

# The GW Psychiatrist

The Newsletter of the George Washington University Department of Psychiatry and Behavioral Sciences

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## The Chair's Column

### *Humanistic Psychiatry and Neuroscience Research*



**James L. Griffith, MD**

neuroscience research would constrict psychiatrists' scope of practice to the point where only diagnostic interviews and psychopharmacology would remain. The role of psychiatrists as broadly-skilled clinicians who use dialogue and relationship therapeutically would end. Yet the potential power of neuroscience research *to expand* effectiveness of language- and relationship-based therapeutics has not been adequately examined. The latter could hold promise for expanding the psychiatric scope of practice by training humanistic psychiatrists who would also

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Photos from this year's Resident Retreat, along with other departmental events, are included throughout this newsletter.



## The Chair's Column

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This spring marked the publication of "Neuroscience and Humanistic Psychiatry: A Residency Curriculum" in *Academic Psychiatry*, an article which describes our department's efforts over the past two decades to ground our GW psychiatry residency curriculum in neuroscience research (see attached). This curriculum has viewed hope, empathy, trust, compassion, and intimacy as biological phenomena. Our everyday capacities to converse together, to work together, and to share together our experiences in living can be described both in terms of information transfer within brain circuits and signaling pathways, and in terms of psychological theories and works of art. We can take seriously our embodiment as persons without reducing human experiences to the physical tissues of nervous systems.

Past efforts to integrate humanism and neuroscience research in psychiatric training have not dealt adequately with critical epistemological and pedagogical differences between neuroscience research and humanistic psychiatry. Humanistic psychiatry focuses on the mental health of whole persons. It relies upon phenomenology for much of its clinical knowledge, tracking the patterns of a person's first-person lived experience within its contexts of family, community, and culture. Inquiry and dialogue are methods that seek a collaborative understanding of a patient's life that can help the patient to utilize personal agency, problem-solving, and relational support to achieve therapeutic ends. Humanistic psychiatry has been more about "doing with," rather than "doing to" a patient.



PGY-1s at the Resident Retreat



Christina Puchalski, MD

Psychiatric neuroscience research, however, has sought to elucidate the neurobiology of major psychiatric disorders, such as schizophrenia or bipolar disorder. It has largely utilized experience-distant, context-free observations under controlled laboratory conditions in order to describe neural structures and the processing of information within the nervous system. It has sought prediction and control over variables that can attenuate psychiatric symptoms. Pharmacological and other somatic treatments derived from neuroscience research have been more about "doing to" rather than "doing with" a patient.

"Neuroscience and Humanistic Psychiatry: A Residency Curriculum" describes the heuristic methods we have employed to teach psychiatry residents how to hold simultaneously the first-person phenomenology of humanism and the third-person empiricism of neuroscience research without reducing the therapeutic potential of either. In the *Phaedrus*, Plato argued that good theories should "carve nature at its joints." Psychiatry, however, has proven to be the most slippery of sciences, in that its therapeutics repeatedly have turned out to be either "all brain, no person" or "all person, no brain." I hope you will read "Neuroscience and Humanistic Psychiatry: A Residency Curriculum" to see how we are teaching a humanistic practice of psychiatry that is grounded in neuroscience research.



## Perspective on Resident Wellness Program

Eindra Khin Khin, MD

At the 43<sup>rd</sup> Annual Meeting of the American Association of Directors of Psychiatric Residency Training (AADPRT) in March 2014, Drs. Lisa Catapano, Lorenzo Norris, and Eindra Khin Khin presented the George Washington University's Psychiatry Resident Wellness Program. In a workshop entitled "The Role of Resident Wellness in Promoting Well-being and Preventing Burnout in Psychiatry Residents," our team was joined by Drs. Robert Feeley and David Ross from Yale School of Medicine. In this presentation, the cost of and risk factors for resident burnout, including personality characteristics, coping strategies, and environmental/programmatic factors, specifically as these relate to psychiatry training, were discussed. In addition, the literature on the effectiveness of physician and student wellness programs on promoting health and preventing burnout was reviewed. How such programs contribute to the development of professionalism and self-care as set out by the ACGME Milestones was also explored. After presenting two models of resident wellness programs from GWU and Yale, the audience engaged in an active discussion on developing a model of a resident wellness

In this discussion, the multifaceted approach of our Resident Wellness Program was highlighted as unique, comprehensive, and pragmatic by the audience. Some of the key features of our multi-dimensional program are demonstrated below:



Graduating PGY-4s with Dr. Lisa Catapano, MD, Director of GWU's Psychiatry Residency Training Program

