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In This Issue

Editorial

Sarah B. Johnson, M.D., Editor-in-Chief



Over the past year, we have noticed an increase in the number of submissions to the Residents' Journal, as it has grown in popularity. In response to this growth, we will be adding a second editorial position next year to ensure that these pieces find a good "home." In this month's issue, we deviate from our usual format to include a wide range of material, featuring a selection of pieces submitted by contributors that were not solicited by monthly editors. In an interview with Dr. Nancy Rappaport, Dr. Ruth Gerson addresses issues related to the impact of suicide on families. Dr. Partam Manalai discusses the neurobiology, clinical spectrum, and psychopathology of antisocial personality disorder. Then, Dr. Matthew L. Prowler reflects on how personal life experiences can influence the "artistry" component of our field. In an article on countertransference, Dr. Deepak Kumar reminds us of the power of insight into human nature. Dr. Ashley R. Sholes presents a case report on neurosyphilis as a medical mystery. We conclude with a poem by Tracey Nicole Liebman, reflective of her work on a psychiatric ward.

Understanding Suicide: An Interview With Dr. Nancy Rappaport

Ruth Gerson, M.D.
Cambridge Health Alliance, Cambridge, Mass.

The following is an interview with Nancy Rappaport, M.D., conducted by Ruth Gerson, M.D., on the impact of suicide on families. Dr. Rappaport's memoir, In Her Wake: A Child Psychiatrist Explores the Mystery of her Mother's Suicide, describes her process of exploring and coming to terms with her mother's death. In this interview, Dr. Rappaport discusses this process and how it has impacted her clinical work. Dr. Rappaport is the Director of School-Based Programs and Mental Health Director of the Teen Health Center at Cambridge Health Alliance; she is also an Assistant Professor of Psychiatry at Harvard Medical School. Dr. Gerson is a second-year psychiatry resident at Cambridge Health Alliance.

Dr. Gerson: How did you decide to begin studying your mother's life and tragic death?

Dr. Rappaport: I don't think there was a moment when I decided this was what I wanted to do. But definitely, there was a process. I had a heightened awareness when my daughter Lila was born. I understood the tremendous love a mother has for a baby, and I realized that my mother loved me. And later, as I got older, I realized I would survive my mother. I began writing letters to her, which were very raw. Then I received a call from my stepmother, which I describe in the book, to let me know that she had a trunk of my mother's belongings, and I began reading her journals—her novel—which were very evocative of how much she wanted to be in our lives, her yearning to be our mother. It really took me 10 years to digest all of this.

Dr. Gerson: What has the process of searching and writing meant for you? How have you dealt with opposition from your father and other family members?

Dr. Rappaport: My family has been remarkably generous about the book. Suicide creates an enormous weight for a family, and as I say in the book, suicide demands to be explained, so people search for blame because the one person who can really explain it is dead. But in some way, my family has been brought closer by the process, by their generosity and willingness to talk about it. The one who has been magnanimous but also struggled is my father. It was really courageous of him not to have blocked it.

In terms of the process, it changed over

time, and there were several drafts, several versions of this book. I tried very hard to show the different perspectives, to take a balanced view. And it started as cathartic, but with the later drafts, I wanted people to be moved and to learn at the same time.

Dr. Gerson: Patients who are considering revisiting and working through particularly difficult or traumatizing times in their lives are often advised to wait until they are in a safe and supportive environment and equipped to cope with the tumultuous emotions that arise. What allowed you to begin studying your mother's life when you did?

Dr. Rappaport: I didn't always know it was the right time. There were times, reading my mother's journals, that I wasn't sure that I could handle it. But a few things made it possible. One was having a life to go back to: being a mother, a wife, a doctor, having those other roles and supportive relationships. Self-care and pacing myself was also important. I'm also a marathon runner, and in a way this too was a test of endurance. But what really kept me going was that I needed to tell this story, in a way that felt like a calling. I wanted to achieve a level of understanding that was larger than myself.

Dr. Gerson: Adolescents and young adults frequently struggle with anger and disappointment when they realize that their parents, who they have loved and idealized, are not perfect. What was it like to delve into your parents' complicated relationships and personal struggles?

