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Inside

EDITORIAL

Conceptualizing Psychiatric Disorders in a Historical Framework: The Twentieth and Twenty-First Centuries

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> "The twentieth century will be remembered as a century marked by violence. It burdens us with its legacy of mass destruction, of violence inflicted on a scale never seen and never possible before in human history. But this legacy—the result of new technology in the service of ideologies of hate—is not the only one we carry, nor that we must face up to. Less visible, but even more widespread, is the legacy of day-to-day, individual suffering." (1, p. ix)
> —Nelson Mandela

The 20th century marks a time of scientific development: from the invention of the radio and television to the creation of the computer and the atomic bomb, from the discovery of the double helix structure of DNA by Watson and Crick to the creation of animal clones and artificial nucleotides. New knowledge during this time gave rise to unique considerations and responsibilities about war, power, and mankind. More importantly, as Nelson Mandela emphasizes in the above quote, these changes are reflected through their effects on the human mind and brain.

The traumatic effects of war and terror on human beings have long been known. According to psychologist Edward Tick, posttraumatic stress disorder, or PTSD, has acquired more than 80 names over the years (2). During the Civil War, the internist Da Costa noted that many veterans suffered from shortness of breath, anxiety, and chest pain, and he named the syndrome "irritable heart." It was not until the 20th century that these concerns heightened. Following World War I, the term "shell shock" arose, and following World War II, it evolved into the phrase "war neurosis" (2). In 1980, PTSD became an official diagnosis when the American Psychiatric Association added it to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (3). This addition marked a change in the conceptualization of the disease, as the etiological agent was placed outside the individual (a traumatic event) rather than seen as an inherent, individual weakness (a form of traumatic neurosis). Decades later, we continue to realize this disorder's impact on individuals' lives (4).

Effects of war and terror on psychiatric health are manifested in numerous psychiatric consequences that befall people who endure these events.

Effects of war and terror on psychiatric health are manifested in numerous psychiatric consequences that befall people who endure these events. PTSD is often comorbid with substance use, depression, anxiety, dissociative, and somatic symptom disorders. Attachment difficulties in children are common sequelae of war and terror (5, 6). The unknown and the unpredictable, which exist perpetually during times of war and terror, incite inner unrest that wreaks havoc on armed forces and civilians. These are the challenges of the 21st century.

Numerous novelists and journalists have written about the hardship and suffering of populations during wars. Media, as well, continues to flood with stories of trauma. It is our responsibility, as psychiatrists, to endeavor to understand the lasting effects on the mind and brain. The objective of this issue of the *Residents' Journal* is to provide greater awareness and understanding of the impact that war, terror, unrest, and psychopathology have on individuals and their communities.

Dr. Kim is a third-year resident in the Department of Psychiatry, Mount Sinai Hospital, New York, as well as the new Deputy Editor of the *Residents' Journal* and Guest Editor for this issue.

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ARTICLE

War and Children

Michelle Liu, M.D.

Over one billion children worldwide inhabit countries or territories torn apart by armed conflict, war, or terrorism (1), principally in lower- and middle-income countries where 90% of the world's children and adolescents live (2). Armed conflict can last throughout an entire childhood, such as in Liberia where civil war caused widespread trauma from 1989 to 2004 (3). The effects of war extend beyond isolated areas of crisis: in 2016, the United Nations High Commission on Refugees reported that 59.5 million people worldwide were forcibly displaced, and over half of these were children under the age of 18 (4).

The present review provides an overview of research on the psychological impact of war and conflict on children, including the types of mental disorders that arise following war trauma; differences in the type of exposure, individual traits, and environmental characteristics that increase risk for mental disorders; and interventions to minimize psychological harm following exposure to war and conflict.

PREVALENCE OF MENTAL DISORDERS FOLLOWING CONFLICT

Children exposed to war manifest a higher rate of mental disorders compared with children in the general population (5), although prevalence data are inconsistent and likely depend on the nature of the trauma, the duration of exposure, diagnostic criteria used, and cultural discrepancies (6). The distress of a child following trauma may be overlooked due to children's difficulties communicating or articulating their experiences (7). Adults tend to underestimate the posttraumatic stress reactions of their children, and their initial response to the effects of trauma on their children may be denial (8). While it was previously believed that children did not understand or remember traumatic occurrences, there is now increasing awareness that children are very vulnerable to the stresses of war and terrorism.

