References

1. Mataix-Cols D, Conceição do Rosario-Campos M, Leckman JF: A multidimensional model of obsessive-compulsive disorder. Am J Psychiatry 2005; 162:228–238
2. Everitt BS, Landau S, Leese M: Cluster Analysis, 4th ed. New York, Oxford University Press, 2001
3. Abramowitz J, Franklin M, Schwartz S, Furr J: Symptom presentation and outcome of cognitive-behavior therapy for obsessive-compulsive disorder. J Consult Clin Psychol 2003; 71:1049–1057
4. Calamari JE, Wiegartz PS, Riemann BC, Cohen RJ, Greer A, Jacobi DM, Jahn SC, Carmin C: Obsessive-compulsive disorder subtypes: an attempted replication and extension of a symptom-based taxonomy. Behav Res Ther 2004; 42:647–670

JOHN E. CALAMARI, PH.D.
North Chicago, Ill.

Dr. Mataix-Cols and Colleagues Reply

TO THE EDITOR: We were pleased to read Dr. Calamari's letter in relation to our recently published review. It highlights methodological and conceptual issues that are unlikely to be easily resolved. Rather than diametrically opposite techniques, factor analysis and categorical approaches, such as cluster analysis, are likely to be complementary because they constitute different ways of looking at the same phenomenon—the heterogeneity of OCD (1). Both have demonstrated their usefulness. For example, tic-related OCD and early-onset OCD both appear to be overlapping and valid subtypes (2). Our preference for factor analytical techniques to address the *classic* symptoms of OCD is twofold.

First, our model hypothesizes that obsessive-compulsive phenomena are normally distributed in the general population (3, 4) and are not limited to the traditional diagnostic boundaries of OCD, i.e., they may be present in many other neurological and psychiatric conditions. Conceptually, a dimensional approach seems to reflect this more accurately. Second, if one adopts a strictly categorical approach, patients need to be unequivocally allocated to only one subtype: a patient is either in cluster X or in cluster Y but not both. We doubt that nature is so exact regarding these symptoms. This is one of the main limitations of the DSM-IV multiaxial system and has been heavily criticized. Along with other theoreticians (5, 6), we propose that a dimensional approach can better deal with the problem of comorbidity or the coexistence of various symptom types in OCD. In short, we reiterate the idea that different methods of analysis are probably likely to yield complementary results. We are glad that Dr. Calamari concurs that considering the heterogeneity of OCD is the direction to take in this important area of research.

References

1. McKay D, Abramowitz JS, Calamari JE, Kyrios M, Radomsky A, Sookman D, Taylor S, Wilhelm S: A critical evaluation of obsessive-compulsive disorder subtypes: symptoms versus mechanisms. Clin Psychol Rev 2004; 24:283–313
2. do Rosario-Campos MC, Leckman JF, Curi M, Quantrano S, Katsovich L, Miguel EC, Pauls DL: A family study of early-onset obsessive-compulsive disorder. Am J Med Genet B Neuropsychiatr Genet 2005; May 12. http://www3.interscience.wiley.com/cgi-bin/abstract/110493822/ABSTRACT
3. Rachman S, de Silva P: Abnormal and normal obsessions. Behav Res Ther 1978; 16:233–248
4. Mataix-Cols D, Cullen S, Lange K, Zelaya F, Andrew C, Amaro E, Brammer MJ, Williams SCR, Speckens A, Phillips ML: Neural correlates of anxiety associated with obsessive-compulsive symptom dimensions in normal volunteers. Biol Psychiatry 2003; 53:482–493
5. Krueger RF, Piasecki TM: Toward a dimensional and psychometrically informed approach to conceptualizing psychopathology. Behav Res Ther 2002; 40:485–499
6. Maser JD, Patterson T: Spectrum and nosology: implications for DSM-V. Psychiatr Clin North Am 2002; 25:855–885

DAVID MATAIX-COLS, PH.D.
London, England
MARIA CONCEIÇÃO DO ROSARIO-CAMPOS, M.D.
San Paulo, Brazil
JAMES F. LECKMAN, M.D.
New Haven, Conn.

