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COMMENTARY

Addressing the Mental Health Needs of Medical Trainees: The Role of Psychiatrists

Wardah Athar, B.S., Corey Horien, B.A.

It has long been acknowledged that medical trainees experience higher rates of mental health problems than age-matched populations, with depression and burnout being particularly severe issues that have been well described in the literature (1, 2). The high prevalence of mental health difficulties among trainees has the potential to negatively affect patients, as one research group found that depressed trainees committed significantly more medication errors compared to non-depressed trainees (3). Despite these data, it appears that trainees still perceive many barriers to accessing and utilizing proper mental health resources. Survey data published in 2010 revealed that depressed trainees reported many deterrents to receiving adequate treatment, including insufficient amounts of time, a desire to handle problems on their own terms, a paucity of convenient treatment avenues to access, and apprehension regarding confidentiality (1). Thus, while the mental health of medical students and residents is becoming better studied, there remains much to be done to ensure that all physicians in training receive appropriate mental health support.

To help address these issues, medical training programs will need to come up with creative, multifaceted solutions. Medical training programs will need to come up with creative, multifaceted solutions. One such program attempts to identify individuals displaying behaviors consistent with suicidal ideation and depressive symptomatology. The Suicide Prevention and Depression Awareness Program at the University of California, San Diego (USCD) School of Medicine, led by a committee of faculty, housestaff, and medical students, has developed an online suicide screening tool that identified individuals at risk and connected them with counselors as needed (4). A 4-year assessment of the program revealed that 8% of respondents qualified for “high suicide risk,” and of these respondents, 76.9% were not receiving mental health care at the time of the survey. Data such as these suggest that early screening programs may provide a way to identify, and subsequently support, at-risk trainees.

While the long-term efficacy of the UCSD program is still to be seen, the need to generate novel, evidence-based solutions to address the mental health needs of trainees remains. Although we are still early in our training and recognize that we have much to learn about what it means to practice effective self-care as medical trainees, we hope that by engaging with these issues now, we can contribute to the shifting culture surrounding mental health across specialties. As students interested in pursuing careers related to psychiatry and mental health, we believe that psychiatry trainees in particular have an opportunity for modeling mental health for patients and colleagues. We ourselves have been inspired by the many ways that psychiatry residents, both at our institution and around the country, are leading by example when it comes to practicing effective self-care, maintaining an appropriate work-life balance, and ensuring the wellbeing of colleagues. It is our hope that this commentary offers a chance for readers to reflect on their own mental health and serves as a discussion point for those currently in training.

Wardah Athar and Corey Horien are third-year students in the M.D.-Ph.D. program at Yale University, New Haven, Conn., and are both supported by an NIH/NIGMS T32 GM007205 grant.

The authors thank Dr. Nancy Angoff for assistance with this commentary.

REFERENCES
COMMENTARY

Should Psychiatrists Perform Competency-to-be-Executed Evaluations?

Jordan Howard, M.D.

Those who say “yes” often see a competency-to-be-executed evaluation as an opportunity to advocate for a patient in need, specifically, being able to testify with expertise that a patient’s rights and life would be violated should an execution be carried out. However, as residents and the upcoming generation of psychiatrists, it is important to understand and adopt why the World Psychiatric Association, World Health Organization, and World Medical Association have declared that psychiatrists should not participate in assessments of competency-to-be-executed evaluations (1–3). These and many other organizations have cited that as psychiatrists, our skills, expertise, and advocacy should be in the best interest of a patient’s health and well-being. It’s hard to reconcile this objective with a competency evaluation plan that potentially renders a patient appropriate for lethal injection. Granted, it is a slippery ethical dilemma. Psychiatrists must reconcile beneficence and nonmaleficence and determine if evaluating and recommending treatments for inmates with the goal of restoring capacity to the point that they can understand the basis for their execution is assisting law officials carry out justice or a way to partake of capital punishment.

To resolve the debate, we should call upon the Hippocratic Oath. Understanding the implications and the philosophy of this oath will remind us that despite the noble efforts to rescue the incompetent, our priority is to never risk participation in a patient care scenario in which harm is the end-goal.

One may question the Hippocratic Oath and how the role of the psychiatrist in these evaluations is defined as harmful? Those who advocate for psychiatrists to perform these evaluations may define harm in the physical sense and suggest that psychiatrists are not directly hurting the patient. Others may argue that a patient on death row was put there by the legal system, not the psychiatrist. From this viewpoint, once it has been ruled that an inmate go to death row, no more harm can be done. The psychiatrist evaluating can only question the validity of that ruling.

To counter, I would recall Milgram’s famous social experiment and the concept of diffusion of responsibility (4). Milgram’s study explained how individuals are able to participate in horrendous actions with innocent mindsets because they deflect the responsibility of the acts onto others, particularly authority (4). Psychiatrists who perform competency-to-be-executed evaluations may analogously pin responsibility on legal directives from the judge and state laws. This, however, does not exempt psychiatrists from their primary responsibility in providing care to those in need and upholding their commitment to never harm patients. Whether you are slamming the gavel, performing the competency-to-be-executed evaluation, or delivering the injection, any participation in a series of events that leads to the intentional death of an individual should be considered harmful and would violate the Hippocratic oath.

