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## In This Issue



This issue of the *Residents' Journal* includes a special section on DSM-5. The section begins with an article by Editor-in-Chief Monifa Seawell, M.D., on the importance of educating ourselves and our patients about DSM and how the diagnostic changes in DSM-5 might affect the mental health community as well as treatment. Next, Hassan M. Minhas, M.D., and Associate Editor Arshya Vahabzadeh, M.D., discuss autism spectrum disorder as a new diagnostic category in DSM-5 and how the revised criteria might result in more accurate diagnosis. Last, Senior Editor Sarah M. Fayad, M.D., provides an overview of transitioning to DSM-5 while in psychiatric residency training or fellowship, emphasizing changes to the multiaxial system, dimensional assessments, and changes to diagnoses.

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# Talking to Our Patients About DSM

Monifa Seawell, M.D.  
Editor-in-Chief

The creation of DSM-5 has been accompanied by a multitude of mixed emotions in the mental health community. The general public, as well as the lay press, has also been vocal about the revisions, often expressing concern about the changes in DSM-5 and how these changes will affect the delivery of mental health services. Whatever position you take on the revisions to DSM, be it praise or disapprobation, DSM-5 is here. As mental health professionals, we must not only be prepared to educate ourselves about the latest revisions to our diagnostic text, but we must also be prepared to initiate discussions with our patients about the changes to DSM and what it will mean for them.

Although many of our patients carry diagnoses that are defined in DSM, many may not know exactly what DSM is or may be misinformed about the text and its intended purpose. In light of the widely published changes to this diagnostic textbook, practitioners should initiate conversations with and encourage questions from patients. Familiarizing yourself with the following discussion points will equip you to engage in meaningful discussion with your patients about DSM and its recent changes.

## What Is DSM?

The DSM, or *Diagnostic and Statistical Manual of Mental Disorders*, is a textbook that contains descriptions of recognized mental health conditions. It is used by health care providers in diagnosing mental disorders.

## How Old Is DSM?

The first edition of DSM, DSM-I, was published in 1952. Since that time, DSM has undergone several revisions. The five subsequent revisions are identified with a different roman numeral, including DSM-II, published in 1968, DSM-III, published in 1980, DSM-III-R (revised),

published in 1987, DSM-IV, published in 1994, and DSM-IV-TR (text revision), published in 2000. The roman numeral system was abandoned beginning with DSM-5 (1).

## Why Do Mental Health Professionals Use DSM?

By providing a defined set of criteria for each mental disorder, DSM helps mental health professionals speak the same diagnostic language, communicate more effectively with one another, and communicate with other medical professionals. Standardization of diagnoses occurs throughout medicine, not just within psychiatry, for the same reason. For example, if “Mr. A” is psychiatrically hospitalized and diagnosed with DSM-defined major depressive disorder and panic disorder during his hospitalization, his inpatient psychiatrist can effectively communicate with his outpatient psychiatrist and primary care doctor about exactly what conditions he has. Much in the same way that a diagnosis of diabetes implies that a minimum set of glycolic parameters have been met, DSM seeks to achieve a similar standardization with mental disorders.

## Why Are Certain Disorders Removed From DSM, and Why Have Other Disorders Been Added?

Since its inception in 1952, each subsequent edition of DSM has sought to further expand on the existing knowledge of mental illness. As the understanding of mental illness and human behavior has expanded and developed, so has the content of DSM. Over the years, behaviors that were earlier considered to be pathological (such as same-sex sexual attraction) were removed from DSM, no longer considered disorders, and rightly recognized as normal human behavior. In each subsequent edition of DSM, new

diagnostic classifications have been added based on expert consensus, improving research in psychiatry and empirical data collection (2).

## My Psychiatric Diagnosis Was Included in DSM-IV-TR But Is Not in DSM-5. Does This Mean My Symptoms Are Not Real Anymore?

Removal of a diagnosis from DSM indicates that at present, researchers do not have sufficient data to support that a particular set of symptoms can be considered a definable disorder. However, patients should be reassured that removal of a diagnosis does not mean that the symptoms they experience are not real or impactful on their lives. For example, although hypochondriasis will no longer be included as a distinct diagnosis in DSM-5, it does not mean that patients with this symptom cluster (as defined in DSM-IV-TR) do not continue to experience difficulties as a result of their somatic concerns. We should inform those patients whose diagnosis will no longer be included in DSM that the removal of the diagnosis signals that scientists’ understanding and knowledge of the symptoms has evolved and that it is not an indication that the symptoms do not affect people’s lives or that suffering from the symptoms is not real.

## I Have Been Given a Psychiatric Diagnosis That Was Not Included in DSM-IV-TR But Is Newly Recognized in DSM-5? What Does This Mean?

With the inclusion of several new mental disorders in DSM-5 (3), patients whose symptoms previously

did not carry a diagnostic label may now be given a formal diagnosis. Patients may react to this in several ways. Some who have long suffered may feel relief because their symptoms have been defined and named. For example, an individual who engages in hoarding may feel relief in knowing that his or her symptoms and behaviors are not “all in their head” and that the scientific community recognizes such symptoms as a definable illness. However, some patients may also have mixed emotions about being newly “labeled” as having a mental illness. Provid-

ers should be prepared to explore patients’ reactions to receiving new diagnoses.

## Where Can I Go To Learn More About DSM?

To learn more about DSM and DSM-5, both patients and providers can visit APA’s website (<http://www.psychiatry.org/practice/dsm/dsm5>).

As mental health professionals, we are trained to talk with our patients. Being equipped to discuss DSM with

our patients is an important clinical tool.

*Dr. Seawell is Editor-in-Chief of The Residents’ Journal and a fellow in forensic psychiatry at Case Western Reserve in Cleveland.*

## References

1. <http://www.dsm5.org/about/Pages/faq.aspx#12>
2. <http://www.psychiatry.org/practice/dsm/dsm-frequently-asked-questions>
3. <http://www.psychiatry.org/practice/dsm/dsm5>

### NEW EDITORS

*The Residents’ Journal* would like to congratulate the two newest members of our team. Dr. Misty Richards, a PGY-1 resident at UCLA, has been selected as the 2013–2014 Associate Editor. Dr. David Hsu, a PGY-5 resident at UC Davis, has been selected as our 2013–2014 Deputy Editor. Dr. Hsu will be entering a geriatric psychiatry fellowship at Harvard in July. Both Drs. Richards and Hsu have demonstrated a long-standing commitment to *The Residents’ Journal* and have made multiple, important contributions. We welcome them to the *Residents’ Journal* and look forward to working with them over the next academic year!

# Autism Spectrum Disorder in DSM-5

Hassan M. Minhas, M.D.  
Arshya Vahabzadeh, M.D.

Autism spectrum disorder is a relatively new term that is being introduced in DSM-5. Autism spectrum disorder encompasses several previously separate diagnoses, including autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger's syndrome. Autism spectrum disorder is one of the most common neurodevelopmental disorders, with an estimated prevalence rate of one in 88 in the pediatric population (1). There has been a progressive increase in the reported prevalence of the disorder. While different ascertainment methods have been utilized, rates as high as one in 50 children have been reported (2). The increase in rates of the disorder may be partly explained by increasing diagnosis and awareness.

