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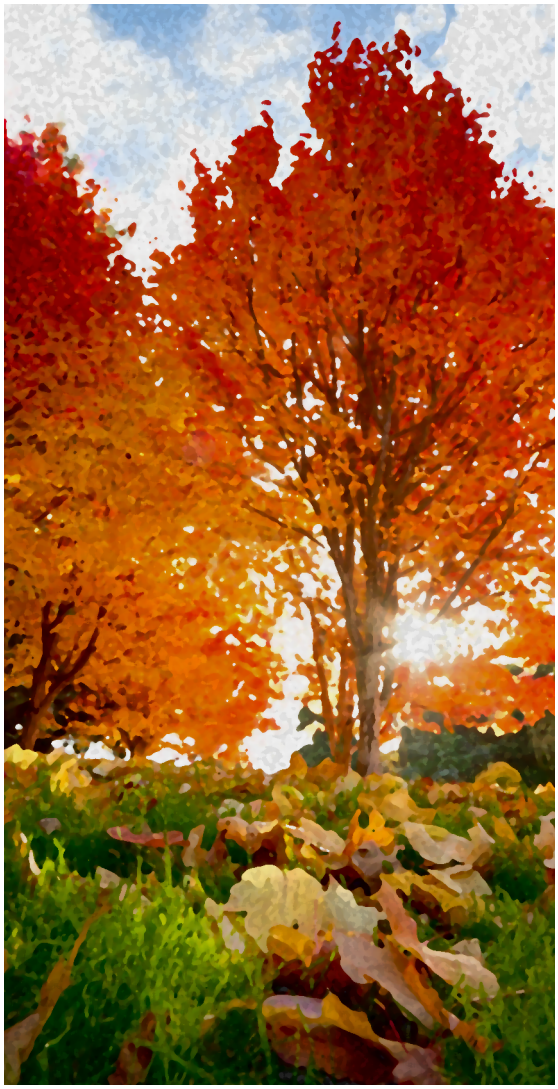

ARTICLE

Mental Health and the Juvenile Justice System: Where Has History Taken Us?

Divya Kiran Chhabra, M.D.

Juvenile justice is a system designed to navigate youth crime via police, court, and correctional involvement, but history has shaped and given this system the responsibility to also function as a vast mental health care system. Understanding this system's past helps to highlight changes that must be made for its future.

HISTORICAL CONTEXT

From ancient Greek civilization to English Common Law, the precedents to the American system, youth offenders were punished as adults, and although this has largely changed, a gray area clouds the way children are viewed in criminal justice today (1). In the early 1800s, with the introduction of child psychodynamics in America, the field recognized that children do not have the same moral capacity as adults (2). Childhood consists of unique developmental stages, including adolescence (3). As child poverty rates increased during the 1800s, reform movements decriminalized delinquency by removing youths from the adult justice system to "treat" youthful offenders rather than punish them (4). Children were placed with families in rural areas, houses of refuge, reform schools, and group cottages (5).

JUVENILE JUSTICE IN THE UNITED STATES

In the 1960s, due to rising crime rates, the juvenile justice system shifted from a community-based system to a punitive-based system, straying from the original vision (6). Over the next 30 years, harsher punishments were given in an endeavor to prevent homicides, as part of the "get tough" movement and the "war on drugs" during President Ronald Reagan's administration (7). Simultaneously, public mental health services for children decreased, and this rerouted youths into the criminal justice system (including the adult system), which is now primarily comprised of correctional facilities (8).

Until the 1990s, reliable studies on mental health statistics in the juvenile justice system were scarce (9, 10). Federally mandated research and investigations on mental health services in the system were conducted for the first time in 1998, revealing inadequate mental health care and screenings in several states (11). It was also during this time that recognition of the mental health needs for all youths grew, and leaders realized that previous estimates of the prevalence of "emotional disturbance" in this population were low (12, 13). Lastly, until this point, a stark disparity existed in the legal mental health rights between youths and adults in the criminal system (14). Although the need for large-scale change in the punitive system was acknowledged during this time, the problems were deeply rooted and still affect our system today.

