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In This Issue



This issue of the *Residents' Journal* features a variety of topics. Nitin Chopra, M.D., discusses a case of a young woman with paranoid and psychotic symptoms resulting from the use of synthetic marijuana, emphasizing the need for diagnostic measures, evidence-based treatment guidelines, and identification of active ingredients in cannabis-like substances. Chad Hooten, M.D., describes a case of withdrawal from ketamine prescribed for chronic intractable migraine headaches, cautioning clinicians of potential situations that may arise from use of this medication. In a perspective, Andrew Pierce, M.D., presents a fictional narrative of violence on an inpatient psychiatric unit. In a review article, Pravesh Sharma, M.D., discusses various reactions to patient suicide and offers a proposed outline of the responsibilities of psychiatrists in inpatient settings. Hun Millard, M.D., M.A., provides recommendations for recognizing and addressing alexithymia in psychotherapy, using a case example. Lastly, Samidha Tripathi, M.D., offers commentary on the novice therapist.

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“Fake Marijuana”: A Real Problem

Nitin Chopra, M.D.

In the United States, synthetic marijuana has developed into a \$5 billion industry and is the second most frequently used illicit substance after cannabis (1). The present case report describes symptoms and treatment in a patient with chronic use of synthetic marijuana.

Case Report

“Ms. S” is a 26-year-old African American woman with a self-reported history of bipolar disorder and schizophrenia who presented to a local emergency department with confusion, agitation, paranoia, sexual delusions, and thought disorganization twice in a 1-month span. Both visits to the hospital were similar in nature. In regard to the aforementioned diagnoses, neither could be verified through previous records or reports from collateral.

Laboratory tests conducted in the emergency department included a complete blood count, comprehensive metabolic panel assessment, thyroid-stimulating hormone level measurement, and urine drug screen. The patients’ complete blood count, comprehensive metabolic panel, and thyroid-stimulating hormone level were within normal limits. In the same timeframe, at an outside facility, the patient had received a CT scan of the brain with contrast that was unremarkable.

The patient noted almost daily use of “serenity,” which she identified as synthetic marijuana. On both presentations, her urine drug screen was positive for cannabinoids. Given the similarity of her presentation on the second admission, the laboratory test for synthetic marijuana was sent out and found to be negative.

On both presentations, the patient was admitted to the inpatient psychiatric unit for further evaluation and stabilization. On her first admission, she was agitated and too paranoid to integrate into the milieu of the unit and therefore required seclusion. She was started on risperidone (0.5 mg orally twice daily) to target her psychotic symp-

toms. The paranoia and disorganization persisted, requiring an increase in dose to 1 mg (orally twice daily). On the second day of admission, her thoughts cleared remarkably, she no longer required seclusion, and she adjusted well to the milieu.

Risperidone was selected on the second admission, since it had improved the patient’s psychosis within 72 hours on her previous visit to the unit. At this time, she was not as agitated as previously, and she did not require seclusion. Her paranoia and disorganized thought process improved within the first 24 hours of admission.

On both admissions, the patient did not require additional interventions or consultations and was discharged within 4 days. She was encouraged to pursue sobriety and rehabilitation. However, she was not motivated to cease consumption of serenity.

Discussion

Per the American Association of Poison Control Centers, after a surge in 2011 and 2012, with more than 5,000 reported cases both years, there was an apparent stabilization in the number of reported cases over the last couple of years (2). As with other substances historically, the decline may be attributed to some compounds present in synthetic marijuana—JWH-018, JWH-073, JWH-200, CP-47,497, and cannabicyclohexanol—being placed under control by the Drug Enforcement Agency (3). This may also be due to underreporting, under- or misidentifying, or the plethora of new active ingredients comprising synthetic marijuana.

Packages have been evasive in their listing of ingredients, often listing only herbal ingredients, some of which have known cannabis-like properties (1). The remaining active agents are thus unknown to users and an enigma to clinicians. Based on an extensive review of the literature, several additional compounds have been identified in various products reported as synthetic marijuana (1, 4–7).

Identifying synthetic marijuana has been a challenge for patients and clinicians alike. With over 100 names reported in the literature (Table 1), the street or “brand” names of such products have been growing rapidly, making it challenging to recognize and distinguish given agents as synthetic marijuana or other designer drugs. The psychotropic agents *Salvia divinorum* and Kratom have been detected in a few products (1).

As seen with the above patient, many individuals using synthetic marijuana have negative tests for synthetic marijuana. Additionally, in some instances, a basic urine drug test has been negative for cannabinoids (6). Most laboratories only seek to identify the most commonly found compounds (JWH-018 and JWH-073) (8). However, it is evident that producers quickly (within weeks) adapt to changes in legislation, using variations on old compounds, which are unidentified or not detected on tests (4, 9). Moreover, with results often taking up to 2 weeks to obtain, often well after the patient is discharged, their clinical utility has been minimal.

Synthetic marijuana may trigger acute psychosis, worsen a chronic psychotic disorder, or trigger chronic primary psychotic disorder in predisposed individuals (9). The psychotic episodes have been found to vary in duration from days to months (8, 9). The variation in length is not clearly understood. Synthetic cannabinoids are more potent compared with cannabis and could have longer half-lives, potentially leading to prolonged toxicological effects (6). There is also considerable inter- and intrabatch variability, making clinical effects unpredictable (6). The possibility of alternative designer drugs misidentified by users or clinicians as synthetic marijuana further complicates treatment.

