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Inside

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EDITORIAL

Looking Forward

Rachel Katz, M.D.
Editor-in-Chief

Welcome *Residents' Journal* readers to the 2017–2018 academic year. Thank you for your continuing support of the Journal. I write to introduce our new Editorial Board and share a few thoughts.

I extend our appreciation to Katherine Pier, M.D., the 2016–2017 Editor-in-Chief, for her leadership, notably while she and her husband welcomed a beautiful baby girl. She now joins our esteemed group of Editors Emeriti who continue to provide guidance and mentorship to our board. I welcome back Oliver Glass, M.D., as our Senior Deputy Editor, and Michelle Liu, M.D., as our Culture Editor, and introduce Anna Kim, M.D., Helena Winston, M.D., Erin Fulchiero, M.D., and Shawn McNeil, M.D., as our new board members. This group comes from a diverse set of backgrounds and areas of expertise, from internal medicine, YouTube fame, editorial work with the Guggenheim, science journalism, and global health.

Together we hope to create relevant issues that educate, inspire, and question the status quo. We seek to address topics that provoke curiosity and combat stigma. We aim to normalize the challenges inherent to this marathon we call medical training. And most of all, we hope to help you, our readers and authors, learn to write as physicians and psychiatrists. Let this be your forum for professional exploration.

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In an age of ever-evolving technology and science, it can be difficult to find a resource that is targeted to the level of the trainee. We are excited to introduce new projects to help you during your training. The first will be a column titled "Medicine for the Psychiatrist," discussing the management of medical and neurologic issues commonly encountered in our population. We will also introduce a regular podcast including summaries of our articles, as well as interviews of psychiatrists from various subspecialties discussing career development and mentorship (which will also be available in the online PDF version). Last, we will be expanding our social media presence to help you prepare for board exams, and provide an additional forum for networking, discussion, and further contribution. Notably, we will be featuring artwork on our Instagram page and welcome your submissions.

In an age when sample size often dictates academic value, we can forget that medicine started with the individual patient and doctor. A novel observation leads to a case report, a case series leads to prospective studies, then randomized controlled trials. We are where we are because curious individuals asked "why?" and "how?" Ask these questions regularly. Observe what keeps you excited or puzzled after long days. That is where to begin. You are part of the next era of psychiatry. We hope you'll join us on that journey.

ARTICLE

The Utility of Assessing Nonverbal Communication in the Psychiatric Evaluation

Khushminder Chahal, M.D.

"You see, but you do not observe," begins Sherlock Holmes in the 1891 short story *A Scandal in Bohemia,* by Arthur Conan Doyle. The passage that follows illustrates the idea of mindful observation, as Holmes makes a point to distinguish it from just seeing the steps that lead up to the room in which he and Watson stand (1). In fact, this concept of active observation is integral to the practice of medicine. As William Osler said, "the whole art of medicine is in observation" (2). Physicians perform evaluations based on the patient's communication of ailments. Oxford Dictionary defines communication as "the imparting or exchanging of information" (3). This exchange can take many forms when interacting with a patient. Most commonly what physicians conceptualize as communication is that which is spoken by the patient. However, literature continues to reveal the importance of nonverbal behaviors in communication.

THE STUDY OF NONVERBAL COMMUNICATION

All forms of communication other than words can be considered nonverbal communication (4), including vocal tone, facial expressions, posturing, and bodily movements. In his 1882 book, *The Expression of the Emotions in Man and Animals,* Charles Darwin put forth the idea of bodily movements representing internal emotional states as a result of evolution and inheritance. He argued that these movements we see accompany certain emotional states are universal to our species and that they serve a purpose while in that emotional state (5). This was demonstrated by his understanding of the function of these movements, as muscular movements serve a purpose while in a certain emotional state. The "expression" is the sum of those underlying muscular movements. These expressions serve an evolutionary benefit for survival and evolve into habits that are inherited, known as "serviceable habits" (6).

An example of this can be demonstrated simply by the facial expression for "disgust." Disgust can be defined as "a feeling of revulsion or profound disapproval aroused by something unpleasant or offensive" (7). From an evolutionary approach, this stimulus must therefore be one that threatens the individual. In the presence of such an offensive stimulus, whether it be a physical substance or a mental thought, the aim of the body is to prevent or remove it (8). The muscles of the face that contract, with the function of preventing/removing the toxin, give rise to the facial expression that represents disgust. This expression is that of a raised upper and lower lip, a raised and wrinkled nose, lowered eyebrows, and raised cheeks. The result is a functional closure of the mouth and nose, thereby preventing the inhalation or ingestion of a toxic substance (9). Over time, this facial expression has come to represent the emotional state of disgust. Thus, the presence of such a facial expression is communicating (nonverbally) disgust at the stimulus—that the stimulus is unpleasant or offensive.

