

Whatever Happened to Our Legacy of Caring?

By Donald W. Hammersley, M.D.

Over time, the ebb and flow of caring in our society are reflected in its institutions, including those for the mentally ill and disabled. In 1844, when the organization that later became APA was founded, there was a growing awareness of the need to provide the mentally ill with a safe haven in a supportive, caring environment as an alternative to residing in local jails and poorhouses or living as homeless scavengers. The moral treatment philosophy triumphed over punitive, repressive, exclusionary, and stigmatizing practices.

Dr. Hammersley is a former deputy medical director of APA and was instrumental in the development of APA's hospital and community psychiatry services.

APA's founders were medical superintendents of public and private mental hospitals. These physicians were drawn together not by any aspiration to form an organization of a new profession of psychiatrists, but by concern about the care of the mentally ill. Imbued with the tradition of caring in medical practice, they were drawn to the challenge of developing and managing specialized residential institutions just for the mentally ill. They believed in small facilities with carefully laid out and furnished patient areas. They thought a location in the country was ideal, as long as it was conveniently accessible for visitors. Healthful food, good hygiene, useful activity, and a caring, supportive staff along with an environment free of noxious influence and stress were all

specified in the early publications of the founders.

These medical superintendents provided the roots or foundation from which organized psychiatry evolved—the deep concern and humane caring for the mentally ill.

One hundred years later, a human tragedy became apparent across the country in the form of huge, overcrowded, understaffed institutions that warehoused several hundred thousand patients at bare subsistence levels. The exposés of these snake-pit conditions in the 1940's and 1950's brought renewed public awareness and commitment to address the plight of the mentally ill. When World War II was over,

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A first choice in psychosis.

RISPERDAL (Risperidone) Tablets
Before prescribing, please consult complete prescribing information of which the following is a brief summary.
INDICATIONS AND USAGE: RISPERDAL is indicated for the management of the manifestations of psychotic disorders.
CONTRAINDICATIONS: RISPERDAL is contraindicated in patients with a known hypersensitivity to the product.

WARNINGS
Neuroleptic Malignant Syndrome (NMS)
A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported.

Tardive Dyskinesia
A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. If signs and symptoms of tardive dyskinesia appear in a patient on RISPERDAL, drug discontinuation should be considered. However, some patients may require treatment with RISPERDAL despite the presence of the syndrome.
Potential for Proarrhythmic Effects: Risperidone and/or 9-hydroxyrisperidone appears to lengthen the QT interval in some patients, although there is no average increase in treated patients, even at 12-16 mg/day, well above the recommended dose. Other drugs that prolong the QT interval have been associated with the occurrence of torsades de pointes, a life-threatening arrhythmia. Bradycardia, electrolyte imbalance, concomitant use with other drugs that prolong QT, or the presence of congenital prolongation in QT can increase the risk for occurrence of this arrhythmia.

PRECAUTIONS
Orthostatic Hypotension: RISPERDAL may induce orthostatic hypotension associated with dizziness, tachycardia, and in some patients, syncope, especially during the initial dose-titration period, probably reflecting its alpha-adrenergic antagonistic properties. The risk of orthostatic hypotension and syncope may be minimized by limiting the initial dose to 1 mg BID in normal adults and 0.5 mg BID in the elderly and patients with renal or hepatic impairment (See DOSAGE AND ADMINISTRATION). A dose reduction should be considered if hypotension occurs. RISPERDAL should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemia, heart failure, or conduction abnormalities), cerebrovascular disease, and conditions which would predispose patients to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medications).
Seizures: RISPERDAL should be used cautiously in patients with a history of seizures.

Hyperprolactinemia: As with other drugs that antagonize dopamine D₂ receptors, risperidone elevates prolactin levels and the elevation persists during chronic administration. Tissue culture experiments indicate that a proportionally one-third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if the prescription of these drugs is contemplated in a patient with previously detected breast cancer. As is common with compounds which increase prolactin release, an increase in pituitary gland, mammary gland, and pancreatic islet cell hyperplasia and/or neoplasia was observed in the risperidone carcinogenicity studies conducted in mice and rats (See CARCINOGENESIS). However, neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time.

