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This issue of *The Residents' Journal* includes a section theme on specialists in psychiatry. Margaret W. Leung, M.D., M.P.H., examines the interface of psychiatry and palliative care. Next, Monifa Seawell, M.D., discusses a potentially emerging subspecialty within forensic psychiatry: criminal profiling. Last, Carla Marienfeld, M.D., outlines psychiatrists' role in delivering global healthcare and questions whether global mental health could be a specialty for U.S. residents.

Editorial

Medical Students and *The Residents' Journal*

Joseph M. Cerimele, M.D.
Editor-in-Chief

The resident physician's role as an educator has been described in this journal as well as in other publications (1–3). Residents in psychiatry are responsible for teaching clerkship medical students about the recognition, diagnosis, and management of psychiatric disorders. I know many residents who have prepared standard talks on schizophrenia, bipolar disorder, alcohol withdrawal, and other common presentations to deliver to groups of medical students during their time on the psychiatry clerkship. Some residency training programs even teach residents how to teach and enforce systematic ways of assessing a student's performance.

Beyond clinical matters, residents in all disciplines also teach students "the ropes" of day-to-day hospital work. We routinely instruct students in how to spend their time before rounds, how to present a case to the attending physician, how to document disease progression or resolution, how to establish effective ways to talk with physicians from other services, how to implement strategies for communicating with other hospital staff members, and (painfully) how to obtain records from an outside hospital. Thanks to residents' efforts, students are generally proficient in these tasks by the end of the third year of medical school.

Residents with academic writing experience may also be able to teach medical students some parts of academic medicine, such as how to prepare a manuscript for submission to a journal. Few medical schools require medical students to learn how to write and submit a manuscript. Residents, through daily interactions with students, could teach the basics of writing. A series of brief discussions on different manuscript types, literature searches, and writing and editing could lead to the student and resident completing and co-submitting a piece. Through collaboration, the medical student would learn how to prepare and submit a manuscript (and learn in more detail a portion of psychiatry), and the resident would likely learn how to guide and advise an interested student. This joint process could be sparked in several ways. For example, a student may wish to write a case report about a patient seen during the clerkship. At my institution, clerkship students are required to deliver a 30-minute presentation on the evidence supporting a specific intervention. Residents usually help students develop relevant clinical questions and often review the students' arguments prior to the presentation. Medical student presentations like this occur throughout the country and could also serve as the basis for a Review or Treatment in Psychiatry article.

The Residents' Journal would like to encourage medical student authorship. We have previously published pieces by medical students (4) and are planning to publish a series of medical student-authored articles in one of the upcoming issues, in a section guest-edited by a resident. Residents and fellows can also be authors on these pieces, but the medical student should be both the first and corresponding author. These manuscripts will be peer reviewed. We hope that residents will confidently take on this mentoring role and that students will be encouraged by the opportunity to learn an academic skill.

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The Role of Psychiatry in Palliative Care

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The Interface of Palliative Care and Psychiatry

In a specialty where the disorders we treat are chronic and our somatic treatments have limited success, psychiatry is palliative care that focuses on improving our patients' quality of life through relief of pain rather than cure, works in a multidisciplinary setting, which involves patients' families, and integrates physical, psychological, and spiritual aspects of care. The domains of care between palliative care and psychiatry are, therefore, not so disparate.

Modern medicine has changed the course of dying from death occurring suddenly because of infection or accidents—a century ago—to moving toward a chronic disease model where the predictability of death is uncertain. The uncertain timing of death created the modern hospice movement that cares for people dying over weeks, months, and even years. Between the process of living and dying, hospice patients experience loss, grief, and hopefully acceptance in the realm of their physical, psychological, social, and spiritual aspects of care. Assessing and treating psychiatric conditions in the terminally ill present multiple challenges, including physicians' lack of knowledge about depression, anxiety, and delirium in the context of terminal illness, avoidance of exploring psychological issues because of time constraints or concern that exploration would cause further distress, physician reluctance to prescribe psychotropic medications, and physician hopelessness that can lead to therapeutic nihilism (1).

Psychiatric Illness During the End of Life

Depression and anxiety are common in patients receiving palliative care. Physical or somatic symptoms may tend to overshadow psychological or cognitive symptoms. In a Canadian sample of patients receiving palliative cancer care, nearly 25% of the patients had DSM-IV criteria for either anxiety or depression, and 10% met criteria for more than one disorder (2). Diagnoses for depression included major depression and dysthymia, and diagnoses for anxiety included generalized anxiety disorder and panic disorder. Patients diagnosed with depression spent 37 days longer in home/long-term care and received 27 days more hospice inpatient care than nondepressed patients (3). As in all cases of developing a differential diagnosis for all psychiatric symptoms, depressive and anxious symptoms may be a result of physical causes (i.e., poorly controlled pain, pulmonary emboli, hypoxia, medication-induced, withdrawal states) and/or psychological causes (i.e., existential distress, separation, unresolved conflicts with family, excessive somatic preoccupation).

