

Residents' Journal

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Contents

Global Mental Health: An International Perspective on Local Challenges	
Nomi Levy-Carrick	1
Transcultural Reflections on the Stigma of Mental Illness in Pakistan	
Nauman Ashraf	2
Bipolar Disorder as Culture-Bound Syndrome: A Book Review	
Helena Hansen	3
Conducting Mental Health Research in Rwanda: A Resident's Experience	
Anna Yusim	4



Global Mental Health: An International Perspective on Local Challenges

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The World Health Organization (WHO) will formally launch the Mental Health Gap Action Programme on Oct. 9, 2008, providing an action plan to “scale up services for mental, neurological and substance use disorders for countries especially with low and lower middle incomes...[by] building partnerships for collective action and...[reinforcing] the commitment of governments, international organizations and other stakeholders” (1). It is thus an appropriate moment to consider what it means to express an interest in global mental health, particularly in the midst of residency training.

First, it signals an appreciation for the impact mental health has on communities and economies throughout the world. Neuropsychiatric disorders account for 12%–14% of the global burden of disease—second only to infectious disorders (23%), and more than AIDS, tuberculosis, and malaria combined (10%) (2). Estimates by WHO in 2002 suggest that 154 million people globally suffer from depression, while 25 million suffer from schizophrenia, 91 million from alcohol use disorders, and 15 million from drug use disorders. Another 50 million suffer from epilepsy and 24 million from Alzheimer’s disease and other dementias (which accounts for many of the patients among the neuropsychiatric designation in these estimates.) About 877,000 people die by suicide worldwide every year (3).

WHO highlights that “mental illnesses affect and are affected by chronic conditions such as cancer, heart and cardiovascular diseases, diabetes and HIV/AIDS. Untreated, they bring about unhealthy behavior, noncompliance with prescribed medical regimens, diminished immune functioning, and poor prognosis” (3). Put another way, there is “no health without mental health” (4). As physicians, we face the challenge of treating patients as people, addressing their mental health needs in the context of their overall health. This

interplay between medical and mental health care has also been emphasized in reports by Doctors Without Borders/Médecins Sans Frontières: “The integration of both physical and mental health messages in the communities [leads] to a better understanding of health and the relationship between physical and mental aspects in the community” (5). A convincing model for various levels of psychosocial integration in primary health care settings has also been outlined and implemented in many operational programs (5).

The treatment gap between need and care is significant. As part of WHO’s call for action, a recent *Lancet* Global Health Network series was introduced focusing on global mental health, noting that “every year up to 30% of the population worldwide will suffer from some form of mental disorder, and at least two-thirds of those receive inadequate or no treatment, even in countries with the best resources” (6).

The Same and Not the Same

Global mental health programs have received serious international attention over the past decade. One of the starting points was the WHO International Consortium in Psychiatric Epidemiology in 1998, which shortly thereafter launched the WHO World Mental Health Survey Initiative. Also, Project Atlas was launched in 2000 to map mental health resources around the world, and its findings were published in the “Mental Health Atlas 2001” and again in 2005. These efforts document the variability in resources available both within and throughout the international community. The seeming absence of progress subsequent to the publication of these reports highlights the formidable challenges of translating policy statements into programmatic realities.

Moreover, recent studies have taken the veneer off the notion that there is necessarily a better

prognosis for schizophrenia in the developing world (7). For example, the confluence of extended family care and stigma can lead to significantly increased durations of untreated psychosis, which is associated with increased levels of severe global disability. The imbalance in research available in lower- and middle-income countries (in comparison with that available in higher income countries) is formidable, and may have contributed to this longstanding and accepted—but in some important ways, inaccurate—characterization (8). It is also a sober reminder of the role that cultural competency plays in assessing the interethnic and intersocietal diversity that contributes to treatment gaps, even in high-income countries.

What Kind of Action? Commitment to Whom?

