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This issue of the *Residents' Journal* begins with synopses from the 2015 APA Annual Meeting in Toronto, written by resident-fellow monitors. Amit Mistry, M.D., monitored the session on how extended combat improved our ability to effectively treat veterans; Crispa J. Aeschbach Jachmann, M.D., monitored the session on attention deficit hyperactivity disorder in adults; Crispa J. Aeschbach Jachmann, M.D., and Kashmira Rustomji, M.D., co-monitored a session on the evaluation and treatment of behavioral emergencies; and Elizabeth Tiffany, M.D., monitored a session on melatonin and light treatment in body-clock disorders. A review article by Walter S. Mathis, M.D., examines opioid prescribing and iatrogenic addiction. Another article by R. Scott Johnson, M.D., J.D., L.L.M., and Matthew R. Ayers, D.O., discusses the diagnosis of sexual sadism disorder in forensic populations. A case report by Shayna Carp, M.D., and Matisyahu Shulman, M.D., describes a first manic episode in a young male patient after initiation of St. John's wort. Lastly, Amir Adam Tarsha, M.S., presents a review of the book *Fifty Shrinks*.

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# Monitoring the Meeting: Resident Takeaways From the 2015 APA Annual Meeting

Rajiv Radhakrishnan, M.B.B.S., M.D., Editor-in-Chief

The APA Annual Meeting, first established in 1844, is the largest psychiatric meeting in the United States and draws over 13,000 attendees from all around the world. The 2015 meeting was held in Toronto on May 16–20 and featured over 500 scientific sessions. This is an exceedingly large amount of information for anyone to be able to keep track of and to assimilate. In order to help us keep with this task, we offered residents and fellows attending the APA meeting, an opportunity to submit a brief synopsis of the sessions they attended.

The following are the synopsis of the APA 2015 Annual Meeting that the residents and fellows have kindly compiled for us. A special thanks to Amit Mistry, Crispa Aeschbach, Kashmira Rustomji, and Elizabeth Tiffany for their contributions.

As an additional reminder, the upcoming 2016 APA Annual Meeting is scheduled to be held on May 14–18, 2016 in Atlanta. Residents and fellows attending the meeting will have a similar opportunity to submit synopses of the workshops and plenaries. Typically each year the APA has provided resident-fellow members an opportunity to volunteer as monitors for some of the scientific sessions at the Annual Meeting in return for the meeting's registration fee and course fee. This can therefore serve as a great opportunity to both attend the meeting and submit a synopsis in the *American Journal of Psychiatry-Residents' Journal*. We look forward to your active participation.

## HOW EXTENDED COMBAT IMPROVED OUR ABILITY TO EFFECTIVELY TREAT VETERANS

Amit Mistry, M.D.  
Department of Psychiatry, University of Oklahoma, Oklahoma City, Okla.

The workshop focused on combat-associated mental trauma and posttraumatic stress disorder (PTSD). Paul S.

Hammer, B.S., M.D., began by sharing the experience of a corporal who lost a fellow soldier due to injuries sustained on the battlefield. The corporal carried his mortally wounded comrade to a military hospital where surgeons frantically worked to save the soldier's life, but sadly, he died in surgery. Feelings of grief and guilt overtook the corporal. He was in a state of shock. This is when a surgeon took the corporal outside, and together they walked around in circles while the surgeon methodically explained the surgery. By the end, the corporal understood that he was not to blame for the soldier's death. This story served to illustrate that combat traumas require early intervention and that the treatment is as unique as the patient (1). Andrew Mortimer, D.O., followed by outlining current treatment guidelines (2) and the success of using a color-rating scale to initially assess combat stress. He identified three main types of trauma: fear-based (fear of dying), loss-based (death of a comrade), and moral injury, which is going against one's self-image or moral code, resulting in an internal conflict (killing in combat).

Jeffrey Millegan, M.D., M.P.H., concluded the workshop by proposing mental fitness, developed through daily meditation, as a preventive measure to combat trauma. Through daily meditation, one could decrease the lag time between a triggered stress response and returning to a relaxed resting state, thus limiting pathological activation of the stress response pathway that is involved in PTSD (3). The research showed that with seven minutes of daily meditation, this group kept their mental focus consistent throughout rigorous military training and had a faster return from a stress state to a resting state.

More research into mental fitness and its application is required, but it is anticipated that mental fitness will be

incorporated into future military training to help soldiers develop a resistance to mental trauma and PTSD.

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## ADHD IN ADULTS: FROM CLINICAL SCIENCE TO CLINICAL PRACTICE

Crispa J. Aeschbach Jachmann, M.D.  
Department of Psychiatry and Behavioral Sciences, University of Texas Health Science Center, Houston.

Drs. Craig Surman and Paul Hammerness led a course on the diagnosis and treatment of attention deficit hyperactivity disorder (ADHD) in adults. Inattention, impulsivity, and hyperactivity present differently in adults compared with children due to increased cognitive demands (e.g., organization, prioritization, self-structure, planning) and to greater consequences in independent life. Symptoms affect function in life roles, leading to underperformance in employment and education. Dr. Hammerness encouraged clinicians to “embrace the clarity that ADHD is based in childhood.” A childhood history, including family constellation, temperament,

and elementary school education, sets the stage and extreme childhood behavior is typically easily recalled (1). The diagnosis of ADHD is made by prompting patients to tell compelling narratives about symptoms and their impact on functioning in elementary school, home, and social settings. Assessment concludes with current severity and dysfunction, with a focus on compensation burden, consequences, and role impairment (2).