While capital punishment is still permitted in this country, competency-to-be-executed evaluations are necessary to thwart inappropriate judgments. However, psychiatrists should consider how they reconcile these evaluations with their oaths to do no harm prior to assuming this responsibility.

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The author thanks Monifa Seawell, M.D., an Editor Emeritus of the Residents’ Journal.

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With increasing sophistication of medical knowledge and technology, the number of organ transplantations in the United States increases every year. With a high prevalence of substance use disorders among transplant candidates (1), the role of the addiction specialist in the evaluation and treatment of this population is increasingly relevant. According to data from the Organ Procurement and Transplantation Network, liver disease as a result of alcohol consumption is the second leading indication for liver transplantation, representing almost 50% of end-stage liver disease patients; however, these patients only account for 15%–20% of liver transplant cases (1–2). Addictive disorders can significantly affect candidacy selection and post-transplant outcome; hence, the involvement of an addiction specialist is essential for meaningful evaluation of the patient. Given the shortage of organs, the process of organ allocation has raised important bioethical questions, especially given the controversial subject of alcohol use disorder in the transplant community (1, 2).

Liver transplantation programs vary in the selection criteria for candidates, but in general 3–6 months of abstinence is one of the main requisites (3). Many patients with alcohol use disorder and end-stage organ disease fail to meet selection criteria or die waiting for an organ.

The present article provides discussion of the challenges that the patient and the clinician will encounter throughout the pre- and post-transplant period. Additionally, it encourages psychiatrists to get involved in the process of evaluation of patients with alcohol use disorder and liver disease who are in need of a transplant.

PRE-TRANSPLANT EVALUATION

Addiction specialists are beginning to play a more prominent role in the selection and preparation of patients for transplant. Many patients who develop alcoholic liver disease are at risk for comorbid substance use and mood disorders (1). This patient population experiences fewer cravings, which leads to an inflated sense of confidence and creates resistance to alcohol use disorder treatment; they are also less motivated to receive treatment than patients without end-stage liver disease (4). Additionally, for some patients, the assignment of an organ motivates their decision to become abstinent. The transplant community is invested in selecting patients who will be able to maintain abstinence. Studies have shown multiple predictors of relapse to drinking, including increased severity of alcohol use disorder, short abstinence maintenance prior to transplant, a positive family history of substance use, and lack of social support (5–7). The addiction specialist should provide a good assessment and recommend high-intensity treatment for patients with these factors to make sure they increase the probability that they will achieve abstinence and are considered for transplant.

During the assessment of eligibility for a liver transplant, if the candidate is found to have alcohol use disorder, the treatment should focus on enhancing the motivation toward abstinence. Close monitoring that includes urine samples, breath or blood toxicology and markers, collateral information from friends and family, and relapse prevention training is recommended (7, 8). Studies suggest that the longer the abstinence prior to transplant, the less likely the patient will relapse (1). Additionally, there is pharmacotherapy that helps patients achieve sobriety. Based on their pharmacologic profiles, acamprosate, topamax, and baclofen are generally safe treatment options with moderate efficacy for alcohol use disorder in this patient population. In a small retrospective study, baclofen was not only safe and efficacious in the treatment of alcohol use disorder in patients with alcoholic hepatitis, but it also improved their clinical profile, decreasing liver enzymes (9).

POST-TRANSPLANT PERIOD

After transplant, treatment for alcohol use disorder, comorbid psychiatric conditions, and maintenance of motivation for recovery are essential to ensure treatment success. Ongoing alcohol use can interfere with the patient’s recovery by preventing treatment participation and also directly harming the graft (10). The inability to adhere to immunosuppressive regimens, which is common in the setting of alcohol use disorder, can lead to graft loss (up to 17%) (11). Alcohol use disorder and other comorbid substance use can be toxic to the graft and can also predispose patients to cardiovascular disease and can increase the risk of infections, which are common conditions in immunosuppressed patients. Transplant patients who relapse to drinking have also been shown to suffer from higher mortality rates due to cardiovascular disease and cancer (11, 12). Abstinence is critical in the post-transplant period to ensure good outcomes.

Up to 50% of patients will consume some alcohol after transplant, many within the first year (10). However, up
to 70% will remain abstinent or have very minimal drinking (10). One study evaluated alcohol relapse after liver transplantation and its impact on survival; interestingly, while there was no significant association between relapse and poor outcomes in the first year, the 10-year survival rate decreased considerably among patients who relapsed (41% vs. 85%, p<0.01) (11). Another study found that alcohol use disorder patients had lower survival rates after transplantation, even within the first year post-transplant (13).