Psychiatry residents are generally trained to focus on mental illness in the individual patient's pathology, as defined by DSM-IV criteria. It is important to recognize the increased ambition implicit in focusing on mental *health* rather than mental *illness*. According to WHO, mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (3). This challenges policy makers to concentrate on issues beyond the more "reactive" realms of responding to natural disasters, complex emergencies, and other trauma-based events. Rather, it charges countries with establishing frameworks for more proactive programs to "prophylax" populations from the effects of these traumas, and then to look beyond these psychoeducation-based interventions to provide mental health care to all patients, not least those in resource-poor settings. Possible interventions include the incorporation of some mental health services in the primary care sector, establishing referral networks and humane tertiary care facilities for the chronically mentally ill, and addressing substance abuse issues, suicide preven-

tion, and other special programs. Integral to all these efforts is a need to address the formidable effects of stigma (working with the media to reduce it), human rights (working with legal groups and governments to preserve them), and mental health policy overall (including advocacy, promotion, prevention, treatment, and rehabilitation).

Implications for Trainees

What does all this mean for an American psychiatry resident? Ultimately, international initiatives succeed only as a function of the cumulative achievements of local programs. Mental health treatment principles are the same throughout the world: differential diagnosis, treatment plan, treatment implementation (including medications for severe psychoses), and psychosocial treatments. The challenges—of adherence, stigma, or cultural issues—also exist in countries of every income level. The differences internationally are generally those of availability of services, medications, and psychosocial treatments. It can be instructive, for example, to be mindful of what one's armamentarium of medications would be if using only those on the limited WHO Model List of Essential Medicines—for psychosis: chlorpromazine, fluphenazine, and haloperidol; for depression: amitriptyline and fluoxetine; for bipolar disorder: carbamazepine, lithium carbonate, and valproic acid; for generalized anxiety and sleep disorders: diazepam; and for obsessive-compulsive disorder and panic attacks: clomipramine (9). Consider also principal areas for action in mental health policy: who is financing your patient's care? How does legislation and patient rights influence their admission and the organization of services offered? What human resources and training are necessary to provide adequate care? What cultural issues come into play in coordinating care? What areas of quality improvement would most affect the course of their management? What information systems have facilitated (or impeded) your management? How could you advocate better for their

care? And what would guide your research or evaluation of their treatment outcomes? These same questions apply in local, national, *and* global realms, and the hope is that a solid foundation in the former will translate into meaningful involvement in the latter.

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Transcultural Reflections on the Stigma of Mental Illness in Pakistan

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More industrialized societies are beginning to view mental illness as just that—an *illness*. However, in less industrialized societies this is not the case. As an international medical graduate, I have seen this first-hand.

I come from Pakistan, where mental illness is largely seen as a product of inhabitation by evil spirits or supernatural powers. Patients are very rarely brought to psychiatrists early in the course of illness and are usually treated by nonmedical

persons. Patients seek treatment from a *Baba Ji*, *Sufi*, or various shamans, who provide "treatment" in the form of purification rituals, ingestion of herbs, and exorcisms (1). Psychiatric patients are frequently labeled as "mad" by Pakistani society and permanently abandoned by their family members. I witnessed this in my fourth year of medical school when a patient with paranoid schizophrenia was successfully treated with medications only to be rejected by his family upon discharge. The family's

rejection ultimately led to the patient's relapse and readmission. The patient's mental illness was thought to reflect on the entire family's honor. Furthermore, the family lived 3 hours away from the nearest psychiatrist and did not have ready access to psychiatric care in case the illness recurred. The dishonor brought upon the family and the lack of access to care ultimately led to the family's rejection and abandonment of this patient.

There is a severe shortage of psychiatrists in Pakistan, with only 350 trained professionals for a nation of 150 million people. Surveys have shown that very few Pakistani medical students are interested in this field (2). In my medical school class of more than 400 students, only 4 or 5 planned to enter the field of psychiatry. Yet the need for psychiatrists continues to grow. Rates of suicide in Pakistan have increased from a few hundred before 1990 to almost 7,000 in 1996, which is probably an underestimate given the legal, sociocultural, and religious sanctions against suicide.

