

### Ritualistic Use of Fluoxetine by a Former Substance Abuser

SIR: Much has been written regarding the benefits as well as the unwanted effects of fluoxetine (1–4). To the best of our knowledge, there have been no reports of an antidepressant effect associated with its ritualistic use by a former substance abuser.

Ms. A, a 33-year-old woman with dysthymia, avoidant personality, and polysubstance abuse, entered psychotherapy to address lifelong issues of depression, shyness, and fear of rejection, particularly in relation to men. Her drug and alcohol use was a “soothing” experience that allowed her to withdraw from a rejecting and critical world. Fearing that her addiction was preventing the attainment of her goals, she had made the decision to stop using drugs.

Despite a period of psychotherapy without drug use, Ms. A made minimal progress. After her concerns regarding addiction had been addressed, a trial of fluoxetine, 20 mg every other day, was initiated, but the dose was soon decreased to 10 mg every other day because she reported overstimulation. This dose of less than 20 mg required that she open the capsule. Within 2 weeks she had titrated the dose to between 1 mg every other day and 1 mg every day, depending on her desired energy level. This was done by emptying 1 mg of white fluoxetine powder onto a plate. With her illicit drug experience, “the dosing was simple.” She ingested the powder by sucking it into her mouth and described the experience as similar to “speeding”—giving her increased energy and the ability to interact socially with others. She stated that using more than 1 mg/day caused excessive stimulation and that ingestion of less than 1 mg every other day caused severe drowsiness. Now, 7 months later, at a dose of 1 mg every other day, her appearance has improved, she has made social contacts, and she is making good use of psychotherapy. She often reports feelings of euphoria but shows no signs of mania or excessive stimulation.

Although 20 mg/day is the standard antidepressant dose, clinical experience with fluoxetine indicates that a lower dose is often sufficient, and patients open the capsule for this purpose. However, a dose of 1 mg every day or every other day is unusual. It is possible that this low dose has a positive physiological effect in a person with lifelong dysthymia. Indeed, patients often respond to minimal doses of neuroleptics and antidepressants. It is also possible that the low dose has a placebo effect derived from Ms. A’s reenactment of her illicit drug use. Like addicts who become excited when visiting a place where they have previously used a drug, this patient got both excitement and comfort from recapitulating an act that had provided relief and safety in the past. It is also possible that her account of “speeding” might describe euthymia in a person who has been depressed much of her life.

Because of fluoxetine’s popularity, other interesting re-

ports are likely to appear. For example, anecdotal reports from Italy indicate that a new “illicit” drug known as “bye-bye blues” has been identified as fluoxetine.

### REFERENCES

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### A Case of Amitriptyline Abuse

SIR: I wish to report on a case of amitriptyline abuse for euphorogenic effect.

Ms. A, a 24-year-old abuser of alcohol and cannabis, consulted her family physician because of anxiety, depression, and insomnia. Unaware of her drug abuse, he prescribed amitriptyline, 200 mg. About 30 minutes after taking each dose, she would experience relief from her symptoms that lasted about 2 hours. By increasing the dose, she found she could intensify these effects and prolong them for up to several hours. Her “high” consisted of feelings of relaxation, giddiness, and contentment. Frequently, this progressed to incoordination, slurred speech, and confusion. Sometimes she would forget how much she had taken and ingest up to 2 g. This intoxication was often followed by sleep and retrograde amnesia. These effects developed quite apart from concurrent use of other drugs and, in fact, amitriptyline became her recreational drug of choice.

Six months after beginning amitriptyline, Ms. A was brought to the hospital in an unresponsive state. An ECG showed sinus tachycardia of 100 bpm and a widened QRS interval. A neurologic examination showed coma, conjugate gaze, hyporeflexia, and pupils 4 mm and reactive. Her serum amitriptyline level was 1131 ng/ml. Two days later her sensorium was clear. She emphatically denied that she had attempted suicide and showed no signs of depression.

Ms. A continued her amitriptyline abuse. She was arrested for erratic driving; when results of a breathalyzer test were negative and the blunting of her senses worsened,