Dr. Rappaport: We revisit our parents all the time; it's not a linear process. There's

a constant evolution of the way you see people, to be less conflicted about how you see them, a constant negotiation between closeness and distance. The thing that is amazing about adolescents is the tremendous loyalty they have to their parents, no matter what. Sometimes when therapists are starting out, they mistakenly think they can in some ways replace the parent, but really the goal is to help families be resources for each other.

Dr. Gerson: In your book you describe many parallels between your patients' struggles and those faced by members of your family. You also discuss how things might have been different had your mother's doctors had modern techniques and medications at their disposal. How did the experience of writing this book change your work with your patients?

Dr. Rappaport: I don't think I understood the relationship between impulsivity and suicide and how it crosses diagnoses. I pay much closer [attention] to impulsivity now when I'm doing risk assessments. And it's difficult because how do you tolerate working with someone who's suicidal, wanting to make a difference in their life but also knowing it's their choice to live? Surviving a family suicide helps you understand that you will try to keep someone alive, but eventually you are somewhat impotent. And when I am working with teenagers who are suicidal, rarely [do] I share my family history with the parents. I'm very careful to make sure it's about them and their child, but sometimes I say, "I want to do everything I can to keep your family from having to deal with that kind of loss."

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The other piece is [that] there is really no data collected about family members of people who commit suicide. I'm not sure why not; there are 33,000 suicides a year. I think we need to be more sensitive to the families and integrate families into treatment, to ask them, "How are you understanding what happened, how are you managing?"

Dr. Gerson: Do you have any advice for therapists or families of children or adults affected by suicide?

Dr. Rappaport: Suicide is going to have a different meaning in different family members' stages of life, at graduation or the birth of a child, etc. And it's an ambiguous loss, and people have ambivalent feelings about it. It's complicated by the fear of intergenerational transmission or fear that it's contagious. So it's important to open lines of communication between family members, between siblings, and encourage people to ask others' experiences.

There is also a tendency, I think, to overvalue the work of therapy, but there are many other avenues through grief—creating narratives, learning coping [skills]—so it's important to honor the ways individuals are managing, their different ways of dealing with things. As my son says to me in the book, "Just because you talk about how you lost your mother doesn't mean Papa doesn't have any feelings about losing his mother." It's important to respect the different ways that people connect with the dead person.

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New Outlook on an Old Problem: Antisocial Personality Disorder

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Antisocial personality disorder is a common psychopathology, affecting 1% of the general population and 15%–25% of people in detention facilities. The definition, neurobiology, and clinical spectrum of the disorder, however, have remained unclear. Individuals with antisocial personality disorder show deficits in at least three dimensions of their social interactions: interpersonal, emotional, and behavioral (1). In this regard, antisocial personality disorder resembles learning disorders. Both individuals with learning disability and persons with antisocial personality disorder show information processing deficits in some areas, while they may maintain other executive functions.

There is a dearth of literature on the neurobiology of antisocial personality disorder, and no definitive neurological defects have been identified. However, some similarities with normal children have been observed. Children activate larger areas of their brain to complete a mental task compared with adults (2). Adults with antisocial personality disorder, nonetheless, seem to continue activating larger neuronal mass.

One simple test to measure executive functioning at lower levels is the Go/No-Go task. An example of this task is instructing an individual to press a button when seeing any letter except “X.” Functional magnetic resonance imaging of the brain during this task found that

both children and adults show activities in the prefrontal cortex. However, children show higher volume activation, particularly in the dorsolateral prefrontal cortex (2). Interestingly, people with antisocial personality disorder and borderline personality disorder show more extensive and bilateral activation on the Go/No-Go task as well (3).

Other similarities have also been observed, for instance, in sensation seeking risky behavior and perspective taking performances. In thrill seeking behavior (e.g., the gambling task), adolescents show lower neuronal recruitment and continue to choose riskier options compared with adults, a characteristic shared with posttrauma antisocial behavior (4). Perspective taking refers to the ability to take another person’s perception and viewpoint. Normally, children not affected by autism develop this skill by preschool age. Similar to autistic children, a subset of individuals with antisocial personality disorder perform poorly on perspective taking tasks (5).

