Letters to the Editor

An Analysis of Religion and Mental Illness

Dear Editor:

We read the article by Baetz and others (1) with interest, as we emphatically agree with the principle of acknowledging the spiritual aspect of patients’ lives to address the person as a whole. However, we were disappointed to find that the published results do not seem to support the clinical implications stated at the beginning of the article. Unfortunately, the cross-sectional nature of this study does not allow us to assess the potential benefits of “support[ing] this potentially significant coping resource” or of “involv[ing] spiritual advisors, such as clergy or chaplains, when needed.” Although the authors may have shown a correlation between religious involvement and mental health, they have not demonstrated that external support for religious involvement has any effect upon patient outcome.

The researchers surveyed 88 adult psychiatric inpatients regarding measures of mental health and satisfaction and measures of religious commitment. These factors were then correlated with outcome variables. The authors found that high levels of religious commitment correlated with lower depression scores, shorter length of stay, higher satisfaction with life, and lower levels of alcohol abuse. Insofar as correlation does not imply causation, any or none of these variables may be causally linked.

The authors state that “religious coping was the only factor found to have a significant impact on psychiatric length of stay.” However, the basis for this finding was the Religious Coping Index (RCI), a composite measure that includes observer ratings. There is significant potential here for bias, given that the study authors’ strong support for increased religious involvement in psychiatric illness has previously been quoted and published many times. Baetz and others’ paper has 39 references: Koenig and Larson have each been referenced 14 times. Larson is also an author of this paper, and he has jointly published many times with Koenig; we feel that this may represent an abuse of the “Matthew effect” described by Robert Merton (2). Specifically in this case, quoting one’s own articles repeatedly has the effect of presenting one’s opinions as scientific fact.

Further, we find the title phrase, “An Association With Mental Health,” to be misleading. Specifically, the researchers only examine symptoms of depression. They omit other symptoms, such as those studied by Spencer (3), in which being a member of the Jehovah’s Witness faith may be a risk factor for a schizophrenic illness—an explanation being that strongly religious patients may have high emotional expressivity, which is known to correlate with schizophrenia. Even if Baetz and others’ findings are valid for depression, they cannot necessarily be applied to other mental illness.

We suggest that future studies examining the actual impact of spiritual involvement and counselling upon psychiatric inpatients be randomized and that the presence (or lack of) spiritual involvement not be disclosed to treating psychiatrists prior to the patients’ discharge from acute care.

References


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Casimiro Cabrera-Abreu, LMS, MSc, MRCPsych
Regina, Saskatchewan

Reply: An Analysis of Religion and Mental Illness

Dear Editor:

We thank Dr Patel and Dr Cabrera-Abreu for their interest in our article, as well as for their critique, which we will attempt to address. They state that, owing to the cross-sectional nature of the study, we cannot make any statements about outcome. It should be noted, however, that length of stay was determined, allowing us to assess this aspect of outcome. We do note, in the introduction and in the section on limitations, that causality cannot be determined—a point that Dr Patel and Cabrera find important to restate.

The Religious Coping Index (RCI) is a simple, 3-item questionnaire developed for use with persons having severe medical illness, including mental illness. To deal with any potential bias, we did not conduct any of the interviews or administer the RCI; we relied instead on a trained research assistant.

The frequent quoting of research done by Dr Koenig and Dr Larson was cited as a potential drawback. It should be noted that these 2 psychiatrists have in many ways led the way in the research of spirituality and mental health in the US, and their inclusion in various studies indicates the value of collaboration in advancing this field. Some of the articles quoted comprise extensive reviews of the published research to date, not just their own work.