CHILDHOOD ADVERSE EXPERIENCES

The negative long-term effects of childhood trauma or adverse childhood experiences on physical and mental health are well established in the literature (4). Childhood adversity, commonly experienced as child abuse, neglect, and/or household dysfunction has been linked to increased risk for various long-term chronic illnesses. It increases the risk for depression 4.5-fold and suicide attempts 12.2-fold (7). Childhood adversity may increase impulsive behaviors, reward orientation, and unhealthy lifestyle choices (4). Epigenetic changes, posttranslational modification, and an unregulated inflammatory response may accompany the behavioral and cognitive response to childhood trauma (4). Exposure to war or terrorism increases a child's risk for both medical and psychiatric disorders in adult life.

PSYCHIATRIC DISORDERS FOLLOWING TRAUMA

The past two decades have marked increasing interest in the psychological impact of war on children (9). The relationship between exposure to war trauma and development of acute stress disorder and posttraumatic stress disorder (PTSD) is well documented in the literature (1, 3, 6, 9, 10). Children may experience acute PTSD, with hyperarousal, re-experiencing, and sleep disruption, or chronic PTSD, characterized by dissociation, restricted affect, sadness, and detachment (6). Exposure to trauma increases both internalizing and externalizing reactions in children. Internalizing reactions, such as depression, suicidal thoughts, worry, and anxiety were prevalent among Liberian youths exposed to armed conflict (3) and in a study of 300 Syrian refugee children in Turkey (1). These Syrian refugee children who had been exposed to war commonly exhibited anxiety and excessive fears, manifested by dependent behavior, clinging to parents, and fear of being left alone or sleeping in the dark (1). After 9/11, 15% of New York City school children surveyed had developed symptoms of agoraphobia, 12% developed separation anxiety, 10% developed generalized anxiety, and 9% developed panic attacks (8). Externalizing behaviors, such as delinquency, bullying, and drug and alcohol use, also appear to increase after trauma (7).

RISK AND PROTECTIVE FACTORS MEDIATING TRAUMA

Characteristics of the Trauma

Traumatic exposure can be direct or indirect. Direct exposure occurs when a child has personal experience with a traumatic incident, such as living in a conflict zone or experiencing the death of a parent. Conversely, indirect exposure occurs through television, the Internet, or hearing others talk about a traumatic event. Indirect exposure through media can also produce significant distress. Following the 9/11 attacks and the Oklahoma City bombing, children who watched more television coverage of the traumatic events experienced more posttraumatic stress symptoms (8, 11). War and conflict are often accompanied by changes to a child's environment; for example, a child may experience the closing of his or her school after destruction of infrastructure or financial hardship after loss of family members (12).

When children are exposed to war and conflict directly, the number of conflict-related traumatic events (11), the duration of the threat (13), and the severity and nature of the threat mediate psychological outcomes and distress. Severe reactions occur when there is threat to the child's life and/or physical harm (1, 13), as well as in cases of death of a parent or loss of social support (14).

Children's Individual Risk and Protective Factors

Many children demonstrate incredible resilience, and recovery is the expected outcome of acute stress responses for most children (13). However, when traumatic exposure has lasting effects on a child, individual differences mediate these effects. A child's developmental stage affects his or her reaction to trauma, and reactions range from regressive behaviors in younger children (15) to problems at school, nightmares, and substance use in older children and adolescents (1, 14).

Individual genetic vulnerabilities also play a role in response to trauma. Maternal anxiety and depression levels are correlated with the child's levels (11), and severity of PTSD in fathers has been linked to that in children (6). Protective factors include religion (correlated with fewer PTSD symptoms) (11), emotional regulation, self-control, problem-solving skills, and a close relationship with caregivers (1).

Characteristics of the Environment

Conflict and war may damage a child's environment and subsequently impair a child's ability to recover from a traumatic event. For example, the 1989–2004 Liberian civil war damaged infrastructure such as schools and health services, which impaired Liberia's ability to treat injuries or address concerns (3). Children who have access to more resources (e.g., higher socioeconomic status and quality education) tend to fare better after trauma (1).

Conflict and terrorism may have devastating effects on individual families, through the loss of family members or disruption in household routines (1). Moreover, children may lose parental support, parenting styles may change, and negative parental expressions increase levels of distress in children (8). Following a traumatic event, parenting style can mediate a child's reaction to stress; punitive parenting styles are associated with less resilient attitudes in children (11), while a parent who provides emotional support, encourages self-esteem, and answers questions directly may minimize the effects of trauma (6, 8).

