Psychiatric Bulletin (1989), **13**, 148–150

Correspondence

'Cannabis psychosis'

DEAR SIRS

The recent report on 'cannabis psychosis' (Littlewood, *Psychiatric Bulletin*, **12**, 486–488) and psychiatrists' conceptualisations of this challenged its validity and specificity as a diagnosis. The concern expressed by black community groups was that "whatever the psychiatric consequences of cannabis might be, cannabis psychosis was a particularly broad term which was being employed in situations where psychiatrists had not taken enough time to understand the social antecedents of personal crises". It is acknowledged that some in the Carribean community share the belief that 'cannabis use can precipitate psychiatric illness'.

We would like to present a case which adds a further dimension to the debate – the notion that the 'cannabis psychosis' label may be less stigmatising and painful to patients than recognition that they may have a serious chronic mental illness.

The patient, Mr J., is a 25 year-old single black male. He is unemployed and lives with his parents. His father is a building labourer and very strict with the whole family. His mother has a long history of schizophrenia with bizarre speech, behaviour and self-neglect. She is cared for by the father and has refused medication consistently. He has four siblings of whom the eldest sister has a history of a single psychotic episode.

The patient has one daughter aged 3, cared for by his girlfriend. His first presentation was in 1982 with mutism, bizarre behaviour, second and third person auditory hallucinations. Cannabis screen was negative. Since then he has had bizarre behaviour including undressing in public, eating lighted cigarettes and smearing himself with faeces. He exhibits thought disordered speech and auditory hallucinations with bizarre delusions.

Cannabis screens performed following admissions have been consistently negative. Some between admissions have been positive. During an admission this year the patient and family claimed he had smoked cannabis, which had precipitated the severe relapse. On this occasion the cannabis screen taken under supervision was negative. When told the result, both patient and family adhered to the belief that cannabis was the main precipitant. It became clear that they were avoiding admitting the severity of the illness and the need for long-term prophylaxis. Indeed follow-up and treatment of this patient continues to be extremely difficult.

The contribution of cannabis to psychotic reactions remains controversial. Psychiatrists should bear this in mind as they may unfortunately collude with aetiological explanations that impede long-term follow-up and treatment.

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DEAR SIRS

Dr Littlewood makes an interesting and persuasive argument for "community initiated research" (*Psychiatric Bulletin*, November 1988, **12**, 486–488). The results of his study support this approach to research by virtue of their significant contribution to the continuing debate on "cannabis psychosis". However, there appear to be inconsistencies between the ideological stance taken and the final presentation of this study.

Dr Littlewood talks of "collaboration" with black and ethnic minorities in research into "transcultural" psychiatry. He refers to his own project as being "initiated by black community groups". Why then, does only his name, and not also that of one of his "collaborators" or "initiators", appear at the head of the article.

The unacceptability of transferring to the community responsibility for "old type", "prejudicial", studies is well made but are the new studies to be subject to a new colonialism whereby the (black) community initiates and collaborates while the (white) researcher takes the credit? Or, are the initiators of such research perhaps unwilling to defend it publicly? Surely, credit and blame alike should be shared by all participators.

I would like to know why "responsibility remains with the researcher", when the very nature of this research indicates that he cannot possibly, in reality, be the only one responsible for it.

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DEAR SIRS

Dr Cook raises an important question which I dealt with perhaps too briefly in my paper.

There are always questions of "responsibility" and "authority" for any publication: rare indeed is the case in which a single individual has conceived of, carried out and published research unassisted in some way. My project was unusual in that its title referred specifically to its genesis in the suggestions of the community groups I cited. Its theme – the way

psychiatrists understand and use the notion of "cannabis psychosis" – was not my own idea: that I made clear in title and text, and indeed was one of the reasons for preparing the work for publication. Psychiatrists, as I noted, must now be prepared to carry out research projects suggested by the minority groups whom for so long they have treated as the objects of "disinterested" academic research.

In the study in question I carried out the work in my own way, and the groups concerned were not collaborators in the method nor in implementation. That might perhaps be our next step; indeed even offering our professional research procedures to psychiatric service users and their communities to use as they see fit. That was not intended in this study, nor have I claimed it to be so.

I am *accountable* to the groups who advised me; they are not however *responsible* for the way I carried out and used their suggestions. Given the power of psychiatry I certainly think we should be wary of claims that we carry out research *on behalf of* others, but we can hardly hold others accountable for our actions.

That issues of quite serious responsibility are involved is perhaps indicated by reviewing the history of "cannabis psychosis" in Birmingham. In the 1970s it was not apparently diagnosed among either blacks or whites (Royer, 1977).

By the mid-1980s it was diagnosed 95 times more commonly in local Afro-Carribbean patients than in whites, and was an issue given extensive coverage (McGovern & Cope, 1987). The heavily publicised research project was then started. By 1988 the diagnosis had disappeared completely (Milner & Hayes, 1988a, b).

Whether this is something one "takes the credit" for (Dr Cook's phrase) depends on the future standing of cannabis psychosis: if it becomes a recognised category then clearly the paper will hardly be regarded with enthusiasm. Blame or credit, I remain accountable. (Alternatively one might argue that it was irrelevant, that it was merely part of a general lay and professional unease with the diagnosis.)

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Let the old man drink

DEAR SIRS

The physiological changes of ageing make the elderly more vulnerable to alcohol (Vestal *et al*, 1977). Organic brain affliction, and cardiac and pulmonary diseases increase this sensitivity further. Alcohol in them, even in small doses, can cause acute confusion, disinhibited aggressive behaviour, sleep disturbance and emotional lability (Schuckit, 1982). Despite the Royal College of Physicians' advice on the safe drinking limit, such limits in the elderly are still unknown.

Failure of doctors to recognise the social decline and relying on abnormal physical signs for diagnosis creates difficulty in detecting the problem drinker (Murray, 1986). But surprisingly we find some psychiatrists, despite evidence of alcohol's contribution to the ill health in their elderly patients, are reluctant to wean them off. On the contrary, they "prescribe" "whisky" or "brandy" to some as a daily dose or as a night sedation. The rationale of this approach is (a) it is too late to treat; (b) he has lived so long, leave him alone; (c) it is a pity to take away his favourite drink. We agree with the elderly people's right to enjoy a drink, but believe that the sick elderly should be advised to stop drinking.

Although *Proverbs* (31:6,7) quotes, "Give strong drink unto him that is ready to perish, and wine unto those that be of heavy hearts. Let him drink, and forget his poverty, and remember his misery no more", this pessimistic and do-nothing view is at variance with our understanding in the field of geriatrics. The future welfare of sick aged people depends on more optimistic endeavours.

We look forward to readers' comments on this matter.

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Grading of nurses

DEAR SIRS

I have just discovered that the staff nurses, who work with me in our psychiatric day hospital, have been