Fast forward 90 years, and it was the paper by Ekman and Friesen (10), "Constants Across Cultures in the Face and Emotion," that confirmed the universality of human expression of the core emotional states. In this study, in which Ekman and his team assessed facial expressions among isolated tribal members in New Guinea, it was shown that no difference was found in the ability to identify facial expressions when comparing them to other cultural groups. Emotions as separate, discrete entities, and the universal expression of them, have since been proven within many fields such as neuroscience and cross-cultural studies (6). In fact, 88% of experts within fields pertaining to nonverbal communication endorse the existence of "compelling evidence for universals in any aspect of emotion" (11).

NONVERBAL VERSUS VERBAL COMMUNICATION

The importance of understanding nonverbal communication in isolation is of little benefit. Its utility is best served when in comparison with verbal communication. It is the assessment of congruency between the two forms of communication that yield the most valuable information. A patient who states "that's fine" but shows the facial expression of disgust and looks away while saying it is communicating something much different than the patient who leans forward and looks directly at his or her physician and states "that's fine" while nodding his or her head. Albert Mehrabian classically demonstrated that when inconsistencies in different forms of communication are present, tone and bodily movements are more trusted than is verbal content (words) (12, 13). This demonstrated well that the influence of tone of voice and bodily movements was stronger than that of verbal content when incongruence was present. Attentiveness to such incongruence can be of great utility to physicians when interacting with their patients.

UTILITY IN THE PSYCHIATRIC EVALUATION

Mindfulness of nonverbal communication will allow a physician to better understand the patient. This understanding may come in the form of obtaining more information than is verbally volunteered, distinguishing deception from truths, and achieving better diagnostic clarity. Often, these insights can be gained from only a short time of observing the patient.

These brief samples of patient behavior are known as "thin slices," which are defined as brief excerpts of expressive behavior that are sampled from a behavioral stream (14). That is, any sample of the patient's behavior that is enough to predict traits of the patient. In usually less than 5 minutes—even as short as seconds—these brief excerpts provide a window into the patient's state (14). Often, they provide information that the patient may not volunteer.

A common example of brief moments of patient behavior that are very telling, in as short as seconds, is smiling. Patients often smile habitually, as a smile is socially accepted as warm, engaging, and overall positive. But a well-attuned physician may be able to identify the type of smile. For clinical purposes, a useful distinction to make may be of enjoyment versus nonenjoyment smiles. That is, smiles that are truly representing positive emotions of happiness and are subconscious (and hence, true representations) versus smiles that are consciously created for social purposes. The "Duchenne smile," named after French neurologist Guillaume Duchenne, involves the orbicularis oculi, pars lateralis, and zygomatic major muscles in conjunction, whereas other types of smiles do not (15). The Duchenne smile is the best smile to indicate enjoyment and positive effects of happiness. It is distinguished from other smiles by the involvement of the musculature surrounding the orbit, which can be seen as wrinkling around the lateral sides of either eye. This visible difference can help identify smiles created deliberately to conceal the experience of negative emotion, which may aid physicians in identifying deception.

Deception in the patient-physician interaction has been a long-standing challenge to physicians. Usually deception in the clinical encounter is motivated by themes of exploitation, protection, and shame (16). Often, physicians rely on inconsistencies in the story or the patient's report of symptoms to determine deceit (17). However, as Darwin stated in 1882, "They [the movements of expression] reveal the thoughts and intentions of others more truly than do words, which may be falsified" (5). In fact, even when facial movements are attempted to be falsified, there is leakage of those muscles that cannot be consciously controlled (18).

Later, the discovery of "microexpressions," expressions lasting 1/25 to 1/5 of a second, were shown to represent such leakage and reveal true emotional states (19, 20). The Facial Action Coding System has since been developed by Paul Ekman and his team as an objective method for quantifying facial movements, and it has been used not only in clinical settings but also in research, law enforcement, and behavioral detection settings.

Observation of the congruency of verbal and nonverbal communication provides physicians with a great amount of information that can guide their diagnostic formulation of the patient. The common "feel" of a patient within the first few moments of an encounter speaks to this and demonstrates the profound effect of nonverbal communication, even subconsciously. Studies have shown that "thin slices" can accurately predict personality disorders (21), as many psychiatrists will attest to when they speak of a patient giving off that "feel" of a personality disorder. The intuitive feel of a patient with schizophrenia, described in 1941 as "praecox feeling" by Dutch Psychiatrist H.C. Rumke, has also been associated with predicting the disorder (22). "Thin slices" also accurately predict depression (23), and even suicide risk for attempts (24) and reattempts (25). Anxiety varies based on whether it is an acute state anxiety or a chronic trait anxiety, as state anxiety is better communicated verbally, and trait anxiety is better communicated nonverbally (26). This demonstrates that even chronic states can be predicted by a momentary observation of nonverbal communication.

KEY POINTS/CLINICAL PEARLS

- Assessment of congruency between verbal and nonverbal communication can aid in determining the validity of a patient's complaints.
- Emotions can be assessed using understanding of facial expressions.
- "Thin slices" represent brief excerpts of expressive behavior that are sampled from the interaction with a patient; these excerpts can provide diagnostic clarity.
- Documentation of nonverbal behaviors in the Mental Status Examination can provide support of the diagnosis.

