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## In This Issue



This issue of the *Residents' Journal* begins with an article by Juliet Muzere, D.O., on racial and ethnic disparities in suicide rates among American Indian/Alaskan Native youths. Jason Beaman, D.O., and Scott McIntosh, M.D., provide important data on the use of synthetic cannabinoids. Eveleigh Wagner, B.A., presents an enlightening and artistic critique of Sir John Everett Millais' *Speak, Speak!*. David Marcovitz, M.D., offers his commentary on working with medical students in emergency psychiatry. Last, Whitney E. Black, M.D., comments on how therapeutic outcomes are affected by the vocabulary that is used to communicate with patients.

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# Racial and Ethnic Disparities in Suicide Rates Among American Indian/Alaskan Native Youths

Juliet Muzere, D.O.

Suicide is the third leading cause of death among children, adolescents, and young adults in the United States (1). The Centers for Disease Control and Prevention analyzed data from 2005 to 2009 to examine the differences in the prevalence of suicide by sex, race/ethnicity, age, and education attainment (2). Suicide rates by race/ethnicity and age group revealed different patterns, with the highest rates occurring among American Indian/Alaskan Native adolescents and young adults (aged 15–34 years) (2). The Child Trends DataBank also revealed similar data regarding the disproportionate rates of suicide among American Indian/Alaskan Native youths and also demonstrated differences in gender (3). In 2010, rates of suicide among male teens were highest among American Indians at 24.3 per 100,000 and non-Hispanic whites at 14.2 per 100,000, followed by Hispanics (8.1 per 100,000), African Americans (6.8 per 100,000), and Asians and Pacific Islanders (6.3 per 100,000) (3). Among female teens, American Indians also had the highest rate at 11.0 per 100,000, followed by non-Hispanic whites (3.5 per 100,000), Hispanics (2.9 per 100,000), and Asians and Pacific Islanders (3.1 per 100,000), with African American females having the lowest rate at 1.1 per 100,000 (3).

In a study of nonfatal suicidal behaviors, over 6,000 U.S. adolescents and parents completed a survey in conjunction with the National Comorbidity Survey Replication Adolescent Supplement (4). Results revealed that the lifetime prevalence of suicidal ideation was 12.1%, with the lifetime prevalence of suicide plans at 4% and suicide attempts at 4.1% (4). A third of those with suicidal ideation (33.4%) had made a plan, and one-third (33.9%) had attempted suicide. Among those who had developed a plan, 60.8% attempted suicide, while 20.4% of those endorsing suicidal ideation but without a plan had made an attempt (4). Additional

data examining nonfatal suicidal behaviors exposed differences in race/ethnicity, as well as gender. According to the Youth Risk Behavior Survey, American Indian/Alaskan Native high school students report higher rates of suicidal behavior than the general population of high school students (21.8% compared with 15.8%) (5). The percentage of female American Indian/Alaskan Native high school students reporting suicidal thoughts and behaviors was shown to be higher than that of Caucasian female students and American Indian/Alaskan Native male students (5). Although female adolescents attempt suicide at higher rates than male adolescents, male youths have a higher rate of completion (6). Suicide by firearms is the leading method (49%), followed by suffocation (38%), and then poisoning (7%) (4).

## Rates of Suicidal Behavior Among American Indian/Alaskan Native Youths

For *Healthy People 2010*, the term “health disparities” was defined by the U.S. Department of Health and Human Services as health “differences that occur by gender, race or ethnicity, education or outcome, disability, living in rural localities, or sexual orientation” (7). For *Healthy People 2020*, the definition was updated to include health differences associated with social, economic, and environmental disadvantage. The affected include individuals who have steadily encountered greater obstacles to health care because of race, ethnicity, socioeconomic status, gender, age, religion, sexual orientation, geography, or mental, cognitive, sensory, or physical disability. These factors have been historically linked to discrimination and/or exclusion (8). Most of the research involving health disparities in mental health is targeted toward adults; however, children and adolescents also experience

similar challenges in obtaining quality psychiatric care. Factors that contribute to the disparities among American Indians/Alaskan Natives include historical trauma, cultural barriers, poverty, stigma, and barriers to mental health treatment (9–15).

