

ISSUE 1 | VOLUME 4 | SPRING 2016

The GW Psychiatrist

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



THE GEORGE
WASHINGTON
UNIVERSITY

WASHINGTON, DC

GLOBAL MENTAL HEALTH P. 3
RESIDENCY 2016 P. 6
FIVE TRIMESTERS CLINIC P. 8



- 3 The Chair's Column: Why Global Mental Health?
- 4 International Perspectives in Psychosomatic Medicine
- 5 From the Program Director
- 6 From the Associate Program Director: On Core Values and Recruitment
- 6 Reflections on the Residency Fellowship in Health Policy
- 7 Updates from Children's National Health System
- 7 World Handball Champion? Sam Goodman, M.D., Emeritus Professor of Psychiatry
- 8 Five Trimesters Clinic: Notes on the 2nd Biennial Perinatal Mental Health Conference
- 9 Great Expectations: The Intern Perspective
- 9 Kudos & Congrats
- 10 Emotionally Focused Therapy
- 11 Changing Faces of Leadership in Psychiatry
- 11 Sanity and Survival: Grand Rounds Summary



**THE GEORGE
WASHINGTON
UNIVERSITY**
WASHINGTON, DC

THANK YOU, WRITERS AND READERS!

Editor: Jason Emejuru, MD

Contributors: Victoria Anderson, Trevor Forde | Advisor: Lori Kels, MD, MPH

Senior Marketing Manager: Sean Liphard

Design: Kelly Sullivan

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

2120 L Street, NW, Suite 600 | Washington, DC 20037

202.741.2888 | gwdocs.com/psychiatry

The Chair's Column: Why Global Mental Health?



*James Griffith, MD
Leon M. Yochelson Professor and Chair*

The American College of Psychiatrists awarded its 24th Annual Award for Creativity in Psychiatric Education to our GW Global Mental Health Program for its teaching innovations in psychiatric education. The American College of Psychiatrists noted that the GW global mental health program has matured since its creation in 1998 into a national model for teaching global mental health in psychiatry residency education as a four-year curriculum of didactic seminars, supervised clinical training, research, and mental health and human rights advocacy. Why has global mental health achieved such prominence at GW? This question can be answered in two different ways. The first is historical. In the late 1990's the GW psychiatry residency found itself without a mission. Through the 1980's and early 1990's, GW psychiatry was organized around the George Washington University Health Plan (GWUHP), the nation's first, most successful, and longest lasting health maintenance organization created to train residents from all medical specialties by credentialing them as HMO providers (Clemons et al, 2001). In 1994, the *U.S. News and World Report* ranked George Washington University Medical Center as third in the nation as a medical school organized around primary training. During this era, GW psychiatry residents provided mental health services for 90,000 GWUHP subscribers in downtown Washington. By the late 1990's, however,

GWUHP had collapsed in the economic upheaval of the Clinton health care reform. The GWU psychiatry residency lost its national identity. Making global mental health a new centerpiece for the GW psychiatry residency made sense for three reasons: (1) Washington held the nation's most multicultural patient populations with over a hundred languages represented in school systems of Washington and its suburbs (*USA Today*, September 24, 1997); (2) a dozen full-time and clinical faculty members were leading figures in cultural psychiatry, trauma treatment, ethnopharmacology, torture-survivor rehabilitation, and human rights advocacy; (3) our physical proximity to NIMH and international NGO's provided unique resources for global mental health (Griffith, 2014). The other answer came from an ethical commitment to further mental health for those who stood outside mainstream America — a commitment to leave no one behind.

This commitment included within its scope those who lived in low- and middle-income countries, in zones of armed conflict, and as immigrants and refugees in our country. In 1998 the GW Department of Psychiatry began providing the psychiatric component of mental health services at Northern Virginia Family Services, whose multilingual psychosocial programs included a Program for Survivors of Torture and Severe Trauma funded by the U.S. Office of Refugee Resettlement. GW psychiatry residents studied cultural psychiatry, learned therapies for posttraumatic symptoms,

treated patients in clinics for immigrants and refugees, and conducted asylum evaluations for political refugees in our Human Rights Clinic. By 2015, the global mental health track had enabled GW psychiatry residents to train in 10 countries and to publish a number of journal articles.

