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Inside

In This Issue

The ongoing Internet and social media revolution, discoveries of newer psychopharmacologic agents, and a diversifying U.S. population underscore the need for continuously updating and validating psychiatry residency curricula. An immense undertaking of this sort usually begins with the small step of describing the issues at hand. Thus, it is fitting that the last issue of this academic year's *Residents' Journal* includes articles on psychosocial functioning in pediatric bipolar disorder (Arman Danielyan, M.D.), psychopharmacology education (Ragy Girgis, M.D.), the effect of social media on mental health (Erin L. Belfort, M.D.), and religion and spirituality in residency training programs (Mary E. Camp, M.D.). I sincerely hope that these contributions will initiate a dialogue about the need for timely revitalization of residency curricula with changes that are reflective of current times.

Deepak Prabhakar, M.D., M.P.H., Guest Section Editor
Detroit Medical Center/ Wayne State University

Editorial

Handoff

Joseph M. Cerimele, M.D.
Editor-in-Chief

My term as Editor-in-Chief of *The Residents' Journal* expires at the end of this academic year. In July, Sarah Fayad, M.D., the current Associate Editor, will move into the Editor-in-Chief position. Monifa Seawell, M.D., a third-year resident from Wayne State University and past author, reviewer, and Guest Section Editor, will fill the Associate Editor role. I will remain on as Senior Editor, a new position.

I am pleased with the manuscripts we received this year. Resident physicians, medical students, and fellows have found many ways to present cases, literature reviews, and other articles in an educational way for readers. Often, these contributors were first-time authors, making their accomplishments even more noteworthy.

Overall, I feel that each manuscript submitted after October 2010 was strengthened by our new peer review process. Peer review at *The Residents' Journal* has accomplished many objectives: authors received valuable comments and then learned and practiced the revision and resubmission processes, reviewers learned the basics of how to review a manuscript via directed readings and practical experience, and readers ultimately read a stronger, more informative article. We are always looking for more peer reviewers (particularly since some reviewers graduate from residency training) and encourage any interested resident or fellow to contact us.

We would like to thank each resident and fellow who peer reviewed at least one manuscript from October 2010–May 2011, often volunteering to serve in this role. We also thank the Guest Section Editors, who often reviewed and re-reviewed manuscripts several times prior to submission. Guest Section Editors also reviewed at least one manuscript outside of the section they guest-edited.

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Assessment of Psychosocial Functioning in Adolescents With Bipolar Depression

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Pediatric bipolar disorder is a chronic and recurrent condition that seriously disrupts the lives of children and adolescents (1). Bipolar disorder affects approximately 2%–4% of the U.S. population in its various syndromal and subsyndromal forms (2). It is a highly recurrent, costly, and impairing illness, leading to high rates of disability, comorbidity, medical problems, and suicide attempts or completions. Although the phenomenology of pediatric bipolar disorder has been described extensively, there are limited data on the psychosocial, behavioral, and cognitive characteristics of the disorder, particularly in the depressed phase of the illness. Depression associated with pediatric bipolar disorder may be the most lethal phase of the disorder, with increased rates of suicidality (3). Depressed adolescents with bipolar disorder have significantly higher rates of morbidity and mortality (4), including psychosocial morbidity with impaired family and peer relationships, impaired academic performance with increased rates of school failure and drop outs, increased levels of substance abuse and suicide attempts and completion, legal difficulties, and multiple hospitalizations. Adolescents with bipolar depression are also more likely to experience worse outcomes than those with an index manic or mixed episode (5). Social impairments associated with bipolar depression in youth have been shown to persist during the remission phase of the illness (6).

Despite the fact that psychosocial functioning in youth with bipolar depression is significantly impaired, the outcome measures in the majority of efficacy studies typically utilize rating scales for assessment of affective symptoms only, whereas indicators of patients' performance in school, at home, and with peers—which would be reflected in psychosocial, cognitive, and behavioral characteristics—are often missing. Significant impairment in health-related quality of life in patients with bipolar disorder, including impairments in social, occupational, and emotional functioning as well as work and relationship problems, have been reported (7). There are limited data on the family environment. However, in a prospective longitudinal study of children with pediatric bipolar disorder, participants exposed to low maternal warmth were four times more likely to relapse after recovery compared with those exposed to high maternal warmth (8). There are also limited data on the effect of executive dysfunction, which has been suggested to be one of the core deficits in pediatric bipolar disorder, on psychosocial functioning in youth with bipolar disorder (9).

Highlighting the significance of psychosocial functioning, DelBello et al. (10) utilized assessment measures in a double-blind placebo-controlled trial of the use of quetiapine in adolescents in the depressed phase of bipolar disorder. The present article is a review of some of the assessment instruments utilized in the evaluation of psychosocial and other areas of functioning in youth with bipolar disorder.

Assessment Instruments

Behavior Rating Inventory of Executive Function (BRIEF)

BRIEF is a standardized validated instrument used for assessment of 5- to 18-year-olds in their performance on everyday tasks at home and school based on executive functioning skills (11). This parent-rated measure contains 86 items, which parents score as 1 (never), 2 (sometimes), or 3 (often). It consists of two indices and eight scales. The inhibit, shift, and emotional control scales encompass the Behavioral Regulation Index. The initiation, working memory, planning, organization of materials, and monitoring scales encompass the Metacognition Index. These two indices comprise a Global Executive Composite score. Raw scale scores are transformed into T scores for interpretation. The normative sample has a mean T score of 50, with 1 standard deviation of 10. Scores ≥65 are considered to be potentially clinically significant. This assessment measure has previously been used to assess deficits in executive functioning exhibited by children with attention deficit hyperactivity disorder.

