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ARTICLE

The Supreme Court, Child Abuse, and the Role of the State

Shelley Co, D.O.

An estimated 24% of children are victims of abuse in their first year of life (1). In 2015 alone, approximately 1,670 children died from abuse, and almost 700,000 victims of child abuse were reported to child protective services (1). In *DeShaney v. Winnebago County Department of Social Services* (1989), the Supreme Court grappled with the fundamental question of a state's constitutional duty to protect victims of child abuse. Mandated reporters (e.g., physicians, teachers, social workers) likely consider their duties completed once they have reported a child abuse situation to the appropriate agency (e.g., child protective services, law enforcement agencies, or child abuse reporting hotlines) (2), with expectations that the state will appropriately intervene. However, in *DeShaney,* the Supreme Court concluded that the Constitution does not legally require states to protect its citizens, including abused children, from harms that the state did not directly generate.

THE FACTS OF THE CASE

Joshua DeShaney lived with his father, Randy DeShaney, in Winnebago County, Wisconsin. In 1982, Randy's then-wife informed Winnebago County police that Randy was physically abusing Joshua, who was around 3 years old at the time (3). The Winnebago County Department of Social Services investigated the claim, but Randy denied the allegations, and the inquiries stopped (3). In 1983, Joshua presented to a hospital with multiple bruises and abrasions covering his body (4), leading the treating physician to suspect child abuse and report the injuries to the Department of Social Services (3). The hospital was then granted temporary custody of Joshua, and a multidisciplinary team examined the case (4). The team concluded that there was not enough evidence to keep Joshua away from his father's custody but implemented the following protective measures: Randy was required to enroll Joshua in a preschool program and participate in counseling services (3).

Subsequently, a juvenile court returned Joshua to his father (3). A Department of Social Services caseworker also started making monthly visits to the DeShaney home (4). The caseworker noted suspicious injuries on Joshua's head and observed that he was not enrolled in school, as previously agreed upon. Later that same year, Joshua again went to the hospital with suspicious injuries. Despite all of this, the Department of Social Services took no further action (3).

In 1984, when Joshua was 4 years old, his father beat him so badly that he suffered a massive brain hemorrhage and fell into a coma (3). The child underwent emergency neurosurgery, which revealed evidence of older brain hemorrhages (4). This, coupled with bruises in various stages of healing on his head, was consistent with shaken baby syndrome (4). Given his permanent brain damage, Joshua was expected to live the rest of his life institutionalized (4). Meanwhile, his father pled no contest to felony abuse charges and was sentenced to 4 years in prison (4).

THE PATH TO THE SUPREME COURT

Joshua's mother, on behalf of Joshua, filed a lawsuit against Winnebago County, the Department of Social Services, and several individual Department of Social Services employees (3). The lawsuit claimed that by failing to intervene to protect Joshua from his father, the parties deprived Joshua of his liberty rights, without due process of law, thereby violating his rights under the Fourteenth Amendment (3). Both the United States District Court for the Eastern District of Wisconsin and the Court of Appeals for the Seventh Circuit found in favor of the defendants (i.e., the county and Department of Social Services). Joshua and his mother appealed to the Supreme Court (3).

THE COURT'S OPINION

Chief Justice William Rehnquist delivered the Supreme Court's opinion, finding that the State (i.e., the state of Wisconsin and its local governmental agencies and their employees) had no legal duty to protect Joshua because the due process clause did not require the State to protect its citizens from the actions of private individuals (5). According to Rehnquist, the intent of the due process clause was to prevent the State from abusing its power and protect the people, by holding that no state will "deprive any person of life, liberty, or property without due process of law" (3). This did not mean that a state must ensure that people were protected from each other (3). Thus, a state's failure to protect an individual from private violence, as in Joshua's case, did not violate the due process clause.