No pharmacologically specific antidotes to synthetic marijuana have yet been identified (5). There have been no formal studies comparing different treatment regimens (8). At present, treatment has

TABLE 1. Street and Commercial Names for Synthetic Marijuana Products

Albino rhino buds	D-rav	K3 Legal	Spice
Aroma	Dream	Kronic	Spice 99
Aztec thunder	Earth impact	Krypto buds	Spice 99 (ultra)
Banana cream nuke	Everlast	Magic	Spice arctic synergy
Barely legal	Exclusive cherry	Mojo	Spice diamond
Bayou blaster	Exclusive mint	Moon rocks	Spice Egypt
Bee stinger	Exclusive original	Natures organic jagoda (blackberry)	Spice gold
Black box	Experience: Chill	Natures organic truskawka (strawberry)	Spice gold spirit
Black mamba	Experience: Ignite	Natures organic wisnia (cherry)	Spice silver
Bliss	Experience: Red ball	OG Potpourri	Spice smoke blend
Blue lotus	Ex-ses (platinum)	Pep spice	Spice tropical synergy
Blueberry	Fake marijuana	Red magic	Spiceworld420
Blueberry posh	Fake weed	Red merkury	Spicey XXX
Bombay blue	Fusion	Scope	Ssplice platinum
Caneff 5 star	Galaxy	Sence	Star fire
Chaos cherry	Galaxy gold	Sensation blackberry	Syn
Chaos mint	Genie	Sensation blackberry 2	Tai fun blackberry
Chaos original	Gorilla	Sensation orange	Tai fun orange
Chill out cherry	Gorillaz	Sensation vanilla	Tai fun vanilla
Chill out mint	Happy tiger incense	Sensation vanilla 2	XXX
Chill out original	Herb dream	Sense	Yucatan fire
Chill zone cherry	Herbal incense	Serenity	Zen
Chill zone mint	Highdi's almdrohner	Skunk	Zen ultra
Chill zone Original	Humboldt gold	Smoke	Zohai
Chillin XXX	Ice bud extra cold	Smoke n' skulls	Zohai SX
Chill X	K2	Solar Flare	Zombie
Clover spring	K2-Blond	Space	
Dark matter	K3	Space truckin'	

been supportive and symptom-based, with reports of various benzodiazepines and antipsychotics being used. Antipsychotics have generally been used in those with psychosis and behavioral disturbances or a history of psychotic disorder and in those whose psychotic symptoms do not remit spontaneously (8). Some clinicians have been conservative in their use of antipsychotics because of concern for decreased seizure threshold (9). There have been reports of varied success with quetiapine, olanzapine, and aripiprazole (10). At our institution, in cases of acute, severe psychosis, we have had clinical success with risperidone, an affordable, high-potency antipsychotic. Clinical experience dictated our trial of low-dose risperidone with the above patient, resulting in remission of psychotic symptoms in a couple of days. Risperidone should be considered both clinically and in future investigations.

Conclusions

Synthetic marijuana continues to be a conundrum to clinicians. Beginning in 2014, there has been a trend of increased reports to poison control centers, indicating that despite imposition of legislative barriers,

the problem remains very real. Paucity of diagnostic measures, inability to identify actual composition, and lack of evidence-based treatment guidelines leave us in a precarious situation. Clearly, continued investigation and advocacy are warranted.

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References

1. Spaderna M, Addy PH, D'Souza DC: Spicing things up: synthetic cannabinoids. *Psychopharmacology (Berl)* 2013; 228:525–540
2. American Association of Poison Control Centers: Synthetic Marijuana. <http://www.aapcc.org/alerts/synthetic-marijuana/>
3. Gunderson EW, Haughey HM, Ait-Daoud N, et al: "Spice" and "K2" Herbal highs: a case series and systematic review of the clinical effects and biopsychosocial implications of synthetic cannabinoid use in humans. *Am J Addict* 2012; 21:320–326
4. Vardakou I, Pistos C, Spiliopoulou C: Spice

drugs as a new trend: mode of action, identification and legislation. *Toxicol Lett* 2010; 197:157–162

5. Rosenbaum CD, Carreiro SP, Babu KM: Here today, gone tomorrow ... and back again?: a review of herbal marijuana alternatives (K2, Spice), synthetic cathinones (Bath Salts), kratom, salvia divinorum, methoxetamine, and piperzaines. *J Med Toxicol* 2012; 8:15–32
6. Harris CR, Brown A: Synthetic cannabinoid intoxication: a case series and review. *J Emerg Med* 2013; 44:360–366
7. Seely KA, Lapoint J, Moran JH, et al: Spice drugs are more than harmless herbal blends: a review of the pharmacology and toxicology of synthetic cannabinoids. *Prog Neuropsychopharmacol Biol Psychiatry* 2012; 39:234–243
8. Castellanos D, Thornton G: Synthetic cannabinoid use: recognition and management. *J Psychiatr Pract* 2012; 86–93
9. Woo TM, Hanley JR: "How high do they look?": identification and treatment of common ingestions in adolescents. *J Pediatr Health Care* 2013; 27: 135–144
10. Oluwabusi OO, Lobach L, Akthar U, et al: Synthetic cannabinoid-induced psychosis: two adolescent cases. *J Child Adolesc Psychopharmacol* 2012; 22:393–395

A Case of Withdrawal From Prescribed Ketamine

Chad Hooten, M.D.

The use of ketamine in the medical field is gaining in popularity. It has long been used as an induction agent for anesthesia and has more recently been proven to show efficacy in treating psychiatric disorders such as depression (1). Additionally, it has been shown to have efficacy in the treatment of chronic pain (2) and is becoming more popular as a treatment choice for an increasing number of pain-related illnesses, including migraine headaches (3).