The idea that the title’s reference to mental health may be too inclusive was also critiqued. Although we did study depressive symptoms, the subjects had high comorbidity and presented with various other diagnoses. Along with depressive symptoms, we also examined broader aspects of mental health, such as alcohol use and satisfaction with life.
The reference to a single 1975 article about Jehovah’s Witness membership being a predisposing factor for schizophrenia in fact represents what Dr Patel and Dr Cabrera are critical of—forming a conclusion from cross-sectional data. It should be noted that the study referred to is more than 25 years old; given our current understanding of the considerable influence that genetic and other biological factors have on the etiology of schizophrenia, it is unlikely that religious factors contribute much to causing the illness. High expressivity may be more related to relapses. Recent studies do indicate, however, that religious activity may be associated with reduced symptoms in patients with chronic mental illness (1).

We are always open to ideas for future research that may help to determine the impact of spiritual involvement and invite more dialogue and collaboration to help further understand this area.

Reference


Marilyn Baetz, MD
Rudy Bowen, MD
Gene Marcoux, MD
Ron Griffin, PhD
David B Larson MD (deceased, March 2002)
Saskatoon, Saskatchewan

Re: Canadian Psychiatric Inpatient Religious Commitment: An Association With Mental Health

Dear Editor:

Dr Baetz and others (1) must be endowed with unusual perspicacity if they think it possible to demonstrate that religion has a beneficial effect on mental health—especially after the events of September 11, 2001, in the US, and in the light of ongoing carnage now taking place in the name of God in the Middle East, Northern Ireland, the Balkans, India, and elsewhere. Add to this events such as the many cases of clergy molesting children sexually, and it is not surprising that an increasing number of people are beginning to view religion as the most destructive of human inventions.

One intriguing finding of this article was that patients who attended church and other religious activities had shorter hospital stays than did those whose religion was just in their heads. Not surprising! Early in the history of Christianity, human-to-human contact was discovered to have a beneficial effect, hence the word “fellowship.” If truth be told, the human-to-human contact is the important one, not the human-to-God contact.

The main problem I had with this paper was its use of psychiatric inpatients to prove the point. Unless the authors subscribe to the view that biological factors alone cause mental illness, they might have considered that the psychological and social factors of religious indoctrination may have contributed to the patients’ psychiatric hospitalization. They did report, after all, that “The intensity of religious beliefs was more pronounced among the more severely ill subjects.” How can that observation help their case?

The only way to demonstrate the role of religion in mental health is to compare a group of devout believers with a group of committed atheists or humanists, provided those in the latter group have either never been indoctrinated with religion or have completed the often-painful metamorphosis from believer to thinking human being. This kind of study has yet to be done anywhere, as far as I know.

I did notice a high degree of selectivity in the list of references. Notably absent is the work of Batson and Ventis (2). In 1982, after examining all the correlational studies and the few behavioural studies to date, these authors came to the following conclusions:

Being more religious is not associated with greater mental health or happiness or with greater social compassion and concern. Quite the contrary, there is strong evidence that being more religious is associated with poorer mental health (Chapter 7), with greater intolerance of people who are different from ourselves (Chapter 8), and with no greater concern for those in need (Chapter 8). The evidence suggests that religion is a negative force in human life, one we would be better off without (Page 306)

We should all remember that an ability to juggle statistical data is no substitute for critical thinking.

References


Wendell W Watters, MD
Hamilton, Ontario

Reply: Canadian Psychiatric Inpatient Religious Commitment: An Association With Mental Health

Dear Editor:

Dr Watters raises some interesting issues, on which we are happy to expand. He also provides data on which we are unable to comment, because they involve economics, politics, history, and the law.

The question of social support as a possible confound was certainly considered in this study and controlled for in the analysis. As to undue reliance on studies of inpatients, we agree that this has often produced a distorted view, and we acknowledge this in our paper. We have collected population and outpatient data...
that we are now analyzing, and preliminary results support our conclusions. One of the article’s main findings—the correlation between worship attendance and religious coping and length of stay—could by definition only be studied in inpatients. It would be peculiar if, as Dr Watters asserts, religious involvement played a part in hospitalization and was also associated with reduced length of stay.

