BENJAMIN RUSH AWARD
MILLENIAL MADNESS: RELIGION AND INSANITY IN AMERICAN HISTORY

Ronald L. Numbers, Ph.D., *155 East Wilson Street, #403, Madison, WI 53703*

SUMMARY:

As early as 1812 Benjamin Rush in *Medical Inquiries and Observations Upon the Diseases of the Mind,* the first major American work on mental illness, noted the baleful effects that often accompanied "researches into the meaning of certain prophesies in the Old and New Testaments." His work with patients at the Pennsylvania Hospital had convinced him mental breakdowns frequently resulted "from an attempt to fix the precise time in which those prophesies were to be fulfilled, or from a disappointment in that time, after it had passed." Indeed, during the mid-nineteenth century, American asylum superintendents so frequently diagnosed Millerites and other millennial groups with "religious insanity" that it ranked among the leading causes of mental illnesses for institutionalized Americans. Although the incidence of "religious insanity" declined sharply in the late nineteenth century, as a consequence of changing doctrinal and diagnostic fashions, down to the year 2000 critics continued to question the mental health of ardent millenarians from Jehovah's Witnesses to Branch Davidians.

REFERENCE:

1. Ronald L. Numbers and Janet S. Numbers, "Millerism and Madness: A Study of 'Relgious Insanity' in Nineteenth-Century America," Bulletin of the Menninger Clinic 49:289–320, 1985.

LECTURE 24
CITY OF ONE: A MEMOIR OF CHILDHOOD LOSS AND ITS AFTERMATH

Francine Cournos, M.D.

SUMMARY:

This presentation will offer both a personal and professional perspective on childhood loss and its aftermath. One component of the presentation will involve the presenter reading from her recently published book, *City of One: A Memoir.* The book recounts the presenter's experiences with the deaths of both her parents in childhood, her subsequent experiences as an orphan and foster child, and her adult search to make sense of her somewhat eccentric early life.

This personal story of loss will be integrated with the literature on childhood breavement, including perspectives from psychoanalysis, empirically-based studies of bereaved children, and clinical studies examining the association between childhood parental loss and the onset of childhood and adult mental illnesses such as depression and anxiety disorders. Implications for the capacity for intimacy in adult life will also be addressed.

REFERENCE:

1. Cournos, F. City of One: A Memoir, New York, W.W. Norton, 1999.

LECTURE 25
APA'S SEYMOUR D. VESTERMARK AWARD
OFF THE WALL: A QUARTER CENTURY OF OPPORTUNITIES FOR CREATIVITY IN PSYCHIATRIC EDUCATION

Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 500 South Preston, Suite 214, Louisville, KY 40292*

SUMMARY:

This lecture will offer attendees the opportunity to follow one psychiatric educator's involvement in developing formal lectures, informal and voluntary individual and small and large group opportunities, mandatory and elective programs for students, residents, and faculty, directly and indirectly defined as psychiatric education.

Beginning with programs related to students and residents' personal mental health, including the major area of prevention, such support systems and educational opportunities have been created such as: The Student Hour, The Health Awareness Workshop, the Physicians and the Arts elective, the S.O.U.L. and Advocates programs, and The Office for Faculty and Student Advocacy. Psychiatric resident seminars, begun in the late '70s and still ongoing, include: Gender Issues in Human Development Across the Life Cycle, Psychodynamic Psychotherapy: academic year/semester observing a senior faculty treat one patient with second year residents sitting in. After the patient leaves, a 40 minute discussion of dynamics and related assigned readings ensues.

Expanding on the usual definition of mental health are lectures to the entire academic medical center community on sexual harassment and medical student mistreatment. Lectures about attitudinal, behavioral and complementary i.e. integrative medicine and gender issues in medical practice to the juniors rotating on psychiatry will be discussed.

Finally, the use of videos, exhibits of student and physician art and school opportunities to participate in the arts will be highlighted.

REFERENCES:

1. Health Awareness Workshop Reference Book, Dickstein CJ: Proactive Press, Louisville, KY 1998.

LECTURE 26
THE HUMAN GENOME PROJECT, MEDICINE AND SOCIETY

Francis S. Collins, M.D., *National Human Genome Research Institute, National Institute of Health, Building 31, Room 4B09, 31 Center Drive, MSC 2152, Bethesda, MD 20892-2132*

SUMMARY:

Initiated in 1990, the Human Genome Project is a bold effort to determine the map and sequence of all the human DNA, as well as to develop technologies and information about the genomes of other model organisms to facilitate an understanding of this "instruction book" for human biology. Since its initiation the project has been characterized by a series of highly specific goals, all of which have been met or exceeded. That track record is now being extended to the human sequence itself, which though originally scheduled for completion in 2005, is now hurtling towards completion 2 or 3 years sooner than that. In fact, a "working draft" of the human genome sequence, covering 90% of the human genome, is expected to be in hand midway through the year 2000.

The consequences of this information for medicine and society are substantial. Together with efforts to catalogue the common variations in the human genome, the derivation of the precise sequence of the estimated 100,000 genes in the human genome will allow the genetic contributions to virtually every disease to be discovered. This will include the unraveling of the hereditary components of common psychiatric illnesses, including schizophrenia, manic de-

pressive illness, obsessive compulsive disorder, autism, and other conditions where heredity seems to play a significant role. Many clinical consequences can be anticipated. First of all, genetic diagnostics are likely to begin to play a significant role in establishing a precise diagnosis and predicting response to therapy. In some instances, risks of future illness may be predictable by genetic testing, and may allow institution of prophylactic measures to reduce the likelihood of that illness coming about. Perhaps most importantly, the molecular insights which result from a detailed specification of the genetic contributions to illness should lead us to a new generation of drug interventions which are more highly effective than prior options.

REFERENCE:

1. Collins F: Medical and Societal Consequences of the Human Genome Project. New England Journal of Medicine 1999; 341:28–37.

MEDIA SESSIONS

SUNDAY, MAY 14, 2000

1. THE PIANO
The Forum for the Psychoanalytic Study of Film

PROGRAM DESCRIPTION:

In *The Piano,* director Jane Campion transports the audience to another world and time immediately and with absolute precision. The gray of her New Zealand sea and sky is grayer, grander, more forbidding than our experience of it elsewhere. The stark image of the piano standing in the swirling surf will endure. The movie is a critically acclaimed, stunningly photographed romantic period fable about an unhappily married mute woman who plays the piano to express herself. It tells a story of love and fierce pride, and places it on a bleak New Zealand coast where people live rudely in the rain and mud, struggling to maintain the appearance of the European society they've left behind. It is a story of shyness, repression and loneliness; of a woman who will not speak and a man who cannot listen; and of a willful little girl who causes mischief and pretends she didn't mean to. This haunting, erotically charged, original drama pleases fans of offbeat, multi-layered fare.

2. THREE SEASONS

PROGRAM DESCRIPTION:

Three Seasons is a drama written and directed by Tony Bui, and based on a story by Tony Bui and Timothy Linh Bui. If you're looking for answers, this film mostly poses questions. It introduces and then traces the steps of five central characters, a cylco driver, a prostitute, an American GI, a young girl and a little boy. The lives of these five are intertwined as they try to find happiness or just get by. You should prepare yourself for some soul-searching questions about the great continuum of life and your place in it. This movie is a little self-indulgent at times and can be a little predictable, but first-time writer/director Tony Bui has incredible promise.

MONDAY, MAY 15, 2000

3. BLACK AND BLUE: DEPRESSION IN THE AFRICAN-AMERICAN COMMUNITY

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize signs and symptoms of depression; understand the importance of seeking help for depression from a health professional; and appreciate the importance of spirituality and stigma as barriers to help-seeking for depression in African Americans.

PROGRAM DESCRIPTION:

Black & Blue is an educational videotape developed to educate African Americans about depression in an effort to address the disparity between need for and use of mental health care among this group. The specific aims of the videotape are to: 1) present the major symptoms and causes of depression as expressed by consumers and health professionals who have experience dealing with the illness; 2) emphasize the importance of recognizing depression and getting treatment from a health professional; 3) discuss standard treatments for depression, including antidepressant medication and psychotherapy; 4) emphasize the importance of treatment to avoid negative consequences such as poor physical health, loss of productivity, substance use disorders and suicide; and 4) provide information about how and where to get treatment.

REFERENCES:

1. Cooper-Patrick L, Powe NR, Jenckes MW, et al: Identification of patient attitudes and preferences regarding treatment of depression. Journal of General Internal Medicine 1997; 12:431–438
2. Sussman LK, Robins LN, Earls F: Treatment-seeking for depression by black and white Americans. Social Science Medicine 1987; 24:187–196

4. THE D FILES

PROGRAM DESCRIPTION:

The people of Northern New Mexico share some of the tragedies brought about by drugs and drinking in their communities. While exposing the pain and waste of human potential, they also put forth possible underlying causes and show how to build sobriety to enhance the strong spiritual and cultural presence of this unique area.

