The American Journal of
Psychiatry
Residents' Journal

September 2018 Volume 13 Issue 9

Contents

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COMMENTARY

A Connection Between Veterans and Physicians: Operation Urgent Fury

Renee Noyola-Williams, M.D., M.Sc.

When I was a third-year psychiatry resident, my training at the Fayetteville Veterans Affairs Medical Center incidentally placed me in contact with U.S. veterans who were deployed to the Caribbean island of Grenada for Operation Urgent Fury in 1983. These were unique patient encounters because of my own connection with this island as an alumna of St. George's University School of Medicine in Grenada.

During Operation Urgent Fury, U.S. military forces had a mission to invade Grenada, secure the area, evacuate American medical students, and rescue Grenadian hostages following a violent political coup. At the time, it was considered to be the largest deployment of U.S. servicemen after the Vietnam War. Unfortunately, 19 U.S. troops were killed in action, and 116 were wounded (1).

My first encounter with people directly affected by this historical event was as a medical student in Grenada. I attended a fundraiser for Friends of the Mentally Ill and met a Grenadian attendee whose life had been affected by the political instability decades ago. He was quiet and polite but still living with judgment from others. This was my first time getting to know local Grenadians, but by unforeseen circumstances it would not be my last encounter with the people affected by the political events of the early 1980s.

One day while working at the Fayetteville Veterans Affairs Medical Center outpatient clinic, I was interviewing a veteran who when asked about his military experience began describing his role during the invasion of Grenada. It was an unexpected moment that caught me off guard. When I moved to Fayetteville, it never crossed my mind that I might treat a patient who had been deployed to Grenada. Knowing that it can be difficult for veterans to talk about their military experiences, I did not interrupt him. He spoke without knowledge that I was a graduate of the same medical school that his mission had targeted. At the end of his visit, I thanked him for his service. It was the easiest thank you I have ever given to a veteran, yet it felt like an inadequate gesture. Sharing personal information with a patient is always a delicate matter. However, in this case, out of sheer gratitude, I shared the connection to Grenada that I had initially withheld; it was a pleasant revelation for me, and I thought that he might agree.

Seldom do veterans get to see the tangible outcomes of their efforts overseas.

At first, he was quiet and perplexed, but this was followed by a smile. We simultaneously reached the same conclusion: that the doctor now treating him directly benefited from his bravery more than 30 years ago. It was a surreal moment for both of us. Seldom do veterans get to see the tangible outcomes of their efforts overseas. I wanted him to know at least one of the everlasting impacts of that mission. I shared with him that St. George's University School of Medicine continues to graduate hundreds of medical doctors every year, with more than 15,000 practicing physicians. I was the first alumna he had met, and he expressed his gratitude for sharing these details.

For me, this was an unforgettable encounter because I realized, for the first time, that these moments of connection enrich the lives of veterans as well as the lives of those who work with them, beyond what any medication can do.

At the time this article was accepted for publication, Dr. Noyola-Williams was a fourth-year resident in the Department of Psychiatry and Behavioral Medicine, East Carolina University/Vidant Medical Center, Greenville, N.C.

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ARTICLE

Military Culture: Working With Veterans

Gregory Burek, M.D., M.S.

According to the U.S. Department of Veterans Affairs (VA), around 70% of physicians in the United States have received some of their training with the VA. A total of 178 of 183 U.S. medical schools are affiliated with the VA, and 43,565 medical residents, 24,683 medical students, and 463 advanced fellows received some or all of their clinical training within the VA system in 2017 (1). Despite this training, most clinicians do not feel adequately prepared to provide high-quality care for veterans. In a recent study, only 13% of mental health providers met readiness criteria for culture competency in treating veterans (2).

To better serve this population, it is imperative that clinicians understand military culture. The present article provides clinicians with useful information to consider when treating active-duty service members and veterans.

INDIVIDUAL EXPERIENCE

The military experience of all veterans is unique. Their branch of service (Marine Corps, Navy, Army, Air Force, or Coast Guard), their rank, their job (referred to as their military occupation specialty [or MOS]), and the period during which they served (World War II, Korea, Vietnam, Gulf War, Operation Iraqi Freedom/Operation Enduring Freedom, or "peacetime") all have an impact on their experience during active duty and after leaving the service.

Veterans' rank has a great impact on their individual experience. Military ranks differ by branch and are compared between branches by pay grade (enlisted ranks, E1–E9; officer ranks, O1–O10). Veterans will often make statements such as, "I was an E-5," rather than saying, "I was a sergeant" (in the Army or Marine Corps), or "I was a petty officer second class" (in the Navy or Coast Guard). Enlisted personnel make up approximately 82% of active-duty military service members, most of whom enlisted shortly after completing high school. This is important to recognize, because while their civilian peers were leaving home for college or their first job, the enlisted veteran may have been leading troops or fighting in combat.