Clearly, psychiatry and the juvenile criminal justice system are historically intertwined. According to the Northwestern Juvenile Project, a longitudinal study that began in 1998 in Cook County, Illinois, 66% of males and 74% of females arrested and detained in the area had a mental disorder, with one in 10 having thoughts of suicide or a prior suicide attempt. Ninety-three percent of youths in this study had experienced physical, sexual, or verbal trauma, and 47% of females and 51% of males suffered from a substance use disorder (15). Similar results have been replicated in other studies, including a national study administered by the Office of Juvenile Justice and Delinquency Prevention that surveyed more than 7,000 youths in over 200 centers nationally (16). These findings are startling considering that 1.3–2.2 million youths were arrested annually between 2012 and 2016 (17). According to the Office of Juvenile Justice and Delinquency Prevention, although the juvenile crime rate has decreased nationally, the rate of children and adolescents processed in the system yearly has significantly increased since 1985, and an increased proportion of cases result in detention (18). Research has shown that long-term confinement in the justice system alone is detrimental to mental health (19). This is distressing, since those entering the system have higher rates of mental disorders to begin with (15).

Mental health screening, assessment, and treatment became mandatory in the early 2000s (20). However, a gap persisted between policy and implementation, and these policies alone are not an adequate resolution for an incredibly entrenched and multifactorial disparity. In 2006, the Federal Advisory Committee on Juvenile Justice reported that lack of appropriate staffing, lack of administrative capacity, insufficient research, heavy caseloads for social workers, lack of wraparound services, and lack of vigilant monitoring of adherence to mental health guidelines and policies are all barriers to successful implementation (21).

CONCLUSIONS

More recently, the system has been working toward a more rehabilitative and collaborative, versus punitive, approach, and, slowly, legal changes have been made (22). However, more needs to be

KEY POINTS/CLINICAL PEARLS

- Historically, youth offenders worldwide were punished as adults, and it took a much deeper understanding of development before reform occurred.
- Despite our knowledge of development, politics and history in America have shaped the juvenile justice system to, in many ways, still treat children as adults and to function as a vast mental health care system.
- Research that has been conducted in the juvenile justice system reveals that children involved with this system have higher rates of suicidality, trauma, and other mental disorders, and the long-term confinement these children undergo is even more detrimental.
- Mental health screening, assessment, and treatment became mandatory in the system in the early 2000s, but a gap still exists between policies and intervention.

done. Screening and assessments must be conducted earlier in the process and become completely standardized and research-based (20). Research has shown that diversion programs and evidence-based treatment services, such as wrap-around services and various types of therapy, are more efficacious when they are centered in the community rather than use of these treatments within the system (8, 20). Moving forward, the juvenile justice system should play a larger role in connecting children and adolescents with child protection, education, and outside child welfare agencies.

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CASE REPORT

Misdiagnosis or Comorbidity: Borderline Personality Disorder in a Patient Diagnosed With Bipolar Disorder

Nicole Peterson Scott, M.D.

The current and central biosocial theory of borderline personality disorder as defined by Dr. Marsha Linehan (1) focuses on impairment in the domains of affective, behavioral, and interpersonal functioning. Impulsivity, aggression, and affective instability, key behaviors in borderline personality disorder, are connected to a dysfunction of serotonin (2). A polymorphism within a specific serotonin transporter gene has been associated with suicide, impulsivity, addiction, and emotional lability (3). A confluence of biological predisposition and environmental effects produces a borderline personality disorder phenotype (2).

Borderline personality disorder can commonly be confused with or misdiagnosed as bipolar disorder, largely because of the overlapping symptoms relating to affective instability (4). Some believe that bipolar disorder and borderline personality disorder are separate entities that, in some cases, can coexist (5), while others see them on a spectrum together (6). In the present case report, the patient was formerly diagnosed with bipolar disorder but later given the diagnosis of borderline personality disorder.

CASE

"Mrs. W" is a 29-year-old woman who presented to the inpatient psychiatric hospital via the police after she texted a male friend repeatedly, following consumption of five alcoholic beverages, stating that she wanted to kill herself. Upon interview the following day, she appeared calm and cooperative and had little memory of sending the text messages. She held a previous diagnosis of bipolar disorder and endorsed past symptoms consistent with past manic episodes, such as elevated and irritable mood, hyperactivity, racing thoughts, hypersexuality, reduced need for sleep, pressured speech, and grandiosity. She also displayed poor impulse control and emotional dysregulation. She admitted to problems with affect (specifically anger and loneliness), impulsive action patterns (suicidal gestures, sexual deviance, and substance abuse), and interpersonal relationships (abandonment issues, dependency, and entitlement).