The Court acknowledged some instances in which a state is obligated to protect individuals, such as those who are incarcerated or involuntarily committed for mental health reasons, under the Fourteenth Amendment (3). A state's obligation toward these individuals stems from that state having imposed restrictions on their freedoms, thus limiting their ability to care for and act for themselves (3). However, the Court stated that this did not apply to Joshua because he was not under the State's cus-

tody when he was harmed by his father (3). Even though Joshua was under the State's custody for some time (i.e., when a hospital was granted temporary custody of him in 1983), the Court argued that the State did not become permanently responsible for guaranteeing his safety (3). While Rehnquist admitted that "the facts of this case are undeniably tragic," he asserted that the physical damage inflicted upon Joshua was done by his father, not the State, and the State cannot control the actions of an individual (3). In addition, the Court contended that had the State removed Joshua from his father's custody, the State itself would have faced charges of violating the due process clause by inappropriately infringing upon private matters (3). Rehnquist, furthermore, left it up to individual state law to determine liability in cases in which a state has failed to act. The due process clause would not be the basis for determining state accountability.

KEY POINTS/CLINICAL PEARLS

- The Winnebago County Department of Social Services received the first report of suspected child abuse involving Randy DeShaney and his son, Joshua DeShaney, in 1982 and would receive several reports of child abuse until 1984, when Randy beat Joshua to the point of a coma and massive brain hemorrhage.
- Joshua DeShaney's mother, on behalf of Joshua, filed a lawsuit against Winnebago County, the Department of Social Services, and several Department of Social Services employees and argued that these parties violated Joshua's rights under the Fourteenth Amendment by failing to intervene to protect Joshua from his father, thus depriving Joshua of his right to liberty without due process of law.
- Chief Justice William Rehnquist delivered the Supreme Court's opinion in *DeShaney v. Winnebago County Department of Social Services* (1989) and stated that there is no constitutional duty for states to protect child abuse victims; however, individual states may establish their own laws to define state responsibility to the victims of child abuse.

DISSENTS

Justice William Brennan contended that the Court failed to see that "inaction can be every bit as abusive of power as action, that oppression can result when a State undertakes a vital duty and then ignores it" (3). He argued that an individual who notifies the Department of Social Services of suspected child abuse is not obligated to do anything else after making the report, since the Department of Social Services exists to receive these reports and decide what action is required (3). Thus, the Department of Social Services, an entity of a state, assumes a duty to intervene when necessary because the cases would then fall under that state's purview (3). Brennan even claimed that there is a restriction on the freedoms of abused children caused by limited access to nongovernmental sources of aid because a suspicion of child abuse is communicated only to the Department of Social Services and no other private entities (3). Because of this limitation on freedom imposed by a state, each state assumes a unique responsibility to these children and has a constitutional duty to protect them (5).

Brennan also criticized the Court's view that the Fourteenth Amendment invokes only the notion of negative liberty (5). Negative liberty refers to an individual's freedom from the power of the government; positive liberty, on the other hand, refers to the notion that government resources can be used to enforce an individual's liberties (5). To Brennan, the idea of positive and negative liberties is, moreover, irrelevant to the present case because of the existence of the Department of Social Services, which is created by each state to protect children like Joshua (5). Justice Harry Blackmun also dissented and reiterated Brennan's notion that "the facts here involve not mere passivity, but active state intervention in the life of Joshua DeShaney—intervention that triggered a fundamental duty to aid the boy once the State learned of the severe danger to which he was exposed" (3).

CONCLUSIONS

It is alarming that a state is not legally bound under the Constitution to act to safeguard a child when mandated reporters suspect child abuse and notify the appropriate agency. Certainly, the State was not the agent who physically beat Joshua into a coma, but the State did play an indirect role in Joshua's fate. What, then, should determine state liability in child abuse cases—individual state laws or the Constitution? Either way, a state should be held accountable in cases like Joshua's because of the current structure in which mandated reporters are obligated to inform state agencies of suspected child abuse. A state assumes a special relationship with child abuse victims, since it is the epicenter for dealing with mandated reporters, alleged child abuse victims, and suspected abusers. Physicians are legally compelled to report suspected child abuse cases to state entities and would be held accountable for failing to report; therefore, a state should be held accountable for what happens next (i.e., after the report is made), until a better schema in which a state is not the only entity privy to child abuse reports is established.

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ARTICLE

Psychiatric Comorbidities With Cyclic Vomiting Syndrome

Ramkrishna Makani, M.D., M.P.H., Tapan Parikh, M.D., M.P.H.