Dr Watters mistakenly attributes to us a finding that is actually a quote from a study by Neeleman and Lewis: “The intensity of religious beliefs was more pronounced among the more severely ill subjects” (1). We note that in general our population had a high incidence of comorbidity and psychiatric hospitalizations, but in this study we did not compare the intensity of belief with the severity of illness.

The most interesting proposed “head-to-head” study is actually between 2 religious positions. Sellars, the author of the Humanist Manifesto I (1933), states elsewhere that humanism is really a nontheistic religion (2), perhaps making it an ideal choice for one of these positions. Such a study would not necessarily be definitive: it would just add to other studies like it.

The reference to Batson and others (3) is 20 years old. Since then, there has been a large increase in research on spirituality and mental health, with increasingly stringent methodology and controls for potential confounding variables. Batson and others (3,4), however, do note that religiousness has different components and that there are different ways to measure these aspects and mental health and types of mental illness. They actually conclude that findings depend on the way one measures religiousness and mental health and the confounders, such as social desirability. They did find that certain types of religiousness are associated with undesirable qualities. This is no surprise: like psychotherapy, medication, and hospitalization, religion can be distorted and misused. They also found that some types of religiousness are associated with positive qualities—but in convoluted thinking, any positive quality may be seen as a defence. Interestingly, they concluded that the more positive type of religiousness is associated with more frequent worship attendance.

We wish to clarify the obvious: the method did not set out to prove or demonstrate anything. The null hypothesis is that religion has no correlation with the dependent variables. We found this not to be the case. Dr Watters refers to this as “juggling statistical data.” We find numbers and statistical analysis refreshing because they are logical and reproducible, unlike opinions.

References

Marilyn Baetz, MD
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Oxcarbazepine Treatment of Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) can be a difficult illness, because current treatment options are only partly effective (1). The disorder has been treated with anticonvulsants, based on the evidence that possible neuronal changes in the limbic system occur after exposure to trauma and cause a lowered arousal threshold that leads to reexperiencing symptoms (2). The literature since the 1980s has reported that carbamazepine reduces PTSD reexperiencing symptoms (3–5). I report a case in which a patient with PTSD was tried on numerous medications, including carbamazepine, and successfully treated with oxcarbazepine, which is chemically related to carbamazepine (6).

Mr A, aged 46 years, had a history of chronic PTSD and was treated over the years with several medications, including carbamezapine, valproate, fluoxetine, sertraline, nefazodone, trazodone, paroxetine, clonazepam, and buspirone. He thought that carbamazepine had helped him, but he felt “drugged” and admitted to a lack of compliance caused by frequent blood draws to monitor his carbamazepine serum levels. On initial evaluation, Mr A was taking sertraline 150 mg daily and clonazepam 0.5 mg twice daily. Shortly after passing a significant anniversary date, he experienced frequent nightmares, intrusive thoughts, and flashbacks. His score on the Hamilton Anxiety Rating Scale (HARS) (7) was 23, and his score on the Clinical Global Impression Severity (CGI-S) (8) was 7. His condition left him dysphoric and fatigued, which contributed to occupational impairment. Mr A agreed to a trial of oxcarbazepine, begun at 150 mg twice daily. Initial laboratory tests included a complete blood count, hepatic enzymes, and serum electrolytes, all within normal limits. After 1 week, the oxcarbazepine was raised to 300 mg twice daily, and a serum sodium check was within normal limits. After 2 weeks at 300 mg twice daily, Mr A’s dosage was increased to 450 mg twice daily. At this dosage, he began to experience less frequent and less severe nightmares. His HARS score decreased to 13, and his CGI Global Improvement score was 1. Mr A feels that he has significantly improved in all aspects of functioning since starting oxcarbazepine, especially at work. At 4 months, he maintains his high level of improvement, and his nightmares are infrequent.

