

## TREATMENT HIGHLIGHTS

### NIGHT EATING SYNDROME

#### Night eating syndrome is found to be common among psychiatric outpatients.

This study, conducted at 2 outpatient psychiatric clinics, was designed to determine the prevalence of night eating syndrome and coexisting psychopathology among psychiatric patients. Night eating syndrome was diagnosed if at least 1 of the following 2 criteria was met: (1) evening hyperphagia (intake of more than one-third of total daily calories after the evening meal) or (2) nighttime awakening at least 3 times per week, with ingestion of food. Coexisting psychiatric diagnoses and medications were determined via chart review.

Night eating syndrome was diagnosed in 12.3% of the total sample (49 of 399 patients).<sup>1</sup> Patients with night eating syndrome were more likely than those without night eating syndrome (a) to have an active or remitted substance use disorder (30.6% vs 8.3%) and (b) to be prescribed atypical antipsychotics (38.8% vs 30.8%). Patients with night eating syndrome had, on average, a higher body mass index (BMI) than patients without the syndrome (BMI of 33.1 vs 27.7). Compared to patients with normal weight, those who were overweight were 2.5 times more likely to have night eating syndrome, and those who were obese were 5.2 times more likely.

The authors cite research associating treatment with sertraline<sup>2</sup> with a reduction in night eating syndrome symptoms. The authors conclude that “night eating syndrome is a prevalent disorder among psychiatric outpatients and is associated with substance use, atypical antipsychotic use, and obesity. Treatment is available to manage this syndrome.”

<sup>1</sup>399 patients were administered the Night Eating Questionnaire. 205 of the 399 patients scored at least 20 (out of a possible score of 56) and were selected to participate in a semistructured telephone interview. 121 of the patients were available for the interview. Night eating syndrome was diagnosed in 12.3% of the initial group (49 of 399) or in 15.6% of the initial group minus those unavailable for the interview (49 of 315).

<sup>2</sup>Generic name (Trade name): sertraline (Zoloft)

Lundgren JD [Dept of Psychiatry Weight and Eating Disorders Program, University of Pennsylvania, 3535 Market St, Ste 3123, Philadelphia, PA 19104-3309; email: jlundgre@mail.med.upenn.edu], Allison KC, Crow S, et al. Prevalence of the night eating syndrome in a psychiatric population. *American Journal of Psychiatry*, 163: 156-158, 2006. Support: National Institute of Mental Health; National Institute of Diabetes and Digestive and Kidney Diseases.

## QUICKSTATS

### DRINKING AND DRIVING

The following data pertain to driving in the United States in 2004.<sup>1</sup>

- In 34% (14 409) of all (42 636) motor vehicle crash deaths, a driver had a blood alcohol concentration (BAC) of .08 or higher.
- In 5% (2285) of all (42 636) motor vehicle crash deaths, a driver had a BAC between .01 and .07.
- 76% of all motor vehicle crash deaths occurring from midnight to 3am involved alcohol. (The greatest number of fatal crashes during any 3-hour period occurred midnight to 3am on Saturdays and Sundays.)

During a 1-year period (2001-2), national survey data,<sup>2</sup> derived from face-to-face interviews of 43 093 adults in the United States, indicated the following:

[The authors note that these are probably underestimates because heavy drinkers tend to underreport occurrences of drinking and driving.]

- 11.3% of adults reported having, more than once, engaged in at least 1 of the following drinking and driving behaviors in a motor vehicle:
  - driving while drinking (4.5%)
  - being a passenger of a drinking driver (6.6%)
  - driving after having too much to drink [according to the driver] (2.9%)
  - drinking while riding as a passenger (7.6%)

(Overall, men were 2 to 3 times more likely than women to report the above drinking and driving/riding behaviors. Also, the prevalence of the above drinking and driving/riding behaviors declined with age.)

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## QUICKSTATS

### BINGE DRINKING

The estimates of binge drinking shown in the table below are based on data from the Behavioral Risk Factor Surveillance System (BRFSS), a collaborative project of the Centers for Disease Control and Prevention (CDC) and US states and territories. BRFSS attempts “to collect uniform, state specific data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population. . . . Data are collected from a random sample of adults (one per household) through a telephone survey.”