While there have been rare case reports of ketamine withdrawal and withdrawal symptoms in patients utilizing ketamine recreationally (4, 5), there have been no published case reports, to our knowledge, of a patient undergoing withdrawal from a legally obtained prescription for ketamine. The present case is of a woman with chronic intractable migraine headaches who was admitted to the hospital for suspected sepsis and was taken off ketamine with catastrophic results.

Case

“Ms. B” was prescribed an unconventional regimen for migraines. She had a catheter, a long-term central line, in her right subclavian artery for the purpose of receiving intravenous ergotamine at home under the recommendation of a neurologist. She was also prescribed ketamine in the form of 40-mg sublingual troches (t.i.d.). This was supplemented with naltrexone (15 mg q.h.s.), which is prescribed to potentiate the effects of ketamine. Additionally, she was prescribed topiramate (200 mg q.h.s.), pregabalin (50 mg/day), and acetaminophen/hydrocodone (10 mg/325 mg p.r.n. for pain). The patient presented to the hospital for a persistent fever and was found to be septic due to gram-negative bacterial infection of her permanent central line. She was admitted to the medicine unit for intravenous

antibiotics and observation. On hospital day 2, she was found to be hypotensive during routine morning vital sign measurements. The primary team examined her medications and discontinued any that may have been contributing to her hypotension, including ketamine. Our psychiatry consultation-liaison service was consulted later in the day after the patient made suicidal statements.

On interview, the patient admitted to having three episodes in the past meeting criteria for major depressive episodes. She had only one trial of phenelzine 30 years ago, which was terminated after a few weeks due to mild activation. She had not sought psychiatric help since that time. She denied any family psychiatric history. She also denied any history of tobacco or illicit drug use and admitted to very rare use of alcohol. At the time of our examination, she denied depressive, manic, or psychotic symptoms. In addition, she denied suicidal thoughts of any type but stated that she had made statements threatening her life in an attempt to draw attention to the fact that she desired her ketamine to be restarted. She did complain of symptoms that she attributed to discontinuation of ketamine, including sweatiness, increased anxiety, irritability, itching, nausea, and increased headache pain. These were consistent with symptoms she experienced in the past when she ran out of ketamine and distinct from symptoms that were noticed when she ran out of other medications. It was determined that she was in the early stages of withdrawal from ketamine. We recommended restarting ketamine troches. The hospital pharmacy did not carry these in stock but maintained and dispensed her home supply. The patient was discharged home the next morning before ketamine was restarted, and therefore we were unable to re-evaluate her. She had been

instructed to follow up with her neurologist but declined an offer to follow up with psychiatry.

Discussion

The above patient’s ketamine was prescribed by a neurologist for the express purpose of treating her pain. Because she had not been seen by psychiatry in 30 years, it is unlikely that her neurologist prescribed the ketamine to treat depression and chronic migraines concurrently. Multiple studies have shown the efficacy of treating treatment-refractory depression with ketamine (6–9), although it has yet to be approved for this use.

It remains uncertain whether there is a discontinuation syndrome or withdrawal syndrome with physical symptoms associated with the prolonged use of ketamine. To date, there are exceedingly rare case reports addressing this issue (4). As a result, the addictive potential of this drug remains controversial (10). The present report addressed the emergence of a withdrawal syndrome as it may present under a prescribed medication regimen.

With the increasing use of ketamine, both in the treatment of psychiatric disorders and in chronic pain management, it is prudent that consult psychiatrists as well as the general psychiatric public be on guard for potential situations that may arise from this medication.

Dr. Hooten is a fourth-year Chief Resident in the Department of Psychiatry at the University of Texas Health Science Center San Antonio.

*For additional cautionary advice regarding the use of ketamine, see the [commentary by Alan F. Schatzberg, M.D.](#), in the *American Journal of Psychiatry*.*

References

1. Berman RM, Cappiello A, Anand A, et al: Antidepressant effects of ketamine in de-

- pressed patients. *Biol Psychiatry* 2000; 47:351–354
2. Backonja M, Arndt G, Gombar KA, et al: Response of chronic neuropathic pain syndromes to ketamine: a preliminary study. *Pain* 1994; 56:51–57
 3. Afridi SK, Giffin NJ, Kaube H, et al: A randomized controlled trial of intranasal ketamine in migraine with prolonged aura. *Neurology* 2013; 80:642–647
 4. Critchlow DG: A case of ketamine dependence with discontinuation syndrome. *Addiction* 2006; 101:1212–1213
 5. Pal HR, Berry N, Kumar R, et al: Ketamine dependence. *Anesth Intensive Care* 2002; 30:382–384
 6. Murrugh JW, Iosofescu DV, Chang LC, et al: Antidepressant efficacy of ketamine in treatment-resistant major depression: a two-site randomized control trial. *Am J Psychiatry* 2013; 170:1134–1142
 7. Zarate CA Jr, Singh JB, Carlson PJ, et al: A randomized trial of an N-methyl-D-aspartate antagonist in treatment-resistant major depression. *Arch Gen Psychiatry* 2006; 63:856–864
 8. Lapidus KA, Levitch CF, Perez AM, et al: A randomized controlled trial of intranasal ketamine in major depressive disorder. *Biol Psychiatry* 2014; 76:970–976
 9. Ghasemi M, Kazemi MH, Yoosefi A, et al: Rapid antidepressant effects of repeated doses of ketamine compared with electroconvulsive therapy in hospitalized patients with major depressive disorder. *Psychiatry Res* 2014; 215:355:355–361
 10. Jansen KL, Darracot-Cankovic R: The nonmedical use of ketamine, part two: a review of the problem use and dependence. *J Psychoactive Drugs* 2001; 33:151–158

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A Two-Way Street: Contemplating Violence on Inpatient Psychiatric Units

Andrew Pierce, M.D.

