ing. What neither the decision in *Hargrave* nor the Bazelon Center have an answer to, however, is what happens when—as a result of severe mental disorder—trust cannot be built and an alliance cannot be established. To pretend that such situations do not exist hardly advances a "new vision for public mental health."

Paul S. Appelbaum, M.D.

Antihostility Effects of Adjunctive Divalproex

To the Editor: In the March 2004 issue, Dr. Citrome and his colleagues (1) reported on a study in which they conducted a post hoc analysis of a large data set from a multicenter trial to compare the specific antihostility effects of divalproex when it is used alone and in combination with risperidone and olanzapine. The authors found that combination therapy was associated with a modest but statistically significant reduction in the hostility item on the Positive and Negative Symptom Scale (PANSS). Although this effect diminished and was no longer significant after day 7, the authors concluded that adjunctive divalproex "may be a helpful augmentation strategy in reducing hostility."

I would caution clinicians about the inconclusive nature of the findings of this secondary analysis. *Psychiatric Services* rarely publishes the findings from clinical trials, although it occasionally publishes reviews of such studies. Therefore, I also question the usefulness of the publication of preliminary research in a journal that has such a wide readership among clinicians who treat patients in the public sector.

The Cochrane Collaboration (2) recently reviewed all the studies of valproate for schizophrenia, including complete data from the primary publication of the multicenter trial (3) from which Dr. Citrome and his colleagues obtained their data. The Cochrane review emphasized the fact that divalproex had no sustained effect after an initial accelerated response in the four-week study. The review stated that there was "very little evidence to support the use of valproate in schizophrenia." Despite the lack of evidence, the use of valproate and other anticonvulsants has increased substantially, especially in the public sector. The New York State Office of Mental Health reported that 34.9 percent of state hospital patients with a diagnosis of schizophrenia were receiving valproate in 2001, and almost half of all patients were receiving an anticonvulsant (4).

Post hoc analyses of data are prone to type I errors, such as finding a difference when, in fact, there is no difference (5). Because of their limitations, such secondary analyses are more often used to generate hypotheses for further trials. When evaluating the usefulness of the findings of clinical trials, clinicians should consider whether the study participants are similar to their own patients, whether outcomes are clinically significant, and whether potential benefits outweigh any involved risks. Participants in the divalproex combination trial presented with an acute exacerbation of schizophrenia with prominent symptoms of hostility or excitement or both. Individuals in state psychiatric hospitals are more likely to have been given valproate or other anticonvulsants for aggressive behavior that is repetitive or persistent, and they are treated with these agents long-term.

Finally, the trial in question did not identify any adverse effects from the addition of divalproex, although the report of the full clinical trial noted that combination therapy with risperidone and olanzapine produced somnolence in 29 and 38 percent of trial participants, respectively. Sedation could also explain some of the effects of the agent, which is an issue that Dr. Citrome and his coauthors do not adequately address.

Robert Eilers, M.D.

Dr. Eilers is medical director of the division of mental health services of the New Jersey Department of Human Services in Trenton.

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In Reply: Dr. Eilers makes the excellent point that our report of the specific antihostility effect of adjunctive valproate (given as divalproex) cannot be easily generalizable to a state hospital population. Adjunctive valproate in such settings is not usually used at the "front end" of treatment but at the "back end" when other treatments have failed. Moreover, the trial specifically excluded patients who were treatment refractory.

No reports have been published of controlled trials of sufficient magnitude to adequately answer the question of whether or not adjunctive valproate is useful for patients with persistent symptoms of schizophrenia or persistent aggressive behavior (1). The high rate of use of adjunctive valproate among patients with schizophrenia in hospitals operated by the New York State Office of Mental Health (2) is indeed astonishing and is probably comparable to rates in similar settings across the country. This widespread use of adjunctive valproate does not necessarily mean that the strategy is effective, and further research is needed. Trials of longer duration and with more chronically ill patients will be needed to test this treatment approach. As noted, our study did not provide support for a specific antihostility effect for coprescribed valproate beyond the first week of treatment.

The parent study was valuable because it provided evidence that the major effect of adjunctive valproate appears to be on the positive symp-

toms of schizophrenia (3). No differences were found in the use of adjunctive lorazepam between the monotherapy and combination groups, which reduces the possibility that the ameliorative effect of valproate was by a general sedative effect. In our post hoc analysis we specifically included the presence or absence of sedation in the statistical model, as well as adjunctive use of potentially sedating rescue medication. Although the possibility of a type I error is always present, the general methodology employed is similar to that used in other published studies by our group, including a preplanned analysis that had obvious face validity in demonstrating the advantage of clozapine as an antihostility agent (4).

These issues are important for clinicians working in public-sector psychiatry, where we have the daunting responsibility of managing patients with serious and persistent mental illness, whose illness is often refractory to standard treatment approaches and who may exhibit persistent aggressive behavior. Readers of *Psychiatric Services* are the ideal audience for this type of open debate. More research in this area is needed.

Leslie Citrome, M.D., M.P.H.

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Positive Experiences With Giving Gifts to Patients

To the Editor: Dr. Krassner's thoughtful efforts to think through guidelines for the giving of gifts to one's patients, published in the May 2004 issue (1), underscores how seasoned clinicians can offer valuable assistance to trainees and junior colleagues in important areas of clinical practice.

I have had positive experiences with gift giving among very ill clinic patients and higher-functioning private patients, but always after giving careful thought to each case. I monitor for any countertransferential spill; the objective is to acknowledge a life goal or accomplishment for which the patient has worked hard. Recently a clinic patient who had lost her children to foster care when she was hospitalized for a psychotic disorder regained full custody after an arduous three-year battle with the court and foster care bureaucracies. The patient's religious beliefs precluded gifts; however, she was delighted to receive from me a small floral teacup and a theme glass for each of her children to celebrate their reunification.

I have given small wedding gifts to private patients who have achieved a love relationship; small baby gifts, including a "consolation" gift for the older sibling in the case of patients who have had a child; and a small office gift for a 9/11 survivor who returned to her firm having replaced her boss, who died saving her life.

One long-term patient to whom I have given small books for Christmas and her birthday berated me when I forgot one of her birthdays (I do not keep track of the date). Because she organizes her inner life around themes of deprivation and victimization, exploration of her response to my lapse was most productive.

I assure Dr. Krassner that, if he errs in the area of gift giving, he will learn from the experience.

Sue Matorin, M.S., A.C.S.W.

Ms. Matorin is treatment coordinator of the affective disorder team at Payne Whitney Clinic of New York Presbyterian Hospital in New York City and faculty member in the department of psychiatry at Weill College of Medicine at Cornell University in Ithaca.

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1. Krassner D: Gifts from physicians to patients: an ethical dilemma. Psychiatric Services 55:505, 2004

Expanded Policy on Disclosure for Authors

Psychiatric Services has extended its policy on disclosure of financial and other support to include authors of opinion pieces, such as Open Forum, letters to the editor, and Taking Issue commentaries. Previously only authors of articles, brief reports, and columns were required to submit disclosure forms to the editorial office and to disclose financial and other support in an acknowledgment paragraph in the manuscript. However, affiliations alone may not reveal important associations with sources of support, and such associations will now be listed for authors of all contributions to the journal.