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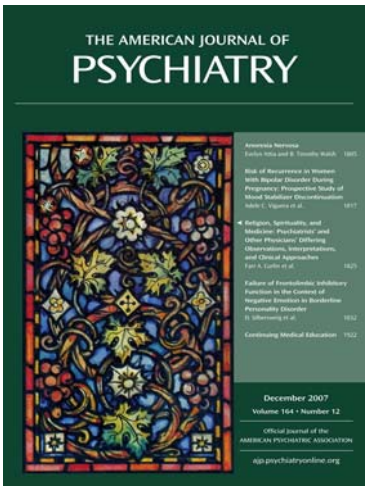

At some point during their postgraduate years, residents and fellows realize that despite spending 4 to 6 years after medical school to become a psychiatrist, there will be limits to their training and experience for many clinical situations. Within our specialty there are subspecialties, and embedded within these subspecialties are complex situations that require training, experience, and sometimes dedicated treatment facilities. Psychiatrists-in-training may have rotations that include such facilities, if they exist at their training sites, but they do not graduate from their training able to handle such cases by themselves. It can be frustrating to have chosen the specialty of psychiatry, only to realize that the ability to treat autism, childhood-onset schizophrenia, adolescent conduct disorder, opiate addiction, melancholia requiring ECT, personality disorders requiring psychoanalysis and other intensive psychotherapies, violence requiring forensic evaluation, and mixed dementia and psychosis in the elderly, to mention just a few, is still elusive.

A good example of the limitations of most of our training and experience is anorexia nervosa, which is one of the most life-threatening psychiatric illnesses. The most serious cases require hospitalization, preferably in a unit dedicated to behavioral management of this illness, in addition to specialized therapies targeting the behavior of both the patient and his or her family. Most residents will be exposed at some time during their training to either adults or adolescents with this disorder, but few will feel competent to lead their treatment, particularly for the more serious cases that come to academic medical centers. The Residency Review Committee that accredits residency training recognizes this limitation and does not mandate that residents actually treat these patients or attain any specific level of proficiency.

Evelyn Attia, M.D., and B. Timothy Walsh, M.D., were invited to contribute this month's "Treatment in Psychiatry" to address the issue of the diagnosis and treatment of anorexia nervosa by psychiatrists who do not have special training in the illness (1). Drs. Attia and Walsh are experts in this illness, and their recent research articles on the diagnosis and treatment of anorexia nervosa have appeared in the *Journal of the American Medical Association* and the *American Journal of Psychiatry* (2, 3). An additional article from them will appear in the February 2008 issue and has just been posted online as part of our new "AJP in Advance" feature (4). The questions we asked them to consider in their "Treatment in Psychiatry" feature were 1) how do general psychiatrists recognize anorexia nervosa, 2) can general psychiatrists initiate treatment for anorexia nervosa, and 3) when should patients be referred to specialized treatment centers? We may think some illnesses in particular mandate specialty treatment, but anorexia nervosa is not only a good example of an illness for which most psychiatrists feel that their expertise is limited, but it is also an example of an illness for which patients and their families often seek help first from a pediatrician or family physician, who most often then refer the patient to a general psychiatrist and not to a specialized treatment center.

"Treatment in Psychiatry" is a feature designed to convey the latest information on clinical problems that most experienced general psychiatrists feel they could always use help with, such as anorexia nervosa. Each article begins with a vignette of a typical patient who represents a level of complexity that general psychiatrists would find challenging, but not outside their scope of practice. The problems discussed in this series range from a child with attention deficit disorder who develops psychotic symptoms after receiving stimulant medication, to an elderly man with possible mania or fronto-temporal dementia, to a veteran returning from combat who acts violently toward his wife (5–7). "Treatment in Psychiatry" topics for 2008 include: how to recognize and treat the subtle signs of akathisia that cause patients to fail to take their antipsychotic medications, how to evaluate and treat a psychotic young person who is obsessed with violence, and how to treat a depressed and suicidal adolescent in light of recent FDA warnings about antidepressants and suicide.

In their article, Drs. Attia and Walsh discuss the diagnostic criteria for anorexia nervosa using the case of a college student, who cleverly attributes her recurring weight loss to a desire to avoid gaining the "freshman 10 pounds." They evaluate the evidence in the research literature for the prescription of pharmacotherapy and behavioral therapy and advise psychiatrists on when to treat a patient themselves and when to seek referral to a specialized center. Finally, as in all the articles in this series, Drs. Attia and Walsh conclude with personal recommendations on how they would proceed with a case similar to the one portrayed in the vignette.

I hope that you find these cases stimulating and, in particular, that they help you measure what you are learning against the scope of practice of other psychiatrists.

Robert Freedman, M.D.