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Approved in the US in 1999, oxcarbazepine is an anticonvulsant used as an adjunct and as monotherapy to treat partial seizures in adults and as an adjunct to treat partial seizures in children from ages 4 to 16 years (9). The primary mechanism of action appears to be blockage of voltage-dependent sodium channels (9). The drug is structurally related to carbamazepine but is not metabolized to the 10,11-epoxide, which lessens the incidence of side effects associated with carbamazepine (10). Studies have shown oxcarbazepine to be as effective and better tolerated by patients having difficulties with carbamazepine, although this observation pertains to patients with epilepsy (10). Although hematologic and hepatic toxicity have not been reported, hyponatremia has been associated with oxcarbazepine (9). Common side effects related to oxcarbazepine use appear to be dosage-related and include somnolence, dizziness, vomiting, and nausea (11). Oxcarbazepine does not require serum monitoring (12); thus, frequent blood testing is not needed.

Because this had been a factor in this patient’s previous noncompliance, and because he had experienced a decrease in his PTSD symptoms while on carbamazepine, he was expected to do well on oxcarbazepine. As with all single-case reports, caution is advised in interpreting results; however, based on this case, further studies done in a controlled fashion may be warranted.

References


Timothy Berigan, DDS, MD

Tucson, Arizona

Voice Mail as a Transitional Object in the Treatment of Borderline Personality Disorder

Dear Editor:

One of the psychodynamic theories related to borderline personality disorder (BPD) is that the patient was unable as a child to traverse the rapprochement subphase of the separation–individuation process described by Mahler. As a result, the patient was unable to develop a sense of emotional object constancy (1,2). Adler formulated such patient difficulties as an inability to maintain holding and soothing introjects when faced with separations (1). Winnicott described how children use transitional objects to help tolerate negative affects and aloneness until evocative memory is established (1). Psychiatric staff commonly observe an association between a diagnosis of BPD and the presence of transitional objects on the inpatient ward (3,4).

In therapy with patients having BPD, it is important to create a containing environment (1). This can help the patient manage anger and other painful feelings that are triggered by separations from the therapist and can lead to increasing suicidality (1). Adler describes the use of transitional objects to create a holding therapy environment (1). However, some therapists express concern that the use of transitional objects can be gratifying and promote regression and dependency.

As a junior resident working in therapy with a patient suffering from BPD, I was always unsettled by panicked phone calls. My patient, a First Nations woman who had experienced severe childhood abuse and neglect, sometimes called from a closet where she held a knife to her chest. I was surprised to find how little intervention it took to settle the situation: it seemed that just hearing my voice was enough. Later in therapy, I acquired voice mail. She confessed to me that she frequently called my voice mail between sessions to hear my voice and that this helped her. Since that experience, I have had several other patients with BPD who have used voice mail in this way. Some find the experience “grounding,” while others find that it reinforces my role as the caring therapist.

Voice mail is a standard way of receiving messages that can provide a personal message 24 hours daily, 7 days a week. It is not a gift for the patient, nor is it created especially for the patient. There is no limit to the length of the message left. Conversely, the caller can choose not to leave a message, and the receiver will be unaware of the call. Patients can be warned that there may be a variable delay before a call is returned, and other plans for access to immediate resources can be discussed, as appropriate. The use of voice mail by a patient with BPD in some ways mimics the rapprochement phase, because the patient can use the therapist’s voice as a way of checking back and “refuelling” between sessions. However, voice mail does not gratify the patient with the therapist’s presence. Moreover, use of voice mail can be explored within therapy sessions.

In therapy with patients having BPD, voice mail is a tool that can assist in
containing, soothing, and holding strong emotions. With this tool, crisis phone calls, emergency room visits, and self-harming gestures may be reduced.

References


Susan J Finch, MD, CM, FRCPC
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Critical Appraisal of Extended Treatment Studies in Attention-Deficit Hyperactivity Disorder

Dear Editor:

Russell Schachar and colleagues’ excellent review (1) offers a sobering and necessary balance that illustrates the current limitations of our knowledge regarding treatment effects in attention-deficit hyperactivity disorder (ADHD). With regard to the combination of pharmacologic and nonpharmacologic treatment approaches, it is instructive to note that the literature does not address an important practical issue for children responding to short-term stimulants in the classroom. We know that most treatment studies have found positive benefit for short-acting stimulants, even though these medications give a benefit for only 90 minutes, approximately. Why these short-acting medications work as well as they do throughout the school day, given their short duration of action, is an important and relatively unexplored question.