An officer is an individual who obtained a commission by having completed at least a bachelor's degree and graduating from an officer candidate school (referred to as an OCS) or military academy. Officer ranks tend to be more familiar to the civilian population (e.g., lieutenant, captain, colonel, admiral, or general), but titles differ between the different branches of services. Because the majority of U.S. veterans served in the enlisted ranks, usually ≤4 years, it would benefit clinicians to become more familiar with the E1–E5 ranks.

SHARED EXPERIENCE

There are many things that all service members have in common (see box). Sacrifice is at the top of the list of their shared experience. Time away from family and friends, long hours of duty, and very hard work are just a few of the enormous obligations that veterans have during their service.

Ironically, service members forfeit many of the freedoms that they fight to protect. They give up a piece of their individuality to become a part of something larger than themselves. While serving in active duty, uniformity is the rule: dressing the same, speaking the same, and behaving the same. The right to free speech, the right to bear arms, protection from illegal search and seizure, and the right to a trial by jury are all relinquished. Additionally, unlike in civilian jobs, once a contract to join the military is signed, it cannot be freely withdrawn by the signee. Without a proper discharge, a service member can be criminally charged with desertion.

Despite all of the privileges that veterans give up, working as part of a team and being able to rely on those around them inspires a sense of pride, belonging, loyalty, and brotherhood known as *esprit de corps*. This is why many veterans feel a sense of comfort and connection with other veterans, even with those from different branches of service or from different eras. "I got your six" is a way of saying "I've got your back," which embodies this idea.

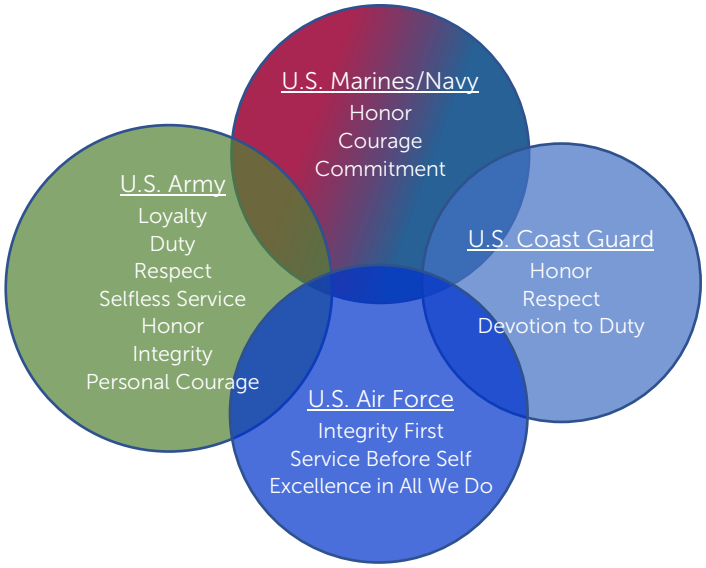
In the civilian world, an individual's beliefs and values can be ambiguous and may change over time. In the military, values are spelled out and explicitly taught from the beginning. Each branch of service holds its own core values (Figure 1). However, despite differences in verbiage, honor, courage, duty, and service above self are common values shared by all service members. These traits and ethics epitomize holding oneself to a higher standard and remain with the veteran over the course of a lifetime.

At some point in most veterans' experiences, they are confronted with their own mortality. By joining the military, they put themselves in harm's way.

Common Traits Among Service Members

- Sacrifice
- Discipline
- Holding self to higher standards
- Teamwork
- Being part of something greater
- Belonging, loyalty, brotherhood
- Fighting spirit: never giving up
- Suppression and denial
- Dark humor: sarcasm, morbidity
- Concerns about seeking care
- Moral injury

FIGURE 1. U.S. Military Core Values



They may have considered it when they signed the contract, or they may not have appreciated it until they were "down range" with rounds screaming past. Dark humor, with morbid jokes about death, are ubiquitous in the military. Whether serving during a time of war or peace, killing and dying in service to one's country are common themes. Speaking flippantly about death is not a morbid preoccupation, it is a way of coping with this overwhelming burden. Thus, it is important for clinicians to note that a veteran admitting to thoughts about his or her own death may not necessarily be suicidal ideation, it is often a continuation of this mentality. These thoughts are often hidden from family and friends as well as from clinicians due to fear of judgment. This fear of judgment is what may prevent veterans from talking openly with civilians and from seeking professional help. Discussing the veteran's thoughts about death, if approached from an empathetic and nonjudgmental stance, can bolster trust and expose possible internal conflicts, including moral injury.