Violence associated with hospitalized patients with mental illness presents a complex problem for mental health workers, systems, and society (1). Aggressive behavior has been found in 16% of psychiatric patients during the first week of hospitalization, and persons with mental illness are more likely to perpetrate violence in the year after diagnosis than the general population (7% vs. 2%) (2). Despite studies indicating psychological and physical trauma to patients and health care workers, as well as the efficacy of alternatives, the use of restraints and seclusion remains a common psychiatric procedure (1, 3, 4). The incidence of seclusion with restraint is reported to be as high as 12% in inpatient psychiatric settings (5).

The following narrative intends to stimulate contemplation of violence on psychiatric units and to provide a context common to resident physicians. The narrative does not represent an actual occurrence.

The screech of the pager rips through the night air and pierces the reprieve of my slumber. I free myself from the industrial-grade bedding and fumble for the phone beside the nearly long-enough twin bed. Twelve of the past 14 nights were spent stalking the ward. Each one teeming with anxiety, survival, doubt, and triumph.

“Psychiatric Hospital, this is Susan,” sings the nurse on the line. “Is this the doctor?” A grunt confirms my existence to us both. “We need you immediately. There is a problem with ‘Mr. Jones,’” she says with composed urgency.

I’m walking now. The florescent lights flick above my head. A burly security

guard meets me as I turn the corner. The man nods as the card reader beeps, and the heavy metal doors give way to the Acute Psychosis Unit.

To the uninitiated, the stillness of the ward reassures, but the keen mind perceives the disturbance. The unit is silent. Several patients hover in the doorways of their rooms. The boom of a man’s voice shatters the tenuous peace.

*To the uninitiated,
the stillness of the
ward reassures,
but the keen mind
perceives the
disturbance.*

“I will not be corrupted with your pills,” screams Mr. Jones.

An assemblage of staff is gathered near Mr. Jones, endeavoring to soothe him, but each attempt accentuates the dwindling optimism. I join the chorus of de-escalation and summon my training. Despite my efforts at redirection, distraction, bargaining, and finding common ground, the patient’s distress intensifies.

Mr. Jones is walking now. His gaze darts erratically as his paranoia flourishes and terror swells. Disorganized thoughts spew from the patient. He bangs the door to the unit with his fist then performs a frantic pivot. He crouches with

knees bent and fists raised. The fear takes hold, and he swipes the neck of the nearest nurse.

“Susan,” I whisper. “Are we ready?” She opens her palm to reveal two syringes.

“Administer the medications.”

The words drift in the air as Mr. Jones is subdued. The swiftness of the action constrains the struggle. The injections puncture the skin. The medications wash over the patient, and his invective ceases. As he is eased onto his nearly long-enough twin bed, he turns to me and murmurs, “Am I the violent one?”

Dr. Pierce is a second-year resident in the Department of Psychiatry, University of Florida, Gainesville, Fla.

References

1. De Benedictis L, Dumais A, Sieu N, et al: Staff perceptions and organizational factors as predictors of seclusion and restraint on psychiatric wards. *Psych Serv* 2011; 62:484–491
2. Choe J, Teplin L, Abram K: Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns. *Psych Serv* 2008; 59:153–164
3. Rain SD, Steadman HJ, Robbins PC: Perceived coercion and treatment adherence in an outpatient commitment program. *Psych Serv* 2003; 54:399–401
4. Hardesty SJ, Frueh BC: Efforts to reduce seclusion and restraint use in a state psychiatric hospital: a ten-year perspective. *Psych Serv* 2014; 65:1273–1276
5. LeGris J, Walters M, Browne G: The impact of seclusion on the treatment outcomes of psychotic inpatients. *J Adv Nurs* 1999; 30:448–459

Various Reactions to a Patient's Suicide and the Responsibilities of a Psychiatrist in an Inpatient Setting

Pravesh Sharma, M.D.

Suicides, which inflict potent scars on the memory of a psychiatrist, trainees, staff, families, and other patients, are not an uncommon phenomenon in psychiatry. Suicide was among the top-10 leading causes of death for all age groups in 2010. In 2008–2009, 3.7% of the adult U.S. population reported having suicidal thoughts (1). It was estimated that 68% of psychiatrists lost patients to suicide (2). Among trainees, it was found that 47% had experienced patient suicide during their training (3). Psychiatrists often find themselves at a loss to know what to do under such testing circumstances (4). In the present article, various individual reactions to patient suicide are discussed, and a proposed outline of the responsibilities of a psychiatrist in the event of a suicide in an inpatient unit is provided.

State of Mind of the Psychiatrists, Trainees, and Staff

A patient's suicide can be a traumatizing experience for the health care professionals involved in treating that patient (5). The Accreditation Council for Graduate Medical Education does not have any requirements for adult psychiatry programs to cover suicide-related topics. Moreover, there are few guidelines informing residency training programs on how to prepare their residents for the possibility of a patient's suicide and its aftermath (6). A study conducted by Pilkinton and Etkin (7), published in 2003, found that only one-third of residents were educated about the impact of suicide while in training. In addition, the authors found that after a patient's suicide, residents were hesitant about using employee assistance programs. Furthermore, only one-third of postgraduate education directors re-

ported that they had a policy in place in the event of a suicide (7). Such policies lay out clear, printed guidelines for residents in the occurrence of a patient's suicide. The aim of these guidelines should be "responsiveness, support, and education" of residents (8). The absence of such policies and reluctance of residents to seek professional help may result in severe reactions. The response may include symptoms of posttraumatic stress disorder (9).