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Helping Veteran Patients Gain Access to Care

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Consider the following: you are treating a military veteran and come to the conclusion that they might be better served in the U.S. Department of Veterans Affairs (VA) health care system rather than where you are currently caring for them. Given the likelihood that you have found, or soon will find, yourself in this situation, the logical follow-up question is, "What can I do to help such a patient receive care through the VA?"

Armed with some very basic information, you can help veteran patients start on the path to accessing VA benefits, as well as connect them with organizations that will shepherd them through this process at no cost. This article includes a discussion of who is entitled to VA benefits, a brief description of the process required to access those benefits, and contact information for some organizations that help veterans with their applications (information about the application process is subject to change, especially as efforts are underway to streamline the process for returning veterans. The latest guidelines are available at www1.va.gov/health/index.asp).

Veterans entitled to health care through the U.S. Department of Veterans Affairs can be classified in three basic categories, all of which require discharge from service under other than dishonorable conditions:

• Recently discharged veterans who served in combat zones: entitled to "blanket" coverage for a period of 2 years after leaving the military

• Veterans who applied for and were granted "service-connected disability": entitled to receive monthly stipends and free treatment for their disabilities

• Veterans without "service-connected disability": entitled to use VA health care for a minimal charge. If the veteran earns below a certain level of income, care may be free

If you think your patient may already be enrolled in the VA system, you can confirm this by contacting the nearest VA health care facility, available from www1.va.gov/directory/guide/home.asp. Once enrollment is verified, arranging access to care is fairly straightforward.

If your patient is eligible but is not enrolled in the VA system, some further action is required. First, a copy of the veteran's discharge certificate, also known as Form DD-214, is needed. Copies of lost DD-214 forms can be requested online at www.archives.gov/veterans/evetrecs/. Although the patient may leave your care by the time the document becomes available (turnaround time is estimated at 10 days), requesting the DD-214 is still worthwhile, for the patient is likely to need the document eventually.

With the DD-214 in hand, the next step is to apply for benefits through the VA. This involves gathering medical records and filing forms, both of which can be challenging for patients dealing with mental health issues. The odds of these patients accessing care can be greatly enhanced by putting them in contact with one of several national organizations that shepherd veterans through the application process at no cost. Three such recommended groups are:

• AMVETS (www.amvets.org/NewAMVETSsite/service /claim_services.html)

• Disabled American Veterans (DAV) (www.dav.org/veterans/claim_representation.html)

• The American Legion (www.legion.org/?section=veterans&subsection=vt_generinfo&content=vt_healthcare).

If your patient declines such help, direct applications can be made online on their behalf at vabenefits.vba.va.gov/vonapp/main.asp.

Assisting veteran patients with this process may take some time and effort, but the investment is well justified by the difference it can make in their lives.

Old Age

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The structure of American society is such that aging can be isolating for many individuals. Like every stage of life, old age is neither inherently miserable nor inherently sublime, having its own unique problems, joys, and fears. The elderly have the potential for reflection and observation that can only come from having lived an entire lifespan. Thus, the elderly have many ways of contributing to society, and their wisdom enables them to be advisers and judges. For example, Michelangelo (1475–1564) felt toward the end of his life that his greatest creations were still to come. In Sonnet 1, Shakespeare wrote that one must contribute to the world in one's own special way, and not just take without giving anything in return:

Within thine own bud buriest thy content,
And, tender churl, mak'st waste in niggarding:
Pity the world, or else this glutton be,
To eat the world's due, by the grave and thee.
(11–14)

Old age is also inevitably a stage of physical loss and grief. However, there is another aspect to this

stage of life, which is the development and growth of new relationships, such as with grandchildren (in some cases great-grandchildren) and other acquaintances who enrich our lives. Also, there is the wonder and awe of seeing the new developments and changes that this fast-growing world has to offer.

Harsh realities of aging certainly exist, such as the heedless attitudes of society in terms of job opportunities for the elderly and poverty in old age, and even the prejudice of some physicians. As Oscar Wilde wrote in *The Picture of Dorian Gray*, "Youth! Youth! There is nothing in the world but youth!" The ability to change and adapt has more to do with one's lifelong character and not one's age. Some elderly individuals may collaborate with those that wish to ostracize them by acting "senile;" others may deny their true feelings in an attempt to "age gracefully" and obtain the approval which is otherwise denied to them. Other self-sabotaging behavior can be the result of a refusal to identify oneself as elderly at all. Of course, considering oneself young is not simply a prejudice or delusion, as healthy elderly people can feel strong and energetic, much like they did in their earlier days.

The elderly are not always victims; they can become exploiters and manipulators of younger people. This energy could be better directed toward the greater benefit of others, as well as themselves. There may be anger at the brevity of life and loss of vigor, attractiveness, and sexual prowess. Indeed, it is the middle-aged who bear the heaviest personal and social responsibilities, as they are called upon to support those at both ends of the spectrum of life.

