

The GW Psychiatrist

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

THE CHAIR'S COLUMN

Dr. James Griffith

On the evening of October 11, we will celebrate the incorporation of the Washington Center for Psychoanalysis into our George Washington University Department of Psychiatry and Behavioral Sciences as a new academic division.

This is a momentous event for the WCP and our department, the fruition of negotiations that began in earnest two years ago but had been periodically discussed for over two decades.

The new affiliation between the WCP and our department is the only affiliation between a psychoanalytic institute and a psychiatry department that has occurred in recent history. Nationally, there have been three psychoanalytic institutes embedded within departments of psychiatry at Columbia University, New York University, and Emory University. In 2003, the Menninger Institute navigated a move to Baylor University after continued existence at its longstanding Kansas home became untenable due to changes in national health care economics. Unlike the Menninger move, creation of our GW-WCP affiliation has not been driven by duress, but by the promise of new vistas for joint educational and research programs that can fulfill core missions for both.

The rarity of psychoanalytic institutes within university departments of psychiatry can perhaps be explained by the emergence during recent decades of psychopharmacology and the descriptive diagnostic systems of DSM-III, -IV, and -V as dominant forces shaping the evolution of American psychiatry. A more important question, however, is why a rapprochement of psychoanalysis with academic psychiatry makes sense now. From my perspective, three reasons stand out.

First, the past 50 years of psychotherapy outcome research have firmly established that psychotherapy is among the most highly effective treatments in all of medicine with an effect size of approximately 0.8 in meta-analyses inclusive of multiple kinds of clinical problems and diverse patient populations. However, the active elements that contribute most to this effectiveness are those that engage a patient's subjective experience, such as the mobilizing hope, emotional attunement, and building a collaborative therapeutic alliance. Psychoanalysis and psychodynamic psychotherapy remain our major therapeutic methods for understanding, witnessing, and responding to a patient's subjectivity.

Second, psychoanalysis is an important method for conducting inquiry that tracks patterns of a person's lived experience within contexts of family, workplace, community, and culture. As such, a psychoanalytic perspective can add a depth of understanding to clinical treatment, psychiatric education, and the medical humanities.



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Third, the emergence of cognitive and social neuroscience provides methods for the scientific study of phenomenological observations that psychoanalysts have drawn from their patient's lives. Psychoanalysis, always strong in generating hypotheses but weak in empirically testing them, has gained a new route back into the world of medical science. Psychoanalytic methods lend themselves to mixed methods research in which functional brain imaging, the methods of empirical cognitive and social psychology, and psychoanalytic inquiry simultaneously can examine the same human behaviors, discovering "the patterns that connect" as Gregory Bateson would put it.

As a departmental Chair, I hope that the presence of the WCP will solidify a national identity for our psychiatry department as a center of excellence for psychotherapy practice, training, and research. In our mid-Atlantic region, we want to be the psychiatry department to which patients turn first when psychiatric symptoms have become treatment refractory or carry medical co-morbidities, because our clinicians can provide complex treatment programs that seamlessly integrate somatic, psychotherapeutic, and family or social interventions. However, our best accomplishments likely will be in medical education. WCP members on our clinical faculty already make vital contributions to teaching and supervising our residents and medical students. We anticipate new opportunities for residents to study within the educational programs of the WCP. We likewise hope that the resources of our department, medical school, and university open new opportunities for students and fellows of the WCP. We are excited that the WCP is now part of our department's identity as we face future challenges and opportunities together.

MESSAGE FROM THE RESIDENCY PROGRAM DIRECTOR

Dr. Lisa Catapano

Dear residents,

It is my pleasure to write this for our second Psychiatry Residents' Newsletter. We were very pleased at the success of our inaugural newsletter and are looking forward to using this as a vehicle to highlight significant events and accomplishments by and for our residents.



As we settle into the fall, hopefully, we are all adjusting to our schedules and duties for the academic year. It's an important time to take advantage of the less hectic periods of time at work to take a step back and remind ourselves of our overall goals for the year, and for whatever phase of our career we are in. It's often hard to remember to do this; as physicians we tend to be good at putting our heads down and blinders up, deferring short-term pleasures and long-term plans, and getting the work in front of us done.

