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Inside

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ARTS AND CULTURE

July 6th, 2016: A Reaction to the Shooting of Alton Sterling

Travis Meadows, M.D.

"I want my daddy."

Through a river of tears, these words were spoken by the eldest son of Alton Sterling as he broke down watching his mother, newly widowed, as she addressed the public regarding the murder of her husband by police officers. As I watched this video and heard the words of this broken young man, my heart ached, my eyes swelled, and I too felt broken.

I am angry. I am beyond tired. I am rattled at my core.

I fear that these feelings will continue, and in one form or another, these episodes will recur. I recognize that my country, my home, is critical of zoo keepers killing a gorilla who may have threatened the life of a small child; relatively, I wonder if the cops who savagely murdered a human being, pinning him to the ground after tazing him could ever be appropriately denounced.

I am a black man. I am the proud son of a black woman, and I am a loving uncle to a black child. I am also a black psychiatrist. It is my personal and professional responsibility to speak up for a community that is being repeatedly traumatized and victimized. What would once have been called paranoia toward law enforcement becomes justified when a person has to fear for his life because of his race. This should not be the case.

It is my personal and professional responsibility to speak up for a community that is being repeatedly traumatized and victimized.

As much as I want to be resilient, to feel resilient, and to carry this weight with a raised chin, I cannot. Instead, I am anxious. My thoughts are scattered. My fingers are tense. My mood is soaked in grief. While this is my reaction, I also know that it is a shared experience by the black community.

If you take from my words nothing else, please let it be an increased sensitivity to and awareness of the impact that events like the shooting of Alton Sterling have on the black community. We are forced to be weary of the men and women entrusted to protect our rights and our lives. We are weighted with the task of maintaining a positive self-image when it would seem the complexion of our skin is viewed as a target for violence and aggression. We are left without peace, but instead a constant worry.

Tomorrow I will be expected to have healed my wounds and be ready to lend a listening ear and comforting voice to others. They will look to me seeking confirmation, validation, solutions. They will not realize that looking back at them is the face of someone who is, himself, struggling to cope.

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The author acknowledges the families of the victims of recent social injustices for sharing their stories. The author also thanks his mother for helping to give him the strength to write this piece, as well as Katherine Pier, M.D., for her encouragement and editorial assistance.

COMMENTARY

From Sociopathy to Social Recognition

Michael Miller, M.D.

The Supreme Court's *Obergefell v. Hodges* guarantees the right of homosexual individuals to marry, a nearly unbelievable event when one considers that just over 40 years ago, being homosexual itself was considered a mental illness. Until 1974, homosexuality was listed in the DSM as a mental disorder. Originally classified as sociopathic and "ego-dystonic," homosexuality remained a diagnosis until 1987. Today, the American Psychiatric Association explicitly states its view on homosexuality, indicating that same-sex orientation has unclear origins, does not impair an individual's judgment or functioning in itself, and does not (and should not) call for psychiatric treatment (1).

The case of homosexuality raises an uncomfortable but critical question: What is mental illness? This is not a new question, and the answer remains unclear. The DSM draws the line at when clinical distress or functional impairment occurs, using criteria "based largely on social norms, with 'symptoms' that all rely on subjective judgments" and "reflect current normative social expectations" (2). Concerns about pathologizing the normal have come up repeatedly, embodied by the British Psychological Society's statement noting the "continued and continuous medicalisation of [the public's] natural and normal responses to their experiences [...] which do not reflect illnesses so much as normal individual variation" (2).

Homosexuality is not the first condition dubiously deemed a mental disorder. In the 19th century, African slaves who attempted to run away were said to suffer from *drapetomania*, with the prescribed treatment of the removal of both great toes (3). Instances have also been described of housewives refusing to do housework, with resulting hospitalization and ECT (3). In the 1970s, accusations of corruption by the U.S. Attorney General's wife toward the Nixon administration were dismissed as delusions, only to be later verified in the Watergate investigation. The case coined the eponymous "Martha Mitchell effect," in which mental health providers dismiss true claims by their patients as symptoms of illness (4). This effect was seen more recently when psychiatrists used a Long Island woman's descriptions of her Twitter account as evidence for her mania. Her claims were later found to be factual, but only after her 8-day involuntary stay at a hospital with medication (5).

Psychiatric syndromes are almost always idiopathic, and questions of moral perception or social acceptance are irrelevant to accurate diagnosis.

What can be done to help circumvent such "diagnoses"? Clinicians should attempt an objective exam using the form of the presenting phenomenology, rather than the content, while acknowledging cultural context and attempting to gain collateral information. Concurrently, psychiatry as a field should continue its search for specific biomarkers and imaging through projects like the BRAIN [Brain Research through Advancing Innovative Neurotechnologies] Initiative, both for more valid measures of disease and to avoid fad diagnoses or clinician bias.

