LETTERS TO THE EDITOR

Re: The Neurobiology, Neuropharmacology, and Pharmacologic Treatment of Paraphilias and Compulsive Sexual Behaviour

Dear Editor:

Dr Bradford recently reviewed the pharmacologic treatment of the paraphilias and compulsive sexual behaviour (1). As a recognized expert in forensic psychiatry and an opinion leader he is potentially an important agent in changing physician practices and patient outcomes (2). Therefore, we believe it is imperative that Dr Bradford’s recommendations be based on the best available empirical evidence, if they are to do more good than harm.

To support his algorithm for the treatment of paraphilias Dr Bradford reviewed selected clinical studies, briefly describing some of them (1). There is a relatively high risk that narrative reviews of this type will be tenuous, incomplete, or, worse still, based on biased study selection and citation. As well, they may advocate therapy even after it has been shown to be useless or harmful (3–6).

To allow clinicians to employ them confidently treatment recommendations should, whenever possible, be based on 3 elements: empirical evidence from a systematic review, an examination of the evidence’s strength, and explicit specification of values or preferences associated with outcomes (7). Dr Bradford’s review fulfilled none of these methodological requirements.

Clinician confidence in Dr Bradford’s recommendations must be undermined by the fact that his review does not include the methodologically robust metaanalysis by White and others (8). The objective of this metaanalysis was to determine the effectiveness of therapies to assist people who have sexual preference disorders and those who have been convicted of sexual offences. A comprehensive search of the world literature in August 1998 identified only a single randomized controlled trial of antirelational medication that met methodological criteria intended to minimize bias. This trial found that medroxyprogesterone (MPA) together with imaginal desensitization was no better than imaginal desensitization alone for problematic or anomalous sexual behaviour and desire (9). Yet, Dr Bradford did not cite this trial or any original study published after 1998.

White and colleagues reported, “At present there are so few data to either support or refute the use of antirelational drugs, such as medroxyprogesterone, that it is difficult to justify their use outside of a well-conducted trial.” This statement contrasts with Dr Bradford’s suggestion that “clinical studies show that MPA has a significant impact on deviant sexual fantasies and deviant sexual urges and behaviour.”

Clinicians are left with less confidence in Dr Bradford’s recommendations than might have been the case had they been derived from a review process that was less prone to bias. We think clinicians should use antirelational drug treatments with caution.

Sex offenders are often under intense pressure to comply with clinical treatment recommendations, regardless of the weight of evidence (or lack thereof) supporting the recommended treatment. As such, we believe researchers must be methodologically rigorous in studying their treatment. Clinicians carry a heavy ethical responsibility to evaluate carefully the evidence supporting any treatment they recommend to these patients. False confidence in treatments for sex offenders can result in harm, not only to the patients but also to those whom we would most wish to protect.

References


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Open-Label Risperidone Treatment of 6 Children and Adolescents With Autism

Dear Editor:

Autistic disorder is a pervasive developmental disorder characterized by impaired reciprocal social interaction, communication skills, and imaginative activity. No effective pharmacologic strategies have been developed for treatment of its core symptoms. Nevertheless, pharmacotherapy is an important treatment modality and often part of a comprehensive therapeutic program.
An imbalance in the serotonergic neurotransmitter system may underlie aspects of the pathology observed in autistic patients (1). Risperidone, an atypical antipsychotic that is both a serotonin and dopamine antagonist, has been shown to treat adults with autism effectively (2). Studies have shown that risperidone also improves symptoms in several psychiatric disorders of older children and adolescents (3–5). In this letter, we describe its use for treating children with autism. Our sample consisted of 9 subjects with a DSM-IV diagnosis of autistic disorder (7 males and 2 females; median age 7.1 yrs, range 3.4 to 13.4 yrs). Screening procedures included medical history, physical and neurological examinations, complete blood count, electrolytes, glucose, serum urea nitrogen, creatinine, liver function, urinalysis, ECG, EEG, and auditory evoked potentials. Patients were drug-free for at least 4 weeks before the beginning of the trial. No other psychoactive medication was given during the study.

The subjects underwent a 12-month trial. Risperidone was started at 0.5 mg daily and titrated upward to a maximum of 3 mg daily.

