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at least according to a colleague who is familiar with the Wisconsin system. With some regret, he told me there were now productivity expectations. But to my surprise, they didn't seem as restricted as what I was used to.

Available medication tends to be the cheapest generics, but that is becoming more and more common in the private sector. More importantly, from a clinical standpoint, older generics are often proving to be adequate. In prison, some of the side effects can be less problematic, or even desired by the guards, I'm told, including some sedation and reduced sexual interest. I assumed medications that were potentially addicting and subject to more diversion would be restricted. On the other hand, would propranolol be prescribed more often in an effort to decrease aggression and violence?

One particular ethical challenge in prison would involve duty-to-warn issues. A psychiatrist's ability to maintain confidentiality of patients in prison would seem limited, and there could be some danger in withholding some information.

Certainly, efforts to maintain confidentiality have been challenged in managed care, and the Tarasoff rule has made all clinicians cautious about adhering to confidentiality agreements in cases of perceived danger to others or property.

Clinically speaking, prison and jail settings are known to have high percentages of people with alcohol and other drug abuse disorders, posttraumatic stress disorder (PTSD), attention-deficit disorder (ADD), and some hidden psychosis. All of this seems familiar, especially in the cases of PTSD and ADD. Less familiar in these settings are people with personality disorders such as antisocial and such V codes as malingering. I have been curious to learn the distinctions between being evil and/or ill, mad and/or bad, and the role of religion, corrections, and mental health as far as criminals are concerned.

I was warned that countertransference was potentially a big problem in the prison setting. Unresolved issues with dependency, control, and narcissism can pose problems. Temptation to withhold treatment or rescue fantasies might impair competent care. Horror can come from reports of undue suffering. An old colleague told me of a patient "in solitary confinement for over a year, sometimes no meds, fully psychotic, a bucket for a toilet, no mattress, cold air (on purpose), and brutal treatment from the guards. When he got out of solitary, the voices told him other prisoners were going to attack him, so he attacked them first and soon returned to solitary."

Maybe my previous exposure to the most brutal stories of trauma, of grandparents witnessing the torture of their grandchildren in Serbia, would prepare me for this.

Signs

As I continued to explore this ethical map to prison, I began looking for signs telling me whether I should proceed through the gate should I arrive there. My wife noticed that I was wearing more striped shirts. Was this an identification with the image of prison couture? A community psychiatrist colleague I had known for many years, wrote me: "You may want to think twice about this. Prisons are not a good fit for ethics experts."

After that, I was just about to decide against this idea of working in a prison, when I saw an outpatient from the downsized community health system. As I wrote his prescriptions, he noticed two books on my shelves, "Sweet Auburn: Reflections of a Prison Psychiatrist" and "Prison Madness." He asked whether I worked in a prison. I answered, no but I might be.

The patient, who was studying to become a psychologist, said he, too, had been thinking about doing this kind of work. "There are so many with mental illness in there," he said. "They need someone to care about them." Soon after that, another patient heard I was going to work somewhere else part-time. "I assume it's something compassionate," she said.

I was flattered. Since she was a peer counselor and would find out, anyway, I told her it was to be prison work. She lit up and exclaimed, "I'm so glad! My Jewish friend says you all try to heal the world." How could I refuse after that?

Now I usually don't write an ethics column about something I have not personally experienced, in addition to studying. This column is an exception. Maybe it can be called an exercise in "imaginative ethics," if you will. So, I wonder, do the issues explored here ring true for those who have exposure to prison psychiatry? What have I missed, especially in an ethical sense? Should everyone have a brief prison psychiatric experience, both for their own education and as a public service?

This could be the biggest ethical challenge of my career. It involves a precarious balancing act of different ethical principles: my safety, society's desire for security, and patient care of the underserved—all in a unique setting. I'll keep you posted. ■

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Analog Scale Measures Stress in ED Trauma Patients

BY PATRICE WENDLING

CHICAGO — Israeli investigators have developed a visual analog scale to measure the intensity of acute stress reaction symptoms in the emergency department.

The scale is similar in design to the widely used Wong-Baker Faces Pain Rating Scale, and accurately predicted the level of emotional reactions weeks after a traumatic event in two studies.

The new scale is the first to measure acute stress reaction symptoms occurring right after a traumatic event, Dr. Ilan Kutz explained at the annual meeting of the International Society for Traumatic Stress Studies. Instruments are available to measure acute stress disorder, but the disorder is typically diagnosed after the first 4 weeks. It's likely that no scale has been developed to measure acute stress reaction symptoms because "it's considered a normative response and so fleeting that people never bothered to attach much attention to it," he said.