Views on homosexuality have shown a remarkable turnaround: what was once considered a "sociopathy" is now socially recognized. Psychiatric syndromes are almost always idiopathic, and questions of moral perception or social acceptance are irrelevant to accurate diagnosis. Clinicians must strive for a diagnosis based on the patient's presenting symptoms, rather than social or personal bias, to ensure that treatments are helpful to patients and to avoid the misuse of authority by the psychiatric profession.

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ARTICLE

Synthetic Cannabinoid Use in a Transitional Housing Shelter: A Survey to Characterize Awareness of Risks and Reasons for Use

Brian S. Barnett, M.D., Micaela Owusu, M.D., M.Sc.

Synthetic cannabinoids are man-made compounds that act through the brain's cannabinoid receptors (CB1 and CB2) to induce mind-altering effects. The CB1 receptor affects the dopamine system, which is thought to modulate psychotic symptoms (1, 2). One common synthetic cannabinoid, JWH-018, has four times greater the affinity for CB1 than tetrahydrocannabinol, the primary cannabinoid found in cannabis. Another synthetic cannabinoid, AM-694, has recently begun to appear on the illicit market and is associated with hallucinations and delirium (2). In contrast, cannabis contains cannabidiol, an antagonist to both CB1 and CB2 that may protect against psychosis but is not found in synthetic cannabinoid mixtures being sold (1–3). This may explain why synthetic cannabinoids are associated with higher risk of episodic psychosis following use than cannabis (3, 4). In addition to psychosis, there have been multiple other reported morbidities associated with synthetic cannabinoids usage, including tachycardia, hypertension, cardiac arrest, pulmonary infiltrates, renal impairment, seizures, and suicidality (5, 6).

Originally developed in the 1970s (5), synthetic cannabinoids are now being covertly synthesized, sprayed on plant material, and sold in convenience stores as incense or potpourri under names such as K2, spice, and Scooby snacks. Illicit laboratories have circumvented issues of legality by introducing novel compounds that differ slightly from previous versions, especially when older versions were outlawed. The Synthetic Drug Abuse Prevention Act of 2012 now enables the Food and Drug Administration to ban all cannabimimetic substances, allowing for the inclusion of current and unreleased synthetic cannabinoids. Therefore, all synthetic cannabinoids are now technically illegal for human consumption in the United States. However, they continue to be marketed under the guise of use as incense or potpourri.

Few studies have explored why and how individuals use synthetic cannabinoids. In one survey of users, 54% of participants reported that the intoxication from synthetic cannabinoids, which often includes hallucinations, is unique (7). More than half reported use in group settings, and one-third reported an inability to decrease usage and development of tolerance. A New Zealand study examining the use of synthetic cannabinoids in psychiatric patients on a forensic inpatient unit (1) revealed that patients preferentially used synthetic cannabinoids due to easy procurement, increased potency compared with marijuana, non-detection in urine, and beliefs that they were safe because they were legal and sold as "herbal" products.

In 2014, staff at a local Boston Department of Mental Health transitional housing shelter noted a rapid increase in synthetic cannabinoid usage among residents, who discussed their use in the shelter's substance use group therapy sessions. We investigated shelter resident attitudes about synthetic cannabinoids and their use patterns in order to find potential points of intervention to increase awareness of the dangers of synthetic cannabinoids and decrease resident usage.

METHOD

Study Procedures and Participants

This study was approved by the Partners Human Research Committee (protocol #P000088; Massachusetts General Hospital). In December 2014, residents from an 80-bed Boston Department of Mental Health transitional housing shelter who were ≥18 years of age and who openly acknowledged synthetic cannabinoid use were recruited. Written, informed consent was obtained from participants. In calculating our ideal sample size, for the study's total population we used the number of homeless individuals in Boston being treated for substance use disorders in 2015 (N=614) (8) to serve as a proxy for the number of homeless synthetic cannabinoid users, although this likely overestimates the number. Using Slovin's formula (9), n=N/(1+Ne2) (where n=sample size, N=total population, and e=error tolerance, with an error tolerance of 5% and a total population of 614), the calculated ideal sample size was 242 participants. However, only 10 individuals were identified as meeting inclusion criteria, and two declined to participate.

Data Analysis

Semi-structured interviews were conducted addressing subjects' histories of substance use, their perceptions of the effects of synthetic cannabinoids, their reasons for use, and their knowledge of associated risks. Interview contents were de-identified and transcribed during the interviews. Transcripts were reviewed and coded for themes/categories. Codes were compared, and those on which there was consensus were included in the final analysis.

RESULTS

Demographic Characteristics

Eight participants were included in the study, of which five were males (63%), with a mean age of 38 years (range: 22–61 years). Five participants (63%) were diagnosed with primary mood disorder and three (37%) with a primary psychotic disorder. All were prescribed antipsychotic medications. One-half of the participants in the group were also misusing alcohol and marijuana. Half of participants used synthetic cannabinoids daily, with the amount used ranging from one to 10 joints per day. The duration of synthetic cannabinoid use ranged from 2 to 12 months.