HOW TO APPROACH VETERANS

The following bullet points are suggestions for clinicians on how to approach veterans in the clinical setting. (Additional resources are presented in Table 1.)

- **Ask questions**. The military has a lot of abbreviations and acronyms, as well as jargon and slang. Asking the veteran to explain military terminology will show interest, and it can help build rapport and lessen resistance.
- **Listen**. All veterans have a unique story about why they joined the military, what they did while serving, and how they feel about it. A clinician can show interest in the veteran as an individual by asking questions such as, "What branch were you in?", "When did you serve?", "What was your MOS?", "Where were you stationed?", and "Were you deployed?" Listening to the veteran's story will help to establish rapport and help to put the veteran at ease. It is crucial that veterans' first experience with a clinician be positive and welcoming, even at the expense of having to schedule a follow-up appointment to address all of their concerns.
- **Show concern.** When a veteran says "I'm fine," it does not mean that he or she is not experiencing psychological distress or medical illness. Most of military training teaches men and women how to suppress their feelings. "Suck it up" and "rub some dirt in it" are common responses to complaints about discomfort, illness, or injury. When the veteran says, "I'm fine," he or she is often having difficulty admitting any hardship. This is an opportunity for the clinician to show empathy and concern. This is when the clinician should put down the clipboard, turn away from the computer, look the veteran in the eyes and say, "I am here for you." "How can I help?"

TABLE 1. Resources for In-Depth Training in Military Culture for Treating Veterans

Resource	Organization and Agency	Website
Military Culture: Core Competencies for Health Care Professionals Self-Assessment and Introduction to Military Ethos	CDC Train	https://www.train.org/cdctrain/course/1056248
Military Facts: For Non-Military Social Workers	Department of Veterans Affairs, Center for Integrated Care	http://www.mirecc.va.gov/cih-visn2/Documents/Provider_Education_Handouts/Military_Facts_for_Non_Military_SW_Version_4.pdf
Overview of Military Culture	Jeanette Hsu, Ph.D., VA Palo Alto Health Care System	https://www.apa.org/about/gr/issues/military/military-culture.pdf
Military Culture: Community Providers Toolkit	Department of Veterans Affairs, National Center for PTSD	http://www.mentalhealth.va.gov/communityproviders/military.asp
Health Professionals page	Real Warriors website	http://www.realwarriors.net/healthprofessionals
Military Cultural Competence	Uniformed Services University of the Health Science, Center for Deployment Psychology	http://deploymentpsych.org/online-courses/military-culture

KEY POINTS/CLINICAL PEARLS

- Veterans and active-duty military service members are part of a unique culture; it is important for providers to understand this culture in order to better serve this population.
- It is essential that providers listen to veterans' unique stories and not make assumptions about their personal experiences.
- Veterans share a common set of values, which guide and motivate their behavior, and they continue to hold these values long after taking off the uniform.

- **Build trust and respect**. Never say "I understand" to a veteran. This phrase, even when said with empathy, may cause a veteran to withdraw or become angry. Respect and trust can be elicited with other empathetic statements or questions, such as "How was that for you?" or "I can't imagine what that was like for you."
- **Understand trauma**. Not all trauma is military or deployment related. Service members carry the wounds and traumas of their lives with them into the military. Moreover, stress is an everyday part of military life, long before deployment to combat. Traumatic events, including sexual trauma and losses, can occur on a military base just as easily as on the battlefield. These traumas can sometimes be more difficult to heal, because they are unexpected. Ask veterans about painful experiences they may have had apart from deployment or before enlisting.
- **Refrain from judgment**. Servicemen and women have been put in situations where split-second decisions dictate dying versus going home to their families. Postdeployment, these decisions often weigh heavily on their minds and their conscious. This is referred to as moral injury. It is not helpful for the clinician to express his or her opinions or moral judgments. The clinician should be supportive and empathetic while the veteran works through these issues.
- **Thank the veteran with sincerity**. "Thank you for your service." Although well intended, this phrase has been overused and can sound shallow and contrived. Instead, clinicians should aim to be more spontaneous and less automatic. "Welcome back," "Welcome home," or even just "Thank you" can give the intended message without ringing hollow.

CONCLUSIONS

The topics discussed in this article are merely the tip of the iceberg, intended to provide clinicians with a glimpse into military culture. Being aware of this information is a first step toward better serving the veteran population.

Dr. Burek is the VA Chief Psychiatry Resident at the Medical College of Wisconsin and a former U.S. Marine. Prior to his medical training, Dr. Burek served as an infantryman with the 2nd Light Armored Reconnaissance Battalion, and he served in combat during Operation Iraqi Freedom.

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CASE REPORT

Challenges in Diagnosing Factitious Disorder

Muhammad Zeshan, M.D., Raminder Cheema, M.D., Pankaj Manocha, M.D.