Child Behavior Checklist (CBCL)

CBCL is a standardized instrument for the assessment of behavioral problems and competencies of children and youth aged 4 to 18 years, as reported by their parents (12). CBCL has undergone extensive reliability and validity testing in both clinical and nonclinical populations. This instrument has 11 subscales for delinquent behavior, aggressive behavior, withdrawn behavior, somatic complaints, anxiety/depression, social problems, thought problems, attention problems, externalizing problems (which includes delinquent and aggressive behaviors), internalizing problems (which includes withdrawn behavior, somatic complaints, and anxiety/depression), and total problems (which includes externalizing, internalizing, social, thought, and attention problems) (12). A cut-off score of 70 (2 standard deviations above normal level) has been recommended as a clinically meaningful threshold for a standard deviation with regard to age- and sex-matched healthy comparison children and youth. Biederman et al. (13) found that children and adolescents who had been diagnosed with pediatric bipolar disorder had a distinct profile on this measure, referred to as the CBCL-juvenile bipolar disorder phenotype. The CBCL-juvenile bipolar disorder phenotype has been defined as the sum of

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scores on the anxiety/depression, attention problems, and aggressive behavior subscales, and a cut-off score of 210 is 2 standard deviations above normal level. In another study, the CBCL-juvenile bipolar disorder phenotype was reported to occur in approximately 1% of children ages 7, 10, and 12 years old (14).

Family Environment Scale (FES)

FES is a validated scale developed to measure social and environmental characteristics in all types of families (15). This scale assesses the interpersonal relationships and overall social environment within the family. It is a 90-item true-false questionnaire grouped into 10 subscales with three dimensions. The relationship dimension includes subscales for cohesion, expressiveness, and conflict. The personal growth dimension includes subscales for independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, and moral-religious emphasis. The system maintenance dimension includes subscales for organization and control. The relationship and system maintenance dimensions reflect internal family functioning, and the personal growth dimension reflects links between the family and larger social context. Normative FES data have been collected and reported by Moos and Moos (15). The normative sample consists of 1,432 families from the United States. It does not exclude parents with bipolar disorder. Evidence of validity and reliability has been described elsewhere (15). This scale has been found to have good internal consistency and good test-retest reliability (15) as well as good construct and discriminant validity (16).

Child Health Questionnaire–Parent Form 50 (CHQ–PF50)

Health-related quality of life can be assessed using CHQ–PF50 (17), which measures 14 domains of health. This assessment measure contains 50 items and is completed by parents. Physical domains include physical functioning as well as role/social limitations as a result of physical health, bodily pain/discomfort, and general health perception. Psychosocial domains include role/social limitations as a result of emotional-behavioral problems, self-esteem, mental health, general behavior, emotional effect on the parents, and time effect on the parents. A separate domain measures limitations in family activities. The general health perceptions domain measures overall health and parents' ratings of their child's potential to get sick as well as their health status over time. The change in health domain is a measure of variation in health over the past year. The parental effect-emotional domain measures parents' reported distress due to their child's physical, psychological, and social well-being. The parental effect-time domain is a measure of parents' reported amount of limited personal time due to their child's physical, psychological, and social well-being. The family activities domain measures the occurrence of disturbances in typical family functioning over the previous month. Finally, the family cohesion domain is a measure of interpersonal relationships assessing how well family members get along (17). This questionnaire has undergone extensive validation.

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Conclusions

Depression associated with bipolar disorder is a complex condition causing significant impairments in adolescents suffering from pediatric bipolar disorder and their families. It affects multiple domains by causing impairments in cognitive, behavioral, and family functioning, which in turn leads to overall impairment in quality of life. Clinical evaluation of youth with bipolar depression should include not only assessment of the severity of affective symptoms but also more comprehensive review of the various aspects of these patients' lives, including behavioral, emotional, executive, family, physical/somatic, and social dimensions. This can potentially lead to a truly multidisciplinary approach in developing management strategies by targeting academic, social, and other aspects of functioning.