Behavioural ratings were carried out at baseline and at fixed intervals (3, 6, and 12 months). The following instruments were employed: Clinical Global Impression (CGI) (6), Behavioural Summarized Evaluation Scale (BSE) (7), and Vineland Social Maturity Scale (VSMS) (8).

Most of the screening tests, including complete blood count, liver function, electrolytes, glucose, serum urea nitrogen, creatinine, urinalysis, and ECG, were also performed 3 times during the study (at 3, 6, and 12 months). Blood pressure was monitored during the first days of the trial. Side effects were evaluated using the Extrapyramidal Symptoms Rating Scale (ESRS) (9).

Three patients were withdrawn from the study due to family noncompliance, and 6 subjects completed the whole trial.

All parents reported some behavioural improvement, such as increased awareness and social interaction, as well as decreased self-abuse, irritability, hyperactivity, and sleep disturbance.

Five of the 6 risperidone-treated patients were categorized as responders on the basis of the CGI Scale. The Wilcoxon signed-rank test showed that the decrease in the total BSE score between baseline and month 12 was statistically significant (P = 0.03). No significant changes were noted using the VSMS.

Untoward effects included mild sedation (2 cases) and weight gain (1 case). One of the patients experienced an epileptic seizure 6 months after starting risperidone therapy. Liver function tests, EGG, and other laboratory studies remained within normal limits. Blood pressure did not vary from normal values.

Our study showed that risperidone was able to reduce self-abuse, aggression, and hyperactivity in autistic children. The obvious factors hampering its generalization include the small number of patients, the unblinded nature, and the lack of control groups. Controlled research is needed to further evaluate the efficacy of risperidone in treating autism.

References

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Bupropion and Drug-Induced Parkinsonism

Dear Editor:

I report the case of a 48-year-old male physician who presented with a major depressive episode (MDE). He had suffered with seasonal affective disorder (SAD) for several years. He described himself as always having been obsessional and perfectionistic.

Initially, he had responded positively to citalopram at a dosage of 20 mg daily, although he had experienced significant sexual side effects and a withdrawal syndrome when he discontinued it. There is a positive family history of depressive illness in his mother postmenopause, requiring hospitalization and responsive to medication management. His 18-year-old son also presented with depressive illness at the same time as the father and initially responded positively to bupropion (Wellbutrin).

Major depression was evident in clinical interview, with self-report, Beck Depression Inventory (BDI), and the Hospital Anxiety and Depression and (HAD) Scale showing moderately severe depression with associated anxiety. The patient was taking beta blockers for essential hypertension, which was well controlled. He had self-medicated with nefazodone at doses up to 200 mg daily, with little evident benefit apart from improved sleep pattern. When he was next assessed, the depressive affect was more significant. Bupropion SR was added at a dosage of 150 mg daily, with some clonazepam as needed for breakthrough panic. Clinical improvement in
depression was evident within 8 weeks, as reported by the patient and his family and as observed in interview.

At 12 weeks, the patient complained of tremor, nausea, micrographia, and shuffling gait. These symptoms had emerged within 10 weeks of the initial bupropion prescription. He discontinued the bupropion and the symptoms resolved over 10 days. The depression worsened, however, as the extrapyramidal symptoms resolved. Attempts at reintroducing the bupropion at lower doses were unsuccessful, and the patient now continues on nefazodone plus fluoxetine, with the addition of light treatment, with significant clinical improvement.

A review of the literature from the Drug Information Service showed 2 case reports of reversible orofacial dyskinesia affecting the eyes and tongue in a 70-year-old woman receiving bupropion at doses from 75 to 225 mg daily. Other symptoms included hand tremor, nausea, and dizziness. After discontinuation, the dyskinesia receded, and other side effects disappeared.

Two other geriatric patients (aged 85 and 72 years) were treated with bupropion for major depression and experienced a “falling backward” reaction. Maximum dosages in each patient were up to 400 mg and 350 mg daily, respectively. Neither patient had a history of orthostatic hypotension or vertigo. Both did manifest other symptoms consistent with parkinsonian syndrome (for example, akinesia and shuffling gait). After bupropion was discontinued, these adverse effects resolved within 1 to 2 weeks.

