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Moral Distress and the Importance of Psychiatric Ethics

Jennifer Huang Harris, M.D.

Andrew Jameton originally defined moral distress as “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (1). The concept of moral distress is significant because it considers the consequences to an individual when ethics fail to be translated to practical application, and is particularly illuminating in the context of psychiatry.

Most of the research thus far has focused on the field of nursing, in which the distress is created by the “lack of power and control over the resources necessary for them to fulfill their role obligations” (1). In contrast, the moral distress of psychiatrists emerges from the “nature of the role itself,” in the conflicting responsibilities inherent in the power they possess (2).

Psychiatry is unique among the medical specialties in its power to infringe upon the rights of patients and treat them against their will (2). This power is granted to psychiatry by society because the pathology of its patients lies in their “will”—their ability to discern reality, reason logically, and make accurate judgments. The psychiatrist is called upon to substitute his or her own judgment for that of the patient’s. However, this power is granted to the psychiatrist with responsibilities to both the patient and society, and the psychiatrist must often mediate between the often conflicting responsibilities.

For example, we often encounter the situation when we are asked to evaluate a patient whose family members demand hospitalization and medication against the patient’s will, even when the

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patient is not clearly a danger to him- or herself or to others. In such a case, whose needs do we serve? The patient’s or society’s?

The conflicting responsibilities create a series of antagonist relationships that contribute to moral distress in psychiatric providers (3). There is the antagonistic relationship with the patient, as above. On the consult service, antagonism with the patient can occur due to the perceived threat of being labeled incompetent or insane, and antagonism with the primary team occurs when psychiatrists are asked to resolve ethical dilemmas by deeming the patient incompetent (4). There is the antagonistic relationship with society, when the psychiatrist must act in fear of reprisal from the law.

Dangers lie on all sides. If the patient whom we deemed safe to return home were to kill him- or herself or others or be the perpetrator of a mass shooting, the evaluating psychiatrist would be held responsible for predicting the future. Yet if we fail to balance this responsibility to society with responsibility to the patient, we run the risk of

becoming the psychiatrists complicit in the Nazi extermination of the mentally ill and the hospitalization of political dissenters in the Soviet Union.

Ethics is fundamental to the practice of psychiatry, and lack of ethical discussion in clinical settings is correlated with moral distress (2, 5). Without clear delineation of our responsibilities and limitations, we carry a burden of guilt and inadequacy (3). We need clear thinking in psychiatric ethics so that we act for the good of both our patients and society, preserve our integrity, and retain our ability to engage in our work (5).

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The Right of Psychiatric Patients to Leave Against Medical Advice

Rami Abukamil, M.D.

Psychiatrists commonly encounter patients who wish to leave against medical advice. When faced with this situation, a physician should evaluate the need for treatment. This evaluation should include assessments of risk, the level of disability, the ability to provide for basic needs, as well as the capacity to make rational treatment decisions (1).

In Michigan, a voluntary patient can request a discharge by signing the 72-hour release form or, alternatively, by writing a “3-day letter.” If the examining physician determines that the patient requires involuntary hospitalization, the treatment team has 3 days to complete a petition for hospitalization and two physician certificates and file them with the court. In that event, the patient must remain in the hospital until the court makes a determination (2).

Common situations in which voluntary patients leave against medical advice include when they lack insurance coverage or are dissatisfied with services (3). The outcome relies on whether the doctor has a duty to involuntarily commit the patient or to discharge the patient against medical advice (3, 4).

In *Solbrig v. United States*, a veteran committed suicide after being discharged against medical advice. The plaintiff alleged that the patient should have been involuntarily committed. The court found for the defendants, highlighting the fact that while the veteran reported suicidal thoughts on admission, he had demonstrated no intent or plan. Furthermore, on his discharge

The decision to
discharge is ultimately
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responsibility.

examination, the veteran was “clear-headed” and no longer reported suicidal thoughts. Given these findings, the court found no breach of duty or malpractice (3, 4).

In *Wilson v. Blue Cross of Southern California*, a patient was admitted to a hospital for treatment of depression, substance use, and anorexia. The initial plan was to hospitalize the patient for 3–4 weeks. The patient was discharged after 10 days, when the insurance company refused payment. The patient committed suicide approximately 3 weeks after discharge. The psychiatrist testified that had the patient been allowed to complete the recommended course of hospitalization, the suicide could have been prevented. The Court of Appeals found in favor of the plaintiff and reversed the trial court’s dismissal on summary judgment of the case, arguing that both a treating physician and managed care organizations could be found liable (3, 4).

Thorough documentation can offer the best legal protection; this entails a record of all risk assessments, highlighting the risk and protective factors, and the interventions. Important interven-

tions include the use of moral suasion to help the patient accept hospitalization, communication with significant others and family members who can report on the patient’s specific symptoms, triggers and behaviors, and addressing modifiable factors, such as removing access to weapons. Appealing to third-party payers or helping the patient establish financial arrangements should be considered when denial of coverage becomes an obstacle (1, 3, 4).

The decision to discharge is ultimately the psychiatrist’s responsibility. However, the psychiatrist must make that decision in a way that benefits the patient and avoids harm to the patient and the community.

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Ethical Considerations Regarding End-of-Life Planning and Palliative Care Needs in Patients With Chronic Psychiatric Disorders

Rebecca L. Bauer, M.D.

It has been well established in the literature that individuals with chronic psychiatric disorders suffer from increased and earlier mortality than the general public (1). Those with schizophrenia die up to 25 years earlier than those without psychiatric disease (2, 3). Numerous factors contribute to poorer health outcomes aside from limited medication compliance, including under detection of medical conditions and detection at more advanced progression. Nevertheless, there is a lack of literature on how to address unique palliative care needs that can present in those with chronic psychiatric disorders and also how to increase utilization of these services sooner in psychiatric patients facing end of life. Palliative care for those with pervasive psychiatric disorders can be ethically challenging for providers, as often the burden toward beneficence is much stronger than the value for autonomy.

ADVANCE CARE PLANNING

To preserve autonomy for end-of-life decisions, patients are encouraged to discuss and document their choices in advance. Psychiatric care for those with chronic psychiatric disorders can often be driven by paternalism, especially when patients decompensate psychiatrically throughout their lives. It can be difficult for providers to re-establish that sense of autonomy for these patients, as often they are thought of as one of the most vulnerable populations. Even when patients have established guardianship, they may still be capable of communicating their wishes. One study included a review of the presence of a documented health care proxy in the

medical records of those with chronic psychiatric disorders and found that only 1 in 344 records included such a designation (4). However, a study based out of Massachusetts demonstrated that patients with chronic psychiatric disorders were interested in participating in end-of-life planning with their providers. Out of a sample of 150 patients, 72% believed someone should be designated as a proxy to make medical decisions if they were incapable to do so (5). Complex and often ethically driven fears that patients lack the capacity to understand, such as the permanence of a DNR [do not resuscitate] order, can lead to avoidance. When these discussions do not occur, patients are placed at risk of receiving aggressive and unnecessary life-sustaining measures. Families and providers can be left with the difficult burden of making the decision in acute care settings, which again ultimately favors a paternalistic approach when autonomy is not allowed through advanced planning.

