Letters to the Editor

Re: Diogenes Syndrome in a Pair of Siblings

Dear Editor: We refer to the interesting letter from Dr Esposito and colleagues in France, describing 2 siblings who lived in severe domestic squalor (1). One was an unmarried woman, aged 61 years; the other was her brother, aged 58 years and suffering from a physical handicap. The authors state that Diogenes syndrome is rare in a pair of siblings and that the few reported cases of a pair living together all concerned married couples. We agree that the frequency of cases of severe domestic squalor encountered by health workers in the community is not reflected in a comparable number of reports in the medical literature. However, we are also aware of various reports that refer to cases wherein 2 or more persons were found to be living together in squalor.

We have identified at least 70 reported cases of 2 or more people mentioned or described as living together in a state of severe domestic squalor (references available on request). In research undertaken by one of us, 15 of 81 people living in squalid conditions shared their accommodation with other people (2). Among them were 5 couples and a family of 3, all of whom were included in the sample. Another of the 15 subjects was a mother whose son sometimes lived with her but was thought not to be responsible for much, if any, of the squalor. The 15th was a female home-owner who lived in severe squalor but whose boarding lived in a separate, and much cleaner, part of the house. With specific reference to siblings living together, we found 4 case reports in addition to 5 pairs of siblings mentioned in a series of cases of Diogenes Syndrome or severe domestic squalor. One case report is that of a man, aged 73 years, who was bedridden with severe arthritis and lived with his sister, aged 77 years (3,4). Another report concerned a single woman, aged 50 years, who suffered from mild developmental disability and lived in squalor in the downstairs rooms of a house she shared with her sister, who occupied the upstairs and thus (it is implied) mostly escaped the squalor (5). The case of 2 sisters who lived in a rural area in uninhabitable conditions and who resisted services or assistance has been described in Spanish (6). Perhaps most striking of all is the case of the “hermits of Harlem.” Granick and Zeman referred to these individuals in their research on 105 newspaper reports (published from 1942 to 1959) of aged recluses living in New York (7), and they were also referred to in lay accounts of the “strange and unusual” (8). The hermits were siblings living in a state of severe self-neglect. One was described as the brightest in his university class, and the other aspired to be a concert pianist and played at Carnegie Hall. The brothers became increasingly reclusive after the death of their mother. They stopped all utilities and refused to open mail or answer the door. After an attempted robbery of their house in 1938, they never left the house together again and lived in almost total isolation until 1947, when they were found dead. After their deaths, the house was found to be filthy and severely cluttered with boxes stacked from floor to ceiling. Almost 50 tons of debris were removed from it.

The question of how and why individuals come to live in a state of severe domestic squalor and social isolation is often puzzling. How and why 2 people can come to live in such conditions is doubly intriguing. The problem may not, however, be as uncommon as first appears.

References


Can J Psychiatry, Vol 50, No 9, August 2005
noticed simultaneous lingual dyskinetic movement, but this was only obvious after she opened her jaw widely. When we asked, she could suppress all these movements for a few seconds. Although she was aware of the movements, she had no difficulty in carrying out daily activities. Her Abnormal Involuntary Movements Scale score was 9. We replaced ziprasidone with aripiprazole 10 mg daily, which we gradually increased to 20 mg daily, with marked improvement in her finger and lingual TD (observed within 6 weeks of beginning aripiprazole therapy).

This patient’s typical antipsychotic–induced TD was ameliorated by clozapine treatment. Unfortunately, because Mrs S gained weight, we had to replace clozapine with risperidone. Subsequently, we withdrew risperidone because she developed galactorrhea. Mrs S never displayed any dyskinetic movements while taking risperidone. Dyskinetic movements did reappear, but in her other hand and only after she had been taking ziprasidone for 6 months. Since hypothyroidism is not documented in any literature as a risk or contributory factor, we can firmly say that Mrs S experienced ziprasidone-induced TD. In a previous case report of ziprasidone-associated TD, the patient had been taking ziprasidone for 4 months prior to the reappearance of TD and also had a history of typical antipsychotic–induced TD (4). Interestingly, ziprasidone acted as a prolactin-sparing agent in our case; however, it caused TD, which responded well to aripiprazole.

In conclusion, ziprasidone can induce TD, especially in those patients with schizoaffective disorder and a history of typical antipsychotic–induced TD.

References

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Re: Evaluation of a Children’s Temper-Taming Program

We are prompted to write a response to the recently published article by Williams and others (1). These authors describe a brief cognitive-behavioural intervention for young children with anger control difficulties (called kNOw Problem Pathway). This program consists of 8 weekly 1-hour sessions for the children and 3 sessions for their parents. Although the research design used in this study did not include random assignment, the authors were nonetheless able to offer convincing, statistically significant, pre- to posttest changes in the relevant measures.

