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Volk v. Demeerler: A Jarring Collision Between Psychiatry and the Law

Willa Xiong, M.D.

In the seminal 1976 case *Tarasoff v. Regents of California*, the California Supreme Court ruled that it is the duty of therapists to protect identifiable victims of imminent physical threats made by patients (1). Following this ruling, a majority of other states recognized a duty to protect the public, which includes warning potential victims, contacting law enforcement, or pursuing hospitalization of the patient (2). Although the Health Insurance Portability and Accountability Act (HIPAA) specifies the requirement for a “serious and imminent threat” to breach physician-patient privilege (3), there is no general federal law pertaining to an obligation to protect. Consequently, significant state-by-state variation exists, ranging from the duty being mandated by statute to being allowed by common law to a lack of guidance entirely (2).

In the ruling on the 2016 case *Volk v. Demeerler*, the Washington Supreme Court specified the duty of the state’s psychiatrists to protect third parties from a patient’s “dangerous propensities,” even in the absence of threats or identifiable victims (4). The case involved a patient diagnosed with bipolar disorder who murdered his girlfriend and her son and then committed suicide. There was no evidence of homicidal ideations or worsening symptoms during the patient’s last visit to his psychiatrist, nor did he have a past history of homicidal ideations toward the victims (4). Nevertheless, the patient’s psychiatrist was held liable for not warning appropriately. The ruling was highly contested, since the expansive duty to warn the general public, rather

The law may not always align with clinical practice.

than only identifiable victims, places an unfair burden on clinicians (5).

A patient’s “dangerous propensities,” or possible elevated risk of violence compared with that of the general population, is not equivalent to the patient acting out violently. Comprehensive assessments of a patient’s words or demeanor, as well as of relevant events, may lead a psychiatrist to believe that a genuine threat is likely to occur and that action should be taken. However, without some evidence, a patient with “dangerous propensities” may engage in violence that a psychiatrist simply cannot predict. The *Volk* decision does not acknowledge this need for an evidence-based assessment and does not specify when a patient’s latent “dangerous propensities” are likely to turn into a serious and imminent threat to another person’s safety. In other words, the adjudication is not workable under both clinical care standards and the federal HIPAA standard.

Although the *Volk v. Demeerler* case was filed in pursuit of justice by seeking damages for an injured party, the decision ultimately hinders psychiatrists from providing effective care. Individual liberty rights are at risk of being infringed, given that psychiatrists may seek involuntary hospitalization prematurely the moment a patient voices suicidal or homicidal ideations. Patients may withhold information during vis-

its in fear of such civil commitment. To avoid liability, clinicians might steer clear of providing care to high-risk patients entirely. Access to mental health treatment could, ironically, be curtailed for those who need it most.

The law may not always align with clinical practice, as in the case of *Volk v. Demeerler*. The intersection of psychiatry with the legal system is indubitably complex, and necessarily so, given the differing aims of the two fields: justice versus therapeutic care. In this issue of the *Residents’ Journal*, authors address a variety of topics relevant to forensic psychiatry in hopes of providing some insight into these complexities.

Dr. Xiong is a fourth-year resident in the Department of Psychiatry, Washington University School of Medicine, Saint Louis, and Guest Editor for this issue of the *Residents’ Journal*.

REFERENCES

1. Tarasoff v Regents of University of California. 551 P.2d 334, 1976
2. National Conference of State Legislatures: Mental health professionals’ duty to warn. Washington, DC, National Conference of State Legislatures. <http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>
3. US Department of Health and Human Services: Sharing information related to mental health, health information privacy. Washington, DC, US Department of Health and Human Services. <https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html>
4. Volk v Demeerler. 386 P.3d 254, 2016
5. Moran M: Court expands Tarasoff duties in Washington state. Psychiatr News, Jan 2017. <http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2017.2a4>

Prison Hospice Care: Life and Death Behind Bars

Victoria J. Tann, M.D.

When you have to change a man's diapers and it goes against everything that you've ever really stood for, what you realize is that it's this whole different side of you that says this is the humane thing to do, this is the right thing to do It was real humbling. (1)

Hospice care is a unique field that enables psychiatrists to use their skillset to improve the quality of life and experience of death for terminally ill patients and their families. Prison hospice is an expanding specialty that should be considered by physicians who are interested in the legal system, hospice care, and care for vulnerable populations.

An increase in both the U.S. prison population and average inmate age has burdened the correctional system with caring for chronically and terminally ill incarcerated persons. One response to this problem was the Sentencing Reform Act of 1984, which provided the option of compassionate release for dying inmates. However, this policy has been largely ineffective, with release of few incarcerated persons and with some inmates dying in prison during the long petition process (2). Prison hospice programs offer an alternative to compassionate release and provide both inmate volunteers and psychiatrists with the unique opportunity to care for individuals in the criminal justice system.

Psychiatrists involved in prison hospice programs provide expertise in establishing an individual's mental capacity and in identifying and treating common end-of-life problems, such as anxiety, depression, and delirium. They also bring with them skills in psychotherapy and familiarity with grief (3). While directly addressing issues surrounding death, they are further equipped to ensure that pre-existing mental health diagnoses are appropriately addressed. The literature recognizes that large numbers of incar-

An increase in both the U.S. prison population and average inmate age has burdened the correctional system with caring for ... terminally ill incarcerated persons.

cerated persons have a psychiatric disorder that is undertreated, untreated, or undiagnosed (2, 4).

