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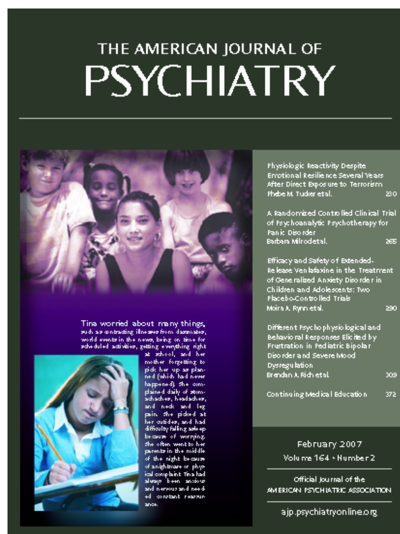

Editors' Column

In our initial focus group at the 2006 APA Annual Meeting, residents asked for commentary from the editors on how to read articles that appear in the *Journal*. In response to this request, we published the first Editors' Column in October 2006, wherein we provided an overview of the relationship of articles to other features of the *Journal*. The feature *In This Issue* gives you a quick summary of an article, and the accompanying editorials provide commentary to help place the article into context, guide you to its strengths and limitations, and then present a clinical message from the article's results. The second Editors' Column, published in December 2006, provided information about the methods of clinical trials, including how patients are enrolled and how the study is conducted ethically. This month we will discuss how to directly approach an article in order to discern for yourself what has been discovered. For our example we will use Milrod et al.'s "A Randomized Controlled Clinical Trial of Psychoanalytic Psychotherapy for Panic Disorder" from the February 2007 issue of the *American Journal of Psychiatry*. A link to this article and an editorial on clinical trials for psychotherapy by Arthur Rifkin is in this issue of the Residents' Journal.

According to David Lewis, one of our Deputy Editors, there are two definitive questions he asks of an article: "Am I interested?" and "Am I convinced?" You could try to answer the first question by reading the *Abstract*, but abstracts tend to be very condensed, because they are written for databasing purposes (e.g., PubMed). The *Introduction* oftentimes immerses you into a sea of unfamiliar references to other papers. Many readers try the *Methods* section first, because that is familiar territory. Within the descriptions of patient evaluations in the *Methods*, you can see yourself diagnosing patients and assessing their symptoms. The *Results* are often a maze of statistics for most papers (we will tackle that problem later). Therefore, it may be most helpful to move to the *Discussion*, usually the last section, which for the Milrod et al. article begins on page 270 in the February issue. The first paragraph of the *Discussion* is a good place in which to find an answer to the question, "Am I interested?"

The first paragraph of the *Discussion* is the authors' opportunity to tell us what they believe they have discovered. For instance, Dr. Milrod and her colleagues tell us that this is the first study to show that psychodynamic psychotherapy is effective for the treatment of panic attacks, as well as for treating the phobic avoidance that people who suffer from panic attacks often develop. I have personally treated people who suffer from panic attacks, and I know that they are often quite difficult to treat. Therefore, as a clinician, this article is of particular interest to me. Now the question is, can the article convince me?

To be convinced that a finding is true, some readers may think that the answer can be found through a careful reading of the *Methods*, but the *Results* are often a better choice, because therein the data can be found. If it is not clear how the data were acquired or analyzed, then clarification can be found in the *Methods*. In the Milrod et al. article, we can learn a lot from the first paragraph of the *Results*. The authors employed two treatments: 1) panic-focused psychodynamic therapy and 2) applied relaxation. At this point it may be necessary to consult elsewhere to find out more about the therapies used and also about the four scales that are used to measure the results in this study. Readers frequently give up at this point, because the various therapies and scales discussed are often unfamiliar. However, there are two things we here at the *Journal* do to help you. First, if you read the full text version online, you can click on a reference and it will take you to MEDLINE or to a full text version of the article describing the scale in question. That is okay if you want to go into the article in more depth, but you can end up with a lot of windows open on your screen. An alternative, unique to the *American Journal of Psychiatry*, is a *Patient Perspective*. We ask authors to tell the story of a patient in the study, so that you can read a clinical description of a patient, the treatment that was given, and its results. Generally, this feature appears as a figure at the end of the *Results*.

