

Inside

- 2 Training the Next Generation
Sarah M. Fayad, M.D.
- 3 Considerations in the Treatment of Pediatric Bipolar Disorder
Matthew E. Hirschtritt, B.A.,
Allison Tweedie, M.D.
- 6 Borderline Personality Disorder and Associated Axis I Comorbidities
Michele Retrouvey, B.Sc.
- 8 Ethics and Medical Abandonment in a Rehabilitation Facility
Kedar Kirtane, B.S.,
Jennifer Sbicca, B.S.
- 10 Co-Occurring Eating, Borderline Personality, and Substance Use Disorders
Maria Levine, M.D.
- 12 How Well Are Residents Informed About Boundary Crossings and Violations?
Archana Devi Brojmohun, M.D.
- 14 Book Review
Michael Ascher, M.D.,
Shruti Mutalik, M.D.
- 15 Test Your Knowledge
- 16 Residents' Journal Info

In This Issue



The education of medical students is one of the many duties assigned to residents as part of their professional training. *The Residents' Journal* is committed to providing opportunities for medical students to develop skills that will benefit them in their own future training. This issue features three articles authored by medical students. Matthew E. Hirschtritt, a second-year student, is the lead author of an article on the treatment of pediatric bipolar disorder. Michele Retrouvey, a fourth-year student, discusses axis I comorbidities of borderline personality disorder. Finally, Kedar Kirtane and Jennifer Sbicca, both fourth-year students, present a case report on the ethics surrounding medical abandonment in a rehabilitation setting.

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Training the Next Generation

Sarah M. Fayad, M.D.
Editor-in-Chief

Resident physicians are involved in a multitude of activities during their professional training. Among these are patient care, research, patient advocacy, and education of medical students and other residents. *The Residents' Journal* has featured several articles detailing the resident physician's role in educating medical students (1–3). The role of *The Residents' Journal* in teaching medical students has expanded further to include education of the “next generation” in a more interactive and involved way, as medical students have become interested in developing their skills not only as clinicians but also as authors of published work. This type of interactive education serves to teach medical students a skill that is not encountered during their clinical rotations

and helps them to gain experience developing scholarly ideas and projects. They also gain the experience of having their manuscripts undergo peer review and learn how to respond to peer reviewer comments, thereby strengthening their scholarly projects and preparing them for possible careers in academic medicine.

In this month's issue, we are pleased to feature three manuscripts authored by medical students. The topics chosen by each of these authors reflect a diversity of interests. It is my hope that the process of developing a scholarly project around a specific topic will help to stimulate medical students' interest in academic writing as well as further their knowledge in the critical appraisal of scientific literature. Many students also find the process to

be quite enjoyable. In the coming year, we welcome submissions from medical students. I encourage those who are interested to begin working with a resident to develop their scholarly ideas. We look forward to helping train the next generation in a skill that is not frequently taught during this phase in their education.

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Considerations in the Treatment of Pediatric Bipolar Disorder

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Over the past two decades, there has been a sharp increase in the number of diagnoses of pediatric bipolar disorder, which has been accompanied by questions from both the medical and lay communities regarding over-diagnosis and treating youth with behavioral disturbances. In this context, psychiatric residents are likely to encounter youth with suspected or previously diagnosed pediatric bipolar disorder in their clinical experience. This article aims to provide residents with an overview of the epidemiology, diagnosis, and treatment strategies with regard to pediatric bipolar disorder; a set of questions to direct further, more detailed studies on the disorder; and a summary of the controversy surrounding diagnosis of the disorder, along with a framework in which both clinicians and researchers may make reasoned decisions based on scientific evidence.

In the period from 1993 to 2003 alone, the annual incidence of pediatric bipolar disorder diagnosed in office-based settings increased from 25 to 1,003 visits per 100,000 in the population (1), a trend paralleled among hospitalized children (2). This trend may be a result of previous underdiagnosis of the disorder that is now being rectified. Approximately 50% of cases of bipolar disorder occur before age 19 years, and there are long delays in the diagnosis of early-onset mania (3). However, significant heterogeneity of manic symptoms among youth, along with controversy surrounding the difference between elated and irritable mood (4) in the context of growing awareness of pediatric bipolar disorder, suggests that the disorder may be increasingly overdiagnosed. The debate over the diagnosis and treatment of pediatric bipolar disorder has yielded intense discussions in which polarized views are expressed, leaving clinicians and families without clear

understanding. Such confusion is only amplified by nonscientific articles in the lay media (5) that present one extreme circumstance rather than a thoughtful consideration of all viewpoints.

Diagnosis

DSM-IV-TR does not distinguish the diagnosis of bipolar disorder based on age, although the characteristics and presenting symptoms in youth may differ from those in adults (6). Adults with the disorder are most often characterized by a cyclic pattern of distinct phases of mania and depression; however, controversy exists as to whether youth may present with a history of rapid, recurrent episodes cycling over a 24-hour period or chronic irritability. Leibenluft (7) suggested that severe, nonepisodic irritability with frequent outbursts may be a distinct clinical entity of pediatric bipolar disorder. She, along with a group of investigators, proposed diagnostic criteria for a new condition in youth called severe mood dysregulation, which is defined by non-episodic abnormal mood, hyperarousal, and increased reactivity for at least 1 year, without manic symptoms. Yet one study suggested that relative to children with narrowly defined pediatric bipolar disorder, children who meet criteria for severe mood dysregulation are approximately 50 times less likely to develop (hypo-)manic or mixed episodes over a 2-year follow-up period (8). Such findings make the clinical definition of the disorder unclear. Adding to the diagnostic confusion, the symptoms of pediatric bipolar disorder are very similar to, and in some cases seem indistinguishable from, those of attention deficit hyperactivity disorder (ADHD) during initial clinical evaluations.