KEY POINTS/CLINICAL PEARLS

- Exposure to war and terrorism is linked to posttraumatic stress disorder, depression, anxiety, externalizing behaviors, and many other psychological sequelae in children and adolescents.
- The severity and nature of the traumatic exposure, the individual characteristics of the child, and the stability of the child's environment may mediate the effects of traumatic exposure.
- Interventions should focus on promoting resiliency at a community-level, identifying at-risk children and families, and mental health treatment for those children or families in distress.
- A child's relationship with caregivers is crucial to recovery from a traumatic event; following trauma, efforts should be made to reunite families.

INTERVENTIONS

The devastating effects of war and terrorism call for a "multilayered" approach to supporting communities, families, and individuals. Following a traumatic event such as 9/11, the first interventions should target communities to promote safety, self- and community efficacy, connectedness, and hope (1). Priority should be given to reunite families (12) and restore infrastructure. Schools should have emergency plans. First responders, such as police, firefighters, medical personnel, and teachers, should be trained regarding the effects of trauma on children and effective communication regarding traumatic events (13).

The literature supports using community-wide screening to identify children and families at high risk for trauma-related psychological distress. Children whose lives are personally disrupted by trauma, such as those who have witnessed family members killed and/or had their homes demolished and/or have become orphaned or live in distressed families, are particularly vulnerable (10). Because adults often have difficulty recognizing children in distress, children with the greatest need may go unrecognized, making screening essential (16). Screening and aid may be delivered in clinic or school settings; schools are readily accessible, may help normalize the experience, and reduce stigma about mental health care (16).

Finally, children and families who manifest psychiatric symptoms will benefit from mental health care. While research supports the use of psychotherapy, there is limited information on specific pharmacologic interventions for psychiatric disorders related to war trauma. Trauma-focused cognitive-behavioral therapy, in combination with resilience-based and symptom-based techniques that can take advantage of the child's social network, may be particularly helpful (10).

CONCLUSIONS

The literature examining the effects of war and terror on children shows significant levels of psychological distress and psychiatric problems following exposure to conflict. Internalizing disorders such as PTSD, depression, and anxiety, as well as externalizing behaviors, are prevalent following exposure to war and terrorism. Future research should investigate interventions to reduce a child's distress and improve resiliency in the setting of war and terrorism.

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ARTICLE

The Role of Psychiatrists in the Growing Migrant and Refugee Crises

Nikhil "Sunny" A. Patel, M.D., M.P.H., M.S., Nina Sreshta, M.D.

Psychiatrists have a responsibility to protect the well-being of our patients; this duty is particularly salient when human rights are at stake. We advocate that one important way psychiatrists can be involved in protecting the rights of vulnerable people is through assisting in legal proceedings in asylum cases.

MIGRATION IN LIMBO

Since 1975, the United States has been a world leader in refugee resettlement, welcoming over 3 million refugees (1). Within a week of his inauguration, President Trump enacted draconian border controls. The President's Executive Order suspended the U.S. Refugee Admission Program, barred entry to citizens from seven predominantly Muslim countries, and barred entry to Syrian refugees indefinitely. Protests at U.S. airports and cities erupted immediately, and lawyers across the country filed lawsuits challenging these restrictions.

There is historical precedence for barring certain ethnic groups from entering the United States. The Immigration Act of 1882 placed a 10-year ban on Chinese laborers; of note to psychiatrists, this same law also placed a permanent ban on "any convict, lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge" (2). In 1924, a formalized quota system based on national heritage was enacted that excluded nearly all nonwhite immigration.

It was not until the Immigration and Nationality Act of 1965 that this system of race and nationality quotas was abolished, broadly opening the country to immigration from the rest of the world. Neither of the two authors of the present article, both of whom are from South Asia, would be here without this 1965 law. President Trump's Executive Order, banning entry based on nationality, arguably violates the Immigration and Nationality Act and is certainly contrary to its spirit. In this way, the order recalls discrimination and exclusion not seen in this country in half a century.

PSYCHIATRISTS AND ASYLUM EVALUATIONS

The United States is party to international treaties that protect the rights of refugees, such as the 1967 Protocol Relating to the Status of Refugees; such commitments were operationalized in the United States Refugee Act of 1980. This created a system for resettlement of refugees, and asylum status was given to individuals who were already present in the United States and would be considered refugees by international law.

As of 2015, one of every 122 persons worldwide is a refugee, internally displaced person, or asylum seeker (3). Once in the United States, asylum seekers must demonstrate that they are unable or unwilling to return to their country of origin because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (4).

The adjudicator (asylum officers or immigration judge) assesses the asylum seeker's credibility, which is critical to the outcome of the case. According to the USCIS Adjudicator's Field Manual and the REAL ID Act of 2005, credibility is defined as "involving a witness' trustworthiness and believability" and "demeanor, candor, or responsiveness" (5, 6). The law mandates accurate reporting of even minor details and inconsistencies, and failure to do so can be the basis for removal. This standard for assessing credibility can pose unique problems for those who are victims of psychological trauma.