5. FAMILIAS UNIDAS SABEN

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation families and clients should be more aware as to what a mental illness is. They should understand that there are different illnesses, and what symptoms to look for.

PROGRAM DESCRIPTION:

This educational video is designed to target monolingual Spanish-speaking families and clients to teach them about mental illness. It addresses cultural factors, religious beliefs relating to mental illness and concerns about stigma, which impede access to professional care. This video also details the symptoms of major illnesses, including schizophrenia, depression and bipolar disorder. The family members featured in this video talk about their own experiences in facing the challenges of mental illness, and encourage those watching not to be afraid to seek help for themselves or their loved ones.

6. RABBIT IN THE MOON

PROGRAM DESCRIPTION:

Rabbit in the Moon is a documentary memoir about the lingering effects of the World War II internment of Japanese-Americans. It is also the story of two sisters, both former internees, film-maker Emiko Omori and writer Chizuko Omori, who revisited the absence of this vital history in their lives while searching for the memory of their mother. Visually stunning and emotionally compelling, this film examines issues that ultimately created deep rifts within the community, reveals the racist subtext of the loyalty questionnaire and exposes the absurdity of the military draft within the camps.

7. AFFLICTION

PROGRAM DESCRIPTION:

Affliction was written and directed by Paul Schrader and based on the novel by Russell Banks. Actor Nick Nolte portrays Wade Whitehouse, the sheriff of a small New Hampshire town, whose uniform, gun and stature do not make up for a deep feeling of worthlessness. He drinks, he smokes pot on the job, he walks with a sad weariness, his ex-wife hates him and his young daughter looks at him as if he is crazy. It is a movie, which rewards at many levels. Its characters are fleshed-out human beings capable of good and evil

and in the grips of intense suffering, not the formulaic cardboard creations, which populate so many recent Hollywood productions.

8. SOLDIER CHILD

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the horrific exploitation of children by warlords in some countries and to appreciate the heroic efforts being undertaken by fellow mental health clinicians to rehabilitate such abused children.

PROGRAM DESCRIPTION:

South African filmmaker, Neil Abramson, documents the atrocities of child abductions occurring in Northern Uganda. A rebel movement calling itself the Lord's Resistance Army, led by a man named Joseph Kony, abducts children and turns them into child soldiers. Once stolen from their homes and put into military service, boys and girls as young as seven years in age are tortured, starved and forced to kill their countrymen. For children, and on the behalf of human rights everywhere, this is a film not to be missed.

REFERENCES:

1. Cohn I Goodwn-Gill GS: Child soldiers: the role of children in armed con. Press, 1994
2. Frankel M et al: Boy Soldiers in Newsweek August 1995, pp 44–46

9. TRAVIS

PROGRAM DESCRIPTION:

Travis Jefferies is a ten-year-old African-American boy with a warm personality, an infectious smile and full-blown AIDS. When we first meet him, Travis is six and has been unable to eat for months due to intractable sores in his mouth, esophagus and stomach. This film documents the complex life of this vital child born with HIV/AIDS, who, with the help of experimental drug therapy and his grandmother's unwavering love and support, struggles to survive and pursue a dignified, happy life.

10. THE OTHER SIDE OF BLUE: THE TRUTH ABOUT TEENAGE DEPRESSION

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize teenage depression, understand its causes, the impact of teenage depression on school and family life, and the role of treatment.

PROGRAM DESCRIPTION:

This educational documentary video was designed to help increase public awareness about teenage depression. There is a widespread misconception that depression in adolescents is normal. It is usually dismissed as "teenage blues." Most people don't realize that eight to ten percent of teenagers suffer from true, clinical depression. Depressed teenagers often appear irritable rather than sad. They may get into trouble at home, school, or with the law, or they may turn to drugs and alcohol as a way of coping. This unique video uses contemporary-style imagery and special effects to portray the experience of teenage depression in a compelling and highly personal manner. It tells the emotional stories of four teenagers suffering from depression and their lengthy struggle with this debilitating illness.

REFERENCES

1. Birmaher Betal: Childhood and Adolescent Depression: A Review of the Past 10 Years. Part 1. J Am Acad Child Adolescent Psychiatry 1996; 35:1427–1439
2. Birmaher Betal: Childhood and Adolescent Depression: A Review of the Past 10 Years. Part II. J Am Acad Child Adolescent Psychiatry 1996; 35:1575–1583

11. BLACK TAR HEROIN: THE DARK END OF THE STREET

PROGRAM DESCRIPTION:

Filmmaker Steven Okazaki and sound recordist Jason Cohen spent two years in San Francisco's drug otherworld, chronicling the lives of five young heroin addicts, Tracey, Jake, Jessica, Oreo and Alice. This extraordinary documentary captures not only the pain and brutality of lives devastated by heroin, but also the addicts raw yearning to get their lives back.

12. HOPE AND REMEMBRANCE: RITUAL AND RECOVERY

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to help a community in the healing process following a large scale disastrous event by recognizing that many survivors/victims will in fact have common thoughts, feelings, beliefs, and reactions to the trauma, yet again believe that they are alone in their response.

PROGRAM DESCRIPTION:

This video was developed and designed to assist government planners, mental health clinicians and other groups in helping a community in the healing process following a large-scale disastrous event. The video outlines the following points: 1) individual reaction to traumatic events; 2) an overview of rituals and ceremonial activities; 3) visual images of various ritualistic symbols; 4) the role of survivors and family members in planning a ceremony; 5) the role of mental health professionals in planning a ceremony; 6) the logistics of planning an event; 7) rescue worker recognition; and 8) children and rituals. It is about those who have survived and their journey to understand, comprehend, make sense of the event and memorialize their loved ones.

REFERENCES:

1. Green BL, Grace MC, Lindy JD, et al. Buffalo Creek Survivors in the Second Decade: comparison with unexposed and nonlitigant groups. Journal of Applied Social Psychology 1990; 20:1033–1050
2. Lutchterhand E, Sociological Approaches to Massive Stress in Natural and Man-Made Disasters: International Psychiatric Clinics 1971; 8:29–53

13. MUSIC THERAPY AND MEDICINE: PARTNERSHIPS IN CARE

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to define music therapy and identify illnesses that respond to music therapy.

PROGRAM DESCRIPTION:

This video is a documentary that communicates how music therapy plays a vital role in the treatment of children and adults with a wide range of diagnoses. The video, which has won two national awards,

was filmed at major medical centers in Cleveland, Ohio and New York City, and captures actual music therapy sessions in progress. Interviews with patients, physicians, family members and other health care professionals provide testimony regarding the use of music therapy to decrease depression, pain and medication requirements, as well as increase relaxation, positive attitudes toward hospitalization and improve coordination and rhythmic gait.

REFERENCES:

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

14. ON WINGS OF SONG

PROGRAM DESCRIPTION:

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

15. DANCING THROUGH DEATH: MONKEY, MAGIC AND MADNESS IN CAMBODIA

PROGRAM DESCRIPTION:

This is the story of Thavro Phim, who came of age under the Pol Pot regime and lost his father, brother and grandfather to the bloodthirsty Khmer Rouge. What kept him going was his Buddhist faith and dedication to Cambodian classical dance where he performs the role of Hanuman, the magical white monkey. The film takes us back to the years 1975–79 when 90% of the dancers were executed or died of starvation or disease. Their story leads to Cambodia's killing fields, the refugee camps and to Yale University's Cambodian Genocide Project which helps families access information about their loved ones.

TUESDAY, MAY 16, 2000

16. REGRET TO INFORM

PROGRAM DESCRIPTION:

Fresh from its world premier at the 1999 Sundance Film Festival, this groundbreaking film portrays the devastation of the Vietnam War through the eyes of women, both American and Vietnamese, who lost their husbands. Intensely personal, yet universal in scope, *Regret to Inform* tells of love cut short and of war's lasting effects on the people left in its wake. Ten years in the making, this film is quiet, yet moving. What initially began as a letter from Mrs. Sonneborn to her late husband has evolved finally into a poignant, powerful statement on the personal toll of war.

17. UNCERTAIN BORDERS PART 1: BOUNDARY ISSUES IN PSYCHOTHERAPY

PROGRAM DESCRIPTION:

Doctors Glen Gabbard and Thomas Gutheil, along with Nanette Gartrell, Richard Kluft, Laurie Pearlman and Anne Pratt, describe in two parts how boundary issues may surface in a therapist's work, and outline strategies for the prevention of boundary violations. In Part I, *Boundary Issues* explores a wide range of topics, including self-disclosure by the therapist, time and place of therapy sessions, gifts and services, clothing and language, and physical contact. The particular boundary issues that arise in therapies with trauma survivors also are highlighted and the need for consultation and supervision is stressed.