Among methods used to validate pediatric bipolar disorder as a diagnostic entity, researchers have attempted to use

retrospective as well as longitudinal prospective studies of children, adolescents, and adults with bipolar disorder. In a recent retrospective study of 480 adults with bipolar disorder, 14% of patients reported an early onset (age 12 years or younger) of the disorder, and 36% reported onset in adolescence (ages 13–18 years) (9). In addition, earlier onset was associated with greater delay to first treatment, and adults with childhood-onset had greater severity of mania and depression and displayed more days depressed and more ultradian cycling over a year of naturalistic observation (9). Likewise, data from a longitudinal National Institute of Mental Health (NIMH)-funded study (10, 11), conducted at 4 and 8 years after study enrollment, showed that manic symptoms often relapse and recur over an extended period. Forty-four percent of patients at the end of 8 years, who were at least 18 years old, still had manic symptoms. Taken together, these data suggest that patients with childhood-onset bipolar disorder may show continuity with adult bipolar disorder and may develop a more severe phenotype relative to those with the adult-onset form of the illness. However, these results also imply that some children initially diagnosed with pediatric bipolar disorder do not meet criteria for bipolar disorder as adults. Therefore, youth diagnosed with the disorder may consist of a more heterogeneous population than originally thought. Likewise, there is significant overlap of manic symptoms (e.g., grandiosity, agitation, and reckless behavior), ADHD (e.g., hyperactivity, irritability, and dangerous play), and normal behavior (e.g., boasting, imaginary play, and overactivity) (12). Use of structured interviews, such as the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) and the Washington

continued on page 4

continued from page 3

University-K-SADS, may help determine whether youth with suspected pediatric bipolar disorder meet diagnostic criteria. However, differences between adult and pediatric presentations of bipolar disorder are still a matter of controversy and are not resolved by current diagnostic tools.

Treatment

Just as in other pediatric psychiatric disorders, such as unipolar depression and anxiety disorder, there are fewer Food and Drug Administration-approved medications for bipolar disorder in children than for the disorder in adults. Lithium is approved for children ages 12 and older; aripiprazole, risperidone, and quetiapine are approved for children ages 10 and older; and olanzapine is approved for children 13 years or older. Although a complete overview of studies involving these drugs is beyond the scope of this article, an excellent summary of relevant studies by Pfeifer et al. (13) reflects the infancy of the field, and practice parameters for diagnosis and treatment of pediatric bipolar disorder have been published (12). Compared to pharmacologic clinical trials for adults with bipolar disorder, there are few clinical trials for children. Even among studies on lithium (the gold standard treatment for adult bipolar disorder) or divalproex sodium (which has been used extensively for treatment of pediatric epilepsy) there are few well conducted safety and efficacy trials for youth with pediatric bipolar disorder. Other nonpharmaceutical treatments include psychotherapeutic interventions (e.g., psychoeducational therapy, relapse prevention) (14) and ECT for treatment-refractory illness. However, ECT studies for children are severely lacking, in part because of concerns about adverse effects (e.g., impairment of memory and new learning), historical misuse of this treatment, and inaccurate media portrayal (15). In this context, child and adolescent psychiatrists largely use clinical judgment.

Evidence-based use of psychopharmacologic agents has been hampered by limited randomized, double-blinded, placebo-controlled studies in youth or by head-to-head comparisons of com-

Table 1. Questions Regarding Treatment of Children and Adolescents With Bipolar Disorder

For the Clinician	For the Researcher
What currently accepted diagnostic category does my patient best fit? Does he or she meet criteria for bipolar disorder?	What are the characteristics and empirically supported subtypes of mood and behavioral disturbances in youth? How can these data be used to create meaningful diagnostic categories?
What therapeutic approach is most effective to address my patient's psychiatric condition, in which the benefits outweigh the risks?	What is the comparative effectiveness of pharmacologic and behavioral treatment modalities based on patient characteristics?
How will the choice of treatment(s) reflect the expectations of the patient's caregivers?	What are the greater societal benefits and costs of treatment of youth with bipolar disorder?

monly used agents. However, despite the severity of pediatric bipolar disorder and possibility of improvement with therapy, not all youth with the disorder receive treatment. In the aforementioned NIMH study, fewer than two-thirds of the patients received antimanic medication over the 8-year observation period (16). The authors suggested that this finding may be explained by under-recognition of the disorder by primary care physicians, who made up an increasingly large percentage of the treating physicians during the study. Regardless of the reasons for the finding, it is evident that youth with pediatric bipolar disorder may not be receiving appropriate care in the community.

