Letters to the Editor

Bongs, a Method of Using Cannabis Linked to Dependence

Dear Editor:

Bongs are a type of water pipe popular among adolescents using cannabis because they allow for stronger effects than joints from the same amount of cannabis and because they are easy to buy or make. This study assessed the link between bong use and cannabis dependence in adolescents.

Participants were 390 students (221 boys, 169 girls; mean age 17.1 years, SD 1.1; range 15 to 20 years). They were drawn from a random sample of 14 classes from 3 secondary and grammar schools in the departments of Haute-Garonne and Pyrénées-Orientales, France. Participants completed a questionnaire assessing the frequency and preferred method of cannabis use. We assessed cannabis dependence according to DSM-IV criteria (1), using a self-report questionnaire derived from the Mini International Neuropsychiatric Interview (MINI) (2). This questionnaire comprised 7 items corresponding to DSM-IV criteria for substance dependence. Participants received a diagnosis of cannabis dependence if they met 3 or more of the 7 DSM-IV criteria. The questionnaire validity had been assessed in a preliminary study (n = 23 adolescents). In the preliminary study, the questionnaire was followed after 8 to 15 days by a clinical interview that employed the MINI module for assessing substance dependence. Agreement between the questionnaire and the interview for the diagnosis of cannabis dependence was evaluated with Cohen’s kappa coefficient, which was judged satisfactory at 0.79. Cronbach’s alpha coefficient of this questionnaire was 0.76.

Of the 390 participants, 55% were cannabis users; of the girls, 43.8% were cannabis users; of the boys, 63% were cannabis users. Reported frequency of use was as follows: 41% used cannabis less than once monthly but at least once in the last 3 months, 17.9% used cannabis 2 to 3 times monthly, 26.8% used cannabis once or more than once weekly, and 14.3% used cannabis once or more than once daily. The preferred methods of use were joint (49.5%), bong (33.5%), ingestion (8.5%), and pipe (4.5%).

Of users, 43.7% met the criteria for cannabis dependence. There were no significant differences between boys and girls for the frequencies of cannabis use, for the preferred method of use, or for dependence. The rate of cannabis dependence among bong users was significantly higher than among joint users (54.4% vs 25%, P = 0.0002).

The link between bong use and cannabis dependence may reflect the fact that bong use contributes to dependence and (or) that dependence leads to using stronger methods, such as bongs.

References

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Obsessive–Compulsive Symptoms in Schizophrenia Induced by Risperidone and Responding to Fluoxetine

Dear Editor:

Risperidone has been reported to induce or exacerbate obsessive–compulsive symptoms in schizophrenia patients (1) but may also be efficacious as an augmentation strategy in refractory obsessive–compulsive disorder (OCD) (2). Atypical antipsychotics such as risperidone may induce OC symptoms at low dosages, owing to high 5-HT₂/D₂ antagonism, whereas they may improve OC symptoms at high dosages, owing to high D₂ antagonism (3). For instance, a patient with bipolar disorder was reported to present OC symptoms with low-dosage risperidone; however, these symptoms reversed at higher dosages, suggesting an inverse dosage–response relation (3). We report the case of a schizophrenia patient without a history of obsessions or compulsions who developed risperidone-induced OC symptoms that responded to fluoxetine.

Case Report

Mr A, a 49-year-old married man, working full-time, has a 26-year history of chronic schizophrenia. His medical history revealed essential hypertension. He was stable on intramuscular (IM) haloperidol decanoate 270 to 350 mg given every 4 weeks for over 10 years. After he developed tardive dyskinesia, haloperidol decanoate was switched to risperidone 6 mg daily. His antihypertensive medications, taken for several years, remained constant. After 3 weeks of risperidone, he developed ideas of reference. Risperidone was increased to 8 mg daily. One week later, the ideas of reference took on delusional proportions and obsessional qualities. Risperidone was increased over the next 8 weeks to 12.5 mg daily. Valproic Acid was then started (for putative antipsychotic-induced therapeutic tolerance [4]) and titrated to 1500 mg daily over 3 weeks. Six weeks after the risperidone increase to 12.5 mg daily, and 14 weeks after risperidone initiation, Mr A developed obsessional thinking. He described his obsessions as recurrent, intrusive “crazy thoughts of killing [his] wife” that occupied much of his time and generated anxiety. Fluoxetine 10 mg every 2 days was started. Over the next 8 weeks, the obsessions persisted without psychotic

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symptoms. Fluoxetine was increased to 10 mg daily, and 3 weeks later his obsessions completely resolved. Nine months after fluoxetine initiation, Mr A was stable on the same medication regimen.

