The Residents' JOURNAL

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Inside

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In This Issue

Resident Physician Writing and Publishing

Joseph M. Cerimele, M.D.
Editor-in-Chief

In this issue, we give particular attention to resident physician writing and publishing. Anna Yusim, M.D., a former Issue Editor and multi-contributor to the Residents' Journal, addresses the mechanics of writing as a resident physician. Also in this issue, Misty Charissa Richards, M.S., a medical student researcher, and Michael Choi, M.D., a psychiatry house officer, report on the stigma of schizophrenia and how it affects mental healthcare at both the patient and physician levels. Finally, a new feature, Treatment in Psychiatry, focuses on a common clinical scenario encountered by residents.

Editorial

Joseph M. Cerimele, M.D.
Editor-in-Chief

Starting this month, I will begin a 1-year term as Editor-in-Chief of the Residents' Journal. I am a third-year resident at Mount Sinai School of Medicine, New York, and worked as the Issue Editor for the February 2010 issue. I am excited about serving in this role and would like to invite resident physicians to e-mail me comments and questions about the Journal. Sarah Fayad, M.D., a third-year resident at the University of Florida College of Medicine, Gainesville, Fla., will serve as Associate Editor, a newly created position. She will oversee the decision making on all unsolicited submissions.

The Residents' Journal provides an opportunity for previously unpublished residents to learn how to write for a medical journal, and the Journal's role of editing and publishing residents' manuscripts is important. For instance, Lee Robinson, M.D., wrote his first article several months ago and submitted it to the Residents' Journal. The article was accepted and published (1), and he is now looking forward to submitting a second manuscript to a peer-reviewed journal.

We plan to highlight young physicians' experiences with learning the process of writing and publishing in two ways. First, published articles by first-time authors may be emphasized in a New Author series. In this series, we will ask new authors to briefly (in one paragraph) describe their experience with writing (e.g., idea development, the writing process, how much time the article took to write) and submitting (e.g., navigating Manuscript Central, responding to editorial requests) a manuscript. Second, we will invite resident physician-researchers to describe how they learned the writing and publishing process and to summarize their recently published manuscripts.

Additionally, many residents have reported enjoying the Treatment in Psychiatry and Clinical Case Conference articles, and we plan to include more of these article types.

Finally, the present issue includes Author Instructions for all article types as well as upcoming issue themes. Consider submitting a manuscript to the Residents' Journal to learn the basics of publishing and to ensure continued success of the Journal.

Address correspondence to Dr. Cerimele at joseph.cerimele@mssm.edu.

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Publishing as a Resident

Anna Yusim, M.D.
Columbia University Medical Center, New York

To Publish or Not to Publish?

Publishing as a resident is both rewarding and challenging. The rewards include the opportunity to develop and share an idea with colleagues, express your creativity, enhance your credentials, and possibly present your work at a national or international conference. The challenges include lack of time, funding and mentorship. In residency programs with long hours, heavy call schedules, and high caseloads, residents are frequently faced with the choice of spending their precious little free moments working on a manuscript, devoting time to friends and family, catching up on much-needed rest and exercise, or preparing for a case conference the next day. If the resident is not prone to masochistic workaholic tendencies and overcommitment, he or she is unlikely to choose the manuscript, unless it happens to be on a topic he or she finds interesting. Thus, one rule for publishing as a resident is to write about what interests you, what you are passionate about, what you find compelling!

If you have come across many compelling topics in residency but find time to be your limiting factor, you are not alone. If the dominant culture of your institution does not encourage and incentivize scholarly activity like publishing, research, and presenting at conferences, it is unlikely that residents will engage in such activities (1–4). Alignment of incentives to encourage resident scholarly activity like publishing has been implemented with success in numerous psychiatry and nonpsychiatry residency programs nationwide (5–8).

My Personal Experience

My own journey of publishing as a resident has entailed many positive experiences, a few negative experiences, and a great deal of learning along the way. I feel fortunate to have had some excellent mentors to guide me, critique my papers, constructively challenge my ideas, provide feedback on multiple drafts, and ultimately help me to publish my work. Writing for publication—a research article, case report, literature review, or commentary—involves long hours and a steep learning curve. After a seemingly endless iteration of drafts as well as critiques from mentors, my papers would slowly take on the shape of a scholarly academic manuscript worthy of publication and sometimes would even be published. My negative experiences in publishing have entailed navigating unfamiliar bureaucratic waters and, by virtue of being a resident, sometimes getting the short end of the stick. In retrospect, it has been through these latter experiences that I learned the most. For example, I once had a faculty member review a manuscript of a small research study I did. This faculty member had some experience with the topic, and I was grateful when he agreed to review the manuscript. When I received his review, I was surprised to learn that he had made himself the first author in return for his feedback. This is an unusual experience, since the majority of mentors with whom I worked have been very gracious, generous, and supportive. However, this example illustrates some of the challenges residents may encounter in the academic publishing process. I wish I could offer words of wisdom on how to conclusively and definitively avoid such experiences, but it is often in dealing precisely with these sorts of challenges that we learn and grow the most.