The word factitious comes from the Latin adjective *facticius*, meaning "made by art" or "artificial." Descriptions of symptoms of what is now referred to as factitious disorder first appeared in the medical literature in the early second century A.D., although the term factitious was coined in 1843 (1). Factitious disorder was first described by Richard Asher, who named the condition Munchausen syndrome (2), and it is defined as the deliberate feigning or exaggeration of injury, impairment, illness, or a psychological condition with the aim of assuming the patient role but no other obvious gain (3). Factitious disorder was initially recognized as a formal diagnostic category in 1980 in DSM-III (4) and was later classified into three major subtypes in DSM-IV-TR (5). Further changes to the criteria for factitious disorder were made in DSM-5 as follows: the disorder is now classified under somatic symptoms and related disorders; description of the disorder has changed from "motivation to assume a sick role" to "deceptive behavior is evident in the absence of external incentives"; and the disorder is now subclassified as "factitious disorder imposed on self" and "factitious disorder imposed on another," thus removing factitious disorder by proxy from the appendix (3).

The exact prevalence of factitious disorder in hospital settings is currently unknown; however, it may account for 0.6%–3.0% of psychiatric referrals (6). The estimated lifetime prevalence of factitious disorder imposed on self in clinical settings is 1.0%, and in the general population, it is estimated to be approximately 0.1%, with prevalence ranging widely across different studies, from 0.007% to 8.0% (7). According to one estimate, factitious disorder costs the United States $40 million per year (8), but the financial impact may be much higher than current estimates in the context of underdiagnosis. The medical literature suggests that the prevalence is higher among females, unmarried individuals, and health care professionals (9). Although the etiology of the disorder or pretense is unclear, there is documented association with psychosocial factors, neurocognitive impairment, and neuroimaging abnormalities.

In the present case report, we highlight the diagnostic challenges clinicians may face in diagnosing and treating patients with factitious disorder.

CASE

"Mr. C" is a 60-year-old man who presented to our facility with a self-reported psychiatric history of bipolar I disorder and borderline personality disorder, a self-reported substance use disorder of alcohol and cocaine use, and a self-reported medical history of chronic obstructive pulmonary disease (steroid dependent with multiple intubations), hypertension, insulin-dependent diabetes mellitus, and hyperlipidemia.

The patient was admitted to our facility endorsing command auditory hallucinations. On evaluation, when asked to explain the circumstances of his admission, he stated, "I am hearing voices telling me to kill myself." When asked to elaborate, he reported having experienced traumatic events in his life, which affected him severely. He stated that his parents died when he was 7 years old and that he was sexually abused by his stepfather at age 10, which lasted for 3 years. He reported that his wife and one of his daughters died in an accidental house fire in 2007, another daughter died in a car accident in 2013, and his girlfriend died in 2014. Further, he reported having manic symptoms, such as elated mood, rapid and pressured speech, decreased need for sleep, racing thoughts, and thoughts of a special connection with God, which lasts for 1 week if left untreated. He was unable to recall when he was last psychiatrically well.

He reported two suicide attempts, both in 2007, first by overdosing on 10 lorazepam tablets, followed by a second attempt in which he tried to hang himself. A review of the patient's records showed several psychiatric hospitalizations over 10 years, with similar presentation of command auditory hallucinations of self-harm along with affective dysregulation. The records confirmed a positive history of alcohol and cocaine use. His medical admissions were in the context of exacerbation of chronic obstructive pulmonary disease or asthma symptoms after medication noncompliance. The records showed that, on average, the patient was hospitalized more than 300 days per year over the past 5 years (2011–2015). Additionally, the records indicated that multiple psychopharmacological medications, such as antidepressants, antipsychotics, and mood stabilizers, had been prescribed, with inconsistent improvement in symptoms. There was no record of follow-up visits or treatment after his discharges from the hospital.

The patient's intentional falsification of symptoms and deceptive behavior without any obvious gain led to a diagnosis of factitious disorder. In addition, our treatment team observed splitting behavior (i.e., his initial idealization of his psychiatrist and positive attitude toward the treatment team were reversed when his diagnosis was explained to him). Supportive and trauma-focused psychotherapy were provided but with limited benefit.

Our treatment team made several attempts to contact the patient's family without success, and thus informa-

tion pertaining to sexual abuse, multiple losses in the family, and suicidal attempts remained nonverifiable. Our team also questioned the accuracy of all self-reported information, since the information was reported inconsistently during different conversations with different team members.

