The American Journal of
Psychiatry
Residents' Journal

January 2019 Volume 14 Issue 1

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COMMENTARY

The Mental Health of ICE Detainees and Their Families

Erik Bayona, M.D.

As the fall season drops its foliage of deep oranges and golden yellows to the ground, it also signals the upcoming flurry of holiday gatherings with loved ones. I pause for a moment to recall the events of the past spring when news of child separations at the U.S.-Mexico border caused an uproar, and I remind myself that although the uproar has quieted down, the repercussions of those actions are still being felt by many in this country. As psychiatry trainees, we are familiar with the process of how acute distress can give way to long-standing detriment to mental health. For people, both U.S. citizens and undocumented immigrants, who remain within our country but separated from their families, this holiday season is sure to be a challenge. The issue of immigration has been hotly contested for decades, and deportation is not new. In fact, under the Obama administration, more than 2.7 million people were deported (1). So if deportation is not new, then why is there such controversy at this time?

Not until recently, under the current president's administration, have we seen a series of policies laced with anti-immigrant rhetoric such as the "zero tolerance" policy, which actively used separation of families as a tactic to deter people from coming to this country. These policies were considered so dangerous to the physical and mental health of those affected that several professional associations, including those within medicine such as the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, and American Academy of Pediatrics, released position statements calling for an end to family separations. On June 20, 2018, after facing much international criticism and pressure, President Trump reversed this controversial policy. Despite having a deadline for reunification of families mandated by the courts, there are currently several hundred children yet to be reunited with their parents as a result of adults being held in detention facilities indefinitely or who have already been deported (2). There are currently more than 13,000 migrant children in detention centers across the country, and they are now being moved into tent cities in Tornillo, Texas, which is potentially worsening the mental health of these children (3). Child and adolescent psychiatrists have commented on the trauma that is caused by separating children from their parents, which not only profoundly inhibits the ability to form trusting attachment relationships early in life but can lead to adverse health outcomes and poor life chances throughout the life course (4).

There are currently more than 13,000 migrant children in detention centers across the country.

The concept of "structural violence" was recently discussed by Grace et al. (5), who posit that recent U.S. immigration policies have not only sought to deter immigration by targeting the safety of the family unit but have created a "violence of uncertainty" that makes life in the United States an unlivable experience through insecurity, which for many is the fear of not knowing whether they will be detained by U.S. Immigration and Customs Enforcement (ICE) from one day to the next or whether deportation will lead to the loss of their children. This uncertainty creates mistrust in places such as doctors' offices and hospitals, which deters people from seeking medical care when it is needed, thus creating multiple health crises in these communities (5).

During my child psychiatry rotation, I met a teenage girl who became distraught after learning that her father might be deported. She subsequently made a suicide attempt by taking her mother's prescription medications. She is a U.S. citizen, but her father is not. For psychiatry trainees, teenage suicide is an important topic as well as an unfortunate but common occurrence. The insecurity felt in many communities is creating new health issues while exacerbating existing ones. Up to a quarter of the adults deported from the United States in the past few years have been parents of children who are U.S. citizens (6).

The health consequences of being detained are poorly understood. To date, no formal research has been conducted on this highly vulnerable population—for obvious ethical considerations. However, enough news reports have surfaced that we can theorize a pattern of mental health implications. According to Human Rights Watch, there have been 74 deaths in U.S. immigration detention centers from March 2010 to May 2018 (7). Immigration advocates have criticized the use of solitary confinement for detainees, which often results in severe mental health consequences; for example, a 40-year-old man with a history of schizophrenia reportedly committed suicide shortly after being held for 21 days in solitary confinement (8). All detainees are supposed to undergo a comprehensive medical evaluation, including mental health screening. However, the details of what exactly is provided are unclear. A disturbing report emerged in July 2018 when a federal judge in Califor-

nia ordered the Trump administration to halt the use of psychotropic medication in migrant children unless parental consent or a court order has been obtained (9). Apparently, a facility in Texas was giving psychotropic medications to children without parental consent. A lawsuit against the facility is currently pending, although the facility denies any wrongdoing. These issues affecting the mental health of detainees are extensive and complicated, and the health effects are widespread and have an impact beyond immigration status.

