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In This Issue

In this month's issue, we focus on the role of research in residency. An editorial describes the *Residents' Journal* review process and invites residents to serve as peer reviewers. Doreen M. Olvet, Ph.D., discusses the process of obtaining research funding. Next, Lance Feldman, M.D., examines existing research supporting the use of routine laboratory studies in the admission of patients to psychiatry wards. Last, Weronika Micula-Gondek, M.D., shares her experience with incorporating her research interest into the clinical responsibilities of residency training.

Editorial

The Residents' Journal and Review

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

In recent weeks, several residents have independently asked me two questions: 1) What happens to a manuscript after it is submitted? 2) Does the *AJP Residents' Journal* peer review the submitted manuscripts? The first question is easily answered. After submitting a manuscript online through Manuscript Central, it undergoes journal processing. The editorial staff identifies and assigns the article to an Editor, a timeline is established, and the assigned Editor is subsequently notified of the submission. Some steps of this process are e-mailed to the corresponding author (e.g., notification of submission, requests for revisions), but most occur without informing the author directly. Authors can always check a manuscript's status on the Manuscript Central website.

Answering the second question requires an understanding of a typical peer review process. Roberts et al. (1) described the editorial and publication process for larger, peer-reviewed journals (Figure 1). Overall, the *Residents' Journal* differs from this reported process in several ways. First, manuscripts are rarely rejected during the triage/initial editorial review. Two of the Journal's roles are to encourage resident authorship and to teach residents the writing/reviewing/revising process. Initial rejection would be contrary to these goals. Second, we do not send the manuscripts to peer experts for review; rather, Dr. Fayad and I review each manuscript. Non-expert, unblinded review by the managing editors is unusual for a journal. This is the largest deviation from the standard review process. Third, most submitted manuscripts to the Journal do not report original research, making the need for statistical review rare. Additionally, we do not use a scoring system for our review and do not have the option of asking for the opinions of other peer reviewers. Reviewers' comments are generally sent to the author as embedded text in the original manuscript file, as a separate document, or in the body of the e-mail asking for revisions. In the manner of other journals, we will move toward sending comments in the body of an e-mail from the editorial staff.

As editors-reviewers, we initially examine the manuscript for adherence with Journal guidelines and specifications. Then, we comment on the manuscript's content, structure, references, and style. Our comments (and requests for a revision by a certain date) are sent to the corresponding author through Manuscript Central.

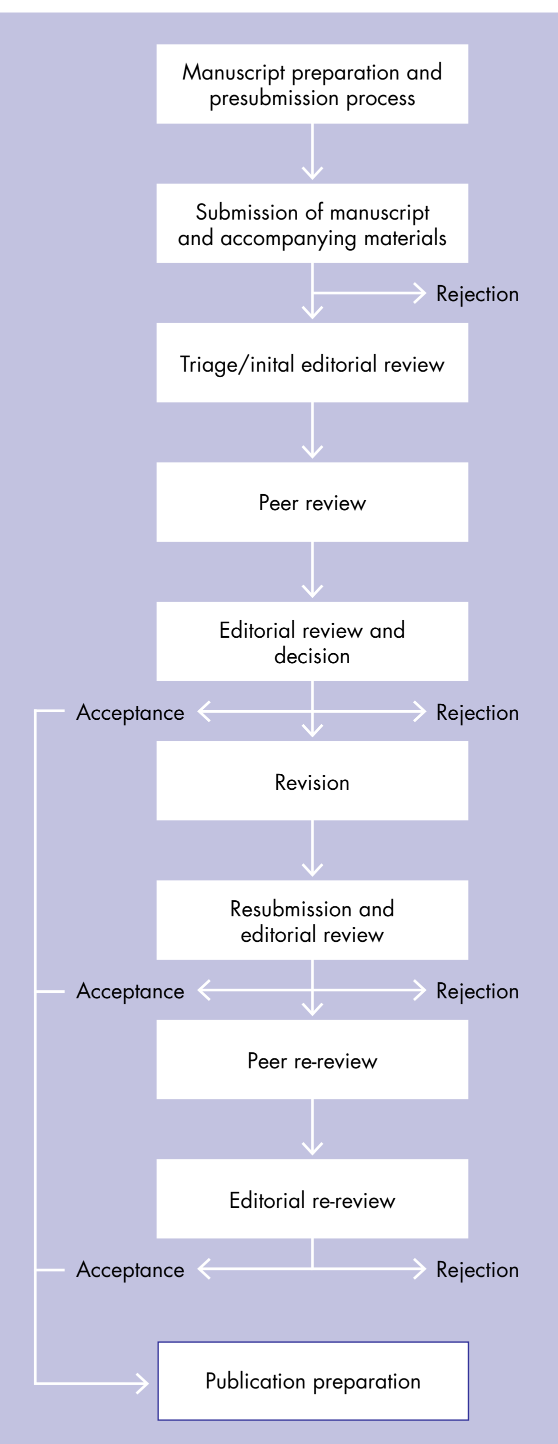
We do not yet have the resources (e.g., a pool of reviewers) or the production schedule to externally peer review each submitted manuscript. One of the Journal's goals is to develop this system. We plan to initiate a trial peer review process for submitted manuscripts this winter, and I ask residents interested in participating to e-mail me. We will correspond with interested resident reviewers via e-mail and will have deadlines for each review. We look forward to creating this useful academic process with your help.

