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Monitoring the Meeting: Resident Takeaways From the October 2015 APA Mental Health Services Conference

RACIAL/ETHNIC AND SEXUAL/GENDER MINORITY TRAINING EXPERIENCES IN PSYCHIATRY: PAST, PRESENT, AND FUTURE DIRECTIONS TO IMPROVING TRAINING CLIMATE

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This symposium focused on elucidating the very real and pervasive modern forms of subtle and unintentional exclusion based on social differences. Unlike the traditional definition of microaggressions, defined as “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group” (1), this workshop emphasized how microaggressions go beyond race. There is both established and emerging literature that shows how microaggressions extend into other socially constructed identities that embody privilege in different ways, such as income, social capital, religion, ableness, sex, and sexual orientation (2). The impact that microaggressions have on the well-being of individuals is indeed cumulative (3). The panelists shared experiences that aimed to increase awareness and accountability of the impact that microaggressions can have on the well-being of trainees. By sharing their experiences, they demonstrated how microaggressions are very complex and often a challenge to identify, examine, and even confront. For example, such subtleties as “you speak English really well” (despite being born and raised in the United States), or “are you a nurse?” (to a female resident), or “you look too masculine” (to a self-identified lesbian resident) are often confusing, shocking, frustrating, and hurtful. More importantly, however, this session emphasized how it is even more difficult to acknowledge and be accountable for the microaggressions we ourselves commit. It is absolutely critical that we recognize the fact that most of us, including people in positions of power, alternate between being the “recipient” of a microaggression and actually “committing” a microaggression. Recognizing that we all have implicit biases is important in facilitating an environment where we can discuss and deal with difficult topics, such as microaggressions and implicit bias (4). The following were key points made by the panelists:

• We all commit microaggressions. Every resident starts their training with his or her own experiences and biases (5).
• Recognize microaggressions. Microaggressions should be acknowledged, examined, and addressed to support an optimal training environment.
• It is virtually impossible to prevent microaggressions, but you can minimize their impact by creating a supportive environment where residents can address and process their experiences.
• Assess potential for change. Residency leadership and residents alike should have appropriate training in implicit bias to understand how microaggressions affect the training environment.
• Facilitate an open dialogue about diversity issues; this can create a welcoming environment where underrepresented residents are celebrated and not just tolerated.

REFERENCES

SEXUAL ORIENTATION, GENDER IDENTITY, AND SEX DEVELOPMENT COMPETENCIES IN MEDICAL EDUCATION: IMPLICATIONS FOR PUBLIC PSYCHIATRY

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Robert Wood Johnson Foundation Clinical Scholars Program, David Geffen School of Medicine of the University of California, Los Angeles.

Kristen Eckstrand, M.D., Ph.D.
Department of Psychiatry, University of Pittsburgh Medical Center and Western Psychiatric Institute and Clinic.

Dr. Hurley chaired a workshop addressing medical education competencies on sexual orientation, gender identity, and sex development. The session began by defining terminology for a diverse set of patients, including lesbian, gay, bisexual, and transgender (LGBT) people and those born with differences of sex development (DSD). These populations experience a greater degree of mood and anxiety disorders, suicide, trauma, and substance abuse (1) (2), and the minority stress model describes specific stressors and coping mechanisms that significantly affect these mental health outcomes (3). The workshop highlighted
the valuable role community and public psychiatrists play in supporting the optimal mental health of these populations (4), as well as the significant variability in the training received with respect to these patient populations. During the workshop, educational strategies that optimize care for individuals who are LGBT and/or those born with DSD that are essential to the modern practice of community and public psychiatry were reviewed.

The session introduced the audience to competency-based medical education, specific competencies addressing sexual orientation, gender identity, and sex development, and the work of the Association of American Medical Colleges (AAMC) Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development. Competency-based medical education is an educational framework beginning in medical school to support effective learning for the development of knowledge, skills, attitudes, and behaviors necessary for clinical practice. Achieving and assessing competence extends into postmedical graduate education. The AAMC created an advisory committee in 2012 to promote LGBT and DSD health through advancement of medical education on sexual orientation, gender identity, and sex development. The committee developed competencies specific to these populations and mapped them to the preexisting framework of competency-based medical education.

The AAMC Advisory Committee authored a publication (5) that describes how to 1) integrate these competencies into existing medical curricula, 2) promote the necessary institutional climate change across levels of experience, including faculty and administrators, and 3) assess the achievement of physician competence in these areas. During the workshop, participants were presented with a roadmap to the application of these initiatives, which included the use of hypothetical questions/discussions within existing didactics, cases, and rotations, increasing faculty awareness of relevance to other topics, and an emphasis on understanding the key differences between populations. All individuals have an important role to play in promoting the integration of these issues into curricula and training, and there are opportunities within all modalities to integrate the competencies across domains. Participants were encouraged not to ignore spontaneous opportunities teaching to raise issues pertaining to sex, sexuality, and gender. Given that these competencies map onto the domains used by the Accreditation Council on Graduate Medical Education, session participants highlighted the applicability of this work to psychiatric graduate medical education. The workshop also reviewed the hidden curriculum and tools, specifically including the AAMC Graduate Questionnaire, Human Rights Campaign Foundation’s Healthcare Equality Index, Campus Pride Index, Outlists, SafeZone programs, and other LGBT-specific events as tools for assessing the climate of colleges of medicine and other educational environments.

