Evidence-Based Psychiatry

Dear Editor:

The CPA position paper, editorial, and 2 review articles on evidence-based psychiatry in the June 2001 issue of The Canadian Journal of Psychiatry are most timely, thought-provoking, and exceedingly well done. I congratulate Lesage and others for their particularly lively and penetrating analysis.

Of central importance is the discussion of the several different orientations (medical, economic, bureaucratic, and political) that must be integrated if the practice of evidence-based psychiatry is to thrive. In this connection, I suggest that 2 additional perspectives might be added: the orientation of the practitioner and the orientation of the scientific investigator.

Practitioners are not oriented toward trying to establish general truths and probabilities but, rather, to drawing on the store of already-established truths and probabilities to help individual patients. They seek to integrate this scientific information with other available resources to treat as effectively as possible the particular individuals in their care. A scientific investigator, on the other hand, is not concerned with the care of individual patients but with increasing the store of scientific truths and probabilities and thus increasing the benefits available to the many people who are or may become mentally ill.

This difference in orientation involves differences in perceptions, habits of thought, and values that are often not fully recognized by either practitioners or investigators—much less by the other participants in the development and operation of the health services. Particularly in psychiatry, the meaning of theory and evidence is apt to be viewed very differently by practitioners and investigators. It is my impression that bridges of understanding are sorely needed in this area, and I wonder whether more discussion of this topic in journals and seminars might not prove exceedingly useful.

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Evidence-Based Psychiatry: Response

Dear Editor:

The letter of such an eminent psychiatrist as Professor Alexander Leighton is a much valued token of appreciation. What we call “evidence” deserves more attention than we usually pay. We agree with Leighton that our journals do not usually print much about those categories of evidence that do not meet the narrow criteria of objective science: they rely on other sources to teach clinicians to look into intersubjective and socio-political matters outside the scientific bases of their profession.

True to his teaching skills, Professor Leighton humanely raises the issue of linking both the public health and the clinical perspective to health services planning. He respects both legitimate perspectives and gives the right words to each. Tansella (1) has framed the debate as “the archeologist vs the astronomer” point of view (with clinicians in the former role and epidemiologists in the latter). Wing (2) has presented it more coldly, as the top-down and bottom-up approaches—both needed to best estimate needs for mental health care in the population.

The message from Leighton and from these authors is that neither perspective can be reduced to the other, nor will one win over the other by virtue of being closer to “real needs”—a virtue claimed by both perspectives. As Leighton suggests, a bridging dialogue is needed to promote understanding of each perspective; dialectics can uncover the contradictions in our actions. For our society, such a dialogue can reveal the need for a democratic debate over priorities for care and services.

References


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Research Ethics and Forensic Psychiatry: A Comment on Regehr and Others

Dear Editor:

There is a distinction to be made between research to develop assessment techniques and the subsequent application of those techniques. Regarding development research, the Mental Health Act of Ontario does not require patient consent for the use of clinical records, provided clinical information is not disclosed. In this way among others, archival research differs from the “research” considered at Nuremberg. The Canadian Tri-Council Policy permits waiver of informed consent if the research involves minimal risk, if the waiver is likely to vitiate subjects’ rights and welfare, if the research could not practicably be conducted without the waiver, if subjects receive pertinent information whenever possible and appropriate, and if the waived consent does not involve therapy. The development research leading
to the actuarial assessment discussed by Regehr and others (1) was entirely archival, and data on individuals have never been disclosed. Because Regehr and others say that their client has never been released, he could never, by definition, have been a subject in that research.

The research was applied by providing client scores on the actuarial assessment to their clinical teams. Regehr and others critically note that consent for this scoring from clinical records was not obtained. However, by law, the Ministry of Health and its hospitals do not require consent either to score assessments from patient files or to communicate that information to the Ontario Criminal Code Review Board.

Interviews are not required for the Psychopathy Checklist (PCL-R). The manual states that, “Valid PCL-R ratings may be made solely on the basis of collateral information if there is sufficient high-quality information available” (2, p 6). Data from hundreds of cases obtained without interview are included in the manual. Excellent predictive accuracies have been repeatedly demonstrated using PCL-R scores obtained without interview.

Regehr and others note that actuarial assessment does not measure fluctuations in the risk of a new violent or sexual offense. However, because actuarial instruments based on static information are the most accurate (3), it is poor practice to disregard an actuarial estimate of long-term risk on the basis of clinical judgement. Although clinicians manage short-term risk using dynamic indicators, these cannot validly be used to modify estimates of long-term risk. Indeed, the accuracy of dynamic indicators has not been established even for short-term prediction.