Stimulants are first-line treatment for ADHD at all ages, with no hierarchy of agents, as all show robust efficacy. Clinical preference is for long-acting formulations. Conduct assessment for cardiac symptoms and medical history (e.g., fainting, chest pain, or shortness of breath with exercise and palpitations or seizures) and family history (e.g., arrhythmias, sudden death during exercise, cardiomyopathies, Marfan syndrome) to assess for vulnerability for cardiac problems before starting stimulants (3). ECG is not recommended for screening but heart rate and blood pressure should be monitored (3). Focus on baseline symptoms (consider using rating scales), and gradually increase dose for symptomatic and functional improvement (4). Stimulants are maintained at the lowest optimal dose in anticipation of long-term treatment. Separate assessments of response and tolerability are recommended (5). Red flags for misuse include patient response to medication focused on mood and energy instead of cognitive enhancement, clinical intuition, and third-party concerns. Nonstimulants have more modest effect sizes. Atomoxetine is approved by the Food and Drug Administration and also a first-line treatment. Double-blind studies support bupropion and desipramine, especially with mood symptoms. Clonidine and guanfacine may be used adjunctively. Psychosocial support and cognitive-behavioral therapy can also be helpful (6).

Co-occurring psychiatric conditions complicate the clinical presentations of adults with ADHD. Treatment prioritization of the more severe disorder is recommended (6). ADHD symptoms (e.g., disorganization, inattention, low frus-

tration tolerance) can be the primary driver of sadness with prominent demoralization often mistaken for major depressive disorder.

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## THE EVALUATION AND TREATMENT OF BEHAVIORAL EMERGENCIES

Crispa J. Aeschbach Jachmann, M.D.  
Department of Psychiatry and Behavioral Sciences, University of Texas Health Science Center, Houston.

Kashmira Rustomji, M.D.  
Department of Psychiatry, SUNY Downstate, Brooklyn, N.Y.

An expert panel of clinicians led by Dr. Nordstrom from Denver Health presented an enriching course on emergency department psychiatry. Dr. Zeller presented the Project BETA [Best practices in Evaluation and Treatment of Agitation] guidelines for emergency room settings. Treatment goals include the exclusion of medical etiologies, rapid stabilization of acute crises, and treatment in the least restrictive environment possible (1). Forming a therapeutic alliance and formulating an appropri-

ate disposition and aftercare planning are essential to emergency care (2). Dr. Powsner emphasized that de-escalating agitated patients involves avoiding physical force or involuntary medications. Restraint and seclusion should be avoided. De-escalation reduces documentation and improves treatment adherence. Techniques include etiquette as a substitute for empathy, listening, agreeing when possible, and offering choices. Medications also help manage the symptoms of agitation. Dr. Nordstrom recommended that when choosing a medication, your choice should consider patient preference, oral over intramuscular administration, onset of action, and diversion risk. Second-generation antipsychotics remain first-line treatments. Dr. Zun underscored mental illness as underdiagnosed in medical emergency rooms. TAPS [triage algorithm for psychiatric screening] can better identify patients requiring psychiatric transfer (3). There is no substitute for a thorough history and physical examination. Quick screening tools and clinical judgment are efficient and cost effective. Dr. Berlin shared his advanced interview tips for engaging your patient in the emergency department: turn off your phone, sit down, and listen (4, 5). Evaluating patients is an iterative process. Tune into your own clinical instincts to scan for acute symptoms and dangerousness. Always ask, Why did the patient present now?

For the most up-to-date information on emergency medicine, visit <http://westjem.com/>.

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## MELATONIN AND LIGHT TREATMENT OF SEASONAL AFFECTIVE DISORDER, SLEEP, AND OTHER BODY-CLOCK DISORDERS

Elizabeth Tiffany, M.D.

Department of Psychiatry and Behavioral Neuroscience, University of Cincinnati College of Medicine, Cincinnati.

Melatonin is secreted from the pineal gland in response to darkness and entrains the body clock to light and dark. Without melatonin, most tend to have a body clock that is slightly over 24 hours (1). This 4-hour course presented research supporting the use of melatonin and light therapy, in conjunction or alone, for treatment of body-clock disorders and improvement in mood and sleep quality.

Before treating a body-clock disorder, it should be determined whether the patient is phase-delayed, with sleep shifted later, or phase-advanced, with sleep shifted earlier in the day (1). Phase

delay can be treated with melatonin about 8–12 hours after desired wake time. In contrast, phase-advanced patients should be given melatonin upon awakening. Light therapy (2,000 lux–10,000 lux) given 12 hours opposite of the melatonin dosing can be used independently or in conjunction. Care should be taken to adjust light or melatonin slowly by about 15 minutes per day, as administration that is highly disparate from the current body clock can be disruptive and worsen symptoms (2). Jet lag, an acute mismatch between the circadian rhythms and current clock times, can be seen in terms of phase shifting. Eastward travel can be thought of as a phase delay, and westward travel as a phase advance. Care must be taken for greater than 6 time zones (i.e., greater disparity) so as not to disrupt the body's clock too suddenly (1).

Nomograms are available to assist in determining optimal timing of melatonin or light. Shift-work sleep disorder tends to be phase delayed (3). Bright light should be avoided after a shift is completed, and melatonin should be taken 1½ hour prior to bedtime (1). Perhaps the most well-known use of light therapy is for seasonal affective disorder, which is commonly a phase-delayed pattern that can be treated via light therapy in

the morning or with melatonin 0.3 mg at 2:00 p.m. and 6:00 p.m. or with a combination of the two (4).

Currently, little is known about the long-term effects of daily melatonin. Additional research is necessary for improved measurement of onset of melatonin secretion and greater consensus as to the definition of melatonin onset.

The above session was presented by Alfred J. Lewy, M.D., Ph.D.

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# JobCentral

Job opportunities for graduating residents and fellows are listed on JobCentral, a free service provided by APA for its members ([jobs.psychiatry.org](http://jobs.psychiatry.org)). Browse over 2,000 job postings based on location, work setting and position type, create an account and set up job alerts.