Cyclic vomiting syndrome is a debilitating clinical syndrome. It is characterized by intense, recurrent, intractable nausea and vomiting episodes lasting for hours to days, interspersed with symptom-free intervals that can last several months. It was first described in English pediatric literature in 1882 by Samuel Gee, who delineated symptoms as "fitful or recurrent vomiting" (1). Cyclic vomiting syndrome was considered a pediatric functional gastroenterology disorder with a 0.04%–2% prevalence (1). Increasingly, cyclic vomiting syndrome is becoming recognized in the adult population; however, the prevalence in adults remains unknown (1). The exact etiopathogenesis is unknown, and the disorder is associated with migraines, mitochondrial dysfunction, and neuroendocrine abnormalities (1).

Rome III diagnostic criteria are used for cyclic vomiting syndrome diagnosis. Per Rome III classification, patients have stereotypical vomiting episodes with acute onset (2, 3). The episodes occur multiple times in a year. Individuals with the disorder are usually asymptomatic between episodes. They classically experience intense nausea and vomiting after initially being asymptomatic. The most debilitating vomiting period may manifest with up to 20–30 vomiting episodes per day (see Figure 1) (4). Psychiatric comorbidities in cyclic vomiting syndrome are often unknown, and very few prospective studies are available in the literature (4). Anxiety disorders and depressive symptoms are the most common psychiatric findings among patients (4). The present article is a review of the literature, with emphasis on psychiatric comorbidities.

METHOD

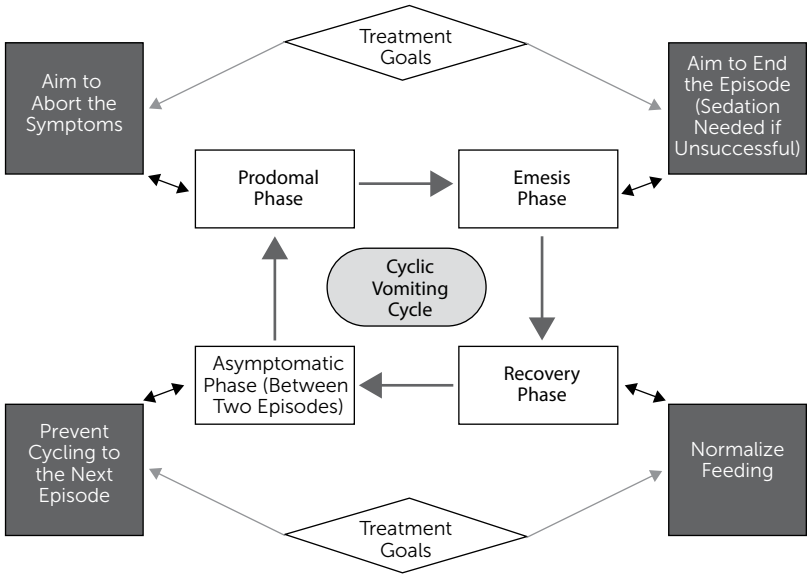
We conducted a search of articles on Medline, PubMed, PsycINFO, PsychiatryOnline, and Cochrane Library. We used the search term "cyclic vomiting syndrome." From a total of 315 initial results, we narrowed the search to include only psychiatrically relevant articles, which resulted in 34 articles for our review.

DISCUSSION

Psychiatric symptoms such as anxiety and depression are observed in the prodromal phase and the acute emetic phase in cyclic vomiting syndrome (5). The most commonly associated psychiatric disorders include anxiety disorders and mood disorders (6). Less frequent associations are attention deficit hyperactivity disorder, oppositional defiant disorder, and somatic symptom disorder (7). A pilot study among children and adolescents with cyclic vomiting syndrome reported that approximately 54% of adolescents met cutoff criteria for anxiety disorders, the most common being generalized anxiety disorder and specific phobia (4). Approximately 15%–18% met criteria for major depression and dysthymia (4).