This is a helpful skill to have in many ways, but it often comes at the expense of keeping an eye on long-term personal and career goals. So, if you find yourself at a time of relative stability and calm in your daily work, take a step back and remind yourself why you came to residency, and what you hoped to learn here.

For interns, you might spend some time contemplating the transition to your new identity

as a physician and psychiatrist, and try to get to know some other psychiatrists, to see what they are like and what they do. For mid-level residents, this is a good time to think about post-residency goals and how you might start pursuing them: invite a faculty mentor for coffee; contact a recent GW graduate who is in a fellowship or has a job you are considering; ask an attending to help you find an interesting case of [insert your particular clinical interest here] and help you write it up as a case report; identify a senior resident with similar career goals and ask them to sit down with you and share their knowledge and experience thus far. Some senior residents are, at this point, well into their post-graduation planning, and others are just starting. For all residents towards the end of their training here, at some point in the coming months it may be useful to take a step back from job planning and fellowship interviews, review one's goals for residency, and consider how best to take advantage of the last months of training here.

For all of us, at every stage of our career, there is a tension between attending to the daily details of work and to our big-picture career goals, just as there is a tension between meeting residency requirements (or performing reimbursed clinical work) versus doing an extra, interesting, and fulfilling project on the side. Taking a step back periodically allows us to assess whether we're close to finding the right balance.

ANNIVERSARY OF RESIDENT WELLNESS PROGRAM***Dr. Eindra Khin Khin***

At the George Washington University Department of Psychiatry and Behavioral Sciences, resident, faculty, and staff wellness is an institutional priority. With this core value in mind, the Resident Wellness Program was first launched in November of 2012. Its mission is to support overall wellness and integration of professional and personal aspects of our lives by providing a more positive, supportive, educational environment, raising awareness of burnout and its symptoms, decreasing the stigma associated with admitting burnout symptoms, creating a proactive, strength-based approach to addressing them, and enabling the development of prevention and coping strategies.



Our Wellness Program takes a multi-dimensional approach, employing various tools to foster a sense of wellness and balance in our residents and faculty. Since its inception a year ago, a diverse set of monthly group activities have taken place that spans multiple domains: arts and culture (opera, movie, cultural festival), fitness (yoga, biking, running, boot camp), health (nutrition counseling), and just plain fun (painting session, karaoke, salsa lesson)! As part of our Wellness Program, we also have in place individual-based, class-based, and residency-wide mentoring for our residents in a variety of settings, ensuring that everyone has a “go to” person who understands the stressors and challenges of academic medicine and supports growth and wellness. In addition, we offer a range of wellness resources on stress management as well as professional counseling.

While the responsibility of wellness lies with the individual, the value of having a department who champions wellness cannot be underscored enough. This enables physician self-care to be a part of the daily fabric of residency education and clinical practice for our residents and faculty.

<http://www.gwupsychiatry.org/resident-wellness.shtml>



CHIEF'S CORNER**Dr. Lori Kels**

As I write this column, I have just spent my second day in the Residency Fellowship in Health Policy. In our classroom in the Department of Health Policy on K Street, I found myself surrounded by 25 other residents and fellows in various medical specialties from different training institutions. I am struck by this unique opportunity to spend 3 weeks surrounded by my enthusiastic peers, immersed in lectures. We also get a chance to visit places that are so close to our department office, yet seemingly so far away in the average day of a resident and clinician: Capitol Hill, the AAMC, and think tanks across the ideological spectrum from the Brookings Institution to the Heritage Foundation to the Cato Institute, among others.

I remember my interest in this course as a residency applicant four years ago, and now find myself still excited to be a part of it. I couldn't



have known then that the opportunity to spend three weeks learning about and discussing policy would be even more memorable, and frankly even more fun than I imagined, because I am able to do this along side two of my fellow psychiatry residents.

As I look ahead toward the upcoming recruitment season, and I reflect on my own experience thus far at GW, I realize more than ever the importance of the wonderful people here. I believe that more than any great experience in our training (and there are many, starting with our first outpatient during second year, through Thursday morning psychopharmacology didactics, to name just a few), it's our residents, who have somehow all come together through the match or by transferring, who have made these past three years such a rich and rewarding experience.

It's an honor to be your chief resident this year, and I look forward to continuing to work with you all in the coming months. Thank you for all you do.