However, our global mental health curriculum provided all our psychiatry residents with expertise as applicable in the U.S., as in low income countries. First, skill sets for global mental health were the same as those needed for urban, multicultural populations in the U.S. Global mental health training was ideal preparation for future community psychiatrists. Second, global mental health required clinicians to learn how to address suffering from sources other than psychiatric illnesses. Addressing social suffering from demoralization, grief, loss of dignity, and violations of human rights was essential in low income countries but also important in the U.S. Third, global mental health required a clinician to engage families and communities as units of treatment, not just individual patients. In many low income countries a person was more a family member than an individual. Skills for family-centered care were needed throughout our U.S. healthcare system. Fourth, the practice of global mental health relied upon building resilience, not just treating psychopathology. Drawing upon patients' spiritualities and other cultural practices as sources of resilience was vital for promoting mental health in low income countries, but of similar importance in the U.S. Global mental health has been a good fit for the natural strengths of our department. It also has extended the reach of our humanistic commitment into the wider world. The training that our residents have gained has outfitted them well for psychiatric careers at home. After 17 years, our Global Mental Health Program has shown how the global is also local for Psychiatry.

References

- (1) Clemens NA, MacKenzie KR, Griffith JL, & Markowitz JC: *Psychotherapy by psychiatrists in a managed care environment: Must it be an oxymoron?: A Forum from the APA Commission on Psychotherapy by Psychiatrists* *J Psychother Pract Res* 10:53-62, 2001.
- (2) Griffith, JL. *Marie Rohde interview with James L. Griffith, MD: Global mental health, one refugee at a time.* *Health Progress* 95(2):54-59, 2014.
- (3) "Educators challenged by diversity's demands," *USA Today*, September 24, 1997.

International Perspectives in Psychosomatic Medicine



Thomas Wise, MD

For psychosomatic medicine, the subspecialty of psychiatry that integrates our field with other medical specialties has a global presence in which our own program at Fairfax has been actively involved.

For three decades, the Psychosomatic program at Inova has been actively involved in psychosomatic organizations both in North America and Internationally. Currently, Dr. Catherine Crone is president of the Academy of Psychosomatic Medicine (APM). I have been president of the APM; the American Psychosomatic Society and am currently president of the International College of Psychosomatic Medicine. Both Dr. Crone and I recently presented at the European Association of Psychosomatic Medicine in Nuremberg, Germany as part of the faculty representing the Academy of Psychosomatic Medicine. This past summer, I also presented a plenary lecture in Glasgow, Scotland at the World Congress of Psychosomatic Medicine, and this past fall I was a visiting faculty in Berlin for both residency training and a course for postgraduates in Consultation-Liaison Psychiatry. These activities are part of our long term focus on psychosomatic medicine as a vital element of Psychiatry. Our own fellowship program has had visiting fellows from the UK, Canada and Japan.

The contemporary growth of psychosomatic medicine has been substantial both within the United States, as well as Western Europe, but also Asia, where psychosomatic therapies were developed that focused upon mindfulness rather than our Western psychobiologic tradition. In the United States, consultation liaison

psychiatry became increasingly popular in the 60s and 70s led by charismatic leaders such as Thomas Hackett, Morton Reiser, Eugene Meyer and James Strain. These psychiatrists, along with others at UCLA, and Rochester, focused primarily on the severely medically ill with particular interest in hemodialysis; cardiovascular disease and cancer. The concept of biopsychosocial was popularized by George Engel, who was an internist and psychoanalyst, not a psychiatrist. His "New Medical Model" was a reaction to his observations that physicians were solely focused upon organic pathology rather than also considering the life setting in which they developed and coped with their illness. Sadly, his work has been forgotten by many physicians, but psychosomatic medicine continues to keep his approaches alive. Over the past decade it has become apparent that health utilization is dramatically augmented by comorbid psychiatric. This has led to psychosomatic medicine working in primary care settings. Concurrently, the target of such interventions has shifted from the individual to a population based approach.

In Europe and the United Kingdom, there has been a different developmental path at the interface between psychiatry and medicine. In the United Kingdom, individuals such as Sir David Goldberg studied the role of "neurotic disorders" in primary care settings. Goldberg developed

the General Health Questionnaire (GHQ) to designate a patient as having a "minor" psychiatric disorder such as anxiety, depression or somatization. Easy to score, the GHQ has been translated into many languages and used internationally. Over the past 20 years, consultation liaison psychiatry has made significant advances as a specialty in the United Kingdom, although there is no formal certification process as in the U.S. In the U.K., psychosomaticists' work is similar to the United States, especially with a focus on the somatizing patient. Australian psychiatry has had a strong psychosomatic group who have trained in both the U.S. and U.K. and regularly contribute to the literature. In the U.S., the Patient Health Questionnaire (PHQ) developed by Kurt Kroenke is similar in its goals at the GHQ. It is a simple method of screening patients to identify those with depression who are in need of psychiatric assessment and care. The GHQ screens for both anxiety and depression.

