Current PSYCHIATRY

Not all reactions need analysis

Drs. Muskin and Epstein bring much needed attention to the clinical usefulness of countertransference and to the challenges psychiatrists face in helping medical colleagues and staff deal with their reactions to "difficult" patients ("Clinical guide to countertransference," CURRENT PSYCHIATRY, April 2009, p. 24-32). Their article, however, fails to recognize categories of reactions to patients other than countertransference, nor does it offer any systematic approach for preparing medical professionals to deal thoughtfully with their reactions to difficult patients.

For instance, projective identification is given mention only as a potential problem in working with borderline personality disorder patients. Furthermore, no specific mention is given to the range of reactions that would be considered justifiable and would not require additional reflection and analysis.

At Jefferson Medical College in Philadelphia, PA, we have developed a didactic conference entitled "Difficult patients and our reactions to them," taught to third-year medical students during their psychiatry clerkship. The conference distinguishes among types of reactions students may have to patients, including justified reactions, projective identification reactions,[1] and countertransference reactions. A key point emphasized to students is that not all of their reactions to patients are dictated by their subconscious.

Drs. Muskin and Epstein's article provides an initial road map for acting as a consultant to other medical professionals' problematic reactions.

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Our hope is to take the next step and expose future physicians in a range of specialties to a method of thinking through their reactions to difficult patients.

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Unconscious reactions

Although any attention to the intersubjective realm is welcome in a time dominated by a biological model, it was disappointing to read Drs. Muskin and Epstein's "classic Freudian" approach to countertransference ("Clinical guide to countertransference" CURRENT PSYCHIATRY, April 2009, p. 24-32).

For at least 50 years, modern clinical theory has observed and incorporated the simple fact that the physician-patient interaction always involves 2 minds, with unconscious elements. Our ability to decipher the unconscious communication—often captured in what could be mistaken for distracted thoughts as well as intense emotional reactions—is what distinguishes clinicians from their patients.

Most clinicians—unlike consultation-liaison psychiatrists who have focused on this interpersonal domain—have come to accept the fact that the distinction between "the patient's stuff" and "our stuff" is tricky to maintain. We always are working through our own internal world; it is always an interaction. Perhaps this article and audio was aimed at nonpsychiatric physicians and therefore was made more accessible and formulaic. Hopefully, in the future, a more sophisticated discussion can be offered.

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Drs. Muskin and Epstein respond

We thank Drs. Hartley and McFadden and Ms. Sawicki for their comments regarding our article on countertransference. In the limited space, we could not cover all of the areas germane to the topic. Our approach permits consideration of what is transference and what is countertransference, particularly in the general hospital environment.

The directionality of the "stuff" Dr. Hartley mentions is important because some reactions to patients occur in the absence of any transference originating from the patient. This is unique to the nonpsychiatric environment but may play an important role in shaping the care of the patient. We are sorry that she is

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disappointed in our approach, as it is one that stands the test of time in its utility.

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Mobbing is not PTSD

Giving all due respect to James Randolph Hillard, MD, I cannot agree with his posttraumatic stress disorder (PTSD) diagnosis, given the information he provided in "Workplace mobbing: Are they really out to get your patient?" (Current Psychiatry, April 2009, p. 45-51). He does not make a case for DSM-IV-TR Criterion A (the person has been exposed to a traumatic event in which both of the following were present: the event involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others [A1] and the person's response involved intense fear, helplessness, or horror [A2]),[1] despite what other "stress" symptoms the patient experienced.

If data exist that correspond with Criterion A, let us know. Criterion A exists for a purpose, and unless it's changed in DSM-V clinicians should stick to what's defined and not make up their own diagnosis.

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Reference

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Dr. Hillard responds

Dr. Nizny makes a very interesting point. DSM-IV-TR requires that a patient must meet 6 sets of criteria for a PTSD diagnosis. The patient described in my article convincingly met Criterion A2 and Criteria B, C, D, E, and F. In terms of Criterion A1, DSM-IV-TR states: "Traumatic events that are experienced directly include, but are not limited to, military combat, violent physical assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarcerations as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness."

I think I can make the case that the patient described in my article meets the "letter" of Criterion A1 by arguing that he experienced threat of "serious injury." He faced loss of livelihood, loss of much of his core identity, and loss of nearly his whole social network, which consisted mostly of people at his place of employment.

