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## In This Issue



This month's issue of the *Residents' Journal* focuses on the topic of adolescent psychiatry. The first onset of many mental illnesses often occurs during adolescence, resulting in impaired functioning in families, in schools, and among peers, and early identification, assessment, and treatment are important to outcome in adulthood. First, Justine Wittenauer, M.D., and Michael Ascher, M.D., present informative data on the risk factors, assessment tools, and intervention models for substance use disorders in adolescents. Next, Michael Nevarez, M.D., discusses how mindfulness-based approaches can be beneficial in treating adolescents with more common disorders, such as anxiety and mood disorders, as well as those with autism spectrum disorder, substance abuse, learning disabilities, and conduct disorder. Last, Sara M. Coffey, D.O., provides enlightening information and recommendations on how psychiatrists can provide consultation to schools after youths are exposed to a traumatic event.

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# Adolescent Substance Use Disorders

Justine Wittenauer, M.D.  
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Adolescence is a transitory period, during which the risk of developing a substance use disorder is elevated. Some researchers believe that adolescents are at heightened risk for developing addictive disorders because of immature neuroconnectivity and/or imbalances in the expression of the motivational learning system, which creates greater disinhibition and results in higher risk behaviors (1). Adolescents at higher risk for substance use disorders likely have neurobiological risks because of distinctive serotonergic hypothalamic-pituitary-adrenal axis and/or neurophysiological functioning compared with lower-risk adolescents (2). Early intervention for adolescents who misuse substances is critical because research has shown that these individuals go on to abuse substances more heavily during adulthood (3). With a greater understanding of risk factors and current substance use patterns, targeted prevention and treatment plans can be developed. Intervening variables and subsequent treatment options are examined in the present article.

Since 1975, the use of substances among high school students has been surveyed and monitored through grants sponsored by the National Institute on Drug Abuse. Data collected from over 45,000 high school students in the national 2012 survey indicated that 41.5% of 12th graders had consumed alcohol within 30 days of the survey, 17.1% had smoked cigarettes, and 25.2% had used some form of illicit substance (4). In a national psychiatric epidemiological survey of 10,148 adolescents, ranging from ages 13 to 17, it was estimated that 8.9% of adolescents met criteria for drug abuse or dependence and 6.4% for alcohol abuse or dependence. Furthermore, the total prevalence of substance use disorders was 11.4%, with boys having 5–11 times higher rates of substance use disorders than girls (depending on the age group) (5). While the general number of high school students abusing substances has remained relatively stable over the past decade, the trend of abused

substances has fluctuated. For instance, among 9th- to 12th-grade students, the estimated prevalence of inhalants decreased from 20.3% in 1995 to 11.4% in 2011. From 2009 to 2011, the prevalence of marijuana use increased, from 20.8% to 23.1% (6).

It is important to understand the demographic profile of those at higher risk for developing a substance use disorder when initiating prevention programs and interventions. Factors that elevate risk for substance use disorders in adolescence may be stratified into biological, community, peer, and family influences. Additional factors that may elevate risk include family alcohol and drug behavior attitudes, early-onset of aggression, peer rejection in elementary grades, and association with drug-using peers (7). Childhood psychiatric disorders, including attention deficit hyperactivity disorder, conduct disorder, and mood, anxiety, and learning disorders, may also play a contributing role in the development of substance use disorders (8). Adolescents between the ages of 12 and 17 with substance use disorders have a 26.4% chance of developing a secondary mood disorder, with average time to onset of 11 years (9). Studies involving prevention of substance use in high-risk populations have been limited to a few small randomized control trials. While some of these studies have shown promise, further research is warranted (10).

In addition to the direct impact of substance use, such as intoxication or disinhibition, adolescents may also experience secondary effects, including risky behavior and increased rates of suicide or mood disorders. The Youth Risk Behavior Surveillance System is published by the Centers for Disease Control and Prevention and surveys representative samples of high school students in grades nine through 12 for their participation in health risk behaviors that may result in unintentional injuries or violence. According to the 2011 results, 8.2% of

students drove a motor vehicle after consuming alcohol within 30 days of the survey. Binge drinking was a common concern; 21.9% of students had consumed five or more drinks in a row within the last 30 days of the survey (6). The risk of suicide also increases and is dependent on the particular substance used, as well as the total number of substances. Users of heroin within a 12-month time period have a 46.2% risk of suicidal thoughts and behaviors, while high school students who use alcohol have a 9.2% risk (11). Longitudinal studies are also beginning to reveal neurotoxic effects of substances. In a study conducted in New Zealand among 1,037 individuals, IQ testing was performed on individuals at age 13 and again at age 38. Even after adjustment for education, an 8-point decline in IQ score was present over multiple neuropsychological domains among individuals who had onset of persistent weekly marijuana use before age 18. The most prominent impairments occurred within executive functioning and processing speeds, although these differences did not meet statistical significance when compared across other domains (12).

While all youths in primary care should be screened for substance misuse, individuals who demonstrate specific signs, such as changes in cognition, mood, behavior, and overall impairment in psychosocial or academic functioning, should be thoroughly screened. A recent review examined the most commonly used screening tools for adolescent substance use disorders, including the CRAFT, RAFT, CAGE, and AUDIT questionnaires. CRAFT has been cited as the most studied and evidence-supported screening tool for adolescent substance use disorders in the primary care setting (13) (Table 1). Comprised of six questions, each endorsed response is worth 1 point, and a score of 2 or more points has a sensitivity of 0.76 (specificity, 0.94; any substance use disorder: sensitivity, 0.80, specificity, 0.86; dependence: sensitivity,

TABLE 1. Components of the CRAFFT Questionnaire<sup>a</sup>

1. Have you ever ridden in a <u>C</u> ar driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to <u>R</u> elax, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs when you are by yourself, <u>A</u> lone?
4. Do you ever <u>F</u> orget things you did while using alcohol or drugs?
5. Do your <u>F</u> amily or friends ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into <u>T</u> rouble while you were using alcohol or drugs?