Knowledge

Six participants (75%) believed that possession and use of synthetic cannabinoids was legal. The most commonly used descriptors for synthetic cannabinoids by participants were "flowers," "potpourri," and "incense." Seven participants (87%) understood that synthetic cannabinoids consist of plant material sprayed with synthetic chemicals, while one believed that they were natural substances. Three participants (32.5%) believed that there were no health risks associated with use.

Usage Patterns

Interestingly, most individuals started using synthetic cannabinoids after moving to the shelter and were not aware of their existence previously. One participant (13%) reported previous use at a nearby shelter. Half reported daily synthetic cannabinoid use, most commonly in the form of a joint. Nearly all participants (N=6 [75%]) used synthetic cannabinoids in groups rather than alone. Participants preferred synthetic cannabinoids to marijuana due to lower cost (63%), easier accessibility (38%), and subjectively more desirable intoxication (38%). Six users (75%) obtained the substance directly from convenience stores. Two users (25%) were supplied with synthetic cannabinoids by individuals selling from within the shelter.

Effects

Perceived positive effects of intoxication brought on by synthetic cannabinoid use, as well as negative effects, are summarized in Table 1. Five participants (63%) reported increasing tolerance. Four participants had attempted to discontinue use, three of whom also reported withdrawal symptoms. These symptoms included craving (N=2 [66%]), cough (N=2 [66%]), irritability (N=2 [66%]), and anxiety (N=2 [66%]).

TABLE 1. Perceived Positive and Negative Effects of Intoxication Brought on by Synthetic Cannabinoid Use Among Residents in a Transitional Shelter

Effect	N	%
Positive		
Relaxation	5	63
Increased sociability	4	50
Increased laughter	3	38
Religiosity	1	13
Negative		
Nausea/vomiting	4	50
Aggression	4	50
Dry mouth	3	38
Hallucinations	3	38
Increase in appetite	3	38
Lightheadedness	3	38
Fatigue	2	25
Chest pain/palpitations	2	25

DISCUSSION

Since their arrival on the recreational drug scene in 2004, synthetic cannabinoids have rapidly increased in popularity. Simultaneously, concern has mounted about their negative effects. We sought to learn why, in a shelter population of chronically mentally ill individuals, synthetic cannabinoids are used to the exclusion of other substances. We were also interested in assessing participants' knowledge of synthetic cannabinoids and their risks, as a way to inform potential strategies to decrease use. Study limitations include a small sample size and retrospective design.

Multiple factors promoted the use of synthetic cannabinoids in the study population, including perceived legality and safety, easy access, and low cost. Additionally, their use appears to result in a desirable state of intoxication that consists of increased relaxation and sociability, which may be particularly valued in a population in which social interactions can be anxiety- or paranoia-provoking. These reasons are similar to those of a 2012 survey of users who reported that curiosity, positive drug effect, and relaxation were primary reasons for use (7).

Some participants reported tolerance and possible withdrawal, indicating likely dependence. A study in mice demonstrated that the synthetic cannabinoids JWH-073, 081, and 210 have psychological dependence potential (10). A study of patients requesting detoxification services due to synthetic cannabinoid withdrawal revealed that agitation, irritability, anxiety, and mood swings were the most common components of withdrawal (11). In line with this, participants in our study reported withdrawal symptoms that included craving, irritability, and anxiety.

With the passage of recent U.S. federal legislation now making possession of synthetic cannabinoids illegal, there is new potential for intervening in their sale. However, enforcement of these

KEY POINTS/CLINICAL PEARLS

- Synthetic cannabinoids are man-made compounds that act through the cannabinoid receptors to induce mind-altering effects and can be much more potent than naturally occurring cannabinoids such as tetrahydrocannabinol.
- Although they are illegal for human consumption under federal law, packets of synthetic cannabinoids are sold in convenience stores and gas stations as incense and potpourri under names such as "K2," "spice," and "Scooby snacks."
- Adverse effects of synthetic cannabinoids documented in case reports include cardiac arrest, hypertension, pulmonary infiltrates, renal impairment, tachycardia, seizures, psychosis, and suicidality.

laws has been inconsistent. Clinicians in New Zealand noted a decrease in patient visits for treatment of synthetic cannabinoid withdrawal following their outlaw (12). Therefore, informing patients about their illegality may be one approach to decreasing usage. Given that participants were using other substances simultaneously, it would be prudent for providers to screen for the use of synthetic cannabinoids in patients already known to be misusing other substances. Additionally, nearly half of the participants believed that no potential risk to their health from using synthetic cannabinoids exists. Thus, patients who are actively using synthetic cannabinoids would benefit from further education about the dangers of these substances.