The occurrence of OC symptoms in chronic schizophrenia ranges from 7.8% to 46.6% (5). In this report, we suggest that the OC symptoms resolved through 2 possible mechanisms of fluoxetine: first, increased serotonin through 5-HT reuptake and, second, inhibited cytochorme P450 enzyme 2D6 (which would increase risperidone concentrations because risperidone is metabolized by 2D6). This last effect of fluoxetine would be in keeping with the inverse dosage–response relationship of risperidone; that is, at high dosages, D2 antagonism improves OC symptoms (3).

**References**


Emmanuelle Levy, MD, FRCP can present a highly atypical case of a young male forensic patient who perpetrated 2 serious criminal code offences to ensure a maximal prison sentence.

**Case Report**

An 18-year-old, single male with a high school education was referred for a court-ordered psychological assessment to determine his fitness to stand trial and criminal responsibility for 2 sequential armed bank robberies. These robberies were carefully planned and perpetrated on the same day for the purpose of attaining a lengthy period of incarceration (ideally, between 4 and 12 years, according to the patient). The patient believed that incarceration would allow him to lead a stress-free and “interesting” existence and to enjoy the free services provided by prisons, such as schooling and gym activities. No clinical evidence supported either his lack of fitness for trial or his candidacy for a defence of “not criminally responsible on account of mental disorder” (NCRMD), and he was subsequently convicted and sentenced by a judge to less than 2 years in a provincial jail.

Physical assessments (that is, computerized transaxial tomography, ECG, urinalysis, hematology, and clinical chemistry testing) yielded no findings that could account for the patient’s behaviour. Collateral history revealed no prior contacts with the criminal justice system, no history of violence against either self or others, and a community perception of the patient as “a really good kid” and “the poster boy, baby sitting in the neighbourhood.”

However, the patient reported to the police that he had had “thoughts of harming and killing others” for as long as he could remember. He also reported to psychological examiners that he had experienced suicidal thoughts (for example, slashing or hanging) since age 4 years but had never made any attempts other than harmless self-injurious gestures. His overt mental status was unremarkable, although he verbally (and upon psychometric examination) endorsed every symptom of mental illness that was queried, while evidencing a dearth of insight. He displayed no evidence of distraction from voices during clinical interviews. Marked evasiveness was present; for example, the patient stated that it was “possible” that he was experiencing the various queried symptoms. Similarly, inconsistencies existed between patient-reported and clinically observed symptoms; for example, his concentration was good, although he reported that it was not. As he acquired knowledge, the patient also modified his personal history to agree with psychopathology indicators. However, psychotic provenances for such crimes as rape, robbery, and cheque forging have been found to be unusual. Finally, a psychometric examination with the Millon Clinical Multiaxial Inventory-III (MCMI-III) was consistent with malingering.

Both hallmark and numerous related symptoms of borderline personality disorder (2,3) were also present. These included intense anger, inability to tolerate even minimal levels of stress, obsession with controlling relationships and termination of relationships that became close, a farrago of psychotic-like and
other serious symptoms redolent of multiple diagnostic impressions, suicidal thoughts and gestures, excessive dependency, and undermining the realization of personal goals.

To my knowledge, this is the first description of a case of criminal behaviour motivated by the desire for a lengthy period of incarceration that was in turn engendered by the characteristics of a specific psychological disorder, namely, borderline personality disorder.

References
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Autoamputation in Psychosis: Diagnostic Issues

Dear Editor:

Self-mutilation (SM) is a rare but extreme manifestation of mental illness. A review on the topic defined this act as “the commission of deliberate harm to one’s own body severe enough to cause tissue damage,” excluding conscious suicidal attempts or acts associated with sexual arousal (1). SM is most commonly seen in 4 populations: persons with mental retardation, persons suffering from psychosis, persons in prison (where it is associated with antisocial personality disorder [APD]), and persons with borderline personality disorder (BPD).

Case Report

A 38-year-old man with a history of psychosis was transferred from a Christian retreat. He had amputated his left thumb with a paring knife because a voice that he said was God’s told him he had sinned by “holding [his thumb] up to God.” On initial presentation, he had a blunted affect, severe thought blocking, and obvious interaction with internal stimuli, as well as a fixed hyperreligious delusional system. He had no insight into either his physical or psychic symptoms and denied any suicidal ideation. A drug screen and organic workup were negative, and antisychotics were started. The plastic surgery service was consulted to reattach the severed digit. After surgery, his hallucinations improved dramatically, although his delusional beliefs were slower to recede.