#### Percentage of Adult Binge Drinkers in 2004

[Binge drinking was defined as having five<sup>(1)</sup> or more alcoholic drinks on one occasion.]

	% Binge Drinkers		% Binge Drinkers		% Binge Drinkers
Alabama	12.7	Maine	14.9	Oklahoma	13.0
Alaska	16.3	Maryland	12.8	Oregon	13.1
Arizona	15.5	Massachusetts	16.9	Pennsylvania	17.6
Arkansas	11.2	Michigan	16.1	Puerto Rico	12.2
California	14.7	Minnesota	19.8	Rhode Island	18.2
Colorado	17.2	Mississippi	10.4	South Carolina	13.5
Connecticut	14.8	Missouri	16.2	South Dakota	16.9
Delaware	17.4	Montana	17.0	Tennessee	8.2
District of Columbia	16.6	Nebraska	17.6	Texas	15.6
Florida	12.4	Nevada	18.0	Utah	9.2
Georgia	12.1	New Hampshire	16.0	Vermont	16.1
Idaho	12.6	New Jersey	14.4	Virginia	13.7
Illinois	17.5	New Mexico	13.0	Virgin Islands	13.6
Indiana	14.4	New York	15.2	Washington	14.2
Iowa	18.9	North Carolina	9.5	West Virginia	9.7
Kansas	12.8	North Dakota	20.4	Wisconsin	21.8
Kentucky	9.6	Ohio	16.9	Wyoming	16.1
Louisiana	14.2			<b>Nationwide</b>	<b>14.9</b>

<sup>1</sup>According to several sources (including the National Institute on Alcohol Abuse and Alcoholism), binge drinking by adults is defined as (a) men having 5 or more alcoholic drinks on one occasion or (b) women having 4 or more alcoholic drinks on one occasion. For the purpose of this survey, having 5 or more alcoholic drinks on one occasion was defined as binge drinking for either men or women.

SOURCE: *Behavioral Risk Factor Surveillance System Survey Data*. Centers for Disease Control and Prevention, 2004 [<http://apps.nccd.cdc.gov/brfss>].

#### Footnotes for the QUICKSTATS article on page 1

<sup>1</sup>*Traffic Safety Facts 2004: A Compilation of Motor Vehicle Crash Data from the Fatality Analysis Reporting System and the General Estimates System*. The National Highway Traffic Safety Administration (NHTSA), 2005. (The 222 page report is available online at <http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/TSFAnn/TSF2004.pdf>. A summary report, *2004 Traffic Safety Annual Assessment—Early Results* is available online at <http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/RNotes/2005/809897.pdf>.)

<sup>2</sup>Chou SP [Laboratory of Epidemiology & Biometry, Rm 3073, Div of Intramural Clinical and Biological Research, NIAAA, NIH, 5635 Fishers Ln, MS 9304, Bethesda, MD 20892-9304; email: pchou@mail.nih.gov], Dawson DA, Stinson FS, Huang B, Pickering RP, Zhou Y, & Grant BF. The prevalence of drinking and driving in the United States, 2001-2002: Results from the national epidemiological survey on alcohol and related conditions. *Drug and Alcohol Dependence*, in press.

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## TREATMENT HIGHLIGHTS

### OBSESSIVE-COMPULSIVE SYMPTOMS AMONG PATIENTS WITH SCHIZOPHRENIA

#### **Obsessive-compulsive symptoms are found to be common among patients with schizophrenia.**

This study examined how often, and with what impact, obsessive-compulsive symptoms occurred among outpatients with schizophrenia or schizoaffective disorder. The participants were 100 outpatients with schizophrenia or schizoaffective disorder who were being treated at either of 2 Veterans Affairs hospitals. Diagnoses of schizophrenia, schizoaffective disorder, and obsessive-compulsive disorder were based on responses to a clinician-administered checklist. Also, patients were screened for (a) obsessive-compulsive symptoms (Florida Obsessive Compulsive Inventory) and (b) symptom severity (Yale-Brown Obsessive Compulsive Scale). 58 of the patients agreed to further assessments, including (a) the Positive and Negative Syndrome Scale and (b) the Social and Occupational Functioning Scale.