**Dr. Lisa M. Cullins, MD** as the new Training Director for the Child & Adolescent Psychiatry Fellowship Program, Director of Outpatient Psychiatry at Children's National Medical Center, and Assistant Professor of Psychiatry, Behavioral Sciences and Pediatrics at George Washington University School of Medicine. She completed her Adult Psychiatry Residency at UCLA Neuropsychiatric Institute in Los Angeles, CA and her Child & Adolescent Psychiatry Fellowship at Columbia Presbyterian Hospital in New York City, NY. Dr. Cullins has devoted most of her career to training and education, community psychiatry and systems of care, in particular, working with children and adolescents in the child welfare system and other underserved populations. Dr. Cullins is an advocate for quality and access to care for children and families and has been an active participant in American Academy of Child and Adolescent Psychiatry (AACAP) as current Co Chair of Workforce Committee, Adoption and Foster Care Committee Member and Secretary of Regional Organization, Child and Adolescent Psychiatry Society of Greater Washington (CAPSGW).

## Chief's Corner

### L i K I MD MPH

Our residents have accomplished so much during this past year: not just taking care of their patients and supporting one another, but also publishing articles, presenting at conferences, traveling around the world on global mental health projects, winning awards, matching to fellowships, continuing wonderful program traditions like Retreat, and growing our residency family with expanding families of their own, just to name a few highlights. I am so proud to be associated with you and with our program. As I meet with my patients and supervisors for the last few times, and say goodbye to clinical sites and the wonderful staff that keep them running, I am grateful for the experiences and the people that have shaped this phase of my training. There were certainly some tough days (and nights) along with the way, and having the support of my family, friends, colleagues, and

It has truly been an honor to serve as your chief this year—I've really enjoyed getting to work with you and to know each of you better in my role. You have taught me so much, and I am very grateful for the opportunity and for your support. I know that the residents are in great hands with Elizabeth as Chief Resident for the upcoming year, and that she will continue the wonderful job that she is already doing in her new position. I wish her and all of you the best for the upcoming year! I can't wait to hear of all your continued accomplishments in the next year and the

### Elizabeth Greene, MD

It's hard to believe that we're at the start of another academic year, but here we are! With so much happening at this time of the year – retreat, orientations, GME and rotation site paperwork (ugh!), summer vacations – it's sometimes tough to find the time to pause and reflect on the past year and really think about the new year. What have you learned this past year and what do you want to focus on in the coming year? Personally, I feel I've become a lot more comfortable with medications and psychotherapy, but there is still plenty to learn!

This is also a time for me to consider the goals that I have for the residency program, not just myself. As the incoming chief resident, I hope to be a trustworthy and accountable liaison between my fellow residents and the faculty members above me. While I do have a few specific ideas up my sleeve, what I really want to do is to help you feel that this program is *your* program and that you're getting out of it what you want.

Please feel free to reach out to me at any point this year to discuss your



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**Sanaa Bhatti** (PGY-3) – Child and Adolescent Psychiatry Fellowship, Mount Sinai Hospital in Manhattan

**Richa Maheshwari** (PGY-3) – Child and Adolescent Psychiatry Fellowship, New York University

#### MILESTONES:

**Elizabeth Greene** (PGY-3), our incoming chief resident, welcomed her 2<sup>nd</sup> son, Samuel (Sammy) Leyvik Greene, on December 5<sup>th</sup>.

**Karen Wooten** (PGY-2) welcomed her 2<sup>nd</sup> daughter, Alice Lynn Brehm, on May 10<sup>th</sup>.

#### BIRTHDAYS:

June 3: Stefani Reinold & Linda Ojo

June 6: Stephanie Cho

June 16: Lynsey Tamborello

June 22: Amanda Holloway

July 18: Rushi Vyas

August 11: Jason Emejuru



Spring 2014 Newsletter and Resident Retreat Committee



## Integration of Primary Care with Psychiatry at INOVA

Thomas Wise, MD

The increasing focus upon population health – managing a defined group of individuals with a set amount of financing for such care – has reinforced the need for integration of psychiatry into primary care. The establishment of the Primary Care Medical Home has been considered a vehicle for such integration. While the exact method for such integration is still in its infancy, the concept of collaborative stepped care developed by Wayne Katon and colleagues at the University of Washington has improved care for a variety of patient categories. Their work, however, has been in a closed-panel health maintenance organization and may not be feasible for other forms of medical settings. At Inova, we have begun to use the Patient Health Care inventories (PHQ) to screen for affective disorders. We are piloting such screening for depression, and will view how this works for medical home practices within the Inova Medical Group, our multispecialty group practice. As one pundit mentioned, all politics are local – and this may be operant for primary care integration. We need to devise feasible methods depending upon the

local settings. To date, it seems psychiatrists and primary care physicians need to be in larger groups. The electronic medical record is also essential. We will continue to develop processes that address such needs to better integrate our two specialties.



