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ARTICLE

Advocating for Underrepresented Applicants to Psychiatry: Perspectives on Recruitment

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The importance of a diverse physician workforce in improving population-based health outcomes has been described in numerous studies (1–3). These findings have promoted the development of recruitment frameworks in the United States (such as the identification of underrepresented minorities in the American Medical College Application Service) to encourage enrollment of diverse applicants in medical schools. Despite these efforts, little work has been done to explore the role of diversity-conscious recruitment at the level of residency education, resulting in a lack of organizational guidance in residency recruitment efforts (4). In psychiatry, racial disparities between the physician workforce and patient population suggest that the critical need to train psychiatrists with diverse backgrounds is being unmet (5, 6).

Here, we highlight the importance of diversity in residency training, explore potential barriers psychiatry residency programs face in recruiting underrepresented residents, and suggest various opportunities through which residents can advocate for diversity-conscious policies in their own residency programs.

HISTORICAL PERSPECTIVES ON DIVERSITY IN RECRUITMENT

Diversity-conscious recruiting in medical education began during the civil rights movement and resulted in the goal of the Association of American Medical Colleges (AAMC) to achieve 12% enrollment of underrepresented minority students in medical schools (7). The term "underrepresented in medicine" emerged in 2003 from the AAMC to describe "racial and ethnic populations that are underrepresented in medical professions relative to their numbers in the general population" (8).

In 2009, the Liaison Committee on Medical Education developed a set of diversity goals to urge programs to institute policies that would increase diversity in medical education programs (9). This extended beyond the traditional understanding of underrepresented in medicine to include diversity in gender, sexual orientation, physical or mental ability, and socioeconomic background.

Today, neither the Accreditation Council for Graduate Medical Education nor the American Association of Directors of Psychiatric Residency Training has developed diversity-conscious recruitment policies, leaving residency training programs to develop their own recruitment strategies.

Significant racial disparities between the psychiatric workforce and the general population persist. African Americans comprise approximately 6.6% of all psychiatry residents in the United States compared with a 13.12% representation in the general population, and Hispanics comprise roughly 8.3% of U.S. psychiatry residents compared with a 17.1% representation in the general population (5, 6).

Reduced recruitment of underrepresented physicians may adversely affect the quality and quantity of care for underserved populations (1, 2). Studies have found that patient-physician racial concordance results in greater perceived quality of care, increased receipt of preventive care, and higher satisfaction with overall health care among minority populations (3). The importance of patient-physician racial concordance can be partially explained by the neuroscience of prejudice. An interactive set of complex neural structures involving the amygdala has been linked to fear conditioning (10), and recent studies show that early exposure to diversity diminishes amygdala response and reduces the salience of race later in life (11). Perhaps diversity in psychiatry residency programs would not only promote better quality of care but also attenuate any implicit prejudice among psychiatry trainees.

CHALLENGES AND DISPARITIES IN REPRESENTATION

Despite the advantages of diversity in residency programs, there are significant barriers in achieving diversity, including limited understanding of how underrepresented applicants select programs, a lack of existing diversity in psychiatric departments, and the perceived lack of diversity among faculty and staff. Identifying specific qualities that underrepresented applicants seek in residency is essential in recruitment, because it aids in understanding the barriers and in finding solutions. Unfortunately, data are limited regarding underrepresented psychiatry applicants and recruitment strategies among psychiatry residency programs.

Several studies of nonpsychiatric residency programs show that underrepresented applicants tend to favorably rank programs with greater gender and racial diversity (4, 12). Furthermore, programs with greater diversity may be perceived as being more committed to providing care for underserved communities and demographic groups, a feature that may be attractive to underrepresented applicants (4, 12). One study showed that underrepresented minority students were more likely than both Caucasian and nonunderrepresented minority students to show interest in providing care for the underserved (1). Conversely, in

programs lacking diversity, underrepresented minority applicants may feel negatively stereotyped, less confident, and a decreased sense of belonging (12).

Although existing diversity in a program may be important, the perception of diversity may also be a significant barrier to consider. In a case study, the Diversity Recruitment Committee at the University of California, Los Angeles (UCLA) examined barriers in recruiting successful underrepresented-in-medicine applicants. Although the UCLA psychiatry program takes pride in its diverse residents and diverse patient population, the perception of this diversity was limited by lack of resident involvement with electives that offer care for underserved populations, lack of coordination with medical school diversity efforts, and limited interactions between existing underrepresented-in-medicine faculty and applicants (4).

