

# The American Journal of Psychiatry

## Residents' Journal

January 2018

Volume 13

Issue 1

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# Beauty in Ashes: Reflections on Hidden Resilience After a Hospital Shooting

Mena Mirhom, M.D.

Behind every exquisite thing that existed, there was something tragic.  
—Oscar Wilde

Everything changed in an instant when the 16th floor of Bronx-Lebanon Hospital became a crime scene after a deadly shooting. In the days and weeks after the tragedy we endured, it was as if the air we breathed was heavy with the weight of our grief, hovering over every interaction. Casual small talk in the hallways prompted sincere reflection and a moment of pause before we answered.

In the midst of the pain, there was a hidden beauty. I was hesitant to write this because honest reflection can be almost frightening with a subject this painful. However, as we know all too well, it is often necessary and therapeutic. I needed to write these words because psychiatry does not deal with pain in storage but in process. It's in this very process that we allow ourselves to see the hidden hope and beauty in our pain.

After the tragedy, we saw one another in the truest sense—as a kind of family. In the usual hustle and bustle of our busy days, we followed routines and stayed within boundaries that we cherished. Prior to the tragedy, in our medical culture, members of every discipline had a specific place to sit, and every member of the established hierarchy stayed within well-defined lanes. After the incident,

The chief resident  
and the housekeeper  
embraced to  
comfort one another  
because they felt  
the same pain.

these partitions melted away. The chief resident and the housekeeper embraced to comfort one another because they felt the same pain, in different uniforms. An attending wept with a resident, and both acknowledged their vulnerability. There was an awareness that everyone began to embrace in the hospital: that we were not alone and that there is much more that unites us than divides us. We began to truly see each other. Words like “unity” and “equality” took on new meaning to us because we all realized that tragedy does not discriminate or regard titles. Suddenly, the prospect of losing everything put into perspective the value of the genuine community within our hospital.

Tragedy has a way of forcing a magnifying glass upon our character (1), our fears, and our instincts. Over the course of these weeks, I witnessed trauma produce severe stress (2) but also posttrau-

matic growth and unbelievable kindness (3). There is a resiliency that comes with surviving such tragedy and knowing that you did so together. Now, the hallways are beginning to fill with hope. This hope is not rooted in blind optimism or denial but a sincere experience of the depth of the power of the human spirit. It is the hope of beauty seen in the midst of ashes.

Dr. Mirhom is a second-year psychiatry resident at Bronx-Lebanon Hospital Center Bronx, N.Y.

The author thanks Dr. Panagiota Korenis, Residency Training Director and Vice Chair of Education and Inpatient Psychiatry at Bronx-Lebanon Hospital, for her continued mentorship and support.

Details regarding the *July 2017 tragedy at Bronx-Lebanon Hospital Center* can be viewed online.

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# A Seizure by Any Other Name: Challenges and Long-Term Implications of Psychogenic Nonepileptic Seizures

Jordan Yardain Amar, M.S.  
Rachel Leah Dillinger, B.A.  
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Psychogenic nonepileptic seizures are a spectrum of somatoform disorders that present with clinical signs of seizure-like events without organic etiology. Specifically, psychogenic nonepileptic seizures represent a subtype of conversion disorder in which patients experience involuntary physical events without abnormal or epileptiform activity on EEG monitoring (1). The American Epilepsy Society estimates that 20%–30% of intractable seizures seen at specialist epilepsy clinics are attributable to psychogenic nonepileptic seizures (2). A patient with psychogenic nonepileptic seizures in the United States can expect an average monthly medical cost of \$1,359 (3), adjusted to \$24,313.56/year, per the 2017 consumer price index (4). Given an average duration of 7.2 years before the proper diagnosis is made and an estimated prevalence of 2–33 cases per 100,000, these costs represent a substantial burden on the health care system (5). In this article, we highlight the barriers to care in management of psychogenic nonepileptic seizures and the associated diagnostic challenges. We further posit strategies for addressing these barriers to meet the treatment needs of patients more effectively.

