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Patient Management Exercise

FOR SLEEP, SEX, AND EATING DISORDERS

REVIEW

This exercise is designed to test your comprehension of material presented in this issue of *FOCUS* as well as your ability to evaluate, diagnose, and manage clinical problems. Answer the questions below, to the best of your ability, on the basis of the information provided, making your decisions as you would with a real-life patient.

Questions are presented at "decision points" that follow a section that gives information about the case. One or more choices may be correct for each question; make your choices on the basis of your clinical knowledge and the history provided. Read all of the options for each question before making any selections.

You are given points on a graded scale for the best possible answer(s), and points are deducted for answers that would result in a poor outcome or delay your arriving at the right answer. Answers that have little or no impact receive zero points. On questions that focus on differential diagnoses, bonus points are awarded if you select the most likely diagnosis as your first choice. At the end of the exercise, you will add up your points to obtain a total score.

VIGNETTE PART 1

You are a general adult psychiatrist in a private group practice in a small city, and your first appointment of the day is a new patient, Mrs. S. You received a summary from her most recent visit to the psychiatric emergency department at the local tertiary care hospital, with the patient's signed consent, that describes Mrs. S as "drug-seeking, most likely bipolar disorder II with psychotic features versus schizoaffective disorder."

Mrs. S arrives on time. On her intake form she wrote that her chief complaint at the moment is an inability to have sexual relations with her husband, whom she says wants a divorce because she is "frigid." She is somewhat conservatively dressed, her hair is pulled back into a bun, and she wears red horn-rimmed glasses with small clear crystals at the tips. She is obese and has apparent acne vulgaris on her cheeks, and she has good hygiene and is well groomed. You introduce yourself and offer your hand, but she seems not to have noticed and moves to sit in the chair opposite you; she immediately takes a tissue from the box on the coffee table. She is tearful and looking downward.

CME Financial Disclosure

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You take your seat on the other side of the coffee table and wait for her to gather her composure. A few minutes pass without her saying anything. Then she says, "I don't know why I'm here. It all seems so useless. I've been trying everything, and now John wants to leave me. It feels like I can't do anything right. He hates me." She begins to sob. She still has not looked up from the floor. You wait, but she does not offer any further information about what is so upsetting. Then she says, as if reluctantly, "I suppose you need a history, right?"

Mrs. S is a 35-year-old married woman with two adopted children, a 16-year-old son and a 15-year-old daughter, from her first relationship, which was not a marriage and which ended "amicably." She is still close to her previous partner, she says, and although he would like to see his children, her current husband does not like him and will not allow him to come to the house. She was seen twice over 1 month in the local university's adult general psychiatry residents' clinic 2 years ago for a major depressive episode after a serious suicide attempt by overdose on acetaminophen. She recovered from the overdose without medical complications but remained depressed and anhedonic, with poor sleep, poor concentration, ruminating thoughts, and occasional impulsive behavior but no further suicide attempts. She had mild psychotic symptoms in the form of a non-command-type denigrating voice. She fired the treating resident at that time and did not return until recently, when she came to the hospital's psychiatric emergency room complaining of panic symptoms and suicidal ideation without intention or plan. She was not hospitalized, and she was referred to your clinic because she refuses to see another "inexperienced wannabe psychiatrist." She fired previous residents because she felt they were not responsive enough to her need for higher doses of benzodiazepines. Additionally, she admits to several visits over the past 6 months to three different medical emergency rooms with complaints of anxiety and panic.

She reports allergic reactions to lithium, fluoxetine, sulfa drugs, olanzapine, penicillin, and codeine. Her current medications include 60 mg of duloxetine daily, 20 mg of aripiprazole daily, and 0.5 mg of clonazepam twice a day. Previous medication trials included olanzapine, risperidone, lithium, fluoxetine, paroxetine, bupropion, buspirone, and alprazolam.

She completed all four modules of dialectical behavioral therapy in a group setting approximately 2 years ago and has had eight sessions with a master's-level therapist who used cognitive behavior therapy and supportive psychotherapy.

The patient has a history of opiate dependence after several surgeries, which included a cholecystectomy and several other operations that she adamantly refuses to discuss.