The session concluded by encouraging participants to download the AAMC publication, Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD: A Resource for Medical Educators, which is available at www.aamc.org/lgbtdsd. (View the Faculty Development Video Series available at www.aamc.org/axis, and you can contribute to and utilize the resources available at MedEdPORTAL: An Integrated Learning Platform, via www.mededportal.org.)

REFERENCES


Supported by the Association of American Medical Colleges Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development. Current and prior members of this Committee are acknowledged for their contribution to this project.

DO YOU HAVE ACCESS TO GUNS?
Tanuja Gandhi, M.D.
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I truly wish that I never had to ask the question in the title, but it is a part of modern-day reality and, therefore, safety assessments in psychiatry. Indeed, it is essential to talk about gun safety, as access to guns has become ubiquitous and firearm-related injuries are a major public health problem (1). The speakers described quite succinctly the challenges faced by clinicians in having the gun safety conversation. The talk highlighted that while as mental health professionals we screen for gun access, easy access to guns remains a reality, with many people probably owning guns for home security and self-defense. While emphasizing the importance of having this conversation (2), the speakers suggested an alternative to the uncomfortable and often difficult “do you have a gun” in your home conversation. That is, by asking open-ended questions inviting a discussion on this topic.

During the workshop, Drs. Soliman and Jain emphasized that “engagement can be a better goal than predetermined outcomes.” The myriad number of ways clinicians could talk about guns with patients and their families surprised me. They presented an “AEIOU” mnemonic-based approach, an excellent tool for residents to ensure a comprehensive safety assessment. “A” stands for “access to weapons,” “E” is “experience
with weapons,” “I” stands for “ideation or intent to carry out an assault,” “O” is for “operational plan on how to access weapons,” and “U” is for “unconcerned with consequences, suicidal, or hopeless.” Furthermore, Dr. Rozel drew our attention to the tendency to focus on removal of guns than the overall safety conversation. He discussed the importance of gun awareness among clinicians in order to obtain better gun use history and open the discussion about “safer storage” of guns (3). Dr. Rozel also noted that “parents often tend to overestimate their gun safety measures at home,” an important issue that hit home with the video of “3-year-old ‘Toby’ opening a gun safe,” which was played during the presentation.

So how do we have effective gun safety conversations? The speakers described the significance of using motivational interviewing techniques to have this conversation with unwilling and resistant patients and their families. The stages of change model can be used to understand the issues around accepting and implementing healthy behaviors in terms of gun safety. Toward the end of the session, Dr. Rozel addressed some of the legal and political challenges that clinicians tend to face while addressing the gun safety issues and the importance of being acquainted with the gun laws of your own state.

In summary, this session offered a new outlook on discussing guns through a motivational interview-based approach. While our efforts to remove guns from the home may not yield successful outcomes in all cases, having an open discussion about gun access, safe storage, and other safety measures would definitely enhance public awareness about the risks and responsibilities that come with gun access and ownership. Psychiatrists are in a unique position to advocate for gun safety and reduce stigmatization of the mentally ill (4).

The comprehensive handout describing “The Gun Talk” is a valuable resource for any mental health professional.

REFERENCES

Pharmacological Advances in the Treatment of Schizophrenia

Javier Ballester, M.D.
Brian A. Frankel, M.D.

Schizophrenia is a devastating worldwide illness that affects approximately 1% of the global population. Despite decades of research, its pathophysiology still remains an enigma, and virtually all neurotransmitter systems have been implicated in the etiology of this disease. Since the discovery of chlorpromazine in 1950, more than 50 different drugs have been developed, revolutionizing the treatment of schizophrenia. So far, these drugs have proven to be effective in the treatment of positive symptoms, but unfortunately the efficacy on negative or cognitive symptoms is still minimal. The second-generation antipsychotics, introduced in the decade of 1990 (not taking into account clozapine, first introduced in 1971), promised to be effective in the treatment of negative symptoms while at the same time reducing the incidence of extrapyramidal symptoms. However they have shown to produce metabolic side effects (diabetes, hyperlipidemia), and large national-funded studies have proven these drugs to be no more effective than typical or first-generation antipsychotics. This panorama has pushed researchers to look for different molecules intended to target negative or cognitive symptoms while at the same time having a more benign spectrum of side effects. The present review focuses on antipsychotic drugs currently in development (3) (Table 1).

DOPAMINE SYSTEM

Phosphodiesterase (PDE) 10A Inhibitors

The PDE enzyme specifically inactivates the intracellular second messengers cAMP and cGMP. Inhibition of PDE 10A results in potentiation of the D1 activity and inhibition of the D2 receptor (4). PDE 10A inhibitors are being evaluated as stand-alone drugs or as augmentation agents. Drugs targeting several members of the PDE family are already successfully introduced to the market, such as those targeting PDE3 (milrinone), PDE4 (roflumilast), or PDE5 (sildenafil). The preferential expression of PDE10A in the striatum has led efforts in investigating their role in diseases such as schizophrenia or Huntington's disease (5). Examples of current clinical trials include AMG579 (phase 2, Amgen) or OMS643762 (still recruiting patients at the time this article was accepted for publication).