The authors are fourth-year residents in the Adult Psychiatry Residency program at Massachusetts General and McLean Hospitals, Boston.

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ARTICLE

Current Issues Regarding E-Cigarettes

Robert Lee, D.O.

The use of electronic cigarettes (e-cigs, vapes, and electronic nicotine delivery systems [ENDS]) is growing, and implications of their use need to be explored. The benefits of these devices as nicotine replacement are countered by an expanding body of knowledge regarding potential health hazards and social consequences. ENDS have shown to produce a number of harmful chemicals, and there is yet no regulatory process overseeing the production and sales of these devices. The public holds a misconception that electronic cigarettes are safe, and as their use continues to grow, renormalization of the act of smoking is a concern. Tobacco use is the single, largest preventable cause of death in the United States (1), and as health care professionals, it is important that we continue to educate ourselves. In doing so, we will be able to provide up-to-date information and aid in making informed decisions.

HISTORY

Electronic cigarettes are battery-powered devices that vaporize a nicotine solution. The modern e-cigarette was produced in 2003 by a Chinese pharmacist (2), as he attempted to create a healthy alternative to cigarettes. Since the introduction of e-cigarettes to the American market in 2007, there has been a dramatic evolution in their form and function to cater to the consumer. The original device was underpowered and inconsistent in its ability to produce vapor. To keep up with the evolving demand of the consumer, a variety of models are being manufactured. They allow for greater control over battery voltage and heating temperature, thereby modifying the amount of vapor produced. Vaporized solutions, or e-liquids, are comprised of various ratios of propylene glycol, vegetable glycerin, water, nicotine solution, and flavorings (3).

The steady increase in popularity of e-cigarettes has become an important public health topic. In 2009, the Food and Drug Administration (FDA) attempted to block the importation and sale of these devices, stating that they were unauthorized drug delivery devices. In 2010, the U.S. Court of Appeals ruled against the ban and determined that unless marketed as therapeutic, e-cigarettes should be regulated as tobacco products. In April 2014, the FDA issued a proposal to extend its regulating authority to cover e-cigarettes and other tobacco products. Finalization of this proposal is pending (2, 4, 5).

EPIDEMIOLOGY

On September 1, 2014, the World Health Organization determined that in 2014 there were 466 brands of ENDS products, with an estimated $3 billion spent globally on these devices in 2013. By 2030, sales are anticipated to increase 17 fold (6). Data on ENDS from North America, the European Union, and South Korea indicate a doubling of use in both adolescents and adults from 2008 to 2012. While the majority of e-cigarette users fall in the age range of 30–50 years old (7), the number of adolescents using ENDS is growing. The Centers for Disease Control and Prevention indicates that e-cigarette use among middle and high school students has tripled from 2013 to 2014 (8).

SAFETY

Initial e-cigarette advertisements promoted ENDS as safe alternatives to cigarettes. The only byproduct was said to be water vapor. The literature suggests otherwise. In an investigation of 10 commercially available e-fluids in Poland, carbonyl compounds were detected in the vapor produced. Greater ratios of propylene glycol to vegetable glycerin generated significantly higher levels of compounds such as formaldehyde, acetaldehyde, acetone, and butanal (all classified as carcinogens or irritants). Also on those e-cigarettes that allow for user adjustable batteries, increased voltages resulted in higher levels of carbonyls produced (3). Another study focused on the flavoring components of the e-liquid. Diacetyl, 2,3-pentandedione, and acetoin were detected (9). Diacetyl is a compound used in food flavoring. Although diacetyl is included in the FDA GRAS [generally recognized as safe] database, this only applies to the ingestion of the substance. The Occupational Safety and Health Administration database warns of the respiratory damage (i.e., bronchiolitis obliterans) that can be caused by the inhalation of this compound. In another study, 22 vaporizers were tested and found to produce an aerosol that contained heavy metals (tin, silver, iron, nickel, aluminum), silicate beads, and nanoparticles (10). All of the heavy metals produced are included in the FDA's database of harmful and potentially harmful chemicals. The implications of the presence of these substances are unknown. Although many chemicals are present to a lesser extent than in cigarettes, some are found in higher concentrations, and chemicals not found in cigarettes are also present. This may indicate the intrinsic problems with e-cigarettes. However, studies have not established the safety of e-cigarettes in relation to smoking. Therefore, drawing conclusions regarding e-cigarette safety is difficult, especially in an environment of change within the industry.