While psychiatric disorders are prevalent in hospice patients, these disorders do not predict rates of mental disorder and existential distress as patients near death. Although patients who met DSM-IV criteria for major depression, generalized anxiety, panic disorder, and posttraumatic stress disorder in one study were less likely to acknowledge their terminal illness, comorbid psychiatric disorders did not predict psychotropic medication use, nor did the prevalence of psychiatric diagnoses increase as death neared (4). The application of DSM-IV criteria to patients in the palliative setting, therefore, may be challenged because diagnoses such as adjustment disorder, depression, and anxiety do not capture the existential distress, demoralization, hopelessness, and loss of meaning and purpose in life (5).

Psychopharmacology During the End of Life

Somatic treatment for depression and anxiety in the palliative setting does not differ significantly from the nonpalliative setting. However, the urgency of treatment and a patient's survival time and mental clarity influence medical decision making. For example, a patient diagnosed with major depression and has less than 4 weeks to live may benefit more from a stimulant instead of a selective serotonin reuptake inhibitor (SSRI) to achieve faster efficacy. Benzodiazepines are commonly used to treat anxiety, and special preparations such as diazepam, administered rectally, may be useful in patients who cannot swallow. In the palliative care setting, excessive use of benzodiazepines may alter mental status, making nonbenzodiazepine medications such as hydroxyzine and haloperidol alternative options. In the treatment of depression, SSRIs can be titrated to their minimally effective dose without the side effects of orthostasis, memory impairment, sedation, or altered consciousness that are associated with tricyclics. Stimulants play an important role in cancer patients in stimulating appetite and increasing energy level and a sense of well-being.

Psychotherapy During the End of Life

The nature of suffering is further magnified at the end of life, superimposed by existential and spiritual challenges. Psychotherapy is important in facilitating a process of growth even at this late stage of life. Hastened death has been associated with hopelessness, a loss of sense of dignity, and lower physical functioning (6). Psychodynamically, a patient's request for physician-assisted suicide can be viewed from a desperate plea to be relieved of suffering to a need for control in response to rage and/or hopelessness (7). Various modalities of therapy, including cognitive behavioral therapy, psychodynamic life narrative, interpersonal therapy, existential psychotherapy, and supportive therapy, have been used to understand, manage, and work through feelings re-

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lated to illness and dying. Dignity therapy is a newer application of therapy, which addresses psychosocial and existential distresses by creating a sense of meaning and purpose. Individual and group therapy sessions focus on themes such as generativity (e.g., one's life has represented something and symbolically transcends death), role preservation, and continuity of self (e.g., personhood remains intact despite advancing illness) (8). In addition to direct patient care, psychiatrists can play an important role in consultation and liaison for members of the palliative team to understand and manage complicated family dynamics; facilitate communication among the patient, family, and team; support team members' countertransference; and emphasize the need for professional self-care.

While there are no data available identifying how many psychiatrists practice within a palliative care framework, they play an important role that can enhance collaboration between palliative medicine and psychiatry to create an integrative approach to patients' well-being and quality of life as well as extended care to families (9). Psychiatrists can sit for a subspecialty board certification in hospice and palliative medicine, which may lead them to work in a palliative care consult service. Alternatively, as commonly seen in local communities or health systems, psychiatrists can either be part of an integrated treatment team or serve as a consultant-liaison. While palliative care provides comprehensive end-of-life care that recognizes the effect of psychiatric morbidity for dying patients and their families, psychiatry can interface and integrate with palliative medicine to enhance excellent end-of-life care to those suffering.

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Criminal Profiling: A Pseudoscience or Future Psychiatric Subspecialty?

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Criminal profiling involves inferring the characteristics of someone who has committed a crime (1). It has also been defined as "the process of using behavioral evidence left at a crime scene to make inferences about the offender, including references about personality characteristics and psychopathology" (2). Similarly, Snook et al. (3) described profiling as "the practice of predicting a criminal's personality, behavioral, and demographic characteristics based on crime scene evidence." While there appears to be some consensus about what criminal profiling is, there is fierce debate surrounding its scientific validity. Many have demanded dramatic reforms, with some deeming such profiling as "unsalvageable" and calling for a moratorium. However, others defend criminal profiling as a blossoming field that has just as much potential as it does problems and believe that psychiatrists are in a unique position to perform profiling.