KEY POINTS/CLINICAL PEARLS

- Barriers to diversity recruitment include an incomplete understanding of how underrepresented-in-medicine applicants select and rank residency programs, existing lack of diversity, and perceived diversity within a program.
- During recruitment efforts, it is important to be mindful of interactions with underrepresented applicants and demonstrate interest in follow-up communications.
- To increase retention of underrepresented students, residents should maintain a compassionate and interested demeanor toward diverse medical students.

NEXT STEPS AND INTERVENTIONS

Although significant challenges in recruiting underrepresented applicants exist, residents can play a critical role during the recruitment process, because they often provide informal guidance for residency program leadership in recruitment programming. Additionally, residents' awareness of the need to specifically recruit underrepresented applicants may promote changes in the recruiting activities of some programs. For example, in selection committees, one can advocate by speaking enthusiastically to a program director on behalf of underrepresented applicants. After interview day, programs can communicate directly with underrepresented applicants a sense of gratitude for visiting and an invitation to request more information.

Another potential avenue for change is to consider international medical graduate applicants during recruitment, a category of applicants who fill approximately 30% of general psychiatry residency positions and 50% of fellowship positions annually (6) and serve as a significant source of cultural and ethnic diversity. International medical graduates are the target of significant stigma in residency recruitment as a result of concerns related to limited American clinical experience and the impact on a program's reputation if applicants deemed less competitive are accepted (13). Concerns about the quality of medical care provided by international medical graduates appear to be unfounded. A 2017 mortality analysis of older patients treated by internists in U.S. hospitals found that patients treated by international medical graduates had slightly lower mortality rates after adjusting for patient and physician characteristics and fixed hospital effects (14). Furthermore, according to the American Psychiatric Association, international medical graduates play a critical role in caring for underserved populations in the United States: they generally receive a higher proportion of their income from Medicare and Medicaid, have been shown to work longer hours in the public sector, and more frequently treat patients with psychotic disorders (15). Thus, increased recruitment of international medical graduates achieves two important outcomes: enriching the diversity of training programs and caring for underserved patient populations.

Finally, resident involvement with program diversity committees, participation in outreach efforts with medical student interest groups, and interest in underrepresented medical student rotators are interactions that can lead to an inclusive atmosphere within an academic environment. Although residents may have less influence on the culture of an institution as a whole, the culture of an individual program is directly dictated by those working in it. By explicitly advocating for diversity-conscious recruitment and applicant selection, residents can shape program values and priorities to provide fertile ground for underrepresented applicants to flourish.

CONCLUSIONS

Projected changes in the demography of the United States suggest a need for an increasingly diverse physician workforce. The successful deployment of diversity-conscious recruitment programs for medical school admissions provides promise that similar efforts can be made in residency recruitment processes. Initial, but limited, interventions in this setting provide some evidence that an emphasis on recruiting diverse residents can have a meaningful impact. Psychiatry residents are key stakeholders to advocate for diversity-conscious recruitment, promote a culture of valuing residents from diverse backgrounds, and highlighting the need for, and importance of, interventions specific to diversity-conscious recruitment within individual programs.

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CASE REPORT

Depression: What's Buprenorphine Got to Do With It?

Sean Lynch, B.A., and Ori-Michael Benhamou, M.D.

Buprenorphine is an opioid medication typically prescribed for treating opioid use disorder. However, literature supports its utility for treatment-resistant depression (1). Buprenorphine has a unique method of action: it is a partial agonist of mu opioid receptors and an antagonist of kappa and delta opioid receptors (2). Recent research shows that the kappa opioid receptor's role is crucial in buprenorphine's function as an antidepressant (3). Acute administration of kappa opioid receptor antagonists has been shown to produce antidepressant effects, while agonists exhibit prodepressive effects (3).

The function of buprenorphine as an antidepressant is intriguing, since it is common for patients with substance use disorders to have a co-occurring mood disorder. One study found that in patients with a substance use disorder, 53% had a comorbid psychiatric illness (4). Additionally, patients with co-occurring substance use and mood disorders have a higher risk of suicide (5). Health care professionals often categorize such patients as "substance abusers" or "drug seekers," which minimizes the impact of their mood disorder and impedes its treatment (6). We present a case of co-occurring disorders, in which buprenorphine-naloxone fulfilled both its prescribed purpose of treating opioid use disorder while also treating the patient's severe depression.