Potential for Cognitive and Motor Impairment: Somnolence was a commonly reported and dose-related adverse event associated with RISPERDAL treatment. Since RISPERDAL has the potential to impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that RISPERDAL therapy does not affect them adversely.
Rare cases of priapism have been reported.
A single case of TTP was reported in a 28-year-old female patient receiving RISPERDAL. The relationship to RISPERDAL therapy is unknown.
Risperidone has an **antiemetic effect** in animals; this effect may also occur in humans, and may mask signs and symptoms of overdosage with certain drugs or of conditions such as intestinal obstruction, Reye's syndrome, and brain tumor. Caution is advised when prescribing for patients who will be exposed to temperature extremes.

The possibility of a **suicide attempt** is inherent in schizophrenia, and close supervision of high risk patients should accompany drug therapy. Prescriptions for RISPERDAL should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose.
Clinical experience with RISPERDAL in patients with certain concomitant systemic illnesses is limited. Caution is advisable in patients with diseases or conditions that could affect metabolism or hemodynamic responses. Because of the risks of orthostatic hypotension and QT prolongation, caution should be observed in cardiac patients (See WARNINGS and PRECAUTIONS).

In patients with severe renal impairment (creatinine clearance <30 mL/min/1.73 m²), or with severe hepatic impairment, a lower starting dose should be used. Patients should be advised of the risk of orthostatic hypotension, especially during the period of initial dose titration.
Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that RISPERDAL therapy does not affect them adversely. Tell patients to notify their physician if they become pregnant or intend to become pregnant during therapy; not to breast feed an infant; to inform their physician if they are taking, or plan to take, any prescription or over-the-counter drugs; to avoid alcohol.
No specific laboratory tests are recommended.
The interactions of RISPERDAL and other drugs have not been systematically evaluated. Caution should be used when taken in combination with other centrally acting drugs and alcohol.
RISPERDAL may enhance the hypotensive effects of other therapeutic agents with this potential and it may antagonize the effects of levodopa and dopamine agonists. Chronic administration of carbamazepine or clozapine with risperidone may increase the clearance of risperidone.
Risperidone is metabolized by cytochrome P₄₅₀2D₆, an enzyme that can be inhibited by a variety of psychotropic and other drugs. Analysis of clinical studies involving a modest number of poor metabolizers (n=70) does not suggest that poor and extensive metabolizers have different rates of adverse effects. No comparison of effectiveness in the two groups has been made. In vitro studies showed that drugs metabolized by other P₄₅₀ isozymes are only weak inhibitors of risperidone metabolism.