A recent article on impulse disorders casts light on this question (2). In it, Strayhorn makes the point that one aspect of working with impulse disorders concerns facilitating the development of “a positive momentum.” Perhaps this is an important clue as to why the short-acting medications work as well as they do. In theory, the longer-acting stimulants provide better coverage throughout the school day; however, many children do receive good benefit from short-acting preparations—a seeming paradox. This suggests that the sustained action of these short-acting medications might be explained in terms of the development of positive momentum. If children with ADHD “get on track” for 90 minutes at the beginning of the morning and afternoon school, their positive momentum may carry them along for the remaining time. If children are more able to achieve success in the class, albeit for a short period, their self-cognitions are more likely to be positive than negative. Perhaps this is the underlying mechanism behind the sustained benefit of short-acting medications beyond their pharmacologically effective time window. If so, facilitating positive momentum with cognitive and behavioural techniques begins to make more sense. The interaction wherein the pharmacologic effects of a short-acting stimulant allow the teacher to help the child get on a positive track may be a fruitful source of further research investigating how teachers can help children with ADHD enter the learning group.

Schachar’s article notes that currently available randomized treatment studies have some significant limitations regarding the wide array of outcomes that are important to measure for children and adolescents with this common disorder. An important and underexplored outcome is related to public health—driving safety and ADHD. Recent research emphasizes the increased risk of dangerous driving behaviour in young drivers with ADHD and other impulse disorders (3). Ongoing research in this very important area of impulsivity and dangerous driving raises the possibility of identifying high-risk groups early and developing early preventive intervention strategies for an underrecognized public health issue.

References


Laurence Jerome, MBChB, Msc, MRCPsych, FRCPC
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Gabapentin-Induced Paradoxical Exacerbation of Psychosis in a Patient With Schizophrenia

Dear Editor:

Gabapentin is an anticonvulsant that is increasingly prescribed to patients with schizophrenia (1). Uses of anticonvulsants in this population have traditionally included antipsychotic augmentation and control of aggression and impulsivity (1). Gabapentin is reported to have antianxiety and hypnotic effects in patients with schizophrenia (2) and panic disorder (3). Documented behavioural side effects include hypomanic and manic mood changes, aggression, and agitation (4–6). We report a case of paradoxical worsening psychosis associated with initiation of gabapentin in a patient with schizophrenia.

Mr A, aged 23 years, was diagnosed at age 18 years with schizophrenia according to DSM-IV criteria. He has permanent, full-time employment. His medications prior to starting gabapentin included clozapine 425 mg daily, procyclidine 10 mg daily, divalproex sodium 1000 mg daily, and fluoxetine 30 mg daily. He has been maintained on divalproex sodium since his initial presentation for affective symptoms. Fluoxetine was added to alleviate medication-induced obsessive–compulsive symptoms. No recent medication changes have been made. His baseline psychotic symptomatology included rare paranoid thoughts, auditory hallucinations, and delusions. His baseline psychotic symptoms were well controlled on clozapine and divalproex. He was started on gabapentin 300 mg daily with good control over agitation and aggression.

The case of Mr A raises the possibility of identifying high-risk groups early and developing early preventive intervention strategies for an underrecognized public health issue.

References

ideation and rare auditory hallucinations. He presented with complaints of decreased sleep, and gabapentin therapy was initiated at 300 mg nightly. After 4 days, he noted increased paranoid ideation, increased auditory hallucinations, and racing thoughts. Although his sleep significantly improved with gabapentin, worsening psychosis necessitated 2 days off work. He stopped the medication after 4 days and noticed a gradual decrease in symptoms over the following 8 days. He denied concomitant alcohol or drug use and was compliant with medication. He was seen 2 weeks after starting gabapentin therapy and judged to be at baseline.