Refugees and asylum seekers almost always have significant trauma exposure and thus are at high risk for posttraumatic stress disorder (PTSD). Several studies have estimated the rates of PTSD to be 28%–36% among the asylum-seeking population (7, 8). Symptoms of PTSD, such as disordered memory, numbness, and reduced responsiveness to the outside world, can make it difficult for asylum seekers to be granted legal status.

Psychiatrists can play an important role in asylum proceedings. In particular, immigration courts often rely on psychiatric evaluation and testimony to help assess the veracity of the asylum seeker's claims. As expert witnesses, we can provide context and corroboration for an asylum seeker's trauma and thus reinforce the credibility of the asylum seeker, as well as explain how mental illness affects behaviors, possess the ability to talk about the trauma, and comment on overall demeanor.

Over the last 8 years, psychiatry residents at the Cambridge Health Alliance have participated in conducting approximately 70 pro bono psychological assessments for people seeking asylum through the staff psychiatrist-supervised Cambridge Health Alliance Asylum Clinic. Psychiatry trainees participating in the clinic perform psychological evaluation, prepare legal affidavits to the court, and observe staff psychiatrists testify on the client's behalf.

Our experience working with asylum seekers has been illuminating in a number of ways. First, we have seen the power of the psychological assessment

in asylum proceedings; asylum seekers who have a medical or psychiatric evaluation and testimony on their behalf have much higher rates of being granted asylum (9). Secondly, the psychological asylum interview is unlike clinical therapeutic work, as the goal is not therapeutic, but rather as experts, we observe and report traumatic history and psychological findings objectively. Given the need to ascertain such information, the traumatic history must be elicited. Therefore, the client may disclose harrowing details of torture and persecution that are rarely seen in a typical psychiatric setting. Coming so close to the human atrocities, terror, strength, and resilience of asylum seekers is a truly unique experience and window into the abject suffering they endure before coming to America.

RE-EXAMINING OUR ROLE IN THE ASYLUM PROCESS

Our work on asylum applications has also revealed serious problems in the asylum process, as well as the role of the psychiatrist in this process. Asylum seekers are trapped in the iron cage of Weberian bureaucracies that comprise the immigration system in the United States; it can take years for cases to be adjudicated. There is currently a backlog of more than half a million cases, and immigration courts are unable to deliver timely decisions to people seeking refuge (10).

While the outcome of this work is often satisfying, as the entire life trajectory of an individual may be altered as a result of asylum status being granted (or not) by the courts, the involvement in the process makes us privy to the shortcomings of the process. One shortcoming is the court's reliance on our diagnoses regarding psychopathology; as a result, we are tasked to find labels of disorders that help legitimize patients' claims. Asylum seekers are not entitled to an attorney, and those who are unable to afford one or unable to secure an attorney pro bono are severely disadvantaged against the U.S. government's attorney. Therefore, representation and access to the psychological evaluation is a privilege that many severely marginalized people do not have.

Given that certain experiences are more likely to cause traumatic sequelae, the role of the psychiatrist can realign into truly thinking preventatively. Political and sexual violence, social marginalization, and deprivation have proven to contribute to psychological sequelae. We therefore believe that psychiatrists ought to be involved in social policy to prevent downstream traumatic effects.

KEY POINTS/CLINICAL PEARLS

- Asylum seekers are at high risk for post-traumatic stress disorder (PTSD); several studies have estimated rates of PTSD to be 28%–36%.
- Psychological assessment greatly helps the odds that an individual will be granted asylum.
- Psychiatrists should reconceptualize their role to help safeguard human rights; one way to do this is through assisting in asylum legal proceedings.

BEYOND CULTURAL COMPETENCY: DEVELOPING HUMILITY

As trainees, there is a concerted effort to help cultivate cultural competency. The Substance Abuse and Mental Health Services Administration describes cultural competency as the "ability to interact effectively with people of different cultures" and that it "helps to ensure the needs of all community members are addressed" (11). Competency cannot be predicated on having knowledge of all cultures, as it would be impossible to be facile with the customs, worldview, and mores of all people one treats. We believe that language around competency should include humility (12). Tervalon and Murray-García (13) argue that humility helps ground one to "a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations." Cultivating humility is a more worthwhile pursuit, as the language of competency harkens an idea of fulfilling perfunctory criteria to master; however, the pursuit to deliver culturally attuned care is a constant one.