One challenge in prison hospice programs is pain management. Diversion of narcotic medications in prison settings is a recognized concern. Apprehensions about misuse or abuse may present barriers to care, especially considering the highly publicized opioid epidemic. Despite these concerns, the majority of prison hospice respondents to a 2011 survey reported use of long-acting opioid medications to treat pain. Less than one-half of respondents endorsed the use of short-acting medications and patient-controlled analgesia (5). Many psychiatrists have fellowship training in addiction medicine and can offer pharmacologic expertise pertaining to the use, prescription, and potential drug interactions of several medications used to treat pain and anxiety in terminally ill patients.

Prison hospice programs, like other hospice care programs, are multidisciplinary. Psychiatrists participating in prison hospice programs work side by side with other health professionals and also may have the unique opportunity to work with inmate volunteers. Many prison hospice programs enlist inmate

volunteers, who are required to meet strict selection criteria and undergo several hours of prerequisite training (1, 5). Although some might question the use of incarcerated persons to care for their ailing peers, the majority of prison hospice programs report never experiencing an incident in which a volunteer took advantage of a patient (5). Participation in prison hospice has the potential to significantly benefit the lives of volunteers, as they may see their work as a way to bring value to their own lives or as contrition for their past criminal offenses. Volunteers recognize the emotional strain of coping with the loss of their fellow inmates but endorse use of positive coping mechanisms in dealing with grief (1, 5).

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REFERENCES

1. Cloyes KG, Rosenkranz SJ, Supiano KP, et al: Caring to learn and learning to care: inmate hospice volunteers and the delivery of prison end-of-life care. *J Correct Health Care* 2017; 23(1):43–55
2. Hanson A: Psychiatry and the dying prisoner. *Int Rev Psychiatry* 2017; 29(1):45–50
3. Irwin SA, Ferris FD: The opportunity for psychiatry in palliative care. *Can J Psychiatry* 2008; 53(11):713–724
4. Gottfried ED, Christopher SC: Mental disorders among criminal offenders: a review of the literature. *J Correct Health Care* 2017; 23(3):336–346
5. Hoffman HC, Dickinson GE: Characteristics of prison hospice programs in the United States. *Am J Hosp Palliat Care* 2011; 28(4):245–252

Impaired Physicians: Obliterating the Stigma

A. Benjamin Srivastava, M.D.

A few minutes after taking cocaine, one experiences a sudden exhilaration and feeling of lightness One senses an increase of self-control and feels more vigorous and more capable of work.

—Sigmund Freud, *Über Coca* (1884)

Freud's well-known use of cocaine is thought to have influenced his professional transition from a neurologist to the father of psychoanalysis. Similarly, it is believed that cocaine played a role in William Halsted's career success, including his development of paradigm-shifting surgical innovations. While many historians of medicine believe that quite a few of the successes of Freud and Halsted were influenced by their cocaine use, their addictions to cocaine and use of other substances (i.e., Freud's use of alcohol and Halsted's use of morphine) led to immense interpersonal conflict, physical harm, and personal anguish (1). Freud and Halsted are two examples of an underrecognized phenomenon: the impaired physician. This article provides an overview of physician impairment, a condition that is encompassed in the practice of forensic psychiatry, including prevalence, contributing factors, intervention, evaluation, and treatment.

Evidence suggests that addiction among physicians is similar to addiction in the general population. The prevalence of substance use disorders is reported to be 15% among physicians and 13% in the general public (2). In both the physician and general populations, experimentation of substance use at a young age and family history of addiction may contribute to the development of addiction (3). Both impaired physicians and their counterparts in the general population give similar reasons for initiating drug or alcohol use, including curiosity, peer pressure, and availability of a given

substance (4). However, in contrast to the general population, physicians have very easy access to controlled substances. Consequently, common reasons for initiating use, facilitated by easy access, include attempting to treat psychiatric distress associated with burnout and attempting to self-treat physical pain (2, 5).

USE BY MEDICAL SPECIALTY

Research suggests that differential patterns of substance use disorders are found in different medical specialties. However, specialties that are found to be overrepresented vary among different studies (2, 6). Nevertheless, anesthesiology has attracted significant attention because anesthesiologists with substance use disorders have particularly high rates of relapse, overdose, and suicide (3, 6, 7). Anesthesiologists disproportionately represent physicians who abuse and are addicted to fentanyl, which may be explained by the "second-hand exposure hypothesis." By using liquid-chromatography mass spectroscopy methods to measure fentanyl particles in the air of an operating room, Gold et al. (8) found the highest concentration of aerosolized particles to be located near the patient's expiratory circuit, which is close to where the anesthesiologist is positioned during an operation. Given that one of the contributing factors to the development of addiction is a family history of addiction, exposure to fentanyl particles may prime an anesthesiologist who is at greater risk due to family history by altering reward circuitry, thus resulting in cravings, drug-seeking behavior, and addiction (3, 8, 9).

INTERVENTION AND TREATMENT

Impaired physicians are difficult to identify for a variety of reasons. In ad-

dition to ease of access to substances, as mentioned previously, physicians may be more adept at hiding substance use from their colleagues compared with other professionals because they know the signs and symptoms of drug addiction and are better able to conceal them in the work environment (e.g., covering up track marks) (10). Additionally, physicians are less likely to self-report substance use because of professional implications, stigma, and lack of awareness about mechanisms for reporting and avenues for referral to treatment (10). Thus, most impaired physicians do not receive adequate treatment. Of those who do, nearly 75% are referred via external sources (e.g., colleagues, loved ones, a state board of medicine) (11).