Framework for Weighing the Risks and Benefits of Treatment

Consideration of whether to administer treatment includes, at least, the following three issues: 1) whether the patient meets criteria for pediatric bipolar disorder; 2) what treatment options are available (making sure to pay attention to the risks and benefits of each option); and 3) the implications of treatment beyond the individual patient. Addressing the first issue requires understanding how to apply diagnostic categories, some of which will likely change with the upcoming DSM-5. Specifically, DSM-5 may include the diagnosis of temper dysregulation disorder with dysphoria, characterized by frequent temper outbursts with a persistently negative mood, beginning between

ages 6 and 10 years (17). The second issue requires careful examination of the literature, combined with clinical experience, the characteristics of the patient, and the expectations of the caregivers. The third issue may be more abstract than the previous two in clinical practice but may involve consideration of the high economic and medical burden of untreated bipolar disorder versus the side effects, such as metabolic syndrome from medications that may not be appropriate (18). Sample questions within this framework are presented in Table 1.

Conclusions

The diagnosis and treatment of pediatric bipolar disorder is far from being straight-forward. Specifically, clinicians rely on diagnostic criteria for bipolar disorder designed for adults and need to distinguish the pediatric form of the illness from conditions with similar presentations, such as ADHD. Appropriate clinical decision making and reasoned research approaches depend on careful consideration of multiple parameters. In many cases, it is unclear whether the child or adolescent meets diagnostic criteria for pediatric bipolar disorder, ADHD, severe mood dysregulation, or any psychiatric condition at all. Diagnosis of pediatric bipolar disorder should be carefully considered, taking into account multiple perspectives (e.g., patient, caregivers, teachers), and decisions regarding treatment strategies should involve the balancing of risks and benefits to the

continued on page 5

continued from page 4

patient and his or her family. Clinically relevant research goals may include determining empirically supported subgroups of patients with the disorder and pediatric bipolar disorder-like behaviors as well as safe and effective treatments for these youth.

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Borderline Personality Disorder and Associated Axis I Comorbidities

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Borderline personality disorder is the most widely studied personality disorder (1). This disorder is characterized by a pervasive pattern of instability in affect, impulse control, interpersonal relations, and self-image. It affects approximately 1%–2% of the general population (2) and is the most prevalent personality disorder in clinical settings, with a 2:1 female to male ratio (3).

Clinically, patients present with intense mood reactivity. They report intense periods of dysphoria, experiencing rage, sorrow, shame, panic, or terror. Chronic feelings of emptiness and loneliness are often described. Disturbed cognition, misperceived reality, inability to integrate under stress, and severe depression may be present. Patients with borderline personality disorder exhibit impulsive, aggressive behaviors (“acting out”) and see others as either all good or all bad (“splitting”), while underutilizing more mature defenses, such as humor and sublimation. Intense, unstable relationships and fears of abandonment are a hallmark of borderline personality disorder. Suicidal threats, gestures, and behaviors are ubiquitous to the borderline construct. Approximately 60%–70 % of patients attempt suicide, and 9% succeed. This is 400 times the rate of completed suicide in the general population and more than 800 times the rate among young women. Case-based studies of completed suicides indicate that borderline personality disorder is typically the most prevalent axis II diagnosis (4). Self-mutilation is also central to the disorder. The most common forms are cutting, cigarette burning, and pinching. While the goal of self-mutilation is not to die, such behaviors doubles the risk of completed suicide (5).

Borderline personality disorder patients suffer from a higher number of axis I disorders than the general population, meeting criteria for 3.4 to 4.2 axis I disorders throughout their lifetime. Comorbid

borderline personality disorder and axis I diagnoses are negative prognostic indicators (4). This article focuses on major depressive disorder, post-traumatic stress disorder (PTSD), eating disorders, and substance abuse.

Depression

Patients with both borderline personality disorder and depression do not exhibit classical symptoms of depression. Abandonment fears, self-destructiveness, and hopelessness are often seen. Feelings of emptiness and loneliness are more linked to borderline personality disorder-associated depression. This emptiness has been postulated to be the result of a lack of early attachment in childhood or a residual effect of unexpressed rage. Furthermore, the feeling of emptiness experienced by these patients usually does not resolve, even when borderline behavioral markers do. The number of depression remissions is reduced by comorbidity with borderline personality disorder, while improvements in borderline personality disorder are often followed by improvements in depression symptoms. However, improvements in depression are not followed by improvements in borderline personality disorder. (6).

PTSD

While PTSD in the general population is 10%, rates among individuals with borderline personality disorder have been reported to be between 25% and 56% (7). Borderline personality disorder patients are more likely to have experienced significant trauma than individuals in the general population (8). Additionally, certain features of PTSD overlap with core traits of borderline personality disorder; for example, affective instability, perceptual and cognitive disturbance, and interpersonal dysfunction are seen in both disorders (9). Patients with both PTSD and borderline personality disorder re-

port higher levels of distress, physical illness, anxiety, and depression than those with borderline personality disorder alone (7). Further, the occurrence of PTSD in these patients decreases the likelihood of remission from borderline personality disorder (10).

Eating Disorders

Both anorexia nervosa and bulimia nervosa are 20 times more prevalent among individuals with borderline personality disorder than in the general population (11). The most frequent axis II diagnosis associated with bulimia nervosa is borderline personality disorder, especially for the binge and purge types (12). There is a high rate of comorbidity (31.5%) between eating disorders and borderline personality disorder (13). Comorbidity is characterized by chronicity, low levels of overall functioning, and more severe clinical profiles. Furthermore, comorbidity is associated with more psychiatric symptoms and a substantially greater degree of psychological distress.