Unfortunately, many patients with chronic psychiatric disorders face complex social issues that can limit treatment decision making. A lack of family due to lower rates of marriage or strained family relationships are factors to consider when aiding someone in choosing a health care proxy (6). In addition, homelessness is a key issue in patients with pervasive psychiatric disorders that must be addressed in the palliative care planning process (2). Forging a relationship with patients and providing support through social work services or emotional care through support groups or chaplaincy services can serve a crucial role in end-of-life plan-

ning in those with unstable social situations (7, 8).

SYMPTOM MANAGEMENT

When considering palliative care needs, it is common to address underlying somatic symptoms such as pain, nausea, and energy level, but underlying psychiatric symptoms should also be addressed. When a patient presents with altered mental status, one should be diligent in ruling out potential delirium versus an exacerbation of their prior psychiatric disorder. When underlying psychiatric symptoms such as psychosis, mania, or depression worsen in a palliative setting, aggressive attempts should be made to treat these symptoms to improve quality of life. Patients can be better understood by exploring thought content that overtly appears delusional as a possible disorganized attempt to communicate underlying physical distress. For example, a case report described a patient with schizophrenia and comorbid head and neck cancer who presented with complaints of a fractured face and tongue and was found to have oral thrush and headaches (9). It is well documented that individuals with schizophrenia express pain less often and differently than others, and thus understanding changes in mental status as possible underlying physical distress can help address nonverbal suffering (7, 10).

Refusal of treatment is possible, and when guardianship is not present, capacity should be frequently evaluated. Physicians often are strongly motivated to uphold the oath to heal, and in patients with pervasive psychiatric dis-

orders that drive can challenge patient autonomy when insight and judgment are often impaired. For treatment of psychiatric symptoms with psychotropic medications, legal processes should be reviewed for involuntarily medicating patients. However, mental health providers can educate treatment teams on the use of emergent administration of psychotropic medications. Efforts to alleviate agitation, fear, or anxiety secondary to psychosis can be a palliative-driven treatment to relieve nonphysical pain. As mentioned previously, effectively communicating with patients and building rapport can improve trust, compliance, and ultimately enhance outcomes.

**PATIENT-PHYSICIAN
RELATIONSHIP**

It is important to consider the relationship between the patient and the provider when discussing the palliative needs of those with chronic psychiatric disorders. Underlying psychotic symptoms, such as paranoia or delusional thought content, can impair patients’ ability to trust their providers, especially those with whom they are not familiar. In addition, nonpsychiatric providers can often be uncomfortable caring for psychiatric patients and can harbor conscious or unconscious stigma (2). Stigmas include fear of violence, ideas of psychiatric illness directly correlating with mental incapacitation, and overall sense of psychiatric disorders being a burden to care. Psychiatrists can serve as an advocate for patients and attempt to mend relationships with external providers when patients themselves feel prejudiced.

**WORKING AS A
MULTIDISCIPLINARY TEAM**

Collaborative care can bridge the gap between psychiatry and other fields of palliative medicine. A study examining end-of-life planning for psychiatric patients in the Veteran’s Affairs (VA) health care system found increased access and advanced planning for end-of-life care among veterans with schizophrenia and terminal illness compared

to the general population. These veterans were found to have improved end-of-life planning, with 58% having an advance directive, 63% having a physician DNR order, and 55% ultimately enrolled in hospice (11). The collaborative nature of the VA health system, including partnership with psychiatric providers, appears to have improved outcomes. The study supports the need for collaborative care between psychiatry, primary care, and specialty care providers (e.g., oncology) when addressing end-of-life planning. By incorporating the expertise of various fields, neither the underlying psychiatric disorder nor the terminal condition is neglected.

Respect for autonomy while relieving pain and suffering is an important principle common to both palliative care and psychiatry. Incorporating cross-training between palliative care and psychiatric nursing staff is a means to emphasize common skills in patient care. Integrative training can help prepare nursing staff to address obstacles those with psychiatric disorders can pose in achieving these goals (12). Efforts have also been made to push for an incorporation of palliative care education into psychiatry residency programs. One study found that 97% (N=95) of residents surveyed agreed that they desired formalized palliative care training (13). Mutually, palliative care teams have expressed interest in having psychiatrists more involved, as only 10% of palliative care teams have a full- or part-time psychiatrist employed as a member on their team (14). As the interest in incorporating palliative care into end-of-life planning expands, there is potential for psychiatry to also expand into this growing field of medicine.

TABLE 1. Role of Psychiatrists in Palliative Care

Address end-of-life planning including advance directives.
Evaluate for capacity.
Rule out delirium when psychiatric symptoms exacerbate.
Educate on appropriate palliative use of psychotropic medications.

**PALLIATIVE APPROACH IN
TREATMENT-RESISTANT
PSYCHIATRIC DISORDERS**

Although controversial, cases have been reported of severely treatment-resistant psychiatric disorders, such as anorexia nervosa, being converted to a palliative approach (15, 16). Similarly, severe psychosis in patients with thought disorders can lead to refusal of basic needs, such as nutritional intake. Patients’ psychiatric disorders can medically place them at risk, at times requiring involuntary treatment. Use of palliative approaches in neurodegenerative conditions, such as advanced dementia, are more widely accepted because there is no effective cure to prevent ongoing mental decline (17). However, in disorders such as anorexia, treatment options are limited, and in cases of the most severe thought disorders, individuals can be resistant to all treatment approaches. Ethically, such cases are challenging. Incorporating ethics committees in cases in which severe psychiatric disorders are solely responsible for the terminal medical decline can help clarify goals and ensure all viable treatment options have been reasonably explored.

KEY POINTS/CLINICAL PEARLS

- Advanced care planning is important to discuss with patients in the outpatient setting to persevere autonomy.
- When exploring palliative care needs in patients with chronic psychiatric disorders, addressing social barriers and lack of support is imperative.
- Incorporation of psychiatric providers into multidisciplinary teams can ensure that both the terminal condition and the psychiatric disorder are appropriately managed.