Of the 100 patients with schizophrenia or schizoaffective disorder, 23% met full criteria for a diagnosis of obsessive-compulsive disorder, and 30% were categorized as having obsessive-compulsive symptoms (based on having at least 2 symptoms). 19% had at least moderate obsessive-compulsive symptoms, and 5% had severe symptoms. In 72% of the patients with obsessive-compulsive symptoms, the onset of those symptoms coincided with or followed the onset of psychotic symptoms. No association was found between concurrent obsessive-compulsive symptoms and the severity of positive and negative symptoms of the psychotic disorder, the level of functioning, or the number of days hospitalized. The authors recommend further studies “to define the relevance and pathologic basis for the co-occurrence of OC [obsessive-compulsive] symptoms in persons with schizophrenia.”

Byerly M [UT Southwestern, Psychiatry, 6363 Forest Park Rd, Suite 651, Dallas 75235; email: Matt.Byerly@utsouthwestern.edu], Goodman W, Acholonu W, Bugno R, & Rush AJ. Obsessive compulsive symptoms in schizophrenia: Frequency and clinical features. *Schizophrenia Research*, 76:309-316, 2005. Support: National Alliance for Research on Schizophrenia and Depression; National Institute of Mental Health.

### CHARACTERISTICS OF DISTRESSED COUPLES WITH INFIDELITY

#### **In couples seeking marital therapy, certain qualities of the relationship and of the individuals are found to differentiate couples with and without infidelity.**

This study sought to determine whether, in couples seeking marital therapy, certain qualities differentiated couples in which there was infidelity from those in which there was no infidelity. The data for this study were obtained from an ongoing study of marital therapy, in which 134 couples received up to 26 sessions of a behavioral therapy. Infidelity (current or past) was reported by 19 of the 134 couples. Self-report questionnaires were completed periodically (at the start, during, and at the end of treatment) to assess relationship and individual functioning. At the end of treatment, the therapists completed a questionnaire pertaining to the couples who had reported an affair. The questionnaire addressed several affair-related variables, including the following: who had the affair; when the affair began and when it was revealed; how long the affair lasted; what the degree of physical and emotional involvement was; and what proportion of the therapy was focused on the affair.

Compared to those not reporting infidelity, couples reporting infidelity were found, on average, to have greater degrees of the following: (a) marital instability, (b) dishonesty, (c) arguments about trust, (d) narcissism, and (e) time spent apart. Additional findings pertained to the men who had engaged in affairs, who were found, on average, to be older and to have greater degrees of substance abuse and sexual dissatisfaction. Most of the affairs reported by the 19 couples began prior to the start of the therapy, although only approximately one-third were revealed to the spouse prior to the start of the therapy. Approximately one-quarter of the affairs were not revealed to the spouse, but revealed to the therapist outside the context of the couples sessions (by 2 patients during the treatment period and by 3 patients after treatment had ended). Most cases of infidelity were reported to have involved a single affair in which there was sexual intercourse and moderate emotional involvement.

The authors offer several cautions relating to interpreting the findings. They note that participants entered the study seeking therapy for marital problems and speculate that not all participants disclosed current or past affairs. Also, the participants of this study may not be representative of those who engage in infidelity but do not seek therapy. The authors comment, for example, that many spouses who have affairs but are satisfied with their marriage might not seek therapy. In contrast, the participants in this study were “highly distressed couples seeking marital therapy.” The authors state that “given that many affairs are not revealed early in therapy, the current findings can assist therapists in being attentive to factors that might increase the likelihood that affairs are occurring.”

Atkins DC [Fuller Graduate School of Psychology, 180 N Oakland Ave, Pasadena, CA 91101; email: datkins@fuller.edu], Yi J, Baucom DH, & Christensen A. Infidelity in couples seeking marital therapy. *Journal of Family Psychology*, 19:470-473, 2005.

➔ Also see the March 2005 issue of *The Complete Practitioner* or search the *Subscribers' Area* of our Web site for <infidelity>.