# Opioid Prescribing and Iatrogenic Addiction

Walter S. Mathis, M.D.

The United States is in a period of dangerous opioid prescribing and use. Between 1999 and 2010 the number of opioid prescriptions filled annually doubled (1), while the total mass prescribed quadrupled (2). The four-fold increase in opioids prescribed tragically parallels the four-fold increase in fatalities from opioid overdose during the same period (2). This striking parallel suggests that prescribing habits are enabling if not contributing to opioid misuse. A survey of patients seeking treatment for opioid abuse found that 79% of males and 85% of females indicated that their first exposure to opioids was a legitimate prescription for pain (3). These results indicate that some opioid addictions start in the doctor's office. The present article presents a literature review on the risk of iatrogenic opioid addiction, examines the evidence for stratifying risk in opioid prescribing, and explores how well residents are trained to address this issue in clinical practice.

## RISK ESTIMATION

Early analyses found a very low risk of addiction secondary to prescribed opioids. For example, a study published in 1980 documented only four cases of addiction out of 11,882 patients receiving narcotics (4). A heavily cited Cochrane review confirmed the earlier low estimates of risk, finding that "signs of opioid addiction were reported in 0.27% of participants in the studies that reported that outcome" (5). However, later meta-analyses have been at best ambiguous and at worst alarming about such rates. Minozzi et al. (6) found that the incidence of developing iatrogenic opioid dependence ranged from 0% to 24%, with a 0.5% median, while the prevalence ranged from 0% to 31%, with a median of 4.5%.

The majority of these studies have a number of weaknesses. First is inconsistent jargon. Terms such as "aberrant use," "abuse," "addiction," "dependence," "misuse," "nonmedical use," and "pseudoaddiction" are used as study measures, though often vaguely and with poor substantiation. This limits generalizability and interstudy aggregation. Also, clinical treatment trials are often for short durations (typically only 4–8 weeks), often exclude high-abuse risk patients, and employ lower daily doses than commonly seen in clinical practice, all potentially leading to underestimation of risk (7). Ultimately, even if the risk is low, the staggering number of opioids prescribed yields a significant number of patients developing iatrogenic addiction.

## RISK FACTORS

The majority of addiction risk studies have focused on chronic noncancer pain patients. The risk factors identified to date break down into characteristics of the patient, morbidity of the patient, and drug-related factors. A patient or family history of a substance use disorder correlates with increased risk of opioid misuse, as does being younger, white, and male. Greater risk is seen in those with greater pain experience and pain-related limitations. Psychiatric comorbidity such as depression or anxiety disorders, psychiatric outpatient visits, and psychotropic medication use are associated with increased risk of opioid misuse (8).

The risk of addiction to any drug is proportional to the duration of exposure; even low-risk patients treated with opioids for long periods of time have a high risk for developing dependence (9). Chronic pain patients receiving high daily doses (>120 mg of morphine-equiv-

alent doses) are at higher risk of misuse. Additionally, patients endorsing "craving" for their medications were significantly more likely to demonstrate aberrant drug behaviors and have abnormal urine toxicology screens (8).

There are at least 14 screening instruments for opioid risk assessment. The sensitivity of these screening tools for detecting aberrant use in chronic pain patients is variable, ranging from 70% to 90%, and none have been fully validated across a variety of settings and populations (9). The clinical utility of screening instruments may be limited, so knowledge and integration of the risk factors play crucial parts in assessing risk and formulating treatment plans.

## TRAINING

There is a remarkable discrepancy between the increased use of opioids and the comfort level of the prescribers and resident training. Studies of prescriber comfort have focused on primary care providers. In the United States, a plurality of opioid prescriptions are prescribed by general practitioners, family medicine physicians, and osteopaths (28.8%), followed by dentists (8%) and orthopedists (7.7%) (10). Notably, one survey of primary care providers found that 40% of respondents reported that their training preparation for chronic pain was "unsatisfactory," and 45.7% reported that their preparation for opioid dependence in practice was "unsatisfactory" (11).

This discomfort grows from the foundation often set during residency training. One study found that 57% of residents in primary care clinics rated their preparation for handling chronic nonmalignant pain as "fair" or "poor." They were also less likely to document relevant substance use

issues or order urine drug screens, further suggesting training deficiencies in appropriate chronic opioid management (12).

A dated but demonstrative review from 1985 of over 25,000 pages in 50 major textbooks of emergency medicine, medicine, pediatrics, and surgery found only 54 pages on the treatment of pain (13). To assess how much has changed in the last 30 years, the author of the current paper surveyed 12 recent texts in critical care, emergency medicine, medicine, obstetrics/gynecology, orthopedics, primary care, and surgery. In a total of more than 21,000 pages, only 30 pages provided discussion on opioid management of chronic pain, and 22 pages addressed opioid addiction. The vast majority of this information was found in medicine and primary care texts. The 9,000 pages from critical care, obstetrics/gynecology, orthopedics, and surgery had zero pages on opioids in chronic pain or opioid addiction. This additional review underscores the opinions of residents and practicing physicians about their limited preparation.

The training and preparedness of psychiatry residents on this topic is less studied. Limited data on the opioid prescribing habits of psychiatrists focus on buprenorphine and methadone. However, psychiatry is the only residency to have required addiction training (14). Further clinical training and board certification is available in addiction psychiatry, one of the few programs in graduate medical education with an explicit requirement to work with the chronic pain population (15).

However, this training does not necessarily translate into confidence in practice. For instance, 80.6% of general psychiatrists do not feel comfortable with office-based opioid treatment with buprenorphine (16). A potential consequence of the specialization of the addiction fellowship is a delegation of such care to the subspecialists. A survey found that 72% of addiction psychiatrists prescribed buprenorphine compared with only 4% of general psychiatrists (17).