<sup>a</sup> Details regarding the validity of the CRAFFT questionnaire are described by Knight et al. (14).

0.92, specificity, 0.80) (14). CRAFFT has also been shown to promote adolescent endorsement of truer symptoms when administered through paper format than when administered verbally by a nurse or a physician (15).

Practice parameters according to the American Academy of Child and Adolescent Psychiatry include guidelines for screening, evaluation, monitoring, and treatment. Family therapy approaches are cited as having the most supportive evidence, although both cognitive-behavioral therapy (CBT) and motivational enhancement therapy also have a level of efficacy. Practice parameters make no formal recommendations for maintenance medication, although they do indicate the utility of medications in substance withdrawal states (16). Medications approved for the treatment of addiction in adults, such as acamprosate, disulfiram, methadone, buprenorphine, and naltrexone, may be used in adolescents but are not approved by the Food and Drug Administration for this purpose. Most of the evidence for the above medications arises from limited case reports. Treatment options are variable and range from inpatient services with detoxification capabilities to acute residential programs and lower levels of outpatient care.

Both multidimensional family therapy and multisystemic family therapy have shown effectiveness. Multisystemic family therapy is a home-based program that integrates the roles of school, social network, family, and the neighborhood. This intervention is particularly popular with juvenile court programs. Goals of this treatment modality include promoting and improving family functioning while

subsequently decreasing the adolescent drug use (17). Multidimensional family therapy is a family-focused therapy that not only targets family functioning but also youths and parents within family and peer contexts. In a 1-year controlled effectiveness trial between multidimensional family therapy and peer-group intervention, multidimensional family therapy demonstrated statistical improvement with regard to substance use frequency, delinquency, and internalized distress (18).

CBT and motivational enhancement therapy can be used individually or as a combined treatment. In the Cannabis Youth Treatment Study, a combination of motivational enhancement therapy and CBT was found to be similar in outcome in terms of total days abstinent and the percentage of adolescents in recovery compared with the adolescent community reinforcement approach and multidimensional family therapy (19). Motivational enhancement therapy was used to assist with resolution of ambivalence toward problematic substance use, as well as to increase the motivation to stop using. CBT was used to teach coping skills to handle substance refusal, to establish supportive peer groups, and to develop problem-solving skills for high-risk situations.

While much of the current research demonstrates variability in the demographic data related to substance use in teens, one variable appears to exhibit a common theme: during the adolescent development years, the risk of substance use disorders is elevated. Furthermore, it appears that early-life substance use has been shown to increase the risk of prob-

lematic substance use in adulthood. In an attempt to understand the magnitude of this problem, high schools are frequently administering surveys to their students, and valuable prevention and intervention data are being studied. Preliminary positive-outcomes research has shown the promise of CBT and multisystemic family therapy as effective treatment modalities. Co-occurring psychiatric disorders and behaviors related to substance use disorders, such as suicidality and mood disorders, are being investigated as well. However, major questions still exist in relation to issues such as the role of gender, age, family environment, peer pressure, exposure to substance use, and drug of choice. More targeted research is needed to study these areas in order to reduce the negative effect of substance misuse on the individual, the individual's loved ones, and society at large.

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## References

1. Chambers RA, Taylor JR, Potenza MN: Developmental neurocircuitry of motivation in adolescence: a critical period of addiction vulnerability. *Am J Psychiatry* 2003; 160:1041–1052
2. Schepis TS, Adinoff B, Rao U: Neurobiological processes in adolescent addictive disorders. *Am J Addict* 2008; 17:6–23
3. von Sydow K, Lieb R, Pfister H, Höfler M, Sonntag H, Wittchen HU: The natural course of cannabis use, abuse and dependence over four years: a longitudinal community study of adolescents and young adults. *Drug Alcohol Depend* 2001; 64: 347–361
4. Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE: Monitoring the Future: National Survey Results on Drug Use, 1975–2012, Volume I: Secondary School Students. Ann Arbor, Mich, Institute for Social Research, University of Michigan, 2013
5. Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J: Lifetime

- prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry* 2010; 49:980–989
6. Eaton DK, Kann L, Kinchen S, Shanklin S, Flint KH, Hawkins J, Harris WA, Lowry R, McManus T, Chyen D, Whittle L, Lim C, Wechsler H; Centers for Disease Control and Prevention (CDC): Youth risk behavior surveillance–United States, 2011. *MMWR Surveill Summ* 2012; 61:1–162
  7. Hawkins JD, Catalano RF, Miller JY: Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychol Bull* 1992; 112:64–105
  8. Weinberg NZ: Risk factors for adolescent substance abuse. *J Learn Disabil* 2001; 34:343–31
  9. Kenneson A, Funderburk JS, Maisto SA: Substance use disorders increase the odds of subsequent mood disorders. *Drug Alcohol Depend* 2013; 133:338–343
  10. Salvo N, Bennett K, Cheung A, Chen Y, Rice M, Rush B, Bullock H, Bowlby A: Prevention of substance use in children/adolescents with mental disorders: a systematic review. *J Can Acad Child Adolesc Psychiatry* 2012; 21:245–252
  11. Wong SS, Zhou B, Goebert D, Hishinuma ES: The risk of adolescent suicide across patterns of drug use: a nationally representative study of high school students in the United States from 1999 to 2009. *Soc Psychiatry Psychiatr Epidemiol* 2013; 48:1611–1120
  12. Meier MH, Caspi A, Ambler A, Harrington H, Houts R, Keefe RS, McDonald K, Ward A, Poulton R, Moffitt TE: Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proc Natl Acad Sci U S A* 2012; 109:E2657–E2664
  13. Pilowsky DJ, Wu LT: Screening instruments for substance use and brief interventions targeting adolescents in primary care: a literature review. *Addict Behav* 2013; 38:2146–2153
  14. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G: Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Arch Pediatr Adolesc Med* 2002; 156:607–614
  15. Knight JR, Harris SK, Sherritt L, Van Hook S, Lawrence N, Brooks T, Carey P, Kossack R, Kulig J: Adolescents' preference for substance abuse screening in primary care practice. *Subst Abuse* 2007; 28: 107–117
  16. Bukstein OG, Bernet W, Arnold V, Beitchman J, Shaw J, Benson RS, Kinlan J, McClellan J, Stock S, Ptakowski KK: Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. *J Am Acad Child Adolesc Psychiatry* 2005; 44:609–621
  17. Henggeler SW: Efficacy studies to large-scale transport: the development and validation of multisystemic therapy programs. *Annu Rev Clin Psychol* 2011; 7:351–381
  18. Liddle HA, Rowe CL, Dakof GA, Henderson CE, Greenbaum PE: Multidimensional family therapy for young adolescent substance abuse: twelve-month outcomes of a randomized controlled trial. *J Consult Clin Psychol* 2009; 77:12–25
  19. Dennis M, Godley SH, Diamond G, Tims FM, Babor T, Donaldson J, Liddle H, Titus JC, Kaminer Y, Webb C, Hamilton N, Funk R: The Cannabis Youth Treatment (CYT) Study: main findings from two randomized trials. *J Subst Abuse Treat* 2004; 27:197–213