## Historical Perspective

Autism was first described by Dr. Leo Kanner in 1943 (3). Around the same time, Dr. Hans Asperger described Asperger's syndrome (4). The clinical presentation of autism spectrum disorder was initially conceptualized as a childhood-onset type of schizophrenia. DSM-I and DSM-II referred to autism as "schizophrenic reaction, childhood type" and "schizophrenia, childhood type," respectively. DSM-III made a distinction between autism and schizophrenia. DSM-III-R divided diagnostic criteria for autism into three core symptom domains: impairment in social interaction, impairment in verbal and nonverbal communication, and restricted repertoire of activities and interests. These three core autism symptom domains were also recognized in DSM-IV, with autism spectrum disorder being placed under the category of pervasive developmental disorders, which is a subcategory of disorders usually first diagnosed in infancy, childhood, or adolescence.

## DSM-5

There has been growing consensus that the different disorders grouped under DSM-IV-TR pervasive developmental disorders are in fact a group of conditions that exist on the same continuum.

DSM-5 will address this concern by delineating the criteria for autism spectrum disorder. However, there will be a change in the number of core autism symptom domains, from three to two. DSM-IV domains of impairment in social interaction, impairment in communication, and restricted repertoire of activities and interests will be categorized as 1) deficits in social communication and interaction and 2) restricted repetitive behaviors, interests, and activities. The social communication and interaction domain will have three criteria, all of which must be met to qualify for diagnosis, and the restricted repetitive behaviors, interests, and activities domain will have four criteria, of which two must be met. To qualify for a diagnosis of autism spectrum disorder, persons must meet criteria for both domains. Those who only meet the social communication and interaction criterion will be diagnosed under the new "social communication disorder" category, which is mutually exclusive with autism spectrum disorder. Rett's disorder will be eliminated from DSM-5 because it now has a known genetic etiology: a mutation in the *MECP2* gene (5).

These changes in DSM-5 effectively 1) integrate several previously separate disorders under the autism spectrum disorder continuum, 2) change diagnostic criteria from the previous triad of symptom domains to the dyad of limited social communication and repetitive behavior, and 3) make meeting criteria for autism spectrum disorder more stringent (6, 7).

There has been criticism of combining the different conditions under the umbrella term autism spectrum disorder. Some have argued that diagnostic subtypes remain clinically useful, and instead of the spectrum approach, diagnostic criteria should be refined (8). However, the growing consensus has been that it is not possible to identify subtypes of autism spectrum disorder. In fact, the concept of an "autism spectrum" has been described as early as 1998 (9, 10). Differences in autistic disorder and Asperger's syndrome have been found to be largely in terms of severity of symptoms and degree of impairment as opposed to qualitative differences (10, 11). A review examining the validity of autism spectrum disorder subtypes found that differences observed across subtypes were better explained by the participants' IQ (12). A 12-site study showed that categorical diagnostic subtypes of autism spectrum disorder were not reliable across sites even with well-documented fidelity using standardized diagnostic instruments (13). In fact, the strongest predictor of diagnosis was the site location as opposed to any characteristic of the pediatric cohort.

DSM-5 will combine a spectrum conceptualization with an assessment of severity level and use of specifiers detailing associated deficits in functioning. This will allow diagnostic accuracy and inter-rater reliability while also retaining descriptive information that will likely be of great clinical utility in terms of describing individual patient presentation and impairment. Given that persons with autism spectrum disorder have such a wide variety of phenotypic presentation, this approach will provide more information than the poorly defined categories that it is replacing. At first glance, it may seem that combining the categories into an autism spectrum disorder continuum will result in less defined "types"; however, the DSM-5 approach would likely ensure

retention of a higher degree of useful descriptive information.

The change of diagnostic criteria to a dyad has demonstrated higher validity when compared with DSM-IV criteria. A study using factor analysis to test the construct validity of the proposed changes found that autism spectrum disorder is a dyad, not a triad, with distinct social communication and repetitive behavior dimensions (14). The dyad system is intended to be clearer and simpler and will avoid the confusion between the overlapping “social” and “communication” categories in DSM-IV.

Perhaps the most controversy has surrounded the increasingly stringent requirements to qualify for the diagnosis of autism spectrum disorder. Individuals must meet all three criteria for the social communication and interaction domain and two of the four criteria for the restricted repetitive behaviors, interests, and activities domain. This may change the composition of autism spectrum disorder; in particular, some groups have questioned whether individuals with pervasive developmental disorders other than autistic disorder may face a more difficult time qualifying for the autism spectrum disorder diagnosis (15). A study conducted when the first draft of DSM-5 criteria were applied to a DSM-IV field-trial population revealed that the criteria would accurately exclude 94.9% of persons who did not receive a clinical diagnosis of autism spectrum disorder. However, only 60.6% of persons with autism spectrum disorder per DSM-IV criteria would continue to be diagnosed in accordance with DSM-5 criteria (16). However, the methodology and conclusions of this study have been questioned, and more recent studies have found much higher sensitivities (17, 18). Some studies have found that young children may have the greatest risk of being underidentified by DSM-5 criteria, particularly those previously diagnosed with pervasive developmental disorder not otherwise specified or those with higher cognitive functioning (19, 20). Given that a diagnosis of pervasive developmental disorder not otherwise

specified did not require restricted repetitive behaviors, interests, and activities, it is easy to understand why some individuals with a diagnosis of pervasive developmental disorder not otherwise specified may not qualify for an autism spectrum disorder diagnosis. It is for this very group of patients, however, that the “social communication disorder” diagnosis may be most appropriate. In fact, it is likely that this new diagnosis will more accurately communicate the social communication and interaction deficits, as opposed to the large and poorly defined pervasive developmental disorder not otherwise specified group. Additionally, DSM-5 does not require functional delays to be present before age 3, but rather will extend this until “social demands exceed limited capacity” as long as symptoms were present in early childhood.

## Discussion

Autism spectrum disorder is a new diagnostic category in DSM-5. It reflects a growing consensus that the previously separate disorders classified as pervasive developmental disorders actually represent an autism continuum. The revised criteria will provide more accurate diagnostic criteria and, as a result, more appropriate treatment interventions. Coupled with improved and more accurate diagnostic categories, the dimensional conceptualization introduced by DSM-5 will provide useful and descriptive patient-specific information.

The new diagnostic criteria has been shown to be more specific, thus reducing the rates of false positives. There was initial concern regarding sensitivity, and some have questioned whether persons with DSM-IV diagnoses may not meet diagnostic criteria using DSM-5.

The initial research that found low sensitivity had significant methodological limitations, and subsequent, more robust studies have shown that sensitivity for autism spectrum disorder in DSM-5 is comparable to that of DSM-IV. Additionally, the introduction of a new diagnostic category, “social communication disorder,” will capture individuals

who may not meet criteria for autism spectrum disorder but who may still have social communication and interaction deficits.

