July 2014

Cannabis abuse and THC content are on the rise

The authors of the July 2014 Residents' Voices article (What we ought to talk about when we're talking about decriminalizing *Cannabis*, Current Psychiatry, July 2014, p. 45-46 [http://bit.ly/1uAb7iK]) highlight the mental health complications of *Cannabis* and mention that, when *Cannabis* is juxtaposed with other illicit substances, it appears innocuous.

On the contrary: Data from the 2011 Drug Abuse Warning Network highlighted the rising involvement of *Cannabis* in emergency department (ED) visits. The report indicated that of the 1,252,500 ED visits involving illicit drugs in 2011, the most common illicit drug involved was cocaine, which accounted for 505,224 ED visits, with *Cannabis* a close second at 455,668 visits—not including synthetic cannabinoids, which came in fifth, with 28,531 ED visits.[1]

Another useful point to buttress the concerns raised by the authors is that the potency of delta-9-tetrahydrocannabinol (THC), the primary psychoactive ingredient in *Cannabis*, has increased gradually over the years. The University of Mississippi Potency Monitoring Project, a National Institute on Drug Abuse–funded landmark project that studied samples of *Cannabis* confiscated by law enforcement in the United States between 1993 and 2008, revealed that the mean THC content increased from 3.4% in 1993, to 8.8% in 2008.[2] The THC content of *Cannabis* is responsible for most of its psychoactive effects, so that the higher the THC content, the greater the adverse effects on mental health.

A major phytocannabinoid, cannabidiol (CBD), also present in *Cannabis*, appears to counteract the adverse effects of THC, particularly by means of its antipsychotic property. Compared with the rising mean THC content of *Cannabis* from 1993 to 2008, CBD content has remained relatively the same: a mean of 0.3% in 1993 and 0.4% in 2008.[3,4]

Several factors have been postulated for the trend toward a high THC–low CBD profile in recent years: cultivation methods, the preference for cultivating seedless female plants (*sinsemilla*) that tend to have a high THC content, and global availability of seeds over the Internet. The high THC–low CBD profile has been linked to an increased risk of *Cannabis* dependence and increased treatment-seeking for *Cannabis*-related problems.[3]

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Research for 'Rx: *Cannabis*' is needed

Regarding the essay by Drs. Gershan and Gangahar on decriminalization of *Cannabis*, I want to comment on issues surrounding prescription *Cannabis*.

It is clear that *Cannabis* can exacerbate psychosis, among other risks, but its potential benefits remain relatively unexplored. The authors correctly point out that, among indications for *Cannabis*, none are FDA-approved. Yet, because off-label prescribing is pervasive and accepted in psychiatry, lack of FDA approval of indications for Cannabis is not an especially compelling argument against such prescribing.

Lack of research and funding hampers efforts to conduct trials of the therapeutic value of *Cannabis*, as does its Schedule I status (ie, "no currently accepted medical use and a high potential for abuse" [language of the Controlled Substances Act]). There are reports of benefit in intractable epilepsy and posttraumatic stress disorder (PTSD) that merit further inves-

continued

tigation; however, such research is hampered, I believe, by bureaucracy. For example, an approved study at the University of Arizona of the use of *Cannabis* to treat PTSD has remained in regulatory limbo for longer than 4 years because of the immense hurdles involved in performing research on this substance—despite how pressing such research is, given the large number of veterans returning from active duty with this diagnosis and the paucity of treatment options.

Perhaps, there also is something "missing" in the debate about research into *Cannabis*.

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The 'decline' of psychoanalysis

There are many interesting aspects of Dr. Nasrallah's review of the changes in psychiatry in recent decades (Post-World War II psychiatry: 70 years of momentous change, Current Psychiatry, From the Editor, July 2014, p. 21-22, 49-50 [http://bit.ly/1m8HcdC]). There is no doubt that great strides have been made, particularly in the care of the more seriously ill, and that those accomplishments owe a good deal to the introduction of psychoactive agents.

However, his reference to the "decline" of psychoanalysis was unfortunate and a gratuitous insult to those of us who continue to practice psychoanalysis and who recognize how much psychoanalytic thinking has contributed to the psychotherapeutic practices of non-analyst psychiatrists. If by *decline* he means that patients who once were in analysis now are being treated with medication alone, he is correct. That might not always be in the best interest of patients, but it is a fact. If by *decline* he means that in *all* instances *all* patients benefit more from pills than they would from analysis, his viewpoint is derived from misinformation.

Since academic psychiatry and psychiatric publications became wholly owned subsidiaries of the pharmaceutical industry, this dismissive attitude about psychoanalysis has attained the status of established wisdom. Psychoanalysts understand that one size does not fit all, no single treatment is the best choice for all patients, and medications can be of great value. Why can't psychopharmacologists show a similar respect for psychoanalysis?