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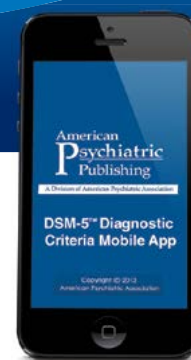
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# Mindfulness-Based Approaches in Adolescent Psychiatry

Michael Nevarez, M.D.

In 1979, Dr. Jon Kabat-Zinn founded the Mindfulness-Based Stress Reduction Program for chronic pain (1), which sparked a growing enthusiasm for the application of mindfulness ideas and practices in the medical world. Despite its roots in Buddhism, mindfulness is not inherently religious and is often taught independent of religious or cultural connotation. In contemporary Western psychology, mindfulness is often defined as the awareness that arises through intentionally attending to one's moment-to-moment experience in a nonjudgmental and accepting way (2). Interest in mindfulness-based approaches with adults has grown rapidly, and an expanding research base suggests that these are efficacious with meta-analytic reviews showing a medium-sized effect (Cohen's  $d=0.50$ , approximately) on a variety of mental health outcomes (3). Accordingly, interest has spread regarding the effectiveness of mindfulness-based approaches with adolescents, and the present review aims to provide a survey of the current research base in this population.

In the United States, 1 in 5 children and adolescents have a mental health disorder that leads to impairment in daily functioning (4), with anxiety and mood disorders (particularly depression) being the most frequently reported (5). Additionally, level of response to psychological treatment among adolescents has not been robust, with some investigators reporting that 55%–60% of patients may be left with continued impairment (6). This suggests room to augment psychological treatment for adolescents, for whom mindfulness may play a role. Even though the cognitive abilities of youths differ from those of adults, depending on developmental stage, it has been noted that children and adolescents have the faculties to engage in the process of mindfulness and formal meditation (7). Furthermore, adolescents are capable of the basic prerequisites for mindfulness training the same as adults: the willing-

ness to explore a novel experience and the ability to follow directions (8).

## Studies in Adolescent Populations

Mindfulness-based interventions for adolescents are an emerging field of study. Current research has been limited by a number of methodological issues, including small sample sizes, purely self-reported outcomes, lack of comparison groups, and variations in intervention. These limitations have made isolating the effects of mindfulness training on measured outcomes difficult. In addition, a review noted that a meta-analysis or overall effect size calculation is not yet possible because of variability in methodology (9). The principal mindfulness-based approaches include mindfulness-based stress reduction, mindfulness-based cognitive therapy, dialectical-behavior therapy, and acceptance and commitment therapy. Mindfulness-based stress reduction and mindfulness-based cognitive therapy use traditional mindfulness meditation practices to develop mindfulness skills, whereas dialectical-behavior therapy and acceptance and commitment therapy use mindfulness techniques and/or nonmeditative component skills of mindfulness (9). The scope of the present review is on mindfulness-based stress reduction and mindfulness-based cognitive therapy approaches and their adaptations in the literature, since they include mindfulness practice at their core. Interventions based on mindfulness-based stress reduction/mindfulness-based cognitive therapy typically involve experiential learning programs that include weekly group practice, a core curriculum of mindfulness practices (body scan, sitting, movement, and walking meditations), and emphasis on intentional mindful awareness of activities of daily living. A common focus is to use the sensation of the breath and the body as “anchors” for attention, when attention wanders or becomes scattered. Through these practices, participants develop skills

and attitudes that include focusing, sustaining, and switching attention and accepting their present moment experience without judgment or elaboration (9).

In specific clinical populations, interventions have been studied for autism spectrum disorder, substance abuse, attention deficit hyperactivity disorder (ADHD), learning disabilities, and conduct disorder. Research in individuals with autism spectrum disorder is limited to three small studies without comparison groups. One study examined 14 adolescents (of which four had autism spectrum disorder) with externalizing disorders and their parents using a modified mindfulness-based cognitive therapy protocol (10). Results showed improvements in social interaction, awareness, impulsive behavior, and measures of positive mood; however, effects on the autism spectrum disorder subgroup were not investigated separately. The other two studies of individuals with autism spectrum disorder involved adolescents receiving an intervention based on mindfulness; their mothers taught them to shift their attention from their emotion (e.g., anger, frustration) to the soles of their feet (11, 12). Results of these studies showed a decrease in aggression; however, final conclusions about the effectiveness of mindfulness could not be drawn given the small group sizes and narrow focus of the intervention. Two studies of the same group of adolescents with substance abuse disorders used a multicomponent mindfulness-based stress reduction intervention focused on improving sleep to prevent relapse, but neither study had a comparison group (13, 14). The first study, conducted by Bootzin and Stevens (13), included 55 participants and found significant improvement on some sleep indices after a six-session instruction on home meditation. The second study, conducted by Britton et al. (14), analyzed questionnaires from the original participants and found that mindfulness practice frequency correlated with increased sleep duration and improvement