**Pregnancy is found not to protect women with a history of depression from a relapse of depression.**

This prospective, naturalistic study investigated the commonly held belief that pregnancy-related hormonal changes provide “protection” from depression, “and that discontinuation of psychiatric medications should be almost uniformly pursued given concerns regarding prenatal exposure to these agents.” [See the box, below, for a description of recent findings concerning the risk of fetal exposure to antidepressants.] The study was conducted at 3 treatment centers specializing in the treatment of psychiatric illness during pregnancy. 201 pregnant women with a history of major depression were assessed monthly throughout pregnancy to determine the risk of a depressive relapse. To be eligible to participate, the women needed to (1) have a pre-pregnancy history of major depression, (2) be pregnant for fewer than 16 weeks, (3) have had a stable (nondepressed) mood for at least 3 months prior to their last menstrual period, and (4) currently (or recently, within 12 weeks prior to their last menstrual period) have been receiving antidepressant medication. Changes in pharmacological and nonpharmacological treatment were noted on a tracking sheet at each visit. The status of depression was assessed throughout the study. Of the 201 women, 13 had miscarriages, 5 terminated their pregnancy, 8 chose to drop out of the study, and contact was lost with 12 of the women.

Of the 201 women, 86 (43%) had a relapse of major depression during the pregnancy. Half of those women relapsed during the first trimester. 68% of women who discontinued antidepressant medication during the pregnancy experienced a relapse, compared to 26% who stayed on antidepressant medication. After adjusting for a number of variables (ie, marital status, number of prior depression episodes, type of antidepressant, and treatment center), women who discontinued their medication were 5 times more likely to relapse during their pregnancy, compared to women who stayed on medication. Among the patients who discontinued (65 women) or decreased (34 women) their antidepressant medication during the pregnancy, 60 (61%) resumed antidepressant medication during their pregnancy.

Factors that were associated with a higher risk of relapse during pregnancy included: (a) having a longer duration of depression (more than 5 years) or (b) having a history of more than 4 episodes of depression. Another factor associated with a higher risk of relapse during pregnancy was age, with those aged 32 years or older having a 60% lower risk of relapse, compared to women who were younger than age 32. The authors note that data from this study “suggest that women with histories of even highly recurrent depressive illness are likely to discontinue antidepressant use during attempts to conceive or after conception. However, such changes in treatment should proceed while patients are informed not only about the risk of prenatal exposure to medication, but also the risk of relapse associated with changes in ongoing pharmacological therapy.” The authors conclude that “pregnancy is not ‘protective’ with respect to risk of relapse of major depression.”

Cohen LS [Perinatal and Reproductive Psychiatry Clinical Research Program, Dept of Psychiatry, Massachusetts General Hospital, WACC 812, 15 Parkman St, Boston, MA 02114; email: Lcohen2@partners.org], Altschuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA: Journal of the American Medical Association*, 295:499-507, 2006. Support: National Institute of Mental Health.

Antidepressant Use During Pregnancy and Risks to the Newborn

The authors of the above study note that recent research has indicated an increased risk of cardiovascular malformations in the infants of mothers who took the selective serotonin reuptake inhibitor (SSRI) paroxetine<sup>1</sup> during the first trimester [see the December 2005 issue of *The Complete Practitioner*]. They cite other research indicating that taking certain antidepressants shortly prior to giving birth is associated with “neonatal jitteriness and transient neonatal distress.” Specifically, the labels of SSRIs and serotonin norepinephrine reuptake inhibitors (SNRIs) state that neonatal exposure to SSRIs or SNRIs late in the third trimester has been associated with respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, abnormal tone, hyperreflexia, tremor, jitteriness, irritability, and constant crying. The complications are possibly caused by a toxic effect of the drug or possibly by discontinuation of the drug. Newborns experiencing such complications may need prolonged hospitalization, respiratory support, and tube feeding [see the July 2004 issue of *The Complete Practitioner*]. In a recent study,<sup>2</sup> an association was found between the maternal use of selective serotonin reuptake inhibitors (SSRIs) after the 20th week of gestation and persistent pulmonary hypertension (PPHN) in the newborn. Even with treatment, 10-20% of infants with PPHN will not survive. The authors of that study note that additional research is needed to determine if a causal association exists.

