namically oriented clinician. I would like to share two thoughts I have about this study.

First, the authors noted that adolescence is a time of turbulence and flux. Given the regression and disruption that an acute stressor can provoke, the presence of an acute axis I diagnosis clearly confuses the picture. The authors found, however, that the absence of four symptoms—inappropriate, intense anger; suicidal threats or gestures; identity disturbance; and emptiness or boredom—accurately predicted that a patient would not have the diagnosis at follow-up. The significance of these findings is uncertain (1). I was surprised to see no reference to Kernberg (2) or Akhtar (3) for a discussion of a diagnostic differentiation between identity diffusion and adolescent identity crisis. Akhtar notes that identity diffusion is characteristic of more severe character pathology and exhibits the contradictory symptoms of intense affect and an "intense and malignant emptiness" that may be defended against by self-mutilatory behaviors. Also present in identity diffusion are multiple types of identity disturbances. It would appear the predictive significance of the absence of this constellation of symptoms lies in its association with severe character pathology.

Finally, the authors did not specify whether or not the adolescents in this study received outpatient psychotherapy between their initial interview and the follow-up 2 years later. In other words, we do not know if treatment affected follow-up results. I think this is an important consideration for both the stability of the diagnosis and the efficacy of treatment, if any.

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JEANETTE M.S. ZAIMES, M.D.
Philadephia, Pa.

Ms. Garnet and Colleagues Reply

TO THE EDITOR: We would like to thank Dr. Zaimes for her thoughtful comments on our finding of high negative predictive power of four criteria for diagnostic stability of borderline personality disorder in severely disturbed adolescents. The patients in our study group were adolescents who were diagnosed with structured assessments during an inpatient hospitalization and later at 2-year follow-up. Dr. Zaimes raises the interesting point that noted experts might regard several of these criteria, especially identity disturbance, as signals of the presence of a particularly severe personality disorder. Insofar as severity is positively associated with diagnostic stability, her comments corroborate our findings.

Dr. Zaimes also raises the issue of whether or not the adolescents in our study group received outpatient psychotherapy in the interim between hospitalization and follow-up. Indeed, the majority of our patients did receive such treatment (71% [N=5] of the diagnostically stable group and 79% [N=11] of the diagnostically unstable group). While treatment can certainly have an impact on diagnostic stability, causal judgments cannot be made in follow-along study designs such as ours. Definitive conclusions regarding treatment efficacy require control groups and random assignment.

KATHLEEN E. GARNET, M.A.
KENNETH N. LEVY, M.A.
JONATHAN J.F. MATTANAH, B.A.
WILLIAM S. EDELL, PH.D.
THOMAS H. MCGLASHAN, M.D.
Storrs, Conn.

Lithium or Desipramine Augmentation of Fluoxetine Treatment

TO THE EDITOR: Maurizio Fava, M.D., et al. (1) recently described the results of a study in which patients who failed to respond to an 8-week regimen of fluoxetine, 20 mg/day, were randomly assigned to one of three treatments: fluoxetine, 40–60 mg/day; fluoxetine, 20 mg/day, and lithium, 300–600 mg/day; or fluoxetine, 20 mg/day, and desipramine, 25–50 mg/day. The study demonstrated the value of a higher dose of fluoxetine for patients who failed to respond to a lower dose. The authors concluded that lithium augmentation and combined fluoxetine and desipramine treatment were less effective. We disagree with their interpretation of the findings. Specifically, we think the doses of lithium and desipramine were inadequate and accounted for the failure of these strategies.

Early studies (2, 3) of lithium augmentation found no correlation between lithium levels and outcome, but these studies employed a lithium dose of 300 mg t.i.d. At this dose, most patients have lithium levels above 0.4 meq/liter, and no relationship is evident. Stein and Bernadt (4), however, demonstrated that augmentation with a lithium dose of 250 mg/day was ineffective, while the addition of a 750-mg/day dose differed significantly from placebo treatment. The negative results for low-dose lithium are consistent with the negative report of Zusky et al. (5), who also used low-dose lithium augmentation. In the Stein and Bernadt study, the average lithium level for patients who received a low dose was 0.25 meq/liter. Patients in the Fava et al. report had an average lithium level of 0.21 meq/liter, which would thus appear inadequate.

In our preliminary report of the combined use of desipramine and fluoxetine in 14 inpatients (6), dose levels of desipramine ranged from 40 to 225 mg/day, with a median of 125 mg/day. Subsequently, we examined desipramine dose during combined treatment in another 12 patients from a pilot dose-finding study and in nine patients who participated in an ongoing prospective study. In these patients, desipramine dose was adjusted to reach a target blood level of 160 ng/ml. Of 24 patients who received combined treatment and who achieved blood levels in an appropriate range, only four (17%) achieved an adequate desipramine blood level on a regimen of 50 mg/day or less, which was the dose employed by Fava and associates. Most patients (N=14 of 24) required a dose of 75–125 mg/day. Four patients needed 175 mg/day or more. Our assumption has been that adequate desipramine blood levels (7) would be required during combined fluoxetine and desipramine treatment. Fava et al.'s data support that view.

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