HARM REDUCTION

Nicotine is the addictive chemical in cigarettes, and the combustion of tobacco produces carcinogens. Nicotine alone is not the culprit for most diseases associated with tobacco use. Therefore, the use of non-combustible and less toxic forms of nicotine delivery is a means of decreasing use and limiting mortality from smoking (11). Long-term nicotine replacement (patch, gum, lozenge, etc.) has been established as safe, but the presence of harmful chemicals associated with ENDS use argues against the absolute safety of e-cigarettes. Forsalinos and LeHouezec (11) argued that e-cigarette safety needs to be considered in relation to smoking. For harm reduction, a balance between acceptability and risk must be considered. To do this, studies need to be conducted to determine the effectiveness of e-cigarettes in the decrease and cessation of smoking. In a randomized controlled trial of e-cigarette use for smoking cessation, conducted by Bullen et al. (12), e-cigarettes with nicotine were at least as effective as nicotine patches for successful smoking cessation at 6 months. Those subjects who relapsed but continued to use e-cigarettes smoked fewer overall cigarettes. If e-cigarettes can decrease the amount of smoking, next is to determine whether smoking reduction reduces long-term risks. Additionally, the risks of dual use of e-cigarettes and tobacco are unknown and must be explored. At this time, it cannot be concluded that e-cigarettes are a reliable method of harm reduction. However, ENDS continue to be a valuable piece of technology. The scientific community needs to continue to conduct research and collaborate with manufacturers to work toward safe devices.

RENORMALIZATION

Another category of users does not use e-cigarettes as a cessation tool or replacement strategy. These are tobacco-naive individuals. Within this group, the number of adolescent and youths continues to grow. The Public Health Cigarette Smoking Act of 1971 limited cigarette advertisements in the media, and the Family Smoking Prevention and Tobacco Control Act of 2009 banned the use of candy- and fruit-flavoring in cigarettes (5). These regulations limited the appeal of cigarettes to youths. These rules, however, do not yet apply to e-cigarette marketing and sales. As the number of younger users continues to grow, concerns arise that the attraction of e-cigarettes may strengthen and popularize the act of smoking itself (13). A recent study of adolescents in Los Angeles found a positive association between ever use of e-cigarettes with initiation of combustible tobacco use (14). In this study, 9th- and 10th-grade students from 10 different schools were surveyed at baseline and at 6 and 12 months to assess for tobacco use. Students with any prior use of combustible tobacco products were excluded. While other factors that could contribute to the association between e-cigarette use and initiation of combustible tobacco use can exist, the study adjusted for demographic factors (sex, race, socioeconomic status, etc.) and continued to demonstrate a statistically significant positive correlation. This study is limited in that it focuses on initiation outcomes, and the cohort examined is geographically specific. However, the study does indicate that further research is needed to determine the relationship between e-cigarette use and smoking initiation.

DISCUSSION

The escalating use and evolving culture of e-cigarettes is occurring despite little knowledge of their risks and benefits. The long-term effects are still unknown. Use in children and adolescents is associated with nicotine use and potential for renormalization of smoking. Studies have revealed the inconsistencies in production of devices and the presence of noxious chemicals. Unfortunately, due to lack of regulation, the potential harm is difficult to mitigate, let alone monitor.

As clinicians, it is often difficult to know how to advise patients regarding e-cigarette use. What we do know is that there continues to be greater than 480,000 tobacco-related deaths yearly (1), and ENDS use is not a perfectly safe alternative. Some hazardous chemicals associated with traditional tobacco are produced to a lesser degree in e-cigarettes, while others are not. There are currently no data that address the safety of these substances as they pertain to e-cigarette use, and no conclusions can yet be drawn regarding the safety of e-cigarettes in relation to smoking. With continued research and regulation by the FDA, consistency and safety of e-cigarettes will be further improved. Until that time, it is reasonable to conclude that no universal recommendation can be given to patients. What we can do for our patients is to provide data regarding the potential harms of ENDS use while stressing the hazards of traditional cigarette use.

At the time this article was accepted for publication, Dr. Lee was a fourth-year resident in the Department of Psychiatry at the University of Texas Southwestern, Dallas.

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KEY POINTS/CLINICAL PEARLS

- Evidence suggests that e-cigarettes may work as well as nicotine patches for smoking cessation and may help patients reduce the number of cigarettes they smoke when used concurrently.
- Use of e-cigarettes continues to increase with the current majority falling into the age range of 30–50 years old; however, younger generations are quickly growing, with a tripling of middle and high school students from 2013 to 2014.
- E-cigarette juice byproducts contain carbonyls compounds from the vaporization of propylene glycol and vegetable glycerin.
- Inhalation of the flavoring compound, diacetyl, has been shown to have adverse effects on health.

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ARTICLE

Innovative Mobile Clinics Serving Children and Families of Riverside County With Limited Access to Behavioral Health Services

Carlos Fernandez, M.D.