in self-efficacy about substance use. A feasibility study of an 8-week intervention teaching mindful awareness practices in a mixed group of individuals with ADHD (adults, N=32; adolescents, N=8) showed pooled results, with improvement in self-reported ADHD symptoms and some significant changes in neurocognitive measures (15). The authors noted that potential effects of group support and psychoeducation were difficult to assess in this study without a comparison group. One pilot study addressed individuals with learning disabilities, since this population often has higher levels of anxiety and school-related stress (16). A mindfulness meditation intervention with 34 adolescents involved a 5- to 10-minute meditation before each class period (daily for 5 weeks), led by classroom teachers. Self-rated anxiety and social skills, teacher-rated social skills, and academic achievement all demonstrated significant differences. Finally, Singh et al. (17) conducted a study of three adolescents with conduct disorder at risk for school exclusion and who underwent a 4-week mindfulness meditation intervention followed by a 25-week practice phase led by an instructor. Results were a substantial decrease (up to 52%) in the number of self-reported aggressive and noncompliant acts, and all students avoided further threats of expulsion.

In a heterogeneous clinical sample receiving current or recent psychiatric outpatient care, Biegel et al. (18) conducted the only randomized controlled trial, to our knowledge, of a mindfulness-based stress reduction intervention in adolescents (N=102; ages 14–18). This study included a randomly assigned wait-list comparison group who received treatment as usual and an intervention group who participated in treatment as usual plus an 8-week modified mindfulness-based stress reduction program. Measures of perceived stress, anxiety, and several psychopathological symptoms all differed significantly posttest ( $p < 0.05$ ; effect size [Cohen's  $d$ ] range: 0.15–0.79), with similar results at the 3-month follow-up (effect size range: 0.28–0.92). Clinical measures of mental health, made by clinicians blind to treatment conditions, revealed significant improvement

in the treatment group ( $p < 0.0001$ ) and at follow-up ( $p < 0.0001$ ). Moderating effects on outcomes were also explored. More time spent in sitting meditation practice led to improved clinician-rated functioning and declines in self-reported depressive and anxiety symptoms at the 3-month follow-up ( $p < 0.05$ ). This study presents more sound methodology and analysis than other studies of adolescents, with promising findings for future research.

In an intriguing study with a nonclinical sample, Hilt and Pollak (19) examined the effectiveness of interventions to help youths disengage from ruminative states. A negative mood induction followed by a rumination induction was studied in 102 adolescents, followed by random assignment to distraction, problem solving, or mindfulness interventions. Compared with problem solving, brief periods of distraction and mindfulness (8 minutes of instructional audio recording) were helpful in breaking the ruminative state. The authors concluded that mindfulness may not need to be intensively practiced to be beneficial.

## Conclusions

The empirical base of mindfulness-based interventions for adolescents is limited and reflects its early stage of research. Most current studies are of various methodologies and focus on feasibility and effectiveness rather than rigorous experimental design. An exception is the study by Biegel et al. (18), which showed more diligent methods and may open the way for replication studies and larger randomized controlled trials in adolescent populations. As noted by the investigators of these studies, methodology limits the generalizability for mindfulness-based approaches, and notably the safety of these approaches in more acutely ill adolescent populations (e.g., psychosis, mood episode, and suicidal ideation) is not established. Yet, the initial research suggests that mindfulness-based interventions may have value for psychological symptoms in adolescents and overall have been acceptable and well tolerated by the participants studied (9). The field has also been hindered by an absence of measures that assess mindfulness in youths;

however, known mindfulness scales in the adult literature have recently been adapted and validated for children and adolescents (20). Another challenge to both the research and clinical realms is the fact that “adolescence” incorporates a wide range of ages, developmental maturity, and level of involvement in school and family systems. This points to the appropriate reality of adapting any proposed intervention, including mindfulness, to the needs and abilities of the adolescents (and/or their families) sitting across from us. With its focus on decreasing reactivity to negative inner experiences through labeling mental events and promoting a nonjudging stance, mindfulness may add to the repertoire of coping strategies for youths to manage psychological difficulty and promote resilience. As a beneficial consequence, such strategies may be particularly important to share with younger patients when lifelong habits are being formed.

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## References

1. Center for Mindfulness: <http://www.umassmed.edu/cfm/index.aspx>
2. Kabat-Zinn J: Mindfulness-based interventions in context: past, present, and future. *Clin Psychol Sci Pract* 2003; 10: 144–156
3. Grossman P, Neimann L, Schmidt S, Walach H: Mindfulness-based stress reduction and health benefits: a meta-analysis. *J Psychosom Res* 2004; 57:35–43
4. US Department of Health and Human Services: Mental Health: A Report of the Surgeon General. Rockville, Md, National Institutes of Health, 1999
5. Hyman S: Mood disorders in children and adolescents: an NIMH perspective. *Biol Psychiatry* 2001; 49:962–969
6. Emslie G, Mayes T, Laptook R, Batt M: Predictors of response to treatment in children and adolescents with mood disorders. *Psychiatr Clin North Am* 2003; 26:435–456
7. Black D, Milam J, Sussman S: Sitting-meditation interventions among youth: a review of treatment efficacy. *Pediatrics* 2009; 124:532–541

