Letters to the Editor

Re: Unfree Associations: Inside Psychoanalytic Institutes

Dear Editor:

Dr Paul Steinberg’s interesting review (1), of Unfree Associations: Inside Psychoanalytic Institutes, by D Kirsner (2), raises several points that concern all of us who belong to professional organizations.

Steinberg, and apparently not quoting Kirsner, diagnoses 4 psychoanalytic training institutes in New York, Boston, Chicago, and Los Angeles, as being “pathologically functioning,” “dominated by narcissistic characters,” and exhibiting “childlessness and fratricidal behaviour.” He further states that they have “irredeemable narcissism, even paranoia.” Such psychopolitical descriptors are usually reserved for books concerning fascists, dictators, or the present “war on evil,” and appear politically dismissive rather than offering useful dynamic insights or objective criticism. He wonders about comparing the functioning of psychoanalytic institutes with other institutions, such as universities and hospitals and their leaders. My recent books (3,4) have attempted to look at an impossible dream. Toronto: Clarke/Coach House; 1996.

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Reply: Unfree Associations: Inside Psychoanalytic Institutes

Dear Editor:

Dr Frayn is critical of me for being the messenger of Kirsner’s concerns and criticisms about psychoanalytic institutes; he apparently takes exception to my reading of Kirsner’s description. I do not believe that my review was one-sided, as Dr Frayn indicated. In suggesting that the author might have compared psychoanalytic institutes with other institutions, I was implying that the former might not suffer by the comparison. I also pointed out that Kirsner was aware of positive qualities in the central figures but focused on activities illustrating less admirable characteristics. I indicated that this text is extremely well documented and that Kirsner’s reporting appears balanced, fair, and objective. As well, in the concluding chapter, Kirsner offers constructive opinions about how psychoanalytic institutions need to change. Dr Frayn may well be correct in suggesting that many of the shortcomings Kirsner describes cross the boundaries of most, if not all, professional groups. This does not invalidate analysis of the groups Kirsner describes. In fairness to Dr Frayn, Kirsner certainly devotes much (in my opinion, too much) space to describing the failures of the organizations in question. I cannot agree that this necessarily does a disservice to

References

many and fails to enlighten those who wish to avoid the mistakes of the past. It may be painful to read about such serious difficulties in respected professional organizations. However, in my opinion, uncovering these difficulties is analogous to uncovering one’s personal difficulties in psychoanalysis and is necessary for improvements to be made.

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Improving the Mood Disorder Questionnaire to Detect Bipolar II Disorder

Dear Editor:

The Mood Disorder Questionnaire (MDQ) (1) is a self-assessment screening tool for a broad diagnosis of the bipolar spectrum (that is, bipolar I [BD I], bipolar II [BD II], and bipolar not otherwise specified [BD NOS], according to DSM-IV criteria). It has 13 questions covering hypomania symptoms, clustering of symptoms, and impaired functioning. Its criteria for a diagnosis within the bipolar spectrum are more than 6 positive questions, plus clustering of symptoms, plus moderate-to-severe impairment. Compared with the Structured Clinical Interview for DSM-III-R (SCID), the MDQ had sensitivity of 73% and specificity of 90% for a bipolar spectrum diagnosis in clinical samples (1) and sensitivity of 28% and specificity of 97% in community samples (2). Accord- ing to the MDQ, community frequency of the bipolar spectrum was 3.4%—a figure similar to that achieved by adding figures reported in the DSM-IV (meaning underdiagnosis of BD II [3,4]). One limitation of the MDQ is the required moderate-to-severe impairment (5). Because hypomania in BD II often shows improved functioning (6,7), the MDQ is biased against BD II and should be improved to better detect it. Using a semistructured interview focusing on past overactivity, clinicians probing for past hypomania found (with high interrater agreement) that BD II was present in approximately 50% of clinical and community samples of subjects with depression (8–11).

This study aimed to test the usefulness of the MDQ in a clinical sample and to modify it to increase its detection of BD II. In a private practice, 101 consecutively remitted outpatients with BD I, BD II, or major depressive disorder (MDD) were given the MDQ during follow-up visits. Soon after, they were interviewed with the SCID-Clinician Version (SCID-CV) (12). The interviewer was blind to MDQ results. Setting and interview methods are reported in detail elsewhere (9,13). There were many more remitted BD (BD I and BD II) than MDD patients because BD patients were followed up more frequently.