This matters because while as psychiatric evaluators we may not have gone through the trials and tribulations that asylum seekers have experienced, approaching their plight from the lens of humility helps us to more effectively advocate for them. One example is that cultural idioms of distress may not be neatly covered under our DSM-formulated construct of PTSD or other definitions of mental illness. Thus, we must allow space to consider a patient's phenotypic presentation without insisting that we adhere to such Western constructs.

RECONCEPTUALIZING OUR ROLE: SAFEGUARDING RIGHTS

Performing asylum evaluations should not be viewed as a charitable exercise in which we lend our professional expertise to aid legal proceedings, but rather a responsibility and moral obligation to advocate and speak out on behalf of the most vulnerable. We need to step out of the clinic and academic spaces and partake in the work in jails and detention centers. We ought to resist policies that harm people and families, whether they are wantonly discriminated against based on their country of origin, religion, sexual orientation, or gender identity. As doctors, we have distinct responsibilities as professionals; we also must not forget our responsibilities as human beings. By participating in the asylum process, we can advocate for and help those without the political agency to obtain a better life. Justice requires this of us.

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COMMENTARY

Steering the Helm of Posttraumatic Stress Disorder Diagnosis and Treatment

Bruce Bassi, M.D., M.S.

In 1980, *DSM-III* formally established a diagnosis of posttraumatic stress disorder (PTSD) for healthy individuals who developed chronic symptoms following a traumatic event (1). Previously, *DSM-I* and *II* included categories such as "gross stress reaction" and "transient situational disturbances," which acknowledged the acute effect of trauma (2, 3). But more importantly, the diagnosis of PTSD addressed a growing political and social issue: the recognition of individuals who had been largely stigmatized and previously ignored by the mental health field (4). The history of PTSD provides a good example of how the social context of a diagnosis can influence future data collection and treatment.

In the late 1970s, returning Vietnam veterans were recognized by psychiatrists to be "hurting and in need of psychological help." However, the military-government establishment led them to fear that "VA doctors are likely to interpret their rage at everything connected to the war as no more than their own individual problem" (5). To circumvent the notion that PTSD had political and philosophical origins, research shifted focus to the concept of a normative biological stress response, which served as a justifiable counterargument. Nonetheless, the conceptual underpinnings of PTSD, particularly the goal of treatment being to dampen the stress response, pervaded the approach to diagnosis and treatment for years to follow (4).

Initial biological studies of PTSD suggested the condition is analogous to fear conditioning responses in animals, which led to stress exposure therapy (consisting of controlled reminders of trauma) becoming firmly rooted as the standard of care. Likewise, pharmacotherapy aimed primarily to attenuate symptoms. While this approach benefitted some patients and had evidence-based support, it ignored a body of evidence that trauma survivors demonstrated hypersensitive neurobiology, which was not captured in the stress exposure model that emphasized a system overdrive (4). With the increase of PTSD symptoms in *DSM-5* from 17 to 20, it has allowed the criteria to be met in more than 600,000 ways, demonstrating that this broad phenotypic diversity necessitates the need for diversity in treatment approaches (6).

As treatment providers, we are often overly optimistic in our abilities to repair the damage, and we need to better explain ... that some things will never be the same after trauma.

A recent paper summarizing an expert panel discussion of PTSD, entitled "What I Have Changed My Mind About and Why," provides an insightful overview of how far we have come in starting to embrace "non-traditional" therapies (7). The authors describe a shift in framework from the old model of reducing the stress response to one of promoting adaptation and resilience. As treatment providers, we are often overly optimistic in our abilities to repair the damage, and we need to better explain to patients that some things will never be the same after trauma. As such, our job should not be solely to remove symptoms, suppress arousal, and blunt emotions, but to also focus our patients on their strengths and embrace mindfulness and healing through meaning (7). The article highlights how much social factors and stigma can affect diagnosis, research, and treatment. The history of PTSD is a good example of how adaptation is not only a recommended characteristic for patients, but a necessary one for providers.

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ARTS AND CULTURE

Unexpected Trauma

Samantha Swetter, M.D.

Going to work at the VA, I expected trauma. I prepared myself to hear harrowing stories of combat, the type of which nightmares are made. What I found was far different. Instead of hearing trauma that fits perfectly into the *DSM-5* definition of posttraumatic stress disorder (1), I found myself listening to patients tell traumatic stories of everyday occurrences. This made me think that perhaps in this population, my preconceived notion of binary trauma may not be helpful.