CASE

A 47-year-old Caucasian man with a history of depression and polysubstance abuse, including a significant history of prescription opioid abuse, presented to our emergency department after ingesting hardware nails, requiring foreign body removal. While in the emergency department, it became clear that the patient had suicidal intent, and psychiatric services were called. He reported worsening feelings of anhedonia and hopelessness for an unspecified period of time, as well as insomnia and escalating suicidal ideation over the past several days. He exhibited symptoms of opioid withdrawal, including mydriasis, rhinorrhea, myalgia, anxiety, gastrointestinal cramps, and restlessness and anxiety. He disclosed that he had been using prescription opioid medications for more than a decade, originally prescribed for pain while serving in the military, which eventually led to opioid use disorder. He had poor insight, loss of interest, low energy, poor eye contact, and was disengaged during conversations with his health care team. He was involuntarily admitted to the inpatient psychiatric unit of our behavioral health center as a result of his suicidal ideation and impulsive behavior.

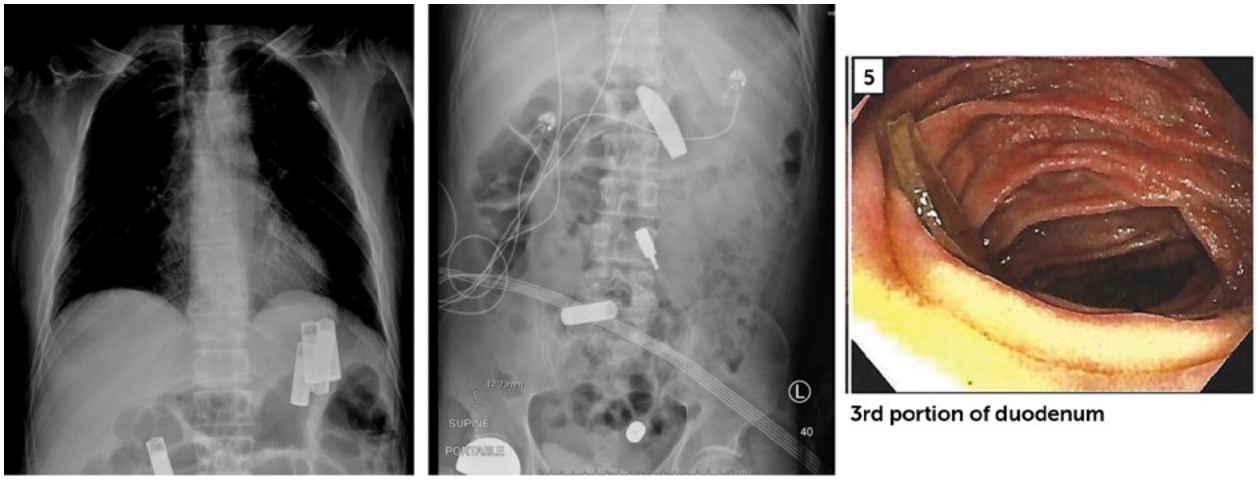
The patient's psychiatric history included seven previous hospitalizations after suicide attempts. He was originally diagnosed with depression in 2010, although he believed that he had depression for many years before his diagnosis. Additionally, he had a history of foreign body ingestion, including nails and lithium batteries. During previous inpatient hospitalizations, he underwent multiple medication trials, including sertraline, quetiapine (300 mg/day), fluoxetine (40 mg/day), and methadone (40 mg b.i.d.). Throughout these trials, he reported little to no benefit, and after many months he became nonadherent to the medications. He endorsed periods during which he was not using opioid medications but still experienced severe depressive symptoms. As a result, he was given the tentative diagnosis of treatment-resistant depression. However, this diagnosis was preliminary, because medication adherence could not be confirmed.

Throughout the first weeks of the patient's treatment on the inpatient unit, he remained withdrawn, refusing to participate in any group activities or to engage with any of the other patients. He would not comply with vital sign checks and frequently became combative and disagreeable. He could not identify any goals for his treatment and had little to say when approached. While on the unit, he ripped out his IV, shoving the needle into his stomach, and swallowed batteries and a plastic knife. Endoscopy was required to retrieve the foreign bodies, which were lodged in his stomach and bowel (Figure 1).

His initial treatment included valproic acid (500 mg b.i.d.) as a result of unwitnessed seizures and to provide a mood-stabilizing effect, but he denied improvement, reporting continual suicidal ideation, anhedonia, and hopelessness, spending most of his time in his room lying supine on the bed.