Professionally, trainees may start to have feelings of self-doubt and anxiety, find themselves preoccupied with the bereaved family's reaction, and have fear of condemnation from colleagues (Figure 1) (10). Unfortunately, a sense of demoralization and disheartenment prevails among health care professionals (11). A patient's suicide may also result in a psychiatrist being overly cautious in dealing with subsequent suicidal patients, having a defensive approach toward patients at risk (12). This is particularly more distressing for trainees because the residency years constitute a vulnerable period, both professionally and emotionally (13).

Psychiatrists' Responsibility

Psychiatrists' Responsibility Toward Themselves

A psychiatrist may find him- or herself in a situation in which it becomes important to stand up as a leader and apply "postvention" (a term coined by Edwin S. Shneidman, an American suicidologist) to describe activities that alleviate the repercussions of suicide on the team, on the family of the departed, and on him- or herself. It is advisable to promptly inform the immediate supervisor about the suicide and seek direction. It is always especially helpful to talk to a supervisor or mentor who has gone through a similar

experience. At this time, it also becomes critical to have formal or informal support from colleagues, staff, and family (14). It would be apt to summarize the deceased's history prior to suicide and describe the treatment team's work, estimation of suicide risk at the time of discharge, and treatment plan at the time of suicide. This document may be requested later from the coroner's or medical examiner's office (15). It would not be appropriate to apologize in the summary, drawing conclusions. Lastly, the psychiatrist and the staff should participate in psychological autopsy. The purpose of this process is to talk openly about one's feelings regarding the patient's demise without blaming each other and to examine how one might act differently in the future. Since malpractice lawsuits are a major concern for any physician, a psychiatrist also faces a looming fear of being embroiled in a lawsuit. In such a situation, it is imperative to be conservative and involve counsel at all stages (16).

Psychiatrists' Responsibility Toward Staff

It is the responsibility of a psychiatrist to maintain an organizational structure of the inpatient unit and sustain normalcy so that care of other patients is not affected. It would be of immense help to the staff if a psychiatrist can make him- or herself available when needed so that feelings of disappointment and hurt can be shared and expressed. If the staff wishes to attend the patient's funeral, it should be encouraged (9).

Families

Families' State of Mind

The reaction of the deceased's family is extremely variable, from being in shock, being in isolation, being hostile and searching for answers to a sense of guilt and shame because of the social

FIGURE 1. Summary of the Individual's Reactions and the Psychiatrist's Responsibilities

Groups	Reactions	Responsibility of the Psychiatrist
Psychiatrist/ staff	<ul style="list-style-type: none"> • Self-doubt • Fear of condemnation • Fear of lawsuit • Blame game 	<ul style="list-style-type: none"> • Talk to supervisor and colleague • Psychological autopsy • Seek legal advice • Maintain harmony
Family	<ul style="list-style-type: none"> • Hostility • Denial • Suicidal ideation • Shame 	<ul style="list-style-type: none"> • Attend funeral • Remain in contact • Avoid defensive remarks • Explain the efforts made before suicide
Other patients	<ul style="list-style-type: none"> • Vulnerability to suicide • Poor doctor-patient relation 	<ul style="list-style-type: none"> • Secure the inpatient unit • Call for immediate ward meeting

stigma associated with suicide. Some family members may have feelings of being relieved if the patient's death was a result of chronic stress or pain (17). It is important to understand the ongoing conflict in the minds of the relatives of the deceased. For example, consider younger parents who have lost their child to suicide. They may develop "parental identity crisis," where they start to doubt their capabilities as parents with their surviving children (9). The families of those who have completed suicide appear to be at an increased risk of inflicting self-harm and undergoing emotional turmoil (14).

Psychiatrists' Responsibilities Toward Families

One of the biggest blunders a psychiatrist can commit is to avoid reaching out to the family because of fear of facing hostility and accusations. Although, there are no legal requirements for a physician to contact the family after the suicide of a patient, it would be empathetic on the psychiatrist's part to contact the deceased's family personally (16). The psychiatrist's presence at the funeral may allow family members to ask questions, expressing their grief, and the psychiatrist could make an endeavor to discuss his or her effort during treatment prior to the deceased's suicide. It would also be appropriate for a psychiatrist to express his or her own personal sorrow to the family. A physician need not be defensive and self-critical during this visit. Before ending the meeting, the clinician should provide the family with contact information for future correspondence. In case

the family refuses to talk to the psychiatrist and exhibits anger, it is prudent to refer the family to the primary care physician or a colleague for emotional support. Sometimes, the mere presence of the psychiatrist is sufficient. The family needs to find a vent for their emotions, and the psychiatrist's visit could facilitate this. Additionally, before visiting the family, it is important for a clinician to acquaint him- or herself with the deceased's spiritual and religious beliefs (18).

Other Patients

State of Mind of Other Patients

When the news of a suicide breaks in the inpatient unit, the admitted patients become more vulnerable to committing suicide (19). In the aftermath of a suicide, the remaining patients undergo four stages: shock, recoil, posttrauma, and recovery (20). One needs to be vigilant about recognizing these stages early. For example, when hearing of the suicide of a fellow patient, another patient may become distraught and express suicidal thoughts. Moreover, the patient-doctor relationship might be at stake if some patients try to trivialize the staff and physicians by constantly reminding them about their inability to save the patient from committing suicide.