For psychiatry residents across the country, it is now more likely than ever that each of us may encounter someone who has been affected by these policies or that a medical colleague may refer someone in crisis to our care for mental health evaluation or treatment. We must remember our Hippocratic Oath, calling us to the service of all of humanity, not just for a few that have been designated worthy. It is by working together to end inhumane policies that create negative health consequences that we can help to heal our country.

Dr. Bayona is a second-year resident at the University of New Mexico, Albuquerque.

Editor's Note: To view further discussion on family separations, see the recent article by Kohrt et al. in *Psychiatric Services.* APA resident-fellow members can receive a free online subscription to *Psychiatric Services*; visit https://ps.psychiatryonline.org.

REFERENCES

1. Reardon S: Health toll of immigration policies begins to emerge. Nature 2017; 544: 148–149
2. Kopan T: 34 more separated kids released; hundreds remain in custody. Atlanta, CNN Cable News Network, 2018. https://www.cnn.com/2018/09/20/politics/separated-children-deported-parents-reunifications/index.html
3. Dickerson C: Hundreds of migrant children quietly moved to a tent camp on the Texas border. New York Times, September 30, 2018. https://www.nytimes.com/2018/09/30/us/migrant-children-tent-city-texas.html
4. Sidhu S, Ortiz O, Prasad A: Haunted souls: tales of immigrant children torn from their parents in America. AACAP News, September/October 2017, pp 219–221
5. Grace BL, Bais R, Roth BJ: The violence of uncertainty: undermining immigrant and refugee health. N Engl J Med 2018; 379:904–905
6. Danaher F: The suffering of children. New Engl J Med 2018; 11:138–139
7. Human Rights Watch: Code red: the fatal consequences of dangerously substandard medical care in immigration detention. New York, Human Rights Watch, 2018. https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration
8. Olivares J: ICE detainee diagnosed with schizophrenia spent 21 days in solitary confinement, then took his own life. The Intercept, July 27, 2018. https://theintercept.com/2018/07/27/immigrant-detention-suicides-ice-corecivic
9. Schmidt S: Trump administration must stop giving psychotropic drugs to migrant children without consent, judge rules. Washington Post, July 31, 2018. https://www.washingtonpost.com/news/morning-mix/wp/2018/07/31/trump-administration-must-seek-consent-before-giving-drugs-to-migrant-children-judge-rules/?noredirect=on&utm_term=.13a0e98d74b5

INTERVIEW

An Interview With Psychiatry Residency Program Director Toni L. Johnson, M.D.

Interviewed by Oliver Glass, M.D.

Dr. Johnson is Vice Chair and Residency Program Director for the psychiatry residency program at East Carolina University, Brody School of Medicine/Vidant Medical Center in Greenville, N.C. Previously, she was the program director at Case Western Reserve/MetroHealth System in Cleveland. She completed residency in psychiatry at the Cleveland Clinic, where she also served as chief resident. Dr. Johnson has interests in graduate medical education and meeting the mental health care needs in underserved and minority communities.

Oliver M. Glass, M.D., is Editor-in-Chief of the American Journal of Psychiatry Residents' Journal. *He completed his psychiatry residency training at East Carolina University and is a PGY-VI forensic psychiatry fellow at Emory University in Atlanta.*

Dr. Glass: Dr. Johnson, I appreciate you agreeing to participate in this interview. Could you please tell me what drew you to serving as a psychiatrist in eastern North Carolina?