Publications from our Fairfax program have reported results from GHQ screening of primary care patients in respect to health care costs and diagnostic attention for both anxiety and depression. Other reports from Fairfax focused on chronic pain patients and GHQ results. Another link with international research was early investigations into abnormal illness behavior utilizing the Illness Behavior Questionnaire developed



From the Program Director



Lisa Catapano, MD, PhD

One of the hardest aspects of our work as psychiatrists is maintaining perspective – for our patients, of course, but also for ourselves. We learn early in our training that, in our work with our patients, we are exposed to the most difficult of human struggles: acute and chronic mental illness and/or trauma, often accompanied by social conflict or isolation, violence, financial or housing instability, and the wish to die. One of the most important challenges in learning to be a psychiatrist is to develop the ability to care about our patients and invest ourselves in their well-being without being overwhelmed by their pain. On the one hand, guiding patients through their worst times is a privilege, and we can often use the experience to remind us to be grate-

ful for the good things in our own lives. On the other hand, we can, and I think often do, carry this line of thinking too far. Being with someone who is in acute pain, or who has suffered unspeakable trauma, can make us think that we have no right to be upset about what seem to be smaller or less significant crises in our own lives. A critical part of self-care is to respect that whatever is the worst thing in your life right now is the worst thing in your life right now. It may be, and frequently is, smaller or less dramatic than the challenges people around us face. Nevertheless, if we do not respect and attend to our own conflicts, disappointment, illness, loneliness, or fear, we are not living our own lives fully, and will likely not have the resilience and stamina to do this work as well or as long as we might otherwise.

International Perspectives in Psychosomatic Medicine

in England and Australia. Such research was helped by consultations from English and Australian psychiatrists. An ongoing focus of research at our program has been the role of Alexithymia in medically ill patients, a construct was developed in Boston but has been a personality measure similar to French constructs and a focus of research in Germany. Over the summer, I collaborated with Turkish colleagues have investigated alexithymic rates in panic disorder and the role of alexithymia in illness behaviors.

In Germany, Austria and Switzerland, psychosomatic medicine took a different path. Psychosomatic medicine developed as a unique specialty wherein the physicians were trained in internal medicine as well as psychodynamic aspects of personality rather than formal psychiatry. These physicians worked in a collaborative basis with

psychoanalytically trained psychologists. The specialty was separate from psychiatry or internal medicine and over the past 25 years a small cohort of German speaking psychiatrists came to the United States to train in consultation liaison psychiatry and went back to establish the field with a more psychiatrically focused consultation model. Japan also has a strong psychosomatic tradition composed of psychiatrically informed internists. Korea and China also have large psychosomatic organizations, but the actual training of such physicians is more heterogeneous.

The international organizations for psychosomatic medicine are primarily in developed countries which have strong health systems and well-organized psychiatric divisions that offer training in this area. Europe, however, differs from United States in that each nation has its own unique system. This leads to difficulties in developing standardized fellowship training objectives. The research, however, from Germany, the

United Kingdom, Switzerland, Dutch, Italy, Spain and Portugal, are all focused on similar issues as their Anglophonic investigators. These research reports are commonly in English language journals such as the Journal of Psychosomatic Research; Psychosomatics; and Psychosomatic Medicine. Concepts such as vital exhaustion as a precursor to cardiac events arose in Maastricht in Holland. British psychosomaticists have been successful in developing short term therapy for irritable bowel patients with comorbid depression and anxiety – just to name a few areas that are important for international psychosomatic specialists.

The international perspective has allowed our Fairfax/GWU program to remain a leader in this exciting subspecialty. It reminds us that maladies such as anxiety, depression and pain knows no borders. Working with colleagues from around the world offers new insights, reifies current approaches, and enhances our professional lives.

