

PSYCHIATRY UPDATE

SOLVING CLINICAL CHALLENGES, IMPROVING PATIENT CARE

CURRENT PSYCHIATRY and the American Academy of Clinical Psychiatrists welcomed more than 650 psychiatric practitioners from across the United States and abroad to this annual conference, which was headed by Meeting Co-chairs Richard Balon, MD, and Donald W. Black, MD, April 16-18, 2015, at the Hilton Chicago in Chicago, Illinois. Attendees earned as many as 18 AMA PRA Category 1 Credits™. We welcome you to join us next year in Chicago, March 10-12, 2016.



▲ Donald W. Black, MD

THURSDAY, APRIL 16, 2015

MORNING SESSION

Attention-deficit/hyperactivity disorder (ADHD) is a lifespan disorder that is “everywhere,” **Anthony L. Rostain, MD, MA, University of Pennsylvania Perelman School of Medicine**, began—including in adults and even “seniors.” This means that the disorder “is not a diagnosis of exclusion,” and that “comorbidity is the rule,” including learning difficulties. Among adults, the focus of symptoms and management is on executive dysfunction and its characteristics: difficulty multitasking, problems keeping commitments, and excessive reliance on help from others. Inattention and disorganization are hallmarks of adult ADHD, and become worse as environmental demands (work, home) increase; hyperactivity decreases with age. Dr. Rostain recommends ruling out other causes of a patient’s symptoms when an adult self-reports ADHD, including transient stressors, medical conditions, psychiatric disorders, and malingering.

Donald W. Black, MD, University of Iowa, reviewed DSM-5 criteria for **borderline personality disorder (BPD)** and offered tips for avoiding misdiagnosis, including obtaining collateral information and using rating scales. Co-occurring disorders, such as depression and substance abuse, are common. Treatment for BPD patients includes psychotherapy (individual or group), medication, and lifestyle changes. Psychotropics treat symptoms

of depression, anxiety, hostility, and impulsivity of BPD but *not* the fundamental nature of the disorder. When establishing a patient’s treatment plan, consider the stage of illness, evaluate for any co-occurring disorders, and ask the patient what he (she) wants from treatment.

Dr. Rostain began by discussing the neurobiological basis of ADHD, which guides pharmacotherapy. He reviewed the response rate of FDA-approved agents for **adults with ADHD**, including stimulants, atomoxetine, and alpha-adrenergic agonists. Best response is seen with stimulants, but some patients improve with bupropion and tricyclic antidepressants (TCAs).

Employ a multimodal treatment approach, Dr. Rostain recommended, which should include psychoeducation and environmental restructuring, because, as he says, “Pills don’t teach skills.” He also reviewed strategies for treating ADHD in patients who have a comorbid disorder, such as bipolar disorder, major depressive disorder, or substance abuse.

Patients with **psychotic depression** meet criteria for major depressive disorder but also have delusions or hallucinations. Diagnostic issues include increased guilt, cognitive impairment, paranoia, and increased hopelessness. **Anthony J. Rothschild, MD**,



▲ Henry A. Nasrallah, MD

University of Massachusetts Medical School, reviewed methods for differentiating psychotic depression from schizophrenia, posttraumatic stress disorder, obsessive-compulsive disorder, and body dysmorphic disorder. There are no FDA-approved medications for psychotic depression, Dr. Rothschild explained; however, evidence shows that the combination of an antidepressant and an antipsychotic is superior to monotherapy with an agent from either class. In addition, he noted, studies show a high response rate with electroconvulsive therapy (ECT).

AFTERNOON SESSION

Return of symptoms after initial remission—while the patient is still taking an antidepressant—is considered tachyphylaxis, or “poop out.” **Residual depressive symptoms**, when a patient meets criteria for remission but still has troubling symptoms, is a different phenomenon, although symptoms can overlap. First, **Dr. Rothschild** advised, ensure that patients are given an adequate trial of an antidepressant. Options are similar when tachyphylaxis or residual symptoms are present: switch drugs or add augmentation therapy, such as lithium, thyroid hormone, or an atypical antipsychotic. Data on the efficacy for bupropion and buspirone are not strong. For **treatment-resistant depression** when a patient does not respond to 3 adequate antidepressant trials—consider ECT or rTMS, if available, or a monoamine oxidase inhibitor or a TCA.

Dr. Black defines **antisocial personality disorder (ASPD)** as a disorder of lifelong serial misbehavior, one characterized by impaired relationships, aggressive behavior, non-aggressive delinquent behavior, manipulation, and a disturbing lack of conscience. There is no standard treatment for ASPD, and no FDA-approved medications; however, potential treatments have not been adequately studied, he pointed out. Cognitive-behavioral therapy might be appropriate in mild cases; some patients benefit from specific programs—for example, ones that address drug or alcohol addiction or anger, although evidence is limited. When treating ASPD patients, Dr. Black concluded, be mindful of high attrition, possible misuse of prescribed

medications, and drug-drug or drug-alcohol interactions.