Address e-mail correspondence to Dr. Cerimele at joseph.cerimele@mssm.edu.

Reference

1. Roberts LW, Coverdale J, Edenharder K, Louie A: How to review a manuscript: a "down-to-earth" approach. Acad Psychiatry 2004; 28:81–87t

Figure 1.
The Editorial and Publication Process



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The Basics of Grant Funding for the Young Investigator

Doreen M. Olvet, Ph.D.
Zucker Hillside Hospital, Psychiatry Research, North Shore-Long Island Jewish Health System, Glen Oaks, New York

As a psychiatry resident or postdoctoral research fellow, the world of grant funding can be daunting. Knowing what grants are out there and how to write a successful proposal are important first steps toward gaining independent funding for your research. The goal of the present review is to use information that I have garnered through my own attempts to understand how this whole process works as well as through guidance from inside the National Institute of Mental Health (NIMH) to provide facts about what grants are available and how to prepare a successful application.

NIMH, the major governmental funding agency for psychiatric research in the United States, offers a variety of grants, ranging from individual fellowships for young investigators to major research initiatives that support multisite consortiums. One example is the Ruth L. Kirschstein National Research Service Award (NRSA) for Individual Postdoctoral Fellows (F32), which funds research training for recent graduates of Ph.D. or M.D. programs. The F32 award provides a minimum of $37,740 annually for up to 3 years. Applicants can apply for this award at three different points throughout the year (April, August, and December) and have two opportunities to revise their application. The F32 application review process leads to a proposal score (based on a 9-point scale indicating a strong [score of 1] or weak [score of 9] application), and reviewer feedback, which should be used to guide the resubmitted proposal. According to Dr. Nancy Desmond, Associate Director for Research Training and Career Development at NIMH, "In fiscal year 2009 which ended 9/30/2009, the success rate for individual postdoctoral fellowship applications (F32) was 26% at the NIMH" (1). This is encouraging news for young investigators.

Research proposals mirroring NIMH's current interests are more likely than other proposals to be funded. Dr. Desmond comments on this as follows:

"NIMH is interested in supporting basic and clinical research that will transform the understanding and treatment of mental illnesses. The NIMH Strategic Plan encourages research that will fulfill four objectives: 1) promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders; 2) chart mental illness trajectories to determine when, where, and how to intervene; 3) develop new and better interventions that incorporate the diverse needs and circumstances of people with mental illnesses; and 4) strengthen the public health impact of NIMH-supported research. The complete NIMH Strategic Plan is available at: http://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml." (1)

It is important to do your homework prior to fully developing your application to find out where your research project will fit into the overall NIMH structure.

Another avenue of funding is private foundations. Private foundations typically raise money through donations and offer grants to investigators who study a particular psychiatric disorder. For example, if you are interested in studying schizophrenia or depression, consider the NARSAD Young Investigator Award. There is only one opportunity to apply for this award each year, and it provides $30,000 a year for up to 2 years. Unfortunately, NARSAD does not provide feedback on the proposal, and it cannot be resubmitted. There are also a number of foundations that support research in other psychiatric domains, such as the International Obsessive Compulsive Disorder Foundation and the International Bipolar Foundation (see reference 2 for recommendations on how to search for private foundations). Applying for such grants can serve as a foundation for a strong research career and will present a significant advantage when applying for larger grants in the future.

