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معروف شاعرہ روبینہ ممتاز روبی کے شعری مجموعہ "مسکراتی تلخیاں" کی تقریب اجراء کے موقع پر تحریک نفاذ اردو و شام اردو کی نشست سے پروفیسر رضیہ سبحان، محترم انور شعور، محترم عاصم صدیقی، جناب مسعود شیخ، پروفیسر ڈاکٹر نزہت عباسی، محترمہ نسیم انجم، جناب خلیل احمد خلیل ایڈوکیٹ، سحر علی، مہر جمالی، سرپرست اعلیٰ تحریک ڈاکٹر سید مبین اختر اور صدر تحریک سید نسیم احمد شاہ اظہارِ خیال کرتے ہوئے۔

At
Karachi Psychiatric Hospital

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Neurocognitive Symptoms May Identify Psychosis

By Heidi Anne Duerr, MPH

News Briefs

IN A CLINICAL HIGH-RISK STATE OF PSYCHOSIS, neurocognitive impairment may be an indicator of later psychotic disorder, according to new research published in JAMA Psychiatry. The case-control, observational trial was conducted across 8 university-based, outpatient programs studying the psychosis prodrome in North America. Seidman and colleagues1 leveraged 19 neuropsychological tests and 4 factors derived from factor analysis (eg, executive and visuospatial abilities, verbal abilities, attention and working memory abilities, declarative memory abilities) to measure neurocognitive dysfunction among 264 (137 male and 127 female) healthy control patients and 689 (398 male and 291 female) clinical high-risk patients aged 12 to 35 years.

Patients at high risk were significantly impaired on attention and working memory abilities and declarative memory abilities. In addition, those patients in whom psychosis developed had significantly worse attention and working memory abilities and declarative memory abilities. The researchers further found that in those who transitioned to psychosis, time to conversion was significantly predicted by high verbal (premorbid) abilities, impaired declarative memory abilities, and a combined score of unusual thought content or delusional ideas and suspiciousness or persecutory ideas items.

“To our knowledge, this is the largest and most definitive study of cognition in the high-risk period before onset of psychosis/schizophrenia,” Larry J. Seidman, PhD, a psychologist at Beth Israel Deaconess Medical Center and Professor of Psychology at Harvard Medical School, said. “This is part of a paradigm shift in the way we are focusing on the earlier, prodromal phase of the disorder in an effort to identify those most likely to develop psychosis.”2

Ultimately, his group is interested in assisting clinicians in identifying those most at risk and then “developing interventions to improve a person’s chances for not getting it, making it milder or delaying it.” He added, “We are also testing a number of cognitive remediation and enhancement treatments to determine their role in the evolution of the illness. There’s more evidence suggesting that early intervention reduces the number of people who transition to schizophrenia.”

AIMS: Abnormal Involuntary Movement Scale

Persons taking any kind of antipsychotic medication need to be monitored for movement disorders. The AIMS (Abnormal Involuntary Movement Scale) aids in the early detection of tardive dyskinesia as well as providing a method for on-going surveillance.

Although the incidence of TD has been relatively low in recent years, changes in prescribing may result in increased occurrence. Clinicians will need to be alert to these possibilities and employ tools that will help them pick up developing problems as soon as possible.

This simple checklist takes only 10 minutes to complete and uses a 5-point rating scale for recording scores for 7 body areas: face, lips, jaw, tongue, upper extremities, lower extremities, and trunk.

Smartphone friendly AIMS scale.

An instructional video has been created to show how to conduct the AIMS examination and how to score the findings. Dr. Jay Pomerantz demonstrates each step of the AIMS procedure. With the help of a "standardized patient", he also shows what the different levels of symptom severity look like and explains how they should be scored.

It is suggested that you download and print out the AIMS Form and the AIMS Instructions before viewing the Instructional Video so that you will be able to follow along on each step of the examination and the scoring of the abnormal movements.

Downloading and printing out the AIMS Instructional Video Program Guide also in advance of viewing the video will give you a complete description of the information on the video and the length of time of each segment so you can skip forward and back.

Point of Care

These scales are easily used online and via mobile devices for assessment at the point of care. Score, share and record results.

Find them by suspected diagnosis:

Exploring the Psychosis-Depression Interface: Clinical Implications

By Albert H. C. Wong, MD, PhD

SIGNIFICANCE FOR THE PRACTICING PSYCHIATRIST

There is overlap in the causes of depression and psychotic symptoms.

- When depression and psychotic symptom clusters occur together, treatment with drugs that have efficacy in both symptom domains can be effective.
- When more than one drug is prescribed, care should be taken to select combinations that do not share similar adverse effects.

Patients often present with both depressive and psychotic symptoms, which can complicate diagnosis and treatment. While there are obvious differences between feelings of depression and associated neurovegetative symptoms, and the hallucinations and delusions of psychosis, there is accumulating evidence of shared causes. There is also increasing overlap in the medications used to treat these symptoms.

This article reviews the distinction between depressive and psychotic symptom domains, current knowledge about the etiology and neurobiology of depression and psychosis, and how this knowledge can inform the treatment of patients with features of both.

Background

The comorbidity between mood and psychotic symptoms has been known since at least the second century, when Galen noted that patients with depression could also have delusional beliefs. However, there has been ongoing debate in psychiatry about the diagnostic classification of psychotic and mood disorders. During the 19th century, Emil Kraepelin and others favored a separate category for schizophrenia and psychotic disorders with a mood component, such as bipolar disorder. This approach has largely been maintained in DSM-5. As a result, depressed and psychotic symptoms are usually thought of as being separate entities with different causes.

Differential diagnosis

Clinically, the differential diagnosis rests primarily on the timing, progression, and overlap of psychotic versus depressive symptoms. Patients with schizoaffective disorder have psychotic

symptoms that persist with and without mood disorder symptoms. In depression with psychotic features, patients generally have a history of previous depressive episodes, and the current episode begins with classic depression that worsens over time, at which point psychotic symptoms emerge. Conversely, patients with primary psychotic illnesses such as schizophrenia can become depressed when they realize the poor prognosis, loss of function, and dependence on caregivers—much as with any chronic medical illness. A reactive depression of this sort in schizophrenia is more likely when a psychotic episode has resolved and the patient has insight into his or her condition.

Patients who initially present with classic depression can develop psychotic symptoms, typically when the depression is severe. These psychotic symptoms are often an extreme extension of their negative thoughts and low mood, but sometimes there can be more bizarre delusions and hallucinations that seem disconnected with their mood state. Common mood congruent delusions include unrealistically hopeless perspectives about concrete stressors, such as divorce, job loss, or death of a loved one. Patients may feel as if they will never be able to attract another mate, find another job, or overcome grief. Other patients develop somatic delusions or hallucinations that there is a bad smell emanating from their body due to a terminal illness or that there is some other severe medical problem that remains undiagnosed. Patients may also experience irrational fears or persecutory paranoia, to the point where they feel the need to arm themselves or take measures to avoid being followed.

Psychotic symptoms in schizophrenia or other primary psychotic disorders such as delusional disorder can be subjectively different from those in psychotic depression. The classic description of delusions in schizophrenia by Schneider captures the themes of external control through thought control, insertion, and withdrawal. Modern manifestations of these same themes can include delusions about microchips implanted into the teeth or skull that are used by the government or scientists to control the patient. Patients may also have delusional fears about electronic tracking devices in their car or home and may feel that their body movements are also being controlled by an external agent. Auditory hallucinations in schizophrenia are almost always of human voices that recapitulate the delusional beliefs, often making comments about the patient that indicate constant surveillance.

Diagnosing the cause of depressive symptoms in schizophrenia is complicated by several factors. The first is that depression can mimic negative symptoms of schizophrenia: anhedonia, low motivation, social withdrawal, and flat affect. In addition, antipsychotic medications, through blocking dopamine D2 receptors, strongly inhibit dopamine signaling to the nucleus accumbens, one of the main structures in the reward pathway. Antipsychotic medications can thereby sap motivation and reduce responses to rewarding stimuli and generate behaviors that are clinically indistinguishable from a primary depressive disorder.

Treatment decisions

The question of what causes depressed and psychotic symptoms is clinically relevant to the choice of treatment. The cause of symptoms is generally not a diagnostic criterion in the DSM, and this approach has inadvertently obscured thinking about psychiatric disease etiology. The traditional view is that there are different causes for psychotic and depressive symptoms, which is consistent with the idea that they exist on the opposite ends of a spectrum. In this spectrum model, depression or bipolar disorder with psychotic features could be seen as being in the middle, where the 2 symptom domains overlap. Patients with both psychotic and depressive symptoms therefore have the unfortunate co-occurrence of 2 different disease processes, and thus there must be individual treatments directed at each symptom cluster.

An alternative view is that psychosis is a manifestation of a more severe form of illness, with depression at the milder end of a spectrum of severity rather than etiology. In this second framework, the causes of depressive and psychotic symptoms are shared, and the clinical presentation depends on the disease severity in a given patient. Postpartum depression and psychosis are a good example of this paradigm, since the origin or at least trigger for the psychiatric symptoms is clearly related to childbirth and the attendant changes in hormonal milieu. Thus, the treatments for both symptom clusters should be similar, differing only in more aggressive treatment when psychosis is present.