The etiology of cyclic vomiting syndrome remains unknown. It is difficult to delineate whether anxiety and/or depression is the cause or the result of this syndrome. However, in one study, a significant association between anxiety and health-related quality of life in children and adolescents was found, with lower quality of life reported with higher level of anxiety (8). In another study, depression was found to be comorbid but not as common as anxiety (4). In a study of 31 participants, anxiety was noted in 84% of the study population and depression in 78% (7). Overall, psychiatric comorbidities have high impact on quality of life. Panic disorder is the most common form of anxiety in patients with cyclic vomiting syndrome (7). Symp-

FIGURE 1. Different Phases of Cyclic Vomiting Syndrome



toms of panic disorder usually respond to lorazepam (7). Cyclic vomiting syndrome in adults is typically indicated by abdominal pain, higher rates of anxiety and depression, and rapid gastric emptying (1), as well as successful suppression of attacks by chronic amitriptyline therapy (9). Amitriptyline is thought to modulate vomiting through its anticholinergic and serotonergic effects (10). However, providers need to be aware of its cardiotoxic potential in overdoses (10).

Management of cyclic vomiting syndrome and its associated psychiatric comorbidities includes pharmacological and psychosocial interventions. Current literature suggests that various pharmacological agents, such as valproate, barbiturates, cyproheptadine, amitriptyline, propranolol, erythromycin, and mirtazapine, may be beneficial for prophylaxis (11). Intravenous fluids, ondansetron, and sedation with intravenous lorazepam may potentially provide relief during the vomiting phase (12). Cognitive-behavioral therapy with a multidisciplinary approach has been favorable in children, but evidence is lacking in adults (13). A behavioral approach in combination with amitriptyline has the potential of increasing remission rates (13). The role of marijuana use remains controversial (14, 15). For example, marijuana use is reported to be associated with cannabinoid hyperemesis syndrome, which also has vomiting as its major symptom. However, the differentiating feature is that in cyclic vomiting syndrome, an individual has no vomiting between episodes, and cannabinoid hyperemesis syndrome is associated with nausea and vomiting after each cannabis use (15). Contradictory to reports of increased emesis with cannabis use, a study based on a survey of cyclic vomiting syndrome patients found that most of these patients reported some improvement in nausea and vomiting symptoms with cannabis use, and per the hypothesis in this survey-based research, chronic marijuana use might have antiemetic effect (14). Additionally, hot water bathing was found to be associated with marijuana use, although hot water bathing itself was observed in both the marijuana-user group and the non-user group, and the clear effects are not known (14).

Lastly, it is important to consider the health care cost associated with cyclic vomiting syndrome. In a recently published article summarizing health care access and utilization reports per the 2010–2011 National Inpatient Sample database analysis, the diagnosis of cyclic vomiting syndrome was associated with an overall cost approximation of $400 million over 2 years (16). The average hospitalization frequency is not known.

KEY POINTS/CLINICAL PEARLS

- The most frequent psychiatric comorbidities observed in patients with cyclic vomiting syndrome appear to be anxiety and depression.
- The exact pathophysiology of cyclic vomiting syndrome is unknown, and thus further studies are needed to investigate the causes of this disorder.
- Amitriptyline has shown promise when used as a preventive measure, but more studies are needed to confirm its efficacy in treating cyclic vomiting syndrome.
- Treatment requires an integrated approach between medicine, gastroenterology, and psychiatry.

CONCLUSIONS

Cyclic vomiting syndrome is a common, idiopathic, functional disorder that is difficult to treat due to lack of standard diagnostic and treatment guidelines, and it requires collaborative care between medicine and psychiatry. There is a high prevalence of psychiatric disorders comorbid with cyclic vomiting syndrome among both children and adults. These findings strongly suggest the need for careful and detailed psychiatric screenings in patients who have this disorder. If comorbid conditions are left untreated, the consequences may have significant medical and/or mental health impact, which could lead to social, family, or academic impairment. While amitriptyline may be beneficial in some individuals, further studies are needed to confirm its true efficacy. The cardiotoxic potential and side-effect profile of amitriptyline is an important limitation of use of this drug, which providers must keep in mind. Long-term outcomes could be understood with prospective studies with larger sample sizes. The lack of awareness of cyclic vomiting syndrome among health care professionals presents a great deal of challenge in early diagnosis and treatment.

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TREATMENT IN PSYCHIATRY

Transgender Patient Care on the Inpatient Psychiatric Unit

Courtney Saw, M.D.

