Letters

RACE AND PATIENT VIOLENCE

John Battaglia, MD, describes many valid factors that could predict violence in an inpatient setting (CURRENT PSYCHIATRY, February 2004, p. 14-21). However, we disagree that being "nonwhite" is among these factors.

Studies that cite race as a predictor of patient violence have not been adequately controlled for significant variables. By contrast, Silver[1] showed that race does not predict violence among persons with mental disorders when neighborhood disadvantage is statistically well-controlled.

Using race to predict patient violence may explain why nonwhite patients inadvertently get excessive medication. In a retrospective study,[2] African-American patients with schizophrenia were:

- 1.8 times more likely than their white counterparts to receive excessive doses of typical antipsychotics
- more likely than white patients to be treated with older, high-potency antipsychotics.[2]

Many researchers have demonstrated other differences in treatment of nonwhite vs. white inpatients and have proposed that nonwhites face barriers to diagnosis and drug management of psychiatric disorders. A review of 344 persons with schizophrenia[3] found pronounced variations in treatment (such as use of atypical neuroleptics) based on race, even though the data were adjusted for demographic and clinical characteristics. After controlling for relevant variables, Allegra et al[4] found that poor Latinos and African Americans not classified as poor are less likely to receive specialty psychiatric care than their white counterparts.

Using race as a variable in inpatient settings discourages objective clinical management, albeit not deliberately. In this way, a relatively inexperienced doctor subconsciously learns to consider race to explain a patient's violent actions.

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Dr. Battaglia responds

Drs. Adetunji, Mathews, and Budur raise some interesting questions about race and statistics, and this of course is an area of intense scrutiny that requires further study.

Race and culture are inextricably linked, and studies designed to ferret out the differential aspects are often subject to the same criticisms they attempt to clarify. I agree that we must all keep an open mind for interpreting data in this intriguing area.

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CLARIFYING RISK FACTORS FOR VIOLENCE

Dr. Battaglia's article on patient violence is most useful. I've been waiting for an article that clari-

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fies the risk factors we need to watch for in patients with a history of violence. To be able to copy and paste this article from *currentpsychiatry.com* into my psychiatric materials is great.

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BIPOLAR I VS. BIPOLAR II

I agree with most of the points in Dr. Shivakumar and Dr. Suppes' article on the Texas Medical Algorithm Project (TMAP) and with the algorithms they mentioned (CURRENT PSYCHIATRY, February 2004, p. 22-40).

However, the article does not address the difference between bipolar type I and bipolar type II disorder. While this may at first seem trivial, recognizing the difference is crucial to planning treatment. Since rapid cycling and depression are more prevalent than hypomania in bipolar type II, patients with this form of the disorder often require different medication(s) than do those with bipolar type I.

Also, some psychotropics are appropriate for outpatient treatment but not for inpatients and vice-versa. For example, lamotrigine takes time to work up to an effective dosage without significantly increasing the risk for rash; this would be reasonable treatment for an outpatient with bipolar type II but is not practical for an inpatient, especially with bipolar type I.

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Dr. Suppes responds

Dr. Wilson raises the issue of treatment recommendations for bipolar I versus bipolar II disorder.

All treatment guidelines—including the American Psychiatric Association Guidelines, Texas Algorithms, and others—are based on evidence gathered from studies of bipolar I patients. The full article from the TMAP consensus conference discusses this issue as well as the paucity of data available to make treatment recommendations for patients with bipolar II disorder.[1]

Unfortunately, this has not changed dramatically over the last 4 years. The good news is that numerous ongoing studies will reveal how best to treat bipolar II patients.

Dr. Wilson also notes that time to response makes a medication appropriate for use in one setting but not in another. Given today's brief inpatient stays, any antidepressant or maintenance medication started during hospitalization will not begin to work until after discharge. Following titration guidelines with lamotrigine is critical, but as with antidepressants the time to response is a few weeks. Thus, these medications will require outpatient monitoring to assess efficacy and tolerability.

Delineating treatment for patients with bipolar II disorder is important. No matter how the prevalence is evaluated, bipolar II disorder affects many individuals. We recently reviewed the evidence in this area[2] and were struck by how little attention this patient group has received to date.

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