RESIDENTS IN PRINT

CBT In Palestine. Presented at the 2013 Conference of the European Association of Behavioural and Cognitive Therapy. Marrakech Morocco. Sept. 26, 2013. Authors include clinical faculty member Samah Jabr MD and resident Michael Morse MD, MPA.

Kels CG, Kels LH. (2013). "Medical Privacy After Death: Implications of New Modifications to the Health Insurance Portability and Accountability Act Privacy Rule." *Mayo Clinic Proceedings*, 88:10, 1051-1055.

Slootsky V. (in press). "Lessons About Childhood PTSD From a Conflict Zone in Israel." *American Journal of Psychiatry Residents Journal*.

Presentation. Sept 28, 2013. D'Silva S. The Healing Journey of Trauma Recovery. Torture Abolition and Survivor Support Coalition (TASSC). Monthly Community of Healing Meeting. Washington, DC.

Presentation. Mar. 2013. D'Silva S. Wellness, Mental Health and Cancer. ENHANCE (Head and Neck Cancer Support Group). Monthly meeting. George Washington University Hospital, Washington, D.C.

PARANOIA*Dr. Daniel Lieberman*

As a resident, I took call in the Bellevue psychiatric emergency room. It's a wonderful place. Our chairman used to call Bellevue the Noah's Ark of psychiatry. "If one exists," he said, "we have two."

But Mr. Jones was fairly ordinary. He showed up around 2:00 AM, homeless and disheveled. His thought process was broken, his affect was intense, and he was scared. The Secret Service followed him everywhere, he told me, and he needed protection. I gave him something better: an order for Haldol, and a trip upstairs to the inpatient unit. Easy case. I climbed back onto the stretcher in the hallway where residents sleep, and closed my eyes.

An hour later a nurse woke me up. Two Secret Service men were here, she said, and they wanted to talk to me about Mr. Jones.

If you're a New Yorker who mails threatening letters to the President of the United States, it's not irrational to worry about being followed by the Secret Service when the President gives a speech at the U.N. It's an annoyance people who suffer from certain kinds of mental illness have to put up with. Yet more and more, we're all having to put up with these annoyances. It's no longer just people who suffer from schizophrenia who sound paranoid. These days, it's everybody. You might worry about the government reading your email, or tracking your movements using the GPS in your cell phone, or running your Facebook posts through a thicket of algorithms to find out if you might be the enemy.

Maybe you worry about pictures of your license plate being snapped as you drive from place to place. They're date-stamped, time-stamped, and location-stamped, then stored with millions of others in a government database. The cameras that take them were supposed to be for catching speeders.

But what does all this have to do with the theme of this column: psychiatry and smart phones? Nothing, I hope.

Three weeks ago my phone upgraded itself to Android 4.3. Two weeks later, 26 apps alerted me that they had new versions ready to be installed. They had been updated to work better with the new operating system.

There was a long list. I tapped on the first one—TripIt—and was asked to agree to a new set of permissions. There were a lot. Among other things, the new version wanted to access to my address book. TripIt is a great app. (This column is supposed to be about recommending apps. So, there you go. TripIt). I tapped "Accept." I assumed TripIt wanted to see my address book so it could call my friends and family in case my plane crashed. Nice feature.

The next one was a note-taking app that wanted access to my microphone. The developers probably added the ability to record dictations. I tapped "Accept."

The next one was Pocket, an offline reader. Like TripIt, Pocket said it needed access to my address book. I deleted the app. Privacy-violating jerks.

There were 23 more. This was taking a long time. At the bottom of the list was a button that said "Update all." I hesitated. My finger hovered in the air above the touch-sensitive screen. I tapped.

We give away our privacy in return for security and convenience. It's the easy path of least resistance, and maybe it's best not to think about it. It's a personal decision. As psychiatrists, though, things get more complicated. It's not just about us anymore; we have a duty to protect the confidentiality of our patients. If convenience is at odds with this duty, we have a problem.

Your cell phone may be the most intimate possession you own. How much control do you have over it? Do you know which permissions you've granted your apps? Are there patient phone numbers in your call log? Which apps have access to the log? Which apps can turn on your microphone?

Do you know anything about the companies who made the apps on your phone? Are they reputable? Does it matter? Verizon, Google, Microsoft, and Facebook all gave the NSA access to the records of millions of their customers.

Do any of your patients work with classified information? Do any of them have reputations that could be harmed if someone found out they were seeing you? Are any of them journalists?