Substance Abuse

Substance abuse is extremely common among patients suffering from borderline personality disorder. Female patients prefer alcohol and sedatives, while male patients prefer stimulants. The overall prevalence ranges from 11% to 69% (14). In fact, the rate of drug abuse among patients with borderline personality disorder is considerably higher than that found in the general population (15). Comorbidity is associated with educational, employment, and behavioral difficulties (14). Evidence also suggests that substance abuse in these patients increases the risk for serious self-destructive behavior (15). Patients with comorbid substance abuse have higher levels of impulsivity and disinhibition than those with either

continued on page 7

continued from page 6

substance abuse alone or borderline personality disorder alone. Substance craving and use are associated with negative emotional states, social rejection, and tension at a higher rate than that found in the general population (4). The strongest overall predictor of remission of borderline personality disorder is the absence of comorbid substance abuse.

In summary, patients with borderline personality disorder experience several axis I comorbidities, including major depressive disorder, PTSD, eating disorders, and substance abuse. As a general rule, comorbidity with an axis I disorder begets a poorer prognosis for these patients.

Michele Retrouvey is a fourth-year medical student at Eastern Virginia Medical School, Norfolk, Va. The author thanks Dr. Jose Nieves, Department of Psychiatry, Virginia Medical Center, Newport News, Va., for assistance with this article.

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CALL FOR PAPERS

The Residents' Journal is looking to publish articles on disorders of memory, dementia, and other types of cognitive impairment (e.g., impairment subsequent to brain trauma)

SAMPLE TOPICS ARE AS FOLLOWS:

- Treatment in Psychiatry article discussing the clinical assessment and differential diagnosis of subjective memory complaints;
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- Review article of the different domains of memory and the disorders affecting each domain; and
- Review article describing cognitive impairment associated with substance use

We will consider manuscripts on other topics.

Ethics and Medical Abandonment in a Rehabilitation Facility

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“Mr. K” was a 47-year-old homeless man with a history of alcohol abuse and benzodiazepine dependence. He presented to an inpatient rehabilitation service for treatment, which was his third presentation for similar complaints. He strongly desired treatment for his alcohol dependence and stated that alcohol had “ruined” his life and that he hoped to “get sober as soon as possible.” However, he informed the treatment team that he planned to continue using benzodiazepines after completing the rehabilitation program, since he did not believe that benzodiazepine dependence was problematic. During his inpatient rehabilitation, the patient received group therapy and routine management of alcohol withdrawal, including a benzodiazepine taper. In the course of group activities, he frequently interrupted the group sessions. The house staff received complaints from other patients on the unit regarding his disruptive behavior.

After 3 days, the treatment team was notified that Mr. K did not have insurance. He initially reported not wanting to pay for inpatient rehabilitation. When informed that the treatment costs totaled \$2,500 a day and that he would likely have to stay several days due to significant benzodiazepine use, he requested to remain for treatment and later stated that he would pay for the inpatient treatment out-of-pocket. Ultimately, he completed the treatment necessary for safe alcohol withdrawal. Because of Mr. K’s disruptive behavior and noncompliance with benzodiazepine addiction treatment recommendations, he was discharged, with follow-up care arranged at an intensive outpatient treatment program.

Discussion

The four core medical ethical principles

of autonomy, beneficence, nonmaleficence, and justice are the classic starting points for a discussion regarding appropriate patient care (1). The principle of beneficence guides physicians in making medical decisions in the patient’s best interest. Nonmaleficence is the belief that physicians should not harm patients in their endeavors to treat illness.

The important decision in this case report was whether discharging the patient was ethically appropriate and, upon discharge, whether termination of patient care constituted abandonment. The most traditional interpretation of the term abandonment indicates a unilateral withdrawal of care for a patient without first enacting a formal process to ensure that the patient will have access to the services of another equally qualified physician (2). However, as emphasized in the traditional interpretation, in order to maintain nonmaleficence toward the patient, a physician must secure appropriate clinical care immediately before and after formal termination of his or her relationship with the patient is complete.

In a position paper by the American College of Physicians, Snyder and Leffler (3) argue that “physician-initiated termination is a serious event, especially if the patient is acutely ill, and should be undertaken only after genuine attempts are made to understand and resolve differences.” Furthermore, the American Medical Association Code of Ethics (4) clarifies the health professional’s obligation surrounding a potential withdrawal of care: “Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to

permit another medical attendant to be secured” (4).

Much of the treatment at the rehabilitation facility where Mr. K was being treated was centered on group therapy. His presence was disturbing the group’s milieu and was detrimental to providing a given standard of care to him and other patients on the unit. Furthermore, treatment for alcohol dependence must often co-occur with treatment for benzodiazepine dependence. Mr. K declined this treatment recommendation. He insisted on not being treated for benzodiazepine dependence and reported to the treatment team that he planned to resume use of benzodiazepines subsequent to discharge, which would possibly make the alcohol detoxification futile.

Ethically, a patient’s ability to pay should bear no weight on a clinical recommendation. The principle of beneficence does not include financial considerations. Yet to knowingly push this patient, who was recently homeless, into a further state of destitution also seems unethical because of the duty of nonmaleficence. While any life-threatening disease should be treated without concern for financial status, long-term goals for a patient can be managed at a practical level and involve considerations regarding the financial situations of the patient. Acuity is important when deciding the appropriate course of action.

It is also ethical that a patient requiring emergency treatment cannot be turned away regardless of payment status. Similarly to the way a patient presenting with life-threatening appendicitis is provided immediate care, a patient presenting with life-threatening alcohol use and in benzodiazepine withdrawal must be cared for appropriately. Failure to provide care to an individual in life-threatening with-

[continued on page 9](#)

continued from page 8

drawal violates the ethical principle of beneficence and constitutes physician negligence.