<sup>1</sup>Generic name (Trade name): paroxetine (eg, Paxil)

<sup>2</sup>Chambers CD, Hernandez-Diaz S, Van Marter LJ, et al. Selective serotonin-reuptake inhibitors and risk of persistent pulmonary hypertension of the newborn. *New England Journal of Medicine*, 354:579-587, 2006.

## FDA NEWS AND REVIEW

### APPROVAL

**New Drug: Emsam** (selegiline transdermal system)  
Transdermal patches contain either 20 mg, 30 mg, or 40 mg of selegiline that deliver, on average, doses of 6 mg, 9 mg, or 12 mg, respectively, of selegiline over 24 hours.

Indication: treatment of major depressive disorder  
Approval Date: February 28, 2006

Emsam is co-promoted by Somerset and Bristol-Myers Squibb (BMS). Additional information is available from BMS by telephone (800-321-1335) or on the Web (<http://www.bms.com>).

The labeling (ie, the prescribing information) states: "EMSAM (selegiline transdermal system) is a transdermally administered antidepressant. When applied to intact skin, EMSAM is designed to continuously deliver selegiline over a 24-hour period. . . . Selegiline (the drug substance of EMSAM) is an irreversible inhibitor of monoamine oxidase (MAO), a ubiquitous intracellular enzyme. MAO exists as two isoenzymes, referred to as MAO-A and MAO-B. Selegiline shows greater affinity for MAO-B; however, as selegiline concentration increases, this selectivity is lost with resulting dose-related inhibition of MAO-A."

The **Hypertensive Crisis** subsection of the **WARNINGS** section includes the following text: "EMSAM is an irreversible MAO inhibitor [MAOI]. MAO is important in the catabolism<sup>1</sup> of dietary amines (eg, tyramine). In this regard, significant inhibition of intestinal MAO-A activity can impose a cardiovascular safety risk following the ingestion of tyramine-rich foods. As a class, MAOIs have been associated with hypertensive crises caused by the ingestion of foods with a high concentration of tyramine. Hypertensive crises, which in some cases may be fatal, are characterized by some or all of the following symptoms: occipital headache which may radiate frontally, palpitation, neck stiffness or soreness, nausea, vomiting, sweating (sometimes with fever and sometimes with cold, clammy skin), dilated pupils, and photophobia. Either tachycardia or bradycardia may be present and can be associated with constricting chest pain. Intracranial bleeding has been reported in association with the increase in blood pressure. Patients should be instructed as to the signs and symptoms of severe hypertension and advised to seek immediate medical attention if these signs or symptoms are present."

<sup>1</sup>Catabolism is an aspect of metabolism that entails the breaking down of complex molecules into simpler molecules. This process can result in the release of energy and is important in the preparation for disposing the molecules from the body.

Use of the 20 mg patch (6mg/24hours) does not require dietary modifications. However, dietary modifications are required for individuals using the 30 mg (9mg/24hours) or 40 mg (12mg/24hours) patch. The dietary modifications are described in the labeling (adapted from Shulman KI & Walker SE. *Psychiatric Annals*, 31:378-384, 2001). The list of modifications appears in the labeling under the heading of **Dietary Modifications Required for Patients Taking EMSAM 9mg/24hours and 12mg/24hours** and includes the following text:

**"The following foods and beverages should be avoided beginning on the first day of EMSAM 9mg/24hours or 12mg/24hours treatment and should continue to be avoided for two weeks after a dose reduction to EMSAM 6mg/24hours or following the discontinuation of EMSAM 9mg/24hours or 12mg/24hours."** [The text below is adapted from the labeling.]