Differences Between Somatoform Disorder, Factitious Disorder, and Malingering

Diagnosis	Mechanism of Illness Production	Motivation for Illness Production
Somatoform disorder	Unconscious	Unconscious
Factitious disorder	Conscious	Unconscious
Malingering	Conscious	Conscious

DISCUSSION

In the above case, our differential diagnosis included factitious disorder, malingering, and conversion disorder (see box). Our patient did not appear to have any motivating external gains, such as financial compensation or avoiding jail or prison time, differentiating from malingering. The feigning of illness appeared to be due to an unconscious desire to gain sympathy, as observed in the patient's records, which showed repeated visits to medical emergency departments at different hospitals.

Because of vague and inconsistent presentation of symptoms, factitious disorder is challenging to diagnose as well as to treat. Symptoms may become worse for no apparent reason and may not improve after standard treatment. To obtain "the sick role," patients with this disorder may falsify symptoms, fabricate their medical history, and manipulate medical investigations to simulate a condition that requires immediate medical attention. They often attempt to prevent their treatment team from contacting family members and frequently change providers (i.e., doctor shopping) in an effort to hinder continuity of care. They frequently go to different emergency departments at different facilities, which can result in unnecessary laboratory and imaging tests, longer hospital stays, and overutilization of resources (8).

Differentiation from malingering remains challenging, since this may require understanding the concepts of primary and secondary gains. The motivation to receive affection and the desire to undergo medical procedures is often the primal inclination (10). The primary gain is seeking medical attention to receive emotional support. By contrast, in malingering, the patient feigns physical or psychological symptoms for external incentives (secondary gains), such as gaining disability benefits, acquiring leave from work, evading military service, or procuring a justifiable absence from a court of law.

Although often seen by medical doctors in emergency departments, factitious disorder is routinely underrecognized and usually results in unnecessary consultations, investigations, treatments, hospital admissions, and surgical procedures. This may cause iatrogenic harm to the patient (11) and underscores the need for early detection. Additionally, there is evidence that early detection of factitious disorder and identification of comorbid illnesses, along with development of an empathic relationship with the patient, may help in the attenuation of maladaptive behaviors, leading to better outcomes (9, 12).

Management strategies for patients with factitious disorder include exploring the patient's symptoms in a nonconfrontational manner. Showing disinterest in the fabrication but maintaining interest in the patient conveys to the patient that the provider is concerned. This may improve the therapeutic alliance and prevent the patient from doctor shopping. The medical literature also shows that increasing the number of follow-up visits reduces the frequency of self-injurious behavior.

CONCLUSIONS

Patients with factitious disorder often seek treatment from many providers and have frequent emergency department visits, some of which lead to inpatient hospitalizations because the treatment team may be manipulated into ordering extensive tests or performing unnecessary medical or surgical procedures. Patients may also inflict self-pain to prolong their hospitalizations and to hide their collateral information. This patient population is typically nonadherent to long-term follow-up, thus limiting improvement in their symptoms. Improving the therapeutic alliance by focusing on the patient's need for attention may be achieved by scheduling short-interval visits and psychotherapy.

Dr. Zeshan is a child and adolescent psychiatry fellow, Boston Children's Hospital, Harvard Medical School, Boston. Dr. Cheema is a child and adolescent psychiatry fellow, Baylor College of Medicine, Houston. Dr. Manocha is a third-year psychiatry resident at Bronx Lebanon Hospital, Icahn School of Medicine at Mount Sinai, Bronx, N.Y.

The authors thank Muhammad A. Tahir, M.D., Research Assistant, SUNY Upstate University, Syracuse, N.Y., and Raheel Memon, M.D., Clinical Observer, Center for Behavioral Health, Florida Hospital, Orlando, Fla., for their assistance with this article.

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KEY POINTS/CLINICAL PEARLS

- The prevalence of factitious disorder imposed on self in clinical settings is approximately 1%.
- In the United States, factitious disorder costs up to $40 million annually in medical expenses.
- Diagnosis of factitious disorder involves longitudinal review of records rather than focus on cross-sectional current symptoms.

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Reflections on the Spade and Bourdain Suicides

Somya Abubucker, M.D.

When Kate Spade died by suicide on June 5, 2018, and Anthony Bourdain 3 days later, I felt shock and grief, as if I had lost people close to me. After all, I—along with millions of others—owned Kate Spade bags, dreamed in Kate couture, and experienced more of the globe with Anthony Bourdain than with anyone else. They were cultural icons and role models and epitomized the American dream. Kate Spade made her first prototype hand bags out of scotch tape and paper and went on to launch a brand that would define New York fashion in the 1990s (1). Anthony Bourdain started as a dish washer and transformed himself into a world-renowned chef and writer, hailed as the "Hemingway of gastronomy" and someone who spoke truth to power and delighted in marginal subcultures (2). Both had mythic beginnings and fabled careers. Their lives were stories that people loved to tell. In the vernacular, they were "living the life."