I wanted to understand this to be able to relate to my patients, so I went to someone with firsthand experience, my husband, who was deployed to Operation Iraqi Freedom as a private. I spoke to him about his service, his enrollment process, his training, and his deployment. Through his open reflection, I began to appreciate the profound gravity of signing a document that grants a disembodied entity control over your life. The strategic dismantling of your individuality through training, which starts with the multiday "processing." He explained "processing" to be a dehumanizing assembly-line patrolled by drill sergeants. He described the omnipresent understanding that you were a private, the lowest level in your new social hierarchy, and how those who worked in "the process" often treated you with little civility. All of this to be handed your new identity, your only distinguishing characteristic: "dog tags."

Through ... open reflection, I began to appreciate the profound gravity of signing a document that grants a disembodied entity control over your life.

He talked about Basic Training, where small infractions of one recruit would spiral into group punishments, creating constant fear of retribution. The helplessness of joining a cohort of people dissimilar from you as a teenager—a forced culture. The pain of separating from your family and the anxiety of not knowing when you would be able to talk to them again. He spoke of the stress of rapid deployment. The heartbreak of seeing your family ties weaken and unravel in your absence. And most importantly, the survivor's guilt, which makes your struggles pale in comparison to those with serious injuries or those who paid the ultimate sacrifice, leaving the implicit understanding that you need to "push through it," with festering emotional wounds.

Then you come home, expecting happiness, but instead find the need to reintegrate into your distanced family and a foreign civilian culture. And once again, you are expected to "push through it," with what is oftentimes little support. All of these microtraumas accumulating into the emotional weight of what it takes to become "an army of one."

These are the stories I found reflected in my patients. My patients who were now coming to the VA in hopes someone can understand and help them. And while I will never understand the sincere sacrifice they made by signing those papers, I hope that I can at least acknowledge the impact of these nonbinary traumas and help my patients do more than just "push through."

Dr. Swetter is Chief Resident in the Department of Psychiatry, Mount Sinai Hospital, New York.

REFERENCE

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC, American Psychiatric Publishing, 2013

ARTS AND CULTURE

Baton Rouge: The Summer of Turmoil, a Test of Strength

Carine Nzodom, M.D.

In the morning of July 5, 2016, Alton Sterling, a black man, was shot and killed by police in the parking lot of a convenience store in Baton Rouge. The entire country was shocked as images of the event were relayed by social media and broadcast on television. The shooting prompted protests in our state capital, and the streets were flooded with people singing, praying, and demanding justice.

Baton Rouge was beginning to recover when, on a Sunday morning less than 2 weeks later, I found the streets eerily quiet as I drove to work. I began to feel uneasy. Upon arrival at the hospital, I saw many police cars, and when I entered the building, I heard the announcement of a "code gray." I quickly learned that "code gray" is an alert for the potential of a combative person or other security emergency. Three law enforcement officers had been shot to death, and another three wounded that morning. The wounded were being treated at our hospital, and there was concern that the shooter might come to finish what he had started.

My patients in the ER were unusually anxious. Some were afraid of being hurt and others of being discharged. One patient told me, "They got it coming, I'm tired of them killing us." Another simply said she wished the violence would stop.

I tried to remain calm despite sensing the sadness, fear, and anger of those affected every time I walked the halls. I wondered if I should say, "I'm sorry," or if joining them in prayer would be appropriate. I wondered if there was anything I could say or do to provide them with some comfort. What I did instead was simply say "hello" as I walked by.

We human beings have the ability to come together when we are able to identify our commonalities.

Later that week, in a group to process feelings and concerns about violence in our city and country, one resident colleague expressed that he no longer felt safe going to gay bars with his husband since the shootings in Orlando. Another expressed her fears for the safety of her police officer husband, and another stated, "My husband is a big black guy; now he is even more anxious when he goes out." One faculty member expressed the belief that we should always carry guns for self-protection. I became more acutely aware of our shared vulnerabilities and of how complex the issues of race, gun violence, and police brutality are.

The floods came a month later. After days of unceasing downpour, the rivers in the area backed up to an unprecedented degree. An unbelievable 60,000 homes were lost, and thousands of businesses were underwater—and 13 lives were lost. August's natural disaster forced July's social disasters into the background as South Louisianans spontaneously and remarkably joined forces to save themselves and begin another recovery.

Through all of this, I struggled between balancing my personal feelings with my duty to provide my patients the best care. As an African-American woman, it is hard to ignore the issues of racial tension, especially when some of my patients expect me to take a stand. Instead, I continue to focus on each patient as an individual and work with my community to address social issues.

The community moved forward and tried to normalize. The leaves fell, and Thanksgiving came and went. The events of that summer made us stronger, hopefully. We looked forward to a peaceful winter.