## COMORBIDITY AND PREDISPOSING FACTORS

While there is no clearly discernible cause of this disorder, it is widely thought to be a manifestation of increased psychological burden, since comorbidities such as anxiety (25%), de-

pression (38%–54%), and chronic pain (57%) have been reported (6). However, the most strongly correlated factors appear to be trauma-related. Past history of nonsexual (86.6%) and sexual (30%) trauma has been well documented (7). Many of these psychosocial issues are unknown or unrecognized when a patient presents for initial evaluation, emerging only after a strong therapeutic alliance has been formed between the patient and the provider (8). Importantly, there appears to be no temporal relationship between the trauma and the onset of seizure-like events, with lapses ranging from days to years (9), and thus providers must be mindful of this when obtaining a patient's history.

## STIGMA AND PROVIDER MISUNDERSTANDING

Patients with psychiatric conditions frequently experience feelings of stigmatization at higher rates than those without psychiatric conditions (10). In a subgroup analysis, the odds ratio of perceived stigma among patients with psychogenic nonepileptic seizures compared with those with epilepsy was found to be 4.27, suggesting a fourfold greater odds in an individual's lifetime (11). Contributing factors to perceived stigma include perceptions of weakness and difficulty in clinical management (12). A survey of 143 neurologists in an academic setting indicated that patients whose symptoms were “less explained by organic disease,” including but not limited to psychogenic nonepileptic sei-

zures, were perceived as “very difficult” or “extremely difficult” to treat (13).

However, assumptions of malingering appear to be the most heavily cited source of perceived stigma. In one investigation at a university medical center, as much as 48% of ancillary staff members who cared for patients with psychogenic nonepileptic seizures regularly described these seizures as “fake” and attributable to patients' voluntary control (14). Similarly, as much as 20% of primary care physicians mistake psychogenic nonepileptic seizures for a conscious attempt to deceive for either primary gain (e.g., Munchausen's syndrome) or secondary gain (e.g., malingering) (15). This belief reflects a core misunderstanding among some providers: that patients with psychogenic nonepileptic seizures exert a greater level of control over their events than their epileptic counterparts. In fact, the opposite may be true, as epileptic seizures are commonly accompanied by aura or prodromal signs enabling the patient to recognize the impending event and react accordingly (16). Nonepileptic episodes typically do not involve such warning signs.

In light of this misunderstanding within the health care system, patients frequently report a lack of provider empathy (17). Empathy levels shown by health care providers have been found to affect both the quality of care and treatment outcomes in numerous pathologies (18). In our review of the literature, we found no studies that directly assessed the impact of provider empathy on patients with psychogenic nonepileptic

seizures. However, it stands to reason that provider education, both formal and informal, may improve empathy and overall patient outcomes.

## DIAGNOSTIC CHALLENGES AND THE RULE OF 10S

Epilepsy and psychogenic nonepileptic seizures are not mutually exclusive disease processes (19). LaFrance and Benbadis (20) were the first to report that 10% of epilepsy patients experience comorbid psychogenic nonepileptic seizures, while, similarly, 10% of patients with psychogenic nonepileptic seizures have comorbid epilepsy. Epileptologists colloquially refer to these results as the “rule of 10s.” However, more recent investigations suggest that the true prevalence of comorbidity may be as high as 35%–50% (20). This overlap makes clinical distinction more challenging. Several differences in presentation between epileptic and nonepileptic seizures have been noted across the literature (21, 22). These findings are summarized in Table 1. Given the variability in the presentation of both conditions, the International League Against Epilepsy recommends the use of clinical characteristics as guides to diagnosis, rather than absolute qualifiers (23). Nevertheless, in one survey of physicians in an academic hospital, 62% of respondents felt that they could differentiate psychogenic nonepileptic seizures from epileptic seizures purely on clinical presentation (24). Such limited diagnostic strategy may further delay correct diagnosis and access to care.

Numerous investigators have found utility in physical examination techniques, such as the Hand Drop Test and Hoover’s sign, to differentiate disorders of hypoactivity (namely, catatonia versus pseudoparalysis) (25). Psychogenic nonepileptic seizures and epilepsy are both disorders of hyperactivity; however, in our review of the literature, we found no clinical examination that reliably differentiated them.