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References

1. Birmaher B, Ryan ND, Williamson DE, Brent DA, Kaufman J: Childhood and adolescent depression: a review of the past 10 years, part II. J Am Acad Child Adolesc Psychiatry 1996; 35:1575–1583
2. Merikangas KR, Akiskal HS, Angst J, Greenberg PE, Hirschfeld RM, Petukhova M, Kessler RC: Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2007; 64:543–552
3. Patel NC, DelBello MP, Bryan HS, Adler CM, Kowatch RA, Stanford K, Strakowski SM: Open-label lithium for the treatment of adolescents with bipolar depression. J Am Acad Child Adolesc Psychiatry 2006; 45:289–297
4. Goldstein TR: Suicidality in pediatric bipolar disorder. Child Adolesc Psychiatr Clin N Am 2009; 18:339–352
5. Strober M, Schmidt-Lackner S, Freeman R, Bower S, Lampert C, DeAntonio M: Recovery and relapse in adolescents with bipolar affective illness: a five-year naturalistic, prospective follow-up. J Am Acad Child Adolesc Psychiatry 1995; 34:724–731
6. Goldstein TR, Miklowitz DJ, Mullen KL: Social skills knowledge and performance among adolescents with bipolar disorder. Bipolar Disord 2006; 8:350–361
7. Calabrese JR, Hirschfeld RM, Reed M, Davies MA, Frye MA, Keck PE, Lewis L, McElroy SL, McNulty JP, Wagner KD: Impact of bipolar disorder on a US community sample. J Clin Psychiatry 2003; 64:425–432
8. Geller B, Craney JL, Bolhofner K, Nickelsburg MJ, Williams M, Zimerman B: Two-year prospective follow-up of children with a prepubertal and early adolescent bipolar disorder phenotype. Am J Psychiatry 2002; 159:927–933
9. Pavuluri MN, West A, Hill SK, Jindal K, Sweeney JA: Neurocognitive function in pediatric bipolar disorder: 3-year follow-up shows cognitive development lagging behind healthy youths. J Am Acad Child Adolesc Psychiatry 2009; 48:299–307
10. DelBello MP, Chang K, Welge JA, Adler CM, Rana M, Howe M, Bryan H, Vogel D, Sampang S, Delgado SV, Sorter M, Strakowski SM: A double-blind, placebo-controlled pilot study of quetiapine for depressed adolescents with bipolar disorder. Bipolar Disord 2009; 11:483–493
11. Gioia GA, Isquith PK, Guy SC, Kenworthy L: Behavior Rating Inventory of Executive Function (BRIEF): Professional Manual. Lutz, Fla, Psychological Assessment Resources, 2002
12. Achenbach TM: Manual for the Child Behavior Checklist/4–18 and 1991 Profile. Burlington, Vermont, University of Vermont Press, 1991
13. Biederman J, Wozniak J, Kiely K, Ablon S: CBCL clinical scales discriminate prepubertal children with structured interview-derived diagnosis of mania from those with ADHD. J Am Acad Child Adolesc Psychiatry 1995; 34:464–471
14. Hudziak JJ, Althoff RR, Derks EM, Faraone SV, Boomsma DI: Prevalence and genetic architecture of Child Behavior Checklist-juvenile bipolar disorder. Biol Psychiatry 2005; 58:562–568
15. Moos RH, Moos BS: Family Environment Scale Manual, 3rd ed. Palo Alto, Calif, Mind Garden, Inc., 2002
16. Dickerson VC, Coyne JC: Family cohesion and control: a multitrait-multimethod study. J Mar Fam Ther 1987; 13:275–285
17. Landgraf JM, Abetz L, Ware JE: The CHQ User's Manual. Boston, HealthAct, 1999

Psychopharmacology Curricula: A Call for Innovation

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Needless to say, specific training in psychopharmacology is a critical component of educating today's psychiatric trainees. The benefits to patients of different training strategies for residents has been demonstrated (1, 2). The present article will review the current state of education in psychopharmacological management. In particular, it will cover how psychopharmacology has traditionally been taught, the limitations of these methods, and some suggestions put forth by both residents and master educators to improve existing methods.

A Need for Novel and Innovative Educational Techniques

Training in psychopharmacology has historically been insufficient, and the development of new educational modalities in psychiatric residency programs has lagged behind their development in training programs in other medical specialties (3). First, in both the United States and Canada, almost one-quarter to one-half of trainees have rated their psychopharmacology training as poor to fair (for a review, see Naranjo et al. [4]). In addition, the relatively low pass rates on the psychiatry board examinations suggest that improvements in training are warranted (5). Finally, Crane (6) specifically investigated the effect of a traditional teaching method (lecture) on the doses of antipsychotic medications prescribed by physicians with the hopes of decreasing rates of tardive dyskinesia and found that this educational method was unproductive. Together, these reports suggest that training in psychopharmacology needs to be reassessed.

Limitations of Traditional Educational Modalities and Ways to Improve Them

Training in psychopharmacological management has previously consisted of some mixture of didactics and supervision (7). Unfortunately, these methods, particularly didactics, can be limited. Too often, lecturers attempt to include too much information in a didactic session, leaving trainees overwhelmed and unable to benefit much from what they hear (8). It is also unhelpful for trainees to sit through lectures in which faculty primarily lecture on their research interests and leave out the most clinically relevant and beneficial information (9). Lectures are also limited by the "passive" nature in which trainees participate in such exercises. This gives trainees less responsibility, as well as less motivation, for their training (7). Such formats also tend to overemphasize the management of treatment-resistant patients or otherwise less common situations (10). All of these pitfalls can limit the benefit of a psychopharmacologic curriculum.

Two graduating residents, Georgiopoulos and Huffman (9), sought to improve upon the teaching of psychopharmacology to residents by detailing their own experiences from residency as well as by highlighting what did and did not work for them. They emphasized how important it was for their instructors to appreciate their level of training, including their limited knowledge of basic psychopharmacology at the beginning of their residency. They also had positive experiences with their weekly supervision as well as with their 24-hour backup supervision. They emphasized that being presented with long lists of side effects or augmentation strategies were unhelpful and that interactive learning, in which different teaching modalities were implemented, was better received. They suggested that more training in the dynamic considerations of psychopharmacological management as well as in very basic instruction in the actual use of medications (e.g., dosing, interactions) would have been more helpful to them. Georgiopoulos and Huffman felt that being evaluated by experts in the field in real-time was a helpful exercise. They also mentioned that greater instruction on how to become effective teachers as well as on practice management considerations would have been beneficial to them.