Through our summer of turmoil, I learned to appreciate and admire my patients' resilience. I found that we human beings have the ability to come together when we are able to identify our commonalities. Now, more than ever before, I believe that strength is defined by one's ability to stand back up after a fall, not to remain standing.

Dr. Nzodom is a third-year resident in the Department of Psychiatry, Louisiana State University, Baton Rouge, La.

The author thanks her mentors, Drs. Kathleen Crapanzano, Travis Meadows, and Mark Zielinski, for their encouragement and editorial assistance.

BOOK FORUM

Rewriting the Narrative With Logotherapy: Review of *Man's Search for Meaning*

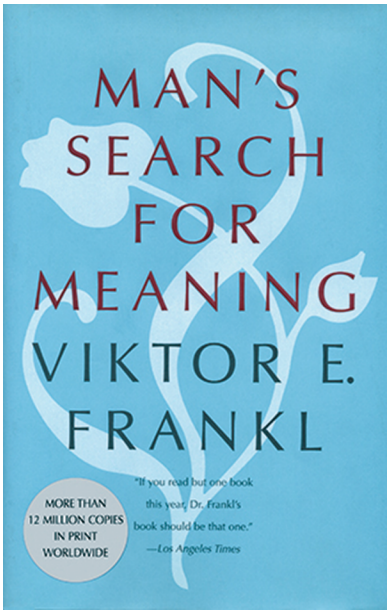
Matthew LaCasse, D.O.

Viktor E. Frankl (1905–1997), an Austrian psychiatrist, is best known for his contribution of logotherapy. His most famous book, *Man's Search for Meaning*, takes us through his torturous time spent in the concentration camps of World War II. Frankl walks us through times of terror, horror, and human suffering through the lens of his brilliantly formulated logotherapy. Not only is it inspiring and therapeutic for those who read it, but it is also a wonderful introduction to logotherapy, a tool that should be in every mental health professional's tool box.

Frankl explains that logotherapy is a "meaning-centered" psychotherapy, and he writes that it "focuses on the meaning of human existence as well as on man's search for such a meaning" (pp. 98–99). In Frankl's logotherapy, the desire to find meaning in one's life is the primary motivational force, contrasted with Freud's drive for pleasure and Adler's drive for superiority. Instead of focusing on the past, logotherapy is choice and future-oriented, accepting the inherent meaningfulness of life. Frankl explains that humans live and die for meaning and purpose, not merely to resolve conflicts or defenses.

Through logotherapy, one is able to attribute meaning to every aspect of life, including terror and pain. Frankl quotes Nietzsche: "He who has a *why* to live can bear almost any *how*" (p. 104). This basic principle is particularly helpful for those who have experienced unavoidable trauma, as well as those facing existential crises. Finding meaning and purpose aids in calming the neuroses.

In their article published in the *American Journal of Psychiatry*, Steven Southwick and colleagues (1) demonstrated the usefulness of logotherapy in combat veterans facing posttraumatic stress disorder (PTSD). They identified four main existential issues that PTSD sufferers often contend with, namely, a skewed external locus of control, a foreshortened sense of future, guilt and survivor guilt, and a loss of meaning and purpose. An example given is that of an ICU nurse who served in the Persian Gulf War. After returning from service, the nurse was tortured with impairments, stagnancy, and symptoms of PTSD. Using the logotherapy technique of dereflection (shifting emphasis away from problems, failures, and symptoms toward successes, goals, solutions, and empowerment [1, p. 170]), the veteran learned to take the residual effects and use them to his benefit. He used his memories as reminders of the need for caretakers. He learned that his expertise had heightened secondary to his caretaking experiences while at war, something few other nurses have. Extrapolating meaning from his experiences allowed for a deeper understanding of purpose and empowered him into action.



by Viktor E. Frankl. Boston, Beacon Press, 2006, 184 pp., $19.95.

Although logotherapy has broad applications, *Man's Search for Meaning* demonstrates most clearly its utility in the setting of trauma. In my career thus far, I have learned many treatment modalities, such as psychodynamic, cognitive-behavioral, exposure, hypnotic, and eye movement desensitization and reprocessing therapies, as well as many pharmacotherapies, for traumatized patients. Never have I discussed the role of logotherapy until reading Frankl's account. Reading *Man's Search for Meaning* has given me a new perspective on trauma, life, and therapy.

Dr. LaCasse is a third-year resident at Homer Stryker M.D. School of Medicine, Western Michigan University, Kalamazoo, Mich.

The author thanks Dr. Peter Longstreet for the introduction to *Man's Search for Meaning* and continued support.