In the psychopathology of antisocial personality disorder, some data are suggestive of patterns similar to those found in learning disability and warrant further exploration. Analogous to individuals with mathematic disorders, persons with antisocial personality disorder may be unable to comprehend what is socially expected. If the disorder is, at least in part,

a learning problem, the management will have to be changed dramatically and emphasis will have to shift to preventive measures, including early detection and education.

Dr. Manalai is a third-year and Chief resident at Saint Elizabeth Hospital, Washington, DC.

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Writing for the “Blue Journal”: The Residents And Fellows Edition of *The American Journal of Psychiatry*

Date: Monday, May 24, 2010

Time: 9:00 AM to 10:30 AM

**Location: RM 346/347 in the
Morial Convention Center**

An Education

Matthew L. Prowler, M.D.
Children's Hospital of Philadelphia

My father died before he saw me become a doctor. I often wonder what he would have thought of my choice of psychiatry. In fact, his death led me to this choice in many ways.

I was applying to medical school when he was diagnosed with malignant renal cell carcinoma. He died 6 months after the diagnosis.

My father was my hero. A successful architect, he was the most intelligent, witty, and well-rounded man that I knew. He was stoic and proud; he projected strength, and at 6'3" and 200 pounds, he assumed the pose seamlessly.

I never really challenged his authority or views. More than anything, I wanted his approval and to live up to his high standards. He unquestionably loved my sister and me, and he showed it. But he was somewhat aloof, not open or expressive with his emotions.

Despite his vital strength, he began slipping away quickly. He became more weak, quiet, and withdrawn. At the time, I was consumed with my own needs. I selfishly wanted so much more from him. I wanted to talk about life, death, love, God, everything. It was our only chance. I wanted to laugh about memories and cry about how messed up and random life can be, as it was taking away a man in his prime. At times, I would initiate these conversations, and he would just shut down. And I became furious with him.

My mother took the family to see a therapist. My father said that he did not want to burden us. Looking back now, he was probably trying to protect us from all the emotions he was feeling that were right under the surface, emotions from which he probably *wanted* to unburden himself.

But I was more focused on what he said next. As I was urging him to talk about what he was feeling, he said, "Maybe it's just easier for you to deal with emotions than me." And he began to cry. It was the first time I had seen him cry since the diagnosis. I never conceived that anything could come easier to me than it did to him. Really, it felt like a gift.

In the ensuing weeks and months of overwhelming grief, I tried to find meaning from our tragic loss. I held closely to the memory of that session and my father's words, as if he had bequeathed a direction for me. I realized my great curiosity about emotion and behavior. I liked asking questions and wanted to know why people act the way they do.

And I was attracted to the fact that psychiatry, like architecture, combines science and art. While we revolutionize our understanding of neuroscience, we cannot deny that much of our current practice relies on what could be called artistry as easily as "nonspecific factors."

Now, as a therapist, I find myself on the other side of these sessions. Throughout training, I have focused on learning the science in order to apply evidence-based data and thereby facilitate something meaningful for a patient or family.

The artistry is more difficult. I practice active listening, attending to cues. It sometimes doesn't seem like enough.

Faced with moments of uncertainty, I obsessively want a roadmap. We talk about healthy infant and child development. But, we don't discuss mid- and end-of-life development to the same extent.

As Freud aged, he conceptualized a "death drive." Erikson wrote about in-

tegrity versus despair. Jung described his own transcendent near-death experience and found it consistent with his ideas of a collective unconscious.

But in the office, how can I manage my own values and morals and not presume to teach or guide a healthy or "right" way to live and die based on my views?

Several months ago, my advisor and eminent child psychiatrist Elizabeth Weller succumbed to her battle with breast cancer. She worked until the end, not openly discussing her impending death. We met weekly in the months before she died. I began reexperiencing the emotions that I had felt around my father's death. In dealing with the grief, I wanted to confront her mortality head-on. In one session of supervision, several weeks before she died, I even started asking her the same questions that I had asked my dad. She reacted in a similar way, by pulling away. Later in the same meeting, with regard to the clinical case we were discussing, as if sensing my earlier emotional frustration, she looked me wisely and sweetly in the eyes and said, "The most important thing I can teach you, Matthew, is always listen to the patient first; let that be your guide."