Others have suggested similar and additional means of enhancing psychopharmacology curricula. Glick et al. (10) emphasized first that increased time should be allotted for teaching psychopharmacological management to trainees. They encouraged putting together a coordinated and centralized curriculum, with an identified course director who is responsible for its implementation. Further, given the importance of the brain in psychiatric disorders as well as the necessity for clinicians to be able to understand scientific literature in order to continue learning well after formal training has stopped, trainees should be educated in neuroscience and basic research methodologies. The authors also emphasized that residents should be exposed to information that is relevant for clinical practice, such as that there are often many ways of approaching a situation depending on the setting and clinical context. Using evaluation strategies, implementing games, and establishing journal clubs were additional recommendations put forth that may increase the effectiveness of psychopharmacology curricula (10).

Zisook et al. (7) suggested additional, alternate methods for teaching psychopharmacology. One point emphasized was the importance of establishing the opportunity for trainees to learn beyond residency or their formal training, especially given the quickly changing nature of the field of psychopharmacology. The authors recommended using journal clubs, not only to learn about new research findings but also to develop habits for lifelong learning. They also suggested that journal clubs need not be limited to reviewing original research articles (7).

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Zisook et al. went on to describe the benefits of incorporating problem-based learning into psychopharmacology curricula and, similarly, keeping the training patient-centered, for example, by utilizing case conferences or other means to have an attending present for an evaluation with the patient and trainee (7). Finally, they discussed the potential benefits of incorporating games and modern technology (e.g., Web-based curricula) into a psychopharmacology curriculum (7).

Conclusions

In summary, traditional methods of teaching psychopharmacology have been limited. Fortunately, alternate methods are available and have been suggested and implemented. These methods tend to provide relevant and practical information, promote interactive learning, and encourage lifelong learning.

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References

1. Alexander B, Nasrallah HA, Perry PJ, Liskow BI, Dunner FJ: The impact of psychopharmacology education on prescribing practices. Hosp Community Psychiatry 1983; 34:1150–1153
2. Dixon L, Weiden PJ, Frances AJ, Rapkin B: Management of neuroleptic-induced movement disorders: effects of physician training. Am J Psychiatry 1989; 146:104–106
3. Lathers CM, Smith CM: Development of innovative teaching materials: clinical pharmacology problem-solving (CPPS) units: comparison with patient-oriented problem-solving units and problem-based learning: a 10-year review. J Clin Pharmacol 2002; 42:477–491
4. Naranjo CA, Shulman RW, Ozdemir V: Development and evaluation of a clinical psychopharmacology educational curriculum. J Clin Pharmacol 1997; 37:474–479
5. American Board of Psychiatry and Neurology: 2004 Annual Report of the American Board of Psychiatry and Neurology. Am J Psychiatry 2005; 162:1560–1563
6. Crane GE: The prevention of tardive dyskinesia. Am J Psychiatry 1977; 134:756–758
7. Zisook S, Benjamin S, Balon R, Glick I, Louie A, Moutier C, Moyer T, Santos C, Servis M: Alternate methods of teaching psychopharmacology. Acad Psychiatry 2005; 29:141–154
8. Zisook S, Glick ID, Jefferson JW, Wagner KD, Salzman C, Peselow ED, Stahl S: Teaching psychopharmacology: what works and what doesn't. J Clin Psychopharmacol 2008; 28:96–100
9. Georgiopoulos AM, Huffman JC: Teaching psychopharmacology: two trainees' perspectives. Acad Psychiatry 2005; 29:167–175
10. Glick ID, Salzman C, Cohen BM, Klein DF, Moutier C, Nasrallah HA, Ongur D, Wang P, Zisook S: Improving the pedagogy associated with the teaching of psychopharmacology. Acad Psychiatry 2007; 31:211–217

The Effect of Social Media on Mental Health and Its Relevancy to Residency Training

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The use of Internet social networking sites as well as cell phones among adolescents and young adults has skyrocketed in recent years. The present article is a review of recent findings in the use of social media among this population and in the possible associated mental health risks of excessive media exposure. Additionally, the importance of taking a media history when evaluating our patients is highlighted as well as the relevancy of this issue to residency training.

Recent Findings

Recent data suggest that 93% of adolescents use the Internet regularly (1), spending an average of 7.5 hours per day occupied with total media exposure (2). Similarly, the use of cell phones has increased dramatically, with 83% of 17-year-olds owning a cell phone (3) and spending 1.5 hours per day engaged in receiving and sending text messages (2). Text messaging, in fact, has overtaken all other forms of communication among adolescents (3).

Adolescents go online to use social networking sites such as Facebook or MySpace to check e-mail, to seek information, or to play virtual games. In a recent study, the least likely reason for an adolescent to be online was to search for information about sensitive health topics such as drug use, sexual health, or depression (1). Interestingly, adolescents from low-income families were more likely to seek health information online compared with their more affluent peers. Adolescents may preferentially seek health information from informal sources such as chat rooms or instant messaging (4). This may be particularly true for troubled adolescents who are even less likely to seek professional help and who may be vulnerable to certain content, including websites that glorify or normalize eating disorders, sexualized behavior, substance use, self-injury, or suicide (5, 6).