What should we do?

This column doesn't intend to answer that question—only to mark it as important. It's a hard question. Should we turn off our phones when we're with patients? I don't. It takes too long to restart. Is the duty to protect a patient's privacy absolute or relative? Perhaps convenience is a legitimate countervailing priority. Even when we treat public figures, we don't hire a security agency to sweep the office for hidden listening devices. It would be too much trouble and expense. And tin foil hats look stupid.

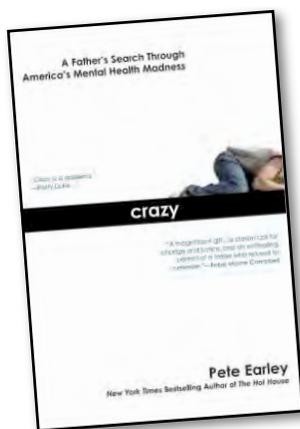
RESEARCH UPDATES IN THE DEPARTMENT***Dr. Michael Compton***

In addition to several ongoing projects on diverse topics, Dr. Michael Compton's research team has recently completed all data collection for his 5-year study of first-episode psychosis. A total of 252 first-episode patients were interviewed from a number of sites in both Atlanta and Washington, D.C., collecting extensive data. In the upcoming months, the team will be conducting analyses and writing papers on topics such as:

- The patients' "pathways to care," or the various help-seeking contacts along their pathway from the onset of psychiatric symptoms to their initial hospitalization for psychosis. Understanding pathways to care will help to develop better ways to identify and engage young people with an emerging psychotic disorder.
- The ways in which adolescent/premorbid cannabis use influences the early course of schizophrenia and other psychotic disorders. For example, the team will test its main hypothesis that adolescent/premorbid cannabis use is associated with an earlier age at onset (age at onset being a crucial early-course feature because it is a predictor of longer-term outcomes).
- The various sociodemographic, clinical, and environmental factors that are predictors of adolescent/premorbid cannabis use in young people who later develop a psychotic disorder.
- How a diverse set of "neurological soft signs" (a known trait marker in schizophrenia), measured by the Neurological Evaluation Scale, group together, and how first-episode patients within this sample might 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.

CRAZY: AMERICA'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS***A Book Review by Dr. Stefani Reinold***

Little did I know that a casual summer read on maternity leave would so profoundly impact me. In



Crazy, Pete Earley, author and father of a mentally ill son, magnificently captures the everyday struggles of not only the loved ones of those suffering from mental illness, but also the medical and legal systems' trials -- and at times, failures -- in the care of America's mentally ill. Utilizing his journalism

background, Earley researches the history of deinstitutionalization and beautifully articulates the need for patient reallocation in hospitals instead of jails. In this textual documentary, Earley begins with his own roots: his son. The book documents Earley's experiences with his son's first psychotic break and

subsequent journey with schizoaffective disorder. The personal account adds a sense of emotion that is so tangible to the reader, one cannot help but keep turning the pages.

Along with personal ad lib, Earley shares his research from interviews with the Miami county jail and the psychiatric issues at hand within the country's jail systems. He follows some real life families and their own accounts of how mental illness affected their lives and the lives of their families. He goes beyond limits to reach homeless people and rehab small groups to fully immerse himself in the madness of the world of mental health care in the United States. Most remarkable, though, is Earley's ability to touch the heart and soul of every reader, to not only humble us to understand that mental illness can affect any one of us, but also to inspire them to believe what Earley wholeheartedly believes: that we can all make a difference in the lives of the mentally ill.

GWU PSYCHIATRY RESPONDS TO NAVY YARD SHOOTING

Dr. Julia Frank

The psychiatry department played a significant and meaningful role in the GW Hospital response to the Navy Yard shooting on Sept 17, 2013. As soon as the hospital received notification of the emergency, it ordered partial activation of the emergency plan.

A command center was established, patients who could be discharged were identified, and patients in the emergency department were quickly evaluated. Within an hour, the hospital asked the psychiatry department to provide solace to the family of one of the victims, and Shana Palmieri and Lorenzo Norris responded to the call. Throughout the day, the department also supported case management in staffing a family resource center, which had been quickly set up to handle calls from people seeking information on missing family and friends.