Anecdotally, withdrawal to noxious stimuli, such as ammonia capsules (“smelling salts”), has been suggested to be a useful technique in some hospital settings, but in our review of the literature

**TABLE 1. Clinical Distinction Between Epileptic and Psychogenic Nonepileptic Events**

Demographic Characteristics and Clinical Indications	Epileptic Seizures	Psychogenic Nonepileptic Seizures
Age at onset (years)	Bimodal: most common among children and adolescents	All ages, but most common among individuals aged 20–35
Gender	1:1	3:1 in favor of females
Motor activity	Bilateral, stereotyped, synchronous movements	Asynchronous, commonly involves lateral (“side-to-side”) movements and pelvic thrusting
Urinary incontinence	Common	Uncommon
Duration	2–3 minutes	Often prolonged more than 3 minutes
Fatigability	Rare	Common
Sequelae	Tongue biting, head trauma, nonbracing trauma	Braced trauma
Amnesia	Common	Variable, nondefinitive
Prolonged ictal atonia	Very rare	May be present
Postictal symptoms	Headache common, usually drowsy, confused	Headache rare, often awake and reoriented quickly
Eyes	Usually open	Often closed, with forced eye closure suggesting psychogenic nonepileptic seizures
Vocalization	Uncommon	May be present
Autonomic signs	Cyanosis, tachycardia common with major convulsions	Uncommon

we found only one case series to support efficacy of this evaluation (26). Moreover, clinicians should be cautioned against attempting this technique with a patient with unknown pulmonary history, as it may trigger exacerbation of underlying respiratory conditions (e.g., asthma, emphysema). Of the induction techniques, verbal suggestion appears to be the most consistent. In one investigation of patients with confirmed psychogenic nonepileptic seizures, clinician suggestion of a “seizure” evoked an episode in 54% of patients (27). This technique is highly reliant on provider skill. Furthermore, inductive methods have drawn significant criticism for misleading or deceiving patients, as they may strain the patient-provider relationship (28).

Correct diagnosis remains dependent on secondary testing. In 96% of tonic-clonic seizures and 60% of complex partial seizures, serum prolactin levels increase more than three times the upper limit of the normal range within 20 minutes of onset (29). Still, lack of prolactin elevation is not diagnostic of psychogenic nonepileptic seizures, since levels may remain within normal limits following frontal lobe seizures and simple partial seizures (30). Randomized trials of patients assigned to video EEG monitoring consistently show both positive predictive value and negative predictive value greater than 90% for psychogenic nonepileptic seizures (31). Accordingly, 24-hour video EEG remains the gold standard for diagnosis of psychogenic nonepileptic



seizures, as endorsed by both the International League Against Epilepsy and the American Psychiatric Association. The presence of physical seizure-like activity without the presence of epileptiform or ictal discharge on video EEG is a positive result. However, given that video EEG is available only at specialized (tertiary) centers, it remains an expensive option with somewhat limited availability.

## **APPROPRIATE TREATMENT MODALITIES: A PATIENT-CENTERED APPROACH**

Proper treatment of psychogenic nonepileptic seizures necessitates a strong patient-provider relationship. Early psychoeducation, within 4 weeks of diagnosis, has been shown to improve performance on the Work and Social Adjustment Scale and to reduce seizure-related emergency department visits (32). Conversely, delays in psychiatric intervention are associated with poorer working memory and executive function (33). The key to establishing appropriate care is presenting the diagnosis to the patient and his or her family in a nonjudgmental, empathetic manner, while treating the patient with cognitive-behavioral therapy. With this approach, patients are approximately three times more likely to experience remission of their symptoms within 3 months of starting treatment (34). However, the inverse is also true: some patients will experience exacerbation of symptoms after their diagnosis is revealed, and premature discontinuation of neurologic follow-up may lead to resistance to accepting the diagnosis and worsening of symptoms (35).

Decisions regarding antiepileptic drugs are equally challenging. The majority of patients with psychogenic nonepileptic seizures are prescribed long-term (1 year or longer) antiepileptic drug therapy prior to receiving the correct diagnosis, exposing them to unnecessary adverse effects. Furthermore, prolonged nonepileptic events (>5 minutes) are often mistaken for status epilepticus. These patients are at risk for intubation and medically induced coma (36).