Problems Plaguing Criminal Profiling

Lack of Regulations

One of the widely cited problems of criminal profiling is the lack of an official regulatory organization. This has led to a dangerous situation in which anyone can perform criminal profiling without being held to a professional standard. Turvey (1), a founder of the Academy of Behavioral Profiling, agrees that criminal profiling has been infiltrated by unscientifically founded techniques and advocates for regulations in the field (1). The Academy of Behavioral Profiling attempts to institute some guidelines, including a code of ethics and the 75-item Profiling General Knowledge Exam (4). However, the organization cautions that passing the exam does not correlate with being certified in criminal profiling, nor does it indicate proficiency in profiling, since a passing score only demonstrates attainment of sufficient knowledge to meet qualifying criteria (4). While regulations could hypothetically lead to more consistencies in the field, this would not necessarily translate into improved profiling outcomes, as some argue that criminal profiling is a mythical technique that cannot be legitimately performed by anyone, regardless of training.

Lack of Standardized Profiling Methods and Guidelines

Criminal profiling has also been cited for lacking empirically supported, standardized techniques or guidelines for generating profiles. Methods vary widely among profilers and have even included the use of prayer and purported psychic abilities in generating offender characteristics (1). Typologies, or classification systems that describe the offender's traits and characteristics, are another profiling method. The Federal Bureau of Investigation Behavioral Science Unit's organized-disorganized dichotomy is a famous typology (5), as is Keppel and Walter's typology of serial sexual homicides (3, 5) and Holmes and Holmes classification of serial murderers (Table 1).These typologies have been deemed flawed by many and highly criticized because they assume that a person behaves in a single way across all aspects of life, ignoring situational variance.

Unreliable Accuracy

Profilers' predictions have been criticized for being unreliable and having low accuracy. Unfortunately, empirical studies testing their skills are rare (6). In a study by Pinizzotto and Finkel (7), a closed homicide and closed rape case were used to compare the abilities of profilers and nonprofilers. Differences in profiling accuracy were assessed as well as qualitative differences in the methods and process used by the profilers (7). Among other tasks, participants composed a profile using a multiple-choice questionnaire. Profilers were more accurate in predicting the rapist's character traits but not superior in profiling the murderer, and no qualitative differences were reported. The authors indicated that the results could have been influenced by a small sample size (N=28), variation in data presented in the rape and homicide cases (the rape case included a victim's statement), and a murderer who did not follow common interpersonal violence patterns.

Profilers are often criticized for manipulating the way in which their predictions are perceived. Godwin (5) stated that profilers may use techniques such as "confirmation bias" (drawing attention to those things that confirm predictions while ignoring anything contrary to them), "selective thinking" (selecting evidence that favors the profiler's theory), and "post hoc fallacy" (assuming a cause-and-effect connection between the profiler's prediction and future evidence, without ruling out the possibility of chance) to increase their perceived profiling accuracy. Many profilers also rely heavily on anecdotal reports of successful profiles they have generated, which may be inflated accounts of their abilities, lacking objectivity and saturated with the aforementioned techniques.

Can Psychiatrists Perform Criminal Profiling?

Despite these issues, Michael McGrath (8), forensic psychiatrist and past president of the Academy of Behavioral Profiling, argues that forensic psychiatrists are in a unique position to perform criminal profiling because their "experience with psychopathy and severe psychopathology place them in an enviable position when it comes to deducing personality characteristics from crime scene evidence." He cautions that in order to do so, psychiatrists would need to be motivated to independently obtain

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extensive additional training, since there are no formal training programs for forensic psychiatrists who wish to engage in criminal profiling. He also notes that the psychiatrist who performs criminal profiling should be careful not to misrepresent themselves as multidisciplinary experts and that psychiatrists should remove themselves from further aspects of an investigation, such as competency assessments and treatment, after performing profiling for a case.

While positive, McGrath's view of criminal profiling and the potential role for psychiatrists may not be held by others in the field. In a survey of forensic psychiatrists and psychologists (N=161), which assessed their attitudes toward, knowledge of, training in, and experience with criminal profiling, only 10% reported having made a profile for an investigation (2). Less than one-half believed that profiling was reliable or had enough scientific evidence to be admissible in court. However, in this same study, more than 95% of respondents believed that criminal profiling should be researched empirically, which could be interpreted as the studied population demonstrating some interest in further advancements in this type of profiling.