On day 5, the patient was past the point of dangerous alcohol withdrawal. He continued to report plans to obtain alprazolam once he left the hospital. His ability to pay was unrelated to his subsequent discharge and future plans.

The decision was made to discharge the patient after safe alcohol withdrawal and arrangement for follow-up care with an intensive outpatient addiction treatment center. Follow-up evaluation with an intensive outpatient facility after discharge ensured that a continuum of care would be established and that a termination-of-care issue would be avoided. Because Mr. K stated that he intended to continue to use benzodiazepines by filling a prescription he had received from his primary care physician and even buying these medications illegally, it was deemed medically futile to withdraw him from benzodiazepines; therefore, the medical team was not concerned that he would have a life-threatening withdrawal episode. Furthermore, after contacting his outpatient physician, it was discovered that the primary care physician was un-

aware of Mr. K's addiction and stated that he would not prescribe benzodiazepines to him in the future.

It is important to note the negative feelings, and possibly anger, the team of physicians, nurses, and social workers may have felt for the patient. His refusal to follow treatment recommendations and constant interruptions during group sessions created an antagonistic relationship between him and the health care professionals. The concern with such negative feelings on the part of a health care team is that treatment will be hindered. One recent review article described studies demonstrating that ill feelings toward a patient can be associated with adverse treatment outcomes (5). Successfully managing these concerns, through cognizance regarding physician-patient boundaries and self-insight, can help to promote positive treatment outcomes.

Conclusions

We offer the following three guidelines on which physicians can base their decisions when deciding how to ethically manage a difficult patient and avoid patient medical abandonment in cases of substance and/or prescription drug use: 1) payment status should bear no weight on treatment of acute drug withdrawal;

2) clinicians should ensure to the best of their ability that all patients receive adequate, timely, and appropriate treatment for acute drug withdrawal; and 3) clinicians should strive to effectively manage negative feelings that can arise during a similar clinical encounter.

Kedar Kirtane and Jennifer Sbicca are fourth-year medical students at the University of Florida College of Medicine, Gainesville, Fla.

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Case Report

Co-Occurring Eating, Borderline Personality, and Substance Use Disorders

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“Mr. D” was a 26-year-old single, Caucasian man who had been previously diagnosed with borderline personality disorder and bipolar disorder. He was referred by his primary care physician to the psychiatry clinic for evaluation of restrictive eating patterns. He reported that he had been restricting his caloric intake while alternatively bingeing and purging for the last 3 years. The patient also reported a lifelong struggle with depression and severe anxiety, along with panic attacks and poor eating habits. He has lived with his mother his entire life. His parents divorced when he was 11 years old, and he has recalled being abused by his father. He was often bullied in childhood, even by his older brothers, because he was overweight. He described himself as an impulsive and unhappy man. At age 23,

Mr. D admitted that he had an uncontrollable urge to eat. He gained more than 100 lbs over a 6-month period, from 160 lbs to 260 lbs (at 5’8”). At that point, he became disgusted with himself and started to restrict his caloric intake to 350 calories per day. His main source of food was ice cream, which he ate throughout the day, “bite by bite.” He also started using laxatives, diuretics, and excessive amounts of dietary supplements, such as green tea extract and hydroxycut. He reported that he once took more than 50 different diet pills together after realizing that he had regained 2 lbs. After 5 months, Mr. D’s weight had dropped to 118 lbs.

At age 24 years, he began to cut his wrists. On one occasion, he cut himself so deeply that stitches were required, and he was hospitalized psychiatrically for almost

a month for depression and suicidality. He also tried cocaine, as an anorexigenic agent, for the first time at this age. He admitted snorting cocaine on a daily basis for 1 year.

While at the hospital, Mr. D was started on a regimen of lamotrigine for impulsivity, clonazepam for anxiety, and escitalopram for depression. Concurrently, he received treatment for an eating disorder. He received the same medications for 2 years while starting weekly psychodynamic therapy sessions. His depression, panic attacks, impulsivity, and cutting behaviors resolved, and his bingeing, purging, and restrictive eating patterns ceased. Despite numerous setbacks, including one episode of electrolyte imbalances and a weight of

continued on page 11

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continued from page 10

118 lbs, he subsequently gained 50 lbs in 3 months and then 30 additional lbs over a 2-month period. The patient has reported being unhappy with his current weight of 190 lbs but is afraid that if he tries to lose weight that he might die from anorexia. He said that he still has problems with occasional binges on carbohydrate-laden foods, but he denies purging. He has also reported a depressed and labile mood, low energy, loneliness, emptiness, and a return to his bingeing behaviors. Currently, he is exercising excessively in order to lose weight but is no longer using diet pills, diuretic, or laxatives.

Discussion

The treatment goal at our clinic for this patient was psychodynamic therapy and medication management to stabilize his anxiety and mood symptoms. In the past, the patient had benefited from combined treatment with lamotrigine, clonazepam, and escitalopram along with psychodynamic therapy. He remained stable (i.e., symptom free) under this regimen

for almost 2 years, his longest period of stability.

Eating disorders commonly co-occur with personality disorders (1, 2) as well as substance use disorders (1, 5). The majority of individuals with anorexia nervosa also suffer from anxiety disorders and have a diagnosis of cluster B or C personality disorders. These patients are also prone to increased risk of mood disorders.