For physicians who do enter treatment, the usual mechanism involves a state physician health program. Physician health programs are state-level entities that work with their respective boards of medicine to arrange treatment and subsequent monitoring of impaired physicians. Physician health programs formally emerged in the 1970s after a series of American Medical Association-sponsored reports and conferences on impaired physicians (12). After a physician suspected of impairment is referred to a physician health program, a qualified physician with expertise in either addiction psychiatry or addiction medicine performs a comprehensive evaluation, with a focus on addiction and psychiatric histories. Subsequently, recommendations for treatment and future monitoring are made to the state physician health program, which then drafts a contract detailing the requisite treatment and monitoring with which the physician must comply in order to retain the ability to practice medicine (10, 11).

Physician health programs typically have arrangements with a select group of treatment centers that deliver state-of-the-art treatment, usually with specific programs geared toward impaired physicians. Following acute medical detoxification, residential treatment for approximately 90 days is generally recommended, although some contracts allow for intensive outpatient treatment. Treatment is almost exclusively focused on abstinence, and participants receive individual, group, and family-oriented therapy. Attendance at Alcoholics Anonymous, Narcotics Anonymous, or Caduceus (i.e., a 12-step-based fellowship for physicians) meetings is usually required. Additionally, psychiatric comorbidities are closely evaluated and treated. The treatment centers may also provide resources for addressing outstanding addiction-related legal issues (10, 11).

Following successful completion of residential treatment, the impaired physician begins the monitoring phase of the contract. Participating physicians undergo frequent drug testing with a variety of modalities, including urine screening and hair and nail clippings. The specialized urine testing can detect “club” drugs, alcohol, hallucinogens, and other substances not detected in standard urine drug screens. During the monitoring period, which typically lasts 5 years, participating physicians are required to continue their attendance at monitored group meetings and mutual support meetings (e.g., Alcoholics Anonymous, Narcotics Anonymous). Additionally, individualized requirements for establishing care with a primary care physician, psychiatrist, or therapist may exist. The consequences for noncompliance with contract obligations (e.g., missed appointments and meetings, intentional false statements, relapse) depend on the

severity of the offense. Consequences can include warnings, increased intensity or frequency of monitoring, mandated return to residential treatment, or referral to the state board of medicine for punitive measures (10, 11).

PHARMACOTHERAPY FOR PHYSICIANS WITH OPIOID ADDICTION

While pharmacotherapy for opioid use disorder in the general population is considered standard care, its role in the treatment of impaired physicians is not definitive (13). For physicians with opioid addiction who are enrolled in a physician health program, the prescription of opioid substitution therapy, specifically buprenorphine or methadone, is rarely utilized (11, 13). Many physician health programs have informal policies prohibiting opioid-substitution therapy use due to safety concerns. Buprenorphine and methadone have the potential to cause CNS side effects, and there is no robust literature demonstrating that physicians can practice medicine safely while undergoing treatment with opioid substitution therapy (13, 14).

Conversely, non-opioid maintenance therapy pharmacotherapy (e.g., naltrexone) may have considerable benefit. In 1984, Washton et al. (15) demonstrated that oral naltrexone could be successfully used in the treatment of physicians with opioid addiction. Merlo et al. (16) retrospectively studied the utility of either oral or injectable naltrexone treatment in a sample of anesthesiologists enrolled in a physician health program. In the cohort treated with naltrexone, more than 90% remained relapse-free throughout the duration of their monitoring contracts and successfully returned to work. However, more than

70% who were not treated with naltrexone relapsed at least once, with only 9% returning to work (16).

OUTCOMES AND IMPLICATIONS

In a landmark study, more than 900 physicians from 16 physician health programs were followed longitudinally for the entire 5-year duration of their monitoring contracts. Seventy-eight percent maintained drug screen-confirmed abstinence from alcohol or drugs, and 72% returned to practicing medicine without restrictions (10, 17). Outcomes were consistent across physicians surveyed, irrespective of substance type or number of substances used. As mentioned previously, most physician health programs prohibit opioid substitution therapy, and therefore physicians with opioid addiction were monitored under abstinence-only contracts (e.g., without opioid substitution therapy). Interestingly, the physicians with opioid addiction had rates of 5-year abstinence, relapse, and return to work similar to the rates among physicians who had addiction problems with other substances (13). Of the physicians who completed 5-year monitoring contracts, more than 90% reported a satisfactory experience and would recommend the physician health program to others, and nearly 85% reported continued attendance at 12-step and other mutual support meetings (18).

The physician health program model has implications in addiction treatment that extend beyond the treatment of impaired physicians. Because of the success of physician health programs, professional licensing boards that govern commercial pilots, attorneys, and other health care workers have adopted this model of care. Despite issues and circumstances unique to impaired physicians (as well as other professionals with licenses), certain components of physician health programs may be extended to addiction treatment in the general public, with the potential to improve outcomes. Currently, most addiction treatment available to individuals in the general public focuses on standard sets of treatment services (e.g., medication and/or counseling) in time-limited settings (19). In contrast, the physician

KEY POINTS/CLINICAL PEARLS

- The prevalence of substance use disorders among physicians is similar to that of the general population.
- Physician health programs provide a comprehensive system of referral, evaluation, treatment, and long-term monitoring, resulting in 5-year abstinence and return-to-work rates nearing 80%.
- The focus on longitudinal, continuing care and 5-year outcomes could be extended to addiction treatment in the general population.

health program model focuses on 5-year outcomes with frequent monitoring and continued support, which could become the standard of care in mainstream addiction treatment (10, 19).