Conclusion

Criminal profiling is widely rejected by many in the scientific community. Plagued by issues such as a lack of profiling standardization, absence of a regulating organization, faulty offender classification systems, a need for extensive additional training, and an overall question as to the validity of the practice, it seems that any attempts to develop criminal profiling into a recognized psychiatric subspecialty would be met with broad resistance. However, there are some who advocate for psychiatry (i.e., forensic psychiatry) involvement. Further empirical research and regulations are needed.

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Table 1. Serial Murder Typologies

Federal Bureau of Investigation Behavioral Science Unit Typology of Serial Murder	Keppel and Walter Typology of Serial Sexual Murder	Holmes and Holmes Typology of Serial Murder
Organized: Crime committed in organized manner/crime scene organized. Higher functioning individual, kills out of revenge, plans crime, creative person with need for control, "forensically aware" (5). **Disorganized:** Crime committed in a disorganized manner/crime scene disorganized. Crime committed out of uncontrolled sadistic sexual impulses, lacks "forensic awareness" (5), leaves behinds evidence at crime scene.	**Power-Assertive:** Rape is planned while the murder is unplanned and occurs as means of controlling victim. Through violence, offender asserts ultimate control of the situation. **Power-Reassurance:** Rape is planned while murder is unplanned. Offense is prompted by a "seduction and conquest fantasy" (5). **Anger-Retaliatory:** Rape and murder occur as means of seeking revenge against women because of failed former relationships with women. **Anger-Excitation:** Rape and murder provides gratification for offender. Offender takes pleasure in inflicting fear and pain.	**Visionary:** Murder prompted by visions or auditory hallucinations **Mission:** Murder prompted by conscious need to kill off particular group of people **Hedonistic:** Murder has sexual undercurrent **Power/control:** Murder prompted by need for sexual satisfaction and control of victim

[a]*Data taken from Snook et al. (3) and Godwin (5).*

Time for a Global Mental Health Specialty for U.S. Residents?

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Mental illness is a serious global health problem. In 2000, the World Health Organization noted that depression was the leading cause of disability, as measured by years lived with disability, and the fourth leading contributor to the global burden of disease, as measured in disability adjusted life years (1). In addition, approximately 14% of the global burden of disease has been attributed to neuropsychiatric disorders (1).

Yet, the burden of mental disorders is greater given the underestimation of the connection between mental illness and other global health challenges. Mental disorders increase the risk for communicable and noncommunicable diseases and contribute to injury (1). For example, untreated depression may decrease a patient's motivation to comply with infectious disease medication. Challenges arise in managing patients with co-occurring disorders, such that mental illness comorbidities complicate help seeking, diagnosis, and treatment, ultimately influencing prognosis (1). For this reason, many international psychiatric groups endorse the World Health Organization's proposition that there is "no health without mental health" (1). In response to the growing need and interest, in 2007, *Lancet* published a series of summative articles highlighting resources needed, current treatments and prevention efforts, current systems of mental health care, barriers to care, and a call to action for the provision of mental health care to low- and middle-income countries.

Interest in global health has grown among medical students and residents. Medical education has responded with increasing curriculum, educational focus, and medical experiences abroad. One study conducted in 2008 (2) found that 59% of medical schools offered elective rotations abroad for residents, 45% offered opportunities for preclinical research abroad, and 11% had formal global health track options for students. In residency education, international health experiences were associated with an increased likelihood for a career choice in an underserved area and were noted to have a positive effect on participants' clinical skills and attitudes and to aid in the recruitment of residents (3). However, psychiatry residency programs remain noticeably silent within the literature about the education, training, and international health experiences available to residents.

While there is a clear need for increased care abroad, some of which can be mitigated by responsible work abroad during medical training, the United States is also becoming more culturally diverse. Almost all healthcare professionals now treat patients whose cultural, religious, and political backgrounds are different from their own. To provide effective care, it is essential that they understand variation in healthcare beliefs, practices, and expectations. With this in mind as well as the documented effect that international healthcare experiences can increase a physician's likelihood of practicing with underserved populations, many residency programs outside of psychiatry have implemented programs for cultural/global education among residents as well as to recruit top quality residents (4–6). In addition, the importance of this is reflected in the Accreditation Council for Graduate Medical Education psychiatry program requirements concerning cultural competency and cross-cultural communication and the DSM-IV cultural formulation. So, is it time to consider global mental health education in psychiatry residency?