In order to learn the nuts and bolts of how to write a research proposal, take advantage of resources at your own institution or at scientific meetings. Dr. Desmond reports, "Many academic institutions offer grant-writing workshops through Offices of Postdoctoral Affairs, related offices, or perhaps as part of an institutional training program or Clinical Translational Science Award (CTSA)

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Tips for Grant Writing From Dr. Nancy Desmond

1. Plan ahead. Allow sufficient time before the targeted funding deadline to craft a strong application and to allow time for critical feedback from your mentor(s).
2. Be an informed consumer of information about available funding opportunities (6) and institute funding priorities (e.g., the NIMH Strategic Plan [7]).
3. Contact an NIMH program officer (8) well in advance of the funding deadline to receive specific technical feedback on your qualifications and on the concept for your application. One of our important responsibilities is to provide technical feedback to potential applicants. It's helpful to include your NIH biographical sketch and a rough draft of your proposed specific aims with your initial inquiry so that we have some background information to review in advance of a conversation.

The above tips were obtained via an interview with Dr. Desmond.

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there. NIMH staff frequently participate in grant-writing workshops that are organized as part of scientific conferences." There are also a number of books (e.g., references 2, 3) and websites (e.g., reference 4) that are helpful in preparing a grant application. However, make sure to adhere to the guidelines set forth by each individual funding agency.

Grant funding is essential for survival in research. Searching the Internet and talking to your supervisor and peers are great ways to find out about grant opportunities. Additionally, the Science Careers website has an extensive list of grant and funding opportunities available (5). If you are not quite ready to delve into writing a major grant proposal, you can apply for smaller training and travel grants through a variety of professional associations. For example, the Society for Psychophysiological Research offers a Research Fellowship Training Award (up to $5,000), which can be used toward equipment or training at another institution to enhance your knowledge of psychophysiological methods. Additionally, the Society for Biological Psychiatry awards a $1,500 travel fellowship that can be used to defray travel costs in order to attend their annual meeting. The bottom line is that you will not get funded if you do not apply. If you are fortunate enough to secure a grant early on in your career, the more likely you are to get funded in the future. And do not get discouraged if you do not get funded right away. Simply going through the experience of writing and submitting a grant is an invaluable skill that will help make the next submission a breeze.

Dr. Olvet is a postdoctoral research fellow in the Recognition and Prevention Program, Zucker Hillside Hospital, Psychiatry Research, Glen Oaks, N.Y.

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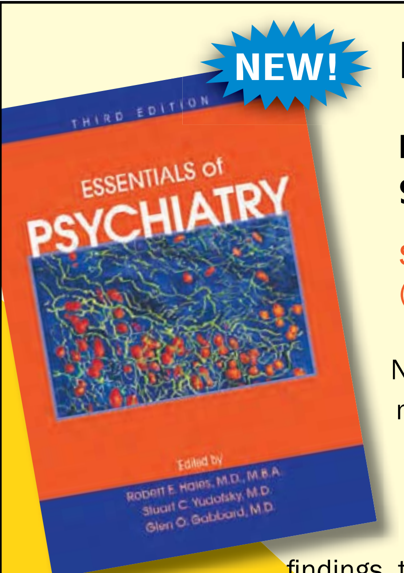

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The *First* and *Last* Word in Psychiatry

Routine Psychiatric Admission Labs: Do They Make Cents?

Lance Feldman, M.D.
Department of Psychiatry, University of Toledo, Toledo, Ohio

With ever increasing budgetary constraints, the time has come for many psychiatric facilities to take an in-depth look at all feasible cost cutting measures. The practice of ordering routine psychiatric admission labs is one such potential avenue for cost savings. Few studies have been conducted to determine the clinical usefulness of screening for medical emergencies that may arise on an inpatient psychiatric unit (1). In addition, little consensus can be found in the literature regarding which tests need to be obtained and where (emergency department vs. psychiatric unit) (2). Therefore, in many instances, the practice of obtaining laboratory examinations is far from evidence-based.

From the perspective of emergency department physicians, few laboratory screenings for psychiatric patients are routinely useful and should be determined based on the patient's history and physical examination (2). One report goes as far as to state that "routine laboratory testing has been shown to be neither cost-effective nor necessary in the medical clearance of [emergency department] patients with psychiatric symptoms" (2, p. 4). In fact, emergency department physicians have even advocated for the use of a general screening tool for psychiatric patients that would determine the need for any further assessment (3). These screening measures included vital signs, prior psychiatric history/age, orientation/Folstein test score, evidence of acute medical problems, and presence of visual hallucinations. The usefulness of routine toxicology screens among child and adolescent psychiatric emergency room patients has also been challenged (4).