Relapse reinforces the widely held perception that alcohol use disorder is a matter of willpower, a belief likely to dissuade potential donors from participating in organ donation (14). Given the shortage of organs and the risk of the surgery, as well as the cost of transplant, donors and others in the transplant community might want the organs to be allocated to patients that will adhere to recommendations and succeed medically.

**CLINICAL CONSIDERATIONS**

Transplant patients are a vulnerable and complex population. The role of the addiction specialist is very important at both a clinical level and an ethical level in an era in which the need far exceeds the availability of organs. This shortage of organs leads to an ethical mandate to select the candidates with the highest chances of a good outcome and survival. There is evidence that patients with addictive disorders, especially alcohol use disorder, are less likely to be listed for transplantation even when indicated (15). The role of educating other physicians and advocating for patients in the multidisciplinary team is essential throughout the evaluation for eligibility and management of the patients. Despite the high prevalence of alcohol use disorder in this population, abstinence rates are significantly higher when compared with patients without end-stage liver disease. The transplant team should not reject patients with alcohol use disorder before the appropriate addiction treatment is offered. Capitalizing on the patient’s motivation for consideration for transplant, we can promote abstinence and ensure better post-transplant outcomes and better quality of life for our patients.

Helping the medical community to conceptualize alcoholic liver disease as the byproduct of a complex disease with treatment can help destigmatize psychiatric patients to increase their chances of receiving the medical treatment that they need.

At the time this article was accepted for publication, Dr. Matos-Santana was a fifth-year addiction psychiatry fellow in the Department of Psychiatry, Yale School of Medicine, New Haven, Conn.

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Conceptualizing Bulimia as Addiction: A Resident’s Personal Experience

Spencer Hansen, M.D.

“[A]s the pursuit for the neural basis of addiction advances, it is clear that the search intimately involves understanding the neurobiological basis of motivation and choice for biological rewards such as food.” (1)

I became obsessed with staying thin in Junior High. I joined cross-country in high school, principally as a weight-loss strategy. I graduated high school weighing 144 pounds. Thirteen years later, I entered residential treatment for an eating disorder, weighing 115 pounds at 6 feet of height.

Now in recovery, I consider myself well acquainted with eating disorders. I spent 10 years prior to residential treatment bulimic, with intermittent anorexia. The 2 months before treatment I was vomiting three times every day, hours at a time. I was spending more than $100 every day on food. At that point I believe that I was struggling not only with a “feeding and eating disorder” (1), but also with a behavioral addiction, an addiction that involved “poor emotional and behavioral regulation and the development of rewarding, but maladaptive, habitual behaviors” (2). DSM-5 describes addiction as a “problematic pattern” of behavior “leading to clinically significant impairment or distress” (3). I was an impaired, distressed individual suffering from bulimia.

The Director of the National Institute on Drug Abuse, Nora Volkow, along with Roy Wise (1), stated that “choice is initiated in part by means of the prefrontal cortex.” Berner and Marsh (2) implicated the prefrontal cortex in the pathophysiology of bulimia, arguing that “developmental trajectories of self-regulatory and reward-based learning functions, and the overlapping frontostriatal circuits (originating in the PFC) that support these capacities, deviate from normal in bulimia (4).” While there is no clear evidence to date to support this argument, Berner and Marsh used neuroimaging studies to show that the number of binge/purge episodes in individuals with bulimia is inversely associated with prefrontal cortex activity (2). Research is only beginning to characterize the specialized brain circuits of those with eating disorders (4). The interplay of gene expression, neurotransmission, and cortical function in eating-disordered individuals is complex. What has been consistently observed in reviews of the literature and research is that persons with bulimia tend to show enhanced impulsivity and impaired inhibitory control (5, 6). I was very impulsive and felt “out-of-control” in my behaviors.

Analogous to the addicted individual who, by DSM-5 criteria, must dedicate a “great deal of time” in pursuit of his or her addiction, my behaviors consumed a large number of waking hours. My concentration and memory suffered. My focus targeted what would go in and out of my mouth and where my next binge/purge could happen. This focus, or anticipation, helped alleviate some of the anxiety and dysphoria I felt between each binge/purge cycle. Kalivas and Volkow (7) stated that when “stimuli predicting drug availability are presented,” there is activation of the nucleus accumbens. Similarly, functional MRI studies using food stimuli in adults with bulimia show activation of the nucleus accumbens. These parallel findings suggest a similarity in the neural circuits involved in anticipating substances in individuals suffering from addiction and from those with bulimia.

Despite “persistent or recurrent social or interpersonal problems caused or exacerbated by the effects” of my eating disorder, I continued to engage in the behaviors (3). My marriage suffered. I lost contact with family members and became a recluse at work. I endured instead of enjoyed relationships. One Christmas morning, I left my family to go indulge in behaviors in a parking lot. I remember the steaming vomit drilling a hole into the snow.