#### ***Tyramine-Rich Foods and Beverages to Avoid***

**Meat, Poultry, and Fish to Avoid:** Air dried, aged and fermented meats, sausages and salamis (including cacciatore, hard salami and mortadella); pickled herring; any spoiled or improperly stored meat, poultry and fish (eg, foods that have undergone changes in coloration, odor, or become moldy); spoiled or improperly stored animal livers

**Vegetables to Avoid:** Broad bean pods (fava bean pods)

**Dairy to Avoid:** Aged cheeses

**Beverages to Avoid:** All varieties of tap beer, and beers that have not been pasteurized so as to allow for ongoing fermentation

**Miscellaneous Foods and Beverages to Avoid:** Concentrated yeast extract (eg, Marmite), sauerkraut, most soybean products (including soy sauce and tofu), OTC supplements containing tyramine

#### ***Acceptable Foods and Beverages, Containing No or Little Tyramine***

**Acceptable Meat, Poultry, and Fish:** Fresh meat, poultry and fish, including fresh processed meats (eg, lunch meats, hot dogs, breakfast sausage, and cooked sliced ham)

**Acceptable Vegetables:** All vegetables are acceptable, except for broad bean pods (fava bean pods)

**Acceptable Dairy:** Processed cheeses, mozzarella, ricotta cheese, cottage cheese, and yogurt

**Acceptable Beverages:** As with other antidepressants, concomitant use of alcohol with EMSAM is not recommended. (Bottled and canned beers and wines contain little or no tyramine.)

**Acceptable Miscellaneous Foods and Beverages:** Brewer's yeast, baker's yeast, soy milk, commercial chain restaurant pizzas prepared with cheeses low in tyramine

Note: All health professionals are encouraged by the Food and Drug Administration to report serious adverse events related to any medication, medical device, or special nutritional product (eg, dietary supplement). To file a report, contact MedWatch by telephone (800-332-1088), by fax (800-332-0178), or via the MedWatch Web site (<http://www.fda.gov/medwatch>).

*This is the first installment of a two-part series on bullying. Part two will appear in an upcoming issue of The Complete Practitioner. Both installments are derived from “15+ Make Time to Listen... Take Time to Talk, an Initiative,” developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The initiative emphasizes the importance of parents listening to and providing guidance to their children at least 15 minutes each day. The “listening and talking” theme can also be applied by other concerned adults, such as teachers and counselors. The questions presented below and on page 7 are excerpted from “Make Time To Listen... Take Time To Talk... ABOUT BULLYING.” An introduction for parents (similar to that which appears in the publication) precedes the questions, below.*

### Welcome to “Make Time To Listen... Take Time To Talk... ABOUT BULLYING”

This document consists of interactive questions to start conversations between parents/caregivers and children. Schools, adults, and children can use these questions to start conversations about bullying and how to prevent it.

There are no “right or wrong” answers, just statements that make us think about the issue of bullying and ways to prevent and/or stop it. The questions are listed under different headings so that there is flexibility in how the questions can be asked to lead to meaningful dialogue about bullying prevention and interventions. The purpose of the conversation starter questions is to help start meaningful dialogue about the critical issue of bullying and the prevention of bullying.

There are no rules. Everyone is a winner if we begin to talk and listen to one another, but you can't be a winner if you don't answer the questions honestly. No one is looking for problems, but if bullying is an issue at school, home, or in your community, then this is a safe way to start to understand and hopefully resolve the problem.

**Go ahead, get started, and remember that these are only some questions to start conversations, and you don't have to finish all the questions to continue talking.** Use your own judgment on how many questions to ask, when, and for how long. If you or your child feels uncomfortable talking about the issue, you may choose to stop for a while and continue the discussion at a later time. If major problems do arise, please seek the help of a mental health professional.

#### Listen - Learn - Respect

These questions are to be used to start conversations about bullying and bullying prevention. Feel free to adapt the questions to your own conversational styles. The questions are designed to generate open and honest discussions. Please be careful to respect any concerns or sensitive issues raised by the answers. Again, if problems do arise, please read the additional materials provided by this project, take a break and talk about the issue later, or seek the help of a mental health professional.