In evaluating the efficacy of antiepileptic drug therapy, a lack of response is the most common “red flag” for identi-

## **KEY POINTS/CLINICAL PEARLS**

- Clinically, nonepileptic events can best be differentiated from epileptic seizures by asynchronous movements, lack of tongue biting, and minimal postictal changes.
- While no examination finding allows for definitive diagnosis, verbal suggestion is the most reliable, although it may hinder patient trust.
- Video EEG monitoring is the gold standard for diagnosis, and patients likely benefit from early referral.
- Early psychiatric intervention, in the context of multidisciplinary care, leads to improved long-term outcomes in patients with psychogenic nonepileptic seizures, who already face significant provider misunderstanding and stigma.

fying psychogenic nonepileptic seizures and determining the need for referral to a tertiary epilepsy center for video EEG monitoring (37). Additionally, there is an associated placebo effect between psychogenic nonepileptic seizures and antiepileptic drugs. One study reported that 46.8% of patients with sole psychogenic nonepileptic seizures treated with antiepileptic drugs achieved complete or partial remission (38). Patients may therefore benefit from early referral to a tertiary center in lieu of empiric antiepileptic drug therapy, despite greater initial costs. This is especially true considering that the likelihood of developing epileptic seizures more than 1 year after a diagnosis of psychogenic nonepileptic seizures is remarkably low, and a diagnosis of psychogenic nonepileptic seizures does not seem to inhibit patients from seeking future neurologic care (39).

## **IMPLICATIONS FOR THE NEXT GENERATION OF PROVIDERS**

The aim of this article is to underscore the systemic challenges in diagnosing psychogenic nonepileptic seizures, as well as the necessity for earlier diagnosis and intervention. Patients with undiagnosed psychogenic nonepileptic seizures (or impaired insight into their condition) continue to present with seizure activity to primary care providers, urgent care facilities, and emergency departments. This not only contributes to the negative misconceptions held by some health care providers but also leads to a host of problems for the patient, from high financial burden to medical sequelae, such as antiepileptic drug

side effects, intubation, and even the induction of a medically induced coma for prolonged episodes.

Earlier diagnosis and treatment of psychogenic nonepileptic seizures is critical to provide better patient outcomes and to avoid adverse effects associated with overtreatment. While patient history and clinical presentation are essential components of diagnosis, health care professionals must use all the diagnostic tools available. More frequent utilization of 24-hour video EEG will aid in decreasing the time between patient presentation and recognition of the disorder. Further education on the nature of psychogenic nonepileptic seizures is necessary for health care providers, leading to better understanding and decreased stigmatization.

It is imperative that neurologic, psychiatric, and primary care providers are in frequent communication with each other to ensure that patients receive consistent information in a compassionate manner. The therapeutic alliance between patients and clinicians is a cardinal element in providing the necessary care to patients and in helping to negate the stigma associated with their condition. While the task of such coordination may seem daunting, it is the duty of health care providers to accept this charge and be the leaders in engendering a change that will improve the quality of life for thousands of patients each year.

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## Deep Sea Listening: Oil on Canvas

Megan Lin, B.A.

Psychiatry is a diverse, broad, and expansive field, much like an ocean. For patients with mental disorders, it can be challenging to navigate this “ocean” of information. As psychiatrists, we serve as “ocean guides” or navigators for our patients, but only if they are attuned to listening to the proper information. The practice of focused listening can enable accurate diagnosis and improve patient satisfaction.

In the painting below, I hope to convey the importance of taking time to listen to each patient’s story, even in the

**As psychiatrists,  
we serve as “ocean  
guides” or navigators  
for our patients.**

midst of the chaos of everyday life working in the medical field.

The idea for this painting was inspired by how the anatomy of the cochlea of the inner ear resembles a nautilus seashell.

The idea was then expanded to include the surrounding pieces of the ear replaced by other ocean inhabitants. Imagine the semicircular canals as ribbons of seaweed, the sea turtle as the tympanic membrane, the malleus as a piece of coral on the turtle’s back, and the dolphin filling in as the incus and stapes.

Megan Lin is a fourth-year medical student at the New York Institute of Technology College of Osteopathic Medicine, Old Westbury, N.Y.



Painting by Megan Lin, Great Neck, N.Y., 2017.

# The Walrus in the Room

Ronil S. Shah, M.D.