In the major cities of Pakistan, such as Hyderabad, where I attended school, more educated people have started to recognize the biological basis of psychiatric problems. But the majority of Pakistanis live outside these urban areas. The magical-religious model of mental illness previously discussed contrasts with the biopsychosocial model prevalent in the Western world, where the stigma of mental illness has decreased over the years (3). But even in the

Western world, mental illness is still not considered just another disease of the body, like a fractured hand or myocardial infarction. People suffering from mental illness may believe they have a “disease.” But mental illness often brings with it a sense of shame, guilt, and stigma for both the patient and family that is rarely seen with somatic ailments. As a result, people may avoid seeking treatment.

There was a time when people did not want to be seen wearing glasses, but awareness and education have mostly removed this stigma. Some factors associated with the decrease in stigma surrounding mental illness include education about the illness, an understanding of the biochemical and genetic basis of psychiatric disease, policies that encourage mentally ill patients and their families to seek professional help, culturally appropriate diagnostic tools and treatment options, and adequate access to care in rural and urban regions. Another factor which has contributed to this increased tolerance and decreased stigma is

celebrities who openly discuss their own struggles with mental disorders in the media. A change toward increased awareness will not only help more people become involved with the care of mentally ill patients, but will also increase the support available to them from family and society. This support is of the utmost importance for a mentally ill patient.

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Bipolar Disorder as Culture-Bound Syndrome: A Book Review

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Bipolar Expeditions: Mania and Depression in American Culture, by Emily Martin. Princeton, NJ, Princeton University Press, 2007, 400 pp., \$35.00.

If Kay Jamison, who argued that bipolar disorder fosters creativity by retrospectively diagnosing famous artists and authors in history (1), helped to usher an era in which mania is valorized, Emily Martin might be the anti-Kay Jamison. Both Martin and Jamison write from the vantage point of their own diagnoses, but that is where the parallel ends. Rather than asking how bipolar disorder fosters creativity, as Jamison does, Martin issues a sharp critique by asking how bipolar disorder itself works as a concept in popular culture, and what uses the increasingly widespread concept has in contemporary American society.

Emily Martin is an award-winning medical anthropologist of renown among social science and humanities scholars. With the publication of *Bipolar Expeditions: Mania and Depression in American Culture*, she turns from her previous subjects of inquiry (women’s physiology, immunology) to the problem of bipolar disorder, applying her formidable skill to unearth how the details of clinical practice reflect popular culture.

An ethnography that interweaves self-reflection with interviews and observations of bipolar support group members, clinicians treating bipolar disorder, and pharmaceutical marketing professionals, Martin’s book does not recognize bounda-

ries. Like a psychotic person, it breaks down the distinction of self and other; it does not respect private property. And private property is precisely what the book takes on.

In *Bipolar Expeditions*, Martin uses herself to challenge the idea that living with the diagnosis of manic depression is an intimate, personal affair. She cannot keep her own diagnosis within the confines of her psychiatrist’s office; at every turn she shows how her experience affects her students, her colleagues, and her written and spoken words. She wrestles out loud with standing “in a doubled position” as a person who uses psychopharmacology and therapy, but also questions their historical and cultural significance. As a member of the support groups about which she writes, she offers her story in order to replace “secrecy and fear” around the stigma of mental illness with “collective responsibility.” At the same time, she avoids glamorizing the diagnosis as a famous anthropologist coming out as bipolar. She points out that the bipolar creativity portrayed in the media is one that furthers the status quo rather than challenging it. Moreover, she documents how the creative potential of the people in her study is hindered rather than helped by bipolarity.