I knew I had persistent physical and psychological problems related to my behaviors, but I continued in them. My parotid glands swelled. My voice was hoarse. I felt sharp, right-sided periscapular pain following purges. I felt heart palpitations. I had bilateral lower extremity edema, was always faint, and felt depressed all the time except when in a binge/purge episode.

Like with any addiction, I developed tolerance for my behaviors. My initial binges consisted of around two thousand calories over 30 minutes. Over the years, I needed to consume more calories for longer periods to achieve the same sense of control, emotional numbness, and euphoria. A 30-minute binge and purge cycle, once satisfying, became a disappointing experience. I needed more time and food. Philip Seymour Hoffman, who died from a drug overdose, explained this phenomenon in an interview on Fresh Air:

“It’s not a great pleasure for me to have a couple of glasses of wine. That just—that’s kind of annoying .... Do you know what I mean? Like, why aren’t you having the whole bottle? .... That’s
much more pleasurable. So, to somebody who doesn’t understand that, they just don’t understand it. (8)

Eating just one cookie at a social event was “not a great pleasure.” If I could not binge and purge the whole plate of cookies, I was irritated.

The “withdrawal” I experienced following behaviors aligns with addiction literature that details signs of withdrawal common to every abused substance, for example, signs of anxiety, irritability, dysphoria, malaise, hyperkatifeia (hypersensitivity to emotional distress), and alexithymia (9). My wife witnessed these signs in me first-hand.

In-vivo microdialysis reveals decreases in dopaminergic and serotonergic transmission in the nucleus accumbens during substance withdrawal (9). Research with rats using analogous protocols demonstrates increased dopamine levels in the nucleus accumbens compared to controls during sucrose binges (6). Additionally, underweight rats showed enhanced dopamine release with sucrose binges (10). Such findings could implicate neurochemical reward systems in bulimic persons that act to drive behaviors. I remember feeling abnormally euphoric, to the point of laughter, when eating food after prolonged fasting. Perhaps I experienced enhanced dopamine surges during these episodes.

I experienced psychosomatic relief when bingeing. My physical weakness abated, my parotid glands decompressed, my gastrointestinal pain dissolved, and my anxiety and depression subsided. Volkow and Wise (1) suggested that just as there are “neuroadaptations ... documented in the opioid system on the cocaine abuser and in alcoholics ...” preclinical studies show adaptations in the opioid system after administration of palatable foods. The opioid system may explain the analgesic effect of my binges on such “palatable foods.”

The constant eating calmed and soothed me. I felt excited when I saw a whole cake in front of me, ready for consumption. I felt many times a sense of “well-being, confidence and euphoria,” especially when eating 20 consecutive Big-Macs (3). I felt that I could accomplish great things and that everything would be okay. Dysphoria almost always followed my binge/purge episodes, along with physical exhaustion.

I required inpatient treatment to break a tortuous cycle of preoccupations, binges, negative affective states, and more preoccupations—the addicted person’s cycle (3). I needed 24-hour supervision, locked bathrooms, and weight restoration before I could engage in therapy.

In recovery, I met with other substance abusers in 12-step groups. The thoughts driving my disordered behaviors closely resembled the thoughts driving the behavior of a substance abuser.

My binges/purges eased my psychological pain the same way substances ease the pain of an individual with a substance use disorder. Those with eating disorders can find meetings with a 12-step group, such as Eating Disorders Anonymous, or call my sponsor. For treatment of substance abuse, the emphasis is on psychodynamic psychotherapy, CBT, motivational enhancement, and 12-step facilitation, all of which are considered more efficacious in the long-run than pharmaceutical treatment alone (11). The same approach is most efficacious for treatment of eating disorders.

The American Society of Addiction Medicine (14) describes addiction as “reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.” I offer this review of the literature and my personal experience to support the idea that an eating disorder, specifically bulimia, may be conceptualized as an addiction when considering the patient and proposed treatment modalities.

Dr. Hansen is a second-year resident in the Department of Psychiatry and Behavioral Sciences, Tulane University, New Orleans.

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KEY POINTS/CLINICAL PEARLS
• Developmental trajectories of self-regulatory and reward-based learning functions and the overlapping frontostriatal circuits that support these capacities deviate from normal in bulimia.
• Functional MRI studies using food stimuli in adults with bulimia show activation of the nucleus accumbens.
• The thoughts driving disordered behaviors in bulimia closely resemble the thoughts driving the behavior of a substance abuser.


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**CASE REPORT**

**Somatic Symptom Disorder: Costly, Stressful for Patients and Providers, and Potentially Lethal**

Wesley Davison, M.D., Jessica Simberlund, M.D.

Patients with somatization disorders have twice the annual medical care expenses and use twice as much outpatient and inpatient services as controls (1). They tend to be dissatisfied with their medical care when treatments fail and often “doctor shop.” It is difficult for patients to accept that psychosocial factors may contribute more than underlying pathophysiologic factors to the disorder given the severe and unrelenting nature of their symptoms. In fact, somatoform disorders are associated with significant disability that is equal to or greater than that associated with major medical disorders such as chronic obstructive pulmonary disease and congestive heart failure (2).