## DISCUSSION

There is an unsettling escalation of opioid use in the United States, and prescribers clearly play a role. Stemming the rise in opioid addiction and fatalities requires better training of doctors. The specialties caring for the majority of chronic pain patients do not provide adequate training, while specialties dealing with acute and postprocedural pain provide next to none.

The role of psychiatrists in pain management is unclear, and the psychiatrist is often engaged later in the treatment course. Addiction is a behavioral health condition, and psychiatry plays an important role as a liaison to those who treat pain more routinely. It is imperative that psychiatrists help their peers appreciate the gravity of the opioid-prescribing problem, as well as the relative risk of and risk factors associated with iatrogenic opioid addiction. Psychiatrists should also improve their use of prescription monitoring programs in states where they are available. A small survey found that psychiatrists use prescription monitoring programs infrequently (18), potentially limiting coordination of care between multiple care providers and increasing the risk for prescribing hazardous concomitant medications (e.g., benzodiazepines). Identification of a patient with addiction history or high-addiction risk being treated with higher doses of controlled substances could prompt interpreter contact to alert others of the addiction concern and lead to safer, more coordinated care.

Every specialty that prescribes opioids must better train their residents in pretreatment risk stratification, the treatment of high-risk patients, and monitoring for aberrant use and behav-

iors (19). Risk reduction in high-risk patients includes tailoring of the strength and duration of prescriptions, integration of non-opioid therapies, and consistent use of prescription monitoring programs. For more comprehensive training recommendations, see Charlton (20).

Over-reliance on screening can potentially lead to sorting patients into groups—lack of vigilance for the “good patients” and hypo-analgesia for the “bad patients”—potentially pushing those in pain to seek relief from illicit sources. Risk stratification and screening tools are just that—tools. One cannot predict outcomes, good or bad, with certainty. However, this should not preclude assessment of known risk factors to inform clinical decisions.

Patients, institutions, and care team sympathy often put pressure on prescribers to provide pain relief. Effectively balancing adequate pain management against the hazards of addiction and misuse is the clinician's obligation. Improved education and training will enable opioid prescribers to more accurately assess the patient, make better informed clinical decisions, and ultimately practice in a way that promotes the patient's best long-term outcome.

Dr. Mathis is a fourth-year resident in the Department of Psychiatry, University of Arkansas for Medical Sciences, Little Rock, Ark.

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## KEY POINTS/CLINICAL PEARLS

- Rising mortality from opioid use parallels increased opioid prescribing.
- Estimated rates of iatrogenic opioid addiction are small but significant.
- There are well-characterized risk factors for iatrogenic opioid addiction.
- Physician training (from MD survey, resident survey, and textbook analysis) has not kept pace with opioid prescribing.

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## CALL FOR APPLICATIONS TO THE 2016 RESEARCH COLLOQUIUM FOR JUNIOR INVESTIGATORS

AMERICAN  
PSYCHIATRIC  
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**SUNDAY,  
MAY 15, 2016  
8:00a.m.–5:00p.m.  
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**Questions?**  
[colloquium@psych.org](mailto:colloquium@psych.org)

### ATTENTION PSYCHIATRIC RESIDENTS, FELLOWS, JUNIOR FACULTY

The Research Colloquium is accepting applications for the 2016 meeting in Atlanta, Georgia, held in conjunction with the annual meeting of the American Psychiatric Association. MDs who are senior residents, fellows, or junior faculty in psychiatry are eligible to apply.

Successful applicants will receive \$1,000 travel stipends to discuss their research in a small group setting with distinguished senior leaders in psychiatric research.

The Colloquium provides a one-day, immersive, research experience for junior investigators in the early phases of their training in psychiatry. It represents an important opportunity for mentorship, guidance, information on research career development and grantsmanship, and networking.

**Deadline: December 15, 2015**

Pre-application technical assistance is available.

Eligibility details and application packet: <http://psychiatry.org/psychiatrists/practice/research/research-colloquium>

# Sexual Sadism Disorder in Forensic Populations

R. Scott Johnson, M.D., J.D., L.L.M.  
Matthew R. Ayers, D.O.

“The healthy man does not torture others—generally it is the tortured who turn into torturers.”  
—Carl Jung

As the Marquis de Sade, incarcerated for his immoral and sadistic acts, sat rotting in Paris’s Bastille prison days before its storming during the French Revolution, he likely did not imagine that sexual sadism disorder would come to bear his name more than 200 years hence. Although “Liberté, Égalité, Fraternité” was a battle cry of the revolutionaries, this singular aristocrat believed in an altogether different type of liberté: a libertine lifestyle in which social norms and moral codes were utterly eschewed lest they interfere with one’s own carnal sensory pleasures. It is with this historical backdrop that we can best understand the origins of sexual sadism disorder, which the DSM-5 defines as follows:

Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors.

The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (1, p. 695)

This definition is not markedly different from that which appeared in the DSM-IV-TR.

Sadism, as described by the DSM-5, does not have a direct corollary in the ICD-10 Classification of Mental Health and Behavioral Disorders, a classification system that is endorsed by the World Health Organization and is used

by non-U.S. practitioners. The ICD-10 uses an umbrella category titled disorders of sexual preference, under which several subcategories can be found. Disorders of sexual preference are generally defined by the ICD-10 as follows:

The individual experiences recurrent sexual urges and fantasies involving unusual objects or activities.

The individual either acts on the urges or is markedly distressed by them.