CONCLUSIONS

There is a lack of research on end-of-life care in those with serious and pervasive psychiatric disorders. Psychiatrists play a key role in the longitudinal care of these patients and can make an impact by incorporating advanced care planning into routine psychiatric care (see Table 1). When facing a terminal illness, addressing underlying mental health needs is crucial in the field of palliation. Further studies are required on how to best deliver palliative care in those with chronic psychiatric disorders. Thus far, collaborative care has proven to be most effective. Psychopharmacology has allowed psychiatry to relieve mental suffering throughout a person's life. However, building relationships through empathic communication and compassionate care can preserve beneficence and autonomy as all individuals, including those with psychiatric disorders, face their end of life.

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Patient-Targeted Googling and Psychiatry: A Brief Review and Recommendations in Practice

Alexander Cole, M.D.

The ever-increasing utilization of social media services by both the public at large (1) and clinicians and trainees (2–4) has changed how physicians make use of information posted online. One consequence of this trend is the advent of patient-targeted googling (PTG), an information gathering technique used by members of a health care team to search for information about a patient online. Limited data on the prevalence of PTG use among mental health professionals suggest that it is common and often includes inappropriate searching for patient information (5). Case reports have demonstrated beneficial uses of PTG (6)—including, for example, using social media to contact a patient lost to follow-up after a previously discovered genetic mutation was found to be clinically significant (7)—and multiple studies have revealed the utility of social media in identifying patients at increased suicide risk (8–9). Despite some promising applications, PTG is a technique rife with ethical concerns deserving of the psychiatrist's attention prior to engaging in a search for patient information. The present article will review published guidelines on the use of PTG and make practical recommendations for psychiatrists who are considering this technique in the care of their patients.

A FRAMEWORK FOR INCORPORATING PTG INTO PRACTICE

Few formal guidelines have been published concerning the use of PTG in the clinical setting. A position paper discussing the use of the Internet by physicians briefly mentions PTG but makes no specific recommendations for incor-

porating the technique into practice (10). A more thorough discussion of PTG in the context of psychiatry, by Clinton et al. (11), reviews potential issues related to its use, including the exploitation of patients based on discovered information, violations of patient privacy, subjugation of a patient's interests to the curiosity of the psychiatrist, and harm to the psychotherapeutic relationship. The relative ease and anonymity afforded by online searching may promote regular, casual searching of information about patients and heightens these concerns. The authors recommend that the decision to utilize PTG should be determined on a patient-by-patient basis and always in service “to the patient's best interests” and offer a series of questions for the psychiatrist to ask him- or herself as guidance for performing ethically permissible searches.

Due to these concerns, review of the ethical issues surrounding PTG, particularly for younger clinicians who are more likely to utilize the Internet in the course of clinical care, is warranted. The following guidelines are based on the framework developed by Clinton et al. (11) and will similarly emphasize concrete, practical considerations over abstract ethical constructs.

Framing a Search

The rationale behind a search, the specific information being sought, and how that information will assist in the patient's treatment must be identified prior to a search. PTG performed out of simple curiosity or that is unlikely to contribute positively to a patient's treatment has no clinical utility and may be quite harmful (11). Patients may perceive accessing publicly posted information in the context of a treatment rela-

tionship as an invasion of privacy and violation of trust (12). The breadth of information available online is potentially more invasive than traditional violations of clinical boundaries—for example, visiting a patient's home or place of work—and the ease of finding personal information online may provide a false sense of acceptability to psychiatrists. Because of these concerns, PTG may be most appropriate as a tool of last resort, utilized only if other routes of information gathering have failed.

The consequences of discovering unexpected information in the course of a search and its impact on the treatment relationship is also worth considering. A case report involving a nurse's impromptu use of PTG to find information about a mother whose behavior toward her child raised concerns highlights the difficulties of managing unexpected information (13). When weighing the risks and benefits of conducting a search, attentiveness to the potential impact of all discovered information is suggested.

Obtaining Informed Consent

It is recommended that informed consent be obtained prior to beginning PTG (14). Patients should be made aware of the purpose and risks of a search, including the potential discovery of unrelated personal information and documentation of search results in the patient's medical record (11). By obtaining informed consent, the psychiatrist maintains honesty in the therapeutic relationship, informs the patient of both the risks and benefits of a search, and welcomes the patient to provide the sought information on his or her own terms before relying on PTG. In some cases, a patient may refuse to consent to a search; the decision to continue a search in this setting warrants care-

ful consideration due to the potentially negative impact on the treatment relationship if the search is later disclosed to the patient.

Completing a Search and Assessing Obtained Information

No standard protocols for performing PTG have been published. Lane et al. (6) briefly discuss some of the tools available for performing PTG, including public record databases, as well as innumerable resources accessible via search engines. Additionally, McNary (15) recommends using search terms that limit the potential of discovering information unrelated to the focus of the search.

Some commentators have argued that the uncertainty surrounding the accuracy of information obtained online requires caution (16) or even precludes the use of PTG in clinical care (13). Concerns raised about information obtained online include the interpretation of online lingo and differences in an individual's online and real-world persona, which may weaken the reliability of PTG (17). Attempts to verify discovered information prior to use in decision making are paramount but may not be possible. Using information obtained from third parties (e.g., social media posts) especially requires caution. Simple misidentification, particularly in cases using common names, can also occur. Because of these concerns, verification of discovered information with the patient or additional collateral is recommended.

Documenting and Disclosing Discovered Information

At the conclusion of the search, any information used in clinical decision making should be documented in the patient's medical record (15). Consistent documentation of the results of all PTG can assist in avoiding casual searches and ensure that the medical record reflects a clear rationale for treatment decisions.

The decision to disclose the results of PTG to the patient is more controversial. Clinton et al. (11) state that the decision to disclose information should be made on an individual basis. In the author's opinion, information that guides management decisions should be disclosed to the patient with few exceptions. Direct disclosure of obtained information also allows the patient to correct inaccuracies, informing the psychiatrist's judgment regarding the reliability of the information. Withholding information from patients may undermine the inherent trust of the treatment relationship and introduce a degree of secrecy that is unlikely to be therapeutically productive. The necessity of a search requires consideration if the disclosure of identified information to the patient may be problematic.

Should unexpected information relevant to ongoing treatment be discovered—for example, evidence of active substance use or acute suicidality or homicidality—direct discussion of concerning findings with the patient is recommended. Information sugges-

tive of acute danger should not be ignored; in addition to an ethical duty to act, the psychiatrist may be exposed to medicolegal liability for ignoring evidence of acute danger (15). Discovered information that is not clinically significant need not be disclosed, though may shape a psychiatrist's impression and treatment of the patient with therapeutic consequences (11).

Reassessment of Continued Searches

Repeated searches on a single patient warrant self-monitoring of the psychiatrist's motivations for continued PTG in order to avoid ethically dubious searches (11). Consultation with an ethics service for an opinion on the necessity and appropriateness of repeated PTG can help avoid searches that may not be therapeutically beneficial.