I am fairly sure, however, that such an argument does not follow the spirit of Criterion A1, which seems to imply that PTSD should be diagnosed only if there has been a physical threat. On the other hand, I do not have much sympathy with that concept. Why should threats of physical harm be more likely to produce symptoms than other types of threats? Recent empirical studies[1] do not support the existence of a posttraumatic stress syndrome uniquely associated with physical threats, as opposed to all other threats.

Dr. Nizny notes that Criterion A exists for a purpose, but for what purpose? Michael First, MD, co-chair and editor of DSM-IV-TR, was quoted as giving a partial answer: "The litigation about PTSD when we were working on DSM-IV was going crazy, so we thought it would be wise to limit it to high-magnitude events…there was a huge debate over how broad versus how narrow Criterion A should be."[2] In the same article, Dr. First is quoted as stating that the definition "should change with the next revision of the Diagnostic and Statistical Manual." The committee that designed the criteria for PTSD in DSM-IV in 1994 would probably have preferred to have seen this patient diagnosed as "adjustment disorder with mixed anxiety and depressed mood," probably to make it less likely that he could successfully sue for damages.

I am convinced that workplace mobbing can present a pathogenic stress to victims that is as severe as that caused by physical injuries or threats. Furthermore, I am convinced that mobbing victims are entitled to have their day in court, as are victims of physical injuries in the workplace. Finally, I am convinced that when psychiatrists underestimate the severity of stress involved in workplace mobbing, they are at risk of failing to treat their patients appropriately. For these reasons, I have not chosen to use a "strict constructionist" approach to diagnosis in this case.

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Mania: The other pole

Most of the research and diagnostic and treatment guidance regarding bipolar disorder focuses on depression ("Controversies in bipolar disorder: Trust evidence or experience?" Current Psychiatry, February 2009, p. 26-39). Why is there not more focus on the mania, which can be as debilitating and lethal as depression? What therapeutic guidance is there for bipolar patients in whom mania is the

continued on page 68

TREATMENT An effective drug

Mr. B tolerates gabapentin well and his anxiety symptoms are much more sporadic, shorter, and more easily controlled by conscious exercise. The content of his thoughts is less disastrous and less ego-dystonic. He feels less dysphoria associated with clozapine and does not need as much clonazepam. He overcomes his avoidance of all fear-provoking triggers except walking across bridges.

Mr. B and I explore issues of object relationships and intimacy, establishing emotionally significant relationships with others, and the association between these and his distrust and paranoia. We also investigate the relationship between his criminal activity and feelings of loneliness or lack of control. Mr. B is able to verbalize positive and negative feelings and to feel in cognitive control of them.

Mr. B continues his regimen of clozapine, clonazepam, and gabapentin. He moves to independent housing and applies for employment.

Clinical Point

Mr. B was willing to try gabapentin because he feared seizures and the drug lacked sexual side effects

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continued from page 8

predominant state and who no longer want to live with minds that are bombarded day and night with inescapable, racing thoughts?

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Drs. Miller and Noel respond

We agree that manic episodes can be debilitating for the patient. Marital strife, job loss, legal problems, financial extravagance, sexual indiscretion, and embarrassment are some potential adverse consequences of untreated mania.

However, it is uncommon to see patients in whom mania is the predominant state. While classical elated mania rarely is seen in clinical practice, patients with bipolar depression often describe concurrent manic symptoms such as racing thoughts without fully meeting DSM-IV-TR criteria for a mixed state. The therapeutic guidance we offer for such patients is to begin with a mood stabilizer (eg, divalproex) and an atypical antipsychotic (eg, aripiprazole), to assess thyroid status and supplement if necessary, and—as a last resort if these measures fail to achieve stability for the patient—to start an antidepressant (eg, sertraline) at a low dose.

Unlike bipolar depression with or without manic features, mania is relatively easy to treat and responds to virtually every antipsychotic—both old and new—most mood stabilizers, benzodiazepines and, in olden days, barbiturates.

In their prospective natural history studies of bipolar I and II patients, Judd et al[1,2] found that depression—not mania or hypomania—is the predominant feature of bipolar disorder. Treatment of bipolar depression presents the greatest challenge to clinicians and is the subject of the controversy about use of antidepressants discussed in our article.

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