Approximately 2 weeks into his treatment with valproic acid, he was evaluated for treatment with buprenorphine-naloxone, which was deemed appropriate because of the patient's opioid use disorder and chronic pain. He was initially prescribed buprenorphine-naloxone in the morning (4 mg–1 mg), afternoon (4 mg–1 mg), and night (4 mg–1 mg), with the dosages later adjusted to 8 mg–2 mg, 2 mg–0.5 mg, and 2 mg–0.5 mg, respectively. The patient reported alleviation of his withdrawal symptoms and improvement in his chronic pain, with no notable side effects. In addition, he exhibited an instantaneous change in behavior, becoming adherent with his medications, complying with vital sign checks, and attending some of the group activities on the unit. He became more outgoing and personable and went on to attend group sessions voluntarily, even leading several activities himself.

FIGURE 1. Endoscopy of foreign bodies in the patient[a]



[a] The panels show an upright abdominal X-ray of multiple batteries lodged in the patient's abdomen (left), an upright abdominal X-ray showing lithium batteries and a piece of a plastic knife in the patient's abdomen (middle), and an endoscopic image of a piece of a plastic knife in the patient's duodenum (right).

The patient started engaging more with his care team and became open to possible changes to his medications. Although he had experienced improvement in his depression, fluoxetine was added in the third month of treatment to reduce residual depressive symptoms. The initial regimen was 20 mg/day, which was increased to 20 mg b.i.d. Two weeks before his hospital discharge, he was started on quetiapine to provide mood stabilizing effects. At this time, it was noted that he had a shift in his views toward medication-assisted therapy. Previously, he had discussed his disdain for psychotropic medications; however, after buprenorphine-naloxone treatment during this hospitalization, he disclosed that he felt that the medication was helpful and desired to continue his regimen.

The patient spent a total of 5 months on the inpatient unit. Upon discharge, he was found to have improved insight and judgment and no suicidal ideation and was optimistic and goal-oriented. He helped to develop his own aftercare plan, conducting a significant portion of the research on his own. He was discharged on buprenorphine-naloxone (morning, 8 mg–2 mg; afternoon, 2 mg–0.5 mg; and night, 2 mg–0.5 mg), fluoxetine (20 mg b.i.d.), and quetiapine (200 mg/day), with plans to follow up with outpatient psychiatry. Two weeks after his discharge, a member of his treatment team spoke with his mother via telephone, who reported that he was doing well.

DISCUSSION

The above patient was prescribed buprenorphine-naloxone to treat his opioid use disorder. However, his depressive symptoms concordantly improved. This was not entirely unexpected, since buprenorphine-naloxone has been prescribed off-label as a treatment for patients with depression that does not respond to treatment with two or more different classes of antidepressants (7).

Our patient's treatment with buprenorphine-naloxone led to rapid amelioration of his mood, allowing him to engage openly with his care team. By relieving his anhedonia and hopelessness, the medication enabled him to advocate for himself. His treatment team recognized the opportunity to engage with him and collaborate toward improvement in his mental health, causing his treatment to become solely patient-centered.

These results demonstrate the potential benefits of buprenorphine-naloxone as a treatment modality for treatment-resistant depression. One benefit of this medication is that it can be prescribed in various forms, such as sublingual tablets, long-acting injectables, and implants. Additionally, it has a low side-effect profile, and it is safe for use with elderly patients and for patients with renal dysfunction (8). However, there is some potential for abuse, particularly when buprenorphine is administered alone, although the addition of naloxone helps to minimize this risk (8, 9). In addition, there is a risk for overdose when co-administered with benzodiazepines (9).

Buprenorphine has been shown to decrease suicidal ideation in patients who are severely suicidal. Yovell et al. (10) showed that buprenorphine significantly reduced suicidal ideation in patients with severe suicidal ideation without substance abuse, as measured with the Beck Scale for Suicide Ideation. This effect was observed within 2 weeks, which is faster than that of conventional selective serotonin reuptake inhibitors.

Studies have shown that patients treated with buprenorphine exhibit significant improvement in depressive symptoms, as measured with the Hamilton Rating Scale for Depression (HAM-D), specifically with reduction in depressed mood, fatigue, and hopelessness (1). These improvements in depressive symptoms have been reported to occur within 48 hours of the first buprenorphine-naloxone dose and maintained throughout the course of treatment (1). Research also shows that while buprenorphine-naloxone causes a significant decline in depression severity during treatment, if discontinued suddenly, there is a significant increase in depressive levels (8).