18. UNCERTAIN BORDERS PART 2: SEXUAL BOUNDARY VIOLATIONS

PROGRAM DESCRIPTION:

In Part II, *Sexual Boundary Violations* examines the "slippery slope" phenomenon, in which small changes in the therapeutic frame can progress to sexual contact. Factors that contribute to sexual boundary violations are discussed, including countertransference, vicarious traumatization, isolation and lack of self-care by the clinician. The program concludes with specific suggestions for prevention.

19. FULL METAL JACKET

PROGRAM DESCRIPTION:

This Stanley Kubrick film is a saga about the Vietnam War and the dehumanizing process that turns people into trained killers as a group of recruits are plunged into a boot-camp hell pitbulled by a leather-lunged DI who views the would-be devil dogs as grunts, maggots or something less. The action is savage, the story unsparing and the dialogue spiked with scathing humor throughout the journey into combat in Hue City.

20. FILMS IN TEACHING PSYCHIATRY, DIVERSITY, MORALITY AND HEALING

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate how films and video can be used to teach about psychiatry, diversity, morality and healing.

PROGRAM DESCRIPTION:

This film has replaced literature as the dominant narrative medium of the 20th Century. Four psychiatrists will share how they use film in teaching. Dr. Levine will demonstrate the use of film clips from feature films to teach about psychopathology and portrayals of psychiatrists and patients based on her teaching at the University of Texas. Dr. Chang will discuss the use of documentary videotapes in teaching about diversity focusing on cultural identity, supports and stressors based on her work at the University of California. Dr. Stone will describe his Harvard Law School seminar, "Law, Psychology and Morality: An Exploration Through Film," focusing on who one is and what one sees, fact and interpretation, empathy identification, ethics and life as moral adventure and methods of interpreting film as a text. Finally, Dr. Lu will describe his intensive five-day film seminars at Esalen Institute focused on healing, transpersonal psychology and spirituality.

REFERENCES:

1. Gabbard G, Gabbad K: Psychiatry and the Cinema (Second edition). American Psychiatric Press, Washington, DC, 1999
2. Summerfield, E: Crossing Cultures through Film. Intercultural Press, Yarmouth, Maine, 1993

21. THE LAST DAYS

PROGRAM DESCRIPTION:

The Last Days is a documentary featuring five holocaust survivors, and others, whose strength and will to live represent the extraordinary power of human spirit. It focuses on the last year of war, when Adolf Hitler, already defeated and with his resources running out, revealed the depth of his racial hatred by diverting men and supplies to the task of exterminating Hungary's Jews.

22. THE THERAPEUTIC RELATIONSHIP IN HOLLYWOOD CINEMA

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the common distortions presented in Hollywood films that deal with psychotherapy and understand how to address those in the clinical situation with patients who come with distorted expectations about the process of treatment.

PROGRAM DESCRIPTION:

When psychotherapy is portrayed in the Hollywood cinema, the therapeutic relationship depicted often bears little relationship to psychotherapy in the real world. The relationship between the psychotherapist and the patient is usually based on the needs of the genre, and the accuracy of the portrayal is subverted to the requirements of the story line. This presentation will present film clips that reflect the therapeutic relationship both in classic cinema and in more contemporary American films. Some of the films that will be discussed include: *Carefree, Snake Pit, The Three Faces of Eve, Bananas, Prince of Tides, What About Bob, Good Will Hunting, As Good As It Gets, Deconstructing Harry* and *Analyze This.* The portrayals of psychotherapy reflect certain views widely held by filmmakers and audiences as well. The clinical impact of these portrayals on patients and therapists alike will be discussed, and strategies of dealing with the clinical issues will be suggested.

REFERENCES:

1. Gabbard GO & Gabbard K: Psychiatry and the Cinema: The Second Edition American Psychiatric Press Washington, DC. 1999
2. Gabbard K & Gabbard GO: The mind doctor at the millenium: Psychiatry and the cinema today. Projections 12:35–58, 1999

23. TRAINING ISSUES IN SHORT-TERM DYNAMIC PSYCHOTHERAPY

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants will have knowledge about the process of learning Short-Term Dynamic Psychotherapy including: 1) Familiarity with basic psychodynamic skills; 2) Difficulties encountered by trainees; and 3) planned systematic ways to address them in supervision.

PROGRAM DESCRIPTION:

Short-term dynamic psychotherapy, a time-limited therapy, is gaining more attention as an effective and efficient treatment modality for a variety of psychiatric disorders. Training in this particular modality requires the trainee to have an adequate knowledge base of psychodynamic theory and to acquire new therapeutic skills throughout the process. The trainees have to change their stance from the traditional active listener role to active participants who confront defenses, evoke and tolerate intense emotions and help develop insights. The supervisor's role is to help the trainees develop a psychodynamic understanding of the patient's problems, to identify the patient's responses in the therapeutic interaction including verbal and nonverbal communication guiding the trainee in making the most appropriate interventions. The use of videotaped sessions for supervision has proven to be extremely helpful in assisting the trainees in overcoming their initial difficulties.

REFERENCES:

1. Goldberg DA: Structuring training goals for psychodynamic psychotherapy. J Psychother Pract Res, 7:1, 10–22, 1997
2. Trujillo M: Short-Term Dynamic Psychotherapy In Psychotherapists Casebook: Casebook, Theory and Techniques, Kutash L, Wolf I (Ed.). San Francisco/London, Josey Bass Publishers, 1986

24. LIFE IS BEAUTIFUL: THE HOLOCAUST AS FABLE

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will understand that the Holocaust defined the reality of survivors and those who identified with them, and films like *Life is Beautiful* are redefining that reality.

PROGRAM DESCRIPTION:

Life Is Beautiful earned the *Best Jewish Experience Award* at the Jerusalem International Film Festival and three Oscars, including best foreign film. Roberto Benigni's film breaks a half-century taboo and takes audiences from the reality of death camps to a bittersweet fable. The fact that audiences and particularly Jews can laugh as well as cry and do not experience this movie as a sacrilege is something of a psychological milestone. Playing the world's most overprotective father, Benigni convinces his young son that their incarceration as Jews at a German death camp during World War II is all part of an elaborate game. From his bulbous forehead to his frantic gestures, Benigni is a clown in the great classic tradition, and he uses every bit of comic business in his vast repertoire to maintain the conceit he's concocted to protect his son. Far from trivializing the horror of the Holocaust, this film underscores an elemental truth vouches by many survivors that the human spirit can triumph over the most horrific adversity.

REFERENCES:

1. Hoberman J: Dreaming the unthinkable. Sight and Sound, Vol 9(2) pp. 20–23. February, 1999
2. Stone A: Escape from Auschwitz-Life is Beautiful turned the Holocaust into a sentimental fable. The Boston Review, Vol 24(2), pp. 35–37. April/May 1999

25. GOOD WILL HUNTING

PROGRAM DESCRIPTION:

This drama, set in Boston and Cambridge, is about rebellious 20-year-old MIT janitor Will Hunting (Matt Damon), gifted with a photographic memory, who hangs out with his South Boston bar buddies, his best friend Chuckie, and his affluent British girlfriend Skylar. After MIT professor Lambeau stumps students with a challenging math formula on a hallway blackboard, Will anonymously leaves the correct solution, prompting Lambeau to track the elusive young genius. As Will's problems with the police escalate, Lambeau offers an out, but with two conditions, visits to a therapist and weekly

math sessions. Will agrees to the latter but refuses to cooperate with a succession of therapists. Lambeau then contacts his former classmate, therapist Sean McGuire (Robin Williams), an instructor at Bunker Hill Community College. Both are equally stubborn, but Will is finally forced to deal with both his past and his future.

WEDNESDAY, MAY 17, 2000

26. REPETITION COMPULSION

PROGRAM DESCRIPTION:

Repetition Compulsion is an animated documentary, which explores how prolonged childhood abuse in the lives of homeless women has set the stage for further victimization on the streets. Weaving dark and violent charcoal imagery with actual interviews of homeless women, the film describes the crippling feelings of worthlessness, depression, powerlessness, paranoia and terror as the women become increasingly more dependent on the homeless men who support, yet continue to hurt them. Born directly out of the filmmaker's experience of working for four years with homeless women who had suffered long, unaddressed histories of physical and sexual abuse, *Repetition Compulsion* gives voice and vision to these women's stories of abuse and survival.

27. ADDICTED TO SEX

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: 1) Understand the emotional pain behind sexual addiction/compulsion and its consequences; 2) Improve diagnostic assessment of sexual addictive/compulsive behavior including past trauma; and 3) Recognize treatment approaches in helping sexual addicts/copulsives gain recovery.

