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WHAT'S NEW

Men are far more likely than women to use prescription opioids for nonmedical purposes, a new survey shows. **2**

Physicians yet again find themselves facing significantly lower Medicare fees for next year. **6**

Dr. Peter Chien thinks the new health care law bodes well for public health psychiatry. **11**

Dr. James W. Jefferson writes that solutions to the problems in psychiatry offered by Dr. Daniel J. Carlat in "Unhinged" are sure to generate controversy. **12**

Dueling guidelines on the treatment of borderline personality disorder prove confounding to U.K. psychiatrists. **15**

Experts say art therapy can help hospice and dementia patients find meaning and closure. **18**

Dr. Carl C. Bell argues that there are ways to get around some of the perceived dangers tied to faith-based interventions. **20**

New evidence blurs some of the distinctions between typical and atypical antipsychotic medications. **22**

Dysthymic Disorder Causes More Disability Than Major Depression

BY DAMIAN McNAMARA

FROM A MEETING OF THE NEW DRUG CLINICAL EVALUATION UNIT

BOCA RATON, FLA. — Dysthymic disorder, also known as chronic low-grade depression, confers a high degree of impairment and represents a significant public health burden, according to a secondary analysis of a large epidemiologic study.

"The point is, dysthymia is a very dysfunctional illness, even relative to acute major depression," Dr. Jonathan W. Stewart said the meeting.

The investigators found greater impairments in some psychosocial-functioning indicators for the previous month and the previous year among people with dysthymic disorder, compared either with others who had acute major depressive disorder or with the general population. The dysthymic patients had greater use of supplemental Social Security disability income and higher receipt of Medicaid insurance, and were less likely to be working full time compared with the other groups, according to results that were published online (J. Affect. Disord. 2010 May 1 [Epub ahead of print]).

"This is not the way a lot of people view dysthymia. Dysthymia is what ruins peoples' lives," said Dr. Stewart of Columbia University and the New York State Psychiatric Institute, both in New York City.

In the previous year, Social Security disability was reported by 14% of the dysthymic group, 5% of the major depression group, and 3% of the general population group. Receipt of Medicaid insurance was reported by 20% of the dysthymic group, 13% of the major depression group, and 6% of the general population participants.

These results come from their secondary analysis of NESARC (National Epidemiologic Survey of Alcoholism and Related Conditions). NESARC features a nationally representative sample of 43,093 noninstitutionalized U.S. adults. Dr. Stewart and his associates identified 328 respondents with dysthymic disorder (without current major depression); 712 with acute major depressive disorder (symptoms for 24 months or fewer); and 42,052 other participants who accounted for the general population group.

See **Dysthymic Disorder** *page 2*

Late-Life Psychosis Mimics Schizophrenia

'Negative symptoms are extremely rare in this group.'

BY BRUCE JANCIN

FROM THE ANNUAL INTERNATIONAL CONGRESS OF THE ROYAL COLLEGE OF PSYCHIATRISTS

EDINBURGH — Age greater than 60 years is a major risk factor for onset of a nonorganic, nonaffective psychosis that's surprisingly common yet largely unappreciated outside the relatively small world of geriatric psychiatry.

"This late-life psychosis looks a bit like schizophrenia, but it isn't schizophrenia. It has risk factors and features that are similar to, and others that are different from, schizophrenia," Dr. Robert Howard observed at the congress.

Several decades ago, he and his coinvestigators studied the age at first psychiatric hospitalization for nonorganic, nonaffective psychosis in the United Kingdom and the Netherlands and demonstrated the existence of two peaks in incidence. The first occurs in individuals in their late teens and early 20s, the time of greatest risk for classic new-onset schizophrenia.

The second peak rises steeply after age 60 and summits in the 80s. The incidence of this late-life psychosis is greater in women than in men, just opposite the gender pattern for schizophrenia in younger people.

"In fact, if you're a woman, the most risky time in your life

See **Psychosis** *page 28*

Dr. Robert Howard emphasizes a conservative approach to prescribing antipsychotics in the elderly.

Negative Symptoms Rare

Psychosis *from page 1*

for developing a psychosis—and I'm not talking about the psychosis associated with dementia—is old age," according to Dr. Howard, professor of old-age psychiatry and psychopathology at the Institute of Psychiatry, King's College London.