Potential Consequences of Excessive Use

There is increasing concern about the effects of high levels of media exposure on health and development. In a cross-sectional study, adolescents who spent more than 3 hours per day on social networking sites and sent at least 120 text messages per day were twice as likely to report substance abuse, suicidal ideation, and school truancy compared with those who did not use social networking sites (7). There is evidence linking high levels of total media exposure in adolescence to increased odds of depressive symptoms in young adulthood (8), especially among young men (9). A recent report on the effect of social media, published in *Pediatrics* (10), discussed a relatively new phenomenon, referred to as "Facebook depression," in which adolescents spend excessive amounts of time on social networking sites and then exhibit signs of depression. Data from a 2002 Swiss cross-sectional study of 7,548 adolescents indicated that more than 2 hours of online activity per day was associated with significantly higher risk of depressive symptoms, obesity, and somatic complaints (11). High-level media users may also be at risk of attention deficit hyperactivity disorder (ADHD), academic difficulties, and poor sleep (5).

Adolescents with ADHD, depression, or social phobia may be particularly vulnerable to Internet addiction (12). A cross-sectional study of 7,888 Dutch adolescents, ages 11–21 years, examined personality traits and compulsive Internet use based on self-report instruments. This study reported a higher rate of compulsive Internet use among emotionally unstable and introverted youths. Furthermore, compulsive Internet use correlated with increased feelings of loneliness and depression. Compulsive Internet use may be a stronger predictor of negative outcomes than the total time spent using the Internet daily (13).

Significant safety concerns have been raised about various online activities such as cyberbullying and sexual victimization. Although bullying is not new, it is the pervasive and intrusive nature of online bullying—outside the confines of the school environment—that may be problematic for vulnerable adolescents (14). There has been legislative interest in controlling youth access to social networking sites due to fears about sexual solicitation and harassment. However, the Growing up With Media Survey suggests that sexual victimization of 10- to 15-year-old youth who use the Internet is uncommon (15). Thus, while the risk of sexual victimization is real, it appears to be lesser than previously thought (14). In general, adolescents are at higher risk of online victimization or harassment by their peers than by adults (5).

It is pertinent to remember that media use is a normative experience for most adolescents, without significant negative mental health consequences. Although the data presented in the present review raise concerns about the correlation of excessive media use and negative mental health consequences, one must avoid ascribing causality to cross-sectional survey-based data (8). It remains unclear whether vulnerable adolescents are more likely to develop unhealthy media habits or whether high media use itself may cause emotional problems. There are also several positive attributes to the use of social media among adolescents. For example, one study suggested that Facebook usage, particularly among adolescents with lower self-esteem, was positively correlated with their social capital or offline relationships (16). Media use may also encourage pro-social behaviors and

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improve academic achievement (17) as well as allow access to health information (10).

Implications for Trainees

Why is it important to learn about media and mental health in residency training? First, it is important for residents to understand the implications of media use regarding their patients. Clinicians should routinely take a media history, particularly for adolescent patients. Are they spending excessive hours online? How are they spending their time online? Has their academic, social, or occupational performance plummeted? Are they bullying or being bullied? Are they posting inappropriate material that places them at risk? An open and curious approach allows adolescent patients to feel comfortable talking about their use of media. If the clinician takes the "one-down" stance, the adolescent is in the position of superior knowledge. This may encourage the discussion and boost the therapeutic alliance while providing further opportunities for psychoeducation and other therapeutic interventions.

Many trainees are themselves using various forms of media and may not be aware of the potential professional and ethical aspects of their own online behaviors. In a survey study, 60% of responding U.S. medical schools reported incidents of students posting unprofessional material online, including Health Insurance Portability and Accountability Act violations, use of profanity or discriminatory language, sexually explicit material, or photographs portraying intoxication (18). A recent article published in *The Residents' Journal* reported on a survey showing that more than 50% of psychiatrists (consisting of members of the Illinois Psychiatric Society as well as psychiatry residents in the state of Illinois) used at least one social networking site (19). More than 70% of current residents and recent graduates reported use of social networking sites, and 16.6% of respondents indicated that patient-psychiatrist interactions occurred via these sites.

In this era of digital communication, training programs should develop curriculum addressing personal use of media, institutional policies regarding patient confidentiality issues, and professional and ethical aspects of social media. This would ultimately enhance patient care while fostering professionalism and ethical conduct.