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## References

1. Baio J: Prevalence of autism spectrum disorders: Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008. *MMWR Surveill Summ* 2012; 61:1–19
2. Blumberg SJ, Bramlett MD, Kogan MD, Schieve LA: Changes in Prevalence of Parent-Reported Autism Spectrum Disorder in School-Aged US Children: 2007 to 2011–2012. Atlanta, Centers for Disease Control and Prevention, National Center for Health Statistics, 2013
3. Kanner L: Autistic disturbances of affective contact. *Nerv Child* 1943; 2:217–250
4. Asperger H: Die autistischen Psychopathen im Kindersalter. *Archiv fur Psychiatrie und Nervenkrankheiten* 1944; 76–136
5. Amir RE, van den Veyver IB, Wan M, Tran CQ, Francke U, Zoghbi HY: Rett syndrome is caused by mutations in X-linked MECP2, encoding methyl-CpG-binding protein 2. *Nat Genet* 1999; 23:185–188
6. Happe F: Criteria, categories, and continua: autism and related disorders in DSM-5. *J Am Acad Child Adolesc Psychiatry* 2011; 50:540–542
7. Frazier TW, Youngstrom EA, Speer L, Embacher R, Law P, Constantino J, Findling RL, Hardan AY, Eng C: Validation of proposed DSM-5 criteria for autism spectrum disorder. *J Am Acad Child Adolesc Psychiatry* 2012; 51:28–40
8. Ghaziuddin M: Should the DSM V drop Asperger syndrome? *J Autism Dev Disord* 2010; 40:1146–1148
9. Frith U, Happe F: Why specific developmental disorders are not specific: on-line and developmental effects in autism and dyslexia. *Developmental Sci* 1998; 1:267–272

10. Prior M, Eisenmajer R, Leekam S, Wing L, Gould J, Ong B, Dove D: Are there subgroups within the autistic spectrum? a cluster analysis of a group of children with autistic spectrum disorders. *J Child Psychol Psychiatry* 1998; 39:893–902
11. Miller JN, Ozonoff S: The external validity of Asperger disorder: lack of evidence from the domain of neuropsychology. *J Abnorm Psychol* 2000; 109:227–238
12. Witwer AN, Lecavalier L: Examining the validity of autism spectrum disorder subtypes. *J Autism Dev Disord* 2008; 38:1611–1624
13. Lord C, Petkova E, Hus V, Gan W, Lu F, Martin DM, Ousley O, Guy L, Bernier R, Gerdtz J, Algermissen M, Whitaker A, Sutcliffe JS, Warren Z, Klin A, Saulnier C, Hanson E, Hundley R, Piggot J, Fombonne E, Steiman M, Miles J, Kanne SM, Goin-Kochel RP, Peters SU, Cook EH, Guter S, Tjernagel J, Green-Snyder LA, Bishop S, Esler A, Gotham K, Luyster R, Miller F, Olson J, Richler J, Risi S: A multisite study of the clinical diagnosis of different autism spectrum disorders. *Arch Gen Psychiatry* 2012; 69:306–313
14. Mandy WP, Charman T, Skuse DH: Testing the construct validity of proposed criteria for DSM-5 autism spectrum disorder. *J Am Acad Child Adolesc Psychiatry* 2012; 51:41–50
15. Tsai LY: Sensitivity and specificity: DSM-IV versus DSM-5 criteria for autism spectrum disorder. *Am J Psychiatry* 2012; 169:1009–1011
16. McPartland JC, Reichow B, Volkmar FR: Sensitivity and specificity of proposed DSM-5 diagnostic criteria for autism spectrum disorder. *J Am Acad Child Adolesc Psychiatry* 2012; 51:368–383
17. Huerta M, Bishop SL, Duncan A, Hus V, Lord C: Application of DSM-5 criteria for autism spectrum disorder to three samples of children with DSM-IV diagnoses of pervasive developmental disorders. *Am J Psychiatry* 2012; 169:1056–1064
18. Wilson CE, Gillan N, Spain D, Robertson D, Roberts G, Murphy CM, Maltezos S, Zinkstok J, Johnston K, Dardani C, Ohlsen C, Deeley PQ, Craig M, Mendez MA, Happé F, Murphy DG: Comparison of ICD-10R, DSM-IV-TR and DSM-5 in an adult autism spectrum disorder diagnostic clinic. *J Autism Dev Disord*. (Epub ahead of print, March 16, 2013)
19. Worley JA, Matson JL: Comparing symptoms of autism spectrum disorders using the current DSM-IV-TR diagnostic criteria and the proposed DSM-V diagnostic criteria. *Res Autism Spectr Disord* 2012; 6:965–970
20. Matson JL, Kozlowski AM, Hattier MA, Horovitz M, Sipes M: DSM-IV vs DSM-5 diagnostic criteria for toddlers with autism. *Dev Neurorehabil* 2012; 15:185–190

## CALL FOR PAPERS

### Submissions for *Psychiatric News* Sought

Would you like the opportunity to have your work appear in *Psychiatric News*? Here's your chance! *Psychiatric News* is inviting members-in-training to participate in a new feature focusing on renowned psychiatrists who are well established in the field or coming to the end of their careers, as well as psychiatrists who have served as outstanding mentors to residents. The articles should capture the essence of the subject (that of a personal perspective of the subject), along with information about the subject's career and his or her accomplishments. The format can vary—for example, it can be written in paragraph form and incorporate quotes from the subject, or it can be written in a Q&A format. The length of each submission should be about 750 words.

This opportunity is being offered to readers of the *Residents' Journal* only. If you are interested in participating in this series, please contact Cathy Brown at *Psychiatric News* at [cbrown@psych.org](mailto:cbrown@psych.org).

# Transition to DSM-5 While in Psychiatric Residency or Fellowship

Sarah M. Fayad, M.D.

Psychiatric trainees, along with psychiatrists, psychologists, therapists, social workers, and others, have been anxiously awaiting DSM-5, which will be published this month. This edition of DSM has garnered much attention and brings about several particularly significant changes to our nosology and classification of mental disorders. For those in residency and fellowship, this brings about a unique challenge and many questions. How will the new DSM be taught? What will be the outcome for those who only have a year left of training versus those who have just begun their training? What will change with regard to preparation for the American Board of Psychiatry and Neurology certification examinations? Many of these questions remain unanswered. However, trainees can educate themselves to better prepare for these significant changes.

## Changes to the Multiaxial System

There are many changes not only to the content of DSM, but to the structure as well. Structural changes can be difficult to adjust to, especially as a trainee. In DSM-5, the multiaxial system will be eliminated (Table 1) (1). All of the diagnoses previously found under axis I, II, and III will be combined into one list that encompasses all mental disorders, including personality disorders and intellectual disability (1). Medical conditions will also be included in this list. Axis IV will disappear, and in its place, clinicians will be able to use ICD-9-CM V-codes, which will soon be replaced by ICD-10-CM Z-codes. Axis V, used by clinicians to make an assessment of a patient's Global Assessment of Functioning Scale rating, will also be eliminated. Section III will contain a measure of symptom severity for individual disorders (1).