In vitro studies indicate that risperidone is a relatively weak inhibitor of cytochrome P₄₅₀2D₆ and is not expected to substantially inhibit the clearance of drugs that are metabolized by this enzymatic pathway. However, clinical data to confirm this expectation are not available.
Carcinogenicity studies were conducted in Swiss albino mice and Wistar rats. Risperidone was administered in the diet at doses of 0.63, 2.5, and 10 mg/kg for 18 months to mice and for 25 months to rats. These doses are equivalent to 2.4, 9.4 and 37.5 times the maximum human dose (16 mg/day) on a mg/kg basis or 0.2, 0.75 and 3 times the maximum human dose (mice) or 0.4, 1.5, and 6 times the maximum human dose (rats) on a mg/m² basis. There were statistically significant increases in pituitary gland adenomas, endocrine pancreas adenomas and mammary gland adenocarcinomas. These neoplasms are considered to be prolactin-mediated. The relevance for human risk of the findings of prolactin-mediated endocrine tumors in rodents is unknown.
No evidence of mutagenic potential for risperidone was found.
Risperidone (0.16 to 5 mg/kg) was shown to impair fertility, but not fertility, in Wistar rats in three reproductive studies at doses 0.1 to 3 times the maximum recommended human dose on a mg/m² basis. The effect appeared to be in females. In a subchronic study in Beagle dogs, sperm motility and concentration were decreased at doses 0.6 to 10 times the human dose on a mg/m² basis. Dose-related decreases were also noted in serum testosterone at the same doses. Serum testosterone and sperm parameters partially recovered but remained decreased after treatment was discontinued. No no-effect doses were noted in either rat or dog.
Pregnancy Category C: The teratogenic potential of risperidone was studied in Sprague-Dawley and Wistar rats and in New Zealand rabbits. The incidence of malformations was not increased compared to control in offspring of rats or rabbits given 0.4 to 6 times the human dose on a mg/m² basis. In three reproductive studies in rats there was an increase in pup deaths during the first 4 days of lactation at doses 0.1 to 3 times the human dose on a mg/m² basis. It is not known whether these deaths were due to a direct effect on the fetuses or pups or to effects on the dams. There was no no-effect dose for increased rat pup mortality. In one Segment III study, there was an increase in stillborn rat pups at a dose 1.5 times higher than the human dose on a mg/m² basis.
Placental transfer of risperidone occurs in rat pups. There are no adequate and well-controlled studies in pregnant women. However, there was one report of a case of agenesis of the corpus callosum in an infant exposed to risperidone in utero. The causal relationship to RISPERDAL therapy is unknown.
RISPERDAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
The effect on labor and delivery in humans is unknown.
It is not known whether or not risperidone is excreted in human milk. In animal studies, risperidone and 9-hydroxyrisperidone were excreted in breast milk. Therefore, women receiving RISPERDAL should not breast feed.
Safety and effectiveness in children have not been established.
Clinical studies did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. In general, a lower starting dose is recommended for an elderly patient, reflecting a decreased pharmacokinetic clearance in the elderly, as well as a greater frequency of decreased hepatic, renal, or cardiac function, and a greater tendency to postural hypotension (See CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS
Associated with Discontinuation of Treatment
Approximately 9% percent (244/2607) of RISPERDAL treated patients in phase 2-3 studies discontinued treatment due to an adverse event, compared with about 7% on placebo and 10% on active control drugs. The more common events (≥ 0.3%) associated with discontinuation and considered to be possibly or probably drug-related included: extrapyramidal symptoms, dizziness, hyperkinesia, somnolence, and nausea.
Suicide attempt was associated with discontinuation in 1.2% of RISPERDAL-treated patients compared to 0.6% of placebo patients, but, given the almost 40-fold greater exposure time in RISPERDAL compared to placebo patients, it is unlikely that suicide attempt is a RISPERDAL-related adverse event (See PRECAUTIONS).

Incidence in Controlled Trials
Commonly Observed Adverse Events in Controlled Clinical Trials: In two 6- to 8-week placebo-controlled trials, spontaneously-reported, treatment-emergent adverse events with an incidence of 5% or greater in at least one of the RISPERDAL groups and at least twice that of placebo were: anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, dyspepsia, rhinitis, rash, and tachycardia.
Elicited adverse events in one of these two trials present at least 5% and twice the rate of placebo were: increased dream activity, increased duration of sleep, accommodation disturbances, reduced salivation, micturition disturbances, diarrhea, weight gain, menorrhagia, diminished sexual desire, erectile dysfunction, ejaculatory dysfunction, and orgasmic dysfunction.
The following adverse events occurred at an incidence of 1% or more, and were at least as frequent among RISPERDAL-treated patients treated at doses of ≤ 10 mg/day than among placebo-treated patients in the pooled results of two 6- to 8-week controlled trials. **Psychiatric Disorders:** insomnia, agitation, anxiety, somnolence, aggressive reaction. **Nervous System:** extrapyramidal symptoms, headache, dizziness. **Gastrointestinal System:** constipation, nausea, dyspepsia, vomiting, abdominal pain, saliva increased, toothache. **Respiratory System:** rhinitis, coughing, sinusitis, pharyngitis, dyspnea. **Body as a Whole:** back pain, chest pain, fever. **Dermatological:** rash, dry skin, seborrhea. **Infections:** upper respiratory. **Visual:** abnormal vision. **Musculo-Skeletal:** arthralgia. **Cardiovascular:** tachycardia.