Her mother had major depression and anxiety and had made one suicide attempt; her older sister had major depression and had made two suicide attempts; her paternal grandfather had alcoholism and died 10 years ago of liver failure; and her father has alcoholism.

She currently lives with her husband of 2 years and the two children from her first relationship in a house just outside of town. She is a homemaker. Her husband works as a firefighter and is often not home for extended periods. They are financially stable.

Mrs. S makes herself comfortable in the chair opposite you and is no longer tearful. She says, "I don't know where to begin." She is looking at the framed medical credentials on your wall. "I've never had sex with my current husband." She again becomes tearful. You notice she grips the sleeves of her blouse with her fingertips. "He wants to. All the time, really. But I . . . can't. Or won't. No, I won't. I don't want to. I can't."

You wait.

"We never actually had sex in two years. I know that seems crazy. He understood for a while. We've been somewhat intimate, but I've never let him enter me. Now he wants a divorce, which I suppose is okay. I know I would want one if I were him. Look at me."

You ask if she was able to have sex in the past with her partner in her first relationship, and she replies that they did have sex, but it was "different." Then she looks directly at you and says, "Since you have a medical diploma from the university I'm going to trust you. I never told any of the other doctors any of this. Especially the residents, because they could not possibly understand. But I don't know what to do anymore. I don't want to lose my family, but I'm carrying a huge secret."

Before she will tell you, however, her tears resume, and she asks for a prescription for alprazolam, 1 mg t.i.d.

DECISION POINT A

Given the above information and presentation, what should you do? (Multiple answers are possible; points are taken away for incorrect answers.)

A1. ____ Continue to wait. She will continue to speak. You should not rush her, especially given her emotional lability. Demonstrate that you are concerned by placing a glass of water in front of her.

A2. ____ Begin the interview with an empathic statement such as, "I can see you are experiencing some emotional pain right now. I want you to know that everything that is said in this room will stay in this room, unless you are thinking of causing harm to yourself or to someone else. In that instance I have a legal obligation to act on that information. Otherwise, it is OK to share anything you want with me."

A3. ____ Begin with an empathic statement: "I understand you were not entirely satisfied with your previous psychiatrist. Can you tell me why you chose to come here today?"

A4. ____ Since she is tearful, push the box of tissues closer to her and wait. Then begin by saying, "I received a note from your previous psychiatrist with a copy of your permission for him to share the information. I'd like to get to know you first, before I make any decisions about medications. You mentioned that you have a big secret you've been carrying around. You describe it in a way that makes me think it is a huge burden to you."

A5. ____ Tell her, "I received a note from your previous psychiatrist with a copy of your permission for him to share the information. I read some of the background, the medications you are currently on, and I must confess I am not likely to prescribe alprazolam in this context. However, I do want to help you. Let's start by your telling me in your own words what you expect from this visit."

DECISION POINT B

What are the four stages of the human sexual response cycle?

B1. Stage 1:_____
B2. Stage 2:_____
B3. Stage 3:_____
B4. Stage 4:_____

VIGNETTE PART II

Mrs. S becomes angry. "Are you going to be like all the other doctors? I came here for help. Are you going to tell me how to feel? Are you going to tell me everything is going to go away? Because it's NOT. You have NO idea." She continues to sob. "Xanax helps me. I know lots of doctors do not like to prescribe it to someone like me, but it HELPS."

You ask her how it helps.

"I get panic attacks. I can't control my anxiety. When I take a Xanax—which I don't abuse, I only use it when I need to—I feel better. Sometimes after I take it I end up having a panic attack anyway, so it's not the greatest medication. I can't sleep. All I do is worry about my husband, what he's going to think of me. . . ."