We propose 2 possible mechanisms to explain our observation. First, gabapentin is a structural analog of the inhibitory neurotransmitter GABA (7). Like benzodiazepines, gabapentin is a GABA-enhancing drug (7). Paradoxical worsening of psychotic symptoms has been documented in schizophrenia patients treated with benzodiazepines (8). Paradoxical aggravation of psychosis by gabapentin may occur through a similar mechanism. Alternatively, gabapentin is known to interfere with amino acid uptake across cell membranes (7). By interfering with clozapine transport across membranes, gabapentin may cause an acute decrease in cerebrospinal fluid or intracellular clozapine, leading to paradoxical psychosis. However, this effect appears rare, because gabapentin with clozapine has been given to schizophrenia patients, with therapeutic benefits (2,9).

References


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Probable Dementia With Lewy Bodies and Risperidone-Induced Delirium

Dear Editor:

To date, there have been few reports of delirium induced by risperidone, a benzisoxazole derivative that is one of the atypical antipsychotics. One study reported that, of 122 elderly persons treated with risperidone, 2 developed delirium (1.6%) (1). There is also a case report of delirium probably induced by risperidone (2). In a few cases, delirium was induced by combined lithium and risperidone (3). We report a case of probable dementia with Lewy bodies (DLB) that was likely induced by risperidone.

Mr A, aged 82 years, was introduced to our university hospital from a general hospital for the treatment of visual hallucinations and aggressive behaviour to surrounding persons. One year previously, he had been treated by tiapride 100 mg and amantadine 100 mg daily for aggressive behaviour and parkinsonism. His mental state fluctuated and gradually deteriorated. In addition to his chief complaints, he also had moderate dementia and experienced repeated falls and transient loss of consciousness. From the above symptoms, he satisfied the consensus criteria for the clinical diagnosis of probable DLB, according to guidelines published in 1996 (4). He also had the following physical disorders: hepatocellular carcinoma, mild chronic renal dysfunction (his serum urea was 27 mg/dl and his creatinine was 1.3 mg/dl), and gallstones.

He was started on risperidone 1 mg daily in the evening of his examination day. By the next morning, he showed a state of extreme excitement. He brandished his cane wildly, and he shouted, “Water has been heavily sprinkled inside my house. A strange woman is coming. There is a rat in the clock.” His symptoms had subsided by the evening of the day 2, and he did not remember his excited behaviour. After his family stopped risperidone, his behaviour returned to what it was on the day of the examination. On day 3, he was started on haloperidol 1.5 mg daily instead of risperidone. His aggressive behaviour gradually diminished, and haloperidol was reduced (0.75 mg daily). On day 14, he was given additional medication of donepezil to treat his visual hallucinations. After 3 weeks, the visual hallucinations had greatly decreased.

Risperidone has recently been used in Japan to treat delirium and paranoid hallucinations in elderly persons. However, it is necessary to carry out more careful observation when risperidone is used to treat patients with probable DLB.

References


Masayuki Morikawa, MD, PhD
Toshifumi Kishimoto, MD, PhD
Nara, Japan
Re: Schizophrenia, Suicide, and Blood Count During Treatment With Clozapine

Dear Editor:

We read with great interest the recent article about clozapine treatment and blood counts (1), which has led us to reconsider another beneficial aspect of periodic blood-cell counts for patients with schizophrenia. More specifically, we refer to the importance of the patient–doctor relationship in reducing suicidality among these patients.

An in-depth analysis of follow-up studies has estimated that 10% to 13% of individuals with schizophrenia die by suicide, making it the first cause of death for this group (2). Most authors suggest that the following characteristics indicate individuals with schizophrenia who are more likely to commit suicide: young age, male sex, white ethnicity, poor premorbid function, never-married status, postpsychotic depression, and a history of substance abuse and suicide attempts. Hopelessness, awareness of illness, and hospitalization are also very important risk factors. In recent years, atypical antipsychotic drugs have changed the therapeutic approach to schizophrenia. These new drugs—as is the case with clozapine—can also affect the suicide rate among these individuals (3). One of the most important risk factors for suicide among patients with schizophrenia is the social isolation they experience. Together with hopelessness, it induces several feelings that may lead to suicide. It should not be underestimated that meeting with medical staff may play a central role in reducing this social isolation (4).