Due to recent medical advances that have led to increased longevity, older people have become a visible phenomenon only of late. The elderly population explosion has been a puzzlement for gerontologists, public health experts, and demographers, who do not know whether to regard this phenomenon as the "aging problem" or the human triumph over disease. Because of research and medical advancement, human beings can now live much longer and more comfortably, with a gradual and predictable decline toward eventual death.

Not everyone may be ready to retire at the age of 60 or 65. According to gerontologists, early old age is 65 to 74 years, and advanced old age is 75 years and above. Our definition of the aging process therefore must change. Much of what we consider "aging" is actually disease and illness, and not a fundamental part of the physical aging process.

Our understanding of emotions, such as grief, can gain enormously from the study of the elderly. This is true for a whole variety of human reactions to stress, as well as for normal events in late life. The natural history of human character, disorders, successful modes of adaptation, and survival characteristics can be studied rather comprehensively in this population. A greater understanding and control over the diseases and difficulties of late life would hopefully make old age less frightening and more acceptable as a truly valuable last phase of life. I end with a quote from *Macbeth*, by William Shakespeare:

> *Out, out, brief candle!*
> *Life's but a walking shadow, a poor player*
> *That struts and frets his hour upon the stage*
> *And then is heard no more; it is a tale*
> *Told by an idiot, full of sound and fury, signifying nothing.* (5.5.19–28)

Book Review

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Manual of Clinical Psychopharmacology, Sixth Edition, by Alan F. Schatzberg, M.D., Jonathan O. Cole, M.D., and Charles DeBattista, D.M.H., M.D. Arlington, Va, American Psychiatric Publishing, 2007, 723 pp., $79.00 (paper).

The *Manual of Clinical Psychopharmacology*, currently in its sixth edition, is an elegant, practical, and reader-friendly compilation of the fundamentals of various psychotropic agents that attempts to bridge the gap between the available research and the art of practicing psychopharmacology. It can often be a struggle for residents and early career psychiatrists to keep up with all the recent advances; this manual may just be the answer for those readers looking for a quick reference or updates on evidence-based psychopharmacology. The book is an excellent, practical, and informative source for a quick bedside discussion and may be useful for residents and practitioners alike.

This comprehensive clinical manual has been updated extensively from its previous editions and discusses new psychopharmacological advances in a concise and easily comprehensible manner. The introductory chapter traces the history of psychopharmacology and recommends that the less experienced practitioner initially focus on just a couple medications in each group, and subsequently expand their armamentarium as they gain more experience. This chapter also identifies some of the legal, ethical, and economic issues encountered in real world practice. However, the chapter on diagnosis and classification appears somewhat simplistic for the clinician and may be substituted instead with a chapter on the basics of pharmacokinetics, including information regarding the phases of drug approval by the U.S. Food and Drug Administration (FDA).

Thereafter, the manual incorporates details on all major classes of psychotropic agents in an uncomplicated manner that includes numerous illustrations and tables highlighting mechanisms of action, pharmacokinetics, drug interactions, dosage, adverse effects, and evidence-based expert advice. These chapters include details on antidepressants, antipsychotics, mood stabilizers, antianxiety agents, and hypnotics, followed by chapters that feature augmentation strategies for treatment-resistant disorders, emergency room treatment, pharmacotherapy for substance use disorders, and pharmacotherapy in special situations, such as pregnancy and mental retardation and in pediatric and geriatric populations. The final discussion on herbal and dietary supplements is indeed a welcome addition to this informative manual for clinicians, residents, and students.

While the authors wonderfully compile an enormous amount of clinical and practical information in this pocket manual, a few areas may need more attention in upcoming editions. For example, results of recent effectiveness trials such as the Clinical Antipsychotic Trials in Intervention Effectiveness study (CATIE), Treatment for Adolescents with Depression Study (TADS), and others could be presented for a quick user-friendly review for the benefit of readers. Similarly, emerging trends in pharmacogenetics that may help the clinician individualize and optimize psychotropic medication use are only briefly mentioned in the book but should be addressed in detail. It might also be beneficial to have a summary at the end of each chapter that identifies the strategies behind choosing a particular agent in each medication class. Furthermore, topics such as managing sexual side effects associated with selective serotonin reuptake inhibitors (SSRIs) and switching from oral to long-acting depot antipsychotics need to be addressed in greater detail.

In summary, this latest edition of the *Manual of Clinical Psychopharmacology* provides a refreshingly informal tone that makes the text easy to understand and follow, even for trainees. It has been compactly compiled by experts in the field and provides an updated psychopharmacology review in a collegial and user-friendly manner. The manual adheres to what the English poet Robert Southey famously said: "It is with words as with sunbeams—the more they are condensed, the deeper they burn."

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