Dr. Kutz and his associates developed more than a dozen questionnaires in an attempt to tackle such assessment issues as how to weight various symptoms (for example, hyperarousal vs. disassociation), how to categorize symptom intensity, and who should conduct the assessment and when. In the end, none of the measures were brief or simple to interpret.

"So we designed, out of a bit of despair, another kind of scale taken from the pain visual analog scale that says distress is something the patient and the clinician can point to," said Dr. Kutz, Meir Hospital, Tel-Aviv, Israel.

The 10-point acute stress reaction visual analog scale (ASR-VAS) includes five faces, ranging from a frowning and tearful face representing "extreme distress" to a smiling face for "no distress." The scale was tested by more than 1,000 Israeli clinicians with no training in acute stress reaction and found to be a simple and intuitive measurement for what the patient was experiencing, with a high interrater reliability, he said.

Dr. Kutz and Rachel Dekel, Ph.D., of Bar Ilan University in Ramat-Gan, Israel, then asked 23 victims of a terrorist attack and their clinicians to use the ASR-VAS to rate the intensity of distress within 30 minutes of arrival in the ED and 3-6 hours later after a clinical intervention.

As expected, patients rated their level of distress somewhat higher on arrival than did clinicians (7.4 points vs. 6 points), and the rating given by both groups had significantly decreased upon the patients' release (6.4 vs. 5), she said at the meeting.

Telephone interviews were conducted by a social worker 4 weeks after the event using the Stanford Acute Stress Reaction Questionnaire and again 4-5 months later using the Post-Traumatic Stress Disorder (PTSD) Inventory.

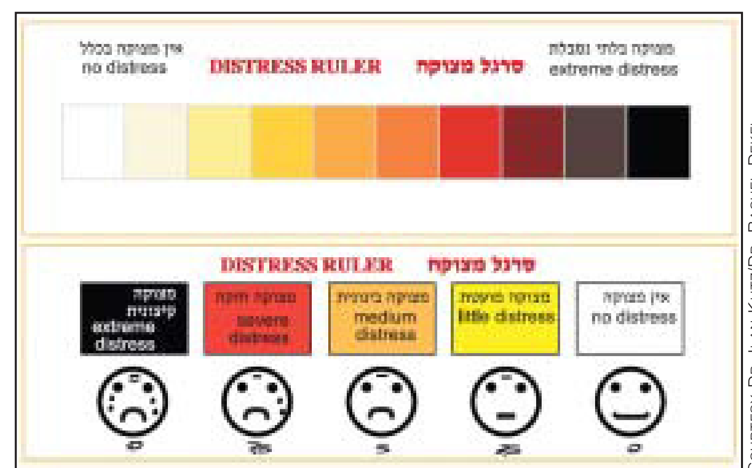
A high positive correlation was observed between the ASR-VAS level of distress upon arrival and the level of distress at the two follow-up interviews, Dr. Dekel said.

In an effort to replicate their findings, a second study with the same protocol was conducted in 62 patients, aged 18-70 years, who experienced a motor vehicle accident but did not require surgery. The patients were subdivided into three groups based on their ASR-VAS scores: 18 "resilient" patients arrived and left the hospital with a score below 5; 23 "adaptive" patients arrived with a score above 5, but experienced a 30% drop or more at release; and 21 "nonadaptive" patients whose score was above 5 at arrival and failed to decrease by 30% or more at discharge.

The nonadaptive group had significantly higher levels of distress on the 4-point Stanford questionnaire 4 weeks after the accident (2.11 points), compared with the adaptive (1.15 points) and resilient (0.69 points) groups, Dr. Dekel reported. The difference was not significant between nonadaptive and adaptive groups.

At 4 months, PTSD symptom levels were also significantly higher in the nonadaptive group than in the resilient group, and trended higher in the adaptive group, compared with the resilient group.

Because of the small size of the subgroups, it was not statistically possible to determine if the scale could predict who will develop long-term distress after a trauma, but it can be used with 90% confidence to predict those who are unlikely to develop distress, she said.



The scale, developed by Israeli investigators, is the first to measure acute reaction symptoms occurring right after a trauma.

COURTESY DR. ILAN KUTZ/DR. RACHEL DEKEL

Dr. Dekel acknowledged that the studies were limited by their small size, the use of telephone interviews, and the potential for car accident victims to be seeking secondary gains through insurance compensation.

Although these early findings should be interpreted with care, Dr. Kutz and Dr. Dekel concluded that the scale would be a useful tool in mass casualty events.

The investigators reported no conflicts of interest or funding support for the studies. ■