Clinical manifestations

Although the clinical manifestations of depression and psychosis appear quite different, there is evidence of substantial overlap in etiology. The heritability of schizophrenia is estimated to be between 70% and 80%, making it one of the most genetically influenced psychiatric disorders—and indeed of any type of illness. The relative contribution of genetic factors to depression is quite low compared with schizophrenia, with heritability in the 30% range. Despite large differences in heritability, there is considerable overlap in genetic susceptibility for major mental disorders, including depression, schizophrenia, bipolar disorder, ADHD, and autism spectrum disorders.

In addition to genetic epidemiological evidence for overlapping origins of both mood and psychotic disorders, there are also examples in which rare genetic variants cause both types of symptoms. The *DISC1* (disrupted-in-schizophrenia 1) gene was originally discovered in a unique Scottish family with high rates of mental illness caused by a chromosomal translocation that severs the *DISC1* gene. Family members with the mutation have a variety of diagnoses ranging from schizophrenia to bipolar disorder and depression. Animal models with *DISC1* and other mutations suggest that gene-environment interactions and genetic background can modulate behavioral phenotype, which may be the case in humans as well. These examples demonstrate that a single genetic cause can result in a variety of clinical presentations that have different diagnostic labels.

Receptor systems traditionally associated primarily with psychosis or cognition, such as the dopamine and glutamate systems, respectively, also play a role in regulating mood. The antidepressant bupropion inhibits the synaptic reuptake of both norepinephrine (like classic tricyclic antidepressants) and dopamine. Protein interactions with the dopamine D2 receptor can regulate depression-related behavior in animal models and are a promising target for new antidepressant drug development. The role of glutamate in regulating mood is clearly shown by the discovery of the rapid antidepressant effects of ketamine, a veterinary and pediatric anesthetic also used recreationally as a hallucinogenic and dance party drug. Although the anesthetic and hallucinogenic effects of ketamine have been attributed to the blockade of NMDA glutamate receptors, recent research suggests that the antidepressant effects are NMDA-independent and may be mediated instead by metabotropic glutamate receptors.

Recognizing that current antidepressants and antipsychotics are symptomatic treatments and that there is overlap in the causes of depression and schizophrenia, a specific diagnostic label is not crucial for optimal treatment. Instead, a more pragmatic focus is to select the simplest medication regimen that will maximize therapeutic effects and minimize adverse effects. As always, minimizing the number of medications prescribed concurrently is likely to be optimal because the number and complexity of drug interactions increase exponentially with additional medications.

Treatment strategies

Both antidepressant and antipsychotic medications can be used to treat comorbid depressive and psychotic symptoms; however, monotherapy with a drug with dual efficacy for both types of symptoms can also be tried. Several medications originally developed and marketed as antipsychotics are now approved by the FDA as augmentation treatments for refractory depression. This trend began with quetiapine and now includes other atypical antipsychotics, such as aripiprazole, and a combined olanzapine/fluoxetine formulation. Although the use of antipsychotics to augment antidepressant treatment is relatively new, the pharmacological overlap in efficacy is not new. Amoxapine is an old heterocyclic compound that has both antidepressant and antipsychotic properties.

The antipsychotics currently approved for augmentation treatment of depression are an obvious choice in psychotic depression. However, quetiapine has quite low affinity for the D2 receptor, and aripiprazole is not a D2 antagonist like other antipsychotics but a partial agonist. Thus, a more potent D2-antagonist antipsychotic (eg, haloperidol, risperidone, paliperidone, fluphenazine, pimozide) may be preferable to achieve sufficient D2 occupancy for antipsychotic effects while minimizing off-target adverse effects when combined with antidepressant medication. Severe depression with prominent psychotic symptoms may also present with strong suicidal ideation or with drastic psychomotor retardation and catatonia, at which point patients may stop eating and drinking. Such scenarios usually require intervention with ECT, which typically has a rapid effect on both psychotic and depressive symptoms.

To minimize adverse effects, it is vital to consider the off-target effects of medications that are to be combined. The most commonly used antidepressants primarily inhibit monoamine reuptake, including norepinephrine, serotonin and, in the case of bupropion, dopamine. Conversely, all antipsychotics bind to dopamine D2 receptor, which is a member of the G-protein coupled receptor family. Therefore, lower-affinity antipsychotics (eg, clozapine, quetiapine, chlorpromazine, ziprasidone, loxapine) tend to cross-react with other G-protein coupled receptors, such as a- adrenergic (causing orthostatic hypotension), histamine (sedation), serotonin (sexual dysfunction, appetite), and muscarinic acetylcholine (constipation, dry mouth, tachycardia, confusion). These receptors, particularly muscarinic acetylcholine receptors, are also blocked by the tricyclic antidepressants (eg, desipramine, imipramine, nortriptyline, amitriptyline); thus, combined treatment with a low-potency antipsychotic may exacerbate anticholinergic adverse effects.

Conclusion

The co-occurrence of psychosis and depression in a variety of contexts, combined with recent genetic discoveries, weakens the diagnostic distinction between these symptoms. There is also increasing overlap in the medications used to treat these symptoms, and a judicious selection of combination therapy can minimize adverse effects and enhance compliance. Further research into the causes of these symptoms may generate better treatment targets that could eventually be more specific and more effective.

Brief Cognitive Behavioral Therapy Interventions for Psychosis

By Narsimha R. Pinninti, MD and Rama Rao Gogineni, MD

TABLE 1. Connect, understand, teach, practice, ask, review (CUT-PAR)

	Strategies	Outcome
C: The deeper the connection, the more effective the intervention	Engage in water cooler conversation; build on a previous positive interaction you had; identify common interests such as sports, music, etc; validate feelings; use humor, particularly self-deprecating type; appropriate self-disclosure	Enhances engagement
U: Understand and break down the problem	Prioritize problems when there are multiple ones; break a problem into small parts; create different time frames for each problem; identify barriers to action steps and problem solve	Clarifying problems creates an actionable plan and reduces barriers to action
T: Teach	New information; simple CBT skills such as rating emotions, self-monitoring, activity scheduling; teach more adaptive perspective; teach or instill hope	Patient learns self-management and life skills and is more hopeful
P: Practice	Practice work should be manageable; have patient buy-in and ask him or her to help; ask patient for feedback about utility of the work and ability to do the work	Learned skills are generalized to real-world situations
A: Ask	Get feedback about degree of comfort in session, the intervention used, barriers to homework assigned, or therapist's style	Helps collaboration and helps the therapist to fine-tune interventions
R: Review	Patient summarizes and then therapist adds to it	Reinforces what is learned in session

TABLE 1. Connect, understand, teach, practice, ask, review (CUT-PAR)

TABLE 2. Managing hallucinations

Hallucinatory feature	Intervention
Triggers: negative emotions, boredom, lack of structure, difficult interpersonal situations, or stress	Teach coping skills to deal with negative emotions; prepare an activity schedule; avoid stressful interpersonal situations; and learn strategies to deal with stress
Content of hallucinations: benevolent or neutral content; malevolent content, eg, "You are worthless"	Inquire whether patient wants these voices gone because they may be serving socialization purpose; provide evidence for and against distressing content and do a role play to show more adaptive response to voices
Beliefs about voices such as "The voices are omnipotent and can make me homeless"	Set up experiment to document predictions of voices and if any, whether they come true
Command voices with disruptive behaviors	Evaluate the pros and cons of behavior; come up with responses to commands; find substitute adaptive behaviors
Stigma of voices: "Voices mean that I am crazy"	Providing normalizing rationale that voices occur in normal individuals (eg, bereavement, going to sleep), and most voice hearers are fully functioning individuals who do not need treatment

We are at a crossroads in our understanding and approach to psychosis. Biological paradigms and treatments are narrow in their understanding of psychoses and limited in their ability to promote recovery. There is evidence that some psychotic experiences are "normal," some are traumatogenic, and many are self-limiting and growth-promoting.

Psychiatrists who treat patients with psychosis in institutional, community, and crisis settings provide evaluations and medication management but rarely consider psychotherapeutic interventions. However, such interventions can be critical in recovery. Current guidelines recommend cognitive behavioral therapy (CBT) as evidence-based psychotherapy for schizophrenia.

Principles of therapy for psychosis

CBT for psychosis (CBTp) follows the general principles and approach of therapy for depression and anxiety with some modifications to address positive psychotic symptoms, cognitive deficits, and stigma associated with psychosis. The stages of therapy include building a therapeutic alliance, developing a formulation, specific interventions to build skills to address symptoms and improve functioning, relapse prevention to enhance resilience, and specific interventions to address stigma.

Ideally CBTp consists of at least 10 sessions over a 6-month period with specially trained therapists. Although CBTp is not widely available, a variety of CBTp-based interventions can be used widely. These components, which take 5 to 20 minutes, are clinically effective. The mnemonic CUT-PAR (connect, understand, teach, practice, ask, review) denotes the basic framework of these interventions (**Table 1**). A deeper connection with a psychotic patient is possible when the psychiatrist has a compassionate attitude, mental state of mindfulness, and uses a variety of strategies as detailed in the Table. Understanding the problem includes turning the existing problems into an actionable plan and enhancing motivation to take action. The take-home work is tailored to the patients' cognitive and motivational capacities and can be as simple as reading given material or rating mood in different situations.