PROGRAM DESCRIPTION:

This documentary is a rare uninhibited look at sexual addiction/compulsion. Cross-sections of sex addicts/compulsives tell their stories honestly and openly. They take us from their first childhood sexual experiences through their worst act of compulsion to how they are recovering today. Interwoven with these testimonies, three sex addiction/compulsive specialists, including a board certified psychiatrist, discuss the history and treatment of this disorder

REFERENCES:

1. Goodman A. Sexual Addiction: An Integrated Approach. International Universities: Press, Inc., Madison, Connecticut, 1998
2. Earle RH, Earle MR.: Sex Addiction: Case Studies and Management. Brumer/Maal, New York, 1995

28. DOCTOR IN HEALTH AND ILLNESS

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: 1) Demonstrate the centrality of behavioral science to patient-centered medical education; 2) Present the "biopsychosocial model" as a practical reasoning approach with real patients; and 3) Demonstrate techniques for transforming "lectures" into memorable presentations.

PROGRAM DESCRIPTION:

This videotape is a montage of highlights from eight sessions of the first-year behavioral science course *Doctor in Health and Illness* (DHI). DHI classes outline as follows: 1) musical tour of development; 2) adolescence: case-based dilemmas; 3) a physician's personal perspective on sexuality; 4) human sexuality discussion panel; 5) disease and illness experience of a transplant patient and family; 6) issues of middle life and the doctor-patient relationship; 7) comprehensive case formulation; and 8) medical student transformation. Sessions shown provoke engagement and participation. Faculty are challenged to create class experiences not easily captured in note-service transcriptions.

REFERENCES:

1. Ludmerer KM: Instilling professionalism in medical education. JAMA 282(9):881–882, 1999
2. Whitman NA: There is No Gene for Good Teaching: A handbook on Lecturing for Medical Teachers. The University of Utah School of Medicine, Salt Lake City, UT. 1982

29. LINKING HEALTH PROMOTION WITH ENTERTAINMENT TELEVISION

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand how mass media can shape the image of psychiatry. In addition, "Following ER" will be dissected as a model for developing strategic partnerships between psysicians and the media in order to improve the public's general medical knowledge and advance public health.

PROGRAM DESCRIPTION:

The media is the public's leading source of information about medical research, diagnosis and treatment, and thus serves as a common reference point in the doctor-patient relationship. For the last four years, the most watched television drama has been NBC's *ER*. In an effort to harness the power and reach of *ER*, a syndicated feature called *Following ER* has been developed. *Following ER* is broadcast each week by local TV stations during the late news after *ER*. The goal of these segments is to educate and motivate viewers to take action on a series of important health topics dramatized on *ER*.

REFERENCES:

1. Langliab AM, Cooper CP, Gielen A: Linking health promotion with entertainment television. AJPH 89:1116, 1999
2. Wallack L: Media advocacy: a strategy for empowering people and communities. Journal of Public Health Policy 15:427, 1994

30. BUENA VISTA SOCIAL CLUB

PROGRAM DESCRIPTION:

In 1996 Ry Cooder gathered together some of the greatest names in the history of Cuban music to collaborate on the best selling and Grammy winning album *Buena Vista Social Club*. This groundbreaking documentary, inspired by the album, includes appearances by legendary performers Ry and Joaquim Cooder, Ibrahim Ferrer, Ruben Gonzales, Eliades Ochoa, Omara Portuondo, Company Segundo and many other renowned Cuban Musicians. Excited by these colorful characters and their extraordinary music, director Wim Wenders traveled to Havana, Cuba, to chronicle the cooperation and camaraderie between Ry Cooder and his veteran friends.

31. TREYF

PROGRAM DESCRIPTION:

Treyf is an unorthodox documentary by and about two Jewish lesbians who met and fell in love at a Passover seder. A humorous and compelling film, *Treyf* situates the filmmakers' own histories within the larger realm of Jewish history. The film takes us on a personal journey from kibbuts summers to their first taste of "treyf," from the Lower East Side of New York to Jerusalem and the West

Bank. With its surprising and striking visual images, this beautiful film manages to keep a lighthearted touch while it explores the pleasures and paradoxes of a progressive, secular Jewish identity. Attempting to redefine "treyf" in a positive light, Madansky and Lebvow discover that their untraditional worldview has deep roots in Jewish history.

32. BEAUTY BEFORE AGE: GROWING OLDER IN GAY CULTURE

PROGRAM DESCRIPTION:

This groundbreaking film explores the power of youth and beauty in the gay community. A diverse group of men, ages 19 to 77, navigate their fears of becoming old, undesirable and alone. The film critically examines the pressure to look young and attractive, the lack of positive older role models and the ways in which AIDS intensifies the fear and process of aging. *Beauty Before Age* offers a male perspective on a historically female issue, and illuminates the larger societal obsession with physical appearance.

33. GOLDEN THREADS

PROGRAM DESCRIPTION:

Profiling the life of 93-year-old lesbian activist, Christine Burton, founder of a global networking service for mid-life and elder lesbians, *Golden Threads*, a film by Lucy Winer and Karen Eaton, exuberantly overturns our most deeply rooted stereotypes and fears of aging. By adding the wry and introspective narrative of the director undergoing a mid-life crisis, the film generates a groundbreaking, intergenerational dialogue about sexuality, life choices and aging. At a time when the media commonly sentimentalizes, dismisses or altogether ignores the old, *Golden Threads* offers an urgently needed antidote.

34. THE WORLD OF APU (Part III of the Apu Trilogy)

PROGRAM DESCRIPTION:

Set in India in the 1930s, this film is the conclusion of the wondrous trilogy (the first two installments are *Pather Panchali* and *Aparajito*) from the great Satyajit Ray, perhaps Indian cinema's greatest director. Based on a novel by Bibhuti Bannerjee, this film follows the life of the young boy and his family as they deal with the tricky problem of arranged marriage. The boy, Apu, is now grown up and has finished his schooling. His attempts to get a job are constantly thwarted by a single-minded bureaucracy, and his life becomes even more complicated when, in a visit to his cousin's wedding, he is talked into marrying the girl himself when the groom has a fit during the ceremony. The film then follows the two newlyweds and explores the love that grows between them, the tragedy that befalls Apu and the completion of the cycle as he attempts to become reunited with his own son after several years of estrangement. Although the story appears simple, its delineation of character makes the film seem timeless, placeless and a fair telling of the pains of love and subsequent troubles. This film is on a par with its predecessors in terms of knowing insight, poetic imagery and ability, but surpasses them in sheer craftsmanship.

35. TREMBLING BEFORE G-D
The Mesorah Society for Traditional Judaism and Psychiatry

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand the conflicts faced by the orthodox homosexual and how his/her society responds to them. This should enable the participant to provide a more culturally-sensitive approach to these issues.

PROGRAM DESCRIPTION:

To most jewishly-informed people, the term "orthodox homosexual," is an oxymoron—an impossible contradiction—unless you happen to be an orthodox homosexual. *Trembling Before G-D* is a feature-length documentary about Hasidim and other orthodox Jews who "come out" as gays and lesbians and the ways in which they negotiate their sexuality and identity in religious communities. It also portrays those who feel they must abandon their intertwined worlds of family and faith. Shot in Israel, Brooklyn, London, Los Angeles, San Francisco and Miami, it is an international project of global implications. Never before has any film or book documented in depth these stories and struggles.

REFERENCES:

1. Frenndel B: Homosexuality and Judaism. J Halacha Contemp Soc. 1986; 11:75–80
2. Spero MH: An examination of The Hacakhic status of homosexuality: Female Homosexual: Behavior and Homosexuality as ones, in handbook of psychotherapy and Jewish ethics: Hacakhic Perspectives on Professional Values and Techniques by Spero, MH, Jerusalem, Fieldheim, 1986, pp 149–172

36. LONE STAR

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand the major influences on the development of individual identity.

PROGRAM DESCRIPTION:

The development of a secure individual identity as part of personality development is a requisite for normal adult function. *Lone Star* is a movie about three sheriffs in a Texas bordertown with a past and present full of racial, ethnic, cultural, economic and gender tensions between the dominant whites, prevalent Mexicans and well-armed blacks. We follow three depressed families whose intertwined pasts are slowly revealed in the solving of a 40-year old murder. The current sheriff believes his father (a past sheriff) might have been the killer. How this questions plays out is the essence of this taut and elegant classic. This movie is clinically useful for psychiatrists who treat individuals or families and want to understand the development of character and family systems.