## Contributing Factors

### Historical Trauma

American Indians have experienced a great deal of misfortune throughout history. This group has endured epidemics, broken treaties, forced relocations, removal of children (who were forcibly sent to boarding schools), prohibition of the practice of language and cultural traditions, and the outlawing of traditional religious practices. By the 20th century, most American Indian tribes had been exterminated, dispersed, or driven onto federally created reservations. These prior traumas have had an adverse effect on the help-seeking behaviors of members in this community and have left many individuals distrustful and reluctant to seek assistance from professionals outside the community (9).

### Cultural Barriers

American Indians/Alaskan Natives face the pressure of adapting to mainstream culture through acculturation, which often leads to conflict regarding the preservation of traditional cultural traditions (9). Assimilation and the abandonment of traditional cultural practices can increase alienation, incite intragenerational conflict, and create a predicament in which an individual does not possess strong ties with either the traditional or dominant culture. This dilemma is a risk factor among youths and contributes to the higher suicide rates found in this population (10).

### Poverty

American Indians/Alaskan Natives are more likely to live in poverty: more than

twice as many in this population live in poverty as those in the total U.S. population (26% versus 12%) (11). In addition to poverty rates, reservations are hindered by low education levels, low employment, substandard housing, and deficient economic infrastructure.

### Stigma

The unfortunate stigma associated with receiving mental health treatment keeps American Indians/Alaskan Natives from seeking and ultimately receiving care (10). Furthermore, many in this population do not trust mental health professionals because they see these providers as part of a “white culture” that is not sensitive to their culture (12).

### Barriers to Mental Health Treatment

Economic barriers to care include cost and lack of insurance. Three times as many American Indians/Alaskan Natives lack health insurance compared with Caucasians (33% compared with 11%) (13). Additionally, American Indians/Alaskan Natives have limited access to employer-sponsored coverage because they have lower employment rates and tend to be employed in low-wage jobs that typically do not offer health coverage. Only one-half of this population possess employer-based health care coverage (compared with 72% for Caucasians). Roughly one-quarter of this population have Medicaid as a primary insurer, with another quarter having no health care coverage, compared with 16% of noninsured individuals in the general population (14). The U.S. government is required to provide health care services, including mental health, to federally recognized tribes through the Indian Health Service, which serves roughly 2.2 million American Indians/Alaskan Natives (15). Indian Health Service funding is limited and must be appropriated by Congress each fiscal year. Unfortunately, this service has historically been underfunded to meet the health care needs of this population (15). Furthermore, only 20% of American Indians/Alaskan Natives have direct access to Indian Health Service clinics, which are largely reservation based (14). Lack of access to mental health services, especially to child/adolescent mental health professionals, is

troubling among American Indian/Alaskan Native communities. As discussed previously, adolescents in this population have the highest rate of suicide, making mental health intervention in this group imperative. Additional access to care issues include lack of education, lack of culturally appropriate services, and mental health professional shortages (13).

Gone and Trimble (16) proposed two pathways toward elimination of mental health disparities among American Indians/Alaskan Natives. The first includes professional knowledge, activities, and institutions in the context of clinical health services. This is achieved by psychosocial intervention in clinical encounters with members of the American Indian/Alaskan Native communities through cultural awareness and competence. Help seeking from traditional healers is common among Native Americans. Research has found that American Indian men and women who meet the criteria for depression and/or anxiety or substance abuse are significantly more likely to seek help from traditional/spiritual healers than from specialty or other medical sources (17). The second pathway proposed is grounded in local knowledge, activities, and institutions in the context of community projects of cultural reclamation and tribal self-determination (16). This strategy achieves therapeutic benefit through collective American Indian/Alaskan Native empowerment.

Flores (18) examined three study interventions that have been successful in eliminating racial/ethnic disparities in children’s health and health care. Features identified were a rigorous study design, large sample size, appropriate comparison groups, and community-based interventions that are culturally sensitive and involve collaboration with members of the community (18). His suggestions for conducting successful interventions include community collaboration in all study phases, pre-intervention qualitative research, careful sample size and power calculations that account for attrition, and use of multiple approaches to ensure optimal participant follow-up (Table 1). Possible challenges include institutional review board approval, attrition, and barriers to sustainability (18).