Heart Transplantation in a Schizophrenia Patient

TO THE EDITOR: Mr. A, in the clinical case conference by Stephanie M. Le Melle, M.D., M.S., and Charles Entelis, M.D. (1), is one of many patients with schizophrenia, schizoaffective disorder, and bipolar disorder who have undergone heart transplantation at New York Presbyterian Hospital–Columbia University Medical Center. The case conference provided an opportunity to reflect on what psychiatric consultants to heart transplant programs have learned about helping patients with severe mental illness and other psychosocial risk factors achieve successful heart transplant outcomes.

First, some psychiatric disorders and psychosocial variables do have an effect on transplant outcomes. Recent substance abuse, severe personality disorders, poor global function, and an avoidant coping style predict worse outcomes (2, 3). Second, in some cases, even high-risk patients can do well with expert management. Third, especially in such cases, good family support is invaluable. Fourth, a longitudinal relationship with the transplant team provides an opportunity to assess and modify psychosocial risks much better than evaluation at a single moment in time. Mr. A was undoubtedly a high-risk patient, but he had the benefit of devoted and expert psychiatric care, time to develop a relationship with his transplant cardiologist, and superb support from his family.

I would demur on one point made in the report. There has been no shortage of previous experiences with the development or exacerbation of psychosis in patients after transplantation who were receiving a high dose of corticosteroid immunosuppressant therapy. The role of steroids in precipitating psychosis and mood disorders in heart transplant recipients has been described repeatedly since the late 1960s (4–6).

As we noted previously (2), the presence of psychosocial risk factors should not be reason to prejudicially deny care; rather, it should stimulate efforts to mitigate these risks to provide the best possible care and outcome.

References

1. Le Melle SM, Entelis C: Heart transplant in a young man with schizophrenia (clin case conf). Am J Psychiatry 2005; 162:453–457
2. Shapiro PA, Williams DL, Foray AT, Gelman IS, Wukich N, Sciacca R: Psychosocial evaluation and prediction of compliance problems and morbidity after heart transplantation. Transplantation 1995; 60:1462–1466

3. Chacko RC, Harper RG, Gotto J, Young J: Psychiatric interview and psychometric predictors of cardiac transplant survival. Am J Psychiatry 1996; 153:1607–1612
4. Lunde DT: Psychiatric complications of heart transplants. Am J Psychiatry 1969; 126:369–373
5. Kraft IA: Psychiatric complications of heart transplantation. Semin Psychiatry 1971; 3:58–69
6. Ling MHM, Perry PJ, Tsuang MT: Side effects of corticosteroid therapy. Arch Gen Psychiatry 1981; 38:471–477

PETER A. SHAPIRO, M.D.
New York, N.Y.

Insight and Aggression in Schizophrenia

TO THE EDITOR: The research literature on the association between deficits in awareness and aggression in patients diagnosed with schizophrenia is limited; therefore, it was pleasing to read the article by Peter F. Buckley, M.D., and colleagues (1). Their findings highlighted the legal dilemma that mental health experts are faced with in many competency-to-stand-trial evaluations. If a schizophrenic patient who physically assaults another person during a psychotic episode lacks insight into his or her mental illness and does not understand the implications of the violent act, is he or she then mentally fit to be held accountable and to stand trial? The authors briefly discussed this sensitive topic but did not elaborate on an answer.

