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. 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*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Depression Among Pregnant Adolescents

To the Editor: Prevalence rates of depression among pregnant adolescents have been reported to be between 16 and 44 percent, at least twice as high as among pregnant adults and nonpregnant adolescents (1). Depression in pregnant adolescents has been associated with poor compliance with prenatal care, low weight gain, smoking, and use of drugs and alcohol, thereby posing a risk of morbidity, such as low birth weight, for offspring (2). Identification and treatment of depression are therefore an integral part of prenatal care.

With increasing frequency, primary care providers now screen for depression. The prevalence of depression among pregnant adolescents indicates the need for routine screening in community OB-GYN clinics. Providers could ask two questions, about depressed mood and anhedonia, that have been shown to be as sensitive as more protracted screens for identifying cases of depression (3).

Access to and acceptability of treatment might be improved by offering treatment directly through community OB-GYN clinics. For adolescents connected with an OB-GYN clinic or provider, this service might circumvent stigma, symptoms of anxiety and avoidance, and lack of familiarity associated with accepting a referral. Providers might help their depressed patients more readily accept treatment by introducing them to a psychotherapist at the time the depression is identified.

No evidence exists that psychopharmacological treatment for depression is safe for the fetus, suggesting that psychotherapy be used instead. However, no research has been published on the efficacy of any psychotherapy treatment for depression among pregnant adolescents. Among nonpregnant adolescents, controlled clinical trials have established the efficacy of cognitive-behavioral therapy and, more recently, interpersonal psychotherapy (4). These findings suggest that either modality or a combination of the two may be helpful to pregnant adolescents.

Longitudinal studies have shown that among pregnant adolescents depressive symptoms increase in severity between the second trimester and third trimester, often due to increased interpersonal stressors such as conflict with the baby's father or lack of support from the adolescent's mother (5). Thus appropriate treatment should extend across the course of pregnancy and should at times include significant family members. It should also be conducted in a group format to improve interpersonal functioning and to enhance social support.

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Assaults on Staff

To the Editor: Flannery and associates (1), the authors of the paper on the Assaulted Staff Action Program in the February 1998 issue, are to be congratulated for their successful efforts both to help assaulted mental health staff and to decrease assault rates by implementing a crisis intervention approach. As the authors point out, the psychological sequelae of patients' assaults on staff may be detrimental for patients, staff, and health authorities.

In a previous study, the authors reported the favorable outcome of their crisis intervention program on assaulted staff (2). I wonder whether it might be useful to expand the scope of the program beyond critical-incident debriefing to generally target crisis intervention for ward staff as a group. All staff are affected by an assault on one of their members. Group interventions produce good long-term results by increasing a group's sense of cohesion, reducing tension, mobilizing team unity and support, and enhancing coping resources (3).

Regarding the reasons for the decline of assaults after implementation of the intervention program, I feel it is important to keep in mind that psychiatric patients tend to watch carefully what staff members are doing on the wards. In our own study of patients' perception of being observed on psychiatric wards, we found that patients are able to differentiate accurately between different observation levels and to perceive variations between traditions of psychiatric care (4). It is likely that psychiatric patients register staff's attitude and sense of mastery and cohesion after an assault and benefit from staff's successful coping with violence.

Parallel processes between staff and patients may play an important role in the aftermath of a destructive act on the ward (5). Assaultive patients usually experience intensely destructive affects and impulses they cannot contain intrapsychically. They cannot accept these impulses as their own, projecting them instead onto other objects whom they consequently assault. An assaulted staff member who has been helped by crisis intervention to regain mastery, attachments, and ability to make meaningful sense of the event may act as a container of such destructive forces.

Restoring a staff member's ability to make sense of the event includes gaining some understanding of why a patient has been assaultive. Such understanding could in turn lead to a sort of ingestion and deescalation of the dangerous destructive impulses. Patients who observe others handling destructive feelings positively, without being overwhelmed by anger, shame, and panic, will probably be less prone to acting out their own destructive feelings, with the result that the ward atmosphere changes and assaults decline. This hypothesis about the importance of containment is supported by the authors' finding in their earlier study (2) that a large number of assaults occurred against new staff members who had not yet been trained in stress management on the ward and were not yet used to understanding assaultive patients in their destructive rage.

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In Reply: Dr. Langenbach's thoughtful comments about declines in assaults after formation of an ASAP team draws attention to possible mediating factors associated with these rates of decline.

The ASAP program (1) does utilize group debriefing procedures for entire ward units in cases where assaults have been especially disruptive to the ward community. This decision is made jointly by the unit director and the ASAP team leader for the facility. Group debriefings are not done routinely because not every assault appears to disrupt the community, and because staffing limitations and staff overtime costs to conduct these debriefings currently preclude such an approach. Declines in the rate of assault suggest enhanced coping resources with this use of ASAP debriefings as needed, but the amount of variance accounted for by these group debriefings as well as the other types of ASAP crisis interventions remains to be examined.

The presence of an ASAP team does appear to change the hospital culture in a favorable manner. The consistent presence of an ASAP team member after each episode of violence appears to provide needed support to the individual employee victim and to the staff in general. Staff anxiety appears to be reduced, which may in turn reduce patient anxiety, favorably raising the threshold for violence. The modeling–containment approaches suggested by Dr. Langenbach offer possible theoretical explanations for why these declines may occur. However, the observed outcome may be influenced by other variables in addition to ASAP, such as advances in medication, staff experience and training, administrative support, and the halo effect.

Raymond B. Flannery, Jr., Ph.D.

Reference

1. Flannery RB Jr: The Assaulted Staff Action Program, Coping With the Psychological Aftermath of Violence. Ellicott City, Md, Chevron Publishing, 1998

Institute on Psychiatric Services Scheduled for October

The Institute on Psychiatric Services—the American Psychiatric Association's annual conference on clinical care and service delivery issues—will be held October 2–6 at the Westin Bonaventure Hotel in Los Angeles, California. Tana A. Grady, M.D., of Durham, North Carolina, is chairperson of the 1998 institute scientific program committee.

A day-by-day overview of the institute program is published in this month's issue of *Psychiatric Services*. A copy of the complete preliminary program is available from the APA Answer Center at 202-682-6000 or from APAfastFAX, APA's facsimile-on-demand service, at 888-267-5400. For additional information, contact Jill Gruber, Coordinator, Institute on Psychiatric Services, APA, 1400 K Street, N.W., Washington, D.C. 20005; telephone, 202-682-6314.