Current Psychiatry | AMERICAN ACADEMY OF CLINICAL PSYCHIATRISTS

PSYCHIATRY UPDATE

SOLVING CLINICAL CHALLENGES, IMPROVING PATIENT

Current Psychiatry and the American Academy of Clinical Psychiatrists welcomed more than 550 psychiatric practitioners from across the United States and abroad to this annual conference, which was headed by Meeting Chair Richard Balon, MD, and Co-chairs Donald W. Black, MD, and Nagy Youssef, MD, March 27-29, 2014 at the Hilton Chicago in Chicago, Illinois. Attendees earned as many as 10 *AMA PRA Category 1 Credits*™.

THURSDAY, MARCH 27, 2014

MORNING SESSION

Obsessive-compulsive disorder can be misdiagnosed as psychosis, anxiety, or a sexual disorder. In addition to contamination, patients can present with pathologic doubt, somatic obsessions, or obsessions about taboo or symmetry. Among FDA-approved medications, clomipramine might be more effective than selective serotonin reuptake inhibitors (SSRIs). Exposure response prevention therapy shows better response than pharmacotherapy, but best outcomes are seen with combination therapy. **Jon E. Grant, JD, MD, MPH, University of Chicago**, also discussed obsessive-compulsive personality disorder, body dysmorphic disorder, hoarding, trichotillomania, and excoriation disorder—as well as changes in DSM-5 that cover this group of disorders.

Patients with **schizophrenia** are at higher risk of death from cardiac and pulmonary disease than the general population. The quality of care of patients with psychosis generally is poor, because of lack of recognition, time, and resources, as well as systematic barriers to accessing health care. Questions about weight gain, lethargy, infections, and sexual functioning can help the practitioner assess a patient's general health. When appropriate, **Henry A. Nasrallah, MD, St. Louis University School of Medicine**, recommends, consider switching antipsychotics, which might reverse adverse metabolic events.

Nonpharmacologic treatment goals include improving sleep, educating patients, providing them with tools for improving sleep, and creating an opportunity for patient-practitioner discussion. Stimulus control and sleep restriction are primary therapeutic techniques to improve sleep quality and reduce non-sleeping time in bed. **Thomas Roth, PhD, Henry Ford Hospital**, also discussed how to modify sleep hygiene techniques for pediatric, adolescent, and geriatric patients.

Donald W. Black, MD, University of Iowa, says that work groups for **DSM-5** were asked to consider dimensionality and culture and gender issues. New diagnostic categories include obsessive-compulsive and related disorders and trauma and stressor-related disorders. Some diagnoses were reformulated or introduced, including autism spectrum disorder and disruptive mood dysregulation disorder. The multi-axial system was discontinued in DSM-5. He also reviewed coding issues.

In a sponsored symposium, **Prakash S. Masand, MD, Global Medical Education, Inc.**, looked at the clinical challenges of addressing all 3 symptom domains that characterize **depression** (emotional, physical, and cognitive) as an introduction to reviewing the efficacy, mechanism of action, and side effects of vortioxetine (Brintellix), a new serotonergic agent for treating major depressive disorder (MDD). In all studies submitted to the FDA, vortioxetine was found to be superior to placebo, in at least 1 dosage group, for alleviating depressive symptoms and for reducing the risk of depressive recurrence.

▲Henry A. Nasrallah, MD

AFTERNOON SESSION

Oppositional defiant disorder is more common in boys (onset at age 6 to 10) and is associated with inconsistent and neglectful parenting. Treatment modalities, including educational training, anticonvulsants, and lithium, do not have a strong evidence base. Intermittent explosive disorder is characterized by short-lived but frequent behavioral outbursts and often begins in adolescence. **Dr. Grant** also reviewed the evidence on conduct disorder, pyromania, and kleptomania.

Cognitive symptoms of schizophrenia often appear before psychotic symptoms and remain stable across the lifespan. There are no pharmacologic treatments for cognitive deficits in schizophrenia; however, **Dr. Nasrallah** listed tactics to improve cognitive function, including regular aerobic exercise. These cognitive deficits can be categorized as neurocognitive (memory, learning, executive function) and social (social skills, theory of mind, social cues) and contribute to functional decline and often prevent patients from working and going to school. **Dr. Nasrallah** described how bipolar disorder (BD) overlaps with schizophrenia in terms of cognitive dysfunction.

Psychiatric disorders exhibit specific sleep/wake impairments. **Sleep disorders** can mimic psychiatric symptoms, such as fatigue, cognitive problems, and depression. Sleep disturbances, including insomnia, obstructive sleep apnea, and decreased need for sleep, often coexist with depression, generalized anxiety disorder, posttraumatic stress disorder, and BD, and insomnia is associated with a greater risk of suicide. With antidepressant treatment, sleep in depressed patients improves but does not normalize. **Dr. Roth** also reviewed pharmacotherapeutic

options and non-drug modalities to improve patients' sleep.