This will create a challenge during the transition period, since many insurers will not immediately implement DSM-5; therefore, clinicians who begin using DSM-5 may still need to use DSM-IV-TR for coding initially. It is thought that most insurers will implement changes by December 2013 (1).

## Dimensional Assessments

A new type of assessment is the dimensional assessment (2), which will allow clinicians to gain valuable clinical data on a full range of psychiatric symptoms. This is quite useful because comorbidities are common, and patients do not always fit neatly into a specific diagnosis without additional symptoms that are seemingly unrelated. The DSM-5 website indicates that symptoms will be rated not only by their presence but also on their severity, allowing clinicians to systematically track patient progress (2).

## Changes in Diagnoses

The changes made to diagnoses has been perhaps the most controversial of the changes to DSM-5, garnering much attention because of concern over what

changes in diagnostic criteria will mean for patients, physicians, and other third parties. Psychiatric trainees should be aware of the changes made to diagnoses and should consider the reasons for the changes so that better patient education can be provided.

Notably, autistic disorder, Asperger's syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified will all be integrated into the diagnosis of autism spectrum disorder. Disruptive mood dysregulation disorder has been implemented in DSM-5; it is hoped that the presence of this disorder will alleviate concerns about overdiagnosis and overtreatment of bipolar disorder in the pediatric population. In addition, substance abuse and substance dependence have been combined to form the substance use diagnosis. The bereavement exclusion has been removed; in its place is a discussion on the differences between grief and depression (3). There are additional diagnostic changes as well. It is important that trainees prepare for such changes, which can be viewed in detail on APA's DSM-5 website ([www.dsm5.org](http://www.dsm5.org)).

TABLE 1. Changes to DSM

DSM-IV-TR	DSM-5
Axis I, II, and III	All diagnoses will be combined in one list.
Axis IV	Use of ICD-9-CM V-code, which will be replaced with ICD-10 Z code in the near future.
Axis V (Global Assessment of Functioning Scale)	Separate measures for symptom severity and disability for individual disorders. Although not yet recommended by APA, clinicians may use the World Health Organization Disability Assessment Schedule for measuring disability.

## Conclusions

DSM-5 is viewed as a “living document” that will undergo ongoing change with the advancement of research and knowledge (4). This is instrumental in providing the best care for our patients. Preparing for the new DSM may be somewhat intimidating, especially while in training; however, there is much information available about these changes and the scientific rationale underpinning them. Psychiatric trainees who implement this information rapidly will be able to provide more edu-

cation to their patients about the changes made. Trainees will also prove instrumental in training medical students about the changes in the classification of mental illness. It is likely that as research advances, so will our way of classifying mental illness. By learning to adapt to the way we view mental illness, we might be able to improve outcomes in the vulnerable patients we treat.

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## References

1. <http://www.psychiatry.org/.../DSM/DSM-5/Insurance-Implications-of-DSM-5>
2. <http://www.dsm5.org/about/Pages/faq.aspx>
3. <http://dsmfacts.org/materials/american-psychiatric-association-board-of-trustees-approves-dsm-5/>
4. <http://www.dsm5.org/Documents/DSM-Name-Change.pdf>



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AMERICAN PSYCHIATRIC ASSOCIATION  
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Residents, fellows, and students are invited to attend this year's *American Journal of Psychiatry Residents' Journal* workshop, to take place at the Annual Meeting in San Francisco. This year's workshop title is "The *American Journal of Psychiatry Residents' Journal*: How to be Involved." Bring your thoughts and ideas about the *Residents' Journal*; hear a brief presentation about the Journal's new developments; meet with *Residents' Journal* editors and editorial staff as well as the *American Journal of Psychiatry* Editor-in-Chief Robert Freedman, M.D. The workshop is scheduled for Wednesday, May 22nd, from 1:30 to 3:00 p.m. in Room 226, Moscone South, East Mezzanine. For further information please contact [ajp@psych.org](mailto:ajp@psych.org).



## Case Report

# Sibling Rivalry: Challenges and Opportunities

Lisa Batson, M.D.

Sibling rivalry refers to a type of competition or animosity among siblings, regardless of age. Behaviors associated with sibling conflict include physical aggression, oppositionality, defiance, avoidance, and moodiness and irritability. Biological, social, and familial factors that may influence behavior and mood must be explored. If a case is not formulated outside the context of presenting symptoms, misdiagnosis, use of unnecessary pharmacotherapy, and an inaccurate treatment plan might result. The following case emphasizes the acute and chronic nature of expressed symptoms and management in sibling rivalry.

## Case

“Evelyn” was a 9-year-old Caucasian girl with no previous psychiatric history who presented to an outpatient psychiatry clinic for “out-of-control behavior.” She was accompanied by her mother. Her father was absent due to work obligations. The mother reported that the child had always been somewhat difficult, but her “behavior had become unbearable” over the past 2 to 3 years and especially over the previous 4 months. The mother described the child’s behavior toward her 3-year-old sister as mean, oppositional, defiant, and physically aggressive, which then provoked the younger sister to react similarly. There was no teacher report of dysregulated behavior, and peer interactions were appropriate.

When interviewed alone, Evelyn maintained good eye contact, was engaged, and acknowledged behaviors described by her mother as accurate. She stated, “I felt left out when my sister was born, and now I feel like inside I love her so much, but outside I can’t stand her.” The father changed jobs 4 months prior and, as a result, only stayed at home 4 days per week. When at home, his attention was directed toward helping the mother with the younger sister. Evelyn felt as though negative attention was better than no attention at all, but

she expressed the desire to obtain positive recognition from her parents. She denied feeling depressed, irritable, angry, or worried outside of the familial context.

In the above case, first-born adjustment toward a sibling birth, frequent absence of a parental figure, a stressed family system, and differential parental involvement contributed to sibling rivalry evidenced by the patient’s dysregulated behavior. Although common, these themes are not present in all sibling rivalry cases. Exploring the family system is therefore crucial to ascertain other contributing factors. In synthesizing reports from the mother and patient, it became evident that the patient’s behavior was in fact “out of control” at times. However, the foundation of such behavior had never been understood, explored, or discussed. The patient began acting out at the time her sister was born. She was no longer her parents’ only focus of attention, which led to feelings of jealousy, loneliness, anger, and attempts to get recognized in any way possible. She knew that she felt love for her sister but also resented her for “taking her place” in the family. Recent worsened behavior coincided with the father’s altered work schedule. His absence provided yet another layer of perceived isolation for the patient, as well as increasing stress within the family system, making it more difficult to effectively mediate conflicts arising within the household or to focus on equally shared attention between the siblings. There was no indication for pharmacotherapy. The family was referred for systemic family therapy, and the diagnosis was coded as V61.8, a sibling relational problem.

## Discussion

The birth of a sibling, as in the above case, is oftentimes marked as the starting point for sibling conflict and competition. Studies focused on rivalry in the context of a

sibling birth have found that children with difficult, less adaptable temperaments tend to display greater distress in response to a sibling birth compared with easier, more adaptive children. Additionally, children are more likely to withdraw, experience sleeping difficulty, and display “clingy” behavior after the birth of a sibling if they are prone to negative moods (1).