Asking for feedback reduces the power differential and allows the psychiatrist to change his or her intervention or style. The importance of feedback is even more important when a patient is from a different cultural background. The patient reviews the session, and the psychiatrist adds to it. The psychiatrist may want to provide index cards or a notebook for the patient to write down what was learned in the session as well as any take-home assignments.

Managing delusions

The CBT approach to delusions is based on the principle of collaborative empiricism. The psychiatrist approaches the delusional belief with an open mind and in a spirit of discovering the truth—akin to the method of a true scientist. There are 8 targets for interventions in delusions.

1 *The first is addressing distress associated with delusions through empathic exploration.* Mary, a 32-year-old woman, believes that men are entering her house at night and talking about rape. The psychiatrist might say, "It must be very scary for you at night when you are hearing this talk about rape." Such a response helps the individual lower her defensive stance and discuss her distress. The follow-up would be to bring up any existing coping mechanisms with a question such as "Can you tell me what helped you to deal with this situation for the past 3 weeks?" Psychiatrists often find useful information about the unique coping strategies of their patient. In the above scenario, Mary found prayer to be helpful in protecting her.

2 *Sometimes a lack of real-world information can contribute to the development of delusions, and an intervention to explain how things work in the real world can sow a patient's doubt of the delusion or change how a patient responds to a delusional belief.* Annie, a 35-year-old woman, stopped taking her antipsychotic medication because she believed that the pharmacy had given her a different-colored pill to poison her. In this instance, the psychiatrist educated Annie about generic medications and about the FDA, which monitors every aspect of medication manufacturing, distribution, and dispensing. Once Annie learned about the oversight of pharmacies, she agreed to go back on the medication as a trial.

3 *A third area in which one can intervene is by narrowing the sphere of delusional thinking with specific questions.* Peter, a 40-year-old man, came into the office anxious and mildly agitated because of a persecutory delusion that people were trying to run him off the road on his walk to the clinic. The psychiatrist asked him whether he felt safe sitting in the office. Peter responded that he did feel safe. With subsequent questions, he reported feeling safe in waiting areas, parking lots, and even the side street—the delusions were activated when he was alone on a busy street. Peter was able to recognize the reason for his distress. He acknowledged that by avoiding busy streets he would be less distressed. He left the session with a sense of better control over his situation.

4 *A fourth area is to evaluate the evidence for and against a particular delusion by asking the patient to think of himself as a prosecutor and present evidence for the delusion;* the psychiatrist is the defense attorney who looks for gaps in the evidence. Then the roles can be reversed. After the discussion, the psychiatrist asks the patient for his perspective on his delusional ideas.

5 *A fifth area of intervention is to ascertain the origin of the delusion.* The patient is asked to describe the origin and the progression of the delusional ideas. The onset of delusions is usually fraught with doubt about the delusion itself. Once these doubts are unearthed, they can be strengthened.

6 *A sixth intervention is to address the utility of the delusion for the individual.* An interesting example of this intervention was given by Dr. Aaron T. Beck. He described a patient with a grandiose delusion of being Jesus Christ. Dr. Beck asked his patient to come up with a list of the benefits of being Christ and then asked him to think about the downsides. The patient realized that it meant he would be crucified. The outcome of the intervention was that a doubt was sown in the mind of the patient about the utility of this belief.

7 *A seventh area of intervention is judicious self-disclosure.* Jason, a 50-year-old man, refused to take showers because of a belief bordering on delusion that he would get pneumonia from taking a shower. The origin for the belief was his childhood experience of getting wet in the rain and contracting pneumonia. This delusion was activated by the boarding home operator who insisted that Jason take showers frequently. The psychiatrist used self-disclosure to inform Jason that he

had been taking showers every day for decades and never developed pneumonia. The patient's homework was to take showers twice a week for 2 weeks, to which he agreed.

8 *The final intervention is to address the theme underlying the delusional belief*—in persecutory delusions it is safety, and in grandiose delusions it is trying to overcome a perceived personal weakness. The outcome for any intervention varies and includes that the client feels he is being listened to, feelings of relief, a stronger therapeutic relationship, weakening of delusional belief, a change in dysfunctional behavior, and facilitation of adaptive behavior.

Hallucinations

The first step in dealing with hallucinations is a detailed evaluation that includes the triggers, content, beliefs about hallucinations, stigma associated with hallucinations, and behaviors of acting out or resisting command hallucinations (**Table 2**). If the hallucinations have positive content and the patient is not distressed by them, no intervention is necessary. For stigma and demoralization, referring patients to websites such as a hearing-voices network can provide access to stories of individuals with voices and encourage them to join a local hearing-voices group. Command hallucinations can be addressed by finding alternative behaviors that are more adaptive. For example, a patient called her mother several times at night to scream at her because of derogatory voices. A substitute behavior was found: disconnecting the phone at night and talking into it when upset.

The outcome of interventions for voices can include learning more about triggers to avoid, enhanced ability to control the voices, being able to ignore the commands, or learning to accept them without letting them interfere with functioning.

Disorganized thinking

Disorganized thinking interferes with communication, and anxiety worsens disorganization. Addressing anxiety is one way to reduce disorganized thinking. The psychiatrist takes on the role of a coach and employs strategies such as changing the topic, enhancing support, narrowing the focus of conversation, and using breathing meditation techniques or progressive relaxation. When disorganization is present without anxiety, the intervention is to bring it to the patient's attention by using an "I" statement, such as "I am having difficulty understanding what you are saying. Can you limit what you say to 3 or 4 sentences and wait for me to respond or clarify." The psychiatrist also keeps his talk to 3 or 4 sentences. If the patient is open to feedback, the psychiatrist lets the patient know when the conversation is clear and when it is not.

Medication nonadherence

Medication nonadherence rates are as high as 47% to 95% among patients with schizophrenia, and optimal utilization of medication is an important part of the recovery process. The task of the psychiatrist is to identify, acknowledge, validate the medication, and empower patients to make

medication decisions in a shared decision-making model. Subjective adverse effects described by the patient are given as much importance as the objective ones observed by the psychiatrist, and medication is framed as a tool to reduce distress and improve functioning—and not as an end in itself. Some of the more specific techniques used to facilitate medication decisions are an evaluation of cost-to-benefit of medication, linking medication decisions to life goals, and complementing information from the patient with objective information from peers or other support systems following the patient's preferences wherever possible.

Conclusions

When added to medication management visits, CBT interventions improve the therapeutic alliance, reduce stigma associated with psychosis, build skills to self-monitor and manage symptoms, reduce reliance on medication, and promote recovery. Moreover, these interventions reinforce skills learned by patients who undergo formal CBTp. Psychiatrists will find the extra few minutes spent with the patient to be personally enriching and professionally satisfying while improving outcomes and satisfaction for patients and their families.

Interventions for Perpetrators of Intimate Partner Violence

By Christopher I. Eckhardt, PhD, Christopher Murphy, PhD, and Joel G. Sprunger, MS

TABLE 1 Intimate partner violence (IPV): important points

What is IPV?

- Physical violence: minor (eg, shove, slap); severe (eg, punch, use of weapon)
- Psychological/emotional abuse: threats of violence, intimidation, denigration, humiliation, and coercive and controlling behaviors

Who perpetrates IPV?

- Men and women show near-equal rates of IPV perpetration; women perpetrate at slightly higher rates
- Overall, men cause more frequent and severe physical injury
- Occurs across age groups and across ethnic, racial, and cultural backgrounds

What are risk factors for IPV?

- Physical abuse victimization and/or witnessing inter-adult abuse in childhood
- History of conduct disorder or antisocial personality traits or disorder
- PTSD in military veteran populations
- Psychopathology, such as depression, dysthymia, generalized anxiety, alcohol dependence, and non-affective psychosis
- Negative emotion dysregulation, such as borderline personality features, disorganized/insecure attachment, and anger problems
- Substance use disorders
- Prior head injury with neurocognitive impairments that involve impulsivity, poor response inhibition, and executive dysfunction

Table 1: Intimate partner violence (IPV): important points

TABLE 2 Treatment approaches for perpetrators of intimate partner violence (IPV)

Traditional approaches

Duluth Abuse Intervention Project (Duluth model): views IPV as a means of male domination in order to assert and maintain power, control, and privilege; male assertion of dominance is implicitly rewarded/permitted in a patriarchal society

- Didactic and psychoeducational group format
- Focuses on exposing the patriarchal/misogynistic attitudes in male offenders
- Encourages accountability and responsibility for the use of coercive tactics in relationships
- Promotes gender-egalitarian behaviors

Cognitive-behavioral therapy (CBT): views IPV as maladaptive response to relationship conflict, with risk exacerbated by distorted cognitions and skill deficits, such as ineffective problem solving and poor mood regulation

- Focuses on a collaborative therapeutic relationship
- Exposes and challenges maladaptive cognitions and beliefs
- Develops effective emotion regulation strategies
- Enhances communication skills

Alternative strategies

Comprehensive case management: in addition to a traditional batterer intervention program (BIP), mental health assessment and additional services for substance abuse

Integrated CBT program for substance abuse and IPV: concurrent intervention programming for reduction in substance abuse and IPV

Culturally focused BIP: designed specifically for African American men with regard to cultural values

Trauma-informed treatment for veterans: helps veterans understand how military and combat experiences may affect intimate relationships; strength and coping resources are emphasized along with the development of new relationship skills

Brief motivational interviewing: a supportive and highly empathic counseling style designed to resolve ambivalence about changing problem behaviors with difficult patient populations

Pharmacological treatment: fluoxetine in combination with CBT for alcohol use and IPV in alcohol-dependent men has shown promise for reducing irritability and partner-reported IPV

Alternative approaches seem to be about as effective as the "traditional" approaches, but serious limitations exist regarding the generalizability of these results because of significant methodological concerns in many of the BIP effectiveness studies.