CASE VIGNETTE

"Juliette" is a 40-year-old transgender woman with bipolar disorder admitted to the inpatient psychiatric unit involuntarily following an interrupted suicide attempt. Juliette uses female pronouns, has been taking estrogen and spironolactone for several years, and is recognized by her family and coworkers as female but dresses androgynously. Her first episode of depression occurred before coming out as transgender, and she has continued to have manic and depressive episodes while living happily as a woman. During a disagreement over access to her belongings, staff on the unit inadvertently refer to Juliette as "he," provoking her to anger. During attempted verbal de-escalation, male pronouns are repeatedly used, further agitating Juliette and resulting in restraints and injection medication.

CREATING A THERAPEUTIC ENVIRONMENT

Special consideration for transgender patients should start prior to their arrival to the inpatient psychiatric unit. Many institutions room transgender patients with patients of the same assigned (by society to the individual at birth), but not affirmed (to which the individual has transitioned or is in the process of transitioning), gender. This can feel invalidating, traumatizing, and discriminatory to the patient, as well as confusing to the roommate. Patients should share a room with others of the same affirmed gender, and if this is not feasible, a private room should be assigned. Staff should be aware of the patient's desired name and pronouns, especially when these do not align with the medical record. In general, withholding an outpatient hormone regimen will acutely worsen dysphoria for patients. Similarly, affirming devices, such as chest binders or breast prostheses, should be permitted unless they pose a significant safety concern.

INITIAL INTERVIEW

Given its relatedness to the patient's core identity and the need for mental health providers to have a full developmental history, a basic understanding of the patient's gender journey is a crucial part of the psychiatric interview for all transgender patients (see Table 1). Questions about their relationships and response to their identity in their social environment can assess for risk and protective factors, especially since the absence of support or exposure to discrimination and violence increases the risk for psychological distress (1–3). When patients volunteer information, clarifying questions about their medical transition process should be asked. It is critical to frame such questions in a manner that will enable the patient to understand the rationale. In gathering this information, it is important to remember that it is never appropriate to ask patients directly about their genitals. Additionally, some individuals undergo social transitioning (usually involving dressing in a stereotypical masculine or feminine fashion) without ever undergoing medical transitioning via either hormones or surgery, and thus it is important to phrase questions in a manner that does not assume the patient desires further medical intervention. At the end of the interview, asking patients whether there is anything that can be done to make their stay on the unit more comfortable can open the discussion to addressing any missed issues.

FOLLOW-UP QUESTIONS AND ISSUES

Throughout the hospitalization, it is important to follow up on how the patient's gender identity has been affirmed

TABLE 1. Sample Interview Questions for the Psychiatric Unit

Initial Interview
"How do you like to be addressed? What name would you like us to use?"
"When people refer to you, do you prefer that they do so as he/him, she/her, they/them, or something else?"
"May we use your preferred name and pronouns during your hospital stay?"
"Thank you for sharing this with us. If it's all right with you, we'll let the staff know so that we can ensure we're addressing you correctly. If anyone has trouble doing so, please let us know, and we will do our best to advocate for you."
"In order for us to better understand your medical history, what steps have you taken toward physically transitioning?"
"Are there any steps you're planning in the near future?"
"Is there anything that we need to know about your transition that is relevant to your medical treatment here?"
Follow-up interviews
"Have you had any trouble with the staff using your preferred name or pronouns?"
"How about with the other patients?"

on the unit. When misgendering occurs, whether by use of an incorrect name or pronoun or disparaging remarks, acknowledge this mistake and facilitate an apology. Afterward, every effort should be made to avoid repeating the mistake and to focus on the therapeutic alliance and achievement of treatment goals.

IMPLICATIONS OF HORMONAL THERAPY

There are many questions regarding the long-term impact of hormonal therapy for medical transitioning. However, given its comparatively recent arrival in the medical field, knowledge of this subject is limited. For patients with serious mental illness and coincidental gender variance, it is important to consider the patient's psychiatric course prior to hormone therapy and whether something else might be driving the psychiatric presentation before concluding that the hormones are responsible for decompensation. Based on the available research data, the World Professional Association for Transgender Health has recognized a "possible increased risk" of manic and psychotic symptoms that "appears to be associated with higher doses or supraphysiologic blood levels of testosterone" (4). To date, there are no data supporting the role of estrogen in psychiatric decompensation (4). Further research needs to be conducted on the natural history of psychiatric symptoms surrounding the initiation of hormone therapy before conclusions can be drawn regarding its impact on serious mental illness.