Dr. Johnson: Thank you for this opportunity to share my experience, Dr. Glass. Many years ago, I made a commitment to practice and teach in the most underserved communities. It is in these settings that I gain the most fulfillment. After I completed psychiatry residency training at the Cleveland Clinic in Cleveland . . . I spent a few years in Cincinnati. Then I returned to Cleveland where I practiced for 12 years in the MetroHealth System, a teaching affiliate hospital for Case Western Reserve University, before relocating to eastern North Carolina. My outpatient practice in Cleveland was an inner-city colocated neighborhood clinic in the heart of the city. I was the first psychiatrist in that clinic to bring a resident, and eventually we set up a resident clinic. After 12 years there, I decided to look for an academic setting again primarily serving an underserved community, but this time I wanted a warmer climate! So, I visited Brody School of Medicine at East Carolina University and its partner, Vidant Medical Center, in Greenville, North Carolina, and immediately felt a connection with the missions of these institutions. Both institutions have a legacy of commitment and service to the surrounding communities. They each purpose themselves to improve the health status of citizens in rural eastern North Carolina, and the Brody mission includes the goal to enhance the access of minority and disadvantaged students to a medical education. This is the perfect learning environment to serve those most in need while also educating and training students and residents to do likewise.

Dr. Glass: What are the most desirable attributes that you look for in an applicant when he or she applies to your program?

Dr. Johnson: That is an excellent question. If only program directors had the perfect recipe, right? I have been a program director for 11 years, and what I know for sure is that there is no perfect recipe of ingredients for the ideal psychiatry resident applicant; however, I believe the best training program is a program of diverse residents, and each resident has strengths. We learn from each other and become better individuals in a program built on diversity. I like to use the analogy of a winning football team (which is a sport I love to watch). A good football team needs the strong, upfront heavy-lifters to be on the line as well as the speedy skill players in the backfield. Everyone comes to the team with certain strengths and talents, yet all players must be athletic and dedicated to the team. Hopefully, they all have a competitive spirit and a love for the game too. For residency, all members of the residency team need more than academic abilities, although that is definitely required. I am looking for resident applicants with maturity, self-awareness, good emotional IQ, a dedication to teamwork, and a fascination with people's behavior, in general, and the human brain, in particular. If a resident applicant has overcome a personal challenge, learns from it, and is a better person in the end, then that interests me. I want an applicant to tell me the story of their journey to become a psychiatrist. All psychiatrists should be able to share a story!

Dr. Glass: Do you have any suggestions for trainees that experience burnout?

Dr. Johnson: Unfortunately, the entire health care system is too often the least healthy work environment. It is ironic and extremely unfortunate that our work and learning environment can have a negative impact on the health and well-being of the physician in training. Thankfully, the need to address this has become the focus of the Accreditation Council for Graduate Medical Education. As of July 2019, the common program requirements for all specialties will require all programs to

show evidence of faculty and resident wellness initiatives. This is good news for trainees, since some programs were not as supportive of residents seeking support and treatment as they really should have been. Psychiatric physicians should take the lead, and psychiatry residents should become active participants in these initiatives, which can positively impact their training experience. Another important understanding is that how you practice and address personal needs in residency is often how you will continue after residency. So, we must model wellness during residency to promote wellness after residency. When we create and support wellness in the training experience, we build a healthier work environment for all practicing physicians.

Dr. Glass: How can a trainee get help if he or she has an untreated mental health condition or substance abuse disorder?

Dr. Johnson: Ideally, a resident should speak with their program director or graduate medical education (GME) representative, who can refer them for professional help. As mental health professionals, it is very important that we not attempt to diagnose or treat a trainee in our program. That is a boundary violation. Our role as clinical educators is to connect medical students and residents in need to professionals outside of the clinical learning environment or at least with someone who will not be supervising the trainee.

Dr. Glass: How should programs help the psychiatry resident who trails behind in one or more of the milestones?