8. Ott M: Mindfulness meditation in pediatric clinical practice. *Pediatr Nurs* 2002; 28:487-490
9. Burke C: Mindfulness-based approaches with children and adolescents: a preliminary review of current research in an emergent field. *J Child Fam Studies* 2009; 2010; 19:133-144
10. Bogels S, Hoogstad B, van Dun L, de Schutter S, Restifo K: Mindfulness training for adolescents with externalizing disorders and their parents. *Behav Cogn Psychother* 2008; 36:193-209
11. Singh N, Lancioni G, Manikam R, Winton A, Singh A, Singh J: A mindfulness-based strategy for self-management of aggressive behavior in adolescents with autism. *Res Autism Spectr Disord* 2011; 5:1153-1158
12. Singh N, Lancioni G, Singh A, Winton A, Singh A, Singh J: Adolescents with Asperger syndrome can use a mindfulness-based strategy to control their aggressive behavior. *Res Autism Spectr Disord* 2011; 5:1103-1109
13. Bootzin R, Stevens S: Adolescents, substance abuse, and the treatment of insomnia and daytime sleepiness. *Clin Psychol Rev* 2005; 25:629-644
14. Britton W, Bootzin R, Cousins J, Hasler B, Peck T, Shapiro S: The contribution of mindfulness practice to a multicomponent behavioral sleep intervention following substance abuse treatment in adolescents: a treatment-development study. *Subst Abus* 2010; 31:86-97
15. Zylowska L, Ackerman D, Yang J, Futrell N, Horton N, Hale T, Pataki C, Smalley SL: Mindfulness meditation training in adults and adolescents with ADHD: a feasibility study. *J Atten Disord* 2008; 11:737-746
16. Beauchemin J, Hutchins T, Patterson F: Mindfulness meditation may lessen anxiety, promote social skills, and improve academic performance among adolescents with learning disabilities. *Complemen Health Pract Rev* 2008; 13:34-45
17. Singh N, Lancioni G, Subhashni D, Singh J, Winton A, Sabaawi M, Wahler RG, Singh J: Adolescents with conduct disorder can be mindful of their aggressive behavior. *J Emotion Behav Disord* 2007; 15:56-63
18. Biegel G, Brown K, Shapiro S, Schubert C: Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: a randomized clinical trial. *J Consult Clin Psychol* 2009; 77:855-866
19. Hilt L, Pollak S: Getting out of rumination: comparison of three brief interventions in a sample of youth. *J Abnorm Psychol* 2012; 40:1157-1165
20. Lawlor M, Schonert-Riechl K, Gadermann A, Zumbo B: A validation study of the Mindful Attention Awareness Scale Adapted for Children. *Mindfulness* (in press)

## YOUR OPINION COUNTS!

To continue to improve the services and resources we provide to our members and the psychiatric community, APA is conducting a comprehensive Needs Assessment Survey designed to ascertain the needs of psychiatrists in training and in the early stages of their career. You should have received an e-mail with a link to the survey, which will be open until November 22. APA invites all of our current and former members who are currently in training or in the early stages of their career to participate.

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# Consultation to Schools After the Boston Marathon Bombings

Sara M. Coffey, D.O.

The availability of media has heightened our awareness and exposure to traumatic events. While these events may include natural disasters, terrorist attacks, and war, actions intentionally caused by malicious intent can be especially difficult to bear. Since 1982, there have been at least 62 mass shootings across the United States (1). In the past 20 years, we have seen the bombing of the World Trade Center in 1993, the Oklahoma City bombing in 1995, the September 11th attacks in 2001, and most recently the Boston Marathon bombings (2). These events differ, but all leave a psychological impact.

The National Child Traumatic Stress Network describes three salient features of terrorist acts. First, they induce a societal atmosphere of extreme danger and insecurity. Second, they inflict horrific personal harm and destruction. Finally, they undermine the implicit social contract between citizens and the government's protective power (2). Exposure to these events has increased our concern for children, families, and communities (3). Children and adolescents can experience increased anxiety even if not directly involved in the traumatic event. Following the Oklahoma City bombing, Pynoos et al. (2) found that exposure to media coverage was related to posttraumatic stress reactions. This finding was prior to the advent of social media sites, such as Facebook and Twitter. Currently, 97% of teenage boys and 93% of teenage girls have access to the Internet, with 63% reporting daily use (4). How this increased availability will affect youths in times of tragedy is yet to be seen.

How parents, school officials, and mental health professionals react to traumatic events can affect how our children and communities heal. In the present article, I share my experience working with the greater Boston area public schools after the Boston Marathon bombings, with the goal of helping others to become better prepared to care for our children and communities when traumatic events happen.

## Clinical Vignette

The 2013 Boston Marathon was in the peak of activity when two explosions set off a chain of events that left Boston and the surrounding communities in shock and dismay. Days later, a police officer was shot, and a car chase led police and bombing suspects to Watertown, Mass., where a shootout kept a city on lockdown for the hours ahead. Everyone was ordered to stay inside their homes as police and SWAT teams infiltrated Watertown. Anxious parents balanced their desire to be informed with a longing to protect their children from the graphic images on the news. Teenagers who knew the suspects were interviewed by the media, only later to be visited by the FBI and school officials. The unexpected visit by federal investigators was upsetting to some students, who were not aware of the implications of talking about an ongoing investigation to reporters. In the last hours of Friday April 19th, 2013, "Captured" appeared below the photograph of the second suspect. As police officers and officials wrapped up the criminal investigation, our schools prepared to contain the anxiety, confusion, and fears of their students returning to class. In the midst of these events, mental health clinicians collaborated with schools to prepare students and staff for their return. Some of these collaborations were new, while others were built on mutual efforts fostered years before.

## Recommendations

### Readiness

Although most schools have emergency plans in place, an unexpected tragedy can shake the core of a school's safety plan. Schools should establish effective relationships with law enforcement, emergency responders, and mental health professionals (5). As mental health professionals, our ability to help prepare, respond, and move forward is integral in our commitment to schools. The long-standing relationship with Cambridge

Public Schools was a powerful resource to rely on. This relationship allowed us to anticipate individual needs of schools, as well as leadership. We encourage mental health professionals to review the American Academy of Child and Adolescent Psychiatry's practice parameters for school consultation as a useful guide to initiating and working with schools (6).

### Response

Here, the objective is to calm the fears of students and staff and re-establish safety and security (5). The response phase can include staff support, accurate factual information, parent outreach, and school meetings.

### Staff Support

Teachers and staff are not immune to the effects of trauma. Leadership should emphasize self-care, education on normal stress reactions to trauma, and how to obtain mental health services. In addition to caring for themselves, teachers should be reminded how to screen and refer students for additional mental health services.