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Case Report

Onset or Worsening of Psychiatric Symptoms After Varenicline Discontinuation

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Varenicline is a partial agonist/antagonist approved by the Food and Drug Administration (FDA) for smoking cessation (1). Case reports have suggested a possible association between the use of varenicline and psychiatric side effects (1–3). However, little is reported about possible psychiatric side effects upon varenicline discontinuation. We present the case of a patient who had an onset of psychiatric symptoms following varenicline discontinuation as well as a case of a patient who experienced worsening of pre-existing psychiatric symptoms after varenicline use/discontinuation.

Case 1

"Mr. B" was a 28-year-old man with no prior psychiatric or substance abuse history who presented to the emergency department for extreme anxiety and suicidal ideation. He had been a 1.5-pack-per-day cigarette smoker and was treated with varenicline for 4 weeks, with successful smoking cessation. The patient subsequently discontinued varenicline abruptly. Within 24 hours, he became irritable, negativistic, and argumentative. Over the next 2 days, he had restlessness, insomnia, impaired concentration, racing thoughts, and depressed mood. He felt "like a fuse had popped in [his] head." He was unable to relax during his hobby of weightlifting and ingested one dose of cyclobenzaprine in the evening and slept for 5 hours. The next day, he felt "panicky" and "sped up" and subsequently presented to the emergency department, though he denied palpitations, hyperventilation, presyncope, nausea, weakness, or paresthesia. His family history included a father with alcohol dependence, a mother with depression, and a sister with panic disorder. Complete blood count and complete metabolic panel results were normal, and a urine toxicology screen was negative. The patient responded to clonazepam (0.5 mg) and was prescribed a regimen of 0.5 mg twice daily and discharged home. At the office appointment, he presented with mild tension, pressured speech, dysphoria, and excessive energy. He was prescribed sodium valproate (500 mg) but discontinued treatment after 2 doses because of adverse side effects. The patient continued treatment with clonazepam (0.5 mg three times daily) until he felt "normal" again after 12 days.

Case 2

"Ms. A" was a 36-year-old, divorced woman with a history of bipolar disorder with psychotic features. She presented to the emergency department with depression and psychotic symptoms. She had smoked one pack of cigarettes per day since age 13 years and was prescribed varenicline by her primary care physician 5 weeks before presenting to the emergency department, with successful smoking cessation after 1 week. She had been euthymic for the last 2 months. The patient reported increased irritability and fluctuating mood within the first week of initiating treatment with varenicline but chose to continue the medication in order to stop smoking. Three weeks after starting varenicline, she abruptly stopped treatment because of continued mood fluctuation and irritability. During the fourth week, she developed racing thoughts, auditory hallucinations telling her to provoke others to kill her, and paranoia consisting of thoughts of being followed and watched as well as an evening of excessive drinking followed by a minor motor vehicle accident resulting in a criminal charge of driving under the influence. During this week, she admitted to sporadic compliance with her psychiatric medications, namely lithium carbonate (450 mg twice daily) and quetiapine extended release (400 mg at bedtime) because she felt as though these medications had stopped working. She was subsequently brought to the emergency department by her mother who added that Ms. A had been up most nights, distractible, starting many projects, and making bizarre comments. The patient reported binge drinking 1–2 times per year and experimenting with marijuana in the past. Her complete blood count and complete metabolic panel results were normal, and urine toxicology screen and ethanol level findings were within normal limits. She was administered intravenous fluids for elevated creatine kinase levels and subsequently admitted to an inpatient psychiatry unit. She was restarted on quetiapine, and treatment with lithium was discontinued. She underwent four ECT treatments as an inpatient, with follow-up treatments every 2 weeks as an outpatient. Two months later, her depression had improved and she did not have delusions, although she had minimal paranoia consisting of suspicion that her coworkers wanted her to leave her job. Despite this, she continued working and followed up her treatment with outpatient psychiatry and chemical dependency services.

Discussion

Varenicline aids in smoking cessation by reducing craving, which is satisfaction from smoking, and reducing withdrawal symptoms by inhibiting nicotine-induced dopaminergic activation via partial agonism/antagonism at the $\alpha 4\beta 2$ nicotinic

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acetylcholine receptor (1).

Gonzalez et al. (4) reported that varenicline had an odds ratio of 3.85 relative to placebo and an odds ratio of 1.93 relative to bupropion during a 12-week active treatment phase and an odds ratio of 3.09 relative to placebo and 1.46 (confidence interval=0.99–2.17) relative to bupropion after 52 weeks of follow up assessment.