The literature suggests that at therapeutic doses bupropion exhibits dopamine-agonist effects, and at high doses it may have a dopamine-antagonist effect. The manufacturer does have some case reports pre- and postmarketing of parkinsonian-type side effects, but no causal relation has yet been established.

There was 1 report of a 53-year-old patient who had a dystonic reaction with nefazodone 2 hours after the first dose. This patient’s chief complaint was lip smacking, with hand and arm gesturing. The symptoms resolved within 1 hour in response to diphenhydramine and benztrapine. The Drug Information search did not yield any kinetic interactions between nefazodone and bupropion that might have resulted in a further increase in bupropion serum levels. There was no family history of neurological disorder or Parkinson’s disease in this patient.

References

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Re: Training Residents for Community Psychiatric Practice—The Resident Perspective

Dear Editor:

It is encouraging to see further study of community psychiatric practice (1). Dr Freedland and others state, “it would seem unlikely that community psychiatry electives would be popular at the PGY5 stage of training,” but I would like to provide a different experience.

For the last 3 years, the multispecialty community training network at the University of Western Ontario has, under the directorship of Dr James Rourke, offered elective community psychiatric experience in rural practice. The elective is offered in all years of training. To date, 3 residents, all at the PGY5 level, have used this opportunity to complete a 3- to 6-month rotation. In follow-up, all residents indicated that this training experience was most appropriate for PGY4 and PGY5 residents. One resident has subsequently gone on to practise in rural community psychiatry, despite no prior career preference. All residents indicated a positive experience with the elective.

These data, although obviously limited, support offering community psychiatric electives to all stages of training in an effort to encourage a career choice in this needed area.

Metamorphosis of Delusion of Pregnancy

Dear Editor:

Delusion of pregnancy has been described in a wide range of psychiatric conditions. It has been confused with, and, for appropriate treatment, needs to be differentiated from, pseudocyesis, simulated pregnancy, pseudopregnancy, and couvade syndrome (1). While pseudocyesis is a somatoform symptom, delusion of pregnancy is a psychotic symptom, necessitating antipsychotic medication with resulting side effects (such as amenorrhea and galactorrhea) that make this distinction difficult. The following case report discusses many pertinent issues regarding the evolution of delusion of pregnancy.

Case Report

Ms A, aged 33 years, single, educated, and with a family history of chronic mental illness, presented to our psychiatric hospital with complaints of abnormal behaviour and 3 generalized seizures. Her history included a psychotic episode that had remitted partially with treatment. During this past psychotic episode, she had cancelled her
engagement, casting aspersions on her fiance's intentions, and was irritable and abusive. She harboured persecutory and referential delusions, including the delusion of being controlled and the delusion of love with a film actor. She believed that she was pregnant and already had 2 children. On treatment with haloperidol (20 mg daily) combined with carbamazepine (600 mg daily) she improved, except for negative symptoms. She later discontinued haloperidol, experienced a recurrence, and was rehospitalized. She had a delusion that, in her previous birth, she was the wife of the Hindu god Lord Rama, as well as a delusion of 7 years' pregnancy. She believed she had had Rama's child, and she had auditory hallucinations from the womb. She also had delusions that she was being controlled through hypnotism, that her hair was being transplanted with another person's hair, and that her brother wanted to have a sexual relationship with her. She had auditory hallucinations about ladies commenting about her and abusing her. Her sleep and appetite were disturbed. She was diagnosed as suffering with paranoid schizophrenia.

Her brain scan, EEG, and routine biochemical parameters were normal. The response to risperidone (6 to 8 mg daily), electroconvulsive therapy (ECT), and flupenthixol (40 mg fortnightly) for adequate duration was poor. Hence, she was given pimozide (up to 8 mg daily). Within 1 week of starting pimozide, the duration of her "pregnancy" gradually lessened from 7 years to 5, 4, and 3 years. Finally, 2 months later, she had only an overvalued idea related to pregnancy. She was reported to be slightly withdrawn, occasionally irritable, and to be helping with household work.