D2/D3 Partial Agonist

Cariprazine is a dopamine D3-preferring, D3/D2 receptor partial agonist. Its mechanism of action resembles the one displayed by aripiprazole, but cariprazine has more robust D3 antagonist-partial agonist affinity (6). The D3 receptor is an autoreceptor that appears to control the phasic, but not tonic, activity of dopamine, and it is mainly distributed in limbic areas, the ventral striatum, and the thalamus (7).

5-HT1A/1B Agonist

Eltoprazine is being investigated as a cognitive impairment augmentation therapy for cognitive symptoms of schizophrenia. A clinical trial is currently underway. It is also being evaluated as an antidyskinetic drug in patients treated with l-dopa and as a pro-attentional drug in attention deficit hyperactivity disorder.

l-DOPA

Based on the different affinities of dopamine receptors and on the allegedly cognitive enhancer properties of the DA1 receptor, a clinical trial is being developed to investigate the potential effects of certain doses of l-dopa as an augmentation therapy for negative/cognitive deficits of schizophrenia (4). A meta-analysis published in 2004 has suggested that adding l-dopa might be beneficial for those patients already taking antipsychotic medication (7).

Stephoodine

Stephoodine acts as a D2 antagonist, a D1 agonist, and a 5HT1A agonist and is being hypothesized as a drug effective in positive symptoms (through the D2 receptor), as well as in cognitive symptoms (through the D1 and 5HT1A receptors) (8). There is currently an ongoing clinical trial being performed at the University of Toronto (4).

YKP1358

YKP1358 is a D2/D3/5HT2A antagonist that is currently undergoing phase 2 of clinical study (SK Bio-Pharmaceuticals). Published studies thus far have investigated the binding properties of this drug on D2 receptors in the striatum.

GLUTAMATE SYSTEM

Bitopertin

Bitopertin is a selective inhibitor of the glycine transporter Gly-T-1 that acts by increasing the levels of glycine in the synaptic cleft and hence potentiating the N-methyl-D-aspartate (NMDA) receptor. A phase-2b multicenter study with more than 300 patients was reported in 2010 and showed that bitopertin improved negative symptoms in patients already taking antipsychotics (9).
D-Amino Acid Oxidase Inhibitors (DAAOI)
D-serine and glycine function as co-agonists of the NMDA receptor. DAAO catalyzes the oxidative deamination of these and other D-amino acids. Increasing the levels of these amino acids could trigger the NMDA receptor that might in turn improve negative and positive symptoms (10). There is currently an ongoing clinical trial using a DAAOI as a drug for treatment-resistant schizophrenia (5).

Positive Allosteric Modulator of Metabotropic Glutamate Receptors (mGluR2s)
The mGluRs are G-protein-coupled receptors that can be categorized into three different groups depending on their pre- or post-synaptic localization. Among all the different receptors, mGluR2/3 and mGluR5 are co-localized with NMDA receptors and have been suggested to play a role in the pathophysiology of schizophrenia. In 2012, Addex Therapeutics reported a phase-2a clinical study in which ADX71149 demonstrated effectiveness in patients with residual negative symptoms (11).

NMDA Antagonist
A recent meta-analysis of randomized placebo-controlled trials found that memantine (an NMDA receptor antagonist initially developed for the treatment of Alzheimer's disease) could be beneficial for the treatment of negative and cognitive effects of schizophrenia for those patients already receiving treat-
ment with antipsychotics. However, the authors concluded that these results need to be interpreted carefully because the number of studies in the literature is still low (12). Additionally, a recent comment published in the same journal questioned these results (13).

ACETYLCOLINE SYSTEM

It has been suggested that one of the core cognitive deficits in patients with schizophrenia is an inability to inhibit the processing of irrelevant sensory stimuli, as measured by abnormalities in specific event-related EEG responses such as P50, N100, and the P300 potentials.

Alpha-7 nAChR Agonists

EVP-6124 is a selective CNS penetrant a7nAChR partial agonist that has shown positive and, in some cases, dose-dependent effects on P50, N100, mismatch negativity, and P300-evoked responses, as well as positive effects on domains of non-verbal learning, memory, and executive function, based on a recently published proof of concept study (14). There is currently a phase-3 study (currently recruiting participants) investigating the use of EVP-6124 as an adjunctive pro-cognitive treatment in patients with schizophrenia already receiving chronic, stable antipsychotic therapy (NCT01716975). GTS-21 (DMXB-A) is another agonist at this receptor that has reached phase-3 study (conducted at the University of Florida) and that is currently recruiting participants in another study from the Veterans Administration (NCT00100165) (15).

Muscarinic Agonists

Xanomeline is an M1/M4 muscarinic receptor agonist that has proven efficacy not only in improving cognitive deficits associated with Alzheimer’s-type dementia but also in behavioral tests predictive of antipsychotic activity by virtue of a decrease in dopamine cell firing in the ventral tegmental area. A study published in 2008 showed that those subjects with schizophrenia treated with xanomeline improved in total Brief Psychiatric Rating Scale and total Positive and Negative Syndrome Scale (PANSS) scores and in measures of verbal learning and short-term memory function (16).