Bipolar disorder is associated with the highest risk of **suicide** and increased lethality among all psychiatric disorders. Lithium has evidence of an anti-suicidality effect and may reduce suicide by decreasing relapse, aggression, and impulsivity. An FDA advisory on increased risk of suicidality with anticonvulsants was based on data about patients with epilepsy, not bipolar disorder. Second-generation antipsychotics, including olanzapine, quetiapine, and lurasidone, have been shown to be effective for bipolar depression. Avoid antidepressants if possible, **Philip G. Janicak, MD, Northwestern University Feinberg School of Medicine**, advised; if you must prescribe one, reassess the need for the drug often. Several psychotherapy modalities have evidence supporting their use in bipolar disorder.

FRIDAY, APRIL 17, 2015

MORNING SESSION

Henry A. Nasrallah, MD, Saint Louis University School of Medicine, offered enlightening historical touch-points on **how psychiatry's understanding of, and its approach to, schizophrenia** have changed in the past 50 years. His goal? To challenge practitioners to rethink ideas about the disorder and how they care for affected patients. From a laundry list of comparative shifts, here are a few of Dr. Nasrallah's "then" and "now" observations:

- *The old paradigm was:* Clinical and functional deterioration are inevitable in schizophrenia. *The new paradigm is:* Complete remission and restoration of function are feasible in many patients when they are fully adherent to the treatment plan.
- *The old:* Long-acting injectable (LAI) antipsychotics are a last-resort treatment, to be prescribed after a patient is stabilized. *The new:* Use LAI antipsychotics early in the course.
- *Old:* Begin treatment when psychosis appears. *New:* Work to prevent conversion to psychosis.
- *Old:* The disorder is considered a consequence of neurochemical dysregulation. *New:* Impaired neuroplasticity is to blame.
- *Old:* Treatment is a matter of trial and error. *New:* We can apply pharmacogenomics to predict a patient's response to various drugs and thus increase the likelihood of therapeutic success.

In his second presentation, **Dr. Nasrallah** described the many pathways to psychosis and several **psychotic disorders** other than schizophrenia, including schizoaffective, delusional disorder, and psychotic disorder caused by a general medical condition. He

listed symptom clusters in psychosis beyond positive and negative symptoms, including neuromotor symptoms, mood symptoms, and neurocognitive deficits. Development of schizophrenia is multifactorial and involves risk genes and environmental factors seen before conception, during birth, and in early childhood; good prenatal care is the best way to prevent schizophrenia, Dr. Nasrallah noted. Several general medical conditions can produce schizophrenia-like psychosis, including some CNS disorders, toxins, autoimmune diseases, infectious diseases, and chromosomal abnormalities. The session concluded with **a live interview with one of Dr. Nasrallah's patients, whose schizophrenia is in remission with clozapine.**

Drug abuse can mask signs and symptoms of bipolar disorder, which can delay diagnosis. Commonly abused substances are nicotine, alcohol, *Cannabis*, and cocaine; polysubstance abuse is the rule. **Bipolar disorder and substance abuse** share common mechanisms: impulsivity, poor modulation of motivational and response to reward, and behavioral sensitization. Treatment approaches should be flexible. **Dr. Janicak** reviewed the evidence for using anticonvulsants, antipsychotics, and bupropion for alcohol, *Cannabis*, and cocaine



◀ Alina Suris, PhD, receives the 2015 George Winokur Research Award from Carol S. North, MD, for her article on sirolimus as a novel treatment for veterans with posttraumatic stress disorder.

abuse; there are no data on treating opioid abuse. He also discussed the evidence for using naltrexone, acamprosate, disulfiram, and varenicline, as well as psychotherapeutic options, to treat substance abuse. Dr. Janicak encouraged clinicians in the audience to treat substance abuse in bipolar disorder patients themselves, instead of referring them to a subspecialist.

Untreated psychiatric disorders increase obstetrical complications, possibly through decreased self-care or increased stress. For mild or moderate depression, psychotherapy might be sufficient treatment; but for severe cases, medication is the first-line approach. In her presentation on **mood disorders during pregnancy**, **Marlene P. Freeman, MD, Massachusetts General Hospital**, advises that clinicians select medications based on known safety information, patient preference, and the previous course of illness. Results of studies that lasted 4 to 5 years do not show major long-term adverse effects of antidepressant exposure on neurodevelopment or neurobehavior. When treating patients for bipolar disorder, valproate is associated with an increased risk of adverse cognitive and neurodevelopmental effects in infants compared with other anticonvulsants; evidence suggests that lamotrigine is a safer option. The research does not show an increased risk of major malformations with second-generation antipsychotics.