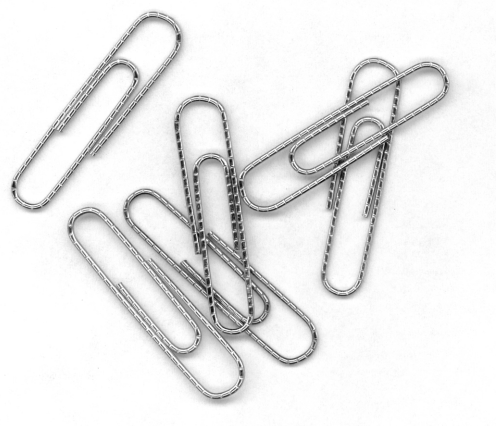
You wait.

"I'm a freak show, doctor. A fucking freak show." She gathers her purse and stands up. "I can't talk to you anymore about this."

You ask her why she feels the need to leave.

"If you aren't going to give me the medication, I'll have to find another doctor."

She starts to sob again and says, "I don't know if it's him or if it's me. Either way, I can't have sex. It's not that it's painful, I'm just afraid."



DECISION POINT C

Which agents affect the first three stages of human sexual response, positively or negatively? Fill in the appropriate boxes in the chart below using the list of agents provided. (Correct answers receive +2 points, incorrect answers receive –2 points.)

Stage of Response	Drug Classes That Have a Positive Effect	Drug Classes That Have a Negative Effect
Stage 1: _____		
Stage 2: _____		
Stage 3: _____		

- Selective serotonin reuptake inhibitors
- Anticholinergics
- Nitric oxide enhancers (e.g., sildenafil, which boosts cGMP action)
- Dopaminergic agents
- Dopamine receptor-blocking antipsychotics, some of which also increase prolactin
- Prostaglandins
- Beta-blockers (block noradrenergic function)
- Norepinephrine and dopamine reuptake inhibitors
- Dopamine-releasing stimulants (amphetamine and methylphenidate)

VIGNETTE PART III

Mrs. S states that she needs to tell you something that will help you understand her problem. She has not told you until now because she was not sure how you would handle the information, but she decided that you seem like an open-minded doctor and "this is too important," she says. "I am a postsurgical transsexual. I was able to have sex with my first 'husband' because at that time I still had a penis. He did not mind it when I started taking hormones and grew breasts, and he was even supportive when I had breast augmentation surgery. However, when I discovered that I would not be satisfied until I had sexual reassignment surgery, he told me he could not maintain the same relationship with me." She smiles. "We're still friends, and he still sees the kids, but he is gay and wants to be with a man." She takes a deep breath. "I can live with that."

You ask if her new husband knows about her reassignment surgery. She says, "No. He actually thinks I'm a woman. I can't bring myself to tell him. My children know, but they're never around, so he never heard it from them. I don't know, maybe he did. But he never let on that he knows. Either way, he says he just isn't going to force me to have sex with him."

DECISION POINT D

Given the above information, what is your differential diagnosis for Mrs. S?

Axis I:	
Axis II:	

DECISION POINT E

Sexual dysfunction is divided into two primary disorders according to whether they describe a dysfunction of desire or of arousal. **Use the following table to classify the listed criteria into one of the three columns.**

Criteria	Sexual Desire Disorder	Sexual Arousal Disorder	Neither
E1. Inadequate lubrication-swelling response of sexual excitement			
E2. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse			
E3. Recurrent delay in or absence of orgasm following normal sexual excitement phase			
E4. Persistently or recurrently deficient (or absent) sexual fantasies or desire for sexual activity			
E5. Persistent inability to attain, or maintain until completion of sexual activity, an adequate erection			
E6. No (or substantially diminished) subjective erotic feelings despite otherwise normal arousal and orgasm			
E7. Recurrent or persistent genital pain associated with sexual intercourse			
E8. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner			

ANSWERS: SCORING, RELATIVE WEIGHTS, AND COMMENTS

High positive scores (+3 and above) indicate a decision that would be effective, would be required for diagnosis, and without which management would be negligent. Lower positive scores (+2) indicate a decision that is important but not immediately necessary. The lowest positive score (+1) indicates a decision that is potentially useful for diagnosis and treatment. A neutral score (0) indicates a decision that is neither clearly helpful nor harmful under the given circumstances. High negative scores (–5 to –3) indicate a decision that is inappropriate and potentially harmful or possibly life-threatening. Lower negative scores (–2 and above) indicate a decision that is nonproductive and potentially harmful.