Reducing disparities in mental health has become a national priority (1). All over the nation, people in ethnic minority groups tend to underutilize mental health services. With increasing numbers of people in the United States, a significant number never receive adequate psychiatric care. Often it is the case that individuals from underserved areas who have diagnosed disorders frequently face problems accessing psychiatric services (2). These medically underserved areas may include a whole county or groups of contiguous counties, in which the residents have a shortage of personal health services taking up to more than 30 minutes of travel time to reach (3). Medically underserved populations include groups of persons of a particular cultural background, gender, sexual orientation, spiritual belief, socioeconomic strata, or legal status, as well as persons residing in isolated geographic locations, that face barriers to health care (4). Underserved individuals can potentially lack insurance coverage and financial resources, as well as face cultural stigma, which may deter them from seeking mental health services. As a result, delayed identification and treatment of behavioral health issues can frequently lead to potentially negative outcomes. Therefore, it is imperative to individualize each patient interaction to explore options to remove barriers (5, 6).

RIVERSIDE COUNTY MOBILE MENTAL HEALTH CLINIC

California's Office of Health Equity policy initiatives were developed at a state level to improve access and quality to care and to increase positive outcomes for individuals in certain racial/cultural communities in the public mental health system (7). Through California's Mental Health Service Act, Riverside County receives funds to implement and provide prevention and early intervention treatment in a non-traditional setting utilizing three mobile recreational vehicles as mental health clinics to reach families directly in their communities, with the goals of increasing access to services, reducing stigma, and providing services in geographically isolated areas (8). As of 2014, the U.S. Department of Health and Human Services reported an approximate shortage of 4,000 mental health professionals in medically underserved areas. From the data, it was concluded that it would take approximately 2,800 additional psychiatrists to eliminate these areas where there was a lack of access to mental health services (9). The University of California, Riverside, Psychiatry Residency Program has identified these alarming shortages and become involved in an ongoing project, initiated by Riverside University Health System-Behavioral Health, aimed at addressing the lack of access in mental health services. In order to bridge barriers and create more access to mental health services, Riverside University Health System-Behavioral Health implemented a mobile prevention and early interventions program, which provides prevention and mental health services intervention for children in the 0- to 7-year-old age range, assisting this patient population with the earliest signs of mental health concerns.

METHOD

Clinical Operations and Services

Clinical teams are comprised of two therapists serving on each mobile unit, with auxiliary support provided by a staff psychologist, mental health services supervisor, and psychiatry residents. The clinical team provides counseling, parenting classes, and consultation while on the mobile unit, periodically providing training for other mental health staff within Riverside University Health System-Behavioral Health. Mobile units rotate throughout various school districts to increase mental health service accessibility. Patients are enrolled in the clinical programs through self-referral and school referrals. The mobile clinics participate in the National Alliance on Mental Health Illness events and mental health fairs, providing information to caregivers, educators, and the community at large. The units are custom-built recreational vehicles, fitted with a playroom and observation room, with a one-way mirror for observation of therapy sessions, which are monitored in real-time during parent-child clinical treatment (10). Three principle therapy modalities are employed in the mobile units: 1) Parent-Child Interaction Therapy, 2) Trauma-Focused Cognitive Behavioral Therapy (CBT), and 3) Strong Kids group. Parent-Child Interaction Therapy is an evidence-based practice consisting of live coaching from a therapist directly to a caregiver of a child with behavioral problems designed to promote positive parent-child relationships and interactions while teaching effective child management skills (12). Trauma-Focused CBT is an evidence-based treatment approach shown to help

children, adolescents, and their caregivers overcome trauma-related difficulties through age-appropriate play-based interventions. It is designed to reduce negative emotional and behavioral responses following child sexual abuse, domestic violence, and other traumatic events (13). Strong Kids group is a prevention and psycho-education group for children currently experiencing the impact of having an incarcerated family member.

KEY POINTS/CLINICAL PEARLS

- Mobile clinics create increased feasibility to patients to access mental health services in geographically isolated areas.
- As of 2014, there is an approximate shortage of 4,000 mental health professionals in medically underserved areas.
- Medically underserved populations include a diverse range of individuals from various cultural backgrounds and spiritual and personal beliefs that have limited mental health service accessibility in various geographic settings.
- Reducing mental health barriers and eliminating disparities in underserved populations is crucial in helping empower patients and families.

DATA COLLECTION

Clinical therapists directly monitor patient therapeutic interventions and input demographic data such as ethnicity, gender, age, working diagnosis, and treatment outcome data into electronic health records to document and examine the children's and parents' progress during each clinical encounter. Preliminary data regarding Parent-Child Interaction Therapy services are presented in this article. The opportunity for continued collaboration with Riverside University Health System-Behavioral Health, Prevention and Early Intervention Mobile Services program and University of California, Riverside, psychiatry residents presents the prospect to initiate future practice improvement projects, along with possible further data analysis to track and improve patient outcomes and develop program initiatives (13).