From the Associate Program Director: On Core Values and Recruitment



Lori Kels, MD, MPH

Ever since Dr. D.W. Winnicott wrote to Charles Schultz in 1955 for permission to cite Linus's security blanket as a "transitional object," the *Peanuts* comic strip has been a source of inspiration for psychiatrists. Perhaps the most memorable line in the annals of mental health was uttered by none other than Charlie Brown: "my anxieties have anxieties."

Nevertheless, when I took my kids recently to see *The Peanuts Movie*, my goals were relatively modest. I hoped first that we'd manage to find seats together, second that the kids would be entertained, and finally that I might end up enjoying a relatively peaceful 90 minutes with some Vince Guaraldi songs in the background. I certainly was not expecting inspiration for this column.

As with any Charlie Brown movie, there are plenty of lessons for both the children and adults in the audience. Perhaps, particularly entertaining for a psychiatrist are the scenes of Lucy confidently doling out advice at five cents a session from her "Psychiatric Help" booth; and for GW psychiatry residents, echoes of Griff's Hope Modules in the lessons that Charlie Brown comes to understand. (Of less educational value was Charlie's first visit to Lucy's booth, in a strip from 1959. Charlie confides, "I have deep feelings of depression...What can I do about this?" To which Lucy retorts, "Snap out of it! Five cents please.")

For those of you who haven't seen this most recent *Peanuts* movie, Charlie Brown spends most of the story trying his hardest

to make a great first impression on the new girl. In this season of constant first impressions for residency programs – recruitment – just about every day is an opportunity to make a good first impression. Watching *The Peanuts Movie* got me thinking about the lesson Charlie Brown comes to realize and how it applies just as easily to residency recruitment season: that it's not so much what we say, but how we (the administration, and most importantly, our residents) carry ourselves that may speak the most about the core values of our program. Thank you to all of our residents who convey through your enthusiasm, excitement, and warmth our program's most important strengths to our applicants, our future residents.

To bring it back to Charlie Brown – and I won't spoil the ending for those of you who haven't had the pleasure of seeing the movie – but as anyone who has seen a *Peanuts* movie before might imagine, Charlie Brown comes to see that his sense of self was a distorted one. It's a good reminder that while interviews coincide with the daily pressures that everyone feels as residents and physicians, the message that you send to applicants in giving your precious time to them at lunches, dinners, or in the hallways of the department, is that we should never lose sight of what a wonderful place this is to practice and learn the profession of psychiatry. By communicating our sense of community and collegiality to our future residents, we help ensure the continued strength and vitality of our program.

Reflections on the Residency Fellowship in Health Policy

Ross Goodwin, MD

This past fall, three weeks of daily adventures visiting policy-making organizations and hearing from renowned experts gave me a glimpse into the complexities of the laws and structures that govern how we attempt to prevent and cure disease in our country. As I came to learn the structures of legislative assistant staffing in Congress, and how eager policy-makers are to hear from expert constituents, I realized the impact that an individual physician can have on the motivations and priorities of lawmakers regarding health care legislation.

In contrast to my medical, scientific perspective based on randomized controlled trials, I learned the refrain that policy is built on anecdotes. Prior to my participation in the fellowship, I assumed

that the best way to impact policy would be to join established professional organizations like the APA or AMA that would lobby on my behalf. I realized through my visits to think tanks and legislative offices, however, that our elected officials crave human stories, and some even dismiss a group of doctors in white coats standing one day a year on the steps of the Capitol.

I remembered that the stories of my patients are compelling and rich, and their experiences should be the driving force behind how our government intervenes to improve health care. The health policy fellowship taught me that I can fulfill a unique role here in our nation's capital, and I resolved to become more involved in the decisions of our elected officials which impact the care of our patients and how we practice medicine.

Updates from Children's National Health System



Lisa Cullins, MD and Martine Solages, MD

There has been a lot to celebrate over the past year at Children's National Health System. We were, of course, filled with immense pride as we watched our Division Chief, Dr. Paramjit Joshi, successfully complete her term as President of the American Academy of Child and Adolescent Psychiatry. We have also welcomed three new faculty members into our division. Dr. David Call (former chief fellow at Children's National) is now ably leading the Gender Development Clinic, which continues to serve gender nonconforming youth and provide needed support for their families. Dr. Mary Gabriel, who was a practicing pediatrician for several years and is a graduate of child psychiatry training via the post-pediatrics portal program, will be involved in our integrated behavioral health programming. She will also provide telephone consultation to primary care providers as a clinician in the DCMAP program. Dr. Angela Sagar has a particular interest in autism spectrum disorders and will be providing services at both the DC and Rockville campuses.