Antidepressants have no efficacy in treating **acute episodes of bipolar depression**, and using such agents might yield a poor long-term outcome in BD, according to **Robert M. Post, MD**, **George Washington University School of Medicine**, **Michael J. Ostacher, MD, MPH, MMSc**, **Stanford University**, and **Vivek Singh, MD, University of Texas Health Science Center at San Antonio**, in an interactive faculty discussion. For patients with bipolar I disorder, lithium monotherapy or the combination of lithium and valproate is more effective than valproate alone; evidence does not support valproate as a maintenance treatment. When a patient with BD shows partial response, attendees at this sponsored symposium were advised, consider adding psychotherapy and psycho-education. Combining a mood stabilizer and an antipsychotic might be more effective than monotherapy and safer, by allowing lower dosages. The only 3 treatments FDA-approved for bipolar depression are the olanzapine-fluoxetine combination, quetiapine, and lurasidone.

FRIDAY, MARCH 28, 2014

MORNING SESSION

Carmen Pinto, MD, at a sponsored symposium, reviewed the utility and safety of **long-acting injectable (LAI) antipsychotics for treating schizophrenia**, with a focus on LAI aripiprazole, a partial HT-receptor agonist/partial HT-receptor antagonist. Four monthly injections (400 mg/injection) of the drug are needed to reach steady state; each injection reaches peak level in 5 to 7 days. LAI aripiprazole has been shown to delay time to relapse due to nonadherence and onset of nonresponse to the drug, and has high patient acceptance—even in those who already stable. Safety and side effects with LAI aripiprazole are the same as seen with the oral formulation.

In multimodal therapy for **chronic pain**, psychiatrists have a role in assessing psychiatric comorbidities, coping ability, social functioning, and other life functions, including work and personal relationships. Cognitive-behavioral therapy can be particularly useful for chronic pain by helping patients reframe their pain experiences. **Raphael J. Leo, MA, MD, FAPM**, **University at Buffalo**, reviewed non-opioid co-analgesics that can be used for patients with comorbid pain and a substance use disorder. If opioids are necessary, consider "weak" or long-acting opioids. Monitor patients for aberrant, drug-seeking behavior.

In the second part of his overview, **Dr. Black** highlighted specific changes to **DSM-5** of particular concern to clinicians. New chapters were created and disorders were

consolidated, he explained, such as autism spectrum disorder, somatic symptom disorder, and major neurocognitive disorder. New diagnoses include hoarding disorder and binge eating disorder. Subtypes of schizophrenia were dropped. Pathologic gambling was renamed gambling disorder and gender dysphoria is now called gender identity disorder. The bereavement exclusion of a major depressive episode was dropped.

Antidepressants are effective in mitigating pain in neuropathy, headache, fibromyalgia, and chronic musculoskeletal pain, and have been advocated for other pain syndromes. Selection of an antidepressant depends on the type of pain condition, comorbid depression or anxiety, tolerability, and medical comorbidities. **Dr. Leo** presented prescribing strategies for tricyclics, serotonin-norepinephrine reuptake inhibitors, SSRIs, and other antidepressants.

Treating of **BD in geriatric patients** becomes complicated because therapeutic choices are narrowed and response to therapy is less successful with age, according to **George**

◀ Boaz Levy, PhD, (left) receives the 2014 George Winokur Research Award from Carol S. North, MD, for his article on recovery of cognitive function in patients with co-occuring bipolar disorder and alcohol dependence.

T. Grossberg, MD, St. Louis University. Rapid cycling tends to be the norm in geriatric BD patients. Look for agitation and irritability, rather than full-blown mania; grandiose delusions; psychiatric comorbidity, especially anxiety disorder; and sexually inappropriate behavior. Pharmacotherapeutic options include: mood stabilizers, atypical antipsychotics, and antidepressants (specifically, bupropion and SSRIs—not TCAs, venlafaxine, or duloxetine—and over the short term only). Consider divalproex for mania and hypomania, used cautiously because of its adverse side-effect potential.

AFTERNOON SESSION

Often, BD is misdiagnosed as unipolar depression, or the correct diagnosis of BD is delayed, according to **Gustavo Alva, MD, ATP Clinical Research**. Comorbid substance use disorder or an anxiety disorder is common. Comorbid cardiovascular disease brings a greater risk of mortality in patients with BD than suicide. Approximately two-thirds of patients with BD are taking adjunctive medications; however, antidepressants are no more effective than placebo in treating **bipolar depression**. At this sponsored symposium, **Vladimir Maletic, MD**, **University of South Carolina**, described a 6-week trial in which lurasidone plus lithium or divalporex was more effective in reducing depression, as measured by MADRS, than placebo plus lithium or

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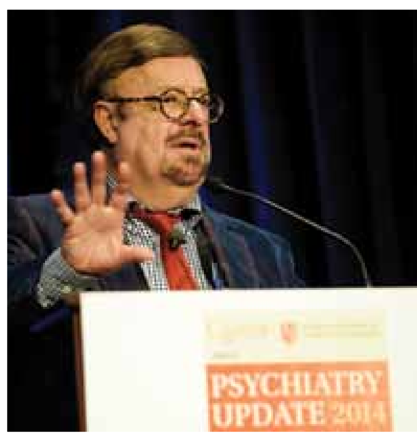

George T. Grossberg, MD

divalporex. Adverse effects included nausea, akathisia, somnolence, and extrapyramidal symptoms.