He chaired an international consensus conference which, after much debate, chose the term "very late-onset schizophrenia-like psychosis" to describe this nonorganic psychosis with onset after age 60 (Am. J. Psychiatry 2000;157:172-8). It's an awkward term, Dr. Howard conceded, but after a full day of argument it was the only one the world's experts on schizophrenia could agree on.

"We used to call it 'late paraphrenia.' That never caught on beyond the U.K. Whenever I speak on this in the U.S., I have to explain that these patients don't have dementia," said Dr. Howard, also the dean of the Royal College of Psychiatrists. These late-life psychosis patients have all the classic symptoms of schizophrenia in the young, with one striking exception: no formal thought disorder.

"I must have personally sat down and spent time with 700-800 patients with late-life psychosis, and I've never seen one with a formal thought disorder. And they very rarely develop negative symptoms. I won't say never, but negative symptoms are extremely rare in this group," Dr. Howard continued.

Elderly patients with new-onset nonorganic, nonaffective psychosis also display several symptoms that just aren't found in younger schizophrenia patients. Roughly 80% of them have partition delusions: a belief that something that normally acts as a physical boundary—say, walls, floors, ceilings—no longer does so.

"These patients will tell you that they don't know how he does it, but the man next door is able to walk through the wall, paint all the ornaments in the china cupboard red, and then walk back out the same way. Or the lady upstairs has a special camera that allows her to see through the ceiling. These are absolutely characteristic of these patients," he said.

Another difference from schizophrenia in the young is that 20%-25% of these elderly patients experience vivid and complex Charles Bonnet syndrome–type visual hallucinations. Dr. William T. Carpenter Jr. said in an interview that the types of psychotic syndromes are numerous, and that hallucinations and delusions are not very discriminating between diagnostic categories. "It may be that many of the late-age–onset psychoses are not schizophrenia," said Dr. Carpenter, who is chair of the DSM-5 Psychotic Disorders Work Group. "Some [cases] may be brief psychosis; others might be disorder or induced by a medical condition or its treatment. In any case, schizophrenia is a very heterogeneous syndrome."

It is clear that patients with late-life psychosis perform very poorly on measures of executive function, motor skills, and verbal ability, according to Dr. Howard. "They do as poorly as autistic children. This has opened up an avenue of potential treatment, because there are groups that treat autistic children with theory of mind enhancement. They train them in theory of mind skills.

"I'd like to study that sort of nonpharmacologic therapy, but it's been difficult to get ethical approval," he said.

Dr. Howard and others have shown that the incidence of late-life psychosis is markedly increased in various immigrant groups living in London compared with the rate in the British-born elderly. Thus, immigrant status is a powerful risk factor for late-life psychosis, just as is well established in schizophrenia in the young.

On the other hand, his study of 269 first-degree relatives of patients with very late-onset schizophrenia-like psychosis showed that the prevalence of schizophrenia in that group was identical to that in 272 matched controls. In other words, late-life psychosis lacks the strong genetic loading that's a prominent feature of schizophrenia in the young. In 19 years of doing MRI studies in search of a structural brain lesion associated with late-life psychosis, Dr. Howard said, he has come up empty-handed.

While examining these issues, Dr. Carpenter said it is important to keep in mind that schizophrenia is a syndrome. "Dr. Brian Kirkpatrick has summarized data (Arch. Gen. Psychiatry 2001;58:165-71) suggesting that relatives of deficit schizophrenia probands have a different morbid risk profile than relatives of nondeficit schizophrenia probands," he said. "With the former, it tends to be schizophrenia and the negative [deficit] symptom form of the syndrome, while with the latter, it tends to be a range of psychiatric diagnoses. The deficit form of schizophrenia is uncommon in females and very rare if it occurs at all in late-age psychosis," said Dr. Carpenter, who also directs the Maryland Psychiatric Research Center and is professor of psychiatry and psychopharmacology at the University of Maryland, Baltimore.

With regard to treatment, Dr. Howard noted that a Cochrane review concluded there is insufficient evidence to make any recommendations, a situation he finds appalling.

Roughly 80% of elderly patients with new-onset psychosis have partition delusions: a belief that something that normally acts as a physical boundary no longer does so.