Although treating the symptoms can be difficult, a good therapeutic alliance helps minimize excessive and unnecessary evaluation and ineffective treatments, reduces medical care utilization and costs, and improves patient satisfaction. Clinicians should help patients focus on functioning and coping, which can be achieved through cognitive-behavioral therapy (CBT) (3, 4). Antidepressants such as selective serotonin reuptake inhibitors have shown some efficacy, whereas opiates have not and should be avoided (5). There is a high rate of comorbidity with other psychiatric disorders, and treatment of these comorbid psychiatric conditions also appears to be helpful (6).

We present the case of an older woman with many of the hallmarks of somatic symptom disorder who resorted to a suicide attempt. The case displays the natural history of suicide in some individuals with somatic symptom disorder, which may help assist clinicians in recognizing warning signs and better treat patients.

**CASE**

“Mrs. M,” a 53-year-old married, unemployed, Orthodox Jewish woman with suspected bipolar II disorder and unspecified pain syndrome of the nose, was transferred to the psychiatry department from an outside hospital after a suicide attempt. For 3 years prior to her suicide attempt, the patient had been experiencing constant tearing and bilateral pain from the surface of her nose. She attributed her nose pain to “pinched nerves” secondary to teeth grinding in the setting of stress from her daughter’s divorce. Initial treatment for temporomandibular joint dysfunction successfully reduced jaw pain, but her nose pain persisted.

The patient sought evaluation by neurologists, neurosurgeons, and pain specialists. Treatment with opiates, as well as gabapentin and other neuropathic pain medications, failed to improve symptoms. Head imaging revealed a right sphenoid meningioma. However, neurosurgeons from outside and within the institution felt the lateralized meningioma could not adequately explain bilateral nose pain. An outside hospital suggested that the patient’s pain might be psychogenic, and thus she sought outpatient treatment with a private psychiatrist.

The patient’s husband and other family members reported that she became increasingly depressed as the pain continued. Her ability to function drastically declined, and she discontinued her once beloved athletic endeavors because she felt limited by pain. Instead, she remained in bed, rubbing her nose, occupied with the pain. She also had minimal appetite, low energy, reduced ability to concentrate, and intermittent passive suicidal ideation.

One week prior to her suicide attempt, the patient had bothersome thoughts, including a new attraction to her rabbi and the feeling she was being “punished for being evil.” She told her husband and saw her psychiatrist the following week. The psychiatrist reportedly told the patient that her thoughts were “foolish” and recommended ECT treatment, since the patient’s medication regimen seemed ineffective. After this psychiatric appointment, she parted from her husband and began the return trip home with her eldest daughter, at which point she jumped in front of an oncoming train. She reported that the attempt was impulsive and the result of “going crazy” after seeing a multitude of doctors, none of whom offered any effective treatment. She denied any recent manic symptoms, suggesting the attempt did not occur during a manic episode. The patient had no prior psychiatric hospitalizations or suicide attempts.

**DISCUSSION**

Like many with somatic symptom disorder, the above patient was an unemployed older woman with a stressful life event and concurrent psychiatric illness. She met DSM-5 criteria (see Table 1) for a distressing somatic symptom that she perseverated on and devoted excessive time to for more than 6 months. As is typical, she saw numerous doctors without finding a satisfactory treatment. She also demonstrated prevalent severe disability, as she gave up physical activities and felt unable to care for her children. As is common, she found it difficult to accept the psychosocial components of her illness, failing to consider that her unhappiness regarding her daughter’s
divorce may have contributed to her nose pain.

Furthermore, the case demonstrates that somatoform symptom disorders, particularly those that are painful, may be a risk factor for suicide. The relationship between somatic symptom disorders and suicide is unclear, given the high comorbidity of depressive disorders that are known to be strongly associated with suicide. One small study of 120 participants showed that somatization disorder is significantly associated with suicide attempt, even after controlling for comorbid depressive and personality disorders (7). Park et al. (8) found that a “medically unexplained pain symptom” specifically increased suicide risk even when co-occurring with another psychiatric illness. In another study of primary care patients, 37% of those with somatoform disorders endorsed any suicidality compared with 7% of those without somatoform disorders. Furthermore, at follow up, 28% of those with somatoform pain disorder endorsed active suicidal ideation. Eighteen percent of these patients had attempted suicide in the past, and 80% of those who had attempted suicide did so within 6 months of the onset of symptoms. Those with suicidal ideation were more likely to perceive that symptoms caused profound negative effects on their life, would last a long time, and were out of their control (9).