Since Dr. Weller's death, her words play over in my mind. In trying to satisfy my need for answers, as I had 8 years earlier with my father, I continued to push before I listened. And I had been missing the point all along. It's not always about asking the right question or even getting the right answer, in life or in practice. The artistry, in the end, is in listening first.

Dr. Prowler is a Child and Adolescent Psychiatry Fellow at Children's Hospital of Philadelphia.



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The Cocoon of Countertransference

Deepak Kumar, M.D.

Mount Sinai School of Medicine-Elmhurst Hospital Center

“In New York City, one suicide in ten is attributed to a lack of storage space.”

---Judith Stone

In retrospect, one finds that there are times in one’s clinical practice—and indeed education—that a defining moment comes unexpectedly. For me, it was a psychotherapy patient who perhaps to this day continues to believe that my work with her was fruitless. And if a patient’s perception is one of the yardsticks by which we measure the success of our care, could I objectively then deem my work with her a success at all?

“Ms. P” was a middle-aged Caucasian woman who had seen better days. Having once had wealth to live a luxurious lifestyle, she bemoaned the poverty that confronted her now, forcing discontent upon her. While her intelligence and desire to lead and create had not diminished, she was forced to “play second fiddle” to many a stranger, including me, secondary to a mandate by the Adult Protective Services, which had concluded that her cluttered apartment was the sign of a cluttered mind. She was referred to me by another resident, “Dr. F,” who described her as a “great narcissist” in urgent need of individual psychotherapy. My first impression of Ms. P was that of a depressed woman who was vulnerable and fragile. Dr. F would remain her psychopharmacologist while I would go on to become her psychotherapist.

We spent the first few sessions gently exploring the decisions that had led her to her current state while I provided liberal support. Her affect gradually brightened, and she appeared more put together. Dr. F pointed out to me how Ms P regularly found time to get her nails and hair done and to continue managing a non-profit organization while claiming that she rarely left her bed. However, she went to great lengths to prove how no progress had been made at all. More importantly, she informed me of her contempt for our city hospital, the population that we served, and the physicians who treated

her. She found that Dr. F’s English speaking skills left much to be desired. And to her, I was someone whose declared aim of helping her was divorced from the real aim of just going through the motions of psychotherapy. She criticized my mannerisms, my office, and everything in between. She sometimes used words that made me wonder whether I needed to do nothing, say nothing, and be nothing in order to avoid her criticism. Upon further examination, I thought her childhood experiences pointed to a deep-seated anger toward her misogynist father and strict mother. Curiously, the more Ms. P vented her anger at me and my institution, the more I advertised her in our psychotherapy class as a great patient to learn from.

Her worst affliction, though, was not contempt for others but self-contempt. She asked who could possibly want to be with a middle-aged, balding, and broke woman. And more than once she declared tearfully that the most terrible poverty is loneliness and the feeling of being unloved. While her parents had long been dead, her sister lived in another city. If one of the keys to happiness is a bad memory, Ms. P appeared to lack it. She remembered every slight and every injustice inflicted upon her by her sister who, according to her, was their parents’ favorite. The sister went on to have a husband and kids while Ms. P remained single and childless. Perhaps no hatred is as bitter as that of near relations because the sister once stormed out of a wedding after she learned Ms. P was also there.

So, Ms. P had turned to music and her numerous cats as two means of refuge from the miseries of life. She found cats to be agreeable friends—they asked no questions, they passed no criticisms. She declared that if she ever decided to let go of them or to resign from her organization, it would be a sign she was thinking of killing herself, but she demanded that I must never take her to the emergency room, or else she would terminate treatment.

She resisted all attempts to explore her life’s story in any depth, either by frequently threatening to quit or by endorsing worsening symptoms in the following session, thereby requiring me to be more supportive. As my frustration grew, I wondered where my strong antipathy toward her, of which I had only recently become aware, stemmed from. It began to dawn on me that she reminded me of a critical attending psychiatrist from a previous training program who never approved of my accent, ethnicity, or work.