TABLE 1. Devising, Implementing, and Evaluating an Intervention to Reduce Racial/Ethnic Disparities in Child/Adolescent Health Care<sup>a</sup>

Approach
Identify the disparities.
Determine an appropriate study design (e.g., observational study, randomized controlled trial).
Obtain institutional review board approval.
Conduct pre-intervention qualitative research in the community to ensure community engagement, intervention tailored to the needs of the community, and cultural and linguistic appropriateness.
Perform careful sample size and power calculations that account for attrition.
Utilize study personnel from members of the community.
Include participation and follow-up incentives.
Blind researchers and study participants.
Utilize multiple approaches to ensure optimal participant follow-up.
Allow for adjustment of key covariates in outcomes analyses.
Convey findings.
Implement means of sustaining intervention.

<sup>a</sup> The approaches listed are defined by Flores (18).

## Conclusions

Eliminating mental health disparities in American Indian/Alaskan Native communities is crucial. Suicide, particularly among youths, is a serious problem. Suicide prevention can be achieved through psycho-educational efforts that incorporate cultural competence. Solidifying the family bond and enhancing the cultural identity among youths is a strategy to thwart suicide. Interventions that include rigorous study design, large sample size, appropriate comparison groups, and community-based interventions that are culturally sensitive and involve collaboration with members of the community can also help reduce this disparity.

*Dr. Muzere is a third-year resident in the Department of Psychiatry and Behavioral Sciences, Morehouse School of Medicine, Atlanta.*

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### DEPUTY AND ASSOCIATE EDITOR POSITIONS, 2014

**We at the *Residents' Journal* are pleased to announce the selected candidates for the positions of Deputy Editor and Associate Editor, as well as the newly formed Editorial Board**

#### **Deputy Editor (2014–2015)**

Rajiv Radhakrishnan, M.B.B.S., M.D.

Dr. Radhakrishnan is a second-year resident in the Department of Psychiatry, Yale School of Medicine, New Haven, Conn.

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**Please join us in congratulating the newest members of the *Residents' Journal* team, who will begin serving their terms in July.**

# Synthetic Cannabinoids

Jason Beaman, D.O.  
Scott McIntosh, M.D.

Physicians are facing new challenges in the area of synthetic drugs. Over the last several years, drugs such as bath salts, spice, and K2 have been widely discussed in the popular media because of their notable effects on human behavior. Synthetic cannabinoids are usually sold and marketed as incense or other benign substances. However, their association with significant health consequences and violence has led to swift action by state and federal legislatures and agencies in an attempt to limit access. In the present article, we provide a review of synthetic cannabinoids, summarizing their history, symptoms, and treatment, as well as legality issues.

Marijuana homologs were first created in the early 1990s for potential pharmacologic purposes and for research (1). Laboratory-created substances include JWH-018, JWH-073, and CP-47, 497. Because of their activity at the CB<sub>1</sub> and CB<sub>2</sub> receptors, the same as delta-9-tetrahydrocannabinol (the active ingredient from the marijuana sativa plant), they were labeled as synthetic cannabinoids.

Synthetic cannabinoids were first manufactured and mixed with organic material, such as grass and other herbs, in 2004. They were sold as incense, meditation products, and bath additives with warning labels stating, “not for human consumption.” They were sold online, in gas stations, and in head shops. The substance was often referred to as “legal high” because of its legal status (2). Cannabinoids were not isolated until 2008. The isolated substances, while containing the basic ingredient of cannabinoids, are marketed and sold under different names such as spice (and other variations such as golden spice, silver spice, and spice diamond), K2, genie, dream, aroma, and eclipse (2, 3).

It is important to understand the manufacturing process for the mixture of synthetic compounds and organic ma-

terial. The organic material is dried on a tray in a drying rack. The synthetic cannabinoid, usually obtained from Asia, is then sprayed onto the dried leaves. This spraying process is done by hand, and thus there can be great variation in the amount of cannabinoid present in each dose (4). This production can occur in home laboratories and is not subject to scientific regulations.

Synthetic cannabinoids are sought for the so-called legal high, marijuana-like intoxication. They are also used for energizing, euphoric, and disinhibiting effects (2). The negative consequences in using these synthetic compounds can be psychiatric and can affect the cardiac and neurologic systems, as well as other organ systems.

Psychiatric symptoms after synthetic cannabinoid use include anxiety, psychosis, and depression. Anxiety is one of the more common side effects and peaks 1 to 2 hours after use. Extreme anxiety following abrupt withdrawal can result after chronic use. Psychotic symptoms include paranoia, hallucinations, and delusions. Psychotic symptoms have been reported to last from 48 hours to 2 weeks (5). Disorganized speech and behavior have also been reported (6). Some symptoms of depression, such as dysphoria and irritability, can be mimicked by intoxication and withdrawal (2).