Charles Goodstein, MD
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Dr. Nasrallah responds

Thank you, Dr. Goodstein, for expressing your view about my editorial. However, it is unfair to describe the editorial as being dismissive and insulting toward psychoanalysts. I was simply stating undeniable historical facts about the evolution of psychiatry—one aspect was the reduced prevalence and influence of psychoanalysis over the past few decades, which was partially because of the advent of pharmacotherapy. The other reason was the emergence of other psychotherapies, such as cognitive-behavioral therapy, interpersonal psychotherapy, and dialectical behavior therapy, which are evidence-based, shorter in duration, and more cost effective.

Psychoanalysis remains an important component of contemporary psychiatry, albeit limited to a smaller subgroup of patients.

In my residency, I was heavily trained in psychodynamic therapy, and many of my supervisors were psychoanalysts. I developed my neuroscience skills in a post-residency fellowship at the National Institutes of Health. Nowadays, residency programs must provide both psychotherapeutic and psychopharmacologic training to psychiatric residents.

Your statement that medications have replaced psychotherapy is inaccurate. We train our residents to provide each outpatient with both pharmacotherapy (when indicated) side-by-side with psychotherapy—whether supportive, psychoeducational, psychodynamic, or cognitive-behavioral therapy, or a combination thereof. I continually warn residents about reducing psychiatric care to giving pills, which would be a travesty.

In addition, I regard psychotherapy as a neurobiological intervention because it modifies brain connectivity and neuroplasticity (see my December 2013 Editorial, "Repositioning psychotherapy as neurobiological intervention," available at CurrentPsychiatry.com).

Last, I wish you would not insult academic psychiatry as being a "wholly owned subsidiary of the pharmaceutical industry." Someone must develop new and better treatments for serious psychiatric brain disorders. The only entities dedicated to doing that, in the United States, are the pharmaceutical industry and the academic psychopharmacology experts. Together, they generate new ideas and develop innovative mechanisms of action and test them in controlled clinical trials to treat disabling mental disorders. It is not fair to impugn the integrity of academic psychiatrists when they are doing what they were trained to do. They have the integrity and objectivity to criticize the industry when necessary. (See page 50 of my editorial under the subheading "Pharmaceutical industry debacle.")

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Why partner with clinical pharmacists?

While reading the "Opportunities to partner with clinical pharmacists in ambulatory care" (Current Psychiatry, Evidence-Based Reviews, July 2014, p. 23-29 [http://bit.ly/1s3yqmh], I became puzzled. Several times, I asked myself, "As a psychiatrist reasonably well-trained in psychopharmacology, why would I need or want to partner with a clinical pharmacist in this fashion?" Indeed, I was under the impression that this is what I trained to do. It called to mind a bumper sticker from the feminist movement of the 1960s that read, "A woman without a man is like a fish without a bicycle." It then occurred to me that a psychiatrist without a clinical pharmacist would find himself or herself in that same lamentable position.

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This month's instantpoll

Mr. B, age 29, with a history of bipolar manic episodes, has started a new job—the second in a month. He has outbursts of energy, appears distracted and exhausted, and is visibly agitated. He denies suicidal ideation and psychotic symptoms. You recommend inpatient treatment, but he refuses. **How would you manage Mr. B as an outpatient?**

- ☐ Obtain blood work and prescribe an antipsychotic
- ☐ Refer him to another provider
- ☐ Agree to treat him, but discuss situations in which he must consent to inpatient treatment
- ☐ Encourage him to quit his job so that he can focus on being treated

See **"Treating bipolar mania in the outpatient setting: Risk vs reward,"** *pages 38-46*

Visit CurrentPsychiatry.com to answer the Instant Poll and see how your colleagues responded. Click on "Have more to say?" to comment.

SEPTEMBER POLL RESULTS

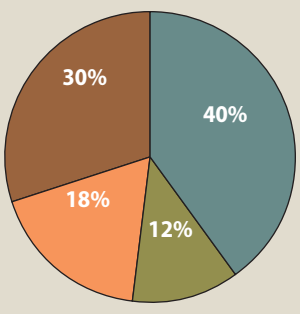
Mr. D, age 40, is admitted to the hospital after a friend finds him overdosing on methamphetamine after a 4-day binge. After 2 weeks, he reports feeling depressed since he began withdrawal. **How would you treat Mr. D's methamphetamine withdrawal?**

40% Monitor Mr. D's depressive symptoms and prescribe an antidepressant if his symptoms persist

12% Add a course of cognitive-behavioral therapy

18% Begin dextroamphetamine, 60 mg/d, to reduce his withdrawal symptoms

30% Prescribe an antidepressant and transfer Mr. D to a residential treatment program



SUGGESTED READING:
Ling W, Mooney L, Haglund M. Current Psychiatry. 2014;13(9):36-42, 44.

Data obtained via CurrentPsychiatry.com, September 2014