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References

1. Lenhart A, Purcell K, Smith A, Zickhur K: Social media and mobile Internet use among teens and young adults. http://www.pewinternet.org/Reports/2010/Social-Media-and-Young-Adults.aspx
2. Rideout VJ, Foehr UG, Roberts DF: Generation M2: media in the lives of 8- to 18-year-olds..http://www.kff.org/entmedia/upload/8010.pdf
3. Lenhart A, Ling R, Campbell S, Purcell K: Teens and mobile phones. http://www.pewinternet.org/Reports/2010/Teens-and-Mobile-Phones.aspx
4. Gould MS, Munfakh JLH, Lubell K, Kleinman M, Parker S: Seeking help from the Internet during adolescence. J Am Acad Child Adolesc Psychiatry 2002; 41:10
5. Strasburger VC, Jordan AB, Donnerstein E: Health effects of media on children and adolescents. Pediatrics 2010; 125:756
6. Lewis SP, Heath NL, St Denis JM, Noble R: The scope of nonsuicidal self-injury on YouTube. http://pediatrics.aappublications.org/content/early/2011/02/21/peds.2010-2317.abstract
7. Frank S: Hyper-texting and hyper-networking: a new health risk category for teens?, in Proceedings of the 138th Annual Meeting of the American Public Health Association, Denver, 2010
8. Lam LT, Peng ZW: Effect of pathological use of the Internet on adolescent mental health: a prospective study. Arch Pediatr Adolesc Med 2010; 164:901–906
9. Primack BA, Swanier B, Georgiopoulos AM, Land SR, Fine MJ: Association between media use in adolescence and depression in young adulthood. Arch Gen Psychiatry 2009; 66:181–188
10. O'Keeffe GS, Clarke-Pearson K; Council on Communications and Media: Clinical report: the impact of social media on children, adolescents, and families. Pediatrics (published online March 28, 2011)
11. Bélanger RE, Akre C, Berchtold A, Michaud PA: A U-shaped association between intensity of Internet use and adolescent health. Pediatrics 2011; 127:e330–e335
12. Ko CH, Yen JY, Chen CS, Yeh YC, Yen CF: Predictive values of psychiatric symptoms for Internet addiction in adolescents: a 2-year prospective study. Arch Pediatr Adolesc Med 2009; 163:937–943
13. van der Aa N, Overbeek G, Engels RC, Scholte RH, Meerkerk GJ, van den Eijnden RJ: Daily and compulsive Internet use and well-being in adolescence: a diathesis-stress model based on big five personality traits. J Youth Adolesc 2009; 38:765–776
14. Schrock A, Boyd D: Problematic youth interaction online: solicitation, harassment, and cyberbullying, in Computer-Mediated Communication in Personal Relationships. Edited by Wright KB, Webb LM. New York, Peter Lang Publishing, 2011
15. Ybarra M, Mitchell K: How risky are social networking sites? a comparison of places online where youth sexual solicitation and harassment occurs. Pediatrics 2008; 121:e350 –e357
16. Steinfeld C, Ellison NB, Lampe C: Social capital, self-esteem, and use of online social network sites: a longitudinal analysis. J Appl Dev Psychology; 2008: 29:435–445
17. Louge N: Adolescents and the Internet. http://www.actforyouth.net/resources/rf/rf_internet_1006.pdf
18. Chretien KC, Greysen SR, Chretien JP, Kind T: Online posting of unprofessional content by medical students. JAMA 2009; 302:1309-1315
19. Agarwal A: Psychiatrists' use of social networking and patient-psychiatrist interactions. Am J Psychiatry Res J 2011; 6(1)13

Religion and Spirituality in Psychiatry Training Programs

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Religion and spirituality comprise an important part of a person's psychosocial makeup, and psychiatrists must develop unique skills to address these topics for comprehensive and empathic patient care. The present review focuses on training recommendations, educational initiatives, and implications for psychiatry residents.

Mandates, Guidelines, and Preferences

The Accreditation Council for Graduate Medical Education (ACGME) mandates training in religious and spiritual topics. The current *ACGME Program Requirements for Graduate Medical Education in Psychiatry* consists of a directive for didactics on religious/spiritual factors that may "significantly influence physical and psychological development throughout the life cycle" (1). Competency in professionalism also requires "sensitivity and responsiveness" to a patient population with diversity in religion (1).

The American Psychiatric Association (APA) *Practice Guideline for the Psychiatric Evaluation of Adults* recommends emphasizing "religion and spirituality that may give meaning and purpose to the patient's life and provide support" (2). Patient beliefs are important for "developing a therapeutic alliance, negotiating a treatment plan, determining outcome criteria for successful treatment, and enhancing treatment adherence" (2). Patient beliefs also influence the informed consent process and handling of privacy and confidentiality, presumably because intrinsic spirituality influences personal preferences while extrinsic practices involve others who may participate in the patient's care.

In DSM-IV-TR, the role of religion is included in the Outline for Cultural Formulation. It also includes a V Code section, Religious or Spiritual Problem, for cases when these issues are pertinent to the focus of clinical attention (3). Psychiatrists, therefore, are expected to appropriately assess, diagnose, and intervene in such clinical situations.

Perhaps an even more compelling call to address religion/spirituality comes from reports of patient preferences. According to a survey of over 1,700,000 patients, which was published in the *Joint Commission Journal on Quality and Safety* in 2003 (4), attention to emotional/spiritual needs correlates strongly with overall patient satisfaction and was ranked second among inpatient priorities every year from 1998 to 2003. However, the report does not distinguish emotional from spiritual needs.

Educational Initiatives

A 1990 survey of members of the American Association of Directors of Psychiatric Residency Training reported that very few residency training directors had a didactic program on "any aspect of religion" (frequently or always, 12%; sometimes, 18.5%) (5). However, most reported that their residents were "supervised on the dynamic impact of patients' religious content" (frequently or always, 33.3%; sometimes, 46%). The study predated the current APA practice guidelines and ACGME mandates and may not reflect current training experiences.