Cardiac effects include hypertension and tachycardia (1). The literature includes a case report of myocardial infarction (6). Neurologic effects include confusion, loss of consciousness, and seizures (1).

Treatment often involves addressing symptoms and waiting for the effects of the substance to wear off. Effects can be seen within 10 minutes of use and last varying lengths of time, depending on the half-life of the particular substance (6). For agitation, a benzodiazepine is the treatment of choice. Sedative antipsychotics can also be used but should be

used with caution because of the potential for seizures.

Laboratory evaluation is dependent on symptoms. A urine drug screen should be ordered so that it is clear what substances are present. An individual complaining of chest pain or other cardiac symptoms should undergo medical evaluation to rule out coronary events.

At the federal level, the Drug Enforcement Administration, legislative bodies, and the Department of Justice are involved in an ongoing effort to include a variety of chemicals used in synthetic marijuana products in the Schedule I category of the Controlled Substances Act. Significant headway was made in July 2012 with the passage of the Synthetic Drug Abuse Prevention Act, which placed certain substances in Schedule I. The Schedule I status of these substances will be maintained on a preliminary basis while the Drug Enforcement Administration conducts further research to pursue permanent implementation. The challenge continues as new substances are discovered. The Drug Enforcement Administration has recently added three more synthetic compounds to the list of Schedule I substances.

Synthetic cannabinoids are frequently contained in products marketed as “herbal incense” or “potpourri,” which are popularly used in smokable form for recreational purposes, despite lacking Food and Drug Administration approval for human consumption or medical use (7). For a substance to meet statutory requirements for temporary Schedule I placement, it must cause imminent hazard to public safety as evidenced by a high potential for abuse, have no current medically accepted treatment use, and lack substantiation for safe use under medical supervision (8).

Since 2010, at least 41 states have enacted legislature to regulate synthetic cannabinoids and substituted cathinones

with varying limitations and penalties for manufacture, sale, and possession (9). Despite extensive legal measures, meaningful reduction in synthetic cannabinoid use has been elusive, since manufacturers are reportedly making minor chemical modifications to synthetic cannabinoid products to render them technically legal while maintaining the desired psychoactive effects (10). Enforcement of synthetic drug laws has also been problematic because these products are often sold in otherwise legitimate stores, and standard urine drug screens do not detect synthetic cannabinoids.

In summary, psychiatrists are facing new challenges daily regarding synthetic compounds. These substances are sought not only for their perceived safety and legality but also because of their lack of detection. Production of these compounds is not consistent and prone to error in dosing. The use of these substances can result in neurologic, psychiatric, and other consequences. Treatment is based on symptoms, and care should be exercised to not use a medication that might interact with the substance.

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## Grief and Hallucination in Sir John Everett Millais' *Speak! Speak!*

Eveleigh Wagner, B.A.

"Speak, Speak!" cries the lover as he stretches his arms toward his phantom-like lady. The gleaming specter parts the heavy curtains while candles illuminate fallen letters on the floor. Such is the scene constructed by Sir John Everett Millais in his painting *Speak! Speak!*, from 1895. The story, reportedly drawn from Ancient Rome, tells of a young man, who while reading love letters late into the night is startled by the vision of his beloved, dressed in her bridal attire (1). Reaching with his right arm toward his bride, the young man draws attention with his left back toward the worn letters on the table. The entire scene is washed in golden candlelight except for the ethereal lady, who radiates her own lunar glow and draws back the heavy curtains with unsettling earthly strength. Her presence creates confusion and begs the question, Is she real or a ghost? To that inquiry, Millais once answered, "That's just what I want. I don't know either, nor does he" (2).

With light and shadow, Millais paints the man's expression full of desperate longing. Reading the letters as an act of mourning, the Roman spends his nights with the memory of his lost love. Could this midnight visitor then be neither earthly nor a ghost but rather the conjuring of a grieving mind? After the death of a loved one, those in grief can experience auditory or visual hallucinations of those lost. Albeit classified as a psychotic feature, hallucinations are considered a dimension of the bereavement experience. Millais' white lady is then contained within the man's mind for only him to see.