DECISION POINT A

A1. +3 The patient is doing a fine job of relating her story. The best approach at this point is to listen carefully to what she says. This is obviously a complicated story. You should make notes about what areas seem to you worth further exploration in order to develop your differential diagnosis and consider what treatment options you would propose. Offering her a glass of water is a nice touch, but not necessary. Tissues should always be handy.

A2. +4 A nice general empathic statement demonstrates that you are actively listening. Establishing formally for the patient that you will maintain her confidentiality is always important, and with this patient perhaps all the more so, given her feeling that her story may contain details that are especially distressing and involve her husband.

A3. –2 This statement places you squarely in a competitive position with her previous psychiatrist. Asking why she chose to come today is an appropriate question, however.

A4. +4 By offering the box of tissues and waiting, you are demonstrating both active listening and empathy through nonverbal communication, which at this point may be one of the more effective means of drawing the patient into a dialogue. After a period of waiting—which, as noted above in A1, is essential—you offer evidence that you took the time to get to know her case before she walked into the room. She will likely feel that you have made a reasonable effort to "do your homework" and be "ready" for her. You follow this with a more specific empathic statement that will draw her attention to the specifics of the matter at hand. This may be too closed a statement, however. If you are concerned about time and wish to elicit what you believe to be highly sensitive information, a more effective possibility might be to use one of Shea's interviewing techniques, known as normalization, and say, for example, "Sometimes people who are harboring big secrets that affect their lives feel as though they are carrying a huge burden. This can impact their ability to function comfortably." You might also use another of Shea's techniques, such as gentle assumption, and suggest, "The secret you are carrying around seems to be impacting your relationship with your husband in an unhealthy way."

A5. –3 While it is true that you have this information, sharing it in this way might cause her to become defensive. She has already expressed her disdain for psychiatrists who are unwilling to supply her with alprazolam. Your concern about a possible abuse of this medication is justified; however, if you wish to establish a good rapport with the patient, as well as a therapeutic alliance, you would be better served by listening to the story before judging her on the basis of other clinicians' experience.

DECISION POINT B

B1. +2 Stage 1: Desire. Not dependent on physiological response, and is a reflection of the patient's motivations, drives, and personality; characterized by sexual fantasies and the desire to have sex.

B2. +2 Stage 2: Excitement. Subjective sense of sexual pleasure and accompanying physiological changes; all physiological responses noted in Masters and Johnson's excitement and plateau phases are combined in this phase.

B3. +2 Stage 3: Orgasm. Peaking of sexual pleasure, with release of sexual tension and rhythmic contraction of the perineal muscles and pelvic reproductive organs.

B4. +2 Stage 4: Resolution. A sense of general relaxation, well-being, and muscle relaxation; men are refractory to orgasm for a period of time that increases with age, whereas women can have multiple orgasms without a refractory period.

DECISION POINT C

Correct answers receive +2 points, incorrect answers receive –2 points.

Stage of Response	Drug Classes That Have a Positive Effect	Drug Classes That Have a Negative Effect
Stage 1: Desire (libido)	Norepinephrine and dopamine reuptake inhibitors Dopamine-releasing stimulants (amphetamine and methylphenidate)	Dopamine receptor-blocking antipsychotics, some of which also increase prolactin
Stage 2: Excitement (arousal)	Nitric oxide enhancers Prostaglandins Dopaminergic agents	Selective serotonin reuptake inhibitors Anticholinergics
Stage 3: Orgasm		Selective serotonin reuptake inhibitors Beta-blockers

DECISION POINT D

Axis I:	Hypoactive sexual desire disorder (–2); sexual aversion disorder (+1); gender identity disorder (+2); rule out benzodiazepine abuse (+1); history of opiate dependence (+1)
Axis II:	Deferred (+2)

Hypoactive sexual desire disorder (–2). Since Mrs. S was able to have sex during her first relationship, the criteria of persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity are not met. She did not describe a lack of desire for sexual activity but a fear that she will be "found out" by her husband, who does not know about how she has transitioned her sexual identity. It is reasonable to expect that if her husband accepted her sexual identity and was truly interested in having sexual relations with his wife, she would likely desire sex.