AFTERNOON SESSION

Most women have premenstrual symptoms; a minority have a full-blown syndrome, now



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known as **premenstrual dysphoric disorder (PMDD)**. This is not an existing mood disorder that becomes worse premenstrually. Clinician and patients should track the temporal relationship of symptoms on a calendar for a few months. Selective serotonin reuptake inhibitors (SSRIs) and venlafaxine have been well studied and are effective compared with placebo, but don't help all patients with PMDD. Consider flexible dosing strategies with SSRIs—perhaps daily use, a higher dosage premenstrually, and as-needed administration. Start with an oral contraceptive or SSRI; if symptoms don't respond, add the other. Serotonergic antidepressants have been shown helpful for hot flashes and **depressive symptoms in perimenopause**. **Dr. Freeman** reviewed the evidence for using complementary and alternative therapies for menopausal symptoms and hot flashes.

Smoking contributes to excess mortality in seriously mentally ill patients as a result of such tobacco-related illnesses as heart disease, lung disease, and cancer. Overall improvement in mental health as well as physical health is seen when a patient stops smoking. All nicotine replacement products are effective, but patients often don't use them long enough or correctly. **Robert M. Anthenelli, MD, University of California, San Diego**, said to begin sustained-release bupropion 1 or 2 weeks before quit date; maintain the dosage for 1 to 12 weeks after quit date and consider maintenance therapy for as long as 6 months. Varenicline is superior to placebo and bupropion, but is known to have gastrointestinal (GI) and sleep disturbance adverse effects. Quitting smoking can increase the blood level of some psychotropics, meaning that you might need to reduce their dosage. It is best to begin smoking cessation when patients are mentally stable, when motivated, and stable on their medications.

In discussing **trends in substance abuse**, **Dr. Anthenelli** noted that drug misuse is faddish. Fentanyl and fentanyl analogues are 100 times more powerful than morphine; ingestion of even a minuscule dose can be fatal. Synthetic cannabinoids primarily are a problem among adolescents; they are more dangerous than marijuana and are associated with aggressive and suicidal behaviors. A standard toxicology screen will not detect



synthetic cannabinoids. E-cigarettes are considered by users to be safer than tobacco cigarettes—and probably are—but they still put patients at risk of nicotine addiction. There are no safety data on e-cigarettes; the devices might contain potentially harmful chemicals and potentially toxic nicotine levels. **Dr. Anthenelli** reported that topiramate is “the best medication I've used” for alcohol abuse disorder. The drug is not FDA-approved for this use, but has been used in a number of studies with positive outcomes.

SATURDAY, APRIL 18, 2015

MORNING SESSION

Psychiatrists are well positioned to **help patients with mental illness lose weight** because of their psychotherapeutic background. Best treatment strategy is diet plus exercise plus behavioral modification. **Robert M. McCarron, DO, University of California, Davis**, recommends keeping it simple and telling patients to only consider calories of foods, and not to worry about sodium or fat content. Ask patients “How many minutes a day of exercise can you do?” but recommend that patients walk for 30 minutes a day at 4 mph, 5 days per week, which will help patients lose 1% to 3% of body weight. For treatment-refractory obese patients, consider medications such as bupropion, orlistat, lorcaserin, topiramate, or metformin; for those with a BMI ≥ 40 , recommend bariatric surgery.

George T. Grossberg, MD, Saint Louis University School of Medicine, reviewed the evidence for **anxiety disorders in older adults**, including generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, and posttraumatic stress disorder. Older patients with cardiovascular disease, cancer, Parkinson's disease, diabetes, GI disorders, or chronic obstructive pulmonary disease are at high risk of anxiety symptoms. In a study of centenarians, predictors of anxiety are worse health perception, financial concerns related to medical expenses, higher number of medical conditions, and loneliness. Secondary anxiety is prevalent in Alzheimer's disease; the condition can present as fidgeting, pacing, anger, or agitation, and can be prompted by a change in routine. Acute, new-onset anxiety symptoms should trigger a complete medical

evaluation, including a review of medications, supplements, and substance use. In geriatric patients, minimize use of benzodiazepines and avoid anticholinergics.

Overall, psychiatry patients do not receive optimal preventive and primary medical care, leading to decreased life expectancy, often as a result of **cardiovascular disease**. Psychiatric patients have a high rate of dyslipidemia, hypertension, smoking, and obesity. Psychiatrists often don't treat these conditions, but they need to be aware of changing standard practices in preventive medicine; be able to recognize a potential problem; and make referrals when appropriate. **Dr. McCarron** reviewed age-based screening recommendations for hypertension, dyslipidemia, and diabetes from the book *Preventive Medical Care in Psychiatry*, which he co-edited. He recommends using online cardiovascular risk calculators to determine which patients need to be screened.

AFTERNOON SESSION

Some older patients who abuse substances took drugs as young adults and never gave them up; others have rediscovered drugs in later life. Potential indicators of alcohol abuse in older patients are changes in cognition, mood, memory, hygiene, or sleep. **Substance abuse in older adults** frequently is comorbid with depression or bereavement, anxiety, and adjustment disorders. **Dr. Grossberg** recommends addressing the topic directly with patients. Although there are few data to guide treatment, prompt detection and appropriate treatment can improve the quality of life of older adults and their family.

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