Our last session occurred shortly afterward. Ms. P announced that she was going to give her cats away and to resign from her organization. I thought of Albert Camus who once said that there is but one truly philosophical problem, and that is suicide. The more I discussed her hopelessness with her, the more I became convinced that it was an ambivalent cry for help that would, nevertheless, force us to end treatment. I ended up taking her to the psychiatry emergency room, from where she was promptly discharged, never to be seen by me again.

Looking back, I wonder if I took her to the emergency room because I was as ready to terminate treatment with her as she apparently had been. When my supervisor asked me if I had felt let down by her supervision, by her “failure to foresee these developments,” or by my colleague who had referred to me a patient she seemed not to like, I thought to myself that if anything would have made a real difference to the outcome, it would have been my ability to venture out of the cocoon of my countertransference early on. But one of us did succeed—Ms. P—who taught me that nothing is as powerful as an insight into human nature, particularly our own.

Dr. Kumar is a fourth-year resident in the Department of Psychiatry, Mount Sinai School of Medicine-Elmhurst Hospital Center, New York.

Neurosyphilis: A Case Report and Review of the Literature

Ashley R. Sholes, M.D.

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Syphilis, caused by the bacterium *Treponema pallidum*, is a sexually transmitted disease that may progress through a number of stages. The natural history of syphilis has been characterized by data collected on infected patients who went untreated (1–3), but the course of illness can be variable. Not all patients exhibit symptoms in every stage. Moreover, the symptoms exhibited can be highly variable.

Primary syphilis consists of a painless chancre, developing at the site of inoculation 10–90 days after exposure. During primary syphilis, the bacterium spreads systemically. Even in the absence of treatment, symptoms of primary syphilis may resolve within 6 weeks to 6 months (4). Secondary syphilis, which occurs weeks to months after the chancre, consists of a systemic illness characterized by fever, rash, headache, malaise, anorexia, and diffuse lymphadenopathy. Secondary syphilis is estimated to occur in approximately 25% of untreated individuals (2). Again, these symptoms typically resolve without treatment. The individual then enters latent syphilis, a period defined by positive seroreactivity but an absence of clinical symptoms of the disease. When untreated, 30% of latent-stage individuals will go on to develop tertiary syphilis.

Tertiary syphilis may develop years to decades after initial inoculation and consists of a wide variety of serious complications. Gummas may form in the skin, bones, and other organs. Aortitis, ocular, and otitic disease are also seen (4). However, it is CNS involvement that accounts for tabes dorsalis and general paresis. Tabes dorsalis, caused by invasion of the posterior columns of the spinal cord, is characterized by autonomic dysfunction, impaired proprioception, diffuse lightning pains and decreased reflexes, but normal strength, in the lower extremities. The majority of patients with tabes dorsalis have some form of pupillary abnormality, with approximately 50% demonstrating the classic Argyll Robertson pupil – a

pupil that does not react to light, but contracts normally with accommodation and convergence (5). General paresis is a progressive dementia characterized by early forgetfulness and personality change, typically developing 10–25 years after infection. It progresses to poor decision making, worsening memory, and eventually severe dementia. Patients may develop depression, mania, or psychosis. Neurologic symptoms at this stage may include dysarthria, hypotonia, intention tremor, and abnormal reflexes. Left untreated, general paresis typically leads to death in an average of 2.5 years (6).

There is no single test to diagnose neurosyphilis. The CSF venereal disease research laboratory examination is the standard test for neurosyphilis. A positive test is considered diagnostic of neurosyphilis in the absence of significant contamination of the CSF specimen with blood. However, because the test is highly specific (specificity 99%) but insensitive (sensitivity 70.8%) (7), diagnosis often relies on a combination of other tests that are both nonspecific and insensitive, requiring that they be interpreted in combination with the clinical assessment. Such combinations may include reactive serologic tests, tests for elevated CSF protein levels, and tests for CSF leukocyte count, which is generally >5 cells/mm³. All patients with syphilis should be tested for HIV.