CONCLUSIONS

PTG can be an indispensable and valuable tool for the psychiatrist in carefully chosen situations (see Table 1). While the process of PTG is itself straightforward, the consequences of its use are less clear and difficult to predict. Using a risk-benefit framework to determine the necessity and impact of a search, as well as acknowledging the invasive nature of PTG and its potential impact on the treatment relationship, is recommended. Discussion with a colleague, superior, or an ethics service *prior* to initiating a search with the goal of clarifying the benefits and appropriateness of PTG can be useful in difficult cases.

TABLE 1. Examples of Appropriate and Inappropriate Uses of Patient-Targeted Googling (PTG)

Appropriate Use ^a	Inappropriate Use
Identifying a patient who is unwilling or unable to identify themselves	Physician curiosity
Acquisition of information critical to medical decision making	<ul style="list-style-type: none"> Verifying clinically irrelevant aspects of a patient's history Searching for personal information irrelevant to a patient's care
<ul style="list-style-type: none"> Attempting to identify and contact a patient's family members if necessary for disposition planning 	Searching for information that may be relevant, but not necessary, to providing clinical care
Searching for information necessary to contact a patient's collateral if the patient cannot provide contact information	<ul style="list-style-type: none"> Searching a patient's social media profile(s) for evidence of substance use
Contacting patients lost to follow-up in clinically urgent scenarios	<ul style="list-style-type: none"> Using social media to verify aspects of a patient's social history
<ul style="list-style-type: none"> Informing patients of abnormal test results that require further evaluation and treatment 	First-line use without initially attempting more focused information-gathering techniques
Attempting to contact a patient when clear evidence of crisis is present	Routine searching for information on all patients regardless of clinical circumstances or urgency

^a These scenarios assume that other attempts at obtaining the requested information—for example, from the patient directly or from designated collateral—have failed.

KEY POINTS/CLINICAL PEARLS

- Patient-targeted googling (PTG) is an information-gathering technique that utilizes various online search engines to find information about a specific patient to aid in clinical decision making.
- Though PTG can be immensely useful as a clinical tool, it is associated with significant risks and ethical concerns, including the violation of patient privacy and harm to the psychotherapeutic relationship; as a result, casual searches for patient information should be avoided and the technique used only if clinically necessary
- PTG should be performed only after careful consideration of the risks and benefits *before* searching for information, a process that should include obtaining consent from the patient directly in most cases.
- Information from PTG that is used in clinical decision making should be documented in a patient's medical record and, with few exceptions, disclosed to the patient at the conclusion of a search.

Moving forward, mental health professionals would benefit from definitive guidelines outlining the ethical use of PTG and similar techniques in routine clinical practice. Guidelines specific to psychiatrists taking into account the sensitive nature of psychiatric illness, the centrality of the relationship between psychiatrist and patient, and the effects of PTG on these aspects of care would be particularly beneficial. Education for younger clinicians—the population most likely to engage in PTG and its problematic use—focused on the responsible use of online information gathering has already begun (18). Before formal guidelines are developed, however, psychiatrists must take care to ensure that online searches for patient information are ethically permissible, are in service to a patient's care, and include prudent assessment of the risks of the practice.

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The Psychiatric Ramifications of Moral Injury Among Veterans

Thayanne Delima-Tokarz, D.O.

As former marine Timothy Kudos (1) puts it, “The ethical damage of war may be worse than the physical injuries we sustain To properly wage war, you have to recalibrate your moral compass Once you return from the battlefield, it is difficult or impossible to repair it.” Most soldiers are able to acutely compartmentalize and rationalize their experiences by their training, warrior culture, and, most importantly, through their military community (2). However, often it is when they separate from the military that the moral conflict surfaces; or, as Meager (3) describes in his book *Killing from the Inside Out*, they reach “moral clarity.”

Moral injury is not a new concept, but the term and clinical construct are relatively new because research in this field is still in its infancy. Acts of commission and omission called for by the active duty are often difficult to reconcile with one’s values in civilian life, causing internal distress and often moral injury (4). Psychiatrist Jonathan Shay (5) coined the term “moral injury” and defined it as a “betrayal of what is right by someone who holds legitimate authority in a high stakes situation.” The definition of moral injury has since been expanded to include “perpetrating, failing to prevent, bearing witness to acts that ultimately transgress one’s deeply held moral beliefs,” creating dissonance (2). Currier et al. (6) carried out a study with recently deployed veterans to better understand contextual factors in which moral injury occurs. Using semi-structured interviews, along with PTSD Checklist and Moral Injury Questionnaire-Military version, four main categories of morally injurious events were generated. These categories included organizational, environmental, cul-

tural, and relational and psychological circumstances (see Table 1). Shedding light into what these experiences entail may help clinicians assess for moral injury in their own patients.

MORAL INJURY VS. POSTTRAUMATIC STRESS DISORDER (PTSD)

After the Vietnam War, service members coming home endured troubling psychological effects that led to the diagnosis, research, and treatment of PTSD, which made significant progress

in the psychiatric care of the U.S. military population. The fear-related symptoms of PTSD alone, however, may fail to fully capture the suffering in the aftermath. It is often what these veterans did, or did not do, in war that continues to haunt them. This is best described as moral injury.

The importance of this internal commotion is apparent in the writing of former marine Gibbons-Neff (7), who stated that “moral injury isn’t so much about how the country understands its veterans; rather it is about how veterans understand themselves.” Not all those

TABLE 1. Main Categories of Morally Injurious Events^a

Category
Organizational
Veterans commonly reported perceiving military leadership as not fully understanding how life truly was like for military members on the ground, as well as being incompetent.
Veterans commonly reported perceiving military leadership as not caring about them and self-serving to their own needs.
Veterans commonly reported coming to accept that decisions to engage in behaviors that led to moral injury were at the directive of military personnel of higher rank.
Veterans in smaller units reported greater sense of vulnerability and lack of accountability.
Environmental
Veterans reported the enemy not following the same rules of engagement.
Veterans reported difficulty at times properly assessing danger and identifying the enemy versus civilians in high-stakes situations.
Cultural and relational
Veterans reported times of internalizing the “kill or capture” mentality in war.
Veterans reported times of distrust or perceived incompetence toward comrades.
Psychological
Veterans reported periods of hopelessness toward being able to return home from war, as well as times of desiring to do whatever it takes to come home.
Veterans reported feelings of numbness and emotional detachment toward some of the events in war.
Veterans reported persistent feelings of fear and helplessness.
Veterans reported feelings of accumulating anger and wanting revenge of the enemy-experienced distress and loss.
Veterans expressed feelings of grief over losses of fellow comrades.