I Don't Have Time to Do Research—Can I Still Publish?

Yes! A research article is only one of many types of manuscripts you can publish. If you come across an interesting and unusual clinical case on one of your rotations, write a **case report**. If you have a patient experience that is particularly meaningful to you and from which you believe other residents and psychiatrists can learn, write an **introspective piece**. If you read a psychiatry-related book that you find intriguing, write a **book review**. If there is a research question that interests you and you are curious as to what evidence-based answers exist in the scientific literature, write up a **literature review** of the subject. These are just a few ideas of manuscripts that do not necessarily involve the time commitment of a full research project.

I've Never Published Before—Where Do I Start?

If you have never published before and are not sure where to start, put together a manuscript and submit it to the Residents' Journal. Instructions for submission can be found at http://mc.manuscriptcentral.com//appi-ajp. The Residents' Journal was created specifically to enable residents without much prior publication

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experience to gain experience by working directly with peers and the editorial staff of *The American Journal of Psychiatry* (AJP). Receiving direct feedback and mentorship from AJP staff editors can be a valuable experience, not only in improving your manuscript but in familiarizing yourself with the publication process, which is knowledge that may prove very useful in your future psychiatry career.

Dr. Yusim completed her residency last month at New York University Medical Center and is a former Issue Editor for the Residents' Journal. During her residency, she published 17 manuscripts in various peer-reviewed journals. She is presently conducting global mental health research at Columbia University Medical Center and starting a private practice. If you have questions about publishing as a resident, contact Dr. Yusim at annayusim@gmail.com.

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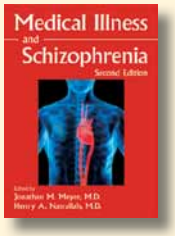

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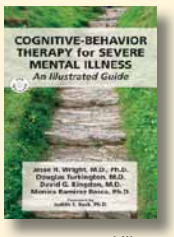

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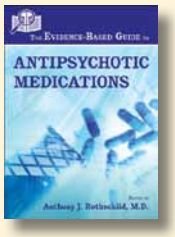

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Power of a Name: The Stigma of "Schizophrenia"

Misty Charissa Richards, M.S.
Albany Medical College, Albany, New York
Michael Choi, M.D.
University of Southern California, Los Angeles

People with psychiatric illnesses bear a disproportionate burden of stigma relative to other medical patients (1). Prejudice and discrimination affect mental healthcare at multiple levels, i.e., patients are less likely to seek care, to be able to access appropriate resources, and to complete treatment once it has been initiated (2). Numerous explanations can be cited for this disparity, but ultimately the stigma results from a fundamental misunderstanding of mental illness that pervades the attitudes of not just the general public but even clinicians and patients themselves.

Schizophrenia has historically been one of the most stigmatized mental illnesses (3). Originally conceptualized as an adolescent-onset form of dementia, it was termed *dementia praecox* by Arnold Pick, in a case report in 1891, before later being popularized by Emil Kraepelin (4). However, it soon became apparent that the constellation of symptoms represented an entity distinct from the general cognitive decline that is the hallmark of dementia. In 1911, Eugen Bleuler coined the term schizophrenia (modern Latin: literally "a splitting of the mind"; German: *schizophrenie*) to emphasize the disorganized thoughts and loosening of associations that are central to the functional impairment of the disease:

"I call dementia praecox 'schizophrenia' because (as I hope to demonstrate) the "splitting" of the different psychic functions is one of its most important characteristics. For the sake of convenience, I use the word in the singular although it is apparent that the group includes several diseases." (4)

Unfortunately, the use of "the word in the singular" for "the sake of convenience" has resulted in the common misperception that schizophrenia is a single homogeneous disease entity. There is now substantial evidence that suggests that the schizophrenia spectrum comprises a heterogeneous collection of related but distinct phenotypes with varying degrees of overlapping pathophysiology, which was apparent to Bleuler even in his time. In fact, it has been calculated that 114 different combinations of symptoms can meet DSM-IV-TR criteria for schizophrenia (5). It is troubling that individuals diagnosed with schizophrenia still tend to be lumped into a single group, stripped of their identity and branded with one particular stereotype. Acceptance and habituation to such a paradigm is how stigma is born, making it that much harder for patients to overcome the dysfunction stemming from this already debilitating set of illnesses.