Results

According to the MDQ, frequency of BD was 17.8% (n = 18). According to the SCID-CV, frequency of BD I was 16.8% (n = 17), frequency of BD II was 59.4% (n = 60), and frequency of MDD was 23.7% (n = 24). To test whether this big difference in BD frequency observed between the MDQ and the SCID-CV was related to the the MDQ’s impairment criterion, calculations were remade after deleting it. The modified MDQ was called the MDQ7, indicating a cluster of at least 7 positive items. The MDQ7 found 65 cases of BD; of these, the SCID-CV identified 57 (87.8%) as BD (BD I, 24.2%; BD II, 63.6%). Among the cases not identified by the MDQ7 (n = 33), 18 (54.2%) were classified by the SCID-CV as BD (BD I, 2.8%; BD II, 51.4%).

Using Stata statistical software (14), we studied agreement between the MDQ, the MDQ7, and the SCID-CV. Comparing the MDQ and the SCID-CV for BD I, we found agreement = 79.2%, kappa = 0.27, and P = 0.0029. Comparing the MDQ and the SCID-CV for BD II, we found agreement = 36.6%, kappa = –0.13, and P = 0.9747. Next, we compared the MDQ7 and the SCID-CV for BD I, finding agreement = 49.5%, kappa = 0.16, and P = 0.0031. When we compared the MDQ7 and the SCID-CV for BD II, we found agreement = 58.4%, kappa = 0.11, and P = 0.1172. Then, we compared the MDQ and the SCID-CV for BD (BD I + BD II) and found agreement = 33.6%, kappa = 0.00, and P = 0.4328. Comparing the MDQ7 and the SCID-CV for BD (BD I + BD II), we found agreement = 73.2%, kappa = 0.36, and P = 0.0001. Logistic regression was used to study associations, sensitivity, and specificity. The MDQ was not significantly associated with SCID-CV BD (Odds Ratio = 1.1, z = 0.17, P = 0.866). The MDQ7 was associated with SCID-CV BD (Odds Ratio = 6.1, z = 3.5, P = 0.000), giving a sensitivity of 87.8% and a specificity of 45.7% for predicting SCID-CV BD.

The MDQ had much higher agreement with the SCID-CV for the detection of BD I, compared with BD II, and low agreement for the detection of BD (BD I + BD II). By contrast, the MDQ7 had high agreement with SCID-CV for the detection of BD. Because the MDQ is a screening tool for bipolar spectrum detection (which then needs to be followed by clinical evaluation), sensitivity is more important than specificity. The modified MDQ’s high sensitivity for BD detection (specifically, modified by deleting the impairment criterion) means few false negatives, or few subjects lost for clinical evaluation (which would then lead to the final diagnosis). The high underdetection of BD II by the MDQ can thus be improved by deleting its impairment criterion.

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Letters to the Editor

Mnemonic for the Diagnosis of Hypomania Associated with Bipolar II Disorder

Dear Editor:

In the area of primary care psychiatry and general psychiatry, the 1990s could be termed “the decade of the antidepressants.” This was a period of intense medical and public education focusing on depression as a legitimate, biologically based illness amenable to treatments with many newly available and different classes of antidepressants. This effort has helped alleviate the suffering of many patients and given clinicians—especially primary care physicians—new knowledge and tools to treat depressive illness. However, 15 years after the introduction of the first selective serotonin reuptake inhibitor (SSRI), fluoxetine, it is becoming apparent that antidepressants do not work for everyone: in controlled trials, the rate of symptom remission for antidepressant therapy is at best 50% (1,2). Of more concern is the observation that antidepressants can make some patients worse by introducing or worsening anxious, agitated, or restless states and sometimes inducing insomnia intermingled with racing thought (3,4). Emerging evidence suggests that these antidepressant activations may be a result of unrecognized bipolar disorder (BD), usually BD II, which is being increasingly recognized as a common mood disorder both in outpatient psychiatry (5) and in primary care (6). Affected patients usually present in the depressed state, because their hypomanic episodes are typically elated and adaptive; patients suffering from depression lack specific recall of them (7). Because patients lack recall of hypomanic episodes, recognizing bipolar illness has been problematic, even in psychiatric settings (8,9). There is an average delay of 8 to 12 years before an accurate diagnosis is made. To help identify possible hypomanic episodes in a depression patient’s history, and thereby decrease the delay in accurate diagnosis, we have come up with a mnemonic incorporating the DSM-IV-R definition of hypomania. The mnemonic is HIGH-4, as follows:

H = Hyperactivity, or distractability, flight of ideas, pressured speech, and racing thoughts
I = Insomnia and irritability
G = Grandiosity, or inflated sense of self
H = Hyperhedonia, or shopping sprees and high-risk sexual activity

4 = 4 days

We believe that, by using this mnemonic to remind ourselves to look for the presence of hypomanic episodes in all depression patients in clinical settings, we can more accurately diagnose BD in a shorter time frame. This will allow us to use more appropriate therapies to treat BD patients and to avoid embarking on an antidepressant misadventure resulting in more suffering for our patients. In other words, when the patient is low, we should think HIGH-4!