PGY-2s at the Resident Retreat

## Global Mental Health Corner

Peter Polatin, MD

Over the past few decades there has been an increasing realization of the important role mental health plays in a region's overall health and economic status. This is particularly obvious in post conflict societies or areas that are recovering after natural disasters. In fact, one does not have to go far from home to appreciate the need for informed mental health services in these situations: witness the long and painful recovery after Hurricanes Katrina or Sandy, or the impact of war related trauma on returning U.S. military service personnel.

The GWU Department of Psychiatry prides itself on having senior clinicians on faculty who have had a great deal of experience working in these very complex areas, and has attracted many strong residents with a passion for this type of work. In the past year, several of our psychiatry residents participated in varied experiences functioning as clinicians, teachers, program organizers, and educators in other parts of the globe.

Please turn to the next page to read some of the fascinating stories our residents have brought back from their global advocacy trips.



PGY-3s, featuring two of our Global Mental Health ambassadors. Read their stories on page 8.

## Global Mental Health Corner: Resident Perspective

### Veronica Slootsky, MD

During the spring of 2014, Dr. Slootsky, a third-year resident traveled to Cambodia to learn first-hand about Testimonial Therapy and its application to the victims of the Khmer Rouge genocide. There, she observed and participated in the supervision of therapists and genocide survivors to discuss their experiences. She participated in the culturally-specific delivery ceremony at the killing fields, and a Buddhist pagoda. There were several opportunities for cross-cultural learning – she hosted seminars on Traumatic Brain Injury and Psychopharmacology in PTSD for local psychiatrists through the Transcultural Psychosocial Organization (TPO) of Cambodia, and taught psychopharmacology classes to psychology students at the Royal University of Phnom Penh. Unsurprisingly, the prevalence of PTSD is high in that population of genocide survivors. Resources are often limited to the use of older psychotropic medications, such as tricyclic antidepressants. Cambodian mental health professionals are currently exploring cost-effective and adaptable treatment modalities to address these concerns. Ultimately, Dr. Slootsky and other GWU Global Mental Health enthusiasts hope to foster a relationship with the Cambodian TPO and one day implement Testimonial Therapy refugee populations in Washington, D.C.

### Michael Morse, MD

In March 2014, Dr. Morse, a third-year resident, led a team from the George Washington University Department of Psychiatry and Behavioral Sciences traveled to Jordan and Palestine to explore opportunities in cooperative global mental health. Dr. Morse founded the non-profit Palestinian Medical Education Initiative (PMED) in 2007 to advance medical education in Palestine through international partnerships and currently serves as its Executive Director (<http://www.pmedonline.org>). Dr. Morse was accompanied on this trip by GW Professor of Psychiatry Allen Dyer, MD, PhD and PMED's Medical Director, Elizabeth Berger, MD, MPhil, Associate Clinical Professor of Psychiatry at GW. Also participating were PMED staff members, Mervyn El-Ghazal, and

Bushra Awidi, MD, as well as PMED's key partner Samah Jabr, MD, who practices psychiatry in the West Bank and teaches long distance as Associate Clinical Professor of Psychiatry at GW. The team visited hospitals, clinics, and training centers in both Jordan and Palestine and developed plans for future projects involving clinical service, training, and research.

### Peter Zemenides, MD

Dr. Zemenides, a fourth-year resident, traveled to Athens, Greece to participate in training program arranged by the Greek Council for Refugees. Alongside Peter Polatin, MD from GWU and Maria Kalli from Greece, Dr. Zemenides trained physicians, therapists, and social workers about the physical and psychological consequences of torture. Due to its geographic location and EU membership, Greece has seen a surge of tortured refugees from Asia and Africa. Limited resources, social support, and medical care have placed a heavy burden on efforts to help these victims of torture. Dr. Zemenides, a Greek American, found the opportunity to contribute to Greece's efforts particularly rewarding. He was specifically involved in training attendees in traumatic brain injury and the pharmacological management of PTSD, matching his personal and professional interests. The feedback he received has reinforced his commitment to these areas of psychiatry and expanded his desire to invest in global mental health.