"It's extremely unsatisfactory that the treatment options we have for these patients at the moment are only those that have been extrapolated from data in young people. There's a tremendous paucity of data, because drug companies are not interested in psychosis in old people unless it's dementia," the psychiatrist said.

When asked about Dr. Howard's assertions, Dr. Dilip V. Jeste, who was part of the international consensus conference and has worked with Dr. Howard several times over the years, agreed in an interview that psychotic disorders in older people have been largely ignored in diagnostic as well as therapeutic research.

"The usual tendency is to apply the same diagnostic criteria and the same treatment regimens for older people as for younger people, although the necessary research base is primarily derived from data in adults under age 65," said Dr. Jeste, the Estelle and Edgar Levi Chair in Aging at the University of California, San Diego.

"This is unfortunate, because there are distinct clinical considerations in older age groups. This is well exemplified in the case of schizophrenia, which is often thought of as a disease more or less restricted to younger people.

"Yet, a number of studies all over the world have shown that schizophrenia can have onset after age 40 or 45. When the onset is much later, say, after 65, then schizophrenia becomes much less common. Yet, schizophrenia-like psychosis is not rare in older people," said Dr. Jeste, who also serves as director of the Sam and Rose Stein Institute for Research on Aging at the university.

In an effort to help gather more data, Dr. Howard recently received funding from the U.K. Health Protection Agency to conduct a randomized, double-blind, placebo-controlled trial known as ATLAS (Antipsychotic Treatment of Very Late-Onset Schizophrenia-Like Psychosis).

Participants will be randomized to 100 mg/day of amisulpride or placebo for 12 weeks, with the primary outcomes being change in the Brief Psychiatric Rating Scale, a quality of life measure, and the Simpson-Angus Scale of Parkinsonian symptoms. At 12 weeks, the patients will be randomized again to determine whether another 24 weeks of amisulpride is of significant additional benefit. Enrollment in ATLAS will begin soon in the United Kingdom.

The impetus for the government-funded randomized trial was a small open-label Greek study; investigators concluded that 5 weeks of amisulpride at a mean dose of 101 mg/day brought significant improvements in the Brief Psychiatric Rating Scale and the Clinical Global Impression of Change Scale and was extremely well tolerated, with no safety issues (Int. J. Geriatr. Psychiatry 2009;24:518-22).

Anecdotally, Dr. Howard continued, he has observed that many patients with late-life psychosis appear to respond to depot fluphenazine decanoate at a mean dose of 14 mg every 2 weeks, or to risperidone at 1.5 mg/day or its equivalent.

"I rarely go above 1.5 mg of risperidone per day. If you're looking after a person with a new psychosis in late life and you're giving them more than that, you're not helping," he said.

Dr. Jeste also emphasizes that older people with psychotic disorders are sensitive to side effects of antipsychotics and do not tolerate doses that are commonly recommended in younger adults. "Psychosocial interventions play a major role in their management," said Dr. Jeste, who also is chair of the DSM-5 Neurocognitive Disorders Work Group. "Clearly, more research in this population is warranted.

"As baby boomers age, we are going to see a dramatic increase in the numbers of older people with various psychiatric, including psychotic, disorders. This is, therefore, a topic of growing public health significance and deserves greater attention by the mental health community," Dr. Jeste said.

At the meeting, in response to an audience question as to whether the female predominance in late-life psychosis could be related to estrogen withdrawal, Dr. Howard replied that he thought it unlikely, since the peak incidence of the psychosis in women doesn't come until 3 decades after menopause.

"I think the difference has much more to do with the ways in which the dopamine system in males and females ages. Parkinson's disease is one and a half times more common in men than women. Psychosis and Alzheimer's disease are twice as common in women as men.

"So it seems that dopa-excess disorders are commoner in older women, and dopa-deficiency disorders are commoner in men," he observed.

Dr. Howard declared having no financial conflicts. ■

MY TAKE

Change in Thinking Long Overdue

What this discussion highlights is that we need to pay much more attention to psychoses in older persons. This is important for caregivers as well as for persons affected themselves. Many researchers and clinicians still think that psychoses are very rare among elderly persons. The time to change this thinking is long overdue. It has very important public health implications, because older persons are an ever-increasing proportion of the population in the United States and other high-income countries.

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