vs. 100.1 mg. Differences in doses were tested using linear models with a normal error distribution. Differences in frequency of use were tested using categorical data models (models of population homogeneity). Statistical significance ($p < .05$) was achieved only on the frequency with which nefazodone is used to treat PTSD and depression, as compared to other drugs. Statistical significance of dose differences was not achieved due to a large variation in dosing of each drug.

CONCLUSION: At this medical center, nefazodone is used significantly more frequently for PTSD than the SS-RIs. Since severity of diagnosis and outcomes were not included in this study, no conclusion can be made regarding differences in efficacy between the groups. A potential pharmacotherapeutic advantage of nefazodone as a treatment for PTSD is its proposed efficacy in treating disorders commonly comorbid with PTSD, such as depression, panic, anxiety, agitation, and sleep disturbance.

**HEALTH-CARE RESOURCE USE AMONG CAREGIVERS OF PEOPLE WITH SCHIZOPHRENIA**

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**OBJECTIVES:** With increasing medical costs, the health of schizophrenia caregivers cannot be ignored. This research evaluated health-care resource use among caregivers of people with varying severities of schizophrenia.

**METHODS:** In June 2000, 376 schizophrenia caregivers from national support groups completed self-administered questionnaires. Mental well being was measured using the SF-12. Schizophrenia symptoms were evaluated as a four-level variable: high negative/high positive (10%); high negative/low positive (17%); low negative/high positive (10%); low negative/low positive (38%). To control for confounders to caregivers’ well being—caregivers’ demographics and involvement, and patients’ demographics and time with schizophrenia—a linear regression model was used.

**RESULTS:** The mean SF-12 score was 48.7 (SD = 10.6). In bivariate, chi-squared analysis, caregivers’ mental well being decreased as schizophrenia symptoms increased ($p < .001$). Controlling for confounders, symptom severity remained significant. Caregivers of people with low positive and negative symptoms had average SF-12 scores six points higher than those caring for people with high symptoms ($p < .001$). Even caregivers of people with only high positive symptoms scored about five points higher ($p = 0.015$).

**CONCLUSIONS:** Caregivers of people with high negative symptoms did not differ from those with both high negative and positive symptoms ($p = 0.616$). Medications and strategies that help control patients’ symptoms, especially negative symptoms, can also help caregivers experience more positive well being.

**RESPIRATORY DISORDERS**

**A COMPARISON OF SIX PHONE INTERVIEWS DESIGNED TO MEASURE HEALTH-RELATED LOST PRODUCTIVE TIME AT WORK**

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**OBJECTIVE:** To evaluate variations in work-loss estimates by phone interview method.

**METHODS:** In phone interviews, total work loss estimates were based on three domains: missed workdays; missed hours, and reduced productivity on days at work while not feeling well. Three different phone interviews were developed. Version 1 (V1) included a lengthy direct assessment of work loss. Version 2 (V2) was an abridged version of V1. Version 3 (V3) included a brief indirect assessment of work loss. Two recall periods at one week and at four weeks were also tested. Combining the three versions and the two recall periods yielded six different interviews. A convenience sam-