Our first year fellows are hard at work caring for children and adolescents on the busy inpatient and consultation services. Despite their considerable workload, they inspire the rest of our department with their enthusiasm for child

psychiatry and their determination to give the best care possible to their patients. The panoply of electives undertaken this year by our passionate and dedicated second year fellows is impressive. The following is just a sampling of their endeavors: SAMHSA/ AACAP Systems of Care rotation, an international elective at the Maudsley Clinic, sleep medicine research at NIMH, advocacy and clinical care at the Korean Community Service Center of Greater Washington, a mental health and spirituality elective at a historically Black church, a mental health and the law elective at Children's Law Center. In addition, with the leadership of Dr. Joshi and Dr. Lisa Cullins, Children's National has a number of exciting new collaborations this year. We have partnered with DC Prep (a public charter school) to provide school-based mental health services. We are also now providing psychiatric services at the Center for Adoption Support and Education (CASE). Finally, we are pleased to have residents from Howard University (our next door neighbor) rotating in our outpatient psychiatry department.

We have set a fast pace for the first half of the year, but are determined to maintain our stride and continue to provide excellent clinical care and advocacy both at the hospital and in the community. We are also sending our best wishes to all our GW colleagues for continued success in your endeavors in 2016.

World Handball Champion? Sam Goodman, M.D., Emeritus Professor of Psychiatry

James Griffith, MD

Last August, Dr. Sam Goodman won a Gold Medal for his age division in the one-wall World Handball Championship in Calgary, Alberta. Dr. Goodman had been a champion handball player in New York City, including a championship at Brooklyn College. However, he stopped competing when he began medical school. After years as a squash and racquetball player, he picked back up handball eight years ago. In the Calgary world competition, he faced a quarter finals opponent who had won three national titles, a semi-finals opponent who had won six national titles, and a finals opponent who had won approximately 30 national titles. He won the quarter final match 25-10, the semi-final match 21-11, 21-4, and the final match 18-21, 21-17, 11-0. Please congratulate Dr. Goodman!



Five Trimesters Clinic: Notes on the 2nd Biennial Perinatal Mental Health Conference

Pooja Lakshmin, MD

This November, I had the opportunity to attend the Perinatal Psychiatry Conference in Chicago, Illinois, along with Dr. Nicole Nguyen and Dr. Julia Frank.

We presented our research poster - "Residents' Perspectives on Developing Competence in Providing Perinatal Psychiatric Care," which included PI Dr. Lori Kels and Dr. Lisa Catapano. Our work was based on qualitative focus group data that we collected from current and past GWU residents who have trained in our Five Trimesters Clinic.

The results focused on several important themes. Firstly, residents reported a strong sense of competency in providing psychopharmacologic therapy and supportive psychotherapy for perinatal psychiatric patients. Moreover, there was a consensus that working with this patient population encouraged residents to examine their own life experiences in relation to current/potential parenthood. Lastly, and perhaps partially in response to this parallel process, as well as the steep learning curve in working with a vulnerable population, residents emphasized the importance and helpfulness of direct and structured supervision by attendings.

Our poster generated quite a bit of buzz at the conference! Folks were impressed by the scope of our clinic as well as the residents' ability to integrate into the clinic and treat the patient population. The conference also gave me the opportunity to attend lectures and symposia in the emerging field of Reproductive Psychiatry. Especially interesting points of discussion included the implications of the profound rise in ovarian hormones during gestation, as well as the role of cortisol in the brain (which we know to be increased in acute stress and depression). The consensus of many speakers and attendees seemed to focus on the ongoing findings that the "pregnant brain" is quite different than the non-pregnant brain! Moreover, the concept of maternal mood fluctuations as a lens for which to study development and attachment in children was an area of much attention. Researchers presented work on maternal exposure to SSRIs and the associ-



In these cases, women often felt they were not fully present at the birth, which can lead to implications on attachment, as well as future pregnancies. Often, the trauma symptoms in these patients are overlooked because their medical history is deemed "normal."

ation with higher executive functioning in a subset of children. These findings are also informing current work in the epigenetics of resilience. Finally, much discussion time was also given to traumatic childbirth and how this can adversely affect mother and baby. A particularly poignant piece of this

topic was the acknowledgment that many deliveries can be termed a "success" in the medical record (normal APGARS, minimal blood loss) and yet - trauma is in the eye of the beholder. In these cases, women often felt they were not fully present at the birth, which can lead to implications on attachment, as well as future pregnancies. Often, the trauma symptoms in these patients are overlooked because their medical history is deemed "normal."