Table 2: Treatment approaches for perpetrators of intimate partner vio...

Intimate partner violence (IPV) occurs at an alarmingly high rate. According to the most recent survey of US adults, almost 7 million women and 5.5 million men experience physical violence, stalking, or rape by an intimate partner each year. Psychological/emotional abuse, including threats of violence and a wide range of intimidating, denigrating, humiliating, and controlling behaviors, is also highly prevalent. Common physical health sequelae from IPV include contusions, soft tissue injuries, sprains, strains, fractures, maxillofacial injuries, and traumatic brain injuries. In addition, the prevalence of PTSD; depression; and anxiety, mood, and substance use disorders is elevated in victims of IPV.

Table 1 provides a summary of salient points regarding IPV. Although the rates of physical IPV are roughly similar for men and women, the rates of physical injury and death are higher for women, and men are most frequently referred for treatment as perpetrators of IPV. "Common couple violence," which is typically bidirectional, non-injurious, and an outgrowth of poor conflict resolution, is distinguished from "intimate terrorism," which is often unilateral, injurious, intensely controlling, and more gender-based in nature. Nevertheless, the findings on gender similarity and mutuality of violence challenge the common assumption that IPV is solely a male-to-female problem.

Risk factors

Although there is no singular profile of the IPV perpetrator, there are several well-documented risk factors and correlates. A high percentage of court-referred IPV perpetrators have been physically abused and/or witnessed inter-adult abuse in childhood. A history of conduct disorder in adolescence and antisocial personality traits or disorder have been found to confer risk for IPV, and adolescent and young adult couples with a history of IPV are characterized by a tendency of both partners to possess similar antisocial traits (ie, assortative partnering).

PTSD is a substantial risk factor for IPV in veteran populations. A number of psychiatric disorders have been associated with men committing IPV, including depression, dysthymia, generalized anxiety, alcohol dependence, adult antisocial behavior, and nonaffective psychosis. A variety of indicators of negative emotion dysregulation are also associated with IPV, including borderline personality features, disorganized and insecure patterns of attachment, and anger problems. The incidence of IPV is typically greater than 50% among both men and women who seek treatment for substance use disorders as well as for couples in marriage therapy. The incidence of head injuries among IPV perpetrators is very high, as is that of subtle neurocognitive impairments that involve impulsivity, poor response inhibition, and deficits in executive functions.

Assessment

IPV is not commonly reported as a presenting concern, but it is readily detected through a brief structured interview or questionnaire. In addition to more extensive self-report measures, such as the Revised Conflict Tactics Scale, a number of brief IPV screening instruments have been developed and validated. Several appear to have good sensitivity for detecting IPV, including the Partner Violence Screen, the Woman Abuse Screening Tool, and the Abuse Assessment Screen. Although it is important to note that research on medical screening of IPV focuses almost exclusively on victims, clinical experience suggests that individuals seeking treatment for other problems, such as substance abuse, are often quite forthcoming about being abusive.

Intervention strategies

Psychosocial counseling for IPV perpetrators is widely available, with well over 1000 programs in the US. Most of these programs predominantly serve court-mandated populations and are focused on men who have assaulted women. Although a range of program philosophies and practices exist (**Table 2**), programs for perpetrators of IPV, often labeled batterer intervention programs (BIPs), tend to advocate an open admissions group modality and can last from 8 to 52 weeks.

There are 2 common types of BIPs. The first assumes a gender-themed root cause of IPV, such that the patriarchal nature of societal and institutional structures reward male domination and justify any means (including physical aggression) that reinforce male power, control, and privilege. For example, the widely adopted Duluth Abuse Intervention Project model aims to prevent IPV via largely didactic psychoeducational reprogramming of (male) offenders. This model focuses on exposing patriarchal/misogynistic attitudes, encourages accountability and personal responsibility, and promotes gender-egalitarian behaviors. Although this approach has been criticized because of theoretical inconsistencies and lack of empirical support, most existing intervention programs use some variation of this model.

A second BIP model uses cognitive-behavioral therapy (CBT). This model aims to change behavior through a collaborative therapeutic relationship, exposure and disputation of distorted cognitions, and various problem-solving and mood-regulating techniques. Couples-based CBT that focuses on enhancing communication and problem-solving skills between partners remains controversial because of concerns about a heightened risk of injury to partners who remain with an abusive individual while simultaneously receiving treatment for potentially volatile relationship conflicts.

Despite the widespread adoption of BIPs, evidence for their effectiveness is limited and inconclusive. Most studies of BIP effectiveness have substantial methodological limitations, including very high rates of sample attrition, inadequate treatment standardization, little or no documentation of treatment fidelity, and systematic biases in random assignment. For men assigned to BIPs, average violence recidivism rates are about 5% lower than those for men assigned to control conditions (eg, probation monitoring), with no differences in effectiveness between the Duluth model and therapeutic CBT programs. Couples-based approaches have not been found to be more effective, or more dangerous, than gender-specific IPV treatments. Thus, the empirical status of BIPs is decidedly uncertain, despite the enormous public health and safety concerns about IPV and the promise that such interventions have in rehabilitating offenders.

Alternative strategies

Interventions designed to enhance motivation and readiness to change have added value, beyond traditional BIP services. In recent years, the focus has been on developing and evaluating

alternative interventions, including medication therapy, comprehensive mental health case management, integrated treatment for substance use problems and IPV, culturally specific interventions, trauma-informed therapies, and interventions targeting motivation to change. Whereas all of these approaches can be well justified conceptually, empirical support remains limited.

An integrated CBT program for substance use problems and IPV produced significant short-term benefits in violence reduction during treatment; however, these differences were not maintained at a 6-month follow-up. Kraanen and colleagues evaluated the effectiveness of a CBT program that primarily targeted substance use disorders with a single session dedicated to IPV. At the 8-week follow-up, significant reductions in IPV and substance abuse were seen. The researchers concluded that a CBT program that targets substance abuse with some content regarding IPV may be a more economical solution in terms of financial and labor costs.

One study of a culturally focused program compared a group of African American men with mixed-race and same-race groups receiving a conventional BIP program. The results did not support same-race or culturally specific programs—the re-arrest rate for participants in the same-race groups was higher than for men in the conventional mixed-race groups.

A trauma-informed treatment for veterans who have perpetrated IPV was recently developed. The treatment was designed to help veterans understand the effect of military and combat experiences on intimate relationships while emphasizing strength and coping resources and the development of new relationship skills. Initial pilot findings suggest that this approach was favorably received by veterans; however, no controlled trial data have been presented.

The focus of several interventions is on motivation and readiness to change, areas of considerable challenge in working with IPV perpetrators (who are often forced by courts or partners to seek treatment). Brief motivational interviewing—a supportive and highly empathic counseling style designed to resolve ambivalence about change—has been shown to enhance positive treat-ment engagement and compliance with behavior change recommendations. Group approaches designed to help clients move through the stages of intentional behavior change have increased treatment adherence for highly resistant IPV offenders in one study and produced lower posttreatment violence relative to standard BIP services in another.

Research on medication therapies for IPV perpetrators is woefully limited. One randomized placebo-controlled trial examined flu-oxetine in combination with alcohol treatment and CBT for alcohol-dependent men who were perpetrators of IPV. Medication produced significant reductions relative to placebo on measures of irritability and partner-reported IPV during this 12-week trial.

Practice recommendations supported by studies

Structured screening for IPV in mental health practice may be warranted for all cases but is particularly indicated for individuals with substance use problems, antisocial behavior, anger problems, a history of head injury, notable impulsivity, or emotion dysregulation. When possible, including a confidential interview with the relationship partner can improve screening outcomes. Screening for IPV victimization in general medical settings remains a controversial topic, in part because a large multisite study found no significant benefits regarding morbidity or mortality. Findings indicate that in more than half of the patients who screened positive for IPV, doctors never discussed the issue with them. Clearly, screening alone is not a magic bullet without subsequent intervention.

Strategies that focus on motivation and readiness to change appear to have added value in engaging IPV perpetrators into treatment and enhancing participation in behavior change interventions. Motivational interviewing uses a high level of empathic reflection and gentle guidance to evoke individuals' articulation of motivation and commitment to change.

Effective treatment for substance use problems can have a substantial benefit in reducing IPV. Integrated approaches that teach relationship skills or involve partners in dyadic relationship enhancement may have added benefit for substance-abusing populations.

Conclusion

Substantial progress has been made in the development of etiologic models of IPV and interventions for individuals who assault their intimate partners. Although clinical approaches based on long-standing models of IPV intervention have modest efficacy, there is a solid conceptual rationale for several alternative strategies for IPV perpetrators. Careful screening for IPV in mental health practice; supportive strategies to motivate behavior change; and integrated services that address IPV in the context of treatment for substance abuse, traumatic stress, neurocognitive conditions, and emotion dysregulation are amenable to integration into regular clinical practice and may have effects that match or exceed standard group interventions that take a one-size-fits-all approach to the treatment of IPV.