On the other hand, psychiatry has been slow to embrace these changing attitudes. Arce-Cordon et al. (5) urged consideration of not just financial and time constraints but potential benefits to an often medically underserved patient population, challenging the notion of cost-effectiveness. Acute medical concerns, such as dehydration and hypokalemia, may affect psychiatric treatment and therefore need to be screened for on admission (6). Thyroid screening is advocated on the basis of the possibility of the manifestation of psychiatric concerns and the common findings of abnormal thyroid levels in adolescent, adult, and elderly patients (7). Lastly, substance use is common among patients with psychiatric disorders. One particular study, which was conducted in a cross-sectional nature at a major urban medical center over the course of 2 months and compared all general medical admissions with psychiatric inpatient admissions, found that 36% of psychiatric patients tested positive for illegal drugs on admission versus 13% of medical patients (8). The authors concluded that the problem of substance abuse in the psychiatric population is widespread, and therefore routine toxicology testing is warranted (8).

At our hospital, the practice of routine laboratory admission orders on the child and adolescent inpatient psychiatric unit was recently discussed. Routine laboratory examinations generally include a complete blood count, a complete metabolic panel, thyroid stimulating hormone level analysis, a lipid profile, urinalysis, serum lead level analysis, serum pregnancy test, and urine toxicology. In our discussion, we emphasized historical accounts of a few cases in which a laboratory screen changed patient management. Our experience with these cases led to a general concern over admitting patients without laboratory analyses.

What role do screening laboratory examinations have in the practice of psychiatric medicine? Perhaps only high-risk patients should be screened, such as the elderly or patients with significant preexisting medical concerns (9). Other potential criteria might include substance use disorders, no psychiatric history, and symptoms of acute disorientation or hallucinations, such as in a patient with delirium, in which case thorough medical evaluation and diagnostic testing may be essential in order to determine the cause of the symptoms (3, 9). A symptom-focused history and physical examination, conducted by an emergency department physician, is likely sufficient to safely and routinely elucidate physical illness from medical illness and has significant potential cost savings to the patient as well as the hospital without compromising patient care. (2). Others, however, feel that it is essential to obtain routine admission labs on all psychiatric patients regardless of the cost, since these patients are more vulnerable to complications due to dehydration and electrolyte disturbances than the general population (6).

What is clear, however, is that psychiatrists need to take an active lead in determining the medical care of our patients. Prospective and outcome studies should be obtained to understand the benefits and risks of routine laboratory examinations in patients with acute and chronic psychiatric illness. The cost-effectiveness of examinations must also be undertaken to justify the use of routine screenings. Without the evidence clearly in hand, it appears too early to determine which, if any, routine screening exams are justified. Relying on the old status quo does not appear to be the answer either. As the evidence builds, a solution to this ever present discussion may be determined.

Dr. Feldman is a Chief Resident in his third year of psychiatry residency, University of Toledo, Toledo, Ohio.

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continued on page 6

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Residency and Research: A Personal Reflection

Weronika Micula-Gondek, M.D.
University Hospitals Case Medical Center, Department of Psychiatry, Cleveland, Ohio

Despite ongoing advances in neuroscience and genetics that has transformed our understanding of the brain, the number of psychiatrists conducting research has declined over the years. Psychiatry has evolved from theory-based to evidence-based practice. However, research training during residency is still not optimal, and fewer residents are interested in pursuing this path.

I used to consider myself solely as a clinician, and I didn't think I would become interested in clinical investigations until I was invited to participate in one of the projects in my department at the beginning of my PGY-3 year. It involved administering a set of manualized cognitive behavioral therapy-based interventions for patients with bipolar disorder. The goal of the study was to enhance patients' medication adherence and improve their overall functioning. Before being considered as an interventionist in the study, I went through a 2-month long learning process. I studied the treatment manual and observed trained interventionists during sessions with research patients. Later, I began videotaped practice with actors and ultimately started administering interventions to research participants. I saw each one of my patients for approximately four sessions and administered several psychotherapy-based interventions. The sessions included education about bipolar illness and medications, helping patients to communicate with their providers, and motivational interviewing for those patients using illicit substances.

Initially very reluctant, I became more enthusiastic as the time went by. I realized that research can be as rewarding as clinical practice. I acquired new skills, helped my patients, and gained more experience. I understood that my patients really enjoyed the sessions, became more compliant with their medications, and gained more control over their illness. I also found myself using some of the learned skills, not only with my research patients but also at different outpatient centers, including community and Veteran's Affairs clinics. Suddenly, I realized that an integral part of my clinical assessment became the question, "How often do you take your medications?" I also became more sensitive to problems with treatment adherence among various patient populations.