1 Includes tremor, dystonia, hypokinesia, hyperkinesia, oculogyric crisis, ataxia, abnormal gait, involuntary muscle contractions, hyperreflexia, and extrapyramidal disorders. Although the incidence of extrapyramidal symptoms does not appear to differ for the ≤ 10 mg/day group and placebo, the data for individual dose groups in fixed dose trials do suggest a dose/response relationship (See DOSE DEPENDENCY OF ADVERSE EVENTS).

Dose Dependency of Adverse Events: Data from two fixed dose trials provided evidence of dose-relatedness for extrapyramidal symptoms associated with risperidone treatment. Adverse event data elicited by a checklist for side effects from a large study comparing 5 fixed doses of RISPERDAL (1, 4, 8, 12, and 16 mg/day) revealed a positive trend for the following adverse events: sleepiness, increased duration of sleep, accommodation disturbances, orthostatic dizziness, palpitations, weight gain, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, asthenia/lassitude/increased fatigability, and increased pigmentation.
Vital Sign Changes: RISPERDAL is associated with orthostatic hypotension and tachycardia (See PRECAUTIONS).

Weight Changes: The proportions of RISPERDAL and placebo-treated patients meeting a weight gain criterion of ≥ 7% of body weight were compared in a pool of 6- to 8-week placebo-controlled trials, revealing a statistically significantly greater incidence of weight gain for RISPERDAL (18%) compared to placebo (9%).
Laboratory Changes: A between group comparison for 6- to 8-week placebo-controlled trials revealed no statistically significant RISPERDAL/placebo differences in the proportions of patients experiencing potentially important changes in routine serum chemistry, hematology, or urinalysis parameters. Similarly, there were no RISPERDAL/placebo differences in the incidence of discontinuations for changes in serum chemistry, hematology, or urinalysis. However, RISPERDAL administration was associated with increases in serum prolactin (See PRECAUTIONS).

ECG Changes: The electrocardiograms of 8 out of 380 patients taking RISPERDAL whose baseline QTc interval was less than 450 msec were observed to have QTc intervals greater than 450 msec during treatment (see WARNINGS). Changes of this type were not seen among about 120 placebo

patients, but were seen in patients receiving haloperidol (3/126).
Other Events Observed During the Pre-Marketing Evaluation of RISPERDAL