5 Domains of Negative Symptoms of Schizophrenia

By Dawn I. Velligan, PhD and Larry D. Alphs, PhD

Lack of awareness of negative symptoms, often confused with anhedonia, is common in individuals with schizophrenia. Patients and relatives are often unaware of the extent of these symptoms and seldom communicate them to the clinician. What follows are the 5 domains of negative symptoms identified from the Negative Symptom Assessment (NSA).

The NSA describes the behaviors that might be observed in each domain. Assessment starts with one question "Starting from the time you get up, could you tell me how you have spent a typical day in the past week?" From this one question, many different levels of clinical information can be gathered.

1. Communication

Patient may produce very little speech even with prodding or, limit responses to 1 or 2 words; may exhibit long pauses before responding to questions; may produce speech that is vague and have trouble clarifying further; may mumble as if it is too difficult to articulate. Is the patient noncommunicative? Do you have to pull out every detail?

2. Emotion/affect

Patient may have a limited range of emotional experiences such as anger, happiness, sadness, surprise, fear or pride; reduced affective expressiveness as evidenced by monotone speech and blunting; reduced ability to display common affective states on request. Does the patient generate a multifaceted answer without prompting?

3. Social Activity

Patient may have few friends; limited desire for or interactions with others; poor rapport with the interviewer; limited desire for contact. Is the patient actively engaged with hobbies and productive activity during the day?

4. Motivation

Patient may engage in little productive activity; spend much of the day sitting or lying around; may not take care of basic grooming and hygiene; has little interest in world events or hobbies;

may have limited life goals or sense of purpose. Is the individual enthusiastic about any specific activities?

5. Psychomotor activity

Patient exhibits slowed movements; may appear that moving requires considerable effort; expressive gestures such as using hands and shaking head that normally facilitate communication may be reduced or absent. How does this individual compare with a person without schizophrenia?

Individuals with schizophrenia frequently do not spontaneously report negative symptoms as problems. They are less concerned about them than their relatives may be. It is important to make accurate assessments of negative symptoms. Although there are no well-established clinical assessment tools to measure treatment progress or failure, this may be one of several helpful instruments. For more information, see "Negative Symptoms in Schizophrenia: An Update on Identification and Treatment," by Dawn I. Velligan, PhD and Larry D. Alphs, PhD, on which this information was based. http://900.91/74AFBp

Treatment Options in Late-Life Treatment-Resistant Depression

By Katarina Arandjelovic, MBBS, Harris A. Eyre, MBBS (Hons), Malcolm Forbes, MBBS, and Helen Lavretsky, MD, MS

TABLE. The incidence of treatment-resistant depression as reported by survey takers

	Answer options	Response count (%)
What percent of your practice consists of difficult to treat patients with treatment-resistant depression?	< 10%	136 (30.2)
	10% - 25%	166 (36.8)
	26% - 50%	95 (21.1)
	51% - 75%	43 (9.5)
	> 75%	11 (2.4)
What percent of your patients with treatment-resistant depression are 60+ years old?	< 10%	187 (41.5)
	10% - 25%	118 (26.2)
	26% - 50%	82 (18.2)
	51% - 75%	39 (8.6)
	> 75%	25 (5.5)

TABLE. The incidence of treatment-resistant depression as reported by ...

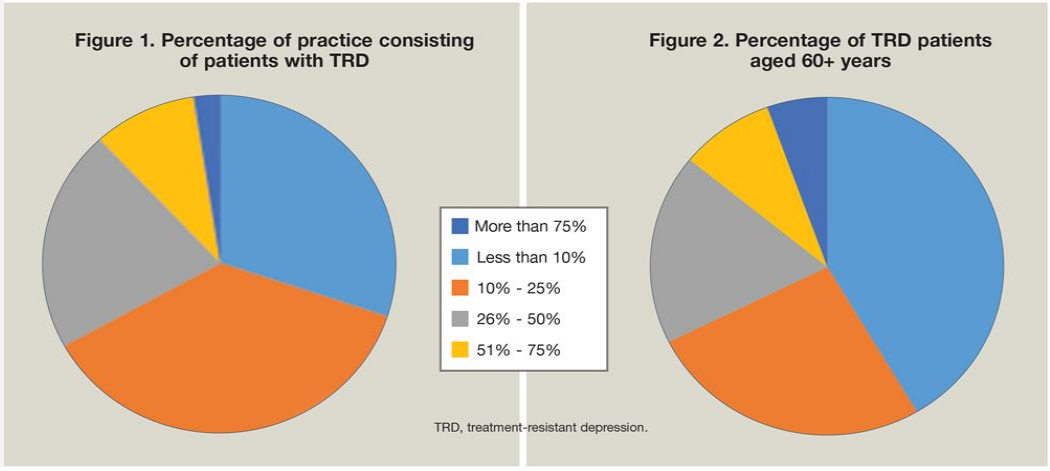

Figure 1 and 2: Percentage of practice consisting of patients with TRD...

Depression is a major public health issue and is associated with significant morbidity, mortality, and economic burden. It is the third-greatest contributor to global disease burden and affects both low- and high-income countries, with a 12-month prevalence of 5.9% and 5.5%, respectively. There is a relative paucity of information on treatment of late-life treatment-resistant depression (TRD). We conducted a survey of the readership of *Psychiatric Times* to assess the general attitudes toward the prevalence of—and the existing treatment approaches toward—TRD in adults 60 years and older.

Here we present the results of that survey and discuss the strengths and weaknesses of various approaches to TRD management.

What the survey revealed

The online survey received 468 responses: 51.6% respondents identified as psychiatrists, 7.7% as psychologists, and 14% as other mental health professionals. The US was well represented, contributing 79.3% of responses: 25.1% came from the Northeast, 16.2% from the Southeast, 17.2% from the Midwest, 8.1% from the Southwest, and 12.7 from the West. The remaining 20.7% of responses came from 41 countries, including Australia, the UK, Canada, and India. Of the respondents, 36.4% had been practicing for more than 25 years. Approximately one-third were in their first decade of practice, and one-third were in their second decade of practice.

The **Table** shows the incidence of TRD as reported by survey takers. **Figure 1** shows the percentages of patients with TRD, and **Figure 2** shows the percentages of TRD patients 60 years and older in the respondents' practices.

Question from survey: Please rate how helpful you would find the results of a large randomized study that compares the risks and benefits of augmentation and switching strategies for TRD in patients who are 60+ years old.

Most (71.7%) respondents stated that such a study would be "helpful," and 61% would find it "extremely helpful." Importantly, 76.6% of respondents believe their practice would benefit from the findings of such a study.

Question from survey: What treatment choices would you like to see in a randomized study for TRD in patients who are 60+ years old?

The most popular options were augmentation with aripiprazole (53.5%), augmentation with bupropion (49.2%), and augmentation with lithium (45.2%). Switching to bupropion and nortriptyline options were less popular, and each scored 28.4%.

Over one-third of respondents suggested alternative treatment options to be studied. The most common suggestions were psychotherapy; augmentation with antipsychotics; transcranial magnetic stimulation (TMS) and deep brain stimulation (DBS); ECT; the addition of a second antidepressant, both typical (SSRI, SNRI, TCA, MAOI) and atypical (mirtazapine), and newer

agents (vortioxetine); as well as methylphenidate and other stimulants, ketamine, and lamotrigine.

Several respondents suggested supplementation with thyroid hormone and, less frequently, folate and omega 3. Other drugs named were memantine, pramipexole, pindolol, nefazodone, buspirone, and glutaminergics. Finally, lifestyle measures such as exercise and various complementary and alternative practices, including acupuncture, were also suggested.

TRD: A significant problem in older adults

Up to 20% of patients with depression do not respond to 2 or more pharmacologically different agents. These patients reflect a significant portion of the mental health professions' workload. The findings of this survey approximately mirror the literature values: the mode response to the TRD-workload question was 10% to 25% of patients.

Depression affects 7% of older adults, among whom it is the leading cause of disability and premature mortality. Depression in older adults is an important risk factor for all-cause dementia and is associated with higher utilization of health care services, caregiver burden, and suicide rates. In older adults, depression is more likely to follow a chronic or relapsing course, and 55% to 81% of older adults with MDD fail to respond to an SSRI or SNRI.

The findings of our survey are more conservative. Older adults accounted for 10% to 55% of the total TRD workload in the practices of almost half of respondents.

TRD is clearly a significant issue in this population. While previous studies—including Sequenced Treatment Alternatives to Relieve Depression (STAR*D), Veterans Affairs Augmentation and Switching Treatments for Improving Depression Outcomes (VAST-D), Predictors of Remission in Depression to Individual and Combined Treatments (PReDICT), and the International Study to Predict Optimized Treatment in Depression (iSPOT-D)—have explored treatment of TRD in young adults, there is a relative paucity of research in the management of TRD in older adults.

There is growing concern about the heightened risks of cardiac arrest and falls and fractures associated with psychotropic medication in older adults. This demographic will continue to grow, which makes this a priority research area. This view was shared by 71.7% of survey respondents.