CONCLUSIONS

Physician impairment is an underrecognized problem that is inextricably linked with high rates of burnout and suicide. However, the advent of physician health programs has produced unparalleled success in addiction treatment and represents a paradigm shift, whereby addiction treatment is viewed as chronic disease management with ongoing treatment, monitoring, and support, similar to the treatment of hypertension or diabetes. The additional focus on long-term outcomes parallels that of cancer treatment (19). The dissemination and implementation of these core elements of the physician health program model is indispensable in addressing one of America's most significant public health crises: addiction.

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REFERENCES

1. Markel H: An Anatomy of Addiction: Sigmund Freud, William Halsted, and the Miracle Drug Cocaine. New York, Vintage Books, Random House, 2012
2. Oreskovich MR, Shanafelt T, Dyrbye LN, et al: The prevalence of substance use disorders in American physicians. *Am J Addict* 2015; 24:30–38
3. Merlo LJ, Gold MS: Prescription opioid abuse and dependence among physicians: hypotheses and treatment. *Harv Rev Psychiatry* 2008; 16:181–194.
4. Merlo LJ, Trejo-Lopez J, Conwell T, et al: Patterns of substance use initiation among healthcare professionals in recovery. *Am J Addict* 2013; 22:605–612
5. Merlo LJ, Singhakant S, Cummings SM, et al: Reasons for misuse of prescription medication among physicians undergoing monitoring by a physician health program. *J Addict Med* 2013; 7:349–353
6. Warner DO, Berge K, Sun H, et al: Substance use disorder among anesthesiology residents, 1975–2009. *JAMA* 2013; 310:2289–2296
7. Alexander BH, Checkoway H, Nagahama SI, et al: Cause-specific mortality risks of anesthesiologists. *Anesthesiology* 2000; 93:922–930
8. Gold MS, Melker RJ, Dennis DM, et al: Fentanyl abuse and dependence: further evidence for second hand exposure hypothesis. *J Addict Dis* 2006; 25:15–21
9. Merlo LJ, Goldberger BA, Kolodner D, et al: Fentanyl and propofol exposure in the operating room: sensitization hypotheses and further data. *J Addict Dis* 2008; 27:67–76
10. DuPont RL, McLellan AT, White WL, et al: Setting the standard for recovery: physicians' health programs. *J Subst Abuse Treat* 2009; 36:159–171
11. DuPont RL, McLellan AT, Carr G, et al: How are addicted physicians treated? a national survey of physician health programs. *J Subst Abuse Treat* 2009; 37:1–7
12. White WL, DuPont RL, Skipper GE: Physicians health programs: what counselors can learn from these remarkable programs. *Counselor* 2007; 8:42–47
13. Merlo LJ, Campbell MD, Skipper GE, et al: Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in physician health programs. *J Subst Abuse Treat* 2016; 64:47–54
14. Hamza H, Bryson EO: Buprenorphine maintenance therapy in opioid-addicted health care professionals returning to clinical practice: a hidden controversy. *Mayo Clin Proc* 2012; 87:260–267.
15. Washton AM, Gold MS, Pottash AC: Naltrexone in addicted physicians and business executives. *J Clin Psychiatry* 1984; 45:39–41
16. Merlo LJ, Greene WM, Pomm R: Mandatory naltrexone treatment prevents relapse among opiate-dependent anesthesiologists returning to practice. *J Addict Med* 2011; 5:279–283
17. McLellan AT, Skipper GS, Campbell M, et al: Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ* 2008; 337:a2038
18. Merlo LJ, Greene WM: Physician views regarding substance use-related participation in a state physician health program. *Am J Addict* 2010; 19:529–533
19. DuPont RL, Compton WM, McLellan AT: Five-year recovery: a new standard for assessing effectiveness of substance use disorder treatment. *J Subst Abuse Treat* 2015; 58:1–5

Call for Submissions for “Monitoring the APA Meeting”

Trainees have an opportunity to submit a brief synopsis of the sessions attended at the 2018 APA Annual Meeting in New York. The synopsis can focus on a single session or summarize multiple sessions in one perspective piece. Limited to 500 words and five references. To submit a synopsis, please visit <https://mc.manuscriptcentral.com/appi-ajp>, and select the **Monitoring the Meeting–RJ** manuscript type for *AJP Residents' Journal*.

For more information please contact the *Residents' Journal* Senior Deputy Editor, **Oliver Glass, M.D.** (oliver.glass@emory.edu).

Malingering: A Result of Trauma or Litigation?

Lauren H. Marasa, M.D.

Malingering, which is defined in DSM-5 as the “intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives,” is easy to define, yet difficult to diagnose (1). Studies have shown that approximately 13% of patients who present to the emergency department for psychiatric symptoms are malingering (2). Not only is this time-consuming for health care providers and facilities, it is reported to cost the U.S. health care system approximately \$150 billion annually (3). Furthermore, an estimated 32% of forensic psychiatry referrals are considered to involve cases of malingering (4). While it is imperative to know how to accurately assess for malingering, it is equally important to understand an individual’s motive to malingering.