REFERENCE

1. Southwick SM, Gilmartin R, McDonough P, et al: Logotherapy as an adjunctive treatment for chronic combat-related PTSD: A meaning-based Intervention. Am J Psychother 2006; 60(2):161–174

Residents' Resources

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

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

AUGUST DEADLINES

Fellowship/Award, Organization, and Deadline	Brief Description and Eligibility	Contact and Website
American Academy of Addiction Psychiatry (AAAP) Resident Poster Competition Medical Student, Resident, Fellow, Travel Award AAAP **Deadline:** August 1, 2017	Medical students, residents, and fellows with an interest in addiction psychiatry are invited to submit an application for a travel award to the AAAP Annual Meeting. • Medical students; Residents (includes general psychiatry residents and fellows in specialty training other than addiction psychiatry); • Addiction psychiatry fellows must be enrolled in an ACGME-accredited addiction psychiatry subspecialty program.	E-mail: Lulu@aaap.org Phone: 401-524-3076 http://www.aaap.org/annual-meeting/travel-awards/
AAAP Early Career Award AAAP **Deadline:** August 1, 2017	General psychiatry residents, addiction psychiatry fellows, and early-career psychiatrists are invited to submit original research in the field of substance use disorders/addiction to present during the Paper Session at the Annual Meeting. Travel and lodging expenses will be covered, and the meeting registration fee will be waived. • General psychiatry residents; PGY-5 or higher addiction psychiatry resident (fellow) in an ACGME-accredited addiction psychiatry subspecialty program; • Early-career psychiatrist who has either completed a psychiatry residency (within 3 years of residency or addiction fellowship completion) or completed an ACGME-accredited addiction psychiatry residency (fellowship).	E-mail: Lulu@aaap.org Phone: 401-524-3076 http://www.aaap.org/annual-meeting/early-career-award/

SEPTEMBER DEADLINES

Fellowship/Award, Organization, and Deadline	Brief Description and Eligibility	Contact and Website
American Psychiatric Association (APA) Resident Poster APA **Deadline:** September 7, 2017	Residents, medical students, and fellows are invited to submit an abstract for a poster they would like to present at the 2018 APA Annual Meeting. • Medical students from U.S. osteopathic or allopathic medical schools; psychiatry resident and psychiatry-subspecialty fellowships; Residents from other medical specialties.	E-mail: program@psych.org https://s7.goeshow.com/apa/annual/2018/abstract_submission.cfm
American Association of Directors of Psychiatric Residency Training (AADPRT) George Ginsberg Fellowship AADPRT **Deadline:** September 12, 2017	Acknowledges the excellence and the accomplishments of outstanding residents interested in education and teaching. • General or child and adolescent psychiatry residency program or in a psychiatry subspecialty fellowship; • Must be a resident or fellow at the time of nomination and award presentation.	E-mail: exec@aadprt.org http://www.aadprt.org/awards/awards_detail?awardsid=57
Peter Henderson, M.D., Memorial Award AADPRT **Deadline:** September 12, 2017	Acknowledges the best unpublished scholarly paper contributing to the field of child and adolescent psychiatry. • Current general psychiatry residents; Child and adolescent psychiatry residents; Individuals who have graduated from a general psychiatry residency training program or child and adolescent psychiatry training program within the last two years.	E-mail: exec@aadprt.org http://www.aadprt.org/awards/awards_detail?awardsid=55

Author Information for *The Residents' Journal* Submissions

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; attending physicians and other members of faculty cannot be included as authors.

To submit a manuscript, please visit http://ajp.psychiatryonline.org/ajp_authors_reviewers, and select a manuscript type for AJP Residents' Journal.

1. **Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
2. **History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
3. **Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2–4 multiple-choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
4. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
5. **Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
6. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
7. **Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
8. **Perspectives in Global Mental Health:** This article type should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow. Limited to 1,500 words and 20 references.
9. **Arts and Culture:** Creative, nonfiction pieces that represent the introspections of authors generally informed by a patient encounter, an unexpected cause of personal reflection and/or growth, or elements of personal experience in relation to one's culture that are relevant to the field of psychiatry. Limited to 500 words.
10. **Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in the *Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
11. **Book and Movie Forum:** Book and movie reviews with a focus on their relevance to the field of psychiatry. Limited to 500 words and 3 references.

Upcoming Themes

If you have a submission related to the themes shown, contact the Section Editor listed below the topic. ***Please note that we will consider articles outside of the theme.***

If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Rachel Katz, M.D., Editor-in-Chief (rachel.katz@yale.edu).

Forensic Psychiatry

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Treating Patients With Comorbid Substance Use Disorders

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