When assessing an older patient with psychosis, first establish the cause of the symptoms, such as Alzheimer's disease, affective disorder, substance use, or hallucinations associated with grief. Older patients with schizophrenia who have been taking typical antipsychotics for years might benefit from a switch to an atypical or a dosage reduction. **Dr. Grossberg** recommends considering **antipsychotics for older patients** when symptoms cause severe emotional distress that does not respond to other interventions or an acute episode that poses a safety risk for patients or others. Choose an antipsychotic based on side effects, and "start low and go slow," when possible. The goal is to reduce agitation and distress—not necessarily to resolve psychotic symptoms.

Anita H. Clayton, MD, University of Virginia Health System, provided a **review of sexual function from puberty through midlife and older years**. Social factors play a role in sexual satisfaction, such as gender expectations, religious beliefs, and the influence of reporting in the media. Sexual dysfunction becomes worse in men after age 29; in women, the rate of sexual dysfunction appears to be consistent across the lifespan. Cardiovascular disease is a significant risk factor for sexual dysfunction in men, but not in women. Sexual function and depression have a bidirectional relationship; sexual dysfunction may be a symptom or cause of depression and antidepressants may affect desire and function. Medications, including psychotropics, oral contraceptives, and opioids, can cause sexual dysfunction.

Providers often are reluctant to bring up sexual issues with their patients, **Dr. Clayton** says, but patients often want to talk about their sexual problems. In reproductive-age women, look for hypoactive sexual desire disorder and pain. In men, assess for erectile dysfunction or premature ejaculation. Inquire about every phase of the sexual response cycle. When **managing sexual dysfunction**, aim to minimize contributing factors such as illness or medication, consider FDA-approved medications, encourage a healthy lifestyle, and employ psychological interventions when appropriate. In patients with antidepressant-associated sexual dysfunction, consider switching medications or adding an antidote, such as bupropion, buspirone, or sildenafil.

SATURDAY, MARCH 29, 2014

MORNING SESSION

Because of the lack of double-blind, placebo-controlled trials, the risks of untreated depression vs the risks of **antidepressant use in pregnancy** are unclear. **Marlene P. Freeman, MD, Massachusetts General Hospital**, described the limited, long-term data on tricyclics and fluoxetine. Some studies have shown a small risk of birth defects with SSRIs; others did not find an association. For moderate or severe depression, use antidepressants at the lowest dosage and try non-medication options, such as psychotherapy and complementary and alternative medicine. During the third trimester, women may need a higher dosage to maintain therapeutic drug levels. Data indicates that folic acid use during pregnancy is associated with a decreased risk of autism and schizophrenia.

James W. Jefferson, MD, University of Wisconsin School of Medicine and Public Health, recommends ruling out medical conditions, such as cancer, that might be causing your patients' **fatigue or depression**. Many medications, including over-the-counter agents and supplements, can cause fatigue. Bupropion was more effective than placebo and SSRIs in treating depressed patients with sleepiness and fatigue. Adding a psychostimulant to an SSRI does not have a significantly better effect than placebo on depressive symptoms. Adjunctive modafanil may improve depression and fatigue. Data for dopamine agonists are limited.

Lithium should be used with caution in **pregnant women** because of the risk of congenital malformations. **Dr. Freeman** also discussed the potential risks to the fetus with the mother's use of valproate and lamotrigine (with the latter, a small increase in oral clefting). High-potency typical antipsychotics are considered safe; low-potency drugs have a higher risk of major malformations. For atypicals, the risk of malformations appears minimal; newborns might display extrapyramidal effects and withdrawal symptoms. Infants exposed to psychostimulants may have lower birth weight, but are not at increased risk of birth defects.

Dr. Jefferson reviewed the efficacy, pharmacokinetics, and adverse effects of vilazodone, levomilnacipran, and vortioxetine, which are **antidepressants new to the market**. Dr. Jefferson recommends reading package inserts to become familiar with new drugs. He also described studies of medications that were not FDA-approved, including edivoxetine, quetiapine XR monotherapy for MDD, and agomelatine. Agents under investigation include onabotulinumtoxin A injections, ketamine, and lanicemine.

Katherine E. Burdick, PhD, Mount Sinai School of Medicine, defined cognitive domains. First-episode MDD patients perform worse in psychomotor speed and attention than healthy controls. Late-onset depression (after age 60) is associated with worse performance on processing speed and verbal memory. **Cognitive deficits in depressed patients** range from mild to moderate and are influenced by symptom status and duration of illness. Treating cognitive deficits begins with prevention. Cholinesterase inhibitors are not effective for improving cognition in MDD. Antidepressants, including SSRIs, do not adequately treat cognitive deficits, **Roger S. McIntyre, MD, FRCPC, University of Toronto**, explained.

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