One study showed a link between weight divergence and borderline personality disorder in adults (2). Another study reported no significant difference between substance use disorder prevalence among patients with anorexia nervosa or bulimia nervosa (3). Patients with bulimia nervosa in that study reported that their eating disorder preceded their substance use, while the inverse was true for anorexia nervosa patients. A twin study showed possible familial overlap between bulimia nervosa and substance use disorders (3). In yet another study, depression and anxiety were increased among individuals with anorexia nervosa (4).

As shown in the present case report as

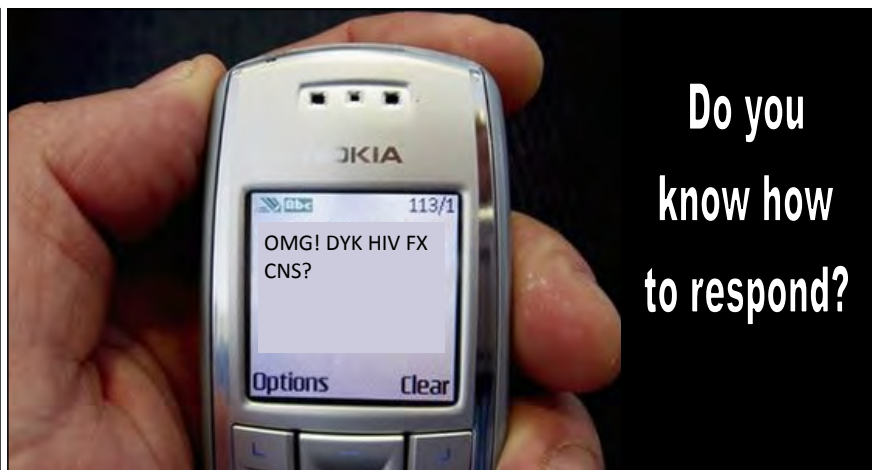
well as in the literature review, treating patients with eating disorders requires a multidirectional treatment plan..

Dr. Levine is a third-year resident in the Department of Psychiatry and Behavioral Science, Stony Brook University, New York.

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How Well Are Residents Informed About Boundary Crossings and Violations? A Cross-Departmental Study Among Nonpsychiatry Residents

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In March 1992, the American Medical Association updated its Code of Ethics following a report from the Council of Ethical and Judicial Affairs, which was published in *JAMA* (1). One of the Council's conclusions was that "education on the issue of sexual attraction to patients and sexual misconduct should be included throughout all levels of medical training" (1). The report clearly stated that its conclusions apply to all medical specialties.

Boundary crossings are harmless deviations from traditional practice, while boundary violations exploit the fiduciary relationship between the patient and the physician. The most severe form of violation is sexual misconduct, which exploits the physician-patient relationship, violates the public trust, and causes both mental and physical harm to the patient (2). Each year, the Federation of State Medical Boards compiles an Annual Summary of Board Actions. In 1990, 40 Ohio physicians lost their licenses or license privileges, as recommended by the Ohio Board, and 54 had their license restricted. In 2009, the comparable numbers were 103 and 113, respectively (3). This dramatic increase in the number of disciplinary actions reflects the influence of the amendment of the Code of Ethics on the Ohio Board.

The ethical challenges of boundary violations by psychiatrists and psychotherapists have been long recognized, mainly because of the inherent emotional intimacy with psychiatric patients during the processes of psychotherapy (4). Clinicians in other specialties also create psychological intimacy through their delivery of medical care and may be more vulnerable to misunderstanding patients' erotic responses to such care (5). Psychiatry residents are introduced to this potential as early as the intern year

Table 1.
Scenarios Depicting Potential Boundary Crossings and Violations Presented to Survey Respondents

1. As a PGY-3 resident, you have a Facebook profile, [on] which you frequently visit and upload pictures of your family and friends. You are checking your account as you do daily and see that a patient of yours, who you have been seeing since being an intern, has sent you a "friend request." You accept.
2. Your mentor asks you to meet him/her for dinner as "supervision" time, and before you know it, you are willingly engaged in an intimate relationship with him/her.
3. Your patient asks you to meet her/him for a lunch appointment, since he/she could not get an appointment soon enough because of your busy schedule. You accept and make plans to meet at the hospital cafeteria.

via seminars and individual supervision, and the topic continues to be discussed throughout residency.

The purpose of this study was to 1) assess the level of nonpsychiatry resident education pertaining to boundary crossings and violations and 2) identify the effects of a 45-minute lecture on increasing awareness and education about boundary crossings and violations among health care professionals in different specialties.

This study was approved by the University Hospitals Case Medical Center Institutional Review Board as well as the University's residency program directors of family medicine, internal medicine, and obstetrics and gynecology. Psychiatry residents were not included because of their prior exposure to the data and their lack of availability, while other residents were free to attend the lecture and complete the questionnaire. An anonymous, 12-question survey was distributed prior to the lecture. The questions described scenarios depicting boundary crossings and violations (Table 1). Participants were asked to designate whether each scenario represented a boundary crossing, violation, or neither. A response of "I

don't know" was designated when a participant was uncertain about the scenario. Consent was implied by completion of the survey, and participants were given adequate time to finish prior to a 45-minute lecture titled "Boundary Crossings and Violations: A Slippery Slope," which was delivered by the author. The lecture covered the definitions of boundaries and boundary crossings and violations, the risk factors for both physicians and patients that lead to boundary crossings and violations, the role of state medical boards, and the legal and personal consequences of boundary violations. The lecture also covered faculty-trainee boundary violations. Following the lecture, participants were given as much time as required to complete postlecture questions; all questionnaires were identical. This methodology enabled the author to measure the immediate learning acquired during the lecture.