A similar drug combination of buprenorphine/samidorphan has been

KEY POINTS/CLINICAL PEARLS

- A significant proportion of patients with a diagnosed substance use disorder also have a co-occurring mood disorder.
- Buprenorphine is typically prescribed to alleviate withdrawal symptoms and treat substance use disorders but also has been shown to relieve symptoms of depression.
- Buprenorphine's antidepressant effects are seen more rapidly than typical antidepressants.
- Buprenorphine can provide a crucial step in the recovery of patients with co-occurring substance use and mood disorders.

shown to achieve this effect. One study demonstrated that patients with depression who had an insufficient response to SSRIs experienced significant improvement in several depression outcome measures, including scores on the HAM-D, the Montgomery-Åsberg Depression Rating Scale, and the Clinical Global Impression Scale (11).

CONCLUSIONS

Buprenorphine-naloxone should be considered as a possible treatment for depressed patients who do not improve with standard treatments and whose depressive symptoms and anhedonia prevent them from engaging with health care providers and becoming involved in their own care. Additionally, buprenorphine-naloxone is a reasonable treatment to consider for patients with co-occurring disorders with chronic pain. Further research investigating the efficacy of buprenorphine-naloxone as a primary or adjunctive treatment for depression is warranted, both in patients with co-occurring disorders and in those without substance use disorders.

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CASE REPORT

Valproate Monitoring in Patients With Hypoalbuminemia

Stephanie Han, M.D.

CASE VIGNETTE

A 50-year-old man with a history of schizoaffective disorder, bipolar type, diabetes mellitus type 2, chronic kidney disease stage 3, and hypertension was brought to the emergency department for swelling of his face and extremities, questionable medication compliance, and recent unusual and threatening behavior. His psychiatric medications included divalproex sodium extended-release (2,000 mg nightly), long-acting injectable risperidone (25 mg every 2 weeks), and trazodone (100 mg nightly). The patient had been stable on this regimen for many years before the days leading up to his presentation in the emergency department. His total valproic acid level on presentation was 65 μg/mL. His complete blood count was unremarkable. His basic metabolic panel was notable for blood urea nitrogen (22 mg/dL), his creatinine level was 2.1 mg/dL, his estimated glomerular filtration rate was 34, his aspartate aminotransferase level was 65 IU/L, and his alanine aminotransferase level was 97 IU/L. The patient's urine drug screen was negative, and an ECG was unremarkable. He weighed 183 lbs and had a body mass index of 28. His bilateral lower extremities showed edema of 1+, and a neurological examination was unremarkable. Further workup revealed nephrotic syndrome with an albumin level of 2.2 g/dL (normal range, 3.6–4.8 g/dL).

In light of the significant renal dysfunction, how should the medication regimen, namely divalproex sodium, be approached in the above case?

DISCUSSION

Basic Pharmacology of Valproic acid

Valproic acid, or 2-propylpentanoic acid, is a branched-chain fatty acid derived from valerian acid, with Food and Drug Administration approval for treatment of seizures, migraine prophylaxis, and manic or mixed episodes associated with bipolar disorder (1, 2). It is available in oral and intravenous formulations as immediate-release and enteric-coated delayed-release as well as extended-release valproate sodium and divalproex sodium.

The mechanisms of action are not fully understood, but broadly, the acute effects appear to be mediated by enhancement of gamma-aminobutyric acid (GABA)-mediated neurotransmission via interference with GABA metabolism and effects on signaling pathways (1). The long-term effects are a result of alteration in multiple gene expression, which is at least partially mediated through direct inhibition of histone deacetylase (which leads to increased acetylation of lysine residues and, consequently, enhanced transcriptional activity) (1).

Valproic acid is highly protein bound, metabolized extensively by the liver, and eliminated by first-order kinetics (3). It also has unusual and variable pharmacodynamic and pharmacokinetic characteristics, including a nonlinear level-dose relationship, a variable degree of plasma protein binding, wide interpatient differences, and pharmacological effect that outlasts presence in plasma (4, 5).

Effect of Chronic Kidney Disease on Pharmacokinetics

Many studies have demonstrated high rates of medical comorbidities in patients with psychiatric disorders, including sequelae of the disorder (e.g., cirrhosis secondary to alcohol abuse), side effects of psychotropic medications, poorer self-care as a result of mental illness, and less efficient utilization of the health care system (6). Poor management of chronic illnesses such as diabetes and hypertension can result in serious sequelae, mainly renal failure. The kidneys serve as primary sites for excretion of many drugs, and thus renal disease can significantly affect drug clearance and steady-state levels (7). It also affects pharmacokinetics, because renal failure, characterized by an excessive loss of protein in the urine, leads to a hypoalbuminemic state (8).