The fact that these patients have to follow a specific pattern of tests (as is the case with periodic blood counts), which leads to interaction with people who may provide warmth and empathy, may alleviate their ever-increasing sense of worthlessness and inadequacy. Most schizophrenia patients experience social isolation, even within their families, and are eager to establish even a tiny interpersonal contact (5). Further, these meetings represent a unique opportunity to check compliance, depressive symptoms, and suicidality. General practitioners and medical staff should always consider the importance of their role when interacting with these people (6). Providing a safe environment to these patients should be paramount, not only among mental health professionals but also among all who interact with them. Such effort no doubt contributes to preventing suicide among schizophrenia patients.

References


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Re: Bilsbury and Others. More on the Phenomenology of Perfectionism—Incompleteness

Dear Editor:

In their letter, Bilsbury and colleagues justly lament the lack of terminology for the unique emotional state that accompanies pathological perfectionism (1). As the authors note, this is particularly relevant to the phenomenon of obsessive–compulsive disorder (OCD). We suggest that the OCD literature also offers a solution to this gap in the phenomenological lexicon.

Hints of this troubling subjective state can be found in the perfectionism literature. Distinguishing between normal and neurotic perfectionists, Hamachek suggests that “they are unable to feel satisfaction” (2). Slade considers the subjective state to be central in differentiating “satisfied” from “dissatisfied” perfectionism (3). These authors, however, primarily focus on classifying types of perfectionism, rather than on capturing the affective state that accompanies them.

The state itself, however, was described lucidly a century ago by the French physician Pierre Janet. In Les obsessions et la psychasthénie (4), Janet provided a detailed description of the development of obsessive–compulsive symptoms that has been praised for containing the best clinical descriptions of OCD ever written (5,6). Despite this, his description has been largely neglected in North America, perhaps due to its incongruence with the DSM system and its eclipse by Freud’s formulation of the anal character, published soon after. Contrary to the current nosological stance, Janet considered anxiety to be secondary in this disorder. Most central to the problem, he thought, are “les sentiments d’incomplétude”—incompleteness—an inner sense of imperfection, connected with the perception that actions or intentions have been incompletely achieved (7). Janet located this feature in what he called the “psychasthenic state,” the first stage in the illness through which he thought all sufferers must progress. This was thought to be characterized by subjective appraisals of the inadequacy of one’s performance and perceptions, together with elusiveness of feelings of satisfaction: “psychasthenics are continually tormented by an inner sense of imperfection” (5).

The self-reports of many individuals with OCD contain repeated reference to profound dissatisfaction related to the need for experiences to conform to exact, yet often-inarticulable, criteria. Clinical examples include the need to express a
thought unambiguously with the best-chosen words, to leave a doorway in just the right way, to have clothing exert equal pressure on both sides of the body, and to maintain belongings in pristine condition.

This specific form of sensory-affective dysregulation is being increasingly recognized in some manifestations of OCD and captured with different terms by different writers. Leading these were Rasmussen and Eisen (8,9), who described it as “incompleteness.” Other more recent examples include “just right perceptions” (10) “sensory phenomena” (11), and “sensitivity of perception” (12). Our group has hypothesized “incompleteness” to be a core dimension underlying both clinical and nonclinical obsessive–compulsive phenomena (13,14).

In our ongoing research with the incompleteness construct, we have found evidence of its utility for subtyping manifestations of OCD, as well as of its clinical value: in our experience, many patients find the term comfortably familiar. As such, we propose that the time-honored term “incompleteness” be considered as one solution to the lexical insufficiency noted by Bilsbury and colleagues.

References

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