Results

A total of 26 residents completed the survey: 10 from family medicine, eight from obstetrics and gynecology, and eight from

continued on page 13

continued from page 12

internal medicine.

One point was awarded for each correct answer. The correct answers for scenarios one, two, and three, as presented in Table 1, are as follows: boundary violation, boundary violation, and boundary crossing, respectively. The results were averaged by specialty and stratified by postgraduate year in each specialty. The median and standard deviations were also calculated. The mean prelecture score among family medicine residents was 4.5 (SD=1.9); postlecture, the average score for this group increased to 8.8 (SD=1.3). The mean prelecture score among obstetrics and gynecology residents was 5.5 (SD=2.0); the average score postlecture was 9.5 (SD=0.7). The mean prelecture score among internal medicine residents was 5.4 (SD=1.7); the average score postlecture was 9.5 (SD=1.6). Furthermore, the median score among the resident groups for each specialty increased considerably postlecture. Similar findings were revealed with decreased standard deviations on the postlecture survey scores among all three resident groups. A paired t test was also administered (the two-tailed p value for family medicine was 0.001; the two-tailed p value for both obstetrics and gynecology and internal medicine was 0.0003). These results denote statistical significance and seem to suggest that residents had an increased awareness of boundary issues immediately following the conclusion of the lecture.

Limitations

According to the information obtained from the University Hospitals General Medical Education office, there were 263

residents and fellows in all three specialties at the time the questionnaire was administered, but only 26 residents (and no fellows) completed the survey. Each postgraduate year was not sufficiently represented (for example, no interns in family medicine and no second-year residents in internal medicine were represented). Some residents were postcall absentees; others were rotating at other facilities. Fellows were not available to attend the lecture. Thus, the sample obtained may not be fully representative of each of the three resident groups. Future studies need to have a larger sample.

The lecture was given during protected didactics in family medicine and obstetrics and gynecology, possibly contributing to better attendance among these two specialties compared with attendance among internal medicine residents, for whom the lecture was an optional noon meeting. (Although there were at least 20 internal medicine residents present by the end of the lecture, only nine had been present from the beginning and thus permitted to complete the survey, and one of these did not participate in the survey.) Ideally, the lecture would be given to all three specialties simultaneously.

A delayed, follow-up postlecture survey was sent to the residents 3 months later. The mean score for residents in family medicine, obstetrics and gynecology, and internal medicine, respectively, was 5.4 (N=5 [with two abstainers]), 6.7 (N=3), and 6.0 (N=1).

Conclusions

This small pilot study suggests that 1) residents in family medicine, obstetrics and gynecology, and internal medicine are not adequately educated about issues

of boundary crossings and violations and that 2) a lecture format on these topics is adequate to increase their knowledge. Based on the positive results of the study and the dire consequences of license restriction on the careers of physicians, the author of the lecture recommends that more effort be extended to educate all clinicians in training about professional boundaries (6).

Dr. Brojmohun completed her residency at the Department of Psychiatry, University Hospitals of Cleveland, Cleveland; she is currently a Consultation-Liaison Psychiatry Fellow at the Cleveland Clinic Foundation, Cleveland. The author thanks Jeanne Lackamp, M.D., and Stephen Levine M.D., for assistance.

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Talking to Families About Mental Illness: What Clinicians Need to Know

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Developing an alliance with families and being able to communicate with families effectively are two clearly stated core competencies in which residents are required to obtain proficiency during the course of psychiatric training (1). The literature clearly establishes the importance of family interventions in the treatment of psychiatric illness (2). *Talking to Families About Mental Illness: What Clinicians Need to Know*, by Igor Galynker, provides clinicians with an invaluable guide to understanding and responding to the concerns of the relatives of those suffering from a mental illness. The book provides illustrative clinical case examples that prepare clinicians to deal with a variety of emotions and concerns that can be expressed by family members. Families need to understand the signs and symptoms of illness and be aware of behavior that can serve to hurt or help a patient's recovery.

This book, largely written by Dr. Galynker himself but with a few coauthors having contributed to select chapters, is a comprehensive compendium of the myriad ways in which mental illness can take a toll on families. He clearly delineates effective strategies to communicate with families with different coping styles. Galynker encourages the clinician to assess families for resilience, knowledge of illness, and material and spiritual resources that could help or hinder the patient's recovery. Moreover, issues of caregiver burden, denial, stigma, and what to tell outsiders are all addressed and discussed in detail.



Talking to Families About Mental Illness

WHAT CLINICIANS
NEED to KNOW



by Igor Galynker. New York,
W.W. Norton & Company, 2011,
288 pp., \$32.95.

Physicians can expect to encounter varying degrees of family involvement, ranging from the “reluctant” family to the “overinvolved” family, with the “willing and involved” family representing a healthy medium. “Happy families are all alike; every unhappy family is unhappy in its own way.” The tone of Dr. Galynker's book is aptly captured in this quote referenced from Tolstoy's classic *Anna Karenina*. The approach is refreshingly direct. Moreover, the author does not shy away from addressing extremely sensitive issues, including catastrophic outcomes of mental illness such as suicide.