Several studies have explored temperament and its contribution to sibling conflict. A particular interest has been on children displaying low persistence, high activity, and strong emotions such as frustration and anger. Researchers have found that children with highly active temperaments experience four times as much sibling conflict as those with less active temperaments and that a difficult temperament in any sibling results in higher levels of conflict and lower levels of positivity in sibling relationships (1, 2). The lack of fit between sibling temperaments may put siblings at risk for conflict, although positive temperamental characteristics in one sibling might function as a buffer to protect the sibling relationship from the potentially negative effects of a difficult temperament in the other sibling (1). All children with difficult temperaments do not necessarily continue to have conflicted sibling relationships. Through experience, maturation, and effective parental monitoring, regulatory skills can be obtained, which in turn influences temperament expression (3).

Parents’ differential treatment of siblings is hypothesized to contribute to variations in sibling relationship quality. Feelings of jealousy, resentment, and anger can emerge when children sense favoritism. Studies of young children have found that siblings express less warmth, more hostility, and tend to withdraw from one another when parents favor one sibling over the other (4). Theories of social comparison suggest that favoritism shapes siblings’ perception

of their position within the family hierarchy. Favored children display less hostility toward their siblings who are not favored, since their position in the family is not threatened. The opposite pattern is true for less favored children (4). Differential parenting can also lead to marital stress and has been linked to longitudinal changes in marital quality spanning the children's middle childhood years to adolescence (5). Differential treatment is often the result of specific parental or marital dynamics. Caregivers should be seen alone to explore differences in parenting if problems within the family continue despite offering parent management education and intervening in family processes (6).

The family system and emotional climate of the household environment is an influential factor in sibling relationships. Studies have consistently shown that negative sibling interactions occur when marital unhappiness, conflict, or lack of emotional cohesion is evident in families (1). Siblings are more likely to handle disputes by means of aggression and coercion when exposed to harsh parenting or chaotic environments. Neutral interactions may be misinterpreted as negatively motivated, self-serving, or hostile (5). Research has demonstrated that outward expressions of anger are distressing to children, even as young as 12 months old (1). Furthermore, elevated levels of parental negative affectivity have correlated with less positivity in sibling relationships (1). Children of depressed parents are more likely to develop depression, anxiety, and externalizing disorders and are at greater risk for social, cognitive, and medical difficulties (7). Depressed parents may display less affection or involvement with their children, communicate less effectively, and demonstrate poor conflict management skills.

Despite the stress that sibling rivalry can pose on a family system, several studies have found that this unique relationship may actually be beneficial. Moderate levels of sibling discord can teach children about compromise, turn taking, and problem solving, as well as provide the opportunity for siblings to vent their emotions, express their feelings, practice open communication, learn to tolerate negative affect, and develop the ability

to empathize (1, 8). Research continues to explore the extent to which the social and emotional competence gained from childhood conflict translates into adulthood. Bedford et al. (9) suggested that adult memories of childhood sibling rivalry, as well as continued conflict in adulthood, might aid in providing a sustained learning experience and promote continued social development. Sibling rivalry in childhood may also affect parenting techniques in adulthood. Mothers who reported sibling rivalry histories in childhood were less likely to use authoritarian parenting strategies or show favoritism and were more aware of the effect that family conflict can have on children's relationships (9).

## Management

Parents' executive functioning is essential in the management of sibling conflict. Early studies supported a direct and authoritative approach to conflict resolution, but more recent studies have found that this approach is not consistently effective, nor does it teach children appropriate conflict management strategies. Smith and Ross (10) found that when parents acted as mediators of conflict, children were able to talk more calmly, share perspectives, listen, apologize, and suggest solutions. Parental mediation included laying down ground rules and obtaining the children's consent to these rules, asking the children to describe what happened and to identify points of contention, encouraging discussion of goals and feelings about issues, and having the children brainstorm resolutions to their disputes while helping to reality check their ideas. Parents utilized active listening, reflecting, and reframing to facilitate their children's understanding of one another's perspectives (10). The impact of this type of conflict resolution model increases with children's age and developmental capability. Modeling appropriate conflict resolution strategies, however, is effective across age groups. A display of calm, nonphysical, and respectful means of conflict management is crucial. The goal is for children to internalize the modeled management strategies and, as develop-

ment proceeds, utilize them regardless of parental presence. Scheduling family meetings to encourage open communication and ensuring that each family member feels equally heard is important. Parents should make an effort to spend equal time with siblings, minimize comparisons, and remain positive.

*Dr. Batson is a second-year child and adolescent psychiatry fellow at the University of Louisville School of Medicine, Louisville, KY.*

## References

1. Brody G: Sibling relationship quality: its causes and consequences. *Annu Rev Psychol* 1998; 49:3-18
2. Mash EJ, Johnson C: Sibling interactions of hyperactive and normal children and their relationship to reports of maternal stress and self-esteem. *J Clin Child Psychol* 1983; 12:91-99
3. Rothbart M, Ahadi SA: Temperament and the development of personality. *J Abnorm Psychol* 1994; 103:55-66
4. Suitor JJ, Sechrist J, Plikuhn M, Pardo ST, Gilligan M, Pillemer K: The role of perceived maternal favoritism in sibling relations in midlife. *J Marriage Fam* 2009; 71:1027
5. Stormshak EA, Bullock BM, Falkenstein CA: Harnessing the power of sibling relationships as a tool for optimizing social-emotional development. *New Direct Child Adolesc Dev* 2009; 126:64-65
6. Josephson AM: Reinventing family therapy: teaching family intervention as a new treatment modality. *Acad Psychiatry* 2008; 32:411
7. Gunlicks ML, Weissman MM: Change in child psychopathology with improvement in parental depression: a systematic review. *J Am Acad Child Adolesc Psychiatry* 2008; 47:379-378
8. Lam CB, Solmeyer AR, McHale SM: Sibling relationships and empathy across the transition to adolescence. *J Youth Adolesc* 2012; 41:1657-1670
9. Bedford VH, Volling BL, Avioli PS: Positive consequences of sibling conflict in childhood and adulthood. *Int J Aging Hum Dev* 2000; 51:59
10. Smith J, Ross H: Training parents to mediate sibling disputes affects children's negotiation and conflict understanding. *Child Dev* 2007; 78:790-805

# Predicting Premature Dropout of Treatment Among Female Substance Abusers

Aparna Iyer, M.D.

Approximately 22 million persons in the United States abuse drugs (1). This is a public health concern, with exorbitant societal costs and debilitating effects on one's family, occupation, and community. Substance use among women poses unique challenges and societal concerns. In utero exposure to alcohol and illicit substances is associated with negative outcomes, including teratogenic effects, cognitive impairment, and sudden infant death. Mothers with addiction disorders often have impaired parenting skills and attachments with their infants (2). Mental health disorders co-occurring with substance use disorders can affect the course of illness and recovery, and treatment of both presents the most effective management strategy (3). Women with both psychiatric and substance use disorders are a relatively understudied population (4).