During its premarketing assessment, multiple doses of RISPERDAL were administered to 2607 patients in phase 2 and 3 studies and the following reactions were reported: (Note "frequent" are those occurring in at least 1/100 patients; "infrequent" are those occurring in 1/100 to 1/1000 patients; "rare" are those occurring in fewer than 1/1000 patients. It is important to emphasize that, although the events reported occurred during treatment with RISPERDAL, they were not necessarily caused by it. **Psychiatric Disorders:** Frequent: increased dream activity, diminished sexual desire, nervousness. Infrequent: impaired concentration, depression, apathy, catatonic reaction, euphoria, increased libido, amnesia. Rare: emotional lability, nightmares, delirium, withdrawal syndrome, yawning. **Central and Peripheral Nervous System Disorders:** Frequent: increased sleep duration. Infrequent: dysarthria, vertigo, stupor, paraesthesia, confusion. Rare: aphasia, cholinergic syndrome, hyposthesia, tongue paralysis, leg cramps, torticollis, hypotonia, coma, migraine, hyperreflexia, choreoathetosis. **Gastro-intestinal Disorders:** Frequent: anorexia, reduced salivation. Infrequent: flatulence, diarrhea, increased appetite, stomatitis, melena, dysphagia, hemorrhoids, gastritis. Rare: fecal incontinence, eructation, gastroesophageal reflux, gastroenteritis, esophagitis, tongue discoloration, cholelithiasis, tongue edema, diverticulitis, gingivitis, discolored feces, GI hemorrhage, hematemesis. **Body as a Whole/General Disorders:** Frequent: fatigue. Infrequent: edema, rigors, malaise, influenza-like symptoms. Rare: pallor, enlarged abdomen, allergic reaction, ascites, sarcoidosis, flushing. **Respiratory System Disorders:** Frequent: hyperventilation, bronchospasm, pneumonia, stridor. Rare: asthma, increased sputum, aspiration. **Skin and Appendage Disorders:** Frequent: increased pigmentation, photosensitivity. Infrequent: increased sweating, acne, decreased sweating, alopecia, hyperkeratosis, pruritus, skin exfoliation. Rare: bullous eruption, skin ulceration, aggravated psoriasis, furunculosis, verruca, dermatitis lichenoid, hypertrichosis, genital pruritus, urticaria. **Cardiovascular Disorders:** Infrequent: palpitation, hypertension, hypotension, AV block, myocardial infarction. Rare: ventricular tachycardia, angina pectoris, premature atrial contractions, T wave inversions, ventricular extrasystoles, ST depression, myocarditis. **Vision Disorders:** Infrequent: abnormal accommodation, xerophthalmia. Rare: diplopia, eye pain, blepharitis, photophobia, abnormal lacrimation. **Metabolic and Nutritional Disorders:** Infrequent: hyponatremia, weight increase, creatine phosphokinase increase, thirst, weight decrease, diabetes mellitus. Rare: decreased serum iron, cachexia, dehydration, hypokalemia, hypoproteinemia, hyperphosphatemia, hypertriglyceridemia, hyperuricemia, hypoglycemia. **Urinary System Disorders:** Frequent: polyuria/polydipsia. Infrequent: urinary incontinence, hematuria, dysuria. Rare: urinary retention, cystitis, renal insufficiency. **Musculo-skeletal System Disorders:** Infrequent: myalgia. Rare: arthrosis, synostosis, bursitis, arthritis, skeletal pain. **Reproductive Disorders, Female:** Frequent: menorrhagia, organic dysfunction, dry vagina. Infrequent: nonpuerperal lactation, amenorrhea, female breast pain, leukorrhea, mastitis, dysmenorrhea, female perineal pain, intermenstrual bleeding, vaginal hemorrhage. **Liver and Biliary System Disorders:** Infrequent: increased SGOT, increased SGPT. Rare: hepatic failure, cholestatic hepatitis, cholecystitis, cholelithiasis, hepatitis, hepatocellular damage. **Platelet, Bleeding and Clotting Disorders:** Infrequent: epistaxis, purpura. Rare: hemorrhage, superficial phlebitis, thrombophlebitis, thrombocytopenia. **Hearing and Vestibular Disorders:** Rare: tinnitus, hyperacusis, decreased hearing. **Red Blood Cell Disorders:** Infrequent: anemia, hypochromic anemia. Rare: normocytic anemia. **Reproductive Disorders, Male:** Frequent: erectile dysfunction. Infrequent: ejaculation failure. **White Cell and Resistance Disorders:** Rare: leukocytosis, lymphadenopathy, leucopenia, Pelger-Huet anomaly. **Endocrine Disorders:** Rare: gynecomastia, male breast pain, anti-diuretic hormone disorder. **Special Senses:** Rare: bitter taste.
* Incidence based on elicited reports.

Postintroduction Reports: Adverse events reported since market introduction which were temporally (but not necessarily causally) related to RISPERDAL therapy, include the following: anaphylactic reaction, angioedema, atrial fibrillation, cerebrovascular disease, diabetes mellitus aggravated, hypothermia, intestinal obstruction, jaundice, mania, Parkinson's disease aggravated, pulmonary embolism, sudden death.

DRUG ABUSE AND DEPENDENCE
Controlled Substance Class: RISPERDAL is not a controlled substance. Patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of RISPERDAL misuse or abuse (e.g., development of tolerance, increases in dose, drug-seeking behavior).

DOSAGE AND ADMINISTRATION
Usual Initial Dose: RISPERDAL (risperidone) should be administered on a BID schedule, generally beginning with 1 mg BID initially, with increases in increments of 1 mg BID on the second and third day, as tolerated, to a target dose of 3 mg BID by the third day. In some patients, slower titration may be medically appropriate. Further dosage adjustments, if indicated, should generally occur at intervals of not less than 1 week, since steady state for the active metabolite would not be achieved for approximately 1 week in the typical patient. When dosage adjustments are necessary, small dose increments/decrements of 1 mg BID are recommended.