A second problem with the terminology is that a misunderstanding of the literal translation has resulted in a substantial proportion of people around the world associating schizophrenia with multiple personalities. A study investigating unprompted associations with the word schizophrenia in Germany found that 31.6% of respondents associated it with split personality (6). Another study conducted in Argentina (7) asked participants, "Do people with schizophrenia suffer from multiple personalities?" Findings revealed that 44.4% of the participants replied affirmatively and 34.9% stated that they did not know. A greater proportion of those who confused schizophrenia with dissociative identity disorder also said that, "the majority is dangerous to others or has violent behavior."

Inaccurate diagnostic labeling has been particularly troubling for cultures that communicate with a pictographic writing style. The traditional label for schizophrenia in Japananese had been *seishin bunretsu byo*, which literally translates to mind-split disease. In 2002, the Japanese Society of Neurology and Psychiatry changed the name to *togo shitcho sho* (integration disorder). This simple adjustment resulted in the percentage of cases in which patients were correctly informed of their diagnosis increasing from 36.7% to 69.7% over 3 years, since most Japanese psychiatrists found the new term more suitable when informing patients of the diagnosis (8).

With the 100th anniversary of the label schizophrenia and the advent of DSM-5, perhaps it is time to retire this antiquated, misleading language in favor of a more modern and accurate term. Such a change would not be unprecedented. Thirty years ago, manic depression was renamed bipolar disorder in DSM-III for similar reasons. In fact, a recent proposal from the DSM-5 Deconstructing Psychosis conference was to replace existing psychotic disorders with a general psychosis syndrome. Some of the proposed terms for this umbrella category include salience syndrome (9) (based on a core inability to appropriately respond to stimuli according to their relevance), dopamine dysregulation disorder (10), and integration disorder. Whatever the new term, the benefits of a less stigmatizing label would go beyond simple semantics. Any decrease in stigma will result in tangible differences in the willingness of patients to seek treatment, the likelihood of physicians to communicate the correct diagnosis, and the public's overall understanding and acceptance of psychiatric illnesses in general.

Ms. Richards is a third-year medical student at Albany Medical College, Albany, New York. Dr. Choi is a third-year resident in psychiatry at the University of Southern California, Los Angeles.

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Treatment in Psychiatry

Acute Psychomotor Agitation in a Patient With Schizophrenia and Alcohol Dependence

Sarah M. Fayad, M.D.
University of Florida College of Medicine, Gainesville, Fla.
Joseph M. Cerimele, M.D.
Mount Sinai School of Medicine, New York

How Should This Case be Managed?

A 34-year-old man with undifferentiated schizophrenia and alcohol dependence resumed daily alcohol use of 500 ml–750 ml of vodka 3 weeks prior to presentation in the emergency room. He had been managed in the psychiatry clinic of the city's medical school and had received risperidone (50 mg intramuscularly) every 2 weeks for the last 10 months (last dosage: 2 weeks prior to presentation). The patient was brought to the emergency room by the police after being involved in a fistfight 8 hours prior to presentation at a local shelter. He agreed to a physical examination (which revealed a temperature of 100.2 °F, a heart rate of 116 beats per minute, and blood pressure of 147/91 mm Hg), toxicology evaluation (which was negative for illicit substances and showed an undetectable ethanol level), and wound care (including suturing a 4-cm forearm laceration). A brief mental status examination revealed disorientation (of the date and time of day) and impaired digit span. He subsequently became agitated, yelling that staff members were trying to poison him, and then paced around the emergency room.

Discussion

Managing patients in the emergency room is challenging. The resident physician must quickly obtain and interpret large amounts of data and subsequently initiate appropriate intervention. The present case demonstrates a common yet difficult scenario. The patient is agitated, delusional, and has recently displayed physical violence. Thus, it is critical to determine the etiology of his agitation in order to provide correct treatment.

How do we best arrive at a differential diagnosis for this patient? Initially, one must take a thorough history to uncover previous diagnoses of undifferentiated schizophrenia and alcohol dependence. The patient is known to have resumed daily use of alcohol during the previous 3 weeks, yet his serum alcohol level is undetectable. Alcohol use disorders are common in patients with schizophrenia, with one study estimating that the incidence of alcohol abuse among these patients ranges from 20% to 60% (1). This highlights the importance of screening for alcohol disorders in patients with primary psychotic disorders. Intoxicated patients recently involved in interpersonal violence may experience head trauma, and diagnostic imaging may be warranted in some patients. In the present case, a shelter staff member informed emergency room staff that the patient did not experience head trauma.

