Letters from readers are welcomed. They will be published at the discretion of the editor as space permits and will be subject to editing. They should be a maximum of 500 words with no more than five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the author for possible reply. Address letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, APA, 1400 K Street, N.W., Washington D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Women's Health Needs

To the Editor: We applaud the call by Sally L. Satel (1), in her editorial in the May 1998 issue, to move women's mental health into the mainstream of psychiatric research. We agree that "both women and men deserve the best psychiatry can offer." We too would be dismayed if we felt medical research that directly addresses women would marginalize women's medical needs. However, we feel that direct attention to gender is necessary for quality clinical care in psychiatry.

Since 1993, medical schools have been required to include women's health in their curricula, and more attention should be directed to women's issues as a result. In psychiatric research in particular, specific attention to gender is imperative to counteract the systematic exclusion of women. For example, women in childbearing years have been routinely excluded from psychopharmacological clinical trials based on the assumption that informed consent did not adequately protect them. Thus standard dosages of psychotropic drugs are rarely adjusted for women's height and weight as compared with males, and side effects are understudied in women.

The discrepancy between rates of diagnosed disorders among women in the general population and those who participate in research is another example of the exclusion of women from research. While 30 percent of individuals with alcohol use disorders are women, they constitute only 8 percent of the participants in alcohol studies (2). Legislation passed in 1991 requiring women to be included in research funded by the National Institutes of Health should help remedy this lack of knowledge regarding women's mental health needs.

Empirical evidence is available to answer many of the important questions posed by Dr. Satel. She suggests that "inherent distortions" exist in women's reports of traumatic experiences and that such reports are sometimes motivated by secondary gain. However, research indicates that childhood sexual abuse is more likely to be forgotten than exaggerated (3), and that women's reports of combat stress are as consistent as the measurement error inherent in psychometric assessment (4).

As for women's perpetration of domestic violence, data show that women often act aggressively against their male partners in self-defense but commit less severe violence and endure far more physical and psychological injury than their partners (5). Dr. Satel suggests that there are disadvantages to single-sex inpatient units; however, improved outcomes have been noted for several disorders, including substance abuse, treated on such units (6).

How can psychiatry make women's mental health mainstream rather than special? Key areas of research and education include the need to focus on conditions unique to women, such as psychological aspects of breast cancer; diagnoses prevalent in women, such as depression; stressors that affect women differently than men, such as violence; and genetic factors, treatment approaches, and barriers to gaining access to care that differ by gender. When these issues become routine components of psychiatric research and services, women's health will not require specialty status.

While Dr. Satel states that the unique needs of women are limited to obstetrics and gynecology, our research agenda asserts that gender differences extend beyond the reproductive function. We argue that the needs of women are marginalized when they are ignored. Differences between men and women do not necessarily make women "special" unless research derived from studies of males is assumed to be the gold standard.

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References

1. Satel SL: Are women's health needs really "special"? Psychiatric Services 49:565, 1998
2. Schneider KM, Kviz FK, Isola ML, et al: Evaluating different multiple outcomes and gender differences in alcoholism treatment. Addictive Behaviors 20:1–21, 1995
3. Williams LM: Recall of childhood trauma: a prospective study of women's memories of child sexual abuse. Journal of Consulting and Clinical Psychology 62:1167–1176, 1994
4. Prins A, Kimerling RE, Cameron R, et al: Properties of the Women's War-Time Exposure Scale. Poster presentation, International Society for Traumatic Stress Studies, Washington, DC, 1998
5. Langhinrichsen-Rohling J, Neidig P, Thom G: Violent marriages: gender differences in levels of current violence and past abuse. Journal of Family Violence 10:159–176, 1995
6. Dahlgren L, Willander A: Are special treatment facilities for female alcoholics needed? A controlled two-year follow-up study from a specialized female unit (EWA) versus a mixed male-female treatment facility. Alcohol: Clinical and Experimental Research 13:499–504, 1989

In Reply: The authors misread my commentary. I don't argue for bringing women's health into the mainstream: women's health *is* the main-

stream. Women buy more pharmaceuticals and go to the doctor more often than men. They live seven years longer and thus are overrepresented among the greatest consumers of health care, the elderly.

True, women of childbearing age had been omitted from phase 1 and phase 2 clinical trials (the safety phases), but they were always well represented in the actual efficacy, or phase 3, trials.

An additional point is that when prescribing medicines, physicians frequently adjust dosages and start at low levels for both sexes. Individual differences within sexes can be greater than individual differences between sexes. Making the necessary adjustments requires hands-on clinical experience.

