

Letters

ANTIPSYCHOTIC DOSAGE CORRECTION

In Dr. Willem Martens' article, "Recovery from schizophrenia: Fact or fiction" (CURRENT PSYCHIATRY, July 2004, p. 19–30), dosages listed for several antipsychotics in Table 3 were inaccurate—specifically risperidone (25–50 mg/d) and ziprasidone (10 mg/d). Some clozapine side effects, such as increased blood glucose and weight gain, were omitted.

Also omitted was the fact that haloperidol reduces positive symptoms, while the atypical antipsychotics reduce negative symptoms.

James Patras, MD
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Dr. Martens responds

The recommended risperidone dosage was incorrect because the decimals were omitted. The correct dosage is 2.5 to 5 mg/d.

Concerning haloperidol, severely disturbed patients often receive 30 to 40 mg/d, and particularly resistant patients have received up to 100 mg/d. Haloperidol is useful for managing acute and chronic psychosis as well as aggression and agitated behavior.

The normal ziprasidone dosage is between 80 and 160 mg/d but can range from 10 mg/d for less-severe cases to 200 mg/d for exceptionally severe and treatment-resistant patients.

Finally, I did not list all possible side effects; there are too many to mention in such a short space.

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IS CONDUCT DISORDER REAL?

I am rebutting "How to reduce aggression in patients with conduct disorder" (CURRENT PSYCHIATRY, April 2004, p. 65–79).

A 15-year-old ended his first two visits with me under police custody and was committed both times. After the first commitment, his grandmother filed a petition alleging unruly/delinquent behavior, and a judge ordered the boy to take his prescribed mood stabilizers.

That was necessary because the hospital psychiatrist had determined that the boy was not mentally ill and that his grandmother needed parenting classes. The youth's original diagnosis—conduct disorder and oppositional-defiant disorder (ODD)—contradicted my diagnosis: bipolar disorder, mixed.

During the second hospitalization, a psychiatrist diagnosed the youth as having attention-deficit/hyperactivity disorder (ADHD). The doctor prescribed methylphenidate and oxcarbazepine, but the patient's guardian did not consent to the medications.

Facing a sentence at the county juvenile detention center, the youth started taking olanzapine, 10 mg at bedtime, and lamotrigine, 25 mg bid titrated to 50 mg bid, as I had prescribed. His grandmother says that he no longer exhibits defiant behavior. At his third visit, he shook my hand and said, "Thank you for finding the right medications for me."

I have seen hundreds of similar cases over 10 years. To paraphrase a colleague, diagnosing somebody with conduct disorder or ODD is like diagnosing a patient with a runny nose after a thorough emergency room examination.

I applaud the American Association of Community Psychiatry's efforts to urge the American Psychiatric Association (APA) to abolish the conduct disorder diagnosis. I also support the many researchers who are requesting elimination of conduct disorder and ODD. These are not real and specific diagnoses but are alleged syndromes that express several conditions.

Manuel Mota-Castillo, MD
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Dr. Malone responds

It is hard to assess Dr. Mota-Castillo's case based on the information he provided. Still, one would not refute any psychiatric syndrome by citing a single case.

Most psychiatric disorders are syndromes and affect heterogeneous groups. This is true for disorders that are more prevalent in adults—such as schizophrenia and mania—and for those that present in childhood and adolescence—such as conduct disorder, ODD, and ADHD. Heterogeneity within disorders is no doubt related to underlying individual differences in genetics and environment and contributes to differences in symptom expression and treatment response.

Dr. Mota-Castillo did not present symptoms listed under DSM-IV-TR, so it is unclear how the patient was diagnosed. Diagnoses:

- are one clinician's impression or the consensus of several clinicians
- are based on one patient encounter or ongoing treatment
- occur with or without input from other sources, such as parents and school
- are made with or without validated structured interviews.

Conduct disorder and ODD are part of DSM

diagnostic nomenclature,¹ and the APA and American Academy of Child and Adolescent Psychiatry recognize both disorders. Reducing aggression associated with either disorder has long been the most common reason for psychiatric consultation in children.²

Also, Dr. Mota-Castillo prescribed olanzapine and lamotrigine, apparently for simultaneous use. The main point of our case was to discourage polypharmacy—something most experts agree should be avoided³—by carefully starting one drug before adding a second. When a child receives two drugs at once, we cannot know the effect of either.

In the 15-year-old's case, as often happens, the prescribed treatment might not have changed the symptoms; some symptoms remit spontaneously.

Nor does drug response clarify diagnosis. For example, both bipolar disorder and aggression in conduct disorder (and in many other conditions) may respond to an antipsychotic.⁴ Lithium and other treatments for mania have been shown to reduce severe aggression

in nonmanic children and adolescents with conduct disorder.^{5,6}

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EXERCISE AND DEPRESSION

Exercise is an important component of depression treatment (CURRENT PSYCHIATRY, June 2004, p. 10-20). Exercise:

- helps metabolize cortisol, which is directly toxic to CNS neurons. Lowering cortisol levels improves neuronal connections.
- raises endorphin levels, which increases global feelings of well-being and activates reward centers in the brain.
- raises core body temperature, which promotes deeper and more restful sleep, during which serotonin is replenished.

Common reasons patients resist exercise include:

Lack of energy associated with a depressive episode. When I explain the benefits of exercise, however, patients are more likely to consider it.

Self-consciousness. Physically inactive patients are often reluctant to exercise in public, so help them choose an acceptable regimen and location.

Time management. I tell patients that exercise will increase their energy, making them more efficient. I also mention that exercise is a lifelong necessity for maintaining health.

I work primarily with young adults in a university health center. The key to getting students to exercise is to start very slowly—5 to 10 minutes of brisk walking three to five times weekly—then add 5 minutes per week until they are exercising about 30 minutes at a time.

I also preach persistence and patience, since the patient must exercise for 6 to 8 weeks to see a benefit. In the interim, I may help them choose a regular time to exercise, then encourage them to

reward themselves by purchasing new walking shoes or exercise clothes if they are still exercising after 2 weeks. If a patient cannot follow a self-imposed schedule, participation in a fitness class may be more effective.

Linda L. Keeler, MD
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The article, “Exercise for depression: Here’s how to get patients moving” shows the value of exercise in relieving depressive symptoms.

The authors summarize the evidence clinicians need for recommending that an exercise program may be just as effective as psychotherapy or pharmacotherapy for treating depression.

I plan to use the article to educate trainees in medicine, psychiatry, psychology, and social work. Thanks for publishing such a balanced, health-oriented discussion.

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