SEROTONIN SYSTEM

5HT3 Antagonists

The 5HT3 antagonists (ondansetron, granisetron, tropisetron) are thought to modulate neurotransmitter release in mesolimbic and mesocortical dopamine neurons, but the exact mechanism of action is still unclear. A recent meta-analysis has shown that the use of 5HT3 antagonists might be beneficial as an add-on therapy for those patients with schizophrenia already stabilized on an antipsychotic (17). Specifically, patients showed a statistically significant improvement in PANSS general scores and on negative scores compared to placebo, with similar side effects reported (17).

HORMONES

Estrogens/Selective Estrogen Receptor Modulators (SERMs)

Numerous findings have pointed to a possible utility of estrogen in schizophrenia. On average, the age at onset is younger and the incidence is greater in males, and unlike males, females experience a second peak incidence after the age of 50. Additionally, premenopausal women experience less negative symptoms and better treatment response than men, and severe symptoms occur more often in the low-estrogen phase of the menstrual cycle. In a recent meta-analysis of four randomized-controlled trials examining estrogen augmentation of antipsychotics, it was found that estrogens were superior to placebo in reducing total symptom severity and positive symptoms (18). Given the long-term risks of estrogen usage, including endometrial hyperplasia and cancer in women and feminization in men, SERMs have been posited as possibly being a better option than estrogens. Evidence for the efficacy of SERMs, however, are not as impressive (19), and fewer studies have been conducted. Currently, there is a phase-1b/2a study being conducted at the University of Indiana in conjunction with Eli Lilly investigating the use of LY500307, a selective estrogen beta agonist, in reducing negative and cognitive symptoms (NCT01874756).

Oxytocin

Oxytocin is a neuropeptide secreted by the posterior pituitary that has been well studied for its role in social attachment, behavior, and cognition. In three randomized-controlled trials of patients with schizophrenia, adjunctive intranasal oxytocin significantly reduced PANNS scores compared to placebo. One of these trials found improvement in social cognition, and another found improvement in neurocognition. All three trials, however, had small sample sizes (20). The National Institute of Mental Health is currently recruiting subjects for a study of oxytocin use in children with schizophrenia (NCT01712646).

Drs. Ballester and Frankel are both fourth-year residents in the Department of Psychiatry, Yale University, New Haven, Conn.

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Paranoid Personality Disorder

Amy Vyas, M.D.
Madiha Khan, M.D.

Since the time of Kraepelin, a pervasive and unwarranted mistrust of others has been considered a cardinal feature of paranoid personality disorder. Other features that have been described prominently in the literature are sensitivity to criticism, aggressiveness, rigidity, hypervigilance, and an excessive need for autonomy. We present the case of a patient with most of these classic characteristics that represent key components of the diagnostic criteria for paranoid personality disorder in the DSM-5 (Table 1).

CASE

“Mr. J” is a 65-year-old Caucasian man with no prior psychiatric history, history of chronic obstructive pulmonary disease, and a benign vocal cord lesion. He was brought to the emergency department by police for concerns of psychosis and delusions. Records stated that the “patient is delusional, in a state of acute psychosis, easily agitated.”

Upon initial contact with the emergency department psychiatrist, the patient reported feeling that the staff at the hospital were against him. He reported never having seen a psychiatrist before, although he reported having been on a selective serotonin reuptake inhibitor in the past to help equilibrate his “serotonin levels.” He did not fully cooperate with the interview, was guarded and evasive, and often said, “You don’t need to know.” His mental status examination was notable for disorganized process and paranoid content. During the latter part of the assessment, the patient became loud, intrusive, and agitated. He pounded his cane on the ground and threw it to the floor in a threatening manner.

He requested discharge but would not elaborate on a safe discharge plan nor allow his family to be contacted. He declined voluntary inpatient hospitalization and threatened to sue the emergency department psychiatrist if he were to be involuntarily committed.

The patient was involuntarily admitted to the inpatient unit due to aggressive behavior and risk of harm to others. He remained at the hospital for 15 days. During the initial part of his stay, he was easily agitated, displayed verbal aggression, exhibited paranoia, and refused treatment. He would not engage in conversation with most team members, with the exception of a medical student on the team to whom he reported paranoid ideations about various family members and friends. He was suspicious and mistrustful of the treatment providers and mostly focused his conversations on legal issues. He claimed that he was being held in the hospital illegally and threatened to sue the providers for holding him against his will.

He reported being estranged from most of his family since his wife’s death. He stated that his daughters “did not understand him.” Very reluctantly, he gave permission for one of his daughters to be contacted. His daughter described him as always being an “eccentric and distrustful person.” She described incidents in the past in which he had held beliefs about others “being against” him, resulting in isolation from friends and family. She described him as someone who “often held grudges and for a long time.” She reported a chronic pattern of behavioral problems, aggression, strained relationships, and suspicious thinking. She also described his behavior as worsening recently. Additionally, the patient reported increasing use of cannabis and synthetic cannabinoids over the past few years; indeed,

### TABLE 1. DSM-5 Criteria for Paranoid Personality Disorder

<table>
<thead>
<tr>
<th>A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:</th>
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<td>1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.</td>
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<tr>
<td>2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.</td>
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<tr>
<td>3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.</td>
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<tr>
<td>4. Reads hidden demeaning or threatening meanings into benign remarks or events.</td>
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<tr>
<td>5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).</td>
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<tr>
<td>6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.</td>
</tr>
<tr>
<td>7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.</td>
</tr>
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</table>

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or a depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

* If criteria are met prior to the onset of schizophrenia, add “premorbid,” i.e., “paranoid personality disorder (premorbid). Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright ©2013). American Psychiatric Association. All Rights Reserved.
the frankly disorganized thought process he displayed during his emergency department assessment and the initial part of his hospital stay was most consistent with intoxication in that it resolved early on without medication, but his paranoia lingered.