In the end, the scale of the emergency was not as great as feared, and the city's and the media's information services were able to meet the need. But we can be justly proud that we had foreseen and were prepared to meet any challenges we might have faced, and may well have to face in the future.

As the department's representative to the emergency planning committee, I have repeatedly made the point that the psychological consequences of terrible events are likely to place demands on the hospital's psychosocial services equal to or even greater than the demands for technical resources.

The committee has been receptive to this argument and has incorporated our services into many aspects of the emergency plan, including provision of timely and targeted mental health information to victims or witnesses of disaster, creating a role for family support services, and offering follow up services should the hospital staff suffer severe stress in the process of responding to various kinds of emergencies. Whether the next one is a blizzard, a hurricane, a loss of power or water, or another terrible event, we are committed to being ready to meet the needs of patients and to support our colleagues in the vital work of restoring a sense of safety and peace to a disrupted community.

TECHNOLOGY

Dr. Sandeep Denduluri

My cousin recently was in town from Santa Clara for a data analytics conference -- he is a prototype MIT educated young Silicon Valley tech junkie. He was excited about a new company called Tableau Software. Tableau's website states that it "helps people see and understand data. Tableau helps anyone quickly analyze, visualize and share information."

1. Imagine a tremendously large XL spreadsheet generated by the hospital EMR with innumerable rows and columns consisting of various clinical, billing, operational, and other data sets
2. Imagine dragging that very large spreadsheet into Tableau's application just as you would an attachment file into an email
3. Tableau, as noted by the buzz makers, will generate a visual representation of statistically notable associations and trends in the best possible visual format to understand what that data means.

This is remarkable and only possible because of massive advances in graphics processing capabilities including virtualization of computing power through companies like VMware, which allows for on demand server/ computing power through the a defined data center.

Notable about the founder of this company is his background in visual design and computer science at Stanford. <http://www.tableausoftware.com/solutions/healthcare-analytics>. It is worth checking out some of the displays available. Regardless of the success of this specific company, extracting and elegantly displaying large sets of dynamic data with speed, low cost, and friendly design is an important trend in current informatics and its growth is assured by tremendous progress in the networking of computers and raw computing power.

If that doesn't convince you, perhaps a 132% increase in the stock price and company value of \$ 4.32 billion dollars since the May 2013 Initial Public Offering will.

MEDICAL STUDENT EDUCATION CURRICULUM REFORM*Dr. Julia Frank*

The department of psychiatry relies heavily on voluntary faculty to fulfill crucial roles in medical student education. Our students benefit greatly from the passion and dedication of faculty clinicians at far-flung sites, from people who lead sections of the psychopathology course, to those who serve as co-mentors in the practice of medicine course.

In the past two years, partly in response to the pressure to maintain our accreditation, and partly because of trends in medical education nationally, the medical school dean's office has been making a major push to streamline, rationalize and standardize the curriculum. In parallel, the administration has insisted on reducing lectures and promoting various forms of active learning. In the near future, students will also be assessed on how well they master specific learning objectives. In the fall of 2014, a new curriculum will be "rolled out", affecting the entering class of 2018. Changes to the second and third years will follow as that class moves forward.

Although many details remain unclear, the underlying principle of the new curriculum is the integration of basic sciences and clinical knowledge, with each segment organized around an organ system. Basic courses in anatomy, physiology, and pharmacology, for example, will disappear. Instead, each discipline will teach material relevant to a particular organ system, in a block course co-directed by a clinician. The biggest change for us in psychiatry is that the psychopathology course will be taught for the last time as a free standing, first year course, next spring. In the fall of 2015, psychopathology will be integrated with neuroscience in a block in the second year. The next big change is scheduled to occur in

the spring of 2016, when students will start their clinical rotations two months earlier than current students do. For the class of 2018 and beyond, the plan is to shorten the psychiatry clerkship to six weeks (the national average) and to try to give each student some mix of inpatient and outpatient experience.

Our challenge is to be sure that students in this curriculum do not lose sight of the whole person and the social context of illness. In some ways, we are ahead of the reform effort, since for years, we have been teaching behavioral sciences through exercises distributed across a curriculum based on clinical cases ("problem oriented/case based learning" or PCL). The curriculum will also continue to cover interviewing and professionalism, elements to which our faculty contribute in the Doctor Patient Society Groups. Without knowing the exact fate of PCL or DPS, we do expect to continue to play a substantial role in these areas.