Dr. Johnson: It is the responsibility of the faculty in the program and specifically the program director to systematically inform residents of their progress along the milestones for psychiatry competency. This should be an ongoing process [that] happens at many levels and in many ways, both verbally and in written format, as well as formally and informally. Residents can only improve if they know specifically what they need to improve upon and in what way they can accomplish this. When we see a struggling trainee, we first try to identify what is the specific knowledge, skill, or attitude that needs improvement. The more difficult part often is why the challenge exists. For example, a resident may be challenged by not being able to report information accurately during handover (sign-out) to the team. Is there an attention problem impairing the ability to receive and prepare the data? Is there an organizational challenge in structuring the data? Is there a communication difficulty in verbally reporting the data or an EHR [electronic health record] challenge in storing the data? We like to catch these challenges very early on and develop a plan for improvement with specific and measurable steps for the resident. I really am a fan of quality improvement, so I may develop an improvement plan for the resident with a PDSA (plan, do, study, and act) approach. We may have a senior or chief resident work with the resident to assist in getting the details of the challenge, and then the resident is involved in creating their plan for improvement. Then we measure and repeat. Thankfully, we have excellent resources on campus, including academic assessment and support to help address the various challenges listed.

Dr. Glass: East Carolina University is known to serve marginalized, underserved patient populations. Rotations span to very rural parts of North Carolina. How is treating those patients different than in urban settings?

Dr. Johnson: As mentioned previously, I have worked in impoverished communities in urban settings and have seen the similar challenges that poverty poses regardless of location. Ability to access quality care and managing life in poverty have some similarities in urban, small town, and rural communities. The mission of Brody School of Medicine and our partner, Vidant Health, is to improve the health and well-being of the 1.4 million people of eastern North Carolina. Like many, this is what attracted me to eastern North Carolina. We have the goal to become the national delivery and educational model for rural health and wellness. The challenge is these folks are geographically spread over a very large rural area with very limited resources. In addition, many of these agricultural-based communities have dealt with deep poverty for multiple generations. On the other hand, the people of eastern North Carolina, however, have an amazingly resilient spirit and strong sense of community, which bonds us together. We saw this recently after Hurricane Florence as well as following Hurricane Matthew in 2016. They way folks with very little to begin with reached out and cared for each other was inspiring. Eastern North Carolina is a unique place.

Dr. Glass: I remember when you had our residency class play a modified version of Monopoly. Can you explain to our readers the reason why you include this in residency training?

Dr. Johnson: I am glad to know you still remember that experience! We know from data gathered by the Association of American Medical Colleges that the parental median income and level of education of U.S. medical matriculates is overwhelmingly from the upper echelon. In contrast, patients who often present to academic teaching facilities are often from lower socioeconomic backgrounds. This is a setup for a lot of misunderstandings and assumptions on both sides. Sociologists have used games or simulations to introduce social stratification and to promote critical thinking. I use a simulated Monopoly game to help learners reflect upon misunderstood attitudes and behaviors of those on opposite sides of the socioeconomic continuum. The boardgame Monopoly is modified and used to increase understanding of the concepts of poverty and privilege in order to challenge learners to consider how socioeconomic resources can [affect] health and health care behaviors. If you recall, each player starts the game with a different income and set of challenges or privileges. Then after we play, we have a group discussion, and each participant has a written

self-reflection exercise to complete. I have been able to take this activity to different levels of learners [and] different specialties and disciplines as well as present it on a national level to clinical educators.

Dr. Glass: Immigrants to the United States may have specific stressors that can complicate their access to mental health treatment. Do you have any suggestions for improving access to care in this population group?

Dr. Johnson: Immigrants, like other marginalized groups, are often left unable to access general health care and definitely challenged to access mental health care. This is especially true for undocumented, uninsured, or underemployed immigrants. Many immigrants face the same issues as other patients struggling in poverty, but the situation can be complicated due to cultural, language, stigma, and legal barriers. This really is a larger health care system issue, but the suggestion I do offer is to have academic and community training sites to partner with immigrant communities' social and faith-based supporting structures in order to better meet the health care, including mental health care, needs of immigrants. We also need to increase language capacity of our mental health work force and take advantage of technology, such as telepsychiatry. I believe the health care setting should be one of the many places of refuge and safety for our immigrant communities.

COMMENTARY

Integrated Care: A Dialect of Disintegration and Integration

Anna Kim, M.D.