Both also suffered from mental illness. Bourdain was public about his, writing openly about his previous substance use disorders, including cocaine, heroin, LSD, alcohol, and tobacco use (2). He was also frank about his depression. In the 2016 Buenos Aires episode of *Parts Unknown*, he expressed a fascination with Argentina, a country with one clinical psychologist for every 696 people in 2012 (3, 4). Compare that with the United States, which according to 2014 World Health Organization (WHO) statistics, had one psychologist for every 3,376 people (5). It is one of Bourdain's best episodes, weaving together the tango, midnight soccer matches, and paeans to red meat to create a nostalgia so authentic and serious that even the first-time viewer feels homesick. The vibrantly colored scenes of Buenos Aries life are interspersed with black-and-white cuts to Bourdain sitting in the office of his psychoanalyst. The camera returns obsessively to an airplane landing strip, where families gather to watch planes take off and land. It is an idyll of the rustics that Bourdain cannot take part in. Just as persistently, the camera returns to the psychoanalyst's office, where Bourdain says, "I feel like Quasimodo." When I first watched the episode, the psychotherapy was darkly jocular, with more than a touch of theater, but in rewatching it, Bourdain's courage at self-disclosure and his not fleeing from the vulnerable act of seeking help bring tears to my eyes.

> A person's appearance is an unreliable index of his or her suicide risk.

Kate Spade also suffered from depression. In a statement released after her death, her husband revealed that she had been under medical care for depression and anxiety for 5 years (6). In an e-mail interview with the *Kansas City Star* on the day after her death, Spade's sister stated that she "refused to seek help lest word get out and sully the brand's upbeat reputation" (7). The viral Facebook tribute by Claudia Herrera posted on the day of Spade's death captures a lot of my own bewilderment. Herrera posted, "I knew when Patrick Swayze was battling pancreatic cancer. I know that Cynthia Nixon is a breast cancer survivor. I know that Selena Gomez has lupus and recently had a kidney transplant. I know that Lance Armstrong is a testicular cancer survivor. But I didn't know that Kate Spade suffered from depression. [S]omehow society has made it more acceptable to talk about breasts and testicles than about the mind" (8). Unbelievable as it sounds, there is much truth to Herrera's indictment. Mental health stigma runs deep in American culture.

The Spade and Bourdain suicides have rendered a tear in the fabric of the everyday, and I ask you, my fellow psychiatry residents, not to let their deaths be in vain. Spade and Bourdain have ignited a national conversation about death by suicide, and we as psychiatry residents have the opportunity to do meaningful work here. This opportunity comes not a minute too soon. On June 7, 2018, sandwiched between the two suicides, the Centers for Disease Control and Prevention published a press release showing that suicide rates increased across the United States by 25.4% between 1999 and 2016 (9). According to data from WHO, a death by suicide occurs every 40 seconds globally, and "[t]here are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide" (10). In the United States, suicide is the tenth leading cause of death; globally it is the 17th (9, 10). This is a crisis.

What can we as psychiatry residents do? First and foremost, we can become better clinicians, increasing our knowledge base about how to take care of patients with suicidal ideation. As the deaths of Spade and Bourdain make clear, a person's appearance is an unreliable index of his or her suicide risk. We can hone our skills in detecting self-harm potential, becoming experts in the causes as well as in risk and protective factors. We can become more aware of stereotypes to avoid and myths to dispel and forge therapeutic alliances with vulnerable populations. We can help patients and families recognize warning signs and create safety plans. We can advocate to restrict access to lethal means of suicide. All of us can continue to improve our listening skills. All of us

need help in walking the fine line between destigmatizing mental illness yet not normalizing suicide. The mind gets sick like the body, and there is no shame in either.

Finally, there is urgent need for research. Much needs to be learned about genetics, etiologies, management, and prevention. Tasks on our front burners should be improving screening tools, developing algorithms for predicting risk, and determining biomarkers. Communication is not limited to academic journals. Psychiatry residents of today don't just publish: we post, we Tweet, and we Insta. We need to be mindful of our social media presence, which can reach a much larger audience than our published papers and commentaries. Even seemingly trivial acts such as liking posts about people with suicidal ideation who sought help and did not attempt suicide can reach vulnerable populations and make a difference.

Dr. Abubucker is a second-year resident in the Department of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine, Baltimore, and Culture Editor/Social Media Editor of the *American Journal of Psychiatry Residents' Journal*.

If you or someone you know needs help, please contact the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). To connect with a trained crisis counselor, a free text message service is available: 741-741.

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The AJP Residents' Journal has launched an **Instagram** page! Send your psychiatry-inspired photos & artwork to the AJP-RJ Social Media Editor Somya Abubucker (stariyal@hotmail.com).

Muhammad ibn Zakariya al-Razi and the First Psychiatric Ward

Musa Yilanli, M.D.