Mr. J continued to refuse treatment, and thus a medication commitment was pursued. Following court approval, he was started on olanzapine (10 mg q.h.s.) and gradually uptitrated (to 20 mg q.h.s.). He subsequently remained medication compliant and tolerated the medication well while showing gradual improvement in his disorganized thought process. Initially, he displayed angry outbursts that precluded meaningful discussions about discharge planning. However, he eventually became calm enough to develop a safe discharge plan. At the time of discharge, he was calm and cooperative and denied all psychiatric symptoms. Nevertheless, he continued to be mistrustful of providers and continued to report paranoid ideations about family members. The patient’s final diagnosis was cannabis-induced psychosis with intoxication, with underlying paranoid personality disorder.

DISCUSSION

Paranoid personality disorder, though a chronic condition, is not commonly encountered in the clinical setting. The prevalence of paranoid personality disorder indicates that it is among the most common personality disorders, with recent estimates varying from 2.4% (1) to 4.41% (2). In 1921, Kraepelin first proposed three distinct presentations of paranoia that correspond to the diagnoses of schizophrenia, delusional disorder, and paranoid personality disorder (3). However, Kraepelin considered paranoid personality disorder phenomena to represent part of the schizophrenia spectrum, since these patients often later decompensated into frank psychosis (4). Paranoid personality disorder first appeared in DSM-III in 1980.

Paranoid personality disorder is a statistically significant predictor of disability (2) and is also associated with both violence and criminal behavior (5). Reports of comorbidities have varied widely, with panic disorder with agoraphobia recognized as a common comorbid psychiatric disorder (6). Regarding personality disorder pathology, schizotypal, narcissistic, borderline, and avoidant personality disorder traits are commonly comorbid with paranoid personality disorder, and indeed there is some overlap of diagnostic criteria with those disorders and paranoid personality disorder (6).

Paranoia in paranoid personality disorder does not represent delusional psychosis but rather a “distinctly paranoid cognitive style” (7). Individuals with paranoid personality disorder rarely seek treatment on their own accord but may do so at the behest of family or coworkers (8). The nature of their disturbance is not conducive to perceiving their own pathology, and their treatment may ultimately be burdened by their mistrust of physicians.

Because paranoid personality disorder patients are unlikely to seek or remain in psychiatric care, relevant treatments for this disorder have received less research relative to those of similarly prevalent personality disorders. There are no Food and Drug Administration-approved medications for paranoid personality disorder. A Cochrane Review of pharmacological interventions for paranoid personality disorder is currently underway (4). Much of the published literature takes the form of case studies or case series. One such case report found cognitive analytic therapy to be an effective intervention (8), while another suggested that in the short-term, the use of antipsychotics in patients with paranoid personality disorder was associated with improved Clinical Global Impression scores (9). Cognitive therapy has been endorsed as a useful technique for the general psychiatrist (10). Recommended approaches to psychodynamic psychotherapy for these patients include working toward helping patients “shift their perceptions of the origin of their problems from an external locus to an internal one” (8), while maintaining special attention to management of boundaries, maintenance of the therapeutic alliance, safety, and awareness of how the therapy may be integrated into the patient’s paranoid stance. In the case of the patient feeling paranoid toward the therapist, aiding the patient in saving face and maintaining a sense of control may be particularly important in preventing escalation to violence toward the therapist (8).

In the above case, our patient presented as paranoid and lacking insight; collateral was required to establish the chronic course of his paranoia. He had, until late in his life, not been involved in psychiatric care. Interestingly, he did seek evaluation for memory problems (fearing he had dementia) sometime after discharge; findings were not consistent with dementia, and he expressed that his chronic cannabis exposure may be the cause of his cognitive problems.

CONCLUSIONS

The diagnosis of paranoid personality disorder involves rigorous assessment and may require collateral. Given the condition’s prevalence, the disabling nature of the illness, and the potential for loss of quality of life for the patient, as well as violence toward others, evidence-based treatments for optimal management of paranoid personality disorder may be effective treatment modalities.

KEY POINTS/CLINICAL PEARLS

- Paranoid personality disorder is one of the more prevalent personality disorders but not commonly encountered in clinical settings.
- Paranoid personality disorder is a predictor of disability and is associated with violence and criminal behavior.
- There are no Food and Drug Administration-approved medications for paranoid personality disorder.
- Cognitive-behavioral therapy and psychodynamic therapy have been shown to be effective treatment modalities.
disorder have the potential to benefit not only sufferers of paranoid personality disorder but society as well. Future research is needed to further explore potential treatments for this prevalent and debilitating condition.

Dr. Vyas is a first-year fellow, and Dr. Khan is a fourth-year resident in the Menninger Department of Psychiatry, Baylor College of Medicine, Houston.