### Parent Outreach

Alleviating parental anxiety is important, especially in schools that are intimately involved with tragic events. Communication with parents can include pragmatic concerns, such as ongoing support within the school, changes within the school, and who to contact with questions or concerns. Additionally, mental health providers can help construct a developmentally appropriate "how to" guide to help parents support their children after traumatic events.

### School Meetings

School meetings clarify concerns and misinformation. They address pragmatic changes within the school. Some school personnel are more comfortable than others in addressing students. Depending on their personality and style, their ability to contain the anxieties of students varies. Leadership and mental health professionals can work together to limit the



negative risk of debriefing students during these meetings.

Depending on the age of the students, identification with the victims or suspects, and students' own intimacy of the event, a variety of concerns can arise. Several high school teachers in our area used their current curriculum to have a discussion about the events, using characters in literature to parse out complicated situations. Using this as a form of instruction allowed students the ability to talk openly and indirectly about their own conflicted thoughts and emotions.

Middle school children worried about a staff member's injuries. A culture of the "have and have-nots" emerged, separating students who were in contact with the staff member from those who were not. Smaller group meetings during the students' advisory period allowed space to provide them with the facts and questions to be answered. These meetings included both familiar staff and consulting mental health professionals to discuss issues around reactions to trauma.

Educating students about media was essential. Teenagers were likely to voice their opinions through social media sites and traditional news outlets. Unfortunately, this display of free speech often led to unwelcome responses, at times bordering on cyber bullying or harassment. Here, the principal emphasized

respect for others, as well as the risks of saying something objectionable. Schools educated students on the consequences of contact with media, informing students that not only were they representing themselves when they chose to speak out, but also their communities.

Students were informed about the normal psychological, emotional, and physical changes that occur after a traumatic event. We discussed common reactions: difficulty sleeping, concentration problems, feelings of sadness, worry, and loss. Students were advised about whom to contact if they needed more support. All students were encouraged to ask for additional help if needed.

### Ongoing Care and Support

Continued monitoring and ongoing support is imperative. Maintaining routines and social activities will be an important way for schools to provide support to students (4). In the weeks and months following the event, certain students might be retriggered, since media attention increases around pivotal moments, trials, and new information. Just as our immediate interventions help provide a sense of safety, so to can our ongoing efforts of support to our students and schools.

*Dr. Coffey is a second-year child and adolescent psychiatry fellow at Cambridge Health*

*Alliance, Cambridge, Mass. The author thanks Dr. Nancy Rappaport.*

## References

1. Follman M, Aronsen G, Pan D: A guide to mass shootings in America. Mother Jones 2012. <http://www.motherjones.com/politics/2012/07/mass-shootings-map> (Accessed July 17, 2013)
2. Pynoos RS, Schreiber MD, Pferfferbaum BJ: Impact of terrorism on children, in Kaplan and Sadock's Synopsis of Psychiatry. Edited by Kaplan HI, Sadock BJ. Philadelphia, Lippincott Williams and Wilkins, 1998, pp 3551–3562
3. Pferfferbaum B, Noffsinger MA, Wind LH: Issues in the assessment of children's coping in the context of mass trauma. Prehosp Disaster Med 2012; 27:272–279
4. Pew Internet and American Life Project: Teen Internet access demographics. Washington, DC, Pew Internet and American Life Project. [http://www.pewinternet.org/Static-Pages/Trend-Data-\(Teens\)/Whos-Online.aspx](http://www.pewinternet.org/Static-Pages/Trend-Data-(Teens)/Whos-Online.aspx). Accessed July 10, 2013.
5. National Child Traumatic Stress Network: The 3R's of school crises and disasters: readiness, response, and recovery. Los Angeles, National Child Traumatic Stress Network. <http://www.nctsn.org/resources/audiences/school-personnel/the-3r-school-crises-and-disasters> (Accessed June 14, 2013)
6. Walter HJ, Berkovitz IH: Practice parameters for psychiatric consultation to schools. J Am Acad Child Adolesc Psychiatry 2005; 44:1068–1083

# Psychiatrist: Turn That Analytical Eye Inward! Arguments for Why Residency Should Include Discussion of Philosophy of Psychiatry

Aaron J. Hauptman, M.D.

Training during the transition between diagnostic manuals is a lucky opportunity to experience the unstable terrain making up our conceptualization and classification of mental illness. This emphasizes our field's uniqueness in its capacity for reinvention and reinvigoration by active, thoughtful discussion of not just what we think but why we think it and how. I would like our residencies to actively embrace these discussions. A wonderful way to do this is through exploration of techniques borrowed from philosophy.

Psychiatry is exceptional for its role in medicine: we so directly interact with the fast-changing junctures of the mind, brain, and medical sciences that resultant, psychiatry risks being inconsistent and discombobulated. As paradigms muddle from one understanding to the next, we re-conceptualize patients, treatments, classifications, and ourselves and our role. Is the future biological, the past psychodynamic? What are the levels of integration of the mind and its physical substrates? Our ideas are in constant, fluid drift.

Openness to discussion is pivotal. While these are essential issues to us as psychiatrists, they are not questions we are trained to scrutinize. This is why I am a strong proponent of the cross-disciplinary field of philosophy of psychiatry. Philosophy of psychiatry is made up of psychiatrists, philosophers, psychologists, and other academics who use philosophical approaches to explore topics in

*While psychiatry is pushed toward evidence bases, an ability to use philosophical techniques . . . will help psychiatry trainees better analyze the mass of new data in a way that is as rational as possible.*

psychiatry. While psychiatry is pushed toward evidence bases, an ability to use philosophical techniques, far from being anachronistic, will help psychiatry trainees better analyze the mass of new data in a way that is as rational as possible. This is not something that has been part of our training, but it is a good time to learn.

This exploration draws attention to the act of discussing, which leads to more thoughtful action. Because resources are scarce and different subfields battle for didactic time, I do not think that this should necessarily be a piece of required

pedagogy; instead, it should be an informal, optional opportunity. The small group format builds community and interest without sacrificing didactic time.