REFERENCES:

1. Glick ID, Clarkin JF, Kessler DR: Grune and Stratton, New York, 1987
2. Livesley WJ, Jang KL, Jackson DN, et al: Genetic and Environmental Contributions to Dimensions of Personality Disorder. Am J Psychiatry 150:1826–1831, 1993

37. ALONE TOGETHER

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to apply some psychiatric paradigms, particularly the deconstructive principles of psychosomatic medicine, in understanding art about the body.

PROGRAM DESCRIPTION:

The body has been a popular subject in 1990s art. Examining the presentation of the body in art can provide insights into our understanding of the body. Artists such as Kiki Smith, Mona Hatoum and Jeanne Dunning push our limits of defining the body and its boundaries. Through the lens of psychosomatic medicine, we will

explore the work of contemporary artist, Spencer Tunick, who photographs individuals and large groups, sometimes hundreds, naked in public spaces. People who pose describe the experience as transformative, changing the way they view their bodies. Slides of his photographs will be shown along with this video, *Alone Together,* that documents the process of a group shoot in Times Square. The discussion will focus on the concept of the naked body from four perspectives: developmental, psychodynamic, sociocultural and legal.

REFERENCES:

1. Cartwright L: Screening the Body: Tracing Medicine's Visual Culture. University of Minnesota Press Minneapolis, 1995
2. McCarthy D, Philbrick H, Finley K, eds: The Nude in Contemporary Art. Aldrich Museum of Contemporary Art, Ridgefield, CT, 1999

38. CAN'T STOP NOW

PROGRAM DESCRIPTION:

This film features six dancers, who at the height of their powers were among the world's most praised artists. Thanks to the vision of Jiri Kylian of Netherlands Dance Theatre III, these superb dancers have been able to continue their careers beyond the age of forty. Their remarkable performances break all stereotypes of the older dancer. These articulate men and women feel that wisdom and experience gives a depth to their performance that is out of the reach of the younger dancer. Their appreciative audiences worldwide have been touched by their spirituality and expressiveness. Among the performers featured are Karen Kain, National Dance Theater of Canada; Gary Cryst, protégé of Nureyev; Jeanne Solan, former dancer with the Harkness Ballet and collaborator of George Balanchine and Jerome Robbins. Here is a film not just for dance aficionados, but for all those who need confirmation that aging need not diminish their capabilities, but may even enhance them.

THURSDAY, MAY 18, 2000

39. STIGMA . . . IN OUR WORK, IN OUR LIVES

PROGRAM DESCRIPTION:

Stigma . . . in Our Work, in Our Lives, was created by The Anti-Stigma Project of On Our Own of Maryland, Inc. The video is a compilation of interviews with people who are members of the mental health and substance abuse communities in the state of Maryland, which includes providers of services as well as consumers and their families. People from a wide range of ages and cultures and with multiple viewpoints have been interviewed. You will hear from providers with national and local perspectives; people with mental illnesses, substance abuse issues and dual diagnosis; providers and administrators from psychiatric rehabilitation programs, mobile crisis services, hospital settings, governmental agencies and advocacy programs; and family members. Those interviewed were conducted by the Project. Interviewees were asked about their thoughts and views regarding the issue of stigma in the mental health and substance abuse service system.

40. NO EASY WAY

PROGRAM DESCRIPTION:

A suicide in the family is completely devastating for many reasons. Not only has a loved one died, but the pain of knowing they suffered in life is almost unbearable. Plus, all the unanswered questions they leave behind can haunt a family forever. Even in the face of such trauma people do survive. You will meet them in this video and find out how each of them copes differently. One thing they all have in common is that they have found there is "no easy way." This program can help survivors of suicide see that they can make it through their grief. It is also excellent training for those who are learning to help suicide survivors.

41. IN WHOSE HONOR

PROGRAM DESCRIPTION:

The Atlanta Braves, Kansas City Chiefs, Washington Redskins and Cleveland Indians all bear American Indian nicknames. American Indian nicknames and mascots have been used in sports for years. So what's wrong? Find out in this moving, award-winning documentary. *In Whose Honor?* takes a critical look at the long-running practice of "honoring" American Indians by using them as mascots and nicknames in sports. It follows the remarkable story of Charlene Teters (Spokane) and her transformation from a graduate student into a national movement leader. *In Whose Honor* examines the issues of race, stereotypes, minority representation and the powerful effects of mass-media imagery and also shows the extent to which one community will go to defend and justify

42. GENETIC DILEMMAS IN PRIMARY CARE

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to counsel patients on the complexities of genetic testing and support patients in the decision making process concerning genetic testing.

PROGRAM DESCRIPTION:

The Atlanta Braves, Kansas City Chiefs, Washington Redskins and Cleveland Indians all bear American Indian nicknames. American Indian nicknames and mascots have been used in sports for years. So what's wrong? Find out in this moving, award-winning documentary. *In Whose Honor?* takes a critical look at the long-running practice of "honoring" American Indians by using them as mascots and nicknames in sports. It follows the remarkable story of Charlene Teters (Spokane) and her transformation from a graduate student into a national movement leader. *In Whose Honor* examines the issues of race, stereotypes, minority representation and the powerful effects of mass-media imagery and also shows the extent to which one community will go to defend and justify its mascot.

REFERENCES:

1. King MC.: Inherited breast and ovarian cancer: What are the risks? What are the choices? JAMA. 269:1975–1980, 1993
2. Hoskins KF, Stopfer JE, Calzooe KA, et al: Assessment and counseling for women with a family risk of breast cancer. JAMA. 273:577–585, 1995

43. TIGER'S APPRENTICE

PROGRAM DESCRIPTION:

Defying cultural dismissal and government censorship, a Vietnamese-American woman investigates ancestral medicines practiced by her great-uncle, a medicine master in Vietnam. Her inquiry into the (tumor, leprosy and gangrene) medicines reveals not only the

medicines' values, but also aspects of her heritage being eclipsed by a culturally homogenizing world.

44. THE VANISHING LINE

PROGRAM DESCRIPTION:

When does life become a fate worse than death? In this age of medical "miracles," an increasing number of doctors, patients and their families are being forced to deal with this troubling, complex and universal question. *The Vanishing Line,* a contemplative, personal film by physician/filmmaker Maren Monsen, explores the timeless implications of this modern medical dilemma. It chronicles one physician's exploration of trying to meet the needs of the dying and their families and looks at the choices involved in treating terminal illness with the right balance of technology, compassion and care.

45. DEATH: A LOVE STORY

PROGRAM DESCRIPTION:

Death: A Love Story is a unique and timely documentary that looks into the extraordinary gift that death can be when we are able to put our fears and confusions about death aside and simply sit and listen to our loves ones as they pass.

MEDICAL UPDATES

MONDAY, MAY 15, 2000

1. INFANTICIDE IN AMERICA: MADNESS OR MALICE?

Margaret G. Spinelli, M.D., *Riverside Drive, #7B, New York, NY 10025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to define and categorize infanticide and neonaticide according to postpartum interval and precipitants; recognize postpartum psychosis as a psychiatric emergency with a unique organic presentation and unpredictable symptoms; identify denial of pregnancy and the concurrence of symptoms which frequently precipitate neonaticide; and differentiate psychotic infanticidal ideation from egodystonic obsessional thoughts of infanticide.

SUMMARY:

Infanticide is child murder in the first year of life and may be a consequence of postpartum psychosis. Neonaticide or child murder within 24 hours of birth is generally associated with denial of pregnancy and secret unassisted deliveries.

Because the prevalence of paychosis in women is highest immediately after childbirth, most countries make a distinction between infanticide and homicide. In the United States these women are punished under general homicide statutes.

The reality of postnatal illness remains controversial in the American judicial system. Expert psychiatric witness testimony must be based on scientific principles in order to be admissible in court. Further systematic investigation of puerperal psychopathology is critical to the recognition and treatment of women at risk and to the prevention of tragedies which follow.

REFERENCES:

1. Wisner KL, Peindl K, Hanusa BH: Symptomatology of affective and psychotic illnesses related to childbearing. J Affect Disord. 30:77-87, 1994.
2. Van der Hart O, Faure H, Van Gerven M, et al: Unawareness and denial of pregnancy in patients with MPD. Dissociation. 4:65-73, 1991.

TUESDAY, MAY 16, 2000

2. SEVENTEEN WAYS TO HAVE A BABY: REPRODUCTION IN THE 21st CENTURY

Charles Strom, M.D., *Medical Genetics, Illinois Masonic Medical Center, 836 West Wellington Avenue, Chicago, IL 60657*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to acquaint attendees with the current state of the art in fertility treatment and to alert them to potential effects of treatments. Specific emphasis will be made on medications and their side effects and the unusual family structures and reproductive conundrums brought about by unusual family structures.