Martin shatters common sense distinctions of public and private, individual and communal. In the process, she makes sense of what may seem counterintuitive on the surface: the conscious self-presentation and sociality of people living with the diagnosis of manic depression. As Martin puts it,

even a “mad” manic can be social.

Manic people, she points out, are conformist: they engage, they gravitate to others; as producers they are “tightly bound to social conventions” and “innovative...in terms the market can value” (p. 259). They are disruptive because they are social to excess: in their pursuits and seduction they invade, they irritate. Depressed people withdraw, but as they descend it is impossible to do so without others noticing. As they become so depressed that they are not able to carry on everyday life, it becomes obvious to all, and all are moved in some way. In both mania and depression, disrupted social rhythms call attention to the sufferer; they bring about a *lack* of privacy. Mania and depression are enacted through social relations, like those in the support groups that Martin describes.

It is an irony that something as private as mania or depression has such a social impact and is experienced through social connections. The “privacy” of the psychotherapeutic cultural model that Americans have for dealing with relational problems is unique: traveling great distances to consult in a sound-proofed room with someone chosen because he or she does not know anyone we know and can guarantee confidentiality. Consider how different the model is from the majority of non-European societies, where relational problems are mediated collectively in the community. Perhaps psychiatrists help to sustain a myth of privacy (of industry, property, individual psyches). Yet each of us brings our personal history

to the present, and this history is created by our experience of other peoples' emotions and realities. In that sense, no act of consumer choice, foreclosure, plant construction, or pharmaceutical advertisement can be private.

Martin exposes a second irony of manic depression. The American media has propagated the idea that the mood of the economy, in particular the stock market, reflects the mood of individual consumers and investors as it cycles between extreme optimism and risk-taking on the one hand and pessimism and withdrawal on the other. But the media has not shed light on the ways that the economy itself *creates* individuals with mood disorders. Using examples ranging from magazine advertisements that portray Ted Turner's bipolarity in order to boost his image with stockholders to stockbroker training programs that teach new traders to "be hypomanic," Martin argues that bipolarity is symbolically cultivated as a heroic property. In the new millennium, bipolarity has become a way of seeing the world, a way of making sense of individuals, making sense of markets, and a way of demonstrating one's value.

Martin's argument about bipolarity builds on a literature that has historically linked psychiatric diagnoses to the ethos of their time. A version of this history, reproduced by people as varied as David Healy (2), Nikolas Rose (3), and Jonathan Metzl (4), is that post-WWII psychiatry offered the metaphor of anxiety disorder and the panacea of benzodiazepines to a generation obsessed with insecurities about the Cold War and changing gender and race relations. In the 1980s, with the introduction of Prozac, an aggressively marketed selective antidepressant free of the side effects of earlier antidepressants, the psychiatric metaphor shifted from anxiety to depression. The Prozac generation of baby boomers confronted the decline of American colonialism and hit the limits of economic expansion. At the same time, physicians' diagnostic patterns shifted just as dramatically from anxiety to depression, with an eightfold increase in antidepressant prescriptions written between 1990 and 2000 (3).

Martin describes the third wave: the bipolar generation. Thrust into broadband speed by the Internet and hardened by booms and busts, from dot-coms to the war on Iraq, this generation's economy demands improvisation, risk-taking, and perpetual motion. Martin's astute observations go beyond metaphor. Like the Indian theater she references, one can create the "conditions that excite a mood" rather than locating moods in individuals. In other words, mental illness may not necessarily come from deep within; it may be overdetermined by the setting that directs its performance.

The shift to the psychiatric metaphor of bipolarity in the market has been accompanied by an expansion of the diagnosis and treatment of bipolar disorder in actual clinics. A standing joke in my department involves attendings in whose care every patient ends up diagnosed with bipolar disorder. Variations on the diagnosis of bipolar disorder are proliferating, such as the new category of "pseudounipolar depression" in those patients with no manic or hypomanic episodes but who report irritability with depression, often accompanied by a family history of bipolar disorder; these patients are thus prescribed mood stabilizers.