DISCUSSION

Lesbian, gay, bisexual, and transgender (LGBT) patients have consistently been identified to have health risks and outcomes that are distinctly different from those of non-LGBT patients (5). Relative to cisgender people, whose sex assigned at birth aligns with their gender identity, transgender individuals, whose gender identity does not align with their assigned sex, have higher rates of tobacco use, HIV infection, and, increasingly, behavioral health concerns (6). Although transgender people are not more likely to have mental illnesses, given that the rate of suicidal ideation and attempt in this population is nine times that of the overall population (7), it is imperative that behavioral health providers be skilled in supporting and treating transgender individuals in the acute setting. Future avenues of research might include evaluation of the impact of specific affirming interventions on transgender patient perceptions of psychiatric hospital stays in the short- and long-term, as well as rates of engagement and re-engagement with behavioral health care by these patients as a function of such interventions.

KEY POINTS/CLINICAL PEARLS

- A basic understanding of the patient's gender journey is a crucial part of the complete psychiatric interview for all transgender patients, with the goal of screening for risk factors, as well as protective factors, that play a role in the patient's mental health; discrimination and violence are major predictors of psychological distress.
- There are limited available data on the effect of hormone therapy on psychiatric symptoms, and thus it is critical to consider the patient's psychiatric course prior to and since the initiation of hormone therapy in addition to whether something else might be driving the psychiatric presentation.
- Special considerations for the treatment of transgender patients on inpatient psychiatric units include the display of symbols indicating acceptance of LGBT patients, continuing hormone regimens, the accommodation of affirming clothing and devices used by patients to align their physical appearance with their gender identity, and rooming patients with other patients of the same affirmed gender or utilizing private rooms if this is not feasible.
- When misgendering or disparaging remarks occur, acknowledge the mistake, facilitate a sincere apology if possible, and return the focus to the therapeutic alliance and achievement of the treatment goals.

Dr. Saw is a third-year resident in the Department of Psychiatry at the University of Pennsylvania, Philadelphia.

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INTERVIEW

An Interview With Forensic Psychiatrist Joseph Browning, M.D.

Oliver Glass, M.D.

The following is an interview with Joseph Browning, M.D., on forensic psychiatry, conducted by Oliver Glass, M.D.

Dr. Browning is a forensic psychiatrist who works at Georgia Regional Hospital in Atlanta, where he performs court-ordered evaluations of competency to stand trial and criminal responsibility. He is also a faculty member at Emory University, where he teaches forensic psychiatry fellows who conduct rotations at Georgia Regional Hospital. He has performed hundreds of formal forensic evaluations and recently served as an expert witness in high-profile cases involving Hemy Neuman and Jesse James Warren. Dr. Browning completed his forensic psychiatry training at Emory University.

Dr. Glass is a fifth-year geriatric psychiatry fellow at Emory University and will be a forensic psychiatry fellow, also at Emory, in the 2018–2019 academic year; he is also Senior Deputy Editor of the Residents' Journal.

Dr. Glass: Dr. Browning, What made you choose to be a forensic psychiatrist?

Dr. Browning: As a trainee, I was attracted to the challenge of critically thinking about a person's diagnosis, behavior, and its intersection with the law. The forensic psychiatrists I encountered in my residency program were thoughtful and confident, and I really wanted to be a part of that.

Dr. Glass: What recommendations do you have for psychiatry residents wanting to become forensic psychiatrists?

Dr. Browning: Do it! Seek out mentors in your program who do forensic work, set up electives, and get involved. My residency program did not have any required forensic rotations, so I worked with Peter Ash here at Emory to set up an elective in order to get a taste of what forensics was all about. It was a great experience and opened up a whole new world of psychiatry for me.

Dr. Glass: What should a forensic psychiatry applicant look for in a program?