Treatment approaches

Approaches to TRD include:

• Dosage optimization

• Switching to a drug from a different class

• Augmentation with a nonstandard agent to the treatment regimen

• Non-pharmacological therapies, including psychotherapy, and interventional methods

Of the treatment approaches suggested by survey respondents, the most popular include aripiprazole, methylphenidate, ketamine, TMS, and pharmacogenetics.

A meta-analysis of 48 trials of augmentation agents in general TRD populations found that quetiapine, aripiprazole, thyroid hormone, and lithium were significantly more effective than placebo, notwithstanding tolerability issues with antipsychotics and lithium, and safety issues with thyroid hormone supplementation.

In TRD in older adults, a double-blind randomized controlled trial (RCT) of aripiprazole to augment venlafaxine therapy afforded 12 weeks of sustained remission in almost half the participants assigned to the intervention group, with a number needed to treat of 6.6. In this group, aripiprazole was associated with mild and transient akathisia and parkinsonism, typically tremor, but not with cardiometabolic adverse effects, QTc prolongation, or increased suicidal ideation. In this same study, severe baseline anxiety and cognitive inflexibility were associated with reduced remission rates. These findings indicate that aripiprazole has good outcomes, tolerability, and safety in TRD in older adults.

The use of methylphenidate in treating depression has been explored following favorable findings in small trials involving palliative care patients and on review. Recently, in a double-blind RCT of citalopram, methylphenidate, and combination therapy to treat depression in geriatric patients, combination therapy yielded a greater rate of remission than either drug alone: time to remission was shorter with monotherapy, which was also associated with enhanced mood and general wellbeing. While 40% of patients in this trial had TRD, efficacy in this group was not analyzed separately. Case reports also support methylphenidate use in catatonic major depression and bipolar depression in the elderly when family members decline ECT. In both cases, methylphenidate use triggered breakthrough in catatonia that enabled the patient to consent to ECT as definitive treatment. Due to the lack of long-term follow up, it is unknown whether the antidepressant effect of methylphenidate is sustained.

The rapid antidepressant effect of ketamine has been widely covered in scientific publications and mainstream media. Where other antidepressants have a lag time to response, often resulting in poor compliance, ketamine infusions have significantly ameliorated symptoms within hours and sustained responses over days to weeks in trials against placebo and midazolam. Trials of repeat infusions have demonstrated sustained effects for 14 and 19 days after final infusion. The major downfalls of ketamine infusion therapy are significant dissociative effects, including perceptual disturbances—usually short-lived—and, in some patients, iatrogenic hemodynamic instability. More recent trials of intranasal ketamine have demonstrated fewer adverse effects and more rapid onset of action of less than 1 hour. This is a promising area of research. To our knowledge, there have been no studies on the use of ketamine in TRD in older adults.

TMS is a promising innovation in the management of depression. It is significantly more effective than placebo and has a greater effect size than antidepressants. TMS is also effective in TRD its efficacy is comparable to that of augmentation with atypical antipsychotics without the adverse-effect profile and it has favorable effects on cognition. When used in combination, TMS significantly potentiates antidepressant action. Furthermore, TMS is more cost-effective than further pharmacotherapy in TRD. TMS also appears to have a sustained effect: the longest-duration study reported that 58% of patients were in remission at 3-month follow-up. The few studies investigating TMS in older patients with depression suggest lesser effect than in younger patients. It may be that age-related structural brain changes are less responsive to stimulation.

Pharmacogenetics were not mentioned by any survey respondents. This is notable given the increasing availability of such tests. It may suggest poor clinical utility of such products, or a lack of clinician awareness of recent RCTs.

Conclusion

TRD is clearly a major burden to communities and health services. In the general adult population, there are a number of promising treatment strategies for TRD in development, including ketamine and pharmacogenetics. There is a clear need for a large randomized study that compares risks and benefits of augmentation and switching strategies in older adults. There is also a need for randomized trials comparing adjunct antipsychotic therapy and ECT; innovative treatments, including TMS, DBS, pharmacogenetic testing, anti-inflammatory adjunct therapy, and ketamine; and complementary and alternative medicines.

Divorce Fosters Alcohol Use Disorder

Joel Yager, MD reviewing Kendler KS et al. Am J.

In divorcing individuals, rates of onset of alcohol use disorder increase, independent of usual risk factors, and decrease with remarriage.

Complex relationships exist between alcohol use disorder (AUD) and marriage. In a study using Swedish registry data, marriage to nonalcoholic spouses reduced AUD risk (NEJM JW Psychiatry Jul 2016 and Am J Psychiatry 2016; 173:911). Now, the same researchers examine divorce and AUD onset. Study data concerned 942,366 individuals (women, 53%) born between 1960 and 1990, without AUD before marriage (mean age at marriage, 30). Follow-up continued through 2008.

At a mean of 7 years after marriage, 16% of men and 17% of women divorced; overall, initial AUD was noted in 1.1% of men and 0.5% of women (mean age, 39). In analyses adjusting for independent AUD risk predictors (low parental education, prior deviant/externalizing behavior, and family AUD history), hazard ratios for postdivorce AUD risk increased significantly (hazard ratios [HRs]: men, 5.09; women, 6.31). HRs were even higher if spouses had no lifetime AUD.

Based on analyses of monozygotic twin pairs discordant for divorce, divorce per se elevated the risk for AUD by about 3.5 times. New AUDs started increasing several years before divorce, peaked in the divorce year, and remained elevated for the entire study period among people who did not remarry. In analyses of 13,039 individuals (29% women) with past AUD before marriage, divorce was associated with increased risk for AUD relapse (HRs: men, 3.20; women, 3.56). Remarriage after divorce substantially reduced risks for first AUD in both sexes.

COMMENT

Registry ascertainment methods yield lower AUD rates than interviews. Still, these findings underscore risks for initial AUD associated with divorce. Clinicians should attend to how AUD onset might herald or contribute to divorce in the first place and how added stresses (plus disinhibiting effects) of divorce generate additional vulnerabilities, particularly among those with other independent risk factors.

Seniors Increasingly Prescribed Multiple Psychiatric Drugs

By Kelly Young

Edited by David G. Fairchild, MD, MPH

The rate of outpatient visits in which seniors are prescribed three or more drugs affecting the central nervous system (CNS) more than doubled over a decade, according to a *JAMA Internal Medicine* research letter.

Using survey data from office-based physicians, researchers examined how often 98,000 patients aged 65 and older were prescribed three or more CNS medications during a single office visit from 2004 to 2013. The following medications were included: antipsychotics, benzodiazepines, nonbenzodiazepine benzodiazepine receptor agonists, tricyclic antidepressants, selective serotonin reuptake inhibitors, and opioids.

On the basis of these data, estimated annual polypharmacy visits in the U.S. increased from 1.5 million to 3.7 million over the study period. The largest increases were seen among rural patients (from 0.7 to 2.2 polypharmacy visits per 100 visits) and among those with a pain diagnosis (0.9 to 2.8 visits per 100 visits).

Of note, the FDA recently required a black-box warning against coprescribing opioids and benzodiazepines because of risks for respiratory depression, coma, and death.

Cognitive Complaints in Survivors of Breast Cancer After Chemotherapy Compared With Age-Matched Controls: An Analysis From a Nationwide, Multicenter, Prospective Longitudinal Study

(**https://doi.org/10.1200/JCO.2016.68.5826**)

Michelle C. Janelsins, **Charles E. Heckler**, **Luke J. Peppone**, **Charles Kamen**, **Karen M. Mustian**, **Supriya G. Mohile**

Abstract

Purpose

Cancer-related cognitive impairment is an important problem for patients with breast cancer, yet its trajectory is not fully understood. Some previous cancer-related cognitive impairment research is limited by heterogeneous populations, small samples, lack of prechemotherapy and longitudinal assessments, use of normative data, and lack of generalizability. We addressed these limitations in a large prospective, longitudinal, nationwide study.

Patients and Methods

Patients with breast cancer from community oncology clinics and age-matched noncancer controls completed the Functional Assessment of Cancer Therapy-Cognitive Function (FACT-Cog) at prechemotherapy and postchemotherapy and at a 6-month follow-up as an a priori exploratory aim. Longitudinal models compared FACT-Cog scores between patients and controls at the three assessments and adjusted for age, education, race, menopausal status, and baseline reading ability, anxiety, and depressive symptoms. A minimal clinically important difference cutoff determined percentages of impairment over time.

Results

Of patients, 581 patients with breast cancer (mean age, 53 years; 48% anthracycline-based regimens) and 364 controls (mean age, 53 years) were assessed. Patients reported significantly

greater cognitive difficulties on the FACT-Cog total score and four subscales from prechemotherapy to postchemotherapy compared with controls as well as from prechemotherapy to 6-month follow-up (all $P < .001$). Increased baseline anxiety, depression, and decreased cognitive reserve were significantly associated with lower FACT-Cog total scores. Treatment regimen, hormone, or radiation therapy was not significantly associated with FACT-Cog total scores in patients from postchemotherapy to 6-month follow-up. Patients were more likely to report a clinically significant decline in self-reported cognitive function than were controls from prechemotherapy to postchemotherapy (45.2% *v* 10.4%) and from prechemotherapy to 6-month follow-up (36.5% *v*13.6%).

Conclusion

Patients with breast cancer who were treated in community oncology clinics report substantially more cognitive difficulties up to 6 months after treatment with chemotherapy than do age-matched noncancer controls.