Overall, I strongly encourage my fellow GWU residents to put as much time and energy as possible into seeking out these type of professional conferences. I know it can be tough to poke our head out from all of the clinical and personal responsibilities to submit an abstract and apply for time away. But, it is worth the effort by leaps and bounds! These conferences are a potent way to immerse yourself in all the academic knowledge you could possibly want in a short period of time. And, equally as important for us as residents, these conferences can be an exciting way to "find your tribe." I'm grateful to our residency program for giving me the opportunity to participate in this type of professional development, and looking forward to continuing to learn and grow in this field.

Great Expectations: The Intern Perspective

Jacqueline Posada, MD

Let me take you back to intern year and the pleasure inherent in the first legal utterance of that simple phrase “Hello my name is Dr. Posada.” We all remember that feeling and the joy it brings. Yet mere months into residency, my expectations have been challenged. We new doctors are adjusting to the rhythms of our chosen field. Our identity as a healer and our sense of obligation to our patients is forced to come to terms with our own limitations. I’ve worked hard to remain constant in my conviction to always offer my intellectual best and maintain the curiosity and willingness to learn that marks a trusted physician. And yet at times I struggle to achieve the goals I set for myself. Coming to terms with this balance is perhaps the steepest portion of a new doctor’s learning curve. I entered medicine certain that I could help any patient with enough compassion, understanding, and a mission for fairness. As a medical student I volunteered and directed a student run free clinic, work that exposed to me the realities of caring for under-served communities. I did not enter GW’s wards unaware of the hardships and injustices we witness as doctors. However, as an intern, I often feel



like a machine, with just enough fuel to see my patients and get through the expected documentation. As I cycle through patient rooms, I have to remind myself to be present to their individual vulnerability--no matter how many patients I see each day.

I have to come to terms with the need to budget my emotional capital. Many of our patients are either homeless or experiencing illness inextricably linked to their poverty. These are still early days for me as an intern and I cannot help but be affected by the rawness in a patient’s story. Each patient encounter can still be a visceral experience. I want to offer my experience as a “green” intern as a reminder to more experienced physicians of these first few months where young doctors realize, and struggle with, the depth of our responsibility to patients. New doctors struggle daily with the realization they cannot always provide the empathy they expect from themselves. I’ve realized that I cannot empathize, or even sympathize, with every one of my patients. At times I am only able to try and view my patient’s situation clearly, simply attempting to withhold judgement and offer objective medical advice. Some days I achieve the gold standard and feel like I can empathize with a patient and the struggles they have endured. On my worst days, I don’t really know what patients really expect from me beyond my medical expertise. When I struggle to give any patient the care I think they deserve, I imagine the doctor I would want sitting at my bedside and try to be that doctor for every patient.

Kudos & Congrats

Lisa Adler, MD, who was awarded a travel grant to present at the American Professional Society of ADHD and Related Disorders.

Sally He, MD, MPH for winning the GWU Hospital Innovation Award for her project aiming to bring the Music and Memory Program to GW

Welcome

Lauren Buckman, who joined the MFA department last summer as our new patient Intake Coordinator.

Robert Stasko, MD, who joined GWU Hospital as a new attending on the inpatient psychiatric unit.

Jerry Perman, M.D., P.A., President of the American Academy of Dynamic Psychiatry and Psychoanalysis



James Griffith, MD

Dr. Jerry Perman, Clinical Professor of Psychiatry and Editor, The Washington Psychiatrist, will serve as the 2016 president-elect for the American Academy of Dynamic Psychiatry and Psychoanalysis. Dr. Perman has been a longstanding teacher and psychodynamic psychotherapy supervisor for our psychiatry residents.

Emotionally Focused Therapy



Sabine Cornelius, PhD, MSW, LICSW

All feelings welcome... is the sign I picture having on my office door. Anger seems to be the least popular emotion among my patients. When asking patients about their feelings toward the boss for criticizing her in front of her colleagues, toward the wife for not appreciating his contributions to household chores, toward the friend who only talks about himself, the most common answers include: I felt so bad I ate a whole box of cookies afterwards. I feel like I failed. I'm used to it. I don't know how to answer that question. I don't feel anything. Do you have a chart with feelings that I could look at? What do people usually feel? I'm not angry. It wouldn't do any good to get angry at him.