References


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Aripiprazole-Induced Improvement in Tardive Dyskinesia

Dear Editor:

Atypical antipsychotics, particularly clozapine, have been reported effective in the treatment of tardive dyskinesia (TD) (1). We report the case of a patient with schizoaffective disorder who showed remarkable improvement in TD following treatment with aripiprazole (APZ).

Case Report

Mrs A, aged 41 years, suffered from chronic schizoaffective disorder of 20 years’ duration and was admitted with psychotic exacerbation. The patient had been free of antipsychotics for the last 6 months but had significant TD in the form of choreoathetoid movement of her upper extremities and truncal dyskinesia. TD was first noticed about 2 years ago, while she was taking haloperidol. Discontinuation of haloperidol and subsequent sequential trials of risperidone, olanzapine, ziprasidone, and quetiapine did not improve the TD. Quetiapine exacerbated the TD and olanzapine, ziprasidone, and risperidone had to be discontinued owing to weight gain, EKG changes, and hyperprolactinemia.
in AIMS score (2). TD has been associated with any significant changes in this trial showing APZ was not found to cause TD. This is supported by a recent study showing that APZ is less effective compared with conventional antipsychotics. Therefore, we can speculate that APZ has less potential supersensitivity to a lesser extent after repeated administration, compared with chlorpromazine at 100 mg thrice daily. Four weeks after APZ was started, she showed only occasional choreic movements of her fingers and scored 2 on the AIMS. She maintained that improvement at the time of discharge and also displayed significantly decreased psychotic symptoms.

APZ, a dopamine–serotonin system stabilizer, is unique in having a partial dopamine agonist and antagonist effect (2). It causes dopamine receptor supersensitivity to a lesser extent after repetitive administration, compared with haloperidol (3). Dopaminergic supersensitivity is currently the most accepted hypothesis for TD (4), and we can speculate that APZ has less potential to cause TD. This is supported by a recent study showing that APZ was not associated with any significant changes in AIMS score (2). TD has been associated with upregulation of the D2 receptors, and another finding favouring a beneficial role of APZ in TD is that it does not upregulate these receptors (5). An interesting observation was that dyskinesia did not remerge after augmentation with a conventional antipsychotic. APZ may have inherent capacity to prevent reemergence of TD caused by conventional antipsychotics because it acts as a functional agonist at dopamine receptors under hypodopaminergic states (2) occurring with conventional antipsychotics. Thus, further trials of APZ in cases of TD are encouraged. Moreover, augmenting APZ with conventional antipsychotics in partial responders deserves more attention, considering recent reports of optimizing treatment using combined typical and atypical antipsychotics (6).

References

Dependent Personality Disorder as a Marker of “Battered Husband Syndrome”: A Case Exemplar

Dear Editor:

I describe the case of a male victim of a female spouse batterer.

Case Report

The phenomenon of husband battering is a not uncommon occurrence that tends to be ignored, dismissed, or selectively attended to. Why men do not report their victimization and why they stay in abusive situations are well-documented (1), if not often documented because of deeply ingrained myths regarding both the potential for, and incidence of, violence in women and the vulnerability of men to such victimization—myths that have led to gross underestimation of the high rates of female perpetrators in abusive families (2).

Dependency has been documented as a risk factor for becoming a victim of spousal abuse (3). This is understandable, given both the characteristic features of dependent personality disorder (for example, submission and over-compliance to the wishes of others to maintain an overwhelming need for support and security and to avoid abandonment) and the associated or comorbid characteristics of the disorder (for example, generalized anxiety and depression, with their associated configuration of such symptoms as low self-esteem and a weak and fragile self-image) (4,5).

Gudjonsson developed a psychometric questionnaire–scale to assess an individual’s susceptibility to complying with the demands of police interrogators (6). The personality characteristics measured by this instrument (for example, eagerness to please and avoid confrontation, along with fear and apprehension when in the company of people making demands and difficulties in coping with pressure) were found to be closely related, if not conceptually identical, to Millon’s conceptualization of dependent personality disorder (4), which in turn has been espoused as conceptually related to the DSM-IV-TR criteria for the disorder (5). Gudjonsson has shown that psychological characteristics such as elevated suggestibility (or being easily persuaded), hypercompliance, unassertiveness, low self-esteem, and anxiety proneness—all of which are features or associated features of dependent personality disorder—can render individuals so vulnerable to psychological pressure and coercion that they will falsely confess to having committed a crime when pressured to do so by police interrogators (7).