In the mid-19th century, the modern-day psychiatrist was referred to as an "alienist." It was the role of the alienist to learn about and care for patients in overcoming their "mental alienation," referring to the mental separation from the self and society (1). "Mental illness" would be the term used today, more so emphasizing the medical aspect of psychiatric illness.

The medical conceptualization of mental disorders dates back to the late 19th and early 20th centuries. Josef Breuer was a physician and neurologist who discovered the role of the vagus nerve in respiration and likewise wrote of the "talking cure" in his work with patient Anna O. (It was later hypothesized that Anna O was actually experiencing seizures.) Similarly, Jean-Martin Charcot, known for his descriptions of neurological phenomena, such as multiple sclerosis, was the first to describe unconscious physical symptom formation as a result of traumatic experiences (2). Indeed, the overlap between behavioral health and the medical field is well established. This begs the question: what has caused the separation over time?

Stigma and popular conception of mental illness have certainly played a role (1, 3). Film has often sensationalized mental illness, as in *One Flew Over the Cuckoo's Nest, Shutter Island,* and *Silence of the Lambs*. It is not surprising that chaotic and poorly understood states of mind have evoked fear in populations as well as a need to psychologically (and literally) compartmentalize persons with psychiatric illness in "insane asylums."

Ultimately, these misconceptions could not last. "Deinstitutionalization," a U.S. government policy that moved persons with psychiatric illness from state-run asylums into the community, began in the 1960s to improve treatment and reduce government spending. From this arose the concept of the consultation-liaison psychiatrist, whose role is to collaborate with members of the medical team to address mental health problems in clinics and hospitals. Studies regarding this model have demonstrated effectiveness in quality and outcomes across a range of diagnoses and settings (3). Movements along these lines have included the 1996 Mental Health Parity Act, the 2008 Mental Health Parity and Addiction Equity Act, and the 2010 Affordable Care Act (3).

> Efforts to integrate behavioral health and primary care services are being re-emphasized in the face of growing needs and increasing barriers.

Today, efforts to integrate behavioral health and primary care services are being re-emphasized in the face of growing needs and increasing barriers. More often than not, primary care services have become the gateway to psychiatric services (4). Importantly, individuals with psychiatric illness may die decades earlier than unaffected persons from untreated and preventable chronic illnesses worsened by poor health habits (4). Additionally, medications that treat mental illness can have physical side effects. Barriers to treatment involve fragmentation of current payment systems, separate medical records systems, geographically distinct practice settings, and lack of standardized communication between fields (5).

The overlap between the medical and behavioral fields has been longstanding, and progress has continued. As further research emerges on the biological underpinnings of psychiatric illness, integrated care becomes imperative. Treatment of the individual as a whole begins with society's construction of the mind, body, and spirit—separate while in one frame.

Dr. Kim is a fourth-year resident in the Department of Psychiatry, Mount Sinai Hospital, New York, and a Deputy Editor of the *American Journal of Psychiatry Residents' Journal.*

REFERENCES

1. Bhugra D: Alienated alienists: a new hope? Lancet 2014; 1:257–259
2. Webster R: Freud, Charcot and Hysteria: Lost in the Labyrinth. Norwich, United Kingdom, University of East Anglia, 2004, http://www.richardwebster.net/freudandcharcot.html
3. Druss BG, Goldman HH: Integrating health and mental health services: a past and future history. Am J Psychiatry (Epub ahead of print, April 25, 2018)
4. SAMHSA-HRSA Center for Integrated Health Solutions. What is integrated care. Rockville, Md, HRSA, https://www.integration.samhsa.gov/about-us/what-is-integrated-care
5. Manderscheid R, Kathol R: Fostering sustainable, integrated medical and behavioral health services in medical settings. Ann Intern Med 2014; 160:61–65

COMMENTARY

The Transition From Student to Teacher

Brent D. Schnipke, M.D.