During the admission, the Minnesota Multiphasic Personality Inventory (MMPI) was administered. Scores suggesting psychosis were high and “consistent with [the possibility that] people who have very deviant religious convictions acting out in asocial or antisocial ways may be obsessed with sexual thoughts” (psychologist’s report, unpublished). These interpretations were consistent with a past diagnosis of APD, a history of cross-dressing, and an arrest for public masturbation. The patient was very troubled by his “sinful” sexual urges in the context of the extremely puritanical Christian belief system that he held when not suffering from psychosis.

Autoamputation of limbs or digits, one severe aspect of SM, is very rare. A case series review found 13 cases from 1966 until this case; all these individuals suffered from psychosis, and 5 endorsed religious delusion (2). A small case series found 2 statistically significant factors that predicted SM in individuals with psychosis: a self-imposed change in physical appearance, and a prior act of self-mutilation (3). Others have stated that patients with command hallucinations, particularly of a religious nature, are also at risk; however, there is little evidence to support this (4).

This case is unique, not only in illustrating the extent to which psychosis can manifest itself but also in illustrating the diagnostic challenges that such events can generate. While this patient clearly had a psychotic episode, he also had traits of an APD, and it remains unclear whether there was an antisocial element to his act. A case series of deliberate self-stabbings delineated 2 groups who committed this act: individuals suffering from psychosis and those with APD (5); however, a distinction cannot always be made. This case shows the need to take into account not only the illness present but also contributing psychosocial factors when a presentation is difficult to understand. In addition, one must be vigilant in assessing individuals at risk for SM to prevent further medical comorbidity, or even death.

References

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A Preliminary Report on Substance Use Patterns in an Adolescent Psychiatric Population

Dear Editor:

The prevalence of substance use among adolescents in Western countries is currently as high as 67.5%, with the age at first use being 12 to 14 years. The Ontario Student Drug Use Study (OSDUS), a 20-year prospective study, reported that 28.3% of high school students had used tobacco, 65.7% had used alcohol, and 29.2% had used cannabis. In addition, multisubstance use in this age group...
increased significantly (1). Despite several large-scale epidemiological studies, there remain unanswered questions pertaining to regional differences in the pattern of substance misuse among adolescents. Accurate information on the magnitude of this problem is crucial for allocation of limited resources.

In a pilot study, we gathered data on adolescents aged 12 to 18 years (minus 1 day) referred to inpatient and outpatient services at the Division of Child and Adolescent Psychiatry, Hotel Dieu Hospital, Kingston, Ontario. These patients had completed the substance use questionnaire (SUQ) appropriately and had given informed consent. We developed the SUQ based on the adult version. It includes questions about the patient’s sex and age, as well as about the frequency, quantity, and type of substance used (2,3). The SUQ also includes questions formulated from the DSM-IV criteria for substance abuse disorder and substance dependence disorder. To ensure that the patients understand the questionnaire, its language is consistent with Grade 8 reading level. The questionnaire was administered by the staff at the inpatient unit and (or) by the intake secretary in the outpatient service. A package including the informed consent form, the SUQ, and 2 envelopes was prepared for each patient. The patients were given information about the study and reassured of its anonymity. If, after reading the questionnaire, the patients decided to participate and were aged 16 years or over, they signed the consent form and completed the SUQ. The patients were younger than age 16 years, their legal guardian was required to sign the consent form before they participated. Upon completion, patients placed the questionnaires in separate envelopes, sealed them, and returned them to the staff.

Preliminary data on 15 adolescent psychiatric outpatients and 34 inpatients show a preponderance of adolescent girls in both groups. This can be explained by the overall higher rates of psychiatric admissions and outpatient clinic attendance for female patients. Further, our data show strong evidence of an association between alcohol and cigarettes, cannabis and cigarettes, and especially, alcohol and cannabis. The association of alcohol and cannabis is statistically significant in both in- and outpatient groups. At the time of writing this letter, we have gathered further data on the above population and added pediatrie outpatients as a comparison group.

The final analysis on all 3 clinical sample populations is in process and will be reported in the near future.

References

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Facialis Palsy Attributable to Depot Antipsychotic Therapy

Dear Editor:

Mrs A, a 42-year-old white woman with paranoid schizophrenia, was treated for 4 years with fluphenazine decanoate 25 mg intramuscularly (IM) every 4 weeks. Owing to mild depression, the medication was changed to zuclopenthixol decanoate 50 mg IM every 4 weeks. She did not receive any other drugs and had no extrapyramidal side effects (EPSEs). After 10 months of zuclopenthixol treatment, she complained of paresthesias on the right side of her face and numbness of the tongue. Clinically, we observed mild oral dyskinesia, and the zuclopenthixol was stopped. One month later, Mrs A presented with right-side peripheral facialis palsy that had occurred overnight after 3 weeks of continued paresthesias. The consultant neurologist found a right-side mandibular deviation without any other neurological signs. There were no signs of infection or other medical condition, and her EEG and CT scans were normal. Owing to suspected preexisting dystonia, biperiden 2 mg 3 times daily and clozapine 25 mg 3 times daily were prescribed; however, the palsy did not resolve. Three years later, the mandibular deviation was severe and caused marked facial asymmetry. Because we suspected tardive dystonia, botulinus toxin was injected into the right pterygoid muscle, with almost no effect. The procedure was not repeated. To date, 10 years later, the neurological condition is unchanged. Mrs A is currently taking olanzapine 20 mg daily and is in stable remission. She was referred to a maxillofacial surgeon, who found a spastic right facialis palsy. She refused the proposed extraction of all teeth and a corrective dental prosthesis.

To our knowledge, this is the first report of nerve palsy in a patient taking zuclopenthixol. Transient palsy has been reported after intoxication with several antipsychotics (1) or after drug-induced extrapyramidal rigidity (2). Our patient was taking relatively low dosages of antipsychotics without any EPSEs. In another case, dystonia presenting as Bell’s palsy (3) occurred in a patient after taking prochlorperazine and quickly resolved after taking diphenhydramine. Anticholinergics did not benefit our patient. Three cases of bilateral facialis palsy and 4 more cases of sensory neuropathy have been reported in perazine-treated patients after intensive sun exposure (4). Since the palsy occurred in our patient in November, sun exposure was not likely
Dear Editor:

Losing a significant person through death is a common experience. Recently, we conducted a study that examined the prevalence of death losses and complicated grief among psychiatric outpatients at 2 hospital clinics (1). We found that 55% of patients reported a death loss; of this group, 60% met criteria for complicated grief. These figures suggest that as many as one-third of the patients seen at outpatient clinics may meet criteria for complicated grief.

Although not recognized as a distinct disorder in the DSM-IV-TR (2), there is reasonable consensus in the field about what constitutes complicated grief. A person experiencing complicated grief often reports preoccupation with, yearning for, and searching for the deceased. Intrusive images, ideas, memories, or recurrent dreams or nightmares associated with the lost person are also frequently reported. Active avoidance of thoughts, communications, or actions associated with the loss are common. Despite the unpleasant nature of these symptoms, patients often seem reluctant to give them up.

The symptoms' debilitating effect often interferes with daily functioning—also a criterion for other disorders, most notably major depression. Despite their frequent comorbidity, we have demonstrated that complicated grief and depression can be clearly distinguished (3).

Clinicians must also be aware of the time since the loss. To avoid pathologizing a normal, acute bereavement response, experts suggest that symptoms must persist for several months after the loss before a diagnosis of complicated grief is considered.

Medical and psychiatric training often devote little time to the recognition of complicated grief. This may lead to its lack of detection. Identifying complicated grief is also made difficult by the fact that patients may not be aware of the causal connection between a significant loss and present difficulties. Therefore, clinicians must consider the etiology of symptoms as well as their phenomenology. This task can be assisted by familiarity with the factors placing individuals at risk for complicated grief and with the indications that the syndrome may be present.

Consistently reported risk factors include loss through suicide; loss of a child or partner; sudden, unexpected, or untimely deaths; lack of social support; and a problematic relationship with the deceased. One of the clearest indicators of complicated grief is the patient’s inability to speak about the loss with composure, even though a long time may have elapsed since the loss. Another indicator concerns anniversary reactions. The clinician may discover that the patient’s symptoms occur at specific dates or times of the year. Alternatively, despite the apparent importance of a loss, there may be a total absence of distress. The affect of the patient may change dramatically when the loss is further explored.

Several resources can help those who are having difficulty adjusting to a death loss. Referral is based on the severity of the individual’s maladjustment. For those with mild-to-moderate difficulties, community peer-support groups or counseling may be appropriate. For those with more severe difficulties, specialized psychiatric care may be required. Antidepressant medications have shown a modest effect on complicated grief symptoms (4), and group psychotherapy has been found to be highly effective (5).

References


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Recognizing Complicated Grief in Clinical Practice

Consistently reported risk factors include loss through suicide; loss of a child or partner; sudden, unexpected, or untimely deaths; lack of social support; and a problematic relationship with the deceased. One of the clearest indicators of complicated grief is the patient’s inability to speak about the loss with composure, even though a long time may have elapsed since the loss. Another indicator concerns anniversary reactions. The clinician may discover that the patient’s symptoms occur at specific dates or times of the year. Alternatively, despite the apparent importance of a loss, there may be a total absence of distress. The affect of the patient may change dramatically when the loss is further explored.

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References


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