In addition, the diagnosis of bipolar II disorder, which does not require patients to meet full criteria for a manic episode, is leading young psychiatrists to rediagnose many people who have long been diagnosed with depression. Psychiatrists cite studies indicating that a number of patients mistakenly diagnosed with depression were actually sent into a manic episode as a result of taking antidepressants without mood stabilizers. It is striking that currently, patients on the inpatient service in my hospital are rarely discharged on an antidepressant alone. These days, most leave with some form of mood stabilizer or antipsychotic. Among prescribers, there is a mania about the risk of causing mania with antidepressants. As a result, doctors prescribe bipolar medications. Does the fact that Lamictal was patented until this year have anything to do with this? What about the fact that second-generation antipsychotics, such as Seroquel

and Zyprexa, whose patents both expire in 2011, are approved by the U.S. Food and Drug Administration and promoted for use in bipolar disorder?

Products create consumers, and new diagnoses create patients. The market literally has turned bipolar, with Seroquel (\$2.76 billion/year in revenue), Lamictal (£0.8 billion/year), and Zyprexa (\$2 billion/year) named the top three profit makers for pharmaceutical companies in 2006 (5,6). Martin calls for psychiatrists' vigilance regarding the social effects of diagnosis, writing, "The authority behind the act of naming means that the person will be treated as if he or she had the condition; this is the sense in which the act of diagnosis is performative" (p. 148).

If we attempt to take Martin's social analysis to its logical conclusion, what does all this mean? Her book gives us some clues. Bipolarity serves certain purposes in the market. Bipolar disorder is sold to Americans as a problem of self-regulation, of impulsive decisions in an era of too much choice. The irony is that the marketing industry within popular media is so advanced, as a technology of social manipulation, that bipolarity is ever more predetermined.

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Conducting Mental Health Research in Rwanda: A Resident's Experience

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This past March, I embarked on a 3-week research trip to Rwanda, sub-Saharan Africa's most densely populated country that has attracted international attention for its cataclysmic genocide of 1994. With the majority of the nation's 9.2 million people living in rural areas and engaged in subsistence agriculture, this mountainous country is aptly called "land of a thousand hills." With the generous support and guidance of Dr. Dolores

Malaspina and the New York University Department of Psychiatry, my trip was undertaken in the context of research planned by Dr. Richard Neugebauer at Columbia University's College of Physicians and Surgeons.

As a nation watched almost one million of its people killed with machetes and short-range firearms over 3 horrific months, the mental health consequences of the Rwandan genocide were

prominently felt throughout the nation. Among the many pervasive hardships of Rwanda's civil war, the civilian populations experienced severe bereavement, refugee exodus to the Congo (formerly Zaire) and Tanzania, and extensive social and cultural disruption. The severe trauma afflicting civilians and the persistence of unpredictable threats in the years to come subjected a substantial proportion of the Rwandan people to

post-traumatic stress disorder (PTSD), depression, and other psychiatric disorders related to violence and loss of life.

The purpose of our study was to gain a better understanding of the views of Rwandan health professionals and government officials on mental health challenges following in the wake of the genocide. We were also interested in assessing whether Rwandan clinicians recognized the types of grief reactions that are described in Western psychiatric nosologies.

To explore these areas, we used audiotaped interviews with key clinicians, mental health leaders and government officials in Rwanda. During my trip, I was able to interview 14 such individuals, including Rwanda's senior psychiatrist, the head of Rwanda's single neuropsychiatric hospital, the prison chaplain (who is responsible for the mental health of the perpetrators of the genocide, or the "genocidaires," as they are called), numerous primary care physicians, and several heads of nongovernmental organizations focusing on the mental health needs of genocide survivors. I was aided in all my interviews, which generally lasted 1-4 hours each, by a translator in French and Rwanda's native language of Kinyarwanda. In accordance with a structured interview, interviewees were asked questions about general mental health policies and practices in Rwanda, the types of clinical problems that a health care professional tended to see in her/his caseload, and general views about how mental health, psychosocial, and adjustment problems have changed since the genocide.