The following three theoretical models have been proposed by Dr. Richard Rogers, one of the leading forensic psychologists in the phenomenon of malingering (5): the pathogenic model, also known as “partial malingering,” which involves a patient exaggerating preexisting symptoms in an effort to control his or her experience of a physical illness or other psychiatric disorder that is simultaneously co-occurring; the criminological model, which involves individuals seeking reprieve from legal consequences; and lastly, the adaptation model, which suggests that malingering is an adaptive process for individuals attempting to cope with extreme stressors and could be an act of desperation or an indication of poor coping skills.

The case report below exemplifies a combination of the three theoretical models of malingering and suggests that the underlying motive may change over a patient’s lifetime. Additionally, the following original theory is hypothesized: once a patient is involved in the criminal justice system, he or she may exhibit ma-

lingering behaviors consciously or even subconsciously. Furthermore, this case theorizes that malingering may be acquired throughout the litigation process.

CASE

“Joey” was a 9-year-old boy who was in an accident while riding a motorbike. He sustained multiple injuries, including a moderate traumatic brain injury (TBI). He was hospitalized for 2 weeks and was initially noted to have spastic quadriplegia, dysarthria, and cognitive impairment. The patient underwent extensive rehabilitation, resulting in a nearly complete recovery from the deficits he sustained in the accident and was left only with a residual, left upper-extremity contracture.

Two years after the accident, the patient’s mother filed a product liability lawsuit against the manufacturer of the motorbike due to the bike’s small size and lack of a safety flag. The lawsuit claimed that the manufacturer negligently failed to warn consumers of the dangerousness of the bike. The case went to trial and resulted in a \$4.5 million verdict in favor of the plaintiff. However, 3 years after the initial lawsuit was filed, the patient was found to be partly at fault, which reduced the awarded amount to \$2.5 million.

During the ensuing lawsuit, the patient underwent extensive psychological evaluation. He was diagnosed with oppositional defiant disorder, and mild neurocognitive disorder was ruled out. The patient, who routinely disrespected his caregivers with racist remarks and indecent behavior, exhibited worrisome signs of underlying and evolving character pathology. The forensic examiner believed that much of this behavior was secondary to the patient’s preexisting oppositional defiant disorder. Clinical examination,

neuropsychiatric testing, and head imaging indicated that there was little to no evidence that his behavior was a result of frontal lobe damage or lingering effects of a TBI. However, both his family and caretakers felt that the behavior was due to his history of TBI.

The patient was later lost to follow-up. Years later, he was found panhandling in the streets by a local television news station. Although his left arm remained contracted, the rest of his body was completely capable and ambulatory. However, he would sit in a wheelchair and masterfully imitate his previous deficits. He spoke in a slurred and muffled tone, despite his speech being clear and concise at baseline. He boasted about receiving \$60,000–\$100,000 each year by panhandling, thereby exposing his fraudulent behavior. He had accumulated a myriad of criminal charges over the course of his life. A timeline of these legal charges, starting at age 18, is presented in Figure 1. The timeline highlights the development of antisocial personality disorder over the ensuing years. Antisocial personality disorder is a common comorbid disorder among individuals who malingering.

At age 33, he was released from jail after being charged with trespassing. From the jail, he went directly to an emergency department and requested narcotics for chronic pain. The emergency department refused to give him these medications. Upon discharge from the emergency department, he suddenly reported suicidal ideation and command auditory hallucinations telling him to “blow” his brains out. He was then discharged to the state psychiatric hospital, where he was admitted for further evaluation. On arrival, he spoke in a slurred manner in front of clinicians but was later witnessed to be speaking clearly and coherently with other hospital staff

Neuropsychological testing was performed, and the results supported the diagnoses of antisocial personality disorder and malingering. While it is known that TBI may increase the risk of comorbid psychiatric disorders later in life, no evidence of any mood or neurocognitive disorder was found in this patient. The team withheld initiation of medication given the numerous inconsistencies in the patient's presentation and results of his psychological examinations. Discharge planning was discussed; however, the patient became physically aggressive and threatening when confronted with such plans. Although patient placement was difficult in this case, the patient was ultimately discharged, without medication, from the psychiatric facility to a local homeless shelter.

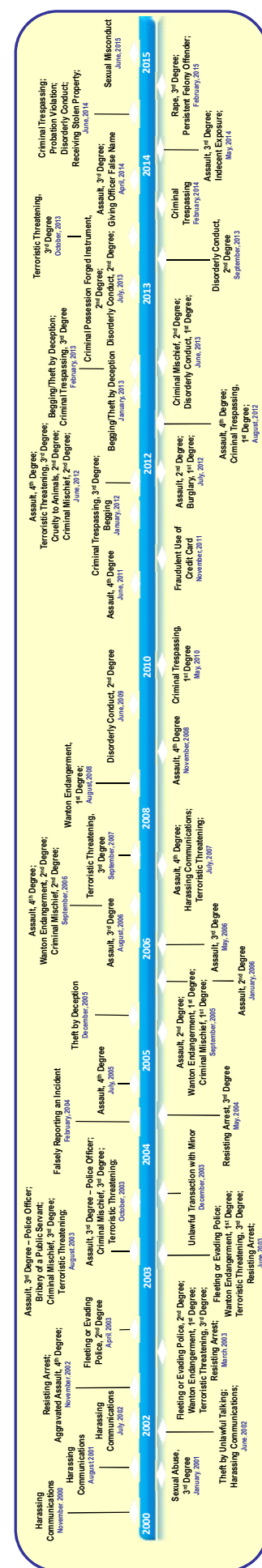
In the above case, the patient repeatedly feigned his neurological and psychiatric deficits for secondary gain. While there was an interplay between the three proposed models of malingering as the patient aged, one could conclude that underling all of these was the 5-year-long trial during which his alleged deficits were under constant scrutiny in a product liability lawsuit, in which a large sum of money was at stake.

young child and vulnerable, the subtle message toward him was likely that he must “look his worst” in order to be rewarded additional damages. This may have subliminally reinforced any pre-existing maladaptive and pathological behaviors.