A later study indicated that Canadian residencies relied on supervision for the majority of religious/spiritual instruction, but a similar study has not yet been undertaken in the United States. Therefore, we do not know the extent to which U.S. residency programs have bolstered training in religion and spirituality. However, from 1998–2006, 32 programs did initiate extensive curricula through the George Washington Institute of Spirituality and Health (7). Outlines of curricula have been published (7, 8), and the didactic components frequently reference the *Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice*, which includes three core modules and nine accessory modules, ranging from basic definitions to specialized religious/spiritual issues in specific populations. The core modules alone require 6–9 hours, although they may be modified for more restrictive schedules (9). Unfortunately, this curriculum is now out of print and not widely available. Having been published 15 years ago, it also needs updating to reflect more recently published curricula and possible sociocultural shifts.

Further, data regarding the effect of such teaching remain sparse. One pilot study of a 6-hour didactic course revealed increased knowledge and skill but no statistically significant differences in other areas such as attitude (8). Changes in clinical behavior and patient outcomes have not been examined.

Apart from didactics, many programs rely on training supervisors to teach about religion and spirituality. Published guidelines recommend that supervisors teach definitions of terms, skills for spiritual assessment, developmental frameworks, and differences between religiosity and pathology. They should also encourage trainee self-awareness and address religious/spiritual countertransference. It has been explicitly recommended that the supervisor avoid "direct involvement with the trainee's spiritual life" and refer the trainee to a spiritual advisor or confidant for attention to these issues (10). These comprehensive recommendations require a significant commitment from the supervisor, and it is not known how often they are put into effect.

Implications for Residents

Regarding the implications for psychiatry trainees, residents first should be aware of practice guidelines and educational mandates concerning religion and spirituality. Residents are a critical part of any ongoing evaluation of curricula, and in addition to providing feedback, they may need to advocate for enhanced learning experiences.

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Second, residents should know that many programs use supervisors to teach about religion and spirituality. Since supervision is a highly individual experience, residents may benefit from bringing religious/spiritual topics to the supervisory experience rather than relying on the supervisor to do so. If a resident feels unable to discuss such issues for any reason, he or she should consider reporting this to the training director or, perhaps, changing supervisors.

Third, trainees may encounter patient beliefs that stir up emotions related to their own worldview. The resident may become angry with a patient whose beliefs remind them of past negative experiences or make positive assumptions about a patient whose beliefs resemble his or her own. Religious/spiritual countertransference should certainly be discussed in supervision. However, in some very personal cases, the resident may choose to consult a spiritual advisor or therapist.

Finally, as the next generation of psychiatrists, perhaps we should consider the overall state of religion/spirituality in psychiatric training. In the mid-1990s, a model curriculum was created, but it has not been updated since that time. Some programs developed in-depth curricula with help from the George Washington Institute of Spirituality and Health, but the award program that supported these curricula has ended. This may represent a lull in attention to religion/spirituality or the completion of curricular design and a need for "next steps" in evaluating the effect of such curricula. In either case, residents might wish to draw attention to this topic in order to continue moving toward comprehensive psychiatric care in this important area.

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References

1. Accreditation Council for Graduate Medical Education: http://www.acgme.org/acwebsite/rrc_400/400_prindex.asp (Accessed March 3, 2011)
2. American Psychiatric Association: http://www.psychiatryonline.com/pracGuide/pracGuideChapToc_1.aspx (Accessed March 3, 2011)
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Text Revision (DSM-IV-TR). Washington, DC, American Psychiatric Publishing, 2000
4. Clark PA, Drain M, Malone MP: Addressing patients' emotional and spiritual needs. Jt Comm J Qual Saf 2003; 29:659–670
5. Sansone RA, Khatain K, Rodenhausen P: The role of religion in psychiatric training: a national survey. Acad Psychiatry 1990; 14:34–38
6. Grabovac AD, Ganesan S: Spirituality and religion in Canadian psychiatric residency training. Can J Psychiatry 2003; 48:171–175
7. George Washington Institute for Spirituality and Health. http://www.gwish.org/ (Accessed February 2, 2011)
8. Grabovac A, Clark N, McKenna M: Pilot study and evaluation of postgraduate course on the interface between spirituality, religion and psychiatry. Acad Psychiatry 2008; 32:332–337
9. Larson DB, Lu FG, Swyers JP (eds): Model Curriculum for Psychiatry Residency Training Programs: Religion and Spirituality in Clinical Practice. Rockville, Md, National Institute for Health Care Research, 1996
10. Bienenfeld D, Yager J: Issues of spirituality and religion in psychotherapy supervision. Isr J Psychiatry Relat Sci 2007; 44:178–186