The preference has been present for at least 6 months. (2, p. 244)

Sadomasochism exists as a subcategory of sexual preference disorder and is defined as “a preference for sexual activity that involves bondage or the infliction of pain and humiliation. This category should be used only if sadomasochistic activity is the most important source of stimulation or is necessary for sexual gratification” (2, p. 244). Interestingly, the ICD-10 definition does not take into account whether consent is given by one or more parties, and this failure to take consensual sex out of the realm of mental disorders has caused some to argue for the declassification of this psychological syndrome as an illness altogether (2).

Regardless of the definition used, the fact that some people seek out opportunities to inflict cruelty, while others utterly abhor it, suggests the existence of a variable that has thus far been largely overlooked in research on personality disorders (3). Presently, sadism is generally seen as either no more than a sexual fetish or as criminal behavior (4, 5). However, it is worth noting that an element of subclinical sadism, not rising to the level of a disorder per se, permeates

our culture. As an example, one need only think of the violence and at times intentional cruelty on display in mixed martial arts bouts, violent films, and video games with cruel content (6). Unfortunately, research to further our understanding of sadistic tendencies has been hampered by the ethical limitations inherent in studying sadism in the laboratory.

## RESEARCH FINDINGS

### Sadism in Forensic Contexts

For psychiatry residents, the most likely place to encounter a patient with a diagnosis of sexual sadism disorder would be in a forensic setting, either in a correctional institution or in a sexual disorder clinic where patients are mandated into treatment by the judicial system, often for crimes against minors. Interestingly, research in a prison setting examining the records of 51 incarcerated sexual offenders by looking at their offense and phallometric data showed few differences between those with a diagnosis of sexual sadism disorder and those without a diagnosis. Furthermore, it was the individuals in the non-sadist group who were the most deviant when differences were found to exist (7). Recent research examining a small group of minors who had committed the extremely rare crime of sexual homicide showed that of criminal recidivators, all three individuals who committed additional homicidal acts subsequent to their first sexual murder held diagnoses of sexual sadism disorder (8). In contrast, only one of the three recidivators in the non-sexual recidivator group even had mere traits of the disorder. Lastly, functional MRI research on sexual sadists suggests that they may have a heightened sensitivity to pain in comparison with nonsa-



distic sexual offenders (9), leading some to hypothesize that a sadist's behavior self-medicates this aberrant pain pathway (10).

### **Sexual Sadism Disorder vs. the “Dark Triad”**

Paulhus and Williams (11) identified a so-called “dark triad” of traits (psychopathy, narcissism, and Machiavellianism) that all share a tendency toward engaging in exploiting others in a callous manner. Recent research has suggested that sadists differ from individuals who possess dark triad traits in at least one particular way. While Machiavellians and individuals with psychopathy will hurt others when personal gain is at stake, and narcissists will generally do so only when their ego is threatened, only sadists have been shown to be willing to engage in repetitive, tiresome tasks solely to inflict pain on others where no personal gain is at stake (3).

### **Prevalence**

Prevalence rates for this condition appear to be extraordinarily low. In one study, not a single visit for sexual sadism was reported in an analysis of almost 500 million U.S. outpatient office visits (12). With regard to clinics that specifically treat paraphilic disorders, sexual sadism is the least common complaint of those with paraphilia, with a prevalence between 2% and 6% (13–16). With an eye toward avoiding overdiagnosis, some in the field have urged caution among practitioners lest they incorrectly apply a sexual sadism disorder diagnosis to fetishists who engage in sadistic acts with consensual partners (17), since the consensual nature of the act precludes it from meeting DSM-5 criteria.

### **Diagnostic Reliability:**

#### **Sexual Sadism vs. Rape**

Research has reported 90% diagnostic reliability with regard to sexual sadism (18). However, both sexual sadists and rapists humiliate, harm, and control their victims, which can cause an inexperienced psychiatrist to diagnose the latter with a paraphilia when they are merely a criminal. Therefore, it is worth noting that the DSM criteria for sexual sadism disorder calls for the diagnosing

### **KEY POINTS/CLINICAL PEARLS**

- Sexual sadism disorder is most likely to be diagnosed in forensic and correctional settings.
- Sexual sadists and rapists are not synonymous, as the sadist repeatedly fantasizes about the physical or psychological suffering of others.
- In order to qualify a sexual sadist for a diagnosis of sexual sadism disorder, the sexually sadistic behavior cannot solely involve consenting individuals willingly submitting to the pain/humiliation.

psychiatrist to infer the perpetrator's motivation, with the key distinction between the two conditions being that the sexual sadist requires the humiliation and harm of others as a necessary prerequisite for his or her own sexual excitation (14).

### **Female Sexual Sadists**

Research on a small group of female sexual sadists demonstrated that while they share many common traits with males, they differ in three distinct ways. First, they prefer to inflict psychological rather than physical pain. Second, they are far more likely to offend along with another co-perpetrator. Third, female acts of sexual sadism are more likely to occur within a pseudo-family unit created by the offender (19).

### **TREATMENT**

Residents should be aware that with regard to the medical treatment of sexual sadism disorder, selective serotonin reuptake inhibitors, cyproterone acetate, medroxyprogesterone acetate, and gonadotropin-releasing hormone agonists have been used. With regard to psychotherapy options, the extent to which treatments applied in forensic settings to incarcerated sexual sadists are effective remains controversial (20).

### **CONCLUSIONS**

It is important for residents rotating in forensic and correctional settings to be aware of this rare paraphilic disorder. Notably, rapists and sexual sadists are not synonymous, as only the latter requires pain for sexual gratification. Female sexual sadists have been shown to be distinct from their male counter-

parts, particularly with regard to their penchant for inflicting psychological rather than physical pain. Furthermore, emerging research appears to differentiate sexual sadists from individuals suffering from the dark triad of narcissism, psychopathy, and Machiavellianism, inasmuch as sadists are the only ones who will engage in work in order to inflict pain on others where no personal gain is at stake. Treatment options, particularly with regard to psychotherapeutic strategies, require additional refinement as yet. Further research is needed to better understand and diagnose this poorly understood patient population.