The interesting aspects of this case are its metamorphosis in terms of the evolution, development, maintenance, and gradual remission of the delusion of pregnancy in response to pimozide treatment (2). The role of cultural factors in psychopathology also become clear, considering that Lord Rama's wife gave birth to her sons after he deserted her. The delusion in this case might be restitutive in the face of the patient's extreme insecurity as a spinster and following loss of a love object. Similarly, it might have a metaphorical wish-fulfillment function or satisfy the "procreative imperative" for women from her socio-economic background in the Indian society.

References


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Home Visits From an Outpatient Psychiatric Clinic

Dear Editor:

State psychiatric clinics in Israel are open to the public, enabling direct access to mental health care. Patients and their families, general practitioners, and non-medical agencies can request an intervention from a mental health team. Home visits are provided as part of everyday care, usually in emergencies.

We report an evaluation of 89 home visits performed by our staff in response to emergency calls. We recorded from patients' files the chief complaint, source of request, diagnosis, visit outcome, and professionals involved. Ages ranged from 18 to 87 years (mean 50.9, SD 18.61). Fifty (56%) patients were women, and 39 (44%) were men. The chief complaint was aggressive behaviour (52% of cases), with psychotic symptoms in 25%, suicidal threats in 13%, and "other" in 11%. Forty-five percent of calls came from family members, 26% from welfare departments, and 19% from general practitioners. Only 5% of calls came from patients. These rates contrasted with other reports (1).

Diagnoses were primary psychotic illness in 49% of the visits, organic mental disorders in 24%, personality disorders in 16%, and primary mood disorders in 11%. Physicians (either residents or specialists in psychiatry) and nurses carried out most of the visits. In 55% of the visits, subjects agreed to come voluntarily to the clinic for further assessment and treatment. In 45%, the subjects' judgment was impaired or they posed a danger to themselves or others, and a compulsory intervention according to the Israeli Mental Health Act was requested from judicial authorities. An interesting finding is that when a specialist in psychiatry was in charge of the visit (n = 33, 37%) only 25% of the visits ended with a request for a compulsory intervention. This contrasted with cases evaluated by residents in psychiatry and other professionals, in which there was an increased trend for requesting compulsory interventions. Although it is not clear exactly why there were fewer requests for compulsory interventions when visits were performed by specialists, we think that this outcome deserves more attention and further research. With community-based treatments, a delicate equilibrium exists between overcrowded clinics (with the consequent need for specialists in psychiatry to be available for consultation and treatment) and the need for less restrictive interventions that may, in turn, add to the demands made on usually overburdened clinicians.

Altered behaviour is a reason for emergency psychiatric assessment (2). Of course, what is of interest is the extent to which altered behaviour is a manifestation of a treatable mental illness. In this report, altered behaviour was recorded as the chief complaint in about one-half of the cases, and psychotic complaints in one-quarter of them. Actually, however, at least three-quarters of the subjects...
suffered from a psychiatric disorder, and it seems that in-home visits were justified.

Allowing direct access by community agencies and the public may impose a great strain on community mental health centres. Nevertheless, this approach allows practitioners to reach more patients. We call for more research in this area of community psychiatry, combining quantitative and qualitative methodologies.

References

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Clinical Characteristics of Delusional Disorder

Dear Editor:

Some patients with psychosis occurring in later years, but without psychogenic psychoses or brain diseases such as Alzheimer's disease and vascular dementia, have systematized delusions but are still able to maintain a good quality of life. These patients have a disease described as a delusional disorder or late-onset paraphrenia.

We report a study investigating the clinical characteristics and the CT brain scan findings in 13 patients over age 65 years suffering from delusional disorder.

Diagnosis was based on the ICD-10 classification. The 13 age-matched subjects who visited the hospitals for physical examination complained of headache and insomnia. They were still able to maintain a good quality of life and had no exogenous diseases.

We evaluated the details of the patients' hallucinations and delusions, their visual or hearing impairments, and their prognoses. To evaluate the rate of atrophy or enlargement in the 2 sides of the brain, the regions of interest were divided into left and right frontoparietal lobe, internal areas of the temporal lobe, the anterior horn of the lateral ventricles, the frontal lobe, and Sylvian fissures. They were measured by NIH Image computer software (W Rasband, National Institutes of Health, Bethesda[MD]. Version 1.58).