WHAT CONSTITUTES AN EMOTION?

I find that patients often have difficulty distinguishing between experiencing the physical sensation of anger inside of their bodies and discharging their anger externally by "kicking and screaming." Many patients are cognitively aware of feeling angry, and of the impulse to kick or scream, but frequently patients are disconnected from the physical manifestation of anger in their bodies. Yet, a feeling without a physical sensation is just a disembodied thought.

WHERE DID ALL THE FEELINGS GO?

Many of our patients grew up with less than secure attachments to their primary caretakers due to a parent's mental illness, chronic pain, separation, death or abuse, which all caused painful feelings. Many of

our patients did not have a loved one showing them how to process basic emotions, thereby teaching them to auto regulate difficult feelings. When it did not feel safe to express anger or sadness, patients learned to avoid them and bury them deep in the unconscious.

WHAT DOES IT MATTER?

If patients void themselves of emotions, they tend to feel disempowered, stuck or empty inside. How many of our patients smilingly report that they shut down their anger, hate feeling pain, push away their feelings, or avoid them by overthinking, overeating, using drugs, sex, or alcohol. However, defending against feelings comes with a price as it causes symptoms and presenting problems. While splitting off feelings allows patients to cope with difficult experiences, it causes suffering in the form of anxiety and unconsciously avoided closeness and intimacy.

HOW DO WE HELP PATIENTS TO RECONNECT WITH THEIR EMOTIONS?

In my own practice, I love working with emotionally focused, experiential therapy modalities, i.e. Emotionally Focused Couples Therapy (EFT), Intensive Short Term Dynamic (individual) Psychotherapy (ISTDP), and Interpersonal (group) Psychotherapy.

My favorite modality is *Emotionally Focused Couples Therapy* following my externship with its founder Dr. Sue Johnson, in Toronto last year, as well as a recent post externship training on working with couples with a trauma history. It is so moving and

rewarding to see patients who come to me feeling lonely and stuck in negative interactional patterns, manage to drop below their defensive anger to underlying attachment fears and longings. For the first time, a wife takes a risk and shares with her husband that when she blames, criticizes or attacks him, she worries whether she matters to him and whether she can depend on him, all she wants is a hug. I am touched to witness the husband, who would previously shut down or get defensive (because he believed that he was never going to be good enough), softening and reaching for her.

In my emotionally focused individual therapy, in particular when drawing on *Intensive Short Term Dynamic Psychotherapy*, I find that patients have the biggest "aha" moments when they experience glimpses of difficult feelings in session, in the transference. Many patients are terrified that their "anger dam" might break and unleash a tsunami, or that they might get forever depressed if they connected with their grief. The shift is amazing when patients have the courage to "lean in," and, unlike during childhood, have someone there with them to hold the fear and pain. I have observed similar tender moments of therapeutic change in patients participating in *Interpersonal Group Psychotherapy*. It makes sense to me that Irvin Yalom's study of 20 "successful" group therapy patients that "learning how to express my feelings," and "expressing negative and/or positive feelings toward another member" were deemed the most salient therapeutic factors. I would like to close with an excerpt from Jelaluddin Rumi's poem "The Guest House," which offers a beautiful image of the therapeutic process:

"This being human is a guest house. Every morning a new arrival. A joy, a depression, a meanness, some momentary awareness comes as an unexpected visitor. Welcome and entertain them all! [...].

The dark thought, the shame, the malice, meet them at the door laughing, and invite them in."