This text is filled with exemplary phrases that a mental health professional could incorporate into his or her lexicon. Galynker encourages practitioners to address the fact that patients and their families may have fundamental differences with regard to reality: “[Explaining] the fact that your son has a mental illness does not mean that he cannot be happy. It is just that his happiness is not like yours or mine” (p. 15). Clinicians are encouraged to be supportive, compassionate, respectful, realistic, clear, direct, and mindful.

This book is particularly relevant to psychiatrists with limited time to devote to psychotherapy with patients and their families. While the intended audience is the mental health professional, the text is readily accessible to any person who is interested in understanding a wide range of mental disorders.

In summary, this book provides clinicians with the information to empower and educate families so that they can effectively advocate and support the patient.

Dr. Ascher is a third-year resident in the Department of Psychiatry and Behavioral Sciences at Beth Israel Medical Center, New York, and Dr. Mutalik is a first-year fellow in Psychosomatic Medicine at Memorial Sloan Kettering Cancer Center, New York.

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TEST YOUR KNOWLEDGE

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions.
(answers will appear in the next issue)

This month's questions are courtesy of Matthew E. Hirschtritt, B.A., who is a second-year medical student at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, Cleveland. (Please see the accompanying Treatment in Psychiatry article in this issue.)

Question #1

A 14-year-old boy presents for initial evaluation of symptoms of unhappiness and insomnia. The patient's parents describe a pattern of chronic fatigue, poor appetite, and poor concentration for the past year. The child is frequently tearful, easily irritated, and withdrawn. There is a family history of depression and substance use. The patient and his parents agree to initiate pharmacotherapy for symptom management. The family returns after 2 weeks and reports that the patient has been exhibiting signs of hyperactivity, fast and loud speech, euphoria, aggression, and irritability, mixed with depressive episodes, within the past week. Which of the following is the most likely cause of the child's symptoms?

- A. Illicit substance use
- B. Rapid or ultradian bipolar cycling
- C. Acute onset of ADHD
- D. Antidepressant-induced mania
- E. Early onset schizophrenia

Question #2

A 12-year-old girl presents with a 3-year history of bipolar I disorder. Her parents retrospectively report prodromal symptoms beginning prior to age 3, including easy distractibility, inattentiveness, insomnia, over-talkativeness, emotional lability, and unusually high energy levels. Which additional symptoms are the parents most likely to report occurring within the past 3 years?

- A. Acute onset of clearly demarcated phases of mania and/or depression
- B. Episodes of mania lasting weeks to months marked by decreased need for sleep
- C. Age-appropriate behavior between distinct episodes of mania
- D. Chronic difficulties in mood, emotion, and behavior regulation
- E. Chronic hyperexcitability with frequent suicidal ideation

ANSWERS

Answers to July Questions. To view the July Test Your Knowledge questions, go to <http://ajp.psychiatryonline.org/cgi/data/168/7/A28/DC2/1>.

Question #1.

Answer: A. Chronic benzodiazepine use is likely to be associated with long-term and persistent cognitive deficits. Although controversy remains, the literature suggests that chronic cognitive dysfunction may result from long-standing benzodiazepines use (1). Impairments are documented in visuospatial and visuomotor abilities as well as decreased IQ, motor coordination, verbal learning, concentration, and delayed response time (1–4). Other chronic effects may include rebound anxiety, psychic drug dependence, and alterations in perception of self, environment, and relationships (1). High-risk populations include men, the elderly, patients with concurrent substance abuse or psychotropic medication use with anticholinergic properties, and patients requiring high doses of benzodiazepines (1, 2).

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Question #2

Answer: C. If a patient fails to respond to a short-acting benzodiazepine for the acute management of insomnia, switching to a "z-drug" is not a clinically useful strategy because there is no clear evidence for a difference in effectiveness, adverse effects, or potential for abuse or dependence. Currently, there is no compelling evidence of a clinically useful difference between the z-drugs and shorter-acting benzodiazepines with respect to effectiveness, adverse effects, or potential for dependence or abuse based on clinical guidelines released in 2004 and reviewed again in 2007 by the National Institute for Clinical Excellence. The expert committee concluded that there is no clear evidence that if a patient fails to respond to one hypnotic drug, they are likely to respond to another. The committee concluded that switching between hypnotics is not an evidenced-based strategy. In fact, they suggested that cost should be the primary factor when deciding to switch from one agent to another.

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▶ We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment in the issue in which their questions are featured. Submissions should include the following:

1. Two to three Board review-style questions with four to five answer choices.
 2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.
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***The Residents' Journal* accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.**

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- 3. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
- 4. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
- 5. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
- 6. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 7. Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Issue Themes

Please note that we will consider articles outside of the theme.

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Section Theme: Addiction
Guest Section Editor: Jonathan Avery, M.D.
joa9070@nyp.org

October 2011

Section Theme: Interventional Psychiatry
Guest Section Editor: Adam Stern, M.D.
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November 2011

Section Theme: Autistic Disorders
Guest Section Editor: Arshya Vahabzadeh, M.D.
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December 2011

Section Theme: Sleep
Guest Section Editor: Dawn Flosnik, M.D.
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January 2012

Section Theme: PTSD and Traumatic Brain Injuries
Guest Section Editor: Brandon Cornejo, M.D., Ph.D.
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February 2012

Section Theme: Family Psychiatry
Guest Section Editor: Michael Ascher, M.D.
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