Many other medical schools have implemented similar reforms. The impact on psychiatry education and recruitment is far from clear. It may be that providing more opportunities for active learning and involving students in patient care earlier will foster the curiosity and humanism for which recruits into our specialty are known. We will make every effort to offset the loss of formal curriculum time with experiences that inspire students both to integrate behavioral principles into their particular specialties -- and to inspire some of them to dedicate themselves to the fascinating science and endlessly absorbing tasks of providing psychiatric care in an evolving health care system.

FALL BIRTHDAYS**October 28**

Nicole Nguyen

November 1

Ross Goodwin

November 10

Jenny Yi

November 20

Karen Wooten

December 16

Sahana D'Silva

December 24

Darlinda Minor

**KUDOS & CONGRATS**

Kudos to Sahana D'Silva for winning 3rd place in the Annual Resident Essay Contest.

Congratulations to Stefani Reinold on the birth of her baby girl, Katherine Grace Reinold, on April 20, 2013.

Congratulations to Ross Goodwin and new wife Meghan on their marriage this May. They met Pope Francis on their honeymoon!

Congratulations to Sahana D'Silva and new husband Aaron on their marriage this June (and July). They shared 3 ceremonies -- first at his childhood home, then in a Methodist-officiated ceremony at the D.C. courthouse, and finally, in an elaborate Catholic "roce" and Hindu wedding in India.

Congratulations to Nicole Nguyen and new husband, Christopher on their marriage this October. They had an intimate Vietnamese American ceremony in Nantucket and ended the magical evening by releasing 50 wish lanterns into the sky.

SPECIAL WELCOME TO:*Faculty & Staff***Dr. Sermsak (Sam) Lolak, MD**

Dr. Lolak has joined the full time faculty as an Associate Professor of Psychiatry and will serve as Director of our GWU Hospital Consultation-Liaison Service. He will also direct the training of the Inova Fairfax-GWU Psychosomatic Fellows at our Foggy Bottom site.

At Stanford University School of Medicine, Dr. Lolak most recently served as Associate Professor of Psychiatry and Associate Director of the Consultation-Liaison Psychiatry Service at Stanford Hospital. Dr. Lolak brings to our residency program skill sets in mindfulness approaches to strengthening patients' emotion regulation, clinical hypnosis, bedside resilience-building psychotherapy, and neuropsychiatry, in addition to his expertise in psychosomatic medicine.

Nakia Hudgins

Ms. Hudgins is our new Residency Coordinator. She is a native of New York City, where she studied Fashion Merchandise Management at the Fashion Institute of Technology. She is currently pursuing a degree in Fashion Design. Since relocating from New York City, Ms. Hudgins served as a Counselor at several family service agencies in the DC Metro area with at risk youth and families. Previously, Ms. Hudgins performed as the Surgery Clerkship Coordinator at Howard University for several years before agreeing to join our team. She comes with many skills and much experience, and we are very happy to have her.

*Psychosomatic Fellows***Baiju Gandhi, MD**

Dr. Gandhi received his B.A. in Psychology and B.S. in Genetics from the University of Kansas, his M.D. from the University of Chicago Pritzker School of Medicine, and his M.P.P. from the Harris School of Public Policy. He completed his psychiatry residency at the University of Maryland/Sheppard Pratt and served as

Chief Resident for Consultation-Liaison Psychiatry during his fourth year of training. He is fluent in Spanish and Gujarati.

Neil Puri, MD

Dr. Puri received his B.A. in religion from Northwestern University and M.D. from Northwestern University Feinberg School of Medicine. He completed his general psychiatry residency at the Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center. Professionally, he is interested in inpatient consult-liaison psychiatry, medical education, and psychodynamic psychotherapy. In his spare time, he enjoys cooking, painting, museums, and live music.

Yu Dong, MD, PhD

Dr. Dong received her M.D. from Tianjin Medical University, and then spent 3 years studying stroke and reperfusion injury at Shanghai Medical University in China. She came to US and received a PhD in Neuroscience from Medical College of Ohio focused on GABAA receptor, benzodiazepine tolerance and epileptogenesis. Dr. Dong completed a postdoctoral training in Neuropharmacology at USUHS. Before joining her psychiatry residency at Baystate Medical Center/Tufts University SOM, she was involved in a large NIH sponsored, multi-center genetic depression study.