My first day of residency was a Sunday. After a several-month hiatus from clinical medicine—graduation and a summer break before residency—I spent that first day trying to keep my head above water. I struggled to relearn basic medical skills: navigating the electronic medical record, conducting an interview, and designing a treatment plan. I was grateful that no one was watching me too closely as I tried to complete my work. And then, the next day, a group of new third-year medical students arrived, looking to me and the other residents. I could see in their eyes the apprehension and uncertainty but also the unashamed excitement to enter the clinical field. I thought back to myself in their position—how had it been 2 years? I didn't feel like I had learned enough to be there as a resident and at least partially responsible for their education.

Yet their enthusiastic questions—even during this vulnerable and scary part of their medical education—have shown me how much I have learned and still have to learn. It is a privilege to be around medical students and occasionally teach them something. This privilege to teach has inspired my own intellectual curiosity, encouraging me to begin again: researching relevant topics, reading recent studies, and distilling what's important. I have come to understand, even after only a few months of residency, that the role of teacher does not replace that of learner but rather augments it. Attempting to teach students makes clear my own knowledge gaps and motivates me to fill them. This constant cycle of learning is what drew me to medicine and will, I believe, keep me going throughout my career.

The role of teacher does not replace that of learner but rather augments it.

Furthermore, these brief moments of teaching and learning have reignited my passion for psychiatry and continually remind me why I chose this field. Covering topics such as the Mental Status Exam and the fundamentals of mood disorders reminds me how fascinating I found these topics when I was a student and still do as a resident. Finally, as I try to pass on all that was passed on to me by excellent residents, I recognize that I might be lucky enough to be the resident whose passionate talks inspire another medical student to consider choosing psychiatry as his or her specialty.

To hear questions from eager third-year students directed toward me—the resident and therefore the individual deemed to have authority and knowledge—reminds me of my place in the educational chain and is, in short, a great and humbling privilege. Their questions are thoughtful and poignant and force me to keep my knowledge up to date. More seriously, they are watching me as an example of how a doctor acts, which motivates me to do my very best. Although I haven't been doing this long, I've already realized that it's one of the great opportunities that I have to make a difference in the educating of physicians and thus in the care of patients. As doctors, what more could we ask for?

Dr. Schnipke is a first-year resident in the Department of Psychiatry, Wright State University Boonshoft School of Medicine, Dayton, Ohio.

ARTS AND CULTURE

Taking a History

Anand Jayanti, B.A.

The first 2 years of medical school sometimes felt like a theater production: I was fitted for a new coat, given lines, and trained as a doctor's understudy. Even from the wings, however, the promise of actual healing felt far away. I went in search of that promise one weekend at a nursing home, volunteering as a medical student to visit patients during the holidays. When I told the nurse that I was assigned to a 98-year-old woman named Anna, she directed her gaze down a dim corridor and said, grimly, "good luck." "Ms. Anna," I said from the doorway, "Can I join you?" "Not like it's my choice, is it," she challenged. "Nothing's my choice anymore."

As we spoke, deprivation of choice seemed to reveal itself as a theme throughout Anna's story, spanning recollections of the Great Depression, two world wars, and life-long poverty. I began to see, however, that her story of destitution was just the stage for her story of triumph. She wasn't resentful of those circumstances; she was nostalgic about them. Work meant a chance to be useful, and need provided a chance to be necessary. "My mother taught me I was as good as my work," she said; for even when Anna had nothing at all, she'd had the choice to work. Tearfully, she confessed that the staff wouldn't even let her wash her own dishes anymore.

Anna didn't choose to grow up during the Depression, she didn't choose to grow old... but she did choose to tell her story.

That night, I reflected on one of her most vivid memories: Anna and her 12 siblings embracing their father, his hands blackened with coal. "It was difficult to fit all 13 of us around him, but we managed," she'd said. I considered how long ago I last hugged my father when he came home from work, even though there was just one of me. I wanted to show Anna that even though she couldn't help with the dishes anymore, she still helped me see life from her perspective of gratitude.