To continue with the Milrod et al. article, the second section of the *Results* then gives the principal result of the study, the comparison in treatment effects between the two therapies. Here we are concerned with seeing that there is significant difference between the two treatments. What we are looking for specifically is a predefined measure of effectiveness that makes sense clini-

cally. Generally, to avoid the problem of multiple comparisons (which we will discuss in future columns), the authors prespecify the measure they will use. They may include other measures, but these are considered secondary after they have specified their primary measure. For major clinical trials, authors are required to register their primary measure before beginning the study. Milrod et al. did this, although the web address they give is the one they used for registration, and not the one you need. If you go to www.clinicaltrials.gov, the website maintained for this purpose by the National Institutes of Health, and enter NCT00128388, then you will find that Panic Disorder Severity Score is in fact the predefined primary measure. Milrod et al. find, using a simple t test, that there is indeed a significant difference between the two treatments.

You sometimes will hear that statistical significance does not necessarily equate with clinical significance. This means that sometimes groups or treatment outcomes can be distinguished as statistically different, but the difference is too small to be clinically important. This usually happens in studies with large groups, because there is greater statistical power to identify small differences as statistically significant when large samples are studied. Milrod et al. give us two additional statistics that tell us that the treatment effect is meaningful. First, they give us the effect size, which is the difference between the two groups divided by the SD (instead of the SE used in the t test). The SD is less affected by the number of people in the study than the SE. Effect sizes over 0.4 are generally considered clinically significant. The 0.95 found in this study, also called Cohen's d, is therefore evidence that the effect is meaningful. A second way to look at significance is to predefine a change in the scale that would be clinically meaningful. The authors defined a 40% change from baseline as a clinically significant response. Then, we also have a 2x2 table, with response versus no response on one axis and psychoanalytic therapy versus relaxation therapy on the other axis, with chi-square analysis used. Table 1 shows a p value of 0.016, which is significant; however the text itself has a typographical error and reports the p value as 0.08, which would not be significant. We will publish an erratum in a subsequent issue.

So now you have enough information to tell if the finding is interesting, and you have made the first steps to determine if you can believe it. In the next edition of the Editors' Column we will discuss some of the common symptom rating scales used in clinical research and begin to address some of the statistical methods used in the analysis of clinical data.

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Residents Treating Schizophrenia: Improving Sense of Effectiveness

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Treating a young patient with newly diagnosed chronic psychotic illness is something that residents and attendings who work on inpatient units probably confront more frequently than the average outpatient psychiatrist in solo practice. For a resident, it can be a particularly difficult situation to navigate for a variety of reasons, aside from the obvious challenge of making a correct and careful diagnosis and choosing an appropriate treatment. First, patients are frequently diagnosed with schizophrenia or related disorders when they are young. It can be quite disconcerting, particularly early in training when most residents do the bulk of their inpatient work, to confront a patient who is similar to the resident in age or life experience and is profoundly and severely ill in a way that will likely alter the course of his or her life. Second, many patients experiencing a "first break" are hospitalized because of a dramatic situation such as a suicide attempt, expulsion from high school or college, fight with family members, or an arrest. These circumstances amplify the feeling of urgency and intensity of the situation. Third, if the patient has an involved family—which, sadly, is frequently more likely to exist at the beginning of the illness rather than the more chronic stages—the family is also experiencing a variety of intense emotional reactions. Given the resident's lack of experience with family work at that stage of training, dealing with the patient's family can seem overwhelming. Finally, there may be a profound sense of grief and hopelessness on the part of the other caregivers, including experienced attendings, ward nurses, social workers, and psychologists.

In the face of all of these stressors, the resident is frequently left feeling that all they have to offer is an antipsychotic prescription. This feeling can dissuade residents from wanting to treat severe and persistent mental illness in the future as an outpatient psychiatrist. This reluctance, in addition to poor reimbursement and other challenges, contributes to the limited options that severely mentally ill patients face in pursuing treatment.

