

The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.

Harlem Hospital Center's Geropsychiatric Service

Harlem Hospital Center's geropsychiatric service has built a program around the needs of a specific minority population: Harlem residents over 65 years of age, almost exclusively African American, who are experiencing psychiatric symptoms.

The service has three components: day treatment, a mobile team for homebound patients, and an outpatient service division. The service is structured to allow clinicians the flexibility to reassess and reformulate diagnoses and treatment plans regularly. Individual patient needs define the structure and the locus of the services provided.

The day program addresses the lack of support and the social isolation of many of our patients. Eighteen to 24 patients attend the program two to four days a week for five or six hours a day. Interventions include individual therapy (usually supportive), milieu therapy, pharmacotherapy, group activities, concrete social services, and counseling. Supportive group meetings are held for home caregivers, in which staff provide education and caregivers share their experiences with one another. Caregivers also obtain some relief in their schedules.

Two psychiatrists and an internist address patients' psychiatric and medical illnesses. The psychiatrists attend to patients in the day treat-

ment program daily, to homebound patients as clinically indicated, and to clinic patients at each outpatient visit. The internist is involved in the initial evaluation of patients, serves as a consultant to the psychiatrists and other clinical personnel, evaluates patients at least once a year, and administers preventive inoculations. The internist also may be responsible for the comprehensive medical care of patients who are confined to their homes.

We track the patients' level of illness-related disability by administering several scales about twice a year, including the Geriatric Depression Screening Scale, the Mini Mental State Examination, the Global Deterioration Scale, and measures of activities of daily living. As a patient's clinical condition changes, he or she may be transferred from one program site to another. When indicated and possible, an adjustment period is allowed during which patients are simultaneously in treatment in two programs. We continually reevaluate each patient's service plan, and when treatment goals are not being met we conduct in-depth analyses to identify needs that require further intervention.

Given the proportion of African-American elderly people who are living near or below the poverty line and the difficulties they have in obtaining care, we have instituted social service components and connections to legal services that provide patients with counsel on housing, use of entitlements, and patients' rights within the health care system. We train and recruit clinicians to encourage sensitivity to patients' cultural, spiritual, and community needs. In-service training is used to educate clinicians about various medical conditions that afflict the elderly, such as visual impairments and arthritis.

We perform evaluations in various settings where the elderly congregate and in patients' homes. We provide transportation for staff to visit patients, and we provide transportation by van for patients who do not have Medicaid coverage who would otherwise be unable to keep their appointments.

We have developed informational and educational connections with other services that are offered to elderly people in our community, including housing, senior citizen centers, protective services for adults, social service agencies, medical institutions, and individual practitioners. We maintain close contact with other formal and informal care providers, such as family, neighbors, home attendants, and physicians. A reverend is available part-time and acts as a liaison with local churches.

In summary, Harlem Hospital Center's geropsychiatric service is a model for providing comprehensive services to an elderly minority population.

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Computer-Facilitated Dialogue With Patients Who Have Schizophrenia

Psychotherapy conducted in a conversational mode relies on auditory language processing, which involves concentration, attention, and working memory. All of these faculties may be compromised in people who have schizophrenia. Some case studies that two colleagues and I published in this journal in October 1997 showed that visual representation of spoken words, displayed by typing the conversation between patient and therapist on a computer screen, may compensate for some of these deficits and enhance communication.

At Taunton (Mass.) State Hospital we conducted a pilot study of the efficacy of this approach with ten patients diagnosed as having schizophrenia or schizoaffective disorder. The study was approved by the re-

search review committee of the Massachusetts Department of Mental Health, and all participants provided written informed consent. We divided the patients into an experimental group and a control group, each comprising four men and one woman.

The mean \pm SD age of those in the experimental group was 37.8 \pm 6.3 years, and they had a mean of 10.6 \pm 1.1 years of education; their first psychiatric hospitalization occurred at a mean age of 28.8 \pm 7 years. In the control group the mean age was 44.2 \pm 14.3 years, the mean educational attainment was 10.4 \pm 1.8 years, and the mean age at first psychiatric hospitalization was 25.8 \pm 14.7 years.

All participants received eight 20- to 30-minute sessions over two to four months. Therapists followed a guideline to select common themes and issues that were to be discussed in the sessions. Topics included the treatment plan and goals, the patient's current functioning, medication issues, identification of treatment team members and their roles, and reasons for hospitalization. In the experimental group, the patient and the therapist sat in front of a computer, with the therapist at the keyboard. The therapist typed a brief version of each question, followed by the patient's responses verbatim. A transcript was given to the patient after each session. For the control group, identical issues were discussed with the usual conversational modality.

All patients answered a 29-item questionnaire administered by the unit nurse before and after the eight treatment sessions. The answers fell into two broad categories: a "negative response" category that included "No, I don't know" or any type of vague or irrelevant response, and a "productive association" category that included any meaningful or relevant response.

The control and experimental groups did not show any significant difference at the pretreatment assessment. For the control group, a mean \pm SD of 8.3 \pm 5.6 answers were categorized as negative responses and 25.8 \pm 9.6 as productive associations;

for the experimental group the figures were 8.8 \pm 7.4 and 27.9 \pm 12.5, respectively.

At the posttreatment assessment, the experimental group showed a significantly lower rate of negative responses (5.3 \pm 3.75 compared with 11 \pm 3.66; $t=-2.61$, $df=4$, $p=.01$; one-tailed test) and a significantly higher rate of productive associations (34.1 \pm 7.8 compared with 26 \pm 7.7; $t=-2.76$, $df=4$, $p=.02$; one-tailed test).

In a comparison of within-group pretreatment and posttreatment differences, the predicted improvement for productive associations was significant for the experimental group ($t=2.25$, $df=4$, $p=.04$; one-tailed test). The predicted decrease in the negative response category was not large enough to be statistically significant. For the control group, there was no significant change in either of the two variables.

The results of this pilot study suggest that therapeutic communication

accompanied by visual representation of spoken words may be more effective in increasing associations and productive thoughts related to the issues the therapist and the patient discuss. The technique may help compensate for deficits in verbal memory, working memory, and attentional process, which can interfere with communication. Such compensation may help patients with schizophrenia better understand and remember the issues discussed in therapeutic encounters. Controlled studies using a longer time frame and a larger sample could help to validate this hypothesis and assess whether the effect persists.

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