Antipsychotic efficacy was demonstrated in a dose range of 4 to 16 mg/day in the clinical trials supporting effectiveness of RISPERDAL, however, maximal effect was generally seen in a range of 4 to 6 mg/day. Doses above 6 mg/day were not demonstrated to be more efficacious than lower doses, were associated with more extrapyramidal symptoms and other adverse effects, and are not generally recommended. The safety of doses above 16 mg/day has not been evaluated in clinical trials. **Dosage in Special Populations:** The recommended initial dose is 0.5 mg BID in patients who are elderly or debilitated, patients with severe renal or hepatic impairment, and patients either predisposed to hypotension or for whom hypotension would pose a risk. Dosage increases in these patients should be in increments of no more than 0.5 mg BID. Increases to dosages above 1.5 mg BID should generally occur at intervals of at least 1 week. In some patients, slower titration may be medically appropriate.

Elderly or debilitated patients, and patients with renal impairment, may have less ability to eliminate RISPERDAL than normal adults. Patients with impaired hepatic function may have increases in the free fraction of the risperidone, possibly resulting in an enhanced effect (See CLINICAL PHARMACOLOGY). Patients with a predisposition to hypotensive reactions or for whom such reactions would pose a particular risk likewise need to be titrated cautiously and carefully monitored (See PRECAUTIONS). **Switching from Other Antipsychotics:** There are no systematically collected data to specifically address switching from other antipsychotics to RISPERDAL, or concerning concomitant administration with other antipsychotics. While immediate discontinuation of the previous antipsychotic treatment may be acceptable for some patients, more gradual discontinuation may be most appropriate for other patients. In all cases, the period of overlapping antipsychotic administration should be minimized. When switching patients from depot antipsychotics, if medically appropriate, initiate RISPERDAL therapy in place of the next scheduled injection. The need for continuing existing EPS medication should be reevaluated periodically.
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Harvard Group Reviews Psychiatrist

Concern about inappropriate treatment, university reputation, spark probe

Controversial Harvard psychiatrist John Mack, M.D., is under review by a special committee at the university, according to a May 4 report in the *New York Times*.

Mack has drawn national attention for writing a best-selling book, *Abduction: Human Encounters With Aliens*, about psychiatric patients who say they were abducted and, in many cases, raped, by space aliens. The book was first published in April 1994 and republished in a revised, paperback edition this May in which Mack responded to critics.

A spokesperson for Harvard Medical School said there would be no official comment on the matter. Mack's publicists for the paperback edition of his book at Ballantine Publishing failed to return a call from *Psychiatric News*, and a secretary for Mack's attorney, Roderick MacLeish Jr., said MacLeish was tied up in a trial.

The paperback edition includes a new preface and appendix to address questions of credibility and alternative interpretations of the experiences that patients described to Mack. But Mack remains firmly committed to the thesis that his patients had genuine encounters with alien beings.

The review committee is reportedly headed by Arnold Relman, M.D., former editor of the *New England Journal of Medicine* and professor emeritus at Harvard Medical School. The committee was set up one year ago by Daniel Tosteson, M.D., dean of the medical school, and has since held more than 30 closed hearings, according to the *New York Times*.

Three members of the committee who spoke on background to the *Times* said that the committee would soon present a report highly critical of Mack. According to one committee member, Tosteson had expressed concern both about Harvard's reputation and "that the cases Dr. Mack described might have been a result of hallucinations for which his treatment was not appropriate," wrote *Times* reporter William Honan.

In his book, Mack says that he had colleagues review the material. He also contends in an appendix to the new edition that "psychiatric examinations and numerous psychological tests have failed to reveal forms of mental illness that could conceivably explain the abduction phenomenon." He goes on to discuss and rebut possible explanations other than actual abductions having occurred.

Submissions Due

Submissions for posters and multimedia sessions at the Institute on Psychiatric Services (formerly Institute on Hospital and Community Psychiatry) are due June 19. The institute will be held October 6 to 10 in Boston. Forms may be obtained by contacting the IPS coordinator at APA, 1400 K Street, N.W., Washington, D.C. 20005; (202) 682-6345.