Sally Satel, M.D.

Employment and Severe Mental Illness

To the Editor: I am prompted to write after reading the excellent article entitled "Policy Reform Dilemmas in Promoting Employment of Persons With Severe Mental Illnesses" by John H. Noble, Jr. (1), in the June 1998 issue. As a neurologist particularly interested in the neuropsychiatric field and closely involved with a local rescue mission that provides services for the homeless, I have been deeply impressed by Desjarlais' description (2) of the communication and cognitive functioning of persons with severe mental illness as presented in his monograph *Shelter Blues.*

His description is certainly concordant with my own clinical observations, which include the realization that clean-cut diagnostic criteria, as one sees in *DSM-IV*, simply do not work. Most of these individuals, who in fact are severely disabled, have injured their brains through drug use and have received brain injuries from head trauma. In addition, many of them started out with at least some cultural deprivation, if not birthright encephalopathies. Finally, they all have psychotic types of distortions in their internal cognitive perception, and also in their perceptions of the world. It is my firm conclusion that the concept of "employment" for this group of people is not only irrelevant but cruel.

Clearly, the basic services, such as nutrition, hygiene, essential medical care, and environmental safety, are where we should start. I do think that some of these individuals, perhaps not all, would be able to fashion daytime activities that would improve their quality of life. But they do not "get better" with habilitation or rehabilitation efforts. I have been impressed over the years that the concept of habilitation or rehabilitation of these severely impaired individuals creates an atmosphere of unrealistic expectations and, from some points of view, can be seen as a cruel hoax.

Dr. Noble's observation that "the big question is whether American society values these possible attainments enough to pay to make them more widely available" is to the point. Our culture seems not to be sufficiently empathetic to the problems and reality of disability.

William S. Masland, M.D.

Dr. Masland, who is in private practice, works with the Crossroads Mission in Yuma, Arizona.

References

1. Noble JH Jr: Policy reform dilemmas in promoting employment of persons with severe mental illnesses. Psychiatric Services 49:775–781, 1998
2. Desjarlais RD: Shelter Blues: Sanity and Selfhood Among the Homeless. Philadelphia, University of Pennsylvania Press, 1997

Telepsychiatry

To the Editor: Telepsychiatry, or, as some of us prefer to call it, "telemental health," is the use of interactive telecommunications technology to provide care to a distant consumer. While Dr. Brown's overview (1) of rural telepsychiatry in the July 1998 issue is a basic introduction for the unfamiliar reader, it does not do justice to the increasing range and frequency of applications now under way worldwide. Like the personal computer and the Internet, interactive teleconferencing will be a common tool in every effective mental health program, both rural and urban, within a few years. A great deal of activity is occurring, with full-time telepsychiatrists working with patients whom they will never see in person and who otherwise would go without treatment.

In a database compiled by the Association of Telemedicine Service Providers, some 50 active telemedicine programs with a mental health or psychiatric component were identified. *Telemedicine Today* surveyed 19 programs in the United States and found that since their inception, they have carried out almost 10,000 clinical interactions, averaging almost 50 consultations a month (2). We are well beyond the demonstration and experimental phase of this technology.

In our project, the Appal-Link Network of Virginia, we have carried out 2,700 clinical contacts with more than 400 seriously mentally ill patients in three and a half years. This network has had a tremendous impact on the public mental health system in our region by enhancing continuity of care. The same inpatient psychiatrist provides long-term community follow-up after the patient is discharged. Community staff and family members readily participate in treatment and discharge planning conferences. Our entire mental health system is more fully integrated.

Several studies will soon be published on the impact of this technology on patients' access to psychiatric care and providers' ability to conduct clinical assessments. The federal Office of Rural Health Policy will conduct a comprehensive nationwide assessment of telemedicine systems, with a special emphasis on telemental health. In the area of reimbursement, several programs already receive Medicaid and private insurance payments. The cost of this technology and its related transmission expense continues to decline. Any interested mental health care organization can now afford to purchase equipment and participate in a service delivery network.

During the past year, seven of the

most active projects in the U.S. produced a report on the history, uses, and effects of interactive telecommunications technology on mental health care. Funded by a grant from the Center for Mental Health Services, the National Telemental Health Report should be available later this year. Telemental health is on the verge of radically improving mental health care, with an impact second only to that of new atypical antipsychotic medications. The ultimate impact is clear. One day anyone, anywhere, needing treatment will have equal access to a high level of clinical care.

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Mr. Smith is director of mental health services at Cumberland Mountain Community Services in Cedar Bluff, Virginia, and project director of the National Telemental Health Report Project.