SUMMARY:

The concept of infertility will be discussed with respect to current definitions and contrasted with historical definitions. Various treatment options for infertile couples will be discussed. The role of the mental health professional in this venue will be discussed. Current treatment options for infertile couples will be presented (17 Ways to Have a Baby) and a discussion of medications used in fertility treatments and their side effects (including multiple gestations) will ensue.

Case presentations of problems brought about by the use of these new technologies will be presented including unsuspected incest, same sex parents, related egg donors, and overprotective parents.

Some religious, ethical and social issues will be discussed with respect to particular case studies.

REFERENCES:

1. Vollenhoven, Beverly, J., Healey, David L., Short and Long Effects of Ovulation Induction, Endocrinology and Metabolism Clinics, 27(4):903-914, 1998.
2. Strom, C.M., Ginsberg, N., Rechitsky, S., Cieslak, J., Ivakhenko, V., Wolf, G., Lifchez, A., Moise, J., Valle, J., Kaplan, B., White, M., Barton, J., Kuliev, A. Verlinsky, Y., Three Births following Preimplantation Diagnosis for Cystic Fibrosis using sequential First and Second Polar Body Analysis, Am J. Obstet. Gynecology., 178(6):1298-1306, 1998.

WEDNESDAY, MAY 17, 2000

3. LIVER DISEASE BY ALCOHOL AND HEPATITIS C: EARLY DETECTION AND INSIGHTS IN PATHOGENESIS LEAD TO IMPROVED TREATMENT

Charles Lieber, M.D., *VA Medical Center-Bronx 151G, 130 W. Kingsbridge Road, Bronx, NY 10468*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be updated on recently developed techniques for early detection of hepatic fibrosis and precursor lesions of cirrhosis. New insights in pathogenis will also be reviewed, including their application to treatment which now results in a better outcome.

SUMMARY:

Three quarters of all medical deaths secondary to chronic alcohol abuse are due to cirrhosis of the liver. Alcohol-induced oxidative stress has been shown to play a major role in the initiation, aggravation and perpetuation of the liver injury. This is strikingly accelerated and aggravated by concommitant hepatitis C infection. Hepatitis C is commonly associated with alcoholic liver disease: a quarter of all patients with alcoholic liver disease have also markers of HCV infection, with an even higher incidence in some urban areas. In patients with hepatitis C and who also drink (even moderately), hepatocelluar carcinoma eventually develops in as many as 50% of subjects. At present, no specific therapy is available since interferon is contra-indicated in that population.

Currently, treatment is most commonly initiated when the patient presents either for serious social or medical problems, including decompensated cirrhosis or alcoholic hepatitis. However, this is much too late a stage since in patients with cirrhosis who continue to drink, more than 50% die within forty-eight months and 66% die if there is additional alcoholic hepatitis. The outcome can be improved though early treatment and, to that effect, early detection is needed. Effectiveness of screening can be greatly improved by the use of markers of heavy drinking such carbohydrate-deficient transferrin. In that group of heavy drinkers, those prone to developed cirrhosis can be identified through the detection of pre-cirrhotic lesions on liver biopsy.

The most recent therapeutic approach focuses on enzymes useful for detoxification, such as CYP2E1. When excessively induced, CYP2E1 becomes harmful and should be down-regulated. PPC is

one of the substances with anti-CYP2E1 properties that is now emerging. Elucidation of the biochemical effects of ethanol and evolving concepts of pathogenesis now provide prospects for improved therapy; future treatments will probably replace monotherapy with cocktails that not only correct dietary deficiencies but also provide those compounds that are lacking as a consequence of decreased nutrient activation secondary to the disease process, as well as agents that control the fundamental process of craving for alcohol, and others that successfully correct the basic intracellular defect caused by alcohol, namely oxidative stress, and that oppose hepatitis C, a commonly associated and aggravating factor of alcoholic liver disease.

REFERENCES:

1. Lieber CS: Hepatic and other Medical Disorders of Alcoholism: From Pathogenesis to Treatment. J Stud Alcohol. 59:9-25, 1998.
2. Lieber CS: Medical Consequences of Alcoholism: Overview In: Galanter M, editor. Recent Developments in Alcoholism. New York, NY: Plenum Publishing Corp. 14:3-166, 1998.

THURSDAY, MAY 18, 2000

4. HUMAN ENGINEERING OF THE JARVIK 2000 HEART FOR PSYCHOSOCIAL ACCEPTABILITY

Robert Jarvik, M.D., *Jarvik Heart, Inc., 333 West 52nd Street, New York, NY 10019-6238*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be aware that artificial hearts and heart assist devices are becoming increasingly common in hundreds of hospitals around the world and counseling to patients dependent on this technology becomes more common as their use expands. When applied as bridge to transplant, patients may focus their attention on obtaining a donor, but as the use of permanent mechanical support increases patients need to accommodate well to the device. This presentation will attempt to create awareness of these issues and present an approach to maximizing the quality of life when an artificial heart is the patient's only choice.

SUMMARY:

In addition to increasing the patient's longevity it has long been a goal to create an artificial heart which provides a near normal lifestyle and allows the patient piece of mind. Early work with replacement hearts demonstrated their hemodynamic efficacy but also created an acute awareness of moment life dependency which some patients could cope with comfortably and others could not. With total artificial hearts device failure means sudden death. Heart assist devices can utilize the residual function of the natural heart to provide an emergency backup and greatly increase the patient's sense of security.

The Jarvik 2000 Heart is a miniature intraventricular rotary blood pump that is implanted in the apex of the left ventricle and augments its pumping capacity. The device is small, silent, and safe. It is only 25 cc in volume and weighs only 90 grams (three ounces). Human engineering considerations directed to our goal of a "forgettable" artificial heart include miniaturizing and simplifying the system, maintenance of all electronics outside the body so that in the event of any malfunction, a backup is immediately available, demonstrating to each patient that it is safe to turn the device off for five minutes or more, which provides ample time to switch to backup equipment if ever necessary, utilizing high capacity Li-ion batteries to provide power for 8-10 hours with a battery weighing only 1.5 lbs, and arrangement of the wearable components and cable for comfort and cosmetics. With the batteries and controller worn under a jacket or dress, it is unnoticeable to casual observers and the patient can mover about normally without drawing any attention.

Clinical trials are planned to begin by early 2000, with attention to the patient's psychological adjustment as one of our major interest. By the time of the APA Annual Meeting in May, we hope to be able to report specific details of patient's emotional reactions to life with this heart.

REFERENCES:

1. Westaby, S., Katsumata, T., Houel, R., Evans R., Pigott, D., Frazier, O.H., Jarvik, R.,Jarvik 2000 Heart: Potential for Bridge to Myocyte Recovery, Circulation, 1998.
2. Macris, M., Parnis, S., Frazier, O.H., Fuqua, J., Jarvik, R., Developmental of an Implantable Ventricular Assist System, The Society of Thoracic Surgeons, 1997.
3. Jarvik, R., Westaby S., Katsmuata T., Pigott D, Evans R., VAD Power Delivery: A Percutaneous Approach to Avoid Infection, The Society of Thoracic Surgeons, 1998.

PRESIDENTIAL SYMPOSIUM

PERSPECTIVES ON THE DOCTOR-PATIENT RELATIONSHIP

Chairperson: Allan Tasman, M.D.
Co-Chairperson: Michelle Riba, M.D.

A The Experience in the Other Chair: The Patient's Perspective
Nancy Osborn, M.S., Sandy Trembath, B.S.N.

B Educating the Next Generation of Psychiatrists
Allan Tasman, M.D.

C The Doctor-Patient Relationship in Psychopharmacology Management
Kenneth R. Silk, M.D.

D The Doctor-Patient Relationship at the Medical/Psychiatric Interface
Michelle Riba, M.D.

E Ethical Issues in the Doctor-Patient Relationship
Paul S. Appelbaum, M.D.

F Cultural and International Perspectives on the Doctor-Relationship
Juan E. Mezzich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to review the scope of areas in which psychiatrists can utilize the doctor-patient relationship to improve patient care and to discuss specific strategies to better understand and manage the doctor-patient relationship.

SUMMARY:

The relationship with our patients provides the context for all our therapeutic interventions. The expansion of our knowledge from clinical research, combined with clinical wisdom, has reinforced our view of the central importance of this therapeutic relationship with our patients. In recent years, however, a variety of forces have impinged on the sanctity of our relationships with patients, including restrictive managed care practices, government and industry interference with the privacy of communication with patients, and the confidentiality of medical records. Changes in medical and psychiatric education have also understandably focused more curriculum time on technological and scientific advances. This symposium will discuss the doctor-patient relationship from a number of perspectives and in a variety of important clinical areas. The symposium begins with a videotape presentation of a patient's perspective on the doctor-patient relationship. This will be followed by a discussion of educational concerns and recommended modifications in residency training curricula. In addition, speakers in the symposium will address ethical concerns, cultural issues, and international perspectives. Therapeutic use of the doctor-patient relationship by psychiatrists when management is primarily pharmacologic, and in the medical setting, will also be discussed.