### Sandeep Denduluri, MD

Dr. Denduluri, a fourth-year resident, traveled to Mseleni, KwaZulu Natal, South Africa. He spent time at the Mseleni Hospital seeing patients on the wards and in the outpatient clinic with the help of Zulu translators. He also visited the satellite clinics in the Mseleni Hospital catchment area, and accompanied social workers and nurses on home visits. Along with Dr. May, he led weekly didactic sessions for the physicians and nurses who expressed frustration with mandates of the Mental Health Care Act. He dedicated his last week to reviewing the hospital's formulary to minimize side effects, working with physicians to create an organized approach to handling admission and legal documents



# Undergraduate Medical Education: End-of-the-Year Update

Julia Frank, MD

The George Washington University Department of Psychiatry and Behavioral Sciences selected Dana Rosenfarb (Class of 2014) to receive the Jerry M. Wiener award in psychiatry. In addition to being an outstanding student, Dana led the psychiatry student interest group for three years. She is going on to residency at Harvard Longwood. Four other members of the class of 2014 matched in psychiatry. Congratulations to the future psychiatrists of the class of 2014! We are so

Next year's entering class will be the first to experience the new curriculum in the medical school. After a foundational course, which will include concepts in behavioral sciences, the department has six hours in each organ block to help students connect various medical problems to the lived experience of real patients. Psychopathology will no longer be taught in the first year. Instead, a combined neuroscience/psychopathology course is planned for late in the second year. We hope to continue to call upon the voluntary faculty who have been such a vital part of the medical student education program to support these new courses, in ways still to be worked out as the blocks are organized. Dr. Charles Samenow is spearheading the department's efforts in the new curriculum.

The department is immensely grateful to Shaira Morales, the medical student program coordinator for six years, who left in April to take a position as a research assistant in the medical school. At the same time, we are delighted to welcome Anthony Crisafio, [acrisafio@mfa.gwu.edu](mailto:acrisafio@mfa.gwu.edu), to the coordinator position.



**Dr. Thomas Wise** was honored as "Advocate of the Year" by the Washington Psychiatric Society.

**Dr. James Griffith** has been awarded the "Distinguished Service Award" by the Washington Psychiatric Society.

**Bruce Shaver** (PGY-1) was honored as the "4-South Physician of the Month" while on his Internal Medicine rotation, and as "4-North Physician of the Month" while on his neurology rotation.



**Veronica Sloatsky** (PGY-3) has been awarded the "Resident Fellow Meritorious Service Award" from the Washington Psychiatric Society.

**Michael Morse** (PGY-3) has been awarded the "American Psychiatric Leadership Fellowship" from the APA.

**Walter Alexander**, one of our beloved receptionists at the MFA, was honored with the "Common Purpose Award" from the MFA for always going the "extra

## Drowzy: Expert Sleep Tracking to Guide the Treatment of Insomnia

Veronica Slootsky, MD and Daniel Lieberman, MD

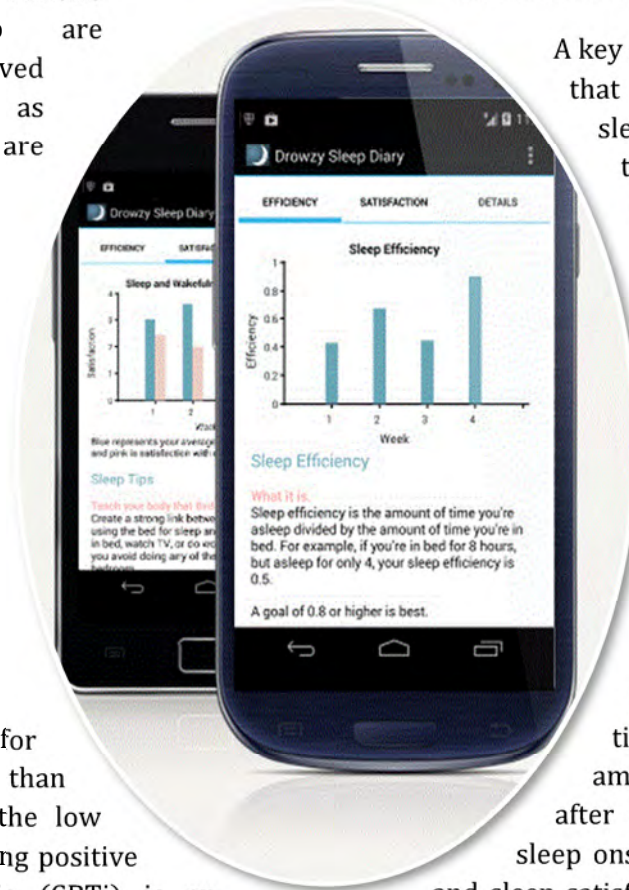
Insomnia is a major health problem affecting millions of people around the world. Fifteen percent of Americans have chronic insomnia, and the effects on physical and mental health can be profound. In addition to effects on the cardiovascular and immune systems, people who are substantially sleep deprived have been found to drive as poorly as those who are intoxicated.