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We present the case of a profoundly intellectually disabled, nonverbal woman in her 40s with Down syndrome who experienced life-long severe self-injurious behavior (SIB), including chronic eye-gouging that resulted in blindness. She had been unsuccessfully treated for SIB with decades of polypharmacy, including neuroleptics, antidepressants, and anxiolytics, but ultimately showed complete resolution of SIB with naltrexone therapy.

CASE

“Ms. B” carried a diagnosis of Down syndrome. She was nonverbal, and while formal neuropsychological testing was not available, the evidence from history and clinical interview suggested profound intellectual disability. In addition to intellectual disability, the patient suffered from severe violent outbursts and SIB that had begun in early childhood. Of particular importance, her SIB took the form of chronic eye-rubbing and gouging. This symptom persisted for decades, was recalcitrant to treatment, and resulted in the patient blinding herself from chronic abrasion and infection. Aggressive and violent outbursts were common in her younger years but improved with age and neuroleptic management. She was first reported to have been seen by a psychiatric practitioner at 30 years old; however, numerous caregiver transfers and a complex psychosocial history resulted in considerable uncertainty about many historical details.

At the time of presentation, Ms. B was in the care of her foster mother. Details of why she was in foster care were vague; however, it was reported to be related to her intense special care needs rather than specific issues in the household of her biological family. Her foster mother was experienced with caring for intellectually disabled individuals and was an excellent supporter. Ms. B received nursing assistance for medication management and activities of daily living. She lived at home with her foster mother.

No specific family history of mental illness was known to providers. There was no known history of early-life trauma or neglect, though this cannot be known definitively, since the patient had undergone numerous housing and care transfers. To our knowledge, she had not been psychiatrically hospitalized, and despite chronic eye-gouging SIB, there was no known history of suicidality. She carried no other primary psychiatric diagnoses. Down syndrome had been confirmed early in life by genetic testing. There was no suspicion of any history of substance use, legal history, or homelessness.

At presentation, Ms. B was being treated with escitalopram (10 mg), paliperidone (3 mg daily), and buspirone (15 mg b.i.d.). The rational for this medication regimen was reported by her foster mother to be unclear. A primary concern had been aggression and self-injury. Despite long-term polypharmacy, she persisted in having constant, daily self-injurious eye rubbing and gouging that resulted in frequent infection. Aggressive behaviors, however, were well controlled on this regimen at the time, though no change in medication had occurred in recent history, and thus it is unknown whether this abatement in aggression was due to the natural history of her condition or medications.

Ms. B presented with her foster mother to an outpatient community care clinic for general medication management. After a few introductory appointments, her foster mother’s primary concern remained self-injurious behaviors, as well as unnecessary polypharmacy. Given the lack of SIB improvement despite numerous neuroleptics, anxiolytics, antidepressants, and other medication families, naltrexone was initiated at 25 mg and quickly titrated to 50 mg. Within 1 month of medication initiation, SIB had ceased entirely. The patient had no further eye gouging and no subsequent infections of the eye. No other SIBs were present. Escitalopram was decreased and discontinued with no adverse effects on mood, anxiety, SIB, aggression, or behavioral symptoms; then, buspirone was tapered and discontinued over 2 months without any adverse effects. The patient remained on paliperidone (3 mg) and naltrexone with persistent resolution in her baseline severe SIB and continued resolution of aggression. There were no side effects of naltrexone pharmacotherapy per her foster mother’s report, and none were apparent on examination.

DISCUSSION

This case evidences the potential severity of SIBs in adults with intellectual disability. Naltrexone was chosen in this case due to failure of approved medications commonly used for SIB in intellectual disability. The risks and benefits were carefully weighed and, in particular, given the seriousness of this form of self-injury, as well as the long-term risks of unnecessary polypharmacy, naltrexone was considered a safe and low-risk option. The options, risks, and benefits were discussed at length with the patient’s foster mother.

Naltrexone was considered with full awareness of the fact that it is not a Food and Drug Administration (FDA)-ap-
proved medication and with attention to the large number of anecdotal reports in the literature suggesting safety and potential efficacy in a range of forms of self-injurious populations. Evidence of naltrexone efficacy in SIB in the heterogeneous population of intellectually disabled adults is limited with few double-blind placebo-controlled studies. As a result of limited data, for example, a recent Cochrane Review concluded that recommendations could not be made for use of naltrexone for SIB in intellectual disability (1). Notably, three of the albeit small studies suggested clinical benefits. Safety, efficacy, dosing, and population variability in the use of naltrexone for SIB in intellectual disability requires further empirical study (1).

Despite limited data, naltrexone is frequently used off-label in self-injuring intellectual disabled patients due to the high side-effect burden of many of the other medications often utilized. Aripiprazole and risperidone are approved for behavioral treatment in autism, but there is little formal guidance for SIB management in these populations.

SIB pathophysiology is not well understood. Dysregulation of a number of neurotransmitters has been linked with SIB, including dopamine, endogenous opioid, serotonin, glutamate, and GABA systems (2). For example, the caudate nucleus, which is heavily innervated by dopaminergic neurons, has been shown to be abnormal in cases of SIB associated with a wide range of neurodevelopmental conditions (3). Glutamate works in a regulatory relationship with dopamine between the basal ganglia and prefrontal cortex and has been implicated in animal studies of SIB (4).