Our patient in the above case had exhausted all non-psychiatric treatment options and made her suicide attempt only after she lost confidence in her last resort, a psychiatrist. She reported that a previous institute told her the pain was “in her head,” and notably she described the attempt as “impulsive” because she was going “craz[y]” from her pain. Clinicians should take care to avoid making patients feel as though they are responsible for their symptoms or that their pain is somehow less real than that attributable to an identifiable physiological cause. This patient’s suicide attempt occurred directly after a visit to her psychiatrist in which the doctor-patient relationship was damaged by the doctor’s use of the word “foolish,” which made the patient feel responsible for her unrelenting pain, as well as hopeless. This highlights the importance of therapeutic alliance in treating somatoform disorder, not only to avoid alienating patients, but also because poor interactions may make patients feel hopeless. Furthermore, the suicide attempt was made directly in the front of the patient’s eldest daughter, whose divorce may have contributed to the onset of the disorder, suggesting that stressors associated with a somatoform symptom disorder need to be actively identified and addressed in psychotherapy, such as CBT.

**CONCLUSIONS**

Unfortunately, psychiatrists are likely the last in the long line of doctors to see somatoform symptom disorder patients. Because of this, it is important that doctors in other disciplines, such as primary care and neurology, be aware of cases showing interaction between somatoform disorders, comorbid mental illness, and suicide. Although existing evidence supports the independent correlation between somatoform disorders and suicide, further research is needed to not only confirm these data, but also to further define the relationship so that improvements can be made in identification and treatment with the goal of reducing suicide and disability.

Dr. Davison is a first-year resident in the Department of Otolaryngology-Head and Neck Surgery, New York-Presbyterian Hospital, New York. Dr. Simberlund is a fourth-year resident in the Department of Psychiatry, New York-Presbyterian Hospital, New York.

**TABLE 1. Somatic Symptom Disorder: DSM-5 Versus DSM-IV**

<table>
<thead>
<tr>
<th>DSM-5 Diagnostic Criteria</th>
<th>DSM-IV Diagnostic Criteria</th>
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<tr>
<td><strong>A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.</strong></td>
<td>Many physical complaints. Beginning before age 30.</td>
</tr>
<tr>
<td><strong>B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:</strong></td>
<td>Each of the following:</td>
</tr>
<tr>
<td>• Disproportionate and persistent thoughts about the seriousness of one’s symptoms.</td>
<td>• ≥Four pain symptoms</td>
</tr>
<tr>
<td>• Persistently high level of anxiety about health or symptoms.</td>
<td>• ≥Two gastrointestinal symptoms</td>
</tr>
<tr>
<td>• Excessive time and energy devoted to these symptoms or health concerns.</td>
<td>• ≥One sexual symptom</td>
</tr>
<tr>
<td><strong>C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).</strong></td>
<td>• ≥One pseudoneurological symptom</td>
</tr>
</tbody>
</table>


**KEY POINTS/CLINICAL PEARLS**

- Somatic symptom disorder may be a risk factor for suicide; suicidal ideation is important to consider when treating these patients.
- Patients with somatic symptom disorder are prone to doctor shopping and will likely feel failed by medical professionals by the time they see a psychiatrist; therefore, a good doctor-patient relationship is essential.
- Pain may be real and very distressing, even if there is no physiological factor causing it; treatment may include addressing comorbid psychiatric conditions, cognitive-behavioral therapy, and selective serotonin reuptake inhibitors.
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In January 2016, a collaboration between the NYU Department of Psychiatry and the University of Ghana Medical School brought me to Accra in the middle of my PGY-2 year. I spent the month at Accra Psychiatric Hospital, one of the oldest and largest psychiatric hospitals in Ghana.

The hawker was a merchant woman in brightly colored wraps, their graceful heads balancing plastic washbasins packed with bottled water and ice sachets; they bobbed through traffic at every intersection. “Sister, sister!”—they called out to me—“buy some water from me!” I was a stranger; notably foreign in every way, but we were family.

These casual greetings spoke of the importance of family in Ghana. In the hospital, an elderly woman was not just your patient—she was your “aunty.” One morning during rounds at Accra Psychiatric Hospital, we saw an elderly woman who was admitted to the ward for bipolar disorder. The patient insisted on speaking outside in the courtyard. Her thin arms trembled as she lifted herself out of the chair and knelt to the ground, pressing her torso into the dirt and gravel of the courtyard floor. The psychiatry resident pleaded with her to get up. “Aunty Eliza,” she repeated, “Aunty Eliza, please let me help you up. I’m the doctor. Do you understand, aunty?”

Family is crucial to psychiatry in Ghana, in a variety of ways. First, it is nearly impossible to hospitalize a patient “involuntarily” in Ghana without a relative agreeing to it. One patient who was brought to Accra Psych by his co-worker one night was discharged and told to return in the morning; he could not be admitted without a relative. Family members were crucial in bringing patients to treatment, often by force. One morning, our teaching conference at Accra Psych was interrupted by screaming. A woman outside was being dragged by her arms into the clinic by a group of relatives. It was quite the commotion. When patients themselves did not make it to the hospital, family members frequently presented on their behalf, for follow-up appointments and medication refills. One young man came to Accra Psych for his great-aunt’s risperidone refill, as the family lived miles outside of Accra. The task of squeezing the frail old woman into a hot, precariously overfilled tro-tro (an overpacked minibus, the preferred method of public transportation throughout Ghana) was too physically daunting, not to mention expensive.