#### General Questions:

- What does “bullying” mean to you?
- Do you ever feel lonely at school or left out of activities? Let's talk about what happens and what you feel.
- What is lunch time like at your school?
- Who do you sit with, what do you do, and what do you talk about?
- What's it like to ride the school bus? Tell me about it.
- Do kids ever call you mean names, or tease you?
- Talk more about how you feel and what you do when this happens.
- Have you ever been scared to go to school because you were afraid of being bullied?
- What ways have you tried to change it?
- Have kids ever bullied you by hitting or pushing you, or other things like that?
- Let's talk about what you do when this happens.

#### Ask these questions if there is an indication that a child may have been bullied:

- Who usually does the bullying? (Boys/girls?) (Older kids or kids in your grade or class?)
- Why do you think they bully?
- Did you talk with an adult at school or a friend about being bullied? Did it help? If not, what would have helped?
- Talk about how you felt when you were being bullied. Take your time.
- Now that we're talking about bullying, what can I do to help?

(continued on next page)

<sup>1</sup>Make Time To Listen... Take Time To Talk... ABOUT BULLYING is available on the Web at <http://www.mentalhealth.samhsa.gov/publications/allpubs/SVP-0051>. The publication was out-of-stock at the time of this printing of *The Complete Practitioner*. To check on its availability in the future, telephone SAMHSA's National Mental Health Information Center (800-789-2647) and select the “speak to an information specialist” option. Also on the Web, see <http://www.mentalhealth.samhsa.gov/15plus/aboutbullying.asp>.

(continued from page 6 — “Make Time To Listen... Take Time To Talk... ABOUT BULLYING”)

**Ask these questions if someone has witnessed bullying:**

- What do you usually do when you see bullying going on?
- Describe what the bullies are like.
- Do you ever see kids at your school being bullied by other kids?
- How does it make you feel?
- Have you ever tried to help someone who was being bullied? What happened?
- What would you do if it happens again?
- Have you ever called another person names?
- Do you think that was bullying? Talk more about that.
- Do you or your friends ever leave other kids out of activities?
- Talk more about this possible bullying behavior.

**Ask these questions to discuss bullying prevention programs:**

- What do you think needs to happen at school to stop bullying?
- Would you be willing to tell someone if you had been bullied? Why? Why not?
- Is your school doing special things to try and prevent bullying?
- If so, tell me about the school's rules and programs against bullying.
- Would you feel like a “tattletale” if you told that someone was bullying you or a friend? Why?
- Let's talk about what your friends could do to help stop the bullying.
- What things do you think parents could/should do to help stop bullying?
- What are some good qualities about yourself?
- Let's talk about why it's so important to feel good about yourself.
- How would all this help to prevent bullying?

**MORE BASIC QUESTIONS TO START CONVERSATIONS**

As stated above, the following questions are part of the original *15+ Make Time To Listen... Take Time to Talk Initiative*. The questions were designed to be used as a part of a “win-win” game where everyone gets a chance to LISTEN and TALK. The basis of the game is to get to know more about your family, friends, and caregivers by honestly answering the questions and carefully listening to the replies. There are no rules since everyone is a winner. However, you can only be a winner if you honestly answer the questions, take a chance on opening true conversations and REALLY LISTENING to responses.

Go ahead, get started, and remember that these are only questions to get conversations started and, like the bullying questions, you do not have to finish all the questions to continue talking.

**Questions:** [NOTE: The following questions can be asked “as is” or as part of a game in which the questions are on preprinted cards, available at <http://www.mentalhealth.samhsa.gov/media/ken/pdf/SVP-0051/SVP-0051.pdf>. (The cards can be cut from the printed document.)]

- What was the best thing that happened to you today?
- What do you love about school/work?
- What does success mean to you?
- What makes you scared?
- What do you remember about your first day at school/work?
- What three things make a person popular in your school/at work?
- What makes you laugh?
- Why do you think some kids/adults dress differently?
- Talk more about this.
- What makes you angry?
- Where would you go if you could travel anywhere in the world? Why?
- What's a skill you wish you had? Why?
- What one thing would you do to make the world more peaceful?
- If you could go back in time and live in any era, what would it be? Why?
- Do you like being challenged? How?
- How can we stop violence?
- What other cultures interest you? Why?
- If you could share anything with your best friend, what would it be? Why?
- If you could write a book, what kind of book would it be? Why?
- If you could sit down with the most powerful person in the world and give that person advice, what would that be?
- Do you learn more when you win or when you lose? Tell me more.
- If you could do one thing to make the earth cleaner and more livable, what would it be? Why?
- (A blank coupon – you decide what to talk about.)