^a For further details, as well as the assessment instruments used, see Currier et al. (6).

suffering from PTSD have moral injury, and, conversely, not all of those with moral injury have PTSD. In addition, an individual suffering from moral injury does not necessarily need to have experienced a trauma of the type required for a PTSD diagnosis (8). It is important to emphasize, however, that moral injury and PTSD can coexist.

MORAL INJURY AND PSYCHIATRIC RAMIFICATIONS

Moral injury explores the contributions of the guilt and shame to postdeployment psychopathology (4). When talking about moral injury, it is important to distinguish guilt versus shame. Guilt is an evaluation of the morality of an action, which creates an opportunity for forgiveness. Shame, on the other hand, is a global evaluation of the self, which leads to self-condemnation, avoidance, and withdrawal (9). Avoidance, in turn, further limits reparative experiences and social connection, resulting in individuals suffering in isolation (2). Signs of moral injury can include interpersonal difficulties, distrust, spiritual/existential crises, psychological problems, anger, substance use, self-destructive behaviors, and self-deprecation (4, 10).

Improving our understanding of moral injury may allow us to devise treatments that target these wounds and address what might be another risk factor for suicide among veterans. The importance of better treatment for combat veterans cannot be overemphasized, given that since 2012, death by suicide is greater than by combat among active-duty soldiers (11). PTSD often focuses on being the victim of a traumatic experience, but it neglects the psychological effects of perceiving that one is the perpetrator even in situations of prescribed acts of killing, such as in war. Studies have shown that being a target of another's attempt to kill or injure is associated with PTSD, while having been the agent of killing someone or failing to prevent death and injury is correlated more strongly with suicide attempts, suicidal ideation, anger, alcohol use disorders, relationship problems, weakened religious

faith, and overall greater psychiatric distress (10, 12–14). A recent study examining different combat experiences found that the act of killing or believing one killed the enemy and firing a weapon at the enemy were associated with increased suicidal ideation. Overall, this study revealed that while the act of killing predicted suicidal ideation with statistical significance, it was not more predictive of PTSD (15). This suggests that moral injury may account for a greater proportion of psychopathology than previously recognized.

SCREENING TOOLS

In order to better address soldiers and veterans suffering from moral injury, assessment instruments could be invaluable tools. Currently, two scales for moral injury have been developed, although neither is yet widely used. One is the 20-item Moral Injury Questionnaire-Military version, which attempts to capture morally injurious events experienced by military populations (16). Higher scores on this questionnaire are associated with poorer work and social adjustments and more severe PTSD and depressive symptoms. The other assessment is the 9-item Moral Injury Events Scale relating to perceived transgressions and perceived betrayals (17, 18). This scale has been shown to have good internal consistency and correlate with other measures of psychiatric distress and can be used to evaluate for prevalence and perceived intensity of morally injurious experiences. Further research in the validity of these scales with different military branches, both genders, and different operational roles are needed, but these assessment instruments may still serve as initial screening tools to capture veterans' experiences with moral injury and their level of distress from it.

Another idea suggested by Nazarov et al. (9) is the creation of a validated assessment tool for identifying individuals at risk and creating early intervention programs. Because shame is central to moral injury and appears to mediate onset of psychopathology, including PTSD, and depression, and possibly in-

crease risk of suicide, individuals more prone to shame may fit into the "at-risk" population (9). The Test of Self-Conscious Affect-3 scale, created by Tangney et al. (19), is one of the most widely used shame scales and separates responses into four categories, including guilt-proneness, shame-proneness, detachment, and externalization of blame. Theoretically, individuals scoring high in the shame-proneness category potentially may be more vulnerable to moral injury and benefit from early intervention programs.

POSSIBLE TREATMENTS

Because research in this field is still in its infancy, treatment of moral injury is still developing. Cognitive processing therapy and prolonged exposure have significant evidence for treatment of military PTSD, but patients also suffering from moral injury may need a special focus targeting the moral dissonance and shame that accompanies moral injury. The first published trial of treatment specifically targeting inner conflicts from morally challenging experiences was referred to as adaptive disclosure. Adaptive disclosure was initially developed for active-duty service members and is composed of six 90-minute sessions, which entail a combination of exposure therapy and cognitive processing therapy but sequences them specifically to target experiences that produce moral injury. Adaptive disclosure includes processing memories and exploring meaning of the experience, and individuals also carry out imaginable conversations with a caring moral authority or a key relevant "other," such as the deceased (20).

Another treatment approach is acceptance and commitment therapy for moral injury. Acceptance and commitment therapy focuses not on trying to change the shame and guilt that comes with the moral injury but rather on accepting it while not letting it dictate the individual's life.

Drescher et al. (4) explored commentaries regarding moral injury based on a diverse group of health and religious professionals experienced in working with military populations; some of the

KEY POINTS/CLINICAL PEARLS

- Moral injury is the conflict caused by transgressions of one's moral code by an individual or leadership.
- Moral injury is distinct from posttraumatic stress disorder (PTSD), as shame is central to moral injury while fear system is central to PTSD.
- The construct of moral injury is important to further understand psychopathology in veterans and possibly to help prevent suicide in military populations.
- Screening tools and treatment of moral injury is still in development and need further research.

suggested approaches included interventions at the spiritual, social, and individual levels, which suggests that a multidisciplinary approach may be the optimal solution for such a complex issue. Group therapy may also be helpful, as social support can serve as powerful healing tools in moral injury (5). An important concept when considering treatment modalities for moral injury is that in moral injury, an individual's judgments and beliefs about a moral transgression may be accurate and appropriate and need to be validated, while promoting acceptance of an imperfect self, as well as self-forgiveness and self-empathy (18).

CONCLUSIONS

The construct of moral injury is paramount to understanding the internal ethical and spiritual conflicts veterans are left with, which account for a significant unaddressed part of their psychopathology. Further research in this field is indispensable to cultivate a better life for our service members and veterans. Raising awareness and appropriate development and use of screening tools are important subsequent steps in the field of moral injury.

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A Need for Improved Detection of Child and Adolescent Sexual Abuse

Fatima Masumova, D.O.

“Meghan” is a 13-year-old referred by her endocrinologist for depressed mood and history of cutting herself. She is interviewed separately with her mother’s permission. She reports feeling depressed for most of the past year. She has daily thoughts of suicide, which are increasing in intensity, and on at least one occasion has tried strangling herself. At age 11, her stepfather allegedly touched her breasts. After a consultation with the hospital’s legal department, this case was reported to child protective services.