CONCLUSIONS

Physicians will benefit from being more mindful of nonverbal behaviors, as it allows for better diagnostic clarity in the psychiatric evaluation. Young physicians would benefit from increased education and training on the topic of nonverbal behaviors by their education and training programs. Doing so will allow for an increased emphasis on objective portions of documentation, such as the Mental Status Examination, and will also allow for more accurate assessments and evaluations.

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The ***AJP Residents' Journal*** has launched an **Instagram** page! Send your psychiatry-inspired photos & artwork to the AJP-RJ Media Editor Michelle Liu, M.D. (Michelle.Liu@nyumc.org).

ARTICLE

Body Modification and Personality: Intimately Intertwined?

Andrew J. Perrin, M.D., Ph.D.

Many psychiatric residents will encounter patients who modify their bodies. Body modification (e.g., tattooing, non-earlobe piercing) can incite many reactions in the observer and can often be a source of stereotyping. An oft-repeated mantra is that possession of significant body modifications (≥1 tattoo or multiple non-earlobe piercings) is suggestive of the presence of a personality disorder in the bearer (1–3). The veracity of this claim is difficult to substantiate anecdotally. Additionally, public perception of body modification continues to change (4).

Up to 20% of U.S. adults bear at least one tattoo (5). Therefore, it is unclear whether body modification has experienced some acculturation or whether possession of modifications still suggests character pathology. The body of literature examining body modification and its relation to personality is large. The present review focuses on the origins of early beliefs and how these may be challenged with more recently published literature.

HISTORY

The oldest examples of body modification date from the Egyptian Middle Kingdom (ca. 2000 BC). Tattooing during this era was reserved for those of high standing, and in fact, navel piercing was routinely used as a sign of royalty (6). Purposeful passage of pointed instruments through appendages was harnessed by classical Mayan civilization (ca. 250–1000 AD) in religious ceremonies. The blood released by these temporary body modifications was used to adorn penitent followers and to demonstrate the virility of holy practitioners (7).

What then caused a change from desirable to deviant? In three great voyages (1768–1780), Captain Cook, a British explorer and cartographer, made the first recorded European contact with the Hawaiian islands and in eastern Australia. He and his crew repeatedly encountered the people of Polynesia, among whom tattooing was prevalent. Tattooing in the South Pacific then served to mark cultural rites of passage, affiliation to one's kin, and identification of one's enemies. Indeed, the modern word "tattoo" descends from the Polynesian word "tatua," meaning "artistic" (1). Cook's men were amazed with these tattoos, with some even choosing to have the same tattoos inscribed on themselves. Upon their return to Europe, which at the time was largely unfamiliar with body modification, such flaunted markings instantly drew admiration. A perceived link between body modification and exotic locales then encouraged select European nobility to undergo modification as well (7).

Over the next 100 years, body modification, especially tattooing, became more and more synonymous with the mariner and the lower socioeconomic classes that seamen inhabited (7). The invention of the electric tattoo gun in the late 1800s further democratized tattooing (8), and as the prevalence of tattoos in the lower socioeconomic classes increased, the desirability of body modification in the upper socioeconomic classes decreased. From the perspective of the upper class, tattoos grew to symbolize the homogeneity of the working masses (7). Ease of tattooing allowed it to be co-opted into criminal identification schemes as well. Thus, by the early 20th century, body modification had become a mark of social deviance (7).

PERCEPTIONS IN THE 20TH CENTURY

In the early 20th century, both medical practitioners and psychiatrists were integral in linking body modification with presumed characterological deficits. The presence of body modifications was identified in "prostitutes and perverts" by the psychiatrist Parry in 1934 (9), and body modifications noted during indoctrination physicals of American World War II conscripts were found to be associated with higher rates of rejection for service (43.8% versus 29.9%). These rejections in tattooed conscripts were more likely to result from "neuropsychiatric reasons," including "psychopathic personality" and "mental defect." Such findings led Lander and Kohn (3), the examining doctors, to state that "there is thus a correlation between … tattoos and the presence of significant psychopathology," a finding subsequently publicized in Time magazine (10).

Further studies in the 1950s and 1960s presented evidence that linked the possession of multiple tattoos to underlying disorders of personality. In a series of works examining hospitalized psychiatric and general medical patients (in aggregate: tattooed, N=111; not tattooed, N=609), Gittleson and colleagues (2, 11) reported an elevated prevalence of personality disorders in those who were tattooed (25% of patients) compared with those who were not (8% of patients) (2). The specific personality disorder diagnoses in those tattooed was not fully delineated in early reports, but in the 1990s Inch and Huws (12) presented a series

of cases that conceptualized tattooing and other body modifications as being a manifestation of borderline personality disorder.

Retrospectively, it is difficult to disentangle the relative contributions of social stigma against body modification on the one hand and objective medical reporting on the other, in the formation of a firm opinion relating body modification and personality. It is also difficult to determine how much the countercultural nature of body modification may have enriched the prevalence rates of personality disorders in the tattooed population, as tattooed persons may have already been more culturally non-conformist in nature to begin with. What is clear is that most of the previous centuries' work was based on case series or on enriched samples of psychiatric inpatients. Limited data were collected from other, broader segments of society, especially those without documented psychiatric diagnoses.