A study of 1-year outcomes among substance abusers after completion of drug treatment found a decrease in the numbers of persons engaged in heavy alcohol and drug use, improved employment rates, decreased illegal activity, and decreased suicidal ideation (5). However, women, particularly if pregnant or the sole caretakers for children, have more barriers to treatment and are less likely to access treatment programs (6).

Length of stay in substance abuse treatment programs is positively associated with good outcomes, yet early dropout rates are as high as 80% (7). The literature suggests that there is a link between premature dropout from treatment programs and patient characteristics (such as the type of substances abused, age, ethnicity, sex, and legal mandate to services). Stress, trauma, and prior failed treatments are also associated with relapse (8–10). Studies have suggested a correlation between insomnia and relapse, revealing that re-

cently sober patients have disordered breathing and leg movements during sleep (11).

The present study aims to explore characteristics associated with higher dropout rates from chemical dependency programs in a female substance-abusing population. Based on previous research, we predicted that insomnia, prior failed substance abuse treatment, history of trauma, and elevated stress would be associated with higher dropout rates.

## Method

We conducted a retrospective chart review of 71 female patients, ages 21- to 53-years old, who received psychiatric care at our clinic and concurrent inpatient treatment at a long-term chemical dependency program. All participants were in the same residential chemical dependency program, where they were expected to engage actively for 9 to 12 months in individual and group treatment focusing on alcohol and drug use. All clients from the program were referred to our clinic for concurrent outpatient psychiatric treatment of co-occurring mental health issues. All patients referred to our clinic for concurrent treatment who had since been discharged were included in this study. Any patients still actively receiving treatment at our clinic were excluded.

The following five participant data were collected: 1) Depression Anxiety Stress Scale scores at intake (measured through self-report); 2) the number and type of prior treatment programs the patient entered but did not complete (based on patient report at intake); 3) trauma history, including any lifetime history of sexual and/or physical trauma; 4) sleep disturbances (based on patient report at intake), characterized, for example, by

difficulty in sleep initiation or continuity or restlessness; and 5) whether residential treatment was successfully completed. The first four of these five were included as variables in the analyses. Treatment success, which was the outcome variable, was measured based on patients' status at the time of discharge from the chemical dependency program and coded as completed or not completed (either dropped out or asked to leave). Demographic data, including age, ethnicity, type of substances abused, and legal mandate versus voluntary admission to services, were also collected.

The mean participant age was 34.7 years (SD=8.47). The ethnic make-up of the study sample included European American (N=59), African American (N=9), Latino (N=1), and other (N=1). Fifty-one patients were legally mandated to chemical dependency program services, while 20 were voluntarily admitted. To ensure accuracy during data collection, two coders independently collected data while remaining blind to each other's ratings, for three sets of five charts. Interrater reliability was greater than 90% for each set. All discrepancies were discussed between raters until consensus was reached for final ratings.

Analyses of variance and chi-square statistics were used to examine the unique relationship of each variable with dropout.

The mean number of days in psychiatric clinic treatment was 221.1 (range, 0–604 days), with an average of 13.77 sessions attended (range, 0–49), 3.41 sessions cancelled (range, 0–15), and 1.86 no-shows to sessions (range, 0–12). The types of drugs abused are presented in Table 1, and based on these data, the sample notably had a variety of substance and polysubstance abuse. Of the 71 patients assessed, 37 (52%) successfully completed treatment, while 34 (48%) did not.

TABLE 1. Alcohol and Illicit Substances Used Among Women in a Chemical Dependency Treatment Program

Substance	Percentage of Participants	Number of Participants
Alcohol	85.9	61
Cannabis	67.6	48
Crack cocaine	52.1	37
Cocaine	49.3	35
Heroin	33.8	24
Hallucinogens	29.6	21
Nicotine	15.5	11
Amphetamines	12.7	9
Benzodiazepines	9.9	7
Intravenous heroin	8.5	6
Other	5.6	4
Intravenous crack cocaine	4.2	3

The mean level of reported stress was 16.7 (SD=11.47), based on a 0- to 42-point scale. Although Depression Anxiety Stress Scale questionnaires were completed for only 38 patients, the mean scores at intake were statistically significant ( $F=9.52$ ,  $df=1$ , 36,  $p<0.01$ ) between those who completed treatment (mean=12.36 [SD=9.64]) and those who did not (mean=22.81 [SD=11.17]).

Sixty-four (90.1%) patients had prior substance abuse treatment, with the mean number of prior treatments being 3.25 (range for prior failed treatments, 0–14). The differences between the mean number of prior failed treatments among those patients who did versus did not graduate from the chemical dependency program fell short of statistical significance ( $p=0.09$ ). The mean number of prior treatments among those who completed the chemical dependency program was 2.73 (SD=2.6), while the mean number among noncompleters was 3.82 (SD=2.7).

Chi-square analysis revealed a nearly significant difference between graduation rates among those with any prior trauma compared with those without prior trauma ( $p=0.06$ ). No significant difference was found in completion status between those who did and did not report sleep disturbances.

## Discussion

We predicted that insomnia, prior failed substance abuse treatment, trauma history, and elevated stress would be associated with higher dropout rates from a chemical dependency treatment program. Although causality could not be determined, there was a significant difference in the graduation rates among patients reporting higher stress at intake compared with those with lower reported stress, and differences approached statistical significance among patients with trauma histories and greater numbers of prior treatments. Eighty-six percent of patients expe-

rienced some form of trauma, a high co-occurrence of substance use and trauma consistent with the literature (12). While there were no observed significant differences in completion rates among patients with reported sleep disturbances at intake compared with those without such issues, sleep disturbances persisting during treatment might affect premature dropout rates.

The small size and relative homogeneity of our sample may limit the generalizability of the results. Further studies should explore the relationship between premature dropout and psychiatric diagnosis (axis I and axis II disorders), specific substances of abuse, types of trauma, and treatment modality.