Hypnotic medications can be effective; however recent studies show an association with increased risk of death. Additionally, when clinicians prescribe hypnotics, they currently have no good way to determine how the medications are affecting sleep patterns beyond the patient's general report.

Effective psychotherapy for insomnia is a better option than sleeping pills, because of the low risk of harm and the enduring positive effects. CBT for insomnia (CBTi) is an evidence-based therapy that has been proven to work as well as medication for many patients. Unfortunately, few people are trained to provide CBTi, so it is difficult for patients to obtain this treatment. It's almost like having a safe and effective sleeping pill sitting on a shelf that nobody can reach.

As personal technology advances, it may become possible to prescribe certain kinds of highly structured psychotherapy as easily as prescribing pills. Previous experience here at GW developing and testing automated treatments for alcohol abuse (motivational

enhancement) and bipolar disorder (mood tracking and social rhythm therapy) has shown efficacy even without professional assistance. Currently, we are collaborating with MFA Sleep Specialist, Dr. Vivek Jain, on the automated CBTi app, Drowzy.



A key component of Drowzy is a sleep diary that focuses attention on maximizing sleep efficiency, which is the ratio of time asleep to time in bed. Even more than total sleep time, sleep efficiency is the metric most closely associated with satisfaction in the quality of sleep. Tables and graphs help users make connections between sleep efficiency and other sleep-related behaviors. Tips on healthy sleeping make maximizing efficiency easier.

Data from sleep diaries can be useful for both clinicians and patients. The Drowzy diary tracks time to bed, sleep onset latency (the amount of time it takes to fall asleep after turning off the lights), wake after sleep onset, total sleep time, sleep efficiency, and sleep satisfaction. These are the variables that sleep specialists find most useful when determining treatment, and can add a layer of precision and objectivity to the evaluation of hypnotic effectiveness. Users of Drowzy can send their data and graphs to a clinician with just a few taps.

We have released the diary component as a free, stand-alone app on the Google Play store so that doctors and patients can begin to use it immediately. Currently, over 1,800 users from over 73 countries have downloaded the program. These data will be used for research purposes with participants' informed consent.

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## Drowzy

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A few of the many questions that may be answered with the data obtained with this application include: Does the time a person gets into bed effect sleep? Is it true that 10-11 PM is associated with the smallest sleep onset latency? What happens to sleep during daylight savings time changes? Does latitude play a role? What about gender and age? Can we measure the effect of large drops in the stock market, heat waves, or important news events—such as a terrorist attack—that could provoke anxiety? Do different countries have different expectations about sleep that can be discovered by comparing levels of satisfaction to hours slept, sleep efficiency, time to bed, etc.?



In the future, we hope that therapists and physicians will be able to “prescribe” the full CBTi app to patients who are having difficulty sleeping, or who are interested in getting off of sleeping pills. Drowzy CBTi will track the user’s progress and provide contextually-relevant information by matching patient-specific information to best practice strategies routinely used in clinical practice. Next-gen Drowzy will communicate with providers so that clinicians with no specific training in CBTi will be able to guide their patients through an effective, evidence-based course of non-drug treatment for insomnia. Please consider recommending Drowzy to your patients who would be interested in tracking their sleep patterns. Visit [www.drowzy.com](http://www.drowzy.com) for more information.



## Kudos and Congratulations

Promotions, New Positions,  
and Retirements

**Dr. Lorenzo Norris** has been appointed Interim Assistant Dean of Student Affairs at the GW School of Medicine at Health Sciences.

**Dr. Michael Compton** accepted an offer in November 2013 as Chairman of the Psychiatry Department at Lenox Hill Hospital in New York City.

**Ms. Beth Broussard** continues to work with Dr. Compton as Research Coordinator on their first-break psychosis research.

**Dr. Richard Blanks** accepted a new position in January 2014 as a faculty member in the Department of Forensic Psychiatry at Wake Forest Baptist Health in Winston-Salem, NC.

**Ms. Shaira Morales** has served as the Psychiatry Clerkship Coordinator for medical school education for 6 years. She recently accepted a position as a Project Manager for Health Care Professional Education in the GW Cancer Center.

**Mr. Anthony Crisafio** has transitioned to his new role as Psychiatry Clerkship Coordinator for medical school education, after working as part of Dr. Compton’s research team for several years.

**Barrie Seidman, LICSW** will be retiring this summer. After 36 years of service in the GW Department of Psychiatry as Co- Director of the Group Therapy Program.