The patient endorsed stressors such as tension with her mother and marital discord. She is married with three children and stated that her husband "would never leave her," regardless of her infidelity during periods of mania. She had never been diagnosed with borderline personality disorder, but she did report a history of self-mutilating behavior, anorexia for 3 years in high school, and two suicide attempts via overdosing on medication at ages 15 and 21, respectively.

After the initial interview with the patient, our team identified this admission as a depressive episode of her preexisting bipolar disorder and therefore restarted her on quetiapine, to which she had reported a good response in the past, as well as lithium. As her 4-day inpatient hospitalization continued, she was compliant with her new medication regimen, and the diagnosis of borderline personality disorder was more thoroughly discussed with her.

DISCUSSION

Borderline personality disorder is seen in approximately 1%–6% of the general population (6). Borderline personality disorder can commonly be confused with bipolar disorder, largely because of the overlapping symptoms of impulsivity, mood instability, inappropriate anger, and suicidal threats (4). The above patient is a good example of a case in which an individual formerly diagnosed with bipolar disorder is also given the diagnosis of borderline personality disorder later. Her history of manic episodes met DSM-5 criteria, as they lasted for longer than a week and included elevated and irritable mood, hyperactivity, racing thoughts, hypersexuality, reduced need for sleep, pressured speech, increased distractibility, flight of ideas, grandiosity, and reckless behavior, and they caused an impairment in self-functioning. Her manic episodes appeared to be in remission when she presented to the inpatient psychiatric hospital, during which time she met DSM-5 criteria for borderline personality disorder. Her behavior was not solely attributed to alcohol intoxication because her history showed an enduring pattern of thinking, acting, and relating characteristic of borderline personality disorder that occurred outside her episodes of alcohol use.

While some believe that bipolar disorder and borderline personality disorder are separate diagnoses that can occur together, others consider them to be related. Borderline personality disorder and bipolar disorder co-occur more often than would be expected by chance alone, given that borderline personality disorder occurs in less than 1% of the population and bipolar disorder in greater than 2%. It is reported that up to 20% of people with borderline personality disorder have comorbid bipolar disorder, and about 15% of people with bipolar disorder have comorbid borderline personality disorder (this difference could be due to overestimating the former or underestimating the latter) (6). Those in favor of two separate disorders conclude that while the comorbid-

KEY POINTS/CLINICAL PEARLS

- Both borderline personality disorder and bipolar disorder may present with a core feature of affective instability.
- Misdiagnosis of borderline personality disorder as bipolar disorder and vice versa is common but avoidable.
- Borderline personality disorder and bipolar disorder necessitate very different treatments; if borderline personality disorder is suspected, antidepressants and mood stabilizers should be used in conjunction with psychosocial interventions such as dialectical-behavioral therapy.

ity rates are substantial, more often than not the two occur independently (5), suggesting two distinct disorders.

Fiedorowicz and Black summarized theories that support the diagnoses being related (6). The first theory posits that they are indeed two distinct conditions that happen to share a few overlapping criteria. The second suggests that bipolar disorder and borderline personality disorder are actually on a spectrum, with bipolar II disorder in the middle, representing the transitioning portion of the spectrum. Fiedorowicz and Black also raise the idea of one as a risk factor for the other, and vice versa, while their final theory identifies a set of shared risk factors that influence both, potentially explaining the link between the two disorders. The true reason for the diagnostic overlap may likely be a combination of different theories.

The above case is a prime example of a case in which a former diagnosis of bipolar disorder should be questioned when reconceptualizing the patient as having borderline personality disorder. This approach to diagnosis presents many advantages for care. Gunderson et al. identified two significant negative effects that can come from omitting a borderline personality disorder diagnosis in the face of a bipolar diagnosis (7). It can leave patients and their families with an unrealistic expectation of what medications can do, as well as a feeling of despair when medications are not very effective. It can also deprive the patient of helpful psychosocial interventions, such as dialectical-behavioral therapy (7). A borderline personality disorder diagnosis will emphasize the importance of outpatient skills-based psychotherapy and highlight that recurrent suicidal ideation may be part of the expected course but does not necessarily require hospitalization. Actually, Dr. Linehan views hospitalization as interfering with treatment for borderline personality disorder patients and recommends a short one-night stay rather than prolonged hospitalization when possible (8). Effective strategies for management in such cases include pharmacologic treatment with lithium to mitigate suicidal ideation and self-injury (9), quetiapine for depression and mood stabilization (10), and quickly discharging the patient to reduce dependence on the hospital while directing the patient toward appropriate outpatient psychotherapy, which clinical trials have supported for borderline personality disorder patients in crisis (11). All of these strategies have the potential to decrease burden of disease and improve quality of life.