Within the context of a legal dispute, a 57-year-old man who was a store manager and retired, pensioned autoworker with a Grade 12 education, was referred by his lawyer for examination to determine his susceptibility to involuntarily succumbing to psychological pressure and coercion. Upon separation from his common-law spouse, he was intimidated and coerced by her into signing an
agreement that included giving up his financial assets to her (for example, his house and pension). During their relationship, she was controlling, critical, and violent (for example, at one point, she hit him over the head with a broom handle with such force that the handle broke). She micromanaged his behaviour and assailed him when his assigned list of weekly chores were not done to her exact specifications (for example, cutting up the vegetables in a particular way when doing his assigned cooking chore). He had no safe place in his house, although at times he attempted to protect himself from her onslaughts by barricading himself in a room with a sofa that he could push up against the door. His spouse behaved well when socializing with others, however, and was also quite pleasant to him between abusive episodes. He never told anyone about the abuse, owing to the embarrassment of being a male victim of a female spouse batterer. The abuse continued following the separation and he had to have his telephone calls blocked and to obtain a restraining order.

The patient’s developmental history included a substantial amount of verbal and physical abuse directed at both himself and his father by his mother (in one incident, for example, his mother went after his father with a paring knife).

The results of psychometric examinations of the patient’s fluid intelligence according to the Test of Nonverbal Intelligence—Third Edition (TONI-3) and psychological status according to the Millon Clinical Multiaxial Inventory-II (MCMII), the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and the Personality Assessment Inventory (PAI) indicated that the patient was somewhat cognitively limited (that is, within the low average range), that he was suffering from a dependent personality disorder in association with generalized anxiety and dysthymia, that he displayed an unassertive and hyperacquiescent interpersonal style, and that he possessed a poor self-concept with limited personal resources for coping with problems and stresses.

This case provided a pellucid illustration of how the presence of a specific diagnosable psychological disorder; namely, dependent personality disorder, can be a marker or significant risk factor for becoming a victim of interpersonal abuse, especially when combined with some of the disorder’s comorbid conditions.

References

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Visually Enhanced Psychosexual Therapy (VEST) in a Multicultural Community

Dear Editor:

There appears to be an increasing demand for sexual dysfunction treatments. Apart from, or instead of, medications (none of which so far help desire problems that are commonest among couples seeking sex therapy), psychosexual therapy has much to offer. Visually Enhanced Psychosexual Therapy (VEST) can significantly improve such treatment, especially in a multicultural setting where lack of language skills handicaps therapeutic progress. Using films and videos as an educational tool has an established history (1–6). In the field of sexology, recent work by several investigators has focused primarily on the erectile or libidinal response to audiovisual sexual stimulation (7–9). Delizonna’s study in particular needs to be heeded, especially in this pharmacologic era, because it demonstrates that achievement of mechanically induced erection or penile tumescence “was not accompanied by a subjective state of physical or mental sexual arousal” (10).

The VEST approach begins by presenting the neuroanatomical and psychophysiological facts of sexual functioning. This factual base enables patients to grasp and concretely visualize the universal biological structure and function of the human autonomic nervous system, its parasympathetic and sympathetic components, and their specific and critical role in arousal and orgasmic release.

In addition to the audiovisual component, this 8- to 10-session, brief, directive psychosexual therapy program uses several treatment elements, including bibliotherapy, relaxation, emotional communication skill training, and sensate focus exercises. Emphasis is placed on teaching the core time-related concepts of being present-centred and process-absorbed, along with how to reach this state.

Visual aids, carefully used, can efficiently explain concepts cognitively and can promote emotional learning. Personal introduction to each program used and prompt postexposure debriefing after patient viewing in privacy are critical elements to increase efficacy and patient comfort with VEST.

More than 25 years of treating people with sexual problems reveals that selection of the most appropriate visual aid requires careful clinical judgement, as the potential to do harm exists. Here one can draw a parallel with the use of medication. Moreover, the therapist must be intimately familiar and comfortable with the material chosen for presentation and confident of its potential to enhance, not impede, the therapeutic flow and rhythm with a particular patient or couple.
Access to a comfortable space with the assurance of viewing privacy, preceded by an active relaxation exercise, enables patients to be more attentive and fully focused on the often emotionally challenging material presented.

In VEST, audiovisual programs are integral to the total therapeutic approach and keep careful pace with patient progress. Thus, various assignments, such as specific readings or sensory, communicative, or relaxation exercises at home between sessions need seamless integration. Their impact benefits from reinforcement within the safe context of the cumulative therapeutic process.

Extensive clinical experience indicates a high success rate (80% to 85%) with VEST, as indicated by sustained reversal of the presenting sexual dysfunction. The World Association for Sexology (WAS) guidelines for ethical use of videos or multimedia in sex education, counselling and therapy, provide useful guidance in the application of these quasi-medications (11).

Note
A version of this paper was presented at the American Psychiatric Association Annual Meeting; May 21, 2002; Philadelphia (PA). A version of this paper was also presented at the Ontario Psychiatric Association Annual Meeting; January 17, 2002; Toronto (ON).

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