*At the time this article was accepted for publication, Dr. Iyer was a fourth-year resident in the Department of Psychiatry, Albany Medical Center, Albany, New York.*

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## References

1. US Department of Health and Human Services: Results from the 2009 National Survey on Drug Use and Health: Volume I, Summary of National Findings. Washington, DC, Department of Health and Human Services, 2010
2. Landi N, Montoya J, Kober H, Rutherford HJ, Mencl WE, Worhunsky PD, Potenza MN, Mayes LC: Maternal neural responses to infant cries and faces: relationships with substance use. *Front Psychiatry* 2011; 2:32
3. Kelly T, Daley D, Douajhy A: Treatment of substance abusing patients with comorbid psychiatric disorders. *Addict Behav* 2012; 37:11–24
4. National Institute on Drug Abuse: Drug Addiction Research and the Health of Women Executive Summary. Bethesda, Md, National Institutes of Health, 1998
5. Drug Abuse Treatment Outcome Studies: [www.datos.org](http://www.datos.org)
6. Breitbart V, Chavkin W, Wise PH: The accessibility of drug treatment for pregnant women: a survey of programs in five

- cities. *Am J Public Health* 1994; 84:1658–1661
7. Wickizer T, Maynard C, Atherly A, Frederick M, Koepsell T, Krupski A, Stark K: Completion rates of clients discharges from drug and alcohol treatment programs in Washington state. *Am J Public Health* 1994; 84:215–221
  8. Hser Y, Grella CE, Hsieh S, Anglin MD, Brown BS: Prior treatment experience related to process and outcomes in DATOS. *Drug Alcohol Depend* 1999; 57:137–150
  9. Hansson AC, Cippitelli A, Sommer WH, Fedeli A, Bjork K, Soverchia L, Terasmaa A, Massi M, Heilig M, Ciccocioppo R: Variation at the rat Crhr1 locus and sensitivity to relapse into alcohol seeking induced by environmental stress. *Proc Natl Acad Sci U S A* 2006; 103:15236–15241
  10. Kubiak SP: The effects of PTSD on treatment adherence, drug relapse and criminal recidivism in a sample of incarcerated men and women. *Res Soc Work Pract* 2004; 14:424–433
  11. Brower KJ, Aldrich MS, Robinson EA, Zucker RA, Greden JF: Insomnia, self-medication, and relapse to alcoholism. *Am J Psychiatry* 2001; 158:399–404
  12. Najavits LM, Weiss RD, Shaw SR. The link between substance abuse and post-traumatic stress disorder in women: A research review. *The American Journal on Addictions*. 1997 6(4): 273-283

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## Case Report

# Psychodynamic Therapy in Patients Who Are Resistant to Treatment: A Critical Piece of the Puzzle

Eric Meyer, M.D.

The biopsychosocial formulation is a powerful tool that residents learn as a means to appreciate the different spheres that influence patient presentations. Compared with the psychological aspects of the formulation, appreciating the biological and social contributions tends to be easier. Methods to improve providers' psychodynamic formulations are described in Samuel Perry's sentinel paper, published in 1987 (1). A psychodynamic formulation offers a succinct conceptualization of a patient's psychological structure, which can guide management through symptomatic evolution while alerting providers of potential hurdles in treatment and helping to navigate resistance (1).

There are many reasons why the psychodynamic aspects of a patient might not be explored. The restrictions of managed health care can leave providers feeling as though they do not have time to explore their patients' ego-structure or fantasy life (2). Providers with less training in a psychodynamic approach might be unaware that they are using psychodynamic techniques (3) or might feel as though they should avoid incorporating such techniques out of concern for patient boundaries (4). The inclusion of psychodynamic training during residency itself has been debated (5). A psychological framework can orient care, keep treatment on track, put symptoms into a context, and help explain transference and countertransference (1). A psychodynamic approach can facilitate fuller treatment responsiveness when combined with other psychological and biological approaches (6). It may also promote an understanding of why prior treatment benefits were limited. The following is a case report of an active-duty serviceman with posttraumatic stress disorder (PTSD) who did not respond to treatment as usual until a psychodynamic approach was incorporated.

## Case

"Mr. A" is a 35-year-old active-duty married Hispanic man with two young children. He presented with irritability, anger, nightmares, feeling estranged from others, and depression. The patient reported that these symptoms started 3 years prior, shortly after his deployment to Afghanistan, where he provided first aid to a family injured by a roadside bomb. He was only able to save the family's youngest daughter. Although she recovered after a prolonged intensive care stay, he has recurrent intrusive nightmares about the event.

The patient reported that his children's screaming exacerbates his current symptoms of affective blunting, avoidance, and irritability. His wife, who has chronic pain, is often unable to assist with care of their children. The patient reported resentment toward his wife as a result but endorsed that he does not communicate these feelings with her. He denied any previous psychiatric history, substance misuse, or family psychiatric history. He reported that his childhood was lonely because of frequent exposure to parental conflict and paternal alcohol misuse. He recalled feeling excited to leave home for the military.

Mr. A was diagnosed with PTSD and chronic and depressive disorder not otherwise specified. He eagerly began treatment as usual: a selective serotonin reuptake inhibitor for anxiety and depression, trazodone for sleep disturbances, and prolonged exposure therapy. Although he initially reported improvement, he soon stopped presenting to his appointments. His commander contacted the clinic, reporting concern that the patient "doesn't feel supported." Shortly thereafter, he was acutely hospitalized, and several medications were added. The discharge summary noted that the "patient seemed very open with the primary team, and was willing to work hard to get better."

After hospital discharge, the patient was again enthusiastic about outpatient treatment, sharing a perception that his inpatient doctors "did not know how to treat his condition." Shortly thereafter, he reported that his medications were no longer working, and his no-show rate increased. The medications were changed, and he completed cognitive-processing therapy with limited symptom improvement. A few weeks later, he required another brief hospitalization, and his medications were changed again. He continued to report difficulties with depression, avoidance, and hyperarousal. He was then enrolled in a 60-day intensive outpatient program. After another brief period of recovery, he began to endorse dysfunction at home and at work, with ongoing symptoms of avoidance. At this time, a psychodynamic formulation was developed over four 1-hour sessions. With the addition of this formulation, the patient's providers could better process his treatment resistance, which enabled him to engage in long-term recovery and self-exploration.

## Discussion

The patient's upbringing is best characterized as one of dejection; he was taught by his mother, who was emotionally unavailable herself, to avoid expressing his emotions secondary to her fears of upsetting his father. As a result, the patient has a negative self-perception compounded by negative hindsight bias, with numerous examples of an overbearing superego criticizing his desires for acceptance. Although his neurotic personality structure limits his ability to openly request approval, his subconscious desires to be accepted have resulted in conflict. He enjoys presenting as "hopelessly broken" or "treatment resistant" because it provides him with special attention from his wife, providers, and work supervisors, followed by a brief "flight to health." When any of these parties becomes exhausted and "fail

to save him” or “reject him,” he then goes to another party, with fresh injuries to repeat the cycle. In his wife’s case, her own pathology limits her ability to keep up with his expectations and strongly reinforces his sense of dejection.

His splitting mimics the triangulation that occurred during his upbringing and perpetuates his feelings of dejection. Recognizing that his transference toward his providers may resemble a parental relationship reinforces the importance of setting clear expectations from the outset. Similarly, providers should expect that he will recover quickly for a short period of time after finding a new party to save him but will then decline as a mechanism of resistance secondary to feeling guilty for his reliance on the provider. This form of splitting should be resisted through frequent family/command involvement.

This case is not uncommon because combat veterans often have increased PTSD symptoms and comorbid psychiatric disorders (7) that can foster treatment resistance (8). Although the above patient had undergone several evidence-based treatments, his psychological structure and ego function had not been taken into account. Accessing a patient’s psyche does not necessarily have to occur under the guise of psychodynamic therapy. It can be as simple as incorporating seven areas of questioning into routine therapy (Table 1) (9).