References

1. Brown FW: Rural telepsychiatry. Psychiatric Services 49:963–964, 1998
2. Allen A, Wheeler T: Telepsychiatry background and activity survey. Telemedicine Today 6:34–37, April 1998

An Olanzapine Trial

To the Editor: Information about the efficacy of atypical antipsychotics in community care settings is limited. Through the Greater Vancouver Mental Health Service Society (1), we conducted an open-label trial of olanzapine with consecutive patients started on the drug during a six-month period in 1996–1997.

Severity of illness was rated on the 7-point Clinical Global Impression of illness severity scale (CGI) (2); the ratings range from 1, indicating that a patient is free of illness, to 7, indicating an extreme degree of illness. Ratings of functioning were made using the 100-point Social and Occupational Functioning Scale (SOFAS) (3); ratings on this scale range from 20, indicating that the patient is unable to function independently, to 90, indicating that the patient is functioning well in all areas. Side effects of olanzapine were noted.

Ratings were taken at baseline and at four, eight, and 12 weeks after entry into the study. Reasons for discontinuation and changes in dyskinetic movements were noted in narratives. Flexible dosing was used. The study proceeded with the approval of the university's ethics review board.

Forty-two patients, 20 males and 22 females, with a mean±SD age of 41±14.3 years (range, 16 to 24) participated in the study. Their mean duration of illness was 14.8±9.9 years (range, 1 to 40). Thirty-two had a *DSM-IV* diagnosis of schizophrenia, four of schizoaffective disorder, and six of nonschizophrenic psychosis.

Subjects were offered olanzapine if they had suboptimal response or intolerance to their baseline treatment with typical antipsychotics (N=13), depot antipsychotics (N=6), risperidone (N=17), or clozapine (N=5) or had not previously been prescribed an antipsychotic drug (N=1).

The mean±SD baseline score on the CGI was 4.4±1.1 (range, 2 to 6); on the SOFAS it was 50±13 (range, 30 to 70). Paired t tests were used to determine whether there were significant differences between scores at the various follow-up points. Responders were categorized as those who improved at least one point on the CGI and at least one category on the SOFAS.

At 12 weeks the mean CGI score was 3.4±1.6 (range, 1 to 6), a significant improvement from baseline ($t=4.3$, $df=35$, $p=.001$). The SOFAS mean score was 59.4±15.7 (range, 35 to 90), also a significant improvement ($t=-3.9$, $df=35$, $p=.005$).

Eleven subjects (26 percent) responded to olanzapine by four weeks, 14 (33 percent) by eight weeks, and 15 (37 percent) by 12 weeks. Seven subjects (17 percent) improved dramatically; one subject had previously received a typical antipsychotic, one a depot antipsychotic, three risperidone, and two clozapine.

The mean±SD dose of olanzapine at 12 weeks was 12.8±6.54 mg per day (range, 2.5 to 35 mg). Side effects were noted in 16 of the 42 subjects (38 percent). Four experienced akathisia, four sedation, and two weight gain; one each reported blurred vision, constipation, worsening of congestive heart failure, difficulty concentrating, and arm pain. One subject had both insomnia and a rash.

At baseline, clinically significant tardive dyskinesia was observed in four subjects. By 12 weeks, one subject had improved, and tardive dyskinesia had disappeared in the other three. Improvement in dyskinesia may represent resolution of extrapyramidal side effects or, as is the case with other atypical antipsychotics (4), may reflect an intrinsic antidyskinetic activity.

Six subjects (14 percent) dropped out of the trial, two because of worsening psychosis, two because of no improvement, one because of difficulty concentrating, and one because of lack of insight.

The study was limited in that neither clinicians nor patients were blind to the drug being prescribed, and no direct comparison was made to another treatment. However, in this cohort of community mental health patients, olanzapine appears to hold promise as an effective and well-tolerated antipsychotic.

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References

1. Sladen-Dew N, Bigelow DA, Buckley R, et al: The Greater Vancouver Mental Health Service Society: 20 years' experience in urban community mental health. Canadian Journal of Psychiatry 38:308–314, 1993
2. Guy W (ed): ECDEU Assessment Manual for Psychopharmacology, Revised. Rockville, Md, US Department of Health, Education, and Welfare, 1976
3. Goldman HH, Skodol AE, Lave TR: Revising axis V for DSM-IV: a review of measures of social functioning. American Journal of Psychiatry 149:1148–1156, 1992
4. Egan MF, Apud J, Wyatt RJ: Treatment of tardive dyskinesia. Schizophrenia Bulletin 23:583–609, 1997