What I recommend is this: Bring out into the open your tucked-away thoughts, the quick reflections between patients, such as “what does it mean for the mind and brain to be the same thing?” or “what are the assumptions in definitions of mental illness?” Residencies should support small group meetings for discussion of core issues in psychiatry and tap into resources like the Association for the Advancement of Philosophy and Psychiatry, journals like *Philosophy, Psychiatry and Psychology*, and texts such as *The Philosophy of Psychiatry: A Companion* (1). There is even a section in *Philosophy, Psychiatry and Psychology* for clinical anecdotes with a philosophical bent, a perfect forum for residents. Many residencies already have small groups started; if they are not already available, maybe we can all find a few interested people in our programs and meet to explore more deeply our experiences of psychiatry, our patients, and ourselves.

*Dr. Hauptman is a second-year resident in the University of Texas Southwestern Austin Psychiatry Program, Austin, Tex. The author thanks Dr. John Sadler for his support.*

## Reference

1. Radden J (ed): *The Philosophy of Psychiatry: A Companion*. Oxford, United Kingdom, Oxford University Press, 2004

# The Importance of a Name

Ayesha Dua, M.D.

“Proper names are poetry in the raw. Like all poetry they are untranslatable.”

~W.H. Auden

“The patient” is a ubiquitous term used by most medical students and staff when referring to patients, irrespective of their distinctiveness. The way doctors both address their patients and communicate with other health care providers has been a topic of debate for years (1–3). First names, last names, sex-based nouns like female, male, lady, and man, and simply a definite article like “the” are all contenders in this battle. My experience as a psychiatry resident has led me to conclude that referring to patients as “the patient” extinguishes the empathic connection with patients that drives excellence in care. The phrase “the patient,” which is a nameless, faceless term devoid of any individualism, is used by our medical community all too frequently.

All resident physicians are capable of establishing quality, personalized relationships with their patients and should be encouraged to do so during every encounter. When residents share stories that range from saving a life in the operating room to making a colossal mistake with medications, a common thread noted is that they tend to remember the patients’ names. Thinking of the patient evokes a strong emotional response, as well as a subconscious realization that the patient is a human

being, not an object with symptoms and diagnoses.

All physicians should feel connected with their patients in order to provide great care. In psychiatry, if that connection is not fostered, our treatment approaches become nothing more than a swirl of medications and generic advice that does not take into account the uniqueness of each patient’s disposition or circumstances. One can begin to foster this bond by simply starting with questions like, “I see your family calls you Judy instead of Judith. Do you mind if I call you Judy? Or would you prefer Mrs. Parker?”

The literature has been traditionally divided on whether to refer to patients by their first or last names, but nevertheless some form of name is favored (1). A recent telephone-based survey from Northwestern University demonstrated that patients prefer being addressed with all or part of their name, as well as a handshake. Interestingly, 50.4% of physicians from the videotaped encounters did not state the patient’s name at all during the initial encounter (2).

By listening, caring, and interpreting clinical presentation to body language, psychiatry residents become skilled at developing quality therapeutic alliances. Studies show that establishing rapport with patients, even those with debilitating mental illness, can lead to better treatment outcomes. For example,

a recent study found that if a satisfying therapeutic alliance was formed earlier on during treatment, patients scored less on the Hamilton Depression Rating Scale, independent of the type of therapy (cognitive-behavioral compared with supportive) or medication to which they were randomly assigned (3).

In psychiatric health, the interpersonal interaction is the core of practice. So what is the importance of your patient’s name? The answer is everything fundamental to being human: respect, empathy, and developing trust, all of which undeniably expand on the quality of patient-doctor relationships.

*Dr. Dua is a second-year resident in the Department of Psychiatry, Rush University Medical Center, Chicago.*

## References

1. McKinstry B: Should general practitioners call patients by their first names? *BMJ* 1990; 301:795–796
2. Makoul G, Zick A, Green M: An evidence-based perspective on greetings in medical encounters. *Arch Intern Med* 2007; 167:1172–1176
3. Arnow BA, Steidtmann D, Blasey C, Manber R, Constantino MJ, Klein DN, Markowitz JC, Rothbaum BO, Thase ME, Fisher AJ, Kocsis JH: The relationship between the therapeutic alliance and treatment outcome in two distinct psychotherapies for chronic depression. *J Consult Clin Psychol* 2013; 81:627–638

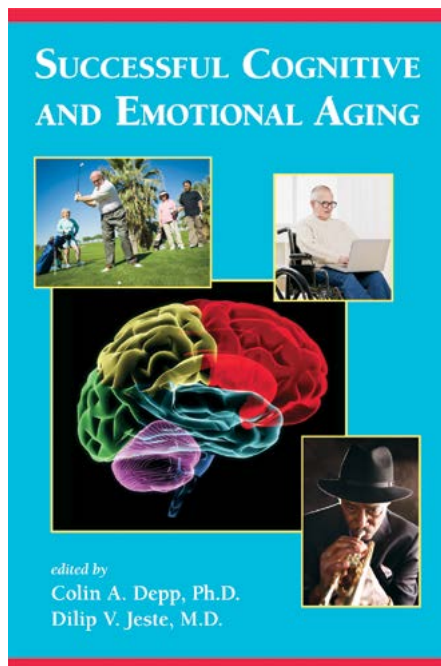
## Successful Cognitive and Emotional Aging

David Hsu, M.D.  
Associate Editor

Depp and Jeste's *Successful Cognitive and Emotional Aging* is a culmination of high-quality research and serves as a valuable resource for those working in the field of aging. The editors have brought together a strong team of contributors who have written an easily accessible and thought-provoking text. Successful aging has received wide attention in the geriatric psychiatry field, and for the first time in history, adults over the age of 60 will soon outnumber children under age 14.