I entered the room, and a steely walrus moustache flopped up to greet me, followed by weary sky-blue eyes and a half-hearted wave from a hefty club, thickly wrapped with overlapping layers of crisscrossing bandages. “Mr. J” had been transferred from the psychiatry consultation service to the inpatient psychiatry floor, and I, one month into residency, was to direct his care. A glimpse into his chart: a late-thirties male, addled by diversified substance abuse, who had “sampled” methamphetamine, and at the end of the trial period found himself waking with deep gashes to his wrists and neck in the sterile glow of the surgical intensive care unit.

To the consult service, he spoke of jumping between alternate realities, interspecies soul swapping, and scaly saurian aliens. By my evaluation, the drug-induced creativity had subsided, and he joked with me about his inability to wipe himself (1). I pitied him, with his arms immobilized distally from his elbows, helpless, and riddled with shooting, fiery nerve pain. On intake, I continued his pain regimen, but over time, with his psychosis clearing and his injuries presumably healing—and in keeping with the literature guidelines—I weaned his oxycodone from the original immediate postop regimen (2).

At first, he demurred with, “If you say so, doc.” This progressed to, “I really don’t think this is an appropriate regimen, sir.” Then it intensified to, “My

Ultimately, I decided  
that doing “right”  
will often clash with  
patients’ wishes,  
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and self-doubt.

pain is not under control, man.” And ultimately it mushroomed to, “Stated goals for shift: not to hate Dr. Shah.” I did not believe that I was neglecting his pain, as every nursing note described the patient laughing with peers, sitting quietly coloring, and sleeping soundlessly through the night. I badgered my attending every evening as I painstakingly double-checked the plan to make sure that it was medically appropriate.

As the intervals between his scheduled oxycodone doses increased, the length of our conversations shortened, with my demeanor becoming increasingly formal. Eventually, my empathy withered to where my gut lurched at having to visit with him at all. What was wrong with me? Had I tarnished those sacred maxims of beneficence, autonomy, and nonmaleficence? Would my program director ask the National Residency Match Program if there was a 90-day return policy? I followed the guidelines, and objective findings and

more experienced providers supported my plan, and the patient’s history of drug abuse was well documented. But I was still haunted for months, long after he was discharged. Ultimately, I decided that doing “right” will often clash with patients’ wishes, creating that all-too-familiar wrenching dissonance and self-doubt. However, learning to stomach that nausea, I imagine, is one of the seminal lessons of the intern year, and coming to peace with just feeling “bad” is good practice for many more patient encounters—odobene-lipped or not—to come.

Dr. Shah is a first-year resident in the Department of Psychiatry, University of Colorado, Denver.

The author thanks Drs. Melanie Rylander and Matthew Deliere for their guidance during the treatment of the patient who inspired this piece.

To protect the patient’s privacy, all personal identifiers have been removed, and some details have been altered.

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## Response to Joshi and Langley-Degroot

Balwinder Singh, M.D., M.S.  
Andrew Hughes, M.D.

*To the Editor:* We would like to thank Drs. Joshi and Langley-Degroot (1) for their letter on our commentary and initiation of this discussion. In our commentary, published in the July 2016 issue of the *Residents' Journal* (2), we called for an increase in the effective use of clozapine for treatment-resistant schizophrenia via increased resident education. Specifically, we recommended the incorporation of clozapine clinics in psychiatric residency training programs. The goal of these programs would be to increase prescriber comfort and familiarity with the appropriate prescription of clozapine.

Drs. Joshi and Langley-Degroot raised a valid concern regarding superior efficacy and improved outcomes of clozapine in the wake of a network meta-analysis conducted by Samara et al. (3). Samara et al. reported that there is "little evidence of the superiority of clozapine compared with other second-generation antipsychotics in treatment-resistant schizophrenia among the randomized effectiveness studies" (3). However, there are some limitations of this network meta-analysis, which need to be carefully interpreted. We have highlighted several limitations that should be kept in mind when interpreting a meta-analysis or network meta-analysis.