Regehr and others adduce neurodiagnostic assessments (a type of static factor) to set aside the actuarial estimate. They argue that neurological impairment renders the actuarial estimate of risk irrelevant. In fact, there are no empirically established estimates of risk based on neurological impairments; their relations both to actuarially estimated risk and to violent recidivism itself are unknown. Similarly, the degree to which treatment for neurological symptoms reduces the long-term risk of violence is also unknown.

References


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Research Ethics and Forensic Psychiatry: Response

Dear Editor:

Thank you for this opportunity to respond to Dr Quinsey’s letter regarding our article on research ethics and forensic patients.

Dr Quinsey correctly observes that the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (1) does recognize that it may be impossible, difficult, or economically unfeasible to contact all subjects in a particular database for consent. Therefore, it does allow for the use of secondary data without consent if it is not possible to obtain consent from individual subjects, if the data cannot be linked to the individual, and if the ethics review board has determined that the risk of harm or stigma to the individual is minimal.

In the case we discuss, the subject in question was available for consent, the research data were derived from clinical data that were then linked to the individual and governed his clinical course in the hospital, and this combined research and clinical information formed the foundation of the hospital’s risk assessment provided to the review board, thereby preventing the patient’s release. Therefore, as we argued in the original article, the research had a devastating effect on this patient’s life and liberty (2).

Dr Quinsey states further that the case example in our article could not by definition have been included in the study, because the patient was never released. In fact, in his testimony given June 30, 1999, Dr Quinsey indicated that the data on this patient were included in a general database of clinical information that was then used statistically to evaluate the outcome measures (3). In addition, in 1998, Dr Quinsey wrote,

Because most of the offenders we studied were institutionalized, it was important that we not miss subsequent violent behaviour that occurred in other institutions that may have been charged had it occurred in the community. Consequently, we examined the records of subsequent institutionalizations (both criminal and psychiatric) and recorded those violent acts that, in the judgement of research assistants, would have led to criminal charges had the incident occurred outside an institution (4).

These points led us to conclude that patients who were not released to the community could be included in the study and, further, that the subject of this paper was included in the research project.

According to Dr Quinsey, the PCL-R manual states that a personal interview is not required to administer the PCL-R. In fact, however, the PCL-R manual strongly recommends interviews. Page 6, which Dr Quinsey quotes, reads as follows:

In some situations (for example research using archival information, clinical assessments of psychotic patients) it may prove impossible to conduct a useful interview. Valid PCL-R rates can be made solely on the basis of collateral information if there is sufficient high-quality infor-
Repetitive Transcranial Magnetic Stimulation is Useful for Maintenance Treatment

Dear Editor:

Resistance to treatment is common in patients suffering from a depressive illness (1). Electroconvulsive therapy (ECT) is an effective treatment for those patients who do not respond to medications, but it may not be acceptable or tolerated by some. Even after an adequate response, many patients need to be placed on maintenance treatment to prevent recurrences. Transcranial Magnetic Stimulation (TMS) is being touted as a treatment that is better tolerated and well accepted in such patients, and a few open-level studies have found that repetitive TMS (rTMS) has comparable efficacy in nonpsychotic depression patients (2,3). To our knowledge, there have been no reports of rTMS used as a maintenance treatment after successful response to the usual course of rTMS. We are hereby reporting such a case.

Case Report

Mrs K is a 45-year-old woman with a long-standing history of depression characterized by several episodes of weight gain (20 to 30 pounds), reversed diurnal variation, extreme anhedonia, fatigue, and suicidal ideation. There is a positive family history of major depression, both in her parents and in her grandfather. Mrs K held a high-level job until 1999, when she ceased work and received disability payments for depression. Over the last 2 years, adequate trials of nefazodone, moclobemide, venlafaxine, citalopram, nortriptyline, and mirtazapine have had little success in relieving her depression. The only antidepressant to which she has shown some response has been phenelzine, but this had to be discontinued when she needed narcotic treatment for another illness. When this medication was subsequently resumed, it failed to obtain any beneficial effect, even at a higher dosage. Mrs K refused ECT and was therefore referred to us for treatment with rTMS. After 10 treatments the depression responded, and her Hamilton Depression Rating Scale (HDRS) score dropped from 21 to 10. During the 2 week post-TMS follow-up, her depressive symptoms started to return, and her HDRS score increased to 16. At this point, she wondered whether receiving more TMS might reverse the downhill course of her depression and return her to wellness. She was therefore offered maintenance rTMS, given weekly or biweekly, and has been doing well on such treatment for 4 months.