RESULTS

The mobile clinic served 132 clients, all of whom reported receiving mental health services for the first time. Having access to mental health services in underserved populations is paramount in providing early intervention through behavioral therapies and addressing mental illness through referral to behavioral health services. Through increased community outreach, preventative measures are set to assist children from developing future negative outcomes (i.e., psychiatric hospitalizations, poor academic/social development). A significant portion of the treated patients would not have otherwise had access to, or engaged in, ongoing treatment if it were not for the mobile clinics going to underserved communities in geographically isolated regions. The aim of serving the underserved population was reached, with treatment services provided primarily to children of Hispanic ethnicity (42%). Oppositional-defiant disorder (87.9% [cumulative]) and intermittent explosive disorder (86.4% [cumulative]) were the two most prominent diagnoses treated with Parent-Child Interaction Therapy in the mobile units, an evidence-based treatment for young children with behavioral problems. There was a statistically significant decrease across all regions on the average frequency and severity of children's behavior (p=0.008) using the Eyberg Child Behavior Inventory measuring pre- and postscores of caregivers of children (14).

CONCLUSIONS

Reducing mental health barriers and eliminating disparities in underserved populations is crucial in helping empower patients and families. Access to behavioral health services is a serious issue requiring innovative measures. Community involvement is pivotal in strengthening ties between communities and mental health by providing services to the people who need it the most, such as those residing in geographically isolated communities (15). Young children with defiant, aggressive, and hyperactive behaviors often meet criteria for *oppositional-defiant disorder* and *intermittent explosive disorder*. The significance of these diagnoses in underserved populations highlights the importance of early intervention, prevention, and identification regarding negative behaviors in children through improved access with mobile prevention and early intervention programs in order to provide support for parents and children to possibly decrease and prevent negative mental health outcomes (i.e., poor academic performance, loss of home placement, child welfare involvement, etc.) (16). Through completing full courses of behavioral therapies, such as Parent-Child Interaction Therapy, children and caregivers are jointly involved in treatment to improve the parent-child relationship, thus reducing the number of children referred for treatment due to behavioral problems (17). University of California, Riverside, psychiatry residents have the opportunity to serve in the role of patient advocate, focused on a patient-centered model. Approaching mental illness from a public health standpoint is central to improving mental health outcomes in communities. The challenge to eliminate mental health disparities and increase access to mental health services to underserved populations requires further research, patient education campaigns, and community outreach in non-traditional settings (per conversation with Lee Richard, M.D., and Girard. Emma, Psy.D., Dec. 1, 2015).

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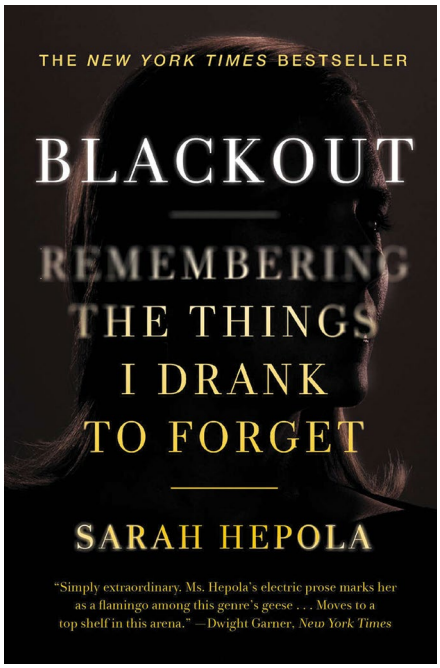
BOOK AND MOVIE FORUM

Blackout: Remembering the Things I Drank to Forget

Reviewed by Ish Bhalla, M.D.

First scientifically described in 1946 by E.M. Jelliinek, an alcohol-induced blackout is an amnestic event during a drinking episode without loss of consciousness. During a blackout, the alcohol user may behave normally, yet have no recollection of events upon sobriety. Blackouts may be "complete" (en bloc) or "incomplete" (fragmented), sometimes distinguished by the ability to recall events with memory cues. The mechanism of this phenomenon is thought to involve alcohol's antagonism of the *N*-methyl-D-aspartate receptor, leading to inhibition of CA1 pyramidal cells in the hippocampus, resulting in a temporary disruption of the encoding step of memory formation (1). Blackout history can provide important insight into a person's relationship with alcohol. Such history can be a source of exploration as a negative consequence of drinking when addressing ambivalence to change.

In her *New York Times* bestselling memoir *Blackout: Remembering the Things I Drank to Forget*, Sarah Hepola describes several such blackouts in the course of her lifelong relationship with alcohol. Hepola's first taste came when she was just 7 years old sneaking sips of beer. She recounts an immediate intoxicating euphoria. Her first blackout came 4 years later when, unknowingly, she removed her clothes at an arcade and was discovered crying in a stairwell. Hepola's alcohol use escalated in college where excessive drinking was commonplace. Working as a writer in Dallas, and later in New York City, she had several anonymous one-time sexual encounters during blackouts. Hepola eventually got sober a few years before the memoire was published, and she discusses her temporary substitution of binge eating for binge drinking. She ends her book by discussing the challenges of dating, working, and socializing while sober, without using alcohol to cope.



by Sarah Hepola. New York, Grand Central Publishing, 2015, 230 pp., $26.00.