A meta-analysis is as good as the included studies (4). A meta-analysis may not only inherit individual biases in the study but also include new biases because of the selection of the studies and heterogeneity among the included study populations and settings (4). A network meta-analysis allows assessment of the relative effectiveness of several treatment options across a network of randomized controlled trials even if no studies directly compared them (5). An important aspect of a net-

work meta-analysis is that if there are inconsistencies between direct and indirect evidence, one should investigate the sources of inconsistency to explain the differences. Meta-regression has been used to explore imbalance distribution of effect modifiers (5). Samara et al. used meta-regression analysis with antipsychotic dose and trial reduction as moderator variables, which did not show any significant effect on treatment efficacy, but the statistical power of meta-regressions was markedly weak (6). This highlights an important aspect and limitation of their meta-analysis, wherein the dosage of clozapine in included randomized controlled trials and duration and the likelihood of underdosing in the industry-funded trials could have constituted a serious problem and affected the results (3). The limitations of the Samara et al. meta-analysis were explained well in their discussion (3). Thus, the results of their meta-analysis could indicate "a problem of the individual included randomized-controlled trials rather than of clozapine" (7). We agree with their conclusion regarding trials comparing clozapine with other second-generation antipsychotics among patients with treatment-resistant schizophrenia and using high-dosage clozapine (3).

Another important aspect of clozapine is the improvement in outcomes other than psychopathology change, such as decreased hospitalization, lower hospital readmissions, reduced suicide attempts, and reduction in the number and severity of aggressive incidents (8). The Samara et al. meta-analysis underscores the importance of not only appraising each trial separately but at the same time understanding the limitations of a meta-analysis or network meta-analysis.

The second point Drs. Joshi and Langley-Degroot raised is regarding the incorporation of exposure to clozapine initiation early in training. We agree with any approach that would be helpful in increasing residents' comfort level and familiarity with clozapine. And this is why we believe that a clozapine clinic could be one such option whereby residents could not only learn about this medication but also receive adequate experience in its use and management of its side effects. While we agree that establishing clozapine clinics in residency training programs would create significant challenges, we believe that the added educational value and exposure would benefit both resident prescribers and patients receiving clozapine. The problems arise when lack of experience with clozapine results in residents being either hesitant to appropriately prescribe clozapine or are undertrained in its safe use.

Unfortunately, current methods of familiarizing residents with clozapine may not be effective. We recently conducted a survey of 164 U.S. psychiatry residents regarding their comfort levels with the appropriate usage of clozapine (9). The results of this survey showed that 41% of resident respondents did not feel comfortable prescribing clozapine. This number is worrying, as it indicates that a significant portion of the future generation of psychiatrists is uncomfortable with the use of one of the most effective treatments in our field. We feel that clozapine clinics may provide a solution to this problem, and most U.S. psychiatry residents appear to share this sentiment. When the residents in our survey were asked whether they would feel more comfortable prescribing clozapine if trained in a clozapine clinic, 83% agreed.

In summary, we agree with Drs. Joshi and Langley-Degroot that there are certain limitations to clozapine treatment and that the incorporation of clozapine clinics in residency training programs would be a difficult task. However, we also believe that there is a concerning lack of familiarity with clozapine among psychiatric residents and that this is a problem that needs to be addressed.

At the time this letter was accepted for publication, Dr. Singh was the Chief Resident in the Department of Psychiatry and Behavioral Science, University of North Dakota School of Medicine and Health Sciences, Fargo, N.D. Dr. Singh is currently an Assistant Professor in the Department of Psychiatry and Psychology at the Mayo Clinic in Rochester, Minn. Dr. Hughes is a second-year resident in the Department

of Psychiatry, Oregon Health and Science University, Portland, Ore.

The letter by Drs. Joshi and Langley-Degroot can be viewed *online*.

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# Call for Applications to Join the 2018 Editorial Board

The *American Journal of Psychiatry—Residents' Journal* is now accepting applications to join the 2018–2019 Editorial Board for the following positions:

## SENIOR DEPUTY EDITOR (SDE) POSITION

### Job Description/Responsibilities

- Frequent correspondence with *AJP-Residents' Journal* Editorial Board and *AJP* editorial staff, including conference calls.
- 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* editorial staff.
- Recruit authors and guest editors for the journal.
- Manage the *Test Your Knowledge* questions on the *Residents' Journal* Facebook and Twitter pages and work closely with authors in developing Board-style review questions for the *Test Your Knowledge* section.
- Fulfill the responsibilities of the Editor-in-Chief when called upon, including forming issue lineup.
- Collaborate with the Editor-in-Chief in selecting the 2019 SDE, Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10–15 hours per week.