CONCLUSIONS

Affective instability is a core feature of both bipolar disorder and borderline personality disorder. Some believe that the two diagnoses are separate entities that can coexist (5), while others see them on a spectrum together (6). Their similarities can cause misdiagnosis, but care should be taken to diagnose as accurately as possible, even if it means changing an existing diagnosis. This allows the patient realistic expectations and access to effective treatment.

Dr. Peterson Scott is a first-year psychiatry resident at the University of Texas at Austin Dell Medical School.

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COMMENTARY

Team Building as an Improved Approach to Residency Rotations

Elizabeth Potter, D.O., Ph.D.

A meta-analysis published in *JAMA* found that the prevalence of depression among resident physicians stands at about 29% and that depression may affect the long-term health of resident doctors (1). In light of this, the following recommendations are proposed to improve the residency work environment.

RESPECT

I routinely treat fellow residents and coworkers with respect. This engenders confidence and allows my team to better integrate with diverse populations. I show respect for the customs and beliefs of others and refrain from discussing political or divisive subjects at work.

FAIR DIVISION OF LABOR

Residents are frequently assigned a "team leader" responsible for the smooth operation of their team. As team leader, I refrain from exploiting other residents, subinterns, or medical students. If a team leader is unfair, team members resent this, work less efficiently, and employ an ineffective management style when they (in turn) become team leaders. Alternatively, if a team leader is fair in dividing tasks, team members may volunteer to take on more duties and work longer hours to improve the quality of the team's work.

START WITH POSITIVE REINFORCEMENT

I praise my team members for work well done. A project manager at Brazil's Institute of Aeronautics and Space noted that "positive reinforcement leads to better cooperation among team members more than rewards and coercion" (2). Neuroscientists recently demonstrated that

Positive reinforcement increases productivity of the team.

increased motivation to perform tasks was critically dependent on activating the brain's dopaminergic "reward" system (3). Thus, positive reinforcement not only boosts morale, it effectively increases productivity of the team. If positive reinforcement does not resolve the issue, I inform a noncompliant team member of the negative consequences that may follow.

ASK FOR VOLUNTEERS

I solicit volunteers to perform various tasks. Team members know their strengths better than anyone else and often volunteer in order to showcase their strengths. This enhances the team's effectiveness.

COVER FOR EACH OTHER

If a team member says he or she cannot report to work, I assess whether the reason is legitimate. If so, I tell the team member, "We are here to help. We have your back." If the reason is not legitimate, I stipulate that unauthorized absences must be made up with additional work days. Team morale will be enhanced when such issues are resolved fairly.

COOPERATE WITH OTHER SERVICES

When hospital workers from another service call my team for help, we show respect and respond promptly to resolve the situation. This improves cooperation among hospital teams.

COMMUNICATE EFFECTIVELY

We use HIPAA-compliant applications for secure text messaging to team members (4). Many attending physicians prefer a voice phone call, so we must be mindful of the surroundings in order to protect patient information.

WORK ON SELF-IMPROVEMENT

I frequently solicit feedback from friends and co-workers. This helps me overcome personal shortcomings and become a more effective team member and team leader.

CONCLUSIONS

While the above practices are not a panacea against the inevitable stresses associated with a medical residency, they may ameliorate the conditions leading to depression among our resident physicians.

Dr. Potter is a third-year psychiatry resident at Larkin Community Hospital, South Miami, Fla. She received her D.O. at the College of Medicine, Nova Southeastern University, Fort Lauderdale, Fla., and she received her Ph.D. in neuroscience at the Johns Hopkins School of Medicine, Baltimore.

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COMMENTARY

Confronting Despair on the Long-Term Care Unit

Dara Wilensky, M.D.

"Nancy," at 75 years old, was among the younger patients I interviewed during my PGY-3 geriatrics rotation, but both her physical condition and her declining cognitive status belied her younger age. She was petite and frail, sitting plaintively in a wheelchair pointed toward a blank wall; she halfheartedly raised a vacant gaze in my direction when I sat beside her. Faint, crusted remnants of her lunch lingered on her shirt.