Dr. Browning: I always tell applicants to the Emory program that they should be looking for fellowship programs that are heavy on evaluation and lighter on treatment. Psychiatry residents have 4 years to learn treatment, but a forensic fellowship is only 1 year. In my opinion, fellows get the most out of spending that year doing as many evaluations as they can. Applicants should also look for a program that provides a good mix of civil and criminal work.

Dr. Glass: How does a forensic psychiatrist make a name for him-/herself?

Dr. Browning: By doing good work. I teach fellows to approach every case objectively and to start with basics. Assume that nobody has ever sat down and really taken a critical look at the diagnosis, the records, and the circumstances of a case. Answer the forensic question that is asked, and give an honest opinion regardless of who might have requested the evaluation. Doing consistently thorough and thoughtful work shows people that you are reliable, dependable, and trustworthy. It makes courtroom testimony so much easier when you have earned the respect of the attorneys and judges you work with.

Dr. Glass: How did you get selected to be an expert witness in the Hemy Neuman case?

Dr. Browning: When the Hemy Neuman case was being retried, the Court ordered an objective evaluation of Mr. Neuman's criminal responsibility. State authorities chose me as the psychiatrist to do the evaluation, since I had a great deal of courtroom experience gained from teaching and working in the system for so many years, and they felt confident I could manage the case. They paired me with a seasoned psychologist to collaborate on the evaluation, and we spent several weeks working together to pore over the evidence and form an opinion.

Dr. Glass: What did you learn from your involvement in that case?

Dr. Browning: Every evaluation I perform is a learning opportunity, and this case was no exception. I spent a lot of time working on what is and what is not bipolar disorder, and I had to figure out how to effectively convey that to a jury in a high-stakes case. I also spent a lot of time with Georgia's unique statutes on criminal responsibility and tried to package that information in such a way that jurors could understand the complexities. More than anything, I learned about managing my own anxiety in my first high-profile court case. I was aware prior to my testimony that the expectations were high and that my testimony would have pretty extensive media coverage. I learned that I could rely on my training and my skills to work through

this case just as I have all the other cases where I have evaluated people and testified in court. At the end it was very rewarding, and I am proud of the work that my colleague and I did.

Note: Hemy Neuman was convicted of murdering his lover's husband outside of a daycare center. Though initially found guilty but mentally ill, Neuman was retried and convicted of malice murder. Dr. Browning testified as an expert witness in the retrial. Dr. Browning's testimony in the Hemy Neuman retrial is available for viewing on YouTube.

MOVIE FORUM

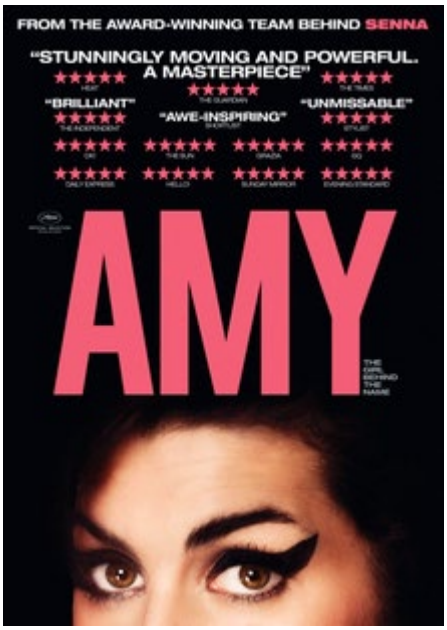
Amy (2015): Getting to Know the Girl We All Knew

Reviewed by Thomas Pyo, M.D.

Amy (2015) is an engrossing biopic documentary about Amy Winehouse and comprises almost entirely home videos from friends and family. This candid footage allows us to witness many intimate moments of the life of a charismatic, humble, and genuine woman. Amy's life follows the turbulent path of a rock-star archetype and tells an all-too-familiar story: a sensitive and talented individual lives intensely like a burning star and then quickly fades away before we even get a chance to know her.

Amy describes herself as a "nervous and nice child" until her parents separated when she was 9 years old. She grew quickly into a rebellious youth after her father left—ditching class, getting tattoos, and running off with her boyfriend. She began taking paroxetine for depression when she was 13 and began to purge at the age of 15. She moved into her own apartment as soon as she could in order to escape family problems and to "smoke weed all day." We watch Amy grow out of her adolescence and fall in love, making goofy banter with her friends, cracking jokes, and acting out silly skits in front of the camera. This is the side of patients we rarely get to see.