The methods used in the kNOw Problem Pathway are very similar to a program that has been in place for nearly 20 years at the Child Development Institute (CDI, formerly Earlscool Child and Family Centre). Our program is named Stop Now and Plan (SNAP™, 2). Both programs rely heavily on, first, making children cognitively and physiologically aware of their emotional responses to situations that may trigger aggressive behaviour and, second, training them to respond effectively by making choices that will reduce their problems. Williams and others refer to this as “choosing it” over “losing it.” In SNAP™ this is referred to as the “critical moment” when children have the choice of making their problems smaller or bigger. In recent years, ongoing research at CDI has led us to conclude that better treatment effects can be demonstrated with sex-specific interventions. As such, we currently offer the Under 12 Outreach Program for boys in conflict with the law and the Girls Connection for girls with disruptive behaviour problems. We recognize that, although there are many similarities in the development of boyhood and girlhood aggression, differences that warrant our clinical and research attention also exist (see 3). Using standardized measures (for example, the Child Behavior Checklist; 4), we have been able to demonstrate significant pre- to posttreatment improvements for these multifaceted, family-focused interventions, with medium to large effect sizes (for example, 5 and 6). As well, our programs are manualized (for example, SNAP™ Children’s Group Manual; 7) and monitored for integrity of treatment delivery.

Williams and others are correct to point out that “longer term follow-up would help determine whether the reduction in anger and aggression is sustainable over time” (1, p 611). When we followed some 447 of our former boys and girls into adolescence and adulthood, we discovered that, our efforts notwithstanding, 41% were subsequently found guilty of a crime 10 years after completing the program. Unfortunately, we do not know what proportion of individuals subsequently received care in the civil or forensic mental health systems. Williams and others’ paper adds impetus to the challenge of evaluating the effectiveness of these kinds of interventions over the long term (1). What is encouraging is that impulse-control programs like the kNOw Problem Pathway and SNAP™ are now sufficiently well-defined to be researched. Continuous evaluation and rigorous research on the risk factors that predict antisocial outcomes will assist in the targeting of children and families who will most likely benefit from these and other interventions.

References

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Reply: Evaluation of a Children’s Temper-Taming Program

Dear Editor: We wish to thank Ms Augimeri and colleagues for their letter in response to Williams and others (1).

We are aware of the SNAP™ program used at the Child Development Institute; we agree that many of the strategies used to make children aware of the link between thoughts (cognitions), feelings, physiologic sensations, and behaviour, together with strategies to further help them use this knowledge to make better choices about their behaviour, are similar between programs. Several researchers have shown that these cognitive-behavioural strategies help to decrease aggressive behaviours (2–4). Both programs are also manualized, which allows consistent training of others and replication of the intervention with integrity across sites and time.

There are several notable differences between the programs as well, as Ms Augimeri points out. We did not run the clinic-based groups described in our paper as sex-specific groups. Within our clinic, the referral rate to these temper-taming groups is greater for boys than for girls, as evidenced by the enrolment in the groups reported in our article (46 boys and 10 girls). It would be easy to run boys-only groups; however, the lower referral rate for girls makes it impossible to assemble all-girl groups and still offer timely service. As we continue to learn more about the similarities and differences in the development of aggression in girls and boys, clinical services may also move toward adopting sex-specific groups.

The other notable difference is in the process of program referral. The groups described in the paper were run through our outpatient children’s mental health service and only included clinician referrals for children and families being seen within the clinic. The Earlscount Under 12 Outreach Program accepts referrals more broadly. Only about 1 of every 6 children with emotional-behavioural problems reaches an outpatient mental health service for assessment and treatment (5), owing to limited availability and inaccessibility of services and high opportunity costs to families (6–8). Many children and families who might benefit from specialized services remain in the community. It is important to provide clinical services that have been evaluated and have shown positive effects, such as the clinical Temper-Taming Program, to clinical children and their families. Community-based services such as the Under 12 Outreach Program, which allow participation without accessing clinical services, have the opportunity to serve a greater number of children and families in need.

Recognizing the importance of this issue, we have adapted and expanded the clinical Temper-Taming Program and have been providing it as a community-based program in Hamilton. It is part of a research study with rigorous evaluation methods—a randomized controlled trial (RCT) funded by the Ontario Mental Health Foundation. Our preliminary results are based on 99/123 pregroup–postgroup evaluations of children and families enrolled in the RCT (that is, 80.5% of the total sample). These preliminary results show that group participation has positive effects on parent-rated child aggression, parent–child relationships, and parenting stress, with small effect sizes. These results suggest that the adaptation of the clinical temper-taming groups provides an effective community-based intervention program.

We agree with Augimeri and colleagues that well-defined, manualized group programs with evidence for effectiveness and with potential to be replicated in other sites are critical to providing a clear, evidence-based intervention for the population of children with aggressive behaviours.

References


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agree with Paykel that the DSM-IV “assigns separate unjustified categories of medical and substance-induced mood disorders” (4, p 95) At the very least, excluding persons with such comorbidity, which is commonly seen in clinical practice, would result in an appreciable underestimate of depression. In this regard, it is of interest that the CIDI even excludes pregnancy as a physical condition that can cause symptoms, although it is reassuring that the probe guidelines acknowledge that pregnancy is not a physical illness!

The exclusion of those who consider their symptoms to be trivial risks the omission of those who tend to deny the significance of their symptomatology and who have poor mental health literacy. Indeed, data exist demonstrating that the mental health literacy of those in the community who have major depression is no more conducive to identifying depression and recommending its treatment than it is for those without depression (5); therefore, to exclude those who believe their symptoms are trivial is not necessarily a strategy based on existing evidence.

Excluding those who have sought treatment but who have not taken medication more than once may also lead to underestimates of depression prevalence. Poor mental health literacy and the presence of side effects that may mitigate against medication use are but 2 reasons why this criterion might exclude those with depression.

We doubt whether many researchers, let alone the average clinician or health planner, are aware of this potential for both the CIDI and the DIS to underestimate the prevalence of depression and its burden on the community (6).

References


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