Albumin is the principal plasma protein responsible for binding to acidic drugs (9). Most psychotropic drugs are highly protein bound, and thus only a small fraction of the total serum drug concentration—the free fraction—is available for pharmacological action (10). In a hypoalbuminemic state such as renal disease, there is less protein available for a drug to bind, and therefore a greater free fraction of drug is found in the plasma (9). Additionally, renal failure leads to accumulation of endogenous binding inhibitors such as uremic toxins and organic acids, which compete with drugs for protein-binding sites and displace them into the plasma (9). Albumin itself also undergoes a conformational change that is hypothesized to alter its binding properties (9).

Sometimes more than one psychotropic agent is used for treatment, and in a setting in which even a single drug can be displaced from protein-binding sites by endogenous factors, the presence of multiple drugs results in greater competition for those limited binding sites. To complicate matters further, many common nonpsychotropic medications are highly protein bound (e.g., aspirin, statins, and antihypertensives) (11). The competition for binding sites can result in many-fold increases in free plasma levels of the displaced drug (11).

Valproic Acid Toxicity

There is considerable debate in the literature concerning the relationship between valproic acid plasma levels and therapeutic effect, but the generally ac-

cepted therapeutic range (for all indications) is 50–100 μg/mL (12, 13). At higher levels, there is potential for toxicity characterized by neurologic, cardiac, respiratory, hematologic, gastrointestinal, or metabolic sequelae (5, 14). Although the effects of valproate overdose are usually mild, more severe and life-threatening events may occur, including coma, arrhythmia, shock, and bone marrow failure (14). Because of the potential for adverse outcomes and the narrow therapeutic range of valproic acid, therapeutic drug monitoring is oftentimes performed. The serum total valproic acid level is usually measured on the assumption that it is reflective of the free fraction of the drug. However, as discussed above, the free fraction usually increases in renal failure and other hypoalbuminemic states (alcoholic cirrhosis, acute hepatitis, burns, etc.). The total concentration of a drug (a sum of free and bound drug) often does not change appreciably with these shifts in equilibrium between free and bound fractions (11). Many studies have shown that monitoring the total valproic acid concentration can be misleading, because it can be normal or even low despite high concentrations of free valproic acid (11). If dosages are adjusted on the basis of total valproic acid levels, patients who are hypoalbuminemic can be overdosed, leading to clinically significant neurologic symptoms or toxicity (10, 15). Thus, there is greater clinical utility and importance in monitoring the free valproic acid concentration, rather than the total, in patients with hypoalbuminemia (3, 4, 11). The largest barrier to regularly monitoring free levels is the absence of widely available free valproic acid assays. In one survey conducted by the College of American Pathologists, only 2% of the laboratories that routinely performed total valproic acid determinations also offered free assays (10). Different theoretical models have been proposed to indirectly estimate the free fraction of valproic acid or to calculate a corrected total concentration for varying albumin levels, but the models are not validated and are not applicable to patients with renal failure, jaundice, or a high total drug concentration, criteria which essentially exclude many of the patients for whom the model is needed (10).

KEY POINTS/CLINICAL PEARLS

- Valproic acid is approved for treatment of seizures, migraine prophylaxis, and manic or mixed episodes associated with bipolar disorder; it has a narrow therapeutic range, and toxicity can result in serious neurological, cardiac, respiratory, hematologic, gastrointestinal, or metabolic sequelae.
- Most psychotropic drugs (including valproic acid), as well as many nonpsychotropic drugs, are highly protein bound; in hypoalbuminemic states, free fractions of such drugs can increase many-fold.
- Total valproic acid levels are oftentimes not reflective of shifts in equilibrium between free and bound drug, and thus it is of greater clinical utility to monitor the free level in hypoalbuminemic states.

CONCLUSIONS

Most psychiatric medications are highly protein bound, as are many common nonpsychiatric medications, thus protein-binding properties of drugs should be carefully considered, especially if a patient has hypoalbuminemia. Because shifts in the equilibrium between free and bound drugs are not consistently reflected in the total concentrations of protein-bound drugs, monitoring only total concentrations can lead to a failure to detect clinically significant drug toxicities. Thus, when a patient has hypoalbuminemia, valproic acid dosing should be based on the free valproic acid levels and the clinical picture.

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INTERVIEW

An Interview With Charles Sophy, D.O.

Oliver Glass, M.D.