Major tolerability issues concerning varenicline in the general population are nausea, insomnia, and abnormal dreams (5). Varenicline-induced exacerbation of psychotic symptoms among patients with previously stable psychiatric disorders has been reported (2, 3). In 2008, the FDA issued a Public Health Advisory indicating the need to screen for preexisting psychiatric illness before treatment with varenicline and to monitor mood for behavior changes during use (6).

However, in one study involving routine treatment for tobacco dependence among patients with and without mental illness, varenicline did not cause a statistically significant change in rates of low mood, disturbed sleep, vivid dreams, and anxiety/panic symptoms. Although the authors could not exclude the existence of other adverse symptoms with low prevalence (7).

Varenicline Discontinuation

A distinct causal association between varenicline and neuropsychiatric side effects is unclear based on available studies, and little is known about the psychiatric effects of sudden varenicline cessation. Distressing visual hallucinations of unknown people was reported in a male patient who discontinued varenicline after 3 weeks of treatment (8). The patient had a negative psychiatric, medical, and alcohol/drug history and no family history of schizophrenia. He was successfully treated with quetiapine (50 mg at bedtime) for 10 days. It was postulated that varenicline down-regulated the cholinergic system and that the abrupt lack of cholinergic stimulation resulting from varenicline withdrawal induced a rebound effect simulating an anticholinergic hallucinosis.

Sudden medication cessation might uncover symptoms of nicotine withdrawal, such as depression, insomnia, anxiety, irritability, frustration, anger, difficulty concentrating, restlessness, and increased appetite (5). However, we believe that this does not fully explain the extreme symptoms in the aforementioned cases. Finally, randomized trials, to our knowledge, have not reported withdrawal symptoms associated with varenicline discontinuation (9).

Conclusion

Varenicline is FDA approved as an adjunct treatment for smoking cessation (1). It remains widely used and has been shown to have significant benefit. We suggest advising patients against the abrupt cessation of varenicline, given the potential for causing or exacerbating psychiatric symptoms.

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Introspection

New on the Job: An MD's First Morning

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The senior resident had seemed benign when she first introduced herself. She sugar-coated the day's agenda with smiles and a friendly accent from somewhere across the ocean. She would protect me. This warm woman, just shy of middle-age, probably had a kid at home and a goldfish named after a Portuguese poet. I thought that there was no way she would throw me to the wolves on my first day.

And then she did.

"There is the new consult in the CCU [critical care unit] on floor 6. You go down and gather the history and see the patient. Work on the note before conference this morning."

I remember thinking that this would be the time that the façade of my academic mastery of the material would come crumbling down. After years of pretending and getting by, I would simply crumble on my first day on the job. After making my way to the sixth floor critical care unit, I perused the environment. I noticed a team of voracious internal medicine residents rounding in the hallway, and I watched as they salivated at the mere whisper of an inaccurate protocol. If a lower ranking resident didn't know the proper dosage for a certain drug, the uppers would surely pounce on the youngling's mistake with a swift correction and citation of the current literature. I hoped that I would be able to stay out of their way and go unnoticed, but my patient's chart was not stowed away in its place among the others. It was with them.

I approached the circle silently and listened in more closely, keeping a safe distance. I heard a resident describe how the family wanted to know about the chances for meaningful recovery despite how debilitated their matriarch had become.

"If Neuro confirms what we've been saying, they'll likely decide to put the patient on CMO."

CMO: comfort measures only. I don't have all of the lingo down yet, but I have that one.

"So when is Neuro coming?"

"They said today, but—"

"Wait, are you from Neuro?" He asked, nodding in my direction.

I indicated that I was, at least during this 2-month rotation.

"You don't look like you're from Neuro."

"I'm just a PGY-1."

"Not just a PGY-1," he corrected.

"I mean, great news; I'm a PGY-1!" I responded with an exaggerated enthusiasm that I couldn't believe had just come out of my mouth.

"I didn't recognize you without your little Neuro bag," a female resident said with a giggle.

"He's from Psychiatry, that's why," said the senior-most resident motioning to my ID badge.

"Well, actually, if you look closely, I'm from Physchiatry," I said, referring to the since-corrected misspelled department name listed on my badge. "The team's going to see the patient with me later this morning. I'll make sure to get a note in the system as soon as possible."

"So, are you like a PGY-1 who's about to finish in 2 days, or—?"

"Actually, it's my first day."

The crowd erupted. The entire demeanor of the group changed, and suddenly I felt like I was one of them.

"Ahhgh! Why didn't you say so? Welcome aboard! Good luck today!"

I even felt a pat on the back.

Moments later, when I entered the patient's room, I heard one of the medicine residents shout, "Go get 'em!"