CHILD SEXUAL ABUSE STATISTICS

Unfortunately, “Meghan” is just one of the many teenagers who suffer abuse from a family member. It is estimated that approximately 15% of girls in their teenage years and 6% of boys ages 2–17 experience genital touching and/or penetrative sexual abuse. Most cases of child sexual abuse are often unidentified, with possibly as much as 95% not being disclosed to authorities (1). Child sexual abuse does not usually happen in front of witnesses, and the only available statistics consist of the cases disclosed to child protection agencies or law enforcement. Of 551 cases of child sexual abuse reports over a 12-month period, 34% did not constitute sexual abuse, 2.5% were erroneous concerns made by children, and 1.5% of these were false allegations (2). These statistics indicate a need for further study of child sexual abuse and improvement in recognition of the symptoms by medical personnel.

CHILD SEXUAL ABUSE ACCOMMODATION SYNDROME

The child sexual abuse accommodation syndrome model, developed by psychia-

trist Ronald C. Summit, M.D., may explain why children often do not report sexual abuse incidents or withdraw their complaints. The syndrome is composed of the following five categories: secrecy (not disclosing the abuse for multiple reasons, including intimidation); helplessness (children are intrinsically powerless and unable to protect themselves against adult intrusion); entrapment and accommodation (children have to endure the circumstances and learn to survive); delayed, unconvincing disclosure (often in adolescence, when the minor is able to overcome anxiety and confront the abuser); and retraction (usually due to guilt and lack of support from family members). Reportedly, this suggestion is based on statistically validated assumptions and observations made in community consultation practice and is endorsed by experienced professionals, as well as victims (3). The child sexual abuse accommodation syndrome model cannot be used to prove whether victims’ statements are reliable or whether the defendants are guilty; however, when acknowledged during legal proceedings, it may explain the victim’s counterintuitive behavior following the abuse (4).

ASSOCIATED SIGNS AND SYMPTOMS

It has been suggested that child sexual abuse differs from physical abuse in that it is associated with more long-term problems for the victims. In many cases, child sexual abuse is associated with multiple psychiatric disorders, including but not limited to depression, anxiety, and suicidality (5). More recent data indicate that different forms of child abuse have similar psychiatric and behavioral effects (6). Women and men

who were victims of child sexual abuse had 2–4 times and 4–11 times higher odds of suicide attempts, respectively, compared to nonabused adults (7). Recognized short-term symptoms of child sexual abuse vary based on a child’s age range. Patients between ages 2 and 6 present with higher rates of inappropriate sexual behavior, have lower intellectual abilities, often display signs of post-traumatic stress disorder (PTSD), and have more depression, anxiety, and social withdrawal compared to nonabused children. Patients between ages 7 and 12 are more likely to have depression, anxiety, PTSD, and suicidal ideation, as well as inappropriate sexual behavior and sexual aggression. Adolescents (ages 13–18) commonly present with depression, anxiety, PTSD, and lower self-esteem and are more likely to have suicidal ideation and complete suicide (8).

CHILD ABUSE SCREENING

Use of screening in the pediatric setting is one proposal to improve child abuse discovery. It has been recommended that a child sexual abuse screening tool should not be classified as a screen of “proof” of child sexual abuse but rather a simple prompt to do a more thorough examination of the child (9). A prospective intervention cohort study on children in seven emergency room departments, conducted in 2008–2009 in the Netherlands, determined that detection of all suspected child abuse would likely increase if systematic screening and emergency department staff training were implemented. Based on previous literature review, the researchers used a screening checklist called the “Escape form,” which consisted of six questions for all types of abuse and

was completed by the emergency department nurse. Using this checklist, the investigators were able to show a positive effect on the screening rate for child abuse (10). In regard to screening specifically for child sexual abuse, some researchers have concluded that screening is potentially helpful in both nonproblematic and suspect pediatric populations. A 2006 study in Brazil resulted in development of a five-question screening test to identify child sexual abuse. The questions were focused on signs of behavior changes, physical signs and symptoms, such as genital/anal injuries, and sexualization symptoms (11).

INTERVIEW TECHNIQUES

Despite multiple areas of overlap between clinical and forensic child sexual abuse evaluation, an important distinction between the two is the purpose for which the evaluation is being made. The primary goal of clinical evaluation is to determine whether abuse has occurred and whether the child needs treatment, whereas the duty of the forensic evaluator is to report the findings to a particular agency or court. The American Academy of Child and Adolescent Psychiatry guidelines for child sexual abuse clinical evaluation include the following: ensuring that the victim is evaluated by the least number of individuals and for the least number of times to limit stress on the victim and to prevent confabulation; conducting the interview in a relaxed atmosphere; obtaining thorough developmental, psychiatric, medical, and social history; gathering information from both parents, as well as performing psychiatric evaluation of each parent; bearing in mind the likelihood of false allegations; maintaining a neutral stance during an interview; gathering supporting data from multiple other sources; possibly using anatomically correct dolls to obtain information from a child who cannot verbalize the experience; prompt medical evaluation of the child by qualified physicians for treatment purposes and forensic evidence; and making recommendations regarding diagnostic im-

TABLE 1. Strategies for Evaluating Alleged Victims of Child Sexual Abuse^a

Interview and examination Relaxing environment and limited interruptions. Avoiding suggestive questions. Videotaping and sharing of information to preserve original report and to limit the number of victim interviews. Use of anatomically correct dolls and drawings to elicit details. Noting signs and symptoms associated with sexual abuse. Noting factors that support the child's credibility. Mental status examination and, if possible, physical and genital examination by qualified clinician.
Report Awareness about state ethical and legal requirements and being prepared to testify in court.
Recommendations If possible, determining whether sexual abuse occurred; making recommendations regarding the child's safety and treatment for the child and family, as well as recommendations pertaining to the offender.

^a For further details, see the Guidelines for the Clinical Evaluation for Child and Adolescent Sexual Abuse, American Academy of Child and Adolescent Psychiatry (<http://www.aacap.org/>).

pression, safety of the child, and treatment (see Table 1). Practice parameters for forensic evaluation of child sexual abuse include additional aspects that should be considered during assessment, such as motivations behind the child's denial or retraction of allegations, an extensive list of reasons behind false allegations of sexual abuse, the child's capacity to testify in court, and more emphasis on collateral information (12, 13). Considering normal sexual behavior in families is also an important issue to keep in mind during assessment (14). The use of suggestive questions was criticized by the jury in the controversial McMartin Preschool Abuse Trial, in which staff members of the McMartin Preschool were accused of child sexual abuse but were later acquitted due to lack of credible evidence. Even short doses of improper interview techniques, such as social influence (e.g., describing to the child what others had supposedly said) and reinforcement (e.g., providing reward for answers), cause significant error rates in children's answers (15).

Some factors that may help distinguish between fictitious and credible accounts include providing a unique detail when describing the sexual abuse encounter, age-appropriate use of words and sentences, emotional response during the interview, child behavior during the period of abuse, and the use of toys and drawing materials (16).