A CHANGE?

A 2000 study reported by Rooks and colleagues (13) was one of the first to report data from a patient population broader than psychiatric inpatients alone. In a consecutive 2-day survey of all patients presenting to a community hospital emergency department, the presence of tattoos was recorded, as well as the primary reason for presentation (a tripartite outcome of injury, illness, or psychiatric/chemical dependency). Although 16% of patients reported possessing at least one tattoo, the investigators were unable to find a correlation between possession of a tattoo and the reason for presentation to the hospital (13). Although this study, due to its design, was unable to definitively disprove a link between tattoos and the presence of a personality disorder, it did provide evidence beyond the scope of the previous works of Gittleson and colleagues (11). While it may be that possession of body modifications has little to do with the reason for patient presentation for acute care, the dissonant results of these two studies focuses attention on the changing perception of body modification over 30 years.

KEY POINTS/CLINICAL PEARLS

- Body modification is encountered often in psychiatric practice, and its presence can influence clinical perceptions of underlying personality structure.
- Previous psychiatric literature presented a link between body modification and the presence of a personality disorder.
- Recent research suggests that previous links between body modification and personality disorders may not hold in the general population but that the presence of tattoos in the forensic population requires a more thorough evaluation to rule out personality dysfunction, especially antisocial personality disorder.
- The changing societal perceptions of body modification reflects the evolving nature of this area.

An additional study by Hohner and colleagues (14) examined the link between the presence of borderline personality traits and body modification. In a sample of 289 women with body modifications, a group manifesting borderline personality traits was identified and then compared with the remaining women who did not manifest these same personality traits. No difference was found in the number or nature of body modifications between the two groups. While a definitive conclusion on the relation between borderline personality disorder and body modification awaits more rigorously designed studies, the work of Hohner and colleagues (14) highlights that the number and type of body modification were not useful discriminators in a modern cohort of women. When compared with the work of Inch and Huws (12), the evidence presented by Hohner and colleagues also suggests that a re-evaluation of previously held assumptions about body modification and personality may be topical.

The above studies highlight potential changes in the diagnostic implications of body modification in a more general population. Ongoing work in forensic settings has suggested that a link between specific personality traits and body modification may be relevant. Detailed study of 36 male forensic patients conducted by Cardasis (15) revealed that significantly more patients with tattoos had a diagnosis of antisocial personality disorder compared with patients without tattoos. Additionally, patients with antisocial personality disorder had a greater number of crudely or self-applied tattoos and a tendency toward having a greater percentage of their total body surface area tattooed. Unfortunately, neither this study nor other more recent works have addressed the diagnostic implications of full-arm "sleeve-type" tattoos. Future studies on this topic could be informative.

CONCLUSIONS

The last 75 years have seen significant change in the societal perception of body modification (16). While initial psychiatric and medical studies placed emphasis on the diagnostic utility of body modifications in identifying personality disorders, studies in broader groups of patients have generated some challenge to long-promulgated diagnostic links between body modification and personality disorders. At the same time, studies in the forensic setting have refined this diagnostic link in a specific population and suggested that antisocial personality disorder must be carefully ruled out in those forensic patients who possess large numbers of crudely applied or self-made tattoos or who have a large area of their body covered by tattoos. While initially seeming contradictory, these two disparate views of body modification are in fact complementary and help to make the resident's understanding of the link between body modification and personality disorder more sophisticated than it was in the previous century. Anchoring quickly on personality dysfunction in a body modifier now seems premature, and it

is advisable to consider body modification more as a signal for further inquiry (17), especially if there is a forensic history. A better understanding not only of coping style and life course, but also reasons for body modification, should help the resident to avoid the rapid application of a diagnosis that can be ultimately difficult to remove if erroneous.

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CASE REPORT

Diogenes Syndrome: A Special Manifestation of Hoarding Disorder

Shehryar Khan, M.D.

The onset of extreme self-neglect in elderly individuals where there is a temporal relationship to the news of a life-threatening illness has been reported in literature and referred to as Diogenes syndrome, named after the ancient Greek philosopher who lived in a barrel in the 4th-century BCE. A depiction of Diogenes, by French painter Jean-Leon Gerome (1), is shown in Figure 1. Macmillan and Shaw first described the syndrome in 1966 (2). The term Diogenes syndrome was later coined by Clark et al. in 1975 (3). The syndrome was named after Diogenes, as the ancient Greek philosopher showed "lack of shame" and "contempt for social organization" (3). However, many authors have argued that there was not much discussion of why the eponym is appropriate and have argued that the term is a misnomer (4–6). There has been a proposal for use of the term "severe domestic squalor" as a better descriptor of this syndrome (4). In the present case report, Diogenes syndrome and severe domestic squalor are used interchangeably to describe the same psychopathological phenomenon. Both these descriptors refer to a person's home becoming so unclean, unhygienic, and repulsive that individuals of similar culture and background would consider extensive clearing and cleaning to be essential (4, 5). The present case report is of a patient with sudden-onset hoarding of garbage, spoiled food, and excreta in his house after a life-threatening diagnosis.