I was drawn to Hepola's skillful use of self-deprecating humor to showcase her neuroticism. I found myself questioning how I would approach a patient like Hepola had she come to my office for substance abuse treatment. How could sobriety possibly compete with the physiologic comforts of alcohol? If using a motivational enhancement approach, I would likely feel the righting reflex, the temptation to correct or provide alternatives rather than guiding a patient through her ambivalence to change (2). While helping Hepola cope during the early stages of remission, an insight-oriented approach might uncover a fear of being alone without her trustworthy relationship with alcohol. Consistent alcohol use during development dampens physiologic arousal surrounding stressful life events. Consequently, when a person stops drinking later in life, the therapist will need to provide support as the patient transitions to a life without a mind-altering drug (3).

Unfortunately, Hepola does not delve into the factors that led her to eventually stop drinking. From the perspective of an early-career psychiatrist, it is helpful to postulate that the discomfort of blacking out eventually outweighed the comforts of drinking. As evidenced from the title of Hepola's memoir, understanding the influence of alcohol on memory may bolster our understanding of why our patients drink and help them to cope once they have achieved abstinence.

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

TEST YOUR KNOWLEDGE HAS MOVED

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

We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment for their questions.

Submissions should include the following:

1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.

**Please direct all inquiries to Rachel Katz, M.D., Senior Deputy Editor (rachel.katz@yale.edu).*

Residents' Resources

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

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

NOVEMBER DEADLINES

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
American Psychosomatic Society (APS) Scholar Awards **Deadline: November 1, 2016**	APS	Between 10 and 24 APS Scholar Awards are presented to outstanding abstract submissions where the first author of an accepted abstract is either a student, resident, or fellow. Each award provides monetary assistance for the APS conference fees, travel, and hotel accommodations.	APS member or in the process of applying for membership; First author on an abstract accepted for presentation at the APS Annual Meeting; Student or trainee enrolled in medical, graduate, or undergraduate school or in residency, internship, or postdoctoral fellow.	NA	http://www.psychosomatic.org/awards/
APS Medical Student/Resident/Fellow Travel Scholarships **Deadline: November 1, 2016**	APS	Scholarships are intended to assist with travel, hotel accommodations, and meeting registration fees to the APS Annual Meeting. Each scholarship will include $500 travel funds, a complimentary registration to the 3-day meeting, and a complimentary one-year membership.	Applicant must be a medical student, resident, or fellow.	NA	http://www.psychosomatic.org/awards/
APS Minority Initiative Award **Deadline: November 1, 2016**	APS	Each scholarship will include travel funds and a complimentary registration.	Applicant must be an underrepresented minority as defined by the NIH to be African Americans, Hispanics, Native Americans and Alaska Natives, and Pacific Islanders.	NA	http://www.psychosomatic.org/awards/
Research Colloquium for Junior Investigators **Deadline: November 30, 2016**	American Psychiatric Association (APA)	The colloquium provides guidance, mentorship, and encouragement to young investigators in the early phases of their training. Held during the APA Annual Meeting.	• Psychiatrists who are senior residents, fellows or junior faculty; • MD degree or be a member of the APA or eligible to become a member of the APA; • Must be receiving their training in the U.S. or Canada.	Keila Barber colloquium@psych.org (e-mail) or 703-907-8690 (phone)	https://www.psychiatry.org/psychiatrists/practice/research/research-colloquium

DECEMBER DEADLINE

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
Association for the Advancement of Philosophy and Psychiatry (AAPP) Karl Jaspers Award **Deadline: December 15, 2016**	AAPP	This award is given for the best solely authored, unpublished paper related to the subject of philosophy and psychiatry. Appropriate topics for the essay include, among others, the mind-body problem, psychiatric methodology, nosology and diagnostic issues, epistemology, biopsychosocial integration, the philosophy of science, philosophical aspects of the history of psychiatry, psychodynamic, hermeneutic and phenomenological approaches, and psychiatric ethics.	Resident or fellow in psychiatry, graduate students and post-doctoral students in philosophy, psychology, or related fields.	Christian Perring cperring@yahoo.com (e-mail)	https://philosophyandpsychiatry.org/jaspers-award/

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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. **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

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

Mental Health of Healthcare Providers

If you have a submission related to this theme, contact the Section Editor Charles Johnson, M.D. (charles.a.johnson@ucdenver.edu)

Childhood Medical Conditions and Psychopathology

If you have a submission related to this theme, contact the Section Editor David Saunders, M.D. (david.saunders@yale.edu)

LGBT Mental Health

If you have a submission related to this theme, contact the Section Editor Mark Messih, M.D., M.Sc. (Mark.Messih@gmail.com)

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