REPORTING CHILD ABUSE

Additional area for improvement is continuous education of physicians and other professionals about child abuse and reporting laws. Statistically, professionals (e.g., doctors, teachers, law enforcement personnel) report child abuse at rates nearly three times that of nonprofessionals (e.g., parents, legal guardians, neighbors) and seven times the rates of anonymous sources (17). Medical personnel alone are consistently responsible for a large portion of sexual child abuse reports; 9.4% of child sexual abuse reports were made by medical professionals in 2006 (18). At the same time, many suspicious cases of abuse are not reported by physicians. A 2008 study found that merely 39 out of 75 clinicians (52%) reported suspected child abuse to child protective services (CPS). Among the factors that influenced physicians in reporting were familiarity with the patient's family, availability of professional resources to discuss the case, projected negative outcome of CPS intervention, and elements pertaining to injury (19). Physicians are required by law to report in good faith all suspected cases of child abuse, regardless of doctor-patient confidentiality. Generally, a report must be made within 48 hours of learning about suspected abuse; however, standards for making a report and penalties for noncompliance vary by state (20).

KEY POINTS/CLINICAL PEARLS

- Sexual abuse affects many children and adolescents worldwide and is associated with many psychiatric problems in victims.
- Regular screening in the medical setting may lead to improved detection of child sexual abuse.
- Continuous education and broad knowledge in child sexual abuse and reporting laws are necessary for early discovery and treatment of affected children.

CONCLUSIONS

Broad knowledge in child abuse and reporting laws, as well as good effort, are needed on behalf of medical providers when interviewing children and teenagers. Required screening for child abuse during each pediatric patient encounter could lead to improved detection rates. However, such screening is hindered by legitimate ethical concerns related to the complexity of proper child sexual abuse assessment. It is important for medical professionals to argue strongly for early detection and treatment of child sexual abuse.

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Late-Victorian Psychiatry as Depicted in *Stonehearst Asylum*

Awais Aftab, M.D.

Early 19th-century asylums witnessed a revolutionary break from the treatment of mentally ill individuals in “traditional madhouses.” “Moral treatment” evolved from the belief that if institutions could provide comfort and structure, the environment itself could be curative. Popularized by reformers, such as the Tuke family in England and Pinel in France, moral treatment soon became the gold standard (1). In the mid-19th century onward, numerous county asylums were built in England as a result of the political pressure of the reformers. The idealistic vision of asylum reform, however, collapsed in the coming decades, under the influence of industrialization, urbanization, and significant increase in birth rates, all of which resulted in a steep increase in the number of mentally ill individuals (1, 2). The asylums were overcrowded, cramped, squalid places, filled with “an assorted rag-bag of social misfits” (2), while being understaffed and underfunded. At the same time, psychiatrists were utilizing various physical treatments. Douche, cold and hot baths, static electricity, massages, injections of testicular fluids, and primitive psychotropics, such as bromide, paraldehyde, and chloral hydrate, were common treatments (2, 3). This was the condition of asylum medicine in the late Victorian era, excellently portrayed in the 2014 film *Stonehearst Asylum*, by director Brad Anderson.

In the film, Dr. Newgate arrives at Stonehearst Asylum, seeking training

in alienism (as psychiatry was called at that time) under the superintendent Dr. Lamb. It soon becomes obvious to him that Dr. Lamb’s practice of psychiatry is highly unorthodox. Patients roam freely, do not receive psychiatric treatments, and their delusions are even encouraged. Patients also interact freely with the asylum staff, and Newgate often finds it difficult to distinguish one from the other.

Hints that something is amiss accumulate; Newgate comes to suspect that the psychiatrically ill patients have seized control of the asylum and are posing as the staff. Newgate discovers that the original keepers, along with the real superintendent Dr. Salt, are imprisoned in the asylum’s dungeon. As the surreal drama unfolds, we also become aware of the physical treatments the patients had been subjected to by Dr. Salt prior to the takeover, such as alternating cold and hot showers and rotating chairs, reflecting commonplace psychiatric practices of that era (2, 4).

The film does an excellent job of replicating the late Victorian epoch in the history of British psychiatry (2), whether it is the monolithic approach to “madness,” use of old-fashioned diagnoses like hysteria, neurasthenia, and dementia praecox, or the physically brutal treatments.

Stonehearst Asylum provides psychiatry residents an invaluable glimpse into this early history by depicting the state of asylums, the aspirations of

moral treatment, and biological psychiatry in its infancy. It also reinforces the modern-day respect for patient autonomy and existing thresholds for involuntary commitment and involuntary treatment. The contrast between the early biological psychiatry and the idealism of moral treatment is representative of a fierce debate of that age. This debate shaped the subsequent historical development of psychiatry and continues to exist within contemporary psychiatry in subtle and modified ways (5).

Dr. Aftab is a second-year resident in the Department of Psychiatry, University Hospitals Case Medical Center/Case Western Reserve University, Cleveland.

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1. Shorter E: A History of Psychiatry: From the Era of the Asylum to the Age of Prozac. New York, John Wiley & Sons, 1997, pp 20–46
2. Rollin HR: Psychiatry in Britain one hundred years ago. *Br J Psychiatry* 2003; 183(4):292–298
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4. Braslow J: Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century (Medicine and Society). Berkeley, Calif, University of California Press, 1997
5. Borthwick A, Holman C, Kennard D, et al: The relevance of moral treatment to contemporary mental health care. *J Mental Health* 2001; 10(4):427–439



AJP Residents' Journal Featured in May 2016 American Journal of Psychiatry!

The May 2016 issue of the *American Journal of Psychiatry* will feature an Education in Psychiatry article titled: "The *American Journal of Psychiatry Residents' Journal*: Training the Next Generation of Academic Psychiatrists"


Authored by past and present Editors of the *Residents' Journal* and AJP Editor Robert Freedman, M.D., this article discusses how the AJP-RJ has transformed over the past decade into a national model for a trainee-led and operated academic journal.

Want to learn more about the *AJP Residents' Journal*? Attend the RJ workshop at the APA Annual Meeting:

"Writing a Scholarly Article"


Tuesday, May 17th • 1:30 PM-3:00 PM

Georgia World Congress Center Building B – Level 3, Room B310



AMERICAN
PSYCHIATRIC
ASSOCIATION

ANNUAL MEETING
May 14-18, 2016 • Atlanta



Writing a Scholarly Article

The American Journal of Psychiatry-Residents' Journal Workshop

Residents, fellows, and students are invited to attend the 2016 *American Journal of Psychiatry Residents' Journal* Workshop, to take place at the American Psychiatric Association Annual Meeting in Atlanta.