That winter, I illustrated Anna's upbringing as a children's book. Throughout my life, I made art to lose myself in another world. In the pages of Anna's story, however, I hoped to help her find herself in this world and show her that the little girl I heard about was still alive within her. I displayed the finished book at my school's library, and by the end of the week, its back pages contained nearly 200 hand-written messages from classmates, professors, and deans.

I returned to the nursing home that Christmas, only to find that she had broken her hip and would be on sedative pain management for the rest of her life. Anna didn't choose to grow up during the Depression, she didn't choose to grow old, and she didn't choose to pass away last February, but she did choose to tell her story. That choice empowered me to participate in the elusive promise of healing that I sought as a fledgling medical student. Even when I felt that I could do nothing, she taught me that I could listen.

Anand Jayanti is a fourth-year medical student at Texas A&M Health Science Center, Round Rock, Tex.

Call for Applications to Join the 2019 Editorial Board

The *American Journal of Psychiatry—Residents' Journal* is now accepting applications to join the 2019–2020 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.
- Recruit authors and guest editors for the journal.
- Fulfill the responsibilities of the Editor-in-Chief when called upon, including forming issue lineup.
- Collaborate with the Editor-in-Chief in selecting the 2020 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 2019, or a PGY-4 in July 2019 with plans to enter an ACGME fellowship in July 2020.
- 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 2020.

DEPUTY EDITOR (DE) POSITION

(three positions available; one with podcast responsibilities)

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 2020–2021 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 2019, or a fellow in an ACGME fellowship in July 2019.
- 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 2020. If the selected candidate is interested in serving as SDE in 2020, he or she would need to formally apply for the position at that time.

ASSOCIATE EDITOR (AE) POSITIONS

(five 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 2019, or a fellow in an ACGME fellowship in July 2019.
- 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 2020. If the selected candidate is interested in serving as DE or SDE in 2020, he or she would need to formally apply for the position at that time.

CULTURE EDITOR/SOCIAL MEDIA EDITOR (CE/SME) 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.
- Peer review manuscripts on a weekly basis.
- 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 2019, or a fellow in an ACGME fellowship in July 2019.
- 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 2020. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2020, 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.
- Peer review manuscripts on a weekly basis.
- 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 2019, or a fellow in an ACGME fellowship in July 2019.
- 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 2020. If the selected candidate is interested in serving as DE or SDE in 2020, he or she would need to formally apply for the position at that time.

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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 shapirrosenberg@gmail.com. The deadline for applications is March 15, 2019.

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 Matthew L. Edwards, M.D., Deputy Editor (ajpresresource@gmail.com).