## RESOURCES

### SUBSTANCE ABUSE

#### PATIENT RESOURCES

**What Every Individual Needs to Know About Methadone Maintenance Treatment** is an introductory booklet that includes the following subjects: "methadone facts, tips on taking methadone, and an important resource list." The booklet is free of charge and can be ordered from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Clearinghouse for Alcohol and Drug Information (NCADI).

**(800) 729-6686 • TTY: (800) 487-4889**

<http://store.health.org> [Click on <Quick Find & Order>, enter <PHD1124> in the <Inventory Number> box, and click on <Search>.]

### CLINICAL PRACTICE GUIDELINES

#### PROFESSIONAL RESOURCES

The following clinical practice guidelines have been added to the National Guideline Clearinghouse (NGC) Web site.

**Failure to Thrive as a Manifestation of Child Neglect**

[http://www.guideline.gov/summary/summary.aspx?view\\_id=1&doc\\_id=8451](http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=8451)

**Autistic Spectrum Disorders. Best Practice Guidelines for Screening, Diagnosis and Assessment**

[http://www.guideline.gov/summary/summary.aspx?view\\_id=1&doc\\_id=8269](http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=8269)

**Diagnosis and Treatment of Headache** [updated]

[http://www.guideline.gov/summary/summary.aspx?view\\_id=1&doc\\_id=8576](http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=8576)

**Guidelines for the Prescribing of Medication for Mental Health Disorders in People With HIV Infection**

[http://www.guideline.gov/summary/summary.aspx?view\\_id=1&doc\\_id=7783](http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=7783)

### Subscribers' Area of our Web Site [www.completepractitioner.com](http://www.completepractitioner.com)

In the *Subscribers' Area*, click on *Search* to access articles from all previous issues of *The Complete Practitioner*. Resource listings are hyperlinked to their Internet sites. The *Subscribers' Area* also includes most of our previously featured assessment articles (many containing full-text instruments).

**Accessing the *Subscribers' Area*:** Your subscriber number (5 or 6 digits) appears in the upper left portion of your address label. It serves as your "user name," enabling you to access an area of the Web site that includes features for subscribers only.

**Note:** If you do not have your subscriber number, you may email a request to receive your number.

### POISON CONTROL CENTERS

#### PROFESSIONAL AND PATIENT RESOURCES

**National Poison Control Hotline** connects callers to a regional poison control center. The hotline accepts calls 24 hours a day, 7 days a week. The hotline can be used in cases of poisoning emergencies, or to inquire about specific substances that may be poisonous, or to obtain information about poison prevention.

**(800) 222-1222**

### SUBSTANCE ABUSE AND HIV/AIDS

#### PATIENT RESOURCES

**Drugs, Alcohol and HIV/AIDS—A Consumer Guide** is a pamphlet that provides information about the titled topic, including resource and contact information. The pamphlet is free of charge and can be ordered from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Clearinghouse for Alcohol and Drug Information (NCADI).

**(800) 729-6686 • TTY: (800) 487-4889**

<http://store.health.org> [Click on <Quick Find & Order>, enter <PHD1126> in the <Inventory Number> box, and click on <Search>.]

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- A 1-credit CE quiz accompanies each issue.
- 1-credit online CE quizzes accompanied by online versions of *The Complete Practitioner* can be accessed at <http://www.athealthce.com>.
- **Several New Online Courses are Available at our Web site:**  
[www.completepractitioner.com](http://www.completepractitioner.com)

NOTE: Quizzes/exams are cosponsored by PsychoEducational Resources, Inc (PER) or At Health, Inc (<http://www.athealth.com>) or by other sponsors. Information about approvals, eligibility, and price can be found on the quiz that accompanies this issue and at the online CE Web sites noted above.

**We welcome your inquiries and comments.**

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