The textbook has 21 chapters and is organized into three main parts: 1) behavioral and psychosocial aspects, 2) biological aspects, and 3) prevention and intervention strategies. The editors and contributors have focused the chapters on the change of emotions, the link between spirituality and wisdom, and the health of centenarians. Generally, as people age, personality traits change. Whereas neuroticism decreases, conscientiousness, social dominance, and agreeableness all increase with age.

Religion has been associated with increased life satisfaction, and spirituality and wisdom may be linked. Wisdom has been defined as "inclusive understanding, widening empathy, broadened appreciation of diversity, and pluralism in both persons and experience (p. 82)." According to George Vaillant, "we can all imagine care without wisdom, but not wisdom without care (p. 87)."



edited by Colin A. Depp, Ph.D., and Dilip V. Jeste, M.D. Washington, DC, American Psychiatric Publishing, 2010, 441 pp., \$52.00.

In the chapter on centenarians, the authors analyze the results of the Georgia, Swedish, Japanese, and French centenarian studies. Although there is not one factor that leads to longevity, centenarians have been described as responsible, easygoing, capable, relaxed, efficient, open to experience, conscientious, and extraverted. All of the aforementioned traits may be related to a longer life span. The editors have also emphasized the positive

role that diet and exercise can play in successful aging.

The most surprising and refreshing chapter in the book is the one on aging, cognition, and technology. There is a "digital divide" when it comes to technology. Access to technology is associated with younger adults, with only one-third of adults over age 65 having access to the Internet, compared with 80%–90% of those under age 65. "Not being able to use technology puts older adults at a disadvantage in terms of their ability to live and function independently and to successfully negotiate the built environment" (p. 353). This chapter stands out among the rest, and perhaps in future editions, it can be expanded to include more ways to close the digital divide.

This text stands at the frontier of geriatric and gerontological research. Clinicians and researchers alike will discover a solid review of important studies in the field of successful aging that they can apply to patients in their practice. At this time, the book is somewhat text heavy and may benefit from more tables and figures to highlight main points of the chapters. However, as prospective studies continue to include results from aging participants, I hope that these editors continue to compile the wisdom that older adults can still teach us.

Dr. Hsu is a fellow in geriatric psychiatry at Massachusetts General Hospital/McLean/Harvard, Boston, and Associate Editor of the Residents' Journal.

# Integrated Care Systems

*Psychiatric News* features highly informative content on the emerging practice model of integrated care.

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The screenshot shows the Psychiatric News website interface. At the top, there's a header with navigation links like 'psychiatryonline', 'DPA Library', 'Books', 'Journals', 'Topics', 'APA Subsites', 'CME & Self Assessment', 'News', 'For Fellows', and 'By PDR'. Below this is the main title 'PSYCHIATRIC NEWS' and a search bar. The featured article is 'Integrated Care: What Does It Mean for You?' dated September 26, 2012, with DOI: 10.1176/appi.ps.2012.13.9.1. The article text discusses the concept of integrated care, its prevalence in theory and practice, and mentions APA's initiatives in this area. A small inset image shows a person's hands fitting puzzle pieces together. To the right, there are other article teasers and a 'Related Article' section.

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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)

This month's questions are courtesy of David Hsu, M.D., a fellow in geriatric psychiatry at Massachusetts General Hospital/McLean/Harvard, Boston, and Associate Editor of the Residents Journal.

## Question 1

The anxiolytic effects of buspirone are thought to be due to which of the following?

- A. Its high affinity to GABA receptors
- B. Presynaptic beta adrenoceptor blocking action
- C. Partial agonism of the 5-HT<sub>1A</sub> receptor
- D. Its dopaminergic properties

## Question 2

Which of the following is not true for Alzheimer's disease?

- A. Apolipoprotein E4 increases the risk of Alzheimer's disease.
- B. The hippocampus is the early locus of pathology.
- C. Apolipoprotein E2 confers protection against Alzheimer's disease.
- D. Prominent motor signs can be found in Alzheimer's disease.

## ANSWERS TO OCTOBER QUESTIONS

### Question #1

**Answer:** B. Men commit suicide at least four times more often than women.

The prevention of suicide may be the most important thing that psychiatrists do in their job. It is therefore important that resident psychiatrists know basic statistics of the suicide phenomenon. Factors of demographics, environments, culture, and climate should be incorporated into a psychiatrist's risk assessment of a patient's potential for self-harm. Men commit suicide more than women. Suicide far exceeds the number of homicides in the United States. Older persons account for 25% of all suicides. Catholics have lower rates of suicide, and suicide increases in spring and fall, not during winter or holidays.

#### Reference

1. Sadock BJ, Sadock VA: Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry, 10th ed. Philadelphia, Lippincott Williams and Wilkins, pp 897–898

### Question #2

**Answer:** C. Alpha-2-adrenergic receptor antagonist

Mirtazapine is a great medication for patients who cannot tolerate selective serotonin reuptake inhibitors due to gastrointestinal side effects. Somnolence occurs in over 50% of patients. Sometimes, the absolute neutrophil count can decrease, which is reversible

#### Reference

1. Sadock BJ, Sadock VA: Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry, 10th ed. Philadelphia, Lippincott Williams and Wilkins, pp 1024, 1064–1066

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. Hsu: davidhsu222@gmail.com.

# Author Information for *The 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. To submit a manuscript, please visit <http://mc.manuscriptcentral.com/appi-ajp>, and select "Residents" in the manuscript type field.

- 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 Themes

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

### Forensic Psychiatry

If you have a submission related to this theme, contact the Section Editor, Tobias Wasser, M.D. ([tobias.wasser@yale.edu](mailto:tobias.wasser@yale.edu)).

### Integrated Care and Psychiatry

If you have a submission related to this theme, contact the Section Editor, David Hsu, M.D. ([dhsu2@partners.org](mailto:dhsu2@partners.org)).

### Mental Health Disparities

If you have a submission related to this theme, contact the Section Editor, Ijeoma Chukwu, M.D. ([ichukwu@uci.edu](mailto:ichukwu@uci.edu)).