With *Speak! Speak!*, Millais offers the opportunity to experience the hallucination of another individual. While he depicts the lover and his beloved interacting in the scene, reality would show, instead, a man awake in bed with his arm



Permission to reproduce *Speak! Speak!* (1895), by Sir John Everett Millais (1829–1896), granted by Tate, London. Copyright © Tate, London, 2013.

outstretched to darkness. Millais allows the audience to experience the Roman's grief through a shared hallucination. The viewer perceives the gleaming bride and shares the Roman's doubt, his longing, and his sorrow. As one critic remarked, "*Speak! Speak!* celebrates the capacity of both art and imagination to make life palpable once more" (3). On canvas, Millais breathes new life into the departed bride, just as the Roman's grief has reanimated his ladylove in his mind's eye. The hallucination restores what has been lost to him. The mind is a most powerful artist.

*Eveleigh Wagner is an M.D. candidate at Emory University School of Medicine, Atlanta.*

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# Working With Medical Students in Emergency Psychiatry

David Marcovitz, M.D.

My wife and I are both PGY-2s in emergency medicine and psychiatry, respectively, so it is not uncommon for us to share with one another our experiences with various supervisors and trainees. After a recent shift, she told me she had struggled with the added challenge of supervising a medical student during a particularly busy evening. The student was having a tough time presenting patients linearly and succinctly. “Was it a third or fourth year?” I asked. “I’m not sure,” she replied. I smiled and raised my eyebrows at her. “What!” she replied, sensing I was preparing to give her a hard time for not “assessing her learner,” though we both know how difficult this can be when clinical demands are intense.

Indeed, many of us have had the experience of walking into a busy shift to learn that we will have a student working with us, sometimes a student we have not met before or will again. Our reactions vary from excitement at having a trainee around (especially for the more educationally minded, altruistic, or narcissistic among us) to frustration that we already feel behind on clinical work. My approach is usually to ask the student for guidance by doing a quick assessment: What year are you? What did the resident have you do on previous shifts? Are you comfortable interviewing patients, or do you

*As residents, we can do more than simply show interest and elicit the agenda.*

prefer to sit back on the first one? (Notice that there are much less empowering ways to phrase the last question, such as “Maybe you would prefer to observe me interview the first few patients?”) I try to let the student assert as much appropriate autonomy as clinical time constraints will allow.

This assessment is invaluable for two reasons. First, by simply taking an interest in the student, we communicate that we value his or her presence and education. Second, often these shifts are tacked onto a primary rotation such that students can take away as much or as little as they put in. In that context, a brief assessment gives them the opportunity to define their own agenda and learning objectives with me. But as residents, we can do more than simply show interest and elicit the agenda. My approach is as follows:

- When I am documenting in ways the student cannot assist with, I try to have some small assignments that can help us both think critically about the case. I ask students to write out a suicide and homicide risk assessment on scratch paper for us to talk over when I get to my safety assessment, or I ask them to look up a topic I haven’t read about lately and to share, briefly, what they have learned.
- I keep various articles on file in my shared drive, and I keep the DSM-5 smartphone app available to share with students. I can e-mail them an article or just pass them my phone when a relevant topic comes up with our patient.

It is easy for us to forget how it felt to be a medical student, walking somewhat blindly into an emergency department shift. Some residents inspired us, and others made us feel superfluous. I would argue that in psychiatry, we have a special calling to engage our students and model for them how they might treat the next generation of medical students they encounter.

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# Outcomes and Alliances: The Case for a New Vocabulary in Psychiatry

Whitney E. Black, M.D.

Though originally described in the psychotherapy literature, the concept of the therapeutic alliance has recently gained attention within the broader culture of health care. Therapeutic alliance has been defined as the collaborative and affective bond between provider and patient (1). Interest in the therapeutic alliance has been growing because of its correlation with outcomes, as evidenced in a meta-analysis conducted by Martin et al. (2). One of the key factors in building a strong therapeutic alliance lies within the vocabulary used to communicate with patients.

DSM-5 challenges the vocabulary in common usage among psychiatrists. For example, the term “mental retardation,” previously prescribed in DSM-IV, has been replaced by the term “intellectual disability.” The latter is used by professional journals and promotes use of a consistent diagnostic language. While this is certainly a valuable goal, it is interesting to consider the other ramifications of this change. Patient advocacy groups, for example, supported this change, asserting that a shift from stigmatizing vocabulary would promote improved patient care for this population. Other similar shifts in vocabulary emerged from DSM-5, including changing “hypochondriasis” to “illness anxiety disorder” and “stuttering” to “fluency disorder.”