Dr. Charles Sophy serves as Medical Director for the Los Angeles County Department of Children and Family Services, where he is responsible for directing the physical and mental health, as well as assisting in ensuring the safety, of more than 40,000 foster care children. He also maintains a private practice in Beverly Hills, Calif.; he is the author of Side by Side, The Revolutionary Mother-Daughter Program for Conflict-Free Communication*; and he is a regular expert guest on "Dr. Phil," as well as a contributor to the "Today Show," CNN, HLN, and many other television programs.*

Oliver M. Glass, M.D., is a PGY-VI forensic psychiatry fellow at Emory University. He is double-boarded in geriatric and general psychiatry. Dr. Glass is also Editor-in-Chief of the American Journal of Psychiatry Residents' Journal.

Photograph courtesy of Charles Sophy, D.O.

Dr. Glass: Dr. Sophy, I appreciate your taking the time to be interviewed for our journal. Let me start by asking about what motivated you to become a doctor and then a psychiatrist?

Dr. Sophy: I grew up in Pennsylvania, and my family wasn't very well off. My father was a coal miner and was self-employed with no medical benefits. We didn't have subsidized health care, and we always paid out of pocket. So, at a very young age, I realized how important it is to have medical care and how having it or not having it can affect the rest of your life. I knew from a young age that I wanted to be a doctor in order to provide medical care to others.

When I started my residency in family practice, I found that I was liking a lot of components on the mental health side. I was fascinated that someone could have a disease that could present itself through hallucinations, behavior changes, etc., because of one organ: your brain.

When I completed my residency, I began working in adult psychiatry and was really interested in helping kids with mental health issues; since they were young, they were still formative and had a better chance of getting healthy. I wanted to aid in that charge, so I did a fellowship in that concentration.

Since there is such an overlap in those two specialties, I always knew that there would be an opportunity that would combine both into a job at some point in my career, because that's where I thought the future of medicine was going. The Medical Director job at the DCFS [Department of Children and Family Services] kind of found me.

Dr. Glass: At some point you moved from Pennsylvania to California. How did your life unfold in that way?

Dr. Sophy: I was in a relationship with someone from the second or third year in medical school through my fellowship. We took our boards in California and saw a whole different world than Pennsylvania ever showed us. So, we looked for jobs out here and we took them. At the time, I was studying primary care and psychiatry.

Dr. Glass: I remember watching you on the TV show "Celebrity Rehab with Dr. Drew" during medical school. Please tell me about your first television appearance and how that happened.

Dr. Sophy: It started when it became public knowledge that I was the physician for Paris Hilton as she was preparing to enter prison for driving without her license. Out of that awareness of who I was and what I did, it took on a life of its own. I started being invited to be on CNN, "Entertainment Tonight," and other shows, and through that process met Dr. Drew. I saw that there was a needed component of presenting the mental health side more fully on his show, so he asked me to be a guest.

Dr. Glass: How did you get connected with Dr. Phil, Dr. Drew, and their shows?

Dr. Sophy: Through all these processes, I ended up meeting Dr. Phil too. But I had also worked with Dr. Phil on cases that overlapped with DCFS.

Dr. Glass: For trainees who dream of pursuing a career in television, what advice do you have for them?

Dr. Sophy: Along their process, they should expose themselves to that world, either as an internship or some other kind of experience, and get comfortable with public speaking and being in front

of the camera. That will lead them to where they want to be.

Dr. Glass: It would seem that it would be a challenge to maintain a work-life balance by working as a psychiatrist and then as a guest on various television shows. How do you do it? What advice do you have for trainees who may struggle to maintain a work-life balance?

Dr. Sophy: Over the years I've come up with the key areas of life that need to be in balance for anyone. It works and it fits into a mnemonic called SWEEP. You need three out of the five in balance, but preferably four or five will be. It's necessary to keep your life in check.

SWEEP is:

Sleep: Are you getting enough quantity and quality of sleep? When you wake up, do you feel good?

Work: Are you fulfilled enough at work—even if staying home is your work—to be happy at the end of the day?

Eating: Are you using food to stay healthy and energetic? Is meal time a time for relaxation and communication?

Emotional expression: Do you let the important people in your life know how you are feeling? Do you allow yourself physical and emotional intimacy?

Play: Are you letting yourself enjoy life? Do you have a way to let go of worry and direct your energy to a positive place?

When you feel as though any of these are lacking, take a step back and think about how you can address them.

Dr. Glass: You published a book titled *Side By Side: The Revolutionary Mother-Daughter Program for Conflict-Free Communication*. What led you to write this book? For trainees who may want to publish a book later in their careers, what suggestions do you have?