REFERENCES:

1. Ursano, RJ.: 'Section I, Approaches to the Patient,' in Tasman, A., Kay., J., and Lieberman, J., eds, Psychiatry. W.B. Saunders Co., Philadelphia, 1997.
2. Tasman, A., Riba, M., Silk, K.: The Doctor-Patient Relationship in Pharmacotherapy: Improving Therapeutic Effectiveness, Guilford Press, 2000.

RESEARCH ADVANCES IN MEDICINE

THE TREATMENT CONTROVERSY IN ALCOHOL DETOXIFICATION

Chairperson: Thomas R. Kosten, M.D.
Participants: George Koob, Ph.D., John Krystal, M.D., and Kathleen Brady, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to understand the neurobiology of alcohol dependence and its efforts on multiple neurotransmitter systems involved in reward and reinforcement as well as withdrawal symptoms and to relate this neurobiology to human neuroimaging findings. Based on these findings, participants will also be able to instruct psychiatrists in the newest pharmacotherapies for withdrawal and relapse prevention in alcoholism.

SUMMARY:

The series of presentations will begin with a focus on animal models of alcohol dependence and outline the neural pathways of reinforcement based on the dopaminergic connections between the ventral tegmental area and nucleus accumbens brain areas. This presentation will also review other neurotransmitter systems implicated in alcohol reinforcement and withdrawal including gamma amino butyric acid (GABA) and excitatory amino acid (glutaminergic—EAA) pathways, as well as involvement of opioid mechanisms. The following presentation will review recent findings using MRS to measure metabilites of GABA and EAA in the brains of living human alcoholics and controls. Significant abnormalities have been detected in these neurotransmitter systems using this innovative technology. The final presentation will review evolving pharmacotherapies of alcohol withdrawal and relapse prevention including the use of antiseizure medications for alcohol withdrawal such as carbamazepine and valproate and the use of novel relapse prevention agents such as naltrexone, antidepressants and acamprosate, which has interesting effects on GABA and EAA neurotransmission. The session will end with a discussion to overview the substantial contribution of basic and clinical neuroscience to the treatment of alcoholism and its tremendous promise for the future of relapse prevention.

REFERENCES:

1. Kosten TR and McCance E: A Review of Pharmacotherapies for Substance Abuse. The American Journal on Addictions 5(4): Supplement 1, S30–S37, 1996.
2. Behar KL, Rothman DL, Peters en KF, Hooten M, Namanworth S, Delaney R, Petroff OAC, Shulman GI, Navarro V, Petrakis IL, Charney DS, Krystal JH. Preliminary Evidence of Reduced Cortical GABA Levels in Localized 1H-Spectra of Alcohol Dependent and Hepatic Encephalopathy Patients. American Journal of Psychiatry 156:952–954, 1999.

REVIEW OF PSYCHIATRY

MONDAY, MAY 15, 2000

SECTION 1 OF THE REVIEW OF PSYCHIATRY

COMPLEMENTARY AND ALTERNATIVE MEDICINE AND PSYCHIATRY

Chairperson: Philip R. Muskin, M.D.

1. **Integrative Psychopharmacology: A Practical Approach to Herbs and Nutrients in Psychiatry**
   Richard P. Brown, M.D.
2. **Uses of Yoga in Meditation and Psychiatry**
   Ina Becker, M.D.
3. **Meditation and Psychotherapy**
   Joseph J. Loizzo, M.D.
4. **Complementary Medicine: Implications Toward Medical Treatment and the Patient-Physician Relationship**
   Catherine C. Chang-Crone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should understand the value of complementary and alternative medicine practices in psychiatric patients. Reviews of herbal and nutrient products will explore known uses and as well problems associated with the substances. There will be a discussion of the theory and practice of yoga and meditation for patients with psychiatric disorders.

SUMMARY:

Billions of dollars are spent annually on alternative therapies in the United States, most of which is out of pocket (Eisenberg et al 1998). What differentiates Complementary and Alternative Medicine (CAM) approaches from conventional (allopathic) medicine is the idea of using the individual's own resources, as well as energy within and outside of the person, to maintain wellness. There is a belief that the body can heal itself, utilizing energy mobilized by external manipulations. The central focus is the individual, not the doctor or the treatment. The unique quality of the whole person in alternative therapies make the concepts of standardization, quantification, generalization and normalization problematic for both research and clinical activity in comparison to conventional medicine. In CAM natural products, plants and nutrients all play an important role as the body exists in an environment from which it is designed to obtain energy, stay healthy and get well.

This symposium will focus on several areas within complementary/alternative medicine. The speakers are physicians who live in both the worlds of allopathic and alternative medicine. Dr. Richard Brown will review herbals and nutrients in a variety of conditions both medical and psychiatric. Dr. Ina Becker reviews both the concepts which inform yoga practice, and how it can be added to the conventional practice of psychiatry. Dr. Joseph Loizzo will speak on meditation, the complexity of meditative practice and its role for the psychiatrist is carefully delineated. Dr. Catherine Chang-Crone will review the practical concomitants of CAM use by patients with medical illness.

REFERENCES:

1. Burstein HJ, Gelber S, Guadagnoli E, Weeks JC: Use of Alternative Medicine by Women with Early-Stage Breast Cancer. *N Engl J Med* 1999; 340:1733–39.
2. Eisenberg DM, Davis RB, Ettner SL: Trends in Alternative Medicine Use in the United States, 1990–1997: Results of a Follow-Up National Survey. *JAMA* 1998; 280:1569–75.
3. Linde K, Ramirez G, Mulrow CD, Pauls A, Weidenhammer W, Melchart D: St John's Wort for Depression-An Overview and Meta-Analysis of Randomized Clinical Trials. *Brit Med J* 1996; 313:253–8.
4. Yager J, Seigfried SL, DiMatteo TL: Use of Alternative Remedies by Psychiatric Patients: Illustrative Vignettes and a Discussion of the Issues. *American Journal of Psychiatry* 1999; 156:1432–38.

TUESDAY, MAY 16, 2000

SESSION II OF THE REVIEW OF PSYCHIATRY

PSYCHOTHERAPY OF THE PERSONALITY DISORDERS

Chairperson: John G. Gunderson, M.D. and Glen O. Gabbard, M.D.

5. **Empirical Studies of Psychotherapy for Personality Disorders**
   J. Christopher Perry, M.D.
6. **Psychodynamic Psychotherapy for BPDs**
   John G. Gunderson, M.D.
7. **Combining Medication with Psychotherapy in the Treatment of Personality Disorders**
   Glen O. Gabbard, M.D.
8. **Gradations of Antisociality and Responsivity to Psychosocial Therapies**
   Michael H. Stone, M.D.
9. **Cognitive Therapy of Personality Disorders**
   Peter Tyrer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to inform and encourage psychotherapeutic treatments of patients with personality disorders.

SUMMARY:

Experts will review the remarkably diverse and clinically significant advances in psychotherapies for personality disordered patients that derive from both the clinical and research literature that have occurred since the *DSM-III* placed these disorders on a separate axis thirty years ago. Presentations will be geared to give clinicians practical take home ideas about how to avoid pitfalls and improve their effectiveness with these traditionally difficult patients. The overall message of guarded and selective optimism about treatment is expected to energize more clinical interest in psychotherapeutic activities.

REFERENCES:

1. Gunderson JG, Gabbard GO (Section Editors). Personality Disorders. In: *Treatment of Psychiatric Disorders,* 2nd Edition, Volumes 1&2. Gabbard GO, Editor-in-Chief. Washington DC: Am Psychiatric Press, pp 2243–2396, 1995.
2. Stone M: *Abnormalities of Personality.* New York: Norton Publishing, 1993.
3. Perry JC, Banon E, Lanni F: The Effectiveness of Psychotherapy for Personality Disorders. *Am J Psychiatry* 156: 1312–1321, 1999.
4. Gabbard GO: Psychotherapy of Personality Disorders. *Journal of Practical Psychiatry and Behavioral Health* 3:327–333, 1997.

SESSION III OF THE REVIEW OF PSYCHIATRY

ETHNICITY AND PSYCHOPHARMACOLOGY

Chairperson: Pedro Ruiz, M.D.