The patient later fit into the adaptation model, with his efforts to acclimate not only to his injuries but to his new status as a "disabled victim." As a child, "performing" for a jury was an incentive that may have exacerbated any underlying character abnormalities during formative years of brain development. The adaptation model also encompasses the patient using his deficits, by exaggerating his impairment, to obtain his needs and desires during the litigation period. Ultimately, and paradoxically, this resulted in an adult who was neurologically recovered but one who had an acquired antisocial personality disorder and malingering behavior.

The patient started to have many legal encounters once he turned 18 years old (as shown in Figure 1). He was charged with “theft by deception” on numerous occasions. Additionally, he was seen carrying his wheelchair up three flights of stairs before raping a woman with disabilities. However, he continued to exaggerate his impairments when charged with such crimes in order to avoid criminal convictions.

Although criminal charges were not pressed by the state psychiatric hospital when the patient became physically aggressive after he was confronted with discharge plans, this was considered as an option. According to the U.S. Department of Justice National Crime Victimization Survey conducted from 1993 to 1999, the annual rate of nonfatal, job-related violent crime was 12.6 per 1,000 workers in all occupations; however, that rate increased to 68.2 per 1,000 when surveying psychiatrists and other mental health professionals (6). Further literature suggests that 40%–50% of psychiatry residents might be physically assaulted by a patient during their years of residency training (7). Although criminal charges pressed by medical professionals against patients are rare, filing charges should be considered as a recourse.



KEY POINTS/CLINICAL PEARLS

- Malingering is defined in DSM-5 as the “intentional production of false or grossly exaggerated physical or psychological symptoms” motivated by secondary gain.
- Accurately assessing malingering is of utmost importance, since approximately 13% of all psychiatric emergency department visits and 32% of forensic psychiatry patients are thought to be malingering.
- The three theoretical models proposed in the development of malingering are pathogenic, criminological, and adaptation.

CONCLUSIONS

Assessment of malingering is important for all psychiatrists. It is also crucial to consider why individuals may adopt the malingering role. For example, when a substantial legal verdict is at stake, it is possible that the litigation process itself may reinforce maladaptive and pathological behaviors, and the individual may learn to rely on or magnify preexisting impairments for known secondary gain.

In the case presented here, the patient’s preexisting oppositional defiant disorder was intensified during a legal trial, since his family and caregivers continuously excused his behavior due to his history of a TBI. The ensuing trial

ultimately reinforced the progression of his antisocial personality disorder, since he was never held accountable for his behavior. Ultimately, the lawsuit over-emphasized his impairments and prior brain injury and deemphasized any responsibility that he had over his actions. Further studies are needed to determine how litigation may affect an individual’s long-term mental health.

Previously presented at the 47th Annual Meeting of the American Academy of Psychiatry and the Law, October 27–30, 2016, Portland, Ore.

Dr. Marasa is a fourth-year resident in the Department of Psychiatry, University of Kentucky, Lexington, Ky.

The author thanks the American Academy of Psychiatry and the Law. The author also thanks her supervisor, Dr. David Shrager, who was the initial forensic psychiatrist to evaluate the patient in this case report during the original lawsuit.

Details in this case report have been altered to protect the patient’s privacy.

REFERENCES

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC, American Psychiatric Publishing, 2013
2. Yates BD, Nordquist CR, Schultz-Ross RA: Feigned psychiatric symptoms in the emergency room. *Psychiatr Serv* 1996; 47(9):998–1000
3. Garriga M: Malingering in the clinical setting. *Psychiatr Times*, March 1, 2007, pp 1–3
4. Pollock PH, Quigley B, Worley KO, et al: Feigned mental disorders in prisoners referred to forensic mental health services. *J Psychiatr Ment Health Nurs* 1997; 4(1):9–15
5. Rogers R: Explanatory models of malingering: a prototypical analysis. *Law Hum Behav* 1992; 18:543–552
6. Friedman RA: Violence and mental illness: how strong is the link? *N Engl J Med* 2006; 355(20):2064–2066
7. Rueve M, Welton R: Violence and mental illness. *Psychiatry* 2008; 5(5):34–48



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Electroconvulsive Therapy: A Historical and Legal Perspective

Hyun-Hee Kim, M.D.

Electroconvulsive therapy (ECT) is one of the oldest medical treatments still in regular use. First performed in 1938 in Italy, ECT was invented to replace less reliable, more unpleasant methods of inducing seizures (e.g., camphor, insulin-coma therapy) (1). Until the 1950s, pharmacotherapy for psychiatric disorders was extremely limited. Hence, ECT was applied broadly—for substance abuse, schizophrenia, hysteria, and anxiety. It was even used for homosexuality, which remained a diagnosis in the DSM until 1973. Earlier forms of ECT often caused severe confusion and memory loss, without justifiable accompanying benefits (1). Safety and side-effect concerns have since been addressed by methodological changes, including the use of neuromuscular blockers, sedatives, physiologic monitoring, airway management, dose titration, and varied electrode placements (2). Nevertheless, such historical precedents have contributed to the stigmatization of ECT among the public.