Manualized therapies (cognitive-behavioral therapy, cognitive-processing therapy, and prolonged exposure therapy) are often more successful when aspects of dynamic therapy are incorporated into the treatment, knowingly or otherwise (3, 6). Similarly, the effect of medication management is likely improved when dynamic factors are taken into account. No matter what the treatment approach, including a thorough psychodynamic description as part of an initial biopsychosocial formulation can assist in guiding treatment. Perry et al. (1) provide guidance for creating such a formulation and recommend the following four areas: summarizing statement, description of nondynamic factors, psychodynamic explanation of central conflicts, and predicting responses to the therapeutic situation.

TABLE 1. Process and Technique of Psychodynamic Psychotherapy

Focus on affect and expression of emotions.
Exploration of attempts to avoid distressing thoughts and feelings.
Identification of recurring themes and patterns.
Discussion of past experience (developmental focus).
Focus on interpersonal relations.
Focus on the therapy relationship.
Exploration of fantasy life.

Psychodynamic explanation of central conflicts can be accomplished using any variety of schemas; ego, object, and self-psychology each have strengths and weaknesses with regard to understanding different patients. In the end, each will typically identify a similar core problem for the patient and help guide future therapy.

For providers who are uncomfortable with a dynamic approach, there are several tools available to help determine underlying psychological processes, such as the Structured Interview of Personality Organization (10) and the Shedler-Westen Assessment Procedure (11). The latter can also be helpful in monitoring improvement in a patient’s underlying psychological structure as treatment progresses.

As seen in the above case, patients with limited response to treatment may benefit from a psychodynamic approach. Similarly, including an initial psychodynamic formulation early in treatment may improve the success of other behavioral health interventions.

*Dr. Meyer is a third-year resident in the Department of Psychiatry, University of Texas Health Science Center at San Antonio, and a teaching fellow at the Uniformed Services University of the Health Sciences, Bethesda, Md.*

## References

1. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure, and clinical application. *Am J Psychiatry* 1987; 144:543–550
2. Schwartz J: Meaning vs. medical necessity: can psychoanalytic treatments exist in a managed care world? *Psychother Theor Res Pract Train* 1997; 34:115–123
3. Kazdin AE: Evidence-based treatment and practice: new opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *Am Psychol* 2008; 63:146–159
4. Norris DM, Gutheil TG, Strasburger LH: This couldn’t happen to me: boundary problems and sexual misconduct in the psychotherapy relationship. *Psychiatr Serv* 2003; 54:517–522
5. Yager J, Mellman L, Rubin E, Tasman A: The RRC mandate for residency programs to demonstrate psychodynamic psychotherapy competency among residents: a debate. *Acad Psychiatry* 2005; 29: 339–349
6. Shedler J: The efficacy of psychodynamic psychotherapy. *Am Psychol* 2010; 65: 98–109
7. Sautter FJ, Brailey K, Uddo MM, Hamilton MF, Beard MG, Borges AH: PTSD and comorbid psychotic disorder: comparison with veterans diagnosed with PTSD or psychotic disorder. *J Trauma Stress* 1999; 12:73–88
8. Katz C, Stein M, Richardson JD, Seedat S, Sareen J: A review of interventions for treatment resistance posttraumatic stress disorder, in *Different Views of Anxiety Disorders*, first ed. Edited by Seleck S. Rijeka, Croatia, InTech, 2011
9. Blagys MD, Hilsenroth MJ: Distinctive activities of short-term psychodynamic-interpersonal psychotherapy: a review of the comparative psychotherapy process literature. *Clin Psychol Sci Pract* 2000; 7:167–188
10. Clarkin JF, Caligor E, Stern B, Kernberg OF: *Structured Interview of Personality Organization*. New York, Personality Disorders Institute, Weill Medical College, Cornell University, 2007
11. Shedler J, Westen D: The Shedler-Westen Assessment Procedure (SWAP): Making Personality Diagnosis Clinically Meaningful. *Journal Person Assess* 2007; 89:41–55

# 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 Caitlin Dufault, M.D., a third-year resident at the University of New Mexico, Albuquerque.

## Question 1.

A 33-year-old woman presents to your office 4 months after she was involved in a serious motor vehicle accident. Her boyfriend, who was driving the car, died at the scene of the accident from traumatic injuries. The woman reports feeling significant guilt that she survived the accident. Although she was told that she performed cardiopulmonary resuscitation on her boyfriend, she cannot remember doing so. She also reports a 3-month history of irritability, diminished interest in her usual hobbies, difficulty concentrating, flashbacks, and frequent nightmares of the event. She admits to deliberate efforts to avoid discussing the accident. In which edition of DSM did this woman's diagnosis, posttraumatic stress disorder, first appear?

- A. DSM-IV
- B. DSM-III-R
- C. DSM-II
- D. DSM-III

## Question 2.

In the DSM-IV-TR Glossary of Culture-Bound Syndromes, which of the following syndromes frequently occurs as a direct result of a stressful event relating to the family and is commonly characterized by uncontrollable shouting, attacks of crying, trembling, sensations of heat in the chest rising into the head, and verbal or physical aggression?

- A. Boufée delirante
- B. Ataque de nervios
- C. Zar
- D. Koro

## ANSWERS TO APRIL QUESTIONS

### Question #1.

**Answer: B.** Test for sensitivity reactions

Medication nonadherence can be addressed with the use of depot antipsychotics (1). Depot typical antipsychotics are oil-based preparations, making the patient more prone to allergic reactions, prompting the use of a test dose for sensitivity reactions. A trail of test depot antipsychotic dose in addition to the trail of the same oral antipsychotic will test for any allergic reactions for the base oil. Atypical antipsychotic depot preparations are water based; hence the base is less likely to cause sensitivity reactions. Psychological resistance and testing for extrapyramidal side effects are not reasons for the use of an intramuscular test dose.

#### Reference

1. Taylor D, Paton C, Kapur S: The Maudsley Prescribing Guidelines in Psychiatry, 11th ed. Chichester, United Kingdom, Wiley-Blackwell, 2012, pp 40-44

### Question #2.

**Answer D.** At 6 weeks

With depot antipsychotic long-acting injections, antipsychotic medication is slowly released over weeks to months. With the initial administrations, it takes 6 to 8 weeks to reach steady state. Because it is not possible to assess effectiveness of the depot dose before 6 weeks, dose adjustments should ideally be made past this duration with the first administrations (1).

#### Reference

1. Taylor D, Paton C, Kapur S: The Maudsley Prescribing Guidelines in Psychiatry, 11th ed. Chichester, United Kingdom, Wiley-Blackwell, 2012, pp 40-44

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.
- \*Please direct all inquiries and submissions to Dr. Vahabzadeh: [arshya.vahabzadeh@emory.edu](mailto:arshya.vahabzadeh@emory.edu).



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- 2. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
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## Upcoming Issue Themes

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

### July 2013

Section Theme: Open  
E-mail Editor: Arshya Vahabzadeh, M.D.  
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### August 2013

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### September 2013

Section Theme: Open  
E-mail Editor: Arshya Vahabzadeh, M.D.  
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### October 2013

Section Theme: Global Psychiatry  
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