I had overheard and read enough about the patient to know what to expect. This elderly woman was comatose after a cardiac arrest, stemming from bilateral pulmonary emboli. She was in a place straddling life and death, and it was my job to assess which way the wind would blow her.

As I approached the patient's bedside, an unfamiliar feeling swept over me. I had been pretending to be a doctor for so long in medical school that I found I was actually pretty good at it. I certainly didn't know if I could test the vestibulo-ocular reflex with the same sensitivity as a seasoned veteran, but I was confident that I knew what it looks like to do so. Much of the nervousness and timidity melted away, and I realized I was right where I was supposed to be. As I prepared to begin my examination, I leaned toward this comatose old woman, knowing how far gone she already was, and introduced myself: "Hello, ma'am. I'm Dr. Stern."

Dr. Stern is a first-year resident, Harvard Longwood Psychiatry Residency Training Program, Boston.

Book Review

Offenders, Deviants or Patients?: Explorations in Clinical Criminology, Fourth Edition by Herschel Prins

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In *Offenders, Deviants or Patients?: Explorations in Clinical Criminology* (Fourth Edition), Herschel Prins discusses the interface between mental disorders and crime. He first reviews the history of forensic mental health, discusses legal responsibility, and explores the ways in which individual cases can be dealt with (nonprosecution, referral for psychiatric evaluation, etc.). The next chapters explore specific psychopathologies (affective, psychotic, etc.), psychopathic personality, and violent crime. Murder, sex crimes, and arson are each discussed in separate chapters. Finally, the book ends with a chapter on assessing risk and how to balance the rights of the offender against the protection of society.

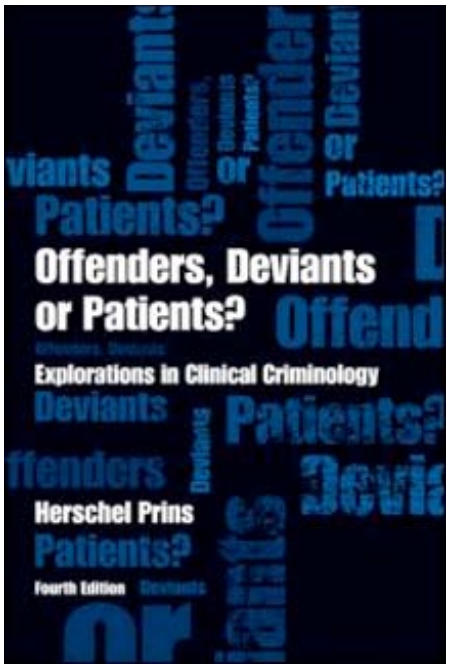
I initially found this volume to be tiresome. The organization of the first chapter is idiosyncratic. Entitled Some Autobiographical Reminiscences and reviewing changes in forensic mental health over the last 50 years, it gives a selective and confusing memoir-like picture of changes the author has seen in his own life and practice. These chapters focus extensively on legal specifics of relevance to those in the United Kingdom and of limited relevance for psychiatric residents training elsewhere.

Quickly, however, my persistence was rewarded. In his discussion on various "altered mental states" and crime, Prins does cover commonly discussed relationships (e.g., between paranoid delusions and violence), but he also delves into little-discussed relationships, such as those between milder depression and theft or between anxiety states and unprovoked violence toward strangers. In his discussion of psychopathy, Prins offers more than an overview of various nomenclatures and classifications. He practically considers the strong feelings aroused in those tasked with managing these patients and ways in which this can create difficulties with management and treatment.

In the later chapters, questions not commonly considered are again explored. In the discussion of violent crime, Prins provides an eye-opening survey of the demographics of violent crime and challenges the common public perception that violence is on the rise. In the chapter on murder, he presents a detailed classification by law, by clinical presentation, and, most interestingly, by motive. He accomplishes a similar task in his discussion of sex crimes; beyond legal and clinical classifications, he explores the various motives for specific acts and gives practical suggestions as to how considering motive can aid in management.

In a final chapter, Prins discusses how to assess risk in mentally disordered offenders. Most valuably, he provides an important corrective to the emotion-driven approaches that greatly hinder balancing individual liberty with societal protection.

These forays beyond basic clinical and legal considerations make this a worthwhile volume for anyone interested in



working with mentally disordered offenders. The author's style is also worth consideration. The same idiosyncratic focus that made the first chapter a difficult read for me made the later chapters a delight. Throughout his discussion, Prins peppers the text with examples from the historical record as well as from literature. In addition to serving an illustrative purpose, such examples help to verify clinical and legal concepts as rooted in human nature, rather than just as byproducts of current professional consensus.