Fellowship/Award	**American Psychiatric Association (APA)/American Psychiatric Association Foundation (APAF) Diversity Leadership Fellowship**
Organization	APA/APAF
Deadline	**January 31, 2019**
Brief Description	The Diversity Leadership Fellowship is designed to develop leadership to improve the quality of mental health care for the following (not limited to) minority groups at risk and underrepresented in psychiatry: American Indians/Native Alaskans, Asian Americans/Native Hawaiians/Native Pacific Islanders, Blacks/African Americans, Hispanics/Latinos, and the LGBTQ community. Fellows will receive mentorship from the National Minority Mentor's Network and at multiple levels throughout APA, attend APA annual meetings, and have the opportunity to sit on the APA Board of Trustees as a nonvoting member.
Eligibility	Applicants must be an APA member and at least a PGY-2 with two remaining years of training in an accredited U.S. or Canadian psychiatry residency program.
Contact and Website	E-mail: podai-afotey@psych.org; Web: https://www.psychiatry.org/residents-medical-students/residents/fellowships/available-apa-apaf-fellowships/diversity-leadership-fellowship
Fellowship/Award	**APA/APAF Psychiatric Research Fellowship**
Organization	APA/APAF
Deadline	**January 31, 2019**
Brief Description	The Psychiatric Research Fellowship provides funding for an early research career psychiatrist to design and conduct a health services/policy-related research study using national data housed at the APA. The fellow's research activities will be carried out under the supervision and guidance of a mentor at his or her institution in collaboration with his or her mentor(s) at the APA Division of Research. Fellows receive a $45,000 stipend and funding to attend 4–5 APA meetings.
Eligibility	Applicants must be an APA member or eligible to become a member of the APA. Psychiatrists who have received their M.D. or D.O. degree and who have completed residency training in general psychiatry or child psychiatry immediately prior to the time the fellowship commences, senior residents (e.g., PGY-3 and above) with at least 50% protected time for research during the fellowship period are eligible. Prior research experience is preferred.
Contact and Website	E-mail: podai-afotey@psych.org; Web: https://www.psychiatry.org/residents-medical-students/residents/fellowships/available-apa-apaf-fellowships/psychiatric-research-fellowship
Fellowship/Award	**APA/APAF Child and Adolescent Psychiatry Fellowship**
Organization	APA/APAF
Deadline	**January 31, 2019**
Brief Description	A 2-year opportunity for residents interested in a career in child and adolescent psychiatry. Fellows receive funding to attend two APA annual meetings and two APA September Components meetings. Fellows receive mentorship from child and adolescent psychiatrists and leaders in the field, attend scientific sessions at the APA Annual Meeting, and participate on an assigned APA council where organizational decisions are made.
Eligibility	Applicants must be an APA member, a U.S. citizen or permanent resident, and a psychiatry resident, fellow, or early-career psychiatrist.
Contact and Website	Email: podai-afotey@psych.org; Web: https://www.psychiatry.org/residents-medical-students/residents/fellowships
Fellowship/Award	**Jeanne Spurlock Congressional Fellowship**
Organization	American Psychiatric Association (APA)
Deadline	**January 31, 2019**
Brief Description	The aim of the fellowship is to provide an opportunity for a psychiatry resident or early-career psychiatrist with significant interest in child and/or minority mental health advocacy to work in a congressional office. The recipient will serve a 10-month fellowship in Washington, DC, during which he or she will be introduced to the structure and development of federal and congressional health policy focused on mental health issues affecting minorities and underserved populations, including children.
Eligibility	Applicants must be an APA member, a U.S. citizen or permanent resident, and a psychiatry resident, fellow, or early-career psychiatrist.
Contact and Website	E-mail: podai-afotey@psych.org; Web: https://www.psychiatry.org/residents-medical-students/residents/fellowships/available-apa-apaf-fellowships/spurlock-congressional-fellowship

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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 Anna Kim, M.D. (annamegkim@gmail.com).

Submissions

The Residents' Journal considers manuscripts authored by medical students, resident physicians, and fellows in the United States and Canada; attending physicians and other members of faculty cannot be included as authors.

To submit a manuscript, please visit **https://mc.manuscriptcentral.com/appi-ajp**, and select a manuscript type for AJP *Residents' Journal*. See **https://ajp.psychiatryonline.org/residents_journal/rj_ifora** for more detailed instructions.

Article: Reports of novel observations and research. May include meta-analyses.

Drug Review: A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug interactions.

Perspectives in Global Mental Health: 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.

Case Report: A presentation and discussion of an unusual clinical event. All patient information must be adequately disguised, with written consent of the patient described.

Commentary: Generally includes descriptions of recent events, opinion pieces, or narratives.

History of Psychiatry: Provides a historical perspective on a topic relevant to psychiatry.

Arts and Culture: Includes introspective pieces, poetry, and reviews of books and films. All submissions must be relevant to the field of psychiatry.

Letters to the Editor: Comments on articles published in the *Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.

Manuscript Type	Word Limit	Maximum Figures and Tables	Key Points*	Maximum References
Article**	1,250	2	Yes	10
Drug Review	1,500	1	Yes	20
Perspectives in Global Mental Health	1,500	0		20
Case Report	1,500	1	Yes	15
Commentary	500	0		5
History of Psychiatry	500	0		5
Arts and Culture	500	0		0
Letters to the Editor	250	0		3

No abstract required for any article type.
*Box with 3–4 key teaching points
**Meta-analyses may be up to 1,500 words with 1 table or figure and 20 references.