Clinical characteristics were as follows: 5 patients had visual or tactile hallucinations, 11 patients had delusions of injury, 2 had delusions of observation, and 1 had descent delusion. Ten patients had visual or hearing impairments. During monitoring, it was found that 2 patients progressed to dementia within 4 years, 2 patients could not be followed up, 1 patient died of pneumonia, and continuous delusional disorder persisted in 8 patients.

There were significant differences in the degree of atrophy of both sides of the frontoparietal lobe. There were, however, no significant differences between the 2 groups relative to the other brain areas.

In previous studies of late-onset paraphrenia, various risk factors, such as female sex, deafness, loss of vision, and living alone were identified (1). In this study, all patients were women and many patients (76.92%) had visual or hearing impairments. Concerning the literature on CT findings on delusional disorder, Flint (2) found that the paraphrenia group had significantly more clinically unsuspected (silent) cerebral infarctions, and all affected patients had subcortical or fronto-lobe infarctions, with 1 patient also having a parietal-occipital infarct (2). Our CT data, however, show that delusional disorder is associated with frontoparietal atrophy.

From the above results, we suggest that delusional disorder is associated with such factors as sex, audiovisual dysfunctions, and frontoparietal impairment.

References

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Sexual Aversion Disorder Treated With Behavioural Desensitization

Dear Editor:

Sexual aversion disorder is a sexual dysfunction characterized by an aversion to genital contact (1,2), unwillingness to have sex, and avoidance of communication or touching that may lead to sex (3). There is little written about sexual aversion disorder (4), and it is generally considered to be difficult to treat (3). I report here the case of a patient with a global, lifelong sexual aversion disorder that responded surprisingly well to a behavioural approach.

Case Report
When I first met Ms G, a 30-year-old white woman, she had been married for 5. She and her husband had never consummated their marriage. Both partners described a loving relationship and described themselves as "shy and conservative." They both were virgins, and she stated she was not fearful of sexuality or a sexual relationship. There was no history of sexual abuse, assault, or rape, and no issues around sexual orientation. Ms G had never experienced orgasm, even during sleep, and had never
masturbated. She enjoyed kissing and cuddling, but was unable to, or allow her husband to, proceed further. She suffered from recurrent major depressive disorder. At the time of assessment, she was suffering from a depressive episode of 1½ years duration only partially treated with nefazodone (Serzone 200) mg twice daily.

Of note was a history of food aversion as a young child, with ongoing difficulties with new foods, which had to be introduced very slowly in combination with established foods. She had seen a sexual counsellor on 15 occasions in the past, which had helped her and her husband develop comfort with nudity and holding.

Ms G desired a pregnancy and so was very motivated for treatment. The treatment plan included switching to Paroxetine (Paxil), which more effectively treated her depression. Simultaneously, 2 behavioural desensitization hierarchies were drawn up, with practical steps leading to increased sexual intimacy. One hierarchy dealt with increasing her comfort in exploring her own body, and the other develop with partner relations. Over the next 5½ months, I saw Ms G for a total of 8 sessions, several of which included her husband. She made steady progress, and within that time she was able to obtain orgasm by masturbation, consummate her marriage, and become pregnant. The couple were able to maintain sexual intimacy throughout the pregnancy and postpartum.

This case illustrates a very good outcome using a behavioural therapy approach that was relatively quick and had required infrequent single-therapist contacts (about every 2 to 4 weeks). The literature favours a behavioural therapy approach (4–6), but with 1 or 2 therapists, and frequent sessions of daily to twice-weekly meetings (5). Moreover, the literature suggests a poor prognosis for sexual aversion disorder especially, as in this case, when it is global, lifelong, associated with depression, and associated with anorgasmia (3). Factors contributing to a favourable outcome in this case include a positive spousal relationship, high motivation, lack of a history of sexual trauma, and direct involvement of the patient in creating and revising the hierarchies.

Perhaps further studies on sexual aversion disorder would bear out some of the observations made here. There may be a subgroup of patients with primary sexual aversion disorder who respond very well to relatively little intervention.

References

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