Cariprazine versus risperidone monotherapy for treatment of predominant negative symptoms in patients with schizophrenia: a randomised, double-blind, controlled trial

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Summary

Background

Although predominant negative symptoms of schizophrenia can be severe enough to cause persistent impairment, effective treatment options are lacking. We aimed to assess the new generation antipsychotic cariprazine in adult patients with predominant negative symptoms.

Methods

In this randomised, double-blind, phase 3b trial, we enrolled adults aged 18–65 years with long-term (>2 year), stable schizophrenia and predominant negative symptoms (>6 months) at 66 study centres (mainly hospitals and university clinics, with a small number of private practices) in 11 European countries. Patients were randomly assigned (1:1) by an interactive web response system to 26 weeks of monotherapy with fixed-dose oral cariprazine (3 mg, 4·5 mg [target dose], or 6 mg per day) or risperidone (3 mg, 4 mg [target dose], or 6 mg per day); previous medication was discontinued over 2 weeks. The primary outcome was change from baseline to week 26 or end of treatment on the Positive and Negative Syndrome Scale factor score for negative symptoms (PANSS-FSNS) analysed in a modified intention-to-treat population of patients who had follow-up assessments within 5 days after last receipt of study drugs with a mixed-effects model for repeated measures. Safety was assessed in all patients who received at least one dose of study drug. This study is registered with EudraCT, number 2012-005485-36.

Findings

Between May 27, 2013, and Nov 17, 2014, 533 patients were screened and 461 (86%) patients were randomised to treatment (230 for cariprazine and 231 for risperidone); 460 were included in the safety population (one patient discontinued before study drug intake). 227 (99%) of 230 patients in the cariprazine group and 229 (99%) of 230 patients in the risperidone group were included in the modified intention-to-treat population (178 [77%] in each group completed 26 weeks of treatment). Mean daily doses were 4·2 mg (SD 0·6) for cariprazine and 3·8 mg (0·4) for risperidone. Treatment-emergent adverse events (eg, insomnia, akathisia, worsening of schizophrenia, headache, anxiety) were reported in 123 (54%) patients treated with cariprazine and 131 (57%) patients treated with risperidone. Use of cariprazine led to a greater least squares mean change in PANSS-FSNS from baseline to week 26 than did risperidone (−8·90 points for cariprazine *vs* −7·44 points for risperidone; least squares mean difference −1·46, 95% CI −2·39 to −0·53; p=0·0022; effect size 0·31). One patient in the risperidone group died of a cause regarded as unrelated to treatment.

Interpretation

Our results support the efficacy of cariprazine in the treatment of predominant negative symptoms of schizophrenia.

Funding

Gedeon Richter Plc.

Irish: The forgotten white slaves

They came as slaves: human cargo transported on British ships bound for the Americas. They were shipped by the

hundreds of thousands and included men, women, and even the youngest of children.

Whenever they rebelled or even disobeyed an order, they were punished in the harshest ways. Slave owners would hang their human property by their hands and set their hands or feet on fire as one form of punishment. Some were burned alive and had their heads placed on pikes in the marketplace as a warning to other captives.

We don't really need to go through all of the gory details, do we? We know all too well the atrocities of the African slave trade.

But are we talking about African slavery? King James VI and Charles I also led a continued effort to enslave the Irish. Britain's Oliver Cromwell furthered this practice of dehumanizing one's next door neighbor.

The Irish slave trade began when James VI sold 30,000 Irish prisoners as slaves to the New World. His Proclamation of 1625 required Irish political prisoners be sent overseas and sold to English settlers in the West Indies.

By the mid 1600s, the Irish were the main slaves sold to Antigua and Montserrat. At that time, 70% of the total population of Montserrat were Irish slaves.

Ireland quickly became the biggest source of human livestock for English merchants. The majority of the early slaves to the New World were actually white.

From 1641 to 1652, over 500,000 Irish were killed by the English and another 300,000 were sold as slaves. Ireland's population fell from about 1,500,000 to 600,000 in one single decade.

Families were ripped apart as the British did not allow Irish dads to take their wives and children with them across the Atlantic. This led to a helpless population of homeless women and children. Britain's solution was to auction them off as well.

During the 1650s, over 100,000 Irish children between the ages of 10 and 14 were taken from their parents and sold as slaves in the West Indies, Virginia and New England. In this decade, 52,000 Irish (mostly women and children) were sold to Barbados and Virginia.

Another 30,000 Irish men and women were also transported and sold to the highest bidder. In 1656, Cromwell ordered that 2000 Irish children be taken to Jamaica and sold as slaves to English settlers.

Many people today will avoid calling the Irish slaves what they truly were: Slaves. They'll come up with terms like "Indentured Servants" to describe what occurred to the Irish. However, in most cases from the 17th and 18th centuries, Irish slaves were nothing more than human cattle.

As an example, the African slave trade was just beginning during this same period. It is well recorded that African slaves, not tainted with the stain of the hated Catholic theology and more expensive to purchase, were often treated far better than their Irish counterparts.

African slaves were very expensive during the late 1600s (£50 Sterling). Irish slaves came cheap (no more than £5 Sterling). If a planter whipped, branded or beat an Irish slave to death, it was never a crime. A death was a monetary setback, but far cheaper than killing a more expensive African.

The English masters quickly began breeding the Irish women for both their own personal pleasure and for greater profit. Children of slaves were themselves slaves, which increased the size of the master's free workforce.

Even if an Irish woman somehow obtained her freedom, her kids would remain slaves of her master. Thus, Irish mothers, even with this new found emancipation, would seldom abandon their children and would remain in servitude.

In time, the English thought of a better way to use these women to increase their market share: The settlers began to breed Irish women and girls (many as young as 12) with African men to produce slaves with a distinct complexion. These new "mulatto" slaves brought a higher price than Irish livestock and, likewise, enabled the settlers to save money rather than purchase new African slaves.

This practice of interbreeding Irish females with African men went on for several decades and was so widespread that, in 1681, legislation was passed "forbidding the practice of mating Irish slave women to African slave men for the purpose of producing slaves for sale." In short, it was stopped only because it interfered with the profits of a large slave transport company.

England continued to ship tens of thousands of Irish slaves for more than a century. Records state that, after the 1798 Irish Rebellion, thousands of Irish slaves were sold to both America and Australia. There were horrible abuses of both African and Irish captives. One British ship even dumped 1,302 slaves into the Atlantic Ocean so that the crew would have plenty of food to eat.

There is little question the Irish experienced the horrors of slavery as much (if not more, in the 17th Century) as the Africans did. There is also little question that those brown, tanned faces you witness in your travels to the West Indies are very likely a combination of African and Irish ancestry.

In 1839, Britain finally decided on it's own to end its participation in Satan's highway to hell and stopped transporting slaves. While their decision did not stop pirates from doing what they desired, the new law slowly concluded this chapter of Irish misery.

But, if anyone, black or white, believes that slavery was only an African experience, then they've got it completely wrong. Irish slavery is a subject worth remembering, not erasing from our memories.

But, why is it so seldom discussed? Do the memories of hundreds of thousands of Irish victims not merit more than a mention from an unknown writer?

Or is their story to be the one that their English masters intended: To completely disappear as if it never happened.

None of the Irish victims ever made it back to their homeland to describe their ordeal. These are the lost slaves; the ones that time and biased history books conveniently forgot.

Interesting historical note: the last person killed at the Salem Witch Trials was Ann Glover. She and her husband had been shipped to Barbados as a slave in the 1650's. Her husband was killed there for refusing to renounce catholicism.

In the 1680's she was working as a housekeeper in Salem. After some of the children she was caring for got sick she was accused of being a witch.

At the trial they demanded she say the Lord's Prayer. She did so, but in Gaelic, because she didn't know English. She was then hung.

Conversion Disorders

Medscape

Author

Scott A Marshall, MD and colleagues

Background

Conversion disorder (Functional Neurological Symptom Disorder) is categorized under the new *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* category of Somatic Symptom and Related Disorders. It involves symptoms or deficits affecting voluntary motor or sensory function that suggest a neurologic or other general medical condition. Yet, following a thorough evaluation, which includes a detailed neurologic examination and appropriate laboratory and radiographic diagnostic tests, no neurologic explanation exists for the symptoms, or the examination findings are inconsistent with the complaint. In other words, symptoms of an organic medical disorder or disturbance in normal neurologic functioning exist that are not referable to an organic medical or neurologic cause.

Common examples of conversion symptoms include blindness, diplopia, paralysis, dystonia, psychogenic nonepileptic seizures (PNES), anesthesia, aphonia, amnesia, dementia, unresponsiveness, swallowing difficulties, motor tics, hallucinations, pseudocyesis and difficulty walking.

Reports of less common manifestations of conversion disorder abound in the literature and include camptocormia, clenched fist syndrome, recumbent gait, odd vocalizations, and pseudo foreign accent syndrome.

Multiple symptoms suggest a somatization disorder. Conversion disorder is a type of somatoform disorder where physical symptoms or signs are present that cannot be explained by a medical condition. Very importantly, unlike factitious disorders and malingering, the symptoms of somatoform disorders are not intentional or under conscious control of the patient.