Muhammad ibn Zakariya al-Razi was one of the most well-known and respected physicians during the 9th century A.D. because of his revolutionary contributions to medicine and psychiatry. al-Razi influenced several medical fields, including pharmacology, pediatrics, neurology, psychosomatic medicine, and medical ethics. He purified alcohol (ethanol) and pioneered its use in medicine. He rejected the notion of the mind-body dichotomy and considered mental health and self-esteem as significant factors that affect a person's health and well-being. With the idea of "sound mind in a healthy body," he was able to help many of his patients to attain complete health. He was one of the first known physicians to describe the idea of psychotherapy. He used psychotherapy in a primitive but dynamic form in his practice.

al-Razi was born in 865 A.D. in al-Rayy, which is located outside Tehran. During his youth, he moved to Baghdad where he undertook medical studies and later practiced at one of the local hospitals. The governor of Rey, Mansur ibn Ishaq, later appointed him to head the hospital in Baghdad (1). al-Razi wrote 237 books in his lifetime, 36 of which are still available today. The most popular of his writings, *Liber Continens*, is considered a medical encyclopedia (2). His books offered explanations for various mental illnesses that plagued society during the 10th century. These books also outlined symptoms and definitions of as well as differential diagnoses and treatments for different mental illnesses.

According to his views, mental disorders should be considered and treated as medical conditions.

While working as the director of a hospital in Baghdad, al-Razi introduced the concept of psychiatric wards as a place to care for patients with mental illness. According to his views, mental disorders should be considered and treated as medical conditions. He conducted very detailed clinical observations of patients with psychiatric conditions and provided treatment with diet, medication, occupational therapy, aromatherapy, baths, and music therapy. Additionally, he practiced an early form of cognitive therapy for obsessive behavior (3). al-Razi described depression as a "melancholic obsessive-compulsive disorder," which is triggered as a result of changes of blood flow in the brain. He stated that physicians should always try to convince their patients of the possibility of improvement in their condition as well as hope in the effectiveness of treatment. As part of discharge planning, patients were given a sum of money to help with their immediate needs and their transition back into society. To our knowledge, this is the first recorded reference to psychiatric aftercare.

al-Razi believed that physicians should be modest, soft-spoken, and gentle when communicating with their patients to ease the anxiety of receiving unfavorable news. He stressed the importance of communicating with patients on a personal level rather than simply making them aware of their illness. He used a cheerful countenance and encouraging words to instill in patients the hope of recovery.

Both psychiatric residents and trainees alike can learn from al-Razi's approach to serving patients with compassion and understanding. He is a valuable source of inspiration from the history of psychiatry, with his original work and distinct style.

Dr. Yilanli is a first-year child and adolescent psychiatry fellow at the University of Arkansas for Medical Sciences, Little Rock.

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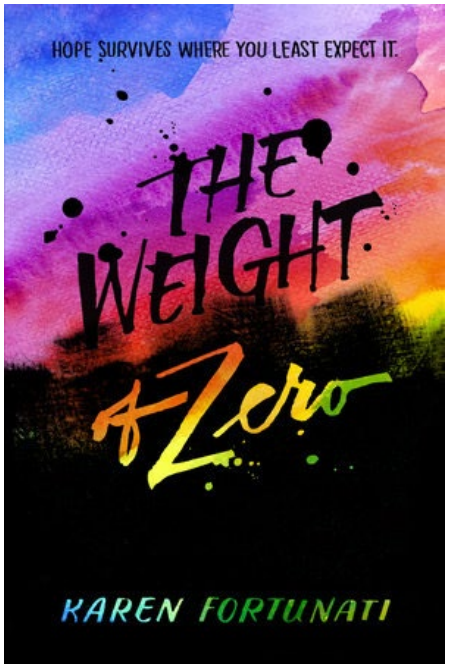
The Weight of Zero

Reviewed by Flavia DeSouza, M.D., M.H.S.

The Weight of Zero, a fictional novel by Karen Fortunati, explores an adolescent female's first encounter with the mental health care system. We meet the protagonist, Catherine Pulaski, after her first suicide attempt, subsequent to a manic phase. She was a popular, bright, advanced-placement student as well as a former ballerina who is abandoned by her closest lifelong friends—who mock and bully her at school—because of her psychiatric diagnosis, bipolar disorder.

Catherine's single mother becomes overly protective and anxious in her desperate efforts to prevent her daughter, who is the only remaining member of her immediate family, from attempting suicide again. Even so, Catherine's depression distorts her worldview; all things are perceived through her gray lens. She blames herself for her mother's fatigue and anxiety, believing that her illness has already ruined her own life and will ruin the lives of all those who love her. She loses hope. Despite her mother's attempts, she secretly and assiduously plans a suicide attempt, believing wholeheartedly that the world would be better off without her in it.