Supported by my mentors, I examined my learning experience with the study. I compared attendance of my patients and their satisfaction reports with the data from patients of trained interventionists and concluded that manualized intervention can be easily learned and disseminated among different treatment centers and providers. I presented my results in poster form during research day at my hospital, and since it was well received, I was encouraged to submit it to one of the national meetings.

Today, after over a year since starting my experience, I try to encourage everyone to seek opportunity and become involved with research during their residency. It's a unique learning opportunity, and some of the new acquired skills can be easily translated into practice outside of the scope of the research study. It allows us to learn more about our patients and look at their problems from a different perspective and to improve our clinical skills. Moreover, it helps develop competence and confidence in certain areas and affects plans for future career planning and training.

Dr. Micula-Gondek is a fourth-year resident in the Department of Psychiatry, W.O. Walker Center, Cleveland.

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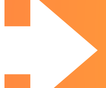
In preparation for the Board Examinations, test your knowledge with these questions (answers will appear in the next issue of the *Residents' Journal*).



1. A mother and her 2-year-old child attend a birthday party. The child is seen interacting and playing with other children, but he is noted to often look back at his mother for reassurance. At times, he will run back to his mother, only to quickly return to play. Who described this phase as "rapprochement"?
A. Jean Piaget
B. Erik Erikson
C. Margaret Mahler
D. John Bowlby
E. D.W. Winnicott

2. A child who has been successfully potty-trained, mastered fine motor skills, and begun to frequently say "no" to members of his core family has likely completed which stage of psychosocial development?
A. Autonomy vs. shame and doubt
B. Industry vs. inferiority
C. Initiative vs. guilt
D. Trust vs. mistrust
E. Identity vs. role confusion

3. An infant and his mother are playing with a toy when the mother takes the toy and hides it behind her back. The infant begins crawling to search for the toy. This infant has likely achieved which milestone?
A. Object constancy
B. Object permanence
C. Separation-individuation
D. Rapprochement

ANSWERS

Answers to August Questions. To view the August Test Your Knowledge questions, go to *http://ajp.psychiatryonline.org/cgi/data/167/8/A24/DC2/1*

Question #1
Answer: C. Thioridazine
Thioridazine has been shown to prolong the QT interval by >30 msec. It has been associated with numerous cases of torsades de pointes and a higher number of sudden deaths when compared with other antipsychotics (1). Although ziprasidone has been shown to cause QT prolongation, the average prolongation of the QT interval associated with this treatment has been reported at 20.3 msec, followed by quetiapine at 14.5 msec, risperidone at 11.6 msec, and haloperidol at 4.7 msec (2).

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Question #2:
Answer: B. Haloperidol, 0.25 mg–0.5 mg intravenously every 4 hours as needed for agitation, with continuous ECG monitoring
In 2007, the Food and Drug Administration (FDA) made new recommendations concerning the use of intravenous haloperidol, secondary to adverse reports regarding QTc prolongation and torsades de pointes. It should be noted that the use of haloperidol in its intravenous form is an off-label use. Based on adverse reports, the FDA has recommended that all patients receiving intravenous haloperidol also receive continuous ECG monitoring (1).
Regarding dosage recommendations, APA guidelines for the treatment of elderly patients with delirium recommend a dosage of haloperidol ranging from 0.25 mg–0.5 mg intravenously every 4 hours (2). Case reports have revealed that prolongation of the QT interval and torsades de pointes occur most frequently in patients who have concomitant risk factors. Meyer-Massetti et al. (3) demonstrated that there were no cases of QT prolongation or torsades de pointes in patients in which the cumulative dose was <2 mg.

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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

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 1,000 words and 10 references.

3. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 750 words and five references.

4. **Original Research:** Reports of novel observations and research. Limited to 1,000 words, 10 references, and two figures.

5. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,000 words, 10 references, and one figure.

6. **Letters to the Editor:** Limited to 250 words (including 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.

Abstracts: Articles should not include an abstract.

References: Use reference format of *The American Journal of Psychiatry* (http://ajp.psychiatryonline.org/misc/Authors_Reviewers.dtl).

Upcoming Issue Themes

November 2010
Issue Theme: Art in the Realm of Psychiatry
Issue Editor: Gabriela Iagaru, M.D.;
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December 2010
Issue Theme: Specialists in Psychiatry
Issue Editor: Jay Augsburger, M.D.;
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January 2011
Issue Theme: Internal Medicine Skills and Psychiatry
Issue Editor: Rosalyn Womack, M.D.;
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February 2011
Issue Theme: Eating Disorders
Issue Editor: Mike Rosen, M.D.;
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We encourage residents to submit manuscripts outside of these themes.
Manuscripts on all topics are welcome and will be considered.