Psychiatrists' Responsibilities Toward Other Patients

In an inpatient setting, it is important for a psychiatrist to introduce a sense of camaraderie in the ward by calling an immediate meeting with all the patients and staff. The patients should be encour-

aged to express their emotions. Decisions can be made to keep the ward locked for added security, and practical measures, such as limiting the ward pass, can be considered. (16, 20).

Conclusions

Patient suicide is a heart-rending but common event in clinical psychiatry. The psychiatrist plays a crucial role in lifting up the spirits of the staff and communicating condolences to the deceased's family members. Moreover, it is essential for a supervisor or mentor to prepare trainees for any eventuality in a manner that the trainees do not feel devastated in the aftermath of a patient's suicide. The treatment team may need to introspect in order to learn from their experience. It is essential to have clear guidelines for every institution advising clinical staff and psychiatrists about their conduct at such a time. Psychiatrists put forth great effort to save their patients' lives. Sad as it may be, the suicide of a patient must not demoralize a psychiatrist, and he or she should not view it as a professional failure.

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References

- Centers for Disease Control and Prevention: Suicide Facts at a Glance, USA. Atlanta, Centers for Disease Control and Prevention, 2012. www.cdc.gov/violenceprevention/pdf/suicide_datasheet_2012-a.pdf (Accessed August 8, 2014)
- Alexander DA, Klein S, Eagles JM: Suicide by patients: questionnaire study of its effect on consultant psychiatrists. *BMJ* 2000; 1571-1574
- Dewar IG, Eagles JM, Klein S, et al: Psychiatric trainees' experiences of, and reaction to patient suicide. *Psychiatr Bull* 2000; 24:20-23
- Zisook S, Shear K: Grief and bereave-

- ment: what psychiatrists need to know. *World Psychiatry* 2009; 8:67–74
5. Hendin H, Haas AP, Maltsberger JT, et al: Factors contributing to therapists' distress after the suicide of a patient. *Am J Psychiatry* 2004; 161:1442–1446
 6. Jefee-Bahloul H, Hanna RC, Brenner AM: Teaching psychiatry residents about suicide loss: impact of an educational program. *Acad Psychiatry* 2014; 38:768–770
 7. Pilkinton P, Etkin M: Encountering suicide: the experience of psychiatric residents. *Acad Psychiatry* 2003; 27:93–99
 8. http://www.psychiatry.utoronto.ca/wp-content/uploads/2011/01/11-Assault_and_Suicide_Policy.pdf (Accessed September 2, 2014)
 9. Gitlin MJ: A psychiatrist's reaction to a patient's suicide. *Am J Psychiatry* 1999; 156:1630–1634
 10. Kozłowska K, Nunn K, Cousens P: Adverse experiences in psychiatric training, part 2. *Aust N Z J Psychiatry* 1997; 31:641–652; discussion 53–54
 11. Chemtob CM, Hamada RS, Bauer G, et al: Patients' suicides: frequency and impact on psychiatrists. *Am J Psychiatry* 1988; 145:224–228
 12. Campbell C, Fahy T: The role of the doctor when a patient commits suicide. *Psychiatr Bull* 2002; 26:44–49
 13. Brown HN: The impact of suicide on therapists in training. *Compr Psychiatry* 1987; 28:101–112
 14. Ness DE, Pfeffer CR: Sequelae of bereavement resulting from suicide. *Am J Psychiatry* 1990; 147:279–285
 15. Hodelet N, Hughson M: What to do when patient commits suicide. *Psychiatr Bull* 2001; 25:43–45
 16. Kaye NS, Soreff SM: The psychiatrist's role, responses, and responsibilities when a patient commits suicide. *Am J Psychiatry* 1991; 148:739–743
 17. Tal Young I, Iglewicz A, Glorioso D, et al: Suicide bereavement and complicated grief. *Dialogues Clin Neurosci* 2012; 14:177–186
 18. Markowitz JC: Attending the funeral of a patient who commits suicide. *Am J Psychiatry* 1990; 147:122–123
 19. Hodgkinson PE: Responding to in-patient suicide. *Br J Med Psychol* 1987; 60(pt 4):387–392
 20. Bartels SJ: The aftermath of suicide on the psychiatric inpatient unit. *Gen Hosp Psychiatry* 1987; 9:189–197

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Alexithymia and Psychotherapy

Hun Millard, M.D., M.A.

Psychotherapy can be a challenging initial adjustment for residents who are first-time therapists. A solid case formulation of the patient is essential in order to strategize a framework of therapy. Some patients are easier to engage in therapy than others because they are talkative, articulate their issues well, and have a level of insight that lends itself to inner exploration. Although most patients are in the middle of the continuum of self-awareness, those patients skewed at either end can leave a novice resident psychiatrist confused and frustrated.

Alexithymia is a constellation of characteristics in which one has difficulty identifying, describing, and processing feelings and bodily sensations related to emotions. Individuals with alexithymia also have an overall constricted imagination and fantasy life and an externally oriented cognitive style (1, 2). There is debate as to whether alexithymia is a deficit in cognitive processing and emotion regulation compared with a personality trait (3). Patients with alexithymia are some of the most challenging for a therapist because of limited introspection. Thus, traditional insight-oriented psychotherapy may not be as effective, since work involves creating mental representations to discharge internal conflict (3–5).