## AS THE WORLD TURNS

### Julia Frank, MD

Recently, I accompanied fifty refugees on a harrowing journey across hostile terrain, as a Red Cross Disaster Volunteer providing front-line psychological first aid. Our party included a three generation family, a mother with an infant strapped across her chest, young women hampered by flimsy shoes and the long skirts demanded by their national costume, a few unattached young men, and smaller family groups. Accompanied by bursts of gunfire, we crossed a no man's land between the group's country of origin and a reluctant country of refuge. En route, we encountered soldiers, a mine field, insurgents and rebels from two warring factions, predatory vendors trying to take what little money the refugees had, and border guards who spoke none of our languages. The weather devolved into a steady rain, turning forestland into swamps of ankle deep mud. When we reached the refugee camp, only the most basic food was available. The UNHCR tents pitched over plywood floors were completely soaked and nearly as filthy as the ground we had just crossed.

This odyssey took place in Bull Run State Park, as part of the Global Refugee Simulation and Conference organized by the George Washington University International Humanitarian Law program (in collaboration with the American Red Cross and other relief and financial organizations). We were walking through genuine mud, accosted by real soldiers and surrounded by the sounds of real gunfire (from a nearby shooting range). Like those who have actually experienced terrified flight, I felt the impulse to put the experience behind me by putting it into words, the need to share my thoughts with others to help me decide, in retrospect, what it all meant.

I was especially struck by the hazards that international relief workers, including medical and mental health professionals, face in the field. My Red Cross pin kept me from being targeted by any of the enactors, but I was not safe from the impersonal hazards—the weather, the terrain and the “mines”—or from the conditions in the refugee camp. My respect for Doctors without Borders has shot up, even as I now give myself permission to relinquish any fantasy of being deployed in a professional capacity, in the

contribution to the safety, basic necessities, and reunion with lost others that immediate survivors need. At the same time, the experience reminded me that I can offer important help at a later stage: a listening ear, an understanding of the physical and psychological consequences of terror and deprivation, and, in a limited way, valid treatments that may limit certain patterns of suffering.

My day in the woods brought to mind the large number of people in this region who have real experiences akin to the conditions this exercise evoked; magnified many thousand fold by the loss of culture, loved ones, and personal identity. I have encountered a small number of them as a volunteer for Physicians for Human Rights (PHR). PHR, along with several of the international law clinics at local law schools, plays a particular role in helping refugees in this region. The PHR asylum network matches willing medical and mental health professionals (and advanced trainees) with lawyers or law students representing applicants for one of several forms of asylum. The professionals do not provide treatment. They elicit or confirm the person's story and tell it in such a way that the court can hear it when considering pleas for asylum. Mental health professionals are called upon to explain applicants' demeanor and difficulty recounting trauma with legal precision, to diagnose them with conditions that justify staying here for treatment, and to offer evidence of the credibility of their claims, based on the nature of their reactions. When treatment is needed, the evaluator may also refer the person to an appropriate agency. Most of this work is uncompensated, though law firms providing pro bono obligation sometimes have funds to pay for expert testimony.

My experience with this simulation reaffirms my commitment to providing the help I can, even on a very limited basis, to those who need it so desperately. If others are moved to consider the possibility of joining up, they may contact Lisa Manrique of PHR ([lmanrique@PHRUSA.org](mailto:lmanrique@PHRUSA.org)). Testifying on behalf of victims of torture, violence and trafficking is challenging, rewarding, and renewing of the values that inspired us to enter our



## Research Corner

### Anthony Crisafio

The research corner of the department is in high gear. We're proud to say that several posters were presented by the research team, faculty, and residents at this year's APA Annual Meeting in New York City. The research team is working on another NIMH grant. This project, focused on psycholinguistics patterns in individuals with schizophrenia, is recruiting patients from GWUH's 6 South, Washington Hospital Center's two inpatient units, and from the McClendon Center.

#### We are also working on several papers and topics:

- Analyzing perceptions among law enforcement of the Crisis Intervention Training (CIT) across Georgia. We are particularly interested in how perceptions differed between CIT-trained and non-trained officers, and between departments that have a CIT program and those that do not.
- The relationship between prenatal smoking and schizophrenia symptoms among first episode psychosis (FEP) patients, in collaboration with Suena Massey, MD. Specifically, the effect of prenatal smoking on the severity of symptoms, in particular those related to reality distortion.
- The relationship between personality domains (the "Big Five") and duration of untreated psychosis in FEP patients. Another novel approach, we are interested in whether this person-level domain has a relationship with schizophrenia and how the domains (openness, agreeableness, neuroticism,
- Looking at the expression of neurological "soft signs" (a known trait within schizophrenia) among FEP individuals and how those individuals cluster together in terms of their expression of the various neurological signs. Those clusters or "subtypes" of patients will then be compared on a number of clinical characteristics.
- Analyzing the relationship between mental health and food insecurity among DC residents. The first study of its kind, we partnered with the USDA, to gain a better understanding of the unique characteristics of individuals with co-morbid food and mental health issues.