Dr. Sophy: After doing a lot of work with my celebrity clients, specifically Paris, I was asked by my publishers to try to memorialize and help to shed light on how a family of good resources could end up in a place like prison. My view is that everyone is equal. It doesn't matter how much money you have, if you break the law and commit a crime, you will face consequences. It doesn't matter your race, creed, religion, or any of that. We are all equal.

Dr. Glass: It has been an honor. Thank you again for your time, Dr. Sophy.

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.

***

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) Resident Recognition Award**
Organization	APA
Deadline	**March 31, 2019**
Brief Description	The Resident Recognition Award is presented annually to outstanding psychiatry residents or fellows from each department or institution who exemplifies one or more APA values. Multiple awards are given each year.
Eligibility	Candidates must be resident or fellow APA members, in good standing in their training program, and exemplify one or more APA values.
Contact and Website	E-mail: cvanwagner@psych.org; Website: https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/awards/resident-recognition-award
Fellowship/Award	**American Academy of Child and Adolescent Psychiatry (AACAP) Pilot Research Award for General Psychiatry Residents**
Organization	AACAP supported by Pfizer
Deadline	**April 1, 2019**
Brief Description	The AACAP Pilot Research Award offers $15,000 for general psychiatry residents who have an interest in beginning a career in child and adolescent mental health research. By providing up to three awards to general psychiatry residents for pilot research programs, the funders support young investigators at a critical stage, encouraging future careers in child and adolescent psychiatry research. Recipients have the opportunity to submit a poster presentation on their research for AACAP's 67th Annual Meeting in San Francisco, October 19–24, 2020. The award also includes the cost of attending the AACAP Annual Meeting for 5 days.
Eligibility	Applicants must be a general psychiatry resident, not have any previous significant individual research finding in child and adolescent mental health, and either be members of AACAP or have a membership application pending. Candidates must agree to submit a poster presentation at the annual meeting.
Contact and Website	E-mail: research@aacap.org; Website: https://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award.aspx
Fellowship/Award	**AACAP Pilot Research Award for Learning Disabilities**
Organization	AACAP, supported by the Elaine Schlosser Lewis Fund
Deadline	**April 1, 2019**
Brief Description	The AACAP Pilot Research Award for Learning Disabilities for Junior Faculty and Child and Adolescent Psychiatry Fellows offers $15,000 for child and adolescent psychiatry fellows and junior faculty who have an interest in beginning a career in child and adolescent mental health research. By providing one award to a child and adolescent psychiatry junior faculty member or fellow for pilot research on learning disabilities, the funders support a young investigator at a critical stage, encouraging a future career in child and adolescent psychiatry research. The recipient has the opportunity to submit a poster presentation at AACAP's 67th Annual Meeting in San Francisco, October 19–24, 2020.
Eligibility	Candidates must be board eligible or certified in child and adolescent psychiatry or enrolled in a child and adolescent psychiatry residency or fellowship program or have a faculty appointment in an accredited medical school or be in a fully accredited child and adolescent psychiatry clinical research or training program. Candidates may not have more than 2 years of experience following graduation from residency or fellowship training and must not have any previous significant, individual research funding in the field. All candidates must either be AACAP members or have a membership application pending and agree to submit a poster presentation on his or her research at the annual meeting.
Contact and Website	E-mail: research@aacap.org; Website: https://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award_for_Learning_Disabilities.aspx
Fellowship/Award	**AACAP Pilot Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows**
Organization	AACAP
Deadline	**April 1, 2019**
Brief Description	The AACAP Pilot Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows offers $15,000 for child and adolescent psychiatry 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 AACAP's 67th Annual Meeting in San Francisco, October 19–24, 2020. The award also includes the cost of attending AACAP's Annual Meeting for 5 days.
Eligibility	Candidates must be board eligible or certified in child and adolescent psychiatry or enrolled in a child psychiatry residency or fellowship program. Additionally, candidates must have a faculty appointment in an accredited medical school or be in a fully accredited child and adolescent psychiatry clinical research or training program with no more than 2 years of experience following graduation from residency or fellowship training nor any previous significant, individual research funding in the field. Candidates must either be AACAP members or have a membership application and agree to submit a poster presentation at the annual meeting.
Contact and Website	E-mail: research@aacap.org; Website: ttps://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Pilot_Research_Award_Child_Psychiatry_Residents_Junior_Faculty.aspx

Information for Authors

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Psychiatry and the Visual Arts
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If you are interested in serving as a **Guest 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.