Case

“Jane” was a 19-year-old young woman who presented with a history of post-traumatic stress disorder (PTSD), panic disorder, binge eating behavior, and chronic lower back pain. Every therapy session was almost identical to the previous one. The patient’s mood checks were reported to be “happy,” but as the session progressed she would be in tears, unable to describe her internal state and angry at someone in her life. She had a variety of physical complaints but was seemingly unaware of any connection between her

physiologic sensations and inner conflicts. Requests for elaboration of affective experiences were often met with shoulder shrugs.

Homework was also a topic of awkward contention. She was noncompliant with assignments. She completed homework only one time in the span of 2 months, which was a daily mood chart rating her depression and anxiety levels. Perplexing at the time was that she rated nearly everything as either “0” or “10,” and similar to her verbal reports there was no depth to her written responses. Her relationships were superficial, but she would become involved in intense conflicts with others over Facebook and text messaging. She had multiple, ongoing interpersonal feuds, her sleep and chronic pain worsened, and the therapeutic alliance suffered.

Recommendations

Therapists often feel bored, angry, or frustrated with patients who have alexithymia (1, 2). The above patient’s routine answer of “I don’t know” became annoying and frustrating but should have been clues to alexithymia. Had alexithymia been detected earlier, then perhaps the therapeutic framework could have been constructed in such a way to promote greater forward movement in therapy.

It is important to consider alexithymia early in the evaluation of a new patient given that the traditional insight-oriented therapy framework may be less effective and leave both the therapist and patient frustrated (5). One review reported that 25% of individuals seeking psychotherapy treatment are alexithymic (3). Standardized assessments may offer the opportunity for early detection. The most common self-report research measure is the 20-item Toronto Alexithymia Scale, which is comprised of three subscales: identifying feelings, describing feelings, and externally oriented think-

ing. Kooiman et al. (6) have suggested that the identifying feelings and describing feelings subscales measure the same symptoms and the externally oriented thinking subscale is unreliable. The authors of the Toronto Alexithymia Scale recommend its use in conjunction with collateral and observer-rated data.

In clinical practice, Kooiman et al. (6) recommend the Beth Israel Hospital Psychosomatic Questionnaire or the Karolinska Psychodynamic Profile over the Toronto Alexithymia Scale. There are also observer methods such as the California Q-set Alexithymia Prototype, the modified Beth Israel Psychosomatic Questionnaire, and the Observer Alexithymia Scale, although these instruments have not been sufficiently investigated. There is no one alexithymia scale that is without controversy, and thus the best approach may be to use a combination of self-report, collateral, and observer scales in conjunction with a structured interview.

Given that the use of instruments to measure alexithymia may be unreliable, time-consuming, or unavailable, a thorough history and case formulation is paramount. In addition to a complete diagnostic evaluation and attentiveness to subtle communication style, there are comorbidities to consider. People with substance abuse, eating disorders, compulsive disorders, depression, anxiety, panic attacks, and PTSD have been noted to have elevated incidence of alexithymia (1, 3). Studies also suggest that there may be associated behaviors, such as somatization, pathologic gambling, binge eating, heightened or prolonged physiological reactions, and flashes of rage, that may be correlated with alexithymia (1, 3, 4).

People with alexithymia have deficits in using mental representation and internal reflection, which may make traditional insight-oriented therapy less effective. The framework of therapy with alexi-

thymia patients should be approached differently. Vanheule et al. (5) outlined the following framework of therapy that may be more effective with alexithymia: 1) having the patient put into words the chain of events that makes up a difficult situation, 2) having the patient explicitly discuss and assess these situations, and 3) talking about the affective responses of self and others and discussing how the patient deals with the difficult situation.

Toward the end of psychotherapy treatment for the above patient, it was not recognized that the patient had great difficulty verbally expressing her feelings, which paralleled my difficulty as a new therapist in recognizing why the psychotherapy was not progressing. Once alexithymia was identified, more empathy toward the patient was possible, which improved the therapeutic alliance, and

the framework of therapy was shifted to a more structured skills-based approach to treatment. More time was spent describing affective experiences out loud, connecting physical sensations to internal thoughts and feelings, and collaboratively constructing assignments to identify and name emotions.

Dr. Millard is a fourth-year resident at the Yale Child Study Center, Yale School of Medicine, New Haven, Conn.

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References

1. Taylor GJ, Bagby RM: Psychoanalysis and empirical research: the example of alexithymia. *J Am Psychoanal Assoc* 2013; 61:99–133
2. Ogrodniczuk JS, Piper WE, Joyce AS: Ef-

fect of alexithymia on the process and outcome of psychotherapy: a programmatic review. *Psychiatr Res* 2011; 190:43–48

3. Lumley MA, Neely LC, Burger AJ: The assessment of alexithymia in medical settings: implications for understanding and treating health problems. *J Pers Assess* 2007; 89:230–246
4. Grabe HJ, Frommer J, Ankerhold A, et al: Alexithymia and outcome in psychotherapy. *Psychother Psychosom* 2008; 77:189–194
5. Vanheule S, Verhaeghe P, Desmet M: In search of a framework for the treatment of alexithymia. *Psychol Psychother* 2011; 84:84–97
6. Kooiman CG, Spinhoven P, Trijsburg RW: The assessment of alexithymia: a critical review of the literature and a psychometric study of the Toronto Alexithymia Scale-20. *J Psychosom Res* 2002; 53:1083–1090

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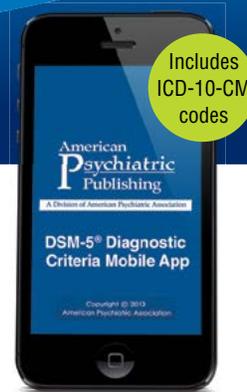
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Confessions of a Novice Therapist

Samidha Tripathi, M.D.