I introduced myself as a psychiatrist, and Nancy told me she had once studied psychology, but this is where any coherent back-and-forth ended. Her lack of relatedness, as well as her semantic aphasia, made it seem as if we were talking in parallel, conversing near each other but not together. Despite her graduate-level education, she could tell me only that her children lived in "x or y, one of those towns around here," and she had once worked "a job of sorts." When I asked where she had gone to school, she launched into another perplexing speech, this time saying, "I had such high expectations, really wanted to be good in my field, good psychologist, good job, a real golden girl of psychology … now I just don't know … looking at what I'm supposed to be doing and being now and that's why." An immense sigh escaped from her, causing her tiny body to visibly deflate. She looked and sounded so despondent but could not articulate what had disappointed her so. We sat in solemn silence for a moment before she said, "I don't really have a sad tale; I'm just a sad person." And later, "Nothing is really wrong, no, no nothing wrong, just nothing right either."

There was so much about my first encounter … that was captivating.

There was so much about my first encounter with Nancy that was captivating. Her speech had such a ruminative, stereotyped quality that it bordered on verbigeration, making palpable her struggle to communicate. I found myself thinking of Nancy in Eriksonian terms as she approached her final task of psychosocial development: retrospection. She was grasping for contentment or ego integrity, and even dementia could not suppress the powerful affect associated with this experience. As she attempted to be proud of a successful family, process professional disappointment, and understand her purpose in the milieu of a long-term care facility, she was wrestling with the existential question of "is it okay to have been me?" and coming up with a resounding "no" for an answer. She was truly in despair.

When I left Nancy's room after our first meeting, I was unsettled. After reflecting on the experience of seeing someone with so little ability to understand her own misery at the end of her life, it would be gratifying to say that I have gained new insight into, or appreciation for, my own burgeoning relationships, career, and identity. But I mostly feel sad. This sadness, though, might be what I am tasked with right now. I can hold Nancy's hopelessness and despair along with her, allowing her space to continue to ask her own questions.

Dr. Wilensky is a fourth-year resident at Harvard Longwood Psychiatry Residency Training Program, Boston.

The patient's name and identifying details in the above article have been changed to protect the patient's privacy.

COMMENTARY

Exploring Humanism in Medicine: Reflection Rounds With Medical Students and Residents

Dan Janiczak, M.D.

Each new rotation brings a variety of change in the educational experience of a medical student or resident. We see a substantially different team compared to the previous rotation, which includes new nurses, staff, and teaching physicians; moreover, there are new expectations and a new field of study with a unique patient population and standards of care. Fast-paced weeks during training require learners to endure a steep learning curve with limited time to master as much knowledge as one can, while reconciling the reality that evaluations are imminent and performance matters. We live in a time where corporate acquisition of hospital systems is the norm, and patient satisfaction scores are paramount. Students and residents learn that patient-centered care is important, often being reminded that compassion and altruism are a priority. However, in personal encounters with patients and teaching physicians, development of these values is less emphasized and supported than the mastery of medical knowledge (1). Some training programs have brought attention to this discrepancy and are beginning to cite these values as requirements to clinical training.

In response to this, in 2014 the George Washington University Institute for Spirituality and Health, in partnership with the John Templeton Foundation, awarded a number of medical schools across the United States with a grant that aided the schools in implementing mentored reflective practice into mainstream clerkship education. Students regularly met for "reflection rounds" on clinical encounters offering an opportunity to examine personal values, beliefs, a sense of self, and the transformation of these aspects over the course of their education.

Reflection rounds enable students and residents to find what gives us meaning in our clinical experiences and refine the image in our minds of the physician we want to become.

As a first-year psychiatry resident, psychiatry rotations were the ideal venue to begin practicing a series of reflection rounds with medical students at Hennepin County Medical Center in Minneapolis and Regions Hospital in St. Paul. Meeting one time per week during the course of a rotation, we conversed about the patient-physician connection, as well as personal and professional development. Reflection rounds enable students and residents to find what gives us meaning in our clinical experiences and refine the image in our minds of the physician we want to become. It is a time in which the group can reflect on expectations and hopes, gathering support from co-residents and other students in navigating an often unfamiliar environment. Such a climate of reflection has been shown to foster an environment of trust, collaboration, and attention to human needs (2). In time, conversation and listening set the stage for each person to take away elements that can aid in individual growth and a sense of solidarity. Further efforts may include taking this practice and examining the impact it has on markers of physician burnout, including emotional exhaustion, depersonalization (i.e., cynicism), and low sense of personal accomplishment.