Dr. Thakur is a third-year resident in the Department of Psychiatry, Mt. Sinai Medical Center, New York.

TEST YOUR KNOWLEDGE

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions.
(answers will appear in the next issue)

This month's questions are courtesy of Deepak Prabhakar, M.D., M.P.H., Chief Resident (Outpatient Department) (PGY-III), Department of Psychiatry and Behavioral Neurosciences, Wayne State University, Detroit.

1. A 35-year-old man presents to the clinic with complaints of urinary retention. The patient was recently started on a tricyclic antidepressant for treatment of depression after he failed trials of several selective serotonin reuptake inhibitors and selective norepinephrine reuptake inhibitors. The clinician is considering switching the medication to a different tricyclic antidepressant. Which of the following medications is least likely to aggravate the patient's urinary retention?

A. Amitryptiline
B. Imipramine
C. Desipramine
D. Trimipramine
E. Doxepin

2. A 20-year-old young woman with a diagnosis of anorexia nervosa is being evaluated in a specialty eating disorders clinic. Physical examination reveals an irregular, fixed, reticulated hyperpigmented patch on the patient's abdomen. Upon further questioning, the patient reveals that she regularly applies a hot water bottle on her abdomen in order to keep warm. The patient is most likely suffering from which of the following skin abnormalities?

A. Erythema ab igne
B. Acrodermatitis enteropathica
C. Dermatitis artefacta
D. Hypercarotenaemia
E. Acrocyanosis

ANSWERS

Answers to November Questions. To view the November Test Your Knowledge questions, go to ajp.psychiatryonline.org/cgi/data/167/11/A30/DC2/1.

Question #1.

Answer: C. Koro

Koro is a culture-bound syndrome commonly seen in individuals of Chinese and Southeast Asian descent. These individuals fear that their sexual organs and appendages are shrinking into their body, which is a result of psychiatric symptoms such as anxiety, panic attacks, paranoia, or hallucinations.

Reference

1. Du N: Asian American patients, in Clinical Manual of Cultural Psychiatry. Edited by Lim RF. Washington, DC, American Psychiatric Publishing, 2006, pp 69–117

Question #2

Answer: D. CYP2C19*3

The CYP2C19*3 mutation is partly responsible for the presence of a higher rate of poor metabolizers among Asian populations. This results in increased sensitivity to CYP2C19 substrates such as diazepam. Hence, the use of diazepam in this patient population warrants careful consideration for side effects and relatively slower dose titration.

Reference

1. Smith MW: Ethnopsychopharmacology, in Clinical Manual of Cultural Psychiatry. Edited by Lim RF. Washington, DC, American Psychiatric Publishing, 2006, pp 207–235

We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment in the issue in which their questions are featured.
Submissions should include the following:
1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.
***Please direct all inquiries and submissions to Dr. Fayad; fayad@ufl.edu.**

Author Information for *Residents' Journal* Submissions

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

1. **Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.

2. **Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,000 words and 10 references.

3. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 750 words and five references.

4. **Original Research:** Reports of novel observations and research. Limited to 1,000 words, 10 references, and two figures.

5. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,000 words, 10 references, and one figure.

6. **Letters to the Editor:** Limited to 250 words (including references) and three authors. Comments on articles published in the Residents' Journal will be considered for publication if received within 1 month of publication of the original article.

7. **Book Review:** Limited to 500 words.

Abstracts: Articles should not include an abstract.

References: Use reference format of *The American Journal of Psychiatry* (http://ajp.psychiatryonline.org/misc/Authors_Reviewers.dtl).

Upcoming Issue Themes

Please note that we will consider articles outside of the theme.

March 2011
Section Theme: The On-Call Experience
Guest Section Editor: Monifa Seawell, M.D.;
mseawell@med.wayne.edu

April 2011
Section Theme: Psychosomatic Medicine
Guest Section Editor: Amit Pradhan, M.D.;
dramitpradhan@hotmail.com

May 2011
Section Theme: Exercise and Psychiatric Disorders
Guest Section Editor: Corey Meyer, M.D.;
cmeyer@challiance.org

June 2011
Section Theme: No specific theme
Guest Section Editor: Deepak Prabhakar, M.D.;
dprabhakar@med.wayne.edu

We invite residents who are interested in participating as Guest Section Editors to e-mail Dr. Cerimele at joseph.cerimele@mssm.edu. If you are interested in contributing a manuscript on any of the themes outlined, please contact the Section Editor for the specified month.