Relatives were often able to provide excellent collateral information (as multiple generations and extended families frequently lived under one roof) in addition to much-needed financial support. Aunty Eliza’s daughter and son-in-law frequented the ward every day; not only to visit Aunty Eliza but to facilitate her entire hospitalization. Her daughter brought her prescriptions to the pharmacy, purchased the medications, and carried the medicines back to the ward to be administered. She paid for the hospital stay. Whereas Aunty Eliza might have utilized Medicare or private health insurance in America, in Ghana her adult children served as her health insurance plan. Nigerian writer Dayo Olapade (1) refers to family and social relationships in African societies as an adaptive and innovative “safety net,” in the absence of reliable alternatives such as government aid or welfare programs.

Signs of a robust and active religious life abound in Accra. Tro-tros and taxi cabs weave through traffic in busy downtown Accra, displaying prominent yellow decals in their rear windows with varying religious messages: “Ask God For Forgiveness,” or “Jesus saves.” (One puzzling taxi simply declared “I'M SORRY” in the rear window.) Roadside shacks selling fried plantains, balls of kenkey (a dumpling made of fermented ground corn) wrapped with banana leaves, and tilapia drying out under the dusty equatorial sun have signs with declarations such as, “God Loves Me.” Billboards announced the upcoming arrival of Pastor Chris, a popular Nigerian pastor who was coming to Accra for a night-long crusade. Car radios blast gospel music interspersed with the shouting of preachers. On Sundays, our quiet neighborhood on the outskirts of Accra was utterly transformed by the rhythm and noise of Sunday church proceedings. For an entire afternoon, the walls and ground shook with the rhythm of the bass emanating from the local church gatherings. Church is the biggest party in town.

Given the importance of religion in Ghana, I frequently encountered patients in whom religion (Christianity as well as African traditional religion) filtered into their delusional constructs or erratic behavior. One young man was brought into clinic by his mother because he had been leaving the house at four or five o’clock every morning to go to the church and “preach.” An elderly gentleman brought his granddaughter to clinic after she started talking to herself in the night; she was convinced that...
she had inherited the “curse” responsible for her mother’s death. Her grandfather told us he intended to seek spiritual help for his granddaughter, after we made sure there was no medical problem. We reassured him that he had been right to seek medical attention. The girl barely moved during the interview; she appeared catatonic.

Indeed, psychiatric disorders go hand-in-hand with spirituality, religion, and superstition in Ghana. Traditional beliefs regarding mental illness long ago involved ideas of witchcraft or sorcery, with beliefs that psychosis manifests when someone puts a curse on you, or “takes you to juju” (2). These traditional beliefs persist in Ghana, particularly among rural populations and in the northern region of Ghana (3). These ideas may perpetuate the stigma of mental illness, as it further separates the biomedical model from the traditional model. Prior research in Ghana demonstrates widespread views that mental illness is not like any other illness, but rather a consequence of lack of self-discipline or willpower (4). Unfortunately, patients frequently internalize society’s beliefs. Barke et al. (4) described “self-stigmatization” as a process by which psychiatric patients “adopt the stereotypes about people with mental illness prevailing in the society and consequently come to perceive themselves as unacceptable. In Ghana I encountered numerous patients who felt “guilty” and “responsible” for their psychiatric disorders. The stigma of mental illness can further exacerbate the treatment gap for mental disorders in Africa, as stigma often deters the mentally ill from seeking treatment (4). Certainly, the commotion of a patient being physically dragged into Accra Psych was an everyday occurrence. In fact, the World Health Organization estimates that out of the 650,000 in Ghana suffering from severe mental disorders and 2,166,00 suffering from mild-to-moderate mental disorders, only 2% are receiving psychiatric treatment (5).

Perhaps the biggest risk resulting from superstitious and spiritual beliefs about psychiatric disorders is the use of inappropriate or harmful treatment methods. I learned during one teaching conference at Accra Psych that elderly women are sometimes labeled as “witches” when they become demented and manifest neuropsychiatric symptoms. They may be banished from the community and sent to “witch camps” (6). Along a similar vein, a recent article calls to attention “prayer camps” in Ghana, where hundreds of mentally ill are placed, often subject to inhumane conditions (7). The article underscores the relationship between supernatural beliefs about mental illness and abusive treatment of the mentally ill; inhumane practices may be viewed as part of the cultural tradition of “removing the evil spirit” that inhabits them.

Ultimately, our priority as health care providers is to ensure the well-being and safety of our patients. Particularly in psychiatry, where establishing a therapeutic relationship is a priority and a requirement, we cannot dismiss religion or spirituality, particularly in a society such as Ghana where religion plays a central role in our patients’ lives. Like the utility of family relationships, religion serves a unique purpose in Ghana as a “complex form of social solidarity” (1). One resident psychiatrist at Accra Psych tells me that she addresses religion directly with her patients. She tells them, “Listen, it is great that you are religious and believe in God. God is fine with you coming to see me and taking the medicines that I prescribe. God created psychiatrists for a reason, right?”