The standard treatment regimen for neurosyphilis is intravenous aqueous crystalline penicillin G (18–24 U/day), administered as either 3–4 million U every 4 hours or in a continuous infusion for 10–14 days. If compliance with therapy can be ensured, an alternative of procaine penicillin G (2.4 million U/intramuscular daily) plus probenecid (500 mg/by mouth four times daily), both for 10–14 days, can be used. After treatment, patients should have repeat CSF testing every 6 months until the CSF white blood cell count normalizes. CSF venereal dis-

ease research laboratory results and CSF protein levels can also be monitored, but these parameters are expected to normalize more slowly. In cases of general paresis, treatment may improve the cognitive or psychiatric disease in relatively early cases or arrest disease progression in approximately one-half of advanced cases. While treatment may reduce new nerve damage, it is unlikely that it will reverse existing damage (5, 8).

The incidence of syphilis has increased over recent years in the United States, following a decline between 1941 and 2000 (9). Given the increasing incidence of syphilis, the potentially devastating long-term outcomes of the disease, and the potential to avoid or minimize adverse outcomes with early treatment, providers must be attentive in their diagnostic work-ups and consider syphilis as a potential cause of psychiatric illness. In the present case, we report the clinical course, laboratory data, imaging results, and symptoms after treatment for a young patient with neurosyphilis manifested as mild dementia with personality change.

“Mr. B” was a 38-year-old right-handed man with no psychiatric or medical history who was brought to an outside psychiatric evaluation by his partner of 15 years. Although Mr. B denied any problems, his partner described 1.5 years of subtle changes in personality. These changes consisted primarily of being more talkative in social situations, flattening of affect, and increased frustration with previously simple tasks. Additionally, the patient was noted to have experienced approximately 1 year of increased difficulty following and engaging in conversations. He was reported to misinterpret what was said to him. He would tell stories repeatedly, using the exact same words and intonation each time, seemingly unaware that he had previously told the same narrative. He was also overinclusive of details

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and used the wrong words in sentences. He had increasing difficulty completing the tasks of his job as a laboratory technician and had been fired for performance problems after numerous attempts at remediation. There was no known contributing family or medical history. On examination, he was noted to be passive, somewhat disengaged, and exhibiting restricted affect. He was diagnosed with an unspecified depressive disorder and started on escitalopram and clonazepam.

At follow-up evaluation, Mr. B and his partner reported no improvement in his symptoms. Basic laboratory examinations were conducted 4 months after initial evaluation, including a complete blood count, comprehensive metabolic panel, and assessment of thyroid stimulating hormone levels. All laboratory results were normal. HIV test results were negative, but rapid plasma reagin was positive. At that time, he was referred to a specialty infectious disease clinic, where serum rapid plasma reagin was reactive (titer: 1:128) and lumbar puncture demonstrated the following results: 78 white cells, protein level of 120, reactive CSF research laboratory results (titer: 1:128), and reactive CSF fluorescent treponemal antibody absorption results. He was immediately started on a regimen of intramuscular procaine penicillin G (2.4 million units daily) and probenecid (500 mg/by mouth every 4 days), both for 14 days. With this, his laboratory findings improved (Table 1).

Per the Centers for Disease Control and Prevention (9) guidelines, Mr. B's laboratory findings indicated early treatment

response. CSF venereal disease research laboratory results and CSF protein levels were expected to improve more slowly than the cell count. If the cell count had not decreased at 6 months, retreatment would have been considered (10).

Despite objective improvement in Mr. B's laboratory measures and some mild improvement in his affect, the majority of his symptoms remained unchanged, and he was referred to a tertiary care memory disorders clinic. He was seen approximately 4 months after completion of antibiotic therapy. On interview, the patient denied symptoms. His partner described symptoms consistent with those described previously. Reviewing the patient's history, it appeared that his exposure to syphilis was likely in the range of 11–15 years prior, during a period when he engaged in unprotected intercourse. His mental status examination revealed residual symptoms of the disease. When he was asked open-ended questions or allowed to talk without redirection, he was overinclusive of details, providing lengthy explanations of day-to-day events. He was difficult to redirect once he started telling a story and did not respond to nonverbal cues in a socially normative manner. His scores on the Mini-Mental Status Examination were 30/30, with the word "world" spelled backwards, and 29/30, with serial 7s. Physical examination was normal, with the exception of slowed bilateral finger tap (with slowness in the left hand much greater than the right), suggesting potential cerebellar damage. Magnetic resonance imaging of the brain with magnetic resonance angiography of the neck and head demonstrated moderate diffuse cerebral and cerebellar