10. **Psychopharmacology in the Context of Culture and Ethnicity**
    Keh-Ming Lin, M.D.
11. **Issues in the Pharmacotherapy of African-Americans**
    William B. Lawson, M.D.
12. **A Closer Look at the Hispanic Response to Psychotropic Medications**
    Ricardo P. Mendoza, M.D.
13. **Ethnopsychopharmacology of Asians**
    Edmond H. Pi, M.D.
14. **Ethnopsychopharmacology in the Public Sector**
    Roy V. Varner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will better understand the role of pharmacokinetics, pharmacodynamics and pharmacogenetics in the psychopharmacological treatment of ethnic minority patients who suffer from psychiatric disorders/conditions. Additionally, they will be better clinically prepared to diagnose and treat psychiatrically ill patients from different ethnic backgrounds.

SUMMARY:

The field of ethnopsychopharmacology has gained much respect and recognition during the last 2–3 decades. Several factors have contributed to this situation including: 1) the growth and maturity of cultural psychiatry, 2) the recent expansion of the ethnic minority populations of this country, 3) the recent advancement of the field of ethnopsychopharmacology resulting from research efforts, and 4) the recognition of the importance of ethnicity, culture and race in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV*). In this session, we will extensively address and discuss three basic pharmacological mechanisms: pharmacokinetics, pharmacodynamics and pharmacogenetics. These three mechanisms will be extensively reviewed with respect to their action and impact in the psychopharmacological treatment of psychiatric disorders and conditions among the major ethnic minority groups who reside in this country. In this respect, our review and discussion will primarily focus on African-Americans, Hispanic-Americans and Asian-Americans and Pacific Islanders, and Native-Americans. Particular emphasis will also be given to psychiatric populations treated in the public sector. Special attention will also be given to metabolic mechanisms and drugs elimination, cross-ethnic and interindividual variations in drug responses, and to the environmental factors that could also play a role in the action of drugs among different ethnic populations. Current knowledge about drug-metabolizing enzymes will also be examined. Hopefully, this session will highly contribute to the dissemination of knowledge related to ethnopsychopharmacology, and will further stimulate educational and research efforts in this very important topic.

REFERENCES:

1. Ruiz, P, Varner RV, Small DR, Johnson BA: Ethnic Differences in the Neuroleptic Treatment of Schizophrenia. Psychiatric Quarterly, 70: 163–170, 1999.
2. Varner RV, Ruiz P, Small RD: Black and White Patients Response to Antidepressant Treatment for Major Depression. Psychiatric Quarterly, 69: 117–125, 1998.
3. Ruiz P: New Clinical Perspective in Cultural Psychiatry. Journal of Practical Psychiatry and Behavioral Health, 4(3):150–156, 1998.
4. Pi EH, Gray GE: A Cross-Cultural Perspective on Psychopharmacology. Essential Psychopharmacology, 2(3):233–262, 1998.

WEDNESDAY, MAY 17, 2000

SECTION IV OF THE REVIEW OF PSYCHIATRY

PAIN: WHAT PSYCHIATRISTS NEED TO KNOW

Chairperson: Mary Jane Massie, M.D.

15. **Pain: Definition and Assessment**
    Russell K. Portenoy, M.D.
16. **Pharmacological and Non-Pharmacological Treatments in Pain Management**
    Russell K. Portenoy, M.D.
17. **Psychogenic Models of Chronic Pain: A Selective Review and Critique**
    Randy S. Roth, Ph.D.
18. **Pain Rounds: The Experts Comment**
    Mary Jane Massie, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the current definitions and assessment methods for pain, will have knowledge of the array of pharmacologic and non-pharmacologic treatments of pain, understand the need for multivariate models in the conceptualization of chronic pain, and will understand how experienced clinicians approach the treatment of patients who have chronic pain and comorbid psychiatric disorders

SUMMARY:

Chronic pain is a critical issue in health care today. The individual with pain suffers physically, often endures the stigma of being labeled "drug seeking" or disabled and is at an increased risk of comorbid psychiatric illness. This session provides an overview of current and controversial topic in the assessment and management of the patient with pain. The multidisciplinary faculty, all specialists in the neurologic, psychologic or psychiatric management of patients with pain, will challenge clinicians to revisit and reevaluate their conceptualizations of the origins of pain symptoms and the impact of psychological factors contributing to pain.

The assessment of the patient with pain, a highly complex biopsychosocial entity, must be approached like the assessment of other patients with challenging chronic illness. In the first presentation the participant will hear an up-to-date overview of the current definitions and classification of pain. The broad range of effective multimodality treatments of pain utilized by interdisciplinary pain specialists will next be reviewed. In the third presentation, the ambiguities that characterize the assessment of chronic pain and the discrepant data on the prevalence of psychogenic pain will be discussed. Using a biopsychosocial perspective, three popular psychological models of psychogenic pain (psychodynamic, depression variant and operant) will be examined critically. Data that challenges the conventional belief that large numbers of chronic pain patients suffer pain with physiologic substrate will be presented. The last presentation will be an informal case conference. An expert panel of practicing clinicians (psychoanalyst, consultant-liaison psychiatrists, directors of pain units and a neurologist) will demonstrate different approaches to establishing framework in which to precede in patients with pain and comorbid psychiatric disorders. The expert's empathic and thoughtful step-by-step approach to diagnostic classification, biopsychosocial formulation, counter-transference issues, psychopharmacologic and psychotherapeutic treatment, family dynamics and potential treatment pitfalls makes less overwhelming the approach to the patient with complicated complaints.

REFERENCES:

1. Fishbain DA: Approaches to Treatment Decisions for Psychiatric Comorbidity in the Management of the Chronic Pain Patient. Med Clin North Am 83:737–760, 1999.
2. Geisser ME, Roth RS, Robinson, ME: Assessing Depression Among Persons with Chronic Pain Using the Center of Epidemiological Studies-Depression Scale and the Beck Depression Inventory; A Comparative Analysis. Clin J Pain 13:163–170, 1997.
3. Max MB: Antidepressant Drugs As Treatment for Chronic Pain: Efficacy and Mechanisms, in Pain and the Brain: From Nociception to Cognition, Vol 22. Edited by Bromm B, Desmedt JE. New York, Raven Press, 501–515, 1995.
4. Payne B, Norfleet MA: Chronic Pain and the Family: A Review, Pain 26:1–22, 1986.

SECTION V OF THE REVIEW OF PSYCHIATRY

LEARNING DISABILITIES

Chairperson: Laurence L. Greenhill, M.D.

19. Children with Uncomplicated Reading Disorders Grown Up: A Prospective Follow-Up Into Adulthood
Rachel G. Klein, Ph.D.

20. Learning Disabilities and the Rise of Psychiatric Disorders in Children and Adolescents
Betty B. Osman, Ph.D.

21. What Cognitive and Neurobiological Studies Have Taught Us About Dyslexia
Sally E. Shaywitz, M.D.

22. Criteria for the Diagnosing of Learning Disabilities: Psychiatric Implications
James Swanson, Ph.D.

23. Language, Reading and Motor Control Problems in ADHD: A Potential Behavior Phenotype
Rosemary Tannock, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to list the characteristic features of learning disorders, specifically reading disorder, mathematics disorder, disorder of written expression, and learning disorder not specified; list the changes in the PET scan of adults with reading disorder; and list the weaknesses of the discrepancy model learning disability.

SUMMARY:

Approximately 5% of all public school students are identified as having a learning disability (LD). LD is not a single disorder, but includes disabilities in any of seven areas related to reading, language and mathematics, including receptive language (listening), expressive language (speaking), basic reading skills, reading comprehension, written expression, mathematics calculation, and mathematical reasoning. Although the prevalence of LD identification has increased in the past 20 years, there is no consensus about the "real" prevalence of LD because there is no agreed-upon definition of LD with objective criteria that has been identified. As Lyon notes (1996), the "field continues to be beset by pervasive, and occasionally contentious, disagreements about the definition of the disorder, diagnostic criteria, assessment practices, treatment procedures, and educational policies."

Five authors present clear and incontrovertible evidence that learning disabilities create occupational, educational and peer relationship impairments that extend across the age-span. Early identification and intervention are essential to prevent long-term failure and demoralization.

REFERENCES:

1. Fletcher JM, Francis DJ, Shaywitz SE, Lyon GR (1998), Intelligent Testing and the Discrepancy Model for Children with Learning Disabilities. Learning Disabilities: Research and Practice, 13 (4):186–203.
2. Lyon GR, Alexander D, Yaffe S (1997), Progress and Promise in Research with Learning Disabilities. Learning Disabilities, 8 (1):1–6.
3. Denekla MB, LeMay M and Chapman CA (1985), Few CT Scan Abnormalities Found Even in Neurologically Impaired Learning Disabled Children. Journal of Learning Disabilities, 18 (3):132–135.
4. Lerner JW: Educational Interventions in Learning Disabilities (1989), Journal of the American Academy of Child and Adolescent Psychiatry, 28 (3):132–135.

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