Dr. Liu is a third-year resident in the Department of Psychiatry at New York University and the new Media Editor for the Residents’ Journal.

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REFERENCES

For anyone who has worked in an inpatient psychiatric unit, it comes as no surprise that many patients in this setting have serious medical comorbidities. As many as three-quarters of individuals with a serious psychiatric illness also carry a chronic medical diagnosis (1), and according to a single study, nearly a third of consecutively screened patients admitted to an inpatient psychiatric unit also had a physical illness, of which 3.5% had physical illnesses that likely exacerbated their psychiatric condition (2). Despite these sobering statistics, psychiatric residency training in the United States has progressively decreased time learning general medicine (3), leaving practicing psychiatrists to rely primarily on their medical school training when faced with medical issues in their patients.

In this setting, Drs. Manu and Karlin-Zysman, internists in an academic medical center, have introduced the second edition of the Handbook of Medicine in Psychiatry, with the goal of addressing “the realities confronting clinicians who work in self-standing, inpatient psychiatric settings” (pp. xxvii). The volume is organized into 40 brief (generally 4–11 pages) chapters and seven parts, including emergency medical conditions (sudden death, cardiac arrest, and respiratory failure), abnormal vital signs, common somatic symptoms (e.g., chest pain), metabolic emergencies, serious psychotropic side effects, management of acute behavioral disturbances (e.g., delirium), and assessment of medical risk. Chapters, authored by academic internists and psychiatrists, include descriptions of each condition’s clinical presentation, differential diagnosis, risk stratification, evaluation, and management, often with clear tables and flowcharts that highlight key concepts. For example, the chapter covering falls and head trauma includes a table of risk factors associated with falls, flow charts that help guide pre- and post-fall assessments, and the Glasgow Coma Scale for quick reference. Each topic includes relevant citations from peer-reviewed sources, which have been revised to reflect updates since the publication of the first edition of this volume.

Unlike general medical texts and reference books, the Handbook expends minimal space on etiology and pathophysiology, emphasizing instead practical methods of assessment and management. This approach is helpful for a quick reference on the wards, but also as a concise refresher for psychiatrists seeking to jog their memory of general medical knowledge. Nonetheless, as expected for a volume incorporating 63 authors, chapters are sometimes uneven in their level of detail. For instance, the chapter covering hypertension only includes a list of antihypertensive drug classes with general guidance for choosing among them; in contrast, the chapter covering thyroid disorders (seen much less frequently than hypertension among psychiatric patients), includes a detailed series of flow charts that guide laboratory assessment and pharmacologic management of hypothyroidism and hyperthyroidism. In addition, certain medical conditions receive little-to-no attention, such as gynecologic issues and medical concerns in patients receiving hemodialysis.

Overall, this updated edition of the Handbook serves a crucial role as both an accessible white-coat reference and a source for need-to-know medical knowledge among inpatient psychiatrists. For psychiatric trainees in particular, this volume consolidates and organizes essential information in the sea of topics covered in online resources such as Epocrates and UpToDate.

Dr. Hirschtritt is a third-year resident in the Department of Psychiatry at the University of California, San Francisco.

REFERENCES

Get Involved With the Residents’ Journal!

The American Journal of Psychiatry-Residents’ Journal is seeking Guest Editors to assist in coordinating special themes for upcoming issues. If you are interested in working with the Residents’ Journal Editorial Board in this capacity, please contact the Editor-in-Chief, Katherine Pier, M.D. (katherine.pier@mssm.edu).

TEST YOUR KNOWLEDGE HAS MOVED

Our Test Your Knowledge feature, in preparation for the PRITE and ABPN Board examinations, has moved to our Twitter (www.twitter.com/AJP_ResJournal) and Facebook (www.facebook.com/AJPResidents-Journal) pages.

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 for their questions.

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 to Rachel Katz, M.D., Senior Deputy Editor (rachel.katz@yale.edu).
Residents’ Resources

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

*To contribute to the Residents’ Resources feature, contact Oliver Glass, M.D., Deputy Editor (glassol@ecu.edu).

SEPTEMBER DEADLINES

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<td>American Academy of Addiction Psychiatry (AAAP) Resident Poster Competition Medical Student, Resident, Fellow, Travel Award</td>
<td>AAAP</td>
<td>Medical students, residents, and fellows with an interest in addiction psychiatry are invited to submit an application for a travel award to the AAAP Annual Meeting.</td>
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<td>Resident Poster Competition</td>
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2. **History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.

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4. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

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11. **Book and Movie Forum:** Book and movie reviews with a focus on their relevance to the field of psychiatry. Limited to 500 words and 3 references.

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

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