Dr. Janiczak is currently a second-year resident in the Hennepin County Medical Center-Regions Hospital Psychiatry Training Program, Minneapolis.

The author thanks his training director, Scott Oakman, M.D., Ph.D., for his support, as well as the participants in the reflection rounds.

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MOVIE FORUM

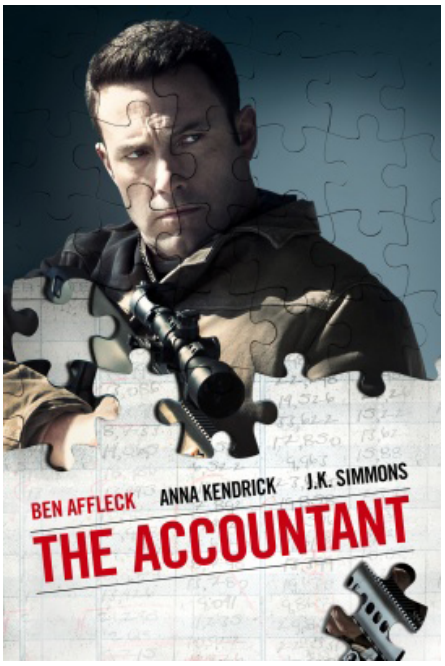
The Accountant: A Cinematic Take on Autism Spectrum Disorder

Reviewed by Somya Abubucker, M.D.

As a medical student seeing autism spectrum disorder (ASD) patients in the clinic, I walked into *The Accountant* with baggage to say the least. This 2016 movie is Hollywood's most recent take on ASD, and it has the dubious honor of being the first to feature an autistic assassin. Cinema is a potent force in our lives, capable of creating culture, as well as being informed by it, and I wondered what role *The Accountant* would play in shaping the ASD landscape.

My experience was as bifurcated as the movie itself. *The Accountant* is an ambivalent work. The obvious dichotomy resides in the protagonist Christian Wolff, a mathematically gifted strip mall CPA by day and assassin by night. The choice of Ben Affleck for this role is telling. In the same year as *The Accountant*, Affleck also reprised the role of Batman, arguably the prototypical divided superhero. The parallels are not subtle: Bruce Wayne/Batman is a template for an autistic accountant/assassin. There was a pleasure in seeing an ASD hero, someone able to leverage his disabilities and differences into strengths. However, it was a guilty pleasure because—while no doubt we need more ASD role models—it is questionable whether an assassin fits the bill.

The deeper dichotomy lies in what the movie tries to accomplish. On the one hand, it is an action thriller whose bottom line is to make money. It has a star-studded cast, slick action sequences, and a body count to rival *Rambo*. Yet it also seeks to be a social commentary, primarily through Wolff's character and the loving attention splurged on developing it. In flashbacks we see him as a young boy who rocks repetitively, ritualistically sings a nursery rhyme, and panics when he loses a puzzle piece. We empathize with his dysfunctional family and the challenges of facing bullies.



Directed by Gavin O'Connor

The movie continues to build the adult Wolff's character layer by layer, shining a light on some of the hallmark manifestations of ASD, such as strict adherence to routines and sensitivity to light and sounds. Wolff's peculiarities are sketched by a friendly hand, and as spectator I never felt the need to laugh at Wolff, but only with him. He may be socially awkward and violent, but the takeaway feeling is being in the presence of an honorable man, one who is philanthropic (he gives most of his money to a neuroscience institute) and lives by a moral code.

Overall, *The Accountant* is a flawed film, not quite succeeding in striking the balance between entertainment and clinical reality. It often errs on the side of sensationalism, perpetuating the stereotype that the only thing redeeming in autism is "savantism." It also does disservice to the ASD community by linking violence to it, especially against the backdrop of the Sandy Hook and Umpqua Community College shootings. However, while the movie falls short of its goal, I commend the effort and applaud it for its greatest strength: allowing the audience to connect with an antihero whose core disability is the inability to connect.

Dr. Abubucker is a preliminary-year internal medicine resident at the University of Hawaii and will be starting her psychiatry residency at Johns Hopkins in 2018.

Residents' Resources

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

To contribute to the Residents' Resources feature, contact Anna Kim, M.D., Deputy Editor (anna.kim@mountsinai.org).