CASE

"Mr. F" is a 78-year-old widowed, Caucasian man with a past medical history of hypertension and coronary artery disease who was diagnosed with carcinoma of the paranasal sinus with leptomingeal carcinomatosis 6 weeks prior. He was brought into the hospital for concerns with regard to worsening dysphagia, fatigue, and serosanguinous drainage from his nose. He had been started on carboplatin chemotherapy infusion 1 month prior. He was admitted to the oncology floor for evaluation and management of his symptoms. While a history was being collected, Mr. F's son shared his concerns with the primary team about his father's hoarding garbage, spoiled food, and excreta at home since the cancer diagnosis. Mr. F lived alone, and there had been accumulation of "waste" congesting and cluttering the living area. Social work was consulted to determine whether there were any safety concerns if the patient was discharged back home, and a psychiatric consultation was requested for evaluation for a psychiatric disorder and assessment of cognitive functioning.

The patient was seen and evaluated by the psychiatric consultation-liaison team. He did not meet *DSM-5* criteria, currently or in the past, for major depressive disorder, adjustment disorder, bipolar disorder, generalized anxiety disorder, obsessive-compulsive disorder, or posttraumatic stress disorder (7). He did not have symptoms of psychosis, and he did not meet criteria for hoarding disorder, as there was no sentimental attachment to possessions in the house nor a perceived need to necessarily keep "waste" at home. Moreover, the patient lacked insight into his situation at home and did not report distress. The impairment was apparent only to his family members who were concerned about his safety at home. He had some demoralization related to his cancer diagnoses but did not have hopelessness and wanted to take it "one day at a time."

The patient did not have a history of current or prior excessive alcohol use or any recreational drug use. However, he had a 50-pack per year smoking history and did meet criteria for nicotine use disorder, moderate, in a controlled environment. Pertinent mental status examination findings included the patient being pleasant, cooperative, and appropriately light-hearted and humorous during the assessment. His mood was euthymic, with intensity, range, and reactivity of affect within normal limits. His thought process was goal-directed. His cognitive testing was completely intact for orientation, executive function, attention, memory, abstract reasoning, naming, and language.

The patient's social history was pertinent for a successful career in the automotive industry for over three decades, and he had started a small family business after his retirement. Upon collateral from his family, it was verified that his "hoarding" behavior, as was referred by the family, had started just 1 month prior, per the family's best estimate, and this was after his cancer diagnosis. Prior to this, there had been no concerns regarding similar behavior.

DISCUSSION

The annual incidence of Diogenes syndrome has been estimated to be around 5 per 10,000 in individuals aged 60 and older and living alone (8). There has

been mixed evidence in terms of prevalence of comorbid disorders. A study of 30 individuals with Diogenes syndrome found that 50% had no comorbid psychiatric disorder (4). Another study of 72 individuals with Diogenes syndrome found that isolation, alcoholism, and psychotic disorder coexisted (3). Although these two studies have the largest sample sizes studied for this disorder, a major limitation of these studies is that both were published before 1975, bringing into question diagnostic validity and reliability. Over the years, several individual reports have been published, highlighting the continued identification of this syndrome.

Extreme self-neglect in elderly individuals, with nutritional deficiencies, was described in patients who had a high intelligence quotient, often with successful careers in the past, who started to live in squalid surroundings and became neglectful of their personal hygiene and nutrition at the onset of life-threatening illness (9). There is a reported case of a woman with "onset of neglect" after a breast lump was identified, and this period of time was associated with sudden-onset of poor personal and domestic hygiene (10). It is interesting to note that the patient had resumption of baseline personal and domestic hygiene after successful excision of the lump (10). A French review on Diogenes syndrome also commented on the abnormal hoarding of random items in the home to be associated with neglect of one's domestic cleanliness (11). The individuals examined had been noted to have struggles with precarity, which can explain an underlying challenge for asking for help (6). Irvine and Nwachukwu described the main characteristics of Diogenes syndrome as being "domestic squalor," "self-neglect," and "lack of shame" regarding domestic hoarding (11). An Australian review of Diogenes syndrome also described the hoarding pattern to consist of rotting food, excrement, or odors likely causing feelings of revulsions among family and visitors, similar to the pattern in the patient in the present case report (5).