Endogenous opioid theories of SIB are particularly relevant in the case of naltrexone. For example, one theory speculates that endogenous opioids stimulated by pain result in down-regulation of receptors culminating in the phenomenon of “pain addiction” (2, 5). SIB may be related to hypothalamic-pituitary-adrenal dysfunction that involves dysfunction of the stress-related substance proopiomelanocortin, which is an endogenous opioid precursor. Naltrexone, a centrally acting opioid blocker that is FDA-approved for alcohol and opioid dependence, may act on this system to provide relief of self-injurious urges (6). Further exploration of SIB in intellectual disability is clearly warranted. This report adds to the evidence of potential benefit for naltrexone in severe SIB in intellectually disabled adults.

Dr. Hauptman is a fourth-year resident in the Child and Adolescent Psychiatry Department at New York University, New York.

The author thanks Virginia Garay, M.D., who is a practicing psychiatrist in Austin, Tex.

**KEY POINTS/CLINICAL PEARLS**

- Self-injury in a range of neurodevelopmental disabilities is not uncommon.
- Aripiprazole and risperidone are Food and Drug Administration (FDA)-approved for treatment of behavioral issues in autism, but many other medications are often used off-label for behavioral management due to side-effect burden and variable efficacy.
- Naltrexone, while not FDA-approved for self-injury in intellectual disability and neurodevelopmental disabilities, has shown some effectiveness in a range of reports. Further research is warranted. The lower side-effect profile compared with neuroleptics may warrant its consideration in treatment-refractory and severe self-injurious behaviors in intellectually disabled individuals.

**REFERENCES**

Before I ever stepped into a VA, long before I opened a medical textbook, I met my first psychiatric patient in Septimus Warren Smith. In *Mrs. Dalloway*, Virginia Woolf, took me deep into the terrifying and lonely experience of posttraumatic stress disorder (PTSD) through Septimus, a World War I veteran. A minor character in the book, Septimus has a profound impact with his brief appearances throughout the text, in his relationships with his wife and doctors, and ultimately with his self-inflicted death. As suicide continues to plague so many of our veterans, perhaps we can learn something from Septimus in the way we approach our patients with PTSD.

“He began, very cautiously, to open his eyes, to see whether a gramophone was really there. But real things—real things were too exciting. He must be cautious. He would not go mad...” (1, p. 119)

Septimus exhibits many symptoms of PTSD, in his time known as “shell shock.” After witnessing the death of his friend Evans in combat, Septimus comes home only to suffer from flashbacks, feelings of guilt and fear, an exaggerated startle response, and experiences of depersonalization and derealization. His wife, Rezia, searches fruitlessly for help from their physician, Dr. Holmes, who repeatedly tells her that nothing is wrong. She then consults Sir Williams, who acknowledges Septimus’ illness and suggests 6-months rest in the country. Septimus, however, is left out of these discussions. Finding himself without a voice and seeing no end in his suffering, he throws himself out the window of their home, and thus ends his life.

“So he was deserted. The whole world was clamouring: Kill yourself, kill yourself, for our sakes.” (1, p. 79)

A couple of years ago, I heard a code blue called to our psychiatric unit. The patient was suffering in his own world filled with combat-related trauma and loss. Like Dr. Holmes and Sir Williams, I was focused on the diagnosis and treatment, and I failed to simply listen and try to understand.

“Men killed in battle were thus saluted, and Septimus had been through the War.” (1, p. 126)

We have come a long way in our recognition, understanding, and treatment of PTSD, yet those who suffer too often fall victim to the fate of Septimus. While we attempt to intervene, let us never lose sight of the individual. The fatalities of war don’t stop when our soldiers come home; the difference is, on the home front, now we have a chance to be there, bear witness to their experience, and hopefully walk down the path of healing with them.

Dr. Chang is a third-year resident in the Department of Psychiatry, Wayne State University/Detroit Medical Center, Detroit.

**REFERENCE**

Call for Applications to Join the 2016 Editorial Board

The American Journal of Psychiatry—Residents’ Journal is now accepting applications to join the 2016-2017 Editorial Board for the following positions:

**SENIOR DEPUTY EDITOR POSITION 2016**

**Job Description/Responsibilities**
- Frequent correspondence with AJP-Residents’ Journal Editorial Board and AJP professional editorial staff.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with AJP editorial staff to prepare accepted manuscripts for publication to ensure clarity, conciseness, and conformity with AJP style guidelines.
- Coordinate selection of book review authors and distribution of books with AJP professional editorial staff.
- Collaborate with the Editor-in-Chief in selecting the 2017 Senior Deputy Editor, Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10–15 hours per week.

**Requirements**
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2016, or a fellow in an ACGME fellowship in July 2016.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2017. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2017, he or she would need to formally apply for the position at that time.

**MEDIA EDITOR POSITION 2016**

**Job Description/Responsibilities**
- Manage our Twitter and Facebook accounts
- Oversee podcasts
- We are open to many suggestions within reason
- Collaborate with the associate editors to decide on content
- Collaborate with Senior Deputy Editor, Deputy Editor, and Editor-in-Chief to develop innovative ideas for the Journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

**ASSOCIATE EDITOR POSITIONS 2016**

**(two positions available)**

**Job Description/Responsibilities**
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Manage the Test Your Knowledge questions on Facebook and work closely with authors in developing Board-style review questions for the Test Your Knowledge section.
- Keep our Twitter and Facebook accounts active and up to date.
- Collaborate with the Senior Deputy Editor, Deputy Editor, and Editor-in-Chief to develop innovative ideas for the Journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

**Requirements**
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2016, or a fellow in an ACGME fellowship in July 2016.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2017. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2017, he or she would need to formally apply for the position at that time.