Case study

A young woman’s family brings her to the hospital and she presents with a chief complaint of “spells.” It seems that over the past several weeks, the patient has suffered from attacks of bilateral arm jerking, followed by bilateral leg jerking after she lowers herself to the floor. Often, her head shakes violently side to side and her eyes are seen to "roll back in her head" followed by

forced eye closure. These incidents follow episodes of emotional outbursts, and the patient is fortunately able to warn others that “I’m about to have a seizure!” After hearing this, her family grabs the patient and places her in a chair or on the ground until the spell is over, which sometimes can wax and wane for 20-30 minutes with varying intensity.

These spells are not accompanied by loss of bladder or bowel continence, but often the patient bites the tip of her tongue and kicks over tables or strikes family members during an episode. This most recent spell occurred while the patient was driving her car, in which she warned of an impending seizure and pulled the car to the shoulder just before losing consciousness; her spell was much more intense than she has had in the past.

She has no significant past medical history and takes no medications. She reports a past history of childhood sexual abuse from a paternal uncle several years ago. On exam, her vitals signs are normal and her neurologic evaluation is without significant findings. She is not orthostatic. Laboratory work-up, including urine toxin screen, is negative.

Pathophysiology

Conversion symptoms suggest a physical disorder but are the result of psychological factors. According to the psychodynamic model, the symptoms are a consequence of emotional conflict, with the repression of conflict into the unconscious. In the late 1880s, Freud and Breuer suggested that hysterical symptoms resulted from the intrusion of "memories connected to psychical trauma" into the somatic innervation. This mind-to-body process was referred to as conversion. Others have introduced attachment theory as a means to understanding conversion disorder in terms of the *freeze response* and the *appeasement defense* behavior seen in animal subjects.

The patient has been postulated to derive primary and secondary gain. With primary gain, the symptoms allow the patient to express the conflict that has been suppressed unconsciously. With secondary gain, symptoms allow the patient to avoid unpleasant situations or garner support from friends, family, and the medical system that would otherwise be unobtainable. According to sociocultural theories, the direct expression of emotions is impermissible and somatization takes its place. In behavioral models, conversion symptoms are viewed as a learned maladaptive behavior that is reinforced by the environment.

The idea that conversion disorder does not have an organic basis has become entrenched. However, some evidence supports the opposite notion. A review of imaging correlates in patients with motor and sensory conversion symptoms is referenced. Studies on the natural history of conversion disorder indicate that many patients subsequently develop or are found to have preexisting neurologic disease. In fact, conversion disorders may be more frequently observed in patients with a past history of a central nervous system injury. The simultaneous occurrence of organic brain disease with conversion symptoms is also observed, most notably in observation of

high rates of organic seizure syndromes associated with psychogenic nonepileptic seizures (PNES). Familial studies have also shown that conversion symptoms in first-degree female relatives are up to 14 times greater than in the general population.

That the diagnosis of a conversion reaction of disorder represents a failed diagnosis of an organic syndrome, perhaps with psychogenic overlay that obscures exam and other findings is usually a valid concern. A recent meta-analysis including more than 1400 cases with follow-up over 5 years reported missed organic diagnosis rates of less than 5%. This correlates with similar reports for the diagnosis of motor neuron disease or schizophrenia. Past rates of misdiagnosis were reported as considerably higher.

Epidemiology

Frequency

United States

Stefansson et al report that the annual incidence of conversion reactions is 22 cases per 100,000 persons per year in Monroe County, New York. However, the reported rates vary widely. In a study of 100 consecutive women following a normal full-term pregnancy, 33 were noted to have a past history of conversion symptoms. In a study of 100 randomly selected patients from a psychiatry clinic, 24 were noted to have unexplained neurologic symptoms. A report by Carson found that 30% of patients at a neurology clinic had "unexplained symptoms."

Overall, conversion disorder is reported to be more common in rural populations, in individuals with lower socioeconomic status, lack of education, and low psychological sophistication. The increased rate of conversion in patients with a past history of sexual or physical abuse is well described.

International

Stefansson et al report that the annual incidence is 11 cases per 100,000 persons per year in Iceland.

Mortality/Morbidity

Individual conversion symptoms are generally self-limiting and do not lead to physical changes or disabilities. In the case of PNES, patients may have driving privileges removed by medical practitioners and may self-limit other activities due to concern over having a paroxysmal event. The symptoms related to the conversion disorder may lead to decreases in quality of life if they are perceived as egodystonic.

Morbidity is often an iatrogenic manifestation of unnecessary diagnostic or therapeutic interventions aimed at establishing an organic diagnosis for the patient's symptoms.

Patients with chronic conversion symptoms rarely may develop atrophy, frozen joints, and contractures from disuse.

Sex- and age-related demographics

Classically, the female-to-male ratio is 2-10:1.

Recent work with PNES reports that males make up approximately 40% of cases. This is a departure from past work, where females made up 80% of cases of PNES in some series.

Overall, female-to-male ratio is variable, but the occurrence of conversion disorder is likely higher in females overall.

The typical onset is between the second and fourth decades.

The reported range is from children to individuals in their ninth decade of life.

Liver cancer is linked to herbal remedies

MIAMI: Researchers have uncovered widespread evidence of a link between traditional Chinese herbal remedies and liver cancer across Asia, a study said Wednesday.

The findings suggest stronger measures are needed to prevent people from consuming chemicals called aristolochic acids (AA), which are derived from the woody vines of the Aristolochia plant family, said the report in the journal Science Translational Medicine.

The acids can be found in some traditional Chinese medicines that are given during childbirth, to prevent parasites and promote healing.

Researchers tested 98 liver tumors that were stored at hospitals in Taiwan, and found that 78 percent contained mutation patterns that indicated the cancers "were likely due to contact with the chemicals," said the study.

Since these acids cause "a well-defined mutational signature," researchers also looked at 89 samples of liver cancer in China, and found that 47 percent showed a link to this traditional medicine component.

In Vietnam, five out of 26 tumors studied were a match (19 percent), along with five out of nine from other countries in Southeast Asia (56 percent).

Low Vitamin D Levels Increases the Risk for Chronic Headaches

(https://www.medscape.com/viewarticle/883135)

Alan R. Jacobs, MD

Researchers from the University of Eastern Finland have published a study investigating the relationship between vitamin D status and the risk for frequent headache.

They assessed 2601 men, aged 42-60 years in 1984-1989, from a population-based cohort derived from the Kuopio Ischemic Heart Disease Risk Factor Study.

They made cross-sectional associations of self-reported frequent headache, defined as weekly or daily headaches and serum 25-hydroxyvitamin D levels.

In those with frequent headache, the average serum vitamin D concentration was 38.3 nmol/L; while in those without frequent headache, the average vitamin D concentration was 43.9 nmol/L.

Those in the lowest serum vitamin D quartile had 113% higher odds for frequent headache compared with those in the highest quartile.

The authors concluded that low serum vitamin D concentrations are associated with a markedly higher risk for frequent headaches in men.

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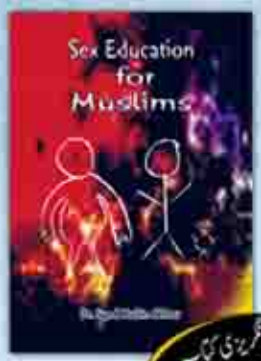

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Sex Education for Muslims

The Quran and Hadees provide guidance in all affairs of life. It isimperative for a Muslim to study the Quran and Hadees,understand them, and make these principles a part of daily life. The most important human relationship is that of marriage. It is through this institution that the procreation and training of the human race comes about. So its no wonder that the Quran and Hadees give us important guidance on this matter. But it is unfortunate that our authors,teachers and imams avoid this topic in their discourses due to a false sense of embarrassment. Moreover most of them are not well versed in the field of medicine and psychology. Therefore it's only people who have knowledge of both religion as well as medicine who should come forward to speak and write on the subject. We have included in this book all passages referring to sexual matters from the Quran, Hadees and Fiqa. These passages provide guidance to married as well as unmarried youngsters. If one reads this matter it would be ealser to maintain proper physical and sexual health, along with an enjoyable marital life. The reading of this matter as well as using it in one's life will be considered equal to.

The same book has been translated into urdu under the title of "نوجوانوں کے جنسی مسائل"

جنسی مسائل

لڑکپن سے جوانی تک کی عمر ایسی ہے جس کے دوران جنسی اعضاء میں کافی تبدیلی آتی ہے۔ اس لئے نوجوانوں کو یہ پریشانی لاحق ہوتی ہے کہ تبدیلیاں فطری ہیں یا یہ کسی بیماری کا مظہر ہیں۔ اتنی بات بتانے کے لئے ہمارے معاشرے میں کوئی تیار نہیں ہوتا۔ نہ والدین، نہ اساتذہ اور نہ دوسرے ذرائع ابلاغ یہ سعی کرتے۔ اس کے بارے میں مستند کتابیں بھی موجود نہیں ہیں بلکہ اگر غلطی سے کوئی لڑکا یا لڑکی اس موضوع پر کوئی بات کر بیٹھے تو وہ سخت ہدف تنقید بنتا ہے۔ اس لئے ان سب چیزوں کو دیکھتے ہوئے ڈاکٹر سید مبین اختر نے یہ کتابچہ تیار کیا ہے جس میں جنسی مسائل کے حوالے سے قرآن و حدیث کی روشنی میں بنیادی مسائل کا حل تجویز کیا ہے۔

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Author: **Dr. Syed Mubin Akhter** (M.B.B.S)

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