Legislative hurdles have limited the use and availability of ECT, at times resulting in treatment being delayed for weeks while patients await court hearings (1). Unlike most other treatments in medicine, including far more invasive procedures, a health-care power of attorney may not be able to consent to ECT on a patient’s behalf (see Table 1). Ten states require court approval if the patient is unable or unwilling to consent (3). Twenty states have specific legislation limiting ECT use, and three have legislation more stringent than APA guidelines (3). For example, in Texas, ECT is banned for use among all patients under age 16, and the state mandates registration of ECT devices and quarterly reports from treating facilities. Such restrictions on ECT stemmed in part from the antipsychiatry and antiauthoritarian movements of the post-World War II era, as well as negative media portrayals (4). These movements brought to the mainstream the ideas that

psychiatric illness was a social construct and psychiatrists were agents of the state who enforced societal norms by pathologizing undesirable behaviors (1). By the 1970s, activists seeking to limit psychiatric treatment found that lobotomies and other biological treatments had been largely phased out. ECT and involuntary commitment remained legislative targets within the broader movement for patient rights and deinstitutionalization. *Wyatt v. Hardin* (1975), *Aden v. Younger* (1976), *Price v. Sheppard* (1979), and similar suits mandated additional ECT oversight, mainly from courts, physicians, and hospital directors (5). Since 1978, APA task force reports on ECT have supported the use of ECT for medication-resistant depression, pregnant or elderly patients, and cases necessitating rapid treatment responses. However, ECT is often the treatment of last resort (5). Delaying ECT not only prolongs distressful symptoms, but also contributes to the development of treatment-resistant affective disorders

TABLE 1. Legislation for ECT by State

Statute Type	State Plus Mandates and Recommendations
More stringent than APA guidelines	California: Three physicians (two board-certified) must agree to treatment and agree that the patient is able to provide consent. Texas: All facilities administering ECT must follow requirements pertaining to the registration of ECT devices and the informed-consent process and submit quarterly reports on all ECT patients. ECT may not be used for patients <16 years old. Two physicians must agree to treatment if the patient is >65 years old. New York: Extensive guidelines for voluntary ECT in mental hygiene laws.
Specific legislation; involuntary ECT requires court approval	Arkansas, Connecticut, Minnesota, Missouri, New York, Ohio, Pennsylvania, South Dakota, Texas, and Virginia
Specific legislation but no explicit requirement for a court order for involuntary ECT	Colorado, Delaware, Illinois, Nebraska, North Carolina, Oregon, Vermont, and Washington
No specific legislation (defaults to APA guidelines)	Alabama, Alaska, Arizona, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Puerto Rico, Rhode Island, South Carolina, Tennessee, Utah, Virgin Islands, West Virginia, Wisconsin, and Wyoming

and worsens catatonia, and it can be lethal in malignant catatonia.

With advances in neurobiological research, the line between psychiatry and neurology has become increasingly blurred and there has been a resurgence in the use of ECT. Yet clinicians may still find themselves having to delay safe and effective treatment while awaiting court approval due to outdated, inaccurate perceptions. As a matter of justice and timely access to effective treatment—and with new knowledge—perhaps it is time to revisit these laws that bar much-needed care.

Previously presented as a research poster at the Annual Meeting of the North Carolina Psychiatric Association, Myrtle Beach, S.C., Sept. 14–17, 2017.

Dr. Kim is a third-year resident in the Department of Psychiatry, Duke University Hospital, Durham, N.C.

The author thanks Dr. Willa Xiong for her guidance and editorial assistance, as well as Dr. Mehul Mankad for his expert guidance on the topic of ECT.

REFERENCES

1. Ottosson J, Fink M: Ethics in electroconvulsive therapy. New York, Routledge, 2004
2. Lebensohn Z: The history of electroconvulsive therapy in the United States and its place in American psychiatry: a personal memoir. *Compr Psychiatry* 1999; 40(3):173–181
3. Harris V: Electroconvulsive therapy: administrative codes, legislation, and professional recommendations. *J Am Acad Psychiatry Law* 2006; 34:406–401
4. Rissmiller DJ, Rissmiller JH: Evolution of the antipsychiatry movement into mental health consumerism. *Psychiatr Serv* 2006; 57(6):863–866
5. Swartz CM: Electroconvulsive and neuromodulation Therapies. Cambridge, United Kingdom, Cambridge University Press, 2009

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Call for Applications to Join the 2018 Editorial Board

The *American Journal of Psychiatry—Residents' Journal* is now accepting applications to join the 2018–2019 Editorial Board for the following positions:

SENIOR DEPUTY EDITOR (SDE) POSITION

Job Description/Responsibilities

- Frequent correspondence with *AJP-Residents' Journal* Editorial Board and *AJP* editorial staff, including conference calls.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with *AJP* editorial staff to prepare accepted manuscripts for publication to ensure clarity, conciseness, and conformity with *AJP* style guidelines.
- Coordinate selection of book review authors and distribution of books with *AJP* editorial staff.
- Recruit authors and guest editors for the journal.
- Manage the *Test Your Knowledge* questions on the *Residents' Journal* Facebook and Twitter pages and work closely with authors in developing Board-style review questions for the *Test Your Knowledge* section.
- Fulfill the responsibilities of the Editor-in-Chief when called upon, including forming issue lineup.
- Collaborate with the Editor-in-Chief in selecting the 2019 SDE, Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10–15 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be starting as a PGY-3 in July 2018, or a PGY-4 in July 2018 with plans to enter an ACGME fellowship in July 2019.
- Must be in a U.S. residency program.