- Write your first scholarly article in the session. (If you are interested in volunteering as an author for the session, please e-mail rajiv.radhakrishnan@yale.edu.)
- Bring your thoughts and ideas about the *Residents' Journal*
- Hear a brief presentation about the Journal's new developments
- Meet with *Residents' Journal* editors and editorial staff
- Meet the *American Journal of Psychiatry* Editor-in-Chief Robert Freedman, M.D.

Tuesday, May 17th, 2016 • 1:30 PM-3:00 PM
Georgia World Congress Center - Building B - Level 3, Room B310

Look for These Events at the Annual Meeting in Atlanta!

(May 14th–18th, 2016)

Visit the Resident Resource Center in the Georgia World Congress Center.

Saturday, May 14th

Medical Student-Resident Competition

Poster Sessions

10:00 AM – 12:00 PM

Interactive Session-Residency Education

1:30 PM – 3:00 PM

Diversity Experiences in Residency Training

American Association for Social Psychiatry

3:30 PM – 5:00 PM

Drawing Depression: A Look at Mental Health Themes in Visual Media

Swathi Krishna, Deepak Penesetti, Aparna Atluru

3:30 PM – 5:00 PM

Sunday, May 15th

Not Just National News: Can Multiple Isolated Incidents of Racially or Ethnically Motivated Violence Traumatize the Larger Minority Group?

Danielle Hairston Mawuena Agbonyitor, Meredith Harewood, Racquel Reid, Rubiahna Vaughn, Aleema Zakers

8:00 AM – 9:30 AM

“Closed”: Resident Tales from the Front Line—and What We Can Learn—When a Psychiatric Emergency Department Shuts Its Doors, APA Child and Adolescent Psychiatry Fellowship

12:30 PM – 2:00 PM

A Resident’s Guide to Borderline Personality Disorder: From the Experts (Part 1 of 2)

12:30 PM – 2:00 PM

American Association of Directors of Psychiatric Residency Training Presidential Symposium

1:00 PM – 4:00 PM

A Resident’s Guide to Borderline Personality Disorder: From the Experts (Part 2 of 2)

2:30 PM – 4:00 PM

Resident Well-Being: Strategies to Prevent Burnout

2:30 PM – 4:00 PM

Monday, May 16th

Neuromodulation Primer for Residents: An Introduction to ECT, TMS, and DBS

9:00 AM – 10:30 AM

Residents Teaching About Racism: A Novel Educational Approach to Combating Racial Discrimination in Mental Health Care, APA Council on Medical Education and Lifelong Learning

9:00 AM – 10:30 AM

The Kids Are Not All Right: Mental Health Impact of Parental Incarceration

Barbara Robles-Ramamurthy, Courtney McMickens (MFP Alum)

9:00 AM – 10:30 AM

Managing Violence Risk and Interview Safety: A Primer for Residents

3:30 PM – 5:00 PM

Tuesday, May 17th

Patient Suicide in Residency Training: The Ripple Effect

9:00 AM – 12:00 PM

Developing and Running a Successful Research Track for Psychiatry Residents

11:00 AM – 12:30 PM

Standing Up to Violence in Police Encounters: The Players, the Victims, the Trauma, and the Solutions

Jared Taylor, Matthew Dominguez, Jessica Moore, Racquel Reid, Elie Aoun (APA Leadership Fellow)

11:00 AM – 12:30 PM

**Writing a Scholarly Article: The American Journal of Psychiatry Residents’ Journal Workshop*

1:30 PM – 3:00 PM

Georgia World Congress Center, Room B310, Building B, Level 3

Burnout in Resident Physicians: What Can We Do?

3:30 PM – 5:00 PM

MindGames

5:15 PM – 6:15 PM

Wednesday, May 18th

Exploration of Medical Students’ Choice of Psychiatry as a Career

9:00 AM – 10:30 AM

Residents' Resources

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

**To contribute to the Residents' Resources feature, contact Hun Millard, M.D., M.A., Deputy Editor (hun.millard@yale.edu).*

DEADLINES

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
Outstanding Resident Award Program (ORAP) Deadline: May 6, 2016	NIMH	This award recognizes residents with outstanding research and academic potential who are currently at the PGY-2 level. Award includes framed certificate, invitation to visit the NIH campus for a 2-day award program, and opportunity to present a poster about their own research.	Resident currently in PGY-2 level.	Joyce Chung, M.D. at 301 443 8466 or chungj@mail.nih.gov	http://www.nimh.nih.gov/labs-at-nimh/scientific-director/office-of-fellowship-and-training/outstanding-resident-award-program/index.shtml
Webb Fellowship Program Deadline: July 1, 2016	APM	This fellowship is designed to support residents and fellows in psychosomatic medicine at an early stage in their career. One-year appointments in which each fellow will have a designated mentor and present a paper at the Annual Meeting. Financial support will be provided for each fellow's organizational membership for one year and for Annual Meeting registration fees.	PGY-3 psychiatry resident or psychosomatic fellow.	http://www.apm.org/awards/webb-fship.shtml	http://www.apm.org/awards/webb-fship.shtml
Trainee Travel Award Deadline: July 1, 2016	APM	To encourage psychosomatic fellows, residents, and medical students to join APM, attend the Annual Meeting. A limited number of monetary awards are given to help offset the cost of attending the Annual Meeting (APM Council determines the dollar amount and number of awards.)	Medical Student, residents, and fellows.	http://www.apm.org/awards/trainee-travel.shtml	http://www.apm.org/awards/trainee-travel.shtml

JobCentral

Job opportunities for graduating residents and fellows are listed on JobCentral, a free service provided by APA for its members (jobs.psychiatry.org). Browse over 2,000 job postings based on location, work setting and position type, create an account and set up job alerts.

Author Information for *The Residents' Journal* Submissions

Editor-in-Chief

Rajiv Radhakrishnan, M.B.B.S., M.D.
(Yale)

Senior Deputy Editor

Katherine Pier, M.D.
(Icahn School of Medicine)

Deputy Editor

Hun Millard, M.D., M.A.
(Yale)

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

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

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
- 3. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based

on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.

- 4. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 5. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 6. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This article type should also include a

table of Key Points/Clinical Pearls with 3-4 teaching points.

- 7. Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 8. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 9. Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Themes

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

Social Media and Psychiatry

If you have a submission related to this theme, contact the Section Editor
Spencer Hansen, M.D.
(shansen3@tulane.edu)

Psychiatry in the General Hospital

If you have a submission related to this theme, contact the Section Editor
Kamalika Roy, M.D.
(Kroy@med.wayne.edu)

Suicide Risk and Prevention

If you have a submission related to this theme, contact the Section Editor
Katherine Pier, M.D.
(Katherine.Pier@mssm.edu)

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