*Residents***Jason Emejuru, MD**

A native of Virginia, Dr. Emejuru completed his undergraduate and medical training at Virginia Commonwealth University. He graduated with his medical degree in 2012 and completed his intern year in Pediatrics at Tulane University. He has a considerable record of community involvement and legislative advocacy for children's interests, and has elected to transfer to our psychiatry training program in order to pursue his interests in child and adolescent psychiatry, consult-liaison psychiatry and global mental health.

*Researchers***Anthony Crisafio, BA**

Mr. Crisafio is now serving as a full-time Research Associate (since Thomas Reed's departure in order to start medical school here at GW). He graduated from GW with a degree in psychology, and has extensive experience as a mental health technician on 6-South. He will be working closely with a number of Core Service Agencies (CSAs) and local inpatient psychiatric units to collect extensive data from patients with serious mental illnesses for our new NIMH-funded research project examining linguistic abnormalities in schizophrenia.

Yazeed Alolayan, MD

Dr. Alolayan is a full-time Research Fellow spending a year with us as part of the GW International Medicine Program. Yazeed is currently applying for residency positions in psychiatry. We are very excited to have him with us for a year. He will be working on a number of our research projects, including one focusing on the problem of food insecurity among individuals with serious mental illnesses, another on neurological soft signs in patients with first-episode psychosis, and another on linguistic abnormalities in schizophrenia.

*Washington Center for Psychoanalysis***Roberta Sorensen**

Ms. Sorensen, COO of the Washington Center for Psychoanalysis, has been an association executive for more than thirty years and has a CAE (Certified Association Executive) designation from ASAE. She worked for the Labor and Human Resources Committee in the US Senate, for the American Medical Association, and as a lobbyist and manager of policy for the College of American Pathologists. She has served as Executive Director of both the Medical Society of Northern Virginia and the Westchester County, New York Medical Society. "Bobbi" has a graduate degree from George Washington University, and she is the mother of two daughters who

also graduated from GWU.

Christine Pembroke

Ms. Pembroke has been with the Washington Center for Psychoanalysis since March 2012. She works part-time supporting admissions to Center programs, handling accounts receivable and accounts payable, and in other areas. She has an undergraduate degree from the University of Vermont and post undergraduate degree from George Washington University.

Kelly Pearce

Ms. Pearce is Website Administrator for the Washington Center for Psychoanalysis. She received a Bachelor of Arts in Art History from American University in Washington, DC. Kelly spent the majority of her career in the DC area, although she did have the experience of living in England for a few years prior to joining the Center. Kelly currently works remotely from Virginia, where she lives with her husband and their two children.

UPCOMING EVENTS

Thursday, October 10

Grand Rounds: "Psychoanalysis in the Wider World"
--Cynthia Stevens, MD

Thursday, October 10

INOVA Fairfax-George Washington University
Psychosomatic Fellowship Open House

Thursday, October 17

Grand Rounds: Hospital Morbidity and
Mortality Case Conference
--Lorenzo Norris, MD

Thursday, October 24

Grand Rounds: "Rapid and Sustained Antidepressant
Effects of Ketamine: Neurobiological
and Therapeutic Implications"
--Mark J. Niciu, Jr., MD, PhD

Thursday, October 31

Grand Rounds: 20th Annual Seymour S. Perlin, MD
Lecture On Suicidology
"Why People Die By Suicide"
--Thomas Joiner, PhD and Robert O. Lawton

PROFESSIONAL MEETINGS

October 22-27, 2013

American Academy of Child and Adolescent Psychiatry Annual Meeting
Orlando, FL

October 24-27, 2013

American Academy of Psychiatry and the Law Annual Meeting
San Diego, CA

November 13-16, 2013

Academy of Psychosomatic Medicine Annual Meeting
Tucson, AZ

February 13-14, 2014

American Psychosocial Oncology Society Annual Meeting
Tampa, FL



Congratulations to Stefani and her husband on the birth of their beautiful daughter, Katherine Grace



Congratulations to Ross & Meghan on their wedding in May 2013



Congratulations to Nicole & Chris on their wedding in October 2013

CONTRIBUTORS

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Thank you to all who contributed to this issue of the GW Psychiatrist. To support the newsletter or contribute for the Spring 2014 issue, please contact gwpsychnewsletter@gmail.com