TABLE 1. Distinguishing Hoarding Disorder From Severe Domestic Squalor (Diogenes Syndrome)

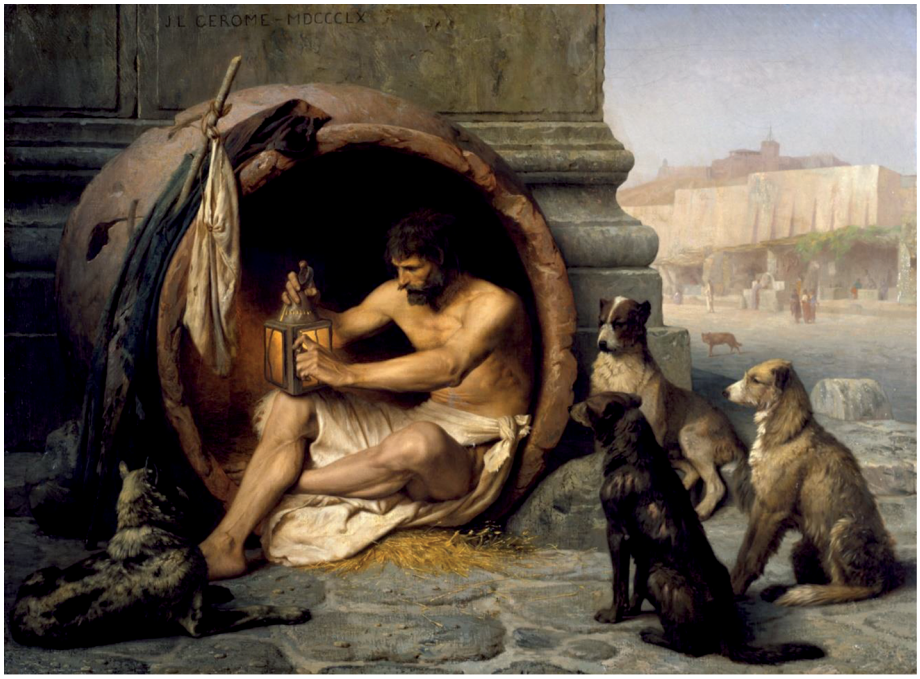
DSM-5 Diagnostic Criteria (A–D) for Hoarding Disorder[a]	Proposed Diagnostic Criteria for Diogenes Syndrome (Severe Domestic Squalor)
Persistent difficulty discarding or parting with possessions, regardless of their actual value.	Excessive abnormal cluttering of invaluable possessions resulting secondary to a transient life circumstance.
The difficulty is due to a perceived need to save the items and to distress associated with discarding them.	There is no sentimental attachment to the possessions.
The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use.	(same as hoarding disorder)
The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).	There is poor insight; the individual may not report distress, and the impairment may be apparent only to those around the individual.

[a] See reference 7.

Increased mortality rate has been reported in these patients, with a 46% 5-year death rate secondary to the physical complications of their underlying medical condition (12). In another study, it was reported that these individuals have a 5.8-times greater 1-year mortality rate than age-matched individuals (13). Dehydration, malnutrition, infections, falls, and injuries are common presentations and likely causes for increased mortality (4).

Out of all the diagnostic categories, Diogenes syndrome is closely related to, but distinct from, hoarding disorder (14) (see Table 1). Key distinctions of hoarding disorder from Diogenes syndrome are that in the latter, there is abnormal

FIGURE 1. Jean-Leon Gerome's Painting Depicting the Greek Philosopher Diogenes (404–323 BC)[a]



[a] Permission to publish this image in the *Residents' Journal* was obtained from and granted by The Walters Art Museum, Baltimore.

KEY POINTS/CLINICAL PEARLS

- Diogenes syndrome is described as behavioral onset of excessive abnormal cluttering of invaluable possessions secondary to a transient life circumstance.
- The individual with the disorder has poor insight, and usually visitors and family members are the ones to first notice the cluttering behavior.
- The disorder is rare but has been associated with high mortality rates.
- The disorder represents a different entity from hoarding disorder and needs to be further studied to be classified as a separate diagnosis.

cluttering of invaluable possessions without any sentimental attachment, with poor insight, and with no distress regarding this cluttering behavior.

In conclusion, Diogenes syndrome, also described as severe domestic squalor in the literature, has been identified in several case reports, and further investigation into this psychopathological process will be important in considering it as a distinct diagnostic entity to be considered for future editions of the *DSM*.

Dr. Khan is a third-year resident in the Department of Psychiatry at Henry Ford Health System, Detroit.

The author thanks Gregory Mahr, M.D., and Deepak Prabhakar, M.D., M.P.H.

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ARTS AND CULTURE

Luke Cage and Police Brutality

J. Corey Williams, M.A., M.D.

At first glance, you might think the new Netflix series *Luke Cage* is just another platitudinous superhero drama from Marvel Comics. But, there is something quite different about this hero: the hero is a dark-skinned black man dressed in a black hoodie. A celebration of this kind of image is radical change from the prototypical white male, caped crusaders casted in Marvel's most recent popular products (i.e., Ant-Man, the Avengers, Captain America, etc.).

The cultural and psychological significance of the show lies not just in having a black superhero, but also in the specific superpower of being bulletproof that may strike an emotional cord in the black consciousness. As a show character proclaimed, "There's something powerful about seeing a black man bulletproof and unafraid."

The show sheds light on several issues: exploitation of black bodies in correctional facilities, misuse of police force on black bodies, and, perhaps more subtly, the experience of living in predominantly black neighborhoods under concentrated police surveillance.