For all positions, applicants should email a CV and personal statement of up to 750 words describing their a bit about who they, their reasons for applying, as well as any ideas for journal development to Katherine.Pier@mssm.edu. The deadline for applications is 3/2/2016.
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 Hun Millard, M.D., M.A., Deputy Editor (hun.millard@yale.edu).

JANUARY DEADLINES

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| APA/Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship | APA and SAMHSA | Section Criteria: Commitment to serve ethnic minority populations; awareness of the importance of culture in mental health; interest in the interrelationship between mental health/illness and transcultural factors; and demonstrated leadership abilities. | • APA Resident-Fellow Member  
• At least PGY 2  
• U.S. citizen or a permanent resident | Tatiana Claridad: tclaridad@psych.org | http://www.psychiatry.org/residents-medical-students/residents/awards-and-competitions/minority-fellowships |
| Deadline: January 30, 2016 | | | | | |
| APA/SAMHSA Substance Abuse Fellowship | APA and SAMHSA | Selection Criteria: Commitment to serve underrepresented populations; demonstrated leadership abilities; and interest in the interrelationship between mental health/illness and transcultural factors. | • APA Resident-Fellow Member  
• PGY 5  
• U.S. citizen or a permanent resident | Tatiana Claridad: tclaridad@psych.org | http://www.psychiatry.org/residents-medical-students/residents/awards-and-competitions/minority-fellowships |
| Deadline: January 30, 2016 | | | | | |
| APA Diversity Leadership Fellowship | APA | 2-year commitment during which fellows attend the annual APA September Council meetings, the APA Annual Meeting, and when funding allows the Mental Health Services Conference. Fellows participate in workshop presentations at the APA meetings, are exposed to training opportunities that develop psychiatry leaders with an interest in improving the quality of mental health care for diverse and underserved populations. | • APA Resident-Fellow Member  
• PGY 2 | Tatiana Claridad: tclaridad@psych.org | http://www.psychiatry.org/residents-medical-students/residents/awards-and-competitions/minority-fellowships |
| Deadline: January 30, 2016 | | | | | |

FEBRUARY DEADLINE

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<tr>
<td>Resident Recognition Award</td>
<td>APA</td>
<td>Presented annually to outstanding psychiatry residents or fellows from each department or institution who exemplifies one or more APA values (compassion, leadership, community service, political action, clinical excellence).</td>
<td>• APA Resident-Fellow Member in good standing in their training program.</td>
<td>Claire Van Wagner: <a href="mailto:cvanwagner@psych.org">cvanwagner@psych.org</a></td>
<td><a href="http://psychiatry.org/psychiatrists/awards-leadership-opportunities/awards/resident-recognition-award">http://psychiatry.org/psychiatrists/awards-leadership-opportunities/awards/resident-recognition-award</a></td>
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MARCH DEADLINE

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<td>The Klingenstein Third Generation Foundation (KTGF) Fellowship Program</td>
<td>KTGF</td>
<td>This award supports research grants to post-doctoral investigators at esteemed American medical institutions. The foundation considers proposals for research projects in the field of child and adolescent ADHD, child and adolescent depression, or access to care.</td>
<td>• Post-doctoral investigator holding a Ph.D. and/or M.D. who has completed all clinical training.</td>
<td><a href="mailto:info@ktgf.org">info@ktgf.org</a></td>
<td><a href="http://ktgf.org/fellowship_prog.html">http://ktgf.org/fellowship_prog.html</a></td>
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<td>Deadline: March 1, 2016 (for complete application)</td>
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(*Nomination for the fellowship are due January 8, 2016.*)
Author Information for The Residents’ Journal Submissions

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The Residents’ Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

To submit a manuscript, please visit http://mc.manuscriptcentral.com/appi-ajp, and select a manuscript type for AJP Residents’ Journal.

1. Commentary: Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.

2. History of Psychiatry: Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.

3. Treatment in Psychiatry: This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article’s content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

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.

5. Original Research: Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

6. Review Article: A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

7. Drug Review: A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

8. Letters to the Editor: Limited to 250 words (including 3 references) and three authors. Comments on articles published in The Residents’ Journal will be considered for publication if received within 1 month of publication of the original article.


Abstracts: Articles should not include an abstract.

Upcoming Themes

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

Integrated Care/ Mental Health Care Delivery
If you have a submission related to this theme, contact the Section Editor
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Psychiatry, Ethics, and the Law
If you have a submission related to this theme, contact the Section Editor
Jennifer Harris, M.D. (Jennifer.Harris@utsouthwestern.edu)

Addiction Psychiatry
If you have a submission related to this theme, contact the Section Editor
Rachel Katz, M.D. (rachel.katz@yale.edu)

*If you are interested in serving as a Guest Section Editor for the Residents’ Journal, please send your CV, and include your ideas for topics, to Rajiv Radhakrishnan, M.B.B.S., M.D., Editor-in-Chief (rajiv.radhakrishnan@yale.edu).