NOVEMBER DEADLINES

Fellowship/Award	American Psychosomatic Society (APS) Scholar Awards
Organization	American Psychosomatic Society (APS)
Deadline	**November 1, 2017**
Brief Description	Between 10 and 24 APS Scholar Awards are presented to outstanding abstract submissions in which 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.
Eligibility	APS member or in the process of applying for membership; first author of 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.
Contact and Website	E-mail: info@psychosomatic.org • Phone: 703-556-9222 • Fax: 703-556-8729 Web: https://psychosomatic.org/awards/index.cfm

Fellowship/Award	APS Medical Student/Resident/Fellow Travel Scholarships
Organization	American Psychosomatic Society (APS)
Deadline	**November 1, 2017**
Brief Description	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 1-year membership.
Eligibility	Applicant must be a medical student, resident, or fellow.
Contact and Website	E-mail: info@psychosomatic.org • Phone: 703-556-9222 • Fax: 703-556-8729 Web: https://psychosomatic.org/awards/index.cfm

Fellowship/Award	APS Minority Initiative Award
Organization	American Psychosomatic Society (APS)
Deadline	**November 1, 2017**
Brief Description	Each scholarship will include travel funds and a complimentary registration.
Eligibility	Applicant must be an underrepresented minority as defined by the NIH to be African Americans, Hispanics, Native Americans and Alaska Natives, and Pacific Islanders.
Contact and Website	E-mail: info@psychosomatic.org • Phone: 703-556-9222 • Fax:703-556-8729 • Web: https://psychosomatic.org/awards/index.cfm

Fellowship/Award	Alonso Award for Excellence in Psychodynamic Group Theory
Organization	American Group Psychotherapy Association (AGPA)
Deadline	**November 1, 2017**
Brief Description	Suitable entries include doctoral dissertations, videos, published papers, and other creative research. Submissions of entries should be e-mailed or mailed to the Group Foundation office by November 1st of each year for consideration. An annual cash prize of $500 is presented.
Eligibility	Qualification varies.
Contact and Website	E-mail: dfeirman@agpa.org • Phone: 212-477-2677 • Web: http://www.agpa.org/Foundation/awards#Alonso

Fellowship/Award	Scott Schwartz (AAPDP) Award
Organization	American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP)
Deadline	**November 1, 2017**
Brief Description	Offering an award for the best original, unpublished paper on psychoanalytic or psychodynamic psychiatry, written (and first-authored).
Eligibility	Psychiatric resident or medical student.
Contact and Website	E-mail: jekatzman@salud.unm.edu • Web: http://aapdp.org/index.php/education/scott-schwartz-aapdp-award

DECEMBER DEADLINES

Fellowship/Award	Association for the Advancement of Philosophy and Psychiatry (AAPP) Karl Jaspers Award
Organization	Association for the Advancement of Philosophy and Psychiatry (AAPP)
Deadline	**December 15, 2017**
Brief Description	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.
Eligibility	Resident or fellow in psychiatry, graduate students and postdoctoral students in philosophy, psychology, or related fields.
Contact and Website	E-mail: cperring@yahoo.com • Web: https://philosophyandpsychiatry.org/jaspers-award/

Author Information for *The Residents' Journal* Submissions

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

To submit a manuscript, please visit http://ajp.psychiatryonline.org/ajp_authors_reviewers, and select a manuscript type for AJP Residents' Journal.

1. **Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
2. **History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
3. **Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2–4 multiple-choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
4. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
5. **Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
6. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
7. **Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
8. **Perspectives in Global Mental Health:** This article type should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow. Limited to 1,500 words and 20 references.
9. **Arts and Culture:** Creative, nonfiction pieces that represent the introspections of authors generally informed by a patient encounter, an unexpected cause of personal reflection and/or growth, or elements of personal experience in relation to one's culture that are relevant to the field of psychiatry. Limited to 500 words.
10. **Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in the *Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
11. **Book and Movie Forum:** Book and movie reviews with a focus on their relevance to the field of psychiatry. Limited to 500 words and 3 references.

Upcoming Themes

If you have a submission related to the themes shown, contact the Section Editor listed below the topic. ***Please note that we will consider articles outside of the theme.***

If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Rachel Katz, M.D., Editor-in-Chief (rachel.katz@yale.edu).

Forensic Psychiatry

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Treating Patients With Comorbid Substance Use Disorders

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