### Requirements

- Must be an APA resident-fellow member.
- Must be starting as a PGY-3 in July 2018, or a PGY-4 in July 2018 with plans to enter an ACGME fellowship in July 2019.
- Must be in a U.S. residency program.

Selected candidate will be considered for a 2-year position, including advancement to Editor-in-Chief in 2019.

## DEPUTY EDITOR (DE) POSITION

### Job Description/Responsibilities

- Frequent correspondence with *Residents' Journal* Editorial Board and *AJP* editorial staff, including conference calls.
- 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 publica-

tion to ensure clarity, conciseness, and conformity with *AJP* style guidelines.

- Prepare a monthly *Residents' Resources* section for the journal that highlights upcoming national opportunities for medical students and trainees.
- Recruit authors and guest editors for the journal.
- Collaborate with the Editor-in-Chief in selecting the 2019–2020 Editorial Board.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10 hours per week.

### Requirements

- Must be an APA resident-fellow member.
- Must be a PGY-2, PGY-3, or PGY-4 resident starting in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the SDE position in 2019. If the selected candidate is interested in serving as SDE in 2019, he or she would need to formally apply for the position at that time.

## ASSOCIATE EDITOR (AE) POSITIONS (two positions available)

### Job Description/Responsibilities

- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Recruit authors and guest editors for the journal.
- Collaborate with the SDE, DE, 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 an APA resident-fellow member
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship

This is a 1-year position only, with no automatic advancement to the DE or SDE position in 2019. If the selected candidate is interested in serving as DE or SDE in 2019, he or she would need to formally apply for the position at that time.

## MEDIA EDITOR (ME) POSITION

### Job Description/Responsibilities

- Manage the *Residents' Journal* Twitter and Facebook accounts.
- Oversee podcasts.
- Collaborate with the AEs to decide on content
- Collaborate with SDE, DE, 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 an APA resident-fellow member.
- Must be an upcoming PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- 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 2019. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2019, he or she would need to formally apply for the position at that time.

## CULTURE EDITOR (CE) POSITION

- Collaborate with SDE, DE, 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 an APA resident-fellow member.
- Must be an upcoming PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the DE or SDE position in 2019. If the selected candidate is interested in serving as DE or SDE in 2019, he or she would need to formally apply for the position at that time.

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For all positions, e-mail a CV and personal statement of up to 750 words, including reasons for applying and ideas for journal development, to [oliver.glass@emory.edu](mailto:oliver.glass@emory.edu). The deadline for applications is March 2, 2018.

# 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 Anna Kim, M.D., Deputy Editor ([anna.kim@mountsinai.org](mailto:anna.kim@mountsinai.org)).