volume loss greater than expected for age but no other abnormalities. Neuropsychological testing revealed an overall level of intellectual performance lower than would be predicted based on prior education. IQ was 94 on testing, when it would be predicted to be near 117. Additionally, there was mild to moderate anosognosia as well as difficulties with complex verbal memory acquisition and retrieval. Signs of frontal executive dysfunction included significant difficulties with verbal inference and implication, insignificantly reduced initiation, significantly increased apathy, and significant increases in disinhibited behavior relative to premorbid baseline.

A diagnosis of neurosyphilis with persisting dementia was made, and Mr. B was referred to a rehabilitation program where the focus of treatment was improving language skills and learning cognitive strategies to cope with his symptoms. After 12 months of therapy, he made modest gains in his language abilities, with fewer naming errors, but continued to struggle with following conversations and managing complex tasks. He was unable to return to work.

Syphilis has been called "the great imitator." The presenting symptoms may be subtle and cross a variety of organ systems. There are few guidelines as to which psychiatric symptoms should lead one to consider syphilis in the differential diagnosis. The American Psychiatric Association Practice Guideline for Psychiatric Evaluation in Adults (11) notes broadly that testing for syphilis should be considered in patients with behavioral or cognitive changes. Specific to the diagnosis and work-up of dementia, Feldman et al. (12) suggest that basic laboratory examinations for every patient should include results for complete blood count, thyroid stimulating hormone levels, serum calcium, electrolytes, and fasting glucose. Additional tests should be applied based on history and presentation. Suggested laboratory examinations include tests for serum vitamin B₁₂ and folate levels, rapid plasma reagin for syphilis screening, and HIV antibodies test.

The broad range of presentations as-

Table 1 Laboratory Results for a Patient With Neurosyphilis Manifested as Mild Dementia With Personality Change

	Pre-Treatment	3 Months Posttreatment	6 Months Posttreatment
Rapid plasma reagin	1:64	1:16	1:64
CSF white blood cell count	78	29	13
CSF protein	120	100	73
CSF venereal disease research laboratory	1:128	1:64	1:32
CSF fluorescent treponemal antibody absorption	Reactive	Reactive	Reactive

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sociated with syphilis, a lack of clear guidelines for testing for the disease, and the potential for clinicians to underestimate the likelihood of neurosyphilis in the antibiotic era lead to a potential for missed or delayed diagnosis of syphilitic disease. The present case illustrates these points in that the patient's presenting symptoms were best categorized as dementia demonstrated by memory loss, aphasia, and disturbance in executive function, yet these symptoms were initially attributed to depression, presumably because of their subtle nature and the low frequency of dementia in young patients. As a result, serologic testing for syphilis, assessment for dementia, and treatment were delayed. Increasing clinician awareness of general paresis is of extreme importance because the response to treatment improves with early diagnosis.

Dr. Sholes is a third-year resident in the Department of Psychiatry at University of Washington Medical Center, Seattle. The

author thanks Ryan J. Kimmel, M.D., for input and assistance with this article.

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Walking Out the Door

Tracey Nicole Liebman, B.A.
New York University School
of Medicine

*Ms. Liebman is a third-year
medical student at New York
University School of Medicine.*

each day when I finished my
work
I walked out of the psych ward
not to return until the next
morning
but my patients who yearned to
live
even to have an hour of freedom
after being locked up on the floor for a
month
were forced to stay as always
inside
they could not understand why they
were locked up
they would tell me
daily
I am not sick
I am not a psychiatric patient
I just want to live my life
each of my patients had things they
missed most
for one it was just a cold and refreshing
diet coke
another hoped to run off to another city
to find her family who
didn't
actually
want
her
one man just wanted to be
free
and live as he always had
on
the
streets
but I,
I was no better than them
but I was the only one
who could just
walk out that
door

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