Changing Faces of Leadership in Psychiatry



Eindra Khin Khin, MD

In an empirical report by Academic Psychiatry in August 2015, Doyle et al investigated the factors contributing to the discrepancy between the strong representation of female psychiatrists in residency and early-career positions and the relatively low number of female faculty in executive leadership positions. In their survey of psychiatry chairs at academic institutions, they found that only 10 percent of psychiatry chairs were female. In addition, they reported that the female chairs were more likely to perceive barriers in their career development, citing little or no mentorship, gender discrimination, and family obligations. Recognizing these common obstacles and more, many are calling for potential solutions to help foster gender equality in academic psychiatry. With

respect to this encouraging national trend, I am proud to say that our home institution is ahead of this curve. In our GWU community, female leaders have been prominently featured in various stages of leadership positions, starting with Dr. Paramjit Joshi as the Chair of the Department of Psychiatry and Behavioral Sciences at the Children's National Health System, Dr. Lisa Cullins as the Director of the nationally recognized Child and Adolescent Psychiatry Fellowship there, Dr. Cathy Crone as the Director of the Psychosomatic Medicine Fellowship at INOVA-Fairfax and the current President of the Academy of Psychosomatic Medicine, Dr. Julia Frank as our previous Director of Medical Student Education for nineteen years, our own Dr. Lisa Catapano as our Psychiatry Residency Director, and many more.

On October 22, 2015, I had the privilege of witnessing Dr. Darlinda Minor, one of our current chief residents, receiving the honor of Rapoport Fellowship at the American Academy of Psychiatry and the Law, the highest honor awarded to the most promising residents going into the field of Forensic Psychiatry. As she stood, tall and proud as the only female recipient of this honor in 2015, amongst her all male co-recipients, I couldn't help but be reminded of the study by Doyle et al. Yes, the tide is indeed turning. I feel very encouraged to see not only the current female leadership figures in the field of psychiatry, but also the rise of the next generation's female leaders. I am excited about the opportunity to become part of this movement for myself, for my female colleagues, and for all of my female trainees.

Reference:

Doyle M, Pederson A, Meltzer-Brody S. Demographic and Personal Characteristics of Male and Female Chairs in Academic Psychiatry. *Acad Psychiatry*. 2015 Aug 26. DOI

Sanity and Survival: Grand Rounds Summary

Allen Dyer, MD, PhD



In 1982 psychiatrist Jerome Frank republished his classic work *Sanity and Survival in the Nuclear Age*. Thirty-three years later, psychological aspects of

war and peace are no less urgent then they were in the Cold War, and the prospect of the global terror threat (even with nuclear arms in the wrong hands) deserves careful attention.

Sanity and Survival was the subject of our grand rounds on November 12. Ibrarhim al Jaffrey, prime minister of Iraq from 2005-2006, once observed to me, "Sometimes things get so bad, it takes a psychiatrist to sort them out." What does a psychiatrist

know that could make a difference? This is a question addressed to four of our junior faculty seriously interested in global health:

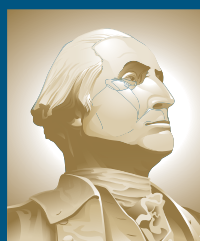
- Dr. Baiju Gandhi talked about Track Two Diplomacy, the informal people-to-people interactions, that have the goal of reduction or resolution of conflict, within a country or between countries, by lowering the anger or tension or fear that exist, through improved communication and a better understanding of each other's point of view".
- Dr. Veronica Sloodsky addressed the Israel-Palestine conflict by reference to "Abraham's funeral," a tradition that suggests that Abraham's sons, Ishmael, through whom Muslims trace their origins, and Isaac, one of the fathers of Judaism, were reunited after their father's death. She gave examples of rabbis and imams working for peace and reconciliation.
- Dr. Michael Morse, who has founded an INGO, Palestine Medical Education Initiative

(pmedonline.org), working in the West Bank and Gaza to improve mental health through community education projects, has pointed out that conflict can be understood as a pathological process, which can be addressed by physicians, through primordial, primary, secondary, and tertiary preventative interventions.

- Dr. Vanessa Torres-Lenza shared with us important specific information about cultural competence and how to perform a Cultural Formulation Interview. Various members of the audience made formative suggestions, which I will incorporate in my upcoming Fulbright project on Peace and Sustainable Development in Burundi. Notably, Dr. Karen Wooten explained the importance of respecting defenses in dealing with traumatic memories in order not to re-traumatize the person, and Dr. Pooja Lakshmin talked about Testimonial Therapy as a way of sharing the narrative in a de-stigmatizing community presentation ceremony.



DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES



THE GEORGE
WASHINGTON
UNIVERSITY

WASHINGTON, DC



The GW Medical
Faculty Associates

School of Medicine
& Health Sciences

THE GEORGE WASHINGTON UNIVERSITY

For patient appointments inquiries, please call 202.741.2888.

For residency inquiries, please call 202.741.2893.

gwdocs.com/psychiatry