Research into the use of cognitive behavior therapy for the treatment of schizophrenia (1) and the importance of family expressed emotion in relapse prevention (2) provides two important ways that residents can bolster their sense of effectiveness. While comprehensive cognitive therapy and psychosocial rehabilitation are not possible in an inpatient unit during a brief stay, the idea that these modalities can be part of comprehensive treatment validates two very important ideas: talking to and listening to the patient is important, and the patient is a real person beyond their diagnosis. While facing a family devastated by a recent diagnosis of schizophrenia is painful, discussing strategies for problem solving within the family and relapse prevention provides the family with something concrete that they can work on, and the resident something useful to offer. While new psychiatry residents are faced with a large amount of didactic information, early training in the basic concepts of supportive psychotherapy and family work would likely increase residents' sense of efficacy and competence in treating inpatients with severe and persistent mental illness. A more satisfying early exposure to these illnesses would hopefully increase the likelihood that residents will feel comfortable treating these patients on an outpatient basis in the future.

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Should We Use Law Enforcement for Emergency Transportation of People With Mental Illness?

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At John Umstead State Hospital in Butner, North Carolina, nearly all patients arrive in a police vehicle, often restrained by handcuffs and shackles. These patients, under involuntary commitment and referred by various outside emergency departments, are mostly nonviolent people with a variety of acute mental health issues. These patients generally wait several hours, often overnight, in their local hospital until the sheriff arrives to transport them as he or she would a criminal. When they do finally arrive at Umstead, they feel violated and persecuted, as they have often told me. These patients start out with a mistrust and apprehension of the mental health system and agents thereof which is quite formidable to overcome.

In North Carolina, almost all patients under civil commitment proceedings are transported to a psychiatric facility by law enforcement. The legal proceedings of involuntary commitment authorizes the state to intervene and places the burden of cost on the state in providing transportation. The use of law enforcement has evolved over time as a less expensive option than EMS to transport these patients. As a result, the cost of transportation is removed from the underfunded mental health system budget. Since most patients who require transport are going to a state hospital due to lack of health insurance, this means that patients who are typically of low socioeconomic status make up the majority of patients who are transported this way. According to a recent study of attitudes toward civil commitment, "police are significantly less likely than families or mental health professionals to perceive mental disability" (1). This is evident in the use of improper restraints and policing tactics, reflecting the lack of training and resources provided to law enforcement officers for this specific task. Such treatment is unfair to the individuals in crisis who are particularly vulnerable and now doubly stigmatized as mentally ill and a criminal.

The anachronistic practice of treating people with mental illness as criminals has been criticized since the early 20th century. Historian Albert Deutsch wrote in 1937, "The disgraceful legal attitude toward the mentally ill ... which has contributed in no small degree to the stigma attached to mental disease–is evidenced in the terminology still widely used in commitment procedures .... The mentally ill person is referred to as a 'suspect' ... he stands trial in the position of a *quasi* criminal" (2). In the late 1930s, an estimated 64% of patients were transported to state hospitals by police and 29% were detained in jails along the way (3). In recent data from an unpublished study from the MacArthur Research Network on Mandated Community Treatment, the lifetime prevalence of patients being transported by police to psychiatric treatment was 38% to 52%.

Clearly, significant public outrage would demand reform if emergency patients with nonpsychiatric illnesses requiring transfer to a different medical facility were transported by police rather than by ambulance. While specific training of EMS personnel and development of new policy and procedures would be required to assure safety when transporting nonviolent mentally ill patients, this should not prevent us from doing so. In fact, mental health professionals have continually demonstrated the competence to maintain safety in hospital settings without the assistance of law enforcement personnel on site. It is time to afford the same rights and respect to people with mental illness as are granted to other hospital patients, without prejudice or question.

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2007 APA Annual Meeting

We would like to invite all residents to participate in a second focus group to take place at the 2007 APA Annual Meeting in San Diego, California. In this meeting, thoughts on the Residents' Journal and ideas on how the *American Journal of Psychiatry* can be of further use to residents will be discussed. The meeting is scheduled for Tuesday, May 22, 2007, at 2:30 to 3:30 p.m. in the San Diego Marriott Hotel and Marina, Columbia Rooms 1-3, North Tower.

For information on the 2007 APA Annual Meeting, including registration and housing, please visit http://www.psych.org/edu/ann_mtgs/am/07/index.cfm. For further information please contact ajp@psych.org.