Consider other terms commonly used in psychiatric practice, such as “antidepressant” and “antipsychotic.” The term antidepressant has become an indiscriminant term applied to a variety of medications with differing mechanisms of action used to treat a wide range of

*Our choice of words might be getting in the way of our communication with our patients ... and, most importantly, their therapeutic outcomes.*

health conditions. For example, we commonly use selective serotonin reuptake inhibitors to treat generalized anxiety disorder and tricyclic agents to address neuropathic pain, but what is the perception of our patients when they hear we are prescribing an antidepressant for these conditions? Many of us use second-generation antipsychotics as augmentation pharmacotherapy in the treatment of major depressive disorder, but what is the psychological effect of giving a depressed, nonpsychotic patient a prescription for an antipsychotic?

Psychiatrists are taught to choose words carefully in the traditional therapeutic process. However, there has been less focus on vocabulary and semantics as they relate to the discussion of diagnoses and medications. Could we be more precise in our language and consequently promote a better therapeutic alliance and improved overall patient care? Our choice of words might be getting in the way of our communication with our patients, their trust

in us, their compliance with treatment, and, most importantly, their therapeutic outcomes. DSM-5 has initiated this shift toward less stigmatizing vocabulary with regard to diagnoses. Instead of labeling medications according to broad classes, we would be well served to describe medications based on physiologic effects or mechanisms of action as well. Starting therapy with a dopamine blocker, for example, might seem to be a very different proposition for some patients, compared with starting treatment with an antipsychotic. And while the effects of shifting our professional vocabulary should result in improved therapeutic alliances and treatment outcomes, such a shift might also lead to more global positive changes in how psychotropic medications and psychiatric illnesses are perceived in the wider arena of health care.

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*The author thanks Dr. Kristen Dunaway for support.*

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*...From the Page to the Stage*



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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)

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.

Why is the Board called the American Board of Psychiatry and Neurology and not the American Board of Neurology and Psychiatry?

- A. There were more psychiatrists than neurologists in its inception.
- B. The Board felt that the "mind" was more important than the "brain."
- C. The field of neurology stemmed from the field of psychiatry.
- D. The American Psychiatric Association (APA) was founded before the American Neurological Association.
- E. The first president of the Board represented the APA.

## Question #2.

Which of the following is true about the founding of the APA?

- A. The original 13 founding members were not "psychiatrists" (four were surgeons, and nine were general physicians).
- B. The founding group met at 10:00 a.m. on October 16, 1844 in Philadelphia.
- C. The original name of the APA was the Association of Medical Superintendents of American Institutions for the Insane.
- D. The first president of the APA was Dr. Samuel B. Woodward, who likely came up with the idea for the first meeting.
- E. All of the above.

## ANSWERS TO MARCH QUESTIONS

### Question #1.

**Answer:** E. Structural MRI has shown overall increased brain size in autism

The most recent study by the Centers for Disease Control and Prevention estimated the prevalence of autism spectrum disorder to be 11.3/1,000. Contrary to popular perception, data from seven surveys suggest that rates of Asperger's disorder are in fact lower than the rates for typical autism (2.6 in 10,000 or one-fifth as common as typical autism). Autism is four times more common in males compared with females, but females with autism have more severe intellectual disability. The most frequently replicated neurochemical finding in autism spectrum disorder is elevation in peripheral levels of neurotransmitter serotonin. Structural MRI has shown an overall brain size increase in autism, and diffusion tensor imaging studies have suggested aberrations in white matter tract development.

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### Question #2.

**Answer:** D: Late age at onset of depression

Up to 5%–10% of people diagnosed with major depressive disorder are later diagnosed as having bipolar disorder. Clinical features that may be pointers to bipolarity might be the presence of psychosis, diurnal mood variation and hypersomnia during depressive episodes, treatment refractory depression, recurrent depression, early age at onset of depression, abrupt onset of depressive episode, greater number of depressive episodes and shorter duration of the longest depressive episode, and family history of mood disorders. The mean age at onset of major depressive disorder is 40 years.

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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. Hsu: davidhsu222@gmail.com.

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- 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.

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