Dr. Johnson is a forensic psychiatry fellow at Massachusetts General Hospital/Harvard Medical School, Boston. Dr. Ayers is a second-year resident in the Department of Psychiatry at Baylor College of Medicine, Houston, Tex.

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# TEST YOUR KNOWLEDGE

## TEST YOUR KNOWLEDGE HAS MOVED

Our Test Your Knowledge feature, in preparation for the PRITE and ABPN Board examinations, has moved to our Twitter ([www.twitter.com/AJP\\_ResJournal](http://www.twitter.com/AJP_ResJournal)) and Facebook ([www.facebook.com/AJPResidents-Journal](http://www.facebook.com/AJPResidents-Journal)) pages.

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 for their questions.

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 to Katherine Pier, Senior Deputy Editor ([katherine.pier@mssm.edu](mailto:katherine.pier@mssm.edu)).*

# Treatment-Emergent Mania After Initiation of St. John's Wort

Shayna Carp, M.D.  
Matisyahu Shulman, M.D.

Herbal supplements and vitamins have become increasingly popular with the general public. Surveys have reported that 17.7% of adults in the United States use non-vitamin, non-mineral natural products (1). Many of these bioactive substances have poorly understood effects and unpredictable results (2). Of particular interest in the present case report is St. John's wort (*Hypericum perforatum* L.). St. John's wort has long been used as an herbal alternative to treating depression and various mood disorders (1). A Cochrane meta-analysis demonstrated that St. John's wort appears to be as effective as popularly used serotonin reuptake inhibitors, although there was some discrepancy in effect size based on the country in which the studies were conducted (3). The efficacy of St. John's wort in improving depressive symptoms is likely due to upregulation of 5-HT<sub>1A</sub> and 5-HT<sub>2A</sub> receptors in the brain, along with the active compound direct affinity for GABA and serotonin receptors (3, 4).

St. John's wort has been reported to be as well tolerated as, with a side-effect profile similar or superior to, traditional selective serotonin reuptake inhibitors (3). The most significant clinical concern in the use of St. John's wort is its many interactions with the metabolism of other medications due to its effects on the C-P450 systems (3, 5, 6).

Although generally well tolerated in clinical trials, case reports have suggested a potential link between the use of St. John's wort and psychiatric adverse events, including mania, psychosis, and anxiety (3). Clinicians must be aware of these issues when advising patients regarding this supplement, especially in light of lax regulation of safety

labeling on many widely available St. John's wort products (2, 7). The present case report focuses on a 23-year-old male patient with no past psychiatric history who presented with a first manic episode after starting a daily regimen of St. John's wort several weeks prior.

## CASE

"Mr. L" is a 23-year-old man who presented to the emergency department with "erratic behavior," as described by his mother. He carried a diagnosis of autism spectrum disorder since early childhood but never received formal psychiatric treatment, since he was high functioning and attended regular school. He was now in college and working part time. He had never had behavioral disturbances and had never seen a psychiatrist before the presenting illness. His medical history was significant only for mild asthma, for which he did not take any medication.

The patient reported a history of intermittently low mood. Four weeks prior to presentation, he began a regimen of St. John's wort and felt a significant improvement in mood. He described increased productivity and exercise and endorsed feeling rested with "definitely less" sleep than he used to need. He pursued new activities, including bike rides beginning at 2:00 a.m. in order to "get [his] health on track," and he expressed particular concern about food labels and spent hundreds of dollars on herbal supplements online. His change in mood was also notable for increased irritability. On one occasion, he broke a television with a golf club following a trivial argument with his mother. He stated that recently these episodes of frustra-

tion were occurring more frequently. He denied any use of alcohol, marijuana, illicit drugs, or cigarettes.

On admission to the hospital, his mental status examination was significant for manic symptoms, including pressured, overinclusive speech and dominating conversation. His thoughts were disorganized and tangential, and he reported plans to improve his health and to help all the other patients on the unit recover. His affect was blunted with normal psychomotor activity throughout the interview.

The patient was started on risperidone (1 mg q.h.s.). During his admission, he exhibited good behavioral control but demonstrated poor insight and eventually was unwilling to increase his medication dose. He denied any side effects or alterations in his mood, movement, or sleep habits while taking the medication. During his hospitalization, his behavioral control and distractibility improved. His speech became less pressured, and he denied feeling increased productivity or goal-directed activity. He continued to exhibit poor insight as demonstrated by his statements of confusion regarding the reason for his admission, why his behavior prior to admission was concerning, and the purpose of the medications. Because his behavioral control and manic symptoms were improved, he was discharged home to the care of his mother after 5 days on the inpatient unit. At the time of discharge, he was instructed to discontinue use of all herbal supplements and continue risperidone as an outpatient.

After the patient's discharge, risperidone was increased to 2 mg (q.h.s.) by his outpatient provider. Shortly thereafter, the patient discontinued risperi-

## KEY POINTS/CLINICAL PEARLS

- St. John's wort, a widely available supplement, has long been used as an herbal alternative to treating depression and various mood disorders and has shown similar effect size to selective serotonin reuptake inhibitors.
- St. John's wort has been reported to be well tolerated but has many drug interactions and may also trigger manic symptoms in some patients.
- Clinicians must be aware of these issues when advising patients regarding this supplement, especially in light of lax regulation of safety labeling on many widely available St. John's wort products.

done because he felt that he did not need it and was subsequently readmitted to the inpatient unit a few months later for continued behavioral disturbances after he elected to restart herbal supplements (although he did not report use of St. John's wort).