Vital sign changes generally suggest diagnoses other than exacerbation of chronic schizophrenia, and the patient would display tachycardia, hypertension, or fever. It is important to consider neuroleptic malignant syndrome in any patient treated with a dopaminergic blocking agent, although the absence of stiffness and a normal creatine phosphokinase value would argue against this diagnosis. Impaired attention may indicate delirium. However, patients in crisis may also have impaired attention (2). Therefore, it is essential to perform further tests of cognition to distinguish between inattention due to anxiety versus impairment caused by delirium (2). One study recommended viewing disorientation to time of day as evidence of delirium until proven otherwise (2). Delirious patients often show disorientation to place and time but rarely to person. Additional findings indicative of delirium include significant impairments in calculation and construction, although assessment of these may be challenging in an emergency setting (2). There is also a difference in the types of hallucinations and delusions experienced in delirium. Visual illusions are more common than hallucinations, and delusions, while often paranoid, are usually plausible in delirium (2). Fluctuations in mental status also suggest delirium.

In the present case, the patient's history, time course, mental status findings, vital signs, and laboratory findings are consistent with delirium, presumably secondary to alcohol withdrawal. With this preliminary diagnosis, appropriate treatment can be initiated, focusing on control of agitation (3). A 1997 study by Mayo-Smith et. al (3) determined that rapid control of agitation reduces the incidence of clinically relevant adverse effects, such as seizures. The authors found sedative-hypnotic drugs to be the most effective agents for managing alcohol withdrawal. Benzodiazepines, specifically, were shown to reduce withdrawal severity as well as incidence of delirium (–4.9 cases per 100 patients; 95% confidence interval [CI]=–9.0 to –0.7, p=0.04) and seizures (–7.7 seizures per 100 patients; 95% CI=–12.0 to –3.5, p=0.003) (3).

Protocol-based therapy involving regular reassessments results in shorter duration of treatment and less benzodiazepine use. The most widely used tool for assessing alcohol withdrawal is the Clinical Institute Withdrawal Assessment for Alcohol–Revised scale (4). Such measures

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may be administered by nursing staff to ensure that appropriate amounts of medications are utilized, thereby minimizing adverse outcomes (seizures, delirium, mortality) and adverse drug effects, such as excess sedation (4).

Additionally, a patient such as the one in the present case should be placed under close observation and should be administered the Clinical Institute Withdrawal Assessment for Alcohol–Revised scale per physician protocol (4). Benzodiazepines are the preferred method of treatment, with the choice of agents guided by duration of activity, rapidity of onset, and cost (3). Dosage should be guided by the severity of symptoms (per Clinical Institute Withdrawal Assessment for Alcohol–Revised criteria), presence of comorbid illness, and history of withdrawal seizures. Neuroleptics, such as haloperidol, may be useful as adjunctive therapy, although caution should be used because neuroleptics can lower seizure threshold.

The patient in the present case did respond to frequent redirection by emergency room staff and ultimately remained calm and quiet. He received intramuscular lorazepam, thiamine, and folic acid. His agitation resolved with lorazepam dosing, but autonomic arousal persisted. Additional lorazepam was dosed, and the patient was subsequently hospitalized for further management of alcohol withdrawal syndrome.

Dr. Fayad is Associate Editor of the Residents' Journal. Dr. Cerimele is Editor-in-Chief of the Residents' Journal.

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In preparation for the Board Examinations, test your knowledge with these questions (answers will appear in the next issue of the Residents' Journal).

1. Which antipsychotic has been shown to be associated with a reduction not only in psychotic symptoms but also with alcohol use among 79% of patients entering remission?

A. Risperidone
B. Thioridazine
C. Haloperidol
D. Clozapine
E. Paliperidone

2. A patient with known alcohol dependence is admitted to the hospital on the medical surgical ward in anticipation of elective surgery. He has no other significant psychiatric history. The psychiatry service is consulted when the patient begins to experience formication. His vital signs are significant only for tachycardia (heart rate of 109 beats per minute). How long has it likely been since the patient's last consumption of alcohol?

A. 6–12 hours
B. 12–24 hours
C. 24–48 hours
D. 48–60 hours
E. 60–72 hours

Author Information for Residents' Journal Submissions

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

2. Treatment in Psychiatry: This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,000 words and 10 references.

3. Clinical Case Conference: A presentation and discussion of an unusual clinical event. Limited to 750 words and five references.

4. Original Research: Reports of novel observations and research. Limited to 1,000 words, 10 references, and two figures.

5. Review Article: A clinically relevant review focused on educating the resident physician. Limited to 1,000 words, 10 references, and one figure.

Abstracts: Articles should not include an abstract.

References: Use reference format of *The American Journal of Psychiatry* (http://ajp.psychiatryonline.org/misc/Authors_Reviewers.dtl).

Upcoming Issue Themes

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OCTOBER
Issue Theme: Specialists in Psychiatry
Issue Editor: Jay Augsburger; augsburj@ohsu.edu (e-mail)

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