As a resident working mostly in urban centers, I regularly hear patients, especially African-American patients, tell me that they are afraid of the police and worry about being a target. The fear is omnipresent and palpable. Perhaps being an African-American physician makes patients more likely to reveal to me these concerns.

As we work with minority patients, we must be careful as to what we choose to pathologize about their experience.

Because we, as physicians, do not typically inhabit the same neighborhoods and are not subject to the same unjust institutional practices as our poor, urban patients, we may have a difficult time relating to their worries. The socioeconomic discrepancy between the physician and patient may make the physician more likely to distort or misinterpret a patient's psychological reaction to a very real threat in his or her community. As a colleague once said after a patient described his fear of the police, "The patient may be suffering from delusional paranoia."

As an African American, I too am concerned about being a victim of police brutality. When I drive down the street and see a police cruiser in my rearview mirror, my grip around the steering wheel becomes a little tighter. One misunderstanding, one false move, could result in my untimely death. This hyperawareness is not simply the result of a few minor acts from "bad apple" officers, but from decades of tension and distrust between communities and law enforcement.

The narrative of *Luke Cage* does not offer a logical, cognitive response to the problem of police brutality. Nor does the show offer social or political solutions to racial impropriety of law enforcement. However, it offers a symbolic representation of unapologetic black strength and resilience, which can speak to people in a powerful way. As we work with minority patients, we must be careful as to what we choose to pathologize about their experience, given the tragic victimization of the black community from police brutality and mass incarceration. As the TV show *Luke Cage* may provide an emotionally evocative narrative, clinical encounters can serve as an emotional outlet if clinicians listen with a nonjudgmental ear to these experiences.

Dr. Williams is a third-year resident in the Department of Psychiatry, Yale University, New Haven, Conn.

ARTS AND CULTURE

The Importance of Medical Interpreters

Emily Tonkin, D.O.

While working on the psychiatry consultation-liaison service at a children's hospital, I was asked to see a 12-year-old girl with lymphoma, multiple medical comorbidities, and limited English proficiency. The primary hematology-oncology team was concerned about oppositional and aggressive behaviors interfering with necessary medical care. Upon reviewing the case and doing a behavioral analysis on several major incidents in which the patient became aggressive or otherwise out of control, it was discovered that often staff was not using medical interpreter services. For example, a phlebotomist was witnessed entering the patient's room and attempting to draw blood without speaking a word to the patient. After implementing a behavioral plan and increasing the use of medical interpreters, the patient's behaviors improved.

Executive order 13166 was enacted in April 2000 to improve access to services for people with limited English proficiency in accordance with Title VI of the Civil Rights Act, which prohibits discrimination on the basis of national origin. As such, health care agencies must provide interpreter services to limited English proficiency patients. Data show that professional medical interpreters are underutilized in the health care setting, and multiple barriers to appropriate use have been identified, including limited time and limited access to interpreters (1). Additionally, alternatives to on-site interpreters, including telephone and video interpreters, have demonstrated some deficiencies (e.g., lack of non-verbal communication, less attention to cultural differences) (1).

Communication barriers can lead to a variety of problems, including aggression, hindrance of care, lack of informed consent, and avoidance of the health care system, among other negative outcomes.

As demonstrated by the opening anecdote, communication barriers can lead to a variety of problems, including aggression, hindrance of care, lack of informed consent, and avoidance of the health care system, among other negative outcomes. Conversely, it has been shown that use of an interpreter increases patient satisfaction, decreases adverse outcomes, and improves adherence and positive outcomes (2). Patients with limited English proficiency have expressed preference for professional interpreters over their bilingual family members and friends (3). In addition to providing accurate and informed language interpretation, interpreters often serve as cultural liaisons between patients and medical staff (2). Nevertheless, there are limitations to interpreter services, including variability in skill level, as there is no standardized certification for medical interpreters (4). Further limitations include delays in assessment (e.g., pain level) while waiting for an interpreter (1).

Despite these limitations, it is of the utmost importance to utilize medical interpreters in order to provide the same quality of care to all patients regardless of their preferred language. Medical providers have a professional and ethical obligation to treat all patients according to a standard of care determined by their field. This obligation cannot be fulfilled with regard to limited English proficiency individuals without the use of medical interpreters. Future efforts to improve interpreter services could focus on implementation of a standardized certification process and recruitment to increase the number of available in-person interpreters in the health care system.

At the time this article was accepted for publication, Dr. Tonkin was a fifth-year resident in the Department of Psychiatry, Louisiana State University Health Sciences Center, New Orleans.

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ARTS AND CULTURE

Hitting Home: A Third-Year Medical Student's Patient Encounter

Natalie Spiller, B.A.

While downing the last drops of a stale coffee, another stack of papers plopped onto my now overflowing desk. I briefly gazed down at the note from the emergency department, "few days of visually disturbing thoughts and paranoia." Tossing the empty Styrofoam cup, I headed to meet the patient, "Miss A." Given her description as a "previously psychotic and combative meth addict," I was surprised when a timid, young woman rose from her chair. Together we walked, and I further observed the stooped posture, downcast gaze, and unkempt hair she bore. We began to talk, and although she was initially guarded, my in-depth knowledge of the shelter she was staying at and specific details of the recovery process helped her to open up and allow me into her world.