Selected candidate will be considered for a 2-year position, including advancement to Editor-in-Chief in 2019.

DEPUTY EDITOR (DE) POSITION

Job Description/Responsibilities

- Frequent correspondence with *Residents' Journal* Editorial Board and *AJP* editorial staff, including conference calls.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with *AJP* editorial staff to prepare accepted manuscripts for publication to ensure

clarity, conciseness, and conformity with *AJP* style guidelines.

- Prepare a monthly *Residents' Resources* section for the journal that highlights upcoming national opportunities for medical students and trainees.
- Recruit authors and guest editors for the journal.
- Collaborate with the Editor-in-Chief in selecting the 2019–2020 Editorial Board.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be a PGY-2, PGY-3, or PGY-4 resident starting in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the SDE position in 2019. If the selected candidate is interested in serving as SDE in 2019, he or she would need to formally apply for the position at that time.

ASSOCIATE EDITOR (AE) POSITIONS (two positions available)

Job Description/Responsibilities

- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Recruit authors and guest editors for the journal.
- Collaborate with the SDE, DE, and Editor-in-Chief to develop innovative ideas for the journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship

This is a 1-year position only, with no automatic advancement to the DE or SDE position in 2019. If the selected candidate is interested in serving as DE or SDE in 2019, he or she would need to formally apply for the position at that time.

MEDIA EDITOR (ME) POSITION

Job Description/Responsibilities

- Manage the *Residents' Journal* Twitter and Facebook accounts.
- Oversee podcasts.
- Collaborate with the AEs to decide on content
- Collaborate with SDE, DE, and Editor-in-Chief to develop innovative ideas for the journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be an upcoming PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2019. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2019, he or she would need to formally apply for the position at that time.

CULTURE EDITOR (CE) POSITION

Job Description/Responsibilities

- Collaborate with SDE, DE, and Editor-in-Chief to develop innovative ideas for the journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be an upcoming PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the DE or SDE position in 2019. If the selected candidate is interested in serving as DE or SDE in 2019, he or she would need to formally apply for the position at that time.

For all positions, e-mail a CV and personal statement of up to 750 words, including reasons for applying and ideas for journal development, to oliver.glass@emory.edu. The deadline for applications is March 31, 2018.

Residents' Resources

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

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

MARCH DEADLINES

Fellowship/Award	American Academy of Child and Adolescent Psychiatry (AACAP) Pilot Research Award for General Psychiatry Residents
Organization	AACAP, supported by Pfizer
Deadline	March 30, 2018
Brief Description	Offers \$15,000 for general psychiatry residents who have an interest in beginning a career in child and adolescent mental health research. Recipients have the opportunity to submit a poster presentation on their research for the AACAP's 66th Annual Meeting in Chicago, October 14–19, 2019. The award also includes the cost of attending the AACAP Annual Meeting for 5 days.
Eligibility	Candidates must be enrolled in a general psychiatry residency; must not have any previous significant, individual research funding in the field of child and adolescent mental health; and must be an AACAP member.
Contact and Website	E-mail: research@aacap.org • Web: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award.aspx
Fellowship/Award	AACAP Pilot Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows
Organization	AACAP
Deadline	March 30, 2018
Brief Description	Offers \$15,000 for child psychiatry residents, fellows, and junior faculty who have an interest in beginning a career in child and adolescent psychiatry research. Recipients have the opportunity to submit a poster presentation on their research for the AACAP's 66th Annual Meeting in Chicago, October 14–19, 2019. The award also includes the cost of attending the AACAP Annual meeting for 5 days.
Eligibility	Enrolled in a child psychiatry residency or fellowship or have a faculty appointment in an accredited medical school but no more than 2 years of experience following graduation from training. Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health and must be an AACAP member.
Contact and Website	E-mail: research@aacap.org • Web: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Pilot_Research_Award_Child_Psychiatry_Residents_Junior_Faculty.aspx
Fellowship/Award	American Psychiatric Association (APA) Resident Recognition Award
Organization	APA
Deadline	March 31, 2018
Brief Description	The Resident Recognition Award is presented annually to outstanding psychiatry residents or fellows from each department or institution who exemplify one or more APA values. Multiple awards are given each year.
Eligibility	Must be a resident or fellow; must be an APA member; and must be in good standing in a general psychiatry or fellowship program.
Contact and Website	E-mail: cvanwagner@psych.org • Web: https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/awards/resident-recognition-award

APRIL DEADLINE

Fellowship/Award	National Institute of Mental Health (NIMH) Outstanding Resident Award Program (ORAP)
Organization	National Institute of Mental Health (NIMH)
Deadline	April 2, 2018
Brief Description	This award recognizes residents with outstanding research and academic potential who are currently at the PGY-2 level. The award includes a framed certificate and invitation to visit the NIH campus for a 2-day award program, as well as opportunity for residents to present a poster about their own research.
Eligibility	Must be a resident currently at the PGY-2 level.
Contact and Website	E-mail: chungj@mail.nih.gov • Web: https://www.nimh.nih.gov/labs-at-nimh/scientific-director/office-of-fellowship-and-training/outstanding-resident-award-program/index.shtml

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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 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).

Prevention and Primary Care in Psychiatry
Neuropsychiatry
Advances in Treating Personality Disorders

Rachel Katz, M.D.
rachel.katz@yale.edu