## Resident Publications and Presentations

Cleary, S.D., **Bhatty, S.**, Broussard, B., Cristofaro, S.L., Wan, C.R., Compton, M.T. "Measuring insight through patient self-report: An in-depth analysis of the factor structure of the Birchwood Insight Scale." *Psychiatry Research*, 2014.

Jabr, S., **Morse, M.**, Awidi, B., & Berger, E. (2014). Mental health care in Palestine: Barriers to excellence. *Washington Psychiatrist*, Spring, 2014; 13-18.

**Slotsky, V.** "The Young Man and the C-pod" *Washington Psychiatrist Magazine*, August 2013 edition.

Kels CG, **Kels LH.** "The Problem with Parsimony (and the Prioritization of Prudence)" *Southern Medical Journal*, 2013 Nov;106(11):597.

Poster: March 2014 Pascoe A, **D'Silva S.** The Twilight Years: Wisdom Teachings and Transgenerational Growth. Society for Humanistic Psychology (Division 32), American Psychological Association. Annual Meeting. Palo Alto, California.

Presentation: April 2014 **D'Silva, S.** Lessons Learned from the Ground Up. Global Mental Health Seminar, Department of Psychiatry. Monthly Lecture. George Washington University School of Medicine, Washington, DC.

Presentation: May 2014 **D'Silva S.** The Need for Spiritual Integration Into Existing Eurocentric Therapies - What Global Cultures Demonstrate in Treating Complex PTSD. Society for the Study of Psychiatry and Culture. Annual Meeting. San Diego, CA.

Presentation: May 2014 **Dong, Y., Ghandi, B., Puri, N.** Medical Mimics of Psychiatric Disorders and Psychiatric Disorders Mimicking Medical Conditions. American Psychiatry Association (APA) Annual Conference - sponsored by APA Council of Psychosomatic Medicine. New York, NY.

Presentation: May 2014 **Puri, N.,** Lolak, S., Cheong, J., Crone, C. The Hateful Patient Revisited and 21<sup>st</sup> Century Medicine. American Psychiatry Association (APA) Annual Conference. New York, NY.

## Technology Corner

Sandeep Denduluri, MD

This spring's tech piece is an informal reflection on how to evaluate an Electronic Medical Record (EMR) system. EMRs can range from a basic word processing application with standardized forms to large enterprise systems such as Cerner, Epic, and the giant Veterans Health Information Systems and Technology Architecture (VistA). There are several products available along the spectrum including systems like Credible, Meditech, and Allscripts.

The first step in evaluating any system is experiencing it as an end user. In the case of an EMR, the end user could be a doctor, nurse, or administrative staff. The end user experience is often largely defined by the Graphical User Interface (GUI). The GUI (pronounced "goeey" in tech talk) can be painful to use and awful to look at, or it can be outright pleasant. The GUI should be intuitive, engaging, and appealing to the eye.

But the GUI is not everything. Beyond the GUI, a good EMR must have a solid system architecture and computer code that is effective in performing various operations of an EMR (i.e., displaying trends in lab work, maintaining an accurate census of patients on the Psychiatry service, etc). Important questions to ask include: "Is this program allowing me to complete otherwise complex tasks with simplicity and effectiveness? Is this program presenting accurate and relevant information? Am I saving time and money?"

One final, and somewhat more advanced consideration is deciding how the system has been designed to store data and retrieve data. This brings up many key questions: "Who are the owners of this data? How portable and interoperable is the data generated by this system? What are the costs associated with walking away and still having access to essential data?"

Unfortunately, we are entering an era when the end users, especially doctors, will be paying a high price for expensive systems with mediocre interfaces and system functionality, and questionable improvements in efficiency and quality of life. The design and

function of the EMR will largely be driven by the needs of non-end user interests, such as payers and administrators. In smaller groups and practices there will still be some room for evaluating EMRs in the key areas presented above.

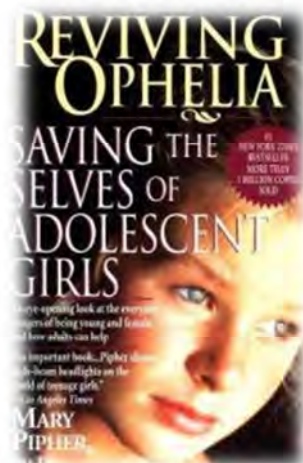
## Book Review

Stefani Reinold, MD, MPH

"Reviving Ophelia: Saving the Selves of Adolescent Girls" by Mary Pipher, Ph.D. is a great read for anyone interested in understanding the profound impact adolescent years have on the rest of our life.