Book Review

Cold War in Psychiatry: Human Factors, Secret Actors

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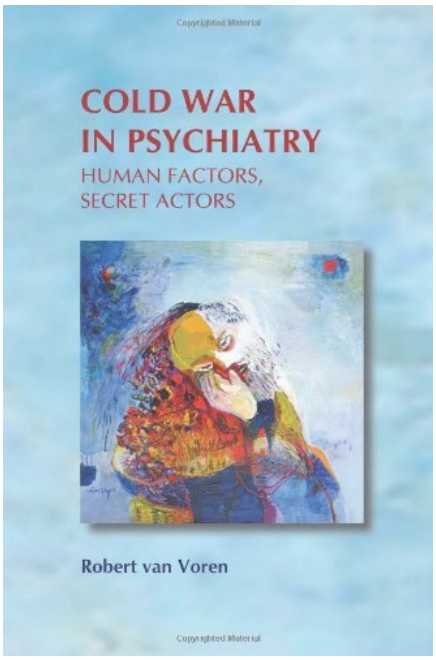
In *Cold War in Psychiatry: Human Factors, Secret Actors*, Robert van Voren revisits the tensions, intrigue, and clash of ideologies that dominated the political stage during the Cold War and compelled the international psychiatric community to address the political abuse of psychiatry used by the Soviets to repress political dissidents. In the 1980s, van Voren led a human rights group that pressured the World Psychiatric Association to expel the Soviet member society and refuse its reentry as long as Soviet psychiatrists continued to collude with the Kremlin's repression of dissidents by overdiagnosing and fabricating psychotic conditions. Thirty years later, the author strives to rework the uncompromising, steadfast vilification of Soviet psychiatry, which had previously dominated his viewpoint, with an increasingly complex understanding of the situation by offering the reader portraits of the important characters at the center of this historical drama. He begins with biographies of two men who at that time held positions in the World Psychiatric Association Executive Committee and seemed to embody the East-West conflict in their disparate appraisals of Soviet psychiatry: Melvin Sabshin, then medical director of the American Psychiatric Association, and Jochen Neumann, a prominent East German psychiatrist. He sketches the course of their youth, medical training, and psychiatric careers, demonstrating how their perspectives were shaped by their backgrounds and places in history. As van Voren takes readers on this historical journey, he portrays other key players in the controversy: political dissidents who disappeared into psychiatric hospitals or the gulag and then resurfaced to speak out against political repression, Soviet psychiatrists who fabricated psychotic diagnoses to label and involuntarily hospitalize dissidents, spies affiliated with the KGB or East German Stasi secret police who infiltrated organizations that were working to address political abuses of psychiatry, psychiatric leaders who struggled with the tension of uniting the international professional community while insisting upon ethical standards within the field, and world leaders who became invested in the political abuse of psychiatry after the fall of the Berlin Wall led to new opportunities to repair the East-West divide.



Cold War in Psychiatry: Human Factors, Secret Actors by Robert van Voren, Amsterdam/New York, Rodopi, 2010, 512 pp., $54.00 (paper).

The style of this book is a bit inconsistent, perhaps by virtue of its origin as van Voren's dissertation as well as his amalgamated autobiographical and historical nonfiction approach in creating the final work. Predominantly, this book is a fascinating page-turner, with colorful and illuminating biographical portraits of complex figures and an intriguing historical journey viewed through the lenses of psychiatry and human rights advocacy. At other times, the writing becomes bogged down in footnotes and archival, factual overinclusiveness. However, these passages are easy to skim and do not overpower the general experience of reading the book.

Residents who have an interest in international politics and human rights issues relevant to psychiatry will enjoy this book. I would recommend it to those looking to understand the origins and development of the World Psychiatric Association as well as the interface between psychiatry and politics and to those who want to learn more about the political abuse of psychiatry.

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TEST YOUR KNOWLEDGE

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

Question #1

1. A 25-year-old man presents to the psychiatric hospital and is involuntarily hospitalized due to bizarre delusions and an inability to care for himself. He has no previously known psychiatric illness and is diagnosed with schizophrenia. Upon discharge, he will have the lowest risk for rehospitalization with monotherapy of which of the following medications?

A. Quetiapine or haloperidol
B. Perphenazine or haloperidol
C. Clozapine or olanzapine
D. Clozapine or risperidone
E. Clozapine or quetiapine

Question #2

2. A 26-year-old young woman is admitted to the psychiatric hospital with psychosis following a brief flu-like illness. She subsequently developed autonomic instability and dyskinesias. An appropriate medical work-up was performed, and the patient was diagnosed with anti-*N*-methyl-D-aspartic acid receptor encephalitis. Which of the following illnesses is she most likely to have?

A. Pheochromocytoma
B. Meningioma
C. Melanoma
D. Ovarian teratoma
E. Cervical cancer

ANSWERS

Answers to May Questions. To view the May Test Your Knowledge questions, go to http://ajp.psychiatryonline.org/cgi/data/168/5/A34/DC2/1.

Question #1.
Answer: D. A favorable family environment with a history of psychotic disorders

Question #2
Answer: D. Using clinical interviews and standardized measurement

Question #3
Answer: B. Combination of trauma-focused psychotherapies

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. Fayad; fayad@ufl.edu.**

Author Information for *Residents' Journal* Submissions

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

1. **Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.

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.

3. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.

4. **Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.

5. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.

6. **Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in the Residents' Journal will be considered for publication if received within 1 month of publication of the original article.

7. **Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Issue Themes

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

July 2011
Section Theme: Suicide
Guest Section Editor: Karthik Sivashanker, M.D.
sivashanker@gmail.com

August 2011
Section Theme: Clinical Trials
(Send e-mail to Joseph Cerimele, M.D.;
joseph.cerimele@mssm.edu)

September 2011
Section Theme: Addiction
Guest Section Editor: Jonathan Avery, M.D.
joa9070@nyp.org

October 2011
Section Theme: Interventional Psychiatry
Guest Section Editor: Adam Stern, M.D.
astern2@bidmc.harvard.edu

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