## DISCUSSION

The emergence of manic symptoms soon after the initiation of St. John's wort in this case raised concern that these symptoms may have been triggered by the herbal supplement. A literature review revealed several previous reports of similar cases (8). In accordance with the Karch and Lasagna criteria for adverse drug events, this case would be defined as a possible interaction because of the temporal relationship and the existence of previously reported cases (3).

At least six cases of treatment-emergent mania have been reported in relation to use of St. John's wort. Moses and Mallinger (9) reported three cases of suspected induced mania secondary to use of St. John's wort for mild depression. All three cases were patients over age 50 with previous psychiatric histories. Joshi and Faubion (8) reviewed a series of case reports involving suspected mania and psychosis in patients taking St. John's wort.

While a definitive consensus regarding risk factors that predict which patients will experience treatment-emergent affective switch has not been reached, several studies have shown an association between antidepressant medication and treatment-emergent affective switch in bipolar disorder (10). Antidepressants that target serotonergic, noradrenergic, and dopaminergic systems have been associated with increased risk of treatment-emergent affective switch. Modulation of these neurotransmitter systems to generate increased catecholamine levels may lead to delayed postsynaptic receptor desensitization and thus increased receptor responsiveness. Some of these changes have been noted to occur in the prefrontal areas, which could explain their association with manic behaviors (4).

Although it is impossible to conclusively determine causality in a single case, the existence of several case reports of similar effects and the temporal relationship between the initiation of St. John's wort and the emergence of manic symptoms creates concern for a causal relationship between the supplement and mania. Clinicians should therefore routinely question patients regarding self-initiated use of herbal supplements. They should furthermore caution their patients, even those who deny using any

herbal supplements, regarding potential side effects and interactions these supplements may have with their current medications and medical conditions. Clinicians must also monitor patients reporting initiation of an herbal supplement for adverse effects or behaviors.

Dr. Carp is a first-year resident in emergency medicine at North Shore-LIJ Health System. Dr. Shulman is a fourth-year resident in the Department of Psychiatry, Zucker Hillside Hospital, Glen Oaks, N.Y.

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# Fifty Shrinks

Reviewed by Amir Adam Tarsha, M.S.

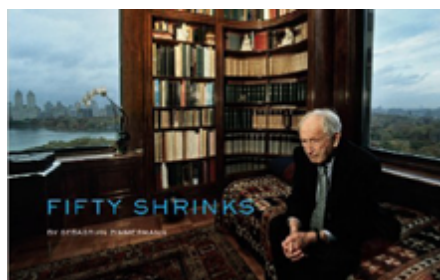
The modern medical student is ordered to memorize, to present, to serve, and, perhaps most daunting, to imagine.

Where do you see yourself in 10 years? What kind of doctor will you become?

While these are important questions, an even better one might be: What are you willing to feel? Most students can envision their future clinical routines; what may be more challenging to comprehend is the emotional weight of the profession they are about to enter. It is challenging for students to imagine what doctoring feels like day in and day out. They cannot know what they are willing and able to bear until it is too late. For students considering a career in the particularly draining field of psychiatry, an understanding of the emotional life of psychiatry's practitioners is critical.

This information is not easily gathered from career-advising fairs, personality tests, and online tools. Fortunately another, arguably superior, career-advising resource is available to students: candid physician narratives.

*Fifty Shrinks*, by Sebastian Zimmermann, M.D., is a terrific source of insight for budding psychiatrists. Readers of the book are treated to poignant stories from 50 psychiatrists and psychotherapists. The pages also contain stunning photographs of the therapists in their work offices—each office vastly different



By Sebastian Zimmermann  
New York, Sebastian Zimmermann, 2014,  
120 pp., \$90.00.

from the next—some purposefully minimalist, others filled with strange trinkets (that, like nesting dolls, surely contain their own layered narratives within them). The juxtaposition of their stories and the place where the story occurred provides a powerful narrative gestalt. The text alone is certainly affecting, but combined with photographic context, the narrative concepts are reified. While the portraits work to humanize the text within the book, it is still the words that will make *Fifty Shrinks* valuable to burgeoning psychotherapists. Zimmermann and the therapists should be applauded for broaching difficult, sometimes traumatic subject matter, including their own fears and doubts. It would have been easier for Zimmermann to print a simple coffee table book, with therapists sipping tea in their quirky offices. Instead, he raises questions that are not

just relevant to psychiatry, but to the human condition as a whole. The therapists' narratives are so compelling that sometimes the reader may find her or himself wishing *Fifty Shrinks* spent more time with each of them—even if it meant profiling half as many psychiatrists.

In the beginning pages of the book, a therapist is contemplating the burden of her commitment to the mentally ill. Borrowing from the poet Rilke, she asks, "Is there one whose gentle hands hold up all of this falling? .... for some, the analyst ... is the one who can hold up all of this falling" (p. 14).

Later in the book, a therapist recounts the story of returning to work after her son was killed. She discusses the challenge of preventing her private emotions from interfering with her practice. Throughout the book, therapists discuss their own psychopathology and the coping mechanisms they have found useful.

In this way, Zimmerman succeeds in giving aspiring psychiatrists a peak into the reality of psychotherapy. As an aspiring psychiatrist myself, Zimmerman had me reconsidering what it means to live and work as a psychiatrist. Halfway through the book, I found myself asking: Is this what I'm going to feel?

Amir Adam Tarsha is a fourth-year medical student at the University of Miami Miller School of Medicine, Miami.