Published in 1994, "Reviving Ophelia" packs a meaty punch on the oh-so-familiar, ubiquitous challenges that face many adolescent girls (and boys). *New York Times* bestselling author Dr. Mary Pipher, a clinical psychologist specializing in adolescent women, captures the trials and tribulations of so many individuals as they endure adolescent years. What happens to our childhood days of make believe or our far-fetched dreams of being president or traveling to Mars?

Through clinical anecdotes and personal stories as a mother to a teenage girl, Dr. Pipher attempts to address the many barriers that adolescents face in reconnecting to their "true selves." She discusses how adolescents suffer due to experiences outside of their control, including domestic violence, substance abuse, sexual abuse, eating disorders, iatrogenic family dysfunction, or poor self-esteem. Many of Dr. Pipher's patients, and adolescents that we face every day, come out of adolescence unscathed. However, as "Reviving Ophelia" points out, some may require more work via therapy, interrelationship improvement, and good old-fashioned soul-searching to overcome adolescent struggles. And, unfortunately, a few remain forever injured and permanently traumatized. For this minority, Dr. Pipher recommends that we providers remain on close watch.





## New 2014-2015 Psychiatry residents

### PGY-1s



#### **Lisa Adler**

Ms. Adler received her B.A. in History from Cornell University in 2009 and will receive her M.D. from New York University this June. She has participated in research studies relating to neuropsychological testing of children with ADHD, and nicotine replacement therapy for inpatients, for which she received the SARET-NIDA Fellowship. She comes to us as part of a couples match, as her partner will be joining our Internal Medicine Residency at GW.



#### **Monika Karazja**

Ms. Karazja received her B.S. in Biology and Spanish from St. Joseph's University in Philadelphia in 2008. She is currently a fifth year medical student at Albert Einstein Medical College, spending the current year pursuing a Master's of Science in Global Mental Health from King's College in London. Ms. Karazja has performed research at Columbia University on the mental health gap in Latin America, and is the recipient of a number of fellowships, including the Global Health Fellowship and Einstein Research Fellowship.



#### **Carrie Lewis**

Ms. Lewis received her B.A. in Performing Arts and Religious Studies from Washington University in St. Louis in 2005. She pursued her post-baccalaureate pre-medical studies at Columbia University, where she also did research involving cerebral monitoring and neuropsychological testing in OR patients. She will graduate with her M.D. from the University of Kansas Medical School, and completed an elective rotation at Children's National Medical Center in Fall 2013.



#### **Terry Price, Jr. (T.J.)**

Mr. Price graduated from Georgetown University in 2007 with a B.S. in Biology and was accepted into Georgetown University School of Medicine via the Early Assurance Program during his sophomore year. He pursued additional coursework in biology at King's College in London, where he played varsity basketball. He will receive his M.D. from Georgetown, and his numerous extracurricular experiences illustrate a strong commitment to teaching, coaching, and mentoring young people.

**PGY-1s***(continued from previous page)***John Tarim**

Mr. Tarim received his B.A. in Biochemistry from Columbia University in 2008. He will receive his M.D. from Albert Einstein College of Medicine this spring, having taken an extra year to perform research in hematology/oncology, and a second year to pursue his Master's of Science in Global Mental Health degree from King's College in London. He was awarded the Albert Einstein College of Medicine Service and Research Golding Scholarship in recognition of research skills and achievements and dedication to community.

**Stephanie Waggle**

Ms. Waggle received her B.A. in Psychology in 2008, and M.S. in Biology in 2009, from Chatham University. She is currently a fourth year medical student at GW and is the recipient of the George Washington School of Medicine and Health Science Health Services Scholarship. Her research with the United Kingdom Civil Aviation Authority involved developing a tool to identify eye injury following laser exposure.

**Upper Year Residents****Shuo (Sally) He, MD, MPH      2014-2015 PGY-2**

Dr. He received her B.S. in Biological Sciences and Psychology from Carnegie Mellon University in 2006. She pursued her M.P.H. from Yale University School of Public Health from 2006 to 2008, during which time she received the International Health Student Travel Fellowship which allowed her to complete a project on stigma, depression and HIV/AIDS in rural China. She graduated with her M.D. from SUNY Downstate in 2012, and pursued residency training at Temple University in Internal Medicine until deciding to switch to Psychiatry.

**Pooja Lakshmin, MD      2014-2015 PGY-3**

Dr. Lakshmin attended the University of Pennsylvania as a Neuroscience major and graduated Phi Beta Kappa. She graduated from Jefferson Medical College, where she did both psychiatric research and volunteer work in the student-run health clinics for Philadelphia's homeless population. She completed two years of residency in Psychiatry at Stanford before returning to the East Coast to be closer to her family.