Sexual aversion disorder (+1). Mrs. S does avoid having sex with her husband out of fear that he will discover her transsexuality. Consequently, she persistently avoids all, or almost all, genital sexual contact with him. This disturbance clearly causes marked distress and interpersonal difficulty, as evidenced by her repeated attempts to find help from professionals and her husband's allegedly seeking a divorce. This sexual dysfunction might be considered better accounted for by her gender identity disorder if one considers only the interpersonal ramifications of keeping her transsexuality a secret from her husband. It is possible to specify subtypes of sexual aversion disorder to include acquired type, situational type, or due to psychological factors.

Gender identity disorder (+2). DSM-IV-TR criteria for this disorder include:

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). It is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, a desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. This is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
C. The disturbance is not concurrent with a physical intersex condition.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Rule out benzodiazepine abuse (+1). From the interview so far, you have not been able to establish a more pervasive pattern to suggest substance dependence. The criteria for substance abuse, however, may apply on further evaluation. For this reason, the diagnosis is considered a "rule-out" until evidence is gathered. The criteria for substance abuse include:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for substance dependence for this class of substance.

Mrs. S has only described a need to obtain more alprazolam despite other physicians' refusal to prescribe adequate supplies. It is possible that she is using this medication to help with the anxiety caused by her marital discord. The primary maladaptive pattern she has suggested is "doctor shopping" for a clinician willing to prescribe a particular short-acting benzodiazepine known for its abuse potential. She has made this a central issue in her presentation despite the more substantial issues that she began to describe only later. For this reason, exploration of the above criteria is crucial to determine whether she has developed an abusive pattern of using this medication. You will be able to offer her safer methods for handling the stress she is experiencing both pharmacologically and psychotherapeutically once you establish an effective and positive therapeutic alliance. Given what you have learned of the experiences of her previous clinicians, you should be careful not to challenge her drug use early in the relationship, as this will drive her from your care.

History of opiate dependence (+1). From the history; there is no evidence of current use.

DECISION POINT E

Sexual dysfunction is divided into two primary disorders according to whether they describe a dysfunction of desire or of arousal. **Use the following table to classify the listed criteria into one of the two categories, or neither.**

Criteria	Sexual Desire Disorder	Sexual Arousal Disorder	Neither
E1. Inadequate lubrication-swelling response of sexual excitement		+2	
E2. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse			+2
E3. Recurrent delay in or absence of orgasm following normal sexual excitement phase			+2
E4. Persistently or recurrently deficient (or absent) sexual fantasies or desire for sexual activity	+2		
E5. Persistent inability to attain, or maintain until completion of sexual activity, an adequate erection		+2	
E6. No (or substantially diminished) subjective erotic feelings despite otherwise normal arousal and orgasm	+2		
E7. Recurrent or persistent genital pain associated with sexual intercourse			+2
E8. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner		+2	

Comments on the "Neither" answers

E2 describes a sexual pain disorder known as vaginismus. Dyspareunia, described in E7, is defined as recurrent or persistent genital pain associated with sexual intercourse in either a male or a female. E3 describes an orgasm disorder, of which there are male and female types. The primary difference between these types has to do with the wide variability in the type or intensity of stimulation that triggers orgasm in the female; otherwise they are essentially the same disorder.

YOUR TOTAL

Decision Point	Your Score	Ideal Best Score
A		11
B		8
C		20
D		7
E		16
Total		**62**

REFERENCES

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders Compendium 2004. Washington, DC, American Psychiatric Association, 2004

Sadock BJ, Sadock VA: Synopsis of Psychiatry, 9th ed. Philadelphia, Lippincott Williams & Wilkins, 2003

Schatzberg AF, Nemeroff CB: Essentials of Clinical Psychopharmacology. Washington, DC, American Psychiatric Publishing, 2001

Shea SC: The Practical Art of Suicide Assessment. New York, Wiley, 2002

Stahl SM: Essential Psychopharmacology. New York, Cambridge University Press, 2000

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