Mrs K suffers from a chronic sinusitis, and previous recurrences have been associated with appreciable deterioration in her mood. The latest recurrence has not yet responded to treatment, although 3 antibiotics have been tried, but it does not appear to have adversely affected her mood, as in the past. Mrs K now feels well and has been functioning satisfactorily, both in the community and at home. Moreover, she is seriously considering a return to work. She has not had any treatment side effects and is eager to continue treatment with the TMS.

Even though further studies are needed, rTMS should be considered a useful addition to the armamentarium in the fight against treatment-resistant depression in both the acute and maintenance phases.

References


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because patients with BD in tertiary care centers are usually the most severely ill and do not represent most patients with BD (2).

I tested the usefulness of the MDQ to assess the frequency of bipolar spectrum disorder among patients in my outpatient psychiatry private center. (Private practice is the first line of treatment—or the second, after family doctors—of mood disorders in Italy, where patients with the most severe mood disorders are usually treated in national health service or university centers.) The sample consisted of 107 consecutive outpatients from my practice who had a mood disorder and a much-improved or remitted MDE. During their first visit, these patients had been diagnosed with a major depressive episode (MDE), with the Structured Clinical Interview for DSM-IV, Clinician Version (SCID-CV) (3), supplemented by information from family members or close friends (as in my previous studies). At 1-month follow-up, they were given the MDQ to self-rate. MDQ self-rating outside the MDE increased the validity of their answers, because during the MDE patients may be biased against remembering past positive events (such as manic or hypomanic euphoric episodes). Systematic, skilled questioning about the history of mania or hypomania, together with information from key informants, is needed to diagnose BDs (4).

The mean (SD) age of the patients was 42.5 (14.4) years. Women accounted for 61.6%, and men accounted for 38.4%. Bipolar spectrum disorders were present in 44.8% (48/107) of the patients who used the MDQ.

This finding is in line with previous reports from the same setting, where nearly 45% of the SCID-CV—interviewed patients with a mood disorder had BD II, and a few had BD I (5,6). It should be noted that the DSM-IV criterion of 4 days’ minimum duration of hypomania for BD II diagnosis—a cut-off not based on data (7)—was not followed in these studies: at least 2 days of hypomania were required for BD II diagnosis, which led to the inclusion of many patients with “soft” BD II, in terms of Akiskal’s (4) and Angst’s (8) reports and the research diagnostic criteria (9).

These findings suggest that the MDQ may be useful for assessing bipolar spectrum disorder frequency in settings like private practice, where patients with BD are usually less severely ill—and represent most patients with the disorder—than are those in tertiary care centers (2). These findings also have important treatment implications, because antidepressants may induce mania or hypomania, rapid cycling, and mixed states in patients with BDs (10–13). Results of the MDQ should alert clinicians to search for “hidden bipolarity” in nontertiary care settings.

References

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Capgras Syndrome and Blindness: Against the Prosopagnosia Hypothesis

Dear Editor:

Some authors suggest that Capgras syndrome (CS)—the delusion that a well-known person has been replaced by a near-identical duplicate—might be related to prosopagnosia, the failure to recognize familiar faces (1–3). We report here the case of a completely blind patient with CS, which challenges this hypothesis.

Case Report

Mrs A, a 26-year-old Afro-Brazilian married housewife, became blind at age 16 years, after a bilateral tuberculous uveitis. She was admitted to our hospital in a severe depressive episode, with marked apathy, weight loss, sadness, and suspiciousness, especially of her husband. She believed that her spouse had been replaced by an impostor, an almost-identical person who was trying to take his place. According to the patient, “He [the impostor] tries to make me believe that he is my husband, but I know he is not him. My husband is a little bit fatter than this man who tries to mimic his voice.” She also based her conviction on subtle aspects of his smell and the taste of his skin. The neurological examination (including cognition), magnetic resonance imaging (MRI), and single photon emission computerized tomography (SPECT) was normal. The patient was treated with imipramine 150 mg and thiourazide 300 mg daily. Her mood improved in 4 weeks, and she was discharged. Nevertheless,

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the belief in her husband’s replacement remained for the next 6 months.