It is not entirely clear, however, why the authors chose an outpatient population, rather than a forensic or an inpatient population, as the nonviolent control group. The outpatients displayed more insight and less psychopathology than the physically violent patients in a forensic setting (jail or court psychiatric clinic). One might argue, however, that the forensic population displayed symptom profiles similar to those of an institutionalized population because both are involuntarily "locked up" and unable to function in society. The significantly higher scores on the Positive and Negative Syndrome Scale (2) total score in the violent group appear to support this view. Consequently, the insight data might simply be a reflection of the clinical difference between outpatients and institutionalized patients that is unrelated to violent behavior. In other words, an outpatient control group, whether *violent* or *not,* would always display higher insight into their mental illness because better awareness is what characterized this group as being able to function in society. In support, the authors reported on the results of Arango et al. (3), who found that lack of awareness predicted violent behavior in inpatients with schizophrenia. The authors, however, did not discuss other studies that have failed to find a relationship between insight and violence in severely mentally ill forensic patients (4), outpatients (5), and inpatients (6). Preliminary analyses of insight data from our inpatient unit at the Nathan Kline Institute for Psychiatric Research–Rockland Psychiatric Center suggest that inpatients with schizophrenia tend to score high on lack of insight—whether violent or not.

References

1. Buckley PF, Hrouda DR, Friedman L, Noffsinger SG, Resnick PJ, Camlin-Shingler K: Insight and its relationship to violent behavior in patients with schizophrenia. Am J Psychiatry 2004; 161: 1712–1714
2. Kay SR, Fiszbein A, Opler LA: The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. Schizophr Bull 1987; 13:261–276
3. Arango C, Calcedo BA, Gonzalez S, Calcedo OA: Violence in inpatients with schizophrenia: a prospective study. Schizophr Bull 1999; 25:493–503
4. Carroll A, Pantelis C, Harvey C: Insight and hopelessness in forensic patients with schizophrenia. Aust NZ J Psychiatry 2004; 38:169–173
5. Yen CF, Yeh ML, Chen CS, Chung HH: Predictive value of insight for suicide, violence, hospitalization, and social adjustment for outpatients with schizophrenia: a prospective study. Compr Psychiatry 2002; 43:443–447
6. Swartz MS, Swanson JW, Hiday VA, Borum R, Wagner HR, Burns BJ: Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. Am J Psychiatry 1998; 155:226–231

DANIEL ANTONIUS, M.A.
Orangeburg, N.Y.

Dr. Buckley and Colleagues Reply

TO THE EDITOR: We appreciate the insightful (no pun intended!) comments on our recent publication examining the relationship between violence, psychopathology, and insight in schizophrenia by Mr. Antonius. His point regarding the differential severity of illness across treatment settings is well taken, and we agree that an acute or long-term inpatient comparison group may have been more apt. He concurs with our statement that research on this patient population is difficult to conduct and, consequently, the population is underrepresented in the psychiatric literature. Because our article was limited in scope by the Brief Report format, we are pleased that the citations of Mr. Antonius in this correspondence further detail the literature on this topic. We have provided more lengthy discussions on the medical-legal implications of lack of insight and the treatment implications thereof in other publications (1).

Reference

1. Buckley PF, Wirshing DA, Pierre J, Bushan P, Resnick S, Wirshing WC: Lack of insight and treatment adherence in schizophrenia. CNS Drugs (in press)

PETER F. BUCKLEY, M.D.
DEBBIE HROUDA, M.S.S.A.
LEE FRIEDMAN, PH.D.
STEPHEN G. NOFFSINGER, M.D.
PHILIP J. RESNICK, M.D.
KELLY CAMLIN-SHINGLER, M.S.S.A.
Augusta, Ga.

Conclusions Inconsistent With Results With Citalopram

TO THE EDITOR: In their article, Eric J. Lenze, M.D., et al. (1), after noting three limitations of their trial (its small size, problems with random assignment, and diagnostic heterogeneity in their study groups) reported positive summary statements in their conclusions and elsewhere. For example, they wrote, "Notwithstanding these limitations, this study suggests that, as in younger people, SSRIs [selective serotonin reuptake inhibitors] are efficacious and well tolerated in the treatment of anxiety disorders in elderly persons" (p. 149).