# 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 Hun Millard, M.D., M.A., Deputy Editor (hun.millard@yale.edu).*

## NOVEMBER DEADLINE

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
Research Colloquium for Junior Investigators  <b>Deadline: November 30, 2015</b>	APA	The colloquium provides guidance, mentorship and encouragement to young investigators in the early phases of their training. Held during the APA Annual Meeting.	<ul style="list-style-type: none"> <li>• Psychiatrists who are senior residents, fellows or junior faculty;</li> <li>• MD degree or be a member of the APA or eligible to become a member of the APA; • Must be receiving their training in the U.S. or Canada</li> </ul>	Sejal Patel, 703-907-8579, colloquium@psych.org	<a href="http://apa-psych.prod.psychiatry.org/researchers/research-training-and-career-distinction-awards/research-colloquium-for-junior-investigators">http://apa-psych.prod.psychiatry.org/researchers/research-training-and-career-distinction-awards/research-colloquium-for-junior-investigators</a>

## DECEMBER DEADLINES

Fellowship/Award and Deadline	Organization	Brief Description	Eligibility	Contact	Website
Association for the Advancement of Philosophy and Psychiatry (AAPP) Karl Jaspers Award  <b>Deadline: December 1, 2015</b>	AAPP	This award is given for the best solely authored, unpublished paper related to the subject of philosophy and psychiatry. Appropriate topics for the essay include, among others, the mind-body problem, psychiatric methodology, nosology and diagnostic issues, epistemology, biopsychosocial integration, the philosophy of science, philosophical aspects of the history of psychiatry, psychodynamic, hermeneutic and phenomenological approaches, and psychiatric ethics.	Resident or fellow in psychiatry, graduate students and post-doctoral students in philosophy, psychology or related fields	Christian Perring: cperring@yahoo.com	<a href="http://philosophyandpsychiatry.org/jaspers-award/">http://philosophyandpsychiatry.org/jaspers-award/</a>
Resident Research Award  <b>Deadline: December 1, 2015</b>	Eli Lilly	These awards provide an honorarium to residents who submit the best, original, unpublished scientific research paper in any area of psychiatry.	Residents or fellows in an accredited psychiatry training program in the U.S. or Canada at the time of application	Alison Bondurant: telephone: 703-907-8639, or e-mail: residentresearch@psych.org	<a href="http://apa-psych.prod.psychiatry.org/researchers/research-training-and-career-distinction-awards/resident-research-award">http://apa-psych.prod.psychiatry.org/researchers/research-training-and-career-distinction-awards/resident-research-award</a>
APA Public Psychiatry Fellowship  <b>Deadline: December 12, 2015</b>	APA	This 2-year fellowship provides experiences that will contribute to the professional development of residents who will play future leadership roles within the public sector psychiatry and heighten awareness of the public psychiatry activities and career opportunities.	<ul style="list-style-type: none"> <li>• APA member or in the process of becoming a member; • PGY2 or PGY3 resident or fellow in a psychiatric training program</li> </ul>	Alison Bondurant: telephone: 703-907-8639	<a href="http://apa-psych.prod.psychiatry.org/residents/fellowships-awards/fellowship-in-public-psychiatry">http://apa-psych.prod.psychiatry.org/residents/fellowships-awards/fellowship-in-public-psychiatry</a>
APA Child & Adolescent Psychiatry Fellowship  <b>Deadline: December 15, 2015</b>	APA	Designed to promote interest among general psychiatry residents in pursuing careers in child and adolescent psychiatry. Fellows will learn about new clinical research, successful treatments for children and adolescents with mental disorders, and many other issues associated with child and adolescent mental health.	<ul style="list-style-type: none"> <li>• APA resident or fellow member; • PGY-1, PGY-2, or PGY-3 resident;</li> <li>• Approval from residency training director or department chair</li> </ul>	kids@psych.org	<a href="http://www.americanpsychiatricfoundation.org/get-involved/fellowships/child-and-adolescent-psychiatry-fellowship">http://www.americanpsychiatricfoundation.org/get-involved/fellowships/child-and-adolescent-psychiatry-fellowship</a>
Jeanne Spurlock, MD Congressional Fellowship  <b>Deadline: December 19, 2015</b>	APA	This fellowship provides all psychiatry residents, fellows, and early-career psychiatrists an opportunity to work in a congressional office on federal health policy, particularly policy related to child and/or minority issues.	<ul style="list-style-type: none"> <li>• APA members and U.S. citizens or permanent residents; • Psychiatry residents, fellows, and early-career psychiatrists</li> </ul>	N/A	<a href="http://apa-psych.prod.psychiatry.org/practice/professional-interests/diversity/awards-and-fellowships/minority-fellowships/jeanne-spurlock-congressional-fellowship">http://apa-psych.prod.psychiatry.org/practice/professional-interests/diversity/awards-and-fellowships/minority-fellowships/jeanne-spurlock-congressional-fellowship</a>

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

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- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
- 3. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice

questions based on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.

- 4. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 5. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 6. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This

article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.

- 7. Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3-4 teaching points.
- 8. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 9. Book Review:** Limited to 500 words and 3 references.

**Abstracts:** Articles should not include an abstract.

## Upcoming Themes

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

### Integrated Care/ Mental Health Care Delivery

If you have a submission related to this theme, contact the Section Editor  
Connie Lee, M.D.  
([Connie.Lee@ucsf.edu](mailto:Connie.Lee@ucsf.edu))

### Psychiatry, Ethics, and the Law

If you have a submission related to this theme, contact the Section Editor  
Jennifer Harris, M.D.  
([Jennifer.Harris@utsouthwestern.edu](mailto:Jennifer.Harris@utsouthwestern.edu))

### Addiction Psychiatry

If you have a submission related to this theme, contact the Section Editor  
Rachel Katz, M.D.  
([rachel.katz@yale.edu](mailto:rachel.katz@yale.edu))

\*If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Rajiv Radhakrishnan, M.B.B.S., M.D., Editor-in-Chief ([rajiv.radhakrishnan@yale.edu](mailto:rajiv.radhakrishnan@yale.edu)).