## JANUARY DEADLINES

Fellowship/Award	APA Psychiatric Research Fellowship
Organization	APA
Deadline	<b>January 31, 2018</b>
Brief Description	The fellowship provides funding for a post-graduate psychiatry trainee, under the supervision and guidance of his or her mentor, to design and conduct a research study on a major research topic.
Eligibility	Must be an M.D. or D.O. and APA member who completed residency training prior to the time the fellowship commences.
Contact and Website	E-mail: <a href="mailto:kbarber@psych.org">kbarber@psych.org</a> • Web: <a href="https://www.psychiatry.org/residents-medical-students/residents/fellowships">https://www.psychiatry.org/residents-medical-students/residents/fellowships</a>
Fellowship/Award	APA/American Psychiatric Association Foundation (APAF) Leadership Fellowship
Organization	APA Foundation
Deadline	<b>January 31, 2018</b>
Brief Description	This fellowship provides opportunities for a psychiatry trainee to engage, interact, and participate at a national level and further develop his or her professional leadership skills, networks, and psychiatric experience. The program creates opportunities to expand relationships with peers and national thought-leaders in the field of psychiatry.
Eligibility	Must be an APA-resident member and enrolled as a PGY-2 at an accredited psychiatric residency training program.
Contact and Website	E-mail: <a href="mailto:psychleadership@psych.org">psychleadership@psych.org</a> • Web: <a href="https://www.psychiatry.org/residents-medical-students/residents/fellowships">https://www.psychiatry.org/residents-medical-students/residents/fellowships</a>
Fellowship/Award	APA Child and Adolescent Psychiatry Fellowship
Organization	APA
Deadline	<b>January 31, 2018</b>
Brief Description	This 2-year fellowship is designed to promote interest and a career in child and adolescent psychiatry; offers travel support for two APA Annual Meetings and two APA September Components Meetings.
Eligibility	Must be an APA-resident member and enrolled as a PGY-2 at an accredited psychiatric residency training program.
Contact and Website	E-mail: <a href="mailto:tclaridad@psych.org">tclaridad@psych.org</a> • Web: <a href="https://www.americanpsychiatricfoundation.org/get-involved/fellowships/child-and-adolescent-psychiatry-fellowship">https://www.americanpsychiatricfoundation.org/get-involved/fellowships/child-and-adolescent-psychiatry-fellowship</a>
Fellowship/Award	APA Public Psychiatry Fellowship
Organization	APA
Deadline	<b>January 31, 2018</b>
Brief Description	This is a 2-year fellowship that provides experiences that will contribute to the professional development of residents who will play future leadership roles within the public-sector psychiatry and heighten awareness of the public psychiatry activities and career opportunities. Offers funding to attend two APA Institute on Psychiatric Services (IPS) meetings and two September Components Meetings.
Eligibility	Must be an APA member and enrolled as a PGY-1 or PGY-2 in an accredited U.S. or Canadian psychiatry residency program with 2 remaining years of training.
Contact and Website	E-mail: <a href="mailto:publicpsych@psych.org">publicpsych@psych.org</a> • Web: <a href="https://www.psychiatry.org/residents-medical-students/residents/fellowships">https://www.psychiatry.org/residents-medical-students/residents/fellowships</a>
Fellowship/Award	SAMHSA Minority Fellowship
Organization	Substance Abuse and Mental Health Services Administration (SAMHSA)
Deadline	<b>January 31, 2018</b>
Brief Description	To enhance the knowledge and capabilities of racial and ethnic minority psychiatry residents to teach, administer, conduct services research, and provide culturally competent, evidence-based mental health services to minority and or underserved populations.
Eligibility	Must be an APA-resident member and enrolled as a PGY-2 at an accredited psychiatric residency training program.
Contact and Website	E-mail: <a href="mailto:mfp@psych.org">mfp@psych.org</a> • Web: <a href="https://www.samhsa.gov/minority-fellowship-program">https://www.samhsa.gov/minority-fellowship-program</a>

## FEBRUARY DEADLINE

Fellowship/Award	American Society of Clinical Psychopharmacology (ASCP) Early Career Research Award
Organization	ASCP
Deadline	<b>February 1, 2018</b>
Brief Description	This award is for those interested in or are beginning to engage in clinical psychopharmacology research. No prior research is required. Funds are provided for costs directly related to start-up or pilot research projects. Mentorship by an ASCP senior investigator is also available.
Eligibility	Must be an ASCP member; enrolled as a psychiatry resident or fellow, doctoral-level psychologists/pharmacists (i.e., Ph.D., Psy.D., Pharm.D.).
Contact and Website	E-mail: <a href="mailto:info@ascpp.org">info@ascpp.org</a> • Web: <a href="https://www.ascpp.org/resources/young-investigator-grant/">https://www.ascpp.org/resources/young-investigator-grant/</a>



# Author Information for *The Residents' Journal* Submissions

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*The Residents' Journal* accepts manuscripts authored by medical students, resident physicians, and fellows; attending physicians and other members of faculty cannot be included as authors.

To submit a manuscript, please visit [http://ajp.psychiatryonline.org/ajp\\_authors\\_reviewers](http://ajp.psychiatryonline.org/ajp_authors_reviewers), 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. **Perspectives in Global Mental Health:** This article type should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow. Limited to 1,500 words and 20 references.
9. **Arts and Culture:** Creative, nonfiction pieces that represent the introspections of authors generally informed by a patient encounter, an unexpected cause of personal reflection and/or growth, or elements of personal experience in relation to one's culture that are relevant to the field of psychiatry. Limited to 500 words.
10. **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.
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.

## Upcoming Themes

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 Rachel Katz, M.D., Editor-in-Chief ([rachel.katz@yale.edu](mailto:rachel.katz@yale.edu)).

**Prevention and Primary Care in Psychiatry**  
**Neuropsychiatry**  
**Advances in Treating Personality Disorders**

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