Although rare in the literature, this is not the first case report of a blind patient with CS. In 1990, Signer and others (4) published the history of a 75-year-old woman who developed a depressive episode with CS 20 months after she completely lost her sight. In 1991, Rojo and others (5) described CS in a 32-year-old man who had been blind for 3 years. Like our patient, he based his belief on nonvisual cues, stating that the skin of his mother’s hand felt softer. As with our patient, the 2 reported cases had an acquired and complete blindness. Curiously, our patient’s behaviour when her husband visited her at the hospital denoted a marked ambivalence: she gave clear signs of being simultaneously very attached to and very suspicious of him. This case reinforces the evidence that, at least for some patients, a facial recognition impairment is unlikely to explain CS. Emotional aspects such as ambivalence and fear of losing a close person also seem to play a role in this syndrome (6). Therefore, we think that the anomalous perceptual process, rather than being the cause, may result from the delusional transformation of the world.

References


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Re: New Century: Overcoming Stigma, Respecting Differences—Dr Myers’ Superlative Presidential Address

Dear Editor:

Dr Myers omitted one stigma that affects everyone in the psychiatric community: the stigma attached to dissociative disorders. For reasons that I cannot understand, the reluctance to deal with, work with, treat, or even acknowledge the diagnosis of dissociative disorders is rampant in the psychiatric field. Why? It is a treatable disorder, the patients get better, and they are the most dedicated and hard-working group one could imagine.

Yes, treatment is time-consuming. Yes, these patients are demanding. That does not preclude therapy, nor excuse dismissing this group of patients, almost all of whom have severe abuse in their backgrounds. We are not talking about false memories, confabulation, hysteria, or “manipulation.” We are talking about emotional pain. Treatment is rarely found in psychopharmacology. It is not rocket science—generally, it means good garden-variety psychotherapy, with attention paid specifically to the dissociative components.

Please, those of you who find it difficult—open your minds to this disorder, and save the next generation from its continued legacy.

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Steroid-Induced Psychosis Treated With Risperidone

Dear Editor:

We report a case of steroid-induced psychosis in a previously well 22-year-old female university student.

Case Report

Four weeks prior to psychiatric presentation, the patient was treated for asthma with oral prednisone (50 mg daily) and a concurrent 3-day course of IV hydrocortisone (150 mg 4 times daily). During this time she exhibited some suspiciousness, which resolved spontaneously in hospital. After the 5-day hospital stay, oral prednisone was tapered by 5 mg every 4 days.

One week after completing her prednisone tapering, the patient was admitted with worsening restlessness, confusion, and anxiety. She was well until 1 week prior to admission. Her family reported a progressive 7-day history of marked sleep disturbance, difficulty initiating and completing sentences, fearfulness with a continual need for reassurance, mood lability, and episodes of staring into space. Her fiancé reported that she thought he was tape-recording her activities. Family history was significant for schizophrenia in a first cousin and an isolated episode of apparent delirium in the father.

At the time of admission, the patient looked her stated age and was appropriately groomed. She appeared fearful, showed significant difficulties initiating speech and basic tasks, possessed a blunted affect, and had persecutory ideation. A physical examination was unremarkable. Laboratory data indicated a mild microcytic anemia, mildly elevated prolactin, and slightly low folate. The remaining investigations were normal, including renal and liver function, electrolytes, complete blood count, B12 level, thyroid-stimulating hormone, arterial blood gas, glucose, luteinizing hormone, follicle-stimulating hormone, estradiol, celiac screens, CT and magnetic resonance imaging of the head, EEG, and sleep apnea studies.
A presumed diagnosis of steroid-induced psychosis was made. Lorazepam 1 mg 3 times daily was given for agitation. Risperidone 0.5 mg once daily was started on day 5 of hospitalization.

During the first 2 weeks, her symptoms were consistently more pronounced in the mornings, with some day-to-day fluctuations. Toward the end of the second week, she was able to follow simple commands and became increasingly independent. She was anxious in group settings, but her persecutory ideation dissipated. Limited spontaneous speech returned. Risperidone was increased to 1 mg nightly.

In the third week, she was able to speak hesitantly but in full sentences. Deficits in memory and general knowledge became apparent, and neuropsychiatric testing revealed impaired attention and concentration.

During weeks 4 to 6, risperidone was increased to 1.5 mg daily, thought disorder diminished, and memory improved; however, anxiety in public places persisted. She was discharged after 43 days.

Corticosteroids are known to cause neuropsyiatric effects ranging from mood disorders to psychosis (1), and patients on more than 40 mg prednisone daily appear at greatest risk (2). Psychosis has been successfully treated with typical antipsychotics (2,3). Risperidone has been used in 1 pediatric case (4).

Our case appears unusual in that psychosis became fulminant after steroids were discontinued. Risperidone appeared effective in treating possible steroid-induced psychosis in our patient. More research is needed to understand late-onset steroid-induced psychosis and its treatment.

References


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