"At 5, my step-father molested me," she began.

I nodded reassuringly.

"My foster siblings and mother's string of boyfriends did the same."

Emotionless, she continued.

"At 14, I attempted suicide, but they took me to the hospital. At 17, I filed for independence from my mother, met ["Mr. A"], and got pregnant with my son," therein tying her to a relationship that itself became abusive for 10 years.

I clearly see my future in this profession as one full of both challenges and hope.

"Are you still together?" I probed.

"Split 7 months ago," Miss A replied, gaze falling to the floor. "I couldn't handle it."

She admitted, as many without proper psychiatric help do, drugs were her outlet to "kill the pain." Now in rehab, she is desperately trying to prove herself a worthy mother for her son.

As anyone with intimate knowledge of someone with an addiction can verify, this disease wreaks astonishing havoc on both the individual and those trying to help. Being a witness to the emotional chaos, chemical overdoses, legal issues, and loss of personal stability, one can gain a keen understanding of just how hard recovery is. In meeting and speaking with Miss A, I saw an eerie resemblance of a close relative in her.

Matching age, gender, race, and mental status, my close relative endured a similar journey. After a catastrophic bout with opioids, leaving her jobless and pregnant, she retrospectively describes the experience: "It's like being stuck in a whirlpool, submerged up to your eyes. All you can do is try to stay alive." She remains firm that it was the lowest point of her life—total loss of stability, pride, and will to live. My relative vehemently acknowledges that drugs were her method to suppressing a darkness she could not face. In her situation, we were lucky to have the support and opportunities to make sobriety a sustainable reality. For Miss A, whether she believed it in her current state or not, this too could be her future. This was no end, simply a different beginning.

Through life encounters like this, whether we are identifying a learning disorder in a child or turning around the life of someone struggling with addiction, I clearly see my future in this profession as one full of both challenges and hope.

Natalie Spiller is a fourth-year M.B.A./M.D. student at the Louisville School of Medicine, Louisville, K.Y.

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).

SEPTEMBER DEADLINES

Fellowship/Award, Organization, and Deadline	Brief Description and Eligibility	Contact and Website
American Psychiatric Association (APA) Resident Poster APA **Deadline:** September 7, 2017	Residents, medical students, and fellows are invited to submit an abstract for a poster they would like to present at the 2018 APA Annual Meeting. • Medical students from U.S. osteopathic or allopathic medical schools; psychiatry resident and psychiatry-subspecialty fellowships; Residents from other medical specialties.	E-mail: program@psych.org https://s7.goeshow.com/apa/annual/2018/abstract_submission.cfm
American Association of Directors of Psychiatric Residency Training (AADPRT) George Ginsberg Fellowship AADPRT **Deadline:** September 12, 2017	Acknowledges the excellence and the accomplishments of outstanding residents interested in education and teaching. • General or child and adolescent psychiatry residency program or in a psychiatry subspecialty fellowship; • Must be a resident or fellow at the time of nomination and award presentation.	E-mail: exec@aadprt.org http://www.aadprt.org/awards/awards_detail?awardsid=57
Peter Henderson, M.D., Memorial Award AADPRT **Deadline:** September 12, 2017	Acknowledges the best unpublished scholarly paper contributing to the field of child and adolescent psychiatry. • Current general psychiatry residents; Child and adolescent psychiatry residents; Individuals who have graduated from a general psychiatry residency training program or child and adolescent psychiatry training program within the last two years.	E-mail: exec@aadprt.org http://www.aadprt.org/awards/awards_detail?awardsid=55

OCTOBER DEADLINES

Fellowship/Award, Organization, and Deadline	Brief Description and Eligibility	Contact and Website
Geriatric Mental Health Foundation's Honors Scholarships American Association for Geriatric Psychiatry (AAGP) **Deadline:** October 1, 2017	Provides residents a 1-year membership to AAGP; Registration and travel costs to attend the AAGP Annual Meeting; Participation in an academic project related to geriatric psychiatry under the supervision of an assigned mentor. • PGY-1, 2, or 3 in an accredited psychiatry residency program.	E-mail: Training@aagponline.org or telephone: 703-556-9222 http://www.aagponline.org/index.php?src=gendocs&ref=GMHFScholarProgram&category=Main
Geriatric Mental Health Foundation's General Scholarships American Association for Geriatric Psychiatry (AAGP) **Deadline:** October 1, 2017	Provides medical students a 1-year membership to AAGP; registration and travel stipend to attend the AAGP Annual Meeting; voluntary participation in an academic project related to geriatric psychiatry under the supervision of an assigned mentor. • Medical students in an LCME or COCA accredited medical school.	E-mail: Training@aagponline.org or telephone: 703-556-9222 http://www.aagponline.org/index.php?src=gendocs&ref=GMHFScholarProgram&category=Main

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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