DESCRIPTION

General Hospital Psychiatry explores the many linkages among psychiatry, medicine, and primary care. In emphasizing a biopsychosocial approach to illness and health, the journal provides a forum for professionals with clinical, academic, and research interests in psychiatry’s role in the mainstream of medicine.

AUDIENCE

Psychiatrists, General and Family Practitioners, Internists, Nurses, Pharmacologists, Psychologists and Health Care Para-Professionals.

IMPACT FACTOR

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**Aims and Scope of General Hospital Psychiatry**

*General Hospital Psychiatry* explores the many linkages among psychiatry, medicine, and primary care. The journal provides a forum for professionals with clinical, academic, and research interests in psychiatry’s role in the mainstream of medicine. The journal expands on traditional models of consultation-liaison, inpatient, and outpatient services in the general hospital to address all aspects of ambulatory, inpatient, emergency, and community care. Examination of novel assessment methods or intervention techniques, and reports from intervention trials that are related to the interface between medicine and psychiatry, are especially relevant to the journal's objectives, as are examinations of these phenomena on cost, cost-effectiveness, and public policy.

*General Hospital Psychiatry* will publish original research articles, topical reviews (especially systematic reviews and meta-analyses), and brief communications on: (1) biopsychosocial approaches to medicine, including models of collaborative and integrated care, (2) inpatient and outpatient consultation-liaison psychiatry, (3) psychosomatic medicine (including research on somatic symptoms, assessment methods in general medical settings, and assessment and treatment in persons with specific medical conditions), (4) inpatient, emergency, and crisis psychiatry, (5) the relationship of psychiatric services to general medical systems (e.g., primary care clinics, hospitals, local/national policy), (6) new directions in medical education that stress psychiatry's role in primary care, family practice, and continuing education, and (7) health psychology.

The journal will not accept case report submissions as of December 2015, but can consider for publication articles that include discussion of one or more cases as part of a comprehensive topical review (typically 50-75+ references).

**BEFORE YOU BEGIN**

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Sex generally refers to a set of biological attributes that are associated with physical and physiological features (e.g., chromosomal genotype, hormonal levels, internal and external anatomy). A binary sex categorization (male/female) is usually designated at birth ("sex assigned at birth"), most often based solely on the visible external anatomy of a newborn. Gender generally refers to socially constructed roles, behaviors, and identities of women, men and gender-diverse people that occur in a historical and cultural context and may vary across societies and over time. Gender influences how people view themselves and each other, how they behave and interact and how power is distributed in society. Sex and gender are often incorrectly portrayed as binary (female/male or woman/man) and unchanging whereas these constructs actually exist along a spectrum and include additional sex categorizations and gender identities such as people who are intersex/have differences of sex development (DSD) or identify as non-binary. Moreover, the terms "sex" and "gender" can be ambiguous—thus it is important for authors to define the manner in which they are used. In addition to this definition guidance and the SAGER guidelines, the resources on this page offer further insight around sex and gender in research studies.

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Types of Articles Published in General Hospital Psychiatry

Regular article (including Reviews): 4000 word limit (excluding cover letter, abstract, acknowledgements, references, tables, and figures), Maximum of 4 tables and/or figures (combined)
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Statistical guidelines. All articles with quantitative data (e.g., original research reports, meta-analyses, brief communications when relevant) should follow the below guidelines whenever possible and should justify deviations from these guidelines. Basic issues. In each report, a primary outcome measure and primary method of analysis should be clearly outlined. All statistical tests should be two-tailed, and an alpha of .05 used (unless further corrections are needed) in most cases. Primary analyses should use continuous versions of variables whenever possible unless the variable is solely or preferentially a categorical variable (e.g., mortality, rehospitalization, remission). Categorization of continuous variables (e.g., at median split, ordinal categories, etc.) may be appropriate for secondary...
analyses. Reporting. In the text of the Results section (or Tables), the primary measure of effect (e.g., between-group difference, regression coefficient, odds ratio) should be listed, along with confidence interval; effect sizes should also be listed when relevant. *p* values should be reported to 2 significant figures, with *p* values <.001 reported as such. Covariates. It is vital to control for relevant covariates, especially in observational studies. However, in regression and related multivariable models, covariates should ideally be identified *a priori* based on prior literature and/or clinical factors. Selection of covariates from a large pool, post hoc, using univariate tests is less desirable although it may be warranted in preliminary or exploratory analyses. Automated stepwise selection procedures (forward or backward) for covariates are discouraged. In addition, authors should avoid overfitting of statistical models and use rules of thumb for ratios of covariates to observations (e.g., 10 observations for each variable in a regression model). *Multiple comparisons. Control for multiple comparisons is a complex and controversial issue, yet should always be addressed and discussed when appropriate. For example, using *P* < .05 as a threshold for significance is appropriate regarding a pre-specified primary outcome but is often insufficiently conservative when multiple comparisons are reported.*

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A structured abstract, by means of appropriate headings, should provide the context or background for the research and should state its purpose, basic procedures (selection of study subjects or laboratory animals, observational and analytical methods), main findings (giving specific effect sizes and their statistical significance, if possible), and principal conclusions. It should emphasize new and important aspects of the study or observations.

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Method: The basic design of the study and its duration should be described. The methods used should be stated and the statistical data/methods provided.

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Conclusion(s) of the study that are directly supported by the evidence reported should be given along with the clinical application, and speculation.

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Divide the main text of the article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line. All full-length articles should at minimum contain the following sections: **Introduction.** Provide an adequate background, avoiding a detailed literature survey or a summary of the results. State clearly the objectives of the work. **Methods.** Provide sufficient detail to allow the work to be reproduced. Methods already
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