The film then shows how remarkably dehumanizing fame can be. Amy is blitzed by paparazzi flashes so gratuitous they border on malicious. Her bulimia and alcohol consumption quickly spiral out of control, and her substance abuse becomes an easy target for the media. Even when she wins Grammy awards and is absent from the event, the audience laughs as the host makes jokes about her addiction.



(Directed by Asif Kapadia)

One of the documentary's central themes is how a strong social support system is a requisite for all other treatment. Amy's former drug counselor stated that Amy seemed willing to receive treatment, but her boyfriend may have opposed the idea so as not to stop the proverbial "gravy train." Amy was surrounded by people hoping to benefit from her success, including her own father, which made it nearly impossible for her to pause her career and seek help. As the end approaches, Amy's friends express their desire to sequester her from the rest of the world in order to keep her safe, and for a moment we are convinced that she has found her way home. But we know it is just wishful thinking.

The film captures the life of a superstar but also tells a story that is relevant to everyone, as Amy is a person who is familiar to most of us. Amy needed help, and in the end she appeared on stage broken and intoxicated, sabotaging her own career, looking for a way out. Aside from telling a remarkable story, the film reminds us of the importance of enlisting the patient's friends and family as allies in treatment and shows us that our patients lead rich, complex lives outside the hospital, which we may need to understand in order to truly understand them.

Dr. Pyo is a first-year psychiatry resident at the UCLA San Fernando Valley Psychiatry Training Program.

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).

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/
Fellowship/Award	**APA Research Colloquium for Junior Investigators**
Organization	APA
Deadline	December 15, 2017
Brief Description	The colloquium provides guidance, mentorship, and encouragement to young investigators in the early phases of their training; held during the APA Annual Meeting.
Eligibility	Psychiatrists who are senior residents, fellows, or junior faculty; must have an MD degree or be a member of the APA or eligible to become a member of the APA; must be receiving training in the U.S. or Canada.
Contact and Website	E-mail: kbarber@psych.org • Web: https://www.psychiatry.org/psychiatrists/practice/research/research-colloquium

JANUARY DEADLINES

Fellowship/Award	Jeanne Spurlock Congressional Fellowship
Organization	APA
Deadline	January 31, 2018
Brief Description	The aim of the fellowship is to provide an opportunity for a psychiatry resident or early-career psychiatrist with significant interest in child and/or minority mental health advocacy to work in a congressional office. The recipient will serve a 10-month fellowship in Washington, DC, during which he or she will be introduced to the structure and development of federal and congressional health policy focused on mental health issues affecting minorities and underserved populations, including children.
Eligibility	Must be an APA member, U.S. citizen or permanent resident, and psychiatry resident, fellow, or early-career psychiatrist.
Contact and Website	E-mail: congressional@psych.org • Web: https://www.psychiatry.org/residents-medical-students/residents/fellowships
Fellowship/Award	**APA Psychiatric Research Fellowship**
Organization	APA
Deadline	January 31, 2018
Brief Description	The fellowship provides funding for a post-graduate psychiatry trainee, under the supervision and guidance of his or her mentor, to design and conduct a research study on a major research topic.
Eligibility	Must be an M.D. or D.O. and APA member who completed residency training prior to the time the fellowship commences.
Contact and Website	E-mail: kbarber@psych.org • Web: https://www.psychiatry.org/residents-medical-students/residents/fellowships
Fellowship/Award	**APA/American Psychiatric Association Foundation (APAF) Leadership Fellowship**
Organization	APA Foundation
Deadline	January 31, 2018
Brief Description	This fellowship provides opportunities for a psychiatry trainee to engage, interact, and participate at a national level and further develop his or her professional leadership skills, networks, and psychiatric experience. The program creates opportunities to expand relationships with peers and national thought-leaders in the field of psychiatry.
Eligibility	Must be an APA-resident member and enrolled as a PGY-2 at an accredited psychiatric residency training program.
Contact and Website	E-mail: psychleadership@psych.org • Web: https://www.psychiatry.org/residents-medical-students/residents/fellowships

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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