Adolescents like Catherine crave social support and validation from their peers, and they seek autonomy from their parents as they determine their place in the world. During this transition into adulthood, psychiatric illness may present for the first time, disrupting the transition and thus making what is already a challenging period of an individual's development a time that may be decidedly painful and chaotic. This story accurately reflects the real adversity in and around the lives of adolescents as well as adults living with psychiatric illness. People who experience depression, manic episodes, or psychosis are often misunderstood and stigmatized as they battle for their minds. Without support, they may remain silent and isolated in their feelings of shame and guilt, increasing the likelihood that either their illness will worsen or that they will develop suicidal ideation.



By Karen Fortunati. New York, Delacorte Press, 400 pp., 2018, $8.63.

Catherine comes to terms with her illness with the care and counsel from a perceptive provider, good medication coverage, and love and support from new friends. She is able to separate her diagnosis from who she is and what she is capable of becoming.

This book is written for an adolescent audience as well as parents of adolescents. Yet it facilitates understanding and empathy in those of us who care for adolescents with psychiatric illness and offer support for their caregivers.

Dr. DeSouza is a third-year resident in the Department of Psychiatry at Yale New Haven Health, New Haven, Conn.

Residents' Resources

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

To contribute to the Residents' Resources feature, contact Matthew L. Edwards, M.D., Deputy Editor (ajpresresource@gmail.com).

Fellowship/Award	George Ginsberg Fellowship
Organization	American Association of Directors of Psychiatric Residency Training (AADPRT)
Deadline	**September 26, 2018**
Brief Description	This fellowship program acknowledges the excellence and the accomplishments of outstanding residents interested in education and teaching.
Eligibility	Applicants must be in a general or child and adolescent psychiatry residency program or in a psychiatry subspecialty fellowship.
Contact and Website	E-mail: exec@aadprt.org; Web: http://www.aadprt.org/awards/awards_detail?awardsid=57
Fellowship/Award	**Geriatric Mental Health Foundation's Honors Scholarships**
Organization	American Association for Geriatric Psychiatry (AAGP)
Deadline	**October 1, 2018**
Brief Description	Provides residents a 1-year membership to AAGP; registration and travel costs to attend the AAGP Annual Meeting; and participation in an academic project related to geriatric psychiatry under the supervision of an assigned mentor.
Eligibility	PGY-1, 2, or 3 in an accredited psychiatry residency program.
Contact and Website	E-mail: Training@aagponline.org; Web: https://www.aagponline.org/index.php?submenu=education_submenu&src=gendocs&ref=AAGPScholarProgram&category=Main
Fellowship/Award	**Scott Schwartz Award**
Organization	The American Academy of Psychodynamic Psychiatry and Psychoanalysis (AAPDPP)
Deadline	**November 1, 2018**
Brief Description	The Scott Schwartz Award recognizes the best original, unpublished paper on psychoanalytic or psychodynamic psychiatry, written (and first-authored) by a psychiatry resident or medical student.
Eligibility	Psychiatry residents and medical students are eligible.
Contact and Website	E-mail: jekatzman@salud.unm.edu; Web: http://aapdp.org/index.php/education/scott-schwartz-aapdp-award
Fellowship/Award	**Alonso Award for Excellence in Psychodynamic Group Theory**
Organization	American Group Psychotherapy Association (AGPA)
Deadline	**November 1, 2018**
Brief Description	This award recognizes original work in the field of psychodynamic group theory. Suitable entries include doctoral dissertations, videos, published papers, and other creative research. An annual cash prize of $500 is presented.
Eligibility	Varies
Contact and Website	E-mail: dfeirman@agpa.org; Web: http://www.agpa.org/Foundation/awards#Alonso
Fellowship/Award	**Karl Jaspers Award**
Organization	Association for the Advancement of Philosophy and Psychiatry
Deadline	**December 15, 2018**
Brief Description	The Association for the Advancement of Philosophy and Psychiatry offers the Karl Jaspers Award for a paper authored by a student, trainee, or early-career academics or practitioners. This award is given for the best paper related to the subject of philosophy and psychiatry and carries a cash prize.
Eligibility	Eligible applicants include medical students, graduate students in philosophy, psychology, and related fields, residents in psychiatry, and individuals who have completed such education and training no more than 3 years prior to the end of the academic year in which the award is to be conferred.
Contact and Website	E-mail: Scott.Waterman@uvm.edu; Web: https://philosophyandpsychiatry.org/jaspers-award

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

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

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

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

Perspectives in Global Mental Health: Should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow.

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

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

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

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

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

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

No abstract required for any article type.
*Box with 3–4 key teaching points
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