Through my short experience in this beautiful country, I began the process of obtaining answers to the aforementioned questions. But what I learned went far beyond the structured interview.

In speaking with the Rwandan people, I was reminded of the power of the human spirit to overcome any obstacle life may place in its way. I saw people whose fathers, mothers, sisters, brothers, sons, and daughters were violently killed before their eyes 14 years ago. I saw women who were raped repeatedly during the war and who are now living with HIV and/or the children they conceived as a result of the rapes. I saw the highest percentage of orphans and widows that exists in any nation of the world. These were among the atrocities. But there was more. I saw a most vulnerable people who had found within themselves the courage to step beyond the darkness of their past and rebuild their lives with strength and integrity. I saw an amazing man, one of my interviewees, who after many years of struggle found it in his heart to forgive the killer of his own mother because he could not carry the pain, anguish, and vengeance within his heart any longer. I saw families who had adopted 10 orphans after the children's birth parents were killed in the genocide. And of all the spectacular things I saw, what amazed and impressed me most was the Rwandan people's capacity to forgive the perpetrators of the genocide and move forward with their lives.

One of my most striking interviews was with the prison chaplain, the individual primarily responsible for the mental health issues of the prisoners and genocidaires. When we think about mental health in Rwanda, we sympathize with the genocide victims and vilify the perpetrators, believing them to represent the basest form of the human potential. But what I learned in my interview is that the genocidaires were often victims as well. Raised in a society where authority was never questioned, education was limited, and

independent thought was discouraged, it is not surprising that when the nation's leaders ordered the Hutus to kill the Tutsis, the Hutus unquestioningly complied. Hutus killed their Tutsi neighbors with whom they had grown up and lived side by side their whole life. Hutu church leaders killed their Tutsi congregation. Hutu fathers even killed their Tutsi wives and children. These people were driven by the terror and fear instilled in them by the authorities above. If a Hutu refused, he or she ran the risk of being seen as a traitor and also killed. Now, after many years of incarceration, many genocidaires are suffering from the same PTSD as the genocide victims. As they sit behind bars for years in Rwanda's overcrowded prisons, they recount their deeds and realize for the first time that they had a choice 14 years ago, a choice they did not recognize at the time. When ordered to kill, they could have refused. They may have lost their lives in the process, but some of the prisoners now wonder whether this may have been better than a life behind bars for unspeakable deeds.

As a young American psychiatry resident embarking on a research project in Rwanda, I approached this endeavor with as few expectations and preconceptions as possible. First and foremost, I came to Rwanda to learn. In the end, I learned a great deal more than I ever expected. In addition to learning about the nation's mental health problems, I learned about human strength and dignity, and the power of a nation and its people to rebuild themselves after everything for which they had once stood had been destroyed. I returned to the United States deeply humbled and inspired, feeling a strong connection to Rwanda, and hoping to return to the land of a thousand hills again in the near future.

Committee of Residents and Fellows

The Committee of Residents and Fellows (CORF) is a permanent standing committee of APA. The Committee is composed of seven psychiatry residents, each representing one of the seven geographic areas into which APA divides the United States and Canada. Additionally, representatives from APA's three fellowship programs participate as active members. Each member is nominated by his/her residency training program and serves a 3-year term.

Since 1971, the Committee has represented resident opinions and issues within the Association and has established effective and meaningful liaisons with many components of APA, as well as with many other organizations that are involved in training and the profession.

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Are you getting the full story? In addition to this online edition of the Residents' Journal, there is an e-mail portion delivered each month. This month's e-mail highlights olanzapine treatment for anorexia nervosa and pharmacogenomics in the treatment of breast cancer and depression.