“She makes me so anxious!” I told my supervisor as we discussed a patient during one of our weekly supervision sessions. Yes, I was nervous, anxious, and perturbed by this patient. “But it’s only been a month since you started working in the outpatient center and as a therapist,” said my supervisor. One month! Wow! I said to myself, it sure is scary. I’m slowly approaching the fifth month of training as an outpatient psychiatrist, and I’m still trying to learn the nuances of therapy. So what is it that makes the first few months of working in the outpatient setting so nerve racking for trainees, and what is it that we can do to make things easier for ourselves (1–3)?

With the way residencies are structured, starting third year as an outpatient psychiatrist can feel like an intern year to most of us. The thought that one is all alone, without the support of an inpatient team, can be anxiety-provoking. Inpatient units provide a structured environment for both the patient and physician alike. Lack of this cushion, or “the milieu,” takes time getting used to. One needs to become more comfortable with talking to a patient, for 1 hour at least, every week. Many residents will experience the same thoughts, such as worries about not knowing what to say or when to say it, saying the wrong thing, or running out of things to talk about.

It is important to firstly recognize that these feelings are very common and that these “automatic thoughts” are modifiable. The first and foremost step to feeling comfortable as a novice therapist is to seek supervision. Our attending and

senior therapists have a world of experience and advice to offer. Not only will this help alleviate anxiety, but it will also help hone skills as a therapist. By recording sessions, maintaining process notes, and later reviewing cases during supervision, valuable communication skills can be developed. It is crucial to be honest about your anxieties and concerns and address them during supervision so that they become valuable learning experiences.

The first and foremost step to feeling comfortable ... is to seek supervision.

Secondly, it is important to understand and be comfortable with silence during a therapy session. There will be periods of silence during a session that may be uncomfortable, but remember the adage “silence is golden.” Acknowledging this can prove to be beneficial. The silence itself can be used as a conversation starter. For example, “Ms. B, you seem very quiet today, is there something on your mind that you would like to talk about?” Furthermore, silent observation of a patient can be very revealing in itself.

Thirdly, acknowledge the fact that you might not have all the answers. An inherent desire of medical professionals is to help their patients; however, there may be times when we might not have solutions

or answers to a problem. Patients may actually feel better that an answer is not obvious, since they haven’t been able to come up with a solution themselves. One way to handle this is to share the problem. An example would be to state, “I don’t know yet how best to help you, but over the next few weeks we should have a better idea.”

Finally, it is a good idea to talk to your colleagues (4). They are probably struggling with the same issues, and knowing that your concerns are normal can be helpful in surmounting feelings or anxiety. Additionally, it is always helpful to share these experiences, as many of them can provide excellent learning opportunities.

Dr. Tripathi is a fourth-year resident in the Department of Psychiatry, Einstein Medical Center, Philadelphia.

The author thanks Dr. Kevin C. Hails for his support.

References

1. Skovholt TM : Struggles of the novice counselor and therapist. <http://jcd.sagepub.com/content/30/1/45.abstract>
2. Hill CE, Sullivan C, Knox S, et al: Becoming psychotherapists: experiences of novice trainees in a beginning graduate class. *Psychotherapy* 2007; 44:434–449
3. Lanouette NM, Calabrese C, Sciolla AF, et al: Do psychiatry residents identify as psychotherapists? a multisite survey. *Ann Clin Psychiatry* 2011; 23:30–39
4. Hahl S, Mintz DL, Bailey A: The role of personal therapy in psychiatric residency training: a survey of psychiatry training directors. *Acad Psychiatry* 2010; 34:21–26

Residents' Resources

Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

July Deadlines

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
<p>American Academy of Child and Adolescent Psychiatry (AACAP) Educational Outreach Program for General Psychiatry Residents or child/adolescent psychiatry (CAP) residents (former Travel Grant Program)</p> <p>Deadline: July 13, 2015</p>	AACAP	Provides the opportunity for general psychiatry or CAP residents to receive a formal overview to the field of child and adolescent psychiatry, establish child and adolescent psychiatrists as mentors and experience the AACAP Annual Meeting in San Antonio, Tex., October 26–October 31, 2015.	General psychiatry residents who are AACAP members or have pending AACAP membership. Child and adolescent psychiatry fellows who are AACAP members or have pending AACAP membership.	training@aacap.org; or (202) 587-9663	<p>General psychiatry residents: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_General_Psychiatry_Residents.aspx</p> <p>CAP residents: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Educational_Outreach_Program_for_CAP_Residents.aspx</p>
<p>AACAP Systems of Care Clinical Projects</p> <p>Deadline: July 13, 2015</p>	AACAP	Collaborate on the development of a poster of a clinical concept within systems of care to present during the Systems of Care Special Program in October. The AACAP 2015 Special Program is a day-long event taking place on Monday, October 26th in San Antonio, Tex.	Child and adolescent psychiatry fellows who are AACAP members or have pending AACAP membership.	clinical@aacap.org; or (202) 587-9671	https://aacap2.confex.com/aacap2/2015/systems/programs/cfpinstructions.cgi

August Deadlines

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
<p>Academy of Psychosomatic Medicine (APM) Trainee Travel Awards</p> <p>Deadline: August 1, 2015</p>	APM	To encourage psychosomatic medicine fellows, residents, and medical students to join APM, attend the annual meeting, and eventually become new leaders of the Academy; a limited number of monetary awards are given to help offset the cost of attending the annual meeting.	Psychosomatic medicine fellows, residents, and medical students.	N/A	http://www.apm.org/awards/trainee-travel.shtml#how_to_apply

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